Perspectives in Infant Mental Health

Contents

From the Editor-in-Chief

By Jane Barlow (United Kingdom)

We start this issue of Perspectives with letters from our President Astrid Berg and Executive Director Kaija Puura describing the way in which WAIMH is striving in the face of the devastation caused to families by the many global crises currently taking place, to enable us to connect, have conversations, network and support one-another. These are timely reminders about the potential for us to connect via our membership platform alongside the urgency of us having conversations with one another to share our experiences and learning. Related to this, we publish an introduction and link to the newly published Australian Position Paper entitled *Infants in Refuge*.

Our first clinical practice paper describes the experiences, research and lessons learned over the past ten years, through a Nordic clinical and academic training collaborative that was established to disseminate the delivery of Child-Parent Psychotherapy. The second paper is the first of a series that will provide a summary of one of the chapters in the newly published 5th Edition of the *Handbook of Infant and Early Childhood Mental Health*, this first paper being focused on the Danish NGO Fairstart Foundation [FS], which has developed a comprehensive approach to addressing significant global stressors that affect parents and caregivers of infants, particularly in the context of non-parental care. FS´s mission is to transform recommendations for childcare from international research into education, tailored to the various needs of partner organizations worldwide, thereby creating an efficient and scalable method by educating staff in partner NGO´s and government agencies as trainers of local caregiver groups. Our third clinical paper explores the transformative potential of the JUSTICE framework in reflective supervision, particularly for supervisors and leaders working with diverse communities globally, using a case study to illustrate its application across a range of cultural contexts. This article advocates for the JUSTICE framework as a necessary tool for advancing equitable reflective supervision, pushing organizations to make a sustained commitment to social justice in leadership practices.

This provides us with a nice segue into our Reflections on Practice section which focuses on the thoughts of five leading IMH clinicians

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– Astrid Berg; Juane Voges; Miri Keren; Hisako Watanabe; and Debbie Weatherston from globally diverse parts of the world (South Africa; Israel; Japan and USA respectively) about the key role of Reflective Practice in effectively supporting the parent-infant relationship.

Our Opinion Pieces this time includes two papers on attachment, the first of which raises questions with regard to the cultural and contextual appropriateness of IMH measures such as some of the standard tools that are currently being used to assess attachment in settings that are very different to those in which they were developed. The second Opinion Piece considers the role of parental attachment styles in nursing interventions for the management of unsettled infants in Newcastle New South Wales, Australia.

Finally, our Letters section provides a response to the Opinion Piece in the last issue of Perspectives by Professor Kai von Klitzing in which he explored the tension between a "culturally sensitive approach" that acknowledges multiple acceptable pathways to young children's mental health and one that is characterized by "cultural arbitrariness" in which there is a blanket acceptance of virtually all cultural practices. This response to his letter addresses some of his assertions and questions regarding non-traditional approaches to conceiving and raising children.

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

With all good wishes,

The WAIMH Perspectives in Infant Mental Health editorial team

From the Desk of the President of WAIMH

By Astrid Berg (South Africa)

Dear WAIMH Members,

Some time has passed since some of us met at the 2024 WAIMH Interim World Congress in Tampere. Those of you who were there will agree with me that it was a welcoming and warm event. Finland is a beautiful country, with friendly people and with digital efficiency! My thanks go to the organizing committee in Tampere – the care they took in organizing and hosting was seen end felt.

Coming from the so-called Global South, I was particularly interested to hear about the various projects taking place in the Scandinavian countries. The reach of WAIMH membership is wide, and as part of that I am very happy to welcome new colleagues from various countries onto the Board, as well as old colleagues in new roles. I am excited by the broadening of our global representation. WAIMH is able to enjoy and benefit from diversity amongst its members – this is something I treasure. We can all learn from one another and be united in our efforts to lessen the burden that our infants and young children and their families are forced to carry.

We are in the midst of global crises – what is happening to the youngest in so many parts of the world is horrifying. "Each trauma is a world onto its own" a colleague told me – and nothing can be more true. Be this in Sudan, Ukraine, Israel, and Palestine. The suffering is too difficult to watch, and yet we must bear witness – this being the only thing which many of are able to do.

One way in which we at WAIMH are trying to do this is by speaking with each other – right now it is via webinars and in our publication Perspectives. We hope to begin conversations with each other – we have a contribution of personal experiences from our colleagues from different parts of the world and it is our wish that this will become a space where we can share difficulties, ask for advice, and also receive helpful information.

The workshops and the conference held in Palestine and organized by the Center for Educational Studies and Applications CARE in July and August of this year, were an example of what can be done in the midst of an impossibly turbulent and dangerous time. To focus on mental health when physical survival is under threat is a challenge, but it was done with the help of community and broader societal and institutional participation.

This work was discussed at a combined Affiliate plus Global Crises working group meeting in September 2024 and will be continued with a presentation from Israel in November. In this way we are hoping to be able keep our focus on the infants and young children that are suffering, without being drawn into endless and unhelpful 'yes, but' political debates.

Our eyes are also on the forthcoming 19th WAIMH World Congress in Toronto in October 2026. We are working towards having presentations from different perspectives in infant mental health that will speak to clinicians, researchers, and policy makers.

In the meantime, it is our hope that peace will eventually prevail and that our common humanity will be what counts.

Photo: Astrid Berg

WAIMH Executive Director Corner

By Kaija Puura (Finland)

Dear colleagues and friends,

Our local newspaper publishes a daily aphorism, and one from this week has lingered in my mind. It was penned by my high school classmate Jouni, now a psychologist and author of several books on coping with life's challenges. The aphorism read: "**Past is history, future is fantasy, the present moment is a gift**." I've found myself repeating this throughout the week as I navigated the news and my exceptionally full calendar. Staying present isn't always easy, but for me it has become a way to alleviate worries about uncertain future events.

Another way I've found to stay in the moment is by spending time with a baby. Since June, I've had the privilege of visiting my granddaughter and her parents weekly. Observing the baby's growth and the parents' journey into parenthood has been fascinating, reminding me of the vulnerability of the newborn phase. To me these weekly visits provide a chance to enjoy early interaction with a baby, something I haven't been able to do for so many years. Playing with the baby, talking motherese and getting the baby to smile and laugh is one of the best ways of staying in the now. The intensity of being with a baby is such a powerful experience. Talking with the mother about her experiences, thoughts and worries has also been rewarding, though also made my heart ache at times. Poorly slept nights, pains in the body, and the constant worries of a new mother have made me wish I could do more. On the other hand I have realized that the for the young mother most important is that I am there, listening and sharing her experiences.

This week, I had the opportunity to connect with a dear friend over Zoom. We shared our thoughts on the current state of the world, and it's easy to feel disheartened by the constant stream of news about wars and disasters, especially when we feel powerless to make a difference. A column in a local paper echoed this sentiment, recounting the story of an elderly woman who always chose the same locker at her local swimming pool for a sense of continuity and security in an

increasingly uncertain world. The columnist emphasized the importance of not giving in to fear, but rather maintaining hope for a better future. She also encouraged readers to resist apathy and focus on the small actions we can all take to improve our circumstances.

My friend and I reached a similar conclusion: it's crucial to care for those around us and do what we can, however small, in the hope that our efforts will contribute to positive change. As members of WAIMH, one way we can make a difference is by joining the WAIMH Global Crisis group, where we can offer our support and presence. The group has facilitated online meetings, providing a platform for individuals from Ukraine, Palestine, and Israel to share their experiences with colleagues from other countries.

Let's remember to listen to and support one another whenever and wherever we can. The WAIMH community is dedicated to making a positive difference for babies, young children, and their families. As a WAIMH member, you are never alone in your work. The WAIMH Central Office is currently developing guidelines on how to utilize our membership platform for connecting, networking, and peer support. Hopefully it also will give us new ways of helping each other and finding new ways of getting the voice of infants and young children heard.

With my warmest regards to you all,

Kaija

Photo: Kaija Puura

A Nordic initiative to improve services for infants and young children by dissemination of Child-Parent Psychotherapy

By Karin Pernebo and Pamela Massoudi (Sweden)

In the first years of life, the risk for exposure to severe stressors and potentially traumatizing events is heightened, with a risk for profound short- and long-term consequences on health and development. Yet services for the youngest population are often scarce, underdeveloped and not research-based. This article describes the dissemination process of Child-Parent Psychotherapy in Sweden and Norway through a clinical and academic training collaborative, research, and the formation of a Nordic network. Experiences, lessons learned, insights, and thoughts from the past ten years will be discussed.

Introduction

Infants and young children exposed to potentially traumatic events such as child abuse and neglect, intimate partner violence, medical trauma, war, natural disasters, or other adverse life events risk negative consequences on their immediate and long-term development and well-being (Grummitt et al., 2021; Hunt et al., 2017; Lippard & Nemeroff, 2020; Yu et al. 2022). Data from various cultural contexts indicate that a substantial proportion of children exposed to maltreatment and interpersonal trauma are under the age of 6 years (Jernbro & Jansson, 2017; US Department of Health & Human Services, 2022). Simultaneously, a solid body of research has established the youngest children's particular vulnerability to adverse neurodevelopmental effects (Nelson & Gabard-Durnam, 2020; Teicher & Samson, 2016). Early exposure is associated with a high risk of significant adverse short- and long-term consequences on physical, mental, cognitive, and social health and development that often persist into adolescence and adulthood (Grummitt et al., 2021; Hunt et al., 2017; Lippard & Nemeroff, 2020; Woolgar et al., 2022; Yu et al., 2022). Many of these children demonstrate post-traumatic stress related to the exposure to trauma and adverse events and often need specific trauma-informed treatment (Hiller et al., 2016; Holt et al., 2008).

While infants and young children are at high risk of negative consequences of traumatic and adverse life events, they are also at an age where interventions can make a crucial difference in their health and development. Intervening early with relationship-based treatment models offers the potential to intervene in the parental caregiving system, with both short- and long-term benefits (Zeanah, 2019). In many countries, effective and evidence-based treatments specifically developed for children aged 0-6 exposed to trauma are scarce and insufficiently offered to young children and families. Many interventions are not effective enough for young children (Gutermann, 2016), and additionally, many interventions are not culturally appropriate and fail to consider the diverse cultural dynamics of the families served, resulting in limited effectiveness. As a result, many children and caregivers continue to struggle with remaining difficulties associated with relational challenges and post-traumatic stress. This is particularly true for the youngest children. (Furmark & Neander, 2018; Hooker et al., 2022; Osofsky & Lieberman, 2011; Vanderzee et al., 2016).

In summary, infants, toddlers, and preschoolers are at higher risk of exposure, risk severe consequences, and have less access to services than older children and adults, despite being at an age when interventions could be the most effective (Nelson, 2020; Sullivan, Roubinov et al., 2024; Zeanah, 2019).

Child-Parent Psychotherapy

Child-Parent Psychotherapy (CPP) is a diversity-informed treatment model developed specifically for children aged 0-6 and their caregivers affected by the consequences of trauma (Lieberman et al., 2015). The model emphasizes a strong commitment to diversity, equity, inclusion, and respect for family and cultural values, which are integral to the therapeutic process. CPP is relationship-based, integrating developmental, attachment, psychodynamic, cognitive-behavioral, social-learning, and trauma theories to provide comprehensive support. . The model aims to decrease the impact of trauma by strengthening the caregiver–child relationship, (re)establishing the child's sense of safety, and restoring the child's development to a typical trajectory (Lieberman et al., 2015). Modalities and interventions include play, attachment promotion, developmental guidance, translation of the child's emotional expression in behavior and play to the caregiver to help them understand each other better, enhancement of dyadic and body-based affect regulation, emotional

support, and processing past caregiver traumas.

Five randomized controlled trials have demonstrated the effectiveness of CPP, showing decreased child and parental psychiatric symptoms, improved child–parent relationships, and increased cognitive functioning (Cicchetti et al., 1999; Cicchetti et al., 2006; Lieberman et al., 1991; Lieberman et al., 2006; Toth et al., 2002). CPP is one of few evidence-based treatments specifically targeting children aged under six years suffering negative consequences of trauma and adverse life events (for an overview see Dozier & Bernard, 2023). In a recent study, CPP was found to be associated with lower epigenetic age acceleration, a biomarker associated with later adverse physical and psychiatric outcomes (Sullivan, Merrill et al., 2024).

The dissemination of Child-Parent Psychotherapy in Sweden and Norway

To improve services for young children, CPP was introduced in Sweden and Norway, where the model had not been previously practiced. Professor Kjerstin Almqvist initiated a feasibility study and training in Sweden in 2013 as part of a research program about treatment for children exposed to violence, funded by the Swedish National Board of Health and Welfare. A training program was developed in close collaboration and with the support of the developers at the Child Trauma Research Program, University of California, San Francisco (Alicia Lieberman & Chandra Ghosh Ippen).

Besides the training of clinicians and trainers, the implementation of CPP in Sweden and Norway has included research and the formation of a Nordic network for CPP to scaffold training, research and clinical practice.

Training

Two Swedish and three Norwegian trainers have been trained who now provide training in Swedish and Norwegian. Training is offered continuously, ten cohorts and approximately 190 clinicians, working in a variety of contexts have been trained, e.g. child and adolescent mental health services, (CAMHS), social services, units specialized in trauma or in infant mental health, children's hospitals, non-governmental organizations (NGOs), and primary health care. The majority

of participants have been clinical psychologists or social workers.

Nordic research

Simultaneously with training and implementation in practice, research has been realized (Almqvist et al., 2018; Norlén et al., 2021; Norlén et al., 2024; Pernebo et al., 2023). Ongoing research includes a follow-up of the effectiveness study and a study on the feasibility of CPP for children in foster care that includes both qualitative interviews with children, caregivers, and therapists, and quantitative data on outcomes e.g. symptoms in children and caregivers. Additionally, a study on the implementation of CPP in Norway is underway.

A feasibility study, conducted in conjunction with the first training, indicated that CPP was appropriate in the Swedish context without particular adjustments. The method was appreciated by clinicians and families, and the positive results from studies in the United States seemed to be similar in a Swedish context. The conclusion was that CPP is a method well suited for the target group in Sweden (traumatized children 0-6 years) without essential adaptations (Almqvist et al., 2018, Broberg et al., 2015). These findings contributed to the decision in 2016 by the Swedish National Board of Health and Welfare to support the dissemination and implementation of CPP in Sweden.

In another Swedish study, Norlén et al. (2021) investigated the experiences of caregivers who had taken part in CPP with their child. Results revealed that caregivers appreciated the intervention. Their reported experiences illustrate how CPP was perceived as improving parenting skills, contributing to the child's development, for example, an enhanced capacity to recognize and regulate feelings and reactions, and improving parents' understanding of and communication with their child.

In a one-group, pretest-posttest design the effectiveness of CPP in a Swedish naturalistic multi-site clinical setting was investigated (Norlén et al., 2024). Reductions in post-traumatic stress and general psychological symptoms with small to medium effect sizes were found in both children and caregivers. Caregivers also reported improvements in the caregiver-child relationship. The study supports that CPP addresses and reduces both symptoms of the

individual child and the caregiver, and improves the child – caregiver relationship. Further, the results suggest that the dyadic model addresses the association between child traumatic stress and caregiving capacities; for example, reductions in the child's PTSD symptoms were associated with a decrease in the caregiver's report of disorganized parenting.

The findings from these three studies (Almqvist et al., 2018; Norlén et al., 2021; Norlén et al., 2024) support that CPP is a promising method for traumatized preschool children, and is possible to implement in various regular services in Sweden.

With the aim to explore the extent to which clinicians trained in CPP continued to work with the model after training and how they experienced its implementation and sustainability over time, a study with a mixed-methods design was conducted (Pernebo et al., 2023). In this study, a survey was distributed to all 66 clinicians in Sweden trained in CPP at the time, and interviews were conducted with a sample of 12 clinicians. The results showed that most clinicians continued to work with CPP after the training, they found the model enjoyable and rewarding, and they were confident that CPP was effective. Few young children, however, seemed to access treatment, and few clinicians had treated enough cases to acquire extended experience or expertise. The organization's readiness to implement new methods, collegial support, and legal processes involving the child were factors that affected implementation and sustainability. In this study it was concluded that the implementation and sustainability of CPP seemed to be both facilitated and hindered by factors at a systems-level, within the organization, and by individual factors. Particularly worrying was the indication that few young children affected by trauma accessed evidence-based treatments, and that serving this population was often not a priority at a systems and organizational level.

A Nordic network

A Nordic network has been established to scaffold CPP training, research, implementation, and sustainability. The aim of the network is twofold. First, it offers an opportunity for trainers and key persons responsible for organizing training, conducting research, or are involved at systems level in CPP-related

activities to meet and support each other in planning and conducting training, meetings, research, and work on a systems level. Second, the network offers an opportunity for all CPP-providers to be connected, share experiences and further learning, and support each other in sustaining fidelity in the model. The network has organized activities and meetings for participants from both Norway and Sweden, including on-site meetings for continuous learning through consultations and case-based learning, webinars, research updates, and reflective learning sessions focusing on specific themes such as working with offending fathers, working with children in foster care, and implementing CPP in social services.

Discussion and Conclusion

CPP has been found to be effective, applicable in a Nordic context, and is appreciated by clinicians and caregivers. The model seems to fill a gap in the services provided for the youngest children affected by trauma. Still, clinicians in the implementation study reported that services for these children were often not prioritized and that few young children accessed treatment (Pernebo 2023). Furthermore, several described a sense of how implementing and providing treatment for the target group ended up being their individual responsibility as clinicians and informal champions for services for young children, instead of being driven by leadership, policy, and national recommendations. This makes the implementation and sustainability of the model vulnerable to staff and leadership turnover, economical strains, and political changes, ultimately leading to scarce and unequal access to care. In Norway this is somewhat less evident due to a system with a national and regional organization, a competence center for child and adolescent mental health, responsible for dissemination, training, and sustainability of evidence-based practices in child and adolescent mental health. In Sweden, this structure is lacking on a national level. Despite a robust knowledge base on the potentially detrimental effects of experiencing trauma at an early age, and on how treatment can help, this knowledge is not translated into policy, sustainable systems and structures, and services that reach children and families.

On a more positive note, there are several findings that convey hope. The experiences of caregivers and

providers, the demonstrated decrease in symptoms in children and caregivers, and the improvement in child-caregiver relationship indicate CPP to be effective. Providers describe CPP as a treatment model and therapeutic approach that gives them a sense of security, with procedures and fidelity measures as something to hold on to when facing complex cases, many times without much support. The CPP model is more than techniques and specific procedures. Its components include reflective practice, care coordination, focus on the therapeutic relationship, and psychoeducation integrated in the engagement and assessment phase. In this work addressing experiences related to historical trauma, racism, power and other injustices that may have been experienced is paramount to CPP work. This professional stance seems to be experienced by providers as concordant with what is needed when working with young children and families struggling with complex issues in the light of exposure to trauma and adversities.

Training in CPP also provides the clinician with a network of colleagues, instilling a sense of not being alone in this work. The Nordic providers have highlighted having colleagues to discuss and reflect with as essential and rewarding, promoting sustainability and fidelity in the model.

Sweden and Norway have been ranked as the best countries in the world for raising children (OECD, 2024) and among the top three for mental health, with scores based on several factors from OECD reports (William Russel, 2024). Our experiences from the dissemination and implementation of CPP, as well as the results from research however, show that there are still challenges and gaps in services when it comes to serving the youngest and most vulnerable citizens affected by trauma and in need of assessment, support and treatment.
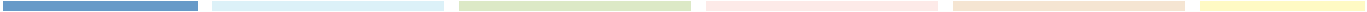
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A global intervention to improve care for infants and children

By Niels Peter Rygaard (Denmark)

Since 2016, the Danish NGO Fairstart Foundation [FS] has developed a comprehensive approach to addressing significant global stressors that affect parents and caregivers of infants, particularly in the context of non-parental care. FS´s mission is to transform recommendations for childcare from international research into education, tailored to the various needs of partner organizations worldwide. This approach focuses on educating staff in partner NGO´s and government agencies as trainers of local caregiver groups. By developing digital education and culturally tailored group training programs, Fairstart has created an efficient and scalable method for training caregivers of infants and children. Results indicate lowered caregiver stress and improvements in child development (Fairstart 2019). The following text highlights the key points from this approach, with a focus on stressors for parents and infants, online education of local partner staff as instructors, and instruments for measuring outcomes from attachment-based training programs. Lessons learned are summarized to inspire future digital designs.

Stressors for Parents and Infants

Across cultures, many families are experiencing unprecedented stress as they adapt to urban life, which often disrupts traditional caregiving structures. Projections indicate that 80 % of the world population will live in major cities by 2050 (World Bank Urban Development 2023). One primary stressor is the breakdown of extended family and community networks, which previously provided a natural support system for child-rearing. In urban environments, parents often face economic hardship, housing instability, and limited access to social services, all of which contribute to parental stress and ultimately affect the quality-of-care infants receive. Additionally, caregivers in alternative care systems (e.g., orphanages or foster care) often lack adequate training (a global need of 1,2 million mental health workers in low-income countries further exacerbates

the problem) (Endale et al. 2020). These stressors necessitate interventions that can provide both parents and caregivers with the tools to deliver high-quality, attachment-based care.

Online Classrooms to Educate Fairstart Partner Instructors

Based on recommendations of care from an international network of researchers, FS developed an online classroom model on the edX virtual platform from Harvard and MIT, designed to educate partner staff as trainers (instructors) across diverse cultural settings. After a local three-day start-up seminar with FS staff, students follow eight 4-hour modules, delivered over a six-month period. Modules cover topics such as attachment theory, caregiver group development, and learning theory. Each module includes instructional videos, research summaries, and practical exercises that caregivers can implement in their daily care routines.

Attachment-Based Online Group Training Programs for Caregivers

Each module prepares a student to conduct a group training session with a local group of caregivers or parents, who then design individualized care plans for children in their care. After

local research and interviews, FS group training sessions are designed and adapted to local cultural strengths, challenges and language. When meeting at the eight three-hour group sessions, caregivers form strong groups for mutual support, and learn and apply new care practices with continuous support from their instructors and Fairstart.

The program includes FS´s simple pre- and post-training questionnaires (Scorecards), designed for illiterate caregivers, to measure caregiver stress and well-being as well as caregiver assessments of child development. An external study found Scorecard reliability and validity for children ages 0-12 to be comparable with other instruments (Hecker et al. 2022). The training programs are not only designed for caregivers of infants but also cover the needs of older children and adolescents (such as sessions on how secure caregiver behavior can enhance brain development). This holistic approach ensures that caregivers are supported through all stages of child development, as illustrated in a feedback interview with three African foster mothers (Fairstart 2021).

Outcomes

The results of Fairstart's training programs have been significant. Over 800 instructors have been trained in 36 countries in close cooperation with partners, ranging from SOS

Children´s Village staff in 13 African countries, to educating municipality staff for Greenland Government. Students have trained caregivers responsible for more than 70,000 children. Caregivers reported greater confidence in managing challenging behaviors caused by separation trauma, and children showed improvements in emotional regulation and social skills (SOS Evaluation Report 2019). In addition to individual-level outcomes, the program has contributed to local systemic changes in the way care is provided. In some partner countries, elements of FS have been included in national parenting programs. Besides, all training sessions are open source online in many language versions, visited by many interested professionals (Fairstart 2024).

Lessons learned: The Power of Intercultural Partnerships and Online Educations

The combination of intercultural partnerships and online education has proven to be a powerful tool for reaching large populations at a relatively low cost. Equipped with a universal serial bus (USB) containing the 21 group sessions, FS graduates now train caregivers in remote and underserved areas, ensuring that even the most vulnerable children receive the care they need. The flexibility of the online model allows for continuous adaptation to local cultural contexts, making the training more effective and sustainable over time. The FS project has spurred much interest from researchers - papers on various aspects of the project have been downloaded more than 5000 times (ResearchGate. net 2024). To further inspire intervention designs, Rygaard and co-editors invited researchers worldwide to describe risk for children in their countries, and their intervention programs (Rygaard et al. 2024)

The emergence of Artificial Intelligence (AI, Chat GPT programs, etc.) may allow for further upscaling and adaptation to local cultures. However, lessons learned show that the success of online-based interventions for infant care only emerge in long-term cooperation and dialogues with partners, and the formation of strong intercultural networks on equal terms. Partners must be involved in program design from the very start, and cultural care traditions and strengths must be merged with the general recommendations from care

research. Another valuable lesson is that trainings of caregivers per se will only have limited effects, unless combined with the strengthening the professional competences of local mental health workers and their organizations. The FS pre-and-post tools for outcome measurement of attachment-based interventions in low-income countries are one attempt to retrieve reliable data, and will hopefully inspire further methodological research.

About this paper

A full version of this paper can be found in Osofsky, J. D., Fitzgerald, H. E., Keren, M., & Puura, K. (2024). Chapter 9: Parenting and Infant Mental Health in Global Perspective: Exploring Standards for Virtual Intervention Designs by Rygaard, N.P *WAIMH Handbook of Infant and Early Childhood Mental Health (Vol 2): Cultural Context, Prevention, Intervention, and Treatment*. Cham, Switzerland; Springer Nature Switzerland AG..

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Reflective practice from around the world

By Astrid Berg (South Africa), Juané Voges (South Africa), Miri Keren (Israel), Deborah Weatherston (United States), and Hisako Watanabe (Japan)

Introduction

By Astrid Berg, Psychiatrist, WAIMH President

Child & Adolescent Psychiatrist as well as a Jungian Analyst

Emerita A/Professor at the University of Cape Town and A/Professor Extraordinary at the Stellenbosch University, South Africa

I am grateful to my four colleagues from different parts of the world, for sharing with us their personal responses to what reflective practice means to them at this point in time.

Whether these come from the context of the sagging couch and the sickly sweet smell of spoiled milk, or mothers struggling with mental illness and impoverished backgrounds, or the therapist sitting with patients hearing war sirens and being frightened for the lives.

What holds the therapist, the mental health counsellor together to enable her to be there for the families, for the infants, in need of holding? What is evident in all of these precious individual accounts? It is the collective notion that we are all human, equally human, and that which evokes despair, anxiety and terror feels the same for all of us. It is our thinking capacity, our ability to reflect, and for brief moments stand outside of ourselves, to suspend judgement and reach a deeper understanding, as is so beautifully depicted in one of our contributions. Only then can we see the other, only then are able to truly be there and have a mind that is open to take in the other.

I hope that these cameos of personal experience will encourage others in the WAIMH family to share their feelings and thoughts about this important topic.

Holding the fragmented mind in mind

By Juané Voges, Clinical Psychology, PhD

Department of Psychiatry, Tygerberg Hospital,

Stellenbosch University, South Africa

A young mother tentatively puts her infant down on the playmat, watching him look at the adults seated around him and then picking up a green block, before turning to her. Mom observes as older women share their struggles with depression, poverty and absent fathers, seeming to relax somewhat before also sharing her own difficulties of caring for her firstborn, while recovering from a psychotic episode and trying to complete school. As the group members encourage and gently guide her, it becomes clear that she feels held within this small community. Through the months that followed, the young mother became able to share her joys and challenges within the group and she seemed to develop a greater sensitivity to her son's bids for engagement.

Working with mothers struggling with various forms of mental illness and distress most of whom come from an impoverished background, I find myself holding sometimes contradictory feelings of hopelessness, uncertainty, confusion, optimism, wonder and joy. Within a weekly mother-infant mentalising group, I aim to create an experience of safety within which group members can reflect on their own and each other's experiences of mental illness and parenting of young infants. However, the most impactful moments often derive from observing and wondering together about their infants interacting at the centre of the group circle.

Reflective practice became a guiding influence in my clinical work when I had the opportunity to collaborate with the late Nancy Suchman on a pilot project focussed on implementing a mentalising intervention with mothers of young infants who suffered from a severe mental illness. Since then, I have found myself returning to one guiding concept time and again – a parent needs a felt experience of being reflected upon, understood and mentalised, in order to provide that experience for her infant or young child.

Parents with mental illness often struggle to make sense of their own thoughts, feelings and experiences – even more so during the journey of pregnancy and early parenthood. Within this context, the mind of an infant may seem especially indecipherable and daunting! I have found that a mentalising group for mothers with mental illness creates a useful framework for encouraging reflective practice between group members and within mother-infant dyads. Mothers in the group can put words to their own feelings and experiences and these can be reflected upon. This experience helps them to feel mentalised, which enables them to reflect more actively on their infants' internal worlds.

Clinicians and patients in war: Some personal reflections

By Miri Keren, M.D., Child and Adolescent Psychiatrist

Associate Clinical Professor at Bar Ilan University Azrieli Medical School

WAIMH Honorary President

In situations of war, the clinician is herself/himself exposed to survival threats. My personal experience as a clinician for almost 12 months now, makes me wonder about the impact of a shared, life-threatening environment on the essence of psychotherapy and its impact on the therapist-patient relationship.

For instance, how to keep a therapeutic reflective stance when, in the midst of a Trauma-Focused Child Parent Psychotherapy session, the noise of the siren cuts the air, and the team together with parents and children have to rush to the shelter together? What can the situation of being-afraid-together bring to the therapeutic relationship? A sense of humanity, facing a shared fate? Could we see it as an ultimate Attachment-Theory-based Interpersonal Psychotherapy setting, especially if we, the clinicians, are able not to be overwhelmed with fear and can put words on the unusual situation?!

Also, being together in extreme existential situations often breaks the standard setting rules. For instance, those families who have fled the war zones find it difficult to come to the clinic. Flexibility and creativity become essential tools: we go to them, wherever they are, and we bring with us our toy kits (including trauma-related toys).

To my mind, the major risk is for clinicians in wartimes is to lose our containing and reflective capacities, to adopt a dichotomous good/bad standpoint… reflecting those of the traumatised parents and the wider political environment. Being a helper is a way to cope. But what does it mean to help, when we have no control over mass processes, politicians, distorted media information, demagogy and demonization? I think that the clinician's role is not only to help parents and infants mentalize and put words to their traumatic experiences, but also and may be even more, to convey a basic trust in humanity, in spite of the surrounding inhumane acts, and to hold hope and trust.

Musings on Reflective Practice

By Deborah Weatherston, PhD,

Infant Mental Health Home Visitor, Supervisor & Consultant

Michigan, USA

One of the greatest gifts given to me has been the opportunity to work reflectively with families referred because their babies or toddlers were not thriving, or their parental caregiving capacities placed them at grave risk, as well as the regularly scheduled meetings with a supervisor who invited reflection about my work and myself. What follows are my musings about reflective practice.

The crisis of poverty surrounded me in my work as an infant mental health (IMH) home visitor. The frail baby's cry, the silent toddler's raspy cough, the young mother's hopeless stare, the fog of cigarette smoke, the sagging couch where they sleep, the chilly room, the sicky sweet smell of spoiled milk…this is what I witnessed on many home visits to very young children and their families who were underserved, marginalized, and undervalued. After shedding my own feelings of despair and vulnerability in response to the overwhelming circumstances of their lives, and opening myself to be present to each parent-infant pair, I would ask myself: *What does this baby need? This toddler? This mother? This father?* I would hold my emotions close to my heart until I could bring them to my reflective supervisor.

Trained in Selma Fraiberg's IMH home visiting model, I would return weekly, building my trust with families and they with me, to consider their immediate needs, connect them with health care, food banks, advocate for housing. Within the context of our relationship, those who felt invisible became visible. Listening to their stories, many of trauma, grief, hopelessness, and loss, helped them to feel heard. Sitting with parent and child together, I held the space for their reflections about the loss of other babies, removal of toddlers for months to foster care, past histories of drug use, abuse, maternal neglect, domestic abuse, and community violence. I listened carefully, offered guidance as appropriate, and tried to respond with empathy, without judgment, to what they shared that made caregiving so difficult. I tried to support their capacities - a baby's

smile, a toddler's first words, a parent's efforts to play. As my relationship with each developed, the veil of depression, pain, or anger shifted enough so that mothers or fathers might hold their babies and respond with warmth to the cries, the hunger, the silence or the upset of very young children in their care. There were things I could not change - persistent poverty, marginalization, discrimination. But I could offer a relationship that impacted their relationships with their children.

What I witnessed and the feelings aroused were often intense. In order to practice reflectively, from a relationship perspective, I needed a supervisor to help me navigate the felt experiences of IMH home visits with babies and families, week after week. The IMH supervisory relationship, founded on mutual trust, provided me with a holding space, an invitation to reflect, to feel held and heard, to be gently guided, to share the burdens, the hopes, and the pains. Supervision became a place for me to think about the impact of relationship centered practice with babies and families whose lives had been altered by trauma, grief, as well as the distress of persistent marginalization, discrimination, and poverty. Thoughts and feelings about my work opened possibility for more deeply personal reflections about other babies, other mothers, my experiences as a parent, relationships, past and present, as well as biases that I held. Such relationship centered supervision strengthened my belief that reflection could restore parental capacity to nurture and reduce the risks of relationship failure between parent and child. Reflective supervision also led me on a personal journey to become more introspective, self-aware. A two-fold, extraordinary gift.

Reflective Moments

By Hisako Watanabe, M.D., Ph. D., Life Development Center, Watanabe Clinic

Japan

Reflective practice is an indispensable part of our clinical encounter, immediately linking to *primum non nocere* (First do no harm) a credo of the Hippocratic Oath and also of infant mental health.

There are moments after a particularly difficult session with a client when I find myself struggling to recall or

understand all that transpired. In such moments, I work to still myself, close my eyes, and stay silent in the darkness for a moment until I find my way back to being grounded. It feels as if having travelled to a different world or having returned to the surface from a deep dive under water, exploring together with my client. In this afterglow of the tangible moments of encounter with a client, I am deeply immersed, body, mind and soul, in a lingering reflection until meanings of what transpired are fully realized.

As we face an increasing number of complex cases of traumatized children in this era of global crises, we need to widen and deepen our capacity for reflection and to pay greater attention to our gut feelings, nonverbal somatosensory clues of affection and caution. To this end, poet Keats's concept of '*negative capability*' is useful. During his short life between 1795 and 1821, he was a young medical doctor who had to experience utter helplessness, witnessing multiple losses, including his family. Keats coined the term, *negative capability* to urge us to suspend judgement in order to reach a fuller understanding. It is a capacity to bend flexibly when encountering something unexpectedly hard to overcome. *Negative* here implies the ability to resist explaining away what we do not yet understand. Inspired by Shakespeare's work full of misconceptions, Keats suggests that we take time to look at matters from multiple perspectives to gain new insights.

Reflective practice takes us back to the basics of life and the enigma of encounters and relationships.

Infants in Refuge: New Position Paper released in Australia

By Lauren Keegan (Australia)

The Australian Association of Infant Mental Health (AAIMH, an affiliate of WAIMH) have released a new position statement on infants in refuge, which partners the earlier position statement on the needs of infants experiencing family violence. Infants under four make up the highest cohort of children entering crisis accommodation, often with their mothers who are fleeing violence.

AAIMH consulted with Dr Wendy Bunston, PhD who has conducted extensive research on the experience of infants in women's refuges and calls for services to move beyond crisis interventions for mothers and provide specialised trauma support for infants, too. You can read a summary of Wendy's doctoral research in an earlier edition of Perspectives.

Dr Nicole Milburn, AAIMH Chairperson, says "Given Infancy is the most rapid developmental period in life. The position of AAIMH is that infants experiencing family violence do not have the time to wait while their mother's recover from what is often significant and cumulative abuse. It is essential that the infant's needs are

recognised and responded to in their own right. They are people who deserve the full range of safety and intervention services that older children, adolescents, and adults have."

You can access the full range of AAIMH Position Statements here.

Considering Cultural and Contextual Bias in Infant Mental Health Measurement

By Nicki Dawson (South Africa)

The development of rigorous testing methods is critical for scientific inquiry. Our profession relies on the foundation of reliable and valid measurement of constructs to validate theories of human development and inform interventions to support optimal outcomes for children. As a result, gold standard tests become our primary trusted source of information. Yet, psychometrics is not without complexity and psychometric testing has a particularly troubling relationship with human diversity. Uninterrogated endorsed measures pose the risk of painting human diversity as deficient.

South Africa provides a stark example of how psychometric measures can be intentionally used to discriminate and even oppress. During Apartheid, culturally biased tests were used to deny educational and economic opportunities to Black South Africans, and ultimately to exploit Black labour and oppress people of colour (Laher & Cockcroft, 2013), the consequences of which still affect millions of Black South Africans 30 years after democracy and liberation.

The possibility of cultural bias in infant mental health construct measurement is critical to engage with, particularly given that parenting practices, contexts and socialization goals for infants are highly diverse globally (LeVine, 1974; Keller & Otto, 2009). Different contexts require different skills to navigate them successfully; and given global differences in cultural values and socialization goals, parenting must and should look different in different contexts.

Mary Ainsworth was mindful of this in some of the earliest measurement development in infant mental health. The Strange Situation Procedure, the gold standard for assessing attachment security in infancy, is an adaptation of procedures originally developed in Uganda (Ainsworth & Marvin, 1995; Otto, 2018). Ainsworth noted that procedural changes were required to evaluate attachment behaviours in the US, as compared to in Uganda, due to variations in infants' typical experiences, which influence what is considered strange or stressful and the intensity of these stressors. During her interview with Robert Marvin in 1995, Ainsworth noted "I have been quite disappointed that so many attachment researchers have gone on to do research with the Strange Situation rather than looking at what happens in the home or in other natural settings - like I said before, it marks a turning away from "field- work," and I don't think it's wise" (Ainsworth & Marvin, 1995, p12).

As infant mental health research and practice extends across the globe, it is imperative that we interrogate the suitability of measures for context. Many of the gold standard tools used in infant mental health research today were developed in parts of the world that represent less than 10% of the global population (Heinrich et al., 2010; Mesman & Emmen, 2016).

Measures of sensitive responsiveness provides a pertinent example. Meta-reviews have shown that current measures of sensitive responsiveness are not strong predictors of attachment security among families from low socio-economic backgrounds (Woodhouse et al., 2020), and studies have sought to understand this. One study in South Africa compared the sensitive responsiveness scores of Black African mothers using two different measures, showing lower mean scores when tests specified behaviours as sensitive or insensitive; and finding that a measure developed in North America correlated with education, while a measure developed in Africa did not (Dawson et al., 2021). This study also found that certain behaviours were relatively absent in the sample, aligning with anthropological studies on cultural variations (Dawson, 2018). Similar findings have been noted in Pakistan, where differences in parental behavioural profiles highlighted potential biases in responsivity testing (Hentschel et al., 2024). In addition, in North America, a study found that an adapted construct, secure base provision, was a better predictor of attachment security in Black and Hispanic families than sensitive responsiveness (Woodhouse et al., 2020).

Theoretical arguments have also been made regarding the contextual and cultural appropriateness of parental mentalizing measures, which analyse interview answers for the presence of mental state language. While little research exists into the measures cross-cultural validity, cultural differences have also been found to exist with regards to the value placed on reflecting on mental states (Aival-Naveh et al., 2022), and mentalizing theory has been critiqued for its Cartesian underpinnings, the philosophical idea of a mind separate from the body (Køster, 2017). African Zulu speakers, for example, may be disadvantaged by such a measure, as their epistemological

framework does not conceptualize a mind separate from the body, and their language contains limited mental state language as a result (Mbaegbu, 2016).

Broader issues of measurement of infant mental health constructs in diverse settings have also been noted. For example, measures are frequently designed to consider dyads (infant and primary caregiver), or triads, centring a parental couple as caregivers (Mesman & Emmen, 2016). Such measures are not easily applied in contexts where alloparenting is common, and caregiving constellations are made of more nuanced family networks. While there have been proposed ways to adapt sensitivity measures for alloparenting contexts (Mesman et al., 2018), such ways of working remain uncommon.

Much is at stake. In a global world where international research increasingly drives the development of interventions for low and middle-income countries, it is ethically imperative to ensure that our measures are culturally and contextually valid. Without this consideration, we risk perpetuating a view of difference as deficient (Scheidecker et al., 2022). By critically examining and adapting our tools, and requiring contextual responsiveness, rather than framing it as a deviation from the gold standard, we can foster a more inclusive and accurate understanding of infant mental health and parenting for optimal child development across diverse contexts. Doing so is a critical step towards promoting equity and justice in the field of infant mental health, ensuring that all children, regardless of their culture and context, are appropriately supported to thrive.

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Considering parental attachment styles in nursing interventions for management of unsettled infants in Newcastle New South Wales, Australia

By Kathryn Thornton, Agatha Conrad, Emily Freeman, and Linda Campbell (Australia)

The presence of lullabies cross-culturally and in folk and classical music attests to the universality of the unsettled infant (Bargiel, 2004). Unsettled behaviour is a developmental phenomenon that is common in the early months of life (St James-Roberts, 2012). Behaviours such as crying and fussiness are ways in which infants communicate with others about their needs. These behaviours reach a peak around six weeks and usually resolve by three to four months of age (Douglas & Hiscock, 2010; St James-Roberts, 2012).

Unsettled infants can be confusing for parents (Ellett & Swenson, 2005; Megel et al., 2011), who can feel overwhelmed (St James-Roberts et al., 2019, p. 20). Their behaviour can have negative impacts on parents' wellbeing (Megel et al., 2011; Oldbury & Adams, 2015), on feeding practices (Vilar-Compte et al., 2022), on the parenting they receive (Oldbury & Adams, 2015; Papousek & von Hafacker, 1998), and on their longer-term outcomes, particularly infants who continue with excessive crying beyond three to four months of age (Brown et al., 2009; Cook et al., 2018; Santos et al., 2015). The peak period of unsettled infant behaviour coincides with the peak time for shaken baby syndrome that can result in lifelong disability or even death (Barr, 2012).

Given the potential adverse outcomes for infants it is essential that when parents seek help that the help offered is appropriate and meets their needs. Effective intervention is needed to avoid the pathologizing of normal behaviours, to ameliorate the potential adverse outcomes for parents and their infants, and to prevent the need for more costly secondary, tertiary, and residential interventions (Douglas et al., 2015). For parents there can be barriers to seeking help or seeking help early. These can include cultural (Zanetti et al., 2023) and mental health issues (Sorsa et al., 2021). Another factor that appears to impact help seeking behaviour is attachment style (Ciechanowski et al., 2002).

Attachment styles impact help seeking behaviour for both physical and mental health conditions. In areas such as diabetes, lupus and heart disease research it has been found that people with a negative view of others tend to seek help later than those with a positive view of others and their symptom levels tend to be higher at initial presentation (Blom et al., 2009; Ciechanowski et al., 2002; Morris et al., 2009; Porter et al., 2007; Vogel & Wei, 2005) Likewise, Adams et al. (2018), in a systematic review, found that people with attachment avoidance (i.e. people with a negative view of others) were less likely to seek "help for mental health concerns and less likely to comply with or complete treatments" (Adams et al., 2018, p. 657).

To tailor interventions knowing a parent's attachment style would be helpful. One way would be to include an assessment of attachment style in the initial assessment. There are a variety of ways to measure attachment style including extensive interviews which are time consuming and expensive to administer, and self-report questionnaires (see Adshead and Guthrie, 2015, for a brief review). Another alternative is to use unstructured interview questions to ascertain a person's attachment style (Demyan & Cosio, 2023). This requires considerable staff training.

One self-report questionnaire that has been used across a range of populations including primary care clinics (Ciechanowski et al., 2001) and breast feeding women (Wilkinson & Scherl, 2006) is the Relationship Questionnaire (RQ) (Bartholomew & Horowitz, 1991). It is easy to administer and requires little time. This can be administered in one of two ways, one that establishes the degree to which the person perceives each style is like them and the other that establishes their perceived predominant style. Ciechanowski (2002) argues that it is "often more useful, clinically, to determine an individuals' predominant attachment style" p. 661.

In New South Wales, Australia, Child and Family Health Nurses can follow children from birth to school age and parents can seek help from them when concerned about their unsettled infants. Parents complete a number of questionnaires as part of the initial assessment process (Health, 2009). Proposed research in this field includes an assessment of a parents' attachment style, for example, using the RQ. The RQ has been shown to be both valid and reliable. If administered to establish the parents' predominant style as suggested by Ciechanowski (2002, 2003) it would only involve parents reading brief descriptive statements of four attachment styles and indicating the one that is most like them. Including the

RQ into the assessment process would not significantly increase the demands on parents or the time involved but could impact on the effectiveness of interventions offered if nurses delivered interventions in line with the parent's attachment style.

Evidence from a variety of studies supports the idea that people with different attachment styles benefit from different interventions (Adshead & Guthrie, 2015; Ciechanowski, 2003; Demyan & Cosio, 2023). For example, as people with dismissing or fearful styles, those with a negative view of others have difficulty forming a trusting relationship, clinicians need to invest effort in the formation of a working relationship before engaging in treatment. Use of the BATHE (Background, Affect, Troubling, Handling and Empathy) model may offer an appropriate way of engaging with these parents (Grabbe, 2015). For these parents the opportunity to talk about how difficult it is to care for a baby who cries persistently as recommended in the clinical guidelines (The Royal Children's Hospital, 2019) would appear to be important. These parents are likely to have delayed seeking help because of their mistrust of others and may have higher levels of distress. Therefore, focusing on their needs rather than providing education about normal development in the early stages of treatment may be more appropriate and result in longer term engagement. Reframing techniques maybe helpful once trust has been developed. For example, reframing infants' crying from a sign that they are in pain to a sign that they are "a vigorous baby" (St James-Roberts, 2012). In addition, nurses could support them to find ways to contain or minimize the crying (St James-Roberts, 2012).

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Many Roads Lead to Family: A Response to Professor von Klitzing

By Alison Steier (United States), Izaak Lim (Australia), Paula Zeanah (United States), Charles Zeanah (United States), and Jon Korfmacher (United States)

Introduction

Kai von Klitzing's article, published in the previous issue of *Perspectives in Infant Mental Health* (von Klitzing, 2024), well describes the tension between a "culturally sensitive approach" that acknowledges multiple acceptable pathways to young children's mental health and "cultural arbitrariness" which constitutes indiscriminate acceptance of virtually all cultural practices. We appreciate his raising complex issues regarding the potential limits of diverse pathways to healthy mental development, particularly ethical questions about the impact of the newer reproductive technologies on the "future child's" experience. We recognize that the use of reproductive technologies presents challenges to the sorting of what are "acceptable" and "unacceptable" pathways which are being debated by practitioners, researchers, legal scholars, religious adherents, and policymakers in countries around the globe. Our response addresses Professor von Klitzing's assertions and questions regarding non-traditional approaches to conceiving and raising children.

Is there really a rights-based ethical dilemma?

Klitzing proposes that an ethical dilemma exists because of the coexistent "rights of adults to fulfill their desire to have children" and "the rights of unborn and newborn children to develop and grow up under the best possible conditions." This argument requires at least three premises: 1) there is a rights-based claim held by adults to fulfil their desire to have children, 2) there is a rights-based claim held by unborn and newborn children to develop and grow up under the best possible conditions, and 3) that these rights claims are incompatible, giving rise to an ethical dilemma.

We argue that these premises are not justified, and therefore the conclusion about this ethical dilemma is premature.

There are notable conceptual weaknesses of a rights-based claim to grow up under the *best possible* conditions (we will call this the "best possible conditions claim"), and we disagree with the assertion that the adult's access to parenthood and the child's access to "the best possible conditions" are mutually exclusive (we will call this the "dilemma claim").

Though not completely clear from his paper, Klitzing seems to be adopting an interest-oriented theory of rights, where rights include "the protection of an interest of sufficient importance to impose on others certain duties, whose discharge ensures the enjoyment by the rightsholder of the interest in question" (Archard, 2015, p. 58). To accept the proposed dilemma of incompatible rights, we must be convinced that unborn and newborn children have such a strong interest in growing up under the "best possible conditions," that a positive duty exists for others to provide this (i.e., that it is *essential* to their wellbeing).

The "best possible conditions claim," appears to be an allusion to the "best interests of the child" account of surrogate decision-making. This account assumes a clear, knowable, objective, and universal standard that supports the optimal development and wellbeing of children.

The "best interests standard" has been the subject of much debate in the bioethics literature (e.g., Archard, Cave & Brierley, 2024; Auckland & Goold, 2019; Rhodes & Holzman, 2014; Salter, 2012). Critics have cited concerns that the "best interests standard" is subjective, indeterminate, polarising, paternalistic, individualistic, and overlooks the harms of overriding parental decisions, among other problems. Furthermore, a systematic review of the normative literature on overriding parental decision-making revealed "a substantial consensus among ethicists that **harm** [not best interests] is the central moral concept when judging the appropriate threshold for state intervention in parents' medical decision-making" (MacDougall & Notini, 2014 p. 452).

Klitzing's "best possible conditions claim" illustrates some of the weaknesses in the best interests standard. Firstly, there is the problem of how to -- and who should -- decide on what these "best possible conditions" are. Certainly, there is strong scientific evidence for the minimally acceptable conditions required for normal child development, i.e., the basic needs to be met and freedom from maltreatment and other serious adverse experiences (e.g., WAIMH, 2016; Felitti et al., 1998). But beyond these "good enough" conditions, normal child development can occur in a wide variety of caregiving conditions -- the equifinality that Professor von Klitzing discusses in the first section of his paper. Therefore, we must return to first principles

regarding the special moral claim that parents have, to raise their children in accordance with their own values, based on their own beliefs about what is in their child's interest, without external interference -- except where the child is subject to, or at serious risk of, significant harm.

Secondly, there are the adverse consequences of insisting on a "best possible conditions" standard. There is, already, concern about the overreach of state agencies in "policing" families, and the intergenerational harms that can come from this, leading some to call for the abolition of the child welfare system altogether (e.g., Dettlaff, 2023). Although we do not support this conclusion, it is clear that state intervention in the affairs of families is a complex and serious business that should be oriented towards supporting families to thrive. This requires a sufficiently high threshold for more coercive practices, such as legally mandated surveillance or removal of children from their families. A "best possible conditions" standard is a very low threshold, which leads to several questions, including: What should happen when a child is not being raised in the "best possible conditions," and should this include state intervention? Which groups in society are likely to be disproportionately affected by a "best possible conditions" standard, and does this reinforce the structural oppression of minoritised groups? How can a "best possible conditions" standard be fairly and realistically applied when there will always be complex social challenges, new and old, that children and families cannot control but have to navigate. In short, asserting a child's right to grow up in the "best possible conditions" without adequately explaining what this means or how it could be upheld without causing systematic harm to vulnerable families, seems problematic.

Even if we accept that unborn and newborn children should have access to "good enough" conditions (e.g., Saunders, 2021)—a more modest and more defensible claim-- there is a problem with formulating the relationship between the right to parenthood and the right to good enough care as a dilemma. A true ethical dilemma occurs when it is impossible to fulfill all the duties one is bound to. That is, to fulfill one duty is to violate another. In making a "dilemma claim," Klitzing is arguing that it is not possible for certain would-be parents (i.e., those unable to conceive without

assistance) to fulfill their desire to have children *and* for those children to grow up under good enough conditions. He questions the strength of the evidence around the developmental outcomes of children who grow up in non-traditional family constellations (see below). The fact that there are methodological limitations in such research and that definitive proof awaits future study, is hardly surprising and an issue for much research linking caregiving to child outcomes. Nevertheless, there is no evidence that we have seen that indicates that children *cannot* (or are even less likely to) grow up under good enough conditions when they have been raised by parents who have conceived using reproductive technologies. There is, in fact, research to suggest that parents who conceive through artificial reproductive techniques are highly sensitive and non-intrusive, perhaps because they are highly motivated (Ellis-Davies et al., 2022).

Our concern is that conflating the known harms associated with child maltreatment with the (actually positive) developmental outcomes of children conceived by reproductive technologies risks creating baseless anxiety and playing into political agendas that seek to restrict the access to reproductive technologies for minoritized groups. Portraying the coexistent interest of adults to be parents and of children to receive good enough care as an ethical dilemma is at best misleading, and at worst harmful to these families.

We acknowledge that the interests of parents and young children are not identical, and there will sometimes be tension between these interests. But accepting that parents and their children have distinct interests is not the same as accepting that these interests are incompatible.

Narcissistic Investment in Traditional and Non-traditional Parents Alike

Klitzing seems to suggest that babies conceived through reproductive technologies are at risk because they are expressions of parental self-fulfillment at the expense of the baby's developmental needs. Why do we think that self-centeredness is more likely to be associated with non-traditional conception? Citing psychoanalytic theory, Klitzing notes that narcissism

plays a role in parent-child relationships. He says that "Initially, parents turn to their babies because they seem to be a part of themselves and promise to fulfill narcissistic needs beyond the parental life span. But the narcissistic satisfaction of having a child comes into competition with the parents' own egoistic needs…". Prioritizing another's needs ahead of one's own needs is the *sine qua non* of healthy parenting and other loving relationships. Raising children necessarily entails stress and drudgery that in healthy parent-child relationships is more than counter-balanced by profound joy. This is the narcissistic balance between love and hate that Professor von Klitzing describes. But is this "balance" less likely for non-traditional parents?

Fortunately, humans have the capacity for healthy narcissistic investment in children, even without bearing them (e.g., biological fathers) or having a biological tie to them (e.g., foster, adoptive and stepparents). Millennia before sophisticated reproductive technologies and legally sanctioned adoptions, adults cared for non-biological children and—consider Moses, Aristotle, Muhammad--all raised and loved by non-biological parents.

It will be some time before we have a meta-analysis of hundreds of studies of the effects on children of the kinds of non-traditional parenting associated with reproductive technologies described by Klitzing. Nevertheless, findings to date also are mostly reassuring about children raised following surrogacy (Patel et al., 2020; Yau et al., 2021) and from IVF (Hart & Norman, 2013; Heinemann et al., 2019; Kennedy et al., 2023).

To be sure, there are complex cultural, ethical and human rights issues involved in surrogacy. In our view, however, it is possible to condemn categorically the exploitation of desperately poor women without condemning all adoptions or surrogacy. An ethical perspective requires appreciating complex distinctions, nuanced analysis and careful language.

Same-sex Parent Families

Klitzing expresses concern about children of homosexual parents even as he notes that there is little evidence to support his concern. On this latter point, we agree: the past 40 years have produced a substantial body of research examining the health, development

and well-being of children raised by parents who identify as gay or lesbian and multiple reviews that summarize this literature (e.g. Manning et al., 2014). Overall, this research has found little evidence of developmental risks to the child. This is especially noteworthy given that much of this research was conducted during a time of little (or at least slowly growing) acceptance of gay and lesbian parenting, so that often these parents were operating without the same supports and legal rights afforded to heterosexual parents. The resilience of these families is frequently noted in the literature, and given changes in attitudes towards gay and lesbian parents in many parts of the world, there have been recent calls to re-orient contemporary research away from an assumption of deficits and towards examinations of stress and resilience within same-sex parent families (e.g., Mazrekaj et al., 2022), just as we would for families with heterosexual parents.

Conclusion

Professor von Klitzing suggests that our field of infant mental health should weigh in on the questions of how, why, and by whom babies are conceived, citing concerns about the limits of equifinality. Such considerations may be clinically relevant, and the journey to parenthood may be included in therapeutic conversations, but clinical attention typically focuses on ensuring the infant has "good enough" experiences within their caregiving relationships to promote their healthy development. Our profession has expertise to guide and inform parenting, however it is important to remember recent historical examples of societal overreach on matters of procreation. For example, the eugenics movement during the late 19th and early 20th centuries sought to improve health, social, and intellectual characteristics through selective breeding (National Human Genome Research Institute [NHGRI], 2022). Nicholai Ceausescu's 1966 Decree 770 sought to increase the Romanian population by preventing contraception and abortion. Both examples resulted in tragic outcomes for thousands of women, children, and families and while extreme, they do provide a cautionary note about possible implications of state or professional-determined decisions about procreation and reproductive health.

If we as clinicians and child advocates are going to draw lines about unacceptable or maladaptive pathways—the "roads" which do not "lead to Rome"--these lines ought to be drawn cautiously and conservatively, informed by clear evidence of harm. Using this criterion, we are on quite solid grounds to stand against violence towards children, for example. In the absence of compelling data indicating harm, it seems wise and salubrious to maintain the therapeutic ethos and unique contribution of the infant mental health field, which has been to strengthen the development and well-being of young children within their important relationships, rather than judge how families are formed.

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Best Possible Child Development - an unreasonable claim? A response to Steier et al.

by Kai von Klitzing (Germany)

Wow! What a remarkable response to my reflections in my paper "Do all ways lead to Rome?"! In this paper, I have reflected on the potential tensions between parental expectations and children's developmental needs. I have discussed the possible impacts of modern reproductive technologies and diverse cultural beliefs on child-rearing practices. Steier, Lim, Zeanah, Zeanah & Korfmacher have drawn upon a substantial corpus of bioethics literature and scientific studies to illustrate that my reflections may lack sufficient vigilance with respect to the potential dangers of discriminatory attitudes towards homosexual parents and the possible detrimental impact of authoritarian state interventions. They even suggest parallels between my reflections and the eugenics movement that emerged during the late 19th and early 20th centuries, as well as Ceaușescu's population policy.

I do not wish to reiterate my arguments. This response gives rise to a number of significant questions that warrant further consideration:

1. Is it not within the remit of the infant mental health community to discuss the potential consequences of modern reproductive medicine on child development without becoming mired in the issue of political correctness?

Even Steier et al. posit that there are ethical boundaries to the ways in which parents in Western industrial societies can fulfil their desire for children, namely by "exploiting desperately poor women" as surrogates for their own offspring. It is my contention that this discussion is of critical importance and we should conduct it with the utmost rigor from the vantage point of the child and his/her right to a healthy development.

2. As infant mental health specialists, should we really waive our claim to provide young children with best possible care?

This is a challenging standard to meet. Of course, it is important to consider the social circumstances in which parents raise their children when assessing the "best possible" outcome. For example, families in countries facing poverty and war have different challenges than those in affluent and peaceful communities, which can afford a range of new medical treatments. However, even in difficult social conditions, it is essential to advocate for the improvement of young children's developmental situations to the greatest extent possible.

3. Is there really always a consistent alignment between the aspirations of adults for access to parenthood and the children's access to positive development?

Of course, both the wishes of the parents and the needs of the children fortunately evolve towards each other most of the time. But this correspondence has to evolve over time, from the infant in the parents' minds to the real child and his/her demands. As we clinicians know, harmony in the parent-child relationship is not always a given and can be fraught with conflict. It requires a constant negotiation of mutual needs and it requires a balancing of both, the rights of the parents and the rights of the child. And yes, society has a responsibility to carefully negotiate the terms and limits of how children should be brought up. In my country, for example, corporal punishment was outlawed about 50 years ago. This was preceded by an intensive social debate. Against this background, it is for example not so easy to decide how we as clinicians and our child protection services should deal with families in which corporal punishment is part of the traditional parental means of ensuring children's respect for the older generation. Moreover, is it really acceptable to allow a market in surrogate motherhood in order to enable parenthood at any price, apart from the fact that only the rich and privileged can afford such measures?

Who, if not we as child mental health professionals, should be involved in this debate? In our liberal Western societies, the freedom and self-realisation of individuals are considered to be of great value. In light of the fact that different individuals have different interests we should be less concerned with political correctness but rather we should take a clear and unequivocal stance with regard to safeguarding the child's well-being. My paper was intended as a stimulus for this discussion and I look forward to further debate.

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Harmony in Diversity:
Nurturing the Youngest Minds Around the World

OCT 2 - 6   **SHERATON CENTRE**
2026   **TORONTO HOTEL**

Hosted in collaboration between Infant and Early Mental Health Promotion at the Hospital for Sick Children and the World Association for Infant Mental Health

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WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

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.

WAIMH is a member-based organization, and as such, 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. We are especially interested in papers that incorporate diverse perspectives and center the cultural contexts and experiences of babies and families across the globe. We encourage submissions that reflect on how cultural, social, and economic factors shape early childhood development and highlight the unique strengths, challenges, and traditions that influence family systems and infant mental health.

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

Full issue publication dates

Spring issue: April

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

Summer issue: August

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

Fall/Winter issue: December

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

Perspectives in Infant Mental Health Submission Guidelines

APA 7th Edition.

12-point font.

1.5 or double spaced.

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

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

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

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

Submission categories:

a. Research Papers (max 3000 words, including references)
b. Clinical Papers (max 3000 words, including references)
c. Professional Development (max 3000 words, including references)
d. Community Voices (max 800 words, including references)
e. Letters (max 800 words, including references)
f. Opinion pieces/Policy/Advocacy (max 1000 words, including references)
g. Book Review (max 800 words, including references)

Further details:
www.waimh.org

Contact

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

Jane Barlow (DPhil, FFPH Hon), Editor-in-Chief
Email: perspectives@waimh.org
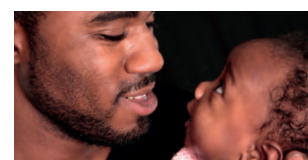
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WHAT IS WAIMH?

The World Association for Infant Mental Health (WAIMH) is a non-profit organization for scientific and educational professionals. WAIMH's central aim 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.

Why become a WAIMH member?

• To promote principles of infant and child health, development and mental health.

• To become part of a global learning community and professional network that speaks for infants, young children and families around the world.

• To have access to resources that promote infant mental health.

• To learn from world experts about the health, mental health and optimal development of infants, toddlers and their families across cultures and around the world.

• To expand your professional, social network.

• To exchange information about infants and infant-family programs.

• To contribute to the protection of health and well-being in infancy, early childhood and parenthood on a global level.

• To get opportunities to keep pace with new findings and innovations in scientific, clinical, and educational research and programs involving infants and their caregivers

• To contribute to a professional global learning community: WAIMH.

WAIMH AFFILIATES

WAIMH encourages individuals in geographic regions (states, provinces, nations, multi-nations) to develop Affiliate Associations to improve its international network of communication, and to allow individuals to focus on relevant local issues. Currently, there are 64 affiliates spanning six continents.

Affiliate Council Chair: Juané Voges

Affiliate Council Representative: Azhar Abu Ali

THE BEACON CLUB

The Beacon Club helps members fulfill WAIMH's mission in international development.

Beacon Club donations:

• Extend the influence of infant mental health to countries now developing new approaches to issues of infancy.

• Make it possible to build capacity for promoting the well-being of infants and their families.

Beacon Club donations sponsor WAIMH memberships and Infant Mental Health Journal subscriptions for individuals from developing countries.

• Donation forms and applications for Beacon Club sponsorship are available online at www.waimh.org

CONGRESSES

WAIMH hosts a World Congress every two years, each in a different country. Our 19th World Congress will be in Toronto, Canada, 2026. WAIMH also hosts Regional Conferences.

E-mail: office@waimh.org

PUBLICATIONS

Infant Mental Health Journal: Infancy and Early Childhood

The Infant Mental Health Journal publishes research perspectives and clinical practices. It provides an interdisciplinary forum for publication of research findings, literature reviews, clinical techniques and case studies, prevention/intervention research, and book reviews related to the biological, social, emotional, and cognitive development of infants and their families in various ecological contexts. Special emphasis is given to high risk infants and high risk families, psychodynamic views of developmental process, and systems approaches to emergent organizational structure.

Editor: Holly Brophy-Herb
E-mail: hbrophy@msu.edu

Perspectives in Infant Mental Health

Perspectives in Infant Mental Health, WAIMH's quarterly newsletter, gives members an opportunity to share research of interest, provides a forum for the exchange of news and views from around the world, and informs members of upcoming events and conferences.
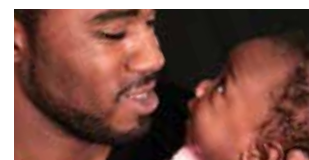
Editor: Jane Barlow
E-mail: perspectives@waimh.org

BECOME A MEMBER

• You can subscribe to the scientific journal, the Infant Mental Health Journal, at a greatly reduced member rate. The subscription fee includes the access to the Wiley database of the electronic journal.

• You can download Perspectives in Infant Mental Health (formerly, The Signal), WAIMH's quarterly newsletter from WAIMH's website. This major interdisciplinary, international communication link for infant mental health professionals is an open access publication.

• You'll get reduced registration rates for regional conferences and for WAIMH's World Congresses.

• You'll have access to WAIMH database, an information network for infant mental health professionals.

The Professional membership rate is $75 annually. Student members pay $45. The membership fee is a yearly cost (Jan-Dec).

Both Professional and Student members may subscribe to the Infant Mental Health Journal at an additional cost. The additional cost of the online journal subscription is $40. The subscription is easily completed through the WAIMH Online Store: www.waimh.org/store

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