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Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

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Presidential Address : Infant mental health in times of the SARS Corona-2 pandemic

By
Kai von Klitzing, University of Leipzig, Germany

President of WAIMH

I live in Europe, in one of the hot spots of the Covid 19 pandemic. In the hospital in which I work, life has changed dramatically. The changes affect infants and parents dramatically. For example, in the department of obstetrics, the largest maternity clinic in town, fathers were not allowed to be present at deliveries of their babies for weeks in order to protect the hospital staff from the virus. Currently, mothers are obliged to wear face masks when nurturing their newborns. Furthermore, no visitors are allowed to see mother and the newborn: no fathers, grandparents, or siblings.

In the whole country, playgrounds have been closed off. All social support interventions for parents and infants are currently stopped. Child protection services are not going out for home visits and treatments can only be executed via video or telephone. The child psychiatry and pediatric in-patient unit can only treat emergency cases and parents are allowed to visit their children only one hour per week. This reminds us of times in the first part of the last century in which parents were generally excluded from children's hospitals before pioneers like Spitz, the Robertson's, Bowlby, and Winnicott pointed to the dramatic harm caused by this praxis of separating young children from their parents. At that time, those infant researchers induced a dramatic change of the practice in Western industrialized countries.

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WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

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Announcement: The WAIMH 2020 congress in Brisbane, Australia, has been postponed to 23-26th June 2021 due to COVID-19.

(Continued from page 1)

The Robert Koch Institute, the central institution of the German Federal Government for the monitoring and prevention of diseases, has prescribed the following recommendations:

> Children should like adults keep a distance of more than 1.5 meters to others. Children should also not meet more than two persons at the same time. Children who cannot constantly keep a distance to other persons should stay at home.

When we realize these restrictions, we have to admit that especially young children bear a major burden of the societies' measures to fight the pandemic. A child in its first years urgently needs close body contact, in the first months to his/her closest caregivers, but later on also to the siblings, peers, other important adults etc. The moment of delivery is essential in the life cycle, and the newborn baby needs the early close contact not only to his/her mother, but also to the father. Loneliness is one major restriction which can cause problems of early parent-child relationships. Especially young parents need support, for example by their parents, their community etc. Still the situation of infants in industrialized Western countries might by bearable when we compare it with the situation of infants (and parents) in regions in which there is poverty, war, and in which large populations live under the conditions of migration. Furthermore, children with handicaps and chronical diseases suffer most.

What can we say? Do young children and their parents bear such a burden facing the humanitarian corona crisis because we have to protect them most attentively from the infection? No, the contrary is the case! There is overwhelming evidence that infants are less vulnerable towards the detrimental influence of the Corona virus as compared to adults, especially elderly people and persons with pre-existing chronic diseases like diabetes, high blood pressure, or oncological conditions. Infants are vulnerable with respect to detrimental environmental shortcomings like neglect, maltreatment, or social economic instability, but they usually do not fall seriously ill when they catch the corona virus (as long as they are in a good enough nutritional state). Scientists and medical doctors believe that this lower vulnerability is due to a more flexible immune system and/or to the immaturity of their ACE 2 receptors where the SARS Corona virus might primarily dock.

Also, pregnant women do not seem to have an increased risk of a severe course of the illness. In most cases, children of Covid positive mothers do not show symptoms after delivery. Only a few cases of newborn illness as a possible sequela of an infection in the mother's body have been reported. To date there is no evidence for the existence of the SARS-CoV-2 virus in the breast milk. In summary, according to our current state of knowledge, the symptoms of Covid19 are markedly less severe in newborns, infants, and older children as compared to adults.

When we know that the virus is of low risk for young children, why do we expect the youngest in our societies to tolerate the highest restrictions, which can put them at risk on their part? Restrictions such as:

1. Reduced contact possibilities after birth, especially to fathers.
2. Emotional exchange with caretakers restricted by mask.
3. Reduced corporal contact with siblings and peers.
4. Interruptions of their nursery settings.
5. Reduced child protection services.
6. No freedom of movement.
7. Closed playing grounds; and
8. No contact with grandparents, etc.

It is not because we want to protect them, but it is because we adults want to protect us. Young children usually do not seriously fall ill but they can be infected by the virus, bear the virus and they can transmit the infection to other children and adults. A pediatric colleague compared the role of young children in the pandemic with a Trojan Horse. They can look harmless, but they can bring you the evil! Suddenly we adults are afraid of children and we think they can infect us.

I think morally it is justified to expect young children to make certain sacrifices for the health of adults, diseased, and elder persons. However, we have to admit that it is an act of solidarity what we request from the young generation towards the old generations. When we bring this to our mind, we have to be very careful in reflecting the limitations of our request. Furthermore, we should ask ourselves:

1. Are we grateful enough towards the children in our societies and enough for those caring for them?
2. Are we willing to repay solidarity to them?
3. Are we ready to stop wasting environmental resources, which they would need for their future lives?
4. Are we willing to stop conflicts, no matter whether in our families, neighborhoods, or between our societies, because young children suffer most from such circumstances?
5. Are we acknowledging and respecting enough, the rights of infants all over the world; and
6. Are we attentive enough towards the relational and emotional needs of young children?

The pandemic represents a true worldwide humanitarian crisis. However, as in all crises there is also an opportunity arising from the current situation: the opportunity of carefully reconsidering fairness and solidarity between the generations in our global world.

WAIMH Executive Director Corner

By Kaija Puura, Tampere, Finland,
WAIMH Executive Director

Dear WAIMH members and colleagues,

First of all I wish to thank you for your patience and understanding during our struggle to reach a decision on postponing the WAIMH Brisbane Congress to June 2021. You may have wondered what took us so long, and I thought I would try to open the issue for you.

The year 2020 has not been easy for any of us with the sudden onset of the COVID-19 pandemic. However, through the numerous discussions with our Australian colleagues and WAIMH Board and Executive Committee members it became quite clear that the situation can look very different in different countries and regions. Currently, in Australia and New Zealand the governments are easing restrictions and looking towards a future with a more open society that might allow social gatherings quite soon. In contrast to that, medical experts and epidemiologists are warning about the possibility of a second or even a third wave of COVID-19. Without a crystal ball we cannot have any certainty about how things will be in June 2021, but through our discussions we have tried to figure out what the possibilities might be and to prepare for them. Postponing the Congress for a year gives us some time to see which of the possibilities becomes the most likely. The best possible scenario naturally is that either there is a vaccine or the virus has been eradicated and we can safely have a Congress with participants from all over the world. But this may not be the case. It is also possible that in June 2021 Australia and regions close to it will be allowing social gatherings, and participants from those regions will be able to attend the Congress in person, while it will be offered as an online event for participants from other continents and regions. It is also possible that in June 2021 we will still have a pandemic situation and we will have to organize a full eCongress online, as many associations are already planning to do. What I trust I can say with certainty is that we WILL have the 17th World Congress of the WAIMH in Brisbane one way or another, and we are looking forward to meeting as many of you as possible – live or online.

WAIMH Executive Director, Professor Kaija Puura.

My grandmother used to say often that there is nothing so bad that it won't bring something good with it – the Finnish version of "Every cloud has a silver lining". One of the good things this year is that it has taught us is to treasure our relationships. And while we have been so desperate to reach out to each other, we have also learned to skype, zoom, meet etc, so we are also more prepared already to find ways of being together. Let us wash our hands, keep each other safe and live in hope of getting together in Brisbane.

Congress News

By Reija Latva, Tampere, Finland,
WAIMH Associate Executive Director

Dear WAIMH members,

As you probably all know by now, the past months have changed the preparations for the 17th World Congress of the WAIMH in Brisbane, Australia originally scheduled for June 2020. From January on, the busy preparations for the upcoming congress changed to a discussion on how to cope with the new situation caused by the global COVID-19 pandemic. In the present situation, the best option turned out to be to postpone the Brisbane congress to June 2021. This gives us time to see what the possibilities will be for organizing the next world congress.

The good side is that all the hard work done by the Local Organizing Committee, Program Committee and the Professional Congress Organizer will not be in vain, as we prepare for holding the Congress in 2021.

At the end of last year, the reviewers did a fantastic job by reviewing all the abstracts submitted for the Brisbane congress, and we wish to extend our warmest thanks to all our reviewers. With the help of the reviewers' work, the Program Committee and the Local Organizing committee put together an interesting Congress program. This program will wait for us, together with new contributions submitted through the upcoming additional call for papers for Brisbane 2021.

This year instead of meeting in person, the WAIMH will organize three interesting webinars for WAIMH members and registrants for the 17th WAIMH World Congress. Keeping Infant Mental Health in Focus in Times of Crisis webinars will be held online on the 10th, 11th and 17th of June 2020. The webinars will be recorded, so that they can be retrieved later on the WAIMH website and WAIMH YouTube channel. You are warmly invited to join the WAIMH webinars!

Let us hope that we can all participate in the Brisbane 2021 congress, hear interesting presentations, meet each other and share the wonderful atmosphere of WAIMH congresses.

From the Editors

By

Maree Foley, Switzerland, Editor-in-Chief

Deborah J Weatherston, USA, Associate Editor

Patricia O'Rourke, Australia, Associate Editor

Jody Todd Manly, USA, WAIMH Board Member Associate Editor

Salisha Maharaj, South Africa, Intern Editor

and Minna Sorsa, Finland, Production Editor

This Spring/Summer (2020) edition of WAIMH *Perspectives in Infant Mental Health* includes reviewed and accepted papers since the Fall/Winter (2020) edition. Each paper calls attention to and consideration of what WAIMH members and allied infant mental health colleagues around the world are thinking, doing, and writing about.

For newcomers to WAIMH, *The Signal* was the former name of *Perspectives in Infant Mental Health*. Furthermore, Emily Fenichel named The Signal after an international contest. At the time Emily was Associate Director of Zero to Three and was also the Editor of the *Zero to Three Journal* from 1992 – 2006. Currently, past issues of *The Signal* (1993 - 2011) can be accessed online. Also, past issues of *Perspectives in Infant Mental Health* (2012 – current) are available by following this link: https://perspectives.waimh.org/perspectives-archive/. Past articles are also available online in text format, which in turn can be shared: https://perspectives.waimh.org/

At the outset, we specifically acknowledge the death of Dr Dora Knauer, a child psychiatrist, and a longstanding WAIMH member. Sadly, she died of the Novel Coronavirus COVID-19, on April 20, 2020, in Geneva, Switzerland. A tribute to her has been written by our President Kai von Klitzing and is included in this issue. It can also be viewed on the WAIMH website.

Amidst many personal losses and challenges, the impact of COVID-19 has necessitated that the WAIMH Executive Committee and Organising Committee postpone the WAIMH 2020 Brisbane Congress. WAIMH Executive Director Kaija Puura addresses the agonizingly complex decision-making process regarding the WAIMH 2020 Congress, in her column. The new dates for the 17th World Congress of the World Association for Infant Mental Health are 23 – 27 June 2021.

Further in response to the global pandemic of COVID-19, the *Perspectives* team with WAIMH acknowledges all parents, caregivers, and infant mental health professionals who are caring for infants and young children, and their families. WAIMH appreciates that all parents, caregivers, and infant mental health professionals are providing this care, each day, during these unprecedented times, with still so much unknown about COVID-19.

Furthermore, we acknowledge all Infant Mental Health (IMH) professionals who are hard at work in their efforts to support infants and their families amidst this COVID-19 pandemic. The challenges are immense; the demands to respond unceasing. WAIMH acknowledges that this is an incredibly stressful, worrying, and anxious time for the IMH specialists and allied colleagues as they walk beside young families whose challenges and worries are currently magnified.

Each day, Infant Mental Health (IMH) professionals are facing complex medical questions from families with young children about COVID-19. Similarly, every day, pregnant women and their families are seeking medical information concerning how to keep themselves and their baby safe. Pregnancy, and caring for newborns, at the best of times, is a time of heightened awareness of health and safety issues. WAIMH acknowledges every pregnant woman, her partner and family during this time.

The WAIMH *Perspectives* team have coordinated setting up the WAIMH COVID 19 website page that focuses on providing resources about COVID-19 with a specific focus on infant mental health professionals and the needs of infants, young children, and their families. This focus is in keeping with the aim of WAIMH: 'to promote the mental wellbeing and healthy development of infants throughout the world…" The resources on the site are designed to provide information and suggestions about how best to respond, manage, and cope, during this incredibly difficult time. They also include special medical Information about pregnancy, infants, and young children. Kai von Klitzing has been and continues to provide carefully screened and updated medical data that keeps pace with new data as it becomes available. You can view the WAIMH COVID-19 resources page via the following link: www.waimh.org.

In addition, the Perspectives team have collaborated with Holly Brophy-Herb, Editor of the *Infant Mental Health Journal (IMHJ)*, in a shared initiative: Infant and Early Childhood Mental Health in the Context of the COVID-19 Pandemic. The flyer that details this initiative, and the call for brief papers for *Perspectives* between July 1 and October 1, 2020 can be viewed in this issue.

A second joint initiative between *Perspectives* and the *IMHJ* is represented in this issue. The aim is to feature *IMHJ* articles that especially draw attention to themes in practice with very young children/families. The first paper to be featured in this ongoing series is by Rachel Ransley, Michelle Sleed, Tess Baradon and Peter Fonagy (UK): "'What support would you find helpful?' The relationship between treatment expectations, therapeutic engagement, and clinical outcomes in parent–infant psychotherapy".

This full issue also marks the retirement of Hi Fitzgerald from his many editorial roles of this WAIMH publication. He was the inaugural WAIMH Executive Director in 1993 when *The Signal* was first published with Charles Zeanah as Editor-in-Chief and since that time has been actively engaqed with the publication including the roles of copy editor and associate editor of *Perspectives in Infant Mental Health*. Of special note and acknowledgement is Dee Končar, Hi's wife, who has also contributed as a production editor of *The Signal* in the 1990's. In honour of Hi's longstanding contribution to this publication since 1993, we invited Hi to write a paper as he reflected back over the past years. Hi's paper is published here, *Forty Years with*

Infant Mental Health: Some Reflections for the Future. Hi's paper is followed by some brief commentaries and in turn these commentaries are followed by a selection of tributes to Hi. These tributes are from a selection of colleagues and friends within WAIMH that offer a glimpse into Hi's immense outreach and support to many people in our field.

Moreover, this full issue includes papers published online since January 2020 and also includes new papers. As the WAIMH *Perspectives in Infant Mental Health* editorial team, we thank each person for their interesting and thoughtful contributions.

We welcome submissions from the field that challenge the way we think about infants, families, culture, and community, and offer fresh perspectives on policy, research, and practice. As always, we invite comments in response to what is published in WAIMH *Perspectives in Infant Mental Health*.

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CORRIGENDUM:

This letter was first published on-line, in Perspectives in Infant Mental Health on *13 March 2020 with the full permission of the author. This letter has been updated by th*e author and is published here with changes made by the author.

Dear Kai,

I do thank you for the article you wrote in the last issue of "*Perspectives in Infant Mental Health*".

I'm an Early Years Educator. I've been working for 20 years with children in Milano, Niger and Mexico City (in Niger I spent 6 years, as a personal commitment for voluntary work, with no salary). I now work in public daily nurseries of the city of Milano.

Since 2017, I have been a member of the WAIMH. I thank everyone who is involved in keeping attention to child development, starting from observation of children's needs. I'm not good in writing; I'll try to explain what I've been experiencing in the public daily care center of Milano (but also in most of the private childcare center there is the same neglect). It's thanks to the commitment of many infant-researchers that I've been able to comprehend how to better care for children I found on my way.

I've experienced with my job how children's needs are the same at any latitudes (as Winnicott said) and how caregiving is a universal experience that allow us to feel and become human beings, who belong to Nature; instead of human beings, who feel self-sufficient and use Nature only as an instrument of power.

> "Whether we refer to attachment behavior as a useful biological function or instead we consider it as an irrelevant infant characteristic, it will depend our way of relating with our human brothers" (Bowlby, 1969, Attachment and loss, vol. 1).

Coming back to Bowlby's words I thought about the many times I found myself working in daily nurseries where attachment behavior was considered as a whim (I think especially at the infant and toddler's need, when he comes to the nursery, to have a key person who care for him).

In June 2018, I wrote a letter to the Responsible of the nursery where I explained to her the emotional neglect that infants and toddlers where experiencing every day at the nursery. Their caregivers were denying them a healthy emotional presence and sensitive attunement. Infants were left crying alone, as a punishment, often in an isolated corner with caregivers threatening them with the tone of their voice and the facial expression of anger and nuisance if they dared to ask for being hold in the arms of their caregiver. She answered to me that I was not a good caregiver if I was tuning to infants, giving an emotional presence, because *infants need to get used to stay alone without the mental presence of an adult: it's the space that helps infant to develop, the caregiver just need to be there as a theater director, who control that the space is well organized, keeping on the sidelines*.

These are the new theories, that some professors of pedagogy of Milano have invented; pure philosophical speculation, without any honest and evidence-based observation of human nature (considering human being as a part of a Nature that surrounds and holds us). In doing so, they create a human being who is self-sufficient from birth. A caregiver is considered competent when an infant never goes towards him to find a holding emotional presence…we are talking about children from 3 months to 3 years old.

For this reason, average staff member to child ratios is not considered important. And so the daily ratio is of 1 nursery educator for an average of 10 infants aged 0-3. Often this ratio becomes 1 adult with over 16 infants when caregivers are not available because of illness, vacation, or administrative work. (Administrative work that should be done not in the hours you're supposed to be caring for infants, but since the caregiver is not considered to give an emotional presence, she can go out of the room more easily).

Beside this, in the same room, 24 infants are kept together, even when there's the possibility to divide into smaller groups in order to diminish the stress felt by infants most of the caregivers prefer to remain in the same room and be a theater director (who speaks with colleagues about the scene). Once I tried to ask my colleagues to divide into smaller group. The answer was: *"infants need to learn to stay in the bigger group, without the presence of the caregiver, let them cry alone"*. I was amazed and I felt powerless.

In response, I just held into the evidence-based researches and tried to keep my emotional presence in the best way I could…it was hard.

Only when there is an "unusual" Responsible of the center (who cares

for the infants and understands the importance of the adult: child ratio in order to guarantee an emotional presence of attunement for every one) she can take the decision, that is not well seen by the Administration, of contracting the hours of the services in order to prevent emotional neglect.

There is a huge and dramatic raising in the number of children who develop externalized/internalized problems and also in secondary school many teens need personal support to be able to remain in the class…and still there is a tremendous lack of evidence-based knowledges. Why?

- Why is it so difficult in 2020 adhering to the knowledge available through scientific research and translating it into concrete instruments for those who daily work with children??
- Why has neglecting infant/ toddlers (but later also children's and adolescents) become socially accepted and is even sustained by university professors??
- Why is taking care of an infant so inconvenient in this society?

I found the same problem in Niger, as in Italy, where similar kind of theories distract attention from essential infants' needs, shifting it towards nonsense matter, not evidence-based, that doesn't lead to any positive change.

I think we are passing through a very difficult historic period, where Nature is covered by false images on internet (created by the need for power and success), however at any latitude, any infant shows us the importance of being seen, and taken in mind.

Childcare is universal and can make people communicate with the language of Nature that goes beyond borders. I think J.Bowlby's words are so true today and help us not to lose our humanity.

I do hope that WAIMH will maintain its commitment to keep children in mind; not in facebook, neither on internet site, and evidence-based will remain the root that connects us with Nature….at any latitude…and that's what we should care to spread…because caring for infants doesn't leave space for personal interest of career, success and money. Many people who take care of infants always give their commitment for free… with no money grant. Nature ask us to do it.

I thank you Kai for writing this article, so "politically uncorrect"; it has given me a lot of courage. Thank-you Kai.

Cecilia Peduzzi

La pédopsychiatre Dora Knauer est décédée du Covid-19. WAIMH member, Dora Knauer has died from COVID-19: A tribute

Dora Knauer in interview of rts.ch.

By
Kai von Klitzing, University of Leipzig, Germany

President of WAIMH

On April 20, 2020, Dora Knauer (70), a long standing WAIMH member from Geneva, has died of Covid 19. According to the Tribune de Genéve, Dora had to be admitted to the intensive care unit three weeks ago but succumbed to the malicious lung disease.

Dora was one of the pioneers of infant psychiatry and worked together with Bertrand Cramer, Francisco Palacia Espasa and Francois Ansermet. She was a member of the Swiss Psychoanalytic Society and the International Psychoanalytic Association (IPA). She essentially contributed to establishing the famous Guidance Infantile in Geneva, at which she conducted seminal research on psychopathology and psychotherapy in infancy. She ran the innovative jardin d'enfants thérapeutique (therapeutic Kindergarten), a day treatment unit for preschoolers, and developed innovative techniques of mother – infant psychotherapy. With all her enthusiasm, sensitivity, and creativity she was devoted to the young children and their parents during the perinatal period.

During my years in Switzerland I collaborated with her on several occasions. Especially I remember a visit at her Jardin d'enfants in Geneva which was a model for a similar unit which we established at the Basel child psychiatry department. She regularly attended the WAIMH world congresses and presented her pioneering work. She was an important member of our association who was always integrating the infant mental health tradition of the French and English speaking world. She was such a devoted person; the community of infant researchers and clinicians owes much to her. We will miss her.

Interview with Dora Knauer
https://www.rts.ch/play/tv/le-journal-du-dimanche/video/decouverte-unige-entretien-avec-dora-knauer-pedopsychiatre-hug?id=3745908

Tribune de Genève: https://www.tdg.ch/geneve/actu-genevoise/pedopsychiatre-dora-knauer-decedee-covid19/story/27844974

WAIMH support in times of COVID-19 pandemic

By WAIMH

Many Infant Mental Health (IMH) professionals are hard at work in their efforts to support infants and their families amidst this COVID-19 pandemic. The challenges are immense; the demands to respond unceasing. In response, the WAIMH has created a specific COVID-19 web-page that includes general resources for professionals as well as special medical information regarding pregnancy, infants and young children.

The WAIMH COVID-19 page will be frequently updated to keep pace with new data and resources as they become available.

COVID-19

WAIMH acknowledges all parents, caregivers, and infant mental health professionals who are caring for infants and young children, and their families. WAIMH appreciates that all parents, caregivers, and infant mental health professionals are providing this care, each day, during these unprecedented times, with still so much unknown about the Novel Coronavirus (COVID-19). While there are many online sites that provide helpful resources about COVID-19, the resources cited at WAIMH website focus specifically on infant mental health professionals and the needs of infants, young children, and their families. This focus is in keeping with the aim of WAIMH: 'to promote the mental wellbeing and healthy development of infants throughout the world…" We hope that you find some helpful resources.

General Professional Resources

Many Infant Mental Health (IMH) professionals are hard at work in their efforts to support infants and their families amidst this COVID-19 pandemic. The challenges are immense; the demands to respond unceasing. WAIMH acknowledges that this is an incredibly stressful, worrying, and anxious time for the IMH specialists and allied colleagues as they walk beside young families whose challenges and worries are currently magnified. The resources listed at WAIMH web-page are designed to provide information and suggestions about how best to respond, manage, and cope, during this incredibly difficult time.

Special Medical Information (pregnancy, infants, and young children)

Each day, Infant Mental Health (IMH) professionals are facing complex medical questions from families with young children about COVID-19. Similarly, every day, pregnant women and their families are seeking medical information concerning how to keep themselves and their baby safe. Pregnancy, and caring for newborns, at the best of times, is a time of heightened awareness of health and safety issues. WAIMH acknowledges every pregnant woman, her partner and family during this time. WAIMH acknowledges every IMH professional who is also seeking answers to these questions. The resources listed at WAIMH web-page are designed to provide some information from reputable sources with high quality information. This page will be updated to keep pace with new data as it becomes available.

A resource for WAIMH re COVID 19

Picture from Georgie and the Giant Germ.

By

Kate Rosenblum, University of Michigan, USA

An interactive story colouring book for young children: Georgie and the Giant Germ: https://tenderpressbooks.com/georgie-%26-the-giant-germ

A COVID-19 interactive story colouring book for young children: Georgie and the Giant Germ was developed to support caregivers in their conversations with young children about #COVID-19 as well as providing a way for children to express their worries. It has been written by: Julie Ribaudo, Paige Safyer, Sara Stein and Kate Rosenblum. Illustrated by Maija Rosenblum-Muzik. It is generously made free and available for download at: https://tenderpressbooks.com/ . Also available for download at: https://zerotothrive.org/covid-19/

More COVID-19 related #IMH resources at https://waimh.org/page/COVID19

"'What support would you find helpful? 'The relationship between treatment expectations, therapeutic engagement, and clinical outcomes in parent–infant psychotherapy": An overview of a recently published paper in the IMHJ

Introduction

By Maree Foley, Switzerland (Editor Perspectives in Infant Mental Health) and Holly Brophy-Herb USA (Editor IMHJ)

The Infant Mental Health Journal (IMHJ) with Perspectives in Infant Mental Health, have teamed up to feature IMHJ articles that especially draw attention to themes in practice with very young children/families. The aim of this new column is two-fold: to draw the attention of the Perspectives readership to new IMHJ papers; and to collaborate together to disseminate infant mental health content to the field. To this end, the IMHJ editor selects published papers and then invites authors to consider if they would be like to be part of this initiative.

The first paper to be featured in this ongoing series is by Rachel Ransley, Michelle Sleed, Tess Baradon and Peter Fonagy (UK): "'What support would you find helpful?' The relationship between treatment expectations, therapeutic engagement, and clinical outcomes in parent–infant psychotherapy". We would very much like to thank each of these authors for engaging with us in this initiative and for preparing this overview of their paper.

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By Rachel Ransley, Michelle Sleed, Tess Baradon and Peter Fonagy, UK

Key question/s:

What are the associations between pretreatment expectations and clinical outcomes and engagement in Parent-Infant Psychotherapy?

Overview of Methods:

Sixty-one mothers of infants participated in interviews about their treatment expectations as well as interviews to assess reflective functioning prior to the start of treatment. Mothers also completed questionnaires assessing parenting stress, depressive symptoms, and sense of mastery prior to treatment, after treatment, and again at a 12-month follow up. A mixed methodology was used to examine participants' expectations through transformation content analysis of pretreatment interviews; recurring themes were classified and quantified. Further statistical analyses explored relationships between the quantified themes of parental expectations, clinical outcomes, and engagement in treatment.

Summary of key findings:

How are parents' expectations about parent-infant psychotherapy (PIP) related to outcomes? Researchers asked parents to describe their expectations about participating in parent-infant psychotherapy. No significant independent correlation was found between expectations and engagement. Yet, one of the six clinical outcomes significantly correlated with parental expectations. Those parents whose expectations centered on improving relationships with their infants through treatment, and who expressed concerns about discussing past experiences, had improved reflective functioning after treatment. These results indicate that PIP may be more effective for some mothers than others and that assessing future clients' expectations before beginning PIP may be beneficial.

Implications for families/ practitioners/ further research:

Participants who held the expectation that treatment would improve their relationship with their infant and who also expressed their concern about speaking about past experiences were more likely to have improved RF after the intervention. This finding offers a new insight into the efficacy of PIP, particularly as the variables uniquely predict improved RF as well as improvements together within a regression model. Although no association was found between expectations and engagement within this study, half of the participants did prematurely drop out of treatment in the eyes of the therapist. Therefore, one must consider the individual perspectives that each parent holds and how this will impact engagement. By ensuring that clinicians explore the potential barriers to treatment or misguided expectations that a client may hold, they will be able to help the client be prepared for PIP. This research highlights the importance of clinicians having specific conversations with clients before they begin PIP. A specific pre-treatment interview/questionnaire could potentially help the clinician become more aware of potential barriers or highlight if the client holds expectations of treatment that are indicative of clinical change. In particular, it could explore clients' views about discussing their past experiences and desires to improve the relationship with their infant, which as the findings from this study suggest, are often indicative of improvements in RF.

IMHJ link to the article: https://onlinelibrary.wiley.com/doi/10.1002/imhj.21787

Full paper citation (in APA):

Ransley, R., Sleed, M., Baradon, T., & Fonagy, P. (2019). "What support would you find helpful?" The relationship between treatment expectations, therapeutic engagement, and clinical outcomes in parent–infant psychotherapy. *Infant Mental Health Journal,* 40(4), 557-572.

Infant and Early Childhood Mental Health in the Context of the COVID-19 Pandemic

By Holly Brophy-Herb, Michigan, USA

The COVID-19 pandemic has resulted in dramatic, rapid changes to the provision of infant/early childhood mental health services, loss of concrete and psychological resources for families, and disruptions to parenting and family relationships. Given the unprecedented nature of the pandemic, little is known about the lived experiences at this time and the impacts of the virus on the mental health of infants, young children, their families, and the professionals who serve them.

In response to this unique challenge, the *Infant Mental Health Journal (IMHJ)* and *Perspectives in Infant Mental Health*, are seeking contributions to three platforms to meet shorter term and longer term needs for dissemination of research. *IMHJ*, the official journal of the World Association for Infant Mental Health (WAIMH), is a peer reviewed, scholarly journal published by Wiley. Perspectives in Infant Mental Health is the professional, open-source publication of WAIMH. General topics of interest for these publication venues include:

- Virtual delivery of infant and early childhood mental health services
- Supporting practitioners' mental health
- Effects of the pandemic (e.g., loss of resources, isolation, racial discrimination, etc.) on:
    - Parental mental health
    - Parent-child relationships
    - Pregnancy, birthing experiences, and/or neonatal experiences
    - Family relationships
    - Infant, toddler, or early childhood social-emotional health

Dissemination Platforms

1. The Voices of COVID-19 special issue in ***WAIMH Perspectives*** will feature case studies and qualitative studies that capture the voices and lived experiences of infants, young children, families, and practitioners. ***The goals of this platform are to describe individuals' and families' experiences, impacts on practices, and other effects of the pandemic and to make information immediately available that may inform future, empirical COVID-19 infant and early childhood mental health research.*** Journal editors will provide peer review for these submissions in an abbreviated review process. Submissions should be 1,000-3,000 words, inclusive of text and references. Although no specific format style is required at the time of submission, use headings/subheadings to organize report content. Submit manuscripts to Maree Foley at maree.foley@xtra.co.nz between July 1, 2020 and October 1, 2020 with the online issue available by December 2020.

2. We are calling for proposals for a **special section** (generally 3-5 papers and a brief introduction) in the ***Infant Mental Health Journal*** on completed COVID-19 infant and early childhood mental health research. ***The goal of the special section is to contribute to an early literature base that can inform and support additional research.*** Innovative, well-implemented pilot studies may be included. Proposals should include a brief description (~ 250 words) description of the COVID-19 related them of the papers, working titles and an abbreviated abstract (~250 words) for each included paper. Proposals are due by December 1, 2020. Invitations will be issued by January 15, 2021. Manuscripts are due by May 1, 2021 with expected publication in Fall 2021, following a streamlined peer review. Submit proposals to Holly Brophy-Herb, hbrophy@msu.edu.

3. We will also be issuing a call for manuscript submissions to a **full special *Infant Mental Health Journal*** issue on 'Infant and Early Childhood Mental Health in the Context of the COVID-19 Pandemic'. **The special issue will be devoted to rigorous research investigating some of the topics described previously focusing on the prenatal-age 5 developmental period, including how the infant and early childhood mental health field can respond most efficiently and effectively in the face of crisis in the future.** Dates and additional information will be forthcoming later in the year.

Inquiries, including questions about appropriate topics, for any of the three platforms may be sent to Holly Brophy-Herb, hbrophy@msu.edu, Jane Barlow, jane.barlow@spi.ox.ac.uk, or Maree Foley, maree.foley@xtra.co.nz

Celebrating Hiram Fitzgerald: Forty years with Infant Mental Health

This column marks the retirement of Hiram Fitzgerald from his many editorial roles of this WAIMH publication. He was the inaugural WAIMH Executive Director in 1993 when *The Signal* was first published with Charles Zeanah as Editor-in Chief and since that time has been actively engaged with the publication including the roles of copy editor and associate editor of *Perspectives in Infant Mental Health*. Of special note and acknowledgement is Dee Končar, Hi's wife who has also contributed as a production editor of *The Signal* in the 1990's. In honour of Hi's longstanding contribution to this publication since 1993, we invited Hi to write a paper as he reflected back over the past years. The title of his paper is: *Forty Years with Infant Mental Health: Some Reflections for the Future*. Hi's paper is followed by some brief commentaries and in turn these commentaries are followed by a selection of tributes to Hi. These tributes are from a selection of colleagues and friends within WAIMH that offer a glimpse into Hi's immense outreach and support to many people in our field.

Forty Years with Infant Mental Health: Some Reflections for the Future

By Hiram E. Fitzgerald, PhD

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Forty-one years ago, Thomas Taflan-Barrett, a clinical psychology graduate student at Michigan State University, asked me to seek a position on the Michigan Association for Infant Mental Health (MI-AIMH) Board of Directors. I followed his advice and much to my surprise, I was elected. During my first year on the MI-AIMH Board (1979) two decisions launched my connection with infant mental health; a connection that has lasted 42 years (and still counting!).

The first Board decision was to establish the International Association for Infant Mental Health (IAIMH)(see Fitzgerald, 1985; Fitzgerald & Barton, 2000), and the second was to establish the Infant Mental Health Journal as its official publication. Eventually IAIMH merged with the World Association for Infant Psychiatry and Allied Disciplines (WAIPAD), creating in 1992, the World Association for Infant Mental Health (WAIMH) (Fitzgerald & Barton, 2000). Affiliate Associations linked to IAIMH transferred to WAIMH and the new organization was off and running. Sixteen years later, WAIMH's central office moved from Michigan State University to the University of Tampere, Finland where it has continued to flourish.

The second decision created the *Infant Mental Health Journal*, with Jack Stack as its founding editor. Problems with the initial publishing house led to the Michigan Association for Infant Mental Health acquiring copyright of the journal (see Fitzgerald & Barton, 2000). Over the years, special issues of the *Infant Mental Health Journal* have drawn attention to substantive issues affecting the development of infants and very young children, including fathers and infants (Fitzgerald & McGreal, 1981; Fitzgerald, Mann & Barrett, 1999; Bocknek, Hosssain & Roggman, 2014), infant and parent depression (Fitzgerald & Field, 1998), early exposure to alcohol and other drugs (Fitzgerald & Olson, 2001), culture and infancy (Tomlinson, Swartz & Fitzgerald, 2006; Fitzgerald, Mann, Cabrera, Sarche & Qin, 2009), the impact of Early Head Start, a USA national intervention targeting families with infants and toddlers (Fitzgerald, Love, Raikes & Robinson, 2005), and infants in foster and kinship care (Clyman & Harden, 2002).

The special issue that especially influenced me was the one honoring the career of Louis Sander (Hoffmann, 2000), in which he made reference to 'the diversity of disciplines that are emerging as the crossroads of infant mental health including biology, neuroscience, physics, genetics, obstetrics, neonatology, pediatrics, psychology, psychiatry, sociology, anthropology, linguistics, et cetera" (Sandor, 2000, p. 5). This multidisciplinary view of infant development was buttressed by Sander's call to view early development from a nonlinear dynamical system framework and understand "change in the individual as part of a larger systems process of change" (p. 5). He also challenged infant mental health researchers and practitioners to seek longitudinal evidence for the dynamic processes of early development, attending to the transitional phases of development and life-course experiences. In effect, Sander was advocating assessing

the relative impact of proximal processes relative to distal processes over the life course. In this regard, he was calling for more person-oriented analyses of development rather than variable-oriented analyses, to gain greater insight into how individuals change (or not) over time, and how such change becomes embedded or nested within increasingly complex systems over time, including the range of neurobiological networks and epigenetic changes organized by experience and synergistically organizing experience (Sameroff, 1983: Emde & Sameroff, 1989).

As infant mental health celebrates its 43rd birthday, the question Sander raised seems as relevant today as it was then: "Where are we going in the field of infant mental health" (p. 5). I believe a good starting point for a broad answer to Sander's question is to expand on his call for more systemic views of early development, and link it to three component areas where I believe infant mental health research and practice can uniquely contribute to a deeper understanding of developmental processes during the early years of life, particularly with respect to the interplay among genetics, epigenetics and lived experiences (Champagne, 2014).

Infants and Families as Dynamic Systems

Loukas and colleagues (1998) described the family "as a unity of interacting personalities," all of which are influenced by the codes, rituals, stories, roles (Sameroff, 1995) brought to the family by parents, grandparents, kinfolk, friends and neighbors and others. Individuals and families develop, organize, and change over the life course. Some experience positive and productive family relationships, some experience difficulties and fail, others find ways to overcome difficulties, build resilience and succeed over time. In every instance, family relationships develop and change over time due to a wide range of endogenous and exogenous influences. New members come into the family system in the form of grandparents, step-parents, foster-parents, uncles, in-laws, non-biologically related kinfolk (e.g., godparents, deep-relationship friends), teachers, peers, religious leaders, neighbors, barbers and hairdresser, and coaches, and all contribute to the individual's relationship experiences and are evaluated and internalized in relation to the individual's emerging sense of self.

For the past two decades I have become increasingly concerned about infant mental health's emphasis on the importance of dyadic and at the most, triadic interactions in early development. Although there are 3 sets of dyadic relationships in a family with two parents and one child, Emde (1991) pointed out that there are 45 dyadic relationships in a two-parent family with 3 children. Imagine a study of social-emotional relationships with 45 dyads per family with a study sample of 100 such families; complex systems indeed! Although many researchers give lip service to systems theory, it is not reflected well in the majority of research published, for example, in the *Infant Mental Health Journal*. A notable exception is Beebe et al's (2016) use of dynamic systems organizing concepts to examine, microanalytically, the organizational processes regulating the emergence of self and interactive-contingencies during dyadic face-to-face mother-infant interactions.

The fact is that we know little about the actual daily lived-experiences of infants and there is either little interest in naturalistic studies of infants and their families, or investigators of such work do not view the IMHJ as an appropriate outlet for such research. For example, during my first tenure as editor of the IMHJ, a paper was submitted dealing with the natural mother-infant separation experiences that occurred during early infancy, using a short-term longitudinal design. Reviewers did not respond positively, with most raising issues linked to extant attachment theory and coding of relationship dynamics within the traditional strange situation attachment methodology. At the time, I could not recall any published study that actually examined how often mothers and infants experienced separations during daily occurrences in lived experience, but I did remember Rheingold and Eckerman's (1970) paper that drew attention to the infants separating from mothers, and the work of Shaffran and DeCarie, (1973) and Soloman-Shaffran and Decarie (1976) that illustrated continuities and discontinuities in infants' responses to strangers during home visits over time, as well as gender differences in infants' responses to strangers during home visits. So, I accepted the paper and to this day, I think it continues to be the only published longitudinal study of naturally occurring daily separations of mothers and infants. Check it out! (Suwalsky, Klein, Zaslow, Rabinovich, & Gist, 1987). The point is, that we tend to exclude the natural world of the infant when we conduct highly constrained cross-sectional studies of what Overton (2015) might refer to as "moments", rather than processes that change (or not) over time. Or, to the dynamic daily events that bring the infant and young child into interactions with others in countless "strange situations" or result in naturally occurring separations from their mothers. Rheingold (1969) not only reminded developmental researchers that the infant is a social being, but also that infants do separate from their mothers (Rheingold & Eckermen, 1970). Why do developmental scientists need such reminders? We need ethological studies to understand infant development as it occurs in more normative or everyday contexts, and, perhaps to ask different questions about adaptations that occur over the life course and the lived experiences that play an explanatory role in shifting individuals to different pathways of development over time.

A different issue that needs to be addressed concerns the researcher's view of what is normative family development. A great many babies are not reared by their parents or are only partially reared by their parents. I think most researchers in the Western world are biased by views that normative development requires parenting practices that stress individualism and the emergence of autonomy as the dominant goals of parenting. Little attention is given to cultures where communal values are the norm and the individual represents a socially constructed being who is always embedded within community (Shwalb, Shwalb & Lamb, 2013). How many assessment tools do we have that are based on such cultural values, in contrast to values that place individualism and autonomy as the gold standards for guiding human relationships and "normative" development (Dauphinais & King, 1992).

So we need to understand parenting better as well and understand within a systems framework, because parents change, so parenting a sixth child is different than parenting a first one, not just because there are six children, but because the dynamics of the family system have changed substantively (Emde, 1991). Marc Bornstein (2010) has made significant contributions to issues related to understanding parenting, especially cross-culturally, and about early child development, and Michael Lamb has led the way on identifying fatherhood in many cultures of the world (Lamb, 1987; Shwalb et al., 2013), and Harkness and Super (1996) exposed similarities and differences in parents cultural beliefs. We need longitudinal studies of families in order to understand life course-pathways other than those characteristic of children raised in families selected because of existing psychopathology (Zucker, Fitzgerald & Moses, 1995; Eiden & Leonard, 2000), low-income and family resources (Shaw, Keenan & Vondra, 1994), at high risk for the development of violence (Nagin &

Tremblay, 1999), or linked to a particular relationship issue in infancy (Sroufe, 2005).

Fathers and Family Systems

Fathers are part of the infant's everyday life experience through direct and indirect effects on family functioning, spousal relationships (including co-parenting), and child relationships (including similarities and differences between relationships with sons and daughters). The *IMHJ* drew attention to fathers and infancy during its second year of publication (Fitzgerald & McGreal, 1981) and subsequently (Fitzgerald, Mann & Barrett, 1999; Bocknek, Hossain & Roggman, 2014). During the 1970s and 1980s researchers focused on studies related to paternal performance. Are fathers capable of providing primary care to infants, such as changing diapers, feeding and bathing them? Relatively few early studies were focused on identifying what unique contributions fathers make to infant and child development. There now is considerable evidence that fathers contribute to early childhood development in ways other than supplying sperm, although contemporary research suggests that pre-conception paternal sperm may in fact cause epigenetic effects affecting the fetus in ways previously attributed to the mother (Day, Savani, Krempley, Nguyen, & Kitlinska, 2016; Finegersh & Homanics, 2014). Infants do develop attachment relationships with their fathers, but evidence suggests that infant-father attachment may be qualitatively different than infant-mother attachment, especially with respect to child gender differences. Lamb (1977) was among the first to note that the quality of attachment may be different for fathers and sons compared to fathers and daughters, and for mothers and daughters compared mothers and sons. Paquette's (2004) activation relationship, which draws on Bowlby's exploration facet of attachment (1973) captures these differences with respect to fathers and sons. The activation relationship encourages exploration and risk taking and often is expressed through father's rough and tumble play (Flanders et al., 2010) and stronger involvement with his children to assist development of skills needed to be effective in dealing with the physical and social world, rather than the inner world of emotion regulation (Yogman, 2000).

Investigators such as Lamb (1976), Park and Sawin (1976) and Pederson and Robson (1969) among others, pushed a research agenda that has resulted in a substantial literature related to fathers' influence on child development, including ghosts from their past that may affect their parenting behavior (Barrows, 2004), just as ghosts affect maternal parent-child relationships (Fraiberg, Adelson & Shapiro, 1975). In addition, attention has been given to the early formation of ghosts, at least within the context of very young boys reared in families with high paternal psychopathology and family conflict (Fitzgerald, Wong & Zucker, 2013).

In addition to their overall influence on child development (Cabrera & Tamis-LeMonda, 2014), why fathers matter has been brought to light especially with respect to the development of boys. Boys have disproportionately higher rates of mortality and morbidity throughout the life span (Bale & Epperson, 2015). If one considers the full range of behavior regulation, cognitive performance and social-emotional behavior, boys have higher risk for behavioral dysregulation (Eme, 2007; Golding & Fitzgerald, 2017) and psychopathology (Hartung & Lefler, 2019) than do girls. While research has rightly drawn attention to the negative correlates of father absence, the effects of father presence also need to be examined particularly with respect to their influence on the balance of children's exposure to risk and resilience factors during early development. In particular, the father-son relationship needs be examined more deeply with respect to the males' disproportionate risk for aggression, antisocial behavior, and violence at all age levels (Golding & Fitzgerald, 2019; Schore, 2017).

Equally important, considerable attention needs to be directed to the positive ways that fathers contribute to children's development. Research in infant mental health tends to focus on the outcomes of negative lived experiences, rather than on resilience building positive parenting practices. Every person's life-course consists of maintaining a space and time on the risk-resilience continuum (Fitzgerald, 2010; Fitzgerald & Puttler, 2018). Research during infancy and early childhood disproportionately focuses on risk rather than resilience, especially with respect to fathers' contributions to resilience (Tyano, Keren, Herrman & Cox, 2010; Hays-Grudo & Morris, 2020). Masten & Barnes (2018) define resilience as "the capacity of a system to adapt successfully to challenges that threaten the function, survival, or future development of the system (p. 99). Their short list of resilience factors include, but are not limited to: caring family, close relationships, skilled parenting, agency, problems solving and self-regulatory skills, self-efficacy, optimism, meaning-making, routines, and well-functioning schools and communities. Too often fathers are not included in such studies of resilience, especially with respect development of infants and very young children, or their inclusion is described indirectly through maternal report.

We also need to understand and respect indigenous knowledge and indigenous cultures to assess how such knowledge and practices provide resilience in ways not well understood by investigators trained and committed to WEIRD (Western, Educated, Industrialized, Rich and Democratic) science (Henrich, Heine & Norenzayan, 2010) and its underlying world views. The United Nations estimates that there are 370 million Indigenous Peoples in over 90 countries. What do we know about the early life experiences of their very young children? We need to examine our theoretical assumptions, our measurement tools, and our implicit biases and we need to practice more participatory action research when engaging in studies of Indigenous Peoples (Sarche & Whitesell, 2012; Lewis, 2019; Wilson, 2008). Culture matters! (Atran, Medin & Ross, 2005; Fitzgerald, Mann, Cabrera, Sarche & Qin, 2010; Tomlinson et al., 2006). Racism and income disparities matter! (Ciciolla, Armans, Addante & Huffer, 2019). For example, after a home visit is completed and the visitor leaves, the family still lives in poverty, the same caregiver is still in the same neighborhood and still attends the same preschool or family home care, and still deals with racist policies and practices. So one either has to have the most powerful intervention ever devised to transform everything--we know that doesn't happen-- or one needs to understand the dynamics of family or environmental/cultural resilience that enable families to adapt in order to endure and succeed in everyday life and focus on building resilience while dramatically reducing risk.

Policy and Advocacy

Dye (1987) defined policy within the context of government actions or inactions, rarely implemented or negated by an individual. Rather, policy making requires many actors to collaborate to propose legislative policy and to enact it, nearly always with some degree of opposition. John (1998) described policy making "as a dynamic, complex, and interactive system through which public problems are identified, legislated and countered by creating new public policy or by reforming existing public policy" (p.2). Transitions in human development occur inter-generationally as well as ontogenetically over the life course. In their advocacy for a dynamic systems approach to policy, Yoshikawa and Hsuch (2001) suggest that, "research that tracks across multiple sectors may begin to suggest productively directions for the

integration of public policies aimed directly at enhancing children's development" (p. 1899).

What does that mean for WAIMH regarding policy positions with respect to infants, very young children and their parents and other caregivers? WAIMH has always been policy shy, reluctant to express its position in relation to world events that endanger families with very young children. However, in 2008 the WAIMH Board of Directors proposed the development of a Declaration of Rights for Infants and Young Children to be ready in time for the 30th anniversary of the United Nations' Convention on the Rights of the Child in 2019. The WAIMH Position Paper on the Rights of Infants was published (WAIMH, 2016), followed one year later by the seminal paper in the *Infant Mental Health Journal* on the worldwide burden of infant mental and emotional disorders (Lyons-Ruth et al., 2017). Each of these documents were intended to provide coherence for the extraordinary variations among countries with respect to issues promoting healthy social-emotional development during the earliest years of development. WAIMH's Rights of Infants contained 7 Basic Principles, and 10 Social and Health Policy Areas as well as endorsement of the UN Convention. Two of the Social and Health Policy Areas specifically reference mothers, fathers, and caregivers within the contexts of facilitating emotional support and parental leave for caregivers (Policy Areas 4 and 7). Lyons-Ruth and colleagues advanced four imperative priorities in relation to enhancing the mental health for infants and very young children (p. 5):

1. Priority on global education regarding the signs of disorder in infancy and toddlerhood.
2. Priority on enhancing the availability of treatment for infants and their caregivers.
3. Priority on developing reliable information regarding infant and toddler mental health in developing and war-torn countries.
4. Priority on enhancing family systems approaches to the study of infancy and early childhood, including studies of the resilience generating influence of fathers.

For me, these documents imply that WAIMH has a clinical, scientific, and moral responsibility for promoting the optimal development of the worlds' very young children and the adults who care for them. To my knowledge, however, WAIMH has not disseminated the Perspectives Rights of Infants to government officials in any country.

Moreover, WAIMH has recently begun to engage in a communication plan. To date, two papers have been published. The first, WAIMH position paper on Infant's rights in wartime (Keren, Abdallah & Tyano, 2019). This paper was published in the *Infant Mental Health Journal*. Second, is a paper published in *Perspectives*, Diversity and the positive impact of culture and supporting families in context – A view from Africa (Berg, 2020). While these papers are a start, many areas remain to be addressed. For example, why has WAIMH not commissioned an article on infant and toddler mental health in developing and war-torn countries? What is the status of global education about signs of disorder in infancy and toddlerhood? Where is WAIMH's position paper with respect to parental leave? The questions are nearly inexhaustible. Where are policy briefs that draw attention to resilience building interventions available to policy makers? As Cabrera noted (2013, p. 14), "intervention science based only on findings of adversity and maladjustment can perpetuate a deficit perspective and promote harmful stereotypes that associate deficits of a select group with an entire group of people."

Writing in the context of policy changes needed to counter racism and discrimination, McKinney et al. (2017) suggest that there is a need for "studies at the exo- and macrosystem levels (Bronfenbrenner, where structural policies embedded in economic and racial inequities contribute to risk." I suggest that similar studies are needed to impress policy makers about broader issues concerning early development than are provided by studies of parent-infant dyads. *Perspectives in Infant Mental Health* would be an appropriate publication for articles related to policy implications of the scientific and clinical studies published in the *Infant Mental Health Journal* and other scientific journals that rarely, if ever, cross the desk of policy makers. The special issue on infants in foster and kinship care (Clyman & Harden, 2002) provides an excellent case in point about translating science to practice/policy. Eight articles address critical issues related to infants being reared in non-parental settings. A concise summary article drawing attention to policy issues in relation to the wealth of information contained in the special issue about non-parental care settings could have ended the special issue, and also disseminated as a policy brief by WAIMH as one of the official sponsors of the Journal. More recently, the *Infant Mental Health Journal's* "Special notice on the COVID-19 crisis" is a step in the right direction because it references a number of publications where readers can find detailed information about the impacts of COVID-19 other than prevalence and death rates.

Despite the publication of the Rights of Infants and 50 years of intensive research focused on infancy and early childhood, Weatherston and Fitzgerald (2018, p. 17) note four key public policy area that continue to challenge optimal development for infants and very young children:

1. Chronic underinvestment in infancy and early childhood.
2. Fragmented efforts to implement or sustain services for children 0-3 especially services supporting social and emotional health and infant mental health.
3. Persistent child and family poverty, increasing the burden of vulnerability infancy and early childhood and stress in early parenthood.
4. The resurgence of racism and discrimination linked to increased migration of human populations throughout the world.

Summary and Key Points

The origins of the interdisciplinary field of infant mental health can be traced to numerous strands of inquiry that emerged during the early part of the 20th century. Its emergence as an organized professional field of clinical science, however, is more recent. I have been studying infants for 54 years, and for 39 of those years was either a member of the board of directors, president, or executive director of professional societies (Michigan Association for Infant Mental Health, International Association for Infant Mental Health, World Association for Infant Mental Health) working collaboratively with clinicians, scientists, and practitioners with extraordinary commitment to understanding the world of infants, very young children and their parents in efforts to truly optimize the quality of relationships that we know lead to productive life-course pathways. The breadth and depth of knowledge that now exists related to the early years of human development arguably is more extensive than any other age period.

Yet, because nature, built environments, human social and political institutions and the environment itself are dynamic, open systems, clinical science and public policy must also be dynamic continually studying the factors that impact infants and

young children and the individuals who provide for their care and development throughout and across the life cycle.

In this essay I drew attention to systems theory, fathers, and social policy, three areas of research and practice that, if intensified, will move infant mental health specialists ever closer to the desired common goal of truly enhancing the optimal development of infants and families throughout our species. Specifically, I believe that the interdisciplinary field of infant mental health must attend to at least the six needs noted below:

- We need more research about infants within the family and larger systems within which they live from an inter-dependent experience perspective.
- We need more person-oriented longitudinal studies/analyses to understand individual differences and the continuities and discontinuities that occur over the life course.
- We need more research about the impact of men/fathers on child development, especially within the first five years of life.
- We need more research focused on the balance between adversity and resilience that reflects the lived experiences that most humans have over the life course.
- We need to examine the impact of cultural context in all studies of human development, particularly with respect to indigenous peoples.
- We need to find ways to translate our science and convey its practical meaning to policy makers, program developments and the legal community.

References

Atran, S. Medin, D. L., & Ross, N. O (2005). The cultural mind: Environmental decision making and cultural modeling within and across populations. *Psychological Review,* 112, 744-776).

Bale, T. L., & Epperson, C. N. (2015). Sex differences and stress across the lifespan. *Nature and Neuroscienc*e, 18, 1413-1420.

Barrows, P. (2004). Fathers and families: Locating the ghost in the nursery. *Infant Mental Health Journal*, 225; 408-423.

Beebe, B., Messinger, D. S., Bahrick, L., Margolis, A., Buck, K., & Chen, H. (2016). A systems view of mother-infant face-to-face communication. *Developmental Psychology*, 52(2), 556-581.

Berg, A. (2020). Diversity and the positive impact of culture and supporting families in context – A view from Africa. *Perspectives in Infant Mental Health*, Vol 28 (1) Spring-Summer.

Bocknek, E. L., Hossain, Z., & Roggman, L. (Eds) (2014). Special Issue: Very young children and their fathers. *Infant Mental Health Journal*, 35, 389-526.

Bornstein, M. H. (Ed.). (2010). *Handbook of cultural developmental science*. New York, NY: Psychology Press/Taylor & Frances.

Bowlby, J. (1973). *Attachment and loss: Vol. 2: Separation*. New York: Basic Books.

Bretherton, I. (2010). Fathers in attachment theory and research: A review. *Early Child Development and Care*, 180, 9-23.

Champagne, F. A. (2014). Early adversity and developmental outcomes: Interaction between genetics, epigenetics and social experiences across the life span. *Perspectives on Psychological Science*, 5, 564-574.

Ciciolla, L., Armans, M., Addante, S., & Huffer, A. (2019). Racial disparities in pregnancy and birth outcomes. In In H. E. Fitzgerald, D. J .Johnson, D. B. Qin, F. A. Villarruel, & J.Norder (Eds). *Handbook of children and prejudice*. (pp 67-98). Cham, Switzerland: Springer Nature.

Day, J., Savani, S., Krempley, B. D., Nguyen, M., & Kitlinska, J. B. (2016). Influence of paternal preconception exposures on their offspring: through epigenetics to phenotype. *American Journal of Stem Cells*, 5, 11-18.

Daupinais, P., & King, J. (1992). Psychological assessment with American Indian children. Applied & Preventive Psychology, 1, 97-110.

Eme, R. F. (2007). Sex differences in child-onset, life-course-persistent conduct disorder: A review of biological influences. *Clinical Psychology Review*, 27, 6-7-627.

Emde, R. N. (1991). The wonder of our complex enterprise: Steps enable by attachment and the effect of relationships on relationships. *Infant Mental Health Journal*, 12, 164-173.

Emde, R. N., & Sameroff, A. J. (1989). Understanding early relationship disturbances. In A. J. Sameroff, & R. N. Emde. (Eds.). *Relationship disturbances in early childhood: A developmental approach*. New York: Basic Books.

Finegersh, A., & Homanics, G. E. (2014). Paternal alcohol exposure reduces alcohol drinking and increases behavioral sensitivity to alcohol selectivity in male offspring. *PloS ONE* 9:e99078

Fitzgerald, H. E. (1985). The Michigan Association for Infant Mental Health: Historical context and contemporary status. In B. Tableman & R. Hess (Eds). *Prevention: The Michigan experience* (pp 35-44). New York: The Haworth Press.

Fitzgerald, H. E. (2010). Birth to work: A community-driven framework for systems change. *The Engaged Scholar Magazine*, 5, 20-21.

Fitzgerald, H. E., & Barton, L. M. R. (2000). History of infant mental health: Origins and emergence of an interdisciplinary field. In J. D. Osofsky & H. E. Fitzgerald (Eds). *WAIMH Handbook of infant mental health (Vol. 4): Perspectives on infant mental health* (pps. 1-36). New York: Wiley.

Fitzgerald, H. E., Mann, T., Cabrera, N., Sarche, M., & Qin, D. (2010). Tidlig barndom og identitet I multikulturelle miljoer (Infancy and identity in multicultural context). In V. Moe, K. Slinning & M. B. Hansen (Eds). *Handbook of infant and toddler psychology* (pp. 269-282). Oslo Norway: Gyldendal Ademisk.

Fitzgerald, H. E., & Field, T. M. (1997). Special Issue: Depression. *Infant Mental Health Journal*, 18, 335-456.

Fitzgerald, H. E., Mann, T. L. Cabrera, N., Sarche, M., & Qin, D. B. (2009). Infants and toddlers in ethnoracial families. *Infant Mental Health Journal*, 30, 425-432.

Fitzgerald, H. E., Mann, T. L. & Barratt, M. (Eds) (1999). Special Issue: Fathers and infants. *Infant Mental Health Journal*, 20, 213-347.

Fitzgerald, H. E., & McGreal, C. E. (Eds) (1981). Special Issue: Fathers and infants. *Infant Mental Health Journal*, 2, 213-296.

Fitzgerald, H. E., & Puttler, L. I. (Eds) (2018). *Alcohol use disorders: A developmental science approach to etiology*. New York: Oxford University Press.

Fitzgerald, H. E., Wong, M. M., & Zucker, R. A. (2013). Early origins of alcohol use and abuse: Mental representations, relationships, and the challenge of assessing the risk-resilience continuum very early in the life of the child. In

N. E. Suchman, M. Pajulo, L. C. Mayes (Eds). *Parenting and substance abuse: Developmental approaches to intervention*. (pp 126-155). New York: NY: Oxford University Press.

Flanders, J. L., Simard, M., Paquette, D., Parent, S., Vitaro, F., Pihl, R. O., & Seguin, J. R. (2010). Rough-and-tumble play and the development of physical aggression and emotion regulation: A five-year follow-up study. *Journal of Family Violence*, 25, 357-367.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry*, 14, 387-421.

Golding, P., & Fitzgerald, H. E. (2017). The psychology of boys at risk: Indicators from 0-5. *Infant Mental Health Journal*, 38(1), 4-14.

Golding, P., & Fitzgerald, H. E. (2019). The biopsychosocial development of prenatal, infant, and toddler boys and the origins of violence in males. *Infant Mental Health Journal*, 40, 5-22.

Grossmann, K., Grossmann, K. E., Freemer-Bobik, E., Kindler, H., Scheuerer-Englisch, H., & Zimmermann, P. (2002). The uniqueness of the child-father attachment relationship: Fathers' sensitive and challenging play as a pivotal variable in a 26-year longitudinal study. *Social Development*, 11, 307-331.

Harkness, S., & Super, C. M. (Eds). (1996). *Parents cultural belief systems: Their origins, expressions, and consequences*. New York, NY: Guilford Pressa.

Hartung, C. M., & Lefler, E. K. (2019). Sex and gender in psychopathology: DSM-5 and beyond. Psychological Bulletin, 145, 390-409.

Hays-Grudo, J., & Morris, A. S. (2020). *Adverse and protective childhood experiences: A developmental perspective*. Washington, DC: American Psychological Association.

Henrich, J., Heine, S. J.K., & Norenzayan, A. (2010). The weirdest people in the world. *Behavior and Brain Science*, 33 (2-3), 61-83.

John, P. (1998). *Analyzing public policy*. London, UK: Continuum Press.

Keren, M., Abdallah, G., & Tyano, S. (2019). WAIMH position paper Infant's rights in wartime. *Infant Mental Health Journal*, 40(6),763-767.

Lamb, M. E. (Ed). (1976). *The role of the father in child development*. New York: Wiley.

Lamb, M. E., (1977). The development of the mother-infant and father-infant attachments in the second year of life. *Developmental Psychology*, 13, 637-648.

Lamb, M. E. (1987). The father's role: Cross-cultural perspectives. Hillsdale, NJ: Lawrence Erlbaum Associates.

Laszlo, E. (1972). *Introduction to systems philosophy: Toward a new paradigm of contemporary thought*. New York: Harper and Row.

Lewis, M. L. (2019). The intergenerational transmission of protective parent responses to historical trauma. In H. E. Fitzgerald, D.J . Johnson, D. B. Qin, F. A. Villarruel, & J.Norder (Eds). *Handbook of children and prejudice*. (pp 43-66). Cham, Switzerland: Springer Nature.

Loukas, A., Twitchell, G. R., Piejak, L. A., Fitzgerald, H. E., & Zucker, R. A. (1998). The family as a unity of interacting personalities. In L. L'Abate (Ed). *Handbook of family psychopathology* (pps 35-59). New York: Guilford Publications.

Lyons-Ruth, K., Todd Manly, J., Von Klitzing, K., Tamminen, T., Emde, R., Fitzgerald, H. E. Paul, C., Keren, M. Berg, A., Foley, M., & Watanabe, H. (2017). The world-wide burden of infant mental health and emotional disorder report of the World Association for Infant Mental Health. *Infant Mental Health Journal*, 38, 695-7805.

Masten, A. S., & Barnes, A. J. (2018). Resilience in children: Developmental perspectives. *Children*, 5, 98-114.

McKinney, M., Fitzgerald, H. E., Winn, D-M., & Babcock, P. (2017). Public policy, child development research and boys at risk: Challenging, enduring, and necessary partnership. *Infant Mental Health Journal*, 38(1), 166-176.

Moffitt, T. E. (1993). Adolescence-limited and life-course-persistent antisocial behavior: A developmental taxonomy. *Psychological Review*, 100(4), 674-701

Nagin, D., & Tremblay, R. R. (1995). Trajectories of boys' physical aggression, opposition, and hyperactivity on the path to physically violent and nonviolent juvenile delinquency. *Child Development*, 70(5), 1181-1196.

Overton, W. F. (2015). Processes, relations, and relational-developmental systems. In W. F., Overton & P. C. M. Molenaar (Eds). *Handbook of chid psychology and developmental science. Vol 1: Theory and method*. (pp 9-62). New York: John Wiley.

Paquette, D. (2004). Theorizing the father-child relationship: Mechanisms and developmental outcomes. *Human Development*, 47(4), 193-219.

Pederson, F. A., & Robson, K.W. (1969). Father participation in infancy. *American Journal of Orthopsychiatry*. 39, 466-472.

Rheingold, H. L. (1969). The social and socializing infant. In D.A. Goslin (Ed.). *Handbook of socialization: Theory and researc*h (pp.777–790). Chicago: Rand McNally.

Rheingold, H. L. & Eckerman, C. O. (1970). The infant separates himself from the mother. *Science*, 168, 78-83.

Roggman, L., & Cabrera, N. J. (Eds). (2017). Special Issue: Playing with daddy: Implications for children's development. *Infant Mental Health Journal*, 38695-7943.

Sarche, M. C. & Whitesell, N. R. (2012). Child development research in North American native communities—Looking back and moving forward: Introduction. *Child Development Perspectives*, 6(1), 42-48.

Sameroff, A. J. (1983). Developmental systems: Contexts and evolution. In W. Kessen (eds). *Handbook of child psychology: 4th edition). Vol. 1. History, theory, and methods* (pp. 237-294). New York: Wiley.

Sameroff, A. J. (1995). General systems theories and developmental psychopathology. In D. Cicchetti & D. J. Cohen, (Eds). *Developmental psychopathology. Vol. 1: Theory and methods* (pp 659-695). New York: John Wiley & Sons, Inc.

Shaw, D., Keenan, K., & Vondra, J. I. (1994). Developmental precursors of externalizing behavior: Ages 1-3. *Developmental Psychology*, 30, 355-364.

Schore, A. N. (2017). All our son's: The developmental neurobiology and neuroendocrinology of boys at risk. *Infant Mental Health Journal*, 38, 15-52,

Schwalb, D. W., Shwalb, B. J. & Lamb, M. E. (Eds). (2013). *Fathers in cultural context*. New York: Routledge.

Shaffran, R., & Decarie, T. G. (1973, March-April). "Short-term stability of infants' responses to strangers." Paper presented at the Society for Research in Child Development, Philadelphia.

Shwallb, D. W., Shwalb, B. J., & Lamb, M. E. (Eds). (2013). *Fathers in cultural context*.

New York: Routledge.

Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment & Human Development*, 7, 349-367.

Solomon-Shaffran, R., & Decarie, T. G. (1976). A more natural approach for use in the evaluation of infants' stranger reactions. *Canadian Journal of Behavioural Science*, 8(1), 98-101.

Suwalsky, J. T. D., Klein, QR. P., Zaslow, M. J., Rabinovich, B. A., & Gist, N. F. (1987). Dimensions of naturally occurring mother-infant separations during the first year of life. *Infant Mental Health Journal*, 8, 1-18.

Tyano, S., Keren, M., Herrman, H., & Cox, J. (2010). *Parenthood and mental health: A bridge between infant and adult psychiatry*. Oxford, UK: Wiley-Blackwell.

Weatherston, D., & Fitzgerald, H. E. (2018). Public policy and infant mental health. *Perspectives in Infant Mental Health*, 27, 15-18.

Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Winnipeg, Manitoba: L Fernwood Press.

World Association for Infant Mental Health (2016). WAIMH position paper on the rights of infants. *Perspectives in Infant Mental Health*, 24 (1-2), 3-5.

Yogman, M. (1982) Development of the father-infant relationship. In H. E. Fitzgerald, B. M. Lester, & M. Yogman (Eds). *Theory and research in behavioral pediatrics. Vol. 1.* (pp. 221-272). New York: Plenum Press.

Yoshikawa, H. & Hsueh, J. (2001). Child development and social policy: Toward a dynamic systems perspective. *Child Development*, 72, 1878-1903.

Zucker, R. A., Fitzgerald, H. E., & Moses, H. (1995). Emergence of alcohol problems and the several alcoholisms: A developmental perspective on etiologic theory and life course trajectory. In D. Cicchetti & D. Cohen (Eds). *Manual of developmental psychopathology Vol 2. Risk disorder and adaptation* (pp 677-711). New York: Wiley.

Brief Commentary Forty Years with Infant Mental Health: Some Reflections for the Future. A lens from USA.

By Julie Ribaudo, Clinical Professor of Social Work, University of Michigan, Ann Arbor, Michigan, USA

Yes, yes, yes and yes. Reading Fitzgerald's (2020) paper left me nodding throughout. Yes, of course humans grow and change throughout their lifetime. Yes, indeed, my own father mattered tremendously. He metaphorically sat with me through many a session as I engaged with fathers interacting with their babies and young children, alert to the ways I might unwittingly impose my gendered expectation of parenting, all the while recalling the thrill of the games (e.g., "hide and go seek" in the dark) my father played with us that heightened our tolerance for anticipation and excitement.

Yes, culture matters tremendously. We don't know what we don't know until we know it. Culture shapes what we "know" and don't know. And yes, indeed, resilience is fostered through proximal and distal relationships. As Bretherton reminded us (1992), Bowlby once wrote, "Just as children are absolutely dependent on their parents for sustenance, so in all but the most primitive communities, are parents, especially their mothers, dependent on a greater society for economic provision. If a community values its children it must cherish their parents" (Bowlby, 1951, p. 84).

Early in my training I was taught to ask, "what would the baby say?" As I finished Fitzgerald's cogent analysis of what remains to be attended to in protecting infant mental health, I wondered what the baby would say. One plea might be: "teach the teachers." The comprehensive approach Fitzgerald outlines will require novel and creative ways of teaching, training and supervising practitioners, researchers, and policy makers. Many institutions of higher education have yet to develop true interdisciplinary education. Continuing to train in our siloed fashions will only further contribute to an emphasis on the very modalities of intervention and research that are limiting our capacity to move the field further. Research funding models that favor lab-based randomized controlled trials vs. community-based, "person-oriented longitudinal studies/ analyses" inhibit creative, cross-cultural, intensive understanding of the lived experience of babies and the families and communities that care for them. Only with paradigm shifts encouraged at the university level will we train the next generation of practitioners, researchers, and policymakers to think with the wisdom Fitzgerald so generously offers.

Reference

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, 28, 759-775.

Brief Commentary Forty Years with Infant Mental Health: Some Reflections for the Future. A lens from Australia.

By Professor Leonie Segal, Foundation Chair Health Economics and Social Policy, University of South Australia, Australia

In reading Hiram's paper there are many issues that I would like to comment on, and I hope to do so more comprehensively, at a later time. However, for now, I will comment on two issues that relate to areas in which I have a particular research interest: first nations peoples parenting style and the associated individualism vs communitarianism; and social determinants.

Considering the issue of first nations peoples parenting style and individualism vs communitarianism. It is of course true that there can be cultural differences in parenting practices. However, we now know much about what is harmful to children, based on decades of empirical and theoretical research. With a growing evidence-base in the last 15 years in particular around the toxic impact of child abuse and neglect for the developing brain [1,2] as well as relational patterning [3]. To argue that what we see in many first nations peoples is a matter of parenting style, and not concerning levels of neglect and abuse, would only make sense if the outcomes for these children were fine. But, if children are not safe [4] – and while accepting that dispossession, racism, intergenerational abuse and neglect, substance abuse are part of the story, this just defines the complexity. Children still require a nurturing environment to thrive and this has to drive policy. Excess hospitalisations, a dead child, a child with feotal alcohol spectrum disorder; these are real outcomes, they are not cultural constructs. And yes, a sense of community and a close identity with the group offers a valuable sense of belonging; but this does not preclude development of an individuated sense of self with agency as a legitimate goal of parenting. In the absence of a strong sense of self with a recognition of agency over one's own life, the role left is that of victim. A well-developed sense of self does not preclude a concern for the wider humanity and a strong group identity can protect the weak but can also create an 'us' and 'them' reinforced by conformity and censure. Let's ensure we are alert to the actual circumstances of the child, and not be prejudiced by the cultural context.

Second, the issue of social determinants. Certainly, working with families in the context of extreme poverty, homelessness, low education, high welfare dependency and similar attributes characterised as social determinants is challenging. But it is useful to think about the dynamic interaction between:

A history of child maltreatment and the associated profound distress (also coined toxic stress) [1] and associated disturbed brain development [2] and relational patterning [3] and

Consequences - such as, poor educational engagement and success, mental illness [5], addictions, criminal involvement, failed relationships, welfare dependency and poverty.

That is, social determinants are inextricably tied up with child maltreatment, in a bi-directional relationship [6]. But, repair of parent child relationships can occur, even in the context of deep poverty and this can be instrumental in helping the child create an alternate future – that is healing of the parent child relationship. Addressing child maltreatment can be a pathway out of poverty and homelessness and intergenerational cycles of child abuse [7] and disadvantage.

References

1. Shonkoff, J. P., Garner, A. S., Siegel, B. S., Dobbins, M. I., Earls, M. F., Garner A. S., et al. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, 129(1):e232-e46.
2. Child Welfare Information Gateway. *Issue Brief: Understanding the effects of maltreatment on brain development*. (2015). Washington, DC: U.S. Department of Health and Human Services, Children's Bureau [Available at: https://purl.fdlp.gov/GPO/gpo87623.
3. Amos, J., Furber, G. & Segal, L. (2011). 'Understanding maltreating mothers: a syntheses of relational trauma, attachment disorganization, structural dissociation of the personality and experiential avoidance', *Journal of Trauma and Dissociation,* 12(5):495-509, doi: 10.1080/15299732.2011.593259.
4. Productivity Commission. *Report on Government Services 2020*. Canberra: Productivity Commission; [Available at: https://www.pc.gov.au/research/ongoing/report-on-government-services/2020.
5. Fryers, T. & Brugha, T. (2013). Childhood determinants of adult psychiatric disorder. *Clinical Practice and Epidemiology in Mental Health*, 9:1.
6. Segal, L., Doidge, J. & Amos, J. (2011). 'Determining the determinants: Is child abuse and neglect the underlying cause of the socio-economic gradient in health?', Chapter 13 in *Determining the Future: A Fair Go and Health for All*, eds Laverty and Callaghan, Connor Court Publishing, Ballan, Victoria.
7. Amos, J. & Segal, L. (2018). 'Disrupting intergenerational maternal maltreatment in middle childhood: Therapeutic objectives and clinical translation', *Frontiers in Psychiatry*, 9:623, doi: 10.3389/fpsyt.2018.00623.

Brief Commentary. Forty Years with Infant Mental Health: Some Reflections for the Future. The need for longitudinal intervention cohorts. A lens from South Africa.

By *Professor Mark Tomlinson, Institute for Life Course Health Research, Department of Global Health, Stellenbosch University, Cape Town, South Africa; and School of Nursing and Midwifery, Queens University, Belfast, UK*

Hiram Fitzgerald has produced a lucid and broad ranging history of the research and clinical application of the research on infant mental health across four decades. There is much that is thought provoking in his sweep of infant mental health and I could comment on each and every point he makes. But I have restrained myself and chosen to focus on point 2 – *the need for more person-oriented longitudinal studies in order for us to better understand individual differences and the continuities and discontinuities across the life course*.

While I completely agree with each point that is made, I would like to suggest an added dimension to this. Because there is much still to be known about the continuities and discontinuities of development we also need to shift more of our time and resources to trying to fix what we know is going wrong and not only to describe it. I am therefore making a plea for more longitudinal intervention cohort studies [1]. Observational longitudinal studies, while key to better understanding dose, mechanism and as Fitzgerald states, continuities and discontinuities, they are limited in their ability to identify true causal effects and of course are limited in what they can tell us about changes based on a new intervention.

Another important reason for the need for longitudinal intervention cohort studies is to better understand how to prevent 'fade-out' of the impacts of early interventions [2]. Most of the evidence we have of the impact of early intervention only tells us that the intervention had an impact immediately post intervention or 12 months later. In terms of mechanisms we desperately need to know more about what we can do to sustain intervention effects across the life course.

References

1. Tomlinson, M., Fearon, P., Christodoulou, J. & Rotheram-Borus, M. J. (2020). Editorial Perspective: Stop describing and start fixing - the promise of longitudinal intervention cohorts. *J Child Psychol Psychiatry*. Epub 2020/02/23. doi: 10.1111/jcpp.13213. PubMed PMID: 32077089.
2. Bailey, D., Duncan, G. J., Odgers, C. L. & Yu, W. (2017). Persistence and fadeout in the impacts of child and adolescent interventions. *Journal of Research on Educational Effectiveness*;10(1):7-39.

Picture from the album of Hiram Fitzgerald. WAIMH Board members in Ahvenanmaa archipelago, Finland, in July 2007. First row from left: Rachel Schiffman, Tuula Tamminen. Second row from left: Elizabeth Tuters, Pälvi Kaukonen, Mark Tomlinson. Third row from left: Massimo Ammaniti, Neil Boris, Hiram Fitzgerald, Bob Emde, Kai von Klitzing, Peter de Chateau and Antoine Guedeney.

Brief Commentary Forty Years with Infant Mental Health: Some Reflections for the Future. A lens from USA

By Tova Walsh, Ph.D., M.S.W., Assistant Professor, School of Social Work, University of Wisconsin-Madison, Wisconsin, USA

Hi Fitzgerald has identified six critical directions for the infant mental health field to continue building on the advances of the past 40 years. One of these directions is to expand research on the impact of men/fathers on early child development. As Hi articulates so well, recent decades have seen an increase in attention to the ways that fathers contribute to children's lives, health, and development. Men's own physical and emotional health and wellbeing, as well as the nature of their involvement with their children and their children's other caregivers, are influential.

As someone who studies men's experiences across the transition to fatherhood, and interventions to support and strengthen early father-child relationships, I share Hi's recognition that the impact of fathers on early development is an important area for continued investigation and understanding. In particular, this research should include and address diverse family constellations, and we must prioritize the incorporation of our findings into practice.

It is a tenet of our field that the parental capacity to nurture an infant or young child is dependent on the extent to which the parent is supported and nurtured, and this is true regardless of the parent's gender or marital status. As we seek to learn more about the role and contribution of fathers, we must attend to the wide range of cultural and social norms for fathers and fathering, and structural barriers to involvement faced by vulnerable and marginalized fathers. And as our understanding of these realities grows, we must reflect and act to expand inclusion of fathers in our work with infants, young children and families in ways that respond to the needs and circumstances of diverse fathers and families.

Brief Commentary Forty Years with Infant Mental Health: Some Reflections for the Future. A lens from Sweden

By Catarina Furmark, clinical psychologist, PhD student Karolinska Institute Stockholm and former chair of the Nordic Association for Infant Mental Health

- How to find ways to translate our science and convey its practical meaning to policy makers, program developments and the legal community.

Hiram Fitzgerald provides an excellent summary of the interdisciplinary field of infant mental health whilst challenging us to reflect on the future. The article offers many "ports of entry" and I have chosen to comment on its very last point – the need to translate existing science and convey its practical meaning to politicians and policymakers.

Even though existing science on the rapid, sensitive, and relationship-dependent brain- and behavioral development of infants indeed is no longer new, there is still a lack of recognition of its significance. The actual concept of mental disorders in infancy is widely unrecognized, as Lyons-Ruth and colleagues point out (2017). Increased knowledge on the impact of mental ill health in infancy and how to promote infant mental wellbeing has still not been matched by increased funding, prioritizing or impact on social policy despite the importance of this knowledge, and "the costs, financial and social, of its failure to do so" (Leach, 2017).

One can easily feel defeated by efforts to change policy, only to experience policy makers reluctance or inability to change – despite their often good intentions. However, we now more than ever need policies that reflect the knowledge we have about how to promote parental and infant mental well-being, support sensitive parenting, increase resilience in families, reduce societal costs and reap the benefits to society when it acts accordingly. What we can do, is with ever renewed efforts, carry on. And, defeat does not automatically mean we have been unsuccessful (Jansson, 2007). When we make the effort to try and change policy, we can sensitize and educate people who may not have been aware of the issue of infant mental health. While this result may not be what we had initially hoped for, it may pave the way for later successes.

We must find the particular times, when the political and/or psychological climate is right for policy change. To be successful, we can adopt the strategy of the "eight P's" (Meredith & Dunham, 1999). We need to *plan* well, using a strategic planning process. We must *prepare,* including doing all the necessary research and becoming experts on existing policies. We need to cultivate *personal contacts* with policy makers, other change agents, and anyone else necessary. Not easy, as the turnover of staff means that the personal contact you had last year, is no longer working in that particular office. We need to take the *pulse* of the community, that is to find out what our families need, to know where to start in order to be successful. We do need a certain amount of *positivism,* framing policy changes and outcomes in a positive way. We need each other, we need *participation* of everyone affected by or concerned with the issue in planning and implementing policy change. We may use *publicity* for our effort in general and for our suggested policy changes in particular. We need to stay *persistent,* not to give up but to monitor and evaluate our actions and keep at it for as long as necessary.

Finding ways for changing policies are not always easy. They are time-consuming, they rarely seem to yield any tangible results, and any efforts need to be repeated over and over again. They can be draining. That is why we need our community. WAIMH as an organization, with its international scientific and clinical community, and its affiliates, has high credibility. There are efforts already as Hiram Fitzgerald mentions in his article; WAIMH's position paper on the rights of infants being one (WAIMH, 2016). This paper has been presented to the Swedish Board of Welfare and to the Department of Welfare in 2017 by members of the Nordic Affiliation. These efforts should continue and be ongoing. The members of WAIMH and affiliates are the appropriate leaders in campaigns for changes in policy. Keep calm and carry on!

References

Jansson, B. (2007). *Becoming an Effective Policy Advocate: From Policy Practice to Social Justice.* Thomson Higher Education. Belmont, CA.

Lyons-Ruth, K., Todd Manly, J., Von Klitzing, K., Tamminen, T., Emde, R., Fitzgerald, H. E. Paul, C., Keren, M., Berg, A., Foley, M., & Watanabe, H. (2017). The world-wide burden of infant mental health and emotional disorder report of the World Association for Infant Mental Health. *Infant Mental Health Journal*, 38, 695-7805.

Leach, P. (2017). *Transforming Infant Wellbeing: Research, Policy and Practice for the First 1001 Critical Days.* Routledge. London.

Meredith, C. J., & Dunham, M.C. (1999). Real Clout. Boston: The Access Project.

World Association for Infant Mental Health (2016). WAIMH position paper on the rights of infants. *Perspectives in Infant Mental Health*, 24 (1-2), 3-5.

Tribute Celebrating Hiram Fitzgerald: Forty years with Infant Mental: A lens from USA

By Joy Osofsky, Past President of WAIMH, Professor of Pediatrics, Psychiatry, and Public Health Head, Division of Pediatric Mental Health, Barbara Lemann Professorship of Child Welfare, New Orleans, USA

It is both an honor and a pleasure to share my thoughts about Hiram (Hi) Fitzgerald. Hi is not only a pioneer and major leader in the infant mental health field, but also, he is also a very special person. While we had known each other for many years, those who read this tribute may not know that my first major endeavor with Hi Fitzgerald was to collaborate to create the World Association for Infant Mental Health (WAIMH) which resulted from a merger of the World Association for Infant Psychiatry and Allied Disciplines with the International Association for Infant Mental Health. It was a wonderful collaboration where we both assumed leadership for the newly established organization with me as President and Hi as Executive Director. I very much enjoyed this period of time working and collaborating with Hi helping to build the field that is now widely recognized as Infant Mental Health because of his skill, finesse, great problem-solving ability and clear direction, all of which were important to move forward. While the work was hard with frequent challenges, it was an exciting joint adventure together with the international Board of Directors in broadening the perspective of WAIMH into a truly multidisciplinary international organization.

I am sure that those who know and have worked with Hi understand what a pleasure it is to be able to call him a close colleague, fine collaborator, and warm friend. I learned quickly that we share a similar style of working, that is, being available most of the time, responding quickly to correspondence, emails and phone calls, and believing that even very challenging situations coming from different cultural perspectives are solvable. In other words, Hi and I agree with the adage that if you need something to be done quickly and well, you should turn it over to a very busy and competent person. I will share a brief story related to my respect for Hi in problem solving that required an immediate and creative response. I was editor of the *Infant Mental Health Journal* at the time that Hurricane Katrina devastated New Orleans on August 29, 2005 with the breach of the levees. Fortunately, the IMHJ office then located with the editor just sent an issue to press in mid-August. In 2005, we still had paper files for the Journal, all of which were then sitting in our filing cabinets on the 3rd floor of my flooded and deserted office building in the flooded city. It was impossible to retrieve the files in New Orleans so Hi and I started to "problem-solve" and figure out how we could retrieve submissions, those that were under review, and start to digitize the journal. Somehow, with Hi's ingenuity, hard work, and again awesome collaboration, we accomplished that work before the next issue was due to go to press! How we did it would not have been possible without Hi's persistence and resourcefulness – and true collaboration!

I am confident that those of you who know Hi will agree that he is a very accomplished psychologist, academician, researcher, teacher, and administrator. While his many professional accomplishments are well respected, I have also very much admired his commitment to his family as a devoted husband, father and grandfather who has always been very involved with family life, taking much pride in his children and grandchildren, and sharing his love of family with others. I was extremely impressed and touched that as Hi decided to begin a new chapter in his life, his family established the Hiram E. Fitzgerald Engaged Scholar Endowment Fund to help students carry out work that "transforms the human experience." I am very fortunate to have Hi Fitzgerald as a wonderful collaborator and friend, and I join my WAIMH colleagues and friends in wishing him much satisfaction and pleasure in the next important phase of his life.

Tribute Celebrating Hiram Fitzgerald: Forty years with Infant Mental: A lens from Australia

By Rochelle Matacz (Clinical Psychologist, IMH Specialist (IMH-E®) and Lynn Priddis (Clinical and Counselling Psychologist), Perth, Australia

Hiram Fitzgerald,

Leaped into our lives with his larger than life presence at a time when our university was looking for overseas professors to build research capacity.

I had of course seen Hiram from afar at WAIMH congresses on panels with people whose names were all stars to us. Rochelle had spent time with Hiram in Ireland as he helped establish the Irish Affiliation of IMH and was a keynote speaker of Ireland's inaugural conference on IMH in 2006. When we considered who to bring out to Australia to help build a research profile in PIMH we sought advice from Debbie Weatherston who without hesitation, immediately recommended Hiram. We proceeded to set about investigating the university systems and processes required to support this if indeed it became a reality and not just a fantasy. Together Rochelle and I bravely sent an invitation to Hi to visit the university for three months and to do this for 2 consecutive years, since in Australia we have a plethora of people who fly in and fly out and leave little impact or

follow up. We were not sure what changes or developments would come from our time together with Hi but in true Hiram fashion he transformed our perspectives and the way we approach the field of IMH in so many ways we never imagined possible prior to his visit.

Hiram arrived with his wife Dee and from the beginning shook us out of our comfort zones. There were a few minor cultural issues to get our heads around such as Hiram's persistence in calling our beautiful red flowering red "Bottle Brush" bush the "Pipe Cleaner" tree. More significantly was his way of viewing the responsibilities that universities have to community and his systematic perspective to improving the lives of vulnerable infants, young children and their families. He guided and shaped our understanding of the significant role the entire system plays in supports families transitioning into parenthood.

Hiram questioned why our focus was on one small part of the system rather than a much broader, holistic perspective that would engage stakeholders across the continuum of care and hold the views and experiences of families at the centre of everything we do in the field. Initially, Rochelle and I talked with Hi about how he might support us to develop a research framework that captured the positive changes in families and the clinical significance of the PIMH intervention work carried out in the newly established university based Pregnancy to Parenthood clinic. We also considered that Hiram might help build awareness of IMH in other areas of the university such as Education and Nursing and Midwifery as well as our Psychology Department.

Well, Hi's first questions to us were "what is the point of evaluating one clinic that has an isolated impact?" How will that change anything across the system and impact more than the 50 families you treat each year? "What is the system of care your clinic sits within and how does it currently function?" What does your clinic offer in relation to improving the system that supports families with infants and young children? We were lost for words and didn't know how to respond to Hiram's direct questions as our perspective up until this point had been primarily focused on building an evidence base for the service we were providing families which we valued and felt pride in delivering within the community.

After we took a few breaths and reflected deeply about Hiram's provocative questions we began to understand the field of PIMH from a new broader perspective. The questions Hiram posed enabled us to develop clarity about what we needed to do and how to proceed which was different to what we had ever imagined. Our minds opened and our perspectives changed. We shifted our focus and commitment to developing a deep understanding of our system and all its complexities and how we might offer interventions that improve the functioning of the system and the family's experiences across the continuum of care. It didn't take long for us to wonder how we could have not taken this approach prior to Hiram's visit. We both feel that this experience exemplifies the impact of Hi's presence. He had the capacity to dramatically shift our perspective towards a direction that will provide a much larger impact on vulnerable families than our isolated service provision could ever offer.

With Hiram's guidance we developed a proposal, and to our surprise received a large grant to conduct a system analysis of the local PIMH system of Care. He has supported us at every stage of the process and with persistence we have now produced a report that has the potential to be so impactful on the wider PIMH system of care and be used as an exemplar for system evaluation and change at a state and federal level.

At all stages of this journey Hiram has generously provided us with his wisdom, expertise and knowledge. His input has transformed how we see ourselves and our capacity to make real and impactful long-term sustainable changes to the emotional lives of infants, young children and their families. It has given us renewed strength and courage to persist with these innovative ways of working from a systems-based approach that our Western Australian system has yet to fully understand. Hiram embodies 'relationship-based work' and has become one of our secure bases that is always available for support, advice, or guidance when things become tricky or overwhelming. He has an amazing capacity to ground us and help keep us focused when we are confronted with barriers or unexpected challenges.

Rochelle had the opportunity to visit Hiram and Dee in East Lansing last year and witness his local work. For the first time she was able to come to terms with the enormity of what Hiram has created at Michigan State University and how his impact stretches way beyond the field of infant mental health and beyond the USA all the way to the Perth, the third most isolated city in the world! We also know that his impact stretches to many other parts of the world.

Acknowledging Hiram also comes with recognition of a very important partner and influencer behind the scenes-known fondly by everyone as 'Dee'. During their time in Australia and Rochelle's visit to Michigan we were able to have many moments of fun together with Hiram and Dee. We shared laughs and got to see the less serious side of Hiram with time spent away from work and with more of a focus on good food and wine, always finishing the night with a night cap of Irish whiskey!!

Tribute Celebrating Hiram Fitzgerald: Forty years with Infant Mental: A lens from Finland

By Kaija Puura, WAIMH Executive Director, Tampere, Finland

In this issue of the Perspectives we celebrate our colleague and friend, Professor Hiram Fitzgerald. Hiram Fitzgerald – or Hi as many of us call him - has had a magnificent academic career and been a significant and central person in WAIMH over the years as one of its founders, as the WAIMH Board President, as the Executive Director, and now, as one of the Honorary Presidents.

I first met Hi in June 1995 when we were preparing for the WAIMH 1996 Tampere Congress and the Board of Directors of WAIMH came to Finland for its meeting and site visit. At that time, I was working as the secretary of the Local Organizing Committee, and in that role, I had the privilege of also meeting Hi's wife, Dolores Fitzgerald – or Dee as she was known, another important person working for WAIMH. I could hardly guess that 10 years later I would be working with Hi, helping to organize WAIMH World Congresses as the Associate Executive Director of WAIMH. Hi was great to work with; no question I asked was too stupid; no detail too small; and, he did not hesitate to give constructive feedback. I also remember having many evenings with lots of fun with Hi and Dee, either "talking shop" or just joking about funny happenings in our lives.

Hi had a wonderful way of helping younger colleagues like me to move forward with their careers. Ever since our first meeting, he recruited me to work as a reviewer, first for the WAIMH Congresses and then, once I had gotten my PhD, for the *Infant Mental Health Journal (IMHJ)*. In addition to that, Hi has generously offered me and many other younger colleagues opportunities to contribute to special *IMHJ* issues about infant mental health or chapters in books. As a result of these opportunities, my list of publications got longer and, of importance, I also found that I had developed a large network of colleagues from around the world I might not have met otherwise. I am grateful to Hi for all that he has made possible for me.

Now that I have been the Executive Director of WAIMH for two years, I am truly thankful for the years that I have known Hi and worked as "Hi's Shadow" (as we often joked about). The basics of the work around preparations for WAIMH World Congresses and many other responsibilities became familiar to me through Hi's guidance, as well as his understanding of the unique characteristics of WAIMH as an organization.

People working in and for WAIMH are like a family where we take care of each other, so that we all in turn can care for infants and families around the world. In many ways, Hi has been my father figure in the WAIMH family and very important, both professionally and personally. Thanks to Hi I also got to know Dee, one of the warmest and most down-to-earth teachers I know, with whom it was easy to reflect on all sorts of problems, big or small. So, if you hear me calling Hi and Dee "dad and mom," that is my way of showing them my gratitude and affection and thanking them for all the support they have given me.

Tribute Celebrating Hiram Fitzgerald: Forty years with Infant Mental: A lens from the international Alliance for the Advancement of Infant Mental Health

By Nichole Paradis, LMSW, IMH-E, Infant Mental Health Mentor-Clinical Executive Director, Alliance for the Advancement of Infant Mental Health

I can say that I have known Hi now for about 10 years. But I have known OF Hi since the very beginning of my work in this field 25 years ago. Hi is a giant in infant mental health, especially in Michigan. His height and commanding voice lend to this "giantness," but mostly it is his reputation that looms large. Many years ago, I asked Hi to send me his curriculum vitae so that I could print it out to keep on file with Endorsement records (back when paper files were still a thing). Hi said to me, "You don't want to print it out, it's far too long." I asked that he send it anyway. And of course, he was right. I had to refill the printer twice because Hi's CV is an astounding 106 pages. It is a remarkable tribute to his commitment to scientific inquiry, but also to Hi's support and promotion of people, organizations, and most of all, infants and families. What also stands out about his CV is the number of other giants in the field that he has mentored and with whom he has collaborated. It seems Hi's passion creates a gravitational pull that has attracted hundreds of other experts. Together, they have advanced the field and paved the way for the application of research into practice.

The Alliance for the Advancement of Infant Mental Health (Alliance) is one of the many organizations who owes much to Hi. Hi was one of the founders of the Michigan Association for Infant Mental Health, the organization that "gave birth" to the Alliance. Hi was integral in establishing the *Infant Mental Health Journal* and served in several editorial capacities since its beginning; he was Editor-in-Chief for at least eight years. Last year, because the Alliance has some responsibilities for managing the *IMHJ*, I had the privilege of chairing the committee to select the next Editor-in-Chief. Hi, of course, was crucial to this effort. Hi shared his incomparable institutional memory that helped me to more fully understand the role the IMHJ itself has played in lending legitimacy to the field of infant mental health.

Hi has been a supporter of the Alliance and our mission to build and sustain a diverse, reflective, skilled, and relationship-based workforce that supports pregnant women, infants, young children and their families with cultural humility. He lets us know when he sees us getting it right, and he lets us know if he sees us missing something important. The Alliance owes Hi a debt of gratitude for his honest feedback. It drives us to do the best possible job for the infant-family workforce. This is just a small part of what makes Hi Fitzgerald a giant force for good for the infants, caregivers, and parents around the world. On behalf of the leaders from the 32 associations for infant mental health that make up the Alliance, we say THANK YOU, and congratulations on an absolutely extraordinary career!

OCD, Perinatal OCD, Parental Preoccupation and Parenting

By Miri Keren, MD, Israel

Introduction

Perinatal depression and postpartum psychosis are nowadays well detected, and numerous studies have shown their detrimental impact on the mother-child relationship and on the offsprings' socio-emotional development (Murray et al., 2019). In contrast, the impact of perinatal maternal or paternal obsessive-compulsive disorder (OCD) on the parent-infant relationship and on the offsprings' outcome, has been scarcely studied. This, in spite of the study published already in 2007 (Fairbrother et al., 2007) that showed new parenthood as a risk factor for the development of obsessional problems. Even in the last edition of the Handbook of Infant Mental Health (Zeanah, 2018), the topic has not been mentioned.

Several cases we have had at our community-based infant mental health clinic have prompted us to look deeper at the phenomenon, and we wish to share this clinical experience of ours with WAIMH members. First to note, is the fact that the reason for referral was not the parental OCD but rather non-specific symptoms in the young child. Such as: separation anxiety and aggressive temper tantrums in a 3 year old boy whose father turned out to have OCD; overeating disorder in a 2 years and 10 months old girl and maternal OCD; strong refusal to stay with mother in a 2 and half year old, and maternal OCD; and autistic-like symptoms in a 3 and half year old and maternal OCD. The youngest and most recent case, which will be described later in detail, was a 5-month-old baby boy, of a mother with OCD, who was referred because of concerning passivity and slow motor development.

In this paper, we will first review the literature on maternal and paternal OCD, while noting a theoretical continuum from normal parental primary preoccupation to perinatal obsessive-compulsive disorder and raising the question whether perinatal OCD is different from OCD in other periods of life. We will end with suggested clinical implications, including the importance to think of, and detect, paternal perinatal OCD.

From normal Primary Parental Preoccupation to Obsessive Compulsive Disorder

Winnicott (1956) described the perinatal period as a unique state of heightened sensitivity, that is like a dissociative state; the aim of which is to enhance the mother's ability to anticipate the infant's needs and to learn its unique signals. He called it: "almost an illness that a mother must experience and recover from, in order to create and sustain an environment that can meet the physical and psychological needs of the infant". Winnicott emphasized the crucial importance of such a stage for the infant's self-development (even before what we know today about the impact of early interactive experiences on the brain development), and the detrimental developmental consequences for infants when mothers are unable to tolerate such a level of intense sensitivity. Postpartum depression may actually be conceptualized as the inability to enter this special state of sensitivity, while perinatal obsessive-compulsive disorder could be viewed as a hyper primary preoccupation and postpartum psychosis as a distorted primary preoccupation.

From maternal to paternal primary preoccupation: A prospective longitudinal study of 82 parents (Leckman et al., 1999) on the course and content of the parental preoccupation showed that it starts towards end of pregnancy and peaks around the time of delivery. Fathers and mothers displayed a similar time course, though the intensity of preoccupation was less in fathers (this maybe well fitted to the fact they need to go back to work and to invest in the external world). Leckman and Mayes (1999) made an interesting link between parental and romantic love with the obsessive- compulsive condition. Furthermore, on the biological level, a link between parental preoccupation and oxytocin secretion has been demonstrated in mothers as well as in fathers (Leckman et al., 2004).

Postpartum period and brain plasticity: The altered mental states associated with this normal hypersensitive period is also a risky time. While many animal studies have shown a distinct neural plasticity of the female brain during pregnancy and postpartum period, an emerging body of research reveals the existence of reproduction-related brain plasticity in human mothers. Hormones and sensory

interactions with the offspring relate to complex structural and functional changes in the various areas implicated in maternal caregiving: areas of reward/motivation, salience/threat detection, emotion regulation, and social cognition/empathy (Barbara-Muller et al., 2019). Thus, the pregnant and postpartum mother's brain evolves in ways that promote mother-infant bonding and sensitive caregiving. At the same time, this brain plasticity predisposes the mother-to-be, to peripartum disorders. Sensitive maternal care lies on a U-shaped curve, where both hypo-reactivity (such as in postpartum depression) and hyper-reactivity (such as in postpartum anxiety) to infant cues in the amygdala, are problematic (Young et al., 2017).

Is Perinatal OCD a subtype of Obsessive-Compulsive Disorder?

Perinatal OCD is defined as an obsessive-compulsive disorder that occurs during pregnancy or postnatally, with either new or exacerbated existing OCD. The clinical presentation is characterized by symptoms that orientate around baby and caregiving, but interestingly, the content of the obsessions differs by time of onset. Pregnancy-onset OCD has been more associated with fears of accidentally

harming the baby by contamination and related compulsions, while the postnatal-onset OCD has been more associated with fears of deliberately harming the baby with avoidance of caregiving tasks and mental rituals (Abramovitz et al., 2003). The prevalence of OCD in the general population is 1.2%, in contrast with OCD 4-9% for prenatal and postpartum OCD (Uguz et al., 2007 a, b, c; McGuinness et al., 2011).

Similarly, Miller and colleagues (2013) studied 461 pregnant women and found that 11% of women screened positive for OCD at 2 weeks postpartum (in contrast to 2-3% in general population). At 6 months, half of them still had persistent symptoms and 5.4% had developed new symptoms. Depression was the most frequent co-morbid diagnosis. The limitation of the study was the lack of antenatal assessment. It is interesting to note that the experience of intrusive thoughts of deliberate or accidental harm occurs in 80% of the general population of parents and even more commonly in new parents (Fairbrother et al., 2008). These thoughts are usually easily dismissed, in contrast with parents with OCD who do not get rid of them and become highly preoccupied and distressed. All this data may suggest that the *Primary Parental Preoccupation* that is inherent to the transition to parenthood, increases the risk for the development of OCD.

Several retrospective studies have reported a significant rate of perinatal onset of OCD between 15 and 30 % (Forray et al., 2010; Neziroglu et al., 2010), raising the possibility of a "hormone related" subtype of OCD. Women with pregnancy-onset OCD or perinatal worsening of preexisting OCD are more likely to experience premenstrual exacerbation of their OCD symptoms as compared to those women with symptoms that are unaffected by pregnancy. This link would be similar to the one found between premenstrual depressive disorder and increased risk for postpartum depression (Bloch et al., 2005). A prospective longitudinal study (Chaudron et al., 2010) of 44 women recruited at a gynecological clinic found that the majority of women diagnosed with OCD in pregnancy (29%) had: long-standing symptoms since childhood; and their symptoms increased in intensity postpartum, though did not change in character. An interaction between gonadal steroids, serotonin, and oxytocin has been hypothesized by the authors.

Postpartum Paternal Psychopathology

Paternal mental health is still a neglected topic in the child development research and clinical literature in spite of the increasing involvement of fathers into the parenting roles (due to several societal changing phenomenon such as women's increasing role in the work force, single gender families, and more) and in spite of what we know about the unique role of fathers in child development. Such as, father involvement and secure attachment has been linked with positive mental and physical health outcomes that persist into adulthood (Cabrera et al., 2000; Flouri et al., 2003; Wilson et al., 2010; Martin et al., 2007). Just in a mother's case, a father's mental health problem can be present before or at entry into parenthood. Entry into parenthood is a challenging developmental task as it involves multi-level changes (personal, marital, social and financial) with a risk of mental health problems in men as well as in women (Wonch et al., 2016). Although father mental health has been rarely examined in comparison to mothers, most studies have been on postpartum and subsequent paternal depression. It occurs in 10% of men (as compared to 5% rate of depression among men in general) during the first postpartum year, the peak being between 3 to 6 months (The 1:2 male to female ratio is kept as some 22% of mothers have post-partum depression (PPD)).

Several key factors have been identified that contribute to paternal depression, including: maternal PPD (Paulson et al., 2010), past history of depression, and the difficulty to express their depression and to ask for help, with a tendency to engage in avoidant, escape, or numbing behaviors (aggression, addiction, suicide). Although many men experience psychological distress in the perinatal period, they may question the legitimacy of their experiences, foregrounding their partner's needs. There is a lack of resources that are tailored specifically to men's information and preparing to become fathers. Fathers tend to manage stress through distraction, denial, and release (Brownhill et al., 2005).

With similar effect sizes to the impact of maternal depression, paternal depression (Wilson et al., 2010) has been associated with maladaptive parenting behaviors toward children, including: increased negative parenting (control, hostility, intrusiveness), decreased positive parenting behaviors (affection, positive involvement, supportiveness), and negative child outcomes, such as internalizing and externalizing problematic behaviors at 3 and 7 years (after controlling for maternal depression) (Hanington et al., 2012; Ramchandani et al., 2005, 2008, 2011; Connell et al., 2002). Although depression and anxiety are highly comorbid, few studies have examined the impact of paternal anxiety compared to paternal depression. Fathers are at the same risk (21%) as mothers (24%) to experience depression and anxiety during pregnancy, post-partum, and after (Luoma et al., 2013) and both maternal and paternal factors predict high paternal symptoms; infant factors do not. Low social support and poor marital quality are risk factors for both fathers and mothers, more than the direct stress linked with the infant's condition (Zelkowitz et al., 2007). The inclusion of anxiety disorders in diagnostic interviews have substantially increased the rate of detected paternal postpartum mental illness (Matthey et al., 2003). Paternal anxiety is associated with overinvolvement and overcontrolling behaviors and these have been linked with both internalizing and externalizing child symptoms (Cimino et al., 2015; Breaux et al., 2014).

Paternal obsessive-compulsive disorder (OCD) is the most under-researched of the paternal mental health disorders (Fisher, 2017; Misri, 2018). Abramowitz et al. (2001) was the first to report four cases of paternal postpartum OCD, and found it very similar to maternal postpartum OCD, even though men do not experience the same postpartum hormonal fluctuations as female. Coelho et al. (2014) conducted a follow-up study to describe prevalence rates and correlates of OCD in fathers in the third trimester of pregnancy and in the first 2 months postpartum. The prevalence of OCD was 3.4% in the third trimester of pregnancy and 1.8% in the postpartum period. Most postpartum cases were of new onset (92.3%).

Of interest, OCD in fathers was significantly associated with OCD in mothers, both during pregnancy and in the postpartum period (Coelho et al., 2014). These figures definitely show the need to actively look for perinatal disorders among fathers, and not only among mothers, as fathers tend to restrain from disclosing their distress and to look for help (O'Brien et al., 2016).

The impact of perinatal OCD on parent and child

Untreated perinatal OCD has been associated (Gezginc et al., 2008) with poor quality of life, impaired physical health, impaired social, marital, and parent-child relationships. The impact of parental anxiety, depression, bipolar disorders, eating disorders, and schizophrenia on the infant have been studied, but parental OCD has received much less clinical and

research attention (House et al., 2016). Weinberg and Tronick (1998) studied infants of parents with OCD, depression, or panic disorder, and found compromised mother-infant interactions in all the three groups. To our best knowledge, there are no other studies among infants of parents with OCD. In contrast, among children and adolescents, Griffiths et al. (2012) conducted semi-structured interviews of ten 13-19 years old who had one parent with OCD and found recurrent themes. Having a parent with OCD meant living in a highly controlled home environment, with frequent arguments, social isolation, a negative impact on schooling, assuming aspects of the parenting role, and participating in their parent's rituals.

Clinical vignettes

A 5-month-old baby was referred to our community-based infant mental health clinic by the mother's psychiatrist who treats her for a severe OCD. The main concern regarding the infant was, on one hand, an extreme passivity and slow motor development, and on the other hand, the mother's compulsive need to stimulate him from fear that he would "get bored". O. is the only child of his mother, 35 years old, and his father, 27 years old. Mother's OCD started in her twenties but significantly worsened during pregnancy. She is also diagnosed with borderline personality traits and eating disorder (mixed periods of binge eating and fasting). She is also described as having a tendency to use her OCD symptoms as an excuse for problematic behaviors at work and at home. Since O's birth, she does not let the father get involved in the baby's care because "only mothers know how to do it", and the marital relationship has become very tense. Mother's own mother was intrusive and forced her to eat. O's father is withdrawn, sad and helpless, does not contradict his wife so as to avoid stormy fights. His wife's obsessive-compulsive disorders, reminds him of his father's; he himself is diagnosed with ADHD and overeating. The observation of her interaction with O. reveals an extremely intrusive pattern of over stimulation and hypervigilance, as if danger is all around. She argues endlessly about the room temperature being either too high or too low for O. Even when the baby drinks from the bottle, she feels an urge to show him toys "so he does not get bored". O. is a very quiet baby, stays still on the carpet, but is attentive and makes good eye contact. Baby does not try to reach toys but grasps them when handled. The treatment plan includes CBT and psychiatric follow up for the mother, and triadic interactive guidance at our clinic. Parents are well aware of the changes that need to be done, but by the first 6 months of treatment, no changes are achieved, O. starts to show signs of motor delay and mother finally says "I am not sure I really want to get rid of my OCD, it often helps me to get things the way I want them to be". Under the threat of involving the Child Protection Services, the mother agrees to have O. start day care (a move the father wanted very much), but they stopped coming to the Unit and mother did not comply with her CBT treatment. Four months later, mother calls and asks for renewing the treatment process, as she and her husband are having a hard time to say "no" to O. (now a year and half old), and to give him autonomy in eating.

This case illustrates the potentially very detrimental impact of perinatal OCD on parenting. The mother's chronic OCD changed its nature with entry into motherhood: it became a "relational" OCD. Its ego-syntonic quality makes it very challenging to treat and requires close collaboration between the adult psychiatrist and the child psychiatrist, each with his/her own lens.

Y.,2 years and 8 months, was referred to our IMH clinic for aggressive behaviors at home and at kindergarten, together with separation anxiety. Mother had just delivered her third child. Y. is the second one. His aggressive behavior was first interpreted by us as being an adjustment reaction to the birth of his baby brother. Father was very reluctant to come to the clinic as he explained: "my wife is the one who deals with the kids, I am at work most of the day". Hence, the treatment started as a dyadic interactional guidance and was aimed at increasing the mother's reflective functioning. During one of the sessions, Mother revealed that her husband has often severe anger outbursts at her not being "efficient enough" at doing all the home and caregiving chores. As it became obvious that part of the problem was around the parents' co-parenting alliance, we persisted in trying to reach out the father. He finally agreed to come, as the marital tension raised, and mother started to threaten she would divorce him. Only then, the father's severe, chronic and untreated OCD with periods of depression was disclosed. Entry to parenthood had exacerbated his OCD as he described "my wife and kids make mess all the time, I come back from work tired and I cannot stand the mess, I am angry most of the time, especially at Y.'s behavior". He confessed he would often lose his temper and become aggressive…. like Y. Treatment became triadic, father agreed to have a CBT treatment for himself, and Y's symptoms almost disappeared.

As this second case illustrates, the impact of paternal OCD on the child is as significant as the impact of maternal OCD.

Conclusion

Perinatal OCD is still a hidden problem with long term consequences on parenting. Challacombe & Wroe (2013) have described how perinatal OCD is often misdiagnosed due to several barriers to detection, including: the shame of disclosing the intrusive thoughts and compulsions; and the fear of being misunderstood and judged as a potentially harmful parent. Postnatal depression diagnosis is often given, instead of perinatal OCD. In severe cases, perinatal OCD can be misdiagnosed as postpartum psychosis. Last but not least is the need to be aware of the prevalence of postpartum psychopathology among fathers, to detect it and treat it early in order to prevent maladaptive paternal behaviors towards the child.

References

Abramowitz, J., Moore, K., Carmin, C., Wiegartz, P. S., & Purdon, C. (2001). Acute onset of obsessive-compulsive disorder in males following childbirth. *Psychosomatics*, 42(5), 429-431.

Barbara-Muller, E., Craddock, S., Carmona, S. & Hoekzema, E. (2019). Brain plasticity in pregnancy and the postpartum period: links to maternal caregiving and mental health. *Arch Womens Ment Health*, 22:289-299.

Bloch, M., Rotenberg, N., Koren, D., & Klein, E. (2005). Risk factors associated with the development of postpartum mood disorders. *J Affect Dis*, 88, 9–18.

Breaux, R. P., Harvey, E.A., & Lugo-Candelas, C. I. (2014). The role of parent psychopathology in the development of preschool children with behavior problems. *J Clin Child Adolesc Psychol.*, 43, 777-790.

Brownhill, S., Wilheilm, K., Barclay, L., & Schmied, V. (2005). "Big build": Hidden depression in men. *Australian & New Zealand J Psychiat*, 39, 921-931.

Cabrera, N. J., Tamis-LeMonda, C. S., Bradley, R. H., Hofferth, S., & Lamb, M. E. (2000). Fatherhood in the twenty-first century. *Child Dev*, 71, 127-136.

Challacombe, F. L., & Wroe, A. L. (2013). A hidden problem: consequences of the misdiagnosis of perinatal OCD. *Br J Gen Pract*, 63: 275-76.

Chaudron, L. H., & Nirodi, N. (2010). The obsessive-compulsive spectrum in the perinatal period: a prospective pilot study. *Arch Womens Ment Health*, 13:403-410.

Cimino, S., Cerniglia, L., & Paciello, M. (2015). Mothers with depression, anxiety, or eating disorders; outcomes on their children and the role of paternal psychological profiles. *Child Psychiatr Hum Dev*, 46, 228-236.

Coelho, F. M., Silva, R. A. D., Quevedo, L. D. Á., Souza, L. D., Pinheiro, K. A., & Pinheiro, R. T. (2014). Obsessive-compulsive disorder in fathers during pregnancy and postpartum. *Brazilian J Psychiatr*, 36(3), 272-272.

Connell, A. M. & Goodman, S. H. (2002). (2002). The association between psychopathology in fathers versus mothers and children's internalizing and externalizing behavior problems: a metanalysis. *Psychol Bull.*, 128, 746-773.

Fairbrother, N., & Abramowitz, J. S. (2007). New parenthood as a risk factor for the development of obsessional problems. *Behav Res Ther.,* 45, 2155–2163.

Fairbrother, N., & Woody, S. R. (2008). New mothers' thoughts of harm related to the newborn. *Arch Wom Ment Health*, 11, 221–229.

Fisher, S. D. (2017). Paternal mental health: why is it relevant? *Am J of Lifestyle Med*, 11(3), 200-211.

Flouri, E. & Buchanan, A. (2003). The role of father's involvement in children's later mental health. *J Adoles*, 26, 63-78.

Forray, A., Focsensunu, M., Pittman, B., McDougle, C. J., & Epperson, C. N. (2010). Onset and exacerbation of OCD in pregnancy and the postpartum period. *J Clin Psychiatry*, 71:1061-1068.

Gezginc, K., Uguz, F., Karatayli, S., Zeytinci, E., Aşkin, R., Güler, O., Sahin, F., et al. (2008). The impact of obsessive-compulsive disorder in pregnancy on quality of life. *Internat J Psychiatry Clinic Practice*, 12, 134-137.

Griffiths, J., Norris, E., Stallard, P. & Matthews, S. (2012). Living with parents with obsessive-compulsive disorder: children's lives and experiences. *Psychol Psychoter*, 85, 68-82.

Hanington, L., Heron, J., Stein, A. & Ramchandani, P. (2012). Parental depression and child outcomes -I smarital conflict the missing link. *Child Care Health Dev*, 38, 520-529.

House, S. J., Tripathi, S. P., Knight, B. T, Morris, N., Newport, D. J. & Stowe, Z. N. (2016). OCD in pregnancy and the postpartum period: course of illness and obstetrical outcome. *Arch Women's Ment Health*, 19, 3-10.

Leckman, J. F. & Mayes, L. C. (1999). Preoccupations and behaviors associated with romantic and parental love. Perspectives on the origin of obsessive-compulsive disorder. *Child Adol Psych Cl*, 8, 635–65.

Leckman, J. F., Mayes, L. C., Feldman, R., Evans, D. W., King, R.A. & Cohen, D. J. (1999). Early parental preoccupations and behaviors and their possible relationship to the symptoms of OCD. *Acta Psychiat Scand*, 100:1-26.

Leckman, J. F., Feldman, R., Swain, J. E., Eicher, V., Thompson, N., & Mayes, L. C. (2004). Primary Parental Preoccupation: Circuits, Genes, and the Crucial Role of the Environment. *J. Neural Transmission*, 111:753-771.

Luoma, I., Puura, K., Mantymaa, M., Latva, R., Salmelin, R. & Tamminen T. (2013). Fathers' postnatal depressive and anxiety symptoms: an exploration of links with paternal, maternal, infant and family factors. *Nord J Psychiatry,* 67, 407-413.

Matthey, S., Barnett, B., Howie, P. & Kavanagh, D. J. (2003). Diagnosing postpartum depression in mothers and fathers: Whatever happened to anxiety? *J Affect Dis*, 74, 139-147.

Martin, L. T., McNamara, M. J., Milot, A. S., Halle, T. & Hair, E. C. (2007). The effects of father involvement during pregnancy on receipt of prenatal care and maternal smoking. *Matern Child Health J*, 11, 595-602.

Martin, L. A., Neighbors, H. W. & Griffith, D. M. (2013). The experience of symptoms of depression in men versus women: analysis of the National Comorbidity Survey Replication. *JAMA Psychiatry*, 70, 1100-1106.

McGuinness, M., Blissett, J., & Jones, C. (2011). OCD in the perinatal period: Is postpartum OCD (ppOCD) a distinct subtype? A review of the literature. *Behav Cogn Psychoth.* 5, 1–26.

Miller E., Chu, C., Gollan, J. & Gossett, D. R. (2013). Obsessive compulsive symptoms during the postpartum period. *J Reprod Med*, 58: 115-122.

Misri, S. K. (2018). Obsessive-Compulsive Disorders in New Fathers: Feeling Out of Control. In Paternal Postnatal Psychiatric Illnesses (pp. 81-99). Springer, Cham.

Murray, L., Halligan, S., & Cooper, P. (2019). Postnatal depression and young children's development. In C.H Jr. Zeanah (Ed.) *Handbook of Infant Mental Health*, 4th edition, New York:

The Guilford Press. pp. 172-186.

Munk-Olsen, T., Laursen, T., Tederson, C., et al. (2006). New Parents and mental disorders: a population-based register study. *JAMA*, 296, 2582–2589.

Neziroglu, F., Anemone, R. & Yaryura-Tobias J. (2010). Onset of obsessive-compulsive disorder in pregnancy. *Am J Psychiatr*, 149, 947–950.

O'Brien, A. P., McNeil, K. A., Fletcher, R., Conrad, A., Wilson, A. J., Jones, D., & Chan, S. W. (2017). New fathers' perinatal depression and anxiety – Treatment options: An integrative review. *Am J Mens Health*, 11, 863-876.

Paulson, J. F., & Bazermore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis. *J Am Med Assoc*, 303, 1961-1969.

Ramchandani, P. G., O'Connor, T. G., Evans, J., Heron, J., Murray, L., & Stein, A. (2008). The effects of pre-and postnatal depression in fathers: a natural experiment comparing the effects of exposure to depression on offspring. *J Child Psychol Psychiatr*, 49, 1069-1078.

Ramchandani, P. G., Psychogiou, L., Vlachos, H., Iles, J., Sethna, V., Netsi, E., & Lodder, A. (2011). Paternal depression: An examination of its link with father, child and family functioning in the postnatal period. *Depression and Anxiety*, 28, 471-477.

Ramchandani, P. G., Stein, A ., Evans, J., & O'Connor, T. G. (2005). Paternal depression in the postnatal period and child development: A prospective population study. *Lancet*, 365, 2201-2205.

Uguz, F., Akman, C., Kaya, N., & Savas Cilli, A. (2007a). Postpartum-onset obsessive–compulsive disorder: incidence, clinical features, and related factors. *J Clin Psychiatry*, 68, 132–138.

Uguz, F., Gezginc, K., Zeytinci, I. E., Karatayli S., Askin, R., Guler, O., Kir Sahin, F. et al. (2007b). Obsessive–compulsive disorder in pregnant women during the third trimester of pregnancy. Compr Psychiatry, 48, 441–445.

Uguz, F., Gezginc, K., Zeytinci, I. E., Karatayli, S., Askin, R., Guler, O., Kir Sahin. F. et al. (2007c). Course of obsessive–compulsive disorder during early postpartum period: a prospective analysis of 16 cases. *Compr Psychiatry*, 48, 558–561.

Weinberg, M. K. & Tronick, E. Z. (1998). The impact of maternal psychiatric illness on infant development. J Clin Psychiatry, 59 Suppl 2, 53-61.

Wilson, S., & Durbin, C. E. (2010). Effects of paternal depression on fathers' parenting behaviors: A meta-analytic review. *Clin Psych Review*, 30, 176-180.

Winnicott, D. W. (1956). Primary Maternal Preoccupation. In *Collected Papers: Through Paediatrics to Psycho-Analysis.* London: The International Psycho-Analytical Library; 1975. pp. 299–304.

Wonch, K. E., de Medeiros, C. B., Barrett, J. A., Dudin, A., Cunningham, W. A., et al. (2016). Postpartum depression and brain response to infants: differential amygdala response and connectivity. *Soc Neurosci.* 11, 600–617.

Yoshida, T., Taga, C., Matsumoto, Y., Fukui, K. (2005). Paternal overprotection in obsessive-compulsive disorder and depression with obsessive traits. *Psychiatr Clin Neurosci*., 59, 533-538.

Young, K. S., Parsons, C. E., Stein, A., Vuust, P., Craske, M. G., & Kringelbach, M. L. (2017). The neural basis of responsive caregiving behavior: investigating temporal dynamics within the parental brain. *Behav Brain Res*. 325, 105–116.

Zeanah, C. H. Jr. (Ed.) (2018). *Handbook of Infant Mental Health*, 4th edition, New York: The Guilford Press.

Zelkowitz, P. & Milet, T. H. (1997). Stress and support as related to postpartum paternal mental health and perceptions of the infant. *Infant Ment Health J*, 18, 424-435.

Perspectives in Infant Mental Health are delighted to share this new paper with you: ***Language Interpretation in the Administration of the Bayley Scales of Infant Development-III for an Indigenous Population in Guatemala***. It has been written by colleagues in Guatemala and USA: Meghan Farley Webb (Guatemala and USA), Boris Martinez (Guatemala and USA), Patricia Rodas (Guatemala), Ana Gonzalez (Guatemala), Peter Rohloff (Guatemala and USA), and Maria del Pilar Grazioso (Guatemala).

This paper addresses cultural and linguistic issues associated with the adaptation of western assessment tools. The authors, Farley Webb et el., state that: "Such adaptations are especially difficult when working in indigenous or minority languages that may not have a standardized written form". The paper especially addresses the interpretation processes specific to the administration of the Bayley Scales of Infant Development-III (BSID-III) in Kaqchikel Maya, an indigenous language of rural Guatemala. A case study is provided that illustrates the interpretation and translation process that was used to adapt the Bayley Scales of Infant Development-III (BSID-III) for use in this indigenous community. While being specific to this rural community, the paper also contributes to our appreciation of, understanding, and discussions regarding the interpretation of psychometric tests in indigenous languages with families and their babies.

Language Interpretation in the Administration of the Bayley Scales of Infant Development-III for an Indigenous Population in Guatemala

By Meghan Farley Webb, Guatemala and USA,

Boris Martinez, Guatemala and USA,

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Abstract

Careful cultural and linguistic adaptation of Western assessment tools can produce meaningful clinical or social information about early child development in non-Western populations. Such adaptations are especially difficult when working in indigenous or minority languages that may not have a standardized written form. In such situations, linguistic interpretation is necessary; however, details regarding interpretation procedures are rarely documented in published manuscripts. This article describes the training procedures, common difficulties encountered, and assumed roles of linguistic interpreters in the administration of the Bayley Scales of Infant Development-III (BSID-III) in Kaqchikel Maya, an indigenous language of rural Guatemala. This case study demonstrates that the use of psychometric tools in indigenous or minority linguistic communities requires the active participation of skilled interpreters, who serve as "co-testers," actively participating in the evaluation process, maintaining caregiver and child engagement through iteration and improvisation "on-the-fly," and mediating a respectful and productive intercultural dialogue between the testing team and participants. We found that hiring and training female native speakers, rather than professional interpreters, allowed us to improve rapport between non-indigenous psychologists and Maya caregivers. Ongoing discussion and training improved the comprehensibility of BSID-III test items. By describing our experiences interpreting the BSID-III into Kaqchikel Maya, this article aims to contribute to the larger discussion of interpretation procedures used to adapt psychometric tests into other indigenous or minority languages.

Keywords: early child development, methodology, minority languages, Maya, Guatemala

Introduction

Previous scholarship has demonstrated that with careful cultural and linguistic adaptation Western assessment tools can produce meaningful clinical or social information about early child development (ECD) in non-Western populations (Biasini et al., 2015; Bornman, Sevcik, Romski, & Pae, 2010; Heo, Squires, & Yovanoff, 2008; Kvestad et al., 2013; Lara Díaz, Gálvez Bohórquez, Gómez Fonseca, Guechá, & Sellabona, 2011; Steenis, Verhoeven, Hessen, & van Baar, 2014). Although many published studies carefully document the procedures used to validate or adapt assessment tools to different cultures (Biasini et al., 2015; Bornman et al., 2010; Clinton, Edstrom, Mildon, & L., 2015; Heo et al., 2008; Kvestad et al., 2013; Lara Díaz et al., 2011; Steenis et al., 2014), the issue of language interpretation is less well represented in the literature. This issue is especially important when working translinguistically or when a language does not have a commonly accepted written form, as is often the case with minority or indigenous languages. Language interpretation is not a straightforward skill, and procedures used to train or incorporate interpreters into the assessment team are rarely detailed in published manuscripts (Wallin & Ahlström, 2006). This article aims to contribute to this discussion by describing the interpretation procedures used during the administration of the Bayley Scales of Infant and Toddler Development (BSID)-III (Bayley, 2006) among a group of Kaqchikel Maya (henceforth Kaqchikel) mother-child dyads in rural Guatemala.

Context

Guatemala is a Central American country of roughly 16 million; nearly half of the population self-identifies as indigenous, speaking one of 22 Mayan languages. Despite their majority, contemporary Maya have been marginalized from the dominant society, and suffer from marked socioeconomic and health disparities (Ministerio de Salud Pública y Asistencia Social, Instituto Nacional de Estadística, & Secretaría de Planificación y Programación de la Presidencia, 2015). Reflecting this dichotomy, Guatemala has the highest prevalence of stunting (low height-for-age) in Latin America, with indigenous children disproportionately affected. In rural Maya communities, stunting rates often exceed 75 percent for children under 5 years of age (Black et al., 2013). Unsurprisingly, in these indigenous communities most children are at risk for delayed ECD (Chary et al., 2013). However, the extent of delay in various domains remains unknown, in large part because linguistic barriers (especially Maya language monolingualism of mothers) impede the adaptation and administration of existing ECD tools.
We recently completed a randomized clinical trial to explore the effects of malnutrition on ECD (NCT02509936) in a rural Kaqchikel population. As part of that study, we adapted the BSID-III to Guatemalan Spanish (the language of our clinical team). However, the target language for administration for the trial was Kaqchikel. While Kaqchikel has had a standard written form for several decades, exceedingly few individuals (including Kaqchikel professionals) are literate in Kaqchikel (England, 2003). It was, therefore, impractical to develop a standardized Kaqchikel written BSID-III, and we explored the feasibility of BSID-III administration with concurrent interpretation from Spanish to Kaqchikel by bilingual interpreters. This paper documents the training procedures, common difficulties encountered, and assumed roles of our interpreters.

Picture from Guatemala by Meghan Farley Webb.

Methods

Participants

Three hundred twenty-four mother-child dyads participated in the administration of the BSID-III in Kaqchikel as part of a clinical trial (NCT0209936). These dyads were recruited for participation from rural hamlets surrounding the city of Tecpán, Guatemala. Child subjects were recruited based on prespecified inclusion criteria, which included: (1) age 6-24 months, (2) height for age Z-score of ≤ 2.5, and (3) no obvious congenital abnormalities or severe medical illness. The age range of mothers was 16-49 years, with an average age of 27.06 ± 6.80 years. On average, mothers had completed 2.29 ± 2.46 years of primary school and their preferred language was Kaqchikel.

The interdisciplinary research team contained both indigenous and non-indigenous staff and included physicians, nurses, anthropologists, psychologists, and interpreters. Importantly, none of the psychologists administering the BSID-III were indigenous or spoke Kaqchikel, making the seven native Kaqchikel-speaking interpreters critical to the team. All interpreters were female, with an age range of 22-27 years. While none of the translators were professional interpreters, all were native speakers of both Spanish and Kaqchikel and were trained to use vernacular language in study encounters.

Procedure

Despite official recognition of Mayan languages (England, 2003), there are no accreditation or training programs for Mayan language translators. Maya linguists often fill the role of "professional" interpreters, without undergoing a training or certification process. Indeed, Maya linguists frequently use standard grammatical structure that varies greatly from vernacular Kaqchikel and employ neologisms which are incomprehensible to typical speakers (Tummons, Henderson, & Rohloff, 2008). Therefore, we hired native Kaqchikel speakers with experience as elementary school teachers rather than linguists. This decision promoted communication and rapport, rather than the use of a formal grammatical register unfamiliar to rural speakers.

Interpreters participated in twenty hours of intensive orientation by the interdisciplinary team that included review of the ancillary materials to be used in the testing (such as stimulus materials and Likert scales) and detailed discussion of each test item, including a discussion of the theory behind and purpose of each item. Training also included guidance on data collection procedures, especially accurate recording of responses, and navigating cultural missteps. Finally, interpreters' training included active participation in the full administration of the BSID-III to both team members and a group of volunteer Kaqchikel mothers. These interactions allowed interpreters to receive feedback on their interpretation and data collection techniques and to practice linguistic and cultural interpretation and the management of interpersonal dynamics between non-indigenous psychologists and indigenous

Picture from Guatemala by Meghan Farley Webb.

caregivers. This practice was critical to strengthening the necessary collaboration between interpreters and evaluators.

Completion of training did not mark the end of the process of interpretation. Throughout the study period, interpreters regularly discussed problematic phrasings with the larger research team who supervised any changes in phrasing. At the mid-point of the study, study coordinators held a focus group with the interpreters to further discuss the interpreters' general impressions and specific concerns of both the questions and interaction portions of the BSID-III. Insights from these interactions form the bulk of the findings reported below.

Results

Early feedback from interpreters centered around the linguistic and cultural impasses they had to navigate during test administration. Unsurprisingly, interpreters reported linguistic difficulties related to word choice. For example, in initial rounds of phrasing testing, the Kaqchikel-speaking members of the research team decided that *"samaj"* (work; job) was the best translation of "activity." However, focus group discussion with interprets revealed that mothers had difficulty applying this word to children. They perceived "samaj" as referring to the duties of adults rather than age-appropriate activities of children. Providing mothers with examples of children's activities clarified our use of "samaj" and improved comprehensibility.

In a similar vein, negative and two-part questions were problematic. Interpreters described caregivers signaling responses incongruent with previous responses or behaviors they witnessed children achieving. Two-part questions were particularly problematic, with most mothers responding to the first half, rather than the whole question, according to interpreters. Interpreters also described mothers' frustration with what they perceived as repeat questions. For example, mothers did not differentiate between children's use of gestures, sounds, and words making items querying children's communication abilities problematic. To ensure comprehension interpreters signaled two-part questions asking mothers to respond to the whole question, not just the first part. Similarly, interpreters pointed out the differences in perceived "repeated" questions.

In addition to these linguistic interactions, interpreters also had to navigate cultural disparities. Interpreters described how BSID-III items querying the type of play between caregiver and children highlighted the fact that the overwhelming majority of mothers did not have time for dedicated "play" with their child. Mothers described days filled with domestic tasks, and, therefore, had a difficult time responding to these items. Similarly, mothers signaled that their children did not like "a variety of foods." However, interpreters felt that these negative responses were demonstrative of endemic poverty and food insecurity rather than any substantial difference in the child's developmental achievements. Questions about dedicated "play" were altered to reflect any caregivers' (especially older siblings') play with children. Interpreters tried providing examples for items querying various foods, but these questions still proved difficult to interpret.

Perhaps the greatest cultural obstacle interpreters had to mediate in the interpretation of the BSID-III was Guatemala's s ongoing legacy of ethnic discrimination against Maya populations. For example, the non-indigenous evaluators cleaned toys after completing interactions, as is normal practice. However, indigenous mothers reacted negatively, perceiving this practice as emblematic of non-indigenous' perception of indigenous peoples as "dirty." Interpreters described having to reassure caregivers that toy cleaning was done with all children regardless of ethnic background and was not because evaluators thought indigenous children were dirty.

Discussion

As focus group discussions and debriefing interactions with interpreters revealed, transcultural and translinguistic interpretation of the BSID-III is not straightforward; it requires navigation of both linguistic and cultural obstacles. Since the role of the interpreter in testing environments is often insufficiently described (Wallin & Ahlström, 2006), this article aims to call to attention the degree to which the interpreter is as an integral member of the testing team. We believe that more detail to the processes of training and integrating interpreters into testing teams is critical when describing such efforts in indigenous or linguistic minority communities worldwide.

We strategically hired non-professional interpreters with experience interacting with women and young children in order to create a framework focused on building rapport and creating a therapeutic alliance. We specifically avoided using "professional" Kaqchikel interpreters, given that they are few in number, typically inexperienced with early child interactions and almost exclusively all trained as linguists or language revitalization specialists and therefore use many neologisms and a high grammatical register that we feared would alienate to our rural cohort (England, 2003). We also chose to employ only female interpreters, given local gender norms that consider childcare "women's work." Furthermore, we felt female interpreters could more easily establish rapport with mothers. These choices, combined with training that explicitly discussed the ways interpreters would have to facilitate and mediate cross-cultural understandings between the research team and caregivers, allowing for successful administration of the BSID-III.

As our experience highlights, the role of interpreters in early child testing

environment extends beyond simple linguistic interpretation. Interpreters facilitate and mediate intercultural interactions between evaluators, caregivers, and children. This allows caregivers from distinct cultural backgrounds or with limited experience with formal testing environments to participate in the evaluation of their children in meaningful ways, ensuring more accurate evaluation (Klein, 2000; Mares & Graeff-Martins, 2012; Thurman, 2015). When caregivers and evaluators do not speak the same language, the therapeutic alliance is immediately ruptured; it is only through interpretation that rapport can be established. In such cases, interpreters become an integral part of the testing team, leaving aside any supposed neutral technical role to bridge the cultural divide between tester and subject.

As this case study from indigenous rural Guatemala demonstrates that the use of psychometric tools in indigenous or minority linguistic communities goes beyond just simple translation and adaptation. It requires the active participation of skilled interpreters, who serve as "co-testers," actively participating in the evaluation process, maintaining caregiver and child engagement through iteration and improvisation "on-the-fly," and mediating a respectful and productive intercultural dialogue between the testing team and participants.

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References

Bayley, N. (2006). *Bayley Scales of Infant Development*. Third Edition: Pearson Education, Inc.

Biasini, F. J., De Jong, D., Ryan, S., Thorsten, V., Bann, C., Bellad, R., McClure, E. (2015). Development of a 12 Month Screener Based on Items from the Bayley II Scales of Infant Development for use in Low Middle Income Countries. *Early Human Development*, 91(4), 253-258.

Black, R. E., Victora, C. G., Walker, S. P., Bhutta, Z. A., Christian, P., de Onis, M., Ezzati, M., et al. (2013). Maternal and Child Undernutrition and Overweight in Low-Income and Middle-Income Countries. *Lancet*, 382(9890), 427-451.

Bornman, J., Sevcik, R. A., Romski, M. A., & Pae, H. K. (2010). Successfully Translating Language and Culture When Adapting Assessment Measures. *Journal of Policy and Practice in Intellectual Disabilities*, 72(2), 111-118.

Chary, A., Messmer, S., Sorenson, E., Henretty, N., Dasgupta, S., & Rohloff, P. (2013). The Normalization of Childhood Disease: An Ethnographic Study of Child Malnutrition in Rural Guatemala. *Human Organization*, 72(2), 87-97.

Clinton, A., Edstrom, L., Mildon, H., & L., D. (2015). Social emotional learning in a Guatemalan preschool sample: Does socioeconomic status moderate the effects of a school-based prevention program? *School Psychology International*, 36(1), 18-35.

England, N. C. (2003). Mayan Language Revival and Revitalization Politics: Linguistics and Linguistic Ideologies. *American Anthropologist*, 105(4), 733-743.

Heo, K. H., Squires, J., & Yovanoff, P. (2008). Cross-Cultural Adaptation of a Pre-School Screening Instrument: Comparision of Korean and U.S. Population. *Journal of Intellectual Disability Research*, 52(3), 195-206.

Klein, P. (2000). *Handbook of Psychological Testing* (2nd ed.). New York: Routledge.

Kvestad, I., Taneja, S., Kumar, T., Bhadari, N., Strand, T. A., & Hysing, M. (2013). The Assessment of Developmental Status Using the Ages and Stages Questionnaire-3 in Nutritional Research in North Indian Young Children. *Nutrition Journal*, 12(50), 1-11.

Lara Díaz, M. F., Gálvez Bohórquez, D. M., Gómez Fonseca, Á. M., Guechá, C. M., & Sellabona, E. S. (2011). Normativización del Invenario de Desarollo Comunicativo MacArthur-Bates al español, Colombia [Normalization to the Spanish-Colombia to the CDI-MacArthur-Bates Communicative Development Inventories]. *Revista Latinoamericana de Psicología*, 43(2), 241-254.

Mares, S. P., & Graeff-Martins, A. S. (2012). The Clinical Assessment of Infants, Preschoolers, and Their Families. In J. M. Rey (Ed.), *IACAPAP Textboook of Child and Adolescent Mental Health* (pp. 1-22). Geneva: International Associoation for Child and Adolescent Psychiarty and Allied Professions.

Ministerio de Salud Pública y Asistencia Social, Instituto Nacional de Estadística, & Secretaría de Planificación y Programación de la Presidencia. (2015). *Encuesta Nacional de Salud Materno Infantil 2014-2015: Innforme de Indicadores Básicos*. Retrieved from Guatemala City.

Steenis, L. J. P., Verhoeven, M., Hessen, D. J., & van Baar, A. L. (2014). First Steps in Developing the Dutch Version of the Bayley III: Is the Original Bayley and Its Item Sequence Also Adequate for Dutch Children. *European Journal of Developmental Psychology*, 11(4), 494-511.

Thurman, S. L. (2015). Ethical Considerations in Longitudinal Studies of Human Infants. I*nfant Behavioral Development*, 38, 116-125.

Tummons, E., Henderson, R., & Rohloff, P. (2008). *So that we don't lose words: Reconstructing a Kaqchikel medical lexicon*. Paper presented at the First Biennial Symposium on Teaching Indigenous Languages in Latin America, Bloomington, IN.

Wallin, A.-M., & Ahlström, G. (2006). Cross-cultural Interview Studies Using Interpreters: Systematic Literature Review. *Journal of Advanced Nursing*, 55(6), 723-735.

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Introduction by Jody Todd Manly, USA (Associate Editor)

While many aspects of childbirth and child development are universal parts of the human experience worldwide, parenting practices and family beliefs and values regarding child rearing are culturally determined; thus, approaches to supporting optimal child development are best viewed within a cultural context. One of the greatest strengths of WAIMH is holding a global perspective that exposes us to wide-ranging beliefs, values, and customs to improve our understanding of cultural influences on child development and how development unfolds in the context of these varied family and community rituals and practices. As part of our WAIMH communication plan to highlight and address important topics affecting young children in today's world, Astrid Berg has written the following beautiful illustration of the role of culture and of several African traditional practices related to babies and their care.

Dr Astrid Berg is an Emerita Professor in the Division of Child and Adolescent Psychiatry at the University of Cape Town and Professor Extraordinary at Stellenbosch University. She is a child and adolescent psychiatrist and fully qualified psychoanalyst. She was a founding member of the Western Cape Association for Infant Mental Health. She has been involved with WAIMH since 1996, attending nearly every WAIMH Congress since that time, including organizing the 13th International Conference of WAIMH in Cape Town, and she is currently in her second term as an Executive Committee Member of the WAIMH Board. Her work with several African cultural groups and cultural brokers has informed her perspective, which she shares with us here.

Diversity and the positive impact of culture and supporting families in context - A view from Africa

By Astrid Berg, Cape Town, South Africa

About culture

Culture is part of all human groupings. The customs, rituals and beliefs we have give meaning to what happens to us and how we live our lives.

An infant is embedded in his/her culture even before birth. Parents have fantasies about their unborn child and these fantasies are colored by the culture from which they came and in which they live. Culture thus forms a blanket, so to speak, whose weft and warp surround the baby from the very beginning.

And we, as human beings, all have this wrap-around – the western, Judeo-Christian one is as much a 'culture' as the First Nation cultures in Australia and the Americas, or the culture of the Amabantu groups of Southern Africa. No group is 'culture-free'.

The developmental niche

How does culture influence the development of a child? The "developmental niche" is a helpful concept which describes the mutual adaptation between the individual and the environment. It consists of three components that are interrelated and interact with one another (Harkness & Super, 1994).

The **physical setting** of daily life is regarded as one of the most powerful ways that culture influences the child. For example, if the social group of which the family is a part lives in a community with a nomadic life-style, or are hunter-gatherers it would be important for that infant to become physically independent fairly soon; here children are expected to help in household chores from an early age and learn from the adults around them about how things are done.

The second influence on development described is that of the **customs of child care**. These are the daily routines such as feeding and bathing that are culturally prescribed sequences of behaviour that are considered 'normal'. They may have originated because of the physical setting but may continue to be practised even if this physical setting has changed.

The **psychology of the care-takers** is the third feature of the developmental niche. In parts of Africa, for example, there is the belief is that children are played with and socialized by their older siblings and peers. Adults may thus not engage with them in

the face-to face and verbal manner that is customary for western mothers.

Most published research on infants comes from Europe and the USA while the majority of infants live in Africa and Asia (Tomlinson, Bornstein, Marlow, & Swartz, 2014)but most of our knowledge about infants and children has emerged from high-income countries. In 2003, M. Tomlinson and L. Swartz conducted a survey of articles on infancy between 1996 and 2001 from major international journals, reporting that a meager 5% of articles emanated from parts of the world other than North America, Europe, or Australasia. In this article, we conducted a similar review of articles on infancy published between 2002 and 2012 to assess whether the status of cross-national research has changed in the subsequent decade. Results indicate that despite slight improvements in research output from the rest of world, only 2.3% of articles published in 11 years included data from low- and middle-income countries--where 90% of the world's infants live. These discrepancies are indicative of the progress still needed to bridge the so-called 10/90 gap (S. Saxena, G. Paraje, P. Sharan, G. Karam, & R. Sadana,. This has contributed to the assumption that the Western way of rearing children is the norm. So if measured with a European yard stick, an African mother's less frequent direct face-to-face contact with her baby could be regarded as disinterest or neglect, but if seen in its context, it becomes clear that the infant's need for interaction is met by others in the environment and not necessarily by the mother alone.

Globalization and the hegemony of the western, industrialized life-style threaten indigenous approaches to infants and child care as they may be perceived as being 'better'. In the words of Mary Ainsworth when she spoke with mothers in Uganda many years ago:

> I do not believe that European methods of infant care are better than your customs just because they are European, or because they are methods used in my own country. I believe that some of our customs are probably better than yours, but I also believe that some of your customs are better than ours. (Ainsworth, 1967, p.20)

Non-western cultures are in danger of giving up on beneficial child rearing practices in favour of modern approaches that are not necessarily better. It thus behooves us to be circumspect when talking about or giving advice and developmental guidance to parents who come from diverse cultural backgrounds.

While not wanting to assume that African societies are homogenous, and that therefore the customs pertain to all the groups of people living on the Continent, there are some basic common denominators that can be identified as influencing child rearing and that should be given attention and, importantly, from which western cultures could learn.

In the following section four practices will be described that are respected in traditional African cultures, but that are in danger of being lost. The first two, *Ubuntu* and the meaning of babies, are part of the worldview of many if not all communities in Africa and thus part of the psychology of the caregivers; the other two practices are more directly practical and belong to the customs of child care described earlier.

Indigenous cultural practices and what we can learn from them

Ubuntu

A recent review of attachment studies in Africa found that secure attachments rates were reported to range from 53.7 to 90.2% (Voges, J; Berg, A; Niehaus, 2019). Thus it would seem that the majority of mothers had the ability to create a safe environment for their infants, amidst adversity, unpredictability or turmoil, and were able to facilitate the healthy development of their children.

What are the factors that may assist parents in creating an environment conducive to secure attachment and that help parents to overcome these challenges? One possible protective factor is the notion of *Ubuntu*. This is a concept that is common to most African traditional cultures. The Xhosa proverb (*Umtu ngumtu ngabantu*), meaning "A person is a person because of another person" (Berg, 2012) best describes this concept. Compassion for others and a sense of community among individuals is central. The individual is seen in relation to the broader community, and personal development is marked by rituals that involve the community within which they live. It is out of this worldview that the proverb "it takes a village to raise a child" (Mooya, Sichimba, & Bakermans-Kranenburg, 2016) is born. The infant is thought of as belonging to the community and the wellbeing of the children within that community is considered a collective responsibility (Tomlinson, Cooper, & Murray, 2005). Mothers can find support from the people around them, even if these are not direct family. Infants thus grow up within a wider network of people whom they can trust and rely upon. Sadly, this collective responsibility is diminishing as urbanization increases, resulting in mothers having to raise their children without the support that tradition encourages.

The meaning of babies

Babies carry the hope for the future: they will ensure that the family thrives and grows; they will provide for the older generation, and they will be the ones who will remember the parents when they have died. The hope in them is thus economical as well as spiritual.

In Africa not only do the nuclear and extended family play a central role, but also the clan – this includes those that have deceased. This structure runs along patriarchal lines. The reverence for the ancestors is introduced to the child from very early on through various means. There is the practice of "praising the child in his clan" – this is a rhythmical incantation that names the child and the child's forebears, one by one, going further and further back into the ancestral history. The child is thus explicitly embedded in the clan structure through this lullaby-like chant.

In the *amaXhosa* tradition of the Eastern Cape in South Africa, the infant is also introduced to the ancestors through a special ceremony, called the *imbeleko*. This ceremony brings together the extended family, as well as the community in which the family live, and they bear witness to the ritual through which the child is introduced to the ancestors (Berg, 2012). The Western equivalent might be the christening ceremony.

In other African cultures the spiritual meaning of the infant's life may be articulated differently. The Beng people of the Ivory Coast believe that each baby is a reincarnation of an ancestor. Thus, when a baby is unhappy for no obvious reason, it is believed that it is trying to communicate a spiritual need and for this, a diviner may be consulted (Gottlieb, 1998). Much of the behaviour of the infant as well as the older child is explained from the basis of the child being part of a much larger life cycle than the one that Western traditions are aware of. This is an example of a very particular way of viewing the child and it may well be changing over time. However, the depth of the spiritual role that is attributed to infants and young children needs to be acknowledged and respected in this community as in all other human groups.

Back carrying

The lived, spiritual link to the ancestors and the community is grounded in the physical closeness to the mothering figure. Most infants in sub-Saharan Africa are carried on their care-givers back. On a practical level it is a method of transport for infants before they are able to walk and reflects an adaptation to the physical environment where prams are not available and also not suitable to the natural terrain. Carrying the infant on her back also enables the mother to be close to her child, ensure its well-being at all times, while being able to have her hands freed to do work. Even when the child is older, the mother will continue with this custom if there is a physical reason, such as a handicap. The Xhosa saying of "the elephant does not complain about his trunk" depicts the acceptance of this task.

Back-carrying provides multiple opportunities for bonding: physical closeness, being swaddled and feeling 'held', being in-tune with mother's physical rhythm and generally feeling 'safe' in the high position on mother's body. It literally provides a 'secure base' for the infant, one that is physically felt.

From a medical point of view there are also advantages for conditions such has hip-dysplasia (Graham) which is rarely encountered in infants in Sub-Saharan Africa. Thus indeed, it is true that: "The mother's back is the baby's medicine" (Wolof proverb) (Timyan J, 1988, p.15).

Unfortunately, urbanization and modern life has encroached on this traditional way of transportation. Increasingly prams and strollers are being used, which may suit the mother better, but which do take away that very special early physical intimacy that is possible in the more traditional settings.

Breast-feeding and sleeping

Being fed and sleeping are the two primary 'tasks' that the infant has to engage with in order to survive and thrive. This early stage of unity between the mother and baby is known as the *Mdlezana* phase in the isiXhosa tradition. It could be likened to the Winnicottian concept of "primary maternal preoccupation" (Berg, 2003). Much of what is accepted in the early stages of child rearing, could be understood in terms of the mother being in the *Mdlezana* phase. The anxiety around sleeping and feeding, so often found in clinical practice in the urbanized population, is not evident with mothers who rear their children within traditional African norms.

Customs originate because of outer realities. Sleeping arrangements thus reflect the physical setting – when the mother is working, she may have the infant sleep on her back, to be put down on the ground once asleep. At night, the safest and possibly only space there is, would be next to the mother, in her bed. In the African tradition it is natural for children to sleep with their parents until such time they can share their bed with their older siblings.

In western industrialized populations co-sleeping has been considered dangerous, as it is claimed that it could lead to sudden unexplained infant deaths. Evidence for a direct link has however of late been questioned. New research suggests that co-sleeping may in fact be adaptive from an evolutionary point of view (Barry, 2019). Sleeping arrangements and habits are part of our culture and are as such a complex phenomenon that is intimately tied not only to physical settings but also to the psychology of the caretakers.

Other customs, such as feeding, mirror the reality of the advantages of breastfeeding: that is, a readily available milk supply. It is considered a given that the child has access to the breast at all times, including the night.

In addition, there may also be attitudes and beliefs about the specialness of mother's milk that may be considered to transmit to the child certain powers (Timyan J, 1988). Maiello describes an infant observation in a community in South Africa which describes the physical one-ness between the mother and her young baby. Maiello describes it thus:

> The transition from 'breast' to 'no-breast' remained fluid. She (the mother) was surprised when I asked how often she fed her baby and replied "Always". This included day and night. She was equally surprised when I told her that European babies usually sleep in a cot separated from their mothers. (Maiello, 2003, p.83)

A practice that ensures the infant's unlimited access to the breast during the first two years of life is the *madzawde* practice among the people of Gorongosa in Mozambique. During the *madzawde* period the mother is free to devote her entire attention to her child. The infant is breastfed and in close physical contact with the mother at all times, while the mother is freed from household and other family duties. The underlying belief is that the environment is polluted and that the infant is vulnerable to this polluted environment; the baby's health could thus be affected if exposed too early to the bigger world. This important period of close connection between mother and child ended after two years with a specific ritual.

The *madzawde* period was disrupted during the war in Mozambique and the intense period of drought in Gorongosa. The struggle to survive made it impossible for the *madzawde* period to be respected and for the associated rituals to be performed.

A study done in Gorongosa after the war ended, found that even in the absence of food insecurity, a high percentage of infants were found to be malnourished. This was attributed to the disintegration of the madzawde practice (Igreja, 2003).

The importance of cultural beliefs and customs is evident in this example which translates the notion of the "First 1000 Days" into practice. It demonstrates the wisdom that underlies many cultural child rearing practices.

The importance of acquiring cultural knowledge and understanding

Child rearing practices are not monolithic, but, are forever moving and adapting to new settings. No culture is static, but changes according to the times and places we live in.

Because of the predominance of research on infants and their parents in western countries, there is a tendency to use the western model as the norm against which different ways of child rearing are not only measured, but also judged. In fact, the opposite could be said to be true: that western cultures could learn from other cultures, such as African cultures. In fact, it may be happening already, as some African traditions are being introduced into Europe and the USA as ideal modes of caring for babies, such as co-sleeping and on-demand breast-feeding.

For the practitioner on the ground it is essential to learn about the culture of the particular family and community, and to reflect on these customs. They may have deeper meaning and they may be more appropriate in the family's context, than what textbooks from Europe or the USA may prescribe.

In conclusion

Traditions and rituals are part of life – the way in which we perceive the world and make meaning of it depends on the cultural group into which we are born. Even the individualized western European way of living has its own 'weft and warp of

meanings' which underlie its customs and life-style. What is regarded as 'the truth' in one group may not be seen as such in another. It is essential that we understand the relativity of our convictions.

It is important not only to acknowledge and respect difference, but to acquire a basic understanding of the world view of the different cultures that are the essential part of our collective humanity.

References

Ainsworth, M. D. (1967). *Infancy in Uganda-Infant Care and the Growth of Love*. Baltimore: The Johns Hopkins Press.

Barry, E. S. (2019). Infant Behavior and Development Co-sleeping as a proximal context for infant development : The importance of physical touch. *Infant Behavior and Development*, 57(May), 101385. https://doi.org/10.1016/j.infbeh.2019.101385

Berg, A. (2003). Beyond the Dyad: Parent-infant psychotherapy in a multicultural society - Reflections from a South African perspective. *Infant Mental Health Journal*, 24(3), 265–277. https://doi.org/10.1002/imhj.10055

Berg, A. (2012). *Connecting with South Africa - cultural comunication and understanding*. College Station.

Gottlieb, A. (1998). Do infants have religion? The spiritual lives of Beng babies. *American Anthropologist*, 100(1), 122–135. https://doi.org/10.1525/aa.1998.100.1.122

Harkness, S., & Super, C. M. (1994). The developmental niche: A theoretical framework for analyzing the household production of health. *Social Science & Medicine*, 38(2), 217–226. https://doi.org/http://dx.doi.org/10.1016/0277-9536(94)90391-3

Igreja, V. (2003). The effects of traumatic experiences on the infant-mother relationship in the former war zones of central Mozambique: The case of madzawde in Gorongosa. *Infant Mental Health Journal*, 24(5), 469–494. https://doi.org/10.1002/imhj.10068

Maiello, S. (2003). The rhythmical dimension of the mother-infant relationship - transcultural considerations. *Journal of Child and Adolescent Mental Health*, 15(2), 81–86. https://doi.org/10.2989/17280580309486552

Mooya, H., Sichimba, F., & Bakermans-Kranenburg, M. (2016). Infant–mother and infant–sibling attachment in Zambia. Attachment & Human Development, 18(6), 618–635. https://doi.org/10.1080/14616734.2016.1235216

Timyan J. (1988). *Cultural Aspects of Psychosocial Development: An Examination of West African Childrearing Practices*. Washington, D.C.

Tomlinson, M., Bornstein, M. H., Marlow, M., & Swartz, L. (2014). Imbalances in the knowledge about infant mental health in rich and poor countries: too little progress in bridging the gap. *Infant Mental Health Journal*, 35(6), 624–629. https://doi.org/10.1002/imhj.21462

Tomlinson, M., Cooper, P., & Murray, L. (2005). The Mother-Infant Relationship and Infant Attachment in a South African Settlement. *Child Development*, 76(5), 1044–1054.

Voges, J., Berg, A., & Niehaus, D. (2019). Revisiting the African origins of attachment research - 50 years on from Ainsworth: A descriptive review. *Infant Mental Health Journal*, 40, 799–816.

WAIMH Connectors and Collaborators Column: Celebrating Dr Niels Rygaard

By Maree Foley, Switzerland and Deborah Weatherston, USA

This column features WAIMH members who are contributing to the fabric and virtues of WAIMH in their region and or community. It especially celebrates their tireless efforts to build working relationships across disciplines and sectors for the benefit of infant and family mental health and development. In this column we introduce and celebrate Dr Niels Rygaard (DPA) (Authorized Clinical Psychologist), from Denmark. Dr. Rygaard has contributed articles to WAIMH Perspectives and presented at past WAIMH Conferences. He has a commitment to relationship health. The WAIMH Perspectives Editorial team would like to congratulate Dr Niels Rygaard who has recently been recognised by the American Psychological Association (APA) Committee on International Relations in Psychology (CIRP) as the recipient of the *2020 APA International Humanitarian Award*. He has been presented this award "in recognition of your sustained and enduring humanitarian services to underserved populations" (APA Committee) especially for services to children without parental care.

Niels Rygaard is the cofounder of Fairstart Foundation, with Morten Jac. In learning about this award Niels was quick to acknowledge the shared work of the Fairstart team. The organisation was "founded based on an increasing interest in the online training programmes developed by Niels Peter Rygaard in collaboration with a team of international researchers" (www.fairstartfoundation.com).

Niels is an:

> Author, researcher and consultant for organisations, NGOs, and governments in the development of caremonitoring systems and education of caregivers.CEO and co-founder of the Danish registered Fairstart Foundation, www.fairstartfoundation.com .

The mission of the Fairstart Foundation is to:

> The mission of www.fairstartfoundation.com is to unite researchers, organizations and daily caregivers, in a joint effort to improve the mental health of world children without parental care. In 20 close partnerships with NGOs and governments, we provided their staff with educations in how to train local groups of foster families and group homes. 600 staff around the globe graduated and trained the caregivers of some 40.000 children, in how to practice attachment-based care. Currently, SOS Children´s Village staff in four East African countries apply our Swahili and Kinyarwanda trainings. With the Greenland government we implement educations in Inuit. I thank WAIMH and all partners for sharing their knowledge and experiences, constantly adding to further developments. (Rygaard, N.P.)

If you are interested to know more about the Fairstart Foundation, here are some links to papers in various languages:

https://independent.academia.edu/NielsRygaard

https://www.researchgate.net/profile/Niels_Rygaard2

In addition, the following link provides a two-minute video with examples from trainings in various countries:

https://www.youtube.com/watch?v=qlW3eMXCJc4&list=PLZ8krePbR-seBtq8zjoB2ayNEvlA-ha7K&index=8&t=2s

For further information about the Fairstart Foundation and/or to contact Niels:

info@fairstartfoundation.com

Book Review

Hush: A Fugue by Dominique Hecq

2017, UWA Publishing, Crawley WA

By Christine Hill PhD, Australia

At first glance this may look like a book about sudden infant death, but it is much more than that. The narrative is non-linear and the prose unconventional, yet like the feeling/thinking process of the therapeutic encounter, it works its way to the heart of the matter to create a space for change. This is a story of loss, love, and reparation – an old story told in a new way, and one we can learn from. Of note, all quotes from this book, in this review, are in italics.

When a baby suddenly dies the whole world feels wrong. Nature is out of order and madness is in the air. Disbelief gives way to guilt and anger, and fear. Grieving parents become incoherent and unreliable; their own relationship struggles to breathe. Siblings fear they will be next, and wonder: "Why?" and "How?" but there is no one to answer. All we know is that when a baby dies part of us goes with her, and for a time, life feels empty as the cot. *Hush: A Fugue* is a disquieting exploration of that emptiness.

The incidence of Sudden Infant Death Syndrome (SIDS), or cot death, has significantly reduced since the 1970s (Raven 2018, p.74) but despite substantial medical research and public health campaigns SIDS continues to be "a leading cause of post-neonatal mortality in many developed countries" (Hauck et al. 2017). However, the absence of a universal system for data-gathering means that accurate statistics are elusive. The statistical picture is blurred further by the fact that the scientific community cannot agree on a definition, with one senior researcher confessing that "it is disappointing that standard definitions of SIDS are either being ignored or idiosyncratically modified to suit researcher's needs" (Byard 2018, p.3). However, the experts do agree on one thing: "SIDS remains a diagnosis of exclusion" (Duncan & Byard 2018, p.16), leaving families and their mental health professionals to manage the gap.

Fortunately, when facts are not enough, we have the arts to help us. The prose poetry of *Hush: A Fugue* confronts the gap as it exposes and explores primitive impulses, nursery ghosts, and creative reparation. Here, we find a mother who employs the act of writing to surpass her grief after the sudden death of her infant son. At first the wild pain of loss engulfs her. Unable to speak, eat, or sleep, she comes close to disappearing herself. She cooks comfort food, almost obsessively, yet it brings no comfort: *"I longed for food...I would not eat...I could not eat lest I implode with guilt or explode with anger"*. Consumed by the fear of *"succumbing to sorrow"*, she could not cry but felt compelled to write, "*for the sheer satisfaction of keeping fear at bay...even if words did not make sense"*. In the writing, something is unlocked. The tears come, and with them, a flicker of hope.

With time, the liveliness of her first child and the quiet presence of an imperfect husband combine to create enough space for the mother to acknowledge the continuity of life: *"the sky became our calendar"*. The tempo of the natural world, with its changing seasons, holds her and gives her something to hold: an experience that is real. She keeps writing. On a cliff-top, before dawn, life is again precarious. We hold our breath as she spreads her arms; in the dark we hear her primal cry, and then,

> *"In the darkness, there came a turning. It was as though the dark itself offered a leitmotif. At that point I saw just two qualities: an ability to be, and to be attentive... An inner world opened up in me. I began to walk and as I walked I began to speak again".*

It was, she says, a glorious dawn.

The appropriately ambiguous 'fugue' of the book's title creates a link between the mother's distorted thinking and the writing's rhythm. By interweaving memories, hallucinations, happy-family scenes, and the loneliness of her struggle with reality, Hecq mimics the contrapuntal composition of a musical fugue, her words on the page like notes on a score. This physical arrangement of words serves to contain the terror of the mother's dissociative fugue state enough for the reader to feel it. The form allows Hecq to find the words to say it; to find those impossible, voiceless words (Hush!), and to play with them, pull and push them to their limits, repeat them over and over

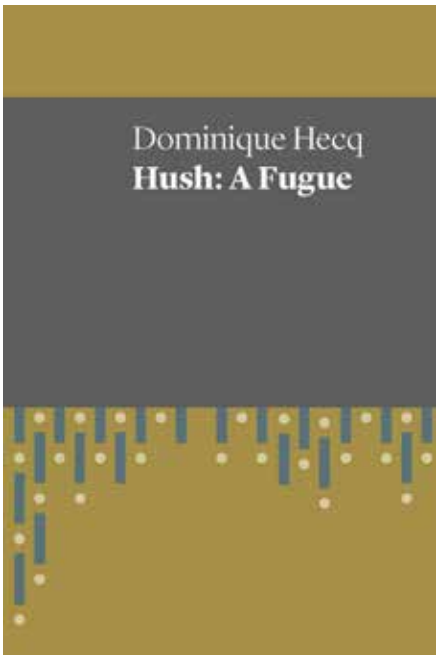

Photo reference: The book cover sourced from UWA publishing: https://uwap.uwa.edu.au/

and over until we know they must be true. She loses words, finds foreign ones, remembers, or shrinks from others. We come to understand that her words are her *Self*. They are starved, silenced, re-invented, and purposefully tossed across the page for us to swallow, digest, and make sense of. The shocking words take us with her, down, down to her *"black sea"*, that place *"between guilt and grief"*; and yet we do not drown.

We do not drown because Hecq saves us, and herself, with the art of her writing. Holding her breath, and paddling like mad, she bravely gathers those dreadful words to her breast. She looks them in the eye, considers them, and orders them to obey her, just as she was obliged to suffer the things they describe. Unflinching, she guides the reader through her dark interior, through madness and fear, to come out the other side, into the light and very much alive. This lived fugue experience and the work of its writing allow her to finally *"put death to death"* and create a poetic monument to her son, David.

When a baby dies there is no consolation, only mourning, but as Hecq so painfully reveals, the path from grief to mourning is not easy, especially when other griefs get

in the way. She reminds us that, at first, the task is to exist, in place and time, to watch the seasons come and go, to allow for the possibility of finding words, and with them, reparation:

> *"I, myself, kept alive as I turned affect into feeling, feeling into emotion, memories into fiction, fiction into being in a relentless process of littering and lettering loss, hope, love.*
>
> *It is a matter of existing within that polarity – between the white centre and the vast periphery, between the black in the white and the colours in the light.*
>
> *To exist is to stitch a wound.*
>
> *To write is nothing but to stitch a wound with a child's hand".*

This is not a book for newly bereaved parents; although after a time, and with guidance, it may offer hope to some, particularly to those who feel trapped by their grief and are unable to mourn. But for those of us whose work is concerned with the mental health of infants and their parents this book is a gift. Until now, our understanding of SIDS has relied on scientific writings which attempt to describe and define, or on the sad recounting of personal stories. Hecq's poetry is different; it takes us deep inside the mad-making experience of losing a child and then, courageously, generously, Hecq takes us with her as she writes her way from grief to mourning, and finally, to self-examination and understanding: *"Perhaps writing, especially poetry, is the art of loss. It is the blanks that are pressing"*. She shows us how art can make sense of things that make no sense.

After the death of a baby families must find ways to get on with their lives. There may be new babies – replacement babies, obliged-to-be-lively babies, filled-up-with-parental-anxiety-babies – who struggle to be in their own skin. These babies find themselves on the other side of the empty space, the space once occupied by another, the space where *"the blanks [...]are pressing"* and where answers might lie. Sometimes that empty space is transported from a past generation where the deceased baby is consciously known to the present as no more than a ghostly whisper, if at all.

When infants appear to have difficulties with sleeping, eating, crying, or myriad other behaviours and their parents come to us for answers it is not immediately clear what (or who) is missing. However, we do know that loss, in its many forms, is not uncommon. *Hush: A Fugue* reminds us that the echoes of grief are always calling. It is our task to listen for them.

References

Byard, R. W. (2018). Sudden infant death syndrome: definitions. In J. Duncan & R. W. Byard (Eds), SIDS – Sudden infant and early childhood death: The past, the present and the future (pp.1-13). Adelaide: University of Adelaide Press. doi: https://doi.org/10.20851/sids

Duncan, J. & Byard, R. W. (2018). Sudden infant death syndrome: an overview. In J. Duncan & R. W. Byard (Eds). SIDS–Sudden infant and early childhood death: The past, the present and the future (pp.15-50). Adelaide: University of Adelaide Press. doi: https://doi.org/10.20851/sids

Hauck, F. R., McEntire, B. L., Raven, L. K., Bates, F. L., Lyus, L. A., Willet, A. M., & Blair, P. S. (2017). Research Priorities in Sudden Unexpected Infant Death: An International Consensus, Paediatrics, 140 (2), 1-10. doi: 10.1542/peds.2016-3514

Raven, L. (2018). Sudden infant death syndrome: history. In J. Duncan & R. W. Byard (Eds), SIDS – Sudden infant and early childhood death: The past, the present and the future (pp.73-84). Adelaide: University of Adelaide Press. doi: https://doi.org/10.20851/sids

Introduction by Deborah J Weatherston (Associate Editor)

"A Beautiful Mess:Early Childhood Mental Health Consultation" is reprinted in WAIMH Perspectives with permission from the Michigan Association for Infant Mental Health (MI-AIMH), the author, and the editor of MI-AIMH's 'The Infant Crier." This article provides a unique and compelling window into the world of early care through the eyes of an infant and early childhood mental health consultant and her team in Michigan, USA. The opening sentences sets a welcoming tone to: "the delicate world of childcare. The days begin and end with separations and reunions, some for the first time in very young lives. How do we support these precious moments of transition? How do we support the caregivers? Emotions and memories are gathered and created, swirling around the room filled with colors and caregiving."

The author writes sensitively and deliberately about relationship centered consultation, with attention to multiple relationships - those between consultant and teacher, teacher and child, teacher and family, parent and child. The narrative is filled with rich classroom scenarios from the Circle of Caring Consultation program that illustrate what the infant mental health informed practitioners observed and learned and the ways in which they worked while present weekly in the classrooms. These classroom observations were coupled with monthly reflective group consultations with teachers, inviting teachers to think deeply about their own values, beliefs, and responses to children and families in their care. The author's commitment to the concept that change occurs within the safe space of a relationship provides the underpinning for each consultation and is threaded throughout the article.

This model for reflective, relationship centered consultation for teachers that leads to reflective, relationship centered early care for all children is one we might wish to see around the world.

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A Beautiful Mess: Early Childhood Consultation – Building Relationships in the Classroom

By Vickie Novell, LMSW, IECMH- E, USA

Clinical Supervisor — Circle of Caring program, The Guidance Center With support of the Circle of Caring Team: Wendy Dawson, LLP, IMH-E; Danielle Davey, LMSW, IMH-E; & Jill VanDoornik, LMSW, IMH-E

Welcome to the delicate world of childcare. The days begin and end with separations and reunions, some for the first time in very young lives. How do we support these precious moments of transition? How do we support the caregivers? Emotions and memories are gathered and created, swirling around the room filled with colors and caregiving. Whom do we trust with this space for such young souls? Fortunately we work with caring teachers who step up to share their creativity and energy with these young families. Of course, teachers bring their own emotions and memories but are often asked to "leave them at the door" as they care for other people's children. On the best day, there is care and concern, victory and resolve. On other days, there are different feelings — ones sometimes not acknowledged or even known. Where do these feelings go? What kind of memories do they awaken? What kind of memories do they make?

Given the Herculean task of development in all domains — the body, the heart, the soul, and the mind, the Early Childhood educator is indeed a jack of all trades. As pressure from the dreaded K (kindergarten) rears its ugly head and families bring in enormous burdens of poverty, trauma, and loss, teachers are often torn. Teachers are torn between the urgency to "get children ready for school" and "Did you hear what happened to that child/family?" Day-to-day priorities in the classroom are often at odds, not always based on child needs, sometimes driven by assessments, scores, and monitoring. Parents come and go, sometimes through only brief interactions, strained by their own days ahead and ones past, with their own journey of school and authority ringing in their hearts and minds. Let us not forget the lives of the teachers; those lives they are supposed to leave at the door. They, too, may be carrying emotional burdens — family illness, financial challenges, family stress, as well as their own trauma and loss.

Positive early childhood teacher-child relationships are highly correlated with future school and peer success, according

to a growing body of research. Yet more and more young children are entering our classrooms with insecure and even disorganized attachment styles. These children seek connection and support in challenging ways, sometimes struggling to accept emotional support and guidance from the kindest, most well-intentioned teachers. So, what are we to do with these rooms filled with energy and possibility, bathed in feelings and memories? There are opportunities for teachers to find high-quality training in child development, trauma and special needs, but teachers are still understandably struggling. Even the best-trained teacher can still experience suffering and vicarious trauma. Developmental trauma or toxic stress occurs when "emotional pain cannot find a relational home in which it can be held" (Epstein, 2014). Early Childhood Educators are a relational home for the children in their care, but the load can be heavy. Where is the teacher's relational home?

The Circle of Caring Early Childhood Mental Health Consultation program at The Guidance Center is helping construct such a home. Through a generous grant from the Head Start Innovation Fund, four Infant and Early Childhood therapists have been working in 10 Head Start classrooms over the past 2½ years. Through monthly group reflective consultation for teachers and weekly classroom-focused reflective consultation, these teaching teams have developed a strong working relationship with their consultants. Based on the original statewide Circle of Caring Child Care Expulsion Prevention Program led by Kathleen Baltman, MA, IMH-E, our consultants–have been learning and growing alongside the staff and teachers. Through our transformation from IECMH therapist to ECMH consultants we have experienced first-hand how beautifully IMH principles and practices address the much-needed emotional support for these classrooms.

Early Childhood Mental Health (ECMH) consultants have a great opportunity to create a holding environment with the teachers so that they, as Jeree Pawl would hope, provide the same for the children and families. Thanks to researchers such as Walter Gilliam, Kadija Johnston, and Charles Brinamen, this growing field is revealing the critical and interdependent needs of these very young children, their families, and the teachers who care for them every day. As part of this professional community, Infant and Early Childhood therapists are well suited to offer this gift of presence for these systems and communities based on our training, experience, and deep commitment to reflective supervision and practice. While our background provides a strong foundation for consultation work, the transition from clinical work to consultation requires training, support, and reflection.

"What about the baby? Which baby?"

So how do we begin? Our port of entry and intervention is the relationship, but which one? As one consultant remarked, "Being in the classroom is like being at a home visit — at the highest volume." So many needs and feelings coming from so many different directions — teachers and children alike. At first glance — and feel — it can be overwhelming and seem like an impossible task. Me contain this? Where do I look? Where do I stand? Or sit? Who do I look at? Who on earth do I interact with? All consultants have experienced that moment of fight or flight, which professionally can look like flight/freeze — stand in the corner and just observe silently without looking at anyone. Or it can result in fight/control — take over group, intervene in behavior management, provide conflict resolution, and model. There is a flush of panic and responsibility, sometimes because of an acute attunement to the children and teachers' internal experiences.

ECMH consultation work, like clinical IECMH work, begins with us, the clinician. Grounded in the belief that the port of entry and intervention is OUR relationship with the teacher, we have the responsibility of maintaining and repairing our centeredness so that our offering of ourselves can provide a place of calm and reflection. Disruptions are expected, as in all relationship work, and "good enough" consultation is the aim. Our response to the disruption — sensitive, thoughtful, and humble — is the very point of healing. Through the ongoing support of our reflective supervisor, we can work to return to that center. Our Circle of Caring program offers weekly group supervision to all consultants. Through this supportive environment, we learn to refine our internal instruments — our open, receptive, curious selves — so we can become more attuned to the implicit, affective communication of the teachers and children.

And so it begins…

At the start of the program more than two years ago, we were acutely aware of the need for a sensitive, deliberate approach. As in any relationship work, beginnings are an opportunity for a different felt experience of being seen, heard, and known. Leaning on the wisdom of mentors, we worked to keep in mind the "consultative stance" (Johnston & Brinamen, 2006) how the attunement to one's way of being with the staff, teachers, and even the system, can communicate the calm, centered, curious state that will be the hallmark of the practice. From the details of meetings and schedules to the desire to approach as equals, we hoped that we were beginning the process of explicitly and implicitly demonstrating our goals and hopes.

Through early interactions and observations, consultants expressed curiosity about the teachers' experiences of help in the professional setting. From the orientation to the project to the first classroom sessions and groups, consultants remained open to learning about the teachers' needs and hopes for support, communication, and comfort with vulnerability and change. Throughout our work we became more and more attuned to adult internal working models (IWM) that inform the internalized expectation of their worth as a teacher/human, their efficacy, and their beliefs about others being helpful (or not), caring (or not), and accepting (or not). The teachers' own personal IWM has been internalized and adapted based on their earlier caregiving experiences. We became more aware of the concept of professional IWMs. Often rooted in one's personal IWM, professional IWMs are the ghosts of past helpers, site leaders, monitors, specialists, parents, and children. Sometimes coined bureaucratic transference, these are the conscious or unconscious expectations and predictions of how the professional will be assessed, be seen, be deemed worthy of help, and how efficacious they will be with the children and families. In addition, the professional IWM contains the experience and expectation of the availability and dependability of professional and emotional support from the work culture: Is it safe to ask for help, and how will that help feel? The following example occurred frequently at the beginning of the project, and again at crisis points in the work:

> Teacher "Mary" had recently entered the program from another agency. During one of the first weekly classroom consultations, the consultant observed a busy, highly emotional classroom. Mary was working with a pair of children who were having difficulty with transition and ownership of materials; she stayed patient and present throughout the

conflict. The situation resolved well and the children moved on to another activity. During a lull in the commotion, the consultant took the opportunity to approach Mary and remark on how she noticed the positive effort that Mary had made, noticing that she was able to contain their feelings and help the children through a difficult time. Mary became teary-eyed and thanked the consultant. The consultant expressed surprise at Mary's reaction, which seemed tinged with sadness. Mary went on to disclose that she had recently left a different system that was highly critical of her, leaving her feeling judged and 'less-than' as a teacher. She was worried to have a consultant in the classroom and relieved to hear positive remarks. The consultant thanked her for being so open and they went on to discuss the goals of the supportive classroom work.

As we entered these relationships we became acutely aware of the need for transparency, predictability, and reliability for these teachers. Not unlike a family in crisis, teachers feel under the microscope and, unfortunately, bear the increasing weight of academic demand, monitoring stress, and systemic expectations. Explicit discussion of what the consultant would and would not do was an important part of the ongoing demonstration of our unique perspective. For example, we communicated at the beginning that there would be no writing down of thoughts or ideas, no strategies or lesson plans, no monitoring or reporting to the administration. Repeatedly we spoke to the concerns, spoken or not, of the worries about judgment and reprisals. We heard the requests for advice and strategies as an indirect expression of a variety of possible feelings. "Am I enough? I feel inadequate. Will you judge me? Are you better than me?" We worked to respond to the underlying feelings of fear, worry, insecurity, and apprehension through our calm, mirroring presence and reflections. Through our words and actions, we strived to communicate that *the teachers* are the experts and they are enough for these children and families.

"The eye of a hurricane"

Early Childhood classrooms, and especially Head Start classrooms, are a sea of emotions and experiences. Competing developmental and emotional agendas call out for skilled teachers who use their ability to stay present and calm to accompany the children through challenges and failures. This emotional work is the heart of learning, the creation of a safe haven and secure base from which to explore. An early childhood teacher must multi-task this emotional work with little to no time to pause, reflect or plan. Add to that the unknown stress and trauma of all classroom participants, and you may wonder how teachers are able to stay present and connected at all. Though we all fall out of the calm center, it is no wonder that teachers feel barraged by needs, both concrete and emotional, and may go into autopilot or fight or flight. No wonder they may lose perspective; hence the need for support to regain their footing.

A central tenant of our program is the firm belief that teachers have their own powerful intuition and ability to create supportive, nurturing responses to children and experiences. The barrier to these responses is, understandably, the dysregulation that occurs when faced with such high needs and limited reprieve and support. Our role with the teachers is to create a safe space where they can become more regulated, whether in the classroom or group setting. Knowing that the purpose of attachment is to promote safety and exploration, we look for opportunities to assess the state of being of the teachers and allow our relationship to become their secure base and safe haven. Inherent in this structure is the belief in *developmental drive*, "motivational structures (that) can also be regarded as fundamental modes of development. As such they are life-span processes that can be mobilized through empathy in the course of therapeutic action with adults". (Emde, 2009)

We stand firmly in the belief that our role is to promote regulation, which will intuitively lead to curiosity. Co-regulation allows for the preoccupation with safety to shift to the "other," us as consultants, the environment, and the children, not from a fear response, but from a neutral or curious state. Creating a safe relationship with the teachers and with each other in the group setting takes time and a gentle approach. At the beginning, "do for" is a state of a sensitive approach to joining the teachers in relationship, all the while remaining keenly aware of the cues and miscues of comfort and acceptance of intimacy. Keeping the components of attachment-seeking behavior in mind, consultants learned each teacher's comfort by noting the affective content of greetings and goodbyes; content and tone of shared work or personal stories; physical cues such as proximity maintenance and comfort, and gaze; and narrative cues, such as fluency of speech, tone, breadth and content of verbal communications. Through this ongoing assessment, consultants begin the process of learning how each teacher communicates emotions, needs, distress, and comfort with support.

Lyons-Ruth et al., (1998) explored the concept of "relational knowing" or "how to do things with others" as the port of entry to change. Lyons' group offers the belief that this internal knowing is "as much affective and interactive as … cognitive… (and) begins to be represented in some yet to be known form long before the availability of language and continues to operate implicitly throughout life" (Lyons-Ruth et al., 1998). This speaks to the belief that our relationship is the agent of change. What exactly, especially in the early education realm, is the underlying mechanism for change? Through creating a "moment of meeting," two equals bring their perspectives, belief systems, and expectations together to co-create a new way of being. With "self as therapist," the consultant will move into the emotional space with a teacher with curiosity and empathy for the teacher's emotional experience. Often seen physically as a moving toward and away, the consultants pace and dose the "being with" according to the assessed comfort of the teachers. Throughout, the consultant develops an awareness of how, and in what circumstances, the teachers become dysregulated; what cues they feel safe showing, and how and if they use the consultant for support from the beginning.

Through the attachment relationship with the consultant, the teacher is given permission to speak the unspeakable without consequences. Robert Emde speaks of *developmental empathy* as a "… temporary sense of oneness with the other, followed by a sense of separateness to be helpful" (Emde, 1989). Through the process of marking and containing affect, teachers are shown that all feelings are accepted and safe to be expressed. Interacting at the level of IWM, these interactions are "new … nonverbal encounters (that) suspend the procedural relational knowledge … (which) overrides earlier relational experiences. It thereby overwrites earlier memories" (Gossmann, 2009).

The nature of early childhood development and early parenting offers us

a roadmap for the supportive work with teachers and staff. As trust and feelings of safety increase, the teacher-consultant will begin to make use of social referencing as a regulation strategy. Robert Emde writes of social referencing as "a process whereby an individual, when confronted with a situation of uncertainty, seeks out emotional information from a significant other in order to resolve the uncertainty and regulate behavior accordingly" (Emde, 1989). During classroom consultation and times of distress, the benevolent presence and non-verbal encouraging stance of the consultant can have the same grounding effect on a teacher. Joint attention regarding a potential conflict or during an evocative experience creates a felt sense of being held in mind, while the consultant attends through a quiet presence, as Winnicott wrote, "being alone in the presence of another" (Winnicott, 1958). This encouraging, quiet attending is similar to a loving mother staying attuned to the almost-rolling infant's expression of distress. That mother expresses a quiet reassurance and confidence in the child's ability and need to struggle through the discomfort, while keeping attuned to the level of frustration so that it does not become flooded or lead to decompensation. If the arousal level becomes threatened, the mother knows the signs of dysregulation and moves in to repair and comfort. One classroom scenario speaks to our work from this vantage point:

> Teacher "Kay" and her consultant had spent considerable time over the years talking about the challenge of being with children while they were distressed without becoming punitive, directive, or moving away. During one observation, a child became inconsolable, and Kay approached him. Knowing this was a touchstone moment for their relationship, the consultant moved physically closer to her in the room while attending silently. The teacher looked to the child, then the consultant, clearly showing signs of distress. The consultant remained quiet but demonstrated understanding and empathy through her body position and facial expression. In the silence, the teacher turned to the consultant and said, "I just don't know what to do." The consultant quietly vocalized empathy and understanding while staying physically present, but not moving to problem solving or even reflection. The teacher then turned back to the child and empathized with his feelings. The child calmed and was able, after a time, to return to classroom activities.

This is a simple example of parallel process at work. Doug Davies, LMSW, PhD., wrote about this through his exploration of the role of the supportive other "to contain big feelings, remain attuned in the midst of distress, set limits on dysregulated or aggressive behavior, and put moment-to-moment experiences into words (which) disconfirms the trauma-based model that she(he) is alone and vulnerable and that relationships don't help" (Davies, 2010).

> **"You had the power all along my dear. You just had to learn it for yourself."**
>
> **– Glinda the good witch**

Our program, and many other IECMH consultation programs, draw from the rich IMH traditions of building reflective capacity as a way to enhance compassion, insight, and empathetic response. Two-hour weekly classroom-focused consultation and monthly two-hour group reflective supervisions complement each other to access not only the explicit narrative reflection work, but also the often more difficult implicit IWM and affective experience support.

Our monthly reflective consultation groups are a unique opportunity for teachers to pause, in a supportive atmosphere, and look more deeply on classroom experiences. During these sessions, the teachers are encouraged to explore more deeply the children's and parents' experiences, as well as their own experiences, reactions and feelings. Over time, these moments support the expansion of their ability to be curious about the multiple meanings of children's behaviors, the feelings behind that behavior, and ways the teacher can meet the underlying needs for emotional support and connection. Through the creation of an open, supportive group, teachers are given the opportunity to reflect on how their own inner perceptions and belief systems color their understandings of behavior and, in turn, their responses to challenging interactions. Through the gentle support of the consultant, as well as affirming peer presence, teachers have become increasingly more insightful to the families' possible histories of trauma, school difficulties, communication challenges, and issues with shame, fear, and confusion. The ability to practice creation of the narrative, and time and space for reflection, allows for a more regulated and deliberate approach to future children and interactions. Through case presentations and group discussion, individual insights become generalized to other children and classrooms. Though the pull for problem solving can be strong, consultants use their leadership to keep the reflective space for the whole group. There have been so many examples of how the change in perspective has directly affected the relationships and children in the classrooms. Here are two brief examples from the groups:

> Teacher "Julie" discussed a family whose child had great difficulty following any routines or group activities. Julie shared that she felt pressured by the mother to force the child to participate, even though by Julie's assessment this was too challenging for him. Through empathy and curiosity about mother's felt experience, Julie began exploring the mother's fears about her child's possible disability and future struggles. Speaking to the consultant the following week, Julie reported that she went from feeling anger and frustration with the mother to sadness and compassion. Julie shared that the next time she saw the mother she noticed that the mom was hovering in the background. From a place of compassion, Julie was able to see the sadness behind the annoyance. She then went over to the mother, stood by her side, placed her hand on her back while they looked together at her child, quietly. Over the next weeks, the mother began sharing her fears about her child's future, and over time was more flexible and worked as a team with the teachers.

Teacher "Alice" found one of the children in her classroom emotionally draining due to his

ongoing behavioral challenges, high activity level, and great need for interaction and guidance. Through the support of the consultant and encouragement of her peers, she was able to admit that she was frustrated. The consultant and peers expressed empathy and compassion, communicating to Alice that her feelings were justified and tolerable in the group. There was a brief conversation and the group moved on to another topic. At the start of the next classroom observation, the teacher approached the consultant with positive energy. Alice had taken the weekend to consider the child's perspective, wondering about his feelings and returned with a special backpack, embroidered with his initial, which just happened to be the same as her son's. She encouraged him to wear it around the classroom whenever he wanted and to collect and keep whatever he wanted in it for the day. The consultant noticed he was more focused, better regulated, and able to follow routines, and though he still struggled in many ways, he was calmer. This was a wonderful example of empathy and parallel process.

The process of change in classroom-based consultation goes through many stages, from building the relationship, to "being with" as a co-regulation strategy, to the co-creation of new narratives and perspectives. This process is not linear or static and is greatly affected by the stressors and regulation of all the players involved. The co-creation of perspectives and narratives takes place in the shared curious space — the "zone of proximal development," as coined by Vygotsky — and is scaffolded by a trusted advisor to move to higher developmental levels. In the consultative relationship, this may include offering the consultant's perspective as slightly different, in the effort to "see the same child." Different from didactic instruction, this perspective sharing is the meeting of equals with different perspectives to create curiosity and creativity in assessment, and ultimately different responses. In this creative, safe space, dyads explore concepts such as cues and miscues, the effect of trauma on attachment and development, and how perceptions and IWM may affect an objective view. Far from the role of expert, the consultant is a side-by-side companion in the experience of turning toward a challenging situation. Through these experiences, a well-regulated teacher can make leaps of perspective and intervention based on new information regarding development, trauma and perspective. Here is a simple example.

Teacher "Cindy" began watching a child with the consultant in the classroom. This child was very busy, but Cindy had positive regard for him and expressed confusion and curiosity about his ability to engage in classroom routines and activities. The consultant took this opportunity to share her observation about the child's limited play skills. She shared her observation that he confidently seemed to play on his own, but could only maintain cooperative play when Cindy and the other teacher supported him. The next week Cindy reported that she had spent the last week more specifically observing the child and providing teacher-led experiences with him and other children, with the long-term goal of building his independent skills to play with others. Cindy also reported that she had begun noticing that other children in the room had varying skills in cooperative play and she was intentionally scaffolding them as well.

The dance of the relationship

Our work through Circle of Caring has been an amazing, emotional, and growing experience. We have borne witness to teachers growing in confidence and peacefulness. Over these few years, teachers have begun instinctively developing curiosity and compassion for even their most challenging children and families. Through an empathetic lens, these amazing teachers are beginning to become freed up to create ways to develop new connections and build safety within their classrooms overall. We have seen first-hand that the strategies and interventions that curious and compassionate teachers create are unique, individualized, and child focused. This confirms our worldview that the creation of a safe space for feeling and being seen and held leads to amazing discoveries. These innovative ways of teaching cannot be taught; these attuned ways of responding to the children come from their own hearts. Hearts that are given a safe space through reflective consultation to speak the unspeakable, process the intensity of the classroom environment, and allow themselves to be open and fully human.

A final story tells the beauty and hope for this work:

Upon entering into one of my new classrooms in my role as a reflective consultant, I remember taking the time to pause. As I listened to the harmonious sound of the children at play, I noticed a bright yellow beanbag chair on the floor. It was a particular shade of yellow that demanded attention. As the weeks went by, the teachers and the children began to show me the meaning of the yellow beanbag chair. This teaching pair showed me many of their individual strengths right away. They were able to respond, attend and support the children when both teachers felt confident in "knowing the problem" and could quickly provide a resolution that worked. When a child became dysregulated to the point of screaming, crying and throwing themselves onto the floor, the teachers would move toward the child, using all of the tools in their toolbox to try and calm them. When this did not work, they would give into the intolerance of the child's big feelings and gently carry them over to the yellow beanbag chair. The screaming child would then be instructed to sit there until they could calm themselves down. This was a pattern that I began to see emerge as the months went by. Together the teachers and I remained curious about the times

that they felt confident and the times that they "just didn't know what to do; nothing is working."

Several months into our work together, one of the teachers discussed a difficult child during the monthly supervision group. As the consultant, I remained attuned, connected and empathic as the teacher spoke about her experience with this child. Some of the group members wondered if this child was "an only child and spoiled." The consultant explored this concept of the spoiled child more with the group. The group worked to define this idea of a spoiled child. "A spoiled child always gets what they want and can do anything without consequence." One of the teachers then began to share her own childhood experience of being like that child. The consultant noticed a slight shift in the tone of this teacher's voice as she spoke. When asked how that felt as a child, the teacher shared, "I was alone a lot. I was left to take care of myself." The group became quiet for a brief few moments. The teacher who was presenting broke the silence by being curious about the use of the yellow beanbag chair with this difficult child. With support from the consultant, the group began to wonder about this experience from the child's perspective. The teacher wondered out loud, as if speaking for the child, "I'm screaming and crying and need help and now I'm alone." The conversation was not without debate and quickly shifted to the other's perspectives. However, as the consultant, I noticed that something shifted for that teacher in that moment. The beauty of this program is that I knew I would see this teacher the following week in the classroom and could revisit this one on one.

The following week the teacher tried to put into the words her experience in the group. The safe exploration and curiosity around the use of the beanbag chair and the teacher's felt experience in the group created a space for both the teachers and the consultant to begin to name when this was happening in the classroom. This allowed the teachers and the consultant to create a language around not only the use of the beanbag chair but the teacher's internal experience that drove her to directing a child to the chair.

Several months later, two children were having difficulty sharing a toy in the classroom. One of the children became very distressed by this and began to cry, letting out a high-pitched shrieking sound that built in intensity. One of the teachers moved close to her. As the consultant, I moved in closer to the teacher as well. She tried talking to her as she swiftly moved in to pick the child up and place her on her lap. This only made the child more upset and her cry more intense. The teacher stood up with the child in her arms and brought her over to the yellow chair. However, today she did not walk away but instead sat close beside the child as she cried. I watched as the teacher's eyes boomeranged around the room until landing on me. Our eyes met and without any words, she conveyed to me her awareness of the change. I stood up and walked over to the teacher and the crying child. I sat next to the teacher and we both took a deep breath. The teacher expressed feeling helpless and unsure. She felt perplexed that trying to hold the child appeared to make things worse. Together we sat through each other's discomfort and, over time, the child calmed. From that day on the yellow chair was no longer used. When children became upset, the teachers would join them where they were, physically and emotionally.

This is why we do this work; why we wade through the emotions and memories with the teachers on behalf of the children and families. Together we work to create possibilities for the teachers, the young families, and ourselves. This journey and dance of healing is paved by presence, empathy, and curiosity with the dream to create a greater world full of loving, relational homes. We, the consultants of the Circle of Caring, are grateful for being able to share in this experience and look forward to the discoveries ahead.

References

Davies, D. (2010). *Child Development: A Practitioner's Guide*. 3rd Ed. New York: Guilford Press.

Emde, R. (2009). Facilitating Reflective Supervision in an Early Child Development Center. *Infant Mental Health Journal*, Vol. 30(6), 664–672 (2009).

Emde, R. (1990). Mobilizing Fundamental Modes of Development: Empathic Availability and Therapeutic Action. *Journal of the American Psychoanalytic Association*, 38(4), 881–913. Research Support, Non-U.S. Gov't, Los Angeles, CA: SAGE Publications.

Epstein, M. (2014). *The Trauma of Everyday Life*. Penquin Press.

Gossmann, M. (2009). Affect-Communication: The "Something More Than Interpretation." *International Journal of Psychoanalytic Self Psychology*. 3:3, 330-353.

Johnston, K. & Brinamen, C. (2006). Mental Health Consultation in Child Care: Transforming Relationships among Directors, Staff, and Families. *ZERO TO THREE*.

Lyons-Ruth, K., Bruschweiler-Stern, N. , Harrison, A. M., Morgan, A. C., Nahum, J. P., Sander, L. , Stern, D. N. & Tronick, E. Z. (1998). Implicit relational knowing: Its role in development and psychoanalytic treatment. *Infant Mental Health Journal*, 19: 282-289.

Winnicott, D. W. (1958). *Collected Papers: Through Paediatrics to psychoanalysis*. London. Tavistock.

Other Helpful Texts

Davies, D. (2012, Summer). The Therapeutic Preschool: An Intensive Extension of Infant Mental Health to Meet the Needs

of Traumatized 3-6 Year Olds. *The Infant Crier*, #133, Michigan Association of Infant Mental Health, 4-8.

Heller, S., Boothe, A., Keyes, A. & Nagle, G. (2011). Implementation of a Mental Health Consultation Model and Its Impact on Early Childhood Teacher's Efficacy and Competence. *Infant Mental Health Journal*. Vol. 32(2), 143–164.

Johnston, K. & Brinamen, C. (2012). The Consultation Relationship – From transactional to Transformative: Hypothesizing About the Nature of Change. *Infant Mental Health Journal*. 33(3), 226-233.

Author Bio

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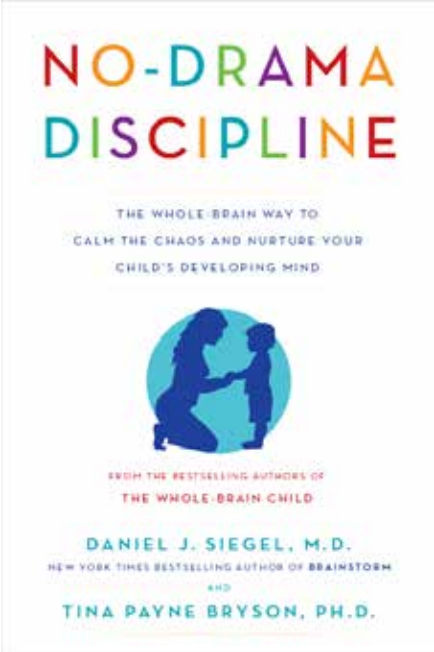
Book Review

Audiobook: No-Drama Discipline. The whole brain way to calm the chaos and nurture your child's developing mind

By Daniel J. Siegel and Tina Payne Bryson

Reviewed by Salisha Maharaj, WAIMH Perspectives Intern Editor



This audiobook, read by the authors Daniel Siegel and Tine Payne Bryson, takes listeners on an intricate journey of discovery of the developing brain and provides clear and practical advice on dealing with all the tensions, tantrums and tears that are often linked to discipline. The authors write with compassion for parents and sensitivity for children who have all struggled in the stormy waters of discipline. At its heart, the book is located within an attachment framework, positioning connection as the key piece to approaching any opportunity for discipline.

This book stands out from other books on discipline as it gives the reader a perspective from which to think about discipline, both from a neurobiological and psychological perspective. It emphasises that the moments between parents and their children that require discipline, are actually some of the most important moments of parenting. These moments provide valuable opportunities to make connections in your child's brain and these connections have a lifelong impact. The goal of discipline is reframed for parents as an opportunity to teach as opposed to punish. Defining the true meaning of the "d" word (to instruct), the authors explain how to reach your child, redirect emotions, and turn a meltdown into an opportunity for growth.

The main premise of "no-drama discipline" is to connect and redirect. The authors emphasise that connection needs to happen before any discipline measure in order to move a child from reactivity to receptivity, and in the long-term, to build a child's developing brain and internal moral compass.

The book includes a step-by-step guide for connection, clear, and simple strategies. For example, like asking why my child is acting this way, what might be behind the behaviour, giving a loving touch and getting to eye level and embracing the child's feelings. The next step the authors outline is to redirect, and this happens largely by asking yourself what you would like your child to gain from the moment. More details about the strategy and easily printable connect and redirect refrigerator sheet can be found on https://www.drdansiegel.com/pdf/Refrigerator%20Sheet--NDD.pdf.

In summary, this book can be recommended to a parent of a child of any age who requires a deeper understanding of their impact on their child's overall development, and how discipline in fact can be positioned as a key to building and strengthening the relationship. It is of particular use to infant mental health practitioners who are in the process of assisting parents to make the transition from being parents of infants to those of toddlers asserting themselves (so rightfully) in the world.

WAIMH and its Affiliate organisations: Strengthening the connection

By Anna Huber, Australia and Jane Barlow, United Kingdom

At its meeting in Tampere in June 2019, the WAIMH executive committee decided to engage in a direct consultation with a number of Affiliate organisation presidents. The goal of this consultation was to develop a better understanding of Affiliates' local circumstances, activities and member needs, to inform the development of improved arrangements to better link WAIMH and local membership.

For WAIMH there have been concerns that some Affiliates do not have a minimum of ten members, which is a requirement to maintain WAIMH Affiliate status. In addition, many presidents or chairs of local affiliate associations are not active WAIMH members (i.e. have renewed their membership each year). WAIMH is concerned that this situation has left many affiliate organisations without full participation, and also reduced WAIHMs capacity to have strong affiliate involvement in decision-making.

As such, in order to get a better understanding of the local context and perspectives of WAIMH affiliates, a number of executive members have collectively spent many hours conducting individual consultations with nearly 20 affiliate chairs of organisations, some of whose membership connection to WAIMH has lessened since they became affiliates. We learned a lot and were extremely grateful for the time each president gave, to share their perspectives and ideas.

We are now working to analyse the rich and diverse qualitative information we have collected as part of this consultation process. Once this process is finalized, and in response to affiliate interest expressed at our ROME meeting, the WAIMH board hopes to pilot a different membership arrangement, which combines local membership with WAIMH membership for Affiliates organisations.

In addition, with this greater understanding, there are many opportunities for WAIMH to better connect with, support and respond to, Affiliates' needs and priorities.

Some of the issues raised by affiliate presidents are summarized below. Please note that the issues summarized below are those of the interviewees, and do not

necessarily reflect an accurate or objective representation of WAIMH.

Many affiliates referred to **local challenges** including:

* Difficulties maintaining local member engagement and active members
* Volunteer presidents and board members lacking time due to busy day jobs
* Financial insecurity of local organisations, and the need to use resources available through other involvements e.g.- own workplaces, academic colleagues
* Challenging local economic circumstances e.g. low wages resulting in different approaches to member engagement including low member fee, no member fees, low fees for activities which bring membership, and student options
* Some small and recently formed local organisations struggling to grow and become sustainable
* Older organisations becoming inactive and hard to re-activate

Interviewees also talked about their **relationship with WAIMH**, highlighting a number of positive and negative aspects of this relationship. Positive aspects of the relation with WAIMH included the following:

* Advocacy - the value of an international voice to support local initiatives in IMH e.g. Infant rights statements; IMH journal articles
* Articles and news through Perspectives that can be used locally
* Potential to help reduce isolation for IMH professionals especially when local conditions for infants and their families require considerable work, and resources are limited
* The opportunity to build relationships with international colleagues through WAIMH congresses in addition to other benefits such as exposure to new ways of working

Challenges that were highlighted included:

* Language barriers to full engagement when Affiliates do not have English fluency
* Better communication from WAIMH at membership renewal time about Affiliate membership requirements
* While WAIMH has an online (Yourmembership) system for renewing membership , awareness of this system was patchy
* Cost of congress travel and participation prohibitive for many
* Change of local office bearers resulting in a loss of knowledge about WAIMH affiliate requirements and loss of relationship to WAIMH people-
* Connections established with WAIMH people and actions undertaken at the local level (e.g. minimum 10 WAIMH members) to achieve affiliate status by previous office bearers may not be known or maintained.
* Communication delays when issues have been raised with WAIMH office
* Local professionals needing to focus on dealing with their own issues feeling disconnected from/not interested in, a more international perspective, and seeing WAIMH as being remote from their concerns.

Ideas going forward include the need for better:

* Sharing of resources among affiliates
* Ways to network with other affiliate presidents
* A review of the ways that the automated (Yourmembership) renewal system is communicated with members

Overall, therefore we feel that that this exercise to strengthen the connections with WAIMH Affiliates has been useful, and we very much hope that this is the beginning of a more productive relationship going forward. To this end, we remind you also about the new Affiliates page on the WAIMH website: https://waimh.org/page/affiliates

WAIMH Office News: Officework and elections

By Minna Sorsa and Sari Miettinen, Tampere, Finland

Dear members

WAIMH consists of a network of persons and organisations involved in promoting Infant Mental Health and the awareness of the impact of the early years on health and well-being in adulthood. As we have about 1000 individual members and about 60 affiliates, we found out in previous years that the WAIMH network of members, associations and organisations affiliated with WAIMH consist of a around 15000 experts working with infants and their families. Thank you for being involved and active!

Spring 2020 has brought uncertainty in the lives of persons we love, and such impact on global economy and our lifestyle, that we dare not yet predict the future. For this reason, we as an association promoting infant mental health globally have opened a resource page, where we share evaluated content only. The page will be constantly updated by the Perspectives Editorial team and the WAIMH Executive Committee.

In the biennial organizational process of WAIMH we invited members to participate in the Membership meeting, which are usually held during the World Congresses. As you must have noticed, with the increasing global spread of COVID-19, it is clear that the 17th World Congress of the World Association for Infant Mental Health regretfully cannot take place as planned in Brisbane, June 7 – 11, 2020.

Membership meeting

The membership meeting took place online and we sent a link to current (2020) members, as we invited each member to participate. We had about 40 participants, thank you! The membership meeting approved of the updated WAIMH Bylaws, we heard an update from the President, the Office and Affiliate Council and 2020 and 2022 congresses. The next congress after Brisbane was published: We will travel to Dublin.

As we want to honor persons who have made an impact on the evolving field of Infant Mental Health, WAIMH offers awards in recognition of individuals from across the world who have made important contributions to the infant mental health community in the course of their careers. A young person within the field was awarded with The New Investigator Award. This year the Awards were presented at the online Membership meeting. All meeting materials are posted to the WAIMH membership website.

New board members and President-Elect

Last autumn we started the process of electing new members to the distinguished WAIMH Executive Committee. WAIMH members could have their say and Catherine McGuire was elected as a new member, whereas Hisako Watanabe was re-elected to the Executive Committee. Their term is four years, starting in June 2020. The results were presented previously in Perspectives in Infant Mental Health.

The Board Nominating Committee was overseeing the process of selecting a new President, the EC Board made their selection of President-Elect in the meeting. All candidates were presented at the WAIMH website. Emerita Professor Astrid Berg was elected to the role of President-Elect. The President-Elect will serve as WAIMH President 2024-28, and Past-President 2028-2032. Campbell Paul started his Presidency in June 2020, and Kai von Klitzing stepped into the role of Past-President.

New membership software with new opportunities

Considering WAIMH impact it is not always obvious that the Central Office, located in Tampere Finland, are working with such enthusiastic and active volunteers from all over the world. WAIMH is in its core a network of persons, who have a heart for infants and families worldwide. This makes WAIMH a specific association. The new website allows for groups to discuss and share information. If you would want to stand up and start a group eg sharing the same research interest, you could use the WAIMH membership platform for free. It is nowadays possible to either register your membership on a yearly basis or choose to renew automatically.

Contact us

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The central office will be on holidays in July, so there may be delays in responses.