

The Ububele Baby Mat Project: A Brief and Cost-Effective Community-Based Parent-Infant Intervention

By

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Abstract

This paper articulates our ongoing thinking about the Ububele Baby Mat Project – a community parent-infant mental health intervention currently offered at four primary health care clinics in and around Johannesburg, South Africa. We present the project as it exists currently and discuss three themes of mothering pertinent to our context. Other in situ factors, such as our therapeutic stance and two person treating team are introduced and briefly discussed. Our use of concepts such as holding, containment and the infant as subject are described in reference to a case vignette that illustrates the themes of mothering and the form of our Baby Mat intervention.

Introduction

The Baby Mat Project is a brief (mostly once off) community-based parent-infant intervention offered by Ububele, a non-profit mental health training institute in Johannesburg, South Africa. It forms part of a larger project called the Ububele Umdlezane Parent-Infant Programme (UUPIP). Umdlezane is an Nguni term that refers to the time, post-partum, when a mother's relationship with her baby is prioritized by other women in the family. These women manage the practical concerns in the home so that the mother can be most available to her newborn child.

The history, conceptualisation and initiation of the Baby Mat is outlined in Frost (2012). It is a project that was developed in response to the need for brief and cost-effective interventions in South Africa. Central to the successful



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implementation of the Baby Mat intervention were many socio-cultural contextual factors specific to South African community settings. These factors were important in gaining access to mother-infant dyads in the communities in which the project functions. For a discussion of these factors, see Berg (2003, 2007).

This paper continues to explore the development of the Baby Mat intervention. The authors begin by describing the Baby Mat Project and communities in which the project functions. They then build look carefully at how Daniel Stern's (1998) motherhood constellation is applicable in our context (Berg, 2007). Following this, they articulate what the Baby Mat Project offers directly to infants and their mothers. Finally, the authors present a case vignette to illustrate the intervention in action. This paper serves to outline the authors' current thinking about the Baby Mat Project – 'thinking in process.'

Description of the Baby Mat

The Baby Mat intervention is facilitated by two practitioners, a psychologist (or intern psychologist) and a co-facilitator from the community. A Baby Mat session begins with an interactive announcement to parents in vernacular. This is an explanation and description about the brief intervention being offered. The introduction outlines the value and importance of an infant's early experiences, the significance of

mother-infant bonding and the ways in which infants communicate. Difficulties in managing these aspects of parenting, given the ordinary demands of life, are also mentioned. The introductory talk includes an invitation to parents to approach the practitioners and voice any concerns that they may have about their infant or about parenting.

The mat (2 fairly large blankets) is set up on the floor in the primary health care clinics in full view of the parents, infants (awaiting their regular weigh-ins, immunisations and inoculations) and nurses at the busy clinics. Caregiver-infant dyads will either approach the mat or be sourced by the co-facilitator through further discussion. Since its beginnings in July 2007, over 1,900 caregiver-infant dyads have accessed the Baby Mat, with between two and six caregiver-infant dyads using the service in each 90-minute session. During the 2012/2013 financial year alone, 390 dyads made use of the Baby Mat.

Community Context

The Baby Mat Project, as a primary health adjunct service, is currently available at three primary health care clinics in Alexandra, and one primary health clinic in Mohlakeng township, Johannesburg. Many of the social difficulties that typified South African Townships prior to 1994, and now in a democratic South Africa, continue without significant change. Alexandra and Mohlakeng remain characterised by poverty, overcrowding, crime and a growing migrant population (Alexandra

Clinic Annual Report, 2009; Alexandra Renewal Project, 2006). Alexandra has recently been a flashpoint for the emergence of widespread xenophobic violence and service delivery protests. The majority of the dwellings are informal “shacks” and Alexandra is reportedly one of the continent’s most densely populated human settlements. There are an estimated 328,579 people living in about 20,000 shacks in an area of 7,6km² (Alexandra Renewal Project, 2006). The population density is 43,234 people/km². Alexandra is 54 times more densely populated than Sandton, an affluent adjacent area. Mohlakeng is a township situated 38 kilometres west of Johannesburg. In 2012 the total monthly income per household was R3200 (USD330) or less for over 60% of the households in the area (Randfontein Municipality Annual Report, 2012). As in Alexandra, child headed households, poverty, violent crime, substance use, unemployment, reliance on government grants and municipality created jobs are aspects of life in the area.

The Motherhood Constellation in Context

The baby mat was envisioned as an intervention that relates directly to the needs of mothers and infants being mothered. It is important to note that our reference to mothers and to mothering is intended to refer to the role, rather than the gender, of the parent or caregiver. The Baby Mat Project originated out of the training in parent-infant psychotherapy offered by Tessa Barradon of the Anna Freud Centre and several of the iterations of such therapy into diverse contexts (James, 2010), as well as the pioneering parent-infant work of Astrid Berg (2007) and colleagues in Cape Town. The interplay of these psychologies (of mother and infant) has been represented in the parent-infant literature through reference to ‘the relationship between infant and caregiver’. Like parent-infant work, the baby mat was designed to support, nurture and encourage this relationship (Baradon, 2002). Our work on the mat and thoughts about our intervention have led us towards searching for ways of understanding and representing the nature of the parent-infant relationship within our context. We have found Daniel Stern’s (1998) motherhood constellation to provide us with a framework in this regard. Our use of Stern’s (1998) ideas in understanding our work on the mat is expanded below.

Of central importance to us was Stern’s (1998) idea that the motherhood

constellation “becomes the dominant organizing axis for the mother’s psychic life” (p.171). This captures a fundamental aspect of the dyads that access the Baby Mat: they are mothers primarily concerned with mothering, or their inability to mother in some way. Simultaneously we remain focused on the experience of the infant as a subject in his or her own right (Salo, 2001). In addition, we are cognisant of the recent research and practice that demonstrates that change in Parent-infant work occurs as a result of direct work with and through the infant (Barrows, 2003).

We have found Stern’s (1998) notion of the motherhood trilogy, mother’s mother-mother-baby, to be relevant to our context. Stern uses the motherhood trilogy to represent the mother’s task in settling into her role as mother (for example, mother to a boy, mother for a second time, single mother), in relation to her own (often ongoing) experiences of being mothered by her mother and in relation to her (real and fantasised) infant. In the dyads that present to us on the mat, mother’s mother may be deceased, absent, abusive, far away or a significant caregiver to the infant. Mother’s grandmother, father’s mother or father’s grandmother at times hold the role of mother’s mother. We have found these idiosyncracies to have significant meaning to the dyad and with the significance of the motherhood trilogy in mind, we almost routinely enquire about mother’s mother on the mat.

Stern (1998) delineates the motherhood constellation in four themes. We have found three of his themes to relate to our work on the mat: life-growth theme, primary relatedness theme and the supporting matrix theme. After introducing these three themes and describing the forms in which they often occur in our context, we present a vignette to illustrate.

Life-Growth Theme

The life-growth theme relates to the mother’s ability to, and fears of not being able to, keep her baby alive, developing and thriving. The presence of this theme on the mat is very often evident. A common presentation relates to dyads in which the mother is HIV-positive and the infant is HIV-negative (though usually only tested at 6 weeks). In many of these presentations, the mother, despite the relief of finding out that her infant is HIV negative, remains anxious in a generalised sort of way about a number of aspects of her infant’s physical wellbeing and development. With mother’s mind filled with this anxiety, we often imagine that the infants in these dyads are overflowing with their own anxieties.

These infants tend to present with very concrete difficulties – difficulties with sleeping, feeding, eating or their emotional regulation. Other presentations of this theme take the form of culturally-based beliefs such as *ibhala* – a red birthmark behind the baby’s neck that, if it moves to the fontanel, is believed to cause a baby’s death.

Primary Relatedness Theme

Stern’s (1998) primary relatedness theme refers to the mother’s ability or inability to know, understand and relate to her infant. This theme is often presented indirectly by the dyads we have seen on the mat and identified by us through observing the interactions of mother and infant. We pay attention to the manner in which the infant is presented to the Baby Mat practitioners by his mother, as well as whether baby is introduced to us and how this is done. We often observe mothers who struggle to think about their infant, who struggle to comfort him or to think about him as a subject in his own right. Occasionally concerns relating to this theme are presented directly, when a mother states that she is concerned about her ability to bond with her baby or when a mother states that she takes out her anger towards the infant’s father on the infant directly.

Supporting Matrix Theme

Stern’s (1998) supporting matrix theme relates to the mother’s need for a supportive structure in which she feels safe and secure enough to do her mothering. In addition to presentations relating to the motherhood trilogy, as discussed above, our dyads often present with themes related to the infant’s father. Conflict in the parental relationship, conflict between mother and the father’s family and absent fathers (through work or otherwise) are examples these presentations. Difficulties related to this theme are described by the mother or elicited through the exploration of the infant’s presented difficulties or interactions with the practitioners on the mat.

A Baby Mat Session: Anele and Kagiso

The following vignette is an example of a baby mat session in which Anele appears to represent difficulties that she and Kagiso are experiencing in the symbolism of the life-growth theme. Difficulties with the primary relatedness and supporting matrix themes are also evident but elicited

through Anele and Kagiso's interaction with the mat practitioners and with each other. The names of the mother and infant have been altered in order to protect their identities. The session is presented from the perspective of the therapist, Nicola Dawson. We would like to thank her for allowing us to use her case as our vignette.

Anele, a well-dressed woman sat on the mat and placed her 9 month old baby, Kagiso, to face me and my baby mat co-facilitator, Brenda. The mom began immediately to explain to Brenda in vernacular, "My son does not sleep at night or during the day. I am exhausted!" Brenda then introduced herself and I introduced myself. Anele gave us her name, but she did not offer her baby's name. I then asked her for her baby's name and she said that his name was Kagiso. I greeted him by name and he held my gaze though did not smile. Brenda took out the string of toys and handed it to Kagiso. He immediately took it and played happily with it. Brenda acknowledged to Anele that she looked very tired and then translated the presenting problem to me. I touched Kagiso's leg and asked him why he wasn't sleeping and letting his mom sleep. I noticed he put one hand on his mom's leg and looked at me when I spoke. Mom responded by saying, "He needs to sleep so that I can sleep". I commented on how Kagiso touched her as if to comfort himself in meeting somebody new.

Brenda asked Anele if we could ask her a few personal questions about herself and Kagiso. Mom agreed and Brenda asked if her pregnancy with Kagiso had been planned. Anele answered flatly, "He was a surprise." While they talked about the pregnancy I asked Kagiso if we could play a game. I had wondered about separation and decided to play

peek-a-boo with him. At the time, he was playing with a string toy. I held my scarf up over my face to play peek a boo. He watched closely, but didn't laugh. Brenda then joined us and took a white elephant and tried to interact with Kagiso. He lunged towards me and continued to play with me. Brenda commented to Kagiso, "You like him." She noted that "even with other toys you won'tt play with me."

I asked Anele why she thinks Kagiso doesn't sleep well. She replied, "I really didn't know." I suggested that perhaps we could think about it together. I asked Anele if Kagiso's father was still around. She said, "He is not always around as he often works in Limpopo". Brenda then asked, "What does dad think about the baby not sleeping?" Anele responded, "He was the one who suggested that I speak to someone at the clinic." I then asked about her parents and she explained, "My dad died in February this year and my mom died in December last year." We expressed our condolences to her for losing them both so recently and so close together. We all sat in silence for a time. Brenda then

asked where her family had lived and Anele answered, They were from Zimbabwe. I went home to bury them both; Kagiso's father joined me." We affirmed that this was very important for her. She reiterated the importance of Kagiso's father's support.

Anele discussed the death of her parents with Brenda and she began to cry quietly; Brenda handed her some tissues. While they were talking, I turned my attention to Kagiso who kept playing with the string toy seemingly unphased (I was surprised by this). I said to him, "This was all a hard business." Anele shook her head and agreed that it had been very hard. We offered our sympathy. When Brenda asked Anele about the rest of the family, she explained that she only has one sibling (a brother) who lives in Cape Town. "My mom was an only child and so I have no aunts."

I pointed out that Kagiso (who was still sitting playing with the strong toy) was 2 months when Anele's mother died. I asked how Kagiso had coped when Anele had found out about her mother's death. I rubbed Kagiso's back, looked at his face and said to him,



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"You were very little when your granny had died. You are still little now, but you were very little then... it must have been hard to have your mom be so sad". Anele explained that Kagiso had never met her mother and was too young to remember her. I tried to explain that I had wondered more if he had noticed her sadness. This seemed to resonate with her.

I asked Anele if Kagiso had struggled to sleep around the time Anele's mom died. When Anele explained that Kagiso had difficulty sleeping from 3 months, I commented, "That was very close to the time of your mom's death and all the funeral travel." At this point, Kagiso pulled himself up, using his mother's body and planted what looked like an open mouth kiss on Anele's cheek. She moved him away, wiped the spit off her cheek and said to Brenda in vernacular, "He was biting me!" Brenda translated this to me and I asked Kagiso, "Are you biting mommy or kissing mommy? Sometimes when we're so little it's hard to make our kisses come out just right". Anele laughed and when Kagiso lost his balance, he began to cry. His posture was very awkward and mom did not respond. I decided to draw her attention to this. I asked her what she thought had upset him. She explained that he was hungry, and flipped him onto his side, and took out her breast. Kagiso latched and began feeding. He immediately calmed down. He then went on and off the breast, looking around for a moment or so and then returning to feed. At one point, while off the breast, Anele zipped up her top and Kagiso became very upset and started kicking me. Brenda pointed to him. Mom took out her breast again and Kagiso latched and immediately settled again. I turned to Kagiso and

said, "It is hard to get you mom's attention when her mind is far from you." Brenda agreed and touched Kagiso's chubby leg and asked Anele if this was "all milk". Mom explained that she also fed him solids. Brenda spoke in "motherese" to Kagiso about all the "milk deposits" on his body, while gently tugging his skin. Brenda said that even though things were difficult that Kagiso was growing well.

The loss of Anele's parents within months of each other shortly after Kagiso's birth appears to have impacted the dyad in numerous ways, but it seemed as though Anele was not able to acknowledge the impact of the loss on her baby's experience. We also noted that Kagiso was not introduced to either of the baby mat practitioners and wondered why not. The sections to follow discuss how we have begun to think about our intervention on the mat. Where relevant, we will refer back to the intervention with Anele and Kagiso as presented.

The Therapeutic Alliance and Therapeutic Stance

In addition to that presented above, we have found Stern's (1998) discussion of the therapeutic alliance to have similarities with our experiences. He describes an alliance based upon the therapist's acceptance of the "good grandmother transference" (p. 186). The therapist within this alliance is more concretely maternal and takes on a more actively nurturing role. Although the 'therapist' on the baby mat is two people, our interventions are often more concretely maternal than in a more formal psychotherapy. We view the specific provision of knowledge as an appropriate part of our relationship to the dyad and an indication of our attunement. Examples of this include brief discussions about a feeding and sleeping routine, the task of mother and infant learning to know one another, the importance of play and the infant as a person who is able to perceive and feel. As Stern (1998) also describes, we work to draw attention to, highlight and encourage the positive aspects of the relationship between mother and infant that we observe during our intervention. Brenda's affirmation of Anele's breastfeeding and Kagiso's healthy appearance provide examples of this in the vignette. We view this therapeutic stance as an integral part of how we meet

the needs of our dyads sensitively and responsively. We also understand it in relation to us working in primary health care clinics and to our positioning within the clinic – amidst the community with whom we are working.

The therapeutic dyad or couple is a key aspect of our intervention. As with our therapeutic stance, the use of a therapeutic dyad rather than a single therapist relates to the needs of our communities. In a society where differences (in race, culture and language) were, and continue to be, divisive it can be difficult for the individual to access something that is new, different or unusual. With the above in mind and the differences between our therapists and co-therapists clearly evident, we have been thinking about the symbolism of the therapeutic couple. Our co-therapists are mostly middle aged, black women (we have recently had a black male in his twenties) while our therapists are white and black, mid-twenties to middle aged, men and women. As our baby mat practitioners work together closely (as a team), we wonder about this representing an overcoming of difference; a coming together across dividers to help with mothering and with the infant and the mother becoming. This is something to consider, as our therapeutic couples, whatever the combination of demographics¹, have been equally successful in attracting dyads to the mat. With a male as therapist/co-therapist we have begun to consider the symbolism in a 'couple' working together in order to meet mother and infant. We believe that this symbolism is also present in all-female therapeutic dyads. Thus in the therapeutic dyad, there is perhaps something symbolically beyond the grandmaternal. These thoughts are leading us towards further considering the meaning present in the role of the father, as it is presented to us by the dyad. It has also resulted in us considering whether there is a paternal element or function in the intervention that we provide.

Holding, containing/ wondering and infant subjectivity

We understand our intervention with our dyads to support the presenting concerns (whether spoken/acted or unspoken/unacted) specific to our context. We have discussed these concerns in terms of the motherhood constellation. This section attempts to articulate how we work with and begin to address the anxieties,

¹ We have not had two men sit on the mat

fantasies and processes underlying the motherhood constellation themes. Our direct intervention takes three forms: a provisional form of holding, a provisional form of containment and engaging with the infant as subject. These ideas are briefly explained below.

Holding

We have made use of Winnicott's (1960) idea of maternal holding in describing our intervention on the baby mat. He uses the concept in his description of the infant's gradual individuation in relation to his mother. As a result, it is a concept that describes a mother's care for her infant at different stages of the infant's development and over an extended period of time. Through the mother holding her infant both physically and mentally, she is able to soothe his anxieties.

Central to Winnicott's (1960) holding is the idea of consistency over time in relation to mothering, a psychoanalysis or psychotherapy (as something occurring over an extended period). We believe that our dyads are held by the therapeutic dyad on the baby mat, but as our intervention may be once off and is very short in terms of time, we have decided to refer to this phenomenon as provisional holding to denote that it is a taste rather than a full experience of being held. We will say for now that the therapeutic dyad holds what is presented as difficult, what is not said or implicitly presented, and through this some of the pieces of the mother and the infant's experience. It is the themes of the motherhood constellation (stated and unstated) that are partially held by the therapeutic dyad in our therapeutic stance on the mat. We also understand our more concretely maternal interventions to relate directly to our partial holding of the presenting dyad. Although direct interactions with our dyads are short, there may be something significant in the baby mat's symbolism and consistent presence at clinic (there is a place to think about mothering and being mothered).

Containing

We have similarly made use of Wilfred Bion's (1962) model of containment in articulating our intervention. His model relates to a mother's capacity for soothing her infant's fears by using her own mind to process his experiences. In this way, a mother is able to articulate and respond to what had been inarticulate, unvoiced and unknown. As Bion (1962) also presents

this model as a process occurring over an extended period of time, we have decided to refer to this phenomenon as provisional containment to denote that it is a taste rather than a full experience of being held. On the baby mat, the therapeutic dyad's containment of the presenting dyad occurs through wondering ('mhlawumbe) and tentatively exploring possible symbolic meanings. It is ideas relating to the motherhood constellation themes that are contained. We have found that seeing and naming the infant's fear or pain is difficult, and that it is often easier to see, name and affirm the infant's enjoyment. We have found that tentatively stating a symbolic meaning to a dyad to elicit startling changes in non-verbal markers. We understand this form of the intervention to provide the possibility of new meanings.

Infant Subjectivity

By engaging directly with the infant – talking to and through the baby (Slade 2007; Salo, 2001) – and attributing possible states of mind, the Baby Mat practitioners begin to promote the baby's coherent sense of self as well as model a way of being with the infant to the parent. We understand this intervention to act as a form of provisional holding, wherein the infant's subjectivity is held by the therapeutic dyad. As in the vignette, this holding can at times be very physical in its form. We view this as an aspect of our therapeutic stance on the mat and as a way of meeting the infant in his world; his experiences of and need for physically-based caring (Winnicott,). We are often left wondering whether we are at times also holding the infant's subjectivity for his mother, who may desire to relate to him more wholistically but struggle to do so as a result of the many possible factors discussed. Our engagement with the infant may also be viewed as a form of provisional containment, wherein we are wondering and symbolizing possible aspects of his emotional world. We are dreaming aloud and together with his mother about the infant as a subject. We also wonder whether this at times meets an unspoken process within the mother which she very often is struggling to sustain.

Tensions Held in intervening

This section describes something of the process of intervention. The time frame, number of people on the mat, explicit and implicit nature of the presenting

difficulties and multiple forms of intervention mean that there are complex decisions to be made in intervening. We have found it helpful to think about these decisions as tensions held by the therapeutic dyad. The first is a tension between an intervention that relates more to partially holding or one that relates more to partially containing. We recognise that these forms of intervention are not mutually exclusive, in line with Ogden (2004) who describes holding and containment as "two vantage points from which to view an emotional experience" (p. 1349), yet within our time frame, a relative focus can result in an intervention that is very different in form. A second tension (always present and perhaps evident in our presentation of this paper) lies between it feeling like there is not enough time to the point of there being no time and therefore no work done, and the idea that the experience we provide is on some level enough. This is also felt as a tension between relying on our referral to interventions of longer duration and working in the time available to us on the mat. This tension interacts with the first in ways that can feel quite confusing to the therapeutic dyad. A third tension is implicit in our intervention with the infant as subject. It lies between giving enough time to the mother and enough time to the infant. This tension feels ever-present in our thinking about the mat, cases seen on the mat and in supervision. It is aided by there being two treating minds on the mat – two people in the therapeutic dyad.

Conclusion

After 6 years of Baby Mat Service and steadily increasing numbers of mothers with their infants using and then revisiting the mat, we are assured of the value of such a service. The introduction of the mat in another township clinic is a first step toward replication. There remain challenges, namely working toward more rigorous evaluation of the intervention and replication in other contexts. There is a need for a continued thinking, questioning and remaining open to the mothers and infants who sit with us and those who share their stories.

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The editors of *Perspectives in Infant Mental Health* are delighted to announce the birth of *The World in WAIMH*, an occasional column intended to generate reflection and dialogue on the roles of context, culture, and community in infant mental health around the world. Our shared hope is that this will offer a space for questioning, challenge, dialogue and interdisciplinary discussion.

The Editors are calling for

- commentary,
- field reports,
- case studies,
- concept or theory building papers,
- research articles,

- book reviews,
- literature reviews,
- and (when proper permission can be obtained) adaptations of previously published articles

(Articles of any length up to 20 pages (250 words per page/12 point font) will be considered for publication. See below for additional guidelines. Please email submissions to Deborah Weatherston at dweatherston@mi-aimh.org)

We welcome articles about individual, family, community and population level practice, policy, research and theory that address questions such as those that follow and that pose other pressing ones.

In our globalized world, every infant and family is affected by forces far beyond their reach, forces that may strengthen, hinder, or undo the work of infant mental health professionals. To be a truly global organization, WAIMH will increasingly need to understand and develop strategies to address these forces. To foster healthy early development around the world, WAIMH will need to extend its reach, and to learn from contexts, cultures and communities that are not or

only minimally represented in its current membership. Among the many questions to answer are:

- What processes can contribute to a more inclusive and expansive knowledge base?
- What kinds of partnerships – with members of cultures not yet represented within WAIMH, with other organizations, with other disciplines such as cultural anthropology or community psychology – are needed to truly put the world in WAIMH?

Roughly 97% of academic research on developmental psychology has focused on less than 1% of the world's population and many of its findings have mistakenly been assumed to be universally applicable, leading us to ask:

- What do we know, and how can we learn, about infant mental health around the world?
- How do local contexts, cultures and communities understand, affect and optimize infants' development? What are the implications of contextual specificities – for example, how 'family' is defined - for infant mental health