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Perspectives in Infant Mental Health

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Contents

Personal Reflections about Trauma and Play and an Invitation to Reflect

By Miri Keren, M.D., WAIMH President, Israel, ofkeren@zahav.net.il

Dear colleagues and friends,

We have launched the Call for Papers for our 2016 WAIMH Congress in Prague, Infant Mental Health in a Rapidly Changing World: Conflict, Adversity, and Resilience, hosted by Israeli and Palestinian Infant Mental Health Associations. I wish to share with you, in these few paragraphs, an unexpected experience related to these themes when I was in Tokyo attending the 6th World Congress on Women's Mental Health, together with Palvi Kaukonen and our host and dear colleague, Hisako Watanabe. In the congress we had a WAIMH Symposium: Trauma, depression and resilience from the lens of Infant Mental Health.

We were in Tokyo also for a Pre-conference WAIMH training day arranged by the Japanese Association for Infant Mental Health. It was a very successful event with participants from all over Japan. We also met the Board of the Japanese affiliate and were able to get involved in issues of infant mental health development on cultural as well as organizational level (see photo on page 18)

Play car Morimori

On the only free day we had we went for a walk in the Yanaka neighborhood, a quiet, traditional and less touristy part of Tokyo. We enjoyed a leisurely stroll, looking at the tiny, neat and flower-filled houses, entering small shops (women on a vacation day...!), far from thoughts about adversities and resilience. As we turned the corner of one of these small streets, our eyes caught a gathering of young kids with their parents. Curious, as infant mental health people often are, we got closer and saw a young man standing

View from the street in the Play car area in Tokyo.

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in the middle of toddlers and parents, explaining something (in Japanese, of course!). Around him were all kinds of wooden toys and musical toys spread on plain mattresses. At first, we thought it was a kind of Sunday outdoor playground for young parents and kids. At some point, we observed all the parents and toddlers suddenly laying down on the ground, hands covering their heads. The kids were playful; the grown-ups were somewhat sober. A young woman approached us - the typical foreigners observing what was happening - and explained, "This is an Earthquake Simulation Teaching Play, so kids and parents learn what to do." She smiled gently at our puzzled looks and told us that she and her husband had been doing this all around the country since 2011, after the Great East Japan Earthquake and radiation accident. She went on to explain, "You see, it becomes part of the playtime and is much less frightening than a formal training …even the younger ones understand. They will remember what they need to do in the case of a new earthquake."

After a while we saw the young man grabbing a teddy bear and showing different ways of quickly wrapping it with the help of only a belt and a plain T-shirt and carrying it like in a kangaroo pouch. It taught to parents how to carry their infants if they have to run for cover.

"Desensitization, mastery and control through being well-informed" would be our professional words. This young couple intuitively understood the power of play in supporting resilience at the community level and have made it their own personal mission.

Photos from Tokyo and the Play car event.

Photos from Congress by Japanese Affiliate for Infant Mental Health at Mita Campus Keio University (Mayrch 2015). Yoko Hamada and Hisako Watanabe. Below Miri Keren and Congress registration.

WAIMH President Miri Keren and Executive Director Palvi Kaukonen meeting with the Board of the Japanese affiliate at Mita Campus Keio University:. From left to right: Yoko Hamada, Palvi Kaukonen, Miri Keren, Yoshie Komuro, Noriko Dalrymple, Hisako Watanabe, Keiko Yoshida and Hiroshi Yamashita.

Trauma and Play

Returning to the World Congress on Women's Mental Health and to our symposium on trauma, depression and resilience, one of the participants commented and asked, "We have so many mass traumas nowadays that individual psychotherapies for all are totally irrelevant. What would you suggest as a way to intervene?" We told them about the couple teaching about an earthquake and what to do as a wonderful way to create resilience in response to trauma.

Two days later, Hisako took us to Kooriyama, the capital of the Fukushima region. We visited the PepKids Koriyama center that Kaija Puura described in the winter 2015 issue of Perspectives. Again, playfulness and the use of play to acquire trauma-related coping skills seemed to be a core component of the Japanese resilience kit for mass trauma.

When there are no children around, the adult's internal playfulness is not triggered and coping is more difficult. This is what we saw on our way to Idate, the village most severely hit by radiation. It is still closed to its inhabitants who were all farmers with wide houses and fields. The houses looked intact, as if nothing had happened. They were not destroyed by the earthquake, but the soil is filled with radiation. Only a few elderly people can be seen in the streets, very few cars are on the road, and there are no kids. Our driver, Mr. NIshida, who once lived in this village, made a sharp turn up a hill to show us the deserted elementary school of the village. Only the statue of a child and a radiation counter that showed that the radiation level was above the norm told us the story.

We had left a sunny Tokyo at 10 a.m. When we arrived at 5 p.m. at the Date Evacue Center, a strong cold wind hit our faces, as if resonating with what we were about to see and hear. We went along the "streets" of the camp, looking for "our man", Mr. Kenichi Hasegawa. Rows of tiny, identical, anonymous-looking houses where people had been living for an undetermined time conveyed a heavy feeling of sadness. Mr. Hasegawa, a sober looking farmer in his late fifties, led us to the gathering room of the camp and started telling us about his public fight for letting the truth come out. He is the leader of the evacuated village and in that role demands that the Japanese Government recognize their unforgivable fault of having postponed the children's evacuation 4 months after the earthquake, as well as not letting the people know that the level of radiation was extremely high. Radiation particles have since then been traced in the children's urine. Elderly people were convinced by the

Photos from Fukushima. Temporary housing (on top) and Pep Kids Koriyama, Fukushima. Fom left to right: Jyrki and Palvi Kaukonen, Hisako Watanabe, Shintaro Kikuchi, Miri Keren, Keeko Omori and Yoko Hayashi.

Evacuation centre in Date. From left to right: Sachiko Sato (Founding president of the Fukushima Network for Protecting Children from Radiation), Keeko Omori (Clinical psycologist of the Heartful Heart Fumushima), Miri Keren, Kenichi Hasegawa (Farmer, photographer and leader of the evacuee of Iidate village), Palvi and Jyrki Kaukonen, Hisako Watanabe, Yoko Hayashi (Mental health worker, member of FOUR WINDS).

Mayor to stay in their homes, but young family members have been mandated by the Mayor to provide their needs, thus also exposing them to radiation. To the question, "Do you have any idea how long it will take until you return home?" Mr. Hasegawa's face became even more somber and his answer made us realize how catastrophic the aftermath of the Tsunami is:

"*Children will never come home - back to Idate. It is too dangerous as the radiation only gets deeper into the soil because it was not well decontaminated from the beginning. Today, the ground is covered by leaves. My sons, who were supposed to continue to farm our land, have been forced to go and look for other farms in another region. Idate will in fact disappear; its land is worthless, even though its houses have not been hit by the Tsunami. Families have been torn apart, many men have become alcoholic, and some have committed suicide. We have lost everything, besides our very lives, but we refuse to give up. We want to let the world know what is going on here. This is why I agreed to come and talk to you, even though you are foreigners.*"

We all remained wordless, speechless. Hisako will present all the statistics and figures that this gentleman has collected at our Congress in Prague.

We went back to our minivan; it was after 8 p.m. Some of the camp houses were lighted, while others remained in the dark. A cold wind was blowing furiously. Palvi, Hisako and I looked at one another, with a shared feeling of humbleness towards those people who had lost so much, yet refused to be passive victims in response to devastating loss.

Reflecting

This one single day felt like a week; it was so full. We ended it with a traditional Japanese dinner at the hotel. Only then could we begin to reflect on what we saw, felt, and heard:

About the multi-faceted and vast disaster

"Japanese people usually do not reveal their negative feelings, I am surprised at how willing they were to share with us the truth of this multi-faceted disaster, to speak out their anger and frustration at the government, to disclose the rising tensions and loss of cohesiveness among the evacuees, and to even tell us about how their own family has been inflicted," reflected Hisako. They really wanted us to know and to spread the word. This fight for the truth has become their mission and they have chosen to cope by remaining active rather than falling into passive despair.

About the use of playfulness as a facilitator of recovery after a mass trauma

Nobody but local professionals such as Dr Shintaroh Kikuchi (the pediatrician and leader of the PepKIds Koriyama), and Mrs. Oomori , Psychologist, could have thought of the PEP Kids amazing project. Indeed, they were among those who saw their children become pale and sad…they were among those who needed to cope with their own existential fears of radiation and uncertainty. Being parents themselves, they let "the child inside them" emerge in the form of this huge indoor playful space, where motor activity and pretend play are the main forms of expression. Play for children is like work for adults. Play conveys energy, as well as a wish to thrive and achieve. The absence of play among normally developing children is an indicator of depression or severe physical illness. Fukushima children were indeed at risk of becoming emotionally sick, after having been confined at home for a year. Now, in turn, the revived children's playfulness is helping their surrounding grown-ups to revive their own libido; their zest and hope in life.

Would Alicia Lieberman say that this is an example of a positive feedback loop of angels? Would Selma Fraiberg call the Truck Play "Psychotherapy in the Street?" These are things for us to wonder about as we think about trauma and its consequences for infants, young children and adults.

I invite each one of you to send abstracts and to come to Prague to continue to wonder and to reflect on ways to reduce the risk of emotional disturbance in the early years and to promote infant mental health.

From the Editors

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This Spring/Summer issue represents a great deal of time and energy spent by those who have shared their work and submitted articles for review, as well as those who reviewed articles and gave authors careful feedback. Though the process is arduous, the end result is rewarding and challenges us to think about policy, research and practice in the developing field of infant mental health. Miri Keren, WAIMH President, shares poignant reflections about her trip to Japan where she observed play as a way to support resilience in children and communities following a trauma or disaster. Sherri Alderman, a developmental pediatrician from Oregon, describes, through a case study, how she has adopted a relationship-based approach as she integrates infant mental health principles into her practice with very young children and parents. Maria Lilja, a home visiting professional in Gothenburg, Sweden, offers a window into an antenatal and pediatric health care program for women with addiction programs, bringing prenatal and postnatal health care and parent support beginning in pregnancy and continuing for 6 month after the baby's birth.

We received commentary, "Observations and Reflections," from Katharin Hermenau, a psychologist from Germany, in response to Neil Rygaard's column that appeared in the World in WAIMH in the winter issue of Perspectives. She challenges and reinforces the thought that "we need to catch up with the rapid changes in the settings in which infants grow up. We need to rethink our child development theories and test whether they still apply to reality and the world today." Lynn Priddis and Rochelle Matacz, collaborators from Australia, celebrate the launch of the Competency Guidelines® to promote work force development and infant mental health more widely in West Australia. Sheryl Goldberg, a social worker with many years of experience in Michigan, USA as an infant mental health therapist, supervisor and consultant, offers her observations about reflective supervision drawing heavily on a research instrument, the RIOS (Reflective Interaction Observation Scale), developed by Christopher Watson and colleagues at the University of Minnesota in the USA. We end the issue with an article by Jennifer Malone and Carolyn Dayton, "What is the Container/Contained When There are Ghosts in the Nursery?: Joining Bion and Fraiberg in Dyadic Interventions with Mother and Infant," in the *Infant Mental Health Journal*. (Vol. 36 No. 3).

We thank all of those who contributed to this spring and summer issue. Clearly, WAIMH's perspective is worldwide, with contributions from Israel, Sweden, the USA, Australia, Germany, Switzerland, Scotland and Finland. An inclusive organization working on behalf of the wellbeing of all babies, their families and communities, we invite comments and contributions from all over the world. Be sure to share WAIMH Perspectives, an open source document, with others in your social media networks.

Author guidelines for Perspectives in Infant Mental Health

- APA, sixth edition, for style
- 12 point font
- Double spaced
- 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 at least 72 pixels/inch
- Manuscripts are accepted throughout the year
- Articles much shorter than 12 pages are also welcome for submission
- Articles from the field must be submitted for review by April 15, 2015 in time for the Spring Issue of Perspectives
- Send the submission to:

  Deborah Weatherston,

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Personal Reflections: Perspectives of a Developmental Behavioral Pediatrician on the Divergent Worlds of Physical and Mental Health

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DISCLAIMER:
Dr. Alderman authored this article in her personal capacity. The views expressed in this article are solely those of the author and do not necessarily represent the views of any agency.

Introduction

As a developmental behavioral pediatrician, I straddle the two professional worlds of mental and physical health made artificially different not by the reality of my clients or the nature of my work but rather by decades of diverse history, education, training, research and funding streams. As a pediatrician I learned about child development. While in pursuit of my masters of public health, I learned about population health. But it was not until I studied infant mental health (IMH) and earned IMH endorsement that I began to see the infant mental health field as complementary to the pediatric profession yet far more inclusive of infant and toddler health and well-being. It was at that juncture that I began in my clinical approach to consider the capacity of the infant and young child as a full participant in the family (McHale, 2007).

IMH Principles Changed my Clinical Approach as a Developmental Pediatrician

There are many key principles and research-based theories within IMH that have changed my clinical approach as a developmental behavioral pediatrician. Perhaps the most fundamental change of all for me was the shift in my view of the child from that of a patient-clinician perspective to seeing the child within the relationships of the family and my role within relationships with the child and, perhaps even more importantly, the parents. Pediatricians are trained out of necessity to rely on the parents and partner with them for follow through on medical recommendations. For me, however, infant mental health took it beyond pragmatic considerations and made it the essence of the work and key to optimizing the child's healthy social emotional development. Infant mental health also opened my eyes, to the importance of the child-caregiver relationship as the venue for promoting the child's development. Focusing on that relationship identifies opportunities for promoting healthy social emotional development and prevention, early intervention and repair when the child's social emotional development is moving off the healthy trajectory.

Introducing the Family

To illustrate, I would like to share a story about Judy, a three year old little girl, and her parents, Tom and Michelle. (Names have been changes to protect confidentiality.) Tom and Michelle came to my clinic for help to address Judy's difficulty with sleep. Judy and her twin sister were Tom and Michelle's second and third child. Their first child was a nine year old daughter who was developing typically and performing well in school. Judy's twin sister was developing typically and doing well at home and in preschool. Tom and Michelle were experienced parents and recognized that the challenges they had managing Judy's sleep problems were not typical.

Judy would take many hours every night to go to sleep. Her parents had tried many things but nothing seemed to work. They dutifully abided by Judy's seemingly endless demands for her ever increasingly complicated bedtime routine. They had not yet transitioned Judy out of her crib for fear that without it she would not stay in bed after lights were turned out.

Judy's crib was filled with toys that she needed each night. Tom followed Judy's commands to carry her around her bedroom to touch each piece of furniture before being placed amongst the toys in her crib. Michelle always had Judy's fuzzy piece of cloth ready for her as Tom placed her in the crib. Michelle read 10-15 books every night before the routine kisses and hugs and night-night farewell. Still, Judy protested and cried for an hour or so before she could go to sleep. Tom and Michelle were exhausted. Their confidence as parents had dwindled. They were open to any suggestions that might bring happiness into their evening time together.

Through the interview process, they also revealed that throughout the day there were other routines that Judy insisted on and things in her life that she needed or avoided in order to get through her day. Judy was slow to wake up in the morning, often arising cranky and unable to be persuaded to dress for the day until she had ample time on the living room sofa wrapped in her favorite blanket. She was sensitive to warm food and bath water. She was intolerant of tags on her clothes. In contrast, the tags on her stuffed animals were a pleasure for her to rub on her nose. Judy did not like the sun shining on her in the car. Unfortunately, she also could not tolerate wearing sun glasses. She gagged on soft foods but enjoyed crunchy snacks. Her parents were well aware of Judy's preferences, tried their best to accommodate Judy's needs and anxiously held their breath when others unknowingly did not respect the necessities of Judy's controlled world. Judy was not adjusting well to preschool. She found the morning routine too rushed for her natural rhythm. She was unable to adapt to the school environment including being with the other children. Her resistance to getting ready for school was growing. She protested her mother's departure from the classroom and cried each morning even though she had been attending her preschool class for several months. She tended to engage in solitary activities in school, mostly doing art work. Her parents had grown accustomed to the challenges present throughout the day and did not see them as problematic as the bedtime routine.

The first time I met Judy I saw a little girl carried into the room in her daddy's arms. She was peeking out from behind her fuzzy cloth delicately held over her nose and thumb, which was hooked behind her upper front teeth. Her eyes were reddened and weepy. She was curious about me but reluctant to leave her daddy's arms . She did eventually warm up, responded to her mother's gentle encouragement and gradually moved from the sofa to the floor amongst an assortment of toys. She gravitated to the art supplies and briefly

scribbled mono-colored designs with hard pressure on several sheets of paper. She collected all the blocks, stacked them next to her and forbade anyone from disrupting her arrangement. She had an age-appropriate sense of humor and would giggle with a glance toward her mother when I made silly faces.

Using an IMH Lens within my Practice as a Developmental Pediatrician

A term heard more and more in medicine is "practicing at the top of your license," which for medical doctors typically means making medical diagnoses, writing medication prescriptions, conducting physical exams and/or assimilating information from a variety of sources into a report. The medical subspecialty model, in general, and the particularly high demand for developmental behavioral pediatric services, in particular, have pushed developmental behavioral paediatricians toward a consultative model of service delivery in lieu of full referral and management. A developmental behavioral pediatric consultation would likely involve conducting a parent interview, physical exam, developmental assessment (or assimilation of developmental assessments conducted by other non-medical professionals) and generation of a report with findings, diagnoses and recommendations to be sent back to the referring source and, if not the referral source, the primary medical care provider (PCP), for implementation. In this scenario, the developmental behavioral pediatrician would remain available to the family as deemed appropriate by the PCP or at some set interval, which might be 6-12 months. I have developed an intermediate approach to serving families referred to me where I partner with the PCP in implementation of recommended services and provide short-term intervention when appropriate taking into consideration both what service would be of benefit to the child and my skill set. My assessments and interventions are always through the infant mental health lens.

Consulting with Both Parents

I was interested in gaining more insight into how Tom and Michelle were meeting Judy's needs and what core challenges they were encountering that were adversely affecting their ability to co-regulate with Judy and be effective parents.

I talked with Tom and Michelle about assessing for sensory challenges using a parent questionnaire. I have found that educating parents about emotional regulation and then framing the development of emotional regulation as universally a part of early childhood typical development is an effective segway to reframing their role as parents in that process.

The parent questionnaire confirmed sensory challenges in multiple areas. Tom and Michelle were ready to follow through with all recommendations.

For all professionals working with children, recommendations are guided by the clinical diagnoses in conversation with parents. Professionals see conditions from the perspective within which they have been trained and have experienced and use diagnoses that they have been trained to use to describe those conditions. Therefore, what a professional calls a particular condition, i.e., the diagnosis, often is discipline-dependent. With physical and mental health systems operating in parallel rather than interwoven, the professional perspectives often differ and a particular constellation of signs and symptoms will receive a different diagnosis. Furthermore, both physical and mental health approaches often do not take an infant mental health perspective but rather view the condition from an individual rather than relationship paradigm. It follows, then, that the recommended approaches to treatment will differ as well.

Considering Different Perspectives

Judy's case illustrates the differences in diagnoses and recommendations that result from different training and perspectives across disciplines. Judy's presentation from a medical perspective would most likely have been diagnosed as a sleep disorder. From a mental health perspective, the diagnosis might have been anxiety disorder. Approaching Judy's condition as a sleep disorder although variable depending on the provider would in most instances likely involve targeting the approach to and environment of the bedtime routine. Specific strategies may vary but would generally involve making suggestions to the parents that they could implement to control the conditions, timing and structure of the bedtime routine. Approaching Judy's challenges from the perspective of anxiety disorder would be more complex. At her developmental age, options are limited. Most would not treat pharmacologically although there are exceptions. Cognitive behavioral therapy while commonly used for anxiety disorder is not a typical option for a child of Judy's age.

My perspective was that in spite of her chronological age, Judy had not yet developed the self-regulation skills necessary for sleep onset, flexibility, change in routines and tolerance of others. Using a sensory integration paradigm, Judy's particular pattern of responsiveness to her environment, i.e., under-responsive to some stimuli and over-responsive to others, was adversely impacting her ability to fully engage in daily activities and interact successfully with peers and adults. From an IMH perspective, placing more and more demands on her parents, Judy was intuitively attempting as best as she could to create the scaffolding needed from her parents to co-regulate. Her parents, however, were themselves experiencing increasing emotional dysregulation by what they experienced as Judy's unmet demands. With increasing sense of inability to parent their child and lack of sense of fulfilment in their role as parents, their resilience to parent was eroding and their own dysregulation was mounting. In the presence of her parents' dysregulation, Judy was not able to receive the co-regulation through her relationship with her parents that her body (and mind) craved. The mutual dysregulation between parent and child was spiralling downward.

Initially, I did not act upon my infant mental health perspective but rather discussed with Tom and Michelle the concept of sensory integration disorder as one way of describing Judy's challenges and recommended further readings for the parents and occupational therapy for Judy. In pursuit of occupational therapy, Michelle learned that there would be a lengthy wait. In response, I revisited my interpretation of the situation, recognized the importance of attachment in co-regulation and the impaired emotional engagement both parents and Judy were experiencing and offered an interactive play approach and parent coaching while waiting for occupational therapy. At the time, I did not think that taking an attachment approach to treatment would fully address the issues. I was not able to anticipate how effective taking that deeper dive into the source of Judy's dysregulation would be in arresting the downward spiralling dysregulation in the family. I explained to Tom and Michelle that I could provide them with a method of interactive play that would build positive engagement between Judy and them, that I would coach them toward mastery of the technique and that they would have to coach each other at home in the process

between visits. Both Tom and Michelle agreed with this plan.

The Intervention

A parent coaching approach creates a learning environment where the parents can see themselves as a part of the solution to their child's challenging behaviors. Realistically elevating expectations for the parents is not only operationalizing the basic IMH concept of children learning first through relationships with their parents but also begins the repair process of building parent self-efficacy.

I used a modified Parent Child Interaction Therapy approach (Eyberg, 1999). The modifications I have made, based on my understanding of IMH, are to emphasize more strongly the attachment-based child directed interaction. I have found that greater mastery of this first part sets in motion the skills needed to more quickly master the adult direction interaction phase that follows, especially when working with very young children. I have also removed the turning away from the child in phase one and instruct the parent to instead simply ignore undesired behaviors. Additionally, I replaced the time-out in phase two with time-in. Another modification that I use is to be in the same room with the parent and child. I work only with very young children and find that they very quickly habituate to my quiet parent coaching and by being in the room with the parent, I can model co-regulation with the parent during stressful moments. With these modifications, I have found that the attachment work can operate without interruptions (turning away) and with time-in parents receive coaching on their own self-regulation and its importance in building their child's ability to regulate. I also work with only one parent at a time to simplify the demands on the child and increase clarity on where focus of attention should be, i.e., between parent and child. This gives the child opportunities to exercise focus and attention and, theoretically, repairs brain architecture.

Continuing our Work Together

Tom and Michelle continued to come to clinic for weekly visits over the next eight weeks alternating who would bring Judy. I began by demonstrating simple play therapy involving following Judy's lead, avoiding any questions and applying simple strategies that would reinforce Judy's experience of my undivided attention to her. I only demonstrated once. Both Tom and Michelle picked up the technique quickly. For the remainder of our visits I stayed back and coached them as they practiced this attachment-based technique. Judy was delighted by her parents' attention during their special play time. Michelle commented on how happy Judy appeared when playing with her mother. I saw how happy Michelle appeared when engaged with Judy. There was shared delight in play together that had no agenda, no demands and no timeline. Between clinic visits, Tom and Michelle continued the stylized play at home coaching each other. They both became more relaxed and appeared freed of their own anxiety with Judy's temperamental l differences and instead became more and more delighted in their daughter's infectious enjoyment.

When Tom and Michelle showed mastery in the play, we began introducing simple commands within the context of play. They were impressed with Judy's ability to follow their commands without so much as a skipped beat in her rhythm of play with her parents. I could see that Tom and Michelle were rebuilding their confidence in parenting and Judy was instrumental in giving them the positive feedback they needed to be the effective and caring parents that they were. Judy was becoming more relaxed as well. Her face was brighter. She began to forget about her fuzzy cloth. Her parents reported that bedtime had become less complicated. They imposed a limit of one toy to take to bed and Judy complied. The ritual of touching each piece of furniture seemed to just disappear. Judy was adapting to the school's routine and had made a new friend.

Tom and Michelle had regained the confidence they needed as parents. They felt renewed efficacy to parent their daughter. That comfort translated into a greater sense of security for Judy. Furthermore, Judy's behavior reinforced her parents' sense of confidence to parent. As her parents grew steadier in their role, Judy became more regulated and less dependent on seeking rituals and strict adherence to routines to get through her day. Judy still had some challenges but was showing greater capacity to work through them and master developmental life skills.

Michelle received a call from the occupational therapist that there was an opening. She and Judy came to the first visit. The same sensory parent questionnaire that I had used was administered again. Much to Michelle's surprise, all areas were within typical range. Then upon further reflection, Michelle began to see all the changes that Judy had made over the last few weeks. Judy's struggles with self-regulation intertwined with sensory challenges undermined and dysregulated her parents who before had not been faced with this degree of temperamental differences in their children. Judy's inability to find the co-regulation supports from her parents further escalated her dysregulation and eroded her parents' confidence to parent. Use of the parallel process and simplifying the parent-child interaction in stylized 'play' promoted regulated focus and attention, created a venue for co-regulation and rebuilt parent confidence. The results were reduction in the parents' anxiety and renewed delight in their child. Judy gained the emotional support she needed and was able to engage more productively in her physical and social environment. The work was on the part of all the individuals occurring within the relationships they had with each other. Judy continued to demonstrate temperamental differences. Her parents, however, were able to more successfully remain emotionally regulated and stay within a co-regulated state when Judy became dysregulated.

Reflecting on an Infant Mental Health Relationship-Based Approach

Taking an infant mental health relationship-based approach to Judy's dysregulation focused on nurturing the core developmental skill that Judy will need throughout her early childhood development and on into adulthood. In contrast, a therapeutic approach focused on the behaviors around sleep could bring about a strategy that might help get Judy to go to bed at night and might even restore some of her parents' confidence but would not build her capacity to self-regulate in other daily activities and would likely result in other behavioral challenges that her parents would not feel capable of managing. If the focus of intervention were on Judy's anxiety, utilization of her parents and the parent-child relationship would less likely be a part of the approach. Judy would be identified as the target; her parents would be viewed less as a part of the solution.

Both Tom and Michelle came to me for our final follow up visit without Judy. I sat with them and reviewed video from our sessions together. They sat together on the sofa with the laptop in their laps and laughed and kidded each other in a relaxed, playful way. They saw the changes each had accomplished and

complemented each other for the positive results of their efforts. They were refueled and ready to get back home to their daughter.

Taking a multi-relationship based approach to the behavioral challenges had instilled in the parents, first and foremost, the confidence needed to be able to co-regulate and nurture self-regulation in their child. Co-regulation between child and parent with the goal of promoting self-regulation is a primary parental responsibility. Development of self-regulation is fundamental and foundational for development throughout the child's early life and leads to academic success, satisfying relationships with peers and adults and a productive and gratifying adulthood. Knowledge of infant mental health gave me this insight into early childhood development and this approach to behavioral health.

Infant Mental Health as a Renaissance

I describe the expansion of my professional knowledge into the world of infant mental health as the renaissance of my career. An appreciation of infant mental health enabled me to displace the medical term, bonding, with the far more accurately descriptive term, attachment. As the world of infant mental health unfolded before me, I truly understood for the first time the post-WWII orphanage atrocities I learned in medical school and the deeper etiology of the medical condition of failure to thrive. Children thriving and learning within relationships was a new discovery for me. Infant mental health principles and interventions have built my capacity to engage with parents and more effectively address behavioral issues in a way that I had not been able to do before.

Providing services that are both physical and mental health-based is rewarding but challenging as well. Working in a profession that blends physical and mental health, I experience, first hand, the siloed systems of the two service areas.

Integration of Physical and Mental Health

Advances in neuroscience, genetics, physical, behavioral and mental health and education research indicate that the lifelong health and well-being of our society is founded on the quality of the environment and experiences the infant or young child has early in life starting with parent-child relationships. In the United States a growing number of children with behavioral or mental health disorders are brought by their parents to medical clinics (Olfson, Blanco, Wang, 2014). To optimize developmental outcomes, most professionals working with young children would agree that there must be interdisciplinary communication, cooperation and collaboration across the system of care, fully reflective of the relationship-rich, stimulating environment within which a child should ideally live. To not do so results in further increase in severity of mental and physical health symptoms, functional impairment, reduced quality of life, increased healthcare costs and premature death (Druss & Walker 2011).

A shift in paradigm from care delivered in isolation to recognition of the complexity of factors contributing to health and well-being was catalyzed in the pediatric world by the publication in 2000 From Neurons to Neighborhoods (National Research Council and Institute of Medicine 2000), a synthesis of the research on the multiple factors affecting early development. Research on social determinants of health have further advanced understanding of the complexity of issues that impact population health (Marmot & Wilkinson, 2005). The American Academy of Pediatrics has published a call for an ecobiodevelopmental framework for medical care for children that recognizes emotional, behavioral, social and physical environmental contributions to health and well-being (Shonkoff & Garner, 2012) and coordination of physical and mental health services (Committee on Psychosocial Aspects of Child and Family Health and Task Force on Mental Health 2009). Nonetheless, physical and mental health continue to be viewed and addressed as separate conditions addressed within separate professional service systems.

A Grand Canyon Separating Infant Mental Health and Physical Health: The challenges and possibilities for integration

If the separation between physical and mental health were described as a ravine, then the separation between physical health and infant mental health would be on the order of a grand canyon. The barriers to uniting physical and infant mental health are multiple and complex.

The broader system infrastructure promotes isolation of physical from mental health service and vice versa. Healthcare coverage benefits often include physical and mental health services as distinctly different services. This perpetuates what is often referred to as a separation of the mind from the body. In contrast, Vincent Fellitti's work on adverse childhood experiences (ACEs) has shown that a wide array of physical morbidities later in life can be correlated with early traumas and that these correlations are common in American society (Felitti, Anda & Nordenberg, et al. 1998). And more importantly, his work has gone on to show that providing mental health services directed at healing the adverse effects of this history of trauma can be effective at addressing physical health conditions when traditional physical health approaches are not.

The steps that a patient typically must accomplish in order to receive mental health services for a physical health condition are illustrated by the following hypothetical example. The patient presents to the medical clinic with a physical condition for which a mental health approach would be the most effective treatment. To receive that treatment requires (1) a physician knowledgeable about connections between physical and mental health, (2) available and connected community physical and mental health services, (3) effective communication across the two service fields, (4) healthcare coverage for both physical and mental health services and (5) the patient's ability to shift from one service area to another to obtain the needed treatment. This last requirement for successful transfer of care is in many instances more challenging than it may seem. Not only are there logistical considerations but there are also emotional factors and often stigmata associated with perceived differences between physical and mental health treatment. Overall, a breakdown at any one of the five critical points will result in no access to the appropriate service. Conversely, if mental health services were integrated into the medical clinic, the physician would be more knowledgeable about such options, there would be more seamless access with less stigma for the patient and the patient would receive appropriate treatment.

Unfortunately, very few clinics have integrated or even co-located mental health services on site. Even fewer mental health clinics have physical health services within their clinics. Most clinicians in both physical and mental health fields must, instead, rely on the referral process to direct their patients to the needed services. Although some physical health clinics are moving toward care coordination staff as a service feature to facilitate a smooth referral, most clinics continue to rely on the patient's ability to navigate the system of

care to receive the recommended mental health services. There is some irony in this expectation that the system of care imposes upon the patient needing mental health services. Not surprisingly, if and how the referral actually happens is vulnerable to mishap.

Some pediatric clinics have shifted to integrated mental health services and have added a psychologist to the clinical staff. In this instance, the psychologist may function both as a clinician for families and as a mental health consultative resource for physicians in the clinic. When the physician wishes to refer a child to the psychologist, referrals can occur quickly and smoothly. The family continues receiving the serve at the same location increasing comfort with the referral and reducing stigma. Services are well coordinated and communication flows efficiently between the physician and the psychologist. As an integrated clinician in the clinic, the psychologist can also review upcoming appointments, identify patients and proactively consult with the physician prior to the visit. As a consultant to the physicians, the integrated psychologist over time builds the physician's capacity and skills for managing mental health conditions without referral. The psychologist often is more knowledgeable about community mental health services as well and can make recommendations for community based referrals when the need for services exceeds the psychologist's capacity or expertise. A clinic with integrated mental health services is, therefore, more successful at assuring the family receives the appropriate care when such services are needed.

Mental health services most often must be obtained through a mental health clinic. Even when the child's parent does successfully find and initiate the recommended mental health services, the process of entry into a new system of care is likely to start de novo with providing basic demographics, presenting one's health insurance card and to the best of the person's ability, reason for the visit. Provider-to-provider communication, which could conceivably avoid putting this on the patient (who has already provided this information at one location), is, in reality, challenging. Pressures to generate revenue preclude the needed time-consuming communication between the physician and the psychologist. In most systems, the physician may not bill for any time outside of direct face-to-face contact with the patient even when providing needed assistance, supports and communication on behalf of the patient to other professionals. Additionally, after the patient has received appropriate mental health services, some psychologists feel professional restrictions to freely share information back to the physician from whom their client was referred. In short, the system is fractured and riddled with precarious navigation at the risk of appropriate patient care.

Most professionals and families alike would agree that we must act on our recognition that the mind and body cannot be artificially separated. The optimal standard of care and most effective service for young children and their families and communities must involve an interdisciplinary approach. That approach can be catalyzed by cross-sector professional relationships facilitated by common language. That common language should be woven into education, training and ongoing professional development welcoming and encouraging of interdisciplinary participation.

Changes in policies must be made in order that the transformation of healthcare can operationalize the coordinated and blended system necessary for optimal health outcomes. The redesign of a health system that is integrated must be a national priority.

Blending physical and mental health services at all levels through changes in policies, education and training models, and payment structures will better assure that people receive the highest standard of care that supports optimal health and well-being for children, families and society. This approach will build social capital, a capable workforce and safe and healthy communities.

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Home Visiting: Antenatal and Paediatric Health Care Services in Sweden

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Child health care.

Photo appears with permission by author.

Antenatal and paediatric health care services are available to everyone in Sweden. They are free-of-charge and have high credibility among families as evidenced by the fact that almost 100 % of women who are pregnant or parenting register and participate. A specialized unit within our antenatal care service is designed to accept referrals of women with addiction problems of alcohol, narcotics and drug abuse. The name of the unit is Team Haga, a cross- disciplinary service for specialized care for substance-abusing pregnant women and their babies in Gothenburg. The goals of the program are to protect the fetus from substance-abuse effects, to support women to stop using during pregnancy and to stay substance-free after delivery. During pregnancy, women see midwives weekly and also have visits to the gynaecologist. After delivery the child health care provider at the unit has contact with the infants and families during the first six months. An important part of the health service is targeted parent support.

Established in 2007, Team Haga has practitioners who are competent in maternal health, child health care, psycho-social work and psychiatric care. Two peadiatric nurses and one peadiatrican working cooperatively, form the team; a great part of the work consists of home visits. The primary goals of the home visiting service includes:

*following the infant´s health and development

*providing parental support

*promoting good and loving relationship between parents and infants so that the children get the developmental support they need

*attending to the infant´s needs, noticing them so that the parents notice and respond appropriately

*encouraging mentalization, supporting parents to become aware of and understand the infant´s feelings and expressions

The women who are referred have many challenges especially because they are living in highly vulnerable social situations and may have a mental illness that becomes more evident when they are substance-free. Pregnancy and early parenthood often provide motivation to make a major life change. However, most of the women referred need a lot of support in continuing to be substance-free and to develop good parenting (Nordenfors & Höljer, 2012).

The big challenge that Team Haga and families face is *how* the goals can be achieved. First, the work must start with assuring that a positive relationship develops between the nurse specialist and parents. Experience shows that the relationship is important, influencing how the parents and nurse can develop a deeper, therapeutic relationship and allowing the specialist to understand and respond to each parent's unique life circumstances (Kurtz, Landy, Jack, Wahoush, Sheehan & Macmillan, 2012). The parents referred, most often women, usually have their own significant needs and struggle to meet their own emotional needs and those of their young children. As is common with many presenting as anxious or depressed, they have an insecure attachment profile. They find it difficult to understand how their own mental illness can affect their own needs and those of the children. William, Domain, Bagett, Mitchell & Larsson (2010) saw in an evaluation that private netting and mental illness are factors that influence abilities to receive a home visiting program.

What do Team Haga pediatric nurses and pediatricians do? We support parents to confidently bathe, feed and care for their children. We talk about how infants and young children express their needs and respond to parents' many questions. Instructions in baby massage complement these services. We work with the parents to support their children's developmental progress by offering a development assessment according to ASQ (Age & Stage Questionnaires) at four months of age and one follow up at about one years old. We listen and provide advice about how parents can support the development of their children.

We also talk about how to secure the home when the infant starts moving. Infants who

have been treated for neonatal abstinence syndrome (Jansson & Velez, 2012) need extra support from their parents. These babies can have problems with their regulation (sleeping, feeding, and crying), muscle tone and motor activity. Weight and other remaining health checks are also performed at home.

Note: Child health care; medical supervision, parent groups and vaccinations are given at the clinic setting.

Antenatal and paediatric home visits are important and most rewarding. However, home visiting services in Sweden are still somewhat unique. There is, however, the experience of a first-time home visit that is offered by the child health care services (Jansson, 2002). Of additional interest, the USA has long had the experience of home visiting programs led by nurses, among others, Nurse- Family Partnership (NFP). NFP studies have demonstrated that in the long run there are personal gains and economic benefits to the community with home visiting services to women during pregnancy and in the first years of a baby's life (Olds et al., 2010).

Team Hega plans to do an evaluation of our home visiting program and provide a follow-up especially looking at developmental (social, emotional, relational and cognitive) for the children. We are starting a study to monitor how the children's life situations, health status and development look after they have left the unit. This is an important step for us in order to further develop the healthcare services for women during pregnancy, their children and their families.

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The World in WAIMH

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The World in WAIMH is a column intended to generate reflection and spark dialogue about infancy and infant mental health within the global community. Our shared hope is to offer space for challenge and interdisciplinary discussion. We ask the WAIMH community for commentary, field reports, case studies, research articles, book reviews, new submissions and (when proper permission can be obtained) adaptations of previously published articles that may be of interest.

The provocative piece, Commentary on INFANT MENTAL HEALTH IN THE GLOBAL VILLAGE: An invitation to reader's debate: Emerging infant environments, and future research, by Niels P. Rygaard, appeared in the Winter 2015 issue of WAIMH Perspectives in Infant Mental Health.

Rygaard's article stimulated dialogue among readers in many countries around the world. Reflections from Katharin Hermeneau of Germany appear below. As always, the editors welcome your response to these columns, as well as your submissions.

Observations and reflections: It takes a village

Commentary by Katharin Hermenau, Germany

I enjoyed reading Mr. Rygaard's reflections on changing infant environments. He deals with a very important topic and has raised equally important questions. I totally agree that research needs to catch up with the rapid changes in the settings where infants grow up. We have to re-think our child development theories and test whether they still apply to the reality and world today.

I like the quote that Mr. Rygaard is referring to: *"It takes a village to raise a child,"* an expression that is commonly attributed to African origins. It holds so much truth for times when relatives care for the child and also for times when parents share the responsibility for care with others. In this sense the quote is still true even for the changing infant environments.

Childcare in Urban Environments

When we try to apply certain developmental theories to the changing urban environments we may struggle. Children with different caregivers (e.g. mother, father, nursery school teacher, day nannies) can show different attachment styles depending on the caregiver. So it is difficult to put each child into one category of attachment style. The behavioral researcher and anthropologist/primatologist, Sarah Blaffer Hrdy (2001) suggested that the attachment quality between mother and child may not be solely important for the development of the child, but, rather, the overall quality of the relationships with all caregivers.

In human history, children were always taken care of by caregivers other than their mothers. Often the close social network (e.g. the family and neighbors) took care of the children. These attachment figures remained part of the child's social network for a long time, so that stable bonds could grow. Today, childcare often takes place outside of the close social network in a more professional setting like kindergarten or nurseries. The kindergarten or nursery can be a part of the social network if the quality of care is good (Andersson, 2003). Studies describe high quality care as: a reliable caregiver, who is sensitive and competent and meets the needs of the child (Ahnert & Lamb, 2004). A problem arises if the caregivers in childcare institutions are not consistently present and may often change. This is a problem we also know from research on institutional care for orphans and children without family support (Hermenau, Hecker, Elbert, & Ruf-Leuschner, 2014; McCall, 2013), even though the situation and state of children in institutional care is of course not equivalent to children in childcare.

While the quality of childcare in Germany is not as high as in Sweden, for example, Germany tries to improve the care concepts in order to react to the changing infant environments and higher rates of children in childcare. Parents with small children may choose a day nanny who takes care of a few children rather than a nursery where there are many children to care for. Some nurseries and kindergartens adjusted and updated their care giving concepts as well. They provide family-like groups, where children from different ages are mixed together and the groups remain stable until a child leaves the group at school age.

If the quality of day care is high, childcare can provide the child with experiences that are quite good. In former times, age-mixed groups of children were an important part of a child's social network. Today, the close social network may not include such age-mixed groups . If the child stays at home with the mother most of the time, childcare in age-mixed groups can provide the child with opportunities to interact with other children and to improve social skills (Ahnert & Lamb, 2004; Andersson, 2003).

It would nevertheless be ideal if the children would still spend a substantial part of their time with their parents. If the parents keep a close relationship to the child and find a balance between time in childcare and time with the parents, the child-parent relationship remains stable (Ahnert & Lamb, 2004). However, stressful and uncertain living conditions at home, long hours in day care and low care quality hold potential risks for the children's development (Andersson, 2003; Hrdy, 2001).

Unfortunately, at least in Germany, findings from research are not very present in public discussions about childcare. The public discussion about the advantages and disadvantages of childcare seems very emotional and lacks scientific support. I can see some parallels to the discussion about whether there should be orphanages or not. However, for both, we can draw one conclusion from research: The quality of care matters more than the setting (Ahnert & Lamb, 2004; McCall, 2013; Andersson, 2003).

Globalization and Changing Environments

As the quote *"It takes a village to raise a child"* is often attributed to having origins in African cultures, it also makes me think about the developing countries in two different ways:
First, theories, like Bowlby's original Attachment Theory, often develop based mainly on the western middle-class family. Applying theories like these to more collectivist communities and care networks like those in African countries, certain theories and concepts reach their limits. So globalization also challenges our western theories. We need to think again and re-adjust them in response to infants and families around the world.

Second, also in African countries, care responsibilities shift and I am very worried about this. For example in Tanzania, parents are often not aware of the importance of quality childcare. Parents and relatives know that education is important. While providing children with the best education they can afford, they often neglect emotional and psychological needs of their children. As a consequence even three-year-old children are placed in boarding schools (Kibakaya, 2014). In order to be successful in their careers, parents often need to be flexible and work long hours. They may live far from their relatives due to the location of their work. Therefore, they pay the schools to take care of the children and hand the responsibility over to the teachers. Parents expect that schools take not only care of the educational development but also of the moral and social development. Children in Tanzanian boarding schools often live in hostels. In these hostels the caregiver child ratio is even worse than in orphanages. However, the children are not seen to be at risk, because their parents are still alive and they are not suffering from poverty. Parents are not yet aware of their importance for their children's healthy development.

Through globalization, western concepts

and theories may be applied in other countries or cultures without prior testing. If the theories only hold true for western settings, cultures and societies, we will struggle to create environments for infants that work for different cultural backgrounds. We need to critically rethink and test our theories to differentiate where we deal with the universal needs of infants and with cultural differences.

With intercultural and global research we need to address the challenges emerging in other countries with fewer resources. We need to establish concepts of universal infant needs and practices. In a globalized world it is even more important to test scientific findings on their global validity and to make them accessible for all. Using scientific findings in order to improve environments for children should not be a western privilege!

Opportunities in Changing Environments

Besides the challenges that urbanization holds for infant development, I think it is important to acknowledge also the new opportunities that emerge:

Networking between mothers is much easier, by accessing information and sharing via internet and new media. Young mothers can use the available information and decide how to raise their children. They do not have to do it the way their (grand-) mothers did. Young mothers from families where corporal punishment was common can decide that they do not want to spank their children. They can use the Internet to gain knowledge and to learn alternative parenting strategies. They can decide to step away from the corporal punishment that was part of their own childhood. I think this may be easier through the digital access to information from all over the world.

The variety of different childcare models can allow parents more influence on their child's care. Ideally, parents could choose who takes care of their child. It does not have to be the mother-in-law or the aunt who may have a different opinion about child rearing and might spank the child.

Globalization can also help to spread knowledge and raise awareness of the needs of children. In countries like Tanzania, psychology gets more into focus in politics and public awareness. Thanks to the Internet we are able to support talented and creative psychologists in Tanzania through exchanging knowledge and supporting research. We are able to forward information via email to young parents in Tanzania; we can supervise school counselors via video chat or voice call. This is also part of the change.

Coming back to quality childcare, the Internet and the new media provide us with a great potential to spread evidence-based interventions to improve the living conditions of many children. With programs like fairstartglobal, the program developed by Mr. Rygaard, it is possible to spread knowledge, enable caregivers and improve the life of many children in a globalized world.

In essence, beside all the challenges that urbanization and globalization hold for infant development, they also bring new chances for change and improvement. It is a very interesting time for research! Let's do not miss this opportunity to keep up with the changes in infant environments!

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Responding to the identified need to build workforce capacity in Infant Mental Health: Launch of the AAIMHI WA Competency Guidelines® in Western Australia

By Rochelle Matacz (President of AAIMHI WA), Perth; Australia and

Lynn Priddis (Associate Professor, Edith Cowan University), Perth, Australia

'Infant'; 'Mental'; 'Health' are three simple words that evoke a multitude of meanings. Recognised as an interdisciplinary field that has progressively grown internationally over the past 35 years Infant Mental Health (IMH) can be defined as:

The healthy social and emotional development of a child from conception, to birth and through to five years; and a growing field of research and practice devoted to the:

* promotion of healthy social and emotional development;
* prevention of mental health problems; and
* treatment of the mental health problems of very young children in the context of their families (Zero To Three, 2012).

IMH in practice can be expressed in a multitude of ways within the parent-infant/young child dyad. At a *promotional* level it is focussed on such concepts as 'first relationships matter' (Michigan Association for Infant Mental Health, 2012) ensuring parents, caregivers and professionals have the knowledge and awareness about why a caregiver's nurturing emotional relationship with their child is of vital importance in the early years. The wealth of empirical evidence has provided professionals with knowledge that an infant and young child's experience of loving close predictable relationship:

* Supports early brain development
* Promotes a baby/young child feeling safe and secure
* Teaches a baby/young child to communicate through smiling, gestures, cries and words
* Helps a baby/young child to express and regulate feelings and manage behaviour and to learn and think

(Michigan Association for Infant Mental Health, 2012)

Preventive approaches in IMH focus on developing parental sensitivity and responsivity. The aim at this level is to enhance secure attachment behaviours and prevent the development of more serious psychopathology in infants and young children who are considered to be at risk due a range of vulnerabilities including and not limited to maternal mental health difficulties, prematurity, abuse and neglect and adverse childhood experiences such as poverty.

Disorders in infancy and early childhood do exist and there is a need for tertiary level service provision in IMH that offers *intervention and treatment services* specifically targeting symptoms indicative of a clinical disorder in this developmental period. Exposure to trauma, abuse, neglect and parental mental illness are established factors that contribute to the development of clinical disorders in infancy and early childhood. These are expressed in a multitude of ways, including disturbed infant-caregiver interactional patterns, early developmental or medical problems in the infant, and/ or chronic functional disorders (crying, sleeping, and feeding). Typically 'disturbances to early development are seen as arising from an interplay of factors in the infant, parent and their environment' (Mares, Newman & Warren, 2011, p. 20) thus requiring practitioners to be skilled in providing interventions that address the range of complexities that present in this developmental period.

Across promotion, prevention, intervention and treatment services in IMH the goal is to reduce suffering and pain. This includes preventing adverse outcomes across the lifespan and promoting healthy development by enhancing emotional well-being and interpersonal competence for infants, young children and their families (Zeanah, 2009).

In order to achieve these goals there is a need for comprehensive approaches to interventions across promotion, prevention, intervention and treatment levels that:

* Support and enhance a caregiver's capacity to nurture infants and young children emotional and social development
* Ensure families in need to additional services can access and successfully engage with them
* Increase the ability of the community to identify, address and prevent social and emotional problems in infancy and early childhood (Zeanah, 2009).

Complexities in defining the IMH workforce

The complexity and uniqueness of IMH comes with the interdisciplinary nature of the field as it belongs to all practitioners working with infants, young children and their families. There are multiple ports of entry into a parent-infant/young children relationship. The target of intervention can vary, ranging from:

The infant/young child's behaviour (a baby who cannot be soothed by his/her caregiver and is constantly distressed and irritable;

A toddler who is showing aggressive behaviours towards his/her peers and staff as he transitions to day care);

The caregiver's behaviour (a first time mother who presents with severe anxiety that prevents her from emotionally connecting to her baby in fear of harming him/her);

Caregiver representations of their relationship with their infant/young child (caregivers who tell us 'I don't like my child, 'I wish I had never had this child'); and/or

The social context in which the child is developing (exposure to parental violence and drug use).

An IMH model of assessment and intervention requires practitioners to consider the dynamics and processes of how relationships function between an infant/young child and its primary caregivers, rather than solely focusing on the presenting concern or port of entry that first presents to the practitioner. The settings can be different and IMH concerns can present in either adult or child services. Despite different ports of entry and variation in how the suffering presents the focus of intervention is the

same. That is, improving the dyadic and family relationships as they directly impact on the infant/young child's development and behaviour across the lifespan and the caregiver's experience of being a parent.

Challenges of defining the workforce

The diversity of the I-ECMH workforce is such that it is often difficult to delineate and is 'not clearly defined by professional discipline, service settings, or traditional academic training programs' (Huang, Macbeth, Dodge, & Jacobstein, 2004, p. 168). It is often fluid and crosses traditional siloed departments. In addition, mental health issues in infants and young children are often first identified in primary health care, child protection, community based interventions, parenting programs, and early learning centres rather than in tertiary mental health services. Typically these settings are not organised around provision of mental health services (Huang et al., 2004). The workforce needs to have the capacity to provide a service that can focus on the infant-parent relationship across the range of settings.

Infant mental health work is complex, and requires a range of skills, knowledge and competencies including the ability to assess risk both to mothers and infants and the ability to take appropriate action so as to safeguard individuals and families, many of whom are extremely vulnerable. It is essential that everyone working in this area of care keeps up to date with the required levels of knowledge and practice in relation to safeguarding procedures (NHS North West, 2011, p. 32).

The workforce includes universal and targeted services as well as tertiary level specialist intervention services. Attention to primary and secondary service providers (examples include and are not limited to Child Health, General Practitioners, Community Parenting Services and Early Childhood Educators) is an important factor when considering a workforce development plan in IMH. This is in keeping with current shifts to create a wider sense of responsibility for IMH that includes services involved in promotion and prevention and understanding of the importance of proportional universalism.

To provide these services to families, Western Australia requires a highly skilled workforce to provide specific relationship based intervention strategies in addition to simultaneously paying attention to the developmental trajectory of the infant or young child to ensure prevention of future development disturbances (Zeanah, 2009). Infants and young children cannot request a service or verbally communicate how they are suffering, therefore as professionals there is a responsibility to advocate and provide infants and young children with the service they require.

AAIMHI WA's response to building workforce capacity in IMH

The Australian Association for Infant Mental Health West Australian Branch Incorporated (AAIMHI WA) is a professional interdisciplinary organisation. It is an active member of the national association (AAIMHI) and is affiliated with the World Association for Infant Mental Health (WAIMH). AAIMHI WA aims to improve the profile and importance of the infancy and early childhood developmental period. The association provides a forum for multidisciplinary interactions and collaboration. Its focus is the promotion of, and support for, the optimal development of infants, young children and their families (conception to 5 years) within a relationship based framework. For over two decades AAIMHI WA has offered training and networking opportunities to a range of professionals in order to enhance knowledge and skills related to Infant Mental Health.

A key strategic aim for AAIMHI WA is to build both capability and capacity in the WA workforce. To this end AAIMHI WA collaborated with the Western Australian Mental Health Commission (WA MHC) on the 'Building the Mental Health of Infants and Young Children: Workforce Competency Based Training Project' (2015). The WA MHC has a number of functions including development and provision of mental health policy and advice to the government, leading the implementation of the Mental Health Strategic Policy, and providing grants, transfers and service contract arrangements. This joint AAIMHI WA and WA MHC project commenced in 2013 and over 60 interviews were conducted with stakeholders involving individual or small groups of practitioners from all disciplines and levels of service (including AAIMH WA members, managers, trainers, academics, policy officers and administrators), published in March 2015 and viewed online.

The project was an innovative response to the growing awareness in the professional community of the need to up-skill people from a range of professions who are working with infants, young children and their families. Key findings from the project were that:

* WA has a dedicated workforce that is open to change and is aware of the need to develop best practice guidelines for working with infants, young children and families.
* There was unanimous support for the development of a reflective practice supervision framework in the IMH workforce. Practitioners and services expressed a desire for a platform to begin implementation of reflective practice supervision into the workforce.
* The most authoritative and comprehensive set of competency guidelines currently in existence is that of the Michigan Association for Infant Mental Health, (MI-AIMH) Competency Guidelines and Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®(2002a, 2002b). An important component of the MI-AIMH Framework is that it articulates IMH competencies specific to reflective practice across four levels. Providing a structure for building and more importantly sustaining skills in the field.

These findings supported AAIMHI WA's focus on workforce development and highlighted the need to adopt a set of competency guidelines that are internationally recognised as the gold standard in IMH. After careful consideration among the AAIMHI WA committee members, consultation with the wider WA IMH community and in response to findings and recommendations from the 'Building the Mental Health of Infants and Young Children: Workforce Competency Based Training Project' AAIMHI WA purchased a license from the Michigan Association for Infant Mental Health (MI-AIMH) to begin using the MI-AIMH Competency Guidelines® as standards to promote IMH in WA. The AAIMHI WA Competency Guidelines® were officially launched in March 2015 by Dr Deborah Weatherston, Executive Director of MI-AIMH.

Western Australia is leading the way internationally as the first Affiliate of the World Association for Infant Mental Health (WAIMH) outside the United States of America to have a licensing agreement to use the MI-AIMH Competency Guidelines®. AAIMHI WA has now joined the Alliance and will collaborate with colleagues in the USA as they embark on the implementation phase of building workforce capacity using the AAIMHI WA Competency Guidelines®.

Establishment of the AAIMHI WA Competency Working Group

Following purchase of the license from MI-AIMH expressions of interest were sought from suitably qualified and committed members to form the AAIMHI WA Competency Working Group. It consists of 11 AAIMHI WA members and can be defined as a group of professionals with an interest or focus on perinatal and IMH from a range of disciplines across a number of agencies working in metropolitan and rural regions of WA.

The following disciplines are represented in the group: Speech Pathology, Nursing, Psychology, Education, Social Work and Psychotherapy, working across government and non- government services spanning across mental health, education, maternity, child health services in community and hospital settings.

The purpose of the Working Group is to support the implementation of the AAIMHI WA Competency Guidelines® into the WA workforce across promotion, prevention, intervention, and treatment levels of service.

Responsibilities include:

* In collaboration with MI-AIMH and consultation with key stakeholders, review and modify the MI-AIMH Competency Guidelines®, as needed, to assure that all terms and provisions are culturally appropriate for the WA context.
* Critically review and modify the MI-AIMH Competency Guidelines®, as needed, to assure that all terms and provisions are culturally appropriate for Aboriginal and Torres Strait Islanders.
* Implement the AAIMHI WA Competency Guidelines® in WA, in collaboration with stakeholders, and develop partnerships for working collaboratively across services and agencies to build workforce capacity in the promotion of IMH in WA.
* Provide advice and links to people and information on the AAIMHI WA Competency Guidelines® and how they can guide training and building IMH Competencies across all levels of service provision.
* Share and disseminate information on events, announcements, and initiatives that relate to the AAIMHI WA Competency Guidelines® and building workforce capacity in IMH in WA.
* Develop a training model for the AAIMHI WA seminar series and other trainings offered by AAIMHI WA that is developmental and meets specific competencies within the AAIMHI WA Competency Guidelines®.

The Competency Working Group in collaboration with MI-AIMH reviewed and modified the MI-AIMH Competency Guidelines® to assure that all terms and provisions are culturally appropriate for the WA context.

AAIMHI WA specifically acknowledges the particular importance that Australian Aboriginal and Torres Strait Island people have in our society. The AAIMHI WA Competency Working Group will continue in collaboration with Aboriginal and Torres Strait Island communities and in consultation with elders to make these competencies meaningful and relevant for infants and young children and their families in these communities.

Next Steps for AAIMHI WA

The framework offers the workforce a professional development plan that focuses on knowledge, best practice skills, and reflective work experiences that lead to increased confidence and credibility across the many disciplines in the infant, early childhood and family services sector. The AAIMHI WA Endorsement® will inform prospective employers, agencies and peers about culturally sensitive, relationship-focused practice promoting IMH. The AAIMHI WA Competency Guidelines® is the first stage of the workforce development plan in IMH and the endorsement process is the second stage of competency building being implemented in WA by AAIMHI WA.

AAIMHI WA Seminar Series aligned to AAIMHI WA Competency Guidelines®

For two decades AAIMHI WA has offered training and networking opportunities to a range of professionals in order to enhance knowledge and skills related to IMH principles and practice. This has been through the AAIMHI WA seminar series in addition to numerous other training events AAIMHI WA has hosted.

In consultation with AAIMHI WA members the AAIMHI WA Seminar Series is now aligned to specific competencies from the AAIMHI WA Competency Guidelines®. The AAIMHI WA seminar series in 2015 follows a developmental pathway to build skills progressively across the core areas of knowledge, skills and practice in IMH. The informal feedback received from members since the introduction of these changes has been very positive.

The AAIMHI WA Competency Guidelines® is providing a structure and a framework to ensure the seminars offer a quality training experience that provides knowledge and skills in IMH. Increasing the seminars from one to two hours in duration gives participants an opportunity for reflection and increases the possibility of integrating new knowledge and skills in IMH into their everyday practice. The seminars provide participants with an introduction to skills that practitioners may choose to develop further through more formal education or conference attendance.

Collaboration and engagement with organisations providing training and skill development in IMH

The AAIMHI WA Competency Guidelines® are available in WA and there will be ongoing collaboration with agencies that are providing training and skill development in IMH. It is anticipated that as training programs are developed and implemented that AAIMHI WA can contribute to developing a more cohesive and integrated training framework for WA that is aligned to the AAIMHI WA Competency Guidelines®. Collaborations with government services such as Child and Adolescent Mental Health Services and Edith Cowan University (ECU) have commenced to develop IMH training that is aligned with the AAIMHI WA Competency Guidelines®.

At ECU in August 2014, a working party was established, led by Associate Professor Lynn Priddis, which included representatives of the departments within the School of Psychology and Social sciences. This team with some external assistance from AAIMHI WA developed the proposal for a Master Degree course in IMH. It was passed at the March 2015 meeting of the ECU University Academic Board.

The IMH course is due to run from February 2016, with applications invited later this year. It is a two year full time or four year part time Master Degree course in IMH with exit points after one and two years respectively for a Postgraduate Certificate in IMH and aligns with Australian Quality Framework levels eight and nine. Course delivery will draw upon experts in the

WA IMH and professional communities for input (including and not limited to paediatrics, psychiatry, psychology, physiotherapy, nursing, counselling, speech pathology, social work and occupational therapy).

The course is written to align with the AAIMHI WA Competency Guidelines®. It is aimed at those with a Bachelor Degree who are already working with infants, young children and their families. It has an emphasis on reflective practice and will include Infant Observation, a research project, and units in theories of IMH, Foundations of IMH, Assessment and Formulation in IMH, Interventions in IMH and current issues and global perspectives in IMH. It will emphasise culturally sensitive practices and will engage and collaborate with local Aboriginal elders and Aboriginal communities to incorporate these in to the course.

ECU has also recently established the 'Pregnancy to Parenthood Clinic', a free perinatal and IMH service for caregivers, infants, young children and families from pregnancy through to three years. It is a training program for students completing the Master of Clinical Psychology degree and is the first training program of its kind in Australia. This training program is designed to ensure the clinical psychology students meet standards specified in the AAIMHI WA Competency Guidelines®.

MI-AIMH Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health® license (Endorsement®), from MI-AIMH

Following implementation of the AAIMHI WA Competency Guidelines® over the next two to three years, the next step for AAIMHI WA is to purchase a workforce recognition initiative, the MI-AIMH Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health® license (Endorsement®), from MI-AIMH.

In preparation, members of the Competency Working Group will work towards earning the Endorsement® through MI-AIMH. Criteria for Endorsement® include committing to group based reflective supervision in IMH, participating in competency-informed trainings and working with infant, young children and their families using a relationship based IMH model of practice.

Following purchase of the Endorsement® license by AAIMHI WA and with technical assistance from MI-AIMH, members of the Competency Working Group will implement the Endorsement® system in WA. They will also have a qualification that recognises their capacity to provide reflective practice supervision to practitioners in WA working in the field of IMH across disciplines and levels of service.

The WA Mental Health Commission (WA MHC) has awarded the AAIMHI WA Competency Working Group with a grant to support implementation of the AAIMHI WA Competency Guidelines®. In December 2014, the WA MHC provided funding for the 11 members of the Competency Working Group to receive 2 hour group based reflective supervision for 12 months. Beulah Warren, an experienced psychologist and inaugural Co-ordinator of the Master of IMH program at the NSW Institute of Psychiatry is providing the monthly reflective supervision for all three groups via Skype.

Summary

In WA there is energy and enthusiasm among the IMH community and those interested in the social and emotional well-being of families with young children in anticipation of the implementation of the AAIMHI WA Competency Guidelines® and how they can contribute to building a sustainable workforce development plan in IMH.

The Competency Guidelines® have the potential to provide a framework for building long term relationships and collaboration between all those contributing to the emotional well-being of infants, young children and their families. AAIMHI WA recognises that this can only be achieved by fully engaging the West Australian community at every step of this exciting new journey it is embarking on. Above all, it is hoped that implementation of the Competency Guidelines® will significantly contribute to improving the lives of all infants, young children and their families in Western Australia.

AAIMHI WA leadership.

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Affiliates Council News

By Maree Foley (Chair of the Affiliates Council), Geneva, Switzerland,

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Anna Huber (Affiliate Council Representative), Canberra, Australia, annahuber.marymead@gmail.com

Greetings to all WAIMH Affiliates. This brief update has five foci: a brief personnel update from Anna; a note about affiliate bylaws; update on the WAIMH study groups; update on the affiliate council voting process survey; and an invitation to raise any affiliate issues/news/special events.

Personal update

News from Anna:

Some of you who attended the WAIMH congress in Edinburgh will know I was elected Affiliate Rep, though you did not see me in the room as I was busy presenting when the election took place. I was however, very honoured to have been chosen by you all to represent all affiliate member organisations on the WAIMH board and executive. As an Australian, I am an enthusiastic traveller. If I am likely to be in your corner of the globe, I'll try and make contact through your local affiliate.

Connecting with local WAIMH affiliates is something I would encourage you all to do whether you are travelling, or at your desk at home or work, as we have a lot to share and learn from each other. The ways we work in infant mental health around the world are diverse and while some affiliate groups have been in place for a while, others are new and developing. Finding others who share our goals to advance infant mental health, wherever we work, can inspire, sustain and encourage us at times when we are isolated, challenged or experience setbacks.

Affiliate By-laws and use of the WAIMH logo

As WAIMH Affiliates we are engaged with two complimentary sets of by-laws: the WAIMH by-laws and the affiliate by-laws. Over the course of our correspondence with some of you, we often return to these documents for guidance. While no set of by-laws can address all the issues an affiliate will address, they do address many of them.

For example, did you know that your association's communication materials are required to display the WAIMH logo and indicate you are an affiliate member? Anna reflected that she was reminded of this herself recently because the Australian Affiliate AAIMHI has been developing new branding and was checking what the WAIMH affiliate requirements are. In addition, having the WAIMH connection clearly displayed on all affiliate communication can also help each affiliate's profile as it directly indicates that your organisation is part of an international organisation.

WAIMH Study Groups (pre-affiliate groups)

WAIMH study groups are groups who as yet do not meet the criteria to become an affiliate. However, they are in the process of developing their membership and are actively engaged with the administrative processes of becoming an affiliate.

There are currently 6 study groups at various stages of readiness on their way to becoming an affiliate. The study group initiative provides emergent groups, such as China, with an identity within WAIMH as they develop into an affiliate. In addition as we support these groups and connect them with other WAIMH members, a pathway is established for new groups to get to know WAIMH members from an array of affiliate.

Update on the AC voting process survey

This survey is ready to be launched and you will receive this soon. The survey is short, brief and reflects the conversations held at both the Cape Town and Edinburgh AC meetings. Minna Sorsa, in the WAIMH Office, has been tirelessly upgrading the data spread sheets and when this process is complete she will then be able to send this survey to you.

Affiliates Corner

An invitation to table any affiliate issues with us over the next couple of months

A core task of the Affiliates Council (AC) involves identifying and meeting the needs of affiliates at varying stages of their development. While groups have unique needs, a shared quest from study groups through to established affiliates is for training and supervision and the sharing of infant mental health knowledge, skills and competent practice training.

In response, the WAIMH Board are actively exploring ways to use WAIMH's developing social media capacity to help address this ongoing need. For example, suggestions have included: the use of webinars, online cyber-guests and sharing keynote speaker recordings via the WAIMH website. Given the centrality of this issue across affiliates, it is our intention to hold this issue at centre stage over the next year. In addition, as we begin to prepare for WAIMH Congress 2016, we wanted to take the opportunity to invite you to share with us:

Any issues that you might like to be considered over the next twelve months. This is always a time when it's busy with many projects on the go; and or

Any special events or milestones within your affiliate.

We will then share this news in the next edition of Perspectives. In addition, it also gives us the opportunity to table any issues on your behalf with the WAIMH Board.

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.

Perspectives from Masters and Doctoral Students

By Angela McLaughlin, University of Edinburgh, Scotland,

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This column focuses on the perspectives of clinicians/students who are engaged in infant mental health research at Masters and Doctoral level. It features a sample of current ethically approved research projects. The column aims to highlight the diversity of student research across the globe that is being conducted by WAIMH members, while also providing a global community of interest and support for each student's research.

If you are a WAIMH member/WAIMH student member who is currently engaged in Masters or Doctoral research, and you have ethical approval for your study, we invite you to share a little bit about your study. This would entail providing the following:

1. Project working title;

2. Name of your institution and department;

3. Name/s of your supervisors; and

4. A working abstract about your research.

Please direct all submissions and enquiries to Angela McLaughlin, Column Co-ordinator.

This column features a doctoral research project being conducted by Wendy Bunston, La Trobe University, Bundoora, Australia. Social Work and Social Policy Department of Community and Clinical Allied Health.

Title: How Refuge provides 'refuge' to infants: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing family violence.

Doctoral Researcher:

Wendy Bunston. La Trobe University, Bundoora, Australia. Wendy can be contacted by email at w.bunston@latrobe.edu.au

Supervisors:

Associate Professor Margarita Frederico and Dr Mary Whiteside.

The purpose of this research is to discover what constitutes 'refuge' for infants. This research explores what the refuge setting provides to the infant in order for the infant to feel safe and protected from harm, following their departure from a relational home experience which involved the use of violence. It elucidates what actually occurs for the infant who first enters a refuge at a time when both mother and infant are likely to be traumatised by their sudden departure from a violent relationship, and/or from their familiar surroundings. It attempts to understand how the infant experiences feeling safe simply by moving into another setting with their mother. Also, what specific things may occur for the infant when they enter refuge accommodation with their mother which facilitates the experience of the infant feeling safe.

Additionally, this study is interested in teasing out the notion of 'refuge', that of providing safety and protection to the infant, and what that means to the mothers and workers in the refuge setting. This research is concerned with giving voice to those who are least acknowledged having a voice in our society: the pre-verbal infant. As such it has focused predominately on infants under 12 months of age. Drawing on infant observations, interviews with mothers and focus groups with staff, this research has been conducted in Women's Refuges within Australia, England and Scotland. It utilises a new 'infant led' qualitative research methodology. This new synthesis brings together the knowledge of 'intersubjectivity' with 'constructivism' in the context of infant led practice. What it offers is a way of respectfully understanding the perspective of the infant within the environment of Women's Refuges.

Reflective supervision/consultation -What is it & why does it matter?

By Sheryl Goldberg, LMSW, ACSW, IMH-E ®(IV), Michigan, USA

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This article was previously published in the Infant Crier, an open aource publication, and appears here with permission from the Michigan Association for Infant Mental Health.

"So, what is Reflective Supervision or Consultation, anyway?" I am asked, yet again. I take a deep breath and orient myself to whom I am speaking. A mental health clinician unfamiliar with early childhood mental health? Someone who offers early care, education, or support services of a different kind? Is it a program supervisor or administrator? Someone who is responsible for workforce development policy and who needs to know what value reflective practices, including supervision or consultation, can offer to their system? Is it a student or new staff person?

My answer will be slightly different for each of these individuals because they each come to that question from a unique place. However, a brief dilemma statement can help move the conversation forward to get a glimpse into what reflective supervision/ consultation (RS/C) is and how it might be important to enhancing the quality of service they offer.

Here are a few good ones:

*A new staff person appears uncomfortable speaking with a parent about their baby's observable atypical development.

*An experienced staff person is having difficulty engaging a particular family.

*A clinician who has worked with older children and their families is now working in an infant mental health (IMH) program; she is observed picking up the baby to play when she walks into one of her families' homes and launching into conversation with the parent about whether the agreed upon time for parent-infant play was spent since she was last there.

*An infant/toddler caregiver feels overwhelmed by a toddler who refuses to stop hurting other children in her care.

*A supervisor has a staff person who is extremely inconsistent in meeting with him.

You might find yourself easily able to see how these dilemma statements could be used to engage in a dialogue that sheds light on how RS/C addresses the issues of relevance. Each of them is a real practice example of an opportunity to engage in mutual exploration, to clarify experiences and perspectives, and to uncover possibilities for further focus.

Let's now consider aspects of RS/C that can inform any responses you might offer:

1. What do we mean when we talk about RS/C?
2. What are its core processes?
3. Why do we believe it is so important to the provision of quality relationship-based services to infants, toddlers, and families, as well as to the growth and health of the professional?
4. How do we use this important relationship process to manage all that there is to balance?

In RS/C we try to balance:

*Attention to the self with attention to the work,

*Attention to the supervisory relationship, with the practitioner-family relationship, with the parent-baby relationship (to what each partner brings to those relationships), and the weird thing we call "parallel process" by which one influences all the others,

*Attention to what is there, what is missing, and to whether all perspectives are represented,

*Attention to emotions stimulated and to thoughts that emerge to be explored,

*Attention to noticing and holding the experience that is there, and also to help support openness to explore what we do not know yet.

What do we mean when we talk about RS/C?

Without citing the literature here, I will summarize by saying that it is a collaborative relationship for learning and support that requires true participation between supervisor and supervisee or consultant and consultee(s). Its most basic expectations are that it:

*Is safe and mutually respectful,
*Is consistent and frequent enough to create continuity and familiarity,
*Pays attention to the emotional experience and thoughts of the supervisee,
*Pays attention to all of these relationships -- supervisor and practitioner, practitioner and family, parent/caregiver and very young child,
*In addition to helping supervisees increase their understanding about a family or dilemma in their work, it provides a "holding environment" within which they can tolerate a bit of ambiguity (and sometimes anxiety or other difficult feelings) long enough to be curious, to be open, and to notice and explore what might be observed in the baby, caregiver, and self.

It may or may not be obvious, but BOTH supervisor and supervisee must be willing to engage in this way.

What are the core processes in RS/C?

We are learning to tease these apart now through various research efforts taking place across the country. Observable elements of RS/C are being codified in a tool under current development by Christopher Watson, Ph.D., along with colleagues at the University of Minnesota and others working in states who have purchased a license to use the MI-AIMH Endorsement ®. This tool, called the Reflective Interaction Observation Scale (RIOS), seems to capture the core processes quite well.

The first core process is the mutual attempt to *Understand the Story* that is being presented about the baby, family, and the work with them, in a way that looks beyond a superficial presentation and considers the influence of history and current contexts. A supervisor and supervisee hope to avoid rushing to judgment as they try to get the best handle on what is happening in order to

figure out where they are and what to do next. This can be one of the hardest things to do in the push to solve the problem, allowing us to move away from the feeling of confusion or the discomfort of not knowing.

The ability to understand and use *Parallel Process* is another important element in RS/C. In IMH, we believe that the most therapeutic thing about what we do is the relationship we offer. We believe that this is true whether we are IMH practitioners acting as therapists or as IMH-informed practitioners working in other systems or disciplines. We hope that the quality of the relationship that the practitioner offers to the family is a new experience that can be taken in by the caregiver and the baby as a source of regulation, consistency, acceptance, appreciation, curiosity, etc., and that the caregiver, having been really seen in this way by the practitioner, will be more able to do this for their very young child.

How can a practitioner do this for a caregiver in a consistent, genuine way if they do not experience this "being seen" and accepted when vulnerable, when clear and strong, when sad or anxious, or when not knowing? Short answer, I do not think they can. The supervisor/consultant's offer of this relationship to the supervisee makes it more possible for him or her to be with the caregiver and very young child in a unique way through this parallel process. It allows them to also use observations about the affective experience at the level of the supervisor and/or supervisee to tell them something about the affective experience of baby and family members.

This adds a layer of quality that goes above and beyond diagnostic formulation and carrying out well-designed treatment plans. This wondering about the effects of relationships upon relationships helps inform the work. The RS/C relationship should help the supervisee pay attention to his or herself in the work in order to increase use of self.

Holding the Baby in Mind is the next element. We all naturally tend to gravitate toward a particular interactive partner in our observations and perspectives. When families or other caregivers are particularly overburdened, or supervisees are overwhelmed by worries, either in their own lives or in response to what the caregivers present, it is easy to lose sight of the baby. Is it too overwhelming to wonder how the baby experiences these things? Is it too sad or frightening? What does the baby bring to the equation? What does the baby mean to the caregiver?

The baby as an interactive partner tells us much about what is important in the work with a family. A supervisor/consultant may have to notice when there are little observations or curiosity about the baby in his/herself, or in the supervisee, and engage in gentle inquiry about this.

The Working Alliance is the term used to describe some of the other characteristics of great import to the RS/C process. This is something that has to be built. I think it starts most hopefully with assuming best intent of the other on the part of both supervisor and supervisee. This is easier said than done sometimes – because of past relationships or the lack of confidence of a new supervisor or of a new supervisee, or of mismatch in style, personality, training, or cultural expectations.

Just as is true in a new practitioner-family relationship, trust and safety have to be grown and tested in order for real comfort to emerge. A pair will have to negotiate how to set their agenda and goals, what the expectations of each other are, how to use their time, and ask for information. They will celebrate accomplishments. They will have to sort through many experiences -- of observing and wondering together, of sitting with silence, of not knowing when the pressure to know feels urgent, or of inquiring about what might be missing. They will need to acknowledge their own feelings as they emerge in order to better understand what is happening in the work and be willing and able to manage intense feelings. They will have to learn how to repair when there are mis-attunements or misunderstandings and to learn and try out new skills. It is a developmental process for each supervisee and supervisor, for each RS/C relationship, and even within that, perhaps for each new type of dilemma.

So, we come full circle as we have looked at these core processes, or elements, and all there is to balance to this final question – Why is RS/C so important to the provision of quality relationship-based services, as well as to the growth and health of the professional?

This is the vehicle for truly supported learning where relationship affects relationship, and where competencies -- theory and knowledge and skills and reflection -- can be tried out in a supported way. Supervisees do this with the help of the supervisor, parents and other caregivers do this with the help of the practitioner, and babies do this with the help of those who care for them. None of us learn from experience alone, rather it is the reflection on experience that teaches.

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A New Resource

By Daniel S. Schechter, M.D.
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Methylation of NR3C1 is related to maternal PTSD, parenting stress and maternal medial prefrontal cortical activity in response to child separation among mothers with histories of violence exposure, by Daniel Scott Schechter, Dominik Andreas Moser, Ariane Paoloni-Giacobino, Ludwig Stenz, Marianne Gex-Fabry, Tatjana Aue, Wafae Adouan, María I Cordero, Francesca Suardi, Aurelia Manini, Ana Sancho Rossignol, Gaëlle Merminod, Francois Ansermet, Alexandre Dayer, Sandra Rusconi Serpa, published in Frontiers in Psychology, section Psychology for Clinical Settings.

Summary:

This paper has replicated and extended findings from a study that I led at Columbia in New York, in which we found that mothers who have interpersonal violence-related posttraumatic stress disorder (PTSD) compared to those without, respond to seeing video-clips in the MRI scanner of their own and unfamiliar children during the stress of separation as compared to play, with less activation of the medial prefrontal cortex (i.e. involved in emotion regulation and dampening the fear response) and greater activation of limbic areas (i.e. involved in fear-response and traumatic memory consolidation). That study supported our hypothesis that routine displays of negative affect and helpless states in infants and young children can act as triggers of maternal PTSD. In the current Geneva study using the same fMRI experimental paradigm but with a larger sample, we additionally found an exciting convergence of traumatized mothers' subjective sense of parenting stress, maternal-child behavioral dysregulation, epigenetics related to dysregulation of the HPA-axis stress physiology (NR3c1 gene coding for the glucocorticoid receptor), and, again the cortico-limbic dysregulation within the mothers' brain that mirrors what we see in her behavior and physiology. The findings further support our hypothesis that infants and young children's emotional communication can trigger mutual dysregulation with a traumatized parent, necessitating specific intervention techniques to help these mothers approach more sensitively what they without help might avoid or, in the worst case scenario, attack.

To view the online publication, please click here.

A Resource from the Infant Mental Health Journal

C. Malone & J.C. & Dayton, C.J. (2015). What is the Container/Contained When There are Ghosts in the Nursery?: Joining Bion and Fraiberg in Dyadic Interventions with Mother and Infant. *Infant Mental Health Journal*. (Vol. 36 No. 3). Pp.262-274.

In the most recent issue of the Infant Mental Health Journal, Johanna C. Malone (Harvard Medical School) and Michigan's own Carolyn Joy Dayton (Wayne State University) explore W.R. Bion's elaboration on Selma Fraiberg's concept of how "ghosts in the nursery" impact the infant-parent relationship. The authors unpack Bion's understanding of how the therapeutic relationship plays a role in emotional containment cycles between mother and infant.

Read the full text at no cost here.

This article appears here with permission from the Michigan Association for Infant Mental Health.

From the Kauppi Campus

-News from WAIMH Central Office

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,

The next WAIMH World Congress will take place May 29th- June 2nd, 2016 in Prague with the central theme of Infant Mental Health in a Rapidly Changing World: Conflict, adversity and resilience. The organizing process of our next World Congress is both challenging and inspiring as the joint Israeli - Palestinian Local Organising Committee works together with the WAIMH Central Office in Tampere and the Professional Congress Organiser Guarant in Prague, mostly via video connection. The Local Organising Committee has taken on itself the challenging task of bringing a bit of the Middle East sounds, voices, stories, and pictures to Prague. The social program of the Congress will be a wonderful mixture of Middle East and Czech hospitality and culture.

World Congress in Prague 2016

Based on the feedback from WAIMH 2014 Edinburgh Congress we have made some changes to the structure of the program. We wish to encourage the submission of abstracts on both scientific and clinical projects, and therefore we have created an abstract structure more fitting to clinical submissions for you to use. The Program Committee also received positive feedback concerning the Brief Oral Presentation (BOP) sessions, and thus the BOPs were added to the submission categories.

The plenaries for the World Congress will address different aspects of early trauma, possibilities for intervention and early development of empathy. Each plenary lecture will also have a short commentary with the aim of complementing theory based plenary with a clinical point of view and vice versa. We hope to create fruitful discussions between participants from different disciplines and cultures throughout the Congress. The plenary presenters will be introduced to you in our forthcoming Congress newsletters, and we will also give you highlights on the program as we come closer to the Congress.

Abstract submission

The online abstract submission system has been open since the launching of the Call for Papers, and we warmly encourage you to submit your work, both clinical and scientific and to join us in creating an interesting and rich Congress program for our 15th WAIMH World Congress. The dead line for submissions is September 15th, 2015.

Read the Call for Papers and submit your abstract: LINK to be added: http://waimh2016.org/

WAIMH Awards

Nominate an exceptional infant mental health professional for one of the awards that WAIMH will announce at the World Congress. LINK to be added.

WAIMH materials

WAIMH Central Office would be happy to send you any materials promoting WAIMH and the 2016 World Congress in Prague. Please send the office an inquiry, so that we can post you materials, or ask for electronic materials (e-mail office@waimh.org). You can also share information from the WAIMH website more easily than earlier since we have added sharing tools to each web page.

Membership

Please renew the WAIMH membership for the year 2015. Go online to the website of the association: 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.

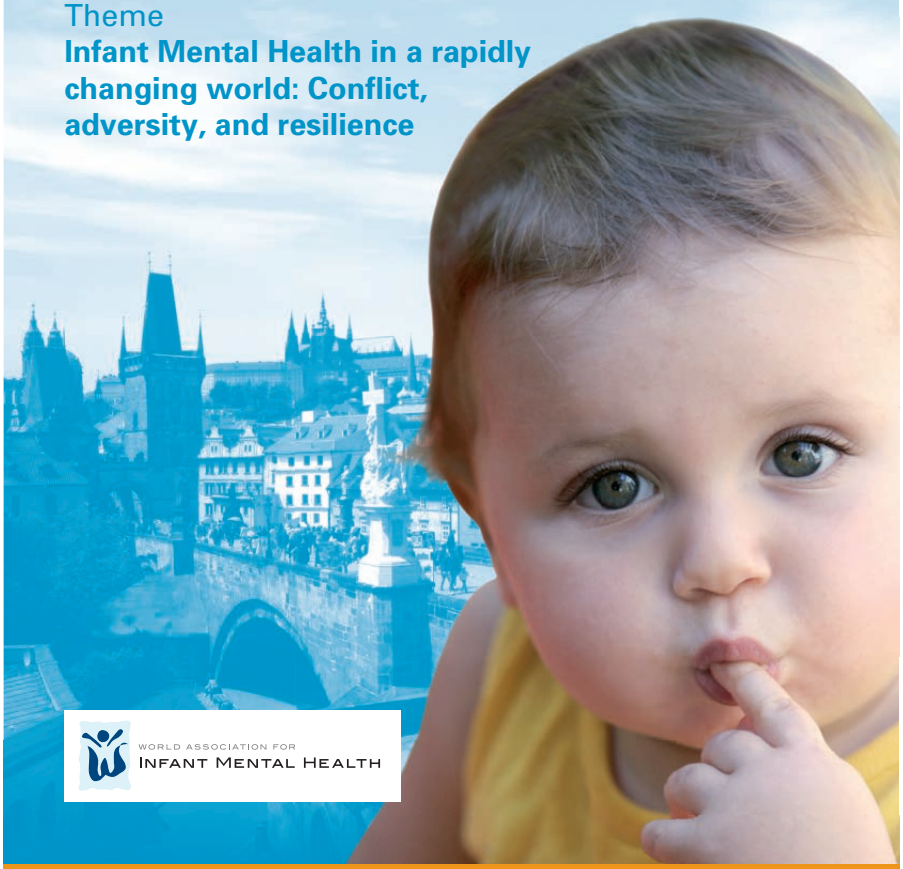
The rates differ according to your country: USA 50 USD, Canada 52.50 USD (including tax) and International orders 62.50 USD. All journal subscriptions are also including access to the online IMHJ at the Wiley. A new popular form of getting access to the journal is the online only option, which is available for members worldwide at the fee of 40 USD.

Please, contact the Central Office of the association, if you need guidelines or support for the membership renewal (office@waimh.org).

15th World Congress of the World Association for Infant Mental Health

May 29 – June 2, 2016
Clarion Congress Hotel
Prague براغ פראג | Czech Republic

Theme
Infant Mental Health in a rapidly changing world: Conflict, adversity, and resilience



WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Call for Papers & Registration

Abstract Submission Deadline:
Tuesday, September 15, 2015
Early Registration Deadline:
Sunday, March 1, 2016

www.waimh2016.org