

# Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

## President's Reflections

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In parallel to the on-going creation of new WAIMH Affiliates, the question of the role that members of infant mental health associations, particularly clinicians, might play in influencing their own country's health policies, besides being a forum for scientific and clinical exchange, is becoming central. In that context, this issue of Perspectives is extremely relevant and valuable.

Of particular interest is the excerpt from the FrameWorks Institute whose authors, Nathaniel Kendall-Taylor and Michael Baran, describe their interesting study based on interviews conducted with health policy makers. Their aim is to identify and describe the implicit assumptions that policy leaders have about children's issues generally and early child development (ECD) more specifically. The assumptions can be seen as the cognitive "filters" through which key scientific messages may be interpreted and misinterpreted. The authors have identified several main assumptions that may explain the scarcity of means allocated to infant mental health in many countries of the world. For example, the idea that early development is important, but survival is more important or that development is a "natural" process that "just happens" as long as the basic safety of a child is secured. Similarly, ECD is seen as important across the field, but at the same time, is not seen as its own stand-alone concept. Last but not least, physical growth and health are the "what" that develops during development. These assumptions explain the dominant focus among policy makers regarding nutritional programs as the main target of intervention.

I would suggest adding to this conceptualization of health policy makers' attitudes, an emotional, even more implicit and less conscious aspect. The subjects

of early child development and mental health evoke powerful and sometimes painful childhood memories in all adults. We often encounter emotional attitudes of judges and attorneys in family disputes... when the best interest of the child is in conflict with the parents' interests. Similarly, the preference for foster families over group homes and orphanages also comes from the implicit, emotional, and very strong assumption that a family, regardless of its level of functioning, is better than a good, attachment-oriented institution. As a consequence, the scientific finding that simply placing a child in foster or family based care does not ensure quality or protection of the child, is most often overlooked.

Still, there are instances of the significant impact of science on social laws. For instance, the accumulated research about a father's role in early child development and his capacity to build an attachment relationship as secure as the relationship between a young child and his or her mother, has led to radical changes in custody laws in many countries, including England, Australia, Belgium, Denmark, New Zealand, and more. By coincidence, on this very week-end, I found in one of the major Israeli daily newspapers a long article about the intention of the government to change the law that has been established since the creation of the state, according to which mothers are «automatic» custodians of the child in the first six years of life in high-conflict cases. The debate has been extremely emotional and has lasted for several years, ending with the compromise of default maternal guardianship until the age of two years.

The dynamic interplay between societal health policies and scientific data about the infant's competencies and brain development, is also the rationale of the effort WAIMH has been currently making



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## From the Kauppi Campus -News from WAIMH Central Office

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to compose an Infant's Rights Statement. We have sent you a first Draft, and your feedback can really make a difference in the end-result!

Besides all of these things, we have been very busy at improving the visibility of WAIMH among other mental health associations. For instance, board members participated in a symposium and plenary at the Asian Association for Child and Adolescent Psychiatry last September. Members will again participate in the next World Psychiatry Association Pediatric Section and a plenary lecture at the Association of Early Psychopathology in Brussels. Central Office staff and members participated in the Australian Association for Infant Mental Health Conference in Canberra and in the Four Winds Conference in Japan, both this past November. Finally, we are continuing to work on creating a Social Media Network for all our members and Affiliates.

Of additional importance, many thanks to those of you who have responded to the survey regarding the revision of DC 0-3R. Your comments are extremely valuable and helpful, mainly because they are the result of clinical work in the real world!

Last, but not least, the preparation for our Edinburgh Conference is going smoothly, thanks to the Local Committee team and the In-Conference Organizer. Abstracts have been reviewed and acceptance letters will be sent in the near future.

# From the Editors

By Deborah Weatherston, Michigan, USA, [dweatherston@mi-aimh.org](mailto:dweatherston@mi-aimh.org), Hiram E. Fitzgerald, Michigan, USA, [fitzger9@msu.edu](mailto:fitzger9@msu.edu) and Maree Foley, New Zealand, [maree.foley@vuw.ac.nz](mailto:maree.foley@vuw.ac.nz).

The Editors wish to acknowledge the life and legacy of Nelson Mandela, one of the world's greatest and most influential leaders. We will honor his work and commitment to humanity in the next issue of Perspectives in Infant Mental Health.

We welcome articles from around the world about individual, family, community and population level practice, policy, research and theory. We invite field reports, particularly case studies about individual challenges and successes in nurturing and supporting healthy development and change through practices promoting infant mental health. We ask for research articles that offer new ways of looking at prevention, intervention and treatment approaches. We welcome, too, book reviews that introduce readers to newly published materials that enrich their work.

Of additional interest, we have added a new column this year, The World in WAIMH, coordinated by Joshua Sparrow. It is a column intended to

generate reflection and offer a space for questioning, challenge, dialogue and interdisciplinary discussion. To be a truly global organization, WAIMH needs to extend its reach, and to learn from contexts, cultures and communities that are not or only minimally represented in its current membership. We invite your responses and reflections.

# The World in WAIMH: A Reflective Space

By Joshua Sparrow, Harvard Medical School, Boston, USA, [joshua.sparrow@childrens.harvard.edu](mailto:joshua.sparrow@childrens.harvard.edu)

As infant mental health workers, we are field builders, and as field builders we must also be advocates. To advocate for the resources and capacities families and communities require to raise thriving babies, we need tools – messages, frames, and messengers – to simply and clearly communicate the purpose and importance of our work. Our messages must resonate beyond our own reflective, relational, developmental, strengths-based, systems theory and culturally informed choir. To succeed in our advocacy, we will need to understand the resistances and objections, the competing priorities, and at a deeper level, the mental models of all those whose support we – and the babies, families and communities we partner with – must have.

The excerpts that follow set forth an approach to these challenges, as well as key findings and recommendations, in the context of the problematic polarization of child survival and child development. It is my hope that this article helps infant mental health workers everywhere reflect on and strengthen their communication strategies to garner broad-based commitment to babies' and children's survival and optimal development around the world. While this piece examines the "implicit assumptions" of international development leaders, it is also my hope that readers will use this as a starting point to develop responses to the "cultural models" of their local stakeholders, to break through their "cognitive filters," and to identify contextual variations in professional cultures that must be accounted for in effective advocacy efforts.

## Finding a Place for Early Child Development in the Hierarchy of Needs (Excerpts)

By Nathaniel Kendall-Taylor (Vice President for Research, FrameWorks Institute) and Michael Baran (Senior Researcher, FrameWorks Institute)

Prepared by the FrameWorks Institute with funding from the Center on the Developing Child at Harvard University and reprinted here with permission from the FrameWorks Institute.

### Introduction

The research presented here was conducted by the FrameWorks Institute and sponsored by the Center on the Developing Child at Harvard University. This report is part of a larger project that aims to translate the science of early child development (ECD) into the field of international development. The guiding question of this larger project is: How can

the science of early child development be communicated to increase science-understanding and create better alignment between scientific research and international development programs and policy?

The following report presents results from the first phase of this larger effort. In the report, FrameWorks analyzes data from a series of cognitive interviews in order to identify and describe the implicit assumptions, norms and patterns of understanding that leaders in the field of international development employ in thinking about their own work, children's issues generally and ECD more specifically. These assumptions can be seen as the cognitive "filters" through which key science messages will be interpreted. The analysis of these "filters," along with other empirical research, will inform recommendations designed to increase

the accessibility of this science to these international development leaders, as they make programmatic decisions for their respective organizations and shape the field more generally.

FrameWorks approached this work through a series of in-depth interviews conducted with a sample of organizational leaders in the field of international development. The focus on leaders was motivated by the project's guiding question: how to create better alignment between the work of international development organizations and the science of ECD. We believed that focusing on leaders of the field would be critical to creating the significant changes required to increase access and understanding of key science messages of ECD. 1 An important subsequent phase of research will explore the similarities and differences between the patterns of thinking documented in this report and

those employed more broadly by members of this field.

Recruiting leaders from international aid organizations poses specific challenges to the way that FrameWorks typically analyzes cultural norms and understandings. FrameWorks adopts a position that many of the norms and assumptions that guide understanding are implicit — that they operate at a cognitive level somewhere below that of the explicit and volitional.<sup>2</sup>

FrameWorks documents these shared implicit constructs as they are brought to bear in reasoning among members of a common culture. FrameWorks has typically studied how Americans' or Canadians' understandings are informed by such shared sets of implicit assumptions — assumptions that can be bundled into patterned collections of propositions and implicit understandings referred to in the literature as “cultural models.”<sup>3</sup>

The basic notion is that individuals, irrespective of demographic or ideological variations, share and employ a common set of underlying mental models about the world that stem from the experiences they share as members of a common cultural group. It is this larger national sense of culture — as the beliefs, norms and understandings that are shared across and shaped by individuals exposed to a common national media and public discourse — that typically constitutes the focus of our research.

The research described here uses the concept and theory of cultural models slightly differently — probing a different level of “culture” for shared implicit understandings. In the analysis discussed here, the sample is based on a shared membership in a professional field.<sup>4</sup> We analyze the data to determine how individuals across this sample make common assumptions as they talk and think. We contend to have found a set of cognitive constructs that function in the same way as “cultural” models, but that are shared by a group of people based on professional expertise rather than a common national culture. In short, we still focus on documenting cultural models, but the “culture” is of a different sort than that which normally constitutes our focus.

FrameWorks' approach is grounded in the notion that, in order to translate the set of ECD science messages effectively, communicators must understand the default patterns of reasoning used to make sense of the issue. Only when they understand “what they are up against” can they be prescriptively strategic and effective. Knowing how the leaders of this field employ a common set of meaning-

making devices allows us to figure out the most effective and efficient ways of fitting the science of early child development into the norms of the field. It also allows us, in some cases, to strategically build on features of this understanding in order to make space for the science of ECD and related policy recommendations. The end goal is to infuse this field with a scientifically faithful understanding of ECD that helps set the agenda and allocate resources towards policies and programs that are in line with the implications of the science of ECD. In this way, laying out the common features of the way these international development organization leaders understand children's issues and early child development creates a map that can be used to craft strategic translations of the science of ECD.

## Executive Summary

Leaders of the field of international development share critical understandings and assumptions that guide the way they think about their own field of work, children's issues in general and early child development.

1. A widely shared hierarchy of needs model poses a major obstacle to communicating the science of ECD, and of shifting resources in the direction of those policies and programs that the science suggests are effective. According to this model, the field's work on children's issues is cognitively represented as a hierarchy of sequential tiers. The key to the model is that the concerns comprising foundational levels of the hierarchy must be satisfied before issues on subsequent levels may be addressed. Issues pertaining to child survival constitute the base of the hierarchy and issues of child development represent some level above this foundation. Putting these spatial and content assumptions together, informants assumed that issues of child survival must be satisfactorily dealt with before work on development can be prioritized. Communicators must be aware that the hierarchy of needs model allows ECD to be acknowledged as “important,” but only prudent to address after, as one informant put it, “we've taken care of child survival.”
2. Leaders applied a zero-sum model of discrete and competing sectors comprised of health, education and justice/rights in conceptualizing the field of international child advocacy. As ECD does not comprise a sector,

this assumption suggests that communications that talk directly about the importance of ECD will be difficult to fit into the existing structure of the field. The sectors are perceived to be discrete and siloed. This model offers both opportunities and challenges for communicating ECD as a process which underlies all aspects of child well-being, without being perceived as competing with any established sector.

3. Leaders of the field think of their work as investments. This metaphorical model was comprised of a set of more specific assumptions: that resources are limited, that the goal is to realize the largest return possible, that returns must be visible and measurable, that they must occur in relatively close temporal proximity to the investment, and that returns must be significant. The investment model presents a particular challenge for translating the science of ECD, which emphasizes the long-term trajectory of effects that begin in childhood.
4. A developmental perspective may run counter to a commonly held children are people too model, closely associated with a rights orientation. This perspective may make some of the science messages — about critical developmental periods, for instance, or the importance of developmentally appropriate interventions — difficult to incorporate into existing perspectives.
5. A tendency to focus on the nuclear family model limits broader definitions of responsibility and recruitment of additional adult actors in child rearing. The representation of “family” as “nuclear family” ran across the majority of our interviews. Even when informants knew that there were other actors and factors engaged, there was a tendency to focus in on the child in the context of a two-parent household and to evaluate that child's risk in light of threats to that model. This common mental model of “family” may be problematic in light of the fact that many of the contexts in which the science of development will likely be applied are not characterized by familial structures that approximate this mental model. In short, communicating about different structures and ideas of “family” will require expanding, modifying or perhaps building a new working model of “family.”
6. A set of core systemic factors — including education, the economy and the health infrastructure — were



perceived as having consistent wide-ranging and diverse effects on child outcomes. This branching-effect model of causality structured an understanding that differentiated between symptoms and root causes, with the best investments in child outcomes addressing the latter. Core issues were, therefore, systemic by definition. This model offers great potential for linking ECD into the causal chains that link interventions to outcomes.

7. Leaders in the field of child survival evinced a surprisingly thin understanding of the process of development. While generally conversational with the idea of ECD, they quickly drew a blank about key science tenets. Once the conversation went beyond “early matters,” “supportive relationships are key” and “having a big payoff down the line,” the science of ECD was largely not accessible. Relatedly, many informants also thought about ECD as a “natural” process that “just happens.” This assumption supported views that development occurs optimally when interventions secure the basic safety of a child, and then stand back to let development run its course. In addition, the assumed “naturalness” of the process allowed informants to disengage from thinking actively about how development happens. This suggests not only that attempts to translate the science into this field have yet to be successful in structuring understandings of ECD, but also that there is relatively unfettered cognitive space on this issue for strategic communications to build such process understandings.
8. ECD was understood as part of everything, but nothing on its own. In other words, ECD was seen as being part of all the field’s sectors but, at the same time, not being its own stand-alone concept. The acknowledgement of its shared centrality may facilitate the embedding of ECD in other topical areas — a tactical strategy that avoids running up against the zero-sum model mentioned above.
9. Leaders tended to take a deterministic approach to development. Once the process of development has been perturbed in some way, they said, there is nothing that can be done. A well-documented assumption in past FrameWorks research, this damage done is damage done model offers communicators an opportunity to introduce the science of neuroplasticity and to demonstrate how interventions

that are grounded in developmental science can change the developmental trajectory.

10. Assuring positive development was understood to rely most centrally on protecting and finding ways to insulate children from their surrounding environments. This assumption creates an understanding of the relationship between children and contexts that makes it hard to see attempts to encourage positive interactions between children and their environments as effective interventions. This, in turn, sets up the nuclear family as protector in opposition to everyone/everything else as the locus of the threats. From a developmental perspective, it limits the range of supportive experiences and contexts that come to mind, and solidifies the hierarchy of needs model described above.
11. Physical growth and health are the “what” that develops during development. This explains the dominant focus among our informants on nutritional programs as the silver bullet intervention. It also demonstrates the importance of developing appreciation for ECD as a process separate and apart from either health or education, but one that influences both.
12. The family bubble model of development predominated. ECD was also seen as the narrow provenance of the family. At times, this assumption crowded out other factors of importance and led to relatively narrow views, especially in comparison with some of the more general models employed by our informants, of the determinants of child development.

The mental models documented here show that, in many ways, existing research on how Americans and Canadians think about ECD is consonant with the way that international development leaders think about the concept. However, this analysis also shows a unique set of mental models that these leaders employ. The documentation of these unique models, primarily the hierarchy of needs model, as well as understandings about how the field of international development is organized, suggest specific strategies for communicating the science of ECD and its policy implications. In general, we suggest avoiding the hierarchy of needs and zero-sum models, all the while embedding ECD into the existing troika of appreciated issues — health, education and, to a lesser degree, rights — and

into the already acknowledged systemic forces — economy, education and health infrastructure — that are seen to shape child outcomes.

- 1 Sashkin, M., Morris, W., & Horst, L. (1973). A comparison of social and organizational change models: Information flow and data use processes. *Psychological Review*, Vol 80(6), 510-526. Valente, T., Pumpuang, P. (2007). Health education behavior the official publication of the Society for Public Health Education. *Health Education and Behavior*, 34, 6, 881-896.
- 2 Quinn, N., & Holland, D. (1987). Culture and cognition. In D. Holland & N. Quinn (Eds.), *Cultural models in language and thought* (pp. 3-40). Cambridge, England: Cambridge University Press.
- 3 D’Andrade, R. (1984). Cultural meaning systems. In R. Shweder & R. Levine (Eds.), *Culture theory: Essays on mind, self, and emotion*. Cambridge, England: Cambridge University Press. Shore, B. (1996). *Culture in mind: Cognition, culture, and the problem of meaning*. New York, NY: Oxford University Press.
- 4 Chi, M.T.H., Glaser, R., & Farr, M.J. (1988). *The nature of expertise*. Mahwah, NJ: Lawrence Erlbaum Associates. Ericsson, K.A., & Smith, J. (1991). *Toward a general theory of expertise: Prospects and limits*. New York, NY: Cambridge University Press.

(WWW.WAIMH.org to read the full article: Kendall-Taylor, N., & Baran, M. (2011). Finding a place for early child development in the hierarchy of needs. Washington, DC: FrameWorks Institute.)

## Babies: Their Contributions - Our Responsibilities



### Key Dates:

Early Registration: Monday 17th March 2014

Late Registration: Wednesday 11th June 2014

### Plenary Presenters

**Jane Barlow**, University of Warwick; **Pasco Fearon**, University College London; **Karlen Lyons-Ruth**, Harvard Medical School and Cambridge Health Alliance; **James E. Swain**, University of Michigan and Yale Child Study Center; **Christine Anzieu-Premmereur**, Columbia Psychoanalytic Center for Training and Research and the New York Psychoanalytic Institute.

### Key Themes

Adolescent Parenting; Alcohol and Other Drugs; Antenatal and Perinatal Practices; Assessment for Family Law Issues, incl. Child Abuse and Custody; Assessment: Diagnostic & Clinical Issues; Attachment Studies and Clinical Disorders; Autistic Spectrum Disorders; Caregiving Contexts; Cross Cultural Studies; Emotion Regulation and Disorders of Temperament; Evaluating Parent-Infant Psychotherapy; Father Infant Interaction; Infant Depression and Early Psychopathology; Infant Mental Health Services and Training; Mother-Infant Interaction; Parenting and Family Process; Prematurity and High Risk Infants; Preventive-Intervention and Community Context; Psychodynamic Psychotherapy

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14th -18th June 2014, EICC, Edinburgh

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# Orphanage Improvement: An Important Part of the Child Protection Discussion

By Meghan E. Lopez, Whole Child International; Ani N. Shabazian, Loyola Marymount University, & Karen A. Spencer, Whole Child International

## Introduction

The impact of investing in early childhood development is paramount for the development of any country (Heckman, 2000). It is imperative that institutions that are home to young children outside of parental care, arguably the most at risk population in early childhood, be part of any national plan for early childhood development. Defining the numbers of children who are orphaned or without permanent parents is a worldwide challenge because of the lack of a consistent definition of the status of these children, lack of documentation on these children and lack of resources to monitor these children and the care they receive. Approximately 88% of children labeled as “orphans” by international agencies have been found to have one living parent (Sherr, Varrall, Mueller, Richter, Wakhweya, Adato, & Desmond, 2008), but regardless these children are part of the child protection system.

Today, there is a strong international movement to prevent children from entering protection systems, to increase family reunification or adoption and to shift those children still in the system from institutional to family based care. There are, however, many factors leading to children’s placement in institutions and in the protection system. These factors, such as poverty, disease, social factors and violence, are major international challenges that are far from being resolved, and pose obstacles to transitions to families regardless of whether children have living parents.

While there is much international effort made to confront these major challenges, each country is ultimately sovereign and governments make independent decisions weighing cultural, political and economic (among others) factors. Despite pressure from the international community, resources will be dedicated and problems will be addressed as each country deems fit. Barriers in reaching the

ideal protection system for children are in many ways similar to other international challenges and include a mix of internal and external politics, historical experiences and simple resource availability and allocation. The same lack of resources that limits a government’s knowledge of exactly how many children are outside of family care also limits its ability to monitor and evaluate existing care—whether institution or family based. In many countries, governments do not currently take fiscal responsibility for children without guardianship and their care—a role filled largely by non-governmental organizations (NGOs). Not having control of the funding in this climate of minimal resources, nascent foster care systems suffer from the same lack of training that institutions do, but with less accountability and less support. Even where resources are more available, children in poor foster care have been shown to be more likely to develop behavioral, educational, and emotional problems than children who are raised by abusive and high-risk parents (Jones Harden, 2004; Lawrence, Carlson, & Egeland, 2006). Simply placing a child in foster or family based care does not ensure quality nor protection of the child.

If countries do have enough resources to begin a comprehensive overhaul of their foster care system, children will still continue to spend some time in institutional care, as they do in countries where there is an established foster care system. Even if children are in transition to family based care or adoption, the impact this time can have in early childhood is enormous. A positive experience in this institutional care period can improve and even facilitate children’s positive integration to families and society; a negative experience can have lifelong detrimental effects (Bruskas 2010; Jones Harden, 2004; Cassidy & Berlin 1994).

Approximately 31.4% of the population in Latin America is described as living in poverty unable to meet basic needs including food, shelter, clothing, water and sanitation, education, and healthcare and at risk for violence (Social Development Division and the Statistics and Economic Projections Division of the Economic Commission for Latin America and the Caribbean, 2012). This developing region is home to approximately 12 million

orphans, the equivalent to approximately 6% of the total population (United Nations Children’s Fund, 2009). As elsewhere, the vast majority of Latin American children’s institutions are ill-prepared to receive children, lacking the fundamental infrastructure support systems required for healthy socio-emotional development and plagued with caregiving practices that create more psychological distress (Rosas & McCall, 2009). Evidence demonstrates that children under the age of three are particularly vulnerable to developmental delays when not provided with appropriate care and attention (Johnson, 2000; Smyke, Koga, Johnson, Fox, Marshall, Nelson, Zeanah, the BEIP Core Group, 2007). More importantly, there is a strong body of international evidence that shows the positive effects of quality care and attention (Baker-Henningham & Lopez Boo, 2010; Center on the Developing Child at Harvard University, 2007; David & Appell, 2001).

The impact of poor caregiving and poor institutional care is far reaching. Research has been consistent in demonstrating that stressful experiences in childhood are pathways toward poor outcomes in adulthood, including premature mortality, disease, disability, antisocial behaviors and serious mental health problems (Caspi, Henry, McGee, Moffitt, & Silva, 1995; Felitti et al., 1998; Whitaker, Orzol, & Kahn, 2006). These poor outcomes have high cost implications for any society and contribute to intergenerational transmission of poverty, poor health and development. Meanwhile, research suggests that perhaps as much as 50% of the impact of stress and risk factors can be mitigated with targeted caregiving (Duncan & Brooks-Gunn, 2000). Early childhood education programs have been shown to have the potential to generate government savings that more than repay their costs and produce returns to society as a whole that outpace most public and private investments (Kilburn & Karoly, 2008). Programs that address early childhood development, especially for children at risk, have consistently shown the significant benefit of investments in young children, while failing to invest is costly to families, communities, businesses and nations (Cobb, 2003). There are no studies on the return of investment for child protection centers, though the



costs associated with adults who have received poor institutional care are well documented (Tobis, 2000; Penglase, 2005). For developing countries the promise of return on investment in early childhood is more than a moral imperative, it is a path out of poverty.

There are studies of the development of children at risk in Latin America (Baker-Henningham, & Lopez Boo, 2010; Green, 1998; Raffaelli, 1999), and studies on positive outcomes for children removed from institutional care (Smyke, et al, 2007; Nelson, Zeanah, Fox, Marshall, Smyke, & Guthrie, 2007), but few studies exist internationally on the impact of intentional improvement of care for children in institutions (David & Appell, 2001; Smyke et al., 2007; McCall, Groark, Fish, Harkins, Serrano, & Gordon, 2010; Sparling, Dragomir, Ramey, & Florescu, 2005; The St. Petersburg-USA Orphanage Research Team; 2005; Vorria, Papaligoura, Dunn, Van IJzendoorn, Steele, Kontopoulou, 2003; Dobrova-Krol, Van IJzendoorn, Bakermans-Kranenburg, & Juffer, 2010). Prior to this effort to systematically improve and assess institutions and caregivers in Nicaragua, no studies existed on the impact of Latin American institutions on children's development.

## Background to Case Study

Whole Child International (WCI) was created in 2004 as a not-for-profit non-governmental organization, with a mission to improve the quality of care for children, prioritizing those children most at risk i.e. those residing in institutions, and those at risk in early childhood. WCI was founded with the belief that there are simple cost effective ways to improve existing institutions and the quality of care they provide using existing resources. Inspired by developmental research such as the Pikler Institute experience (David & Appell, 2001) and Bowlby's Attachment Theory (Bowlby, 1958), as well as current brain research that affirms a secure and caring one-to-one relationship between a caregiver and a young child coupled with adequate nutrition is the most critical component for healthy cognitive, physical, and socio-emotional development (Schore, 2001), WCI aims to improve quality of care to meet the highest standards in child development through the same evidenced based best practices recommended for any early childhood intervention, applied to limited resource settings.

## Nicaragua

Nicaragua has a population of 5,727,707 with 31.7% under 14 years of age, and is the second poorest country in Latin America and the Caribbean after Haiti with a per capita gross domestic product of 7.08 billion dollars (Central Intelligence Agency, 2013). Nicaragua's high poverty rates especially affect vulnerable groups such as children. It is estimated that about 114,000 children live in extreme poverty and 25,000 children and teenagers live on the street. Over 3,000 children and adolescents are currently being placed in child protection centers, called Protection Centers, either because of orphanhood, abandonment or the application of special protection measures established in the Children's and Adolescent's Code (Government for Reconciliation and Unity of Nicaragua, 1998). Enforcing the Code and ensuring quality of care in the child protection centers is a serious challenge for the Ministry of Family Adolescence and Children (MIFAN), the institution charged with oversight of the child protection system. MIFAN suffers from scarce financial and human resources. Only 1 out of approximately 85 child protection centers is public (the rest are run by nongovernmental and religious organizations) and only 30 of the private child protection centers receive some form of partial state subsidy through MIFAN (Ministerio de la Familia Adolescencia y Niñez, 2012). The exact number of child protection centers and the quality of the care they provide is unknown and unregulated due to this same lack of resources in MIFAN and lack of attention by greater non-governmental organization community. Government officials responsible for child protection centers and early childhood programs changed frequently through the early years of WCI's work, only reaching some stability during the two years of the Technical Cooperation (2010-2012), when the largest successes were achieved.

## Intervention Overview

In 2006, WCI began implementation of a multifaceted intervention consisting of intensive training, low cost improvements to the physical environment, and policy and regulatory reform in Nicaragua. First, WCI began its work through a pilot program with MIFAN in the one state run child protection center (Groark, McCall, Fish, & the Whole Child International Evaluation Team, 2008) and later under a Technical Cooperation with the Inter-American Development Bank under the Korean Poverty Reduction Fund (#ATN/

KP/12327-NI).

The premise of the WCI intervention is centered on the minimum set of conditions needed to ensure that every child's basic psychological needs are met-by focusing on four fundamental areas of evidence based best practices. These four practice areas are: 1) supporting an organizational structure that will sustain a primary relationship between caregiver and child; 2) improving the quality of interaction between caregiver and child; 3) ensuring that the physical space supports child development; and 4) ensuring that each child's own sense of being an individual is honored. WCI's intervention is designed to provide for children's socio-emotional well-being through a series of cost-effective interventions. The four practice areas are addressed through three intervention components: a) government training and collaboration; b) organizational training and change; and c) academic training and development.

WCI intentionally works with the existing resources of institutions, teaching them to more effectively use resources at their disposal to the benefit of the children in their care. WCI does not intend to take over the responsibility for institutions or their functioning. It is important to note that this intervention does not address nutrition and throughout the entire intervention there was no change in the nutrition that children received (Groark et al., 2008; Groark et al., in press). Addressing the challenge of accessibility of quality in early childhood care in severely limited resource settings, WCI focuses on the technical guidance and training for the professionalization of early childcare staff in limited resource settings through a train the trainer approach. A key goal of the overall intervention is to create local capacity at every level, lowering the cost of implementation, and ensuring the sustainability of the work.

## Method

### Sample

WCI worked with five child protection centers ranging in population from 13 children in the smallest child protection centers to 79 in the largest. Children residing at these institutions ranged in age from birth to 6 years old and included children with mild to severe special needs. One child protection center was tracked over the course of 6 years; the remaining four were tracked over the course of 2 years. The populations in each orphanage varied over the course of study related to various attrition factors. The inclusion



criteria for child protection centers were the primary child protection centers in the capitol city that care for children birth to 6 years of age.

## Procedures

WCI trained caregivers and other child protection center staff (e.g., administrative staff, cleaning staff, cooking staff, security guards, etc.) through their signature caregiver training program. This program combines interactive classroom trainings on topics such as positive communication, routine care and interactions, environment and materials, observation, freedom of movement, value of play, neuroscience and cognitive development, and professional care and boundaries, with on-site one-on-one technical assistance provided by local staff. WCI also trained government and child protection center staff in Nicaragua's first university level course on early childhood care developed with Loyola Marymount University and The School of Public Health of the National Autonomous University of Nicaragua (Centro de Investigaciones y Estudios de la Salud, Universidad Nacional Autónoma de Nicaragua, Managua).

WCI worked closely with the administrative and supervisory staff of the child protection centers to increase the likelihood of success in application of

what they learned through the various intervention activities. Some activities were purely administrative such as the essential development of regular caregiver schedules and assignments in order to maintain consistent care with the same children (Shabazian & Lopez, 2011). Other activities included necessary physical improvements to each child protection center including providing child size furniture (e.g., beds, cribs, tables, chairs and rockers), introducing child safety gates, and creating protected play spaces for the younger children. The intent of these furnishings was to help facilitate caregiver-child interactions during routines (David & Appell, 2001) while assuring that other children have space to move freely within a safe area. WCI also created developmentally appropriate environments by adding soft spaces, loft play structures, and sand boxes.

Perhaps the largest and one of the most unique aspects of Whole Child's Intervention has been the focus on intensely developing the relationship between the caregiver and a mentor (the WCI local trainers assigned to each child protection center). The mentoring activity, termed "technical assistance", was performed almost exclusively by the local trainers to ensure clear and culturally respectful communication. The child protection centers themselves did not

provide any training or orientation for new staff prior to intervention

Before beginning technical assistance the WCI mentors observed each caregiver for approximately an hour and evaluated her level of independence in successful implementation of sensitive and respectful caregiving based on Gray and Gray's (1985) mentoring scale (see Addendum). Local trainers were cautioned not to evaluate caregivers as «good» or «bad» but rather to assess their level of comprehension and independence in application of quality caregiving based on their actions and activities. This information was then compiled with the entire technical team and the first week of technical assistance hours were allotted based on the ratings, i.e. a caregiver who rates a «P» or Level 5 will only require minimum follow up for answering questions and confirming the rating a task that can be done with an hour or less of observation, whereas a caregiver that is rated a «Mp» or Level 2 shows signs of having participated in training but is not successfully or independently implementing the concepts and may need several hours in each of her shifts. Ratings were reassessed in every instance of Technical Assistance and the information was compiled and analyzed by the WCI technical team in weekly team meetings to re-allot hours of technical assistance for the coming week. Technical assistance

Table 1.

Battelle scores in Pilot Center

	Average	> 90	< 70
2006 pre	63.4	0	0.82
2007 post	76.9	0.148	0.278
2010 pre	72.6	0.05	0.43
2012 post	82.4	0.167	0.146
Total Improvement	+19.0 (+30%)	0.167	-0.62

Table 2.

Battelle scores in orphanages with children typical developing and those with special needs

	2010	2012	Change	%Change
Average in Orphanages serving Typically developing children	72	83.5	12.8	0.19
Average in Orphanages serving children with special needs	48.5	53.5	11.3	0.18
Average Battelle scores for children in All Orphanages	67.3	77.4	10.1	0.16

Note: Change values based on number of children in each orphanage at time 1 (2010) and time 2 (2012) and averages per orphanage.

was never given for greater than a 2 hour block at a time though it was occasionally given in multiple 1 hour blocks, though never greater than three 1 hour blocks in 1 day. This individualized the amount of time that each caregiver received based on her needs and ability to independently apply the concepts learned. All caregivers received at least 1 hour of technical assistance every week (and some received as much as 15 hours), which required some WCI staff to work on «off» hours including very early morning, late evening, or weekends.

Mentoring activities varied based on the activities during the time of mentoring, and the level of independence of the caregiver. Technical assistance included: answering questions to clarify concepts, answering application questions for specific situations that arose, asking the caregiver questions regarding her practice, probing the caregiver to reflect on her practices, and modeling interactions with children. Local trainers received specific training and feedback on their performance in these areas (both «staged» beforehand and «live» with a caregiver) from the WCI Technical Supervisors, Expert Trainers, Expert Technical Consultant and Country Director. Local trainers were specifically instructed to respect the role of the caregiver with the children—in no way to diminish that role by becoming a supervisor or judge, rather to defer to the caregiver and provide feedback in more opportune moments except if a child was in imminent physical danger. Supervisors at each center (director, technical team) were updated at least monthly by the WCI technical team on the progress of the caregivers with specific positive examples of growth and moments that continued to be challenges.

After the 9 months of caregiver training passed, the WCI technical team re-observed every caregiver on all 19 objectives of the caregiver training to provide an overall rating with areas for continued improvement. At this time additional mini trainings specific to each center were provided if there was a concept that many caregivers were not performing independently. In some cases this was a review of the same information presented in the WCI Caregiver Training program, in other instances training was provided on working with children with special caregiving needs. In the first few weeks after the end of the formal WCI Caregiver Training, technical assistance time was more evenly distributed between all caregivers in that most caregivers did have an area they could continue to improve upon. After a month, technical assistance time became more focused on

the caregivers that continued to struggle for independent application.

## Results

Within 4 months of WCI's collaboration with the centers, children demonstrated marked increases in their developmental milestones and those children that had participated in the pilot program showed an average improvement of 13% in their scores since the start of the intervention (Groark et al., 2008). Scores also demonstrated an improvement in the quality of care that children received: caregivers displayed warmer, sensitive, and responsive interactions with children; children's development in all domains (cognitive, language, physical, and social-emotional) improved (Groark et al., in press). (See Table 1 and 2).

Since 2006, children in the pilot child protection center improved on average 30 points on the Battelle Development Index, with the number of children scoring under 70 (i.e., presenting as if diagnostically intellectually disabled, though they are not) decreasing by 62%. Children with special needs were especially positively impacted by the intervention with percentage change of improvements on the Battelle Development Index similar to typically developing children. Height rose on average from the 8th to the 54th (cross sectional) percentile, and weight rose on average from the 5th percentile to the 30th (cross sectional) percentile. (See Table 1 and 2).

## Discussion

The three areas of greatest challenge and simultaneously greatest success were government collaboration, technical assistance and sustainability. First, though WCI enjoyed a positive relationship with the government throughout the intervention, there was no regulatory guidance monitoring or evaluation of the child protection centers independent of WCI efforts. The WCI intervention did not require a monetary investment from MIFAN. Coupled with the pervasive lack of resources at MIFAN, and the push to close child protection centers championed at the international level, for much of the early years of the WCI intervention there was little government interest. There was renewed interest and increased collaboration with WCI following a wave of adoptees being returned from their adoptive families, closing child protection centers following information of the quality of care being shared with MIFAN, the reopening of child protection centers

to be able to accommodate the influx of children, and the increased attention to poor the care being provided for children with special needs.

WCI and MIFAN did eventually collaborate on one major lasting achievement: the inclusion of best practices in the policies governing early childhood care in Nicaragua via the National Early Childhood Policy and the Norms for Restitution of rights and special protection for girls, boys and teens. This document was prepared by a graduate of WCI's university course who is a MIFAN director responsible for all programs for children 0-6 years of age. The policy includes many of the topics covered in the WCI university course including the children's rights perspective in program planning, caregiver and staff preparation and training, keeping siblings together, consistency of caregivers, value of attachment, and definition of small groups of care. Though this new policy has not been fully implemented, the inclusion of these topics which had not previously been discussed on the national agenda was a major sustainable accomplishment and helped highlight the success of the WCI intervention. Many child protection centers have already been voluntarily implementing the new norms based on the WCI recommendations).

A second major challenge was found in providing technical assistance. The concept of having a mentor for a job they had been doing for in some cases more than 20 years was at first difficult for staff to comprehend. While WCI staff was able to engender trust, it became clear that WCI staff needed further training on mentoring, professional coaching and technical assistance. It was also difficult for child protection center staff to reconcile suggestions given by WCI trainers that did not always match with those given by their own supervisors, who were learning as they went through WCI trainings as well. Supervisor support for interventions dramatically improved over the course of the University course; future interventions will incorporate a restructuring of the training time line.

The third major challenge was sustainability. WCI has been committed to the strengthening of local capacity from its inception. During the intervention, WCI restructured our staffing plan and provided greater preparation to the local trainers. By leveraging the supervisory role of the child protection center leaders through their participation in the University course with the guidance from WCI trainers, WCI was able to reduce our role in the major task of directly advising caregivers. This enabled the WCI staff to focus more on helping

supervisors figure out how to enact the necessary changes and mentor their own staff, required to build local capacity to ensure sustainability. Future interventions will continue with an even more aggressive transfer of responsibility to child protection center staff through supporting their development of monitoring and evaluation skill sets.

The choice of having local trainers provide all mentoring activities, with outside experts providing guidance to them, was intentional. Requesting that all child protection center staff (not just caregivers) attend all trainings to engender a pervasive understanding of the role of the child protection center in fostering positive development for all children was also deliberate. These efforts were demonstrated to be successful by children's improvement in the pre and post intervention evaluations. However, from the time of the first post intervention evaluation in 2007 to the next evaluation in 2010, though scores did not dip to their pre-intervention levels, they were not maintained near the level of the post intervention evaluation. The drop in scores and increase in caregiving challenges when centers reverted back to unstable groups with variable caregivers served as a poignant reminder to centers the difference between what the successes had been when best practices were successfully implemented and typical institutional care.

## Limitations

This study used pooled cross-sectional data, a collection of cross-section datasets observed at different points in time. In this case, data were collected at the two child protection centers in 2010 and then in 2012, with different subject groups. The analysis consisted of comparing the differences between the subject groups. The limitation of using pooled cross-sectional data lies in the fact that the same subjects are not followed over time and therefore it is difficult to establish causality.

Further limitations involve the reliability, validity and generalizability of case studies. As this case study focuses on a single intervention in one country, the issue of generalizability is greater than with other types of qualitative research. Another concern regarding case study research is an ethical one, which is introduced by the subjectivity of the researcher. Case studies are based on the analysis of qualitative data, which requires the researcher to interpret the findings and leaves room for personal bias.

## Conclusion and Future Implications

The work of WCI is focused on exploring the possibility of improving resource limited institutions in a cost effective, culturally sensitive manner. Attention given to the problem of vulnerable children outside of family care must incorporate the improvement of the institutions themselves as, despite the best efforts of all involved, children will spend time in these places, sometimes most of their formative years. As we seek to solve the problem of providing care for children outside of family care, especially in limited resource settings, there is value in investing in child protection centers and institutions and the children that reside and receive care there. For many governments of developing countries implementing a new child protection system or radically overhauling the existing system will take too much money and time, and is not part of plans in the foreseeable future. Especially when they do not currently shoulder the fiscal responsibility for children outside of family care, many of whom are cared for in institutions funded by NGOs and religious organizations.

This case study seeks to serve as a counter point to "The Bucharest Early Intervention Project" (Smyke et al., 2007) where it was shown that trained foster care was superior and provided a more positive development experience for children than typical institutional care. Well prepared, supported and monitored foster care is simply not likely to happen in the foreseeable future in much of the developing world. The dichotomy need not be quality (un-attainable) foster care or poor institutional care. There is another cost effective, realistic option. Implementing national regulations and improving the quality of the institutions themselves, as WCI has done, is cost effective and sustainable, though ideally temporary.

Future research should take the lessons of the BEIP and WCI intervention and look to isolate the components to better understand exactly which factors contribute most to children's over all wellbeing. The focus should not be on the walls within which children live, but the relationships that help them do so.

The period of early childhood is crucial in lifelong development. The success of these most vulnerable children is the key to responsible development, a path out of poverty, and will ultimately lead to greater international stability.

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# Participating in an Infant, Child and Family Conference in Hiroshima, Japan

By Elizabeth and Kaspars Tuters, Toronto, Canada, ktuters@utoronto.ca

We want to share our experience of being invited as keynote speakers in the “Four Winds” conference held in Hiroshima on November 2 & 3, 2013.

The “Four Winds” Association is an Infant Mental Health organization in Japan. It is multidisciplinary and has members from different parts of Japan. It was founded by Dr. Hisako Watanabe of Tokyo, after the WAIMH congress in Tampere, Finland in 1996. She and her colleagues were inspired by this event, and in the spirit of the Finnish experience, chose the four cornered multi-color Finnish hat as the symbol of their new organization. Dr. Watanabe told us that the hat itself is symbolic, because it has been used by the Finnish reindeer herders to detect the direction of the four winds so that they can be guided through dark and stormy weather. Thus the Japanese “Four Winds” organization feels this symbol represents the work that they do with infants, children and their families.

We were very warmly received by our Japanese colleagues. The conference took place in Hiroshima. The Four Winds Association holds conferences annually in different parts of Japan. This year it chose Hiroshima to address the topic of major trauma and its continuous impact through intergenerational transmission. The conference was very well organized. More than 400 professionals from different parts of Japan attended.

Kaspars Tuters spoke on the theme of “Dealing with the Continuity of Trauma: Intergenerational Issues.” Elizabeth Tuters presented “Challenges Working Psychodynamically with Infants/Children and their Families: Intergenerational Transmission of Trauma.”

The audience was very receptive and interesting discussions ensued. We found our Japanese colleagues to be knowledgeable and experienced. There was a great interest in work with infants.

After the conference Elizabeth was invited to Tokyo to discuss a clinical case involving infant trauma. There were about a 100 participants in the audience. It was a complex case of cumulative trauma throughout the generations. The two

Tokyo therapists presented their work clearly and in detail. The male psychiatrist worked with the parents, and the female psychologist worked with the daughter. Both met with each other and the staff to process and debrief the impact of the session material. The therapists demonstrated a capacity to understand the child and her family very deeply. The comments and questions from the audience also showed a high level of understanding child development, the child’s inner world and the internalized dynamics carried by the parents – themselves the victims of childhood abuse and neglect.

While in Tokyo, we were invited to speak about our many years of involvement

with the Global WAIMH, at the inaugural meeting of the formation of the Japan WAIMH Affiliate. It was attended by an interested group of multidisciplinary professionals, a number of them also belonging to the Four Winds Association. This group enthusiastically embraced the idea of becoming a part of the global organization that is WAIMH.

We were very impressed by our experience in Japan – the welcoming colleagues that we met, their enthusiasm and the high quality of work that they do. We look forward to welcoming soon the Japan WAIMH Affiliate into the global association.



Hisako Watanabe and Elizabeth Tuters.



From left: Elizabeth & Kas Tuters, Mitsuhaya Kurosaki (organizer of the Hiroshima conference) & Kazue Ikeda.

# WAIMH Belgo-Luxembourgeoise Affiliate, Brussels

By Pascale Gustin, President

## History

Belgium is composed of three linguistic communities: Flemish speaking people in the north of the country and French speaking in the south. Links were spontaneously made by us, French speaking professionals with our French neighbors. During many years we participated in their activities and later we decided to organize our own group, first in an informal way but in May 1998 we became officially a member of WAIMH.

In the beginning we only wished to intensify clinical exchange in a small group with a colleague from Luxembourg. Our intention was and remains to base our theoretical discussions on a clinical base and concrete material to enlighten our therapeutic and preventive prospects.

Another characteristic of the WAIMH Belgo-Luxembourgeoise group is our theoretical range which is humanistic and pragmatic. Our theoretical support is psychoanalysis linked with the perspectives of attachment, developmental psychology, neuroscientific knowledge, and family systems theories. But the common language of this Babel Tower of theories remains clinical work!

We have this cross-breeding culture in common with the professionals from Quebec who have the same experience of a three-fold community where different intellectual movements have to be associated. Yvon Gauthier, Canadian past-president of the international WAIMH helped us take our first footsteps to become an official member of WAIMH.

In the beginning we were a group of child psychiatrists and psychologists coming from different French speaking universities having exchanges about theoretical and clinical theories concerning psychotherapeutic work with babies, children and their parents. Since then we opened our activities to other professionals concerned with mental health of small children and newborns. The enlargement of our group, provoked by numerous

demands for membership and training, led to the reorganization of our activities.

## Our activities

In 2001 we organized our first annual meeting. Little by little our target audience enlarged probably because we proposed discussions about the daily preoccupation of the professionals concerned with childhood and parenthood: interactions in adopting families, stress and pregnancy, interdisciplinary in prenatal prevention, early child abuse and neglect, , unconsolable infants , bodily approaches for infants playing, etc... Our annual meeting usually brings together around 300 to 400 participants.

To maintain our clinical exchanges as lively as possible, we organize, besides the annual meeting, little groups animated by one of the founding members on themes varying in function of the demands. Actually there are 4 groups working on following themes: prematurity, hospitalized children, transition to parenthood and early signs of autism spectrum disorders. New groups can be opened on demand.

## Members

Our association counts about 120 members. Some of them are very active in different sectors, namely the fields of premature birth, childhood health and mental health. We have two kinds of membership: adherent and full members. Most of our members organize or participate in training or education.

## Our aims

We chose the following three aims:

1. Promote reflection, theoretical and clinical research about:
  - different aspects of parenthood
  - psychic development of babies and toddlers concerning sensoriality ,

motricity, cognition and affectivity

- developmental psychopathology and possible psychotherapeutic approaches of specific pathologies.

- 2; Promote prevention and early intervention.
3. Training of various professionals specialized in childhood.

## Creation of a website

In 2012 we decided to create a website which gives us more visibility. We invite you to visit it. You will get more information concerning our activities, the past and future annual meetings: [www.waimhbl.be](http://www.waimhbl.be)

## A particular way of living together

Belgium is a small country known for its chocolate and the singer Jacques Brel but also for its political controversies and debates between the communities which end in general with a compromise and a particular way of living together. In our WAIMH group we try not only to help the circulation of thinking and resources but also to make links between the different institutions of care, rest centers and schools to amplify the collaboration between our networks. As far as we know, in the Flemish part of Belgium a WAIMH group exists called WAIMH VLAANDEREN, also a member of WAIMH international. We have very little exchanges with them because of the linguistic barrier.

## Members of Council

President: Pascale Gustin, Secretary: Geneviève Bruwier, Treasurer: Maggy Camus, Supply treasurer: Gül Jullian, Administrators: Dominique Charlier, Marie Couvert, Marie-Paule Durieux, Christine Frisch-Desmarez, Eliane Pirard, and Luc Roegiers



## 2014 WAIMH World Congress in Edinburgh, Scotland

By Päivi Kaukonen, Executive Director, Tampere, Finland, [ed@waimh.org](mailto:ed@waimh.org), Kaija Puura, Associate Executive Director, Tampere, Finland, [congress@waimh.org](mailto:congress@waimh.org) and Minna Sorsa, Administrative Assistant, Tampere, Finland, [office@waimh.org](mailto:office@waimh.org)

Dear WAIMH members,

As we here in the Northern hemisphere are preparing for winter and those of you in Southern hemisphere for summer, it is a good time to look back at year 2013. The year was very active for WAIMH with the Board of Directors having several web-based meetings and the Board and the Office preparing for conquering a

whole new territory: the social media. The Office asked for bids from several companies specialized in creating websites and campaigns, and chose from three candidates a Finnish firm called Dicole, who have also worked for the WHO. President Miri Keren, President-Elect Kai von Klitzing, the Office personnel and Dicole had a partly live, partly internet-based workshop about future actions. The prospects are exciting, and we hope to engage more and more of our members and Affiliates in the some-projects during the following years.

Next year will also be busy as the 14th World Congress of WAIMH to be held in Edinburgh, Scotland 14-18th June 2014 is now about six months away. It is our great pleasure to inform you that we received 1155 submissions for the Congress, and the five-day congress will include the latest news from the infant mental health scientific and clinical communities. From looking at the titles and themes of the submitted abstracts, it looks like we will have a wide variety of presentations ranging from neuropsychiatric research studies to innovative clinical interventions, and even interactive workshops.

The review boards did a fantastic job, and all the abstracts have now been reviewed and are soon sent to the Programme Committee members. Our warmest thanks to the review boards!

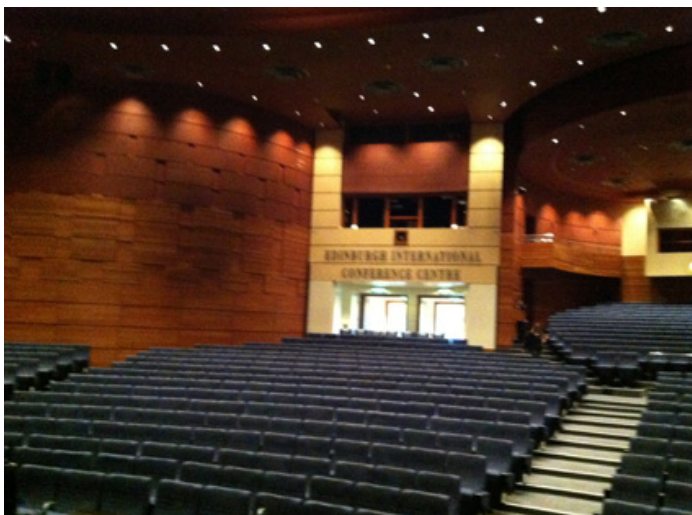
As additional programme the Pre-Congress on 13th June includes two interesting workshops, one including also live supervision. There are also three additional training courses held during 12th and 13th June. During the Congress you can also choose to attend additional Master Classes given by topnotch researchers and clinicians from all over the world. The contents of the additional programmes will be updated soon, so please keep visiting the Congress website at <http://waimhcongress.org> for more information.

The Programme Committee will meet in 9-11 January 2014 in the WAIMH Central Office here in Tampere. Those of you who submitted an abstract will receive a notification of outcome 15th January 2014. After the Programme Committee meeting we will be able to build the actual Congress Programme, so keep visiting the Congress website for more information.

The Early Bird registration extends to Monday 17th March 2014. If you are a WAIMH member when you register for the Congress, you will get a lower fee than non-members.

Last but not least, please renew your WAIMH membership for the year 2014 online at the WAIMH website [www.waimh.org](http://www.waimh.org). There are two separate categories: the student (45 USD) and professional (75 USD) memberships. As a WAIMH member, you have the privilege of ordering the Infant Mental Health Journal at a special rate. The rates in 2013 are: USA 50 USD, Canada 52.50 USD and International orders 62.50 USD. All journal subscriptions are now also including access to the online IMHJ at the Wiley website. Please, contact the WAIMH Central Office, if you need guidelines or support for the membership renewal ([office@waimh.org](mailto:office@waimh.org)).

We hope you all would be active in promoting WAIMH and our next World Congress. From our website you can print a WAIMH Flyer and the Congress flyer to your colleagues. Please ask them to join our multidisciplinary and global association for the benefit of infants all over the world, and to come to Edinburgh to meet other colleagues interested and devoted to infant mental health.



Pentland Hall in Edinburgh International Conference centre. Photo by Minna Sorsa.



The preparations for the WAIMH 14th World Congress include a site visit. Photo by Minna Sorsa.

## A New Resource: Primera Infancia (Early Infancy)

By Miguel Hoffman, miguel.hoffmangmail.com

During the last year, three volumes of a collection, Early Infancy - the Psychosocial Construction of a Human Being, has been published in SPANISH. Therefore, the title in the original print (plus Kindle version) is Primera Infancia- la Construcción Psicosocial de un ser Humano.

For those WAIMH Members interested in giving the reference to Hispanic colleagues working in Infancy Programs or in Parent-Infant Clinics, please direct them to Amazon in all countries, under Books, Author: Miguel Hoffmann. There will be both the printed and the Kindle format of these three volumes. Two more volumes are in either the editing or the production process, and will be available during the coming months and during 2014.

Written in an accessible language and in many chapters using a two level approach, from the essential to the more complex matters, a third and fourth level will be developed by colleagues from Spain and Latin America who are leaders in the field.

Thereby we might have -in due time- a handbook of essential concepts of early development in SPANISH. The available volumes are the initial steps, and appropriate for training purposes in this multidisciplinary field, ranging from volunteers to different disciplines developed during the last decades to approach the initial stages of a human being's development.

## SUBMIT AN ARTICLE TO PERSPECTIVES IN INFANT MENTAL HEALTH

The following are general guidelines for Perspectives:

- APA, sixth edition, for style
- 12 point font
- Double spaced
- 250 words per page
- Articles of varying length are welcome. However, an article should not exceed 15 pages including references. Submissions will be peer reviewed.

Articles describing unique efforts to promote infant mental health, research summaries, and book reviews shorter than 15 pages are encouraged from around the world.

- Send pictures and tables in separate files, with a resolution of at least 72 pixels/inch.
- Manuscripts are accepted throughout the year.
- Submit the article to Editor Deborah Weatherston [dweatherston@mi-aimh.org](mailto:dweatherston@mi-aimh.org)