

Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

President's Reflections Congresses, Social Media and Reflective Space

Contents

President's Reflections: Congresses, Social Media and Reflective Space, M. Keren	1
A Personal Tribute to Nelson Mandela, A. Berg	3
The World in WAIMH: A Reflective Space, J. Sparrow	4
A Community Service Clinical Psychologist Reflects on a Parenting Skills Workshop in Nolungile Clinic in Khayelitsha, Cape Town, T. Dube	5
Commentary, J. Sparrow.....	7
From the Editors, D. Weatherston, H. Fitzgerald & M. Foley.....	7
Affiliates Corner: M. Foley & M. St-André	8
News from the Western Cape Association for Infant Mental Health (WCAIMH): Nurturing the Nurturer, J. Beukes	9
WAIMH 2014 Congress: Two Affiliate Events.....	10
News from the WAIMH Central Office: Sponsor Delegates from Developing Countries to the World Congress, Scotland, P. Kaukonen, K. Puura & M. Sorsa.....	11
A New Resource: For Our Babies: Ending the Invisible Neglect of America's Infants, J. Weatherston	12
A New Resource: Magic Always Happens, Neophytos (Neo) Papanephytous, E. Tronick.....	13
Evidence-Based Practice and Early Childhood Intervention in American Indian and Alaska Native Communities, P. Spicer, D. Subia BigFoot, B. Funderburk, D. Novins	13

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

This issue of Perspectives is the last one before our Congress in Edinburgh, mainly because so many WAIMH board members and members are busy preparing for it. This is the time for me to thank the WAIMH Office, the Program Committee and the Local Committee for their ongoing, intensive work together, including InConference, managing the myriad of details that make such a big event as a World Congress to become real and successful. Don't worry though, the next issue will come out after the Congress, as a double one!

While working on the development of our Social Media guidelines, and just coming back from a 2 day conference at the International Psychoanalytical University in Berlin (where for the first time a conference on parent-infant psychotherapy was held), I am wondering why we in fact still need large events like a congress. Why were close to 1000 abstracts sent to the Program Committee for the 2014 WAIMH Congress, while many of us (especially the younger ones!) are so used at sharing ideas and experiences quickly with Facebook, LinkedIn, Twitter (and probably other channels I have not heard about). Even at the WAIMH Board, we are getting used to having on-line meetings. Money and traveling time are thus spared... Hence, logically, it may make no sense to go on organizing and participating in large meetings or congresses. Still, to the best of my knowledge, there has not been in the last years a decline in the number of conferences that have taken place all around the world. In fact, the opposite may be true: more and more conferences

are held in what was once considered «far-to-reach» places, such as China, Africa, and India.

If so, what need/s do congresses fulfill? One could say "to see places." This might be true to some extent, but most participants stay in the congress rooms and halls for most of the program. So, there must be something else. I suggest it is the need for real togetherness, where informal, unplanned encounters can take place, associative thinking can lead to new understandings, new plans for joint work discussed. Being physically in the same space has, in my view, a different impact than the electronic togetherness LinkedIn or its like, may have. Indeed, when one leaves his/her own country, he/she leaves some of its daily preoccupations, his/her own society's standards, stereotypes, ways of thinking, all that is familiar. When we deliberately go to the unfamiliar, it is less anxiety-provoking than when it is imposed on us and it may become a drive for more in-depth exploration. It is then an occasion to learn to see the other, to develop, as Astrid Berg has so well expressed in her memorial words for Mandela, «regard for self and others.» The creation of a "reflective space" has a cognitive and an emotional component in it, just as reflective functioning has in our clinical work. Maybe the possibility of being together and entering into a reflective space where thoughts and feelings can be shared is a strong motivation for each of us to attend a conference or, more specifically, WAIMH's 2014 World Congress.

Yet, with all this said, don't worry! WAIMH is getting ready to have a Social Media that will enable those who cannot come to our Edinburgh Congress, to listen at least to the plenary speakers. Indeed, this year's congress will be our pilot test for the Dicole Social Media company



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that has been working with WAIMH during these last months becoming to make the organization more accessible during and in-between our biennial congresses. We are currently determining the guidelines for the use of Social Media, keeping in mind our main concerns for confidentiality and reliability.

As Joshua Sparrow has mentioned in his commentary about Thembelihle Dube's fresh and genuine report of her frustrating experiences at trying to make psychological services more responsive, relevant and accessible to the complex needs of a very disadvantaged community in South Africa, creating a reflective space is not an easy task as soon as we go to very disadvantaged populations. Thembelihle Dube has shown how trying to import the Western intervention named as «parenting skills workshop» failed at bringing the parents to attend and reflect on their child's disruptive behaviors, while the more vague, less psychological, phrase, «let's build one another,» resonated much better in these parents' minds and led to a better attendance rate. This leads me to think that reflective spaces may have different foci in various geo-cultural contexts. In our well-nourished, western individual-centered societies, the focus is psychological and very much influenced by the traditional notion of the therapist-patient relationship. In contrast, in other environmental contexts where physical survival is not taken for granted and psychological well-being is not a priority, its focus may be the gathering itself, as a peer group with common adversities, that ultimately leads to moments of reflection.

This interplay between the real and concrete environment and the metaphorical notion of reflective space, may be one more reason to hold our WAIMH Congress in different countries every two years. The environment, very much mediated by the Local Committee, impacts on the nature of the reflective space as it is framed by the Program Committee!

Since our last issue of Perspectives, we have received important feedback from some of you about the draft of the Infant's Rights Statement. Our next Board on-line meeting on that topic is planned for March 27th, so that we will present a fuller draft for comment and reflection in Edinburgh.

Last, but not least, is the reminder for sending us bids for the 2018 WAIMH Congress. The 2016 one will be held in Tel Aviv.

I personally look forward seeing many of you in Edinburgh,

Warmly,

Miri Keren, WAIMH President

A Personal Tribute to Nelson Mandela

By Astrid Berg, Cape Town, South Africa

When Nelson Mandela became seriously ill in June 2013 we all knew that the end of his life might be near; however, one could not help wishing for his immortality, especially when he seemed to recover sufficiently to be taken home many weeks later. Much outpouring of grief occurred during the last hospitalization with vigils, walls of flowers, tributes and prayers in churches. Once he returned to his Johannesburg home, all of this became quieter until the announcement of his final passing on 5th December. A period of intense national mourning, remembering and also celebration set in. In true African style, there was joy at his life, at what he had given and at his now being able to rest in peace. As in life Mandela managed this transition in a way so that we were prepared for it and so that we could manage it with maturity and dignity.

I need to say something about Mandela's name: the story is well known of how his first school teacher gave him his 'Nelson' name, as she could not pronounce Rolihlahla and she obviously made no effort to learn, as was customary attitude of the European inhabitants of the time. Madiba, his clan name, emerged over the years to be used by all or most South Africans. It is an address which signifies respect. As a South African I feel I have the right to call him by this name. However I feel that I am not entitled to call him «Tata», which is the African word for father and which he is increasingly being called - it feels presumptuous for me, as a white person, to want to 'own' him in that intimate way - I wish I could, but it would seem disrespectful if I did.

More than anyone I have known about in my life it is this man and what he stood for that has enabled me to become part of a collective; a naturally more individualistic kind of person who is more comfortable being on the outside of a group than being submerged in it, I have never had any hesitation in identifying intellectually and emotionally with the ideals that Mandela represented and of being part of the society that came into being under his leadership. He is not the only person in the world who has said profound things, but he is the only person that could speak to so many. So what was it, what is it about him? What does he constellate in us that we grieve and cry; that we celebrate and feel immensely proud to be part of his legacy?



The Grande Parade, City Hall, Cape Town 14.12.2013. Photo by Heinz Rode.

Madiba was a respectful human being - not only did he command respect, but he respected the other person, no matter the colour or creed or social standing. This is something which he learnt from the amaThembu Regent who reared him for a large part of his boyhood. «I have always endeavoured to listen to what each and every person in a discussion had to say before venturing my own opinion.» (Mandela, 1994, p.25).

The regard for self and other and the taking of responsibility are probably the highest forms of being human. This is not about power for the sake of self aggrandisement, but signifies the presence of an inner authority that is not threatened or shaken by outer forces.

These noble human values were tested by fate in a way that the old alchemists would have understood when placing their various mixtures over the fire in the hope that gold might appear. In the years of imprisonment and immense hardship these attributes were refined, strengthened, polished until they became the alchemical gold.

And South Africans were ready to see it and to celebrate the man who embodied these highest values with such genuine humility. And this is the other part of the equation that should not be omitted: the peoples of South Africa. Without their willingness to embrace what he stood for, he could not have shone as he did.

This was evident in the outpouring of gratitude that was manifest in the various memorial sites throughout the country in the 10 days following the 5th December

2013. In Cape Town one site was in the city centre, at the Grand Parade. The flags on the City Hall were half mast, the atmosphere sombre, quiet, and respectful. People of all races and all ages filed past in an orderly way, able to read the tributes and place their own on the mountain of flowers; an old, inebriated woman held forth in Afrikaans, English and isiXhosa about Madiba, giving all a sermon about his greatness and her love for him - it was both comical and sad.

One of the most touching posters was one made by two boys - next to photos of them together they wrote the following:

“Because of you, Mr Mandela, we could be friends, be in the same class at the same school. We do not have to live the way our parents did. We will never forget you.”

Ludwe Sokani and Nathan McCabe

The question that was on everyone's lips was: Will South Africa descend into chaos after Mandela? The answer lies in the way its peoples have honoured and continue to honour him - perhaps we have each internalized his ideals; that we no longer need him as a father on this earth, but can honour him as the powerful ancestor that he has become.

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The World in WAIMH: A Reflective Space

By Joshua Sparrow, Harvard Medical School, Boston , USA,

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In A Community Service Clinical Psychologist Reflects on a Parenting Skills Workshop in Nolongile Clinic in Khayelitsha, Cape Town, Dr. Thembelihle Dube puts us squarely before the clash of Western constructs of mental illness, treatment, and therapist-patient roles with those of other cultures. We wonder how to understand what these words - psychologist, therapy, psychoeducation, mental illness, parenting skills, and others - mean here. What explanatory models do parents, professionals, and the children themselves invoke to understand a child's distress, disorganization or disruptive behavior?

Dr. Dube concludes that parents benefit from the opportunity to stop and reflect on the meanings of their children's behavior. Yet she herself believes that their materially impoverished and traumatic environment explains much of it. But then, what role for psychological formulations and treatment? What is the right balance between reflection and action? What is the place of parenting skills and stress management when there is food insecurity, homelessness, and trauma all around? Dr. Dube suggests that it is not 'either or', but, instead, 'both and': we might guess that parents' small successes in understanding and reaching their children help empower them to take on the larger challenges they face.



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A Community Service Clinical Psychologist Reflects on a Parenting Skills Workshop in Nolungile Clinic in Khayelitsha, Cape Town

By Thembelihle Dube, South Africa

In 2013 I worked at the Khayelitsha District Hospital as a community service clinical psychologist. All graduating clinical psychologists in South Africa are required by law to complete a year of community service before they are able to register with the Health Professions Council of South Africa (HPCSA) as independent practitioners. The professional training of clinical psychologists entails a Masters degree of a year of theoretical training (in some institutions this period is two years) and another year for practical training through an internship. Following the internship, clinical psychology trainees are required to do a year of community service prior to qualification. (Dube, 2011; Pillay & Kometsi, 2007; Rohleder, Miller & Smith, 2006).

Khayelitsha is a peri-urban settlement with over half a million residents, half of whom are without formal employment (MSF, 2009). I spent 3 days in the Khayelitsha District Hospital and offered services to two Community Health Centres (CHC) in Khayelitsha: Site B (Day Hospital) and Site C (Nolungile Clinic). At Site C, a primary healthcare site, the occupational therapist, psychiatric nurse and I facilitated a parenting skills workshop.

Setting the scene

In the first week of my community service year, I was assigned a case. A 6 year old girl, Mbali was referred for psychological assessment and treatment. She hadn't been seen as yet because she speaks isiXhosa and my colleague did not. So my arrival was a boon. My colleague had just been offered a permanent post at the Hospital following her community service year in 2012.

I met with my young client's parents; they were open and eager for Mbali to be helped. It was noted that Mbali¹ was very anxious, she was easily startled and was apprehensive around adults. Mbali's parents were unmarried, her mother was currently unemployed and her father had

¹ Mbali is not the client's real name. The client's name is not displayed in order to maintain client confidentiality.

casual work on weekends. Mbali lived with her mother in her maternal grandmother's house along with a few other extended family members and a mentally ill uncle. It came to the fore that Mbali's mother used to work at night when she was a toddler and often had to leave Mbali in the care of her extended family members. It was noted that on more than one occasion Mbali's mentally ill uncle would have psychotic episodes, break windows and there would be a spectacle in the house. Mbali later noted how scary these incidents were for her. There had been no complaints at school about Mbali's behavior. However, her parents had been encouraged to assist her with some of her school work. Mbali's parents noted that she had a lot of friends at school and at home. Mbali hardly spoke in sessions but really enjoyed drawing and colouring in. When the sessions ended Mbali would often refuse to leave and her parents would have to carry her out of the therapy room.

There was a lot going on with Mbali but most of what she was experiencing was as a result of the environmental circumstances that she found herself in. Life at home was at times scary and unpredictable. Her parents were often not there to soothe her and help her make sense of what was happening around her. It was unclear whether anyone comforted her when her uncle became uncontained. There was no structure or routine in Mbali's life, she was expected to merely adapt to the circumstances. I saw Mbali a handful of times before her mother, heavily pregnant with her second child found it too difficult to bring Mbali to therapy and Mbali's father was unable to bring her to therapy due to a death in his extended family. Therapy was abruptly terminated.

A CHC Workshop

More and more, I saw many cases where I felt that the introduction of basic parenting skills could go a long way in facilitating better attachment between parents and their children. Thus the CHC workshop came about. It was a 4-week workshop for parents/caregivers of children who were receiving psychiatric treatment at Nolungile. These were children who had been diagnosed with ADHD, depression,

an anxiety disorder, substance abuse or exhibited 'disruptive behavior' as well as children whose parents had a psychiatric illness and were receiving treatment at the Clinic. The workshop sought to support parents/caregivers by helping them understand why children present with disruptive behavior.

The workshop looked at self-reflection so as to highlight the link between parents' well-being and their children's well-being. The workshop helped the participants gain a better understanding of mental illness and how at times emotional distress can manifest through behavior. The workshop touched on self-care and, in addition, the occupational therapist (OT) discussed stress-management with the participants. Information pertaining to community based stakeholders and resources, was also made available to parents/caregivers for other avenues of support.

First Pilot

The first pilot of the workshop was merely referred to as a parenting skills workshop. The group fizzled out fairly quickly, starting with 5 participants, then 3, then 1 and ultimately we terminated with a single participant. The average age of the participants in the first group was 40, they were all Black isiXhosa speaking females. My team, save for the psychiatric nurse, was relatively young and it didn't help that I look younger than I am. The OT was an English speaking, coloured lady in her mid-twenties. The psychiatric nurse was a middle aged, black isiXhosa speaking male and I, a black isiZulu speaking female in my late twenties. My supervisor implored me to consider, notwithstanding other considerations, what my participants told other community members about the group. One could imagine the difficulty of noting that they were going to a workshop to learn more about how to parent their children led by two, twenty something year olds and some man (the psychiatric nurse).

Second Pilot

The second pilot was then named the Masakhane Club. Masakhane, loosely translated, means 'let's build one another'

in isiXhosa and isiZulu. The participants were female isiXhosa speaking and in their late thirties, they were offered individual sessions with me along with vocational rehabilitation by the OT which aimed at helping them seek employment (assistance drafting a CV etc) or helping their children find suitable schooling and/or work placement in the event of intellectual disability. This sought to offer the clients comprehensive support over and above the workshop and psychiatric assistance. This proved fruitful as the retention rate was higher with group members attending most of the sessions (individual and workshop) however there were heavy rains which led to flooding of most homes as is the case very often in winter in Khayelitsha, many homes are destroyed and families left homeless. Two group members were affected.

The four-week workshop had modest aims to help facilitate a mild shift in the way that parents viewed their children's seemingly disruptive/unusual behaviour. The participants welcomed the Masakhane Club initiative and noted that much of what was covered were things they had never paid much attention to until the workshop. It was almost as though the participants were constantly in motion and the workshop made them stop and reflect on what they were doing and how they were going about doing what they were doing.

Working in Disadvantaged Communities

Working in the CHC's poses numerous challenges as one is working in very disadvantaged communities where most of the clients reside in informal dwellings (shacks), are unemployed and may not know where their next meal is coming from. Substance abuse and violence is rife. Often people are just doing their best to survive. The CHC's are overburdened with high demand and not enough staff to meet the community's needs. For example, one intern doctor at the Nolungile Clinic, noted that on average she saw around 40-50 clients a day. In respect to mental health, one finds that there is not much understanding of the role of a clinical psychologist. Clients often do not know what to expect from an encounter with a clinical psychologist, nor are they familiar with the process of therapy.

In 2011, as part of the requirements for my Masters, I undertook a study to look at the experiences of community service clinical psychologists. It was a phenomenological study with 8 participants. The absence

of understanding the role of a clinical psychologist was one of the themes highlighted, as well as clinical psychologists being a scarce resource and the pressure that it engendered to do more than what they were offering. The community service clinical psychologists had to market themselves and conduct psycho-education at their various community service placements sites, not only to clients but to professional medical staff (nurses and doctors) as well (Dube, 2011).

The majority of the community service clinical psychologists in my study were faced with a heavy workload. The nature of the cases was experienced by some as difficult and in some instances traumatic. The community service clinical psychologists were overwhelmed by the levels of violence: physical and emotional that their clients experienced. They encountered many cases of rape, teenage suicide attempts and substance abuse (Dube, 2011). This mirrored my own experience.

Personal Reflections

Working in a disadvantaged community is a demanding endeavor. The clinician needs to always take into cognizance the salient contextual factors such as socio-economic realities, cultural issues, age, race, language and discourses around illness in general and mental illness in particular. These contextual factors must inform the nature of interventions and guide practice. Thus, in my work in setting up the Masakhane Club I knew it would be important to help people understand what my role is, undertake psycho-education as well as help them understand more about the process of therapy. In this way, I sensitized people to the fact that a psychological intervention is unlike a consultation with a family physician where an assessment is done, medication offered and the individual can take on a more a passive role in relation to the doctor and the drugs are expected to take effect. A psychological intervention requires the client to take the lead and drive the healing process while the psychologist is a collaborative or facilitative partner who creates a space conducive for healing.

The Masakhane Club was able to come about on account of the willingness of the members involved to drive the initiative and constantly remaining in conversation with the institution's leaders with regard to the intervention. I have found that working with a team, in my case the occupational therapist and the psychiatric nurse, is important as it allows the intervention to

be owned by the team and not just by one professional, namely the psychologist. This ensured continuity, especially given the transient nature of a community service psychology post. Whereas the community service clinical psychologists may constantly be changing, the psychiatric nurse and the OT remain.

I am privileged that my training was able to adequately prepare me for the vexing challenges of providing psychological services in the context of disadvantaged communities. However, working in Khayelitsha highlighted the lingering hurdle of how to make psychological services more responsive, relevant and accessible to the complex needs of disadvantaged communities. As well as the desperate need for psychological services offered in the client's vernacular particularly in the treatment of children.

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Commentary

By Joshua Sparrow, USA

At Nolungile Clinic, we are confronted with the limitations of Western mental health service delivery models -originally developed in settings rich with material resources- when deployed in contexts of extreme material poverty. Groups for parent makes sense when clinicians are scarce, and even experience in the US has taught us that they are more effective when:

1. group leaders reflect group members in ways that members can identify with – for example, culture, language, race, class;
2. group members' hierarchy of needs are honored in the group's focus;
3. group members' children are included in the group, so that their actual individual children -rather than the generic child or generic child development- are addressed;
4. material barriers to attendance are addressed;
5. group activities aim to build lasting social capital among parent members directed at raising each others' children.

In her parent groups, Dr. Dube deftly demonstrates the humility it takes to pay attention to what isn't working, and to fix it by re-examining one's professional identity and acquiescing to a redistribution of power in healing relationships. We might wonder whether her new parent group, the Masakhane Club, in which parents "build each other", will provide a different kind of therapeutic experience that comes from effective collective action to protect each other's children. A final challenge in this setting is the sense of urgency that compels us to action yet where resources are not sufficient to determine which actions have been or will truly be worth taking.

From the Editors

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The editors wish to thank each contributor for the time and energy spent on preparing their articles for this issue of Perspectives in Infant Mental Health. Giving voice to things we observe, experience and think about takes courage. We appreciate the personal reflections offered by Astrid Berg following Nelson Mandela's final passing, the candid observations of an internship experience presented by Thembelihle Dube, and thoughtful challenges and summary of WAIMH affiliate activities from the Western Cape by Jeanine Beukes.

Our intent is to offer a window into WAIMH by recognizing the work that is being done on behalf babies and families around the world and challenging new thinking about the integration of infant mental health principles and practices across disciplines and in multiple settings worldwide. We invite your commentary and welcome new contributions from new and seasoned professionals from multiple disciplines - practitioners, research scientists and policy advocates – who share a commitment to optimal health, development and mental health across the globe.

Deborah Weatherston

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Affiliates Corner

March 2014

By Maree Foley , Affiliates Council Representative, New Zealand, maree.foley@vuw.ac.nz and Martin St-André, Affiliates Council Chair , Canada, martin.st-andre@umontreal.ca

Greetings to all Affiliates,

Affiliates want to connect with one another in order to nourish, to stimulate and to sustain their action within their own community. They also want to feel a connection with WAIMH. As Affiliates Council co-leaders, we are always impressed by the dedication, creativity and energy that Affiliates generate for infants and families across the globe and by the degree of determination that Affiliates manifest in terms of keeping their organization alive amidst various political and financial pressures. In this issue of Perspectives, we especially thank the Western Cape Association for Infant Mental Health for bringing the liveliness of their story to our community.

It is heartwarming and encouraging for the Affiliate community to have access to Affiliates who accept to share their stories. These narratives – often produced by people whose English is not their first language – generate greater connectedness and inspire our efforts to improve the lives of infants in our communities. Writing an Affiliate story for Perspectives always involves unveiling not only our strengths and hopes but also our various challenges and even our limitations. Without such risk taking and dedication by Affiliates Presidents, it would simply be impossible to imagine the Affiliates Council as a lively community.

Since the creation of the Affiliates Council, the WAIMH Board has put great emphasis on developing increasingly diversified strategies for facilitating connectivity across our community. For example, the consultative process concerning “infant rights” and attending to developing our capacity to utilize social media. These strategies are underpinned by the objective of bidirectional communication which in turn creates opportunities for Affiliates to increasingly experience ongoing support from WAIMH. It also creates opportunities for Affiliates to play a critical role in nourishing the wider WAIMH community. For some Affiliates, this might also involve transmitting WAIMH

information to their community by adding words in their own language.

We also salute here the determination of various groups of infant clinicians worldwide who demonstrate great determination to launch a new WAIMH Affiliate. This process always involves bringing together local people from various horizons and entails developing a shared vision before applying for WAIMH Affiliate status. These steps – often felt by new Affiliates as somewhat long to accomplish – have a dual impact both at the local and at the international level. In addition to contributing to the diversity of the WAIMH community, launching a WAIMH Affiliate brings increased connectedness and credibility to local infant mental health groups who wish to make their advocacy, clinical and scientific actions more powerful. We especially welcome here the official joining of the Japan Affiliate in the WAIMH Affiliate community.

Over the coming weeks, all Affiliate Presidents will receive a third survey regarding the democratic process for the next Affiliates Council election. The survey will especially focus on role definition within the Affiliates Council for Affiliates Representative and Chair and also for Affiliate Presidents.

Given our global community, surveys are a key way for sharing our hopes and concerns for the future of WAIMH. While they understandably generate more paper work to attend to, by attending to them, we each contribute to the development of our goals as an Affiliate Council. Furthermore, while we acknowledge survey-fatigue, as a Council we are committed to using the knowledge gained from the surveys to increase our global connectedness with each other in support of our local work. An example of this action process is the forth coming Live Supervision events that will take place in Edinburgh - and whose description is included in this issue of Perspectives. These events have been implemented as a direct result of surveying the educational needs of Affiliates. So the participation of Affiliates Presidents truly impacts the functioning of WAIMH.

As we move closer to the Edinburgh conference, we wish you ongoing success with your Affiliates activities. As always, we

are more than eager to respond to queries that you might have regarding Affiliates involvement in WAIMH and we invite you warmly to contribute your words to Perspectives.

News from the Western Cape Association for Infant Mental Health (WCAIMH): Nurturing the Nurturer

By Jeanine Beukes, Chairperson WCAIMH, South Africa

Following the wonderful conference in Cape Town, we were very aware of the degree of exhaustion that most carers of moms and babies (and some of the committee) were experiencing, so we focused our year on Nurturing the Nurturer.

Firstly, a little bit about our affiliate. Our official membership currently stands at 120 people and we have about 50 paid up members that regularly attend meetings in Cape Town. The governance is smoothly organized with a committee of 3 persons democratically elected for a 2 year term of office. Committee members can stand for re-election should they wish to and if they have the memberships' voted support. Chairperson, Treasurer and Secretary are chosen following a voting system by the members. Our members are made up of approximately two-thirds longstanding and one third newer (joined in the last 1 or 2 years) members.

Secondly, keeping with our theme for the year, Nurturing the Nurturers, our WCAIMH monthly meetings have been richly informative, yet the tone gentle and supportive. Overall, they have embraced the themes of diversity, care and contribution. Diversity has been reflected in the wide range of professional backgrounds of the presenters and attendees. Care was especially captured in a sweet moment when Judith Davies (consultant child and adolescent psychotherapist) offered a bowl of sweeties around to all of us as we were discussing maternal bereavement and loss. Furthermore, the subsequent current atmosphere that every-one has something of value to contribute, has resulted in a richer knowledge that is shared through the presentations and through the subsequent discussions and sharing of experiences. In turn, this knowledge has then been taken to a wider range of maternal-infant/professional interfaces.

Topics covered in our monthly meetings included:

- * Nurturing the baby by seeing the mother: Improving child outcomes through maternal mental health interventions. Presented by Dr Simone Honikman of the Peri-Natal Research Project (now in its 10th year).
- * Fussy Feeders: A multidisciplinary panel discussion. This was beautifully presented by Bea Wirz, Mush Perrins and Katherine Megaw.
- * Mentalization-based parenting psychotherapy for at-risk parents caring for young children. Presented by Prof Suchman.
- * The Grandmaternal Transference. Presented by Dr Nicola Dugmore.
- * How can you both Love and Hate your baby?: Addressing ambivalence in the parent-infant relationship. Presented by authors Greg Fried and Lisa Lazarus of "The Book Of Jacob" fame.
- * The Impact of loss and bereavement on early parenthood. Presented by Judith Davies and then followed by cross cultural experiences of loss as shared by the Parent Centre.

An ongoing challenge for our affiliate is striking some balance between keeping the presentations of a high academic standard while allowing accessibility of knowledge to a mixed group of professionals. We strive to uphold research/academic quality (with its impact on the community) while keeping the material practical.

Thirdly, I would like to offer some reflections on our WAIMH congress experiences and reflect on our post congress work in terms of recent projects and connectedness across infant mental health workers. At the outset, our heartfelt congratulations are expressed for the smooth running of the Cape Town 2012 conference. The technical support was of superb quality and presentations were easy to hear and see. I was very impressed with the short video clips by

each presenter giving the core abbreviated version of their talk. It was difficult to make choices as to whom to attend in 2012 and the new speakers found it hard to have a voice.

In addition, the pre-conference workshops offered inspired people at grass roots level. The financial benefit of the conference has also allowed our affiliate to support a community project for the first time that has taken the form of an ongoing support for a Mothers' support group in a disadvantaged community initiated by The Parent Centre. Members of the multi-disciplinary team have visited new and at-risk mothers at their homes on an ongoing basis and have used a great deal of initiative when faced with external challenges like flooding and issues of personal safety. We remain open to financially assisting other organizations that directly serve the community and will serve to contain and hold the carers.

On the other hand, it was generally felt by our current committee that the conference did not bring together the Cape Town infant mental health community in any noticeable way. Individual sponsorships empowered certain individuals, and was of great encouragement to them, but our affiliate as an organization has not been greatly impacted by the input. However, it's early days yet and seeds planted will take a while to grow. We are aware of the need to monitor growth and to stand by with early growing pains.

Fourthly, I want to reflect on our grass roots activities in conjunction with the WAIMH initiative regarding infant rights. It is so good to be part of a vibrant umbrella body like WAIMH. Armed with your recent provisional proposed Charter of Baby's Rights, issues regarding withholding soothing have already been highlighted in our local media- In both English and Afrikaans magazines. There are invitations issued to our committee to contribute, coming from journalists, as we are being recognized as an advocate for the emotional wellbeing of babies.

As always we have to tread carefully and gently and make baby steps in new and kinder ways of nurturing, as we advocate Babies' rights and the anticipated controversy. This has been in line with our committee's decision that the general public needed to be made more aware of the maternal-infant issues on the ground and the valuable research-work combinations that are currently taking place.

Furthermore, our current committee is looking at a 2014 meeting on Infant and Carers' Rights (advocacy role) and how these can be supported. A stand addressing the same topic at the local Baby Expo is also being investigated by the committee. Again knowing that we are well supported by the parent-umbrella body of the WAIMH makes the task of tackling and gently shaking rigid parental practices, less daunting.

Finally, I also reflect on the ongoing challenge for local affiliate members to experience a meaningful connection with WAIMH. For example, by having opportunities at the WAIMH congresses to present about local affiliate work. Unfortunately, our goal of doing this at the up-coming Edinburgh congress will not be realized as the proposed work for presentation was downgraded to a poster presentation. Hopefully we can regroup and present at the next conference. Furthermore, some committee members have the feeling of not being that well linked to WAIMH, but on our side we also need to make the effort to make connections with WAIMH. WAIMH's website and newsletters are really important in this respect. Amidst these challenges, as always, the knowledge that we are not alone is what brings Hope-to these beleaguered mothers, to the carers, and finally, the committee in Cape Town.

In sum, we are looking forward to closely working with WAIMH and Affiliates in the coming year and wish the organizing and scientific committee great patience and wisdom as we march toward the Edinburgh conference.

WAIMH 2014 Congress: Two Affiliate Events

Live Reflective Supervision: Meeting a baby and his family through the experience of live supervision

This workshop (conducted over two sessions) offers delegates an experience of live and real-time supervision. Reflective Supervision is a cornerstone for enhancing a practitioner's effective work with infants, very young children and their families. Reflective supervision focuses on: "the shared exploration of the emotional content of infant and family work as expressed in relationships between parents and infants, parents and practitioners, and supervisors and practitioners" (Weatherston & Barron, 2009, p. 63). Following a brief introduction to the concept of reflective supervision, a live supervision session (approximately 60 minutes) will be conducted. This will involve two senior infant mental health practitioners, respectively, taking the role of supervisor and supervisee. They will engage in a reflective partnership concerning a current clinical intervention with an infant and his/her family, through discussing detailed clinical material. The supervision session will be followed by a facilitated group reflection on the supervision experience and process. This workshop is suitable for anyone who works with infants, toddlers and their families. It is specifically offered in response to educational needs expressed by the Affiliates of WAIMH who have requested learning opportunities about Reflective Supervision in conjunction with opportunities for therapeutically-oriented discussions, to bring back to their communities.

Session 1 (June 14, 8.30 – 10.00 am).

Senior clinician acting as supervisor:

Dr Louise Emanuel (Phd) is a Consultant Child & Adolescent Psychotherapist at the Tavistock & Portman NHS Foundation Trust. She is the Under Five Lead for Camden Services in the Child and Family Department. She is Course Organiser for the PGdip/MA in Infant Mental Health (M9), teaches on the clinical training for

child psychotherapists, and she has been the co-convenor of the Infant Mental Health Workshop for many years. She also has an interest in work with fostered and adopted children, children with learning disabilities, and consultation to organisations. She has numerous publications in the infant field and she has notably co-edited the book "What can the matter be? Therapeutic Interventions with Parents, Infants and Young Children, Emanuel, L. & Bradley, E. eds. (2008) London, Karnac Books. She has lectured in South Africa, Brazil, Taiwan, Australia, Israel, Holland - and taught on observational and clinical courses in Florence and Athens.

Senior clinician presenting case material and acting as supervisee:

Ms Patricia O'Rourke (BA, MGuidCouns, GradDipIMH)

Patricia O'Rourke is a Child Psychotherapist and Psychodramatist. She has worked as a consultant, supervisor and trainer in the public and private sectors in Australia and New Zealand. For the past ten years she has provided individual and group reflective supervision to infant mental health workers from a range of organisations and settings. She is particularly interested in child protection and preventative work with infants, toddlers and their families and she co-ordinates the Infant Therapeutic Reunification Service in the Department of Psychological Medicine, Women's and Children's Hospital, Adelaide. She is currently completing a PhD researching how mothers look at their newborns and whether this can be characterised to assist earlier intervention.

Session 2 (June 14, 12.30 - 2.00 pm)

Senior clinician acting as supervisor:

Pamela Segel (Ed.S, DS III (Developmental Specialist), IMH-E-IV(Mentor/Clinical) is an Early Childhood developmental specialist.

She practices as a home visitor and works with families with children aged birth to three who are at risk for disorders in emotional and social development. Her clients are primarily self-referrals or paediatrician referrals. Families are diverse in culture, ethnicity, and socioeconomic backgrounds. She is an Adjunct Faculty in the Education/ Early Childhood department at Central New Mexico Community College in Albuquerque, New Mexico, USA. Additionally, as an endorsed Infant Mental Health mentor, she provides Reflective Supervision to practitioners in New Mexico.

Senior clinician presenting case material and acting as supervisee:

Ms. Sarah J. Jones is a Member of the Australian Association of Social Workers, a Clinical Member of the Victorian Association of Family Therapists, and a Member of the Australian Association of Infant Mental Health.

Her background was originally in Psychiatry Social Work. She trained in Family Therapy at the Tavistock for several years. On her return to Melbourne she trained with as a Couples Therapist and worked for 15 years at the Royal Children's Hospital in Melbourne. She now teaches on the Graduate Diploma of Infant Mental Health/RCH University of Melbourne.

As part of her own private consultancy practice she works closely with three teams of Maternal and Child Health Nurses and is the external consultant/supervisor to Maternal and Child Health Nurses, employed by the Council. She is also employed by different departments of the Royal Children's Hospital, in particular the Paediatric Palliative Care Program and Paediatric Psycho-Oncology. She wrote two papers in the book, «Baby as Subject; New Directions in Infant Parent Therapy», edited by Frances Thomson Salo and Campbell Paul, Stonnington Press, Melbourne, 2007.

Co-chairs: Maree Foley, Affiliates Council Representative, Martin St-André, Affiliates Council Chair

From the Kauppi Campus

-News from WAIMH Central Office

Sponsor Delegates from Developing Countries to the World Congress

By Päivi 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 WAIMH members,

Only 11 weeks to the 14th WAIMH World Congress in Edinburgh June 14-18, 2014. Congress preparations have proceeded very well with the Local Organizing Committee and the Conference Secretariat In-Conference. We are going to have an excellent scientific program, great plenary speakers, good social programme, warm «baby people» atmosphere and colleagues from all over the world to share experiences, new ideas and details of our daily work. At the moment more than 1200 participants have registered to the Congress.

Sponsor a Delegate Programme

Professor Astrid Berg and the Local Organizing Committee of the WAIMH 2012 World Congress in Cape Town created a Sponsor a Delegate Programme, which offered sponsorships to infant mental health professionals from developing countries with the help of donations from organizations, companies and individual WAIMH members.

Currently many countries around the world are in a very difficult economic situation. Colleagues from these countries have contacted the WAIMH Central Office expressing severe difficulties in funding their participation.

Firstly WAIMH decided to offer a special participation fee category to countries in the World Bank categories low, middle and upper middle. Secondly, we are launching a new Sponsor a Delegate Programme, in which you all can participate by donating money. We are wishing to receive donations from individual infant mental health professionals, our

Affiliate Associations and from your departments and clinics. Our colleagues from developing countries (World Bank classifications low - upper middle) can apply for sponsorship, which will cover their participation fee, gala dinner and accommodation for two nights. The local organizing committee, lead by Professor Jane Barlow, will set up a subcommittee to make the decisions according to applications. More information and all materials will be available at the congress website www.waimhcongress.org as well as our own website www.waimh.org. Please participate in the Sponsor a Delegate Programme and help us to support delegates from developing countries to participate - every donation counts!

WAIMH membership and Infant Mental Health Journal

Please consider joining WAIMH if you are not a member or remember to renew your WAIMH membership for the year

2014 if you haven't already done so. The Professional membership rate is \$75.00 annually and Student membership \$45.00.

Members (professional and student members) may purchase the Infant Mental Health Journal at a very reduced subscription rate: \$50 (USA), \$52.50 (Canada, including \$2.50 tax), or \$62.50 (international orders). The journal is a remarkable membership benefit including also the online journal access. Wiley has also developed a new type of subscriptions, which is the online option \$40.00 worldwide.

Because the goal of WAIMH is to extend influence into countries where infant mental health services have not yet developed and where there is a lack of knowledge, WAIMH has Beacon Club scholarships to offer by application to colleagues in developing countries. A Beacon Club scholarship includes a yearly WAIMH membership and the subscription of Infant Mental Health Journal. The application materials are available on our website.

Social media

WAIMH is planning the way of being present in the social media. We will be inviting you all into the network this summer. We believe that the goals of WAIMH can be further improved by attendance in the modern channels, where most of you are already present, the Facebook, Twitter and You Tube.

Join us in Edinburgh with more than one thousand enthusiastic infant mental health clinicians and researchers. You are all warmly welcome to share the unique WAIMH atmosphere. This time in addition to the traditional singing together we will also have a ceilidh, an evening for dance!

Päivi Kaukonen

Kaija Puura

Minna Sorsa

Book review

A New Resource: For Our Babies: Ending the Invisible Neglect of America's Infants, J. Ronald Lally (2013)

Reviewed by Julie Weatherston, USA

For our Babies: Ending the Invisible Neglect of America's Infants is a new book by J. Ronald Lally, Co-Director of the Center for Child & Family Studies at WestEd in Sausalito, California. The book is a clarion call to reform current policies and practices to protect and nurture babies in ways that increase their chances for healthy development. For Our Babies: Ending the invisible Neglect of America's Infants:

* Describes how current policies are failing infants and toddlers

* Includes testimony from developmental psychologists, child care providers, and health and mental health professionals

* Shares the hopes, worries, and frustrations of American parents

* Provides recommended supports and services as well as economic justification for investing early

"This book will bring to light the harmful aspects of America's treatment of its babies that have been invisible to most of us. It will share research about recently discovered sensitive periods in infant development, during which particular environments and experiences are needed to prevent developmental damage. It will present the current realities American families face with negotiating pregnancy, dealing with delivery, and handling care at home during the earliest months, and searching for and securing out-of-home child care. It will share the words of parents who are desperately trying to patch together services so that their children won't be damaged by their absence during critical bonding times or receive low-quality care. It will show how the informal supports (e.g. availability of

extended family, one parent at home) that many families of the past relied upon when raising children have disappeared and how the United States, unlike many other countries, has not developed formal supports in their place. It will present the work of distinguished economists that shows how attending to early development can actually save the country money." –From the Preface by J. Ronald Lally

This book is part of the For Our Babies initiative. Visit the website, which includes an author blog,

For Our Babies | Facebook

<https://www.facebook.com/ForOurBabies>

Book review

A New Resource: Magic Always Happens, Neophytos (Neo) Papanephytous

Reviewed by Ed Tronick, USA

To write "Magic Always Happens: My Daddy Loves Me!" Neophytos (Neo) Papanephytous drew from his experiences raising his son. Seeing every day as a blessing, Neo and his son find joy in all their daily activities, especially when their two-year-old therapy dog, Mya, joins in!

In "Magic Always Happens" a single father and his son develop an inseparable bond just from living out their daily routine—from waking, making breakfast, walking to school, making dinner, to getting ready for bed. Hidden in those seemingly "mundane tasks" are the magical moments of their day and lives. Themes essential to good parenting such as sharing quality time with one's children, meaning-making, dinner time, schooling, and family structure, "scaffolding" for life, and love in its ultimate form (agape) are well emphasized.

While Neo was born and raised on the Mediterranean island of Cyprus—a world away from his son's upbringing in the New York City metropolitan area, his experience reflected in "Magic Always Happens" shows the impermeable bond between father and son spending quality time together, wherever in the world that may be. Such a loving bond is of course relevant to all loving fathers and their children, all around our global village!

To order, contact: neophd@hushmail.com in Kingston, New York, USA

Evidence-Based Practice and Early Childhood Intervention in American Indian and Alaska Native Communities

ZERO TO THREE Corner



By Paul Spicer, University of Oklahoma; Dolores Subia BigFoot, University of Oklahoma Health Sciences Center; Beverly W. Funderburk, University of Oklahoma Health Sciences Center; and Douglas Novins, University of Colorado

WAIMH is pleased to partner with ZERO TO THREE around articles of interest to the WAIMH world at large. Included here is an article written by Paul Spicer, PhD, an anthropologist, and his colleagues at the University of Oklahoma and the University of Colorado in the USA for ZERO TO THREE (Zero to Three, May 2013). The article explores the problems that tribal communities confront when forced to select from menus of evidence-based practice that were not developed with their unique challenges and opportunities in mind. The authors discuss the possibility for adapting or enhancing

existing approaches but also point out the need for much more research and intervention development efforts for tribal communities. The push for evidence-based practice has generated much needed attention to the intervention needs of American Indian and Alaska Native communities and new research models offer hope that these will emerge from true partnerships between researchers and communities.

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The full article appears on the Perspectives WAIMH webpage with permission:

www.waimh.org/files/Perspectives