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Perspectives in Infant Mental Health

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Contents

From the Editors

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This Perspectives in Infant Mental Health Supplement provides an overview of infant and early childhood mental health (IECMH) as represented in a selection of papers published by the World Association for Infant Mental Health (WAIMH) in *The Signal* and *Perspectives In Infant Mental Health (Perspectives)*, from 1993 to 2021. This supplement is a sequel to the WAIMH ebook (Keren et al., 2022).

The Signal and WAIMH Perspectives in Infant Mental Health

Since 1993, the World Association for Infant Mental Health (WAIMH) has been producing a regular newsletter for members and the global allied infant mental health community. This newsletter was originally called *The Signal*. In 2012, it was re-named: *WAIMH Perspectives in Infant Mental Health (Perspectives)*.

The Signal and *Perspectives* has published papers on a wide array of infant mental health-related topics such as the relationship between parents and infants, caregiving relationships, and service development within infant mental health. The full collection of papers from 1993 to 2021 (access to all papers is available at: https://perspectives.waimh.org/perspectives-archive/.

A summary of the history of this publication from 1993-2021 can be found here (Foley et al., 2021): The Signal and WAIMH Perspectives in Infant Mental Health: 1993-2021 - Perspectives

The WAIMH ebook (Keren et al., 2022)

To recap, the ebook (Keren et al., 2022), provides readers with a nearly three-decade-long window from which to view theories, interventions, and treatment practices within the specialized and interdisciplinary field of infant mental health. It does this by highlighting a representation of papers, published by WAIMH, in *The Signal* and *Perspectives in Infant Mental Health*, from 1993-2021.

The ebook provides an overview of infant mental health principles and observation practices, professional development topics, such as reflective supervision, parent-infant therapeutic modalities and settings, research, as well as contextual topics in the field, such as infant mental health promotion, infants rights, COVID-19, and resilience.

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This supplement

Similarly, the papers in this supplement highlight a representation of papers, published by WAIMH, in *The Signal* and *Perspectives in Infant Mental Health*, from 1993-2021. In contrast, this supplement is more broadly oriented towards clinical concerns. It focuses more on specific issues encountered by babies, young children, and their families, in their communities, such as adoption, depression, family violence, prematurity, and feeding challenges.

Given the depth and breadth of papers published by WAIMH since 1993, the papers highlighted throughout this supplement are but a representation of the whole collection. Access to the full WAIMH open-source collection is available here (Perspectives Archive - Perspectives (waimh.org)

Paper outline

The ten papers in this supplement are ordered around three broad-stroke clinical themes. Theme one focuses on broader familial contextual issues such as exposure to family violence, adoption and foster care, premature babies and premature parenthood, and parental drug addiction. Theme two focuses specifically on the ways infants communicate about their experiences of their internal, external and inter-relational states, such as eating, depression, crying and disruptive behaviors. Finally, the third theme explores the broader issues of cultural representations and research in infant mental health.

Open invitation to contribute papers to Perspectives IMH

The aim of WAIMH is:

> *… to promote the mental wellbeing and healthy development of infants throughout the world, taking into account cultural, regional, and environmental variations, and to generate and disseminate scientific knowledge…* (www.waimh.org)

Over time, *The Signal* and more recently *Perspectives in Infant Mental Health*, have contributed towards this aim, and continue to do so. As editors of this supplement, we thank all the authors, since 1993, for their interesting and thoughtful contributions.

As we move forward, we welcome submissions from the field that challenge the way we think about infants, families, culture, and community, and offer fresh perspectives on policy, research, and practice. We welcome papers, especially in areas where we find new challenges such as digital media and very young children, infants and families in humanitarian contexts, infant mental health ethics, issues of diversity, equity and belonging in infant mental health, and access to infant mental health training and ongoing professional development.

In sum, the WAIMH ebook in conjunction with this supplement, invites readers to consider the open-source WAIMH publications as a readily available resource to support each of us as we work together to progress the social, emotional, and relational health of all infants in their families within their culture and communities.

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Infants living within traumatic situations: Exposure to family violence

By Maree A Foley (Switzerland)

Introduction

This chapter draws on a selection of papers from *The Signal* and *Perspectives* that directly address the issue of infant exposure to family violence as it relates to infant mental health. The Convention on the Rights of the Child (Office for the High Commissioner for Human Rights, 1989) with the UN Child Rights Committee General Comment 13 (UNCRC, 2011) guarantees the right of every child to be free from all forms of violence and the right of every child to a high standard of mental health (Murray et al., 2019). In conjunction, the United Nations, 2030 Agenda for Sustainable Development (United Nations - Sustainable Development knowledge platform, 2015), is committed to ending all forms of violence towards children while also promoting their mental health and well-being. However, the problem of violence towards children endures.

In 2020, the United Nations reported that over 1 billion children are exposed to violence, every year (Office of the Special Representative of the Secretary-General on Violence against Children, 2020). Within the field of infant mental health, infants' exposure to and recovery from traumatic experiences has been well documented (Scheerings & Zeanah 2001; Liberman & Van Horn, 2008).

This chapter is divided into two main sections. The first section highlights papers that specifically address Adverse Childhood Experiences (ACEs) (Felliti et al., 1998; Anda et al., 2006; Cronholm et al., 2015), which include children's exposure to domestic violence, as an adverse childhood experience. The second section of the chapter focuses on papers whose primary focus is infants' exposure to domestic violence and infant mental health practice.

Adverse childhood experiences

ACEs include stressful or traumatic events such as abuse, neglect, violence between parents or caregivers and household issues such as alcohol and substance abuse; and peer, community and collective violence, that occur during childhood (aged 0-18 years). Furthermore, the original ACEs study found that of the adults who had exposure to at least one ACE in childhood, 65 %, experienced health issues as adults. A dose-response was also identified, whereby, higher numbers of ACEs experienced in childhood were associated with increases in mental and physical health difficulties and challenges in adulthood (Felitti et al., 1998).

The ACEs study and subsequent work re-conceptualised the determinants of mental and physical health and built on existing research that had shown the long-lasting detrimental effect of adversity and traumatic experiences (Rutter, 1977; Cicchetti & Toth, 2015). Viewing earlier research, with ACEs, the intergenerational transmission of adversity (Madigan et al., 2019), and brain research collectively, brings the infant and young child sharply into view. It highlights the interplay between the biological embedding of the effects of trauma and the unfolding experiences of a current traumatic environment (see also Hughes et al., 2017).

In 2019, the WAIMH Perspectives in Infant Mental Health editorial team called for the submission of papers on ACEs with a particular focus on infants and young children. The following four papers were published in the 2019 (Volume 27), issue of Perspectives.

Ereyi-Osas, W., Racine, N. & Madigan, S. (2019). Asking about Adverse Childhood Experiences (ACEs) in Prenatal and Pediatric Primary Care: A Narrative Review and Critique. *Perspectives in Infant Mental Health, 27*(3), 8 – 17.

Ereyi-Osas et al. (2019) succinctly state why it is important to focus specifically on the needs of infants and early childhood who are exposed to ACEs.

> Given that pregnancy and early childhood are sensitive periods for experiencing adversity and its intergenerational transmission, identifying ACEs during these periods has been highlighted as a potential step in preventing the cascade of developmental issues characterized by high ACE scores (Garner et al., 2012; Hudziak, 2018). (Ereyi-Osas et al., 2019, p. 8)

In this paper, Ereyi-Osas et al. (2019) address the clinical relationship between clinicians and families. It is well established that infants and young children exposed to ACEs are at risk for long-standing health issues, however, in a practice setting, how do clinicians talk about these issues with families in prenatal and primary health care settings? The authors cite,

> … concerns about the potential for discomfort in being asked to report ACEs, lack of trauma-informed training available to healthcare providers, low availability of resources for individuals with high ACEs, and feasibility of asking such questions, have been raised with regard to obtaining ACE histories in primary care settings. (Ereyi-Osas et al. 2019, p. 8)

The paper reports on a narrative review and critique of the literature that addresses ACEs history taking in clinical settings with women and children under 6 years of age. The review focused on the perspectives of both the women as providers of their stories and of the clinicians asking about their histories. Three key findings include,

> 1) a large proportion of parents (up to 50%) experienced discomfort from being asked about ACEs, particularly parents with high ACEs, 2) trauma-informed training and adopting a trauma-informed approach is needed prior to implementing an ACE history-taking strategy within a clinic or organization (Racine, Killam, & Madigan, 2019), and 3) the availability of resources for patients and families who are asked about ACEs and need additional support is critical. (Ereyi-Osas et al. 2019, p. 14).

Furthermore, this study identified several future directions to better serve infants and their families regarding ACE history taking. For example, there is a need for standardized clinical guidelines regarding ACE history taking, for considering combining ACEs history taking with current resilience factors, and for understanding more about when to ask about ACEs in a primary health care setting. In summary, this paper offers the reader an extensive lens into the experiences of families with young children being asked about their ACEs and the experiences of the clinicians. The paper provides an informed discussion of the care, context, and considerations to be made when implementing ACEs history taking in primary care settings.

Khan, M. & Renk, K. (2019). Breaking the Cycle: Could attachment disrupt the intergenerational transmission of Adverse Childhood Experiences? *Perspectives in Infant Mental Health, 27*(3), 18-26.

Khan and Renk (2019) report on their cross-sectional study that examined inferred (that is non-observed) mother-young child insecure attachment patterns, as mediators in the relationship between mothers' parenting behaviours and their histories of adverse childhood experiences (ACEs), or experiences of childhood maltreatment (CM) (i.e., abuse and neglect). The study data included mothers' (n = 146) self-report data via an online survey. The children of the mothers were aged 1½ to 5 years old.

Khan and Renk (2019) reported that,

> Results indicated that mother-young child avoidant, anxious, and disorganized attachment patterns mediated significantly and fully the relationship between mothers' ACEs and negative parenting behaviors and between mothers' CM experiences and negative parenting behaviors. (p. 18)

The authors suggest that findings indicate an ongoing need for "trauma-informed parenting interventions with ports of entry that could support facilitation of mother-young child secure emotional connections and decrease the risk for maltreatment potential in mothers with histories of ACEs/CM themselves" (Khan & Renk, 2019, p. 18).

In conjunction, the authors acknowledge the limitations of formulating conclusions from self-report data and reiterate that their findings relate to mothers' descriptions of their children and their parenting behaviors. They recommend,

> … to further this work, self-report of perceived mother-young child attachment and parenting behaviors should be combined with "gold standard" observational measurements (e.g., the Strange Situation) in future studies. It is recommended that future studies prioritize utilization of validated and multi-method assessment while simultaneously creating a safe environment in which participants may openly discuss their ACEs and/or CM experiences and their parenting. (Khan & Renk, 2019, p. 25).

Blair, C., Crooker, R., Harvey, M., Jeffers-Woolf, J. Niezwaag, L. & Young, C. (2019). NEAR@Home for Home Visitors: Addressing ACEs in Home Visiting by Asking, Listening, and Accepting. *Perspectives in Infant Mental Health, 27*(3), 31.

This paper presents the professional process of developing the NEAR@Home for Home Visitors program. The program aims to share ACEs research with parents within the practice context of home visiting. See Box 1 for further details. The authors report,

> In 2013, home visiting professionals from the Pacific Northwest region of the United States gathered to address the question: How do we bring ACEs information to parents in a way that feels safe and supported? Systems leaders, home visitors, and tribal leadership from Alaska, Idaho, Oregon, and Washington worked together to develop what is now the NEAR@Home toolkit, a free downloadable guide for home visiting professionals to facilitate conversations around ACEs. (Blair et al., 2019, p. 31)

The practice setting for the tool kit is home visiting,

> Grounded in principles of social justice, infant mental health, and trauma-informed care, the NEAR@Home toolkit aims to support hope and resilience through five core elements of

Preparing, Asking, Listening, Affirming, and Remembering. NEAR combines the latest science from Neuroscience; Epigenetics; Adverse Childhood Experiences: and Resiliency. (Blair et al., 2019, p. 31)

Maharaj, S. (2019). ACEs and IMH: A selection of online resources. *Perspectives in Infant Mental Health, 27*(3), 27.

This brief useful paper provides a non-exhaustive list of free and open-access online resources for readers on the topic of ACEs and IMH. Maharaj (2019) acknowledges the rich array of open-source resources while also noting that, "there is a need for more resources that specifically link ACEs and IMH" (p. 27).

Infants' exposure to domestic violence

This section focuses on papers that directly address the issue of infants' exposure to domestic family violence (Osofsky, 1995 a, b). Domestic violence or intimate partner violence is defined by the United Nations as "a pattern of behavior in any relationship that is used to gain, or maintain, power and control over an intimate partner" (United Nations, 2022). Interdisciplinary research has repeatedly shown that infants and toddlers who witness violence either at home or in their community are burdened with ongoing challenges: in their physical, emotional, and cognitive development, their interpersonal relationships in educational settings, and their close family relationships (Lieberman et al., 2005; Hillis et al., 2016).

Schechter, D., & Rusconi Serpa, S. (2011). Applying clinically-relevant developmental neuroscience towards interventions that better target intergenerational transmission of violent trauma. *The Signal, 19*(3), 9-16.

This paper describes a body of work related to the association of parental post-traumatic stress, parental relational representations, and parental caregiving behavior (Schechter et al., 2005, 2006). Specifically, this paper reports on

Box 1. NEAR@Home for Home Visitors program resources.

For more information and to download the NEAR@Home toolkit: www.nearathome.org

For more information about the program: https://givingcompass.org/article/reducing-childhood-trauma-home-visiting/

Roberts, A., Wacker, A., Franko, M., Schaack, D., Molieri, A., Estrada, M., & Gann, H. (2019). *The region X home visiting workforce study: The health and well-being of the region X home visiting workforce* (Issue Brief No. 4). Denver, CO: Butler Institute for Families, Graduate School of Social Work, University of Denver. Retrieved from https://www.dcyf.wa.gov/sites/default/files/pdf/RegXWorkforceStudyBrief4.pdf

NEAR@Home: *Neuroscience, epigenetics, adverse childhood experiences, resilience: Addressing ACEs in home visiting by asking, listening, and accepting* (3rd ed.). Seattle, WA: Thrive Washington. Retrieved from https://www.nearathome.org

a) The New York Parent Child Interaction Project (NY-PCIP). The NY-PCIP was a National Institute of Mental Health-funded study (USA). The study sample included 77 mothers (aged 18 to 48) with children ages 12 to 48 months old. Full details of the study questions, sample and procedure can be found here: Applying clinically relevant developmental neuroscience towards interventions that better target intergenerational transmission of violent trauma - Perspectives (waimh.org)

b) The Geneva, Switzerland study; an adapted replicate study of the NY-PCIP, which at the time of writing was in process. Findings from the NY-PCIP study included:

Results of the NY-PCIP indicated an interplay between psychological, biological and neurological factors:

a) Psychological - how mothers reflect and think about their experiences of stress. For example, the study found that mothers assessed as suffering from interpersonal violence-exposed PTSD (IPV-PTSD) reported more experiences of parenting stress, were more stressed as shown by MRI scans, seeing video simulations of parent-child separations and also described their children in more negative terms.

b) Biological - how the mothers behaved in relation to their young children's emotional needs, for example, greater maternal PTSD severity was associated with less responsiveness to their young child's bids for joint attention, and disturbances in the parent-child attachment relationship (Schechter & Rusconi Serpa, 2011) and,

c) Neurological patterns that showed mothers with IPV-PTSD were neurologically activated into states of alarm when non-IPV-PTSD mothers were not activated. In turn, these neurological states of alarm negatively impacted the parents' capacity to engage in joint attention with their infant and or toddler.

Regarding the Geneva study, Schechter & Rusconi Serpa (2011), the paper focuses on providing clinical applications of The Clinician Assisted Videofeedback Exposure Session (CAVES) (Schechter et al., 2006).

> The Clinician Assisted Video feedback Exposure Session (CAVES), (Schechter, et al., 2006), was designed as an experimental paradigm both (a) to test our hypothesis that traumatized mothers often misread child distress and defensively avoid helpless states of mind and normative aggression that remind them of their experience of violence; (b) to support the ability of mothers with violence related PTSD to tolerate and integrate the negative, trauma-associate emotions stirred up by routine stresses such as separation and tantrums in stimulating and modelling mother's reflecting functioning. (Schechter & Rusconi Serpa, 2011, p. 12)

The paper provides detailed vignette case material to illustrate the use of CAVES. With the Geneva study in process at the time of publication, the authors conclude by saying,

> … we want to carry forward what we observe to be the connection of a very specific error in the reading of child distress: the mistaking of helplessness and fear for rage and willfulness. We think that this specific alexithymic error is particularly salient to IPV-PTSD as opposed to other forms of parental psychopathology that impact the parent-child relationship. (Schechter & Rusconi Serpa, 2011, p. 15)

Weatherston, D. J. (2019). Book Review: Supporting Vulnerable Babies and Young Children: Interventions for Working with Trauma, Mental Health, Illness, and Other Complex Challenges Wendy Bunston and Sarah J. Jones, Editors. *Perspectives in Infant Mental Health, 27*(3), 34.

Weatherston provides a review of the following edited book:

Bunston, W. & Jones, S. J. (Eds.) (2019). Supporting Vulnerable Babies and Young Children: Interventions for Working with Trauma, Mental Health, Illness and Other Complex Challenges. London, Jessica Kingsley Publishers.

The book, edited by Wendy Bunston and Sarah J. Jones (Australia), focuses on infants and very young children facing a range of illnesses, trauma, and exposure to adversity. Chapter contributors include Julie Stone, Jennifer McIntosh, Christine Hill (Australia), Hisako Watanabe (Japan), Ben Gray (UK), Robyn Hemmens (South Africa), Angelique Jenney and Natasha Whitfield (Canada). There is a specific chapter on infants and violence Keeping the Child in Mind when Thinking about Violence in Families by Angelique Jenney (Social Worker, Director of Family Violence Services for Child Development Institute, Toronto).

Bunston and Jones (2019) describe the intent of the book as follows,

> … [to] … make prominent the voice, experience and perspective of infants and young children who have endured considerable and complex vulnerabilities. This is through providing a range of expertise which brings together a disparate, contemporary and often underexamined areas of working with the world's youngest children. (p.17)

Weatherston (2019) states that,

> … The volume gives the reader a remarkable glimpse of the state of infants, young children and their families from around the world. Although the experiences described differ, the strategies offered by contributors are solidly focused on the social and emotional needs of very young children within the context of nurturing relationships for health and healing. This book is a must-read for each of us in the infant and early childhood mental health community as we struggle to reduce grave risks of disorders of infancy and support the well-being of all children in the face of conflict and crisis… In sum, the volume heralds an international focus on the importance of infancy as a significant period that is in reality, an urgent plea to policymakers, program developers and providers to respond with services that will hold babies and families in mind around the world. (p. 34)

Bunston, W. (2018). How Refuge provides 'refuge' to Infants: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing family violence. *Perspectives in Infant Mental Health, 26*(4), 1-4.

This paper by Wendy Bunston summarises her doctoral research on infants with their mothers in Refuge following family violence. Specifically, the study examined infants' experiences of refuge while in Refuge crisis accommodation with their mothers and examined what the Refuge provided for the infants.

> In 2014 I visited eight women's refuges in three countries; Australia, England and Scotland. I undertook collecting data from ten infants, interviewed ten mothers, and thirteen staff. I endeavoured to capture something of the subjective experience of the infant; first and foremost. This was done through using infant observation techniques I had been trained in as an infant mental health practitioner … (Bunston, 2018, p. 3)

Bunston (2018) summarises the key findings of her study as follows:

1. The infant is not understood to possess their own subjectivity and therefore is often lost from view within the Refuge setting.
2. The mother, not the Refuge, is expected to be the refuge for her infant.
3. Only when the infant is in obvious need do they receive specialist, 'outside' help.
4. It is too painful for the adults in Refuge to see or think about the subjectivity of the infant, or of the infant having their own traumatic memories.
5. The infant is the catalyst for mothers to seek Refuge and it is this relationship which provides the hope for the creation of a different future. (p. 4)

A sample of resources linked to this study and related publications are cited in Box 2.

In addition to the papers cited above, throughout The Signal and Perspectives, there are many references to infants and their exposure to domestic violence. Box 3 provides a sample of these papers.

Final reflections and future directions

The papers above highlight the need to adopt an intergenerational and trauma-informed lens when working with families amidst and or recovering from domestic violence. This approach entails including the infants and young children who have been exposed to domestic violence, as active participants in all assessment and healing work with families amidst and recovering from domestic violence.

As clinicians and researchers, we continue to find ways to be present, compassionate, and proactive in listening to the infant within their family at a time of great suffering and trauma. However, amidst the growth and development of neuroscience and clinical understandings, for example, joining and forming a therapeutic alliance with families in the grip of domestic violence, remains a professional challenge. Reflective supervision, and group and peer supervision are essential practice cornerstones of best practice with families amidst domestic violence.

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Bunston, W. (2018). How Refuge provides 'refuge' to Infants: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing family violence. *Perspectives in Infant Mental Health, 26*(4), 1-4.

Bunston, W., & Jones, S. J. (Eds.) (2019). *Supporting vulnerable babies and young children: Interventions for working with trauma, mental health, illness and other complex challenges*. Jessica Kingsley Publishers.

Box 2. Further resources by Wendy Bunston and colleagues on infants' needs following exposure to family violence.

Bunston, W. (2016). *How Refuge provides 'refuge' to Infants: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing family violence.* PhD Thesis, La Trobe University. Melbourne. Retrieved from http://hdl.handle.net/1959.9/559171

Bunston, W. (2017). *Helping babies and children (0-6) to heal after family violence: A practical guide to infant and child-led practice*. London, Jessica Kingsley Publishers.

Bunston, W., Franich-Ray, C., & Tatlow, S. (2017). A diagnosis of denial: How mental health classification systems have struggled to recognise family violence as a serious risk factor in the development of mental health issues for infants, children, adolescents and adults. *Brain Sciences, 7*(133). doi:10.3390/brainsci7100133

This is a link to an online resource created by Wendy Bunston and Robyn Sketchley, offering online teaching modules, for refuge staff working alongside parents and very young children. The link is here: Refuge for babies in crisis

Box 3. A selection of papers from The Signal and Perspectives on infants' exposure to domestic violence.

Antony, G., Bengough, T., Marbler, C., & Sagerschnig, S. (2021). The Austrian Early Childhood Intervention programme: Support for families with young children in burdened life circumstances to improve relational health and well-being. *Perspectives in Infant Mental Health, 29*(1), 16 – 21. The Austrian Early Childhood Intervention Programme: Support for families with young children in burdened life circumstances to improve relational health and well-being (A brief overview) - Perspectives (waimh.org)

Berg, A. (2017). Protecting infants from violence – Law and Reality in South Africa. *Perspectives in Infant Mental Health, 25*(1), 4 -7. "Protecting Infants from Violence – Law and Reality in South Africa" - Perspectives (waimh.org)

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Adoption and foster care

By Patricia O'Rourke (Australia)

Introduction

In 1945 Renee Spitz brought to light the devastating effects of institutionalised care on young children (Spitz, 1945). However, globally there are still approximately 8 million children in institutions (Bucharest Early Intervention Project, n.d.). The extensive long-term work of the Bucharest Early Intervention Project, with its ongoing 21-year longitudinal study, has further deepened and informed our understanding of and response to the needs of adopted and fostered children (ibid). Research suggests that family-based care alternatives best serve infants and young children (Steele et.al., 2012).

The increasing lack of equity and growing poverty in our communities means that the number of infants and toddlers needing out-of-home care continues to grow and our systems of care struggle to cope (Trimble & Kim, 2019).

In addition, the vulnerability of babies removed from their biological families due to abuse and neglect is better understood. Neglect is a common feature of institutionalisation and constitutes approximately 78% of child abuse cases in the US – far more than all other types of abuse combined (National Scientific Council on the Developing Child, 2012).

This selection of papers from The Signal and WAIMH Perspectives in Infant Mental Health illustrates the significant advances made in understanding the multiple and extensive needs of adopted and fostered children. They highlight some important shifts in thinking around these children, their families - biological, adoptive and foster - and the necessary systems of care required to address the multiple needs of everyone in the system.

Booth, P. (2000). Forming an attachment with an adopted toddler using the Theraplay approach. *The Signal, 8*(3), 2-9.

This article summarises Theraplay – an attachment-based intervention designed to assist parents in building relationships with their children through attachment-based play. The author names four areas of focus: providing structure, engaging effectively, nurturance and challenge. Each focus has multiple playful activities designed to teach parents to respond to the needs of their children in a sensitive and responsive way.

An in-depth case study of the assessment and treatment of the international adoption of 17-month-old Luis from institutionalised care describes him and his challenges in his new family and highlights the relational and developmental challenges commonly experienced in international adoption: miscuing and the inevitable relational estrangement that ensues; the level of dysregulation and inability to use the relationship that results from inadequate early care; and the gradual work to help parents see their actual infant rather than their longed-for imagined child. The work described is engaging, thorough and relevant.

Federici, R.S. (2000). Raising the post-institutionalised child: Risks, challenges and innovative treatment. *The Signal, 8*(4), 1-7.

Federici outlines how domestic adoption possibilities in Western countries had become more limited with lengthy waiting lists. At the same time, information about children's suffering in orphanages particularly in Romania and other Eastern Bloc countries was widespread. Increasingly South American countries as well as Southeast Asian countries like China and Vietnam were seen as viable options. Many parents saw international adoption as their way to have their 'desired child' and between 1992 and 1999 there had been a 250% increase in international adoptions in the US alone.

This article raises the multiple challenges for many children in institutionalised care: pre and postnatal factors, genetic risks, poor medical and nutritional care and most importantly the lack of any attachment figure to mediate these risks. Federici emphasises the need to address relational concerns immediately and writes sensitively about the child's impoverished experience and adaptive responses to this, as well as adoptive parents' frustration, anger and resentment as their attempts to parent these children are thwarted. He highlights assessment and treatment issues, particularly targeting older children, and, while warning of the multiple difficulties, continues to encourage hopefulness and possibility.

Vamos, J. (2009). Nes sous X but not 'abandoned': A preventative and therapeutic framework for care in a maternity hospital. *The Signal, 17*(1-2), 6-11.

Vamos presents her team's Les Bluets' program - an approach informed by principles of the Pikler Institute and psychoanalysis. This program in a French maternity hospital is with neonates who have been left for adoption and their mothers. Their model facilitates 'the newborn's self-organisation and openness to

significant interpersonal exchanges' (p. 10) while containing both the mothers' and staff's overwhelming feelings of distress and guilt that accompany such abandonment.

In two tenderly drawn vignettes, Vamos writes of the pain of the mothers, the disturbance of their babies and the overall distress of the staff involved in planned adoptions. These are not situations where the pros and cons of abandonment and adoption are discussed nor the mothers' decisions and reasons for this. Rather, where this situation exists, the need for staff to witness, support and provide containment for both newborn and mother is highlighted. The requirement for a 'solid professional framework' which can contain the intensity of reactions that each unique situation of abandonment arouses in everyone concerned is emphasised.

A third vignette, while in no way diminishing the pain involved, illustrates the more positive process and outcome for the baby, the mother, and the staff involved using the model they have developed. Here the staff attempt to engage the infant in a process of being adopted rather than waiting in a void to be claimed. Vamos outlines various strategies the staff are engaged in. They accompany the mother through her pregnancy, birth and the two months post birth when legally she can still change her decision, and provide her with an active role postnatally. They get to know each unique baby providing continuity of care over nursing handovers, providing each infant with a designated main caregiver and reducing the number of caregivers as much as possible. They aim to provide 'a privileged and respectful space' facilitating the infant to develop a 'vital and competent sense of self' (p.9) and how this process can have an organising effect on the mother helping her 'repair the abandoning part of herself'.

Rochat, T. and Richter, L. (2010). International Adoption: Benefits, risks and vulnerabilities. *The Signal, 18*(3-4), 19-24.

These authors explore the multiple issues raised by international adoption. They highlight the increasing trend in the US of adopting children from overseas and explore contributing factors. The result is an increased demand for babies in the US but fewer babies available for adoption. They suggest this increased demand is less a result of altruism and more an 'attractive option for infertile couples in Western societies' seeking healthy babies who are 'voluntarily relinquished' (p.19).

The authors note that commercially driven agencies serve the interests of couples who can afford to pay for infants from overseas where they have more choice and enjoy shorter waiting times. Moreover, increasing poverty in 'sending' countries means more infants are abandoned or relinquished by desperate birth families. Rochat and Richter (2010) report growing concerns about social justice and inequity. Closed adoption processes or financial barriers can result in a lack of opportunity for adopted children to learn about their birth culture. Market economies and high demand make it difficult to protect the interests of the child and may pose an increased risk of baby trafficking.

The challenges for international adoptees are similar to those outlined by Federici (above): These children often experience difficulties with the initial transition and adjustment and they have increased risk around medical, developmental and relational factors. They can experience confusion around identity and relating to their culture and identity.

The Hague Convention champions the right of children to be raised by birth parents in their birth country unless compelling circumstances direct an alternative. The authors challenge the process of international adoption on a number of counts. They acknowledge that international adoption may change the life trajectory of individual children, but at a macro level, international adoption may impede the development of family preservation and the system of domestic adoption in sending countries. It may exploit poorer countries at the expense of 'providing for the parenting and family building needs of western society' (p.22).

Zanon, O., Ius, M. and Milani, P. (2016). An Immigrant family's story: A shared care plan for early childhood development: A partnership experience between families, early childhood service, social health services. *Perspectives in Infant Mental Health, 24*(4), 5-10.

This paper outlines the implementation of the national Program for the Intervention and Prevention on Institutionalisation (P.I.P.I.) in Italy and how this partnership model provides a web interface that supports systemic cohesion, team building across various social services enabling joint planning, intervention and ongoing evaluative feedback and data collection.

The authors describe thinking and perspective-taking from the child and family's perspective at all points of intervention. Based on the theoretical concepts of Bronfenbrenner, the framework is an attempt to provide a relational service to neglected children and their families by providing collaborative ways of working between multiple service systems involved. This ecological, relational perspective places the child at the centre of all considerations taking not only the protection of the child into account but their 'whole world' and capturing the 'the hundred languages of children' (p.5).

Early childhood services are promoted as a 'fundamental crossroads' for a variety of services that can over time work preventatively and therapeutically with the family from the base of the 'intimacy and sharing' that has been established with the family as it leaves the very young baby in their care. Relationships with educators within early childhood education are described as every day, longstanding, non-stigmatising and 'light' attachments that can offer interventions at different levels sensitive to a child's and their family's needs at specific times.

A poignant case study outlines how the above processes worked for an isolated immigrant young mother living alone with her baby in a basement. She was encouraged with practical support to accept services that helped her find a home and gradually trust different service interventions that empowered her in her parental role and helped repair her child's early developmental delays and their relational experience.

Berg, A. (2017). Protecting Infants from Violence – Law and Reality in South Africa. *Perspectives in Infant Mental Health, 25*(1), 4-7.

Berg calls for those involved in the care and protection of young children to have a wider and deeper understanding of the importance of early relational health and its impact on a child's ongoing development. Defining violence in South Africa as multi-layered, embedded in poverty

and inequity and systemically rooted in its colonial and apartheid history, it impacts the society's capacity to protect its most vulnerable population – infants and young children.

Berg presents several profound dilemmas and conflicts that confound lawmakers, child welfare and infant mental health workers in South Africa. She names the requirement for cross-sector coordination as the 'great challenge and potential strength' of the First Thousand Days campaign running at the time in the Western Cape Province while acknowledging a scarcity of money and human resources in the South African welfare system. She highlights the challenge of identifying emotional abuse which can be harder to detect than other forms of abuse but which is often a slow-burn developmental disaster for infants suffering it.

Clarifying the state's obligations to children, she points out that the two most basic rights of infants 'namely the right to protection' and 'the right to family care' (p.5), frequently collide. This results in different services like welfare and mental health being at odds over the child's 'best interests'. Berg reflects that at times, the South African state's motivation to maintain a child in their biological family could be viewed within their complex apartheid history as a 'reaction formation' against previous institutionalised systemic racism and abuses.

The clinical example of the long fight over parental rights by foster versus biological mothers and at the systems level of health versus child welfare illustrates the complexities involved.

It is the familiar story of attempted reunification without adequate recognition and understanding by the workers concerned about the crucial nature of attachment ties and the need to prioritise the developmental timeframe of the child. A 30-month-old toddler presents to a health service with behavioural difficulties. She had been removed from her biological mother's care at two weeks and that mother is now attempting to be more in her life. The lack of understanding of the meaning underneath the infant's behaviour by welfare and legal teams leads to resolution only after the child attempted suicide at age ten.

Berg concludes by emphasising the WAIMH (2014) position paper on the rights of the child – in particular, the second basic principle which includes that

> *The infant has the right to have his/her most important primary caregiver relationships recognised and understood, with the continuity of attachment valued and protected.* (p. 6)

Palmer, A.R., Dahl, C., Eckerle, J.K., Spencer, M.J. Gustafson, K. and Kroupina, M. (2021). A case study of the early childhood mental health therapeutic consultation protocol within a specialty multidisciplinary paediatric clinic for adopted and foster care children. *Perspectives In Infant Mental Health, 29*(2), 18-24.

This report describes how integrated service provision can address the physical, cognitive social and emotional needs of infants and toddlers in foster care and reduce the risk of long-term health and mental health effects of their early adversity. The authors outline the numerous prenatal and postnatal vulnerabilities and risk factors that young children in out-of-home care may suffer, then strongly advocate for an early childhood mental health assessment plus a multidisciplinary medical assessment in a paediatric setting.

They raise this dilemma: physicians are underprepared to address the mental health and relational needs of early adversity in young children and mental health clinicians cannot identify and treat the many medical conditions arising from these early adverse experiences. They make the important point that early trauma and relational trauma often result in a profile of symptoms common to that found in autism spectrum disorders. They highlight the critical need for clinicians to be able to recognise the different diagnoses and treatment required, and that misdiagnosis can further disturb a child's development.

The Adoption Medicine Clinic's standardised protocol developed at the University of Minnesota incorporates early mental health and relationship-based assessments into the care provided at their paediatric clinic. The protocol has three parts:

1. Identification of pre and postnatal experiences of adversity and the age and duration of these events, the child's developmental framework and the results from other standardised trauma screening tools.
2. Interviews with foster parents, clinical observation and medical review of the child's current developmental and relational presentation are conducted. A medical and occupational therapy assessment with the child and caregiver is observed by a mental health specialist to clarify the child's capacity to use their caregiver and the caregiver's responses. After consultation with the caregiver about their concerns about the child and their ability to parent that child, decisions are made regarding ongoing placement.
3. There is an evaluation of the child and the foster/adoptive parents' needs and the adequacy of current service provision. Recommendations for appropriate evidence-based interventions and a brief therapeutic educational consultation are conducted with the foster/adoptive parents to enable them to better understand and read their child's signals and cues. There is also the capacity for further intensive treatment for children identified as particularly high-risk.

The case study of Anna demonstrates how this interdisciplinary collaborative protocol works and how Anna's case in particular demonstrates the value of integrating services to address the complexity of need and how this can prevent further cascading risk of placement breakdown.

The authors conclude by suggesting future areas of evaluation and research, emphasising the need to replicate their 'cross-systems integrated care model' and expressing their belief that the use of their protocol will decrease the negative impact of early adversity suffered by fostered and adoptive children over their lifespan.

Conclusion

Young children are the most vulnerable to abuse and neglect and are the largest group in out-of-home care in the US and other countries (Chambers et. al., 2010). The maltreatment that brings them into care is then exacerbated by their early separation from their biological family (Smyke & Bridenstein, 2019). Our understanding of the level

and extent of the ramifications of early childhood maltreatment continues to deepen as we understand the physiological effects of prenatal and postnatal exposure combined with the ongoing psychological and relational consequences. The lifelong cascading effects this harm can cause on an individual's health and well-being is alarming. Out-of-home care therefore needs to provide more than a safe home. It requires systemic responses as outlined in a number of the above articles to the multiple needs arising from the effects of early abuse and neglect.

These articles highlight the many challenges for all involved: birthparents relinquishing their babies, adoptive/foster parents facing issues of grief and loss while trying to connect with and claim a young child that may not remain in their family, plus the distress and disturbance the child may manifest as a result of their original maltreatment that necessitated their removal from family coupled with possible problems arising in institutionalised care and/or multiple placements. For kinship carers like grandparents, aunts and uncles, there are often intense loyalty issues arising from the shift in familial roles and responsibilities.

The articles summarised here illustrate some of the issues identified and systemic shifts in response to children in out-of-home care over the past twenty years. The increased need to maintain a child's identity and cultural connection is now well-known and accepted (see the paper on *cultural representations in infant mental health*, in this supplement). While millions of children globally still grow up in institutionalised care (Goldman et al., 2020), the imperative for family-based care or family-based alternatives is also now widely recognised. The documented over-representation of indigenous and non-white children in the out-of-home care systems of many Western countries attests to the systemic transmission of intergenerational trauma and the legacy of institutionalised oppression and brutality as a result of colonisation (Smyke & Bridenstein, 2019; Fiolet et.al., 2023).

Similarly, the need for integrated systems of assessment and care, early in a young child's experience of out-of-home care is highlighted in the models showcased above. Whenever the multiple systems around the fostered child are making decisions for these children, Smyke and Bridenstein (2019) highlight the need for these decision-makers to always ask the critical question 'whose needs are being met here?' (p.553).

Other possible questions we as clinicians may reflect on are:

1. How does the above information affect how I assess and evaluate the needs of this foster child and their family?
2. How many levels of intervention may be required to meet my young client's needs?
3. What is the emotional and social functioning age of my young client and how can I respond to that?
4. What more do I need to know to ensure a wholistic and systemic response to my young client and their family/families?
5. Have the infant or young child's needs been heard and seen and remained central to all decision-making?

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Premature babies, premature parenthood

By Miri Keren (Israel)

Introduction

When delivery happens prematurely, not only the infant is premature but also his/her parents enter parenthood suddenly, unexpectedly earlier than planned. This may lead to increased parental vulnerability resulting in maladaptive patterns of early parent-infant relationships (Minde, 1993). Sroufe showed the potential perturbation of the emerging attachment relationship (Sroufe, 1989). The early mother-child relationship includes both actions and representations (Stern et al., 1998). The mother's representation of her infant and her behavior style are not independent factors but are interrelated. For example, maternal perception affects the mother's interactive behavior and repeated maternal behavior creates a representation of the infant and the mothering process (Nover et al., 1984).

In this context, Stern and colleagues (1998) conceptualize the birth of a premature infant as a potentially traumatic event. Premature birth derails the parent's ability to imagine the infant's future, makes the recent past of the pregnancy with its fantasies too painful to remember, and captures the parent in the frightening and deceiving present. Still, early studies have shown that when sensitive and secure enough mothers give birth prematurely, they become anxious and inconsistent rather than unavailable and rejecting, and their infants show anxious-resistant type of attachment, rather than avoidant or disorganized ones (Plunkett et al., 1986).

Despite the increased number of premature babies, especially twins (consequent to the high frequency of IVFs) as a result of more advanced medical treatments and higher survival rates of extremely small birthweight premature babies, recent papers about this topic have not been published in The Signal/Perspectives. Only two papers about prematurity have been published in The Signal, one in 1997 and the other in 2002.

A developmental approach for premature children, 1997, *The Signal. 5*(1): 7-13, by Vincenzo Montrasio (Italy).

Montrasio describes the emotional development of premature infants in the context of mother-premature infant relationships. He quotes Minde's findings (1993) that sensitive mothers of premies hold and stimulate their infants more frequently during face-to-face interactions than do mothers of full term infants. This suggests that such commitment to respond leads parents to compensate intuitively and unconsciously to their babie. Montrasio argues that on one hand, severe prematurity make bonding and parenting difficult, and on the other hand, the medium-term outcome of these babies can also be influenced by the mothers' specific responses to their premature babies. He also points out an interesting aspect of giving birth prematurely about the mothers' system of fantasies and representations around their future babies. This system develops rapidly between the fourth and seventh month of pregnancy, and then the fantasies become increasingly vague, so that the gap between the imagined baby and the real one will not be too wide (Ammanniti, 1989). Hence, premature delivery also means that the baby was born prior to the natural "loosening up" or flexibility of the maternal fantasies.

The context of the NICU may be especially difficult for parents as they feel helpless in front of their tiny babies who are lying in an incubator and tied to many tubes. Anxiety, guilt, and grief are experienced by nearly all parents of very small premature babies during a long period of several weeks, sometimes up to 3 months. Hence, the development of a healthy maternal preoccupation is often jeopardized by introducing elements of confusion and disorientation. This may explain why even securely attached mothers are at risk of maladaptive responses to premature birth, especially those for whom the stressful experience brings to the surface past traumatic experiences.

Montrasio ends his paper with a case vignette and implications for therapeutic intervention at the NICU. He concludes with pointing out the need to better study the potentially buffering role of fathers, proposing that the father-child relationship may be an important factor in encouraging the young child to explore outside the family context, thus developing greater social skills and resilience (Yogman et al., 1995).

Intervention programs for premature infants: considering potential mechanisms for change, 2002, *The Signal. 10* (3&4): 1-11, by Ruth Feldman (Israel).

In her paper, Feldman raises the puzzling fact that studies on both increasing (Field, 1995) and reducing (Als et al., 1994) sensory input in the NICUs report improved outcomes in physiologic measurements, neonatal

behavioral scores and long-term measurement of cognitive functions. Her review of the existing studies leads to several propositions about the mechanisms by which intervention programs impact premature babies' state of organization and self-regulation.

Based on two longitudinal studies she and her colleagues carried out through the NICU, Feldman emphasized Kangaroo care, defined as continuous maternal and paternal skin-to-skin contact. Kangaroo care impacted positively on the outcomes for premature babies regarding the integration of the self-regulatory and stimulation approaches, together with the impact on the developing parent-baby relationship.

On the physiological level, Kangaroo care provided a balance between vestibular and proprioceptive stimulation through the mother or father's movement, while buffering the impact of overwhelming auditory and visual stimulation in the NICU. In parallel, it provided continuous and intense parent-baby physical proximity that promoted in both parents feelings of competency and emotional investment. This offered some reparation for the disrupted bonding process. The Kangaroo care program emphasized the active role of parents in caring for their premature babies. In light of these studies, Kangaroo care has been implemented as standard care for premature babies in many NICUs around the world.

Reflections and future directions

The past and the more recent research data on outcomes of premature babies lead to the same conclusion: for some parents, but not all, the traumatic experience of a premature delivery and stay at the NICU has a long-term detrimental impact on the parent-child early relationship. This fact requires clinicians in Infant Mental Health (IMH) who work in pediatric hospitals to detect as early as possible those families at risk of developing negative attributions towards the infant that in turn may lead to a maladaptive parent-child relationship.

To support this practice, a Clinical Interview for High-risk Parents of Premature Infants (CLIP) was developed (Meyer et al., 1993). The CLIP is a semi-structured interview that explores mothers' experiences of the pregnancy, delivery, and hospitalization period, as well as their thoughts and feelings about the infant, and impending discharge. We used it in the context of my work at the Schneider Hospital for Children NICU, to examine its predictive value of early disruptions in the mother-infant relationship being cared for in the NICU (Keren et al., 2003). The relations between mothers' narrative regarding the infant and the premature birth and the quality of mother-infant interaction were examined in mothers of 47 very low birth weight (<1650 gr) premature singletons, prior to discharge. Keren and colleagues (2003), assessed maternal representations (Meyer et al., 1993), using the CLIP.

Ten minutes of mother-infant interaction was videotaped, and global and micro-analytic codes were used to define three interactive variables: maternal adaptation, maternal touch, and infant withdrawal. Factor analysis of the CLIP items identified two factors with eigenvalues of 2.00 and above, termed Readiness for Motherhood and Maternal Rejection. Maternal adaptation to the infant's signal and maternal positive touch were each uniquely predicted by the mother's readiness for the maternal role, and were each negatively related to maternal depression. The infant's interactive withdrawal was independently predicted by maternal rejection. Our study showed that the CLIP interview may be a useful routine tool, both as a wrapping-up tool of traumatic experiences related to prematurity and in detecting those mothers in need of psychological support close to discharge home (and possibly after).

Future studies need to replicate these results, providing further support to the coding scheme, and address the link between maternal representations as depicted by the CLIP interview at the NICU close to discharge and later aspects of the mother-infant relationship and the child's social-emotional growth may be examined. Of additional importance, the use of the CLIP with fathers may be fruitful, too.

I invite our readers to reflect on studies that bridge intrapsychic processes, such as the emergence of the motherhood constellation, and observable phenomena, such as mother-infant interactive behaviors, as they are especially relevant to the field of high-risk infants cognitive, social and emotional development.

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Infant mental health and parental drug addiction

By Maree A Foley (Switzerland)

This chapter draws on a selection of papers from *The Signal* and *Perspectives* that have addressed the issue of parental drug and or alcohol addiction and the impact of this on infants. These infants can begin life with complex health needs and are often cared for across a myriad of care systems that include parental, intergenerational, and/or foster care. Parents suffering from drug and or alcohol addiction, often present with clusters of historical and institutional trauma, that can include childhood trauma, being in out-of-home care as infants, children and or adolescents, and/or current home insecurity.

Mental health issues weave with trauma, family violence, drug and alcohol issues, and sometimes homelessness, with periods of intergenerational imprisonment. Furthermore, parental substance use is also over-represented in populations who have endured intergenerational institutional racism and poverty.

The papers cited below highlight, an infant mental health lens on parental addiction. They collectively headline the intergenerational needs of the infant and their parents as well as the quality and experiences of the infant-parent relationships, within the current generation, and across generations.

Lester, B., Freier, K., Boukydis, Z., Affleck, P., & Boris, N. (1997). Cocaine abuse and preserving infant-mother relationships: Barriers and solutions in the USA. *The Signal, 5*(1), 1-6.

The paper begins with reporting data from 1990 when women, in the USA, who were addicted to cocaine, gave birth to an estimated 300,000 infants. The authors highlight the treatment challenges where the criminality of drug use intersects with a mental health lens. They advocated that drug abuse be viewed as an illness with the development of treatment programs that are tailored to the mother and her infant/s.

The paper highlights the complex system within which drug use occurs while not shying away from the high-risk environment and health needs that parental drug use creates for infants. For example, in 1990, in the USA, the average cost of hospital care for cocaine-exposed infants was $13,222 compared with $1,297 for unexposed infants.

Balancing the health needs of mothers and their infants, the authors challenge the punitive legal and statutory response that often legislates for mandatory parent and infant separation. In turn, infants are placed in over-stretched and under-resourced foster care systems. Advocating for federal funding for treatment and prevention programs was described as an uphill battle given the federal focus on spending for law enforcement in contrast to treatment.

Additional barriers were identified as traditional treatment models being designed for men, with alcohol addiction, and not designed for drug-addicted women, pregnant women, and new mothers. While treatment programs were available to drug-addicted mothers, the programs were scarce, with long waiting lists, and stretched support social services for the mother and her children while she is in treatment.

The authors proposed a series of solutions that included the development of a multidisciplinary infrastructure that creates an attitudinal and institutional change from viewing cocaine use with a criminal lens to viewing it with a public mental health lens. In practice, this would involve removing the obstacles to treatment such as transportation and childcare issues.

Regarding treatment, they cite Black et al. (1994) whereby, "pregnancy offers a window of opportunity to engage the mother in drug treatment, especially since the mother's wish to be a good parent to her child may increase the mother's motivation to change" (Lester et al., 1997, p. 5). They also highlight amidst several nested social and medical support systems for the mother and her family, that "programs must teach mothers and other caregivers how to interact appropriately with the drug-exposed infant so that the child may overcome any developmental vulnerability resulting from drug exposure" (Lester et al., 1997, p. 5).

Fitzgerald, H. (2003). Pathways to addiction and antisocial behavior. *The Signal, 11*(3), 5.

This paper reports on a longitudinal study of family risk for alcoholism conducted at the University of Michigan (USA), by Fitzgerald and colleagues. The study aimed to identify causal pathways, that have their origins in the preschool period, and lead to alcohol abuse/addiction.

In the study, participants who showed sustained antisocial behavior over time were classified as antisocial alcoholics (AALS). This cluster of participants was also more likely to have shown antisocial behavior in

childhood while growing up in risky-rearing environments characterized by parental aggression, violence, parent-child aggression and child-to-parent aggression. Drawing on the metaphor of ghosts in the nursery (Fraiberg et al., 1975), the research team proposed that early risky rearing environments created the context for constructing representational memories that were likely to be re-enacted in the next generation. At the time of publishing this report, Fitzgerald (2003) stated that,

> Our work to date suggests that a developmental pathway to alcohol use disorders, may emerge from environments where intense, uninhibited, distractable negative affect children are over stimulated by the open expression of negative emotions in the family, and as a result construct working models of "appropriate" adult role behavior that are contextually embedded in high risk environments. (p. 15)

O'Rourke, P. (2020). Working therapeutically with infants in the child protection system: Reflections by Dr Patricia O'Rourke. *Perspectives in Infant Mental Health, 28*(2), 7-13.

Patricia O'Rourke's paper, "Working therapeutically with infants in the child protection system: Reflections", provides readers with a window into the practice space as narrated by the psychotherapist, in The Infant Therapeutic Reunification Service (ITRS), a now disestablished service in Adelaide, South Australia.

The focal practice space is the parent-infant/family relationships, family violence, parental addiction and child protection services and systems. The paper is written as a personal reflection on professional relationships with families in an infant-parent unification service. The paper is raw and honest in its practice narrative of the lived experiences of providing at best the conditions for an experience of a secure base from which each family can begin to explore, heal, and rewrite new generational care systems and patterns.

In describing the clients of this service O'Rourke states:

> We know that there is no such thing as a baby – only a baby and someone (Winnicott, 1960). Yet the babies we work with have had no one. Very often their parents, as babies, had no one. There has been no mind to contain and hold them and help them make sense of their experience. This is an unavoidable fact about babies who enter and re-enter the child protection system – they all suffer this.
>
> Another unavoidable fact is that working therapeutically with these babies and their broken parents is very disturbing for everyone involved. The baby's vulnerability, the parent's current distress and history of chronic trauma, disturbs those of us who are highly trained, experienced workers, and disturbs the child protection and non-government agency workers, who are usually less experienced, often overwhelmed, and under-resourced. (p. 9)

The paper presents two vignettes that highlight the features of:

a) the parent-infant assessment process;

b) of working therapeutically with the family care system; and

c) working with the professional care team which includes drug and alcohol services and an array of related services, such as child protection services, early childhood education, and housing workers.

A central message within the paper is that of supervision. O'Rourke states,

> Increasingly, reflective supervision is understood as a necessary requirement that can mean success or failure in any therapeutic endeavour involving infants. Reflective supervision enables a therapist to 'tolerate the intolerable' by mentalising with them, their relational experience with their clients. However, the importance of providing a contained reflective space for a care team to express and reflect together on the dynamics affecting the system, the family, and the workers' responses, is equally critical. (p. 12)

Sorsa, M. (2021). Contemplating Help-Seeking in Perinatal Psychological Distress: A review. *Perspectives in Infant Mental Health, 29*(2), 25-27.

This paper reports on findings from a study conducted by Sorsa, Kylmä, and Bondas (2021) that examined existing state-of-art literature regarding mothering and help-seeking when experiencing perinatal psychological distress (PPD). PPD is "… an umbrella term for depression, distress and anxiety, during the time of pregnancy and the 1st year in a child's life" (Sorsa, 2021, p. 25). Depression, stress or anxiety are experienced by 21% - 27% of the mothers (Obrochta et al., 2020). This paper explores distress from a phenomenological perspective and highlights the experiences of mothers with PPD alongside their help-seeking responses to these experiences. Sorsa et al. (2021) identify the multidimensional construct of "contemplating help-seeking" as an often unrecognized phenomenon of experiences that function as a precursor to help-seeking and that represents a therapeutic window in which to meet women and their young children.

This paper highlights similar issues raised above by Lester et al. (1997). That is, the ongoing challenge to not only provide services but also provide the infrastructure to optimise a young family's capacity to access and make use of the services. Sorsa (2021) states,

> New families with perinatal psychological distress may not recognize themselves being at risk, or being in need of help… Therefore the early help-seeking phase is utterly important and brings a development need to outreach, early, preventive

> and even health promotion pursuit and strategies… Yet, scientifically sound services with a family-centred and infant-centred approach may not have the outreach tools that these families could utilise. The suggestion is to develop earlier service forms, which may include wider ecosystems of care, mental health literacy and cultural questions (p. 26).

Sorsa (2021) concludes with a series of reflective questions, aimed at practitioners who meet and provide health services to women with PPD. For example,

1. How are women approached by professionals within health and social care services and programs?
2. What are the attitudes of staff, and how would they become aware of those? How do service providers engage with families?
3. What are the professionals' sensitivity skills?
4. How would such skills become the capacity of a wider health and social care service workforce? (p. 27)

Antony, G., Bengough, T., Marbler, C., & Sagerschnig, S. (2021). The Austrian Early Childhood Intervention Programme: Support for families with young children in burdened life circumstances to improve relational health and well-being (A brief overview). *Perspectives in Infant Mental Health, 29*(1), 16-21.

Similar to Sorsa (2021), this paper by Antony et al. (2021) describes The Austrian Early Childhood Intervention Programme (Frühe Hilfen) with a particular program focus on the network of relationships that encapsulate the infrastructure of intervention and healing. This program "includes regional Early Childhood Intervention Networks, that reach out to families in need and support them in creating healthy environments for their children. With this objective in mind, mental, social and health resources, and the needs of all family members, are addressed by the outreach programme" (Antony et al., 2021, p. 16).

The focal target group for the Frühe Hilfen are "parents (to be)/families with multiple burdens such as poverty, job loss, illness etc. and a lack of resources. The focus is on the period from pregnancy up to a child's third birthday" (Antony et al., 2021, p. 17). Burdens are described in both social and psychological strain and include financial stress, housing insecurity, mental illness, and addiction of the parent/s. Within this program, families are met by a network of coordinated people and services that include, "A multi-professional team for continuous and comprehensive family support…. At least one person with the task of network management… A variety of regional and local service providers and professionals also function as gatekeepers for families" (Antony et al., 2021, p. 17). Home visits and referrals to community resources are central to the success of the program.

Success for the families has been documented (Marbler et al., 2020; Weigl & Marbler, 2020). 5.000 children under 3 years of age, with their families, had been supported by the program. Antony et al. (2021) summarise the findings as follows:

> The psychosocial health of mothers has improved in nearly 30 per cent of families and that 50 per cent of mothers with symptoms of postpartum depression have improved their mental health until the end of their family support. Further positive results can be seen for the social and financial situation of families, the living situation, the communication in families, the fear of the future, the overstraining and signs of acute violence … Also, the interaction with the child has improved in many families … (p. 19-20)

Finally, based on program data from 2014 to 2020, a central feature of the success of Frühe Hilfen has been the combined sustained uptake and use by the families with the low-threshold approach to participation.

Reflections and reflective questions

Parental substance abuse and addiction have adverse effects on their infants, themselves, and their relationships, including the infant-parent relationship. Current biopsychosocial evidence continues to emerge regards substance abuse and addiction in the pre and antenatal periods (Cataldo et al., 2019; Jussila et al., 2020). In conjunction, this unique period in the family is well-recognised as a potential window for change and healing. Fraiberg et al. (1975) remind us that "… the largest number of men and women who have known suffering find renewal and the healing of childhood pain in the experience of bringing a child into the world … the parent says, I want something better for my child than I had" (p. 389).

As such, infant mental health practitioners are often situated close by the family, aware of the sensitive window for intergenerational growth and change. Furthermore, the relationship between a parent and their young child may also include other significant others to the parent and the young child. For example, parental substance use, infants in foster care and or extended family care, often go hand-in-hand (Baldock, 2007).

In addition, healing work in this field is met with a multifaceted web of challenges. These challenges include parental shame, social stigma, fear of legal consequences, as well as parental expectations of not being able to be helped, or not being worthy of seeking help in the first case. As infant mental health practitioners, our role is often focused on the emerging new parent-child relationship; we are typically not directly involved with addiction and substance use treatment. However, the parent is often in a tussle between their new developmental role as a parent to an infant, which includes learning to be responsive to their baby's cues in a timeframe suited to the baby, while also grappling with their own recovery needs, which can include feeling significantly dysregulated by the immediate needs of their baby. As such, experiences of joint attention and mutual regulation are often disrupted (Schechter et al., 2010; Tronick & Gianino, 1986).

Practitioners also come face-to-face with professional doubts about their capacity to help, and they can also be met with their own prejudices and judgements. Practitioners continue to seek practice narratives about the experiences of infant mental health professionals and the wider workforce,

that offer collegial wisdom and support regarding how to be present with families and their infants who are all suffering the effects of substance use and addiction. Such examples of practitioner narratives include Schafer (2017), Hardy (2017), and Trout (2017).

Reflective questions

To this end, the reflective questions here are oriented towards sharing practice wisdom and expertise:

1. How does the practice of infant mental health in the community navigate the complex interplay between the developmental needs of the infant and the recovery needs of their parents, while protecting and promoting the evolving parent-child relationship?
2. Given the long road of addiction recovery, what might a lifespan treatment modality look like? For example, a treatment modality that grows with the child, the parent-infant relationship, the parents' sobriety journey, and their reflective functioning capacity over time?
3. Relapse can be devastating for the parent, the infant, and their family relationships. They also impact and at times interrupt the therapeutic relationship. Relapses can also abruptly change the course of reunification plans. What narratives can we illuminate and share that illustrate how relapses can be faced, with realism, pragmatism, and compassion, while simultaneously holding the parent-infant relationship at centre stage, for today and tomorrow?

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Eating disorders

By Miri Keren (Israel)

Introduction

Eating disorders are one of the most common reasons for referral to pediatricians as well as to infant mental health (IMH) clinicians. The provision of adequate nutrition to enable growth and development is one of the most important aspects of caring for a baby. The responsibility for feeding the baby usually falls on the parents, particularly on the mother. The feeding relationship between baby and parent is important and forms a crucial basis for the emotional development of the baby and contributes greatly to the parent's ability to experience the care of their baby with confidence and satisfaction (Chatoor & Egan, 1983).

This understanding became the cornerstone of the assessment and diagnosis of eating/feeding disorders (Chatoor, 2002). Feeding has been described as a "relationally embedded phenomenon" (Rosenblum, 2004, p. 61). When the infant's eating skills are compromised, the parent-infant interaction is made more complex and is at risk of disruption (Drotar & Robinson, 2000; Benoit, 2000).

This chapter recollects the few, but important papers that have been published in *The Signal* about Eating/ Feeding Behaviour disorders.

Failure to Thrive: The Myth of Maternal Deprivation Syndrome, 1996, *The Signal. 4*(3&4): 1-6, by Dieter Wolke (UK).

Wolke starts with the historical background of what has been called Non-Organic Failure to Thrive (NOFTT) from the fifties to the eighties, based on the assumption that the observed poor mother-infant interaction was the cause of the infant's eating disorder and developmental delays. Much was written about Failure to Thrive (FTT) but as Wolke reviewed the literature, it was rarely studied systematically. The 1980's saw a major change in the understanding of eating behaviors in infancy, when it became understood that the basis of FTT must be malnutrition as a result of the infant not receiving enough food (neglect), not taking in enough food (food refusal) or not able to use what is taken in.

In 1985, the first prospective epidemiological study was initiated by Wolke together with David Skuse and Sheena Reilly in London. Of 1554 full-term AGA (appropriate for gestational age) infants, 3.3% were diagnosed with FTT (Skuse et al., 1992). Wilensky and colleagues (Wilensky et al., 1996) found the same figures. The most surprising finding from these two studies was the evidence that families of NOFTT are generally not different from those of normally growing infants, and only a very small group of these infants are actually neglected or emotionally deprived.

So, what does explain NOFTT? Wolke and his colleagues suggested several potential pathways that lead to NOFTT: sleepy/easy infants who are not wakened for feeds; infants with subtle oral-motor problems; overfeeding by mothers; and neglect and emotional deprivation (in a very small subgroup).

From Each Side of the Tube: The Early Autonomy Training (EAT) Program for Tube-dependent Infants and their Parents, 2007, *The Signal, 15*(1-2): 1-9, by Marguerite Dunitz-Scheer, Ronny Scheer & Michaela Tappauf (Austria).

Dunitz and her colleagues start by describing their innovative model of a highly specialized "learning to eat program", based on developmental and attachment theory. Their setting is the psychodynamically oriented paediatric ward within the complex of the large Graz 300-bed children's hospital. All paediatricians who work in this ward have additional training in psycho-analysis, psychotherapy, child psychiatry, or psychology.

From their experience with more than 80 infants per year from around the world, the model of the tube-weaning program enables infants to be weaned off their long-term tube dependency within 2-3 weeks by achieving sufficient self-feeding abilities. The uniqueness of the Early Autonomy Training (EAT) model relies upon the integration under one roof of the domains of paediatrics, surgery, genetics, developmental psychology, and intensive care medicine, all of which are commonly involved in severe eating disorders.

In the paper, they first describe the normal development of eating, the important role fathers have especially in the treatment of eating disorders,

self-regulation processes that need to be achieved by the infant, the parents and the team. Let the child be hungry and facilitate autonomy are the two main goals that must be respected and understood on various levels by the child him/herself, the caregivers involved, and the complete medical and nursing staff and paramedical team. The "play picnic" is the cornerstone of the program, based on the idea of offering young children an opportunity to have new experiences with food (mainly touch and exploration) in a comfortable and secure setting (with or without their parents) in their age group. Parents are asked to stay available to their child without intruding. The program is described in detail on the homepage www.kinderpsychosomatik.at.

An Exploration of the Experience of Parents Caring for Babies Fed by Naso-gastric Tube, 2007, *The Signal, 15*(1-2): 10-15, by Libby Ferguson & Campbell Paul (Australia).

In the context of their clinical work at the NICU of the Royal Melbourne Hospital for Children, the authors start with the body of literature related to parental perceptions of tube feeding, usually gastrostomy tube feeding, in older infants and children. Tube-fed children have been found to experience a high level of stress, related to the severity of their child's medical condition and the constant caregiving demands over extended periods. Parents of tube-fed children were found to have higher levels of stress than either of the two control groups. (Pederson, Parsons & Dewey, 2003).

The authors described their qualitative study with parents of six babies who had been interviewed about their perceptions of tube-feeding, using semi-structured interviews. Their study aimed to use a qualitative research paradigm to describe the parental experience of caring for a child who received some or all of their nutrition via a feeding tube. Most of the findings relate directly to perceptions regarding the use of a nasogastric tube (NGT).

They summarized the major themes that arose from the interviews: tube has multiple meanings, often contradictory:

It keeps the baby healthy, but it is unnatural and inconvenient;

It is part of the baby but it is an intrusion into his body;

It signifies severe illness but doesn't need to restrict normal life.

The baby and the effect of the tube on the baby underpins many of the parents' perceptions regarding the feeding tube. Parents express ambivalence towards the tube, tube feeding, and the care provided for their baby. Parents report anxiety about the potential for events that may threaten their baby's life and the need to be constantly vigilant. Responsibility for tube changes falls on one parent, who often feels unsupported. The presence of the tube need not limit social interaction but people around often react negatively to the child's appearance, causing parental frustration and anger. Hospital staff are perceived as generally skilled and helpful but not always consistent. Some staff are inexperienced and cause frustration to parents and distress to the baby.

The authors conclude with the suggestion to use this explorative study as a basis for further exploration of the experience of tube feeding for parents and infants. For instance, the themes could be used as the basis of a comprehensive questionnaire. Also, a study that focused on the experience of the baby would provide information, important to the management of tube feeding and the prevention of eating problems.

Smell, Taste and Flavor, 2007, *The Signal, 15*(3): 8-10, by Peter J. Scheer, and Julie A. Mennella.

Infants are born with the ability to taste and smell and they rely on these senses to search for comfort and food. Scheer and Mennella review the development of these capacities: At birth, infants are sensitive to a wide range of odours, especially those emanating from their mothers. Shortly after birth, mothers and infants can recognize each other through the sense of smell alone. Newborns will prefer their mothers' breast unwashed. Like that observed in other mammalian young, this recognition of and preference for maternal odours may guide the infant to the nipple area, thus facilitating attachment and breastfeeding.

Whereas odours emanating from the mother cue feeding and comfort for the infant, those emanating from infants affect maternal emotional responses and impact on breastfeeding process. Similarly, infants are sensitive to the odour and taste component of flavours and can detect sweet, sour, and bitter-tasting foods. However, sensitivity to salt and other flavours do not emerge until infants are approximately four months of age. Children prefer sweet-tasting foods and beverages and often dislike bitter-tasting vegetables.

The authors wonder whether these preferences are only due to modern marketing, technology, and availability or does it reflect some aspect of their basic biology? Research suggests that these likes and dislikes reflect the latter. From an evolutionary perspective, these responses serve important biological functions. Preference for sweet-tasting foods may attract children to sources of high energy during periods of maximal growth. The avoidance of bitter tastes may have evolved as a protection from poisoning. As senses of taste and smell are the major determinants of whether young children will accept a food, they take on greater significance in understanding the biological basis for children's food choices.

The authors end this short but interesting paper with the problematic aspect of tube-feeding, as tube-fed infants have a relatively constrained olfactory and flavour experience in the context of feeding that is not fully understood.

"Who ate my Porridge?" A Glimpse to the Mother-Infant Bond through the Feeding Scene., 2009, *The Signal, 17*(3): 5- 11, by Elisheva Susz, Tsippy Kalish, Irit Kushilevitz, Ruth Orenstein & Anat Raviv (Israel).

This paper is about naturalistic, at-home observations of four mother-infant dyads during a feeding interaction, some two weeks after delivery and a year after. The aim of their observational qualitative study was to look for mutual changes and adjustments that may take place between the mother and the baby during the first year of life. Among the four dyads, one showed a good-enough style while the other three exhibited anxious-angry feeding interactions. They conclude with the statement that adaptive changes do not necessarily occur spontaneously, thus strengthening the need for early mother-infant psychotherapy.

Reflections and future directions

First, it is surprising to note the lack of more recent papers in *The Signal/ Perspectives*, about the topic of eating disorders in infancy, in spite of its high prevalence among children in their first three years of life. A notable change that has occurred in 2016, with the publication of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: DC 0-5* (Zero To Three, 2016) is the change of the term "Feeding behaviour disorders in Infancy" to "Eating behaviour disorders." The new term places the emphasis on the child's observed behaviours rather than on assumed aetiologies (ZeroToThree, 2016). Indeed, the use of the term "feeding disorders" was somehow confusing as it conveyed that all types of eating problems are relational. However, we know today that the very young child's eating disturbance is not always relational and may be a reflection of his/her characteristics, such as constitutional difficulties for state regulation and/or difficulties in making changes and transitions, sensory aversions, and/or reactions to traumatic medical procedure or condition.

An eating disorder may thus result from either component, while the eating and feeding processes may be impaired because of physiological and/ or psychological reasons. When the disturbed eating pattern is observed only in the context of a specific relationship, the child will be given the diagnosis of Relationship Specific Disorder, while the eating problem is only one of its manifestations, rather than the diagnosis of Eating Behaviour Disorder. In the DC 0-5 classification, three groups of eating disorders are described with clear criteria: Overeating Disorder, Undereating Disorder and Atypical Eating disorders. The state-of-the-art therapeutic approach is multidisciplinary, as the multiple facets of eating, both in infants and parents, need to be addressed (Keren, 2019).

In addition, a new category of Overeating Disorder has been introduced, based on clinical field observations of very young children who are permanently preoccupied with food and eating. This new category needs to be detected more routinely, studied and better understood. Clinicians, both paediatricians and infant mental health professionals, are invited to reflect on the potential aetiologies of this disorder.

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Depression in infancy

By Miri Keren (Israel)

Introduction

The idea of depression in infancy has only been accepted by the mental health and developmental communities within the last 15 years or so. Indeed, although Rene Spitz described the anaclitic depression in infants who lost their caregivers (Spitz, 1946), the general assumption was that young infants are cognitively too immature to experience depression. Similarly, it was once considered that school-aged children were too immature to develop depression.

Since then, the infant's emotional competencies have been widely recognized (Sonkoff & Philipps, 2000). Though clinically recognized by professionals working with infants and young children, the validation of a distinct depressive syndrome in children under the age of 3 years, remains scarce.

A study of the onset of depressive symptoms in preschool aged children has raised the possibility of the existence of symptoms beginning as early as 18 months of age (Luby & Belden, 2012). Other studies suggest that infants of depressed mothers are less active, more withdrawn, and express less positive affect than infants of non-depressed mothers (Murray et al., 2010). Still, to date, there have been no large-scale, empirical, prospective studies of depression in children under the age of three years. This is in sharp contrast to compelling case studies written by infant mental health (IMH) professionals in describing their clinical work with infants and very young children. Quite obviously, in children younger than 3 years, depression is characterized by observable behaviors, such as sad facial expression and tearfulness, and/or irritability and temper tantrums, rather than the child's verbal expression of distress.

Based on these important observations, the diagnostic criteria for Depressive Disorder in Infancy have been outlined in the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: DC 0-5* (ZeroToThree, 2016). Depressed mood or irritability across activities and context, as well as anhedonia (the loss of ability to feel pleasure), are among the most essential criteria for the diagnosis of Depressive Disorder. Besides maternal depression, mentioned above, risk factors for depression in infancy include difficult temperament, chronic illness, multiple adverse health conditions, and chronic pain. The differential diagnosis must include Reactive Attachment Disorder, whenever there is a history of severe environmental deprivation, Adjustment Disorder with depressive features if the onset is linked to a stressful event, Disorder of Dysregulated Anger and Aggression, and organic diseases such as metabolic disorders and tumors.

Surprisingly, we have found only one paper in *The Signal/Perspectives* indirectly related to depression in infancy:

The pediatric consultation: A first encounter with infant mental health, 2011, *The Signal. 19*(2): 1317, by Nahir Bonifacino, Dora Musetti, Andrea Plevak and Magdalena Schelotto, Uruguay.

In this paper, the authors describe their experience with the ADBB Scale (Alarme Détresse Bébé) as an observational tool to detect withdrawal signals in infants between 2 and 24 months of age during the pediatric consultation. The ADBB Scale, developed by Antoine Guedeney (Guedeney & Fermanian, 2001), is based on the notion that withdrawal is a natural defense mechanism used by the baby to regulate their interactions with caregivers (Brazelton, 1975). However, if this is sustained, it may reflect a pathological condition that has its origin either in the parents, in the baby, or in the relationship. Sustained withdrawal is therefore an early symptom of pathology, including severe medical conditions, depression, developmental disorder, post-traumatic disorder, sensorial disturbances, and maltreatment.

The ADBB is easy to teach and use in a routine pediatric setting. It is based on 8 items to be observed by the pediatrician, including facial expression, eye contact, general activity level, self-stimulating gestures, vocalizations, response to stimulation, and the capacity to engage and attract attention. Each item is from 0 to 4. An overall score of 5 or more is considered abnormal.

The authors present their results among 73 babies between the ages of 2 to 24 months from a population at risk. Nineteen percent of their sample presented minor withdrawal scores (scores between 5 and 10) and 6% with more severe signs (scores above 10). The pediatricians carried out a supportive intervention and at a second evaluation, 15 days after the first one, all the babies with minor signs had fully improved, while those with more severe signs of withdrawal had a more guarded prognosis.

Reflections and future directions

Surprisingly, we could not find more papers about the specific topic of depression in infancy published in *The Signal/Perspectives*. One may wonder why. One of the reasons may be the understanding that most cases of depression in infancy are secondary to very adverse environmental circumstances, such as severe maternal depression, neglect, maltreatment, grief, posttraumatic stress disorder, or severe medical conditions. Cases of major depression have been reported only in preschoolers with a positive family history of depression (Luby & Belden, 2012), but not among infants. Still, one has to note that persistent aggressive temper tantrums, irritability, and angry mood among children as young as two years old are criteria for the DC 0-5 diagnosis of Disorder of Anger and Aggression Dysregulation, under the category of Mood disorders (ZeroToThree, 2016) as it was found that these very young children's disruptive behaviors are predictive of depression and/or anxiety at school-age.

Because the existence of depression in babies is often difficult to accept, it is of paramount importance to keep the diagnosis in our minds as we work with infants and young children. We invite our readers to reflect on examples of depressed infants, their caregiving families, and to write about them.

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Crying disorders

By Miri Keren (Israel)

Introduction

Crying in humans is a universal, innate and survival-based phenomenon aimed at signaling emotional and/or physical distress and at bringing help/support. Hence, in itself, crying is not a disorder. Still, it should be considered as a symptom and quite a common reason for referral to IMH clinicians when the infant goes on persistent crying, even though food, physical closeness, safety and regulation have been provided by his/her caregivers.

Crying in the first three months of life is often referred to as "Infant colic" and is considered a benign, self-limited phenomenon, in spite of its unclear etiology. Difficult temperament is almost by definition, accompanied by frequent bouts of crying, together with other features.

As crying is an unspecific signal of emotional distress, it may be one symptom among others of disorders in infancy, such as Anxiety, Depression, Deprivation, or Sensory Processing disorder. Still, clinicians do encounter severe cases of persistent excessive crying with significant functional impairment and a negative impact on the parent-infant relationship.

The DC 0-5 (ZeroToThree, 2016) has defined diagnostic criteria for Excessive Crying Disorder:

> A. The infant cries at least 3 hours a day, 3 or more days a week, for at least 3 weeks ("rule of threes"). B. Crying is not better explained by a medical condition (such as lactose intolerance, gastroesophageal reflux). C. Symptoms of the disorder, or caregiver accommodations in response to the symptoms, significantly affect the infant's and family's functioning. Nights often become problematic. (p. 110)

Over time, The Signal, and Perspectives in Infant Mental Health has published a few papers that specifically address the issue of crying and these papers are summarized below.

Crying and Colic: The Untold Story, 2007, *The Signal.15* (3): 1-7, by Barry M. Lester, Jean Twomey, and Pamela High (USA).

The authors start by defining infant colic, as manifested by a pain cry that is loud, high pitched and can include longer bouts of breath-holding. The commonly held assumption that colic is caused by neuro-immaturity of the gastrointestinal tract has not been empirically supported. Non-biologic causes of colic, such as poor parenting, have not been proved either. The most widely used criteria for diagnosing excessive crying is the Rule of Threes, developed by the pediatrician, Morris Wessel in 1954 (Wessel, 1954).

Lester and his colleagues address the key question of *when does crying become a clinical concern*. They suggest that impairment in other areas of function should be the main criteria (as has been adopted by the DC 0-5). The most common domains affected by excessive crying are sleeping, feeding, disruptions in the parent-infant relationship, maternal depression, feelings of inadequacy, anger, and self-blame.

Excessive crying also often creates marital tension and disruptions in family life. Its prevalence is around 8% of babies (in contrast with 20% of babies with self-limited, non-clinical colic). In their paper, they describe their integrated pediatric and mental health colic clinic, based on 3 to 4 visits with 2-3 weeks intervals. Psycho-education, identification of the ways the infant's crying impacts the parental perceptions, and support measures for the parents, are the main components of the short-term intervention. The authors end their paper with a case description.

What is all that crying about? 2007, *The Signal, 15* (3): 8, by Ronald G. Barr (USA).

Barr writes a provocative short page about strong crying being evolutionary helpful for infants who might receive too little caregiving in the first weeks of life. In most cases, excessive crying is a result of a difficult temperament, to which parents respond in maladaptive ways. Therefore, Barr argues that the intervention needs to be focused on the caregivers' responses to the normal behavior of crying.

Preventing Shaken Baby Syndrome, Caring for Crying, 2007, *The Signal, 15*(3): 9-10, by Eve Krakow (Canada).

Shaken Baby Syndrome (SBS) is the intentional violent shaking of infants, resulting in severe head trauma with bleeding in and around the brain, retinal hemorrahges and bone fractures. About 25% of these infants die and about 80% survive with permanent neurological damage. Excessive crying has been linked to SBS as a trigger that brings exhausted and frustrated parents

to shake their baby. The frequency of SBS peaks at about 10 to 13 weeks, while the crying curve peaks at 5 to 6 weeks.

The author links this delay to the fact that almost 50% of the diagnosed SBS cases have evidence of prior abuse and shaking. As Barr has pointed out (see previous paragraph), in 95% of the cases, excessive crying is a normal component of a healthy baby's development. Therefore, preventive programs need to focus on improving parents' understanding of crying in the first months of life.

The author mentions the PURPLE program developed by the National Centre on Shaken Baby Syndrome (P for crying peak, U for unexpected, R for resistance to soothing, P for pain-like face, L for long crying bouts, and E for evening clustering of crying).

In this psycho-educational program, parents are encouraged to hold, carry, walk and talk to their crying baby, and to walk away and put the baby in the crib for a few minutes to calm themselves.

In this paper, Krakow mentions a British study that compared three different parenting approaches (St James-Robert et al., 2006):

1. The "proximal" form of care includes frequent holding baby in arms, on-demand breastfeeding, and co-sleeping;
2. The "structured" approach, where parents tend not to carry the infant, to let their babies cry, and switch to bottle feeds early; and
3. The intermediate approach.

Their main finding was that the amount and intensity of unsoothable crying at 5 weeks of age, were the same in all groups.

Proximal and intermediate care were associated with less crying at 12 weeks, but better sleep was associated with the structured and intermediate approaches.

***"No sounds, No cry", 2007, The Signal, 15*(3): 13, by Miri Keren (Israel).**

Along with the papers about "too much crying" mentioned above, Keren notes the need to be aware of the other extreme, that is, the lack of expected normal crying. Indeed crying behaviour may disappear under extreme conditions of persistent negative reinforcement, for example in orphanages.

Of note, a latter paper (Dollberg & Keren, 2013) reports on an ongoing study with newly adopted infants who exhibited more sustained withdrawal and less crying, as compared to biological infants, regardless of their emotional and developmental status.

The adoptive parents misunderstood the infant's lack of crying as a sign of their new well-being, rather than the consequence of deprivation and negative reinforcement of crying at the orphanage they just left. It was found that these parents need help to teach the infant that crying is the legitimate and safe way to express distress and to ask for proximity, closeness and protection.

Child Protection Social Welfare professionals, who are those who first encounter and accompany new adoptive families also need to be aware of the significance of the absence of normal crying among newly adopted infants from institutions.

Reflections and future directions

It is surprising to note the small number of papers in *The Signal/ Perspectives*, about such a common topic as excessive crying, and the lack of research studies or case descriptions, despite its potentially dangerous impact on the parents' behaviours. The relatively high incidence of SBS is worrying and prevention is the only treatment.

The readers of this paper are encouraged to reflect on the meanings of excessive as well as the absence of crying in their clinical practice, as well as the cultural aspects of crying, and not only among infants.

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Disruptive behaviors in young children

By Miri Keren (Israel)

Introduction

Disruptive behavior before the age of 5 is a common reason for referral to early childhood outpatient clinics and is predictive of later psychopathology across the lifespan (Keenan et al., 2011; Shaw, 2013; Tremblay, 2008). Clinically significant disruptive behavior can be reliably and validly identified during preschool years (Bufferd et al., 2016), and has been conceptualized as a neurodevelopmental syndrome (Wakschlag et al., 2018), meaning a disorder that is linked to delays or deviations in brain maturation. More specifically, self-regulation, internalization of rules and social problem-solving, are the major developmental tasks of the preschool years; especially in daily situations of demands, transitions, and frustrations. Hence, aggression, temper tantrums, and noncompliance are normative misbehaviors and a hallmark of preschoolers.

The characteristics of disruptive behavior include problems in modulation of irritability, resistance and/or insensitivity to social rules and norms (Wakschlag et al., 2010). Thus, the normal-abnormal distinction is the main challenge in the clinical evaluation and diagnosis of preschoolers referred to clinicians for disruptive behavior. This clinical challenge has prompted the conceptualization of a multidimensional approach (Wakschlag et al., 2015) that entails four core dimensions of developmental processes: temper loss and regulation of frustration; noncompliance and internalization of rules; aggression and capacity to modulate aggressive tendencies; and low concern for others (Bufferd et al., 2016; Wakschlag et al., 2014).

On each of these four dimensions, the child's disruptive behavior is assessed as:

a) *Developmentally expectable*. For example, tantrums when sick or tired, aggressive when frustrated, saying no, and or does not care about others' feelings when upset.

b) *Moderately problematic*. For example, has difficulty calming down, hits someone with an object, does exactly what you said not to do, and or seems indifferent to pleasing others.

c) *Severely problematic*. For example, has tantrums until exhausted, hurts someone on purpose, laughs while misbehaving, and/or enjoys making others mad. Early callous behavior, that is, a lack of empathy, is especially worrying as its early appearance has been shown as a marker of antisocial behavior persistence and severity (Wakschlag et al., 2018).

It has been shown that infants already in the first year of life demonstrate prosocial versus antisocial preferences and empathy concern, while toddlers show empathy, internalization of rules, perform prosocial acts to decrease others' distress, and show expressions of remorse and reparation (Kochanska et al., 2010). Heritability of callous traits has been shown in a sample of adopted children, suggesting some biological basis (Hyde et al., 2016).

Despite its being a common and challenging clinical situation, disruptive behavior in the 5 first years of life has not been addressed in *The Signal* nor *Perspectives*, except for the following paper.

In the Eye of the Beholder: Critical components of observation when assessing disruptive behaviors in young children, 2010, *The Signal. 18*(2): 9-14, by Barbara A. Danis, Carri Hill and Lauren S. Wakschlag, USA.

The authors describe the tool of the Disruptive Behavior Diagnostic Observation Schedule (DB-DOS) that aims at making the distinction between developmentally normative misbehavior and disruptive behavior that warrants intervention. They emphasize the role of direct observation, as opposed to sole reliance on parents' and teachers' reports. Indeed, discrepancies between informants are very common. Direct observation enables the clinician to witness what triggers the behavior, its intensity, its organization, and its flexibility. Also, it provides the opportunity to assess the different contexts in which the behavior appears (such as with a parent, a teacher, or a clinician) and to observe parenting behavior and capacity to regulate the child.

The DB-DOS encompasses three essential components of the observation:

1. The use of challenging/frustrating tasks to elicit disruptive behavior (this is especially useful for those children whose disruptive behavior does not appear at the clinician's office).

2. Observation in different settings. Indeed, in their Chicago Preschool Project sample (Wakschlag et al., 2005), about half of the disruptive preschoolers displayed their behaviors only in the context of their relationship with their parents, and one-third of them were disruptive only at school.

3. Clinical use of the clinician's self. The authors developed a graded hierarchy of prompts for the clinician to use when the child exhibits a disruptive behavior, starting from minimal help to active intervention. In this way, the clinician observes what the child can handle independently as well as how they can efficiently use support from an adult. The clinician is also asked to be aware of how much they initiate and direct positive skills for the child, and how often he/she is proactive before seeing what the child brings independently to the interaction.

In the authors' experience, providing developmentally appropriate challenges and gradually increasing the support they provide, creates opportunities for the child's strengths and weaknesses to unfold. They are aware of the fact that for some clinicians it may be uncomfortable to purposely frustrate the child without providing immediate support. On the other hand, they report that families of these difficult-to-handle children are grateful to them when their observations provide a glimpse into their daily difficulties.

Reflections and future directions

The serious and chronic form of disruptive behavior appears already by the age of 5 years, and this warrants early detection and treatment (Shaw & Taraban, 2017). The DSM V diagnoses of Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) do not address the developmental component and most criteria do not apply to children under 5 years of age.

The conceptualization of an early childhood disruptive disorder phenotype that fits young children has been introduced in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (ZeroToThree, 2016), under the diagnosis of *Dysregulated Anger and Aggression Disorder of Early Childhood* (DDAA), for those young children who exhibit severe, frequent, and intense temper tantrums together with persistent irritable or angry mood. Many of these young children show oppositional behaviors as well, but the core component of this diagnosis is the focus on irritability and dysregulation of anger as expressions of emotional dysregulation, which in turn, lead to dysregulated behaviors.

This conceptualization is interesting as it goes beyond the classical dichotomy between emotional and behavioral symptoms. The symptoms must be pervasive and across contexts, in contrast with transient, relationship-specific presentations of irritability, angry affect, and disruptive behavior. Furthermore, DDAA has been put under the category of Mood Disorders in the DC 0-5, because these children tend later to develop either depression or anxiety disorder, and not necessarily conduct disorder (Brotman et al., 2006).

In light of all these, I would suggest reflecting on the following questions:

1. How can we explain the striking lack of publication about this topic in the Signal and/or Perspectives?
2. How widely used is this new DC 0-5 diagnosis?
3. Do we know what is the best modality of treatment for very young children who fulfill the diagnostic criteria for Dysregulation of Anger and Aggression disorder?

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Cultural representations of infant mental health within two WAIMH publications: The Signal and Perspectives in Infant Mental Health (1993-2021)

By Maree A Foley (Switzerland)

This article focuses on a selection of papers, published by the World Association for Infant Mental Health (WAIMH), in *The Signal* (1993–2011) and *Perspectives in Infant Mental Health* (2012 to current) that directly address issues of culture within infant mental health (IMH) research, assessment, and intervention. This article forms part of a forthcoming WAIMH ebook publication; a sequel to *Global Perspectives on the Transdisciplinary Field of Infant Mental Health 1993 – 2021: WAIMH eBooks Topical Resource Guide, Volume 1*, (Keren et al., 2022).

Cultural expressions of parenting and the caregiving of infants and young children occur within culturally sensitive contexts that inform, protecting, caring for, and socializing children to optimally function in the world the parents perceive that they will grow up in (Bornstein, 2012; Bornstein et al., 2012; Bornstein & Lansford, 2010; Harkness et al., 2007). Similarly, infant mental health (IMH) as a field has highlighted the interconnectedness between cultural and relational experiences of parenting and caregiving, across generations (Fitzgerald et al., 2009; Spicer, 2011; Seymour St. John et al., 2013). Tronick (2007) states that,

> … culture helps define those features of the child's behavior and communication that require attention and response, as well as the culturally appropriate form of the response. (p. 99)

What follows is a summary of selected papers, published by WAIMH in *The Signal* and *Perspectives in Infant Mental Health* (herein referred to as *Perspectives*), between 1993 and 2021, that explore the following themes:

1. IMH within cultural contexts,
2. IMH in humanitarian settings, and
3. Headlining culture within infant mental health interventions and services.

The paper concludes with reflective questions. The questions invite us each to consider how we can grow together, beyond a single story or narrative about culture in IMH. They are an invitation to strive to listen to a rich complete narrative of each baby, in their family and their community, while also being awake to our personally and professionally culturally shaped and dynamic IMH narratives.

Culture in context matters

Keren, M. (2009). Editors Perspective: Is culture really taken into consideration in our tools for assessment and intervention, *The Signal, 17* (4), 9.

In this paper, Keren highlights the importance of attending to culture as an integral part of any IMH intervention and this involves not only being curious and cognizant of the culture of the infant and families we are working with, but also of our own culture, and that which is embedded within of our IMH discipline.

> … while we assess parent-infant interactions, we must know what is the profile of the best-fitted individual to the specific cultural group they belong to: the interactions of mother and infant can be seen as uniquely suited to the cultural goals and expectations. Overlooking it may lead to false diagnoses and irrelevant interventions. (Keren, 2009, p. 9)

In this brief salient paper, Keren provides a plethora of examples, with a focus on attachment behaviors across cultural settings.

> Specifically relating to attachment behaviors across cultures, the Efe people (in the Ituri rainforest in Congo) have adopted a strategy that mitigates against risk of infant's survival, as well as against loss of parents, in the form of multiple nursing and caregiving. This practice enhances the infant's ability to form trusting relationships with a variety of individuals and probably impacts on the infant's and adult caregivers' brains. The Efe infant will show attachment behaviors to any individual in the group when distressed, as opposed to the

> Western infant who is expected to turn only to their immediate caregiver. (Keren, 2009, p. 9)

Lillas, C., & Marchel, M. A. (2015). Moving away from WEIRD: Systems-based shifts in research, diagnosis, and clinical practice, *Perspectives in Infant Mental Health, 23* (1-2), 10 – 15.

This paper examines trends in research regarding diversity and observes a parallel process within the field of IMH. Drawing on the work of Henrich et al. (2010), the paper explores mismatches between research, diagnostic matters, and the families met in the day-to-day context of practice. Lillas and Marchel (2015) state,

> As we explore the mismatches between current research and diagnostic approaches and their incongruence with the "real (clinical) world," we hope to demonstrate that outside of the field of IMH, there is a more recent push to move from the simple to the complex, from the linear to the nonlinear, from the categorical to the dimensional, from the laboratory (isolated) to the community (collaborative) –all embedded within a dynamic systems framework. (p. 11)

This paper explores these emerging shifts in light of the emerging body of evidence-based treatments (EBTs) and concludes with a set of recommendations that remain salient within the IMH field.

1. Be a responsible consumer of EBTs; notice the exact population, setting, and types of providers offering the EBT.
2. Become an advocate for families in communities being offered EBTs that have evolved from subclinical mismatches and disparities.
3. Even with EBTs targeted to actual high-risk clinic populations, not all were found to be superior in outcomes to "usual care" being offered. Do not disregard "usual care" as an anomaly but include it in an expanded database and treat it with respect and as part of the informed choice families have (Weisz & Gray, 2008).
4. Support community-based orientations in research. Get involved on a ground floor level as a practitioner working in a community setting, working with real-world families that have multiple problems and co-morbidities.
5. Use frameworks that hold multiple causalities, cut across diagnostic categories, and shed light on underlying neurodevelopmental processes and dimensions.
6. Accept the challenge to work across silos. Move away from disciplinary fragmentation into interdisciplinary work –whether on an academic, research, or clinical level. (Lillas & Marchel, 2015, p. 14)

Gaskins, S., & Keller, H. (2019). Learning about children by listening to others and thinking about ourselves. *Perspectives in Infant Mental Health, 27* (2), 1-4.

This editorial by Suzanne Gaskins and Heidi Keller was written in response to the Presidential Address by Kai von Klitzing (WAIMH President) published in the previous issue of Perspectives: WAIMH's infants' rights statement—a culturally monocentric claim? (von Klitzing, 2019). Gaskins and Keller (2019) stated, "… who should decide what is best for children growing up in a culturally specific context when these two sets of commitments conflict?" (p. 2). They encouraged WAIMH to continue with its commitment to inter-disciplinary dialogue regarding culture and IMH. In addition, they challenged the notion of universal pathways for child development and stated,

> We fully agree that infants need reliable and emotionally responsive care from continuous caregivers. Our concern is that often a culturally specific model of who is the best caregiver and what is "sensitive care" is used to judge caregiver practices in other cultures. (Gaskins & Keller, 2019, p. 2)

Gaskins and Keller (2019) also challenged WAIMH to continue to be committed to inter-disciplinary dialogue:

> We believe that any group trying to help children should be committed to the principle of "First, do no harm." To this end, there is an urgent need to include anthropologists, sociologists, and cultural psychologists of childhood when formulating policies and interventions, to ensure that whole cultural systems that shape children's lives are considered, not just isolated behaviors taken out of context. (Gaskins & Keller, 2019, p. 4)

For those who wish to further explore the work of Gaskins and Keller (2017), the following resource: Heidi Keller and Kim Bard (Eds.) (2017), *The Cultural Nature of Attachment: Contextualizing Relationships and Development*, Strüngmann Forum, Cambridge: The MIT Press. This edited text presents "multidisciplinary perspectives on the cultural and evolutionary foundations of children's attachment relationships and on the consequences for education, counseling, and policy" (https://mitpress.mit.edu/books/cultural-nature-attachment).

IMH in humanitarian settings

Sparrow, J. (2017). Introductory remarks by Joshua Sparrow. *Perspectives in Infant Mental Health, 25* (3-4), 9.

In this brief commentary, Joshua Sparrow introduces the Perspectives paper below by Maysa El Husseini, Leyla Akoury-Dirani, Rami Elhusseini, and Marie Rose Moro (2017). Sparrow draws attention to the cultural awareness and inclusion of El Husseini and colleagues (2017) as they reflect on IECMH practice in Haiti, following the 2010 earthquake and ensuing cholera epidemic. Echoing and elaborating on Keren (2009), Sparrow reflects,

> When infant mental health workers attempt to repair the disruptions of family ecosystems caused by natural or human-made disasters in cultures different from their own, they often bring interventions from their

> own cultures, along with the unexamined belief systems and cultural constructs that underlie them. Their understanding of those of the cultures they intend to work in are often understandably limited. Their interactions with those they intend to serve are also often marked by the trajectory of colonization and decolonization. (Sparrow, 2017, p. 9)

El Husseini, M., Akoury-Dirani, L., Elhusseini, R., & Moro, M. R. (2017). Considering cultural practices within a psychoeducational community support service for mother-infant health care: Field report. *Perspectives in Infant Mental Health, 25* (3-4), 9-13.

This paper provides a reflection from french interventionists working in Haiti, following the 2010 earthquake where over 230,000 people died and 220,000 people were injured. This disaster was followed by a cholera epidemic, that occurred a few months after the earthquake. The authors stress the importance of holding local belief systems at the centre of all interventions. The paper specifically provides a qualitative narrative concerning infants and parents and their experiences of devastating loss, trauma, and the impact of this on the mental well-being and the feeding relationship. El Husseini et al. (2017) "reaffirm the legitimacy of cultural knowledge" (p. 12), as a foundation stone for new understandings that in turn inform interventions.

> This paper presents illustrations of the work of international NGOs with Haitian caregivers and young children following significant humanitarian crises. At the same time, it raises important social and cultural questions about the interface of Euro-American practices within the cultural fabric of the Haitian community. It is not an exhaustive study of the humanitarian interventions and their impact on the Haitians' cultural beliefs, but illustrates some of the barriers and also possibilities to effective intervention when there are social and cultural differences between those providing the services and those receiving them. (El Husseini et al., 2017, p. 9)

El Husseini et al. (2017) vividly describe what they describe as "ruptures in the cultural dimension" (p. 12). They provide a narrative that further describes this phenomenon:

> Collective crises and potential traumas may create a rupture in the continuity of the cultural transmission, This includes the massive intervention of NGOs and their disruption of the long-established harmony between Euro-American medicine and traditional Haitian culture that Haitian society had evolved. This resulted in a defect in the cultural envelope that protects collective representations. When traditional and internalized collective convictions are shaken, a door to doubt and confusion is opened. The new transmissions that the NGOs dispense penetrate these openings and act as external objects that are difficult to integrate. (El Husseini et al., 2017, p. 12)

The paper is rich in ethnographic details and shows how unintentional contradictory messages were conveyed to mothers during psychological interventions in the humanitarian context. The authors call for local social and cultural dimensions to be central to any intervention and "reaffirm the legitimacy of cultural knowledge" (El Husseini et al., 2017, p. 12). They further state that "… to ensure adequacy and efficacy of their services, the International NGOs need to include an ethnological perspective while applying psychosocial interventions (El Husseini et al., 2017, p. 13).

Box 1. Examples of IMH and cultural context within humanitarian settings.

Zanon, O., Ius, M., & Milano, P. (2016). An immigrant family's story. A shared care plan for early childhood development: A partnership experience between families, early childhood services, social and health services. *Perspectives in Infant Mental Health, 24*(4), 5-10. An Immigrant Family's Story. A Shared Care Plan for Early Childhood Development: A Partnership Experience between Families, Early Childhood Services, Social and Health Services - Perspectives (waimh.org)

Romano, H., Baubet, T., Marichez, H., Chollet-Xémard, C., Marty, J. & Moro, M. R. (2011). Medical and psychological airport reception and care of children from Haiti adopted in France. *The Signal,19*(1),14-16. https://perspectives.waimh.org/2011/03/15/medical-psychological-airport-reception-care-children-haiti-adopted-france/

Moro, M. R. (1994). Psychiatric interventions in crisis situations: Working in former Yugoslavia. *The Signal, 2* (1), 1 -6 Scan_6-28-2019_15-28-54_1.pdf (waimh.org)

Rygaard, N. P. (2015). Infant mental health in the global village. An invitation to reader's debate: Emerging infant environments, and future research. *Perspectives in Infant Mental Health, 23*(1-2), 3- 7. INFANT MENTAL HEALTH IN THE GLOBAL VILLAGE. An invitation to reader's debate: Emerging infant environments, and future research. - Perspectives (waimh.org)

Murray Harrison, A. (2014). "Los Momentos Magicos": A practical model for child mental health professionals to volunteer by supporting caregivers in institutions in developing countries. *Perspectives in Infant Mental Health, 22* (2),10. "Los Momentos Magicos": A Practical Model for Child Mental Health Professionals to Volunteer by Supporting Caregivers in Institutions in Developing Countries - Perspectives (waimh.org)

Other examples that specifically highlight infant mental health within local cultural contexts and humanitarian settings are noted in Box 1.

Headlining culture within infant mental health interventions and services

Culture is significant in research and practice yet over-represented by "Western, Educated, Industrialized, Rich, and Democratic (WEIRD) societies" (Henrich et al., 2010). For example, in Henrich et al.'s (2010) review of the subjects in behavioral science data, subjects from WEIRD societies were identified as the dominant subjects with findings assumed to have relevance across all cultures and cultural groups. However, the majority of infants live in societies recognised as low-middle-income countries and as such, are well-under-represented across global health and wellbeing research (Black et al., 2017; Lu et al., 2020).

WAIMH is an international organization and throughout *The Signal* and *Perspectives*, there is a plethora of papers that address in part, the issue of culture within infant mental health interventions and services, A sample of these papers is represented in Box 2.

Berg, A. (2012). When a little means a lot. *The Signal, 20*(2), 1- 5.

This paper reports on the development of infant mental health as a field of practice and research within South Africa. Berg (2012) eloquently threads and balances the expertise of local colleagues with those from abroad who collectively have contributed to the growth of IMH as a practice in South Africa.

> Living and working in a country where there are not only enormous economic disparities, but also enormous cultural and language differences, we as mental health professionals face many challenges… One of the most profound challenges is that of meeting 'the other' - in essence it is the challenge of life: for the self to engage with an other – it is that on which our whole development is built … (Berg, 2012, p. 1).

Box 2. Examples of papers in The Signal and Perspectives that headline culture within infant mental health interventions and services.

Abatzoglou, G. (2011). Meeting infants and staff at the foundling home: Introducing concepts of transference and countertransference in an institutional context. *The Signal, 19*(1),10-12. Meeting infants and staff at the foundling home: Introducing concepts of transference and countertransference in an institutional context - Perspectives (waimh.org)

Berg, A. (2020). Diversity and the positive impact of culture and supporting families in context. A view from Africa, *Perspectives in Infant Mental Health, 28*(1),33-36. https://perspectives.waimh.org/2020/05/22/diversity-and-the-positive-impact-of-culture-and-supporting-families-in-context-a-view-from-africa/

Brown, K. A., Brown, C., & Berg, A. (2016). A parent group initiative intensive care unit South Africa. *Perspectives in Infant Mental Health, 24* (1-2),16-20. https://perspectives.waimh.org/2016/06/15/parent-group-initiative-intensive-care-unit-south-africa/

Dube, T. (2014). A Community Service Clinical Psychologist Reflects on a Parenting Skills Workshop in Nolungile Clinic in Khayelitsha, Cape Town. *Perspectives in Infant Mental Health, 22*(1),5-6. A Community Service Clinical Psychologist Reflects on a Parenting Skills Workshop in Nolungile Clinic in Khayelitsha, Cape Town - Perspectives (waimh.org)

Fitzgerald, H. E. (2020). Celebrating Hiram Fitzgerald: Forty years with infant mental health. *Perspectives in Infant Mental Health, 28*(1),11-16. https://perspectives.waimh.org/2020/06/26/celebrating-hiram-fitzgerald-forty-years-with-infant-mental-health/

Gonzalez-Mena, J & Briley, L. (2011). Improving infant mental health in orphanages: A goal worth considering. *The Signal, 19*(4),14-16. Improving infant mental health in orphanages: A goal worth considering - Perspectives (waimh.org)

Lopez, M. E., Shabazian A. N. & Spencer, K. A. (2013). Orphanage improvement. An important child protection discussion. *Perspectives in Infant Mental Health, 21*(4),7-12. https://perspectives.waimh.org/2013/12/15/orphanage-improvement-important-part-child-protection-discussion/

Martinez, B. Webb, M., Rodas, P., Gonzalez, A., Grazioso, M. & Rohloff, P. (2016). Field report: Early child development in rural Guatemala. *Perspectives in Infant Mental Health, 24*(1-2),6-8. https://perspectives.waimh.org/2016/06/15/field-report-early-child-development-rural-guatemala/

Peers, R., & Frost, K. (2013). The Ububele Baby Mat Project: a brief and cost-effective community-based parent-infant intervention. *Perspectives in Infant Mental Health, 21*(3),5-9. The Ububele Baby Mat Project: A Bried and Cost-Effective Community-Based Parent-Infant Intervention - Perspectives (waimh.org)

Puura, K., & Berg, A. (2018). Integrating infant mental health at primary health care level. *Perspectives in Infant Mental Health, 26*(2-3),4 – 7. https://perspectives.waimh.org/2018/04/27/integrating-infant-mental-health-at-primary-health-care-level/

Reams, R. & Light, P. (2019). Going the distance: promoting rural participation in the professional development of infant mental health workers. *Perspectives in Infant Mental Health, 27*(3),28-30. https://perspectives.waimh.org/2019/11/08/going-the-distance-promoting-rural-participation-in-the-professional-development-of-infant-mental-health-workers/

Salaka, S. (2011). Reaching out to young parents through the media – Keeping up with the (contemporary) times. *The Signal, 19*(1),9. Reaching out to young parents through the media - Keeping up with the (contemporary) times - Perspectives (waimh.org)

Sebre, S. & Skreitule-Pikse, I. (2011). Attachment-based parent and preschool teacher training and research programs in Latvia. *The Signal, 19*(1),7-8. https://perspectives.waimh.org/2011/03/15/attachment-based-parent-preschool-teacher-training-research-programs-latvia/

Webb, M. F., Martinez, B., Rodas, P., Gonzalez, A., Rohloff, P. & del Pilar Grazioso, M. (2020). Language Interpretation in the administration of the Bayley Scales of Infant Development-III for an indigenous population in Guatemala. *Perspectives in Infant Mental Health, 28*(1),29-32. https://perspectives.waimh.org/2020/05/15/language-interpretation-in-the-administration-of-the-bayley-scales-of-infant-development-iii-for-an-indigenous-population-in-guatemala/

Berg (2012) in acknowledging political and cultural change also reflects, "… have we truly dismantled and discarded our colonial attitude? Have we truly stopped to project our shadow, our inferior, disowned parts onto the racially 'other'? Do we indeed realize that our world view is not shared by all?" (p. 2). In response to these reflective questions, Berg (2012) shares her experiences of working in Khayeltisha and working alongside a colleague who,

> … knew about my patients' beliefs, values and who could help me translate – not only from isiXhosa into English, and vice versa, but help me to get to know the culture in which my patients were embedded. This is more than understanding about poverty, or bridging language differences – it is about obtaining a deep knowing about another system of values and priorities where much is the same, but much is also different. (Berg, 2012, p. 2)

The remainder of the paper is a treasure trove of lived experience and wisdom where Berg (2012) shares that "… often not that much is needed - a little can mean a lot - but that little has to be an attuned, mindful little" (p. 2). Berg shares specifically about the significance of a cultural mediator. A person who has lived experience and knowledge of the culture and world in which the mother has grown up and is currently living. The cultural mediator is a co-therapist. That is, to not literally translate the medical questions to the patient but to culturally translate and engage with the questions and the patient in a way that optimised the patient's security and capacity to respond.

An example of this is provided by Berg:

> Dr: Is she HIV?
>
> CM: Can I ask something, are you both well?
>
> Pt: No I went for an HIV check and they said I'm negative.
>
> CM: when you were pregnant?
>
> Pt: Yes they said I'm negative but even though I have a baby I want to check again
>
> CM: Is it because you have a boyfriend?
>
> Pt: No, but I don't know
>
> CM: What is it that you don't know?
>
> Pt: The other thing is I had TB when I was young. (Berg, 2012, p. 3)

Berg (2012) concludes with a reflective query for WAIMH.

> … we cannot assume to know it all when other people have lived knowledge of a particular context. Let's make links globally, let's listen to each other and let's put into practice what we say we believe, namely that the needs of human infants are the same, but that there are different ways of rearing infants –let's get to know these, let's respect them, but at the same time we need to tell the world what we are continually learning about the beginning of life. (p. 5)

Concluding reflection

While the overall content of *The Signal* and *Perspectives* reflects practice with infants within OECD countries, this paper highlights work across both publications that acknowledge and apprehend experiences of culture within multi-level contexts. All infant mental health research, assessment, treatment tools and modalities, are culturally embedded, though not always culturally articulated. However, there is a growing body of work within the field that is specifically addressing cultural sensitivity in practice. For example, Meurs et al. (2022) advocate for the interdisciplinary convergence of anthropology and psychology as a pathway to translating cultural sensitivity into practice.

As the field of infant mental health grows within an ever-evolving globalization of health context, it is acknowledged that more needs to be done to support local clinicians and researchers to tell the stories of infants and families in their communities and to share their expertise and practice wisdom with the global infant mental health community. Beginning with *The Signal* and carried forward to *Perspectives*, this publication remains committed to addressing cultures in context as part of its aim to promote and protect the mental health needs of all babies in their families in their communities.

Reflective questions: Beyond a single culture and IMH story

Culture shapes the world views of ourselves, in our families and communities and shapes both explicitly and implicitly our views on parenting infants and young children, and on "healthy" parent-child relationships. Culture is also dynamic. As such, it is worthwhile to frequently ask:

1. How have my views and beliefs about parenting young children changed and developed?
2. How has my capacity to listen and bring forth conversations of cultural beliefs and values developed over time?
3. How has my openness and enquiry of the world views of colleagues, supported enriched team/collegial working relationships aimed at providing optimal IMH services/ care?
4. Does my workplace have an articulated cultural competence framework tailored specifically to working with families with infants and very young children?

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Research in infant mental health

By Patricia O'Rourke (Australia)

Introduction

Infant mental health (IMH) is focused on the social and emotional health of babies and young children. As such it is relational and contextual. Infant mental health research addresses the development, prevention, assessment and intervention of infants and their families and training, supervision and systemic issues for workers, organisations and systems. It is often multi-disciplinary, collaborative, and actively striving to address issues across communities and cultures. The full breadth of infant mental health research is not covered in this paper. What is showcased is the variety of work published by clinicians/researchers over the past 20 years in WAIMH Perspectives in Infant Mental Health and The Signal.

The first five papers demonstrate the diversity of research methods and methodologies, population samples, creative approaches to scientific exploration, and the commitment of clinicians to infants and their parents. Three further papers explore the nature of the infant mental health research agenda highlighting current issues and areas to be addressed.

Hermans, V. & Puura, K. (2009). How long do we need to support parents? Results from a five year follow up of the Finnish part of the European Early Promotion Study. *The Signal, 17*(1) 12-16.

This paper reports on a follow-up study exploring whether the effects of the work of trained nurses were still visible three years post-intervention. The original two-year, five-nations study compared results for mothers and infants provided with regular care nursing practice versus results of those treated by primary care nurses upskilled to provide targeted support earlier to families with identified problematic parent-infant interaction. These results showed positive changes in mothers' mental health and interaction in the intervention group, but there were no significant differences noted in child behaviour between the two groups.

Hermans and Puura (2009) followed up for five years looking at whether the increased support resulted in significant changes in child behaviour over the longer term. However, while the original Finnish study reported that the intervention group showed positive changes in both mothers' mental health and their interaction with their infants, there were no significant differences between the two groups of children after five years.

The authors conclude that preventative interventions support improved parenting while the support remains, but that these changes did not necessarily continue over the longer term and that further improvement in the clinical group required ongoing support. However, given that the intervention group began at a lower baseline than the comparison group, the results did show that initial changes were maintained.

Frascarolo-Moutinot, F. & Favez, N. (2009). Systems consultation: a clinical tool joining up research and clinical practice. *The Signal 17*(3) 1-4.

This paper shows the creativity used by researchers/clinicians to combine information gleaned by assessment and intervention processes with data for ongoing research. The authors describe their use of structured family-systems consultations as both a clinical intervention and as part of a research evaluation process. Their research and clinical aims are centred on the observation and clinical assessment of different aspects of family communication. Frascarolo-Moutinot & Favez delineate six underlying principles used in their systemic explorations with families and then describe the two main observational situations they use for family assessment: The Lausanne Trilogue Play and its adaptations and the Picnic Game. Both are videotaped and can be used at different family developmental stages and with children of different ages. Each has a structured system of scoring allowing for assessment of global family functioning and different sub-systems. The data collected in these videotaped semi-standardised assessments is used both clinically and for different ongoing research purposes.

Tardos, A. (2010). The researching infant. *The Signal, 18*(3), 9-14.

This is a small micro-analytical study exploring both the variety and number of interactions with simple, 'non-over stimulating toys' that six infants aged 3-12 months autonomously engaged in as they explored their world. While very small, the study's fine microanalysis is enlightening as it highlights the infants' developing exploratory genius. This paper demonstrates that babies are the ultimate researchers.

Tardos describes how a well-regulated infant engages visually and manually manipulates simple objects (toys) and how this develops over time. Interestingly the babies demonstrated significant differences in their visual

attention and any preference remained stable over time. With toys that were easy to grasp, the infants displayed over 100 different forms of manipulation: initially fine motor activity was sporadic, then increased in frequency and fell away as a new form of manipulation was acquired.

The detailed description of how infants learn to learn without the need for adult instruction and praise is timely. Tardos suggests that future research might compare 'the richness of the manipulation activities' with the 'characteristics of attention of children' (p.14). She proposes that infants provided with time, space and age-appropriate, non-over-stimulating toys are intent on autonomous learning. This fosters cognitive development and may lessen the risk of psychopathology such as attention deficit disorder.

Ereyi-Osas, W. Racine, N. and Madigan, S. (2019). Asking about Adverse Childhood Experiences (ACEs) in prenatal and pediatric primary care: A narrative review and critique. *Perspectives in Infant Mental Health, 27*(3), 8-17.

Exposure to adversity like abuse, neglect and household dysfunction in childhood (ACEs), negatively affects the physical and mental health of infants and young children, with long-term negative consequences that cross generations. Identifying ACEs perinatally is now seen as a preventative measure given that pregnancy and early childhood are known sensitive periods for such transmission. In this article, Ereyi-Osas & Madigan raise several concerns associated with this practice.

Using a narrative review to clarify ACEs history-taking of pregnant women and children under 6 years, the authors explored parents' and healthcare workers' perspectives to understand the implications of asking about ACEs in primary care settings and to identify gaps in the research literature requiring attention.

A systematic search of the literature enabled the selection of nine primary studies. Two tables summarise their results and a flowchart clearly outlines their review process. Three important findings are listed:

1. Parents, especially those with high ACEs, experienced discomfort when being asked about ACEs,
2. Trauma-informed training and care needs to be implemented in any service asking about ACEs and
3. The need for resources and support for families when asked about ACEs is critical.

Important implications listed from the research include the need to use a standardised measure of ACEs to identify those childhood experiences that are most relevant for infant mental health outcomes and that social support is an important buffer of the effects of ACEs on mothers' well-being and functioning. When asked about ACEs, mothers are best served by providers who have an established relationship which is more likely prenatally rather than post-natally. In addition, providers who have training in trauma-informed care, are more comfortable asking mothers the ACEs questions which also helped mothers be a little more at ease as they answered the ACEs questions.

The authors conclude with a warning of how limited the research is on the implications of this increasing practice and therefore the importance of organisations ensuring there is adequate support and resources available to families and relevant training to healthcare providers when taking ACEs history.

Weaver, A. Dawson, A. Murphy, F. Phang, F. Turner, F. McFayden, A. and Minnis, H. (2022). Prioritising Infant Mental Health: A qualitative study examining perceived barriers and enablers to Infant Mental Health service development in Scotland. *Perspectives in Infant Mental Health, 30*(1), 21-28.

This Scottish study into perceived barriers and enablers to IMH service provision in Scotland highlights the ongoing challenges faced when developing infant mental health services. Despite the wealth of extant evidence highlighting what infants need in order to reach their potential and the cost/benefits of intervening early to enhance infants' mental health and developmental trajectories, services focussing on infants and parent/infant relationship rather than parents only, are scarce and difficult to sustain over time.

Societal stigma and lack of understanding were most commonly mentioned with all participants noting that 'the public do not want to accept the idea of "babies" needing a mental health service' (p. 23). Other barriers include a lack of synergy among professionals and organisations and a lack of resources with competing demands. There can be fears around pathologizing babies and blaming parents, and while it's easier to focus on parents especially as babies are 'voiceless' and unable to advocate for themselves, older children's more 'obvious' needs, are often prioritised by services. This, combined with a lack of consistent leadership, professional exposure, and staff burnout, goes a long way to answer the authors' question:

> Why is it challenging to build IMH services, despite the fact that we know that the baby's brain is developing so rapidly?

While most of the above barriers have previously been identified in various studies, the authors report that the factors they identify as enabling have not previously been emphasised. These factors include a level of current optimism and enthusiasm, the will to address stigma, to work collaboratively, and to empower parents. The provision of increased training, education and use of evidence-based guidelines plus the importance of reflective practice were all seen as supports that will ensure success.

The authors conclude that for infant mental health service provision to grow, a public health initiative is needed to 'normalise the term infant mental health, combat the stigma surrounding it, and increase awareness' (p. 26).

Lillas, C. and Marchel, M. (2015). Moving away from WEIRD: System-based shifts in research, diagnosis, and clinical practice. *Perspectives in Infant Mental Health*, 23(1-2), 10-15.

Lillas and Marchel assert that IMH research since at least 2000 has been a multi-tiered research field influenced by various theoretical systems. They claim that the relational complexity embedded in IMH means it fits well with current worldwide developments in research. They highlight the over-emphasis on Western, Educated, Industrialized, Rich and Democratic (WEIRD) societies in research communities and their findings and the need to address issues like 'cultural

and fiscal disparities' in population sampling. They point out that the use of diagnostic categories does not line up with clinical complexity because of the underlying systemic nature of many issues and that linear research methodologies have limited efficacy in this space.

The focus internationally in research has turned increasingly towards 'translational, interdisciplinary and community-based participatory' approaches and the authors encourage IMH researchers to continue to move forward in these areas.

Proposing a parallel process model that is multi-layered and interactional, promoting 'dynamic systems theory, practice and research' (p.13), they liken it to Heller & Gilkerson's (2009) model often used in IMH reflective supervision. The model outlines various movements across interrelated layers that will enable a more inclusive international perspective.

The article concludes with six recommendations (more fully outlined in the paper on *Cultural Representations in IMH* in this Supplement) to infant mental health researchers and clinicians, urging them to use evidence-based interventions, to 'challenge existing mental models and frameworks' and adopt a more complex, collaborative and community-based perspective.

Becker, A. E. and Kleinman, A. (2015). Mental health and the research agenda, *Perspectives in Infant Mental Health*, Fall 2015, 23(4), 10-11.

This paper is a republished excerpt from a longer paper published in the New England Journal of Medicine. While not directly addressing infant mental health, the article emphasises the burgeoning of mental ill health as a global issue, the indivisibility of health and mental health and the ongoing challenge of reducing the global burden of mental illness.

Joshua Sparrow in his introduction to the paper highlights these ongoing challenges that also afflict IMH research and practice: a lack of funding, a limited workforce, WEIRD science contributing to a lack of cultural safety in service provision and widespread stigma associated with structural and systemic 'abuse of human rights'.

The authors call for a mental health research agenda focussing on mental health in populations of less wealthy countries and the need to generate an evidence base within these countries to assist with strategic planning and implementation. They point out that inequitable global research capacity cannot address the specific needs that are urgently required in care and service delivery. They call for more scientific endeavour in resource-poor settings and publications that support this, noting that there are fewer studies of mental health in poorer populations and nations and that the psychiatric literature reflects this thereby perpetuating global health inequity.

One of the main barriers to equitable care in health and mental health is social adversity which 'is both a risk factor and an outcome of poor mental health' as it 'compounds the disenfranchisement that exacerbates social structural barriers to health care' (p.11).

However, the authors claim that the universal stigma attached to mental illness is the biggest barrier to improving global mental health. They argue that it is this stigma that diminishes the mentally ill person and adversely affects both the mental health workforce and policy experts in the mental health field. While they applaud more recent shifts in China and elsewhere to address the 'deeply institutionalised' stigmatisation of mental health, they emphasise this is the hardest and the most important challenge.

Rygaard, N. P. (2015). Infant Mental Health in the Global Village. An invitation to reader's debate: Emerging infant environments, and future research. *Perspectives in Infant Mental Health, 23*(1-2), 3-7.

This thought-provoking essay by Neils Rygaard was published in the following issue in 2015, also addresses the nature of the research agenda, specifically the IMH research agenda, and remains extremely timely. He highlights how the rapid rate of change combined with forecast challenges in our urban environments, creates many challenges for infants and their families. Because of their dependency on daily care in their immediate environment, infants are particularly exposed to and affected by adverse conditions.

Rygaard identifies several risk factors for infants' growing-up environments globally and suggests possible areas of research for IMH. He points to the impact of rapid social global changes like increasing urbanisation, a reversed age pyramid, increasing migration, and the diversification of how a family is defined as ongoing immediate challenges to infants. He highlights the 'inappropriateness of an increased child-labelling diagnostic culture' as a response to what he identifies as a societal response to increased anxiety.

Rygaard proposes several research areas pertinent to infants' development and poses research questions for future research. The areas identified remain current. His reflections on demographic changes have him calling for 'a revision of how we conceptualise infant research' (p. 6) and suggesting that research designs and interventions need to adjust to the differing realities of settings in developing countries versus developed countries.

He concludes by emphasising the need for cross-disciplinary models with a focus on vertical validity and linking micro and macro-processes to better support infants' development. His final question is worth repeating:

> Can the WAIMH forum and other research societies join to design a global interdisciplinary research bank, setting global standards for urban infant quality care, to support systems for infants in the future? (p. 7)

Reflections and future directions

This chapter has presented a variety of research methods and topics of investigation in infant mental health. However, it is only a small sample of the extensive research into infants and their development that exists today. One ongoing challenge for infant mental health research, and research generally is to translate what we know into clinical practice.

How do we inform our communities with our knowledge of infants and what they need to thrive?

How do we integrate infant mental health research with practice wisdom?

It is difficult to work clinically and to take part in research. It can feel like there are never enough resources and time. What do we need to support

our exploration and articulation of what works for infants and families in hospitals and community clinics, in childcare settings and home-visiting services?

Professor Charles Zeanah (2022) speaking on 'Emerging Issues in Infant Mental Health' in a recent web-based lecture series, posed the following question:

> 'We have witnessed a remarkable growth of evidenced based interventions for young children and their families in the past two decades. The looming question for us is, what works for whom? The challenge requires conducting comparative effectiveness trials, comparing different interventions, with attention to moderators of treatment effectiveness and to economic as well as clinical outcomes.'

There is an ongoing need for practice-based evidence to inform evidence-based practice. Creating communities of practice and collaborating on community-embedded programs helps point to 'what works for whom' and 'how come this is so'. Relationship-based, culturally embedded action research is needed in services across the globe so that we can bring more of what we continue to learn about infants and their families into our world.

References

Zeanah, C. (2022). *Session 3, Emerging issues in Infant Mental Health, Laying the Path for Lifelong Wellness*, https://imhpromotion.ca/resources/Documents/Learning Centre/Lecture Series 2022/LS2022_Speaker-Details.pdf

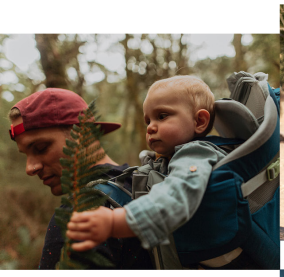







Global Perspectives on the Transdisciplinary Field of Infant Mental Health 1993 - 2021: WAIMH eBooks Topical Resource Guide, Volume 1

Edited by
Miri Keren, Maree Foley, Deborah Weatherston, Kaija Puura, and Patricia O'Rourke





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Global Perspectives on the Transdisciplinary Field of Infant Mental Health 1993 – 2021: WAIMH eBooks Topical Resource Guide, Volume 1

Keren, M., Foley, M., Weatherston, D. J., Puura, K., & O'Rourke, P. (Eds.) (2022). Global Perspectives on the Transdisciplinary Field of Infant Mental Health 1993 – 2021: WAIMH eBooks Topical Resource Guide, Volume 1. Finland: World Association for Infant Mental Health

This World Association for Infant Mental Health (WAIMH) eBook provides readers with a nearly three-decade-long window from which to view theories, interventions, and treatment practices within the specialized and interdisciplinary field of infant mental health. It does this by highlighting a representation of papers, published by WAIMH, in The Signal and Perspectives in Infant Mental Health, from 1993-2021.

This eBook comprises 17 chapters. These chapters provide an overview of infant mental health principles and observation practices, professional development 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. Each chapter provides a summary of the topic as well as an invitation to readers to reflect on future directions, opportunities, and challenges, as we continue to work together to progress the social, emotional, and relational health of all infants in their families within their communities.

Download the eBook

Current WAIMH members can download this eBook for free, and for others the cost is 10USD. Go online to WAIMH Store and download this resource: waimh.org/store

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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.

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Perspectives in Infant Mental Health Submission Guidelines

APA 7th Edition.

12-point font.

1.5 or double spaced.

Maximum 3000 words, including references. At the time of publication, this word limit was under revision by the Perspectives Editorial team. Please keep an eye out on the WAIMH website for an update or contact the Editor-in-Chief at: perspectives@waimh.org

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.

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