

Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

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Presidential Address

All Roads Lead to Rome



By Kai von Klitzing, WAIMH President, Germany,

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It is with great pleasure that we – the World Association for Infant Mental Health (WAIMH) – announce that the 16th World Congress for Infant Mental Health will be held from 26 to 30 May 2018 in Rome, Italy. I cordially invite you take part in this exceptional event.

Why should we take the road to Rome?

Several historical figures have testified that Rome is worth visiting. Sigmund Freud, for example, visited Rome in 1897 for the first time after he had worked on his resistance in his self-analysis. After his stay he concluded in a letter to Fliess: "My trip to Rome was overwhelming, a highlight of my life." Around one hundred years before that, Johann Wolfgang Goethe visited Rome not once but twice, and lived there

for 15 months (between 1786 and 1788). He praised his stay in the eternal city: "Oh wie fühl ich in Rom mich so froh" (Oh, how happy I feel in Rome), in stark contrast to the way he felt facing the grey days of northern countries. And 275 years before that, in 1511, a young Augustinian monk named Martin Luther undertook a long pilgrimage from Germany to Rome to visit the city of the popes and martyrs. When entering the city he fell to his knees and exclaimed: "Sei gegrüsst, du heiliges Rom, wahrhaftig heilig..!" (Greetings, you holy Rome, truly holy...!). But years later when he looked back to his four weeks' stay he described Rome as a "hotbed of sin". What he saw in the city contributed to his urge to reform the Christian church.

It has taken WAIMH 38 years, since it was founded, to come to Rome. I am sure that – like the examples mentioned earlier – WAIMH's visit to Rome will be an amazing experience. I am convinced that all the participants in our world congress will find the visit to Rome will be worthwhile. I promise that it's not just



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the wonderfully warm weather in May, the imposing antique monuments, the fantastic architecture from various epochs, and the world-famous Roman cuisine, that will delight you. The conference program, arranged by our Program Committee chaired by Kaija Puura, will be equally excellent. I call on scientists, clinicians, and infant mental health specialists all over the world to participate by submitting your proposals (abstracts) for the scientific program. Our friends from the Italian Association for Infant Mental Health (IAIMH), under the leadership of Giampaolo Nicolais, will be wonderful hosts and will connect our international participants with the regional, national and European tradition of early care and infant mental health work.

It is said that all roads lead to Rome. The claim refers to the Milliarium Aureum, a monument erected by the Emperor Augustus in the central forum of ancient Rome. All roads were considered to begin at this monument, and all distances in the Roman Empire were measured relative to it. The meaning of the proverb is that many different routes can have the same intended goal. To a certain extent, this multi-finality also applies to the development of young children. Crosscultural studies show that very diverse conditions (different family structures, methods of care, parental ideals and attitudes, and socio-emotional conditions) can lead to positive developmental outcomes. But this multi-finality of developmental pathways does not imply complete arbitrariness. Just as we would never reach Rome if there were no roads, railway stations or airports, no infant can thrive without a caring environment to help them develop a trusting relationship to themselves and others. WAIMH has defined the basic conditions that are essential for infant development, such as sensitive caregiving relationships, nurturing, and legal protection; and in our position paper on the rights of infants (<http://www.waimh.org>) we advocate that these needs should be guaranteed as rights for all infants all over the world.

As scientists, clinicians and infant mental health workers we must painfully acknowledge that the challenges to implementing this are immense. In many families and neighborhoods, violence, neglect and abuse are common. Many infants grow up in conditions of poverty, violent conflict, and war. Our host country Italy is situated in the centre of the worldwide refugee crisis. Millions of refugees, among them many young children, trying to flee poverty, war and

persecution find themselves stranded on the Italian coast after a life-threatening trip across the Mediterranean Sea in leaky and dangerous boats. Not even the wealthy European countries, let alone the rest of the Western world, seem able to muster enough solidarity and support to take the pressure off Italy and help to distribute these stranded refugee families so that they have a chance of a life in human conditions. Clearly, this is not a road that leads to healthy child development. We, the WAIMH and the IAIMH board, have decided to highlight these problems, which jeopardize the development of so many infants, in central symposia and keynotes of our congress.

I very much look forward to meeting you all in Rome in May 2018. I am sure that our conference will be a highlight not only of WAIMH's history, but also of our personal and scientific lives. Don't miss it!



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This issue highlights individuals and groups who are committed to actively supporting the wellbeing of babies and families through direct service that protects and reduces risks. It includes news from an affiliate organization that offers new knowledge and opportunities for shared understanding as well as papers on advocacy efforts and research. The WAIMH community at large has the capacity to affect the developmental and psychological health of very young children and their caregivers around the world. By working together, we can

From the Editors

change the trajectory from certain risk to improved outcomes – but, it will take each and every one of us to contribute.

In his column, “All Roads Lead to Rome,” Kai von Klitzing reminds us of the basic conditions that are essential for optimal infant development: sensitive caregiving relationships, warm nurturing, and protection under the law. He challenges us to join WAIMH in protecting these rights in our own countries and by joining together at the WAIMH Conference in 2018. Astrid Berg offers a poignant view into the law and reality for children in foster care and families in South Africa. A study from the US (Saunders, Biringen, Benton, Closson, Herndon & Prosser) informs us about the importance of emotional availability and possibilities for risk reduction through early intervention service. Two WAIMH Board Members, Jody Manly and Maree Foley, offer inspiring reflections about their

commitments to infant mental health. News from WAIMH Affiliates, with a special focus on the Estonian Infant Mental Health Association, suggests the growth of infant mental health worldwide.

Arthur Miller, playwright, once wrote, “We are all in this together...” We are - babies are - families are. Together, we can make a difference. Hope lies in the relationships we enter into and sustain through our work with, or on behalf of babies and families around the world.

WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH

16TH WAIMH WORLD CONGRESS
WORLD ASSOCIATION FOR INFANT MENTAL HEALTH
Rome | May 26-30, 2018 | ERGIFE PALACE HOTEL

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Massimo Ammaniti
Chair of the Local
Organizing Committee

Giampaolo Nicolais
Vice-chair of the Local
Organizing Committee

Sponsor a Delegate in Rome 2018

Dear colleagues, we started the Sponsor a Delegate-programme for our 13th WAIMH World Congress in Cape Town, and it has proven to be a valuable way to help delegates from lower income countries to get to our Congresses. We will have a Sponsor a Delegate-programme also for the 16th WAIMH World Congress in Rome 2018 and ask for your donations. The official Congress website will be opened 1st May, 2017 and we will provide you further information on how to donate in our Congress newsletter and on the Congress website. Thank you for your generosity!

Protecting Infants from Violence – Law and Reality in South Africa

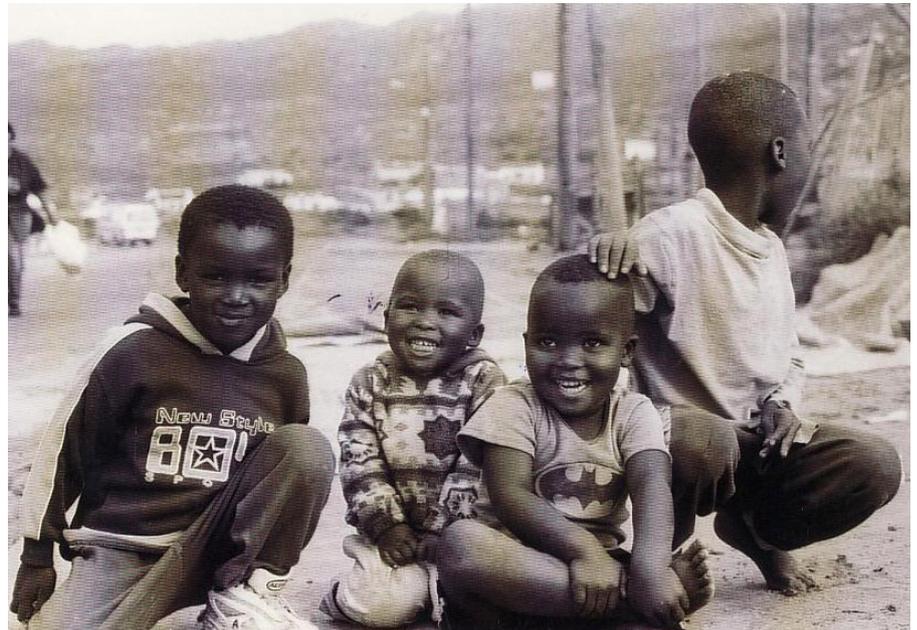
By Astrid Berg, Cape Town, South Africa

Introduction

South Africa prides itself in having one of the most liberal Constitutions in the world, one where the right of everyone, including children is emphasized and treasured. The country's laws are aligned with this Constitution. However, it is not always possible to implement these in a way that would honour the spirit of the Constitution. This is particularly so when it comes to the care of young children. The following description of a common clinical situation will highlight the difficulties encountered. The conflict that surrounded this case was due to two seemingly opposing legal positions that the professionals represented. A resolution of the conflict could have occurred earlier had there been a more in-depth understanding of the young child's early attachment relationships.

Background

Violence is defined "as the intentional use of physical force or power, threatened or actual, that results or is likely to result in injury, death, psychological harm, mal-development or deprivation" by *The World Report on Violence and Health* (Daher, 2002) (p. 5). In South Africa violence against infants and young children is high. The reasons for this are multi-layered and include lack of economic development resulting in poverty and the consequent loss of parental self-worth, parental substance abuse and familial patterns of child maltreatment. All of these come on the background of a violent past that enforced separation on the basis of race, resulting in unequal distribution of resources. The laws of the Apartheid State led to a division between the white minority's relative wealth and the black majority's poverty in terms of governmental service provision. This left the country with a legacy of an inferior educational system for children of colour (though this is slowly changing) as well as an unequal health system that is now gradually trying to transform into an equal delivery of skills and health facilities.



However, the institutionalized oppression for over half a century has left its mark in the collective psyche. Violent acting-out is rife and, as is the case in many societies, the children bear the brunt of the adults' anger. This inter-generational violence manifests in all population groups and is not confined to the formerly oppressed group. However, abuse occurs more frequently in the context of poverty, unemployment and social deprivation (Richter & Dawes, 2008). These social ills affect the majority of the Black African and so-called "Coloured" groupings. Thus, while most studies do not differentiate between the races when it comes to studying abuse, the implication is that the previously oppressed groups are affected the most.

While it is difficult to ascertain exactly how many children are suffering from abuse, there is no ambiguity when it comes to counting how many children have died because of non-accidental injuries. In a retrospective mortuary based survey of 2009, (Mathews S, Abrahamas N, Jewkes R, Martin LJ, 2012) found that the highest rate of children being killed was from 0-4 years with another peak during adolescence.

"Nearly half (44.6%) of the homicides were due to child abuse and neglect. Over a third (35.7%) of child abuse was due to abandonment within the first

week after birth. Almost three quarters of these cases (74%) occurred among children aged 0-4 years and in this age group 54.5% of cases were of girls." P 3 (Mathews S, Abrahamas N, Jewkes R, Martin LJ, 2012)

The authors conclude that

"As a country we are failing our children, current policies and practises in relation to the protection of children are having little effect in keeping children safe in their homes and communities." (p.3)

The authors make a plea for a national response to the problem of child deaths through homicide and a four-pronged approach is suggested. The four areas for action are

- *Increasing or strengthening social welfare responses to child abuse and neglect
- *Intervention and Prevention initiatives
- *Increasing or strengthening health service's response
- *Increasing or strengthening the medico-legal system's response

The above are pleas made to various

governmental sectors that are involved in the caring of children and families, including the Department of Social Development, the Criminal Justice System, the Law Enforcement System and the Department of Health.

In the Western Cape Province of South Africa, a new initiative called “The First 1000 Days” is being promulgated. Its aim is creating public awareness of the importance of a healthy start to life. Its great challenge and potential strength lies in the fact that it is co-ordinating and pulling together the various governmental sectors - health, social development, and education departments.

It will however take time before these messages filter down into the communities on the ground before the whole of the population of the very young will experience a better beginning to their lives. Parents may not be able to give their children what they need, and the responsibility then falls on the State when children are declared in need of care. The South African child welfare system is however under pressure with an urgent need for funding and human resources. (Schmid, 2012) Added to this “crisis” (p4) of lack of human resources to intervene in abusive situations, is the challenge of identifying emotional abuse. This form of abuse is said to be common, under-recognized and difficult to define (Glaser, 2002), but can have devastating effects, leading to an impairment in the child’s functioning.

Personal clinical experience over many years attests to the fact that the emotional abuse cases are the ones that are referred to the mental health services and it is with these emotional abuse cases that there is a particular challenge. The scars are less visible, and often it is a matter of the child’s word against an adult’s. Mostly, the child loses out because of being deemed an ‘unreliable witness’. In terms of legislation however, South Africa’s children should receive adequate protection from abuse and neglect, including emotional abuse.

The rights of the South African child are enshrined in the South African Constitution which in turn is based on four international Conventions: International Covenant on Civil and Political Rights (UN, 1966); African Charter on Human and People’s Rights (1981); United Nations Convention on the Rights of the Child (1989) and African Charter on the Rights and Welfare of the Child (1990). Out of these has arisen the Children’s Act which protects the rights of the child at a national level.

The state bears 3 levels of obligations to

children. The prevention of violence is the first: “Every child has the right to be protected from maltreatment, neglect, abuse or degradation” (Section 28(1)(d)). The provision of protection from further harm and the support and treatment of those who have experienced violence are the other two obligations. The Act further states that “Every child has the right to family care, or parental care (Section 28(1)(b))” (Mathews S, Jamieson L, Lake L, Smith C 2014) (p. 44). The balance between these two rights, namely the right to protection and the right to family care, are frequently in conflict when it comes down to a practical, clinical level. This conflict manifests between the social workers who are given the task of providing a supportive intervention for the family and re-uniting the child with its family at all costs, and the mental health professional, as the spokesperson for the child, who may guard against re-unification for various reasons. It is most frequently about the mental health or lack thereof of the parent and the child’s attachment relationships to non-parental figures.

There is however a caveat that needs mentioning for the local situation. In South Africa there could be more at play than lack of understanding on part of the magistrates (who are the first legal port of call) of the importance of the continuity of care. These motives for reunification have to be appreciated against the backdrop of a political past where families were separated by cruel Apartheid laws. We could now be dealing with a ‘reaction formation’ against these laws by wishing to reunite families at all cost, often to the detriment of the child concerned, as this clinical vignette will illustrate.

The clinical vignette

The toddler, whom we shall name B, was brought to the Parent-Infant Mental Health Service by her foster mother. She was 30 months of age at the time. The foster mother had cared for her since she was 2 weeks old. The referring doctor was concerned about the aggression that had manifested since her biological mother’s return into her life, after not having had any contact over the past year. B also presented crying episodes that lasted for hours, and had sleep difficulties. The doctor also expressed concerns that B’s mother had mental health problems that resulted in her lack of consistency and emotional outbursts. What followed this initial referral was a 10-year battle between various governmental sectors. The Social Development Department continued to

recommend and insist on B returning to her mother and the Department of Health voiced concern about the child’s responses and her explicit wish not to be separated from her foster mother.

There were obvious indications that the biological mother’s state of mind was negatively affecting this little girl – her behavior fluctuated according to the contact she had with her biological mother, culminating in a serious suicide attempt at the age of 10 years. Once she was old enough the child stated that she was scared of mother’s latest partner (who had a criminal record for domestic violence), and that she did not want to live with her mother. Despite these facts, the social workers pursued the line of reunification. The child psychiatric reports did not seem to carry much weight with this sector. However, the legal counsel whom the foster mother was finally able to instruct, used the reports and eventually, after much anxiety and fear, including threats by the biological mother and her partner towards the health professionals involved, the case was handed to a family law specialist, called the Family Advocate.

The office of the Family Advocate was established in 1990 to look after the wellbeing or needs of under aged or dependent children in divorce matters. The role of the Family Advocate is to assist the courts in establishing the best interests of minor children in civil legal disputes. The reports and recommendations made by the Family Advocate enable the court to evaluate the settlement reached by the parties and to establish whether it is in the best interest of the children. In certain instances the Family Advocate assists the courts in matters relating to domestic violence and maintenance (DoJ, 2017).

This path should have been taken much earlier in this child’s life as it would have prevented the distress and anxiety experienced by all involved, including the biological parent, the foster mother and child. In this case, the Family Advocate ruled that the child was to remain with his foster mother until the age of 18 years and that the court hearings were to come to an end. The child’s symptoms resolved almost immediately.

International trends

While dealing with this case and particularly given the threats that were aimed at us by the biological mother’s partner, consultations with colleagues abroad took place as to the legal position

in their countries. In Victoria, Australia, a law is being promulgated or by now has already been promulgated that:

“ensure[s] that the children’s court makes a permanent plan for all children who are out of the care of their parents because of abuse or neglect. The court will be required to make an order within 12 months of the child being initially removed from their parents care. The aim of the law proposed is to ensure that children have certainty with their care over time, and within a relatively short time of having been initially removed from the care of their parents.”

From the State of Michigan, USA, the Michigan Department of Human Services and the Michigan Association for Infant Mental Health issued a joint policy statement for best practices related to infants and toddlers in foster care. Among the many recommendations the statement called for

Whenever possible, when reunification is not anticipated, infants/toddlers should be placed in foster homes that are interested in adoption – “first placement is the last placement.” (MIMH, 2014)

The above are in line with the work done by the Attachment Clinic developed by Gauthier and his team in Montreal (Gauthier, Fortin, & Jéliu, 2004). This Clinic offers consultations to children and their families who are experiencing difficulties related to foster care arrangements, multiple displacements or threatened loss of the attachment figure for administrative or judiciary reasons. The consultations last for over 3 hours and consist of observations and assessment of the child with all the parents involved, with a focus on the quality of the child’s attachment to both sets of parents, biological and foster parents.

Attachment theory proved to be a useful background to the discussions and recommendations given to each case. The following guidelines were developed: (Gauthier et al., 2004)

- * There is a critical time for establishing attachment ties – between 8 and 18-24 months; that is, before 2 years.

- * Continuity of parental figures is essential for healthy development. Rupture of attachment ties is experienced as a trauma, particularly if this is repeated.

- * Progressive reintegration back into the biological family may constitute a severe trauma, particularly if the foster parents have become the ‘psychological parents’ whom the children has learnt to trust. Reactions such as separation anxiety, angry outbursts and destructive behaviours are often the consequence of such a process. Often the team made the recommendation that the child remain in the foster home and not be integrated into his/her biological family.

- * Should an adoption become a possibility, transfer from a foster family to an adoptive family should only be considered if the infant is less than 12 months old.

The longer the child has been with the foster placement, the deeper the attachment and security with that ‘psychological parent’ will be, making reintegration with the biological parent more difficult and risky, as was the case with the little girl presented here. An additional point that is worth noting is that while children in distress are frequently referred for psychotherapy, these efforts will be of little effect if continuity of parenting is not assured. The role of the therapist in the case presented was that of a containing function for foster mother, and to be a voice for the child in the face of adult demands and pressures. It was not about individual psychotherapy with the aim of resolving inner conflicts. However, the central point in dealing with infants and toddlers is that a “child’s time” in the crucial early years is much shorter than the “adult’s time.” A young child cannot wait for the parents to solve their persistent personality problems, childhood traumas, drug abuse, and violence. A child cannot be put “on hold.” p. 394(Gauthier et al., 2004)

Infant Rights

The World Association for Infant Mental Health issued a position statement in 2014. This position paper highlights the special needs of infants and toddlers. It is divided into two parts: seven Basic Principles of Infant Rights that should be endorsed globally, and ten Social and Health Policy Areas that are informed by these principles, but are more context-dependent (WAIMH, 2016) .

The second Basic Principle states that

“Caregiving relationships that are sensitive and responsive to infant needs are critical to human development and thereby constitute a basic right of infancy. The Infant therefore has the right to have his/her most important primary caregiver relationships recognized and understood, with the continuity of attachment valued and protected– especially in circumstances of parental separation and loss. This implies giving attention to unique ways that infants express themselves and educating mothers, fathers, caregivers and professionals in their recognition of relationship-based attachment behaviors.”

Furthermore, the related policy area that informs this Principle should “minimize changes in caregiver during the early years of development”.

In the case vignette given, the above principle was heeded much too late in this child’s life – it remains to be seen how the continual threat of removal from the attachment figure and placement with the biological parent will impact on her as she grows up.

If the right of the infant to have her most important primary caregiver relationship recognized and protected, the suffering that the young child and her foster mother had to endure could have been prevented. The child’s suicide attempt was the most visible manifestation of the great inner turmoil this little girl had to endure. The importance and the depth of the relationship to the foster mother was not appreciated by the social workers

who were set on re-unifying the child with her mother, almost at all costs. It is the misconception that the biological parent has an 'in-born' right to claim the child, irrespective of how long the separation during infancy might have been. It is this misunderstanding that needs to be re-evaluated and re-worked in the education and in-service training of those who determine the fate of these unfortunate children.

Sadly, there remain many little children of all races in South Africa who are victims not only of domestic violence, but also of legally induced disrupted attachments. It is our job to continue to speak out for them. It is hoped that the Infant Rights Position Paper, as well as the First 1000 Days Initiative in the Western Cape, will increase awareness of the special needs of all infants and young children. As Nelson Mandela reminds us in the Foreword to the World Report on violence and health (Daher, 2002):

"Less visible, but even more widespread, is the legacy of day-to-day, individual suffering. It is the pain of children who are abused by people who should protect them..." He ends it thus: "We owe our children – the most vulnerable citizens in any society – a life free from violence and fear. In order to ensure this, we must be tireless in our efforts not only to attain peace, justice and prosperity for countries, but also for communities and members of the same family. We must address the roots of violence. Only then will we transform the past century's legacy from a crushing burden into a cautionary lesson". (p.ix)

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Reflections: Professional and Personal

Perspectives is pleased to introduce two WAIMH Board Members in this issue: Jody Manly and Maree Foley. Each has contributed a portrait in effort to describe her past and current interests in the field of infant mental health.

Reflections: Jody Todd Manly, WAIMH Executive-at-Large

Jody Todd Manly, Ph.D. is a clinical psychologist who is currently the Clinical Director at the Mt. Hope Family Center and a Senior Research Associate and Assistant Professor in the Clinical and Social Psychology Department of the University of Rochester in Rochester, New York. Mt. Hope Family Center is a unique setting that integrates innovative research, evidenced-based prevention and intervention, and education of future mental health leaders to promote resilience and avert maladjustment and psychopathology in the life course of high-risk children and families. Mt. Hope Family Center is a member of the National Child Traumatic Stress Network, where Dr. Manly works with U.S. trauma experts on provision of evidence-based trauma treatments. In partnership with Alicia Lieberman and colleagues at the University of California in San Francisco, Dr. Manly and her colleagues at Mt. Hope Family Center have evaluated Child-Parent Psychotherapy (CPP), a trauma treatment program for children 0-5 and their caregivers, and have supported the dissemination and training in this effective intervention model. Dr. Manly is a member of the CPP faculty and implementation team and has provided training in CPP across the U.S.

Dr. Manly has been a Principal Investigator or Co-Principal Investigator on several federally-funded research projects on the linkages among attachment, trauma, depression, child maltreatment, poverty, domestic violence, and community violence with a broad age range of children from infancy through adolescence, from a lifespan developmental approach. She has more than thirty years of experience in providing clinical services to children who have experienced trauma and their families, and in conducting research with children exposed to violence and maltreatment. Her research has included treatment evaluation studies to evaluate efficacious preventive and intervention approaches that promote positive parent-child relationships, facilitate healing from trauma, and provide treatment for depression. She is interested in identifying developmental processes associated with trauma and clarifying opportune times to break cycles of violence, familial

conflict, and depression that can disrupt the formation of secure attachment relationships and derail optimal socioemotional development.

With her colleagues at Mt. Hope Family Center, she is currently conducting a randomized controlled effectiveness trial of a program entitled Building Healthy Children that evaluates a home-based multi-pronged intervention model for teen parents and their young children (ages birth to three years), combining Child-Parent Psychotherapy to address parent-child relationships and child trauma, Interpersonal Psychotherapy for treatment of maternal depression, and Parents as Teachers home visitation along with outreach support to address concrete service needs and integrate services into children's medical homes. Having seen the impact of maternal depression in teen parents, she has also been evaluating a depression preventive intervention for maltreated and nonmaltreated adolescent girls aged 13-15 years, with the goals of ameliorating depressive symptoms and improving outcomes not only for these young teens, but also for their future parent-child relationships in years to come.

Dr. Manly is committed to training professionals, and she has supervised graduate students in psychology, counseling, and social work, as well as provided workshops locally, nationally, and internationally. She has conducted numerous local, US, and international trainings on the impact of trauma on children's development and on implementation of evidence-based trauma treatment for young children and their families. In conjunction with Dante Cicchetti and Douglas Barnett, Dr. Manly developed a maltreatment classification system that is now being used by research laboratories around the world to operationally define dimensions of child maltreatment. Dr. Manly has published in the area of child maltreatment and evidence-based interventions. She was honored to be appointed as Executive-at-Large for WAIMH and continues to be inspired by the dedicated people around the world who are working on behalf of young children and their families. With



her developmental psychopathology perspective and involvement in both research and clinical practice, she has learned to bridge multiple perspectives, across disciplines and areas of interest, and to be proactive in thinking creatively and working collaboratively to address the difficult challenges faced by families with young children in our world today. She hopes to bring this same collaborative spirit into WAIMH, to build on the excellent work that is currently being done to advance mental health of young children worldwide.

Reflections: Maree Foley, WAIMH Affiliates Chair

I am currently the chair of the Affiliates Council and prior to this role I was the Affiliates Council representative (2010-2014). In 2010, I was elected to this role with Prof Dr Martin St-André who was elected as the Affiliate Council Chair. Our task was to build on the vision of the WAIMH board. That is, the Affiliate Council is to advise and guide the WAIMH Executive Committee regarding the activities and needs of the regions served by WAIMH affiliates and those in the process of developing WAIMH affiliates. In 2014, Martin's term finished and I took the role of chair and Anna Huber was elected as the AC representative. My term of office in this role will finish in 2018.

In addition, I am also the copy editor of *Perspectives in Infant Mental Health*.

I am a past president (2009-2013) of the New Zealand WAIMH affiliate, IMHAANZ (Infant Mental Health Association of Aotearoa New Zealand). The current president of IMHAANZ is Dr Denise Guy. I have added a link here to IMHAANZ (www.imhaanz.org.nz).

My professional background is in social policy and social work (BSW, MPhil), psychodynamic child psychotherapy (PG Dip Ch Psych) and more recently organizational team management (PhD Management). Since 1995, my practice and ongoing trainings have been oriented towards working with families with infants and young children. I have worked in both the public and private sector as a psychotherapist, teacher and clinical supervisor. A mainstay of my practice has been conducting care and protection assessments and where possible working with families and the multi-disciplinary services involved in their care to support healing and family reunification. I have also been engaged with workplace team coaching.

As life weaves its way through paths that unfold one step ahead of where I am, I currently find myself living in Geneva, Switzerland. While my French is improving, I am not yet competent to practice any form of face-to-face client work in French. Instead, I am engaged with high performance team coaching. I am also currently engaged in a new project where I am setting up a new service for UN and NGO organizations who are writing and researching about social policy pertaining to children. The aim of the service will be to assist policy writers with ways to include the unique needs of infants and their families within their briefs, including the

interdisciplinary and lifespan agenda of infant mental health.

While the contexts of my practice are now varied and diverse our field of infant mental health (IMH) remains an anchor for me. IMH as a theory and as a practice remains relevant and salient. In addition, IMH as a global community remains constant. Throughout my career, I have been influenced and continue to be challenged and stretched by many extraordinary people in our field (including esteemed published colleagues and friends, teachers, grass-roots practitioners and treasured clients). I am grateful and thankful to each one of them.

It's always a risk to start naming names of key influences because it's impossible to name everybody. So, I will limit my choice to one person, one key note presentation, one paper: Dr Daniel Stern, the clinical relevance of infancy: A progress report. While, I had read Stern's work, I first heard him speak at the amazing WAIMH Congress held in Paris in 2006.

I arrived in a huge lecture room, jet lagged from my trip from New Zealand. I was feeling nervous and preoccupied about my pending poster presentation. My conference handbook was glowing on my lap from all the highlighter pen I had used to mark all the sessions I would attend; a pending feast of presentations from dawn to dusk. And then Daniel Stern began to talk.

As he spoke I was awake, present and blessed. He spoke of the new dance between the interpersonal, intersubjective and intrapsychic processes. He talked about the paradigm shift towards a two-person psychology. He talked about what it means to experience triadic relationships in therapy. He talked about extended home-visiting programs as a preventive measure. He talked about implicit knowledge. At the end of his presentation he talked about the nonspecific factors of psychotherapy, such as taking the time to be with clients, and to really listen to them. He reported that these factors, above all of our other tools, assessments and theoretical orientations, are having the most effect in bringing about change and prevention.

I have returned, and returned again to the phenomenal memory of his presentation. This paper and the experience of listening to Daniel in Paris never grows old, never loses its zest. The challenges he posed to me as a practitioner and to our IMH community remain current. As a WAIMH



member and as a Board member, I treasure the journey taken so far and look forward to the one ahead as we travel together to fulfil the goals and vision of WAIMH. You can access his paper from this talk in the *Infant Mental Health Journal* (Stern, D. 2008). The clinical relevance of infancy: A progress report. *Infant Mental Health Journal*, 29 (3), pp. 177-188.

WAIMH Affiliates News

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Greetings to all WAIMH Affiliates. This news update includes information about the following:

New WAIMH Affiliates;

1. The WAIMH website and a special area for AC Presidents/Executives;
2. WAIMH Affiliates and 10 Members: A new WAIMH Board decision;
3. Asia WAIMH Affiliate sub-committee;
4. Affiliates Council Pre-Congress;
5. Training and knowledge sharing for WAIMH Affiliates; and
6. Keeping the WAIMH office updated with any changes in affiliate contact details

New WAIMH Affiliates

Estonia have recently been approved as a new WAIMH Affiliate. Welcome Estonia. Furthermore, in this edition, our colleagues from Estonia share news about their work and activities in Estonia.

In addition, another group are nearing the end of their formal affiliate application process. We look forward to formally welcoming them in the near future.

The WAIMH website and a special area for AC Presidents/Executives

A special page within the WAIMH website for WAIMH Affiliate Council members has been set up with the support and the expertise of Minna Sorsa and Anna Hemmi in the WAIMH office. This new page has been developed in response to feedback received at our Affiliate Council meetings. It aims to increase the capacity within our WAIMH affiliate network to share information more easily. Over the next 12 months we will continue to build this page to include information about training, education, infant mental health resources as well as governance issues at the affiliate

level. Soon, we will provide affiliate presidents with specific information about how to access this information within the site.

WAIMH Affiliates and 10 Members

The WAIMH Board recently decided to temporarily waive the criteria for new organisations to have 10 WAIMH members at the time of applying to become a WAIMH affiliate.

The background to this decision is as follows. The issue of equity and accessibility to WAIMH affiliate membership across the globe has increasingly become an issue for new organisations. Over the past 6 years especially, new groups seeking WAIMH affiliate status have often struggled to get 10 WAIMH members. This situation has halted their affiliate development process and decreased their capacity to participate as an affiliate within WAIMH. Similarly, established WAIMH affiliates have also struggled to maintain 10 WAIMH members, however their capacity to participate as an affiliate within WAIMH has remained constant.

As a result of this evolving pattern, the WAIMH Board considered an array of solutions. As a first step to an overarching solution, the Board decided to waive the criteria for new affiliates to have 10 fully paid WAIMH members at the time of becoming an Affiliate. This will be reviewed again over the next year.

Within this waiver period, the criteria of having 10 WAIMH members at the time of application will be viewed as an organisational goal to be achieved over time as the newly established affiliate develops.

Asia WAIMH Affiliate sub committee

At the WAIMH Board meeting last year in Prague, Professor Hisako Watanabe agreed to act on behalf of the Board to specifically support the growth and development of WAIMH in Asia. As many of you know, Professor Watanabe (warmly known as Hisako) has been a foundational member of the Japanese WAIMH affiliate and is an inspirational psychiatrist, professor, researcher, and mentor to many of us.

Recently, colleagues in China who are actively engaged in developing a WAIMH affiliate based in Beijing, requested WAIMH support for an upcoming conference in

Beijing: *International Infant and Young Child Mental Health Update and Progress*. In response, Hisako will attend this conference in Beijing, in April, on behalf of WAIMH. She will be a guest speaker and she will engage with the local group in discussion about the journey of becoming an affiliate. We are sure the conference will be very successful and it will be a major milestone in the overall development of promoting infant mental health in China. We will update you in a later issue about this conference and about the new WAIMH Asia support initiative.

Affiliates Council Pre-Congress

The interrelated issues of training, competency and professional development have been repeatedly identified as areas of need across the affiliates. In addition to developing the WAIMH affiliates page within the WAIMH website, the Affiliates Council will host a half day pre-congress workshop in Rome in 2018. The workshop will be chaired by Maree Foley (PhD) and Anna Huber (PhD).

Planning is in the early stages but it is our intention to provide in-depth information about infant mental health training programmes from around the globe. A breadth of programmes will be featured ranging from well-established formal programmes to those that are not well known but serve unique local/regional training needs. Details about how to access these trainings will be outlined. We also hope to explore arenas of IMH practice and research competency. A cross-cultural lens will be used to prioritise and contextualise competencies. Hopefully, the workshop will also include narratives and stories from infant mental health practitioners and researchers about their journey of becoming an infant mental health specialist and or the experience of establishing an infant mental health training programme.

Over the course of this year we will be directly in touch with affiliates as we prepare for this workshop. We are also keen to hear from any members of the Affiliate Council who may be interested in working alongside us in the preparation and running of this workshop. We would be delighted to hear from you.

Training and knowledge sharing for WAIMH Affiliates

A core task of the Affiliates Council involves identifying and facilitating the meeting of affiliate needs at varying stages of their development. From study groups through to established affiliates there is a need for ongoing training and supervision and the

sharing of infant mental health knowledge, skills and trainings.

In response, the WAIMH Board welcome requests from affiliates and where possible are happy to support groups through accessing online webinars, online cyber-guests and facilitating the availability of keynote speakers. The WAIMH website outlines specific details concerning how your affiliate might directly apply for WAIMH support access.

Keeping the WAIMH office updated with any changes in affiliate contact details

The WAIMH office staff frequently update affiliate data into the WAIMH website. We understand that these details change over time as executive personnel change. We appreciate you updating the WAIMH office about these changes so we can always keep in touch with you with regards to affiliate council matters.

We wish you all the very best with your affiliate activities over the next months. We are always pleased to hear from you: your news, queries and challenges.

Estonian Association for Infant Mental Health

Let us welcome the Estonian Association for Infant Mental Health by joining hands around the world in support of good mental health for Estonian babies, very young children and families. We are so very glad to introduce you to the WAIMH community.

Estonian Association for Infant Mental Health – Eesti Väikelaste Vaimse Tervise Liit – was founded on 21.11. 2014 by professionals who work with children and who have long been interested in the promotion of early childhood mental health. The idea to create the association came about when the three current members of management underwent a year's training in London - International Training School for Infancy and Early Years, organized by Anna Freud Centre, Yale University Child Study Center and The Tavistock and Portman NHS Foundation Trust. After the training, they began to share the new knowledge in a systematic way, and thus a group gathered who have taken the promotion of mental health of young children to heart.

About Estonia

Estonia is located in Northern Europe, our neighbors are Russia, Finland and Latvia. Estonia has an area of 45 339 square kilometers and 1.3 million inhabitants. Estonia's main ethnicity is Estonians, who make up 69.72% of the population. The largest minority group is Russians, who make up 24.8% of the population. Estonia's official language is Estonian.

The Estonian health care system is built on the principle of compulsory solidarity-driven health insurance and private providers of services for universal access. All children are secured for treatment and every child has a family doctor who will monitor the child's development, and to whom one can turn to when a child becomes ill.

Problem spots are the fact that mental health services don't cover the current need, especially few there are not enough services for smaller children and there are few proactive activities and programs. Overall awareness of mental health problems is low.

For families with small children it is very important, that parental benefit is applicable. Before the child reaches 70 days of age, the mother is entitled to the benefit, after that both parents are entitled to the benefit on a turn by turn basis. The right to parental benefit begins after the last day of maternity leave and the benefit is paid for 435 days or 18 months.

education for children in this age. The nurseries and kindergartens network is well developed, partly funded by the local government, but a large part of kindergarten fee is for parents to bear. Some children go to childcare at 18 months old, when the mother's parental allowance ends and she returns to work, but quite often the mother or father of the child stays at home until the child reaches two years of age.

The aim of the EAIMH is to develop cooperation between people who want to create and secure an environment where children's growth and the development of affection between parents and children can take place in the best possible way. EAIMH organizes various training courses and workshops in order to disseminate public scientific knowledge from various child-related areas, create interest in the society on the topic of children's mental health and to highlight the importance of safe development in the first few years of a human's life, share knowledge and generate discussion about the importance of the mental well-being of the families, parents and carers, share knowledge about children's mental health with professionals working with children and to promote mental well-being of professionals working with children.

We are an enthusiastic group, we strive to keep up with new knowledge on early childhood mental health and share the knowledge in different places across Estonia, including smaller towns and communities.

Board of the EAIMH

President: Piret Visnapuu-Bernadt, child psychiatrist, psychoanalytic child- and adolescent psychotherapist,

Members: Tiina Valvas- child psychologist, psychoanalytic child- and adolescent psychotherapist,

Sirje Rass- child psychologist, psychoanalytic child- and adolescent psychotherapist,

Kristel Amjärv- general practitioner, pediatrician,

Diana Kuntor- preschool teacher, experience advisor.



Estonian children, photo by Joonas Roosalu.

Estonian mothers are usually working as the employment rate for Estonian women aged 20-64 is above the EU average. In 2016, 67.5 percent of 20-64-year-old women were participating in the labor market.

Education is in Estonian. The first Estonian ABC book was published in 1575. School attendance is compulsory in the 7-17 years of age, the state ensures free

Emotional Availability and Emotional Availability Zones (EA-Z):

From assessment to intervention and universal prevention

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Abstract

Emotional availability (EA) refers to the emotional quality of a caregiver-child relationship, and it includes dyadic qualities that go beyond those relevant for attachment. In addition to sensitivity, EA also includes a caregiver's capacity to create a positive emotional environment, support learning, set limits, grant autonomy, and regulate negative emotions. Further, this framework considers the child's side, assessing his or her responsiveness to and involvement of the adult. Therefore, although EA certainly assesses attachment concepts, such as sensitivity and responsiveness, it extends upon these by incorporating other important aspects of relationship quality. The EA Scales assess these six dimensions of EA, and they are among the most widely used measurement tools for assessing the quality parent-child interactions. Further, the EA Scales can be used among any age group and have been validated in a wide range of cultures, both within the U.S. and worldwide. In recent years, due to both the comprehensive nature of the EA Scales and their validity as an assessment tool, researchers have begun moving toward applying EA concepts in an intervention setting. We offer recommendations, based in research and our own experience delivering an EA program, for researchers or practitioners seeking to use the EA scales in an applied setting. The "four R's" of Brief EA intervention: resources for psychoeducation, role model videos, reflection, and relaxation/regulation are offered as guideposts for delivering EA concepts as a prevention or intervention program.

The Concept of Emotional Availability

"Emotional availability" (EA) refers to the quality of the emotional connection between a child and adult. Emotional availability emphasizes not only an adult's responsiveness to the child, but also his or her healthy emotional presence. Further, EA encompasses the give and take between adult and child (Emde & Easterbrooks, 1985). Such emotional presence on the part of the adult conveys that the adult is available to respond with appropriate emotions to the child. Similarly, the child's emotional availability to the parent is also important. As has been described in Biringen, Harman, Saunders, & Emde (in press), "Not only are the parent's emotional presence and attunement important for the child, but it is also important for the child to communicate to the parent, and of course, for the parent to be seeing, hearing, and understanding the child's communications" (p.1).

Further, emotional availability of both adult and child refers not only to attunement and responsiveness when the attachment behavioral system is heightened, such as in times of stress, but also during real-life, everyday situations. Can the child and adult connect through shared activities and have fun together? Can the adult support the child in a nonintrusive manner so the child's lead is being followed? At the same time, can the adult offer suggestions that support the child's growth and evolution as a strong and robust individual? The EA framework offers a way to assess these important aspects of adult-child relationships.

Assessing Emotional Availability

The Emotional Availability (EA) Scales were developed by Biringen and colleagues (Biringen, 2008; Biringen et al., 1998), and they encompass an observational system, with the clear premise that observation can assess what is happening in a relationship at a particular point in time.

Attachment theory and systems theories have contributed to this framework, which assesses relationships in everyday, real-world settings (e.g., play, bedtime, feeding).

The Emotional Availability (EA) Scales consist of four adult characteristics (sensitivity, structuring, nonintrusiveness, and nonhostility) and two child characteristics (child responsiveness to the adult and child involvement of the adult). Sensitivity describes mostly the affective presence and appropriate responsiveness of the adult. Structuring refers to appropriate strategies that guide the child and set limits in a preventive manner. Both structuring and nonintrusiveness describe control-related qualities, yet nonintrusiveness refers to the adult's ability to withhold behaviors that could interfere with the child's interests and to support age-appropriate autonomy. The final adult scale, nonhostility, refers to whether or not the adult demonstrates subtle or overt negative emotions. Hostility that is directed toward the child is taken into account, as well as hostility that the child witnesses, such as between spouses or toward other children.

The child's responsiveness to the adult refers to the child's affective presence and emotional responsiveness to the adult's bids for connection. On the other hand, the child's involvement refers to the child's initiative in bringing the adult into interaction in appropriate and positive ways. The EA Scales provide a multidimensional look at interactions. The adult may be affectively present but not structure effectively, or the adult may be unstructuring as well as intrusive. That is to say, each participant of the interaction receives a pattern of scores, and for some interactions the different EA dimensions are only moderately correlated with one another.

Emotional Attachment Zones (EA-Z)

Two of the components described above—adult sensitivity and child responsiveness are ways of describing attachment, and more specifically, what we refer to as “emotional attachment.” Adult sensitivity is used to indicate a zone of emotional attachment for the adult and child responsiveness is used to indicate the child’s zone of emotional attachment. The four zones emotional attachment for the adult are: emotionally available, “complicated,” “detached,” and “problematic/disturbed” (Biringen et al., 2014). These zones are patterned after the four attachment styles, secure, insecure-anxious/resistant, insecure-avoidant, and insecure-disorganized, respectively (Ainsworth & Bell, 1978; Main & Solomon, 1986). The same four zones are used for the child. Further, the adult and child do not need to be in the same zone.

EA-Z is the translation of the Emotional Availability Scales into Emotional Attachment. “Emotionally available” is the high end of EA-Z and refers to an adult who is nurturing a healthy emotional connection, one where s/he is warm and tuned into the child, both verbally and nonverbally. Only the highest sensitivity scores, where the adult embodies a generally positive affective and authentic presence would be placed here. Similarly, only the highest child responsiveness scores, suggesting a healthy emotional attachment to the adult and a positive, robust, or relaxed demeanor, would be placed here.

The middle part of EA-Z refers to an over-connection or a “Complicated” emotional attachment. When an adult is sometimes but not consistently tuned in or the adult’s affective presence is warm/positive, yet immature or unreal/inauthentic, then the adult is categorized as “complicated.” To be placed here, the adult would need to receive a sensitivity score that is in the middle range. For a child to be placed here, the child’s scores would need to be placed in the middle areas of the child responsiveness dimension, suggesting that the child may be dependent, anxious, or otherwise not relaxed and robust in his/her affective presence.

The lower end of EA-Z is referred to as “Detached.” On sensitivity, scores that are lower than the middle range in sensitivity are placed here, and suggest that the adult is cool, mechanical, distant, and potentially avoidant of close emotional connection. Such an adult is still a competent caregiver, especially with respect to basic care, yet, the quality of those interactions may be

emotionally shut down or emotionally distant. Similarly, a child who is emotionally shut down, avoidant, or ignoring of close affectional ties would be placed here.

Still lower than the above would be what is referred to as “Problematic/Disturbed.” This zone suggests that the adult is displaying affective presence that is odd (e.g., stillness or utter silence), does not seem to engage in a basic level of care or interaction, or may be highly intrusive and hostile (e.g. introducing violent themes). Adults with sensitivity scores in the lowest range get placed here. On the child’s side, affective qualities such as dysregulation, odd behaviors (e.g., throwing himself on the ground) or emotional frailty or acting out would be placed here. Children with the lowest responsiveness scores receive EA-Z scores in this zone.

The additional EA dimensions (structuring, nonintrusiveness, nonhostility and child involvement) do not provide as much information about emotional attachment quality and, therefore, do not directly contribute to the zones of emotional attachment. Nevertheless, they hold important information regarding attachment. For example, caregiver hostility is a predictor of disorganized attachment (Lyons-Ruth, Melnick, Bronfman, Sherry, & Llanas, 2004), so it may be relevant when determining a caregiver’s emotional attachment zone.

These additional caregiver and child dimensions are also important aspects of the EA system, not only because relationships occur with non-attachment figures, but also because relationship quality involves more than attachment. When a caregiver is intrusive during play interactions, she may communicate (even unwittingly) that the child is less capable. When a caregiver raises his voice during drop off at school as he realizes his son has forgotten his homework, he signals frustration with the child. When a mother raises her voice to her partner, she communicates to her son that the family is less unworthy of respect. Such ordinary daily events can be outside the traditional realm of attachment-activated times, (such as stress, illness, or danger) but they remain very important to a child’s emerging sense of self.

Given the EA-Z zones and EA Scales have now been described, the question of adult-child concordance arises. Theoretically, the adult and the child can appear very different, both in terms of their EA-Z zone and their scores on the EA scales more generally. Practically, can there be an emotionally available parent in the presence of an emotionally unavailable child (e.g., Complicated, Detached, or

Problematic)? Certainly. This occurs most commonly when the parent and child do not have a shared history (such as adoptive or foster parents or parents who are parenting at a distance after separation, divorce, or deployments). For example, we know that in 22% of adoptive families, parent and child are in different attachment zones (Barone, Lionetti, Dellagiulia, Alagna, & Rigobello, 2015). Can there be an emotionally available child when the adult is not emotionally available? Again, certainly. We have seen this in the context of child care, where a child from a secure and supportive home interacts with a child care professional who is detached and unstructuring with this child and potentially with all the children in the site. Alternatively, we have seen a caring and positively expressive child care professional who interacts with and tries to draw out a cool, lonely, and withdrawn child.

The possibility of the parent and child having different perspectives of the relationship has always been viewed as a real possibility, or should have been, in the field of attachment, given no higher than moderate relations between maternal sensitivity and child-to-parent attachment (De Wolff & van IJzendoorn, 1997). When one brings in the father into the family system, the relation between his side of the relationship (that is, sensitivity) and child-to-father attachment is even more complicated than the relation of the mother’s sensitivity and child-to-mother attachment (van IJzendoorn & De Wolff, 1997).

The Emotional Availability system (the EA Scales and the EA-Z) have been used heavily as an assessment tool in research. Further, cross-cultural studies have demonstrated its validity, both for subcultures within the United States and across the world (for a review, see Biringen et al., 2014). The system is also now used heavily in clinical or practice contexts, particularly by parenting evaluators (e.g., child custody, social service) and sometimes by therapists to evaluate therapy process and potential progress. At present, the system can be used for a wide developmental spectrum (at present, pregnancy-14 years) and thus has had versatile applications as an assessment tool. In addition to pure assessment for the purposes of accountability or to assess clinical outcomes, some have used it to enhance the training of therapists, workshop facilitators, or supervisors of evidence-based practices and programs (e.g., Parents Under Pressure) (Harnette & Dawe, personal communication, 2015).

Moving Beyond Assessment to Intervention

Given the widespread use of the EA framework as an assessment system, it makes sense to expand upon this framework to include preventive and treatment-focused interventions. We have developed and evaluated a 4-to-6 session EA intervention manual (summarized in Baker, Biringen, Meyer-Parsons, & Schneider, 2015; Biringen et al., 2010) that can be delivered in group or individual sessions. The intervention is based in the “three pillars” of our work: attachment, emotional availability, and mindfulness (Biringen et al., 2015). Using these core concepts, the program helps parents or caregivers to consider their own attachment history, learn about emotional availability through psychoeducation, practice mindfulness, and reflect upon a video of their own interaction. A key “active” ingredient of this and other attachment-relevant interventions is the video playback (Bakermans-Kranenburg, van IJzendoorn, & Juffer 2003). Unlike other attachment-relevant interventions, however, ours involves the use of the more multifaceted EA framework, which has proven useful and valid for assessment (Biringen et al., 2014; Lotvin et al., 2015). How do we suggest that researchers, clinicians, and interventionists use EA as part of their intervention approach? Here are the 4-Rs of Brief EA:

1. Resources for Psychoeducation.

Prior to teaching parents and other caregivers skills, it is important to both describe the EA framework and to “sell” the importance of a research-based framework. First, each of the six EA Scales should be described so that participants understand them. Next, offering research regarding the predictive value and importance of emotional availability can make caregivers more receptive to and interested in the intervention. As an example of a successful intervention that does this; the Gottman Couples Method uses psychoeducation to teach couples basic research the predictors of divorce (Gottman & Gottman, 2008). Similarly, an interventionist using the EA framework to facilitate behavior change for a caregiver-child relationship can teach basic research about EA and attachment. This could include describing the positive social-emotional and behavioral outcomes associated with a secure attachment (e.g. Sroufe, 2000). It could also describe how higher caregiver sensitivity and structuring

predicts greater child compliance (Lehman et al., 2002). More basic research on the predictive value of EA for child developmental outcomes, as well as for caregiver well-being, can be found in Biringen et al., 2014. Educational resources may be presented verbally, through a brief handout or booklet, with videos, or through a visual presentation. Some caregivers may find it challenging to receive psychoeducation. For example, a caregiver with an anxious representation may express extreme guilt regarding her parenting behaviors that interferes with her ability to reflect upon the new information. Alternately, a caregiver with a rigid view of relationships may become defensive and protest the ideas presented. If a group facilitator cannot effectively help these caregivers process these internal challenges in the group setting (or if it detracts from other caregivers’ learning), we advise that caregivers be referred to individualized therapy. This could be individual, couple, or family work, depending on the needs and preferences of the caregiver.

2. Role Models Videos.

So that participants can learn to apply their newly acquired knowledge of the EA framework, it is important to show them role model videos of caregivers interacting with their children. In order to foster a full understanding, it is helpful to show a range of cases that represent a variety of EA-Z zones. The use of these brief clips helps participants apply what may initially seem like either abstract or unimportant ideas. Additionally, observing and discussing another parent’s behavior and emotional expression can help set the stage for participants’ self-reflection later in the intervention. As they watch the role model videos, participants are asked to describe what they see, using the language of emotional availability. The facilitator helps to guide this conversation by pointing out both strengths of the interaction and areas of growth. The facilitator should also draw a parallel between the EA-Z zones and attachment styles during this activity so that participants can begin to recognize signs of insecure and secure attachment. Watching and discussing role model videos prepares participants for is the next stage of the intervention, reflection.

3. Reflection.

Participants engage in three types of reflection: (1) Using the role model videos, they imagine what the parent and child are each experiencing. (2) Participants are guided through reflecting upon their attachment history and the parenting they received as a child. (3) Participants engage in self-reflection regarding their own current behavior and emotional expression with their children with their own children.

a. Role model video reflection:

By considering what the parent and child are feeling and doing in the role model video, the participants begin to practice perspective-taking and empathy, both of which are important in their own interactions with children.

b. Attachment history reflection:

Next, when participants reflect upon their own early relational experiences, they can gain insights into their current behavior and states of mind about relationships. This reflection may be relatively brief for some participants and much more elaborated for others. Helping participants to identify their childhood attachment style can be useful in facilitating these conversations. Some participants may have traumatic childhoods or otherwise find it difficult to identify positive aspects of their primary attachment figures, leading them to feel unresolved and confused about relationships. Asking these participants to identify a positive adult figure from their childhood who made them feel accepted, loved, and understood can help them develop a new model for relationships (Lieberman, Van Horn, & Ghosh Ippen, 2005). Nevertheless, it is important to also refer these adults to external services for more extensive therapeutic work. Depending on each of these participant’s situations, this could be additional video-based work using the EA framework, or it may be more targeted trauma-informed individual therapy.

c. Self-reflection:

Finally, participants should be offered opportunities to reflect upon their own interactions with their children. Ideally, this occurs by watching and discussing a short videotaped interaction between the participant and their child. This could also occur through a live observation of the caregiver-child interaction. The facilitator should use strengths-based feedback, commentary that highlights the child’s perspective, and

questions about what surprised the caregiver. For example, strengths-based feedback could include: "That was a frustrating situation, yet you managed to keep your cool" (nonhostility); "Look at how quickly you noticed your child's uncertainty about that new toy. I imagine she felt very comforted when you offered reassurance" (sensitivity). Commentary regarding the child's perspective could include: "Notice how eagerly he showed you that toy, I wonder if he's also showing you how much he loves to play with you" (child involvement); "Did you see how she pulled back a little when you tickled her face with the toy? She may be telling you that's too much" (nonintrusiveness). For older children or adolescents, facilitators may also choose to invite the child to offer insights into his or her feelings and thoughts during the videotaped interaction. During this self-reflection process, it can also help to ask participants what they found surprising while watching themselves. In our interventions, some caregivers have noticed important qualities of their own style, such as, "I looked more aloof with my child than I realized." While some of these constructive self-realizations may come from the participant after a video review, the interventionist can also gently bring about such conversation. Video-based feedback is a powerful tool to enhance parental sensitivity and improve parent-child relationship quality (Bakermans et al., 2003). However, it is also important to maintain a positive, collaborative, and accepting attitude when working with parents/caregivers in order to avoid them feeling judged or stigmatized. For this reason, it is important to build trust and rapport and to use strengths-based feedback.

4. Relaxation and Regulation.

The adult's capacities to regulate his or her own emotions and to stay in the present moment are important to being emotionally available. Therefore, we recommend introducing mindfulness attitudes as a way to promote these skills (Kabat-Zinn & Hahn, 2009). These attitudes can then be integrated and practiced in several ways. The facilitator can offer brief mindfulness meditations that focus on breathing and relaxation. Participants may also choose ways to integrate mindfulness into their daily lives. Finally, participants may choose ways to integrate relaxation and regulation more generally, as self-care. Self-care includes everyday activities (such as exercise, social engagement, sleep, and

proper nutrition), as well as a general attitude of self-compassion. These tools help parents and other caregivers remain calm, relaxed, natural, and comfortable, both with their children and in their everyday lives. Again, for caregivers with rigid, anxious, or unresolved states of mind, this task may be particularly challenging. These caregivers may require referrals to individualized therapy that can facilitate deeper processing.

This process describes the critical and active ingredients of our manualized EA intervention, but it can also be used as an add-on to enhance any treatment process. In particular, self-reflection upon caregiver-child interactions can easily be added to any intervention or treatment delivered to parents or teachers, for it is a powerful tool of change. The process of the "Four R's" is simple, yet profound in its ability to not only convey the language of emotional availability but also to provide seeds on attachment history and mentalizing/insight as one is interacting with one's child. It also imparts to the parent the importance of self-care. Each portion, or "R," of the intervention is a "seed" and an invitation to learn and practice more. The intervention can consist of a brief 1 hour consultation with a parent, conducted by itself in a private practice setting. It could then be repeated in later sessions to gain further depth, and using a new video of the parent and child to track progress. Alternatively, this program can be used in a group setting, allowing the process to become one in which there is collective parenting discussion across participants. Given the wide applicability of the EA framework, across ages and cultural groups, this intervention offers a simple tool to enhance parent-child relationship quality among a wide range of populations.

Brief EA should be conducted by those already trained in the EA system (for more information see www.emotionalavailability.com). Facilitators should also be able to skillfully guide participants to understand the subtleties of perception and observation. Awareness of these qualities is a necessary condition for reworking them. Finally, facilitators should possess basic helping skills, such as empathy, acceptance, and reflective listening skills in order to create a warm and welcoming environment.

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Translating Theory to Practice: New Resource

By Deborah J. Weatherston,

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Tackling the Tough Stuff: A Home Visitor's guide to Supporting Families At Risk

Angela M. Tomlin & Stephan A. Viehweg (2016) Brookes Publishing Co.: Baltimore.

Relationships are at the center of this very illuminating and practical book that integrates developmental and clinical theories with many examples for home visitors to support effective service with families and, most important, healthy outcomes leading to growth and change. Connections between parents and child, parents and providers, and providers and supervisors provide the central theme throughout the book, with continuous reminders that relationships offer the cornerstone for effective service provision and the instrument for optimal growth and change.

Reflective practice goes hand in hand with relationship-centered service. The authors recognize the tremendous stressors that families face. Stress often affects parental capacity to care sensitively and effectively for their very young children. Stressors may include a diagnosis of significant mental illness, parental depression, a motor or sensory impairment, an intellectual disability, substance use or addiction, or domestic violence. Past and present experiences of trauma and loss, as well as economic struggles and severe poverty, exacerbate these risks.

After describing barriers, challenges, and risks, the authors offer practical tips and strategies for home visitors to use when entering into relationships with very vulnerable young children and families. Among the most creative strategy is a problem-solving framework, PAUSE, that blends relationship and reflective skills. The acronym for PAUSE is Perceive, Ask, Understand, Strategize, and Evaluate. The authors offer illustrations for each component, exploring ways to think deeply and reflectively in partnership with families.

News from the WAIMH Central Office

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Dear Colleagues,

The 16th World Congress of the WAIMH in Rome 2018 is nearing and has its theme as the interplay between nature and nurture. This dilemma is not quite as ancient as the city of Rome, but it has been an intriguing question for clinicians and researchers for quite a while.

This time our congress plenaries will address both old and new aspects of nature-nurture interplay. Our plenarists for Rome 2018 include Professor Massimo Ammaniti (Italy), Professor Jay Belsky (USA), Professor Hasse Karlsson (Finland) and Professor Jenny Radesky (USA). The plenaries present new data on issues that have been under study for a long time, like prenatal stress and its effect on both the mother and the developing infant; how the use of smartphones, tablets and computers will affect child development during the early years; and, how our individual characteristics can affect our susceptibility to different environmental stressors. We have not forgotten the global changes in climate and world politics, as the Presidential Symposium will address the crises facing refugee infants and their families in so many countries around the world.

As a novelty for this Congress, the Programme Committee has created what they call a Plenary Interface of Research and Clinical Work, where a researcher and a clinician will present on the same subject and, with the help from a moderator, will create an interesting discussion. One these interfaces will address prenatal stress and another will discuss how fathers influence the development of their sons.

The Programme Committee again proposes a range of ways in which you may be able to present your research with infants and families, your clinical work and other innovations. We are keen to hear from as many of you as possible and to facilitate a lively and collegial exchange

of ideas. Based on the feedback from the previous Congress we have also tried to provide better structures for both clinical and scientific abstract submissions. So please, do feel welcome to submit your work to the 16th World Congress in Rome 2018 to be shared with your colleagues worldwide. The call for papers will be sent out and submission for abstracts start May 1, 2017. The deadline for submission of abstracts will be September 15, 2017. If you are not on our mailing list yet, please send an email to office@waimh.org and we will include you.

The WAIMH has worked really hard to learn how best to use social media for the benefit of the infant mental health community globally. As you may remember, we have engaged Dr. Reija Latva to assist the Central Office with this, as well as volunteer members of the WAIMH family. Please send us your ideas about how we can make the WAIMH Rome 2018 World Congress as visible and as useful as possible through social media.

Over the next months we will provide regular updates in our newsletters about the Congress, plenary keynote speakers, plenary interface presenters and [participants in the invited symposia. We all look forward to seeing you in 2018, and of course you are aware of the old saying: all roads lead to Rome!

WAIMH Awards 2018

WAIMH offers four important awards in recognition of individuals from across the world who have made very important contributions to the infant mental health community in the course of their careers. Interdisciplinary by design, WAIMH invites nominations from the fields of health, mental health, early care and education, early intervention, hospitals, colleges and universities, legislatures, to name just a few.

There are 4 award categories: WAIMH Award, Sonya Bemporad Award, Serge Lebovici Award, Rene Spitz Award.

Required nomination materials for the WAIMH Award, the Sonya Bemporad Award, the Serge Lebovici Award and the René Spitz Award include:

1. A 250-500 word statement indicating why the nominee should receive the award.
2. A copy of the nominee's resume, vita, or biographical sketch. If you are nominating a group, provide a complete description of the group and its members as well as a

brief history of its relevant activities.

3. Three letters of support from individuals who endorse your nomination.

Submit all nomination materials in one packet and e-mail to the WAIMH Central Office postmarked no later than

December 31, 2017. The WAIMH Awards Committee will select each of these awardees.

WAIMH New Investigator Award 2018

WAIMH offers a special award for a promising new investigator.

The purpose of the WAIMH New Investigator Award is to recognize and encourage promising new investigators in infant mental health. The applicant must be a member of WAIMH or must be sponsored by a member of WAIMH. The applicant must have earned a university degree no more than eight years prior to the application deadline. The individual selected as new investigator receives a

cash award, a plaque, and acceptance of his/her paper for publication in the *Infant Mental Health Journal* (this involves exposure to the peer review process as a way of assisting the investigator's professional development). In addition, the new investigator must be prepared to present his or her work at the following world congress. We now call for applications for the WAIMH New Investigator Award.

Required nomination materials for the New Investigator Award include:

A statement indicating why he/she should receive the award

A manuscript of the applicant's research

A curriculum vitae

Submit all nominating materials in one packet to the WAIMH Central Office at office@waimh.org no later than December 31, 2017. The Programme Committee of the 16th WAIMH World Congress will decide the next WAIMH New Investigator Awardee after reviewing the applications.



The recipient of the WAIMH Award in WAIMH 15th World Congress in Prague 2016 was Pia Risholm-Mothander. The WAIMH Award is given in recognition of significant contributions to the World Association for Infant Mental Health, either directly or through one of the WAIMH Affiliate Associations.