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Perspectives in Infant Mental Health

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Contents

Presidential Address

Integrating physical and mental health support for infants

By Kai von Klitzing, MD, WAIMH President, Germany,

Kai.Klitzing@medizin.uni-leipzig.de

The United Nation Children's Fund (UNICEF) published its 2016 report on the state of the world's children, under the title "A Fair chance for Every Child" (United Nations Children's Fund, 2016). The report focuses on child education, children living in poverty, and pathways to equity. From the data presented, UNICEF's executive director Anthony Blake concludes that although "the world has made progress in reducing child deaths, getting children into school and lifting millions out of poverty", (p. VII) millions of children's lives are still blighted, "for no other reason than the country, the community, the gender or the circumstances into which they are born" (p. VII). Without an extensive developmental turnaround, by 2030 – the deadline for the Sustainable Developmental Goals – every year 3.6 million children are likely to die before reaching their fifth birthday. Children in sub-Saharan Africa will be 10 times more likely to die before age 5 than children in high-income countries. Nine out of 10 children living in extreme poverty will live in sub-Saharan Africa. Sixty million primary school-aged children will be out of school (more than half will be from sub-Saharan Africa), and some 750 million women will have been married as children.

Two important factors may lead to a rise in mortality for the under-fives (in contrast to the declining trend of the last 15 years): political conflicts and war, and climate change. According to the UN Refugee Agency UNHCR, at the end of 2015 there were 65.3 million forcibly displaced people worldwide (for details see figure UNHCR Global Trends 2015), including 21.3 million refugees forced to flee from their countries (UNHCR). Half of them are children. "The number of children experiencing prolonged and complex disasters, such as the conflict in the Syrian Arab Republic, is growing. The intensifying effects of climate change are also exacerbating the risks to the most disadvantaged children. Globally, more than half a billion children live in zones where the occurrence of flooding is extremely high, and nearly 160 million live in zones where the severity of drought is high or extremely high. The World Health Organization has projected that approximately 250,000 additional deaths will occur annually through 2030 from malnutrition, malaria, diarrhoea and heat stress attributable to climate change." (UNICEF p 4/5)

UNICEF proposes a wide variety of measures to improve the situation of children worldwide. Forty per cent of neonatal deaths could be averted through key interventions around the time of birth: skilled birth attendants, emergency obstetric care, immediate newborn care (including breastfeeding support and clean birth practices), and newborn resuscitation (p. 21). The benefits of breastfeeding are still under-recognised in many countries. Starting within the

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

WAIMH Central Office
University of Tampere, Medical School, Laakarinkatu 1, Arvo-building Room C221, 33014 University of Tampere, Finland
Tel: + 358 50 4627379, E-mail: office@waimh.org, Web: www.waimh.org

Editorial Staff

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first hour of birth, longer-duration breastfeeding is associated with protection against childhood infections, increased intelligence, and reductions in the prevalence of overweight and diabetes. Research found that if breastfeeding were scaled up to near universal levels, the lives of 823,000 children under age 5 would be saved annually in 75 low- and middle-income countries (Victora et al., 2016).

When reading all this information and numbers I start to wonder: should we advocate for the worldwide improvement in infant mental health at times when the battle for sheer survival and physical growth of the youngest inhabitants of our planet has not yet been won? Around 1 million refugees arrived in my country in 2015, a high percentage of them young children. A large proportion of these children have lived under traumatising conditions for most of their lives, with significant risks to their mental health development, especially if they are under five. If we look at the terrible situations of refugee families on the borders of the European Union, in the boats on the Mediterranean Sea, or in Australian immigration detention facilities, we might think: survival and physical integrity comes first, so let us worry about infant mental health later. But is this hierarchy of action justified?

Each mind lives in a body; the survival of the body without a healthy mind causes tremendous suffering. A healthy mind is essential for human development. As early as 1945, Rene A. Spitz (Spitz, 1945) provided overwhelming evidence that body and mind cannot be separated from each other, especially in infants. Infants who spent their first years in foundling homes in which they were cared for by an inadequate number of nurses showed all the manifestations of "hospitalism", both physical and mental, and had a high rate of mortality. Even though hygiene and precautions against contagion were impeccable, from the third month onwards the children showed extreme susceptibility to infection and illness of any kind (p. 59). The experience of relational deprivation had led to severe mental health deficiencies, which were associated with cognitive as well as physical shortcomings and mortality.

This knowledge, which is based on a massive amount of empirical data and clinical experience, must lead our efforts. It is not enough to provide at-risk children – for example, in refugee camps – with enough food and improved hygiene. In order to really improve their situation and to lay the ground for healthy growth and development we also have to focus on the mental and psychosocial conditions, especially during infancy. Early deprivation, growing up in the care of helpless or desperate parents, and chronic suffering from traumatisation leads to detrimental consequences not only for mental health, but also for physical health, moral development and social coherence. Infants who grow up under conditions of deprivation will be adults with difficulties in caring for the next generation and contributing to a fair society. They will suffer throughout their lives from a basic feeling of being short-changed, which can impede their empathic and mentalising capacities. Early mental health today is the basis for a fair and secure society in the future. So we should support the Sustainable Developmental Goals of the United Nations, but we also have to draw the attention of the public to the fact that survival and enough food are not sufficient. Without support and advocacy for the healthy mental development of the youngest, we will not make progress in the worldwide human condition.

In addition to "comprehensive interventions that cross development sectors to include nutrition, health, and water, sanitation and hygiene practices", UNICEF proposes focusing "on the quality of care provided to infants and young children." (…) "Comprehensive interventions that combine nutrition, protection and stimulation have been shown to produce marked gains in young children's cognitive development."(p. 42) A special edition of the *Annals of the New York Academy of Sciences* (Black & Dewey, 2014) indicates strong empirical support for early child-development programmes and the feasibility and effectiveness of integrating child development and nutritional interventions (p. 1). There is still a lack of empirical evaluation of the effects of adding support that stimulates early development to health and nutrition services (Grantham-McGregor, Fernald, Lia C H, Kagawa, Rose M C, & Walker, 2014). But addressing both physical and mental health in integrated interventions is probably the way we have to go in the future. And the earlier in the life cycle we intervene, the more effective and promising our efforts will be. WAIMH's major aim, of promoting the mental wellbeing and healthy development of infants throughout the world, is therefore justified, precisely in times like these in which we increasingly have to face the struggles for children's survival in almost every part of the world.

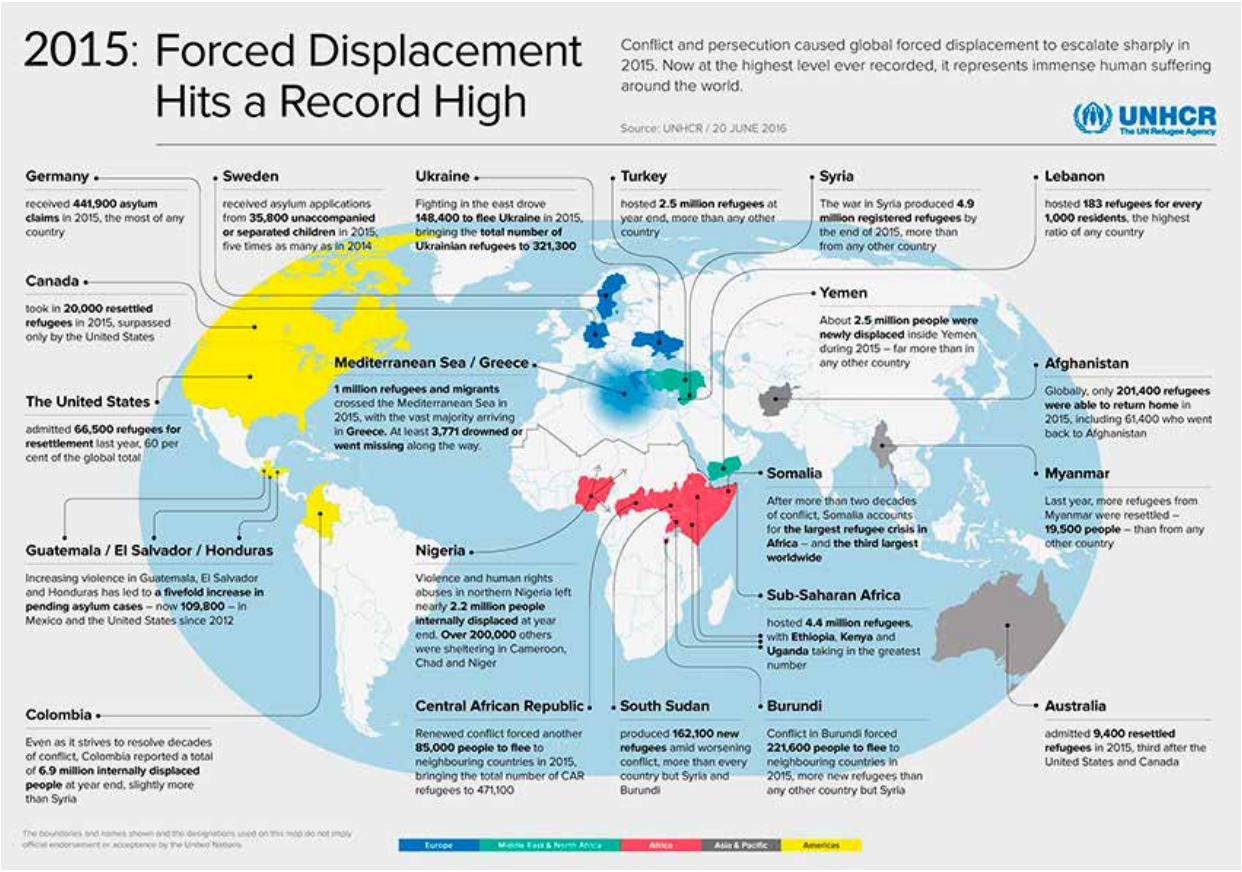

Photo: The UN Refugee Agency (UNHCR): Global trends 2015, Retrieved from: http://www.unhcr.org/global-trends-2015.html

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From the Editors

By Deborah J. Weatherston, Editor, Michigan, USA,

dweatherston@mi-aimh.org

Maree Foley, Associate Editor, Switzerland/ New Zealand, maree.foley@xtra.co.nz

Hiram E. Fitzgerald, Associate Editor, Michigan, USA, fitzger9@msu.edu

This issue of *WAIMH Perspectives in Infant Mental Health* introduces the new WAIMH President, Kai von Klitzing to the members of WAIMH and readership at large around the world. In his President's Address, "Integrating Physical and Mental Health Support for Infants Worldwide," Kai states clearly and eloquently, *"Each mind lives in a body; the survival of the body without a healthy mind causes tremendous suffering. A healthy mind is essential for human development."* This builds on Miri Keren's leadership during her presidency to promote the mental health of infants through WAIMH's Infants' Rights paper and the world of WAIMH in coming years.

Included in this issue is a clinical article focusing on fathers and their important relationships with infants and young children. In addition, we are very pleased to publish the work of two infant mental health colleagues who were honored by their WAIMH Affiliates in 2015: Carolyn Dayton who composed a poem, "The Infant Mental Health Specialist Who Does Not Like Babies", upon receipt of an award for scholarly work from the Michigan Association for Infant Mental Health and Heather Warne who received the Ann Morgan Prize from the Australian Association for Infant Mental Health – Victoria for her paper, co-authored with Patricia O'Rourke, *"Psychodrama and Infant Mental Health: An essay and a conversation."* Both appear here with permission.

Of importance, too, are reflections from sponsored delegates in Ghana and Brazil who attended the WAIMH Conference in Prague. Nana Gaisie (Ghana), Lívia Caetano da Silva Leão (Brazil) and Larissa Ramos da Silva (Brazil) express their gratitude for the support they received to come to Prague and to meet people from around the world who shared their passion for infant mental health.

As the number of Affiliate organizations grows, Maree Foley and Anna Huber have many things to report, as do the WAIMH Executive Officers in Tampere.

We deeply appreciate the contributions each person has made to the summer issue and invite those of you who have commentary or articles to submit for readers around the world.

Professional gatekeeping toward fathers: A powerful influence on family and child development

By Frascarolo, France, PhD

Co-director of the Center for Family Study,

CHUV, Lausanne, Switzerland

Feinberg, Mark, PhD

Research Professor of Health and Human Development

at The Pennsylvania State University, USA

Albert Sznitman, Gillian, MSc

Family and Development Research Center (FADO), Institute of Psychology,

University of Lausanne, Lausanne, Switzerland

Favez, Nicolas, PhD

Professor of clinical psychology and interpersonal relationships

at the University of Geneva, Switzerland, and

Co-director of the Center for Family Study

CHUV, Lausanne, Switzerland

After a few words as to the role of fathers as well as a brief introduction to maternal gatekeeping, a regulator of paternal involvement, the objective of this paper is to invite the reader to reflect on the role that professionals in this field play in this process of gatekeeping, which in general restricts the role of the father.

The role of the father

The role and contributions of the father are numerous. On the one hand, the father can directly construct a warm and caring relationship with his child through quality dyadic exchanges, which, as we will point out later on, have unique characteristics compared to those between mother and child. On the other hand, the father via his relationship with the mother of the child can construct a cooperative coparenting relationship, composed of warmth, support, and positive conflict resolution. Furthermore, when the father is engaged in parenting within the context of a positive coparenting relationship, maternal stress and role overload is reduced. In addition, the child's exposure to the team-like collaboration between his parents serves as a positive model for his or her future interpersonal relationships.

Father-child interaction

« The father has been viewed by some as a substitute for mother, or for mother's ability to meet the baby's needs. Doing so overshadows his actual role as a loving available father in his own right. (…) While the roles of the loving mother and father are not the same, they are complementary and both play a part in the development of their children » (Thomas, 2010; p.71).

In many ways, fathers provide caregiving in a similar way as mothers (Tissot et al., 2015; Udry-Jorgenson, et al. 2015). Indeed, a question answered in the affirmative in the early fatherhood literature was whether fathers are as nurturing and warm as mothers (Parke, 1978). However, research has also demonstrated that there are differences between mothers and fathers both at the neuropsychological level (Feldman, 2015) as well as the behavioral. As compared to mothers, fathers of children younger than 2 years old, use toys less often and more often engage in physical games (Yogman, 1981; Clarke-Stewart, 1978; Forbes et al., 2004). As documented by Yogman (1982) and Power (1985), a greater amount of interference is observed in the interactions of fathers with their children, for example in the form of interrupting the self-driven behavior of the child by sudden tickling. In addition, fathers tend to engage less in pretend games (Power, 1985), and more often propose unconventional play, for example, by using objects in ways that are not typical or by teasing the child (Alber-Labrell, 1989). Furthermore, fathers tend to excite their children more and soothe their children less than mothers (Clarke-Stewart, 1978). Overall, fathers seem to promote the autonomy of their children, in particular during the early years (Frascarolo, 2004), and have a vision of their children that is more focused on the future (Brachfeld-Child, 1986; Labrell, 1996).

Thus, mothers and fathers are equally capable of looking after and satisfying the needs of their children, in different but complementary ways. Fathers, for their part, encourage their children to go beyond their normal comfort zone, whereas, mothers tend to contain and reassure their children. It is therefore important for children to have a close relationship with not only their mother but also with their father, given the unique benefits of both. At the same time, it is important to note that the previously mentioned research studies are slightly dated and merit replication as social norms and expectations evolve.

Coparenting and children's development

As previously mentioned, the father plays an equally important role in coparenting, which is defined as the support parents provide each other in regards to the raising of their children. Coparenting is a pillar of family functioning and has a particular influence on the development of the child distinct to that of parenting (Minuchin, 1974; McHale et Rasmussen, 1998).

Coparenting that is characterized by warmth and cooperation predicts positive socioemotional development in the child (Favez et al., 2009; McHale et al., 2002). In contrast, coparenting that is characterized by competition and absence of support negatively influences child development (Belsky et al., 1996; Favez et al., 2013; Frosch et al., 2000; Lindhal et Malik, 1999). In their meta-analysis of 60 cross-sectional and longitudinal studies with children between the ages of 7 months and 16 years, Teubert and Pinquart (2010) demonstrated that children's internalizing problems (such as anxiety, depression, and social isolation) and externalizing problems (such as behavioral problems, violence, and acting out) are negatively related to parental cooperation and positively related to parental conflict and triangulation (in which the child plays the role of

go-between in the parental conflict). Furthermore, by observing parental interactions, the child constructs mental models of interaction, which will guide his or her future interactions with others.

Gatekeeping: From mothers to professionals

Van Egeren (2004) defines gatekeeping as the ways in which the mother regulates the involvement of the father or the access he has to the child. These maternal behaviors include limiting the father's access and involvement, as well as the provision of access and inclusion of the father in parenting (promoting). The mother can facilitate the father's access to the child by giving him, in his parenting role, space, support, encouragement, compliments, and loving approval. In contrast, the mother can try to control and restrain the father's involvement by excluding, critiquing, devaluing—as well as by taking most of the parenting responsibilities on herself. Depending on the culture and personal history of the father, he can either choose to accept or not maternal gatekeeping. Although mothers traditionally have primary responsibility for children and are thus in a position to enact gatekeeping, fathers too can facilitate or obstruct the relationship between mother and child.

In settings in which professionals are involved in children's care and health -- whether it be at the maternity ward, the pediatrician, the pediatric psychiatrist, « mother-child » consultations, at home with the care nurse, etc. -- there seems to be a pronounced absence of fathers. By not involving fathers in these services and more generally in the caretaking of their children, professionals demonstrate a form of restrictive gatekeeping towards fathers. Such professional gatekeeping most likely results, in part, from professional respect for the traditional role of the mother as the primary caretaking parent for young children, reinforced by the over-representation of women in professions related to these young ages. Such gatekeeping has likely been reinforced by developmental theories that focus almost exclusively on mothers, and the corresponding lack of developmental theories exploring the unique contributions of the father and further supported (Truc, 2006; Turcotte, 2014; Thomas, 2010). Yet it is clear that fathers--as part of the family system--play a part along with mothers and children in maintaining maladaptive family relationships and behaviors. Such maladaptive patterns may be problematic in and of themselves, leading to psychological and behavioral problems in children, or such patterns may impede problem-solving and pose an obstacle to treatment adherence (e.g., attendance at future appointments, maintaining medication schedules, etc.). Developing more adaptive family environments are more likely to be successful with fathers' involvement.

Acknowledging that mothers are more often inclined to participate in consultations as a result of learned behaviors that are deemed socially appropriate (for example, girls are taught to value emotion and communication), and thus participation in early childhood consultations seem to relate more so to "female" culture than to "male" culture (Dulac, 1998, cited by Pouillot & Saint-Jacques, 2005). Furthermore, it is typically mothers who seek out services. Fathers are less often the ones asking for help and are also less accustomed to accepting it (Featherstone, 2003). Moreover, in line with the fact that fathers are often the ones working full-time, the organization of the family and the division of domestic tasks remains somewhat organized along gender lines. Considering that mothers are the ones who are principally responsible for the care of their children, this might lead professionals to be less at ease with fathers and not to include fathers in child-related services. Similarly, in some professional contexts, a number of administrative forms do not even mention the existence of the father except in his role as provider. In the situation where parents are not married, this lack of inclusion is exacerbated (Turcotte, 2014).

This distinction can be observed as early as in the maternity ward, the name of which itself (based on the mother and not the child) seems to already exclude the legitimacy of the father's presence (Truc, 2006). « According to Goody (2001), the « matrifocal structures » lend themselves to the exclusion, and even « remove responsibility » of the man (…). The « removal of responsibility » of the father, in regards to the care of his baby, resulting from matrifocality, can lead to the father not feeling any responsibility for his child. As a result when fathers do try to go beyond the basic assisting role and try to involve themselves directly in the caretaking of their child, they may feel scared of causing harm as a result of these contradicting psycho-social factors. Only an attentive baby nurse or mother who is very thoughtful to her partner can help these fathers to surmount this obstacle that impedes them from « doing » and to help them evolve from spectator to actor. » (Truc, op cit., p. 345)

If the responsibility of involving fathers is left to mothers, the power of maternal gatekeeping is further reinforced -- with the consequence that some may not invite fathers to participate. According to Cowan et al. (1996), fathers who report worse relationship quality participate less in consultations. This may beg the question as to whether fathers were even invited to attend appointments. It would therefore be essential for the professionals to contact the father directly stressing the importance of his contribution to and influence on the development of the child, as well as his role in the clinical work. Given the norms around father involvement, fathers' lifelong experiences, and pressures such as work, inviting fathers to be involved may not elicit the hoped for involvement in a number of cases. However, gentle persistence is needed to continue encouraging fathers to participate in professional situations.

In their study investigating the involvement of fathers in youth protection interventions, Pouliot & Saint-Jacques (2005) noted that health care professionals often attribute difficulty in involving fathers to the fact that in the case of divorce, mothers are often the ones who are legally responsible for the child. The authors noted that although mothers may in some cases be legally responsible for the child, this does not justify the complete removal of father involvement. Further, they write, the discourse of professionals implicitly suggests the superiority of mothers as parents. This attitude and consequent behavior constitutes the basis of professional gatekeeping.

In certain cases, by implicitly highlighting fathers' « inutility », professional gatekeeping can promote the complete removal of fathers from the parenting role (Lebovici, personal communication, 1999). How does the child experience this exclusion of their father? Would the child not be led to discount the importance of his father? Further, if the mother sought help as a result of difficulties she observed with her child, restrictive professional gatekeeping towards the father might only reinforce the family systems root of the problem in some families.

Certainly in many cases after separation or divorce, inclusion of both parents in appointments may lead to greater conflict and difficulty. On the one hand, providers should receive training in ways to defuse and manage such conflict by maintaining a focus on the best interest of the child. On the other, the best interest of the child may require that come couples who are entrenched in hostile conflict not attend appointments together.

Note that professional gatekeeping is part of a « societal gatekeeping » as evidenced by the scarcity and the brevity of paternity leave after the birth of a child, which does not favor the early construction of the father-child bond. For example, in Switzerland, according to the law, fathers receive a paternity leave of one day; in April 2016, the National Council rejected two weeks of paternity leave.

Nevertheless, by systematically not involving fathers in issues regarding their children, professionals treat fathers not as a resource, but rather as a « useless » factor or even a source of « harm ».

Benefits of including the father

It would be of benefit to involve fathers in consultations and in all matters concerning their children (whether or not they live in the same house as their children), not only for the specific benefits this can have for the development of the child, for the coparenting relationship, and for father engagement in parenting, but also for mothers. In fact, involving fathers can reduce « mother blaming » (or « mother self-blaming ») given that, as a result of the fathers' involvement, mothers will no longer be considered as the sole person responsible for the raising and development of their children. The involvement of fathers is beneficial for him whether he has difficulties with fatherhood or not, but especially in the case that he does. In fact, given the desire to be a good parent, which is a concern for most parents, « Men and women are struggling with the type of experiences that they had as children, while at the same time trying to raise children of their own, bent on not repeating the mistakes they felt that their fathers had made» (Thomas, 2010, p.64). However, in reproducing the model of the « absent » father, facilitated by professional gatekeeping, fathers are not supported in their exploration of how to father in their own way, but are rather led into repeating the absent-father model. Thus, if a father has, or has had, difficulties with his respective father or with fatherhood, restricting his involvement will not facilitate the construction of a relationship with his child.

Suggestions for how to promote the involvement of fathers

Different strategies can be put in place to promote the involvement of fathers, for example as suggested by Turcotte (2014) as well as by Pouliot & Saint-Jacques (2005):

1. Adjusting the hours of operation of consultation centers
2. Put pictures of fathers on the walls of waiting rooms and including fathers in informational brochures and publicity related to family services
3. Add questions relating to the father to administrative forms
4. Systematically invite fathers to consultations (whether they live in the same house as their child or not, except in the case of potential violence)

To these suggestions we would add:

5. Include fathers via telephone/video-conference in the case that their physical presence is not possible
6. Rename services to include the father or use the more general term of « family » rather than just mother and child

Finally, as emphasized by Pouliot & Saint-Jacques (2005), in addressing the issue of paternal involvement, it is important to emphasize the importance of developing projects that are centered on the complementary role fathers can have in regards to parenting, specifically in the eyes of professionals and mothers (Bergonnier-Dupuy, 1997; Dubeau et al., 1999; Labrell, 1997; Le Camus, 1995, 1997; Zaouche-Gaudron, 1997). Furthermore, it is of utmost importance to raise the awareness of professionals regarding the issue of paternal gatekeeping as well as encourage professionals to seek training in this domain in order to better equip them for interventions that include the father (Plouffe, 2007).

In regards to therapies, fathers in general may appreciate different qualities in the providers that mothers. Whereas mothers may appreciate an emotional connection with a therapist, many fathers tend to be appreciative of a therapist style that is active and that provides direct guidance. Carr et al. (1998) conclude that "engaging fathers early in the therapeutic process, through the adoption of a competent and directive style, should be a priority" (op cit p.249). Engaging fathers early in the therapeutic process is also important as fathers can provide an additional perspective on children's problems and strengths (Foote et al., 1998 cited by Carr et al. 1998).

The absence of fathers in child-related services, considered to be normal and benign, does not take into account the pain that one can feel when confronted with absence (cf. father hunger, Herzog, 1983). The exclusion of fathers in consultations perpetuates the idea of the « inutility » of fathers in how they perceive themselves, but also in the eyes of mothers and children. And such attitudes on all sides reinforce restrictive gatekeeping of fathers. Nevertheless, an important source of motivation for fathers to be involved in the lives of their children comes from the belief that it would benefit their child. To break this vicious cycle and give fathers a central place in childrearing, it is necessary to recognize fathers' unique approach to parenting and influence on children.

In sum, there are three major reasons to fight against gatekeeping that limits the role of fathers, which is unfortunately practiced by a number of professionals and in which fathers and mothers are complicit: Such gatekeeping risks depriving the child of the specific contribution of his or her father, it undermines coparenting (and as a result the family unit), and it reinforces views that children's development and problems are the sole responsibility of the mother (mother blaming). Establishing professional gatekeeping that promotes the role of fathers will help support the development of engaged fatherhood, reinforces fathers' desires to take on their parental role. Such promotive professional gatekeeping does not subscribe in any way to the reestablishing of the patriarchy of past centuries, but rather promotes engaged fathering and the development of cohesive coparenting, the foundation of the family.

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Holding

By Carolyn Joy Dayton, PhD, LMSW, IMH-E®(IV)

Assistant Professor, School of Social Work

Associate Director, Infant Mental Health Program

Merrill Palmer Skillman Institute for Child and Family Development

Wayne State University, Michigan, USA

The following poem was written and delivered by Carolyn Joy Dayton upon receipt of the Michigan Association for Infant Mental Health 2015 Hiram Fitzgerald Award for new research scientists. It appears here with permission from the author and the Michigan Association for Infant Mental Health where it was originally published.

The Infant Mental Health Specialist who does not like Babies

Act I: Learning to hold. On.

To hold a baby.

To hold a mother.

To fall apart under the weight of the holding;

Knowing that you will come together again in the arms of your family, your friends, your colleagues, your supervisor.

Knowing that you can withstand.

Knowing that staying connected sometimes means falling apart.

Because the weight. . .

it is. . very, very heavy.

Tell me about the baby! Said my supervisor.

Actually, I don't really like babies, I thought, but did not yet have the courage to say.

How can you not want to visit that young, vulnerable mother! she said.

Because I am tired, I thought, but did not say.

Because I'm not sure it will help.

Because she does not listen to me.

Because it is really, really hard for me to listen to her.

But, that mother. . .

It's not fair, I thought, feeling angry, but did not say, and did not let on.

That she cannot hold her baby.

Her mother did not hold her. Her father did not hold her.

There were no aunts or grandmothers or uncles or grandfathers.

How can we ask her to hold her baby? It's not fair. I thought and began to think maybe I would say.

That's it! I thought, but did not say.

I still did not like babies.

But, I thought, I do care about their mothers.

They are heavy though, those mothers.

And tricky, too.

They hide beneath their shame and their suffering.

They sometimes don't come out for a long, long time.

They sometimes make me feel like I don't matter, and they are very, very certain that

they.

don't.

matter.

And, why, after all, would you hold your baby, if you don't matter.

So, I have to matter, I thought, and almost said.

Do I matter?

How do I know?

What if I'm wrong?

What if I don't matter enough?

What if I

can't.

hold.

on.

Act II: Holding on

I was held.

I don't remember it.

I know it felt good though.

Safe. Warm. Contained. Understood.

I was held.

I can remember.

When things went wrong.

When I skinned my legs in the summer riding bikes.

When I lost important things like my Mickey Mouse wristwatch.

When I felt scared of things – real or imagined.

I was held.

It felt good.

I am held.

When I'm scared and tired and I start thinking that maybe I don't matter.

"I don't think I'm doing this right," I say, out loud.

What?, she says. What aren't you doing right?

You know, life, I say.

And, she holds me.

So, I hold on.

To myself. To my others. To the young mother. To her baby.

It's sometimes scary. I sometimes fall apart.

I always come back together.

Because I was held and I am held and I can hold on.

Act III: Reaching Up, or Out. Sometimes Sideways. Mostly just reaching.

So, what's it gonna be, Dayton, I thought, but did not say.

I was looking out at a sea of IMH folks – many of the folks who are still here tonight – because we all continue to hold on to each other

Some of you are interventionists, some researchers, some policy makers.

So many people who matter.

So many people making a difference in the lives of families.

But, how can I matter? How will I matter? How will I make a difference?

I wondered. For a while. And I talked, and talked, and wondered.

I think maybe research. . . . with a clinical focus. . . that has policy implications, I said, to one of my others.

She shook her head.

What? I said.

Nothing, she said. You'll figure it out.

I'm pretty sure a hamburger and a glass of wine will help you figure it out.

Right, I said.

I was being held.

Act IV – Figuring it out, kinda sorta

Fathers, I said.

Why? He asked.

Because they matter, I said, and nobody seems to know.

Not nearly as much as mothers, he said.

But, you're a father, I thought but did not say.

They do matter, I said, to one of my others. They do. And she nodded.

I will try to understand fathers. I say. Today. To all of you.

Because they matter.

Because I have a father.

Because my son has a father.

Because my son will someday be a father.

And all of that matters. To me.

Ann Morgan Prize 2015

Ann Morgan Prize, Australian Association for Infant Mental Health, Inc. Victoria

As a creative pioneer in the field of infant mental health, Dr Ann Morgan has provided immense support and leadership for those working with troubled infants and their families. She has been a passionate advocate for infants and parents, providing transformational interventions for them and inspiration for her colleagues.

To honour Dr Ann Morgan's contribution to the infant mental health field, the Australian Association for Infant Mental Health, Inc. Victoria has established an annual writing prize, the Ann Morgan Prize. It was first inaugurated in 2010 as a way of honouring Ann when she retired from her official role on the AAIMHI (Vic) committee as Vice- President.

The Ann Morgan Prize was created to invite contributions that would illuminate something about the infant's experience and also to be a forum for creative writing not bound by the rules and restrictions defining many professional publications. The invitation to submit is extended to all members of the Australian Association for Infant Mental Health.

Heather Warne received the Ann Morgan Prize in 2015. She was originally trained as an occupational therapist and has spent most of the past 35 years working with children and families in community health settings. Over the past 15 years, she has found her way into the fields of psychotherapy and infant mental health. Heather works as an infant mental health specialist with the Infant Therapeutic Reunification Service based at the Women's and Children's Hospital in Adelaide and maintains a small private practice.

The Infant Therapeutic Reunification Service is a collaborative health and child protection initiative working with parent/s and infants where the infant has suffered abuse or neglect. The service provides comprehensive parenting capacity assessment and where possible, therapeutic intervention that aims to increase the parent's protective and reflective capacities within the developmental time frame of the infant. The focus of the work is primarily on building relationships.

The service provides early assessment and intensive parent/infant therapy for infants under three and their parents, where significant maltreatment and neglect has occurred, or is at risk of occurring. It was set up in 2011 in response to the high levels of infants coming into care and often experiencing multiple placements. Based on the Tulane Infant Team model, the success of the reunification work is higher than average.

Where reunification is not possible, timely long-term decisions that address the infant's developmental timeframe are made and therapy with foster parents and infants may also be offered.

At all levels of intervention the focus is to build reflective capacity to improve outcomes for infants.

The client in the story has generously given permission for the work to be published and presented.

First published in the AANZPA Journal, the article appears here with permission from the authors, Patricia O'Rourke and Heather Warne, and the publisher.

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Psychodrama and Infant Mental Health: An essay and a conversation

By Patricia O'Rourke and Heather Warne

Moments from inside an Infant Therapeutic Reunification Service…

He turns up regularly, weekly, though sometimes la. Today he's on time, and sits awkwardly in the waiting room. He's thick set, 24 years old, pumps weights and drinks Red Bull. He never wears a jumper. His baby, a girl, soon to be a toddler, sits in her pusher, face slightly dirty, big blue eyes alert, wispy hair awry and poking out from under a red and white knitted hat with red pom poms dangling from the ear flaps. Her feet are bare. Today she grins at me, a wide toothy smile – she has a big gap between those two front teeth, and she looks just like her dad. Although her paternity is obvious, in the beginning it was contentious and required scientific verification.

He is less effusive in his greeting, doesn't directly say hello. He's a bit shy, and socially awkward. The greeting is important. Sometimes our parents can't share, not even with their infant, and it can be a mistake to greet the infant first; if the parent flickers, and turns away just slightly with dry displeasure, we're off to a bad start. This dad is not like that, but he is on the edge of his comfort zone, here under duress. Mostly he warms up as we trundle down the corridor, through the grey security door then right, left, left and into the playroom. He reminds me of a friendly but slightly inept bear with a dolly in a flimsy toy pusher.

Usually he connects with me, on his own terms, by way of cars. He relates his latest mechanical exploits – the new shockers he's just installed on the V6, the deal he's wrangled for good second-hand tyres, and after this (meaning the session), he's off to the wreckers with his dad because the timing belt is on its way out. I will ask him again, a little later, about where the baby will be and I'll say something like, 'Wow that's a long time for her to sit in the car …' And he will say, 'Oh she's used to it,' and I will grapple with how much of a problem it is in the general scheme of things.

But today it's a bit different – he sucks on his can of Red Bull and fiddles with his phone as he pushes her along. He's not looking at me. Just as we get to the room his phone rings, and he says can he answer it? Perhaps he's remembering last

time, when, sitting on the floor with the baby, I relayed what I felt, what the baby might feel, as he texted back and forth, one of the candidates he was vetting for a relationship. Perhaps he's remembering something of that conversation, carefully delivered with humour and empathy, so as not to shame him. I said how I felt alone and forgotten right then and there, while he held his phone, in his hands and his mind, and it was probably like that for his baby too. He scrabbled about, keen to tell me that the 'chick' on the receiving end of his attentions was only free now, since it was lunchtime … How would he manage, I wondered out loud, the romance and compulsion of a new relationship, while caring for a baby? Easy he said, we'd only do stuff where she could come too. He has criteria, has learned from his mistakes, he says. Good with kids is on top of his list, and he can provide details.

But maybe he did feel criticised, or there's something else on his mind. Whatever it is, the baby is here, however he feels, and how does he manage that? She's off by herself, busy with the toys, but she looks at him more than when they first came; she was eight months old. Now she's almost walking and he's keen for her to be properly mobile. Small babies are not really his thing.

There's no doubt she's in his heart, I can feel it in the room. He no longer goes out drinking, he doesn't tangle with the law. He's solid and reliable and committed. He's recently been shopping for her, for new clothes, and, apart from the hat, she's decked out in pink. Sometimes she arrives buttoned at the front when I'm pretty sure the buttons belong at the back. Her bottles are clean, and he tells me she gobbles up the vegies he cooks for her. She's healthy, growing well, and meeting her developmental milestones – a far cry from the emaciated, silent, dull-eyed infant who arrived, aged four months, precipitously into his care.

Our service, small, committed, and meagrely resourced, works with infants and parents at risk. All of our clients are involved with the child protection system. Our job is to put the infant first; we grapple with the complexities of parenting capacity assessment, out-of-home care, early decision-making in the best interests of the infant and within their developmental timeframe, and where possible, intensive therapeutic support with the infant and their parent/s or carer/s. Most of our therapeutic work is with mothers and their infants, most of the fathers are violent and don't have what it takes.

This father, however, is not violent, and took on his daughter's care when the mother couldn't do it. Within the hour he'd said yes, and had rallied his network and the basic necessities – cot, nappies, bottles and formula, singlets and grow suits and blankets. Fatherhood was huge for him, and he took it on. She arrived from her mother via a child protection worker, a haunted shell. Her mother was homeless and mostly drugged. This infant, like many we see, had witnessed violence, ugly and terrifying. She was left alone, to scream and despair, her bottles filthy and unfilled. She spent days at a time with mere acquaintances when her mother failed to return. She'd been seriously ill and was way too thin, admitted to hospital for 'failure to thrive'. Her body told the story. Her mother, repeating her own history, did not know how to do it differently.

He had fallen into a relationship of sorts when the mother was 'up'. They met through a friend, and for a few good weeks, she was fun loving and affectionate; then she moved in. She needed somewhere to stay. They talked about children, but she didn't stay faithful. He found the evidence on her phone. By then she was pregnant, and stealing his money, and leaving her other child in his care. He left, or threw her out, it's not clear which. He never went back. She alleged that he threatened their unborn child and took up again with a man who beat her. The father, our client, wasn't at the birth, and she disputed paternity. Hence the test.

He's not good at relationships, he says. As a boy he was angry, difficult to manage, and struggled at school. He received a dual diagnosis that has stuck. Asperger's Syndrome and ADHD. Heavily medicated to keep him compliant, he gained huge amounts of weight, and thus dulled and conspicuous, struggled more at school. He started drinking and thieving, and 'got in with the wrong crowd'. It seems no one heeded that he lived in fear, his father drank and abused his mother. When his parents separated, home was a toxic soup of blame and acrimony. When we talk about it now, he glides over the pain, says his father has given up the drink, goes fishing instead, and that he, the grandfather, has Asperger's as well. The idea that something else was going on is very difficult to face and he doesn't appear to have taken in the recent psychiatric opinion that he was labelled wrongly…

He says he doesn't think his baby has Asperger's, and I agree. We edge about it some more. Trauma can look like Asperger's, I say, and again we talk about her brain, what all those stress hormones do to a small baby, how she learned not to rely on anyone and what she needs now. He says he's getting better at that, and I agree. At some point, he gathers her in, a bit rough, but he holds her close and for a moment she snuggles in. She goes to him more. There's an authentic quality in what he says, and I trust it. He says he's not good at the feeling stuff, and finding a way to say things.

And so it goes. We talk about the past, and what happens in the moment. I try to give to him what I want him to give to her. I wonder what he's thinking and feeling, what does he imagine she's thinking and feeling, tell him what I see him doing, let him know that I like him and know him to be a good person, understand that parenting is hard. Especially when you weren't expecting it and are going it alone when you really want a family, different from when you were little. Back and forth we go, between the baby and him, including both. What do you think

that's like for her? Did you see what she did when you sat on the floor? What do you think it's like for her to see her mother? Is she any different when she gets home? This sounds like an interrogation, but I hope it's not. It's to and fro, joining them up, making links that weren't obvious before.

And I talk about how weird it is to come in here and talk to someone as old as me in ways that he's not used to and not comfortable with and is anything we're doing here helpful because sometimes it's hard to tell … and at regular intervals he talks about cars. He's not deterred by my ignorance.

Although awkward and at times repetitive, these sessions are not that difficult. Despite some worries about the time this baby spends in the car and wrecking yards, and sitting in her playpen next to the latest being worked on vehicle, this dad is good enough. He knows his baby, thinks about her, plans for her. He accepts help. And she relies on him. She makes a beeline for him when she's hurt or frightened, looks for him and cries when he's not there. Though she's too self-sufficient, and cruises the furniture on tiptoes, and parts of her are hidden, she is safe, and held in his arms and mind.

Not so, for others that we see. Young infants, for example, with unexplained bruising or broken bones, the ones who hold themselves rigid and stare with hopeless eyes into the distance, the ones who look down, with flat lifeless faces and their hair worn away in telling patches from too much lying down or rocking back and forth. The ones who spit up their milk and scream without warning, or the ones who are eager and overbright and latch on to strangers with desperate eyes. These are

the ones who are not safe and not seen, and exist in helpless desperation.

As I recall the many such infants who come in through that grey security door, part of my brain disengages, and something else, akin to instinct, takes over, as it does in the room. The language of young infants is powerful and primitive. It is as if they speak through the feeling states that they evoke, how they hold themselves, and where they look. Infants cannot lie. They cannot help but tell the truth of their experience, the truth of their connection with the adult who holds them. Feeling states that are difficult to bear invade the room. Helpful theories and models simply evaporate, and, just as the infant cannot escape, I feel as if I am living on wits alone, with nowhere to hide. Trapped in their bodies, exquisitely sensitive, and helplessly vulnerable, the infant has no choice in the matter … the best they can do is to not look, hold themselves rigid, go still and silent and sometimes floppy, or overly bright and wide eyed, whichever serves them best. There's such rawness in the room, so much excruciating need. And there is always more than one baby, though only one is visible. The mother's infant self, as well as mine, are also present.

The mothers we work with are always wounded, horribly wounded, and champions of survival. They say the things that, logically, we would want to hear, and they trust no one.

'Good mother, no drugs, no violence, reformed, unfairly treated, love my baby, baby perfect, a few past hiccups but all good now. No one will listen, it's so unfair, I've done nothing wrong, I really am a good mother, had a few issues keeping things tidy, I'm not seeing the father, the baby is perfect, my world, my life, I'll do anything for him. I will get him back, I know it. It's just a matter of time and showing up here. I've done everything they've asked of me.'

How can she believe, though we've made it clear, that her best chance is to tell the truth? In her mind the truth, some version of this, would surely seal her fate: her childhood, or what little she remembers of it, was awful. She didn't feel safe, wasn't safe. From early on, she knew violence, abuse, neglect, terror, abandonment, and utter aloneness. She learned to numb herself. At some point, often very young, she fell pregnant. The promise of a baby, as if by magic, would fill the void. Here at last was someone who would love her, and not leave her.

It was not as she'd hoped. The infant screamed, was helpless, needed her. There was no one to help, she trusted no one to help. The partner, jealous, became more violent. She did her best, but sooner or later, she spiralled down, and reports were made. Or even worse, she'd been through it all before, once, twice, three times or more, and they took the baby early, straight from hospital …

We search for the signs that show she recognises her part. She has, though she did not mean to, hurt her baby. Either directly, or indirectly, either way the baby was not safe, as she was not safe. She has to see that she has done to her baby what was done to her, and to face the shame of that. She needs to face and to feel what that was like for her baby. Then we can work with her, that little chink in her armour.

The process will be long, imperfect and blundering, with moments of triumph and no guarantee of success. We will sit through session after session of rage and blame, anguish and grief. It will be the infant who leads the way; he will turn in circles, or back away, he will spill his jumbled world onto the floor. We will sit with chaos, sit in chaos, amongst a sea of plastic coins, pots and pans and teacups, dinosaurs and crocodiles, wild animals and items from a doctor's set. It will be a long time before the train tracks join up and the train doesn't crash. We will wait for the crocodiles to move out of the doll's house. We will try to make sense of it all, and see through the infant's eyes.

My part will be to show up regularly and willingly. The process will challenge me to the core, to sit with what is not contained, to hold a boundary, to stay thinking and connected, with myself and them. At best we will build enough safety for a real relationship to emerge, one in which vulnerability can be shown, pain can be held, and soothing experienced. It will be difficult to get there. The work requires a team, regular supervision, and a shared belief that change is possible; intergenerational trauma does not have to go on and on.

They're back, the dad and his baby. They're fifty minutes late. I go to the waiting room, pleased to see them; I thought they weren't coming. She's straining to get out of her pusher, and missing a sock. He's dishevelled but upbeat. They have been on holiday to see his mum and celebrate the baby's first birthday. They've been on the road since early morning, have just arrived in town. I take a breath and imagine them, flying down the highway in the V6 with the spoiler on the boot and her strapped into the baby seat, staring out the window with eyes glazing over, or asleep. I'm glad they're safe. It's not that he's keen to see me; he's in trouble with his social worker for missing access, and he didn't dare not show up. Nevertheless, he bubbles with news. His mum is proud of him, she even said so, and they went camping, all together, and cooked lamb on a spit. The baby had a great time too, he said, and his best mate has just become a father. He wants to move back to the town he grew up in. It's as if in claiming his baby he has also been claimed, back into his family.

A while ago I asked if I could write about them, and told him why. He laughed, a bit bemused and said 'yeah, sure', as long as he didn't have to write anything.

The next thing, he says, will be to take her fishing, out in the boat. I feel instantly queasy, and I say so. He's been thinking about that, the way he got his sea legs was to get started early, when he was five. She's only one, I say. We'll just do little trips, he says, and if she's not okay, we'll turn around and go back in. He's saving up for a very small life jacket.

Note: The authors suggest the consideration of reflective questions, useful for inviting further thought about the story, individually or within a group:

Reflective Questions

1. What was your emotional response to this story and how does this relate to your own experience of working with parents and infants?
2. How do you feel about working with fathers and infants?
3. In your experience how does father-infant therapy differ from mother-infant therapy?
4. How could you use this father's interest in cars and mechanics to build both the therapeutic and father-infant relationship?
5. What are the strengths and risks that this father brings to the relationship with his daughter? How would you weigh up the risk and protective factors and how would you manage the risks?

WAIMH Affiliates News

Maree Foley

WAIMH Affiliates Council Chair

Contact: maree.foley@xtra.co.nz

Anna Huber

WAIMH Affiliates representative

Contact: ahuber@familiesinmind.com.au

Greetings to all WAIMH Affiliates.

Most recently some of us had an opportunity to meet in Prague at the 15th WAIMH Congress. The Congress was an extraordinary event featuring a rich array of infant mental health related practice and research. In addition, there were wonderful opportunities to connect and relax with each other. This congress in particular was unique in that it was an Israeli and Palestinian Congress hosted in Prague. The sheer logistics of such an endeavour were enormous and we would like to thank everybody that made the congress run smoothly. Especially we would like to thank the local organising committee (Miri Keren, Sam Tyano, Ghassan Abdullah and many other colleagues from Israel and Palestine), the WAIMH programme committee (Campbell Paul, Miri Keren, Kaija Puura, David Oppenheim and Mark Tomlinson), the congress secretariat (GUARANT International), the WAIMH Board and Executive officers and the WAIMH office.

This brief update has three foci: An overview of the Affiliate meetings recently held at the 15th WAIMH Congress; an update on the WAIMH Infant Rights statement; and plans for an Affiliate pre-congress event at the next WAIMH Congress in Italy, 2018.

Affiliate Council meetings at the 15th WAIMH Congress, Prague

There were several main events that the Affiliate council hosted or co-hosted for some or all members. The first event was a reception for delegates whose attendance at the WAIMH Congress was supported by the WAIMH Sponsor a Delegate Program. WAIMH Board members, Astrid Berg and

WAIMH Affiliate Council biannual meetings in Prague 2016. (Photo by WAIMH)

Deborah Weatherston, WAIMH Affiliate Council Representatives, Maree Foley and Anna Huber, the Infant Mental Health Journal Editor-in-Chief, Paul Spicer, and WAIMH Central Office staff, Pälvi Kaukonen and Minna Sorsa, were present to meet and welcome the delegates, all of whom appreciated the support provided to attend the 2016 Congress in Prague.

Each delegate introduced herself to the group after which WAIMH Board members expressed appreciation for their interest and commitment to the field of infant mental health and their shared goal of building infant mental health interest groups in their home countries, progressing the development of their groups to affiliate status and identifying ways in which WAIMH could support these developments. Countries represented included India, Ghana, Egypt, Ukraine, Nepal, Brazil, Palestine and China.

Next, the Affiliate Council provided an Administrative meeting for affiliate presidents and their executive members. The purpose of this meeting was to provide an opportunity to share affiliate administrative issues or concerns for discussion as a group. This type of get together had not been held before but was organised in response to the many queries that Maree and Anna and the WAIMH office field from affiliate presidents between congresses. The meeting was very well attended. The room was full and because the meeting was not structured around a pre-determined agenda, there was plenty of time for people to introduce themselves, raise issues and share ideas and resources, in the interests of all members and aspiring members of the Affiliate Council. Members of the WAIMH office were also represented sharing in furthering understandings about member issues, concerns and suggestions. Affiliate Council presidents will receive a summary of the notes taken at this meeting to share with their executives.

Immediately following the Administration meeting the Affiliate Council with the WAIMH Board hosted a reception for presidents of affiliate associations. This reception was also extremely well attended and gave members an opportunity to get to know each other in a social context. It also provided an opportunity to informally share experiences and ideas from different local perspectives. Discussions included the joys and challenges of working in the world of infant mental health while also running a professional association to support this work.

Finally, the Affiliate Council biennial meeting was a more formal reporting back

to members on the work of the Council in the past two years. A full set of minutes will be sent to all Affiliate Presidents and their executives. In brief, the meeting began with a video from the Western Cape Association of Infant Mental Health that highlighted the growth and development within their affiliate following the WAIMH Congress held in Cape Town, South Africa, in 2012. This video will be available for viewing on the WAIMH website.

Results and recommendations to the WAIMH Board of the member survey on the Affiliate Council voting process were detailed (A full set of these results were previously sent to all Affiliate prior to the Congress). The WAIMH Board have approved these findings and the new voting process will be put into place for the 2018 elections. Also, the issue of supporting presidents to attend the biennial Affiliate Council meeting was presented to the board and is being considered as part of an overarching review of how WAIMH can further develop its practical support of the affiliates.

In addition, members were informed about the Board's plans to further progress the newly published Infant Rights Statement to Declaration status. Affiliates are seen as playing a key role in this process, by promoting and using the document, and giving feedback on their experiences to the board through the Affiliate Council.

Finally, members were presented with an overview of the WAIMH social media initiative by Minna Sorsa and Reija Latva. We were all encouraged to do the web based training in using social media which is available on the WAIMH website. Using various WAIMH social media channels, affiliates can play an important role in promoting awareness of Infant Mental Health and WAIMH by sharing research, clinical knowledge and experiences from around the world.

For those of you who were able to attend these events, your ideas and feedback have helped shape directions for both Affiliate Council and WAIMH Board work over the next two years. They have also provided invaluable information to the board about on the ground issues for WAIMH members and affiliates. For a relationship focused organisation, so much is gained by meeting in person, as so many of us did through these affiliate events in Prague.

WAIMH Infant Rights Statement Survey 2017

The WAIMH Infant Rights statement has been published online and via WAIMH social media. The WAIMH Board encourage each WAIMH member and each WAIMH Affiliate to use this statement within their local and national settings. Furthermore, the WAIMH Board have goals to further develop the statement. The development of this statement involves a multi-pronged approach. All levels of consideration, reflection and action are important. As such, the WAIMH Board are progressing with conversations with members within the United Nations. For example, they will be engaging with United Nations Committee on the Rights of the Child.

Affiliate Council Chair Maree Foley in WAIMH Affiliate Administrative Meeting. (Photo by WAIMH)

In addition, the Affiliates Council in collaboration with the Board will invite WAIMH Affiliates and all WAIMH members to provide feedback on the statement. To this end, in April and May of 2017, all WAIMH Affiliate Presidents, WAIMH members, and WAIMH study group representatives will be invited to participate in an online survey. The survey will be brief and will invite you to share your experiences of using the current Infant Rights statement in your local and national context. Your expertise will also be sought with regard to any areas of the document that you consider could be strengthened, elaborated upon and or further developed.

Projected timeframe:

April and May 2017: Online survey concerning current use and local feedback about the WAIMH Infant Rights Statement.

May 2017: Feedback summary report compiled for the WAIMH Board.

In the middle/later part of 2017 (Board meetings dates are currently being set):

The WAIMH Board will then discuss these findings and key outcomes from the survey process and Board discussion will be provided by email and WAIMH social media to the WAIMH Affiliates, Study Groups and WAIMH members.

WAIMH Congress, Rome, Italy, 2018: Affiliate Council pre-congress event.

The Affiliates Council are planning to run a pre-congress event in Rome, 2018. The theme of this pre-congress will be established drawing on existing feedback from Affiliates who have requested support to engage more fully with issues concerning Infant Mental Health practice. Issues such as practice based competencies, reflective supervision and practice tools have been suggested.

We invite all Affiliate Presidents to consider if they would like to be part of an Affiliate Council pre-congress event organising committee. Planning will begin in September of this year. If you are interested please feel free to contact Maree and Anna.

Finally 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.

WAIMH Sponsor a Delegate Programme for the WAIMH Congress 2016

By Maree Foley

Contact: maree.foley@xtra.co.nz

WAIMH sponsored 14 delegates as part of the WAIMH Sponsor a Delegate programme. The delegates represented an array of countries including India, Brazil, Ukraine and Ghana.

At the Congress, each sponsored delegate was welcomed by representatives of the WAIMH Board (Astrid Berg, Deborah Weatherston, Maree Foley and Anna Huber), the WAIMH Executive staff (Pälvi Kaukonen, Minna Sorsa), and the Editor of the Infant Mental Health Journal (Paul Spicer) at a welcome afternoon tea meeting generously supported by Wiley, Inc., the publishers of the Infant Mental Health Journal. This meeting occurred after the pre-congress events and before the official opening of the congress and provided a space for delegates and WAIMH representatives to meet and get to know each other. New friendships and connections were carried through the congress days and. based on feedback from the delegates, will continue to grow from here on in.

In addition, three sponsored delegates, Nana Gaisie (Ghana), Lívia Caetano da Silva Leão (Brazil) and Larissa Ramos da Silva (Brazil) have written about their experiences of being a WAIMH sponsored delegate and of attending the WAIMH Congress in Prague. These letters, copied below, collectively highlight the core of WAIMH that speaks of deep companionship as it nests in our internal worlds wherever we live and work in the field of infant mental health.

Deborah Weatherston welcomes participants of the Sponsor a Delegate. (Photo by Minna Sorsa)

Members of the Local Organising Committee.

Nana Gaisie (Ghana)

My dream revived that fateful day when I saw the 'Sponsor a delegate' session for persons from developing countries at the WAIMH Congress website.

I am Nana Gaisie and I'm from Ghana. Though a medical doctor and a child development expert by profession, it would take a couple of months to conveniently raise funds to support my registration and accommodation for the whole duration of the conference (not to even mention the cost of the air ticket which was thankfully sponsored by the University of Haifa). The 'sponsor a delegate' package was therefore welcoming news that would bring great economic relief to my pocket.

I quickly jumped at the opportunity which was based on 'first come' criterion. After a gruelling 4 months period of anxious waiting, I was greeted with the good news about how I had been awarded this sponsorship package, even with the option of choosing the hotel I wished to live in from a provided list.

On the 28th June, I arrived in Prague not knowing what to expect as a first timer in a World Congress. I was chauffeured by a polite driver to the Hotel Olympik where I was supposed to reside for the next few days at no personal cost. After introducing myself to the receptionist and further attending to documentations, I found myself in the comfort of a very warm welcoming room, which is just what I needed after travelling for a total of 10 hours from Africa.

My next worry was - 'how do I get to the Clarion Congress Hotel from here?' I soon discovered that I was in one of the few places in the world where the transport

system is so user-friendly.

I felt bursts of heat and nervousness rush through my spine occasionally at the mere thought of joining my team - Sagi Shwartz Avi, Oppenheim David, Sher-Censor Efrat and West Jane - to hold a workshop on Monday evening at the congress.

At the Tea introduction meeting for the 'sponsor a delegate' recipients, however, all my anxieties waned by the warm welcome we received from Astrid, Deborah and the other members of WAIMH. I saw myself making friends and chatting away so comfortably whilst trying to take in the diverse professional backgrounds of my colleagues from low income countries present at that meeting. The euphoria was peaking by the time we gathered for the opening ceremony.

The transport ticket for the entire duration of the congress which was part of the registration package was actually a pleasant surprise.

I soon discovered that I was at home to many others from many other countries who love children as much as I do.

Unfortunately, I met less than 5 people from my Africa out of about 1500 delegates. This woke me up to the fact that infant mental health, as important as it is, is not receiving the premium it deserves in Africa and other developing countries. Even though survival issues are more important in these areas, it is still of essence to consider the quality of life of the children who survive.

As I interacted with other friends who had also received the sponsorship package, we all appreciated the fact that there was a lot of work to do in our home countries.

I marvelled at the buffet of knowledge available to delegates, and the passion of the people presenting at every meeting I attended inspired me so much. The presentations I attended were so insightful, and the posters intriguing. I mused at how some of the presentations I would have loved to be at, had clashing times. But I still availed myself to learn as much as I could.

For instance, the presentation about the involvement of dolphins in the assisted management of autism and other developmental problems in Israel was very revealing.

The gala dinner was superb as it offered me a greater platform to now acquaint with persons such as Charles Zeanah whose papers I had studied as a student at the University of Haifa in Israel. Indeed, I could not believe that I was in the presence of many of the top researchers and clinicians whose works have become monumental in the world. This included persons like Cooper of the Circle of Security fame, Alicia Lieberman of Parent- Child Psychotherapy fame, von Ijzendoon and Slade A. (who for some reason I always imagined to be a male till I discovered that she was Arrieta Slade)

Also Skype connections were used. In photo Miri Keren in Prague and Ghassan Abdallah in Ramallah/ Palestine. (Photo by WAIMH)

I enjoyed looking around Prague as well after the congress. There is so much talk about the city of Prague and its beautiful architecture. The WAIMH experience gave me the opportunity to judge for myself the veracity of that statement. Prague, also known as Praha, is truly worth the talk.

I reminisce the whole trip with joy and awe. It is an accepted fact that WAIMH 2016 was a success and even more so because professionals from low income earning countries and their children were thought of and given the much needed assistance to participate for the very first time in the history of WAIMH.

Thanks to Astrid Berg who mooted the idea, and all who supported in one way or the other.

Lívia Caetano da Silva Leão

Masters and PhD candidate in Psychology at Federal University of Rio Grande do Sul - Brazil

Núcleo de Infância e Família (NUDIF/GIDEP) (Centre of Infancy and Family)

Curriculum

Dear Colleagues,

After a period of hard work finishing my doctoral thesis (yay!) and after reading Nana's beautiful testimony, now I can contribute with my views of the Congress. My first experience attending an international conference was in the 15th World Congress of the WAIMH, in Prague. I have been preparing myself for this huge opportunity since I heard about how amazing was this congress was that was held in Edinburgh, in 2014, and was dreaming about all the big researchers and clinicians I would meet and talk to about infant development.

After dreaming, I knew a committee from the congress was organising to sponsor some researchers from countries like Brazil, and instantly I applied, hoping this could help me going to Prague. When I read the email confirming the sponsorship, I was so happy and amazed, and started to make plans about this journey, feeling opened for the new experiences to come. And I was surprised about what I have found there: brilliant and welcoming people from all over the world, sharing and being receptive to all the works presented in the congress. From that delicious tea offered by you, where I could feel a bit the feeling

of being in the right place in the right time, to the final presentation where many of us could share the emotions with Miri and Ghassan.

It was, so far, one of the best experiences in my life, where I confirmed my will of being a researcher and a professor, and also the love I feel for babies and families. I will never forget the feeling of being holding hands with all the 1500 people there, with the sentiment that many of us have been trying hard to make this world better with our work. I am so grateful for being part of this, and to Deborah, Astrid, and everybody from the committee who generously gave me and other colleagues the opportunity to have such marvellous help. I am sure I will attend the WAIMH Congress in 2018, in Rome, where I hope I can see again all these amazing people that inspired me so much. Thank you!

Best wishes,

Livia.

Larissa Ramos da Silva

Federal University of Rio Grande do Sul

Brazil

Dear members of the WAIMH direction and editors of the WAIMH "Perspectives" journal.

I am sorry for taking so long to write this 'thank you' note. I read the e-mails about writing it and had no time until now to do so. I also want to let you know that, if you want to, it is ok with me if you publish this in the WAIMH journal.

I am so grateful to WAIMH for having the Sponsor a Delegate programme, it is a great way of encouraging students and professionals in infant mental health all around to participate in an important event such as the WAIMH World Congress. Without the sponsorship, I would not be able to attend to the Congress. Being an undergraduate student, the experience of going to the Congress was immensely important to me, both academic and personally. I was very surprised to receive the sponsorship, and very thankful to you for also giving this opportunity to undergraduate students that are only beginning their journey as infant mental health professionals.

It is a wonderful way to inspire young students as myself to continue to be involved with scientific research. The Congress truly inspired me to continue learning with those who have experience in the field and to be a part of these events that bring people from the whole world together to discuss such an essential matter as infant mental health.

I am very grateful to the staff members, who made my registration via internet and answered to all my doubts regarding the programme. They seemed very concerned about the well-being of all the people who received the sponsorship and they made us a very warm reception. I will never forget this experience and how I felt well received by the Congress and the staff.

Above: Master Classes opened the mornings. In middle: Miri Keren stepped down as the President of WAIMH. The Programme Committee Chair Campbell Paul and Associate Executive Director of WAIMH, Kaija Puura. (Photos by WAIMH)

News from the WAIMH Central Office - Successful 15th World Congress

By Pälvi Kaukonen, Executive Director, Tampere, Finland, ed@waimh.org,

Kaija Puura, Associate Executive Director, Tampere, Finland, congress@waimh.org and

Minna Sorsa, Administrative Assistant, Tampere, Finland, office@waimh.org

Dear colleagues,

Thank you to all 1,600 persons who participated in the WAIMH 15th World Congress in beautiful Prague and created such an enthusiastic and warm atmosphere. The event was truly special thanks to the work of the Organizing Committee, co-chaired by Dr. Miri Keren and Dr. Sam Tyano and their colleagues from Israel and the Palestinian Authority. The Scientific Programme, which included many outstanding presentations, was collated by the Programme Committee, chaired by Professor Campbell Paul. Feedback on the Prague Congress was positive regarding the congress program, and we wish to thank all of you who filled in the evaluation form.

During the four congress days, there were eleven parallel sessions. Moreover, the two pre-congress events also provided insights into current important topics, such as the role of infant mental health policies under stable and peaceful conditions and during humanitarian crises and the Diagnostic Classification DC 0-5 (in collaboration with Zero to Three).

At the congress, we also had the opportunity to celebrate new awardees: Pia Risholm-Mothander was presented with the WAIMH Award in recognition of her significant contributions to the World Association for Infant Mental Health (WAIMH) as well as her work with WAIMH Affiliates. Geoffrey Nagle received the Sonya Bemporad Award, which is given in recognition of significant contributions to the advancement of social and public policies that contribute to the mental health and overall benefit of infants, toddlers, and their families. Bernard Golse was the recipient of the Serge Lebovici Award in recognition of significant contributions to the international development of infant mental health. Alicia Lieberman received the René Spitz Award, which is given in recognition of significant lifetime contributions to clinical

Awardees at the WAIMH 15th World Congress: Pia Risholm-Mothander (in upper photo with Astrid Berg) was presented with the WAIMH Award, Geoffrey Nagle received the Sonya Bemporad Award, Bernard Golse (photo in the middle) was the recipient of the Serge Lebovici Award and Alicia Lieberman (in bottom photo) received the René Spitz Award. (Photos by WAIMH)

research. Sarah Bergmann received the New Investigator Award. Congratulations to all awardees once again!

The abstracts of the presentations are available on the WAIMH website as an Infant Mental Health Journal supplement (IMHJ). The editor of IMHJ, Paul Spicer, wants to thank everyone for their contributions to the 2016 Congress and he extends an invitation to submit to the journal. The journal has been included in MEDLINE/PubMed since 2015, guaranteeing free search access for a global audience. Please contact Paul Spicer at paul.spicer@ou.edu to discuss your ideas.

We were especially happy with the success of the Sponsor a Delegate Programme, which aims to provide colleagues from developing countries with the chance to participate in the WAIMH World Congresses. You can read more about the 2016 program in Maree Foley's text, where the sponsored colleagues also talk about their experiences participating in the congress (ADD LINK). This year, the Sponsor a Delegate Programme received 3,000 euros from 47 individual donors, which helped altogether 14 infant mental health professionals from low-income countries to register for the congress and covered their accommodation during the event. WAIMH also participated as a donor so that more applications could be approved. We wish to extend our warmest thanks to all of you who donated money to the programme! Encouraged by the success of the program, we will in due course open the Sponsor a Delegate Programme also for the 16th World Congress in Rome in 2018.

Changes in the Board

The Prague Congress was a time of changes in the WAIMH Board: We want to thank Karlen Lyons-Ruth and Antoine Guedeney for their efforts on the board and for infancy worldwide. WAIMH President Miri Keren stepped down from her four-year position and the new president, Kai von Klitzing, started his term. The new board members starting their four-year terms are Hisako Watanabe (elected by WAIMH members) and Jody Manly (appointed by the president). The WAIMH Board has an important task in guiding the association in new directions and properly managing its economic responsibilities.

Prague 15th World Congress (May 29th – June 2nd)

1,440 submissions: 78 symposia, 44 workshops

1,619 participants - the largest number to date!

Sarah Bergmann is the recipient of New Investigator Award 2016. (Photo by WAIMH)

Social media

WAIMH has an ongoing social media project. The objectives for the World Congress were to prompt visitors to engage in conversation with one another via social media and to make WAIMH's social media presence more visible to WAIMH members and other visitors. In general, there was much active conversation and WAIMH posts were very popular, so that WAIMH and the World Congress were quite visible on social media. Facebook is clearly the main channel used by WAIMH. Twitter was actively used by visitors; for example, the congress hashtag #WAIMH2016 was used 145 times. Instagram as a new channel did not achieve the same level of use as Facebook and Twitter, but it was still used by visitors and created a good base for future usage.

We ask each of you to participate in WAIMH activities via social media: You can like us on Facebook and follow us on Twitter. We intend to offer brief glimpses of presentations at the World Congress in the months to come.

Author guidelines for Perspectives in Infant Mental Health

- APA, 6th edition for style
- Double spaced
- 12 point font
- 250 words per page
- Articles of varying length are welcome. However, length should not exceed 12 pages, word format
- Send pictures and tables in separate files, with a resolution of 72 pixels/inch
- Send the submission to:

  Deborah Weatherston,

  dweatherston@mi-aimh.org