Vol. 32 No. 2 | Summer 2024

Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

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From the Editors

By Jane Barlow (United Kingdom), Maree Foley (Switzerland), and Salisha Maharaj (South Africa)

Welcome to this Summer (2024) edition of WAIMH *Perspectives in Infant Mental Health*. It has been a very busy period since the last issue, with Astrid Berg now having been formally invested in her new role as WAIMH president at the Interim WAIMH World Congress for Infant Mental Health that was held in Tampere, Finland in June. We have also recently received very sad news of the death of Professor Colwyn Trevarthen, Emeritus Professor of Psychobiology and Child Psychology at the University of Edinburgh (Scotland), who died on July 1st at the age of 93. To honour Colwyn fully, Hisako Watanabe (WAIMH Regional Vice President) and Campbell Paul (WAIMH Past President) are in the process of compiling a reflective tribute to Colwyn, a treasured friend and colleague. In the interim, Salisha Maharaj and Maree Foley, from the Perspectives team, have compiled for this edition of Perspectives, a selection of infant mental health and early childhood development-focused academic and free open-source resources where Colwyn Trevarthen is the author or co-author.

We have three IMH clinical papers for you in this edition. The first of these - *The World in Crisis – what would infants say to us? Development and Context* - is based on Astrid's keynote address as the new WAIMH President, which is an erudite and emotional call to action to ensure that we hear the voice of the infant whose early experiences are very often the trauma of wars, displacements, hunger, earthquakes and floods. She examines the research of number of scientists - Piontelli (1992); Marx & Nagy (2015) Frohlich et al (2023)– whose work during the perinatal period has enabled us to better understand the meaning of fetal behaviours. She goes on to examine what scientists such as Meltzoff and Borton (1979) and Stern (1982) have taught us about 'the infant in the world' in terms of their early abilities (i.e. amodal perception) and the importance of their primary caregivers in enabling babies to come into being.

Our second paper is an opinion piece written by Professor Kai von Klitzing "*There are many roads leading to Rome". Growing up in a diverse world; does everything work in child development?*, which provides a

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Perspectives in Infant Mental Health is a quarterly publication of the World Association for Infant Mental Health. ISSN 2323-4822. All opinions expressed in Perspectives in Infant Mental Health are those of the authors, not necessarily those of WAIMH. 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 2024, Vol 32 (2).

thought provoking and challenging examination of the tension between a culturally sensitive approach to infant mental health based on the many diverse pathways to mental health that are now recognised, and the danger that this poses in terms of us moving toward what he refers to as 'cultural arbitrariness' in which all cultural practices are felt to be equal in terms of child development. He demonstrates this by examining recent trends in relation to modern reproductive medicine, and culturally different definitions of child maltreatment.

Our third paper, which was written by Bridget Walsh, with Mavis Moore, and Milagro Guardado entitled *Promoting Reflective Coaching for Home Visitors' Regulation and Practice: an Autoethnographic Account* provides a personal examination of the role of early childhood home visiting coaches in the U.S. In this autoethnographic account, Bridget shares and analyzes her journal entries made as part of an infant-parent mental health fellowship alongside the stories that she compiled about her own experiences of receiving support in her role as a coach, and interviews with HVs that were undertaken to promote her reflexivity. Her paper describes how she used this approach to explore the contribution of reflective coaching to adult regulation and educational and therapeutic transformation.

In addition to the clinical papers, we report the nominees and winners of both the Scientific and Clinical Poster Awards from the WAIMH interim Congress which was very well attended with over 422 delegates from 36 countries. The call for poster presentation submissions in the scientific and clinical categories received over 200 submissions, and here we present the three that were rated as top in each category.

We also report in this edition of Perspectives the result of a survey that was sent to all WAIMH members, with 129 responses in total. The report shows members views regarding how frequently they access Perspectives, their preferred article format, the usefulness of the content and the likelihood of them submitting a paper, with key reasons for not doing so. It also highlights the future topics that members would like us to cover.

We conclude with a note from WAIMH Executive Director Kaija Puura, and some news from WAIMH Executive Office.

The issue closes with general information about WAIMH Perspectives (including the paper submission process). As a reminder, Perspectives papers can be accessed online, with past issues dating back to 1993 currently available by following this link: https://perspectives.waimh.org/perspectives-archive/. Also, past articles are available online in text format, which in turn can be shared: https://perspectives.waimh.org/.

With all good wishes,

The WAIMH Perspectives in Infant Mental Health editorial team

Introducing Professor Jane Barlow. Editor-in-Chief, WAIMH Perspectives in Infant Mental Health

By Maree Foley (Switzerland), Salisha Maharaj (South Africa) and Jane Barlow (United Kingdom)

Photo: Jane Barlow

In June of this year, Maree Foley completed her term as Editor-in-Chief of Perspectives and handed the baton to Jane Barlow.

Jane brings to this role an extensive range of research, writing, and publishing skills in our field and extensive grass-roots relationships with WAIMH members worldwide. She is currently the President of AIMH UK, the UK WAIMH affiliate. She has also recently completed a four-year term on the WAIMH Executive Board as the Affiliate Council Representative for WAIMH.

Jane is a Professor of Evidence-Based Intervention and Policy Evaluation at the Department of Social Policy and Intervention (DSPI), University of Oxford. Jane's primary research interests are the role of early parenting in the aetiology of mental health problems and the evaluation of interventions aimed at improving parenting practices during pregnancy and the postnatal period.

She also undertakes research to evaluate the effectiveness of interventions aimed at preventing child abuse.

She is also an Associate Editor for the Infant Mental Health Journal and an Honorary Fellow of the Faculty of Public Health. She has undertaken several national/international roles, including being Editor-in-Chief of the Child and Adolescent Mental Health Journal and the Social Welfare Group of the Campbell Collaboration.

On behalf of WAIMH and the WAIMH Perspectives team, we welcome Jane to this role. We look forward to her leadership in steering the ongoing development and growth of this longstanding and ever-evolving WAIMH publication.

Introducing our new WAIMH President, Astrid Berg (South Africa)

By Maree Foley (Switzerland) and Astrid Berg (South Africa)

At the Tampere WAIMH Congress in June this year, Campbell Paul completed his term as WAIMH President (2019-2024). As WAIMH President, Campbell helped to navigate WAIMH successfully through COVID-19, a hybrid Congress in Brisbane, Australia (2021), a WAIMH Congress in Dublin, Ireland, in 2023, and an interim Congress in Tampere, Finland (June 2024).

At the close of the Tampere Congress, with much appreciation from WAIMH for all Campbell has done as WAIMH President during his term, he handed the WAIMH Presidency mantle to Astrid Berg (President-Elect).

For those new to WAIMH, here is a little bit about Astrid.

Photo: Astrid Berg

Astrid Berg MBChB (Pret), FFPsych (SA), MPhil (Child & Adolescent Psychiatry)

Astrid Berg is a Psychiatrist, Child and Adolescent Psychiatrist, and Jungian Analyst. She is an Emerita A/Professor at the University of Cape Town and an Extraordinary A/Professor at Stellenbosch University.

Astrid currently consults and teaches at Tygerberg Hospital and is co-convenor of the M Phil degree in Infant Mental Health at Stellenbosch University.

She developed her clinical and academic interest in infant mental health by engaging with IMH specialists locally and globally.

Over more than two decades, Astrid has significantly contributed to developing the infant mental health field in South Africa.

She is the founder of the Western Cape Association for Infant Mental Health (WAIMH affiliate organisation) and has organised two national and one international IMH conference. In 2012, the local Affiliate hosted the 13th WAIMH Congress in Cape Town.

She has been the lead consultant at the University of Cape Town's Parent-Infant Mental Health Service for 18 years.

She has also contributed substantially to the well-being of infants with their families, in their communities, in Cape Town, and across South Africa.

On an international scale, Astrid has been instrumental in advancing the field of IMH through supervision, training, consultation, and service to WAIMH at both the Affiliate level and as an Executive Member. She has contributed to the professional growth and development of many WAIMH members, allied professionals, and WAIMH affiliates. Astrid has been a long-standing WAIMH Executive Committee member and, for the past five years, has been the WAIMH President-Elect. From June 2024, Astrid became WAIMH President.

This edition includes a paper based on Astrid's keynote address as the new WAIMH President, which she presented at the WAIMH interim Congress in Tampere, Finland (June 2024).

The World in Crisis – what would infants say to us? Development and Context. Astrid Berg, President of WAIMH. Keynote address at the WAIMH Tampere Congress 2024

By Astrid Berg (South Africa)

Photo: Prof Astrid Berg at the WAIMH 2024 Interim World Congress in Tampere, Finland. Credit: Anna-Kaisa Noki-Helmanen

Let me begin with a clinical case:

In the early 2000s, the HIV epidemic in South Africa was equivalent to a war zone in many communities, where the incidence was high and where the most vulnerable were being infected through no act of their own – the newborn infants.

Let me introduce you to Baby A and her mother.

> Baby A was four months old when she presented to us in the primary health care clinic. She had been hospitalized with pneumonia due to being HIV+. While the young, first-time mother had been aware of her status, she was shocked that her baby was also infected. The father of the baby had left them, and the mother's only support was a brother. She had not shared her diagnosis with anyone in her family (at that time, HIV was a taboo subject, especially among family members).

We followed this mother and her child until Baby A was three years old.

Baby A and her mother were exposed to many major psychosocial stressors. They suffered from a dangerous communicable disease: HIV. They endured hunger, financial insecurity, no or very limited family support, an absent father, and unemployment.

Despite all these major difficulties, she and baby A came through and did not just survive but thrive.

What were the protective factors, and what helped?

Perhaps it was Baby A's ability to focus on her mother and her mother's ability to smile at her and share pleasure. Both mother and Baby A were open and willing to seek help and be helped. They received support from the community structures that were in place and from the medical interventions that were starting to be administered at that time.

When Baby A was three years old, I received this report from our Developmental Paediatrician:

> "Baby A is in good general health, has no hard neurology, and her mom has an excellent relationship with A and very good insight into her emotional and developmental needs. She is performing at or above her age equivalence for all the subscales, with the exception of some of the fine motor tasks…."

Given our context and setting, especially during those traumatic HIV years, this was a good outcome. We did not experience an actual war or natural catastrophe, but there are parallels between a deadly epidemic and the turbulences currently facing us.

I will return to these in the end.

I have deliberately started this presentation with a clinical case because we can move to meaningful research questions from the clinical case.

Over the course of this paper, I will trace some of the developmental lines in research that have emanated from making hypotheses to observations, as well as concrete, detailed research. And then I will come to the big question of WHAT NOW? given the dire state of the world that infants find themselves in.

Let us go to a hypothetical infant.

> *Our senses are open right from the very beginning, even before birth. We take in what surrounds us, it gets stored in our brains, our bodies, in our very being. We are sensitive to the fluid around us – it gets into our bodies.*
>
> *When we come into the world, we can also see that we like human faces and friendly faces. We can hear the voices we've*

heard before, smell the milk we drink, and feel what's in our mouths.

We are born to connect our senses to persons around us, particulalry to those who care for us. Those we know best, we attach to, and they become our life-giving other, our parents.

We are curious; we want to know the world. We enjoy stimuli that are not too loud, not too much, as we can easily feel flooded by our senses. For us, meeting what's in the world is dramatic and emotional, so we cannot have too much of it.

BUT WHAT ARE YOU ADULTS DOING? DO YOU HAVE ANY IDEA HOW THE WORLD IS AFFECTING US?

I will cast the net wide before answering and look at two themes that are at the centre of Infant Mental Health (IMH): Development and Context.

I will trace a few of the many developments in the field of IMH and thereby honour some of our ancestors.

I will then try to look at what we should do, given this valuable data.

Development

In one of his last great papers, Sameroff, in 2010, developed a Unified Theory that integrates nature and nurture. He employs a dialectical perspective, which shows the interconnectedness between the individual and the context (Sameroff, 2010).

The individual starts in a tiny, imperceptible way – the union of two gametes, and the individual ends when the adult body is dissolved. In this life course of about 80 years, infancy occupies the First 1000 Days – 2 years, plus 9 months of pregnancy. That is a tiny bit. So, why do we focus on it? Why is so much research, publications and theorizing, concentrated on this tiny bit of life?

The main reason has to do with the plasticity and openness of this time of life and the potential that it holds. At no other time in the human life span is there more rapid growth of the body and the brain, and with it, enormous developmental shifts take place.

Anna Freud referred to children's progressive tendencies; it is their forward thrust, vitality, and will to live and move forward that signifies childhood and delights parents and families.

However, while the body will grow if given sufficient food and shelter, the brain and the mind need more; they need relationships with others. Food, shelter, and relationships with others are fundamental; they are the "contexts" surrounding this tiny bit of early life.

The Developmental Origins of Health and Disease (DOHaD) field is gaining increasing traction in global research and writing. Its hypothesis states that environmental factors during critical periods of development have a lifelong effect on biological systems. Such as the central nervous system, the neuroendocrine system, and the immune system. The vulnerability or sensitivity is highest when the organ systems are developing and still immature (Penkler, Hanson, Biesma & Müller, 2019).

The impact of DOHaD research raises our awareness of social contexts and their importance in determining development across the lifespan. We all have enormous social and political responsibility towards those who need it most, as they will be the adults of the future.

The most devastating sector of the current global crises is the fate that has befallen infants. They have no voice; they can only cry if they still have life in them, or they drop into silence – of frozenness or death.

Can we bear to hear what they would say to us? Campbell Paul (Past President of WAIMH) is an expert in giving infants a voice in interpreting their behaviour. His fundamental approach is: What can the infants tell us? Let that be our guiding principle.

Let us try to imagine what they might say, and let us at the same time be informed of the research that proves what they say.

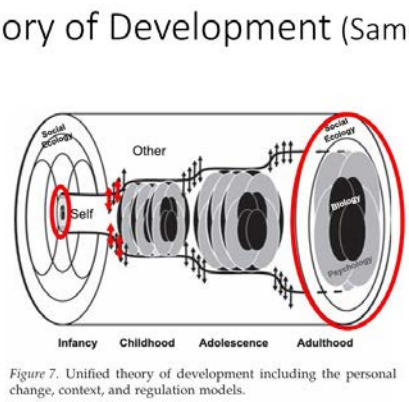

Figure 1. Sameroff, A. (2010). A unified theory of development: a dialectic integration of nature and nurture.

Before entering into the world

So, we are going back to the beginning of the First 1000 Days—to the tiny bit of a human being—and imagining what this small being is telling us. But this is not just fantasy, idealizing, or sentimental talk. Science corroborates what psychoanalysts have imagined long ago.

Observing fetuses while in utero via ultrasound (Piontelli, 1992)

We owe much to Piontelli's work in the early 1990's. Following the Infant Observation model, she started observing fetuses while in utero via ultrasound examinations. She found continuity in aspects of prenatal and postnatal life, with fetuses showing characteristics that would also be observable after birth. She states:

> What I think my findings do suggest is that the interplay between 'nature' and 'nurture'

> begins much earlier than is usually thought, and that certain pre-natal experiences may have a profound emotional effect on the child, especially if these pre-natal events are reinforced by post-natal experiences. (Piontelli, 1992, p. 1)

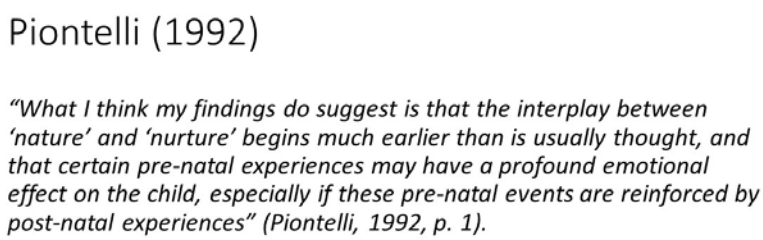

Figure 2. Piontelli (1992).

Measuring fetal behavioural responses to external stimuli (Marx & Nagy, 2015)

Twenty-three years later, we have a study by Marx and Nagy (Marx & Nagy, 2015) which sets out to measure fetal behavioural responses to external stimuli. Fetal movements of arms, head, mouth, arms crossing, hands touching the body, and yawing were the responses that were coded. Maternal touch of the abdomen was a powerful stimulus, with the fetuses displaying more movements of their arms, head, and mouth. The older fetuses in the third trimester responded more than younger fetuses. The maternal voice led to decreased fetal heart rate, which suggests behavioural quieting in response to the mother's voice.

The findings of these two research projects are the result of direct observations. The first one relies on careful descriptions of fetal behaviour based on the IO model. The second employs more sophisticated ultrasound recording that enables the coding of fetal movements in response to outer stimuli.

Transdisciplinary brain research (Frohlich et al., 2023)

The third piece of research I want to introduce is that by Frohlich and colleagues (2023).

From the authorship alone, one can see how the research is becoming increasingly complex: from single authors to two authors and now to ten authors from multiple centres on different continents. Direct observation is replaced by measurements, which are then translated into images of the brain and graphs.

In essence, this large group of researchers is trying to demonstrate concretely the answer to the difficult question of 'when does consciousness emerge?' They set out to look at functional brain data from human fetuses using complicated technical methods.

The measurement of sensory pertubational complexity - means that if one of the senses is stimulated, such as the auditory or visual, then a complex 'disturbance' is seen on the screens of the various devices that they use. One of the findings is that a mismatch in response to sound frequency was visible as early as 28 weeks of gestation. This means fetuses respond to an unexpected sound at this early gestational age. Evidence suggests that there is intrinsic connectivity within the motor, visual, auditory, and thalamic networks.

So, these are concrete data and findings that can be seen and measured even before birth.

The infant in the world

Let us now move to the **infant in the world**!

Let us continue the theme of cross-modal perception. It is this ability that infants have that fascinated me so much when I entered this field.

In 1979, Andrew Meltzoff and Richard Borton published their simple but elegant experiment in *Nature* (Meltzoff & Borton, 1979).

Two different pacifiers were placed in the mouths of infants whose eyes were covered. They were then taken out and shown to the infants.

Infants fixated on the shape matching the tactile stimulus of the pacifier.

Their conclusion was

> … neonates are already able to detect tactual-visual correspondences, thereby demonstrating an impressive degree of intermodal unity. (Meltzoff & Borton, 1979, p. 404)

This automatically brings us to Daniel Stern, whose writings in the 1980s put many of us on the path of infant mental health. There is so much that could be said about this man—a clinician, psychoanalyst, and researcher. It is this unique combination, in fact, his intermodal transfer between these disciplines, that made his writings so compelling.

Here, I only want to focus on what he wrote about when he described the sense of an emergent self—that early phase from birth to 2 months. He asks,

> "How might the infant experience the social world during this initial period?" (Stern, 1985, p. 37).

He answers the question in this way.

> Many separate experiences exist, with what for the infant may be exquisite clarity and vividness….When the diverse experiences are in some way yoked…the infant experiences the emergence of organization… The sense of an emergent self thus includes two components: the products of forming relations between isolated experiences and the process. (Stern, 1985, p. 46-47)

He gives many examples of this 'amodal perception' in different modalities, including touch and vision (as just described), light intensity and sound intensity, and the correspondence between an auditory temporal pattern and a similar visually presented temporal pattern.

This means that infants can "take information received in one sensory modality and somehow translate it into another sensory modality. We do not know how they accomplish this task" (Stern, 1985, p. 51).

Well, perhaps we are getting closer to answering Stern's question by looking at some recent multi-centre research by Mahshid Fouladivanda and her team. The 2021 paper, published in the Journal of Neural Engineering, tells us how far this field has moved into the electronic neuroimaging domain. In fact, it is impossible to really understand the methodology because it is so technical. But we can get to the gist of it (Fouladivanda et al., 2021).

Their study aimed to explore brain networks in neonates through functional magnetic resonance images. There is a rapid change in brain morphology and white matter pathways, particularly during the first few weeks after birth. They modelled brain regions that serve as nodes and are interconnected via white matter pathways.

It may well be that these visible, measurable developments in the infant brain form the basis of the efficiency of amodal perception.

So much for development that goes on within the infant.

Let us move to "context".

The early 'context' of the fetus and infant

So, what about the caregiver's influence? "There is no such thing as a baby, only a baby with its mother" is the perennial quote from Winnicott. Ever since the time of Hippocrates, clinicians have been aware of the association between the postpartum period and depression (Duquaine-Watson, 2022).

I am mindful of current thinking that questions the primacy placed on the role of the mother for the care of her infant, thereby bypassing the responsibility that other persons and institutions have, such as the fathers and the state, AND also bypassing the fact that in many cultures in the world, infant care is not exclusively the ambit of the mother.

However, pregnancy and the early months of life depend on the mother's well-being. She physically carries and feeds this infant.

Increasingly, the research is focussing on prenatal exposure to maternal stress and the risk it poses for mental health problems in later life. The fetal programming and the DOHaD hypotheses mentioned earlier state that during sensitive periods of development, environmental factors, such as exposure to hunger and exposure to stress, affect the organization of the biological systems, with long-lasting effects (Van den Bergh et al., 2020).

> The results of this review on the effects of prenatal exposure to maternal stress suggest that pregnant women and their unborn children ought to be recognized as vulnerable populations and protected accordingly from undue hardship and distress. (Van den Bergh et al., 2020, p. 58)

BUT what happens when there are wars, displacements, hunger, earthquakes and floods?

When the context is so traumatic that development is affected and even disrupted?

My own clinical work showed how the maternal/family environment impacts on caregiver attunement and sensitivity and how that in turn, can impact on the feeding relationship, with potential serious consequences for the child's ongoing physical and mental development. Baby A and her mother are but one example.

> *What happens when the emergent self is overwhelmed with sensations that cannot be linked or yoked, that do not make sense, that defy inherent expectations?*
>
> *What happens when suddenly there is no known 'other', no attachment figure who the infant can see, feel, and hear?*

Perhaps we can most clearly see this in this recording of the original Spitz film of infants who were separated from their mothers.

I have given an overview of research on some of the developments in early pre- and postnatal life. I hope to have shown how early clinical observations have led to focused and specific research and how this is ongoing and becoming increasingly detailed and concrete. Where have we come to? What have we done with this knowledge?

WHAT WOULD INFANTS SAY TO US?

"STOP IT WHERE YOU CAN!"

"The history of childhood is a nightmare from which we have only recently begun to awaken" (de Mause, 1974), and in fact, are going back into.

What are we not hearing? Why are we not listening? I turn to Dan Stern's plea to the WAIMH Yokohama Conference in August 2008.

He delivered a plenary address, "*Perspectives on Infant Mental Health*", and focussed on the state of research generally speaking and in particular as it relates to infant mental health. It was an erudite, provocative 'call to action', which I will never forget.

Stern challenged many sacredly held beliefs about the reductionist approach to research, which breaks up the whole into tiny pieces—the 'higher order' which the infant is capable of is being dissected and ultimately rendered meaningless; he challenged evidence-based medicine, stating that we understand enough to know that in the field of infant mental health, it is time to do something else, to redress that which has been lost.

What has been lost is what babies need, namely mothering [parenting]. We have more than enough evidence for this. He appealed to 'go big', to hold concerts with rock stars, and mobilize the people so that the politicians may realize that the vote, the power, lies with women and men who wish to reclaim the importance of parenting.

I am not sure that rock concerts are enough to help us today.

Infants have no power. They do not have the vote. Whatever voice they have is not translated into adult language, and whatever voice they do have can easily be ignored or silenced.

But underneath this, there is a deeper layer – namely, that there has been, in the history of childhood, a collective denial of infant sentience (Bain, 2020).

In other words, the genuine realization that infants have an awareness that they have feelings, even if they can't articulate these as yet. But this is perhaps too frightening to contemplate for the adult world – it takes us back to our own infancy and early childhood years, plus it places an enormous responsibility on us as adult human beings. Perhaps it is this that we, as a collective human group, are defending against - denying, repressing, or splitting off.

What can we do?

It is WAIMH's stated aim to "…encourage the realization that infancy is a sensitive period in the psychosocial development of individuals" (WAIMH Bylaws, 2008, Article II, Section 1) – which is putting it rather mildly.

The Position Paper on Infant Rights states

> In spite of the existence of the Convention on the Rights of the Child, many societies around the globe still pay insufficient attention to infants, especially in times of stress and trauma (WAIMH, 2016).

You can access this paper in *WAIMH Perspectives in Infant Mental Health* here:

PositionPaperRightsInfants_-May_13_2016_1-2_Perspectives_IMH_corr.pdf (waimh.org)

We have a position statement on Infants in War (Keren, Abdallah, & Tyano, 2019). This paper, published by Wiley in the Infant Mental Health Journal, is open-source. You can access the paper here: https://onlinelibrary.wiley.com/doi/full/10.1002/imhj.21813

We have the Infant Rights document. There is a working group on Ethics in IMH, and we have our Global Crises Working Group.

I am hoping that we will set the process in motion to engage with the World Health Organization formally, but this will take time as the wheels of such global organizations turn slowly.

While we should think big, perhaps the only workable, doable way forward is through small steps—such as supporting and collaborating with the organization CARE Palestine and walking with them, as our Crises Working Group is trying to do.

We need direct contact with key people—we need to share with them the value of 'little' gestures, as Hisako Watanabe so eloquently explains. We need to share and let them know, for example, about the research done on Shared Pleasure by our colleagues Kaija Puura and Anusha Lachman, the value of having moments of reflection, of being with the infant despite the turmoil in the outside world.

Baby A and her mother gave us a glimpse into what can be done in the intimate space between caregivers and infants. What can scaffold and hold them and enable pleasure to be shared between them? We know about the protective function this offers.

We need our affiliates to liaise with colleagues on the ground and on the front line.

And, they need to know that there is an umbrella organization – we in WAIMH – that is ready to provide support, reflective space and advice.

I want to end with a worldview that in Africa has great meaning; that is Ubuntu….the concept that a person is a person because of persons – or, put in another way, I am because you are (Berg, 2012). It is the most succinct description of the centrality of relationships in human existence, a central theme for Infant Mental Health.

Ubuntu also means that if I have enough of something, I should share it with my neighbour. In a world that is so unequal in terms of resources and opportunities for infants to not only survive but thrive, we need to give of what we have, and that is our capacity to listen, to have empathy, and to enable thinking and reflection.

> ***How to translate this human capacity, our Ubuntu, into actions, is the task I would like to set for ourselves as a world association for the next four years.***

My final concluding remark is a part from a poem which a psychoanalyst and friend, Valerie Sinason, wrote in April of this year:

> "What chances do living children have?
>
> But the Esperanto of a single child's cry
>
> Counts more than any blood-soaked flag."

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“There are many roads leading to Rome”. Growing up in a diverse world; does everything work in child development?

By Kai von Klitzing (Germany)

Abstract

Developmental research has shown that there are multiple pathways to positive mental health outcomes. Mainstream research on attachment and early triadic relationships has identified a number of early relational factors that appear to be highly correlated with later mental health parameters. However, as the social rules of relational life in Western industrialized countries become more diverse, young children may be conceived and born under diverse and different conditions. Furthermore, from a global perspective, there is a wide variety of social and cultural conditions under which young children grow up in different parts of the world. On the one hand, a culturally sensitive approach to infant mental health means looking at the diverse pathways to mental health rather than insisting on received wisdom about what kind of early relationships are ideal for the infant. On the other hand, we cannot accept cultural arbitrariness in the sense that all cultural practices are acceptable in terms of child development. I will explore this tension between acceptable diversity and unacceptable arbitrariness by looking at modern reproductive medicine, culturally different definitions of child maltreatment, and young children growing up in violent and neglectful environments.

Photo: Prof Kai von Klitzing at the WAIMH 2024 Interim World Congress in Tampere, Finland. Credit: Anna-Kaisa Noki-Helmanen

Introduction

In the year 20 B.C., the Roman Emperor Augustus had a column erected in the Forum Romanum on which were written the names of all the capitals of the Roman provinces. As "curator viarum" (in charge of road construction), he wanted to connect all the provinces to Rome, which was the center of the Roman Empire. Probably based on this inscription, the phrase "Mille viae ducunt hominem per saecula Romam" (A thousand roads lead men forever to Rome) was created. Centuries later, Jean de La Fontaine took up this phrase in his fable "Juge Arbitre" (the arbitrator) and formulated: "Tous chemins vont à Rome.” (All roads lead to Rome).

In our field, scientists and clinicians are searching for pathways that lead diverse individuals from the early relational circumstances into which they are born to positive mental health outcomes. "Developmental psychopathologists have argued that there are multiple contributors to adaptive or maladaptive outcomes in any individual, that these factors and their relative contributions vary across individuals, and that there are myriad pathways to any particular manifestation of adaptive or disordered behavior." (Cicchetti & Rogosch, 1996, p. 597)

"Equifinality refers to the observation that in any open system, a variety of pathways (...) can lead to the same outcome. In an open system, the same end state (e.g., healthy mental development) can be reached from a variety of different starting conditions and by different processes." (Cicchetti & Rogosch, 1996, p. 597) Mulitifinality, on the other hand, means that the same environmental condition (e.g., an adverse social event) does not necessarily lead to the same psychopathological or non-psychopathological outcome in every individual. (……) Equifinality also encompasses psychological, biological, and environmental contextual processes that lead to diverse, resilient pathways to unexpected competencies, even when the starting point of development was adversity, such as experiences of childhood maltreatment. (Cicchetti & Blender, 2006)

The notion of equifinality, which I think is very important, leads to a number of methodological challenges. For example, a certain relational constellation, let's say the presence of a caring and loving mother in the first year of life, is highly correlated with the ability of individuals to cope with later life crises in adulthood. We are accustomed to saying: the early condition predicts a later capacity. But unless the correlation is 100% (and such correlations never occur in our studies), there seem to be other pathways to this capacity. Thus, when we encounter other family constellations or cultural situations in which the presence of the mother during the first year of life is not guaranteed, we can only say that this may be a risk factor for the majority of babies in a given cultural context, but we need to look for other individual and contextual parameters that may also lead to healthy pathways. This nuanced view of early relationships is often lost

in our clinical application of scientific knowledge.

This attention to the diversity of origins, processes, and outcomes in understanding developmental pathways should not lead to an assumption of arbitrariness about what is beneficial or harmful in child development. "There are limits to how much diversity is possible, and not all outcomes are equally likely." (Cicchetti & Rogosch, 1996, p. 598) Many, but not all, roads lead to Rome. As clinicians and early childhood mental health professionals, we need to assess not which road is the best, but which roads lead to the destination, even if they take detours or overcome difficult obstacles, and which ones do not. What works for whom? Which path might work for which specific baby in a given cultural, social, and familial situation? What alternative paths, contrary to our established beliefs, also work and lead to favorable outcomes? And where are the limits of multiple pathways and diversity? In what situations do we need to intervene?

I will start with our well-established knowledge about development.

Dyadic aspects of early childhood

In the 1950s, a number of important pioneers, many of them from the field of psychoanalysis, began to question the customary way of dealing with babies at that time in Western societies. For example, René Spitz, an Austrian psychoanalyst, who began to observe babies in a systematic, empirical way especially later in his career in Denver, Colorado, found that babies in nurseries who were deprived of a continuously emotionally attuned caregiver developed severe forms of infant depression (ananclitic depression), findings that later led to a dramatic change in baby care practices in most Western industrialized countries. Many others, such as the Robertsons, Margret Mahler, Serge Lebovici, Robert Emde, to name but a few, came to similar conclusions. In modern times, the Romanion orphanage study has shown, in a rather systematic way of modern empirical research, that infants without a continuously attached caregiver are at risk to develop severe early psychopathological disorders, which can only be cured or limited if the relational conditions in which they live are changed for the better in time by placing them in healthy foster families.

Another pioneer, John Bowlby, not only contributed his own careful scientific observations, but also developed his systematic evolutionary theory of attachment, which has been widely accepted and led to a scientifically useful operationalization of early mother-infant interaction patterns by Marie Ainsworth, which then became the basis of an almost exploding branch of attachment research.

The Pediatrician and psychoanalyst Donald Winnicott has opened our minds to a more dynamic view of the relationship between an infant's early environment and his or her individual development. Since the human infant, in contrast to the offspring of many other species, seems to be born quasi prematurely in a state of almost complete helplessness, he or she is initially dependent on an almost perfect environment, in Winnicott's words, on a perfect mother who is in an almost psychotic state in which she can anticipate and feel all the baby's needs in order to satisfy them immediately. "There is no such thing as an infant" is one of the most famous quotations from Winnicott's rich oeuvre. "Wherever there is an infant one finds maternal care, and without maternal care there would be no infant" (Winnicott, 1960, p.39)

The implication of this statement could be that babies need perfect mothers for their growth, or in other words, a perfect environment. This statement often shapes our attitudes toward the hypothetical early mother-infant dyad and, unfortunately, the expectations of many, especially first-time mothers. But we have to realize that the perfect mother or the perfect environment does not exist. If we observe very early mother-infant interactions, we soon realize that the periods of seemingly perfect harmony are relatively short, while longer periods of interaction are often characterized by misinterpretations of the baby's states, misunderstandings, over- or under-stimulation by the mother. Beebe, Lachmann, and Jaffe's (1997) micro-analyses of early interactions have alerted us to the importance of disruptions and subsequent repair in early interactions for the infant's emotional development. Winnicott (1954) draws the following conclusions from similar observations. A mother, an environment, cannot be perfect, only "good enough". This may be frustrating or disappointing for the baby at times, but the discrepancy between a perfect and a good enough environment also implies an impulse for the infant's emotional development: he or she is forced to bridge the gap between the perfect and the good enough. This bridging activity is the starting point for the development of mental activity: thinking, the creation of internal representations of the self and the other, or, more importantly, representations of the relationship between the self and the other, the ability to calm oneself, to respond to frustration, the construction of emotionally rooted concepts of the other's mind (mentalization) etc.

Triadic aspects of early childhood

But what about fathers, grandparents, siblings, etc.? Could it not be that the baby's relational experiences with several different caregivers support developmental progress, especially if the interactional styles of these caregivers are different from one another? Or could the baby be overwhelmed by a disintegration of the relational context? In a landmark study, Feldmann examined 100 couples and their first-born five-year-old infants by videotaping them in face-to-face interactions. Parents' and infants' affective states were coded in one-second frames, and synchrony was measured with time-series analysis. The direction, intensity, and temporal pattern of infant arousal were assessed. The results demonstrated "that fathers and mothers are equally capable of engaging in second-by-second synchrony with their infant, suggesting that mothers are not unique in their ability to match microshifts in infant affect. Each parent, however, seems to offer infants different experiences and practice in affective sharing and arousal regulation. Mothers offer the coordination of socially oriented affective signals, and fathers offer the management of high-intensity turns in positive arousal."(Feldman, 2003, p. 16)

In our own research group, we have tried to broaden our view of early relationships by moving from studying early dyads (mostly mother-child) to early triads (mostly mother-father-child). In several longitudinal studies with data assessment points from pregnancy through middle childhood, we have assessed the predictive value of parental triadic representations on the child's emotional and relational functioning. Can the mother anticipate

to involve the father in her relationship with her offspring. And can the father anticipate to play an important role in the life of his young child without excluding or devaluing the mother? By asking these questions, we sought to overcome the old traditional views of Western bourgeois societies ("; "babies are the mother's business";"the father does not matter in the first year") and open the field to a broader, multi-person view of early childhood.

As a central concept, we defined triadic capacity (Klitzing, 2014) in the context of parenthood as the ability of fathers and mothers to anticipate their future family relationships without excluding themselves or their partners from the relationship with the infant.

We found the following longitudinal relationships:

- Mothers' and fathers' Triadic Capacity, assessed in a prenatally administered semi-structured interview, was associated with the quality of triadic interactions (assessed using the Lausanne Triadic Play Paradigm) (Klitzing, Simoni, & Bürgin, 1999).
- The higher the prenatal Triadic Capacity of the father, the more the four-month-old baby was able to establish a balanced contact with both parents when both parents played with him/her (phase three in the LTP) (Klitzing, Simoni, Amsler, & Burgin, 1999).
- The children of parents with high Triadic Capacities (measured during pregnancy) had fewer behavioral problems at age 4 and were able to tell more coherent stories with more positive themes in a Story Stem task compared to their peers of parents with low Triadic Capacities (Klitzing & Burgin, 2005).
- Finally, parental Triadic Capacities, this time assessed during the first year after birth, predicted positive family climate and fewer behavioral and emotional problems in children at age 9 (von Klitzing & Stadelmann, 2011).

These and many other findings show that there is overwhelming evidence that infants' relational experiences not only with one caregiver but also with other relevant (parental) figures are important, even critical, for young children's psychosocial and emotional development.

It is important

- that these caregivers are well attuned to the child;
- that they provide the infant with a variety of experiences with different interaction rhythms, styles, ways of emotional regulation, and different forms of visual, vocal, and physical messages; and
- that the infant is well integrated in a non-divisive overall relational system without disintegration.

The impact of pregnancy and the transition to parenthood

The interesting question is how parents or other caregivers develop the ability to provide developmentally appropriate care for babies. Most parents have this ability without having to learn it in school or other educational settings. Rather, intuitive parenting or intuitive parenting competence (according to Papousek & Papousek, 1983) is a biologically based pattern of experience and behavior that enables parents to respond developmentally and appropriately to the biological, social, and emotional needs of young children. It is strongly rooted in evolution and is controlled by endocrinological and other biological systems (oxytocin, vasopressin, prolactin, testosterone, and cortisol, among other hormones, regulate parental behavior; see Atzil, Hendler, Zagoory-Sharon, Winetraub, & Feldman, 2012).

In psychoanalytic theory, parental behavior is attributed to the human narcissistic libido system. Initially, parents turn to their babies because they seem to be a part of themselves and promise to fulfill narcissistic needs beyond the parental life span. But the narcissistic satisfaction of having a child comes into competition with the parents' own egoistic needs, the envy of the young generation that seems to have all these opportunities in the future, quite in contrast to the finiteness of the own life cycle. Normally, parents develop a positive balance between narcissistic love and hate, and slowly develop an adequate relationship that evolves from the "enfant dans la tete" to the baby as a real person (Soulé, 1982).

Pregnancy plays a crucial role in this process. Pregnancy is not only an important biological developmental phase for the embryo and fetus, but also an important preparatory process for the parents, in which they slowly move from their fantasies about the future child and their ambivalent feelings to a more coherent attitude toward the coming child. The impact of a pregnancy that is not fully experienced and suddenly comes to a disturbing end can be seen in cases of premature birth, when this essential biological and psychological process is abruptly interrupted.

It is therefore understandable that many studies, both in the field of attachment and in the context of the broader triadic approach, have found many measurable parameters during pregnancy that have proven to be predictive of later mental health outcomes in infancy and childhood, both in terms of children's mental health and in terms of parents' mental health.

However, most of these studies have been conducted in samples with traditional family constellations (mother - father - children) within samples from wealthy Western countries. Furthermore, even in these societies, much has changed in recent decades, and new ways of living together and producing children have developed.

New technologies of "producing" children

For example, in contrast to earlier times, a range of "alternative" ways of conceiving and raising children are becoming more common. From the perspective of infant mental health, our findings must be validated for other family structures, such as single parenthood, mother-mother-infant, or father-father-infant constellations. We should also consider children who grow up with genderqueer parents.

Today, modern reproductive techniques open up countless possibilities for "producing" children without relying on intimate parental relationships. In vitro fertilization is the process of creating a human being outside the womb in a Petri dish. IVF is a proven method of treating parents with infertility issues, but this method also allows homosexual couples and singles to fulfill their desire to have children. In a further development, scientists have developed the intrazytoplasmic injection of morphologically selected spermatozoa, which can be obtained directly from the testes by microsurgical epididymal aspiration (MESA). As in the case of sperm and oocyte donation, previously fertilized oocytes are also donated.

Cryopreserved, deep-frozen embryos donated by a couple who do not want to use them for their own children, are available for embryo donation. The genetic and social parents do not know each other and are not related to each other. The number of siblings and half siblings is unknown to the parents and children. Chromosomal abnormalities can be excluded before the embryo is transferred. Preimplantation genetic diagnosis (PID) can be used to select embryos of a certain sex and with certain characteristics for transfer. The procedure of transfer of the uterus during pregnancy is in progressive development. In Texas, reproductive technicians successfully fulfilled the wish of a lesbian couple to have both parents participate in the pregnancy. The embryo developed for a week in the uterus of one of them before being transferred to the other. Transgender individuals can preserve male or female gametes or embryos at minus 196 degrees Celsius before sex reassignment surgery, so they can become somatic parents even if they identify as the same sex. U.S. companies recommend and financially support so-called "social egg freezing," which allows women to postpone family planning so as not to jeopardize their careers. In November 2018, Chinese biophysicist He Jiankui announced at an international genetic engineering conference that he had succeeded for the first time in intervening in a human genome using the CRISP/Cas9 gene-editing machine and delivering genetically optimized twin girls. He was severely criticized by the scientific community and even sentenced, but he is now free and continues his research (the information is taken from Lebersorger, 2022, pp. 15–20).

The term "artificial maternity" is used to describe a situation in which a gestational carrier gives birth to a genitically foreign child. We've all seen the images of hundreds of newborns born to Ukrainian surrogate mothers waiting to be picked up by their intended parents, who couldn't get to Kiev because the Russian-led war of aggression had just broken out. Gestational surrogacy is prohibited in most European countries. As a result, there is a private market for gestational surrogacy, where women in poor countries offer gestational surrogacy for money. About 3000 to 3500 babies leave Ukraine annually in this way, which is more than the number of children deported by Russia. In the United States, gestational surrogacy is legal, and we estimate that about 10,000 children are born this way each year. The German government is currently planning to legalize "altruistic" surrogacy. For example, a grandmother could carry a girl to term for her daughter so that the baby and her daughter would become sisters (Kelle, 2024). In April 2024 the international fair "Men Having Babies" took place in Berlin. This fair was aimed at men who wanted to have a child through surrogacy. The organizers announced on their website: "This conference provides a unique opportunity (.....) to consult with over 35 reputable gay-friendly agencies, clinics, law firms and other surrogacy providers." (https://menhavingbabies.org/surrogacy-seminars/berlin/)

When we look at all these developments, we have to consider that the typically close connection between the intimate relationship of a couple, the act of procreation by genetically different parents, pregnancy, and the birth of a child is becoming more and more disconnected. The early stages of a child's development take place in a truly multifaceted way. Compared to this development, our knowledge of the consequences for the child's mental health is relatively limited. There has been some research on the well-being of same-sex parent families, but the socio-demographic approach obviously cannot capture the wide range of diverse contemporary forms of parenting. Manning, Fettro, and Lamidi (2014) conclude from their review of over forty studies of U.S. families that children living with two same-sex parents fare as well as children living with two different-sex parents on a wide range of well-being measures (academic performance, cognitive development, mental health, etc.). Schumm et al. (2016) summarize from their systematic literature review that that there are no differences in terms of child outcomes as a function of parental sexual orientation, but that this conclusion is premature given severe methodological limitations (sampling limitations, bias of results due to social desirability in parental self-reports, etc.).

Our unsolved problems are twofold. First, we have an ethical dilemma to solve. Second, we need to think scientifically about infant mental health from the perspective of equifinality that I discussed at the beginning of my paper.

1.) The ethical dilemma is that we are dealing with two facets of human rights, the rights of adults to fulfill their desire to have children, and the rights of unborn and newborn children to develop and grow up under the best possible conditions. Human rights lawyer Bruce Adams (Abramson B., 2004) addressed this dilemma in his presentation to the Committee on the Rights of the Child on September 17, 2004. Article 5 recognizes parents (even if they are only future parents), but also babies before birth as rights holders. Conceptually, the interests of both individuals may be different: "they are on two sides of the balance". So, when we talk about "rights", we should not think of rights in absolute terms. "Few human rights are absolute. Almost all rights require balancing decisions before the abstract statement of the right". In this regard, Abraham distinguishes between absolute rights (such as freedom from torture) and contextual rights. This is very logical. There is the right of, say, a homosexual couple to fulfill their deep desire to have children as a way of giving meaning to their existence, just as there is for heterosexual couples. But there could be a competing right of the future child not to be conceived and born in a way that could pose a great risk to its own development.

2) And here we come to another dilemma caused by our lack of scientific knowledge. We usually argue: The rights of young children, including unborn or yet-to-be-conceived children, must be defined and promoted. But do we really know what is good for a future child? Is it the beginning of a very unhealthy development with a lot of suffering when the child is created in a petri dish by two deep-frozen gamets, then put into the uterus of a woman in a poor country who earns her living as a surrogate mother, and after birth is taken away from this carrying mother and given to a couple from a rich country who seek the final narcissistic satisfaction of having their own child? I intuitively say yes. This procedure violates the rights of several players: first, the carrying mother, who develops feelings for the child in her womb, and second, the child, who is taken from the carrying mother immediately after birth to make the new parents happy.

But we do not really know. Remember what I mentioned at the beginning. Many roads may lead to Rome. But does everything really work in child development? Or should we, as

child mental health specialists and advocates, define limits and criteria for basic conditions of healthy child development that we should advocate for from a child rights perspective? In the Winnicottian sense: Under what conditions can a particular way of conceiving and raising a child be good enough? Of course, we are against childhood under abusive environmental conditions such as violence, sexual abuse and neglect, which exist for more than 10% of all children in our rich societies (Klitzing, 2022).

The parents who use artificial child-producing techniques usually claim that they are characterized by a high level of desire for children, which protects them from neglecting their offspring. This may make it more difficult and controversial for us to decide whether we should define limits from a child rights perspective. Here I would like to recommend drawing on the old but very well thought-out concepts of the French child psychiatrists and psychoanalysts Serge Lebovici and Michel Soulés, who belonged to the founding generation of WAIMH, who saw parenthood as a process of transition from the imaginary ("enfant dans la tete") to the real child (Lebovici, 1988; Soulé, 1982). In order to become good, caring parents, we have to use our narcissistic love of self and partially transfer it to the coming baby ("his majesty, the baby," as Freud said) in order to love and care for the baby from the beginning. But in the process of further development, we must also withdraw our narcissistic love and begin to love and care for the baby as a real person who is different from us and has the right to develop independently. As long as we in the medical field continue to create new, seemingly ominipotent medical techniques for producing babies, and as long as adults from wealthy countries take advantage of the plight of women in poor countries to use their bodies to fulfill their own desire for children, babies run the risk of being used primarily for adult self-fulfillment, without being granted the right to their own individual development.

Cultural diversity

Let me conclude my remarks with a brief look at the call for more cultural diversity in our field. There is no question that more than 90% of the studies on which our common theories of early development are based are studies in the so-called WEIRD countries (Western, Educated, Industrialized, Rich and Democratic). I agree with those who say that many of our developmental norms are an expression of a late colonialist monocentric view of human relations. We have seen that the traditional relational norm of growing up in a mother-father-children context is diminishing even in our Western societies, but even more so in other cultural contexts. The notion of equifinality supports the approach that our beliefs about the centrality of attachment and triadic relationships, as I described them in the first part of my paper, describe one way of early development, but there are multiple others that can also lead to positive mental health development. Scientific observation of aspects of adult-child interaction is often culturally biased. The same observations can mean very different things in different cultures. For example, Feldman, Masalha, and Alony (2006) examined mother-child, father-child, and triadic interactive behaviors in 141 Israeli and Palestinian couples and their firstborn child at 5 and 33 months of age as antecedents of child competence. They found that maternal sensitivity in infancy facilitated social competence only in Israeli children. In contrast, paternal control in toddlerhood negatively affected social functioning among Israeli children but contributed to competence among Palestinians. The authors conclude that different early relational experiences lead to different adaptations of children to different social environments.

Keller, H. & Chaudhary, N. (2017) have criticized current attachment research for being heavily biased toward the mother as the primary attachment figure in the life of the developing child. In this context, they question whether attachment is a truly universal concept and argue for a more culturally sensitive approach to early childhood. They argue that in order to be more universal, the construct of attachment needs to shift its focus from the individual child to the network of relationships that surround the child. Multiple caregivers are the norm in many non-Western societies and contribute to the development and growth of young children. For example, in their study involving 58 families living in and around Delhi (North India) across social class and ecological settings, they found that older children were expected to be caring and nurturing towards young siblings and cousins. In one rural family with multiple generations of relatives living together, a 5.2-year-old girl took care of her 3.1-year-old sister's needs when the mother and other adults were unavailable for an extended period of time. As I read this description, I thought about the widely used Barnett, Manly, and Cichetti (1993) maltreatment classification system, which we also use in our studies for clinical assessment, in which such care for a very young sibling would be an example of inadequate care, which is part of the definition of neglect. The authors describe a number of different rearing settings in Asian or African cultures that are quite different from what we describe in our infant mental health textbooks. Gaskins et al. (2017) list a number of parental behaviors that are viewed differently in different cultures, such as

- the use of corporal punishment and disciplinary measures.
- the practice of leaving young children home alone or under the supervision of other pre-adolescent children.
- forms of co-sleeping between older children and their parents.
- separation of parents and children, e.g. when children are left in the home country to be cared for by relatives.
- the role of fathers, e.g. when fathers are not allowed to see their children in order not to impair the close bond with their mothers.

The developmental outcomes of different parenting practices in different early environments in terms of mental health appear to be quite diverse. Much depends on the context. For example, in the case of left-behind children whose parents have migrated to find work, the consequences for their mental health development depend strongly on the relational situation of the surrogate parents who take over. Diverse parenting practices in diverse early environments lead to diverse mental health outcomes, quite apart from the fact that infant mental health might be defined differently in different cultures. As I said at the beginning: Many roads lead to Rome.

But does everything work in early child development?

The answer is clearly no! Keller and Chaudhary (2017)themselves set limits to their description of multiple caregiving as a fundamental social practice in many cultures. They make "a clear separation between multiple

caregiving as a normative practice and the social neglect of children in disadvantaged contexts (e.g. institutional care, war, extreme poverty, or any situation where care is constantly changing and disconnected), where children are likely to face ignorance, aggression, or abuse." p. 120. For example, I would see it as critical when the child's right to grow up in a non-violent relational context is limited by the parents' claim to authority and autonomy to regulate their children's care and behavior. Gaskins et al. (2017) for example, point out that in some cultures, a strong commitment to parental authority allows the use of corporal punishment to teach children what they need to learn. The norm of non-violence in the education of children, which has only recently been established in Western industrialized societies, could be seen as a danger that leads to the erosion of the authority and autonomy of parents in the care of their children.

At this point, I would say that the claim that cultural diversity can be a legitimate reason for accepting violent parenting practices fails. Violence in the relationship with young children exists in Western industrialized societies as well as in all other cultures around the world. Millions of young children grow up in conditions of war, neighborhood and family violence. The experience of violence and neglect in early childhood is one of the reasons why the intergenerational cycle of violence is perpetuated within and between many societies. It is one of our goals to combat these practices wherever they exist, because violence, in whatever form, cannot be accepted as a healthy means of raising young children.

In conclusion, many roads lead to Rome, but not all. Individual Cultural diversity is an important claim that cannot be misused to accept behavior toward young children that violates their right to grow up in healthy conditions. We need to move toward cultural sensitivity, but not cultural arbitrariness or relativism. It is a long road, but we must travel it in order to define global minimum standards of child rearing, without being exclusive of diversity and difference.

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WAIMH 2024 Interim Congress: Poster Awards

By Salisha Maharaj (South Africa)

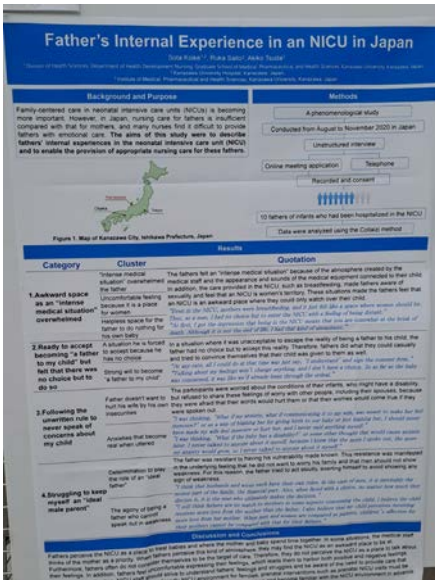
The Interim WAIMH World Congress for Infant Mental Health took place in Tampere, Finland on the 5th to 7th June 2024. The call for poster presentation submissions in the scientific and clinical categories was well received, with over 200 submissions of poster abstracts received by the scientific review committee. During the congress, 150 posters were presented and delegates had the opportunity to view the poster presentations and engage with presenters on their work.

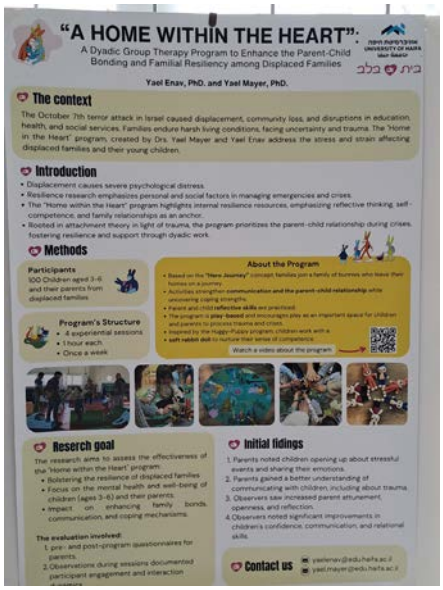
The poster awards committee consisted of Dr Maree Foley and Ms Salisha Maharaj from WAIMH Perspectives in Infant Mental Health team together with the Chair of the Review Panel, Dr Minna Sorsa. Reviewing took place in two phases, a paper-based review of the poster abstracts and a review of the posters at the congress site. The evaluation criteria were related to the significance of the presented content, the way of presenting and the way the poster looked.

Photo: Poster sessions at the WAIMH 2024 Interim World Congress in Tampere, Finland. Credit: Anna-Kaisa Noki-Helmanen

Nominees and Winner of the Scientific Poster Award

1. Fathers' Internal Experiences in an NICU in Japan by *Sota Koike from Kanazawa University* (Nominee)
2. Equity, Diversity, and Inclusion in Infant Mental Health: Addressing Disparities in Perinatal Mental Health among Black Mothers and Birthing People by *Tracey Estriplet-Adams from Fielding Graduate University* (Nominee)
3. "Home Within the Heart" - A Family Play-Based Intervention to Enhance Familial Resilience and Belonging for Displaced Families by *Yael Enav and Yael Mayer from University of Haifa* (Winner)



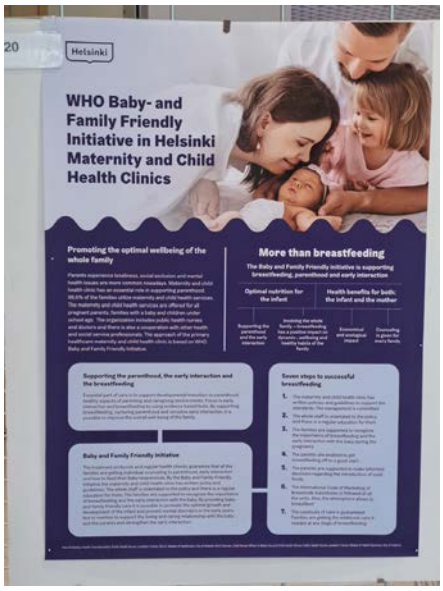


Photos: Nominees and Winner of the WAIMH 2024 Scientific Poster Award.

Nominees and Winner of the Clinical Poster Award

1. Child-Parent Psychotherapy in Sweden and Norway - Dissemination through a Clinical and Academic Training Collaborative, Research and the Formation of a Nordic Network by *Karin Pernebo et al., from Department of Research and Development, Region Kronoberg & Department of Psychology, Linnaeus university, Sweden* (Nominee)
2. WHO Baby and Family Friendly Initiative in Helsinki Maternity and Child Health Clinics by *Kivilaakso, Nina from City of Helsinki, Finland* (Nominee)
3. Para-counsellors in Community-Based Play Labs: Reducing Mental Health Stigma and Promoting Socio-Emotional Development of Children by *Mishuk, Maruf Hossain (name in abstract submission) /Tabassum Amina (name on abstract) from BRAC Institute of Educational Development, Bangladesh* (Winner)

Congratulations to all the nominees and winners! Perspectives in Infant Mental Health is looking forward to receiving manuscripts of nominees and winners for consideration for publication.

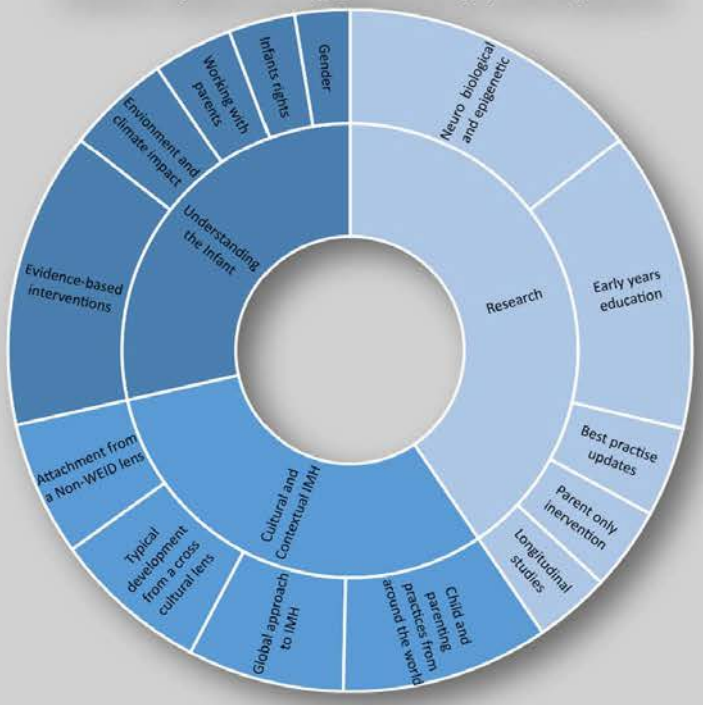


Photos: Nominees and Winner of the WAIMH 2024 Clinical Poster Award.

2024 Reader Survey Perspectives in Infant Mental Health

WAIMH Maharaj, S.

Future topics as suggested by participants



129 participants of which

73 are WAIMH members

The 2024 Perspectives in IMH Survey was designed to engage readers in a collaborative effort to enhance the publication to meet the needs of readers while promoting the vision of WAIMH.

- 69 of the 129 participants accessed the publication whenever a new issue is launched, 28 participants accessed the publication more regularly on a monthly or weekly basis and 30 participants rarely accessed the publication at all.
- 110 of the 129 participants found the article format of content most relevant and accessible, while brief reports proved to be the next most popular format with 77 of 129 participants accessing these. Interviews, blog and video formats were the least relevant to participants.
- 100% of participants found the content enriching their knowledge of infant mental health and 97% of participants found the content as useful to their practical work with infants and their caregivers.
- 68 of the 129 participants would be likely to submit a manuscript to Perspectives but are unsure how, 24 are very likely to submit and 39 of the 129 survey participants are unlikely to submit.
- Participants cited time pressure, lack of confidence and lack of clarity on what is required for a submission to Perspectives.

On Promoting Reflective Coaching for Home Visitors' Regulation and Practice: An Autoethnographic Account

By Bridget A. Walsh and Child and Family Research Center Home Visitors[1] (University of Nevada, Reno, United States)

[1]Avis Moore, Chantell Whaley, and Milagro Guardado

Abstract

There is limited research on the experiences and reflections of coaches of early childhood home visitors (HVs). This article examines the context and experiences of my work as an early childhood home visiting coach in the U.S. in promoting a coaching philosophy and approach to target HVs' regulation and practice. In this autoethnographic account, I share and analyze my journal entries in light of an infant-parent mental health fellowship and related experiences. I also compiled stories about my experiences receiving support, such as reflective supervision and mentorship, to support my coaching work. Finally, I include interviews with HVs to promote my reflexivity. This work examines adult regulation and educational and therapeutic transformation by describing the critical need and approaches for fostering reflective coaching among early childhood HVs. My methods revealed connections: connections between the infant mental health research and my own experiences, ways that I connected to mentors and coaches, and ways that HVs I coached made connections to me and to the families they serve. Coaching is a process of making multilayered connections that require deeply reflective and self-regulating work like what is typical of autoethnographic self-reflection.

Keywords: infant mental health informed coaching; early childhood home visitors; regulation; practice; processes

Key Findings:

- The first author's statement about the difficulty and vulnerability of taking on autoethnographic narrative methods was meaningful and essential to autoethnographic work--especially when considering what taking those vulnerability risks can teach the field about the power of connections for HVs and coaching.
- The study integrated concepts from the Infant-Parent Mental Health Fellowship (IPMHF), such as attachment, regulation, and reflective functioning, into the coaching model. These concepts were used to inform and enhance the coaching practices and to foster a collaborative and supportive environment that values the HVs' experiences and expertise. This approach aimed to create a space where HVs could reflect on their regulation and practices and develop new strategies to support families.
- The importance of a semi-structured, reflective coaching approach that incorporates principles of regulation, reflective functioning, and infant mental health lies in its ability to support the practice and well-being of home visitors (HVs).

On Promoting Reflective Coaching for Home Visitors' Regulation and Practice: An Autoethnographic Account

Positionality Narrative

While I was completing a 15-month transdisciplinary intensive Infant-Parent Mental Health Fellowship (IPMHF) in the United States, one of the luminaries or speakers referred to Weisner's (1997) article about how ethnography is a powerful method to understand human development. The luminary said that ethnography is particularly well-suited to understanding infant-parent mental health. Ethnographic work can create findings that matter to understanding the adaptive endeavors of individuals and communities (Weisner, 1997). I searched library databases and the grey literature for ethnographies about coaching. I found a study about autoethnography to understand team coaching practice (James, 2015). For my capstone project in my IPMHF, I wanted to understand more about coaching home visitors (HVs) individually. I consider myself both a researcher and a practitioner in coaching home visitors. I know "auto" means self, but autoethnography was new to me. I share this not to become the avatar for coaching home visitors; rather, there may be something in my

positionality narrative that resonates with the readership. Autoethnographic methods were not only new to me, but they were also uncomfortable—such methods are the opposite of what I was trained to do. As an undergraduate and master's student, I manipulated variables to determine toddlers' and preschoolers' language abilities and acquisition (Walsh & Chapdelaine, 2004; Walsh & Blewitt, 2006). As a doctoral student, I read Bronefenbrenner (1977) and gained an appreciation for contextual approaches, and as a professor, I gained an appreciation for qualitative approaches, capturing lived experiences, and relationship-based work.

These more vulnerable, more personal methods allow for exploring coaching processes and strategies, particularly when there is only a small body of literature about coaching home visitors (see Walsh et al., 2023, Walsh et al., 2022, Walsh et al., 2021; West et al., 2024). Reflection and reflective practice, or focusing on complex experiences that tend to elicit uncertainty and emotional responses, are essential to Infant Mental Health (Tobin et al., 2024). I share my narrative reflection, which may allow readers to resonate with my experiences and wonder what they might learn about my approach to documenting and reflecting on what coaching home visitors can offer. I have uncovered that the "so what?"when reflecting and explaining upon my work is that coaching fosters multilayered connections between theory, practice, coaches, coachee (home visitor-as-coachee or client), and families.

Coaching Home Visitors

Coaching is a strategy that early childhood (EC) home visiting programs use to reduce stressors and support HVs (National Home Visting Resource Center, 2020). Coaching is an individualized, strengths-based process fostered by a collaborative partnership between the coach and HVs-as-coachees to help HVs create and attain goals (Walsh et al., 2023). Despite multiple calls for EC HV coaching (McLeod et al., 2021; Walsh et al., 2022), more research is needed to better understand coaches and coaching approaches. To help coaching HVs advance in research and practice, descriptions of coaching processes (Walsh et al., 2022), such as narratives of the situated individual(s) or coach and coachees, are needed (James, 2015; Kempster & Iszatt-White, 2013). Autoethnographic narratives about coaching can provide a sense of truth about an experience and insight into complex processes and practices (Kempster & Iszatt-White, 2013). This article seeks to support (1) a coaching program's conceptualization to bolster HVs' efforts and (2) a coach's and HVs' comprehension of effective coaching and lived experiences.

HVs should be coached in a way that honors the parallel process. For example, HVs who experience empathy from the coach and joint planning in coaching can use those competencies when coaching families. In turn, parents may provide support by being responsive to their children (Pawl & St. John, 1998; Walsh et al., 2023). Translating coaching strengths, ideas, and strategies into HVs' work with at-risk families can be challenging, given their work in changing home environments where they have minimal control and encounter unexpected stressful situations, necessitating support for transferability (Walsh et al., 2023). The defining features of HV coaching—collaborative partnerships, individualized HV goals, action planning, observation and focused observation, reflection, strengths-based feedback, on-demand or regular sessions, and the recognition that the HV is a coachee and family coach (Walsh et al., 2022)—empower the HV to take charge of their professional development (PD). Coaching is distinct from reflective supervision (RS) and will be discussed below.

Coaching: Different From and in Addition to RS

RS married with IMH is known as Infant and Early Childhood Mental Health (IECMH) reflective supervision/consultation (RS/C) and is a relationship-based practice that is essential to supporting professionals (Tobin et al., 2024). There is some disagreement about the empirical definition of RS and limited literature on RS in HV (West et al., 2022). However, RS can be measured by the Reflective Interaction Observation Scale (RIOS; Meuwissen & Watson, 2022). A new RS self-report measure is being developed to elucidate how it is practised (Denmark et al., 2024). Similarly, while effective HV coaching remains underutilized and under-studied, there is agreement that coaching is an essential component of PD and matters for HVs' practice and the success of HV programs (Walsh et al., 2022). RS is a nurturing, relationship-centered process that provides a safe and open space for HVs to discuss how their work with families affects them (Haring & Rau, 2024). HVs can share their feelings, perceptions, inner awareness, biases, and beliefs related to their experiences and the families they serve. However, there is always an inherent power differential between supervisors and HVs, potentially impacting RS's collaborative nature (Walsh et al., 2023).

While coaching includes a partnership focused on goals set by the HV in collaboration with the coach (Head Start ECLKS, 2022; Haring & Rau, 2024), RS is collaborative in its focus on a shared purpose. In the coaching process, the HV takes on the roles of collaborator and driver. Coaches may have different education and experiences than HVs, and it is recommended that coaches understand reflection, outcomes, and parallel processes (Walsh et al., 2022). Coaches may also have experience with video recording home visits and HV observation scales (Walsh et al., 2023; Walsh et al., 2022). The coach observes the HV's practice based on the individualized goals and action plans created by both parties. This approach ensures no surprises for the HV during the coach's observation. Regular RS is recommended, while coaching is more flexible, on-demand, and time-limited (Haring & Rau, 2024).

Coaching Processes for a Vulnerable Workforce

In addition to promoting practice, the HV field needs coaching that supports HV well-being, given that many HV programs support family well-being as an outcome (Walsh et al., 2022) and because HVs are regularly exposed to trauma while fulfilling their duties. Early Head Start (EHS) HVs represent a particularly vulnerable workforce, often receiving less training, organizational support, and compensation than other people-oriented professions (Mavridis et al., 2019; West et al., 2018). Reports on EHS HVs' coaching reveal discomfort from integrating coaching ideals into support practices. The emotional toll of HVs' work compounds this methodological gap, frequently leading to secondary stress, trauma, compassion fatigue, and burnout (Alitz et al., 2018; Begic et al., 2019). One EHS HV coach particpant in Walsh et al.'s (in review) study shared, "I've had several of what I call crying sessions," describing HVs' stress with a practice-based model. This participant's account of how coaching has not prioritized EHS HVs' well-being resonated with

me and other HVs, and inspired us to share these experiences and lived lessons with other coaches. Writing from and through personal experiences in tandem with and in the context of the experiences of others can create epiphanies, which are transformative moments and realizations that can alter the course of something (Adams et al., 2015). Autoethnographies start where we are, and I, like others in the field, want coaching to be a positive and transformative space. We need accounts of implementation fidelity but we also need narratives to understand how to get there. This article aims to share these experiences and lived lessons with other coaches.

Coaching can learn from autoethnography. Hallmarks of quality autoethnography include mindful attentiveness, noticing, introspection, deep and active listening, examining sense data perceptions, self-reflexivity, and awareness (Poulos, 2021). Coaching may influence HVs' attunement practices, well-being, thinking, regulation, emotional responses, reflection, and perspectives and strengthen their efficacy by providing a safe, protective space that values the HV as an expert and an equal or a collaborator. This article represents one effort to describe and explain through autoethnographic methods how these processes and mechanisms of coaching influence HVs.

Method

The Context for IPMHF and Coaching Home Visitors

As a professor, I work at a university with an EC home visiting program, and my primary role in the program is as a coach. The EHS program uses Parents as Teachers (PAT) as the curriculum. I completed model training in PAT and recently finished a 15-month transdisciplinary intensive Infant-Parent Mental Health Fellowship (IPMHF). The fellowship values "inter-disciplinary training based on a practice model encompassing promotion, prevention, early intervention, pan-disciplinary services, and discipline-specific services" (The Regents of the University of California, Davis., n.d., Napa IPMHF section). Model training and the IPMHF have shaped my current approach to coaching.

My coaching journey started with five HVs in 2017 during a year-long sabbatical. Coaching HVs was in the nascent stages then. Allen's (2016) family life coaching and literature from the EC field (Artman-Meeker et al., 2015; Elek & Page, 2018; Isner et al., 2011; Rush & Shelden, 2020) formed the first iteration of my coaching philosophy. Allen's (2016) family life coaching is a skill subsumed within the Certified Family Life Educator (CFLE) credential, and I have been a CFLE since 2009. The first iterations of my coaching philosophy, which emphasized dignity and respect for HVs through a collaborative process and ideas about processes and how to promote goal setting and attainment, helped me find my identity as a coach of HVs and informed my coaching approach.

After my first coaching experience, my coaching philosophy shifted as I reflected on my coaching work with my home-visiting research colleagues. Analysis of my coaching transcripts revealed that HVs achieved their goals and demonstrated reflective thinking to promote goal setting (Walsh et al., 2021). We examined the current state of coaching literature in the EC home visiting field and compiled themes that research and practice agendas should consider (Walsh et al., 2022). For instance, HVs have the dual role of HV-as-coachee and as a family coach. We created a published conceptualization that underscores this complexity of coaching in the HV space (Walsh et al., 2023).

About 7 years after my original coaching work and contribution to the EC home visiting literature (Walsh et al., 2022) and conceptualization of coaching (Walsh et al., 2023), I worked with my department chair and the home visiting program to change my academic role statement to include individual coaching of seven HVs once or twice a month at my university's EC home visiting program. The catalyst for this change was a 2023–2024 IPMHF. I completed the 15-month IPMHF in April 2024. I have used concepts and luminaries from the infant mental health field to further inform my coaching approach to working with HVs. This coaching model integrates concepts such as the neurosequential model of reflection and stress response (NMRS) continuum (Brandt, 2023; Brandt & Perry, 2024); rhythm, regulation, relation, and reasoning or the neurosequential model of therapeutics (NMT; Neurosequential Network, n.d.; Perry, 2009, 2023). Tomlin and Vieweg's (2024) PAUSE framework values perspective-taking and thoughtful solution finding by integrating relational skills and reflective practice to help home visitors navigate complex situations by encouraging HVs to pause, reflect, and respond thoughtfully. Brandt and Perry's reflective process approach is equally thoughtful to Tomlin and Vieweg's framework. Brandt and Perry's framework provides rationale for the "regulate, relate, reason" approach based on functional levels of the human brain (brainstem, diencephalon, limbic system, and neocortex). My coaching approach also values attachment and the Circle of Security (Circle of Security International, 2018; Hoffman et al., 2006); understanding mental states and reflective functioning (Brandt & Perry, 2024; Fonagy & Target, 2005; Slade, 2005); coaching as a necessary space (Grimes, 2023); and my participation in RS (individual and group) and consultation/mentoring to strengthen my coaching processes.

In the second half of my IPMHF, I strongly desired to learn more about coaching HVs through descriptive methods. To help me share my narrative, I took an autoethnography class at a university.

Research Design: Autoethnography

By interweaving autoethnography (Adams et al., 2022; Bochner, 2012; Poulos, 2013), concepts from the infant mental health field, and interviews with HVs, I will share coaching experiences to promote HVs' dual regulation and practice. This qualitative approach is about writing from and through experiences in tandem with and in the context of the experiences of others (Adams et al., 2015). This approach will foreground my experiences and reflections (auto), delve into cultural practices, identities, and beliefs ("ethno"), and employ a narrative voice and evocative representations ("graphy"; Adams et al., 2022). Throughout this article, I integrate three types of data sources:

(1) Journal entries in light of an IPMHF and related experiences that have influenced the coaching approach,

(2) Narratives based on notes that captured my experiences receiving RS and consultation to support my coaching work, and

(3) Interviews with HVs to supplement my autoethnographic work and promote my reflexivity.

For this third data source, I interviewed HVs enrolled in coaching (HV-

as-coachee) to supplement my autoethnographic data from my experience as an HV coach. Interviews in autoethnography can help generate new information, validate personal data, and gain others' perspectives (Chang, 2016; Marvasti, 2006). I interviewed three HVs enrolled in coaching via Zoom post-IRB approval. Before data collection, I created 11 interview questions, reviewed by a qualitative researcher not affiliated with this work, and I made minor revisions to the semi-structured guide. Sample questions include: (a) How, if at all, does coaching promote your well-being and regulation? and (b) What, if anything, could strengthen HV coaching in your program? Although I created the questions in advance, I used the flow of the conversation more so than verbatim adherence to the guide (Patten & Newhart, 2018). I analyzed the transcripts using reflexive thematic analysis, with an experiential orientation, utilizing an inductive approach (Braun & Clarke, 2022) based on the hermeneutics of empathy (Braun & Clarke, 2022; Willig, 2014). I read the dataset as a whole and coded the data for singular ideas, and I identified 29 codes. Next, I looked for patterns across codes and the dataset, the foundation for candidate themes. I used reflexivity regarding the interview data, including reflection on my influence as the researcher on shared knowledge (Braun & Clarke, 2022), as well as my experiences as a coach, as documented in my journal entries. I shared the findings with the HVs, and I asked the HVs to consider them within the context of their experiences. HVs suggested no changes to the findings.

Results

Using IPMH Research to Inform Coaching of HVs (Part 1)

First, journal entries for this inquiry reflected luminaries and concepts gleaned from my IPMHF and related experiences, such as becoming a Circle of Security Parenting (COSP) facilitator (Circle of Security International, 2018; Hoffman et al., 2006). There were three areas of journal entries: attachment, reflective functioning, and regulation; these and their related constructs were selected because they are foundational IPMH concepts applicable to most clinical and non-clinical settings, such as coaching. These are the areas I wondered about the most in my work as a coach. If HVs had

Table 1. Regulation.

Luminaries on Regulation	Journal Entries
Co-regulation between the infant and parent helps self-regulatory systems develop and supports adaptation and resilience (Lillas & Turnbull, 2009; Perry, 2023). Co-regulation is the foundation for building self-regulation (Dana, 2023). COSP facilitators are encouraged to be a safe haven for parents to gain support for co-regulation (Circle of Security International, 2018; Hoffman et al., 2006).	For HVs, Ashvsita and Char's coaching sessions seemed to be an opportunity for co-regulation or a chance to regulate emotions through positive and regulating experiences. As a coach, I tried to go into each session ready to provide nourishing, educational, and competent support.
Regulation is central to Perry's NMT, an interdisciplinary, trauma-informed approach to assessing developmental history and the impact adversity may have on self-regulation. The brainstem is the brain area that receives input or signals from the body and the outside world through the senses (Perry & Winfrey, 2021). The NMT model explains that signals are processed *sequentially*, with the brainstem and diencephalon processing the signals first and being responsible for *regulation*. This means that some level of regulation is needed before *connection or relation* with another person is possible or operation in the limbic system or the middle part of the brain. There is minimal *reasoning or reflection* without connection or operation in the higher part of the brain or the cortex. In sum, Perry's model endorses "regulate, relate, and reason" to think about the brain and its sequential functions or processes. The NMRS has evolved from the NMT and addresses neurological concepts during reflection, learning, and creating (Neurosequential Network, n.d.; Brandt & Perry, 2024). During coaching, the first component is regulation to create a safe, protected space. To support this, the coach can take a quiet, calm approach and use a soft tone and low voice with few words. Next in the sequence is related engagement, which includes connecting, reconnecting, and checking in using empathetic exchanges. Reflection can be supported through mentalization, offering alternative perspectives, and guiding the consideration of new directions.	I thought a lot about the work of the NMT and NMRS and how to apply it to coaching sessions. The NMT provided an understanding of the brain's functional levels and the NMRS-informed coaching sessions. Upon critical reflection, I realized that only some have the privilege of lived experiences that allow reflection. Coaching is needed to create the space for regulation, co-regulation, and connection for a HV to set the stage for reflection or a space where the coach and coachee can learn together. I realized that my coaching with Ashvsita includes milestones per se, the first being familiarity and safety. It took approximately four coaching sessions for us to create familiarity and safety because she had previous experiences with coaching and supervision at a different organization where the HV found these types of PD punitive or disciplinary.
Integrating *rhythm* into one's day is healthy (Perry & Winfrey, 2021). One negative impact of trauma is when systems become dysregulated. Rhythmic and regulatory reactions shape stress response systems (Rhythmic Mind, 2018). Rhythmic movements and sounds regulate systems; patterned activity restores balance (Rhythmic Mind, 2018). Not everyone gets regulated similarly; it needs to match their internal rhythm, and it is helpful to find what works best for individuals (Rhythmic Mind, 2018). Movement, breathing, telling stories, and music are ways to be rhythmic to promote regulation (Graner, n.d.).	During coaching, I learned by doing that HVs seem to enjoy and benefit from guided breathing practices. After we did a guided breathing activity in coaching, I would check in, and almost all would report being in a calm mental state after the breath work. There was also a willingness to do breathing work outside of coaching. I gave each HV a link to Headspace, an evidence-based mindfulness and meditation app, to promote finding a breathing rhythm outside of coaching. Two HVs and I engaged in rhythmic work videos led by Luke Graner (2023), particularly the "Breath, Body & the Beat 1: Breathe."
Grimes (2023) discussed anti-bias and anti-racist strategies, such as creating *necessary space* for professionals to discuss race to promote regulation.	As a coach, I want to provide a necessary space for HVs to feel free to say that they think a characteristic (e.g., race) of theirs influenced something. I let my deep and active listening guide me. Ashvsita's authenticity, thoughtfulness, and professionalism drive our coaching sessions. Ashvsita had negative experiences with coaching and reflection in a previous job. We spent five of our six sessions building a relationship before she trusted me enough to set a goal in our coaching space. After she set a goal, we decided that I would observe her on a home visit implementing the goal, and once we were outside the home, I briefly pointed out the many strengths of the visit. She seemed proud, hugged me, and thanked me. I do not think she always sees her strengths, so I often point out Ashvsita's strengths when I authentically see them. Ashvsita explained that one of the mothers on her caseload. Shera. a Black woman. felt

experiences with these in coaching, there could be parallel impacts on parents' influence on their infants and young children. The left-hand column below includes citations highlighting IPMHF luminaries and their scholarly research when applicable. The right-hand column includes excerpts from my reflective journal entries. Please refer to Tables 1 and 2 for these paired citations and reflective journal entries on regulation and attachment and reflective functioning, respectively. This approach was adopted from Carter's (2002) first-person account in which facts and research are presented alongside journal entries. I adapted this approach to help illustrate how IPMH research intersects with my meaning-making, experiences, and applications as a coach, which are embedded in my journal entries.

Experiences and Stories at the Heart of the Parallel Process (Part 2)

The existing literature suggests that HVs should be coached in a way that considers how HVs coach families (Pawl & St. John, 1998; Roggman et al., 2008; Walsh et al., 2023). As a coach, I regularly attend individual and group RS. I also have ongoing sessions with a former PAT National Center director. She describes our work together as mentoring, consulting, and coaching; please refer to Table 3 for definitions provided by Child Care Aware of America (CCAoA) and the National Association for the Education of Young Children (NAEYC; 2023), as these three terms are not interchangeable. Table 3 includes conceptual definitions of the supports I engage in as a coach of HVs.

I reflected on and analyzed my narratives based on my PD notes, which include my thoughts and journals about receiving RS (individual and group) and mentoring, consultation, and coaching. I have included a summary of these stories. Like Zibricky (2014), these stories use active voice to keep thick descriptions and my experience at the center of this inquiry.

Normalize the Phrase: "I don't know, and we can look together."

My prior experiences with coaching HVs encouraged me to treat coaching as an individualized space. I set the tone that coaches and coachees are equal through an in-take packet and during our first session by briefly underscoring the importance of our collaborative work. In my experience receiving

	she was being ignored and treated differently at childcare because of her race. Ashvsita said that Shera started using the "n" word (you [child care site] treat me like a "n" word) to try to capture the anti-Black racism she was feeling. Ashvsita conveyed that Shera's use of the "n" word did not sit well with the staff and the teacher. The White teacher of Shera's Black son was so distraught that Shera felt she was a recipient of racism, and by Shera's use of the "n" word to convey how she felt, the teacher went home for the rest of the day. Ashvsita met with the White teacher and conveyed that she was sorry about how Shera handled the situation. Ashvsita asked the teacher if she could do anything to support her. Ashvsita told Shera that she knew exactly how she felt, and they worked on constructive ways to handle anger in the future. Ashvsita's empathy is a strength, and it fueled her to ensure all parties were okay after Shera used the word "n" to explain how she felt. Ashvsita's expression changed, and she got emotional while sharing this story. I validated her position, invited her, and asked her permission to do some regulating activities; she chose deep breaths and guided meditation. I could tell these activities calmed Ashvsita because I could feel her regulation in her speech and see it in her demeanor. I started to close our hourly coaching session by asking Ashvsita if she would be mindful of anything in the future. She asked, "Do you think I can lead Shera in some breathing?" I said, 'Yes, I know you can." I asked Ashvsita what she likes when we do this, and that was our foundation for preparing Ashvsita when she would try it with Shera. Inviting Shera to do breathing techniques became Ashvsita's goal between now and our next session. As we ended the session, Ashvsita said, "Ever since coaching, I regulate here, regulate there—it's like regulation is everywhere." It was invigorating when Ashvsita wanted to try techniques from our coaching session with a family she serves.

Table 2. Attachment and Reflective Functioning.

Luminaries on Attachment, Reflective Functioning, and Relationship Enhancement	Journal Entries
Reflective functioning is understanding one's own and others' behavior in terms of mental states (beliefs and thoughts) and intentions (Fonagy et al., 1991; Fonagy & Target, 2005). Reflective functioning can be operationalized as mentalizing or mentalization, which includes perspective-taking and empathy (Allen, 2006). The NMRS training includes questions and techniques that can be used during reflection to promote mentalization (Brandt, 2024). For example, "What would be the first step you would need to take?" (Fonagy, 2009, as cited by Brandt, 2024). Mentalization is a capacity that affects regulation and relationships (Slade, 2005). HV programs can target parental reflective functioning, which is the capacity to understand their own and their child's mental states, link them to behaviors, and keep their child's mind in mind (Slade, 2007; Stacks et al., 2022). Caregivers' ability to engage in reflective functioning promotes secure attachment behaviors (Dexter & Wong, 2024; Hoffman et al., 2006).	Reflection is an integral part of coaching. In collaboration with me, a HV named Jules set a goal to increase opportunities for reflective functioning. Jules stated she wanted to be mindful of taking more reflection space each week. We unpacked what this might look and feel like, some challenges, and the benefits of reflective functioning for Jules and the families she serves. Jules noted that she suspects taking more time for reflection would help her be more intentional during home visits and ultimately help families with their reflective functioning, particularly helping parents consider the child's perspective and mental state. I did not hear burnout talk; I heard that the HV desired more growth in her reflective functioning. She wanted to remain curious about her mind and the minds of the children and families she serves and to build protective factors, such as mentalization, to mitigate stress when adversity is present. I posed an action-inviting question to Jules about the first step she needed to take. Her first step was to include reflection time on her weekly calendar and to take time (minutes) for her first time, perhaps after her morning routine. She notes that she walks most mornings. It sounded rhythmic and regulating to her, and after that, she might be ready to inquire about her thinking, nurture her insight, and think about herself and her practice and regulation with families.

coaching, my coach empowered me to appreciate that coaching HVs can include moments I do not know, and we can look together. Char, an experienced HV, was talking about doing home visits with pregnant women at the jail and how a newer HV sought support from her experiences with home visits with pregnant incarcerated women. Because of Char's expectations of herself, she felt pressured to know and wanted to know. First, I assured her that regarding home visits with an incarcerated parent at the national level, experts are starting to build a repository of existing resources and explore what experience, training, and support HVs receive from working with criminal legal system-involved families. Char suggested having monthly meetings for HVs to conduct home visits at the jail to discuss their experiences and share strategies. We discussed how brainstorming together could be a strategy at the meetings. Char said she would say, " I do not know, and we can look together in these future situations." I shared Char's suggestion with the Director, and Char's idea about having an ongoing focus group with HVs conducting visits in jail was implemented.

HVs as Collectors and Sources of Data

In my first RS group experience, I shared a case about an HV and one family. To start, I provided context about the family the HV serves and information about the HV. The HV spoke about one particular family in most coaching sessions. The parent experienced six adverse childhood experiences (ACEs) in his life and had limited relational health to buffer those experiences. His child has four ACEs. The HV conveyed how tirelessly she worked to help the parent progress towards keeping his child and how she experiences secondary stress and trauma in this case. During group RS, a psychologist asked me if I knew if the parent wanted the child. This question stopped me in my tracks. I asked myself what behavior the HV saw that conveyed the parent wanted the child. I tried to come up with something and was taken aback when nothing came to mind. In my next coaching session with Ashvsita, I asked her what behaviors the parent demonstrated to keep his child. Ashvsita started to cry. She said that I gave her a perspective that she does not typically entertain, that not all parents desire to keep their children, and a reality that she has to get better at accepting. I validated her

Gilkerson and Gray's (2023) model of reflective practice that values thinking on the spot is known as Facilitating Attuned Interactions (FAN). This model supports professionals in understanding cues from the family they are working with and themselves (Gilkerson & Imberger, 2016). One aspect of FAN is for the professional to focus on mindful self-regulation to understand and monitor one's calm state for the family (Cosgrove et al., 2019). The FAN approach builds self-awareness and mindful self-regulation, which helps the professional see things from the family's perspective empathically. The FAN complements the COSP Program, an evidence-based parent reflection model informed by attachment and family systems theories. It emphasizes "being with" or feeling safe within one's presence.

I noticed that Ariana also considered the family's perspective and valued meeting the family where they were, as it came up in most of our sessions without prompting. Other HVs benefited from my questions, and I encouraged them to think about what the family might be experiencing. Ariana has navigated challenging support systems to help her own children receive services. I believe this allows her to empathize with families needing mental health and early intervention services for their children. In these times as a coach, I recognized Ariana's experiential and deep knowledge of systems for understanding mental health and developmental disorders and how to support parents in navigating systems and advocating for their children. I offered validation while she shared her stories. She integrated her personal and professional worlds in a way that, from what I can tell, is grounding to families. She has also shared her vision and hopes for changing systems based on the trauma she and others have felt when advocating for their children. I hold space for her, and when the timing is correct, we will explore what goals might be subsumed within her vision and hopes. I will continue to hold space for her hopes and dreams for families with children needing referrals and advocacy for children with mental health and developmental disorders. The next step is to explore how previous successes and new ideas can coalesce into realistic goals and action steps.

After completing COSP training, I titled one journal entry, "Circles Everywhere." I hypothesized that if I have secure hands and hold space for the HV, they could share their explorations and even explore new goals during coaching and know that coaching is also a space to fill their cup when they need a coach to be with them and support them as they work out complex situations.

Table 3. Support for the Coach.

Professional Development Efforts
Mentoring is a dynamic interaction among colleagues with similar interests and roles (CCAoA & NAEYC, 2023). A seasoned individual is the mentor and guides the counterpart or the mentee. Mentoring encourages the mentee's capabilities and promotes their effectiveness in the field (CCAoA & NAEYC, 2023).
Consultation values a collaborative approach and joint problem-solving, where a consultant with specialized expertise collaborates to evaluate and resolve particular concerns on a specific topic or area (CCAoA & NAEYC, 2023).
Coaching is individualized and guided by a skilled coach who has a role different than the coachee and promotes goal setting and attainment (CCAoA & NAEYC, 2023).
A community of practice includes individuals united by a common interest and mutual passion and engaging in ongoing interaction to increase their understanding and expertise (Wenger et al., 2002).
RS is an integral part of the infant mental health field and occurs individually or in groups (Barron et al., 2022). It is an alliance and a safe place for a coach to have dialogue (Lewis, 2023).
Rhythm and regulation exercises help achieve a calm mental state (Perry, 2023). Breathing exercises and movement are two ways to be rhythmic to promote regulation (Graner, n.d.).
Documentation of the coaching sessions using a recording form, such as the one in Appendix A, promotes organization.

thoughts. Then, we did a breathing activity to ground us. She set the goal of mentally collecting data about which behaviors the parent demonstrates that indicate he wants to keep his child and be an effective parent. She said when she sees the parent, or he tells her about anything positive related to parenting, she would point it out as a strength because she feels the parent does not hear about strengths from the other professionals working with this family.

As a coach, my mentor taught me to encourage coaching conversations about HVs collecting their data per se and to think about what indicators they should look for that indicate movement or progress. Simultaneously, what happens if the worst happens on a visit or if the worst outcomes occur for the family? This thinking exercise can be important for anticipating success and managing challenges. HVs can engage in story-telling during coaching, as telling one's story is a way to gain control and may promote resilience (Rhythmic Mind, 2018). Another HV, Elly, resembles a qualitative researcher who is consistently engaged in storytelling during our sessions. I processed this with my mentor, who encouraged me to explore Elly's beliefs about storytelling. My mentor stated, "that stories are how Elly learns about families and creates meaning." This helped me realize that it was Elly's way for me to get to know who she is and that it ultimately led to Elly creating meaningful goals.

Metaphors

Ashvsita once shared that she feels like "a mad scientist" trying to determine what one particular family needs more or less of and how to get results. In processing this metaphor with my mentor, I realized that being "a mad scientist" sounds exhausting; it was my job as a coach to be a sounding board for Ashvsita to determine if she needed a new flask or if there were holes in the flask that made being a "scientist" more challenging. There was one hole in her flask—she often arrived 20 minutes before a visit with a parent to give the parent time to vent before the visit. The parent was in jeopardy of losing her parental rights. Albeit this demonstrated Ashvsita's commitment to her family, it seemed tiring for both the HV and the parent. We explored replacing the vent session with rhythmic and regulation activities. Ashvsita has used other metaphors to describe her work, such as being "an esthetician," these metaphors created a grounding space and gave a starting point for complex cases. When my mentor asked me for a metaphor to describe my work as a coach, I stated, "I need to be an agile and protective empowerer" to provide HVs with the nourishing and competent support that they provide to families they serve.

Defining Feature

My mentor coach asked me for a defining feature of my coaching sessions, which is a strengths-based approach. My coaching caseload has taken a strengths assessment as a reflective assessment that generates a person's top strengths. In the early sessions, we explore the meaning of their strengths through the assessment alongside strengths that the HVs know they have but that were not captured in the assessment. In each coaching session, I explicitly refer to one of their strengths and reframe negative statements into strengths when applicable. I also honor the HVs as experts in their work to help us form a collaborative partnership and identify how they observe or note the families' strengths and apply them to the families.

Simplify Complexity to Maintain Dignity as a Professional

During coaching sessions, HVs inevitably bring up complex topics like substance abuse and families with parental rights uncertainty. Coaching HVs around sensitive topics presents challenges. Herein, there are examples where HVs had questions about the parent experiencing withdrawal symptoms during visits or possibly being high. In the PAT model training, one facilitator shared that being there for families during vulnerable moments was essential. My mentor's perspective differed, and she conveyed that situations including substance abuse warrant more attention. She matter-of-factly explained that if a HV was completing a home visit with a parent who is a cancer patient, and they felt weak and shaky during the visit and maybe had to throw up, many professionals would terminate the session. This example made things crystal clear; HVs must stay authentic in complex situations and have dignity in their vital work. Situations in which HVs believe or observe that a parent is experiencing withdrawal or under the influence and necessitates care beyond the HV.

I heard about burnout at the start of a coaching session with Ashvsita concerning a parent struggling with withdrawal symptoms and sometimes being engaged in visits and other times working with engagement. She referred to it as a "heavy case." Our joint reaction was to make a plan to accommodate the various ways the parent may show up to the visit. I felt like we were doing something, solving a problem, but immediately, I felt exhausted by that prospect. This was a contagious situation—the HV's weight, in this case, was slowly shifting to my weight. I called it out by stating, "Whoa, this feels like a lot; we can choose to carry it or to further look at it. Let's look at it together." She quickly agreed.

I took a few moments to pause during our session and started to consolidate what my mentor taught me. I let the HV know there is no magic approach and that her current preparation is more than enough. I asked her what the approach to the visit would have been if it had been simplified. Ashvsita said, "I am listening." I recalled a visit of hers that I observed. During this visit, she noticed where the parent and child were seated and where everyone in the triad was. This intentional placement allowed the parent to drive the visit and frequently interact with the child, a strategy she could use with her "heavy case." My mentor suggested using watch, wait, and wonder (see Cohen et al., 1999) to simplify the interaction further. When I shared this technique with Ashvsita, she said the parent tends to watch his child with interest. She said she would help him follow the child's needs, which we both agreed eases the pressure of setting the stage for an activity during the visit. Finally, the HV was intrigued by assisting the parent in wondering what the child's perspective is.

Beginner's Mind Gone: Balance of Providing Strategies with Support for HVs' Finding Own Answers

After one of my first coaching sessions with a HV, she thanked me for all the strategies shared during the visit, which I had mixed feelings about. I understand the value of sharing or gaining strategies, but I want coaching to be a learning exchange. In this exchange, methods can be explored, and care needs to be taken to understand the context and how a strategy may be applied or individualized to a family. Coaching is not always comfortable; the discomfort is often where the learning

is. As I coach, my mentor taught me to pause and summarize the themes I hear if an HV has a lot to say on a topic and to apply the themes to the coaching agenda to create a collaborative summary of the session. One question that continuously arises is, "Have I lost my beginner's mind that put HVs in the expert position?" In 2017, it was easy for me to always put HVs in the expert position. My knowledge base has vastly expanded since then, but I always try to keep this question in mind as it helps me have a nimble mind and aim for collaborator and facilitator approaches.

One of my primary tasks as a coach is to promote HVs' goal-setting. Goals represent a framework to achieve desired outcomes (Bailey, 2019; Maes & Karoly, 2005). The coachee can be encouraged to consider where they can be outstanding (Crotaz, 2022) and set goals in several domains, such as professional practice and well-being (Collison & Wolf, 2022). It is essential to consider strengths and think about what individuals have the best chance of reaching (Collison & Wolf, 2022). Operationalizing these concepts, coaches should include goal setting related to the HVs' PD, strengthening specific HV practices or skills, the client's regulation, and those important to the HV. My mentor emphasizes that goal-setting does not have to include a large and complex goal; it can consist of mini-goals, which can be things the HV already does well.

New Knowledge about Coaching HVs from HVs (Part 3)

I identified three revised themes using coding and personal reflection from the HV coaching interviews: (1) understanding the coaching climate to bring regulation, relation, and coaching together, (2) coaching as a resource for decision-making, and (3) balancing strengths and sensitivity to challenges in coaching.

Understanding the Coaching Climate to Bring Regulation, Relation, and Coaching Together

In my interviews with HVs, they described a coaching climate that values "authenticity," "a nonjudgmental approach," "HVs feeling whole," "a grounding place," and "includes empathy and mutual respect." One HV said coaching provides "time to regulate and exhale:" In coaching, it's just me and the coach. We're bringing things to the forefront and working through how to tackle what needs to be tackled in my work with families, taking time to breathe, and celebrating the things that need to be celebrated.

Another HV noted that she thinks "coaching is therapeutic," and she feels "connected during coaching," and relation is the second sequence in the neurosequential engagement model. HVs expressed that regulation and relation, both critical components of the NMT and NMRS, occur during coaching. HVs also expressed that coaching is a place for "reflection," and how HVs operate in higher parts of their brains is addressed in the next theme.

I reflected on a HV stating that she feels "connected during coaching" and the ways that I coach HVs and how they may make the families they serve feel. I feel connected to my mentor when she says something and asks if there are things I could relate to from her experiences. In the IPMH literature, these questions create reveries or connections (Brandt & Perry, 2024) and help me understand my experience of staying present and attuned and ready for reflection. As a coach and researcher, I realized that both coaching and interviewing are processes that can change the thinking and connection of both participants in the dyad (home visitor-as-coachee and coach).

Coaching as a Resource for Decision Making

This theme captured HVs' expressions that coaching is "a resource" and "part of a bigger PD system" that helps HVs "make decisions about their practice and well-being." HVs underscored to me the necessity of a coaching resource that helps with decision-making. All HVs described coaching as a space to "consider a different perspective," "gain a broader perspective," or "appreciate perspectives." All HVs described coaching as a space to plan and reflect on what's working and what is not and viewed coaching as a place to review their practice and playback practice via video and/or discussions about an observation of a home visit. HVs expressed satisfaction with coaching, and one expressed that "having it once a week rather than every other week or monthly" would improve it. Another HV explained, "I feel like you [coach] have been helpful to me a lot," and she has learned "what is included in coaching and when she needs to talk about something with her supervisor."

Balancing Strengths and Sensitivity to Challenges in Coaching

This theme addressed that coaching is a strengths-based process, and it is balanced with a coach's sensitivity to HV challenges. All HVs expressed to me that coaching is strengths-based work, which reflects how I coach them and potentially how they work with their families. One HV said it is a reminder "to use skills that I already possess" to "evaluate strengths and growing points." HVs also alluded to the parallel process. One HV said, "Sometimes we're the only professionals trying to point out their [families] strengths." The coaching narrative of what is going well and encouraging what strengths the HVs noticed is balanced with coaching as a space "to be honest about challenges." Coaching is a place to celebrate successes with families, reflect on what the HV did to support their success, and be honest about the challenges and issues with the families served, HV practices, and HV regulations.

Conclusion

By interweaving and reflecting upon autoethnography, infant mental health concepts, and interviews with HVs, this article advances adult regulation and educational transformation by addressing the critical need for effective reflective coaching among EC HVs. HVs are pivotal in supporting parents, thereby influencing children's development. However, translating coaching strategies into HVs' work with at-risk families presents challenges, highlighting the necessity for support to enhance transferability. I think ways to enhance transferability include mindfulness and connection. Mindfulness includes regulation and nonjudgmental awareness of one's experience (Bishop et al., 2004; Kabat-Zinn, 20023), and greater levels of mindfulness in home visitors are associated with a strong working alliance (Becker et al., 2016) and thus a more empathetic response to families and a better understanding of families' goals (Becker et al., 2016; Snyder et al., 2012). Emphasizing HVs' vulnerabilities, including secondary stress and burnout, underscores the importance of addressing educators' emotional well-being in educational settings. This article addresses strengthening coaching processes to promote HVs'

dual regulation and, potentially, practice.

My autoethnographic approaches also highlight that HV coaching involves making connections between theory and practice, coaches and home visitors-as-coachees, and the families HVs coach. Realizing these connections requires deeply reflective and self-regulating work, including the type of self-reflection that is commonly employed in autoethnography. Providing personal insights through autoethnography such as mine can enhance practitioners' understanding of the human element and the connections promoted in coaching. The practice insights may offer actionable strategies to support HVs in educational settings, fostering a focus on HVs' well-being alongside PD and facilitating educational transformation for coaching.

Throughout this reflective process, I intently thought about coaching processes and created the documentation form in Appendix A. In addition to this form, I journaled about most sessions (some of my entries were captured earlier in this article). I refined my coaching voice and philosophy throughout this process. My reflection leads me to suggest the next steps for the field to continue to consider: My coaching work in 2017 was in person, and currently, it is via an online platform. I think the mode or modes of coaching warrant further investigation.

Reflecting on my coaching experiences helped me realize the importance of both coaching and RS for home visitors and coaches. I receive support as a coach through CoPs, RS, and coaching/mentoring/consultation. Are other home visitor coaches receiving support? What is the recommended dosage for professional efforts to support the coach? Are home-visiting programs able to hire coaches in addition to reflective supervisors? What should the sharing process, if any, look like between reflective supervisors and coaches if they are different people?

Coaching and autoethnography make multi-layered connections that demand reflective and self-regulating work. More narrative work is needed from the home visiting field. Other descriptive work, such as audio or video transcripts analysis, is needed (Walsh et al., 2021; West et al., 2024) to advance coaching training and implementation practices and fidelity. Many HVs also consider themselves coaches (Walsh et al., 2023), meaning that HVs often listen and watch during coaching and think of ways to try the strategies they received in coaching with the families they serve. Perry's (2009) "regulate, relate, and reason" approach may be a natural fit for coaching home visitors and potentially for home visitors to work with at-risk families.

Acknowledgements

Thank you to Melissa Burnham and the Department of Human Development, Family Science, and Counseling for sponsoring the first author's 2023-2024 Infant-Parent Mental Health Fellowship (IPMHF) through UC Davis Continuing and Professional Education, the Parent-Infant & Child Institute in Napa, and the Neurosequential Model Network. Thank you to the Department for changing my role statement to allow me to work as a coach at the University of Nevada Reno's home visiting program.

Conflict of Interest

The authors have no relevant financial or non-financial interests to disclose. The University of Nevada, Reno IRB approved this research with human participants.

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Appendix A

Coach's Name:
Coachee's Name:
Date:
Mode of Session (e.g., in-person, online platform):
Coachee Strengths:
Rhythm or Regulation:
Practice:
Topic(s) Discussed During the Session:
Themes from Previous Session(s) and/or Today's Session:

Please highlight the coaching content and processes used during this session:	
• Safe, Protected Space • Connection and Check-in • Mindfulness Strategies • Regulation Strategies • Motivational Interviewing • Culturally Responsive Practices • Trauma-Informed Care • Strengths-Based Approaches and Partnership Principles • Bias Awareness	• HV Competencies • Professional Relationship Building • Goal-Setting • Action Plan and Reviewing • Observation • Reflection and Feedback
Secondary Stress and Trauma/Weight of the Session and Ideas for Alleviating or Resolving:	
Please state the individualized coachee goal or goals discussed during this session (if any).	
Collaborative Summary of Session:	
Resources Shared or Mentioned:	
What will occur between sessions, if anything?	

The Paradigm Shift in Training for Professionals Working with Infants, Children and Families: Building the Foundation

By Nina Newman and Ira Glovinsky
(School of Psychology, Fielding Graduate University, United States)

…It makes sense to begin with an awareness that every human being incorporates the history of his or her relations with others – a history that is at once social and personal, physical and psychological….

Christina Toren, 2008

Currently, there are escalating crises across multiple domains related to the care and support of infants, children, and families (Baer et al, 2017; Grant et al., 2019; Kim et al, 2018; Madigan & Kim, 2021). We only need to look at the rates of dysregulated behaviors and mood disorders in our youngest children (CDC, 2021; Whitehouse.gov, 2021); expulsion numbers from preschool and early childhood care programs (Gilliam & Shahar, 2006; Steglin, 2018); shortages of quality childcare, the high rates of pediatric mental health problems (Duong,et. al, 2021; Vasilevaet al., 2021); increases in professional burnout and attrition rates (Bassok, et al, 2021; Farewell et al., 2023; Hur et al, 2023; McMullen et al, 2020; Shim et al., 2022); and the rise in adult mental health challenges (Gose, 2023). Although the pandemic may have contributed to these issues, the problems were escalating prior to 2020 (Greenberg et al. 2001; Whitebook, et al, 2014) and continue to have increasing and significant implications for outcomes for child and family populations as well as professionals. Consider that currently a significant number of children may be inappropriately red flagged for and/or diagnosed with Autism Spectrum disorder (ASD) (Fombonne, 2023; Rowland, 2023; Ulbricht, 2024) and ADHD (Kazda et al, 2023; Morgan et al, 2023; Ulbricht, 2024). While it is understood early detection of ASD may result in better long-term outcomes, inappropriate diagnoses can have equally significant but negative ramifications as can misdiagnoses of ADHD.

In part, these issues may stem from focusing solely on behaviors while minimizing what underlies them, consequently overlooking the driving problem (Delahooke, 2020; Siegal, 2020). This perspective then promotes a tendency to focus on the child as the identified 'patient' rather than understanding the child in broader contexts, such as family systems, the environment, trauma, and ongoing changes wrought by development (Bronfenbrenner, 1977). For example, an 18-month-old was recently red flagged for ASD and referred for early intervention. The referral was made because the child consistently laid on the floor, screamed at and kicked his mother. However, no one asked about the mother or the dyad. In fact, the young mother was significantly depressed, non-responsive, and had not been able to bond with her child from the beginning. Consequently, the child's behavior was not inappropriate for the circumstances. He needed an engaged, loving caregiver, but there was none to be had. His behavior was his only means of communicating the problem. ASD was not, in fact, the issue but by focusing on the behavior, the real problem was going unaddressed.

The handling of these kinds of challenges often reflects a reactive mindset which emphasizes management as opposed to understanding. This is further fueled by the limitations of the DSM V, which is constrained, at best, in its characterization of childhood disorders, not adequately accounting for factors such as family dynamics, sensory functioning, physiology and development (Cuthbert, 2015). However, many child professionals, such as educators, early interventionists, health, mental health, and allied health providers have not received the formative training to understand and/or address these complex issues, especially when related to social emotional development, individual differences, sensory/temperament profiles, and the effects of culture, family, and classroom on child functioning.

These limitations often result in mis-cued interactions, misdiagnoses, and/or inappropriate interventions, which then distort perceptions of and relationships with the child and compromise outcomes. Further, the limitations minimize or render invisible relational health, which is foundational for positive development. They also skew assessments and choice of interventions. Further, while the rates of ASD and ADHD (an inappropriate diagnosis for infants and young

children) have increased since Covid, there is insufficient understanding of parent and professional stress rates, mental health issues, potential grief, and dysregulation, all of which can affect children's behaviors (Abdelnor et al, 2022). While efforts are being made to address some of these problems, there continues to be gaps in understanding about the nature of the problems and, hence, how to address them.

The Shift

As noted, across multiple disciplines there is an overemphasis on behavioral models, which do not adequately account for the other contributing factors that can underlie behavior (Cuthbert, 2015; Delahooke, 2020). Even training that aims to incorporate reflective and relationship-based components often does so at levels that the professionals cannot yet make use of as they lack the necessary foundation. First and foremost, training must begin with the development of an understanding of self and then self in relation to others. That is, one has to build an awareness of the effects of one's own history, triggers, biases, and strengths, in order to then be able to reflect on them and then how these factors affect their work with children and families. This is especially important when working with others different from us as we need to develop an understanding of another's meaning making, including how their culture shapes their perspective and understanding of the world (Toren, 2008).

Consequently, we need to support reflection beyond assessing whether an activity went well or not. Instead, it needs to be reframed as the capacity 'to be' with oneself and others. This means learning to pay attention to feelings via our bodies, then using this information to better understand how we feel about and are reacting to given circumstances. What are we bringing to our interactions and how may this affect the people with whom we work – and vice versa. This is vital as these processes facilitate better assessment skills, regulatory capacities, and, importantly, abilities to build effective working relationships with all children and families. As such, education and training should include an emphasis on the internal (felt) experiential processes, beginning with our own histories, especially in regard to our earliest relationships and how they have shaped us.

Where we Begin

The first step is the relationship between the trainer and trainee, which builds over time. Through interpersonal processes, curiosity and enquiry, professionals can begin to develop an awareness of strengths, areas for growth, and an integrated understanding of physiology, temperament, and relational histories. How do we feel and move through the world? Do I need a high level of social engagement, or do I prefer it in smaller doses? Am I calm in noisy spaces, or do they dysregulate me? Can I easily shift from one mental activity to the next? Or do I need more time to process? How do I feel in my body? How do I feel when others are dysregulated? How have my earliest relationships, experiences, and environments affected how I feel today? How has my background and culture shaped my perspective of and feelings about others and the world?

This should start at the earliest stages of professional education and training. Currently, at undergraduate and graduate/professional levels, curriculums are still constricted, often using outdated syllabi and concepts that don't address real world problems, especially in the social emotional realm. Moreover, there are assumptions that all students' funds of acquired knowledge and experiences are similar. That is, we teach and train as if everyone shares the same foundation, has similar backgrounds, learns the same way, and at the same rate. Experience, students, and professionals tell us otherwise. As such, many move into professional spaces without the needed education and training to do the work they will be required to do.

To redress these issues, education and training should include ongoing interpersonal components and reflective work. Over time is especially important as it is a process to build an understanding of self and to integrate knowledge into real world practice. Moreover, it is important to hold in mind that, for many, reflecting on one's own emotions, triggers, and histories and even strengths – ghosts' (Fraiberg et al, 1972) and 'angels' (Lieberman et al, 2005) – may be new experiences, and, occasionally, dysregulating and overwhelming. As such, this underscores the need for a measured process as individuals move through the learning experiences in their own ways.

Without the reflective foundation, professionals are more apt to jump to conclusions, struggle to meet parents or children where they are at, adequately manage their own stress, and maintain regulation. In turn, this makes it more likely that judgment, stress, and bias will creep in while empathy wanes, increasing the possibility of burnout and attrition. It is important to note that these issues affect more than interpersonal dynamics; quite often these unaddressed difficulties inform how systems and policies are developed and implemented, perpetuating a range of challenges, not least of which are non-responsivity to family needs, systemic racism, and poorer overall outcomes.

Next Steps

Coming to know and work with self and others is not a textbook proposition or a top-down operation. Instead, it is a multi-layered relational process (Mahler, 2017), including bodily experiences, as well as cognitive ones and is focused on lived experiences. As previously noted, often this is best accomplished in reflective group settings over time, allowing participants to integrate feelings and develop skills. It has been our experience that the work does not become meaningful until participants can immerse themselves in the process. They must have consistent, on-going opportunities to relate knowledge to daily experiences and to appreciate the meaning of individual differences - how each person, from biology to physiology to sensory to social emotional to cognitive to cultural influences, to environment, and to developmental levels, is constructed differently (Cuthbert, 2015). It also takes time to build an emotional language and the abilities to develop shared meaning making. While initially these processes may feel cumbersome, they find natural rhythms as interpersonal work evolves.

Groups

To develop safe reflective groups, case presentations and discussions, relatable to participants' work, must be at the core. For example, recently an early childhood educator shared an experience with a 'difficult' parent. The child was struggling with behavioral challenges and the school wanted the child evaluated. When approached, the parent became distressed, reframing the situation as an inadequacy of the teacher. The teacher thought the parent was 'in denial', that the child must be

'spoiled' at home, and she (the teacher) was left to deal with the fallout. In her reflective group, the teacher was able to wonder about her angry reaction and assumptions and what triggered them. Eventually, she was able to consider the possibility that the parent may have felt worried, overwhelmed, and concerned about judgement. She also realized she didn't know much about the parent or how the parent perceived any of their interactions. The teacher was able to reflect on her own anxious state and wondered how that might have affected the interchange. By working through this process with peers who shared similar experiences, it afforded the teacher a better understanding of herself and how she might approach parents moving forward. In other words, the opportunity to be in an ongoing reflective consultation group afforded the teacher and other members the opportunity to shift their perspectives and ultimately how they work.

Conclusion

As we contemplate the challenges across child-related disciplines, we must look to consider shifts in education and training, especially in terms of intra and interpersonal components, interdisciplinarity, and especially the understanding of self. Once we can reflect on and have empathy for self, we will be better able to do the same for others. That is, we need to train to support a whole person approach that includes individual differences across body, brain, and mind, and through a cross-cultural lens. Furthermore, development must always be adequately considered because change is going to happen – in infants, children, and adults – as people move across the lifespan. Finally, only with respect for all, practice, consistency, and care in nonjudgmental spaces and in connection with each other can we best learn to develop new ways of being and the skills we need to support the children and families with whom we work as well as ourselves.

Author Note

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We have no known conflict of interest to disclose.

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WAIMH Perspectives in Infant Mental Health. Paper submission

WAIMH Perspectives in Infant Mental Health welcomes papers at any time throughout the year. However, if you are seeking to publish your paper within a certain issue, these are the submission dates for each main issue:

April issue

Submissions received by 1 January will be reviewed for possible inclusion in this issue.

August issue

Submissions received by 1 May will be reviewed for possible inclusion in this issue.

December issue

Submissions received by 1 September will be reviewed for possible inclusion in this issue.

Potential infant mental health (IMH) content areas

Examples of content areas for papers include Infant mental health focused:

- Clinical practice conversations
- Research – especially pilot programs
- Reflective practice and supervision
- Training experiences
- Theory to practice papers
- Organizational/management matters

Formatting your paper submission

1. APA 7th Edition.
2. 12-point font.
3. 1.5 or double-spaced.
4. Maximum 3000 words, including references.
5. All in-text citations, references, tables, and figures must be in APA 7th edition format.
6. Papers with tables and figures. Please submit the paper as a Word-format document with separate files attached for each table and/or figure.

7. All photos must be sent in a separate file with a resolution of at least 72 pixels/inch.
8. All photos need to include:

- A permission statement from the author/s for WAIMH to publish the photo in Perspectives and on all WAIMH printed and online platforms.
- A Photo Credit (if known).

9. All research papers must contain the Ethics Approval Reference Number and Ethics Approval Body Name.

Further enquiries

To inquire about Perspectives in Infant Mental Health or to submit articles, please contact:

Jane Barlow (Editor-in-Chief)

Email: perspectives@waimh.org

WAIMH Executive Director Corner

By Kaija Puura (Finland)

Photo: Prof Kaija Puura at the WAIMH2024 Interim World Congress in Tampere. Credit: Anna-Kaisa Noki-Helmanen

Dear colleagues and friends,

As summer transitions to autumn here in the northern hemisphere, the days are gradually shortening. At the WAIMH Central Office, we experienced a busy yet immensely rewarding summer in 2024. The highlight was the successful WAIMH Tampere Interim Congress, which welcomed 422 delegates from 36 countries. The theme, "Looking for the best care for infants, young children, and families," was thoroughly explored through presentations addressing the diverse needs of children and families, including those affected by the extreme trauma of armed conflicts.

Tampere was the perfect city to host the WAIMH Interim Congress, especially given its connection to the Moomin Museum. The spirit of the Moomins provided an excellent theme for my welcome address. Finnish author Tove Jansson created the Moomin characters in her books from 1945 to 1977, aiming to craft a world of friendliness and warmth in contrast to the wartime reality she experienced in Finland. While the Moomin books were initially written for children, they contain deeper layers that resonate with adults. The characters represent different personalities or aspects of personality that we all exhibit in various situations. For us as infant mental health specialists, the Moomin stories offer profound insights.

The Moomins exemplify a loving family, with Mama Moomin and Papa Moomin as attentive caregivers to their son, Moomin Troll. These furry, round characters with big noses, short arms and legs, and little tails, live harmoniously with a variety of other creatures. Despite their differences, characters like the temperamental and independent Little My or the extremely pessimistic Muskrat are welcomed without question. In the Moomin family and community, everyone is accepted as they are, provided with food and safety, and treated according to their needs. Their commitment to caring for one another, despite their differences, makes them incredibly resilient.
The stories showcase their ability to navigate significant changes, such as moving from Moomin Valley to a small island with a lighthouse, and even surviving natural disasters like floods and comets.

Just like in real life, the Moomin family members grow and help each other to grow. In one of the most touching stories, Mama Moomin heals the traumatized, invisible Ninny with a bit of grandma's medicine and warm affection, allowing Ninny to finally express her anger when she mistakenly thinks Papa Moomin is about to push her beloved Mama into the sea. In another story, Moomin Troll helps Papa Moomin come to terms with uncertainty, while Mama Moomin learns the importance of self-care alongside caring for others. The temperamental, feisty, and fearless Little My encourages Moomin Troll to face the cold and frightening Groke, who then becomes warm herself and no one has to fear her anymore. The highly independent Snufkin, who detests responsibilities, finds himself caring for 24 orphans and realizes that forming attachments isn't so bad after all. These stories of personal growth, born from experiences that are sometimes frightening, awkward, stressful, and unexpectedly warm and loving, resonate with many of us.

These are challenging times, with many concerning events unfolding around the world. Yet, we can all strive to embrace a bit of the Moomin spirit in our daily lives, gradually transforming our world into a more Moomin-like valley. Let's support one another and remain resilient in facing our own challenges, whatever they may be.

With my warmest regards to you all,

Kaija

Professor Colwyn Trevarthen (1931-2024)

By Maree Foley (Switzerland) and Salisha Maharaj (South Africa)

Professor Colwyn Trevarthen, Emeritus Professor of Psychobiology and Child Psychology at the University of Edinburgh (Scotland), died on July 1st at the age of 93.

Colwyn was an extraordinary person, scientist, and advocate for understanding infants and their capacities to communicate and share experiences with their parents, caregivers, siblings, and friends. Colwyn tirelessly showed how infants are social people. They are active participants, as recipients and communicators, in their relationships. Colwyn contributed hugely to the professional growth and development of many WAIMH members, allied members, and the wider infant and early childhood community.

To honour Colwyn fully, Hisako Watanabe (WAIMH Regional Vice President) and Campbell Paul (WAIMH Past President) are in the process of compiling a reflective tribute to Colwyn, a treasured friend and colleague. This will be available soon.

In the interim, Salisha Maharaj and Maree Foley, from the Perspectives team, have compiled a selection of infant mental health and early childhood development-focused academic and free open-source resources where Colwyn Trevarthen is the author or co-author.

Photo: Colwyn Trevarthen received the René Spitz Award at the 14th WAIMH World Congress in Edinburgh, 2014. Credit: Simon Williams

Academic papers

Below are just ten (of the hundreds) of references that have been authored or co-authored by Professor Colwyn Trevarthen in the fields of Infant Mental Health and Early Childhood Development:

1. Trevarthen, C. (1979). Communication and cooperation in early infancy: A description of primary intersubjectivity. In M. Bullowa (Ed.), *Before Speech: The Beginning of Interpersonal Communication* (pp. 321-347). Cambridge University Press.
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An open-source and free-to-access selection of resources

Papers

Making music with your baby: Trevarthen's communication research: Why attachment matters. Microsoft Word - Colwyn Trevarthen 2009 Human Needs and Human Sense The Natural Science of Meaning SAIA Glasgow copy.docx (ddpnetwork.org)

Learning about ourselves, from children: why a growing human brain needs interesting companions. https://atotalapproach.com/images/docs/ColwynTrewarthen2004.pdf (found online free)

Stepping Away from the Mirror: Pride and Shame in Adventures of Companionship. Reflections on the Nature and Emotional Needs of Infant Intersubjectivity. https://ddpnetwork.org/backend/wp-content/uploads/2014/02/Trevarthen-Colwyn-2005-Reflections-on-Infant-Intersubjectivity-.pdf (found online free)

Youtube

Born to Sing and Dance. https://www.youtube.com/watch?v=2kJl6G35TNk

Pre-Birth to Three: Professor Colwyn Trevarthen - Relationships. (15) Pre-Birth to Three: Professor Colwyn Trevarthen - Relationships - YouTube

Child Flourishing Symposium 2014 - Colwyn Trevarthen. Child Flourishing Symposium 2014 - Colwyn Trevarthen (youtube.com)

SAVE THE DATE

WAIMH 2026
19TH WORLD CONGRESS | TORONTO, CANADA

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Nurturing the Youngest Minds Around the World

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World Association for Infant Mental Health

News from the WAIMH Central Office: Member Survey, World Congresses, and IMH Resources

By Neea Aalto, Kaija Puura and Reija Latva (Finland)

Dear WAIMH Members,

The WAIMH 2024 Tampere Interim Congress in June was well attended with 422 participants from 36 countries. We received kind feedback from the delegates, the Professional Congress Organizer, as well as the venue staff on site, noting that the atmosphere at the conference was exceptionally warm. This is thanks to you – thank you all for the wonderful WAIMH spirit!

In this office news, we invite you to participate in a brief survey about the WAIMH member webpage, provide updates on the World Congresses, and remind you of some current membership benefits and resources.

Photo: WAIMH Honorary President Miri Keren at the WAIMH 2024 Interim World Congress in Tampere. Credit: Anna-Kaisa Noki-Helmanen

WAIMH Member Webpage Survey 2024

Your feedback is essential in shaping the WAIMH member webpage to meet the needs of our online membership community and to ensure it is accessible, relevant, and valuable for everyone involved. Please take a moment to answer this brief survey by September 30th.

WAIMH World Congresses

The **WAIMH 2024** Interim World Congress was held in Tampere, the hometown of the Central Office, in June this year, to resume the pattern of the World Congresses occurring in even years. The theme of the Congress was "*Looking for the Best Care for Babies, Young Children, and Their Families*."

For those who couldn't join us, don't worry – the Congress presentations were recorded, and we will notify you once they are available for viewing. If you did attend the Congress and have not yet received a certificate of attendance, you can request it via email: office@waimh.org

The **WAIMH 2026** World Congress will be held in Toronto, Canada, from October 2nd-6th, 2026. The theme of the Congress will be "*Harmony in Diversity: Nurturing the Youngest Minds Around the World*." Preparations for the Congress have already begun. Stay tuned for further announcements!

WAIMH is still open for bids for the **WAIMH 2028** World Congress. It has been our experience that hosting a World Congress can have a stimulating, boosting effect for the local Affiliate, the benefits of which are felt for a long time thereafter. The deadline for submitting a bid is December 15th, 2024. Read more about what the WAIMH Board expects from a bid.

Photo: WAIMH2024 Welcome Reception was hosted by the City of Tampere at the Tampere City Hall. Credit: WAIMH

WAIMH Membership and IMH Resources

As a member of WAIMH, you gain access to materials, congresses, and information that help all of us increase infant mental health globally. There is still time to renew your membership

or to become a WAIMH member for 2024. Please note that the membership year runs from January to December, regardless of when you renew. (Membership effective Jan 01 – Dec 31).

The Infant Mental Health Journal, the official publication of WAIMH, is now Infant Mental Health Journal: Infancy and Early Childhood! The updated title better reflects the journal's focus on infant and early childhood mental health. WAIMH members may order the journal at a greatly reduced member rate through the WAIMH Online Store.

As a reminder, here are some other ongoing online resources for WAIMH members and all our IMH colleagues:

- WAIMH eBook: Global Perspectives on the Transdisciplinary Field of Infant Mental Health 1993–2021. This comprehensive resource spans nearly three decades of insights into theories, interventions, and practices in infant mental health. The 17 chapters cover essential topics such as reflective supervision, parent-infant therapeutic modalities and settings, as well as contextual topics in the field, such as infant mental health promotion, infants' rights, COVID-19, and resilience. The eBook is free for WAIMH members and $10 USD for non-members.
- WAIMH Infants in Crises webpage. This webpage comprises free and open-access resources that focus on the needs of infants and their families amidst global crises.
- Laying the Path for Lifelong Wellness Lecture Series 2022. The 15-part webinar series brings world-renowned experts in infant and early mental health research and practice to you in an accessible and flexible format that can be easily integrated into staff development and continuing professional education. The series is presented jointly by Infant and Early Mental Health Promotion (IEMHP) at the Hospital for Sick Children, WAIMH, and Tampere University.
- WAIMH 2023 Recordings of Presentations.

1. Emotional Brain Development and the Role of Parenting (Nim Tottenham, Columbia University)

Photo: WAIMH2024 Poster sessions took place alongside exhibitors from Finland and beyond. Credit: WAIMH

2. Threat versus Deprivation in Mother's Childhood: Differential Relations to Infant Regional Brain Volumes and Cortisol Responses Over the First Two Years (Karlen Lyons-Ruth, Harvard Medical School)
3. The mother's relationship with the unborn baby – key concepts, empirical evidence, and implications for practice (Jane Barlow, University of Oxford)

Contact Us

You, the members, are important and valuable to us. Please do not hesitate to contact us with any questions you may have regarding WAIMH.

Warmly,

Neea, Kaija and Reija from the Central Office

Email: office@waimh.org

WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH
www.waimh.org

PERSPECTIVES IN INFANT MENTAL HEALTH

Perspectives in Infant Mental Health (formerly, The Signal) is a Professional Publication of the World Association for Infant Mental Health (WAIMH).

It provides a platform for WAIMH members, WAIMH Affiliate members, and allied infant mental health colleagues to share scientific articles, clinical case studies, articles describing innovative thinking, intervention approaches, research studies, and book reviews, to name a few. It also serves as a nexus for the establishment of a communication network, and informs members of upcoming events and conferences.

It is a free open access publication at www.waimh.org

During the past 50 years, infant mental health has emerged as a significant approach for the promotion, prevention, and treatment of social, emotional, relational, and physical wellbeing in infants and young children, in relationship with their parents and caregivers, in their families and communities.

Within this same time frame, the infant mental health movement has expanded to a global network of professionals from many disciplines. This infant mental health global network community of research, practice, and policy advocates, all share a common goal of enhancing the facilitating conditions that promote intergenerational wellbeing; including intergenerational mental health and wellbeing relationships, between infants and young children, parents, and other caregivers, in their communities.

The global reach of infant mental health demands attention to the cultural context in which a young child and family lives, as well as critical attention to issues that affect child development, child health, child mental health, parental mental health and early relationship development.

Invitation to contribute

We invite all members of WAIMH and WAIMH Affiliate members to contribute to Perspectives in Infant Mental Health.

Because WAIMH is a member-based organization, we invite each of you to think creatively and consider submitting an article that provides a "window on the world" of babies and their families –

In the spirit of sharing new perspectives, we welcome your manuscripts. Manuscripts are accepted throughout the year. Articles are reviewed by the Editors, all of whom are committed to identifying authors from around the world and assisting them to best prepare their papers for publication.

Full issue publication dates

Spring issue: April

Papers received by January 1
will be considered for inclusion in this issue.

Summer issue: August

Papers received by May 1
will be considered for inclusion in this issue.

Fall/Winter issue: December

Papers received by September 1
will be considered for inclusion in this issue.

Perspectives in Infant Mental Health Submission Guidelines

APA 7th Edition.

12-point font.

1.5 or double spaced.

Maximum 3000 words, including references.

All in-text citations, references, tables, and figures to be in APA 7th edition format.

Papers with tables and figures. Please submit the paper as a word-format document with separate files attached for each table and/or figure.

We welcome photos of babies and families.

All photos need to be sent in a separate file with a resolution of at least 72 pixels/inch.

All photos need to include a permission statement from the author for WAIMH to publish the photo in Perspectives and also on WAIMH online social media platforms.

Further details:
www.waimh.org

Contact

To inquire about Perspectives in Infant Mental Health or to submit articles, please contact:

Jane Barlow (DPhil, FFPH Hon), Editor-in-Chief
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