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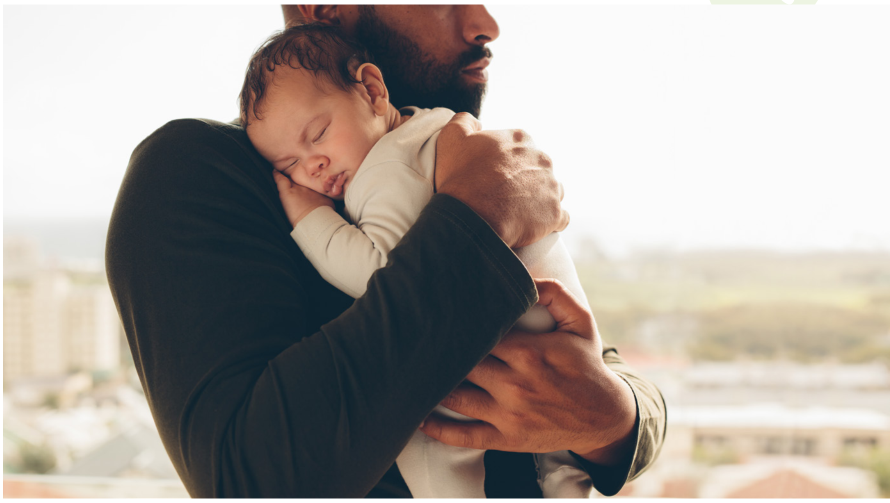
Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

Contents



Presidential Address

By
Campbell Paul, Melbourne, Australia

Associate Professor, President of WAIMH

I feel very privileged to be able to write to you, the members, as President of WAIMH, through our official publication "*Perspectives in Infant Mental Health*" so creatively edited by Maree Foley, Geneva. WAIMH is an important and diverse organisation, now in its 40th year: founded in 1980 as the World Association for Infant Psychiatry, with our first conference in Nice, France.

We have seen many things happen in our world over this time, but perhaps nothing impacting so many people globally and so extensively as the current COVID-19 pandemic. As a strong professional affiliation of colleagues working in infant mental health, it is even more important now, that we share our understanding, research, and practice ideas in the service of helping infants and families through these current crises. We also need to be supporting each other.

In this address, I provide an update about the WAIMH Board and the WAIMH 2021 Congress. I encourage us all as a WAIMH community to keep connected with each other during this global COVID-19 pandemic.

The WAIMH Board: An update

We have a wonderful team of dedicated infant mental health clinicians on the Board of Directors who are supported by the amazing work of Minna Sorsa and Sari Miettinen at the WAIMH office headquarters, located generously at Tampere University, in Finland. The activities of WAIMH would not occur without the ongoing dedicated commitment of our Executive Director Prof Kaija Puura and our Associate Executive Director Prof Reija Latva who commit much of their personal time to translating creative ideas into action for infants.

Following a selection process earlier this year, I am so pleased that we have been able to appoint Prof Astrid Berg as the President-Elect of WAIMH and that Prof Hisako Watanabe has been re-elected as a full member of the Board of Directors. Hisako has done extraordinary work throughout Japan, Asia, and beyond advocating for babies, and drawing infant and early childhood mental health clinicians together. Catherine Maguire from Cork, Ireland is now the Secretary-Treasurer of the Board as well as leading the organisation of the 17th WAIMH Congress in Dublin, which will follow the WAIMH Brisbane Congress in 2021.

Editorial Staff

Perspectives in Infant Mental Health is a quarterly publication of the World Association for Infant Mental Health. Address correspondence to Maree Foley (maree.foley@xtra.co.nz). ISSN 2323-4822. All opinions expressed in Perspectives in Infant Mental Health are those of the authors, not necessarily those of WAIMH's. Permission to reprint materials from Perspectives in Infant Mental Health is granted, provided appropriate citation for source is noted. Suggested format: Perspectives in Infant Mental Health 2020, Vol 28, No. 2 , WAIMH.

Over the last 4 years or so I had the pleasure of working closely with Dr Jody Todd Manly from Rochester, New York, who was appointed by Past President, Prof Kai von Klitzing as the President's Executive at Large. Jody has participated in our congresses and board meetings over this time and contributed enormously to the Board activities. Jody has helped coordinate public communications from the board, and as associate editor of Perspectives has supported the past Editor-in-Chief Dr Deborah Weatherston and current Editor-in-Chief, Dr Maree Foley in transforming the publication into an evolving online vibrant communication. I wish to thank Jody so much for her dedicated contributions and look forward to her ongoing participation in WAIMH activities and links with us.

In sustaining strong links with our colleagues in North America, I have invited Dr Chaya Kulkarni from Canada to be the next President's Executive at Large. Chaya is the Director of Infant Mental Health Promotion (IMHP) based at the Hospital for Sick Children, Toronto, Canada. Chaya has been committed to promoting infant mental health throughout Ontario, and indeed throughout Canada. For example, she has been engaged in advising government on the mental health needs of infants and families as well as influencing policy and service development. I am very excited that Chaya is part of the Board team. I know that Chaya has some wonderful creative ideas that will support us in the mission of WAIMH in the near future.

A Congress Update

Although we did not meet in person in Brisbane in June this year as intended, we will still have our Congress in 2021. The 17th WAIMH International Congress will be held in Brisbane from 22-26 June 2021 and this represents an important opportunity for us to honour infants and their families by sharing our understanding of the troubles that they face and how we may be able to help. This is a chance for us to share with each other what we've learned from our clinical work, our research, the efforts of our public health services, and from working directly with, and supporting vulnerable infants and families in our own countries.

The WAIMH Congress in Brisbane will be a hybrid Congress in that you will be able to participate in a lively and interactive way from your home or office in your own country, or if travel allows you, by being in Brisbane in person. The Congress organisers and the Scientific Program Committee are working to ensure that even more people can participate than before.

The Congress theme of "*Creating Stories in Infant Mental Health: Research, Discovery and Regeneration*" could not be more pertinent to the task facing us just now. Everyone has stories to share about the traumas experienced by infants and their parents and everyone has stories to share about the innovative ways we have responded to try to ameliorate their distress and the impact on the infant's inner world and development. Thus right from the beginning the baby is at the centre of our actions, because, to quote Colwyn Trevarthen, the newborn arrives "with emotions and motives for action which sustain intersubjectivity".

I am sure that each of you will have stories to share at our Congress about the impact of global or localised trauma upon the baby's own inner world and relationships. In my work over the last 9 months, I have learned a lot about how babies and parents can connect with us via telehealth and video/telephone. For example, from the way the baby as patient can use gaze, their gestures, and their voice through small screens. It can be as if you are there in the same room. Playfulness can travel back-and-forth from screen to screen.

Maybe this is not surprising when we look back over the work of Spitz, Winnicott, Tronick, Trevarthen, Emde, Stern and others who showed us how attuned infants are to crucial social communications from others. I use the term baby as patient because it is important that we acknowledge that the baby can suffer in emotional ways, as may we. We must acknowledge the baby's distress, and not avoid it.

At the Congress we will also be very keen to learn more about the positive resources that infants and families may draw upon. The COVID-19 pandemic provides opportunities for doing things differently from before and to learn from some of the qualities of the human condition that sees positive adaptation in the face of stress. Our work with babies and parents, will be very different after this.

Regarding the Congress submission process, if you have already submitted an abstract which has been accepted, you need to do no more at this stage. Our Congress committee were very keen to create space for new developments in response to COVID-19. So, we extended the abstract submission process (to 18 October 2020) to create an opportunity for you to share new developments as they relate to the impact upon infants, families, and healthcare systems of the COVID-19 pandemic.

We look forward to meeting with you in person or virtually at the Congress in Brisbane next year. Each one of us will have experienced the impact of the current global crisis in some way, and we hope that the Congress will provide an opportunity for supporting each other in our work.

Keeping connected and keeping babies in mind as a WAIMH Community through COVID-19

Although the impact of the COVID-19 pandemic globally has been frightening, we also know that so many of the world's infants and families face many other vicissitudes, problems, and frightening scourges. Many of these will be intensified by the global pandemic.

Around the world there are many profound and distressing challenges facing infants and their families. These have all been intensified in the context of the COVID-19 pandemic. We know that some 46 million people have been infected with this virus, and over 1.15 million people have died (World Health Organization October 2020). Babies are now arriving into a world, which is very different to the one that babies were born into, just last year. The COVID-19 pandemic brings with it a serious increase in poverty, unemployment, lack of access to medical care and immunisation, and intrafamilial tension and violence. We have seen global catastrophes before, such as world wars, famine and other pandemics, and our early pioneers in infant mental health played critical roles in recovery for families within their societies.

Compounding the experience of illness and death for so many millions has come isolation, loss, and bereavement along with major increases in unemployment, stress family disruption and family violence. There has been widespread cancellation of childhood vaccination programs, with many children, adolescents, and adults not able to go to school or work, and becoming more and more isolated (Fore, 2020).

Being pregnant and having a baby through this pandemic has for many been terrifying and distressing (Wu et al., 2020) with parents fearful of the effect of the virus itself on the foetus and the mother. This has coexisted with the fear and distress of not being able to have the close support of family and friends during labour and the postnatal period.

So, it is important as infant mental health professionals, that we respond to the specific stresses and strains brought by the pandemic while also not losing sight of the pre-existing urgent pressures on babies and parents. At the moment, there are major refugee camps in Bangladesh, Uganda, Jordan, Tanzania, and Ethiopia, and other countries.

There are currently hundreds of thousands of infants facing dislocation, starvation, loss of parents in the context of war, and fleeing from profound conflict. 2.6 million refugees live in camps and millions more live in other settlements far from their homelands. In the Rohingya refugee camps in Bangladesh less than 1% of children have access to secondary education and there is limited access to proper shelter food healthcare water sanitation and emergency relief. Many young children are separated from their parents as they flee from one country to another, and this separation is sometimes calculated and cold hearted.

WAIMH has taken a strong stand in support of infants' rights publishing the WAIMH Position Paper on the Rights of Infants (2016). In the November/December edition of the Infant Mental Health Journal the WAIMH Position Paper on Infants Rights in Wartime described the lack of recognition of the impact of violent conflict upon the psychological, relationship and developmental needs of infants, insisting that we need to do more for the world's infants to recognise their identity as persons, assert their emotional and physical safety need for psychological care (Keren, Abdallah, & Tyano, 2019).

Closing reflections

As time goes on, we will be learning about different ways of doing things.

There are opportunities to develop new ways of being with mothers, fathers, and babies, through the use of video, social media, and professional telehealth facilities.

Although we have been very worried about the impact upon babies of interacting with necessarily masked carers and clinicians, we can also see that babies have their own resources and resilience. For example, infants use gaze, vocalisation, and other social communicative aspects of interaction to connect with their important caregivers.

We do not yet fully know the impact of masks or quarantining upon infants and their development, although we do know that major illness, and loss of loved ones and immediate family members can have a profound enduring adverse impact on infants.

Earlier this year, through the generosity of our esteemed infant mental health and paediatric colleagues, we were able to deliver, in collaboration with AAIMH UK, the Australian Association for Infant Mental Health, hand the Parent-Infant Foundation, UK, three webinars highlighting the importance of keeping our focus on the needs of the infant in this time of crisis.

Building on the past and looking to the future

We are now planning further webinars for WAIMH members and our Affiliates late this year and in the run-up to the Congress in Brisbane in 2021. We hope you find the webinars stimulating and professionally useful.

The remarkable opportunities for connectedness with modern virtual conferencing will invigorate the affiliative structure of WAIMH. We have 58 Affiliate organisations around the world, so with social media, the WAIMH website and the new medium of online webinars with individual passion for our work, we can reach out, touch, and share together. Each of these complement our crucial publications, the Infant Mental Health Journal and Perspectives in Infant Mental Health. To be effective however, we need to continually reflect on our work and our therapeutic methodologies in a collegial and supportive way.

I really hope everyone can join us in person, or virtually, at the 17th Congress in Brisbane in June 2021. The Congress Local Organising Committee and Scientific Program Committee with the dedicated support of the WAIMH Executive Directors, and our team in the WAIMH Office are building what I believe will be truly marvellous "hybrid" Congress where we will be able to focus our attention on babies, the challenges they face, their essential needs, and how we can build and support families and societies to sustain healthy development. We have entered a new era of global connection but also a world besieged, and even more we need to keep the baby within the family at the centre of our professional attention.

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From the Editor

By

Maree Foley, Switzerland, Editor-in-Chief

As this Summer (2020) edition is released, the global COVID-19 pandemic, shows little sign of abating. Time has taken on a different dimension with little certainty about how this pandemic will evolve. At some point, COVID-19 will pass by and we will be in recovery, alongside every family with young children in our communities. However, this pandemic, has highlighted vast health inequities within communities and across countries. UNICEF has recently released a statement highlighting the unique needs of children during this pandemic: https://data.unicef.org/resources/rapid-situation-tracking-covid-19-socioeconomic-impacts-data-viz/

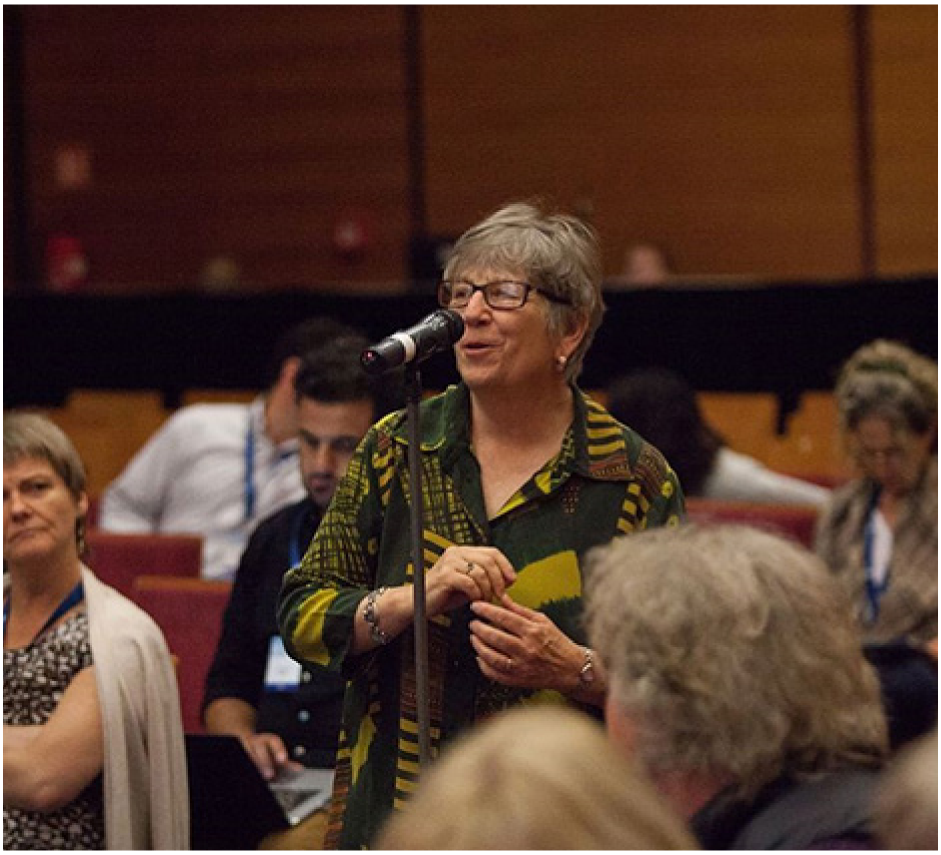
The daily challenge to stay connected with our families while also attending to the challenges to respond to families with young children in our local communities, is immense. Across the globe, there have been huge efforts to keep connected, while the daily narrative includes terms such as isolation and social distancing. Amidst distancing in person and wearing masks, sustaining social connection has become more important than ever.

Within WAIMH, one way we have tried to attend to connection is through the IMHJ and Perspectives project: *Infant and Early Childhood Mental Health in the Context of the COVID-19.* As a Perspectives team, with Jane Barlow and Holly Brophy-Herb, we have been working to prepare the forthcoming special issue on COVID-19. The plan is to have this issue ready for publication, by the end of this year.

This Summer (2020) edition of WAIMH *Perspectives in Infant Mental Health* assembles the articles and notices that have been posted via social media since the Spring Summer 2020 Edition. It has been nearly 18 months since we have been using this publishing format which integrates WAIMH social medial platforms and Perspectives papers and posts. The goal of the publishing format remains the same: to call attention and consideration what WAIMH members and allied infant mental health colleagues, around the world, are thinking, doing, and writing about.

This issue also marks a milestone in the history and development of Perspectives. Debbie J. Weatherston (PhD), who has been a long-standing Editor, Editor-in-Chief, and more recently Associate Editor, is retiring from her service to the publication. During her time with the publication, Debbie has gifted WAIMH and our global infant mental health community with an extraordinary library of topics that remain salient, across time, across cultures, and across the many different contexts from which we meet, and journey alongside, infants and their families. In addition to deep gratitude and thanks, we can collectively embody this gratitude as a global community via our shared commitment, to continue the journey. To continue to meet babies and their families at their tables, to advocate with them and for them across all levels of the political spectrum, and to hold dear each other, as companions in this shared path.

Debbie continues to share her deep knowledge, expertise, insight, and wisdom via local, national, and global platforms, and across genres. This issue features poems from Debbie that have been published in the *Poetry and Practice* section of *Newborn Behavior International (NBI)* network website. https://www.newbornbehaviorinternational.org/poetry/



Debbie Weatherston (PhD) Retired Editor-in-Chief of Perspectives at WAIMH event in Prague, 2016.

name-of-poem-bxjh5. This site is open access and contains an invitation from NBI leaders, Kevin Nugent, and Lise Johnson, to join the NBI worldwide network. You can read more about this at the following link: www.newbornbehaviorinternational.org

As Debbie retires, we welcome a new Associate Editor: Dr Azhar Abu-Ali. Azhar is a senior clinical psychologist, Dubai Health Authority, Dubai, United Arab Emirates. Azhar brings a wealth of experience to the team. She is the inaugural president of the newly established WAIMH affiliate: Infant Mental Health Committee (IMC) of the Emirates Society for Child and Adolescent Mental Health (ESCAMH). We are delighted to welcome her to the Perspectives Editorial team.

Regarding WAIMH news, in this issue: The President of WAIMH, Campbell Paul, provides an update on Executive Council Board news; we feature the WAIMH Award 2020 winners; the *June 2020 Perspectives Biennial Report* is shared; and you can read the most recent WAIMH Congress update.

We feature a paper by Catherine Maguire (Ireland), on behalf of the Irish Association for Infant Mental Health. Catherine contributes a paper to our tribute series to Hi Fitzgerald: *Celebrating Professor Hiram Fitzgerald: Forty Years with Infant Mental Health: A tribute from Ireland*.

This issue also features a paper by Dr Patricia O'Rourke (Australia). Dr Patricia O'Rourke's paper, *Working therapeutically with infants in the child protection system: Reflections*, provides readers with a glimpse into the inner world of the infant parent specialist; an inner world where the therapist purposefully creates a transitional space, for themselves with the infant and parent, and the many and often complex infant family relationships.

This issue contains a series of brief papers on a project led by Dalia Shlomy (Israel), "*A child on the Rainbow Real life stories of parents to children with disabilities. A play accompanied with music, songs, and humour*". Dalia Shlomy has generously shared a link to our readers to watch the play. In the play, the actors, are all parents of children who at some stage of their development received a long-term health diagnosis. Readers also get to hear directly from the parents. It features voices of the parents who participated in the group work and then who were actors in the play: Child on the Rainbow. This paper includes a brief exploration of the Reaction to Diagnosis Interview (RDI) (Marvin & Pianta, 1996) and shares the voices of the parent participants as they reflect specifically on the very early days of learning about the challenges their baby faced as they adapted to parenting a baby with a diagnosis.

A new infant-parent psychotherapy book for sleep problems has been released by Dilys Daws with Sarah Sutton (2020). *Parent-Infant Psychotherapy for Sleep Problems. Through the night.* https://www.routledge.com/Parent-Infant-Psychotherapy-for-Sleep-Problems-Through-the-Night/Daws-Sutton/p/book/9780367187828 This book is currently in the process of being reviewed for Perspectives readers and we look forward to sharing this review with you, soon.

This issue also contains a link to an online presentation from Dr Niels Peter Rygaard (Denmark): *How can online learning improve child mental health – on a global scale? Who needs us the most? Children who lost parental care!* In addition, we draw attention to platform two of the IMHJ -Perspectives initiative: *Infant and Early Childhood Mental Health in the Context of the COVID-19 Pandemic*.

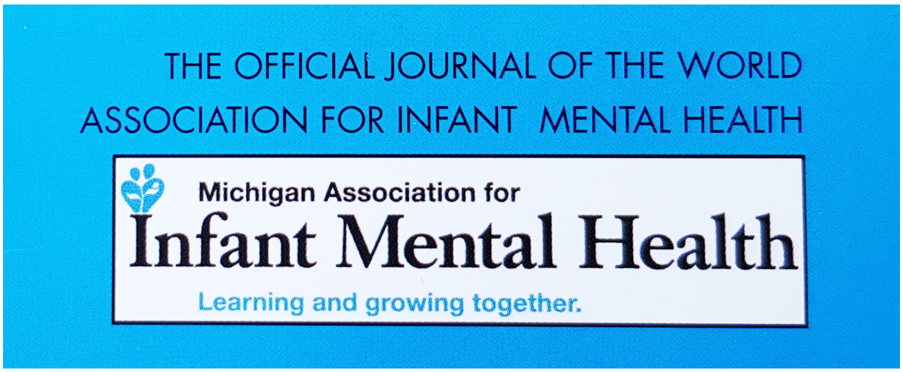
We are calling for proposals for a special section (generally 3-5 papers and a brief introduction) in the Infant Mental Health Journal on completed COVID-19 infant and early childhood mental health research. The goal of the special section is to contribute to an early literature base that can inform 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

On behalf of our Perspectives in Infant Mental Health editorial team I 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*.

Contact Editor Maree Foley:

maree.foley@xtra.co.nz

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



THE OFFICIAL JOURNAL OF THE WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Michigan Association for Infant Mental Health

Learning and growing together.

WAIMH **Perspectives** in Infant Mental Health

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

An Introduction: Working therapeutically with infants in the child protection system: Reflections By Dr Patricia O'Rourke

By Maree Foley (PhD) Editor-in-Chief, Perspectives in Infant Mental Health

Dr Patricia O'Rourke's paper, "Working therapeutically with infants in the child protection system: Reflections", provides readers with a glimpse into the inner world of the infant parent specialist; an inner world where the therapist purposefully creates a transitional space, for themselves with the infant and parent, and the many and often complex infant family relationships. This transitional space also holds the therapist's team and supervision relationships. This personal and inter-subjective space is primarily relational, intentionally relational, and oriented towards the restoration, healing, and wellbeing of the infant in their family.

Holding in mind and the co-creation of a transitional space can be an effortless experience when the relationships held, are seasoned with lightness, joy, and relief when being helped in times of strife. Reciprocity and ease, line the boundaries of the relationship. However, Dr O'Rourke's paper, eloquently outlines parent-infant/family relationships whose world includes engagement with child protection services and systems.

These families, who so many of us have met across the globe, arrive in this newly formed space with suffering and well-crafted self-protection mechanisms that are triggered by the nature of the help-seeking relationship. Unlike families where help-seeking and help-receiving engender relief and hope, for some families, help-seeking has been lined with trauma, aloneness, and further doses of trauma. The therapeutic relationship space and relationship we offer, can often engender fear, mistrust, and hopelessness.

This suffering, awakens the therapist into conscious welcoming, holding, and commitment to the new relationship. This is risky and courageous on the part of the therapist. There is no guarantee of shared joy, of collaboration, of working together to create a new pathway. In fact, these processes are outcomes, they arrive, if they do, much later in the relationship. It's not the starting point. The process along the way is akin to a pilgrim's tale.

Dr O'Rourke's paper describes this process with such generosity to us as readers. Her paper gifts each reader with a view into the process. The narrative is richly raw, real, relatable. The process requires a herculean commitment to healing and restoration of the infant in their family.

Clinicians such as Dr O'Rourke and her team, along with similar services to the families with infants engaged with child protection services, are gold; gold for the infants and their families, and gold for the communities in which these services exist. While infants and their families as a population, remain present in terms of global and national commitments, these commitments can become fluid in terms of organizational practices. At best, the overarching organization, within which the service is situated, potentially provides a secure base within which therapists can brave these primary relationships and carve new pathways with longitudinal good outcomes for infants in and with their families, in their communities. However, this is not always the situation and anecdotally, is too frequently, not the situation.

Amidst excellent outcomes for parents and infants, the service, and the team, within which the work that Dr O'Rourke so eloquently shares, has recently been closed. It is unbearable to ponder and incredibly difficult for the staff and the families, present and future. As a Perspectives team, we invite you to join with us as we hold Patricia and the team in heart and mind as they navigate their way through this organisational decision.

Working therapeutically with infants in the child protection system: Reflections

By Dr Patricia O'Rourke, Adelaide, Australia

Acknowledgement

This work is only possible with a team. Other members of the team were Jon Jureidini, Heather Warne, Sally Watson, Alison Knight, Kiara Price, Georgie Swift and Elsa Jureidini. Finally, thanks to Sharon for her generosity allowing her story to be told.

Introduction

This paper attempts to describe my experience of working therapeutically with infants in the child protection system. It was presented at the national conference of the Australian Association of Infant Mental Health in Melbourne in 2017. My brief was to present a 30-minute session on therapy with harmed infants as part of a 90-minute plenary panel presentation. I remember having a sinking sensation even as I agreed to do it. I was thinking, thirty minutes on therapy with harmed babies! How could I possibly convey the dynamics, the requirements, and the complexities of the work, and to do so, in half an hour? How could I do justice to this work? Would I be able to convey the depth and extent of both the commitment required and the range of feelings awakened for everyone involved?

I wanted to take this audience along with me and give them a sense of what it feels like to work intensively with these babies and their families – what's needed and what's at stake. I decided to tell a story and show pictures.

This paper shifts that spoken story to a written paper. I have tried to maintain the integrity of the original paper while enabling it to be read without the images. I begin with the context within which the therapy sits.

Context: The Infant Therapeutic Reunification Service

The Infant Therapeutic Reunification Service (ITRS), is embedded physically and administratively in a major teaching hospital for women and children in Adelaide, South Australia. The service provides early assessment and therapy for infants under three and their parents where significant harm has occurred or is at high risk of occurring. The ITRS was set up in 2009 to address poor long term outcomes for these infants by providing them a therapeutic intervention and attempting to stop the revolving-door process whereby they moved repeatedly in and out of the out-of-home care system. It remains a very concerning situation. For example, in both the 2016 and 2017 financial years, over 3000 Unborn Care Concerns and High-Risk Infant reports were made in South Australia (Montgomerie et al., 2019). Moreover, it is known that 40% of infants younger than one year when first reported, are re-reported more than 5 times before age 5 (Montgomerie et al., 2018). The number of infants being reported to child protection is increasing annually (Pilkington et al., 2017).

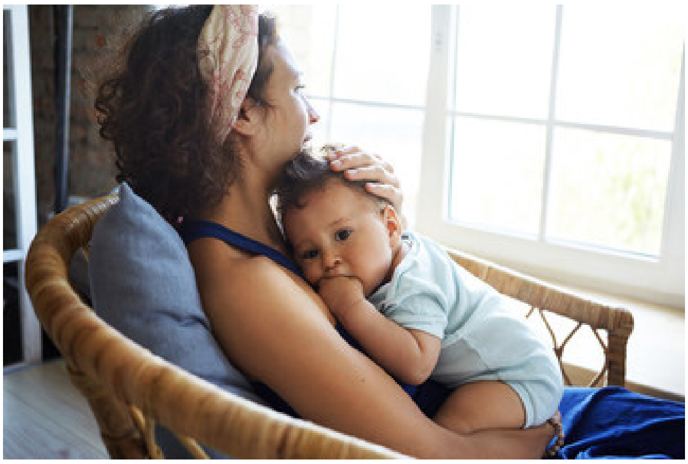
The service takes referrals from Child Protection to assess parenting capacity and whether reunification is viable and in the best interests of the infant. Where indicated, we provide parent-infant therapy to reduce the impact of developmental and attachment trauma on infant and parent to facilitate positive relationships leading to a safer caring environment for the infant. Where reunification is not possible, we make timely long-term decisions that meet the infant's developmental imperative and where necessary provide foster-parents with therapeutic support.

Our Clients

Infants always present to our service suffering from trauma and neglect, with attachment and/or developmental trauma demonstrably affecting their relational capacity.

Parents present with a range of issues that includes a history of childhood trauma and developmental trauma often including being under guardianship themselves as children. They usually have significant mental health issues including family violence and drug and alcohol issues, and some previous psychiatric diagnosis. Homelessness is also frequently an issue and there can also be ongoing forensic investigations. All these concerns impact on parenting capacity. Most parents present, deny any knowledge of maltreatment.

Note: All identifiable names have been changed with pseudonyms, unless otherwise agreed with the client.



Vignette 1: Lila

She seems to think that if she says it, it's true. She's sitting there telling me what a good mother she is, while she dabs at an oozing sore on her leg. A boil, she says. Her infant is here too, lying in her pram. Three and a half weeks old, dressed in a lary pink sundress with a matching hat. It's cool in the room and her tiny arms are mottled.

The only thing that worries her, continues the mother, is that the Welfare might take her baby. Otherwise it's a sure thing that the baby will, in due course, go on to university and have a great life, with both her parents. She digresses to explain how the father too, is being treated unfairly.

Nope, she says, there is no other way of thinking about it. He couldn't have assaulted that other baby because it was already bruised prior to the accusation. She describes the injuries she'd seen in photos of that baby as if she was reading through a shopping list. And anyway, the mother was a bitch who had it in for him.

She backs up her view by stating he was never violent with her, he was totally there for her, throughout the whole pregnancy.

I'm no longer thinking; the feeling in the room is increasingly unbearable. The infant moves in her pram, her arms flail, her fingers find only empty space, her head turns away. The mother notices and gets off the couch. I think she's hungry, she says, scoops her up like a kitten, and plugs the wobbling infant onto her breast. The infant stiffens, and struggles, and then sucks.

HW

Working therapeutically with maltreating families

It's a fine line to walk – always holding the baby in mind while working empathically and authentically with a parent who has hurt their baby or allowed their baby to be hurt. It's clear to me that my only chance to make a difference for the baby is to be able to really get alongside that parent, to see them, to let them see me, and together to see their baby, and to always keep that baby at the centre of any therapeutic endeavour.

In our service that can mean dyadic work with parent and baby, or working with the parent alone while holding the baby in mind, or working with the foster parent and the baby, or all three, sometimes consecutively and sometime simultaneously. It's a moveable feast.

This work requires a team. A team is needed to provide therapeutic assessments, to make decisions, to provide therapy, to hold the system around the baby and to hold us, the workers.

It is a very specific population: parents who have harmed their babies and babies who have been harmed. Children don't enter the child protection system on a whim. Assessment always highlights unacceptable levels of maltreatment and/or neglect. Our basic assumption is that every infant who enters the child protection system has also been psychologically harmed and this often 'is not readily apparent' (Donald & Jureidini, 2014). When this harm is unaddressed, that is, without therapeutic input, even if the baby is placed in a new context of good-enough foster or kinship care, their long term developmental outcomes will be impaired (McCrory, Gerin, & Viding, 2017; Shonkoff, 2012).

We know that there is no such thing as a baby – only a baby and someone (Winnicott, 1960). Yet the babies we work with have had no one. Very often their parents, as babies, had no one. There has been no mind to contain and hold them and help them make sense of their experience. This is an unavoidable fact about babies who enter and re-enter the child protection system - they all suffer this.

Another unavoidable fact is that working therapeutically with these babies and their broken parents is very disturbing for everyone involved. The baby's vulnerability, the parent's current distress and history of chronic trauma, disturbs those of us who are highly trained, experienced workers, and disturbs the child protection and non-government agency workers, who are usually less experienced, often overwhelmed, and under-resourced.

These factors are always present as we make decisions about the care of a baby - whether a parent is safe or can ever be safe to parent that baby. It's a big responsibility to think about, and one that is difficult to hold in our minds.

Assessment: our client is always the baby

While this paper does not discuss assessment in detail, it is important to emphasise that the starting point is always a specialised assessment - of the baby, their parents, and their relationships.

This assessment needs to understand both the level of parenting capacity of the biological parents, and the relational capacity of the infant. We need to assess either or both biological parents, to understand how much they can think and feel about their baby, as someone separate from them, with their own experience and feelings. The one thing, above all else, that demonstrates protective capacity is a parent's ability to take some responsibility for the predicament that their infant is in. The important word here is 'some'.

Most parents when they first attend are overwhelmed and frightened. They no longer have their baby in their care, and they are full of excuses and rationalisations as to why this is so. Over the course of the initial assessment interviews, parents may express a moment of remorse or a moment of thoughtfulness that indicates there is some capacity to work therapeutically with that parent. These moments can flag the potential for protective capacity even though they are often quickly retracted, especially where violent partners have maintained contact, or the police are considering laying charges.

We decide which parent, if either, has some potential to change within the baby's developmental timeframe. We want to understand how clearly this parent can see this baby and how they respond to their needs.

We are also thinking about the harm the baby or toddler has suffered and its effect on their relational functioning, how they signal their needs and respond to their parent. The baby has a lot to say about the relationship. The baby tells us where to focus our work and lets us know when we are making progress.

Vignette 2: Millie

> In the waiting room the infant stands perfectly still, a wee slip of a girl with white blonde hair and big round eyes, looking into nowhere. She is almost transparent. In the playroom she hovers around her mother as if in a permanent limbo, waiting for something that may never sufficiently arise.
>
> Her mother, drab and defeated, agonises over everything, every word tethered to crippling self-doubt. The mother looks down, at no-one, her face contorted. The infant goes to the empty dolls' house and without a sound pushes her head deep into the upstairs room and stays there, unmoving.
>
> Now, just today, eight months on, the infant tells a different story. She bounces in, smiling and chatting, with her pigtails up and out. She's home now, with her mother, whose face I hardly recognize. When she looks at her daughter, she is beautiful, and her infant shines back.

The assessment phase is ongoing, over some time. We also need to hold in mind the baby's current care needs. To limit the harm, we try to ensure that these current needs are met by more than just adequate care – they require the best care possible. Foster-parents need help to understand their baby's experience and how this may be affecting their relational expression. They may for example, need help to understand why this baby is so quiet, so undemanding, so willing to sleep.

Holding and working therapeutically with the system

When we work with a family, we create a care team around that family containing the system and providing a space for reflection. We work therapeutically with the care team that includes the child protection workers, domestic violence service, drug and alcohol services, housing, childcare, and always an in-home reunification service, if we get to actual reunification. This care team is highly susceptible to the disturbed dynamics we're trying to treat in the family. The critical effort required in child protection that isn't direct parent-infant therapy, is this holding of and working therapeutically with the system.

For this reason, we allocate a systemic therapist for each family. Holding the system is a hidden and often unacknowledged therapeutic role. There is no mirror. When you work with a client, you both witness and get feedback from the changes you see in them, in the parent-infant relationship. There's an acknowledgement of the roles of client and therapist. This in itself can be energising. What happens in therapy with a client can be very worrying at times, but the demands are clear.

However, the therapeutic role of holding the system doesn't provide much immediate feedback. It can more easily remain unreflected on, when other work pressures mean time is short, or the service is short-staffed. The dynamics that require systemic work vary from family to family, and from care team to care team. It can feel like a straight case management role, until the process comes unstuck. Then we often discover that the parent-infant therapist, and the therapist holding the system, haven't thought through the underlying dynamics together. Or we may realise that half the care team is operating like the harsh parent so familiar to our clients, and the other half is working from their own rescue fantasies. And we, the therapeutic service, are not immune.

In her seminal paper, Menzies-Lyth (1960), outlines how a social system uses defensive processes, in an attempt to contain anxiety. These defensive processes have been summarised by Jones (2015):

- Projection and denial
- Dehumanisation and depersonalisation
- Ritual task performance
- Splitting: Idealisation and denigration
- Detachment /withdrawal

It is always challenging to reflect on how these ways of coping with anxiety may be operating in us and in our clients and in the system, we are working in and with. In child protection work, it is critical that we acknowledge and manage these defences and the complex transference dynamics that often arise.

Denial: ever-present and pervasive

Think for a moment of the extent and level of denial in our present functioning as a global society and in our own cultural systems. We can only function as citizens by going along with the denial to some extent. Denial plays a major role in how we manage our everyday lives – how we navigate our social systems, how we've navigated our colonial and imperialist history in both my home country New Zealand, and here in Australia. Richard Flanagan (2017), the Australian Man Booker prize-winner, talking about denial said:

> *... Man survives by his ability to forget. We must forget so much in order to go on. Trauma is never just individual. It is passed down through families, into communities and then into generations. And they survive by forgetting…*
>
> *This island here, [Tasmania] was a totalitarian gulag. The horror to its indigenous people is beyond belief. And nothing really happened for a century after that transportation… the island entered a long century of silence which it has only started emerging out of in the last 30 years...*

Now bring to mind, how much denial operates in the family system of a harmed baby - how else could you hurt a baby?

Our parents always start by denying the abuse, or the extent of the abuse, or minimising the impact of the abuse, both for their child and for themselves as children.

Case study: Sharon and her children

Sharon is now a mother of four. When we started working with her and baby Joey, three years ago, she had no custody and little contact with her two older children, then aged nine and six. They lived with their alcoholic father.

When we first met her, Sharon was in a violent relationship with Max and had been for two and a half years. They had a three-month-old baby who was referred to us because of a cigarette burn behind his ear. Both parents denied harming the baby.

There were grave concerns regarding the level of violence and drug use. However, Sharon was assessed as having some reflective capacity.

We began an extended assessment, marked by all of the dynamics present in very violent relationships – lies, recriminations, desperate pleas and a sense that we are part of a system that is somehow, once again, failing this woman and her baby.

The child protection system around Sharon was uncontaining and indecisive. Workers and even offices constantly changed, and consequently, were easily deceived. After three months, they were considering Max to be the primary caregiver of the baby, in spite of his extensive history of violence. Our service offered an extended assessment of both parents and subsequently recommended working with mother and baby to try to extend the window of her reflective capacity.

As the months dragged on, it became increasingly clear that while Sharon was able to attend therapy and demonstrated small changes with Joey, she could not stop idealising this dangerous relationship, and kept returning to a scene marked by violence and drugs. Joey meanwhile was settled in a foster placement. He was doted on by a large extended family who had no time for Sharon – another obstacle to successful reunification.

It seemed hopeless, and then the system changed – the case was moved to a new office and a new child protection team. Their assessment, like ours, was that contact with Max was unhelpful at this time.

Then another bombshell – Sharon, after a weekend of drugs and bingeing with Max, was pregnant again to him, father of Joey, then 8 months old. Now we had two babies.

For three months, I worked intensively with this pregnant mother. She regularly attended therapy with me and met with both her domestic violence worker and her drug alcohol worker. She travelled for four hours on public transport to see her son at child protection offices. She denied any ongoing contact with Max. The care team began to feel hopeful.

Then, the child protection team began to worry that contact with Max, was maybe, occurring again. Sharon herself began to talk about wanting him at the birth of her new baby, because 'every baby needs a father', though she continued to deny having any contact with him. She denied this to me, to her domestic violence worker, and to her drug and alcohol counsellor.

Then a random drug screen returned positive for amphetamines, and (just before Christmas), the child protection team called an urgent case conference because they had proof that Sharon had been having contact with Max all year. More than once, she had even waited while Max attended therapy with a private psychologist, he had accessed to address anxiety and depression[1].

I said to her later that I just could not understand how she could front up each week and lie through her teeth to me. She shrugged and said she didn't really lie, 'just didn't tell the whole truth'. Sharon went off the radar at this point. Everyone was concerned and then she showed up after three weeks at a local hospital, badly beaten, and again wanting to change her life.

Denial and the importance of 'not knowing'

When I started writing this paper, I couldn't describe the sense of betrayal and frustration I had felt, because I actually couldn't remember it. My own self-preserving denial, learned very early in my family of origin, had kicked in. I couldn't

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[1] Max's attempts to access psychological help for himself appeared to be more about maintaining some control over Sharon. He consistently lied to the private psychologist he met with who became aware of this only after he attended a case conference at the specific request of Child Protection Services. The complex dynamics of extremely violent relationships are well described in 'Toxic Couples: The psychology of domestic violence' (Motz, 2014).

remember anything about challenging Sharon, how we got through that time, other than knowing that we did.

I re-read the notes. I read how she had stormed out and then returned apologising, but I still had no memory of it.

It wasn't until I watched the video again that it flooded back. I had had to tell her on a blisteringly hot day, when she was eight months pregnant, had just caught two buses and walked half a kilometre to meet with me, that we would not be recommending Joey return to her care, and that she was not going to be able, in our opinion, to take her newborn baby home from hospital, as she could not keep the baby safe. She had not demonstrated she could keep herself safe.

She didn't really take it in. We talked on about her losing a few battles but maybe not the war. I watched myself struggling to stay in relationship with her, trying to understand. And then I had to repeat it to her, repeat that I couldn't recommend that she was safe to take her baby home. Tearful and angry, she stormed out.

Watching that tape, I felt again the sense of absolute hopelessness and inadequacy as a therapist, and as a person. It all flooded back.

However, like most of our parents, Sharon is made of stern stuff. She came back. I saw her weekly again up to the birth. Together we tried to understand her addiction to this relationship – both of us bewildered by it, as she related details of how he had hurt her, had held a gun to her head, had threatened that he'd always come back, quietly, when it was all over, and kill her.

And she would also talk about how Max still might change and she would remember longingly how he would tuck her up in bed; he 'did that every night'. They might 'even go fishing again…'

We would talk then about her loyalty to him, her 'learned hopefulness', her enduring belief that he could change. And we kept talking too, about how child protection services were going to take this newborn baby and were preparing long term Guardianship Orders until 18 years of age for Joey.

Sharon woke up… She was going to lose all of her children, for a relationship that she increasingly named as violent, hurtful, and hateful to her.

As therapists, we use denial. We use it from the moment we enter the room, to enable us to tolerate that parent, while holding that hurt baby in mind, as we are altogether in the room. Some level of denial allows us to slip in and out of empathising with, and understanding, a parent's experience, while moment by moment, also holding in our minds the sufferings of the baby there in front of us. If we didn't use some denial, we might leap out of our chairs and scream with rage, or begin to rock, crying soundlessly.

Working in the child protection system, it is crucial to recognise the role denial has in our work, and has had, in our own lives, in our own families, and in our own ways of coping.

The notion of 'honesty'

Why did we place so much emphasis on Sharon being honest? Why do we think that any of our families would start from a position of honesty? That's such a long journey for them when they start from a position of such mistrust.

Being authentic is dangerous for our clients. In an authority relationship, why would our clients trust that they can tell us what they know will make us disappointed and angry? Why would they trust until we've demonstrated for long enough a sense of caring, compassion, and thoughtfulness that we can manage the truth without retaliating? Until suddenly, as with Sharon, she takes the risk of being honest, and staying in relationship.

As therapists, we talk about the importance of creating trusting, honest relationships with clients. This is based on our belief in the different experience we are offering—the new, relational experience.[2] As professionals, we assume too readily that people will be truthful, and that therapy has to be honest. If we think about things from a self-preservation point of view, it makes more sense to ask why our clients would hold a moral position that values truth over survival.

Why would they change what they have had to do all their lives to survive? Where has honesty got them in the past? I remember one particularly angry parent, who often raged and sneered at me, especially at the beginning. She told me once how, as a child, she'd been playing in the backyard with her stepmother's children. They were picking on her and throwing stones at her and making her cry when their mother called them in for dinner. When she told the truth about why she was crying and what the kids had been doing to her, her step-mother picked up some of the stones, put them on a dinner plate covered them with sauce and told her that that was dinner and she was to eat it.

So, it is a strange idea that we have, that these parents would tell us the truth, and that we can get disappointed and angry, when they don't. The system can also get very punitive and harsh when untruths, lying, and deceitful acts come to light. The system is in danger then, of acting out the very dynamic we are trying to shift, the very dynamic these parents expect from those in authority—harsh repercussions.

The crucial role of supervision

Our approach is a team approach. Our assessment, therapy, systemic holding, and reflective practice includes the whole team. We know that all of the concerns that we attempt to address in therapy, we hold in our selves. While the team is an attempt to address this, we all feel the isolation of our clients – the babies who have had no one, the parents who have no one, no family, no support, only the services involved.

The level of vulnerability of our families can be intolerable – no safe housing, sometimes no home even where we can begin the reunification work.

A group supervision session: Ann presents Jenny

In the session, Ann presents Jenny - Jenny's intense neediness. Ann presents her response to this: how she wants to cut Jenny off, be dismissive and rejecting of her. Then Ann speaks of her sense of disgust and horror at the level of gross emptiness she encounters in Jenny. Ann experiences it as a black hole that threatens to suck away her own vitality.

This taps into Ann's own feelings as a child of always being experienced as never-endingly needy by an overwhelmed, unsupported, and stiff upper-lipped mother, who herself was contending with the loss of a baby and war trauma. On top of all of this, Ann has recently learned she has a chronic health condition, that both frightens her to think too much about, and saps her vital energy.

Ann realises she experiences Jenny as a refugee child; hands-to-face, pressed against the wire fence, clinging on, pleading.

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[2] The parent-therapist relationship is the primary catalyst for change because within this relationship the parent begins to develop epistemic trust. Fonagy and Allison (2014) write that epistemic trust, a developmental task of infancy, enables social learning in a constantly changing social and cultural context, allowing individuals to benefit from their relational environment. The development of epistemic trust within the therapeutic relationship enables a parent to take in important information from others that previously was dismissed due to mistrust.

To come to this realisation, Ann has to use her own self, to allow and feel those past experiences. She has had to allow that touching of experience-to-experience which is the necessary ingredient of being present with her whole self. She does this in spite of the multi-systemic pressure she is also feeling from a number of systems in her body – kinaesthetically, visually, audibly, proprioceptively - to switch off, change her focus, get angry, do anything, but stay present to herself.

This is what needs to happen, at a micro-level of our functioning, in order to create the meeting - that I/thou moment, there, in the intersubjective space. This will create a 'change moment' (Stern, 2004). And this is only one moment in a process that may occur, if you're lucky, once in a 50-minute session, a session you have every week for months. But this is the power of connection, of truly meeting, of being willing to meet.

Sometimes I think therapy in the child protection space, is like those first responders seen on television who don't turn and run away with everyone else from the chaos or burning buildings, but who run past those fleeing, on towards the smoke and fire.

And that's how I feel too, in this group supervision session. I don't want to see Ann there, hunched and suffering, looking like she's been kicked, feeling like I'm holding her in there for more. I feel the intense pressure to let the pain of the encounter in the group slip sideways, to go along with another group member's helpful suggestion of a 'strategy'.

Instead, I need to push the pause button, help us all face and feel our colleague's pain, our own pain and her client's pain. It's such a struggle to reject the little voice that tells me I could come up with some glib advice, or the other voice that tells me I could possibly look good – I could 'manage it' for us all.

And glowering below all of that are my own feelings of rejection and impotence. My rage wants to shout at them all to wake up, and think for themselves and to just work it out…

Discussion

Working with maltreating parents is inherently difficult. These parents who have had the least relationally themselves, have the most to lose – their baby. Their babies are babies who have had no one. Providing such a baby a 'thinking heart' (Alvarez, 2012) often feels intolerable. At the same time, containing their parent with a loving mind can be discombobulating to both parent and therapist as they are challenged to hold excruciating feelings.

The idea of maltreating parents needing to 'be honest' with therapists and case workers is fraught. While honesty is the cornerstone of a therapeutic relationship, it is fundamentally at odds with many of our maltreating parents' well-worn ways of surviving. Epistemic trust only develops over time – both in infancy and in a therapeutic relationship. Neglected and maltreated babies often cannot wait. It is always an ongoing dilemma: how to build a therapeutic relationship at a pace a maltreating parent can tolerate while holding the baby's developmental imperative front and foremost.

As therapists in this area we work to understand denial and all the ways it operates to sustain us and hold us back. While aspects of denial are illustrated in this paper, those other defensive processes delineated by Menzies-Lyth (1960) are always at play to a greater or lesser extent at some point throughout the therapeutic reunification journey. Going through the motions – ritual task performance – becomes the response of the overwhelmed and defeated clients and workers alike. Exhausted workers can dehumanise their clients, depersonalising their responses to parents who have depersonalised and dehumanised their babies, maltreating and neglecting them. Splitting is often used by our clients and when manifested in the dynamics of the case conference care team working with the family, can seriously derail everyone's best efforts.

Increasingly, reflective supervision is understood as a necessary requirement that can mean success or failure in any therapeutic endeavour involving infants. Reflective supervision enables a therapist to 'tolerate the intolerable' by mentalising with them, their relational experience with their clients. However, the importance of providing a contained reflective space for a care team to express and reflect together on the dynamics affecting the system, the family, and the workers' responses, is equally critical.

Working with infants in the child protections system is an attempt at intergenerational change – to interrupt the transmission of chronic, systemic intergenerational trauma. It requires a united response at all levels of a reflective system.

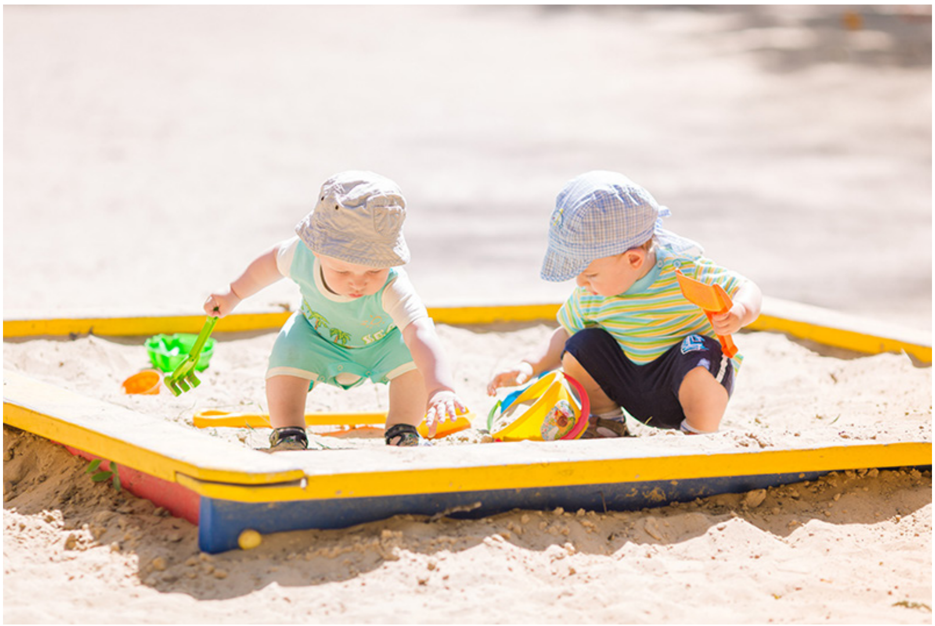
Postscript

Later as I'm leaving the hospital, I see a dad playing with two small sons in a sandpit: the boys' little bodies, dressed against the cold in hoodies and track pants, leaning intently into the sand, heads together. It raises a sob in me…

I remember my own sons, the intensity of their preciousness to me, and the precariousness of our existence, and their solid little bodies solemnly examining the truths of their world in the sandpit.

I realise how vulnerable I'm feeling, how sad. The exhaustion and emptiness, following an ostensibly very successful supervision session, has left me ragged, open and mourning.

It is that familiar grief and loss that is the inevitable cost of living, of being fully alive.



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Introduction: Child on the rainbow: Real life stories of parents to children with disabilities

By Dalia Shlomy, Israel and Maree Foley, Switzerland

For many parents, the birth of a new baby brings joy and wonderment with the ensuing challenges of caring for a totally dependent new bundle of a person. However, "nearly 4% of parents receive distressing news about their child's health" (Barnett, Clements, Kaplan-Estrin & Fialka, 2003, p. 184).

Understanding parents' experiences of receiving a long-term health diagnosis of their infant and or young child, in relation to the diagnostic and prognostic nature of the child's health challenges, is vital. It is vital because this understanding helps to ensure the practitioner optimally provides the conditions within which to provide a secure space for the parents, with their baby, to explore and grow together in their parent-child-family-community-relationships.

Moreover, as Carpenter (2005) states:

> At the point of diagnosis of a child's disability, a parent's first question is hardly likely to be about the local early childhood intervention services. These families are frightened, disturbed, upset, grieving and constantly vulnerable. The role of the professionals involved with them is to catch them when they fall, listen to their sorrow, dry their tears of pain and anguish, and, when the time is right, plan the pathway forward. (p. 181)

The following two papers provide readers with a window into the experiences of parents to children with disabilities: their stories. The first paper is by Dalia Shlomy (Israel) who describes her journey as an initiator, group counsellor, and producer of the play, *Child on the Rainbow*; a play by parents of children with special needs (Shlomy, 2014). Link to watch the play: https://www.youtube.com/watch?v=lJjjBelYpt4&t=17s

The second paper, by Dalia Shlomy and Maree Foley with the parents, features the voices of the parents who participated in the group work and then who were actors in the play, *Child on the Rainbow*. The parents, whose children are now grown up, reflect specifically, on the very early days of learning about the challenges their baby faced and how they adapted to parenting a baby with a diagnosis. This paper also includes a brief exploration of the Reaction to Diagnosis Interview (RDI) (Marvin & Pianta, 1996).

On behalf of the Perspectives team and the WAIMH community we are grateful to every parent who has generously shard their stories with Dalia, their local communities, and now with our global WAIMH community.

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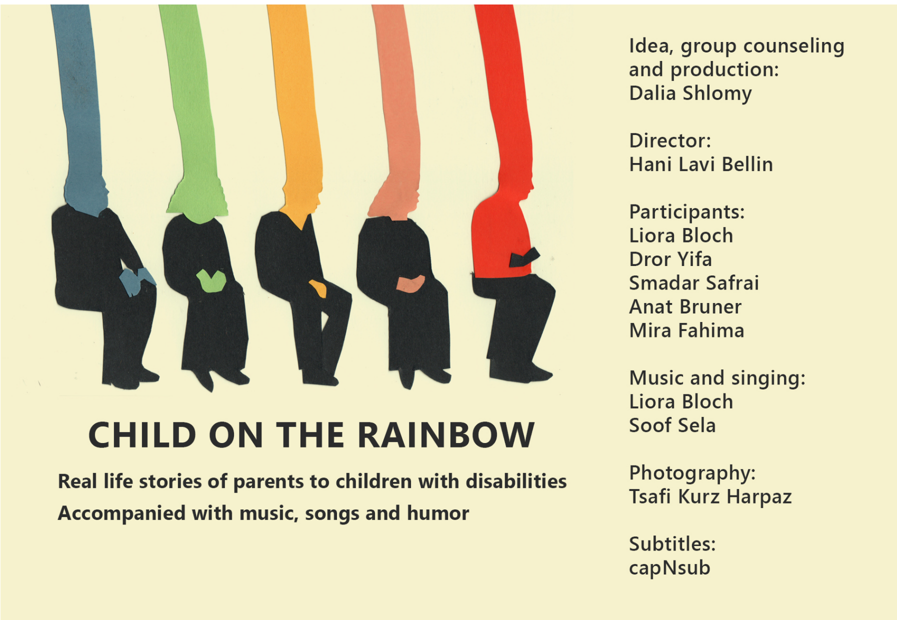
Child on the Rainbow: Real life stories of parents to children with disabilities. A play accompanied with music, songs, and humour

By Dalia Shlomy (Israel) (Initiator, Group Counsellor, and Producer)



CHILD ON THE RAINBOW

Real life stories of parents to children with disabilities
Accompanied with music, songs and humor

Idea, group counseling and production:
Dalia Shlomy

Director:
Hani Lavi Bellin

Participants:
Liora Bloch
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Subtitles:
capNsub

My name is Dalia Shlomy and I want to tell you about the processes that led me to creating the play: *"A child on the Rainbow Real life stories of parents to children with disabilities. A play accompanied with music, songs, and humour".*

I began my career as a paediatric nurse. I remember very well all the times when I had to say out loud that there is a problem with the size of the child's head. I remember the mother who burst into tears and the mother who said to me, "Nonsense, the child is okay."

I remember my emotional upheaval at the time, the hope that maybe everything is fine, the understanding that now it was necessary to act and the anger at the parents who did not act or disappeared.

Later I went to work in programs to locate children at risk, and many times I stood (with the rest of the team) against parents who found it difficult to adapt to the reality of their child and we - the professional team, arguing among us about how to deal with such parents. It was only during my master's degree at Haifa University that I was exposed to the concept of, *challenges to adapting to child diagnoses* and realized that accepting was a process, and I had to accept the process.

In addition to my professional work, I deal with production of events that combine personal stories and poetry. I do this together with my friend who is a musician and a mother of a child with special needs. In one of the conversations between us the question arose: Why not tell the story of parents of children with special needs?

A group of parents and myself as the counsellor, started to meet once a week (I am parent groups counsellor) to expose the difficulties and pains associated with raising a child with disabilities. We used a playback theatre technique that made it possible to touch sensitive points with the required sensitivity. My attachment to the parents gradually increased and their confidence in me grew. The ability to touch pain without fear made it possible to reveal more experiences and events, from the daily life of the parents. I believe that part of my ability to connect with parents even though I am not a parent of a child with special needs, is related to my personal experience of loss and pain. From my painful place, I could understand their painful place.

After a year and a half of meetings that were all documented, we decided to go forward and invite a director, who would help turn the raw material into texts adapted to the stage. At this point, I began to use my abilities as a producer. After another year and a half, the premier took place on the 6th of February 2014.

An important part of the play is the dialogue which takes place between the actors and the audience. The importance of this dialogue; the empowerment experienced, by both parents and professionals.

It has been five years since the Premier took place. The play has been performed more than 20 times and we will continue to appear, as long as we can. Today we are a cohesive group with our own humour and shared experiences. Formally, my role is production, in practice; I feel like the group's big mummy and feel great pride in the group's achievements.

The personal processes of the group members are evident mainly in openness and in the ability to reveal their personal stories. One of the members participated in a national television program dealing with parenting of children with special needs, another found that the stage suited him. Me? I'm happy taking part in all this.

Link to watch the play: https://www.youtube.com/watch?v=lJjjBelYpt4&t=17s

Credits

Dalia Shlomy – Initiator, Group Counselling and Producer

Dr Efrat Sher-Censor - Academic Counselling

Hani Lavi Balin – Director

Liora Bloch- Initiator, Musical producing, Plays the Guitar and Sings

Soof Sela - Piano and Singing

Dror Yifa, Mira Fahima, Smadar Safrai, Anat Bruner, Liora Bloch - Actors (parents)

Tsafi Kurz Harpaz – Photography

capNsub - Subtitles

Child on the Rainbow: Parents talk about what it is like to receive a diagnosis of disability of their babies and toddlers

By Dalia Shlomy, Maree Foley, Dror Yifa, Mira Fahima, Smadar Safrai, Anat Bruner and Liora Bloch

This paper is aimed to support practitioners and clinicians to further understand the parents' experiences of receiving a diagnosis of disability concerning their child. Drawing on the work of Dalia Shlomy and the parents engaged with "Child on the Rainbow" (2014), this paper offers a window into the lives of the babies and young children, with their parents, and in relationship with their community.

In summarizing, how the *Child on the Rainbow* (2014) project came about, Dalia Shlomy reflected:

> The play, "Child on the Rainbow", was created through a relationship between a parent group counsellor and a music teacher, who was also a parent of a child with special needs. From this beginning, of two people, the idea was welcomed by a group of parents to children with special needs. These parents were members of the "Alei Cotert" club operating in the Izrael Valley regional council in Israel.
>
> The raw material for the play evolved from one and half years of playback theatre recordings within which the group explored personal difficulties associated with raising a child with special needs, and with the support of the group, the ensuing journey towards peace and acceptance; of the diagnosis, of their child and of their relationship with their child. Next (which took a further one and half years) a professional director transformed the raw material into a 9-scene play.
>
> Each scene tells a parents' story of their experiences of, for example, coming to terms with the diagnosis, shame, family relationships, society's attitudes, and prejudices. The play also contains poetry, including one piece written by Chanoch Levin (A known Israeli play writer). You can watch the play from the following link: https://www.youtube.com/watch?v=lJjjBelYpt4&t=17s

In preparation for this paper, Maree asked Dalia, if it would be possible to hear more from the parents who feature in the *Child of the Rainbow,* about their early days with their infants and toddlers; who are now grown up. Upon this request via Dalia, the parent's generous responses, shape the heart of this paper. Within the translation from Hebrew to English, as much as possible, we have not changed or overly edited the parent's stories. In doing so, our intention has been to bring into view the voice of the parent, as if we were sitting together, listening to these remarkable people, remarkable parents. We begin with Mira and Barak's story.

Mira and Barak's story

> *Barak was our fourth child. After two girls and one boy I thought I know everything about children and parenthood, but then Barak was born and changed all my ideas. He was a very happy child, did not cry at all but he was very active. Then I noticed that he is not doing what he should do, the first thing was to follow after a moving object. He was looking straight without following with his eyes.*
>
> *The Doctor sent us to a special test, and they told me that biologically everything is all right. Maybe it's a matter of slow development.*
>
> *As the years passed, we noticed that everything was a slow process. He was late standing, late walking, and slow speaking. It took him some years to start speaking. At the age of 3 he still did not speak. Everyone around us comforted us that times will come that we'd like him to stop talking.*
>
> *Today he is speaking fluently, but still got problems of pronounce everything right.*
>
> *The super hyper - activity was shown at the age of 4, when he went to the kindergarten. All the children could sit very quietly listening to their kindergarten teacher, but Barak could not sit. After few minutes he felt that he must walk or run. This, of course was a kind of an interruption at the kindergarten. They wanted to give him the medicine RITALIN, but we objected to give him this medicine because it is a psychiatric type.*
>
> *I still remember that during all his childhood I was in some kind of struggle, all the time, against the education team. I felt that I am his voice and representing his rights.*
>
> *The main thing I was doing in that period is running after every idea or every new method that can help him or cure him. I was absolutely sure that along the time he will be okay and that he will be involved in the lives of his peers.*
>
> *That never happened.*
>
> *Till now he is suffering from lack of friends and he is a very lonely guy.*
>
> *My name is Mira and my son BARAK is 34 years old.*

As we think about Barak, now 34 years old and his mother Mira, their story illustrates the connections between child, family, and community. Further highlighting this point, Falik (1995) reminds us that an infant and or young child's diagnosis is at least a triadic experience including the child, their family, and the community.

Furthermore, in response to a diagnosis, the literature uses terms such as resolution and *non-resolution* (Marvin & Pianta,1996). Based on phenomenological studies of parents, Heiman (2002) found *resilience, coping and future expectations* as core features to appreciate in the process. Barnett et al. (2003), consider the process of *adaptation* to better encapsulate the parents' experiences over time:

> We define adaptation as an ongoing process whereby parents are able to sensitively read and respond to their child's signals in a manner conducive to healthy development… we contend that parental perceptions, thoughts, and emotional reactions to their child's condition are effective avenues for promoting adaptation. (Barnett et al., 2003, p. 184)

In day-to-day terms Barnett et al (2003) state that "healthy adaptation" (p. 197) is central to the development of the quality of the attachment relationship.

> Ideally, parents increasingly are able to learn to love, appreciate … their child. As the child develops a secure attachment, the parent and child are able to build new …. Dreams together. (Barnett et al., 2003, p. 197)

In addition, much has been researched regarding the corelation between a parents reactions and capacities in response to the diagnosis, their caregiving, and their unique infant-parent attachment relationships (Oppenheim et al., 2007; Sher-Censor, Doley, Said, Baransi & Amara, 2017; Sher-Censor, Ram-On, Rudstein-Sabbag, Watemberg, & Oppenheim, 2020).

Furthermore, as the parents voices below indicate, diagnosis can enter the lives of a family at different ages and developmental stages. Indications that prompt a health inquiry in infants and toddlers is required, is not always evident at birth. Within this amazing group of parents, some did not enter the world of diagnosis until their children were older. Continuing the conversation begun by Mira and Barak's story, we now have the opportunity, to listen to the stories of: Smadar and Lishay; Dror and their son; Anat and her daughter; and Liora and Ofri.

Smadar and Lishay: Their story

> *This is the story of Lishay our first-born child.*
>
> *We were a happy young couple with a normal pregnancy excited to become a family.*
>
> *Lishay was born on the 38th week of the pregnancy in a cesarean section due to complications that left him barely alive.*
>
> *The doctors managed to save his life, but they informed us that Lishay had suffered severe damage in large areas of his brain.*
>
> *It was so severe that they couldn't tell us if he would be able to walk talk or see...*
>
> *With this uncertainty we began our journey.*
>
> *From the very beginning, Lishay proved to be a strong and optimistic character.*
>
> *Three times a week he was practicing physical therapy as well as speech therapy and although it was pretty intensive, he always smiled and did it over and over again.*
>
> *At the age of two and four months after endless falls and injuries, Lishay began to walk!!!*
>
> *There are no words to describe how happy and proud he was... (as us)*
>
> *We learned that Lishay has no limitations and he kept surprising us with his achievements.*
>
> *Lishay walks, talk's, sees with a very strong life, loving personality, keeps smiling to the world, even if the world doesn't always smile back to him.*
>
> *Having a child like Lishay and the journey we share together, has made me a better stronger person, not afraid to face any challenges life may bring my way.*
>
> *Lishay opened my eyes and soul and there is not a day gone by without me being enriched by him.*
>
> *The meaning of the full name Lishay Tuvia that we chose for him before he was born, in Hebrew is: my God grace gift, which amazingly was profiled!*
>
> *SMADAR PROUD MOM*

Dror and their son

> *Our son was diagnosed when he was around 11 years old on the autistic spectrum. Till then he was functioning almost as his friends. Although he seldom invited friends or was invited by them, we never thought that he straggles Asperger Syndrome. We noticed it only some years later, so we didn't deal the subject the first years.*

Anat and her daughter

> *In the first few months, I did not notice any particular difficulty. A beautiful baby, sleeps well, eats well. She didn't smile or laugh, but I didn't understand what that meant. Towards the age of one year, I began to be disturbed. She didn't murmur at all. When I showed her pictures in the book, she couldn't point to things I showed her.*
>
> *After age one year she could not follow a simple instruction. I was more troubled but didn't think in terms of a "problem". As she is the fourth child in the family and as the signs of something going wrong increased, the worry grew. We checked hearing, vision, everything is fine. My concern grew more and more disturbing and frightening: what was happening to her? What is the problem? What will it be?*

> *At the age of two and three quarters, we reached a developmental physician. She spoke about Slow Development. Since it was not a Developmental disability, I felt rather encouraged that the gap would be closed later. In spite of treatments at the speech therapist and occupational therapist, this did not happen. The gap between her and same age children, especially in understanding the language and social codes, grew wider. The anxiety of not knowing what the definition of her problem is, was actually increased.*
>
> *At age 5, we were still in that situation. We were looking for all kinds of therapists and ways to help and promote her. Every afternoon, I, her mother, was busy playing with her and teaching her how to play.*

Liora and Ofri

> *It started with a fever seizure. Ofri (second child in the family) was one year and five months old. There was something in the air before. There was a feeling that something in the development, wasn't quite right - but the problem was hard to pinpoint.*
>
> *Losing his consciousness during the seizure was, for me, an experience of a mother who lost her child. I thought he was gone. It was a silent shock to me. I vividly remember my wonder when I heard him cry and realized he was alive. My mother told me at the end of that day that I had aged ten years in a day. I was 33 at the time.*
>
> *An entanglement of hospitalizations, tests and diagnoses began. The seizures were repeated and in fact, Epilepsy and Slow Development were diagnosed. I remember very well, how heroic, brave, I was at the time of hospitalization - and on the contrary, the fall of spirit when we returned home. But the fall was short. No more than a few hours. We were surrounded by an extremely supportive extended family and friends who were equally helpful.*
>
> *Ofri began medication treatment that disrupted all his systems. He was confused, hyper-active. We had to keep an eye on him at all times. There was a therapeutic set of routines we needed to keep. And in spite of all this, at home the joy of living never ceased. We dealt with the situation with a lot of humour and most of all in his acceptance and exposure outside in the most transparent way.*
>
> *Time went by. At the age of six, a Comprehensive Diagnostics was performed, at the end of which came the bad news - Ofri suffers from light Mental Retardation.*
>
> *This letter was a slap in the face. It was the first time it was written in black and white.*
>
> *One had to deal with the absolute knowledge that it was not something that will go away, the various treatments might improve his function - but in fact it was our child who would never be "normal".*
>
> *I remember when Ofri was about three years old, we went to a family holiday dinner at my parents' home. How much I cried on the way. This thought that everyone comes with their healthy children - and we are taking care of a sick child with a mountain of related problems.*
>
> *Looking back - it was hard, but we made a wonderful journey.*
>
> *And the proof is - this is a 30-year-old, communicative and happy guy, high-functioning, independent, earning a living, his world is full of good and mostly - and most importantly - happy.*

While we pause to take in the power, pain, and hope, of these lived stories, it is difficult to know exactly how to move from here, back into theory. But in fact, that is one of the steps of the dance we do together as parents and children with professionals, and as professionals, with parents and their children.

One way that does seem to bridge these different lenses on understanding, is the Reaction to Diagnosis Interview (RDI) (Marvin & Pianta, 1996). The RDI offers a meaningful and structured way to learn and discover together about the journey so far. Of note, the RDI has been adapted to a shorter self-report form of the "Reaction to Diagnosis Questionnaire" (RDQ) (Sher-censor et al., 2020).

A useful, brief summary of the RDI is provided below. It was used as part of a training promotion, presented by Marvin (2013) in Italy:

> The Reaction to Diagnosis Interview (RDI) (Pianta & Marvin, 1992) is a brief, 15-minute interview, derived in part from Mary Main's concept of "resolution of trauma or loss" originally developed as part of the Adult Attachment Interview (George, Kaplan & Main, 1985). The RDI examines resolution of the potential loss/trauma associated with the experience of learning that one's child has a disability or chronic illness. Parents report this to be a period of crisis: the family's routines are disrupted, expectations for the child may be challenged, the parent may feel guilty or may search for a very personal reason/cause, and their sense of themselves as effective parents is challenged. Parents vary in their reports of the diagnostic experience and its aftermath, in their ability to reflect on these experiences, and in their ability to turn their attention to the present and future regarding their child. In other words, parents vary in the degree to which they are able to resolve the crisis of the diagnosis. The RDI assesses this resolution or lack of resolution through videotaping and then coding an individual parent's

> responses to 6 standardized questions with specific probes. The interview requires 10-20 minutes to administer, and 30-40 minutes for an experienced and certified professional to code. The coding yields major classifications of Resolved and Unresolved, plus a number of sub-classifications within each major classification. These sub-classifications are helpful in the coding process, and are useful for planning and conducting interventions (http://www-5.unipv.it/users/aip2014/images/1.RDIWorkshopFlyer-Pavia2013.pdf)

To further elaborate, interview questions within the RDI (Marvin & Pianta,1996) include:

1. *When did you first realize that your child had a medical problem (probe for details)?*
2. *What were your feelings at the time of this realization?*
3. *How have these feelings changed over time?*
4. *Tell me exactly what happened when you learned of your child's diagnosis. Where were you, who else was there, what were you thinking and feeling at that moment?*
5. *Parents sometimes wonder or have ideas about why they have a child with special needs. Do you have anything like that that you wonder about?*

Analysing the Reaction to Diagnosis Interview results (as shown in Table 1) we can understand the parent's place in relation to the diagnosis and adapt our professional counselling to the parent situation. Parents who have come to terms with the diagnosis will demonstrate emotional change, acceptance, hope, and will deal with the cause of the difficulty. Parents who have not yet come to terms with the diagnosis may exhibit one of the following signs: emotional detachment, emotional flooding, anger, depression, disorganization, cognitive distortion, and confusion.

Table 1. Signs of Resolution and Lack of Resolution from Pianta & Marvin (1996) and its Reflection in "Child on the Rainbow" parents monologs (Shlomy, 2014).

Evidence of resolution	Signs of lack of resolution
Acknowledgment of emotional difficulty of learning of the diagnosis	Denial of emotional impact of diagnosis
Recognition of change reaction since learning of the diagnosis	Cognitive distortion related to child's diagnosis or abilities
Suspension of search for an existential reason for child condition	Confusion and mental disorganization (contradicting oneself, loss of memory)
Acknowledgment of the need to move on in their life	Active search for existential reason for child's condition
Accurate representation of child ability	Disoriented or stuck in the past
	Boundary violations (attempts to draw interviewer into collusion against medical personal)

Conclusion-Pause

Carpenter (2005) states:

> At the point of diagnosis of a child's disability, a parent's first question is hardly likely to be about the local early childhood intervention services. These families are frightened, disturbed, upset, grieving and constantly vulnerable. The role of the professionals involved with them is to catch them when they fall, listen to their sorrow, dry their tears of pain and anguish, and, when the time is right, plan the pathway forward. (p. 181)

As we find a place to conclude, it seems more apt to consider this as a place to pause because the conversations, the experiences for the parents and their now adult children, is ongoing, daily. Throughout the *Child in the Rainbow* project, Dalia Shlomy has managed to artfully bridge theory with practice while keeping the heart of our work, babies with their parents in their communities, at centre stage. The play, *Child on the Rainbow* has been performed more than 20 times during the past five years in front of parents and professionals together. And furthermore, after the final applause, what happens next at each show: an open discussion between Dalia Shlomy as the producer, the parents who are the actors in the show, and the audience. So, it seems apt to pause here, before we invite your enquiry and conversation, with a word of thanks to each parent and their child:

Mira and Barak, Thank you.

Smadar and Lishay, Thank you.

Dror and their son, Thank you.

Anat and her daughter, Thank you.

Liora and Ofri, Thank you.

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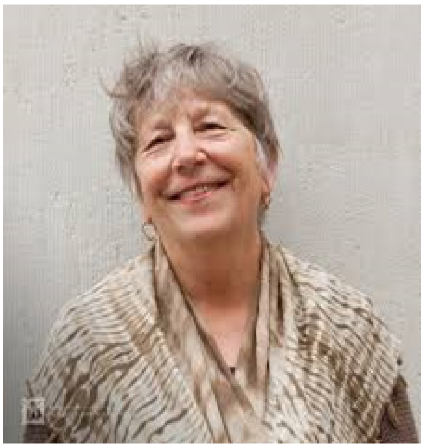
Poems and Reflections

By Deborah J Weatherston, PhD, United States of America



Deborah Weatherston, PhD (Infant Mental Health Specialist and Mentor) is the recently retired, Executive Director, Alliance for the Advancement of Infant Mental Health. She is also a long-standing Editor-in-Chief, and more recently Associate Editor, of Perspectives in Infant Mental Health.

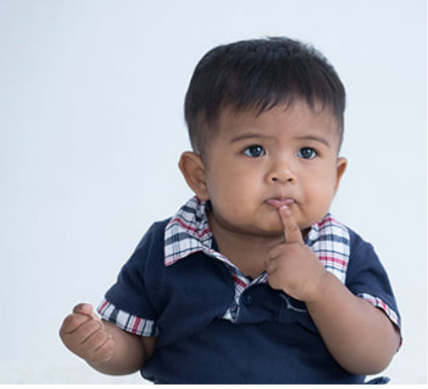
Debbie has been reflecting via poetry, on her experiences as an infant mental health home visitor, and in parallel, experiences within reflective supervision. A selection of her poems, with a reflective commentary from Debbie, about how her poems arrived, have been published in the Poetry and Practice section of Newborn Behavior International (NBI) network website.

You can access her poems and reflections via the following link: https://www.newbornbehaviorinternational.org/poetry/name-of-poem-bxjh5.

More generally, about the site, this is open access site and contains an invitation from NBI leaders, Kevin Nugent, and Lise Johnson, to join the NBI worldwide network.

You can read more about this at the following link: www.newbornbehaviorinternational.org

How can online learning improve child mental health – on a global scale? -Online presentation from Dr Niels Peter Rygaard (Denmark)



How can online learning improve child mental health – on a global scale? Who needs us the most? Children who lost parental care! Here is a link to this online presentation at the APA Convention by Dr Niels Peter Rygaard (Denmark), who was awarded the APA International Humanitarian Award. He has generously shared this link with us all. Thank you Dr Rygaard.

The link: https://www.youtube.com/watch?v=Epmju564FTU.

Book announcement

Recently published infant-parent psychotherapy book for sleep problems

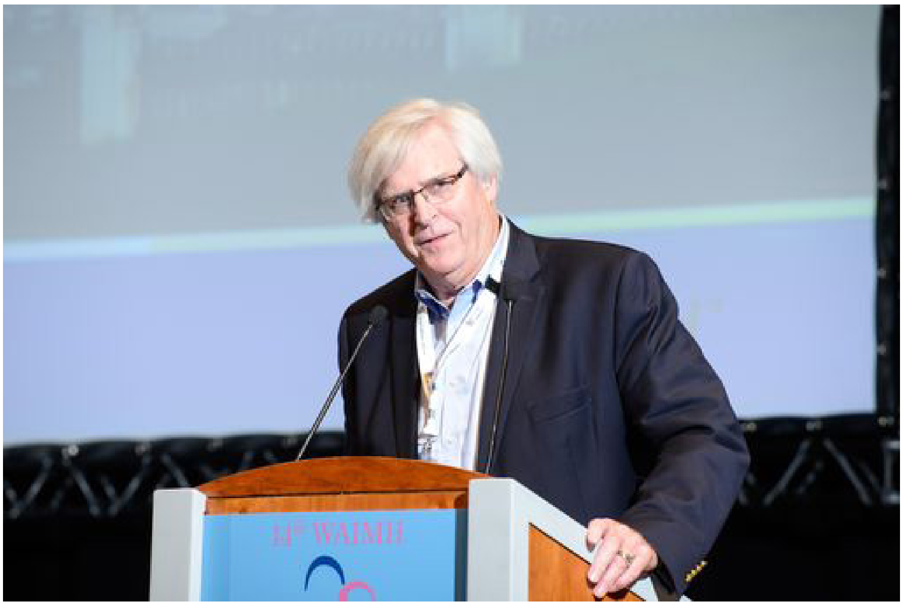
Recently released book by Dilys Daws with Sarah Sutton (2020). Parent-Infant Psychotherapy for Sleep Problems. Through the night.

https://www.routledge.com/Parent-Infant-Psychotherapy-for-Sleep-Problems-Through-the-Night/Daws-Sutton/p/book/9780367187828

Celebrating Hiram Fitzgerald: Forty years with Infant Mental Health. A tribute from Ireland

By Catherine MaGuire, Ireland, Clinical Psychologist, Infant Mental Health Mentor (IMHE®)

Co-Founder, Irish Association for Infant Mental Health



Hiram Fitzgerald in WAIMH 14th World Congress in Edinburgh, Scotland in 2014.

> Go raibh gach ní dá bhreáthacht agat agus, go rabhair slán i gconaí (May you have the best of everything and may you always be well)

Before Professor Hiram Fitzgerald from Michigan State University commenced his powerful Keynote presentation at Ireland's first National Infant Mental Health Conference in Cork in November 2007, he began with the opening words *"We are going to start an Infant Mental Health Association"*. Many of the 350+ delegates at that inaugural event knew little about the field of infant mental health! Of course, the rest is history!

Hiram Fitzgerald is an extraordinary, gifted psychologist, world leader, and journal editor in the field of infant mental health science, research, policy, and practice. Introduced to us by another inspirational world leader, Dr. Deborah Weatherston from the *Michigan Association for Infant Mental Health*, who was already supporting the development and integration of infant mental health in Ireland, we were fortunate to have the joy of getting to know Hiram. In the development of that relationship, we met an immensely generous and visionary leader whom we witnessed, who not only shared his expertise and wisdom with us, but with the interdisciplinary field of infant mental health clinicians and researchers across the world.

By 2009, and with the enduring support and expertise of Debbie Weatherston, the *Irish Association for Infant Mental Health (I-AIMH)* was established and had become an Affiliate of the World Association for Infant Mental Health (WAIMH). From there on, the principles and practice of infant mental health in Ireland began to take shape.

Over the past four decades, Hiram's research and countless publications have shaped policy and practice in how the infant is understood within the context of the family system. He has translated the science and practice of infancy and early childhood and made it accessible to practitioners, researchers, and policy makers.

Hiram's research has particularly focused a lens on the less developed role of fathers during the first five years of development. It was from this perspective, he facilitated a significant workshop at our 2007 Conference entitled, *"Fathers Matter: The Role of Fathers in Early Childhood Development"*, which provided a deep insight into the extent to which the father's presence or father's absence, has on early child development. It also opened the subject matter of this neglected area on the role of men and fathers in their transition to parenthood. This was followed by his inspirational Keynote presentation – *"Connecting Early Childhood Outcomes to Policy and Practice".*

Hiram is also a distinguished professor. He has an accomplished history of publications, alongside the four seminal volumes of the WAIMH Handbook of Infant Mental Health, which he co- authored with Dr. Joy Osofsky. He is the author of many book chapters and his special issue journal publications include his focus on fathers and more recently, the biopsychosocial development of boys and the origins of violence in males. Collectively, his scientific literature has helped bridge the infant mental health knowledge gap here in Ireland; the contribution of his expertise continues to inform us as we endeavour to advance the science and practice of this pivotal early developmental period.

Hiram's Irish Fitzgerald clann ancestry has greatly endeared him to the founding members of I-AIMH. He has been a most generous friend to his Irish infant mental health colleagues.

We sincerely thank Professor Hiram Fitzgerald and send him an Irish Blessing for his generosity, wisdom and leadership to us and we wish him well in all his next endeavours.

Go raibh gach ní dá bhreáthacht agat agus, go rabhair slán i gconaí (*May you have the best of everything and may you always be well).*

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WAIMH Awards 2020

By Astrid Berg, South Africa, David Oppenheim, Israel, Dilys Daws, United Kingdom and Campbell Paul, Australia

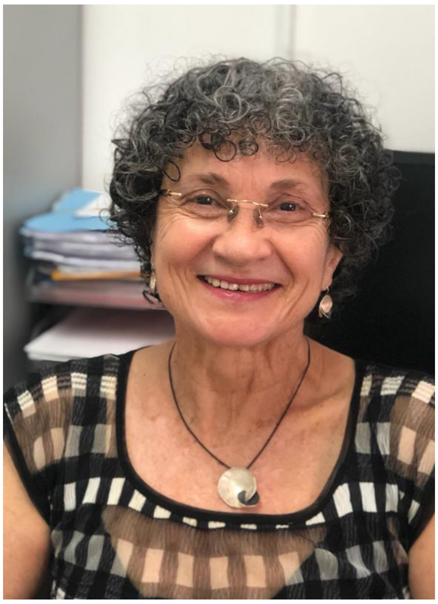
WAIMH offers awards in recognition of individuals from across the world who have made very important contributions to the infant mental health community in the course of their careers. As an interdisciplinary organization, WAIMH invites nominations from the fields of health, mental health, early care and education, early intervention, hospitals, colleges and universities, and legislatures, to name just a few.

Recently, three WAIMH members were honored with the following awards:

1. The Serge Lebovici Award recipient for 2020: Dr Miri Keren
2. The WAIMH Award recipient for 2020: Professor Jane Barlow
3. New Investigator Award recipient for 2020: Dr Lars White

Each awardee was presented their award virtually during the WAIMH webinars that occurred in mid-June. All things going well, the current plan is to conduct award ceremonies, in person, in Brisbane at the 2021 Congress. On behalf of WAIMH, we congratulate Dr Miri Keren, Professor Jane Barlow, and Dr Lars White as recipients of these awards.

The Serge Lebovici Award recipient for 2020: Dr Miri Keren



The Serge Lebovici Award is given in recognition of significant contributions to the international development of Infant Mental Health. Nominees are individuals who have been actively involved in collaborative efforts that have cross-national implications for infant mental health.

Dr Miri Keren embodies the spirit of this award because of her vision in creating and implementing international partnerships on behalf of infants, often in spite of daunting obstacles.

A child psychiatrist by training she is currently the Assistant Clinical Professor at the Sackler Medical School at the Tel Aviv University in Israel. Dr Keren is first and foremost a clinician. As the Director of the Geha Community Infant Mental Health clinic she has devoted her time to treating traumatized infants and their families. For this work she has received numerous national awards. She was the WAIMH Israeli Affiliate President from 2003-2007 and thereafter became its Honorary President.

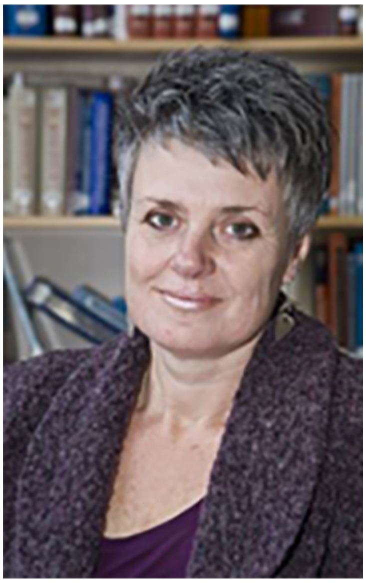
Dr Keren's work, however, goes far beyond the borders of her country. She has maintained close links with her country of origin, France, through symposia and conference participations. She is invited internationally to give courses, including in China and Spain, where she holds a visiting professorship at Valencia University. She is the Chair of the World Psychiatric Association Section of Perinatal Psychiatry and is an active member of the Zero to Three Task Force. She played a key role in the development of the DC: 0-5 Diagnostic Classification. Her respect for cultural diversity had a strong influence on the ability of the Task Force to incorporate different perspectives.

A member of the World Association for Infant Mental Health since 1996, she fulfilled the role of editor of the WAIMH official bulletin "The Signal", from 2007 - 2012. She then become the President of WAIMH in 2012. During this time, she was particularly active in drawing up the position paper on Infant Rights, a document that has been presented to and accepted by the United Nations Committee on the Rights of the Child.

The WAIMH Conference in Prague in 2016 marked a highlight of her presidency in that she was able to host it together with the Palestinian Association for Infant Mental Health. Her dedication to the process of peace and reconciliation in Israel-Palestine continues to this day through her ongoing collaboration with colleagues across the border. The joint Hebrew-Arabic translation of two books on traumatized children is a remarkable achievement and a testimony to the painstaking work done by Dr Keren and her Palestinian colleague, Dr Abdallah.

Dr Miri Keren's activities to promote infant mental health internationally, including across borders marked by ongoing violence, make her richly deserving of the Serge Lebovici Award.

The WAIMH Award recipient for 2020: Professor Jane Barlow



The WAIMH Award is given in recognition of significant contributions to the World Association for Infant Mental Health, either directly or through one of the WAIMH Affiliate Associations.

Professor Jane Barlow is an extremely powerful force in delivering the objectives of the World Association for Infant Mental Health. Jane has been instrumental in improving programs for the mental health of infants, children, and their families in the United Kingdom and way beyond. Jane began her career as a nurse in Lincolnshire, and throughout she has demonstrated an enduring passion for building research, academic rigour, and public advocacy into the foundations of effective health and social services for children and families. Jane is President of the Association for Infant Mental Health UK, and Professor of Evidenced-based Intervention and Policy Evaluation at the University of Oxford.

As the president of the AIMH UK, Professor Barlow has vigorously fostered active participation by all members in the activities of the organisation. Jane has brought together frontline clinicians, researchers, teachers, trainers, and policymakers to make a powerful coalition for the welfare of infants. Recognising the importance of early intervention and supporting those working directly with infants and families, Jane advocated strongly for the profession of nurse health visiting when it was under some threat. Her role in the establishment of the Institute of Health Visiting is just one example of her impact of increased government awareness of and support for early intervention.

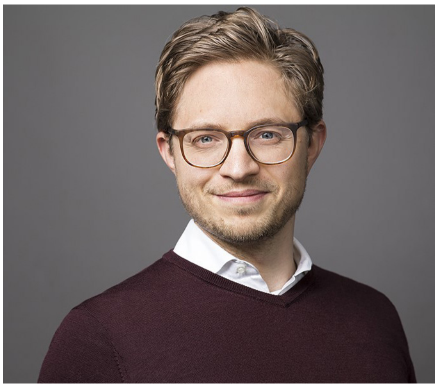
Teaching and training have been at the core of her work. As Pro-Dean of Research at Warwick University Jane developed an innovative and globally available online training in infant mental health.

Jane has been a major contributor to workings of WAIMH internationally, as Affiliate Council representative on the Board of WAIMH, and as Associate Editor for the Infant Mental Health Journal. She has been an active advocate for prevention of violence within families and across the lifespan.

As chair of the Local Organising Committee of the 2014 WAIMH Congress, Jane was instrumental in the overwhelming success of the Edinburgh Congress and has been actively involved in scientific programme committees for subsequent congresses. She has, through her extensive academic activities, encouraged research and program development for infants and their families.

Professor Jane Barlow through her commitment to infants and families, and to the goals of WAIMH is exceptionally deserving of the WAIMH Award 2020.

The New Investigator Award 2020 recipient: Dr Lars White (PhD)



Lars White received his PhD in 2015 in Psychology at the University of Leipzig in Germany in cooperation with Max Planck Institute of Evolutionary Anthropology. Dr. White holds two masters degrees: An MSc (Developmental Neuroscience and Psychopathology) from University College in London and an MA (Psychology) from the International Psychoanalytic University in Berlin.

Dr. White is currently Leader of a Research Group at the Department of Child and Adolescent Psychiatry, Psychotherapy and Psychosomatics at the University of Leipzig.

In his work, Dr. White studies the biopsychosocial mechanisms underlying the impact of early childhood relationships on later outcomes. He examines psychosocial risk and protective factors ranging from child maltreatment and peer victimization to attachment representations and social support.

His research goal is to unpack the dysfunctional social cognitive-affective processes, such as mentalizing, attachment representations, cooperativeness, and neurobiological processes, that are thought to lie at the heart of various mental health problems. For example, he has shown that internal attachment-related representations provide the basis for expectations about new encounters with unfamiliar others. Also, with his colleagues, he has developed a model on the neurobiology of attachment disruption and disorganization, making the innovative proposal that disruptions in early caregiving are associated with distinct neurobiological hyper- and hypo-arousal phenotypes based on the extent to which caregivers act as threatening or insufficient sources of co-regulation. He has also contributed to theorizing about the role of fathers in child psychotherapy, drawing on current knowledge of paternal challenging behaviours, triadic competence, and children's father representations.

Dr. White has been able to secure research funding for his work and has an impressive publication record. This includes papers in leading journals of our field, including Developmental Science, Development and Psychopathology, Journal of Child Psychology and Psychiatry, BMC Psychiatry, and more (and in many of which he is the leading author). Clearly, even at this early stage of his career, he has already made and will undoubtedly continue to make important contributions to the field of developmental psychopathology.

Perspectives in Infant Mental Health

Biennial Report

By Maree Foley, PhD, Editor-in Chief

Thank you

Perspectives in Infant Mental Health is a team, connected with the WAIMH community and from which evolves the regular paper/social media posts, full issue publications, and projects. A huge thank you to everyone who has contributed to this team over the past two years and to all the paper contributors.

Perspectives editorial team: June 2018-May 2020

June 2018- December 2019:

Deborah Weatherston (Editor-in Chief), Maree Foley (Associate Editor) Hi Fitzgerald (Associate Editor), Minna Sorsa (Production Editor), Editorial Board.

January 2019 – September 2019:

Maree Foley (Editor-in-Chief), Deborah Weatherston (Associate Editor), Hi Fitzgerald (Associate Editor), Minna Sorsa (Production Editor), Editorial Board.

From October 2019:

We began work as a new editorial team and the Fall-Winter (2019) issue represented the collaboration of a newly formed *Perspectives in Infant Mental Health* Editorial team:

- 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) WAIMH Perspectives Intern
- Hi Fitzgerald (USA) Consultant Editor
- Minna Sorsa (Finland) Production Editor

Debbie Weatherston and I switched editorial roles in 2019. Debbie has been and continues to be a work horse, quietly efficient and present in so many ways to the myriad of mini projects and papers we have on the go at any one time. She will officially retire from this role in November 2020. Her impact on the publication as we moved from paper to digital platforms has been enormous as is her ongoing impact on the way we work together as a Perspectives team within the WAIMH community. She is a WAIMH treasure.

Jody Todd Manly has fulfilled the new role of WAIMH EC Board member associate editor. Jody has brought her expertise nested within a compassionate and astute editorial eye, to this role. She has been pivotal in connecting Perspectives with the WAIMH Communication plan.

Patricia O'Rourke joined the team in 2020 and she brings a calm clarity about keeping the infant in mind and ensuring the work meets readers, especially those in front-line service. While ever humble, she has quickly become established as a core and valued team member.

Hi Fitzgerald, has recently retired from Perspectives. The current *Perspectives* (Spring-Summer 2020) full issue has a special feature on Hi celebrating his impact and contribution to this publication since 1993.

Salisha Maharaj is the current *Perspectives* Intern Editor. It is a pleasure to work alongside Salisha on our team and she has made a tremendous contribution.

Minna Sorsa works tirelessly in the WAIMH office with *Perspectives* as just one of the many projects that she juggles. She bears with us as we stretch and grow Perspectives. Her work is very much appreciated.

Sari Miettinen, is not officially a production editor, but is very much part of the Perspectives team. She has recently been pivotal in setting up the COVID-19 WAIMH web page and keeping this updated. Her work is very much appreciated.

Review process and change in the editorial team structure (2019)

Review rationale: In 2019, the Editors, with the WAIMH Board and the Executive Director engaged in a reflective review process concerning the structure of the Perspectives Editorial team and the Perspectives Board. Over the past few years, much had changed with regards to the publication including shifting to an online publication, digitalizing recent and past editions, as well as the production of shorter social media-oriented posts.

Process: All editorial board members were contacted with regard to current initiatives within Perspectives and we enquired about their capacity to contribute further at this time to Perspectives. Based on the responses we proposed a change of structure to the WAIMH Executive Committee:

1. To work with a larger editorial team in contrast to the current small editorial team and large Perspectives board. As such, to disband the Perspectives

board structure and focus on a globally representative editorial team.

2. To invite the WAIMH board member who held the communications portfolio to join the Perspectives Editorial team as an Associate Editor.
3. To continue with the primary roles: Editor-in-Chief; Associate Editor; Consultant Editor; and Production Editor.
4. To add two new editorial roles: WAIMH Board Associate Editor; and WAIMH Perspectives intern editor.

Upon approval from the WAIMH Executive Committee, all previous Perspectives board members were sent a letter thanking them and outlining the changes that came into effect October 2019.

Full issue publications June 2018 – June 2020

Throughout the past two years the Perspectives team have worked hard to expand the global reach and to include papers from around the world. We are always looking for ways and relationships to help us to identify new papers for publication from all corners of the globe, including practices, interventions, advocacy, scientific study, infant mental health training and on-going research.

26 (1) Winter 2018

26 (2-3) Summer 2018

26 (4) Fall 2018

27 (1) Winter 2019

27 (2) Summer 2019

27 (3) Fall-Winter 2019

28 (1) Summer 2020

The publication process

With the development of WAIMH social media, submitted papers are reviewed, edited as necessary, and then posted from the WAIMH office, to WAIMH social media platforms. A huge thank you to Minna and Sari. These papers then make up the base of each full issue.

1. The ongoing development and refinement of the Perspectives website

Incredible progress has been made by Minna and Sari with regard to the WAIMH Perspectives website and the associated social media platforms. In addition, all full issues are archived:

- Past issues of *The Signal* (1993 - 2011) can be accessed online.
- Past issues of *Perspectives in Infant Mental Health* (2012 – current) are available. Past articles are also available online in text format, which in turn can be shared.

2. Regular posts and full issues

We run two parallel publishing processes: Keeping the flow of regular articles/posts; and publishing full issues.

3. Peer reviewed papers

We also introduced the capacity to conduct full blind peer review of selected papers. This was first implemented, with 2 papers in the Fall/Winter issue 2019.

4. Four full issues a year to three full issues per year

In June 2019 we decided to move to a three full issue a year schedule instead of 4 as a way to balance the online and regular publishing process between full issues.

5. Post-Production: Member access only first of full issues

The full issue is emailed and uploaded to a member only section on the WAIMH - Perspectives website. There is a staggered release of the full issue of Perspectives that includes new and previously published papers to members first, after which the full issue becomes open source. In addition, a post full-issue production article posting schedule, is established.

Perspectives Initiatives

1. WAIMH Perspectives intern program

Salisha Maharaj (South Africa) has been and continues to be the Perspectives Intern Editor. Thanks so much to Astrid Berg for introducing us to Salisha.

Initiative background: The idea for offering internships arose from understanding the process of community engagement within the overarching editorial process, and in conjunction, appreciating the journey on route to becoming engaged as a professional with WAIMH.

First, the editorial process involves both technical expertise and relationship building. That is, in addition to sourcing, preparing, and publishing papers, one of the outcomes of the editorial process is engagement with the WAIMH membership as well as allied professionals.

Second, the professional journey of joining the extended WAIMH community is made somewhat easier with global technology. However, this ease is not a substitute for supported relationship building and connection. Many of us arrive at WAIMH as established professionals who are on a pathway to bridge our existing professional base with the inter-disciplinary base of IMH.

As such, the idea of internships arose; internships specifically for people who are currently engaged in an IMH training programme and who are new to the field. The over-arching goal is to leverage *Perspectives* as base from which to: get to know new members; provide opportunities to engage with the wider IMH community beyond one's local area; and to also learn and understand from new members about what they are seeing and noticing in our field.

Our aim is to grow this initiative so that interns at any one time represent different regions across the globe. This not only reflects WAIMH's outreach goals but also supports new members getting to know each other through sharing in the work of WAIMH.

2. WAIMH EC Board member as an Associate Editor

Jody Todd Manly has fulfilled the new role of WAIMH EC Board member associate editor. Her work in this role has been pivotal in connecting Perspectives with the WAIMH Communication plan.

3. WAIMH COVID 19 Webpage

The Perspectives team have worked alongside Kai von Klitzing (WAIMH President) and the WAIMH office, especially Sari, with regard to developing the structure, introductions to site visitors and sourcing the content for the WAIMH COVID 19 website pages. This process is ongoing.

4. Perspectives E-Book Project

A two-part book series based on the past papers in the Signal and Perspectives (March 1993 to current) is in motion. This project is being led by Miri Keren and the team which includes Debbie Weatherston, Maree Foley, Kaija Puura and Antoine Guedeney.

Perspectives and IMHJ

We have developed a fantastic collaboration with Holly Brophy-Herb (IMHJ Editor). Thanks, so much Holly.

1. IMHJ Article feature in Perspectives

A joint initiative between Perspectives and the IMHJ involves featuring IMHJ articles that especially draw attention to themes in practice with very young children/families. A new column has been established in 2020. 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 was 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".*

2. IMHJ and Perspectives COVID -19 project

The Perspectives team have collaborated with Holly (IMHJ) in a shared initiative: *Infant and Early Childhood Mental Health in the Context of the COVID-19 Pandemic.*

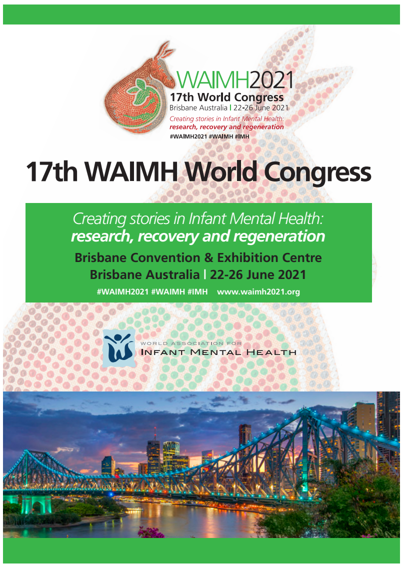
Perspectives will focus on publishing short papers that feature case studies and qualitative studies that capture the voices and lived experiences of infants, young children, families, and practitioners. These will be published in online special COVID 19 issue in December 2020.

Finally, as we move forward, we welcome submissions from colleagues across our diverse field that challenge the way we think about infants, families, culture, and community, and offer fresh perspectives on policy, research, and practice.

Congress News

By Elisabeth Hoehn, Brisbane, Australia

Co-Chair, WAIMH 2021 Local Organising Committee



As the challenges, uncertainties, and opportunities of this year continue, I am writing to provide an update on the progress we are making toward hosting WAIMH 2021 in Brisbane next June.

As this year has progressed, many other organisations and conferences have faced the same challenges that we are facing and many have adopted a fully virtual conference platform. For international conferences that has the added challenge of planning across 3 key time zones. The advantage we have is that we can observe, participate in, and share knowledge and experiences with those who are going before us in this unchartered space of virtual conferencing. Already we have gleamed a lot and our Professional Conference Organiser, ICMSA is well placed to develop and draw on experiences in this space.

After extensive discussion, a decision has been made to hold a hybrid Congress in Brisbane. This hybrid Congress will have a significant virtual component complementing a smaller face-to-face Congress at the Convention Centre in Brisbane. While information and experience about planning a fully virtual conference platform is growing, hybrid conference models have been very limited and so we have the challenge of creating something very new for this WAIMH Congress. This is exiting as it provides an opportunity to create a congress template that WAIMH may be able to use in the future, allowing its congresses to engage with a much wider audience.

We will scope the experience of others and already many concepts for sharing knowledge, mentoring, debate, and reflection and creating social connectedness in the virtual space are emerging. Other conferences are incorporating prerecorded sessions followed by live discussions, synchronous and asynchronous sessions, special interest group meetings, social mixers, live debates and demonstrations, conversations and consultations, regional meetings and experiences, global ambassadors and connections, and a variety of other networking opportunities. We will be scoping many possibilities over the next few months and would welcome any ideas or experiences you can share from attending events in the virtual space. Please share your ideas by contacting our conference organiser via the Congress website.

Additionally, our field of practice is fundamentally embedded in relationship and the WAIMH Congress has provided a space for us to come together, not only to share knowledge and practice wisdom but also to spend time together, strengthen relationships, and build new ones. This provides a richness to our Congress experience that is one of its intangible benefits. The challenge for the Congress in Brisbane in 2021 is how can we incorporate this social connectedness into a virtual space and continue to nurture this relational component of our Congress.

The Program Committee, chaired by Professor David Oppenheim, have already put together a rich program for us, which will only be enhanced by the additional Call for Abstracts. Building on this wonderful scientific program, we are hoping to provide you with a program of cultural activities to enhance your Congress experience despite the challenges we are facing. We are currently revising the registration fees to include a virtual component and encourage you when this is available to register and become part of a cutting-edge conference experience.

We are unable to predict what 2021 will bring, but we would encourage you to put the Congress dates in your diaries and quarantine these dates so that you can actively participate and immerse yourselves in the Congress experience, as if you were attending in person. We are excited to embrace this new opportunity for global connection and look forward to meeting with you at the WAIMH 2021 Congress in Brisbane.