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# Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

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# WAIMH addresses global challenges affecting infants, their families, and caregiving organizations

Our world is facing multiple crises – from wars to floods to earthquakes and financial cutbacks. Never before, in recent times, have so many catastrophes befallen the youngest in the world. Disasters significantly and seriously affect infants and young children. The brain is at a sensitive stage of development in the early years, and thus particularly vulnerable to these stressors.

It is every infant and young child's right to receive nurturing care and to grow up in an environment that ensures security and safety, responsive caregiving and opportunities for early learning. These provisions, together with adequate nutrition and health care, form the pillars upon which early development rests. Without these pillars the future of these infants is at risk – physically and mentally. The impact on humanity could be profound.

It is the one of the purposes of WAIMH to facilitate international cooperation among individuals concerned with promoting conditions that will bring about the optimal development of infants and infant-caregiver relationships. To this end we have established the Infants in Global Crises Working Group and have offered our support to those who are attending to infants and their families in crises situations. WAIMH is also in the process of becoming a non-state actor to the World Health Organization (WHO). If approved, this relationship with the WHO, creates a voice from WAIMH to speak on behalf of babies and their families, on a range of health matters.

We stand firmly behind all the efforts that are taking place globally on behalf of infants, young children and their families. We stand alongside each and every infant and young children worker, wherever they are working across the globe. We confirm our continued

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commitment to promoting a socially inclusive world, by supporting the children whose needs and rights are being undermined by these world events.

Our world is on fire, and unless we place infants and young children at the centre of our policies and efforts, we are in danger of destroying the future.

*Astrid Berg, President of WAIMH*

# From the Editor-in-Chief

by Jane Barlow (United Kingdom)


Welcome to our Spring 2025 issue of Perspectives,

Our first paper in this issue, which is focused on Professional Development, is an excellent piece by Harleen Hutchinson, which describes the JUSTICE Framework in Reflective Supervision and its role in empowering supervisors and leaders globally. Dr Hutchinson argues that this framework equips leaders to address systemic barriers and engage in authentic, multicultural practice. With the aid of a case study, she shows how it can be used across cultural contexts to advance equitable reflective supervision, encouraging infant mental health organizations to make a sustained commitment to social justice in leadership practices.

In Community Voices Barbara von Kalckreuth (Germany) and Jenifer Joy Madden (United States) invite you to join the Global Alliance for Inspiring Non-tech Infant Nurturing and Growth (GAINING), which is underpinned by increasing concern about the impact of extensive screen viewing in very young children (0-3yrs) on key aspects of their cognitive, physical and social-emotional development. They describe one of their strategies - one-page Alerts for government agencies, healthcare professionals, and parents – aimed at supporting infant development and reduced screen viewing in the early years.

We also have four excellent clinical papers. In the first paper Markus Wilken (Germany), Mary Coughlin (United States), and Susanne Hommel (Germany) describe Pediatric Medical Traumatic Stress (PMTS), examining the specific stressor that can occur in the NICU setting, and the evidence about its impact on both infant and caregiver. They argue that recognition of this stress is necessary to prevent problems through the use of Trauma-Informed Developmental Care (TIDC) and Emotional Revival Therapy (ERT). The authors describe how these early interventions in NICU can help prevent later regulatory and attachment disorders in infants as well as perinatal psychiatric disorders in parents.

Our second paper, is an extract from a chapter by Joy and Howard Osofsky that was published in the latest edition of the Handbook of Infant Mental Health. It focuses here on the significant secondary impact of the pandemic that occurred in large part due to the way in which the restrictions that were put in place undermined the core developmental need of young children for relationships. This excerpt examines the way in which such relationships are a central part of their recovery in the post pandemic period.

The third paper from a US team led by Kelly Elliott, describes WeRead, which is an early literacy and language development psychoeducation program available in English and Spanish (Nosotros Leemos), and is designed for caregivers and their children ages 0-3. This article explores the potential for expanding initiatives of this sort and considers how similar models can be applied to other early childhood and parenting support programs.

Our final clinical paper written by a team from Australia led by Sophia Harris, describes ForWhen, which is a national perinatal and infant mental health care navigation service. This paper illustrates the use of care navigation to connect Australian families with perinatal and infant mental health support, through four clinical case studies.

In Opinion Pieces Susanne Hommel, Barbara von Kalckreuth, and Margret Ziegler (Germany) describe the newly published German Diagnostic Classification and Intervention in Infant Mental Health Guidelines. Their commentary describes the major changes to the guidelines, their views about the ongoing limitations of the guidelines, and some thoughts about what future revisions are needed.

Our book review, written by Salisha Maharaj (South Africa), examines *The Politics of Potential: Global Health and Gendered Futures in South Africa* by Michelle Pentecost.

Finally, and in keeping with the need to ensure that equity, diversity and inclusion issues continue to be a priority everywhere, the next edition of Perspectives is a Special Issue focused on Decolonising Infant Mental Health Research, Practice and Intervention. This involves the rethinking and reshaping of the field by identifying and addressing biases in existing theories, research, and interventions. This includes questioning the dominance of Western perspectives and ensuring that non-Western knowledge systems are valued and integrated into our existing knowledge base. We would welcome papers that address systemic injustices across a range of areas (e.g. cultural context; community-based approaches, ethics etc) and across all our submission categories: clinical, research, professional development, opinion pieces, and community voices.

Your sincerely

*The WAIMH Perspectives in Infant Mental Health editorial team*

# From the Desk of the President of WAIMH

by Astrid Berg (South Africa)

Dear Colleagues and Friends in WAIMH

During my presentation at the WAIMH Congress in Tampere in June 2024, I discussed how the Developmental Origins of Health and Disease (DOHaD) field is gaining traction globally.

DOHaD research highlights the importance of social contexts in determining development, emphasizing our social and political responsibility towards those who need it most, as they will be the adults of the future.

> "… these innovative characteristics raise questions regarding potential specific social responsibility…about pathways to a socially just and scientifically robust implementation of DOHaD knowledge In society…" (Penkler et al, 2018)

The words "potential specific social responsibility" ring loudly for me at this critical time and I struggle to know where we as WAIMH position ourselves in the current global situation.

We are not politicians, and we are not there to take sides nor are we there to make categorical statements about complex situations. But we have a "specific social responsibility" to speak out when harm is done to the young – the babies and toddlers specifically. Because they cannot speak, and we, the adult world, need to be their voice and speak for them.

The world news is heart-breaking and devastating on all fronts. What can we do, knowing what we know about the vulnaribility and sensitivity of the developing infant brain?

What does it mean to be human? Is it not about relationships, about caring not just for the self, but also the other? And is it not about caring for those who cannot care for themselves? It is that humantistic tradition which gave birth to the Infants Rights document, it is that for which WAIMH stands.

These are nice words but they are not enough. We also need to act. So, what is WAIMH doing?

There is the Global Crises Working Group – we have had a webinar with Ukrainian colleagues in July 2022. Unfortunately the destruction of infrastructure in Ukraine made it impossible to meet again online. However we were fortunate that we were able to meet as a larger WAIMH group at the Dublin Congress in 2023. It was good to see the eagerness to help each other, and many ideas were discussed.

Thereafter some members participated in a Workshop organized in Palestine, followed by joint meetings with the Affiliate Groups with Palestine and Israeli colleagues.

As a result, there is a strong desire to arrange an in-person meeting, especially with individuals working on the frontlines of current crises in regions where WAIMH has established connections. This requires some planning and organizing, so it is too early to say whether we can make this happen.

Furthermore, our webpage *Infants in Crises* provides a list of the top 10 humanitarian crises listed by the International Rescue Committee as well as a list of resources that might be helpful for colleagues providing support on the ground.

Then finally, as a very long term goal, we have started the process to become a non-State actor in official relations with the World Health Organization. Our unique contributions to this global body could be advocating for the importance of early life interventions, promoting infant mental health, and improving access to effective mental health services for all infants. Due to limitations in global funding, our proposal may not be a priority for the WHO at this moment in time.

Photo: Astrid Berg

In the meantime, we are going ahead with the preparations for the WAIMH Congress to be held in Toronto in October 2026. We will address the various challenges affecting young children and their families, honouring our commitment to supporting the well being of all infants and their caregivers.

Respecting our shared humanity is essential for our prosperity on this planet.

I send my greetings to you all with this aspiration and hope.

# WAIMH Executive Director Corner

By Kaija Puura (Finland)

Dear colleagues and friends,

Here in the Nordic countries, we are experiencing spring with its rapid increase of daylight after the dark winter months. A phenomenon that makes most of us feel almost giddy, particularly on sunny days with clear blue sky and the warmth of the sun on our faces. In a few months there won't be dark even during the night; only a few hours of twilight between sunset and sunrise. In a way our winters and summers are two extremes of darkness and light, and autumn and spring are the times for us adapting to these extremes.

Like nature, also the human history seems to be changing from one extreme to another. One of Finnish emerita professors of psychology, Liisa Keltikangas-Järvinen, gave an interview this week for our main newspaper. Her main message was that in the current Western world we accept such selfish and egocentric behaviour from adults that we usually see in toddlers two to three-years old. In her opinion, our Finnish culture has started to shift from the idea that the society is for taking care of everybody into more egocentric thinking where everybody fends themselves. In a sense there is nothing new in this, throughout our (short) history we have had people who only guard their own power and privileges and some of they may even believe they are working for the greater good. Ken Follet's novel series about Kingsbridge town starting from 11th century to 18th century is a beautiful narrative of the constant struggle between forces of kindness and caring and selfishness and cruelty.

We who work with young children and their families know exactly how much kindness and caring is needed in procuring the best possible development of children. We also know how damaging it is to shun, exclude, neglect and hurt people. Although xenophobia, fear of something different, may be a feature initially developed in our minds to protect our communities in early stages of human history, it can also be a very toxic phenomenon now that immigration is more prevalent than ever before. Would it not be better to get acquainted and learn new things from people from other cultures than to be automatically fearful and negative against them? Having said this, I also must recognize that even within countries and cultures there are people with different abilities, opinions, values and ways of life that can enrich the community.

WAIMH strives for better understanding of how to support young children and their families globally in many ways. The WAIMH board is currently drawing up criteria for member 'working groups' and 'advisory committees' on topics that have been taken up by WAIMH members. The already active working groups include e.g. the Global Crises group. Working groups or advisory committees for aspects of early childhood ethics and for social media in early childhood are under consideration. These multinational groups offer one opportunity for increasing understanding of the similarities and differences we have between various parts of the world.

Another way of working together for kindness and caring has been long suggested by a long time WAIMH member and friend Deborah Weatherston. Debbie is a pioneer in reflective supervision, and while we were talking together a while ago, she asked if we in WAIMH could encourage our senior members to offer to mentor or supervise our younger colleagues worldwide. In this time - thanks to our greatly increased possibilities for online-meetings – this is more doable than ever before. So, if you feel you could give for example one hour of your time per month for one-to-one mentoring or supervision with a WAIMH colleague, please let the Office know. Similarly, if you are a younger colleague in need for mentoring or supervision, let us know.

With my warmest regards to you all,

Kaija

Photo: Kaija Puura

# Call for Papers: Perspectives in IMH Special Edition August 2025: Decolonizing infant mental health research, practice and intervention

Decolonizing infant mental health involves rethinking and reshaping the field by identifying and addressing biases in existing theories, research, and interventions. This includes questioning the dominance of Western perspectives and ensuring that non-Western knowledge systems are valued and integrated into our existing knowledge base. There are several areas in which long-standing systemic injustices within our field require redress:

1. Cultural Context: Recognizing that infant mental health is deeply influenced by cultural contexts. This means understanding and respecting the diverse ways in which different cultures approach parenting, caregiving, and child development.
2. Community-Based Approaches: Developing interventions that are tailored to the specific needs and contexts of local communities. This involves working closely with community members to create culturally relevant and effective mental health services.
3. Epistemic Justice: Addressing the imbalance in whose knowledge is considered legitimate and valuable. This includes recognizing and validating non-Western forms of knowledge and challenging the dominance of Western epistemologies.
4. Ethical Considerations: Ensuring that research and interventions are conducted ethically and respectfully, with a focus on the well-being of infants and their families. This involves being aware of power dynamics and striving to create equitable partnerships with communities.
5. Holistic Perspectives: Adopting a holistic view of infant mental health that considers the social, emotional, and environmental factors affecting children's development. This approach acknowledges the interconnectedness of various aspects of a child's life and the importance of supporting the entire family unit.

Our call for submissions spans multiple categories—clinical, research, professional development, opinion pieces, and community voices—and we welcome diverse perspectives that bring the lived experiences of families, communities, and professionals to light.

Your voice and expertise are vital to creating a holistic understanding that transcends borders and honors the diversity of our shared human experience. We encourage submissions that explore topics such as:

- Clinical Perspectives: Insights into culturally responsive clinical practices that enhance support for infants and families.
- Research: Studies that reveal how cultural context impacts early development and family interactions.
- Professional Development: Best practices and frameworks that foster inclusive, culturally aware professional growth.
- Opinion Pieces: Reflective essays or viewpoints on pressing issues and the future of infant mental health.
- Community Voices: Stories and perspectives from community members that bring to life the traditions, strengths, and resilience within family systems worldwide.

Submissions are due by 1 May 2025 and all contributions will be reviewed by our editorial board to ensure an inclusive, high-quality publication. To inquire about Perspectives in Infant Mental Health or to submit articles, please contact: perspectives@waimh.org

Together, let us amplify voices, broaden perspectives, and celebrate the beautiful diversity that enriches our understanding of infant mental health.

*Perspectives Editorial Board*

# Embracing Discomfort: Empowering Supervisors and Leaders Globally through the JUSTICE Framework in Reflective Supervision

by Harleen Hutchinson (United States)


## Abstract

This article explores the transformative potential of the JUSTICE framework in reflective supervision, particularly for supervisors and leaders working with diverse communities. Rooted in principles of social justice, equity, and inclusion, the JUSTICE framework offers a pathway for leaders to lean into discomfort, fostering growth and cultural humility (Rawls, 1971; Sen, 2009). By emphasizing bi-directional relationships and safe spaces, the framework equips leaders to address systemic barriers and engage in authentic, multicultural practice (Nussbaum, 2011). The article integrates global perspectives and a case study, illustrating the applicability of the framework across various cultural contexts. This article advocates for the JUSTICE framework as a necessary tool for advancing equitable reflective supervision, pushing infant mental health organizations to make a sustained commitment to social justice in leadership practices.


## The Role of Reflective Supervision in a Changing World

Reflective supervision plays a critical role in navigating the complexities of cultural diversity and systemic inequities, particularly in today's global landscape (Sen, 2009). Leaders who model vulnerability are key to this process, embracing discomfort and acknowledging their own limitations. This openness not only fosters spaces of trust where supervisees feel secure in their personal growth (Watson & Gatti, 2012), but also creates inclusive, equitable environments that value diverse perspectives and drive meaningful transformation (Sen, 2009). By addressing power dynamics and imbalances, leaders cultivate reflective spaces where both supervisors and supervisees can engage deeply in self-exploration, leading to profound personal and systemic change (Feniger-Schaal & Oppenheim, 2020).

When leaders invite discomfort into reflective supervision, they promote an atmosphere of emotional safety, encouraging supervisees to be honest and vulnerable. This approach bridges cultural differences and creates equitable practices that empower professionals to serve their communities more effectively. Reflective supervision, when rooted in vulnerability and trust, becomes not just a tool for personal development but a transformative force for systemic equity

## The JUSTICE Framework: A Global Tool for Inclusive Leadership

The **JUSTICE framework** (Hutchinson, 2023) is a powerful and holistic tool designed to guide supervisors and leaders in reflective supervision, helping them navigate complex and often uncomfortable conversations about diversity, equity, and inclusion (DEI). This framework empowers leaders to engage deeply, reflect on their own biases, and address systemic inequalities while fostering relational safety.

**1. J - Justice**

- **Justice** within the framework refers to the equitable treatment of all individuals, ensuring decisions are free from bias and accounting for systemic inequities. Leaders using this pillar must reflect on the societal structures that disproportionately affect marginalized communities and make decisions rooted in fairness (Rawls, 1971). This involves a commitment to dismantling systemic barriers that perpetuate inequality.

**2. U - Understanding**

- **Understanding** focuses on recognizing the long-lasting effects of historical trauma and ongoing discrimination. Leaders must actively work to understand how past injustices continue to shape present experiences. This deeper understanding allows leaders to create environments where individuals feel seen and valued, which is crucial for fostering psychological safety in reflective supervision (Nussbaum, 2011).

**3. S - Social Location**

- **Social location** refers to one's position within systems of power, privilege, and oppression. Leaders must reflect on their own social location and how it impacts their relationships with supervisees. Acknowledging social location enables leaders to address power imbalances in reflective supervision, creating more equitable and inclusive spaces (Sen, 2009).

**4. T - Transparency and Authenticity**

- **Transparency and authenticity** are key to building trust in any leadership role. Leaders must be open about their vulnerabilities, biases, and intentions, modeling the behaviors they wish to cultivate in their teams. Authenticity allows for honest dialogue and helps create a culture of openness, which is essential for navigating difficult conversations about equity and inclusion.

**5. I - Inclusivity in Discomfort**

- The framework emphasizes **inclusivity in discomfort**, recognizing that discomfort is a necessary part of growth. Leaders must create spaces where discomfort is embraced, ensuring that all voices, especially those from marginalized communities, are heard and valued. Inclusivity in discomfort encourages leaders to lean into challenging conversations, fostering deeper understanding and empathy (Nussbaum, 2011).

**6. C - Connecting with Emotions**

- **Connecting with emotions** is central to the JUSTICE framework. Leaders must create opportunities for emotional expression, recognizing that emotions often stem from deep-seated experiences of trauma and resilience. By allowing space for emotional connection, leaders can build trust and foster genuine relationships with their teams, ultimately leading to more effective and compassionate leadership (Sen, 2009).

**7. E - Engagement in Safe and Brave Spaces**

- **Engagement in safe and brave spaces** is the final pillar of the framework. Leaders must actively create environments where difficult conversations can take place without fear of judgment. These spaces should encourage vulnerability, allowing supervisees to express their thoughts and emotions openly. Safe and brave spaces are essential for fostering growth and transformation in reflective supervision (Rawls, 1971).

## Application in Leadership

Leaders utilizing the JUSTICE framework can navigate difficult conversations about DEI (Diversity, Equity and Inclusion) with greater sensitivity and awareness. By focusing on **justice**, **understanding**, and **social location**, they ensure that their decisions are equitable and grounded in empathy. Moreover, fostering **inclusivity in discomfort** and **connecting with emotions** helps leaders build relational safety and trust, which are crucial for effective reflective supervision.

Through **transparency and authenticity**, leaders can model the vulnerability needed to create **safe and brave spaces**. This allows their teams to engage deeply in difficult conversations, ultimately promoting growth and fostering a more inclusive, equitable environment.

The JUSTICE framework serves as a global tool for inclusive leadership, guiding supervisors and leaders in reflective supervision to engage deeply with the complexities of DEI. By leaning into discomfort, fostering transparency, and connecting emotionally, leaders can create environments where vulnerable, and transformative conversations can take place. The framework's emphasis on justice, empathy, and engagement provides a solid foundation for leaders to navigate the challenges of equity and inclusion in a global context.

Leaning into discomfort is essential for growth in reflective supervision, as it creates space for leaders to confront their vulnerabilities and biases, ultimately leading to meaningful change. Discomfort often arises when leaders engage in discussions about power dynamics, cultural differences, or systemic inequities. By intentionally embracing this discomfort, leaders reflect deeply on their own positions and actions, fostering a learning environment where both supervisors and supervisees can grow together (Rawls, 1971). This reflective process cultivates emotional resilience, promoting authentic leadership in diverse and complex settings.

Practical strategies for fostering discomfort include encouraging open dialogue about challenging topics, creating safe spaces for vulnerability, and promoting transparency within the supervision process. When leaders model discomfort, they signal to their teams that growth often comes from leaning into difficult emotions rather than avoiding them. This approach not only strengthens the supervision relationship but also equips both leaders and supervisees to navigate the complexities of cultural and systemic challenges (Feniger-Schaal & Oppenheim, 2020). Embracing discomfort as a tool for growth ensures a deeper commitment to inclusive and transformative leadership.

## Supporting Supervisors: Creating Brave and Safe Spaces

In climates where individuals or groups have historically faced marginalization, the idea of vulnerability can be daunting. For those who have been ostracized, opening up in reflective spaces may seem unsafe due to past experiences of exclusion and silencing. It is the responsibility of supervisors and leaders to provide the necessary scaffolding by creating **brave and safe spaces**, ensuring that vulnerability is met with understanding and support (Brown, 2018). Such spaces foster trust and inclusivity, allowing individuals to engage in honest dialogue without fear of judgment or retaliation.

Table 1. The JUSTICE Framework.

| JUSTICE Pillars | Description |
|---|---|
| **J - Justice** | Equitable treatment, addressing systemic inequities |
| **U - Understanding** | Recognizing the lingering effects of historical trauma |
| **S - Social Location** | Reflecting on power and privilege in relationships |
| **T - Transparency** | Promoting openness and authenticity in leadership |
| **I - Inclusivity in Discomfort** | Embracing discomfort as essential for growth |
| **C - Connecting with Emotions** | Encouraging emotional expression and empathy |
| **E - Engagement** | Creating safe and brave spaces for meaningful dialogue |

By cultivating these environments, leaders enable growth through discomfort. Vulnerability becomes a tool for transformation, empowering supervisees to lean into difficult conversations and self-reflection. This scaffolding not only nurtures emotional safety but also strengthens relationships, ensuring that individuals from historically excluded communities feel genuinely supported and valued. The creation of brave spaces is essential for promoting authentic connections and encouraging risk-taking, which are key elements of personal and professional development (Bennett et al., 2020).

## Empowering Leaders to Navigate Cultural Complexities

In an increasingly diverse world, leaders within infant mental health organizations are tasked with supporting a diverse group of multidisciplinary professionals, especially during multidisciplinary case staffing. These leaders must be equipped to navigate cultural complexities while addressing systemic inequities that impact both their teams and the families they serve. The JUSTICE framework offers a heartfelt and powerful approach to fostering multicultural relationships grounded in fairness, understanding, and inclusivity. By embracing this framework, leaders can create spaces where systemic inequities are confronted, and individuals from diverse backgrounds feel seen, valued, and empowered to contribute fully. This article delves into how the JUSTICE framework can be applied to leadership, focusing on addressing cultural differences, promoting equity, and building authentic, trusting relationships within an infant mental health setting

## Understanding the JUSTICE Framework

The **JUSTICE framework** consists of six key pillars: **Justice, Understanding, Social Location, Transparency, Inclusivity in Discomfort, Connecting with Emotions**, and **Engagement in Safe and Brave Spaces**. Each of these pillars guides leaders in reflective practice and provides a roadmap for creating more inclusive and equitable environments (Hutchinson, 2023; Nussbaum, 2011). By focusing on both individual relationships and systemic structures, the framework empowers leaders to address power dynamics, foster trust, and build authentic connections across cultural lines.

## Case Study: Applying the JUSTICE Framework in a Multicultural Organization

### Background Context

A nonprofit infant mental health organization focused on supporting young children (birth to five) and their families employs a diverse multidisciplinary team (MDT) composed of professionals from various cultural backgrounds, including Haiti, the Dominican Republic, Cuba, Palestine, Israel, Nigeria, and individuals identifying as Black, African American, and Middle Eastern. These team members bring unique experiences shaped by trauma, systemic racism, and oppression. Recently, geopolitical tensions have intensified divisions within the organization, leading to a lack of understanding from leadership regarding the sociopolitical contexts affecting the families they serve.

### The Challenge

The MDT encounters a particularly impactful case involving a two-year-old child exhibiting developmental delays linked to the family's trauma and migration history. The child's mother, a Palestinian refugee, is struggling with postpartum depression, exacerbated by feelings of isolation and the stress of her situation. The team feels increasingly stuck in their ability to provide effective support because leadership struggles with implicit biases, causing tension within the MDT. Leadership's failure to grasp the sociopolitical context prevents effective collaboration and communication, resulting in feelings of frustration and disconnection among team members.

In a recent reflective supervision meeting, the MDT decides to implement the JUSTICE framework to address their challenges and enhance their support for the young mother and her child. They focus on the following components during their discussion:

1. **Justice**:

   The team prioritizes equitable support for the young child and her family. They advocate for tailored resources that specifically address the unique challenges stemming from the family's sociopolitical context. By recognizing and addressing the systemic barriers faced by families in similar situations, they ensure that their practices prioritize fairness and accessibility.

2. **Understanding**:

   To foster deeper understanding, the MDT organizes a reflective workshop where team members share personal experiences related to trauma and migration. They invite community leaders and mental health professionals to provide insights into the specific challenges faced by the families they serve. This shared understanding helps bridge the gap between leadership's perspective and the realities experienced by families, fostering a culture of empathy.

3. **Safety**:

   The MDT establishes ground rules to create a psychologically safe environment for open discussions. Team members are encouraged to voice their concerns regarding leadership's implicit biases and the barriers these biases create in their work. This safety facilitates honest conversations about their experiences, allowing for vulnerability and healing within the team.

4. **Trust**:

   Trust is cultivated through vulnerability and transparency. Team members share their challenges and successes in working with families, allowing for deeper connections and rapport. This trust extends to the families they serve, as the MDT learns to communicate more effectively and empathetically.

5. **Inclusion**:

   The team actively works to ensure that the young mother's cultural background and experiences inform her case plan. They prioritize including her voice in discussions about her child's support, recognizing that her input is essential to developing effective interventions. This inclusion extends to all families they serve, ensuring that care is culturally sensitive and responsive.

6. **Collaboration**:

   During the reflective supervision meeting, the MDT collaborates

on developing a comprehensive treatment strategy for the young mother and her child. They leverage their diverse expertise to ensure that the intervention plan addresses both developmental and emotional support needs. The team emphasizes the importance of collaborative practice, where all member's insights are valued and utilized.

7. **Empowerment**:

   The focus on empowerment involves enhancing understanding and support within the organization to strengthen cultural humility among leaders. The MDT discusses the importance of training for leadership on cultural competence and implicit bias, recognizing that leaders play a crucial role in shaping the organizational culture. They highlight the significance of the parallel process, where the dynamics within the team reflect the supportive practices, they wish to implement with families. By empowering team members to advocate for necessary changes, they build a more responsive and inclusive organization.

## Outcome

By fully integrating the JUSTICE framework, the MDT experiences significant improvements in how they support families from marginalized backgrounds. The reflective supervision process, in particular, enables leadership to model vulnerability and inclusion, which encourages the entire team to adopt these values in their work. As leaders practice transparency and engage in difficult conversations about bias and power, the team is empowered to confront these issues openly. This leads to stronger relationships within the team and with the families they serve. The Palestinian mother, for example, receives more relevant and culturally sensitive support as a result of the team's efforts to address their own biases and lean into discomfort. Overall, the framework enhances the team's emotional connection, deepens understanding, and creates a more equitable and inclusive approach to family support. Leaders' engagement in safe and brave spaces also ensures that the team continues to grow in its ability to serve diverse populations with empathy, authenticity, and fairness.

Table 2. Application of the JUSTICE Framework.

| JUSTICE Framework Element | Application |
|---|---|
| **Justice** | The team prioritizes equitable support for the young child and her Palestinian mother, who faces unique challenges due to the family's sociopolitical context, including potential discrimination and systemic barriers. The team advocates for resources tailored to address the intersection of these sociopolitical factors and the family's individual needs. By recognizing and addressing the biases and barriers that arise from the leadership's own perspectives, they work to ensure fairness and accessibility in their practices (Gilkerson & Imberger, 2016). |
| **Understanding** | To foster deeper understanding, the MDT team organizes a reflective workshop where team members share and reflect on personal experiences related to trauma, migration, and cultural identity. In the case of the Palestinian mother, they invite community leaders and mental health professionals familiar with the challenges faced by Palestinian families. This helps bridge the gap between the leadership's understanding and the mother's reality, promoting a culture of empathy, and addressing the implicit biases that may hinder the support she receives (Sue et al., 2007). |
| **Social Location** | The team incorporates an awareness of **social location**, particularly in understanding the positionality of the Palestinian mother in relation to her cultural, ethnic, and national identity. Reflecting on how their own biases, informed by their race, gender, and class, affect their work, the team acknowledges the challenges in fully supporting the mother due to leadership's own preconceived notions or biases about her background. This reflection fosters understanding of power, privilege, and oppression within the team and their interactions with the family (Brown, 2018). |
| **Transparency and Authenticity** | Transparency and authenticity are cultivated through open dialogue and vulnerability. Team members, especially leadership, are encouraged to reflect on and discuss their own biases and how these affect their decision-making processes. By being transparent about the challenges in supporting the Palestinian mother due to their own preconceptions, they foster deeper connections and trust, allowing for practices more aligned with the family's needs (Gilkerson & Imberger, 2016). |
| **Inclusivity in Discomfort** | The team works to ensure that the Palestinian mother's voice is heard, even when uncomfortable topics such as race, culture, and national origin arise. Inclusivity here means encouraging team members, particularly those in leadership, to lean into discomfort by addressing their biases. The team reflects on how these biases create barriers for the family and work toward more culturally competent and inclusive care (Sue et al., 2007). |
| **Connecting with Emotions** | During reflective supervision meetings, the MDT emphasizes the importance of connecting with their own and each other's emotions, particularly when discussing their challenges in supporting the Palestinian mother. By acknowledging the discomfort, frustration, and emotional strain involved, the team strengthens its emotional connection, allowing for a more empathetic and comprehensive approach to both developmental and emotional support for the family (Gilkerson & Imberger, 2016). |
| **Engagement in Safe and Brave Spaces** | The focus on empowerment is reframed as creating safe and brave spaces where the MDT can engage in difficult conversations around their implicit biases, particularly regarding the Palestinian mother's background. By acknowledging the parallel process, the dynamics within the team reflect the supportive and brave practices they aim to implement with families. This approach empowers team members to address leadership biases and advocate for the necessary changes to build a more inclusive and responsive organization (Brown, 2018). |

## Co-Creating Authentic Relationships in Supervision

Building **authentic relationships** in reflective supervision demands a **bi-directional process**, where both leaders and supervisees grow together through openness and trust. Using the **JUSTICE framework**, supervisors can model vulnerability through **Justice** and **Transparency**, creating fairness and equality in their interactions (Sen, 2009). By acknowledging discomfort and encouraging **Inclusivity in Discomfort**, supervisors and supervisees can engage in meaningful conversations, addressing power dynamics and shared emotions. This co-creation fosters **Understanding** and builds **Relational Safety**, a critical factor for healing, especially for those with trauma triggers (Brown, 2018). When leaders embrace vulnerability, they foster an environment where both parties can grow, learn, and heal through the relationship.

Relational safety is crucial because relationships can sometimes reignite past traumas. Supervisors using the **JUSTICE framework** can help break this cycle by practicing **Empathy** and **Connecting with Emotions**. This compassionate approach strengthens the bond between supervisor and supervisee, transforming potentially harmful interactions into opportunities for growth and understanding. By intentionally creating **safe and brave spaces**, supervisors provide a healing environment where vulnerability is seen as a strength and relationships become vehicles for deep transformation and impactful change.

## Addressing Systemic Barriers in Reflective Supervision

Systemic barriers in reflective supervision often stem from **organizational ghosts**—the lingering effects of historical trauma, unresolved conflicts, and power imbalances that shape organizational culture (Peak & Kronenberg, 2010). These ghosts leave behind remnants of pain that hinder system change and perpetuate inequities. The **JUSTICE framework** helps leaders confront these barriers by promoting **Justice**, **Understanding**, and **Transparency** (Rawls, 1971). By addressing these organizational traumas, leaders can foster relational safety, allowing both supervisors and supervisees to engage in growth and healing.

Through the **JUSTICE framework**, leaders are encouraged to lean into discomfort, using **Inclusivity** and **Empathy** to address the lingering effects of systemic trauma. By acknowledging these ghosts, reflective supervision becomes a tool for healing, where historical inequities are actively dismantled. This approach promotes leadership growth and organizational transformation, creating an environment where equity and inclusion are prioritized (Brown, 2018). By integrating justice-oriented principles, leaders can ensure sustainable change that heals both individuals and systems.

## The Global Impact: Reflective Supervision Across Borders

The global relevance of reflective supervision is becoming increasingly significant, as leaders and supervisors across borders recognize the importance of creating spaces for vulnerability, growth, and healing. In diverse cultural contexts, the **JUSTICE framework** serves as an adaptable tool, allowing leaders to foster fairness, empathy, and inclusivity while addressing systemic inequities in supervision (Nussbaum, 2011). This approach encourages leaders to lean into discomfort and confront the power dynamics that exist within their unique cultural landscapes, enabling true transformation across borders.

The **JUSTICE framework** is particularly impactful because it transcends cultural differences, offering a universally adaptable model for relational safety and organizational growth. By focusing on principles like **Justice**, **Transparency**, and **Inclusivity**, leaders can create environments where trust and understanding flourish, regardless of the specific cultural challenges they face. This adaptability ensures that reflective supervision remains relevant across diverse cultural contexts, fostering equity and growth in leadership practices worldwide (Brown, 2018).

## Conclusion

### Moving Forward with Courage and Commitment

In Embracing Discomfort: Empowering Supervisors and Leaders Globally through the JUSTICE Framework in Reflective Supervision, centering the **JUSTICE framework** allows leaders and supervisors to lead with vulnerability, creating an atmosphere of trust and emotional safety. By doing so, they foster growth not only within themselves but also within their teams, promoting developmental and organizational progress. This approach builds healthy, lasting relational dynamics, supporting both individual and collective success. The framework enables leaders to cultivate environments where genuine relationships flourish, leading to impactful, long-term organizational change (Nussbaum, 2011; Brown, 2018).

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**About the Author**

Dr. Harleen Hutchinson is the President of the Florida Association for Infant Mental Health and the Executive Director of The Journey Institute, Inc. She is a highly regarded Clinical Mentor, endorsed in Infant Mental Health, with over 25 years of experience working with young children and families. Dr. Hutchinson specializes in supporting early relational health and addressing social determinants of health, particularly for BIPOC mothers. Her expertise in reflective supervision and consultation extends locally, nationally, and internationally, providing critical guidance to professionals who work with children from birth to five years old. Through her work, Dr. Hutchinson strengthens the capacity of professionals across systems, ensuring they are equipped to nurture the emotional well-being of young children. Her leadership in early childhood development, trauma-informed care, and equity has made her a pivotal figure in promoting healthy, resilient communities for families, especially in marginalized populations.

# GAINING invites you to join the Infants and Screens Awareness Campaign

by Barbara von Kalckreuth (Germany)
and Jenifer Joy Madden (United States)

## It Began at the 2023 WAIMH World Congress in Dublin

The packed crowd listened closely as Karen Heffler, M.D., delivered her team's findings. Among infants who had higher daily screen time, very concerning behavior had developed. Her slide read: "Association of Early-Life Social and Digital Media Experiences with Development of ASD-Like Symptoms" (Heffler, et al. 2020). Heffler, an ophthalmologist with Drexel College of Medicine's Psychiatry Department in Philadelphia, USA, had reviewed the many global research papers which found an association between screen time and autistic-like symptoms in toddlers and preschool aged children. Heffler's team had also worked with a small group of parents whose toddlers had an autism diagnosis and had viewed screens for an average of five hours per day (Heffler et al., 2022). Her good news: When parents had six months of training to decrease screen time and greatly increase the children's social opportunities, their screen viewing had dropped to a weekly average of only five minutes a day. As Heffler reported in Dublin, "It was a remarkable reduction in the children's screen use after the training program. And we found that the core symptoms of Autism decreased significantly, by 23%...and parents' stress decreased significantly, by 37%."

## Teaming Up

Taking notes in the audience was WAIMH member, Jenifer Joy Madden. An adjunct professor of digital media for Syracuse University in the US, Madden had been following Heffler's work for five years (Madden, 2018). The two had a mission. At the conference, they would seek out members who were also concerned about technology's influence on infant mental health and development. After Heffler's session, Madden handed out invitations to an informal meetup later that day. The cards had a cheery message: "We're Dublin down on Baby and Toddler Well-Being."

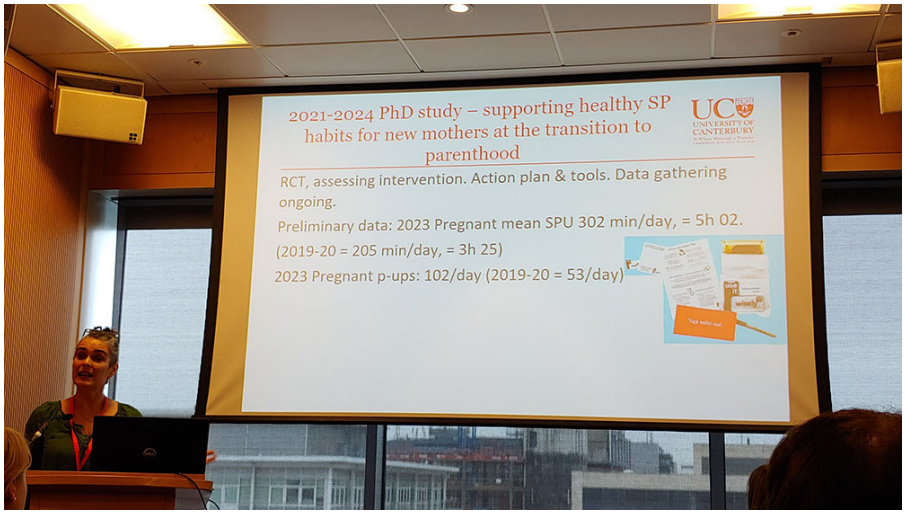


Photo: Miriam McCaleb presents at 2023 WAIMH World Congress in Dublin. Credit: Jenifer Joy Madden

## Effort Pays Off

That evening, WAIMH members from seven nations attended the meetup. One was Miriam McCaleb, PhD of the University of Canterbury in New Zealand. She had presented her research in the same session as Heffler. McCaleb found that new mothers' smartphone use increased in the postpartum period, despite associated risks. Her subsequent research found postpartum screen use increased despite parent education (McCaleb, 2024). "In Dublin, I was struck by the truly global nature of this struggle with distracted caregiving. Delegates from all over the world responded to my findings in remarkably similar ways. The collaboration born of that conference is inspiring, and necessary," McCaleb affirms.

## On To Tampere

At the 2024 Tampere interim Congress Madden and German pediatrician/psychotherapist Barbara Kalckreuth again invited members to a meetup. Kalckreuth had organized a team at the German-speaking Association for Infant Mental Health to write the position paper, "Digital Media and Early Childhood: State of Research, Effects and Recommendations," which they had presented in Dublin. "For parents and other caregivers, the use of all sorts of screens is normal. It is urgent to inform them about the impact on the complex development of their babies and toddlers. Research is increasing and shows significant harms. It is time to get the word out," stresses Kalckreuth. In Tampere, WAIMH members from nations including Greenland, Ethiopia, Bangladesh, and Myanmar joined the effort. As of this writing, 35 countries in the global north and south are represented in what its members have named GAINING—the Global Alliance for Inspiring Non-tech Infant Nurturing and Growth. The alliance was conceived in the U.S., but is truly global in that it has participants from numerous organizations around the world, including members from WAIMH.

## Stepping Into Action

Early on, GAINING decided more awareness is needed—and needed soon. The World Health Organization and numerous national pediatric groups recommend children under 24 months have no screen exposure. Children ages 2 through 5 are advised to have no more than an hour of screen viewing per day (WHO, 2019). Yet, a 2022 international meta-analysis shows that 3 out of 4 two-year-olds exceed the guidelines (McArthur et al., 2022).

GAINING has compiled new research from around the world revealing that infants and toddlers who have regular and prolonged screen exposure may display not only behavior changes (Hill, 2024), but also other developmental harms including disrupted attachment (Gutierrez, 2021), atypical brain white matter formation (Dudley, 2022), changes in sensory processing (Heffler,

2024), and language delay (van den Heuvel, 2019). One of the newest studies, published in 2025 by McCaleb's colleague Megan Gath, M.D. and others at the University of Canterbury found that more than 1.5 hours of "daily direct screen time" at age two was associated with below average language ability and above average peer relationship problems at the age of 4.5. (Gath et al., 2025)

## Time to Alert

Soon after their first online meeting, GAINING decided to go global. Members would write research-based "Awareness Alerts" warning that "extensive and growing global research has intensified earlier findings that frequent and prolonged screen exposure among children ages 0 to 3 can disrupt their cognitive, physical, and social-emotional development." The one-page Alerts offer government agencies, healthcare professionals, and parents strategies for supporting infant development and reduced screen viewing in the early years. María de los Angeles Paúl, WAIMH member from Chile and practicing pediatrician, helped craft the Parents Alert, which is focused on managing screen use in the home and finding alternate activities, including helping with everyday routines and spending time outdoors.

Photo: Barbara von Kalckreuth (on left) and Jenifer Joy Madden in Tampere, Finland for 2024 WAIMH Interim Congress. Credit: Mark P. Madden, M.D.

"To support parents and acknowledge how difficult life can be, we strived to be understanding in what we wrote," says Paúl.

The Alert for health agencies suggests actions including providing screen-free early childcare settings and initiating public health education campaigns. The healthcare provider Alert recommends informing parents and other caregivers about screentime risks and offering screen management strategies starting at the first prenatal visit.

## GAINING Early Progress

Even before the Alerts were finished, GAINING was assisting WAIMH members.

Paula Bleckmann chairs the Media Education Department at Alanus University of Arts and Social Sciences in Germany. "In Dublin, Barbara Kalckreuth and my colleagues presented the GAIMH Position Paper. New research has accumulated since, and the GAIMH team was able to publish a second edition of the GAIMH paper in 2024 (Bleckmann et al., 2024), which now includes research we were alerted to in GAINING meetings," Bleckmann reports. GAINING resources also informed Ireland's new screen time guidelines for children ages two and under. (HSE, 2024)

## Joining the Movement

The Alerts will be released globally on 23 April 2025, which is World Infant, Child and Adolescent Mental Health Day. Since the need is worldwide, WAIMH members from all nations are invited to join the awareness campaign. "Digital devices are present in every child's life so there must be global understanding of what very young children need and do not need for best development. All caregivers should understand that interacting face-to-face with their infants is crucial and absolutely irreplaceable," urges Madden. Read the Awareness Alerts and see GAINING member video messages, along with supporting research studies and caregiver resources on the project website, MyBabyGains.org.

If you have questions, please email info@mybabygains.org.

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# Pediatric Medical Traumatic Stress (PMTS) from NICU to Preschool

by Markus Wilken[1] (Germany), Mary Coughlin[2] (United States), and Susanne Hommel[3] (Germany)

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## Abstract

Each year, nearly 15 million infants are born prematurely worldwide. These infants are exposed to pain, noise and separation during the first weeks of life. The high exposure to pediatric medical traumatic stress places infants and their caregivers at risk for mental health challenges that can persist into adulthood. To advance understanding, early stressors have been studied and linked to the development of later psychopathology. Recognizing these stressors creates a valuable opportunity for prevention through Trauma-Informed Developmental Care (TIDC) and Emotional Revival Therapy (ERT). These approaches equip Infant Mental Health Professionals with effective tools to support premature families and keeping hope up during the NICU journey. These early interventions at NICU help prevent manifest regulatory and attachment disorders in infants as well as perinatal psychiatric disorders in parents.

*Keywords*

Prematurity, Pediatric Medical Traumatic Stress, Trauma-Informed Developmental Care (TIDC), Emotional Revival Therapy (ERT)

*Abbreviations*

ELS: Early-life stress

ERT: Emotional Revival Therapy

TIDC: Trauma-Informed Developmental Care

PMTS: Pediatric Medical Traumatic Stress

## Introduction

Each year, close to 15 million infants are born prematurely worldwide, thrusting families into a world of uncertainty and intense medical intervention (World Health Organization, 2025). The physical and mental development of these vulnerable newborns has long been a central concern in neonatal care. Pioneering research in infant mental health shaped care strategies, emphasizing stress reduction and emotional regulation (Field, 1977; Als, 1982). The positive effects of these interventions have been extensively documented (Givrad et al., 2021). Despite these advances, preterm infants remain at heightened risk for psychiatric disorders from birth into adulthood (Johnson & Marlow, 2011). Johnson and Marlow (2011) describe the "preterm behavioral phenotype" which represents typical psychiatric manifestations of premature born adults characterized by inattention, anxiety, and social difficulties. Early-life stress (ELS), superimposed on immature neural pathways, deranges the developmental trajectory of prematurely born individuals contributing to the emergence of the preterm behavioral phenotype (Schmuecker et al., 2005).

Pediatric Medical Traumatic Stress (PMTS) is a term used to describe the responses of children and their families to trauma within a medical setting (Price, et al., 2016). The suffering during and after intensive care for both baby and parent underscores the importance of Trauma-Informed Developmental Care (TIDC) and Emotional Revival Therapy (ERT) throughout the hospital experience and beyond discharge to reduce the impact of PMTS. These interventions can mitigate the risks of mental health complications, to both baby and family that arise during the NICU stay and span the continuum from early childhood into adulthood. Ideally, these early interventions at NICU and beyond help prevent manifest regulatory disorders in infants, perinatal psychiatric disorders in parents, and disorders within the parent-infant relationship.

## The NICU as a Dual Landscape of Healing and Trauma

The NICU is both a sanctuary of survival and a crucible of stress. For the infant, the soundscape of alarms and ventilators, the glare of fluorescent lights, and the invasive touch of medical procedures replace the gentle rhythms of the womb (Wolke, 1991). These sensory intrusions disrupt critical neural and emotion regulatory networks. In the womb, the baby's sense of self is entirely relational, tied to the mother through a seamless co-regulatory bond that provides both physical and emotional sustenance. Suddenly, that bond is severed, leaving the baby

exposed to bright lights and a cacophony of unfamiliar sounds, with so many hands touching, poking, and sticking needles into them. Tubes are inserted down their throat, often without any comforting reassurances or soothing touch. The babies, with no point of reference to understand the life-threatening situation, is left in a state of utter bewilderment and terror.

A state of shock is a natural response to birth that requires life-sustaining medical interventions for baby and mother, which begins when the two are torn apart. This separation is the first in a cascade of events that disrupts the intuitive bond between mother and child and often positions the caregiver(s) as visitors of their baby within the NICU. Imagine yourself as the parent; you are standing outside *your* baby's room, separated by a door you cannot open. You must ring the bell and wait for permission to enter before you are then required to disinfect your hands and walk a long corridor before reaching your child. Even then, the natural response to gather your child into your arms and hold them in your loving embrace often depends upon the availability, and the permission of someone else to assist you. The power dynamic in these situations casts a long shadow over the caregiver's experience. Parents often describe feeling like intruders in their child's care, rather than being essential to their baby's survival. Parents who are unable to participate in their child's care often struggle with feelings of inadequacy and guilt, which can linger long after the NICU experience has ended.

TIDC seeks to mitigate these stressors, reframing the NICU as a place of healing (Coughlin, 2021). Within the context of earlier viability thresholds, TIDC faces new demands to address the heightened vulnerabilities of extremely preterm infants and their families. For parents, family-integrated care models, informed by trauma-informed paradigms, help to rebuild confidence and foster connection that is quintessential to healing. These person-centered paradigms transform the NICU from an alienating environment to one of shared caregiving. By integrating targeted developmental and relational strategies, TIDC aims to mitigate the compounded effects of early adversity.

## Pediatric Medical Traumatic Stress: Defining the Experience

The experience of the infant in NICU typifies PMTS, with life threatening conditions, the suffocation associated with pulmonary immaturity, repeated painful procedures and prolonged caregiver separation. Unlike older children, newborns in the NICU lack established routines and memories, making it difficult to distinguish the infant's baseline behavior profile from their lived experience of trauma. However, common key stressors associated with NICU hospitalization, that include respiratory distress, procedural pain, and separation from caregivers, are known risk factors for psychopathology (Pierrehumbert et al., 2013). Sleep fragmentation and noxious touch experiences, in conjunction with invasive procedures, further exacerbate the infant's distress. Understanding how these stressors contribute to short and long-term developmental outcomes is essential for creating effective interventions.

## Stressors in the NICU Environment

***Pulmonary Immaturity***: Respiratory distress syndrome is often a preterm infant's first experience outside the womb, characterized by shallow breathing and grunting. It is a breathing pattern not exclusive to pulmonary immaturity but typical for a state of panic and a pretext to a traumatic development. To ensure the survival of the premature infant mechanical ventilation may follow the respiratory distress which alters physical recovery but also the neural pathways that regulate stress and basal affects. Often the infant experiences mechanical ventilation in a state of drug induced dissociation. Once the infant no longer needs external respiratory support, the pattern of dissociation may have become part of the infant's neural networks and self-identity (Schore, 2012). Chronic lung conditions as well as early dissociation limits the individual's quality of life, restricting their physical activities and potentially affecting their capacity for social participation (Lærum et al., 2019). The emotional cost of witnessing an infant's struggle with respiratory distress weighs heavily on parents and caregivers, adding to their sense of helplessness and potentially influencing their capacity to provide attuned caregiving.

***Pain and Procedural Trauma***: NICU infants endure numerous painful procedures daily, often without sufficient analgesia (Carbajal et al., 2008). Premature infants respond visibly to this pain with crying, hypertonus and increase of the heart rate (Pokela & Koivisto, 1994). Despite the aversive reaction of the infant, the painful procedures will go on for days to months, often under-managed. The infant's attempts to withdrawal from the pain results in an enduring state of dissociation. This traumatic state impairs the physiological stability and emotional development of the infant, increasing the risk for developmental disorders (Lammertink et al,. 2022). The long term consequences of early-life exposure to unmanaged pain is associated with altered gene expression linked to greater socio-emotional stress sensitivity and behavioral challenges at school-age (Chau et al., 2014). Pain is a major risk factor for dissociation and a traumatic developmental trajectory, and may pose a risk for disorganized attachment patterns (Wolke et al., 2014).

***Separation from Caregivers:*** Separation exacerbates the infant's stress, depriving them of co-regulation by and safety with their primary caregivers. For infants, the absence of consistent caregiver presence disrupts the natural rhythms of attachment formation, leaving them in a state of affect dysregulation (Schore, 2012). When this absence occurs under the conditions of life-threatening circumstances and constant medical stress, the opportunity for co-regulation is significantly restricted for the baby and their parent. Private rooms within the NICU setting remain rare and are not a guarantee for 24-hour parental presence and so, newborns and their parents may not be able to physically be together for days at a time. The singularly most traumatic experience for a newborn across all mammalian species is maternal separation.

Research confirms the benefits of immediate skin-to-skin contact between baby and the birthing parent, while separation increase the experience of toxic stress and risk of disorganized attachment (Mehler et al., 2023). Skin-to-skin contact during the NICU stay has proven to promote autonomic and neurobehavioral brain maturation in preterm infants positively

impact neurodevelopmental profiles and infant mental health outcomes (Feldman & Eidelman, 2003). Ensuring parental presence and empowering parental involvement, especially during stressful medical procedures, buffers the adverse effects of the NICU experience. Parental presence and participation in medical, parenting and caregiving activities in the NICU are protective factors against PMTS and compromised neurodevelopmental outcomes (Pineda et al., 2017).

## Developmental Consequences of PMTS

Although the prevalence of PMTS in premature infants has not been systematically studied, developmental disorders, physical, neurological and mental health outcomes in this population have been researched for about 50 years (Johnson & Marlow, 2011). Specifically, infants born premature are at risk for disorganized attachment, even when their parents are sensitive caregivers (Wolke et., 2014). For many infants who experience the NICU, the overwhelming stress and absence of a consistent caregiver teaches them that the world cannot be trusted. This lack of trust is often expressed as reduced facial responsiveness to their caregiver's positive emotions over the first year of life (Schmuecker et al., 2015). This interferes with activities of daily living such as feeding experiences. Infants who have experienced 'feeding protocols' in the NICU may learn to not trust the 'feeding experience' because of their lived experience of fear and pain in the setting of non-responsive/ non-attuned 'feeding' interactions. Consequently, these children are at an increased risk for post-traumatic feeding disorder and feeding tube dependency (Wilken & Bartmann, 2014). Prolonged exposure to toxic stress impairs affect regulation, executive functioning, memory, and learning, creating challenges that extend well beyond infancy (Grunau et al., 2009). Preterm born adults who exhibit characteristics consistent with the 'preterm behavioral phenotype' have an increased risk for psychiatric disorders like anxiety disorders and depression (Lærum, et al., 2019). Research has shown that NICU-related stress corresponds with neural patterns akin to those observed in early-life trauma victims, highlighting the long-term impact of unaddressed stressors (Lammertink et al., 2022).

## Early Intervention: Emotional Revival and Healing

Addressing PMTS requires early interventions that prioritize relational repair. In the NICU, TIDC serves as a prevention model, leveraging our understanding of the long-term effects of chronic toxic stress. By equipping caregivers with the knowledge and skills to mitigate these experiences, TIDC transforms the NICU into a space of healing and recovery for infants and families alike. Within a TIDC approach, interventions are designed to minimize stress, support neurodevelopment, and nurture resilience. This approach also deepens clinicians' awareness of the infant's lived experience, fostering greater attunement and responsiveness. However, even with the most effective TIDC practices, pain and separation cannot be entirely eliminated, as the infant remains in a critical medical situation. Despite the prevention intervention some premature infants will suffer from PMTS after discharge. ERT is a new need-based trauma treaement for infants with PMTS. Available since 2021 in Germany infants and parents will be seen bi-weekly in a home-based environment. During ERT the therapist creates synchronized rhythm with the child to re-establish a sense of safety in four phases (Wilken et al., 2023).

### 1: Create Contact

To establish a therapeutic alliance with infants in a state of traumatic withdrawal the therapist needs to gain the infants' trust. To build trust the empathic therapist will track affective states of the infant and regulate traumatic dysregulation. Non-verbal contact through body language, mimicry, gesticulations and intonation activate the sense of self enabling the baby to experience a sense of self-coherence.

### 2: Create Emotional Response

In the initial phase of the ERT treatment, inner withdrawal will not allow the infant to communicate using their emotions. The window of affect tolerance is closed. The infant will primarily express dysregulated traumatized affects. With adaptive affect mirroring the therapist will slowly help the infant to transfer dysregulated affects into emotions. The window of affect tolerance will gradually open. Over the course of the ERT process emotions become more and more part of the infant's communication repertoire.

### 3: Create Intersubjectivity

The revival of emotions marks the beginning of an emerging subjectivity. This subjectivity opens a window of opportunity for the infant and caregivers to foster their developing attachment. Attachment is under development until 24 months. The ERT therapist supports parents in recognizing and responding to their infant's emotional cues, deepening the parent-infant bond. Infants and caregivers will then be able to re-introduce emotions into their communication toolkit.

### 4: Create Meaningful Relationships

Rebuilding trust through nurturing, predictable, well attuned and emotionally supportive interactions is essential to help the infant transition from a state of survival to a state of growth and development. With a deepened process of bonding, the basis for a meaningful and trusting relationship is revealed with a securre attachment organization. As the infant develops new capacities, needs and desires, conflicts may come up. In this phase of evolution, the ERT therapist will guide the caregiver to recognize and respond to their infant's emotional cues, strengethening the parent-infant bond. In this process the parents will be given room to reflect on their own trauma and hurt experienced during the NICU stay. When infants and caregivers can communicate in a balanced partnership, the treatment process can be terminated.

## Conclusions

Research over the last fifty years has shown that the lived experience of NICU hospitalization is a stressful and traumatic life event and may represent a major mental health risk factor for infants. Research has shown that early-life stress and trauma in infancy build pathways of dysfunctional physiological, neurological and mental growth (Schore, 2012). This paper gives an overview of how Pediatric Medical Traumatic Stress may contribute to significant short-term and long-term psychopathology in premature infants and their families. Therefore, prevention and treatment of PMTS in the NICU is paramount.

TIDC represents a paradigm shift, reframing the NICU from a space solely focused on survival to one that fosters resilience and growth for infants and families alike. As a prevention model, TIDC seeks to mitigate the cumulative effects of chronic toxic stress by addressing its root causes and implementing evidence-based interventions that promote healthy development. One of the most transformative aspects of TIDC is its focus on empowering parents as essential members of the care team. This empowerment is critical for fostering a sense of hope and connection, which counteracts the pervasive helplessness often felt by parents navigating the NICU experience.

Transforming the NICU from a place exclusively focused on disease management and medical technology to an environment that acknowledges and responds to the multifaceted human and developmental needs of critically ill babies and their families is a long-term project. Sadly, pain, suffocation and separation will continue to impact babies and families experiencing NICU care around the globe. And Post-traumatic Stress Symptoms will likely be endured for generations to come. Therefore infants and caregivers should have access to early intervention like ERT or Psychoanalytic Parent-Infant Psychotherapy as preventive psychotherapy during NICU stay and in the following 1001 days. Research will show, if these interventions decrease the risk for feeding, sleeping or attachment disorders. With every incremental step toward more holistic care, we move closer toa future where the tiniest humans and their families are met with care that honors their humanity and potential. Together, we can create a world where no family feels alone, no infant's needs to go unheard, and hope becomes the heart of every NICU journey.

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# The Importance of Relationships to Help Young Children, Parents, and Caregivers Impacted by the COVID Pandemic

by Joy D. Osofsky and Howard J. Osofsky
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The COVID-19 Pandemic experienced around the world has impacted young children and families significantly and even more so for those living in poverty with fewer financial and other resources and support. Unfortunately, the COVID Pandemic had an effect on children's development and socialization due to limiting in person opportunities for children and families. Studies following families and children consistently found that the COVID pandemic disrupted access to child-care, limited socialization opportunities for children and families, and increased feelings of stress, anxiety, and other mental health outcomes (Alit et al, 2021 Bullinger, et al, 2021 Del Boca, et al, 2023). Bellandi, D, 2022; Briggs-Gowan et al, 2019; Eagan, et al, 2021). The text that follows provides a section of a full chapter that was reported in Osofsky et al (2024), focusing here on the significant secondary impact of the pandemic that occurred in large part due to the way in which the restrictions that were put in place undermined the core developmental need of young children for relationships, and the way in which such relationships are a central part of their recovery in the post pandemic period.

## The Impact of the COVID-19 Pandemic on Infants, Young Children, and Families

In order to thrive, infants and young children need predictability, consistent schedules, and dependable and emotionally available parents and caregivers who can take sensitive care of them that includes listening to them, playing with them, and planning experiences they can count on and expect. The COVID pandemic changed many of these expectations as children and families were living with "indefinite uncertainty" about when the pandemic would end and their lives would return to normal. First, they had to adjust to the "stay at home" orders so that they could not participate in the usual activities of going to childcare centers, preschools, or schools. For parents who were essential workers, there were many worries about childcare and also stress related to concerns about losing their jobs. For others who could work virtually, balancing providing both childcare and/or virtual schooling for their children was challenging. While advice to practice social distancing was designed to help protect children and families from COVID, it also meant that young children were not able to visit their friends, go out to play, or see their grandparents and other close relatives who meant a lot to them. From a mental health perspective, it would have been more advisable to require physical distancing for safety and encourage virtual social contact with friends or family using technology if possible. If families did not have access to video technology, and many throughout the world did not, telephone contact could be encouraged as a way to stay in touch and to visit friends and family. It would have been important during this time of isolation that a "new normal" be created to find ways to help families keep up with close relationships that are so important for young children (Lyons-Ruth et al., 2017). Virtual contact is also important for parents and caregivers for support to help them be able to provide better care for their children. At the same time as lockdowns were required, for the first time in many countries, wearing face masks for protection was recommended or required in many settings when around other people. For many children and families, masking was uncomfortable, different, and also interfered with them trying to feel "normal."

## Longer term outcomes and ways to Support Resilience in Young Children Following the COVID-19 Pandemic

Infants, young children, and families around the world have experienced much adversity during the COVID-19 pandemic due to the indefinite uncertainty. Masten (2015) and Osofsky (2024) emphasized that some young children, especially with support from parents and caregivers, can adapt and recover showing resilience, while others have a more difficult time. Response and recovery depend upon different factors including the extent of the impact on the young child and family and especially the support provided by family and others.

Resilience in young children depends upon caring, engaged and nurturing family members, close relationships with emotional security and a sense of belonging, planning and problem solving, family flexibility, ability to self-regulate including emotions,

hope and optimism, coherence and understanding of what is happening, routines and rituals. Engagement in school is also important for children who are a little older, as are well-functioning communities that provide support, promotion and protection for children and families.

One of the factors that made it more difficult for young children to show resilience during the pandemic related to the significant impact on parents and families, especially those with fewer resources. The components leading to increased self-efficacy and resilience with a supportive infrastructure at the community level were generally not available during COVID. To support resilience for young children, it is crucial to provide support for parents and families during any disaster, including the COVID pandemic. Masten (2021) considers risks, assets, and adaptive systems in a multisystem perspective to support resilience. The following components are important to support resilience: 1) caring family with sensitive caregiving (nurturing family members); 2) close relationships; 3) emotional security, belonging (family cohesion, belonging); 4) skilled parenting (skilled family management); 5) Skilled parenting (skilled family management); 6) Agency, motivation to adapt (active coping, mastery); 7) Problem-solving skills, planning, executive function skills (collaborative problem-solving, family flexibility); 8) Self-regulation skills, emotion regulation (co-regulation, balancing family needs); 9) Self-efficacy, positive view of the self or identity (positive views of family and family identity); 10) Hope, faith, optimism (hope, faith, optimism, positive family outlook); 11) meaning-making, belief life has meaning (coherence, family purpose, collective meaning-making); (12) routines and rituals (family routines and rituals, family role organization); (13) engagement in a well-functioning school; and (14) connections with well-functioning communities.

To support resilience, what is most important is a consistent emotionally available caregiver to listen to and be with the young child. It is crucial that the needs of young children and families become an important component of disaster planning in order to support resilience. COVID-19 had characteristics of a disaster and therefore recovery includes a community approach involving schools, parents, and caregivers (who themselves may be traumatized), community providers, spiritual leaders, schools, and other supportive groups. The focus needs to be placed not only on the expectable and developmentally related regressive symptoms and behavioral dysregulation in young children, but also on those factors that will build resilience and inevitably will support recovery. Interventions should focus on efforts that will be universally helpful, those that should be targeted for young children with specific reactions, and those that are useful for children with pre-existing and long-term difficulties. It is important to include a community participatory approach in the establishment of supportive services. Respect needs to be given to the strengths and cultures of the impacted communities. To support resilience, more attention should be given to individual and community resilience as well as an effective response to support recovery across systems.

## About this paper

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# WeRead: Promoting Early Literacy Programming Through Community Collaboration

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Photo: FamFair 2024 Storytime. Credit: Christian Vozar

## Abstract

This article introduces *WeRead (WR)* and *Nosotros Leemos (NL)*, early literacy and language development psychoeducation programs designed for caregivers and their children ages 0-3. Offered both in English and Spanish, these programs are inspired by a play-based psychoeducation model and aim to address the growing need for language development and early literacy support in the Denver Metro area. WR and NL programming is made possible through a collaborative partnership involving our generous funder, Taylor Kirkpatrick, the Baby S.T.E.P.S. (Supporting Teachers, Educators, Parents, and Service Providers) Lab at the Graduate School of Professional Psychology, and University Libraries at the University of Denver. This initiative not only highlights a strong interdepartmental university collaboration but also a meaningful community partnership with the Denver Public Library's (DPL) Early Learning Department, the Clyfford Still Art Museum, and Rocky Mountain Human Services (RMHS). Through this collaboration, related programming is promoted for a shared population, creating a greater impact in the community. The article also explores the potential for expanding these initiatives and considers how similar models can be applied to other early childhood and parenting support programs.

*Keywords*: early language development, early literacy, community collaborations

## WeRead: Promoting Early Literacy Programming Through Community Collaboration

Research emphasizes the important role of reading with children, including infants, in fostering early literacy, language development, and parent-child relationships (Byington et al., 2008; Egan et al., 2022; Jimenez et al., 2019; Klass, Miller-Fitzwater & High, 2024; McNally, 2023; Melzi, 2022; Muhinyi & Rowe, 2019; Murray & Egan, 2014). It also highlights the positive impact of psychoeducational programs supporting both English- and Spanish-speaking families (Byington et al., 2008; Child Mind Institute, 2023; Klass, Miller-Fitzwater, & High, 2024). Utilizing the team's extensive knowledge of child development, literacy, and caregiver-child relationships, this programming seeks to partner with, and elevate existing community resources. In Colorado, early literacy initiatives provide books, host Storytimes, and offer text messages with literacy activities, local events, and resources (Colorado Department of Early Childhood, 2024), all of which make a positive difference. Integrating psychoeducational support and promoting awareness of programmes and resource offerings across various organizations may provide even greater benefits to the community.

The WeRead (WR) and Nosotros Leemos (NL) programs embody an approach that integrates group Storytime with psychoeducational support to advance language and literacy development in both English- and Spanish-speaking children while promoting positive psychosocial outcomes for caregivers. This paper presents WR and NL as models for integrating early literacy with psychoeducation as well as highlights additional community partner programs that are advancing similar efforts to support early childhood development.

## Introducing WeRead and Nosotros Leemos

WR and NL serve families with children ages 0 to 36 months, drawing inspiration from WePlay© and Nosotros Jugamos (Antenucci et al., 2024; Gross et al., 2021), a play-based, psychoeducational initiative in the Denver metro area that support young children's development and family's well-being. Feedback from the program highlighted a need for greater focus on early language development and early literacy, leading to the creation of WR and NL. The WR and NL approach is grounded in research that shows when programming is aligned with

families' lived experiences, languages, and cultural contexts, it not only fosters greater engagement and more meaningful, affirming experiences but also promotes enhanced learning outcomes (Gay, 2020). Additionally, recent literature highlighting specific language and literacy needs of Spanish-speaking families emphasized the importance of early interventions that are culturally congruent and linguistically accessible. For example, Herrera et al. (2022) argues that early exposure to bilingual literacy not only supports language acquisition but also affirms cultural identity, which is critical in fostering long-term engagement. Given the importance of integrating skill-building and incorporating cultural identities into literacy programming, research also underscores the importance of programs considering the significance of trusted relationships with clinicians, access to tangible resources like books, caregivers' literacy, and external stressors, such as poverty and competing parenting demands (Jimenez et al., 2023). These insights from the literature help inform best practices in developing a culturally sensitive program.

NL program development involves the intentional design of psychoeducational content, Storytime books, activities, and facilitated discussion topics that are deeply relevant to the cultural and linguistic experiences of Spanish-speaking families. The Early Childhood Readers Collection (ECRC) at the DU Libraries was established as a content and reference guide for WR and NL programming. It features diverse children's literature in print and online formats including books in eight languages beyond English with approximately 100 titles in Spanish. Curated by DU's faculty librarians, it celebrates inclusion across race, gender identity, sexual orientation, and disability, reflecting the diversity of the community. This emphasis offers both mirrors for self-identity and windows to understanding others, fostering belonging and appreciation for diversity, critical tenets of holistic early childhood development.

WR and NL groups consist of four weekly 35–45-minute sessions held at the University of Denver (DU) Libraries campus space. WR and NL include Storytime activities, immersive play, and facilitated psychoeducation group components which are are led by graduate students in the clinical psychology program at DU under supervision by DU faculty and Library Staff. Psychoeducation topics include the benefits of reading together in supporting caregiver-child relationships, language milestones, cognitive and emotional development, positive child behaviors, and other related topics, with time for discussion and questions. Participants also receive resource handouts, "We Readers" kits to extend learning at home, and access to guest speakers such as authors, child development experts, and other community agency leaders providing supportive programming for this population. Program effectiveness is monitored through ongoing evaluation efforts, which are an optional component for attendees to opt in or out of during programming. Based on evaluations and feedback, the WR and NL models will be continually adapted to meet the needs of families.

## The We in WeRead

DPL offers LENA Start Language Development Program, a free initiative available in both English and Spanish, designed to support caregivers of young children enhance interactive communication and support early learning. Over 10 weekly sessions, parents receive personalized feedback on their verbal interactions, with guidance on improving conversations and reading. The program is delivered in a supportive group environment, where participants receive a kit containing books and LENA technology to track progress. Incentives are provided throughout the sessions, with details provided as the program progresses. Through LENA Start, caregivers learn effective strategies for talking and reading with their children while also understanding the importance of these interactions for early language development. Participants are connected to their neighborhood library branch and to one another, forming a parent support group. DPL also collaborates with other agencies and organizations to bring additional resources based on participant needs and interests. In addition to LENA Start, DPL offers a variety of other programs to support children's language development, including Storytimes in English and Spanish and Little University. While Little University is not available in multiple languages, it provides a hands-on learning experience for families, helping them develop early learning skills in their home language. All of DPL's programs are designed to support caregivers in fostering their child's development while making learning enjoyable for both parents and children.

In addition, the CSM is dedicated to aligning itself as a resource for caregiver and infant mental health in the Denver community and beyond. CSM aims to support caregivers and equip them with the skills necessary to comfort and care for infants, which directly benefits infants' mental health. The development of strong relationships, temperament, attachment styles, and a sense of self begins in infancy and is at the center of programming goals. In a 2022 study, Penn's Positive Psychology Center found that "…museums – in particular, art museums – are good at reducing anxiety and depression" (Crimmins, 2022). To address these community needs, CSM offers Art Crawl, a program designed for infants and their caregivers which aims to provide a sense of belonging to young children and families at the CSM, supporting the development and learning of infants, and encouraging the development of community amongst participants. During the COVID-19 pandemic, caregivers, especially caregivers of infants, expressed feeling isolated and anxious. Art Crawl's goal is to cultivate a sense of connection for caregivers, directly addresses those needs.

Furthermore, RMHS offers the Denver Early Steps program, which provides direct intervention services and supports to children ages 0-3 who are not eligible for the Early Intervention program but continue to show a 25-32 percent delay in their development. RMHS provides direct therapy and service coordination supports to all children who qualify for this program. Through this main program, RMHS has been able to develop a subprogram, Developmental Monitoring, which offers informal supports to children who are showing less than a 25 percent delay or are at risk of showing a delay in their development. The RMHS team supports families in completing various screeners and developmental monitoring tools such as the ASQ-3, ASQ-SE, and the PEARLS to help identify the child's needs. In conjunction with these supports, children and families who are eligible for these programs can participate in the variety of generalized parenting classes we offer. These classes aim to help educate parents in areas that we commonly see delays and help build connection with other parents who may be experiencing similar things.

Looking ahead, our goal is to work with DPL, CSM, and RMHS to collaboratively promote each other's programs across multiple locations in the Denver metro area. Through this collaboration, program facilitators will attend each other's events, share resources with attendees, and create opportunities for families with young children to explore all relevant programming that support early childhood development. By engaging with our community partners, we can also introduce families to the WR and NL virtual resource libraries and recruit participants for the WR and NL research study, further strengthening our collective impact.

## FamFair: It takes a village

One primary goal of the WR and NL programming is bringing community and university resources together in innovative and growth-focused manners. Hosting a regular gathering of community and university partners along with the caregivers and young children these resources seek to serve, is the inspiration behind FamFair. This yearly child and caregiver friendly conference style gathering showcases programming including WR and NL along with brief, child-friendly presentations from experts on child development and psychology. In the prior years, two events were hosted at the University of Denver with speakers including faculty, staff, and guests from outside universities and programs. A community resource fair accompanies the event, with community partners hosting tables to showcase their programming, expertise, and offerings to families in the area. Families are encouraged to attend with their children, for as long as they feel comfortable according to their children's ages and comfort. Food and beverages are provided as are books and activities to take home. At the last FamFair, our generous funder, Taylor Kirkpatrick, wrote and recited a story for the event. We include it here as it showcases the family friendly, welcoming community feel of the event along with the focus on child development and early literacy.

*A story about a young moose named Chocolate—Chocolate Moose.*

*Chocolate lived in a bustling forest filled with all kinds of animals, yet he often felt lonely. It wasn't that he lacked company—the forest was lively and full of activity—but no one seemed to understand how he felt. One day, Chocolate decided to change that. He set out to meet the other animals and listen to their stories. He wanted to make new friends and learn about their own joys and challenges. He spoke to the wise owl, Owlivia, who perched high in a tree. Owlivia admitted she loved the stars but often felt isolated way up in the tree, awake while everyone else slept. Then Chocolate met the busy squirrel, Nutmeg, who enjoyed gathering food but constantly worried about the long winter ahead. Finally, he approached the gentle deer, Jane Doe, who loved to prance through the forest but was always anxious about making too much noise and drawing unwanted attention from the hunters.*

*As Chocolate listened, he realized that everyone had their own worries, and by understanding them, he didn't feel so alone anymore, plus he made some new friends. They were no longer moosterious, and the forest didn't feel so lonely anymore. It became a place full of friends with unique stories. The moosteries of the forest became clearer, and Chocolate felt a sense of belonging he'd never known.*

*When the librarian finished, Ashley asked, "How did such a tiny book hold so many feelings?"*

*The librarian winked. "Every story, no matter its size, can make us feel something deep inside. Books help us understand the feelings of others, and through their stories, we begin to understand our own forest better.*

*By reading, we learn how different lives are connected, and we grow closer to one another."*

*From that day on, Ashley knew that books weren't just full of stories—they were full of feelings, lessons, and friendships waiting to be discovered.*

## Summary

WR and NL provide early childhood and parenting support programs that blend early literacy, language development, and mental health support through culturally responsive psychoeducation to the community. These programs increase the availability of comprehensive, community-focused early literacy programs, particularly for bilingual families. The integration of in-person Storytimes, interactive and engaging activities that expand language communication between caregivers and children, psychoeducational support for caregivers, and community partnerships creates a holistic approach to early childhood literacy and language development. The programs' use of evidence-based practices, ongoing feedback and evaluation, and adaptive programming ensure that they are responsive to the needs of diverse communities. Moving forward, similar models could be expanded to other early childhood initiatives, particularly those focusing on underserved communities, with an emphasis on integrating cultural relevance, community collaboration, and continuous evaluation to ensure effectiveness and scalability.

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# Using care navigation to connect Australian families with perinatal and infant mental health support

by Sophia A. Harris, Jessica Arnall, Penny Walls, Megan Leuenberger, Melanie Hughes, Alison Cook, Valsamma Eapen, and Jane Kohlhoff (Australia)

## Parents reaching out for a lifeline

Perinatal mental health challenges are common, affecting 1 in 5 parents during pregnancy and the early years of their child's life. Some parents are at greater risk, including those with a history of mental health diagnoses, lack of social support, low parenting self-efficacy, a traumatic birth experience, and poor relationship quality or a partner facing mental health challenges (Chen et al., 2022; Hutchens & Kearney, 2020; van der Zee-van et al., 2021). If left untreated, mental health challenges can have long-term impacts on the entire family, impacting parenting, relationships, and child development (Myers & Johns, 2018; Netsi et al., 2018).

Recent years have seen increased awareness of perinatal mental health disorders around the world (Howard & Khalifeh, 2020), and the development of major policy initiatives such as the UK's *Antenatal and Postnatal Mental Health Guidelines* (National Institute for Health and Care Excellence, 2014), and the *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guidelines* (Highet, 2023). However, parents continue to face barriers in accessing the mental health care they need, including individual-level barriers such as shame and stigma, time, or logistical factors, and service-level barriers including limited availability and fragmented service landscapes (Byatt et al., 2012; Howard & Khalifeh, 2020).

## ForWhen: a perinatal and infant mental health care navigation service for new and expectant parents

ForWhen (www.forwhenhelpline.org.au) is a national perinatal and infant mental health care navigation service, the first of its kind in Australia. The service is funded by the Australian federal government and delivered by a consortium of early parenting service providers, led by Karitane, a non-government organisation providing parenting support for over 100 years. ForWhen aims to connect new and expectant parents with timely mental health services and supports. Parents access the service through a referral from their health professional such as a general practitioner, midwife, or community-based child and family health nurse, or by directly calling a national phoneline themselves where they are connected with a local state-based Navigator. ForWhen also supports health professionals by providing expert guidance and information related to perinatal and infant mental health, support options, and referral pathways. Since launching in February 2022, ForWhen has supported over 6000 families located around Australia.

This article will illustrate the ForWhen care navigation model through four client case studies[1], highlighting the ways in which care navigation can help parents navigate access to mental health care for themselves and their babies.

> ***Case Study 1: Linh**. Linh had a smooth pregnancy – she felt healthy, kept up with exercise, and prepared for the arrival of her first baby. When her son's birth was a "terrible" experience, it was far from her*


Credit: ForWhen

[1]Names have been changed throughout to protect participant anonymity.

*expectations, and she struggled to come to terms with it. Following the birth, Linh faced a difficult physical recovery including pelvic floor issues, and pain and engorgement from breastfeeding. The trauma of the birth left her grappling with feelings of disappointment and self-blame. To make things even harder, Linh was very isolated. She had a good support in her husband, but he was soon back to working full-time and their extended family lived overseas. Linh had wonderful childhood memories of being raised by "the village" in her home country but she didn't have this kind of support network in Australia. As her son grew, while she felt deeply connected to him, she found it difficult to cope with his disrupted sleep, and eventually attended a parenting service for sleep and settling support. It was here that Linh disclosed thoughts of wanting to disappear, and a nurse referred her to ForWhen.*

***Case Study 2: Callum**. When Callum's partner Emma went into labour at 35 weeks pregnant, it caught both of them completely off guard. This would be their first child, and everything about the experience felt new and daunting. Their son Eli was born premature and needed immediate medical attention including oxygen support; the sight of their tiny baby surrounded by medical equipment was frightening. When the new family were finally sent home together a couple of weeks later, they were relieved, but exhausted. Then, just as they were beginning to feel settled, Emma developed a severe fever and was readmitted to hospital. This time they were on a general ward, without any support from postnatal specialists. Callum found himself taking on multiple roles – learning to be a father while caring for Eli around the clock and supporting Emma through her illness. Though well-meaning, friends and family offered advice that seemed out of touch with their reality, and Callum felt overwhelmed and alone. It wasn't until a scheduled checkup for Eli that an early childhood nurse recognised Callum's distress and offered to help him call ForWhen.*

***Case Study 3: Brooke.** Brooke had a planned pregnancy and was excited to become a mother. However, when she was 6-months pregnant, her partner left, revealing a pattern of infidelity and drug use. After her baby was born, Brooke felt devastated to be navigating the journey of new parenthood on her own, and she experienced postpartum infections that required hospitalisation and prolonged antibiotic treatment. She relocated with her baby to a country town to be closer to family but struggled with the lack of local health and parenting services. Despite having no prior mental health history, Brooke's emotional state deteriorated rapidly. She experienced a growing sense of disconnect from her baby, feelings of guilt, and intrusive and disturbing thoughts of harming herself and her daughter. Feeling desperate for help, Brooke used a health app on her phone to scroll through a list of mental health services and came across ForWhen, and she called the number.*

***Case Study 4: Alex.** The first few months of fatherhood were a whirlwind for Alex. By the time his son was a few weeks old, Alex was back to full-time work. He had always been a light sleeper, and now sharing a room with his partner and newborn baby, he often only managed two hours of sleep a night. Compounding both parents' feelings of overwhelm was a traumatic birth experience which was marked by confusion and poor communication from hospital staff. After this distressing experience, Alex had advocated for his partner's need for mental health support and a formal debrief with the hospital. However, he found little support available for himself as a dad. The pressures of helping in the care of a newborn and working full-time, while supporting his partner through her own anxiety, left him feeling frustrated and it was impacting his ability to connect with his son. Prior to the birth, he had seen a psychologist for help managing stress and he recognised the value of professional support. As the pressures of new parenthood mounted, he knew he needed help again, so one day on his way to work he picked up the phone and called ForWhen.*

## The navigation approach

A Navigator's role is to support and guide clients through the healthcare system, connecting them with services that meet their specific needs, and working with clients to problem-solve around barriers to access. Originating in the field of cancer care (Freeman & Rodriguez, 2011), care navigation has been adopted across diverse health and social care settings, often in response to the recognition that those with complex needs are not accessing the services they need. Navigator competency frameworks – such as the *NHS Care Navigation Competency Framework* – have been developed to define the skills of Navigators and conceptualise their role within health and social care systems. There are now many examples of navigation services designed to support children and families with complex needs, including for perinatal and infant mental health concerns (Harris et al., 2023).

ForWhen Navigators are health professionals (e.g., nurses, midwives, social workers, psychologists) with specialist training or experience in perinatal and infant mental health. When someone rings ForWhen, their call is answered by a Navigator located in their state or territory, who has a thorough understanding of the services available in the local jurisdiction. The Navigator speaks with the caller to 1) understand their mental health concerns, assess safety and risks to themselves and their infant/s, and identify supportive factors, 2) provide information, psychoeducation, and

emotional support, and 3) work collaboratively with the caller to identify their needs and connect them with services appropriate to their circumstances (Harris et al., 2024). Most parents are referred to specialist perinatal counselling or psychology services, though some are navigated to additional services such as parenting support or domestic and family violence services. ForWhen Navigators aim to make parents feel validated and supported and help them to connect to the 'right' help at the 'right' time. This is expected to ease the client's burden of trying to access care while facing mental health challenges and being pregnant or caring for a young baby. ForWhen Navigators also support other clinicians by providing expert advice on perinatal and infant mental health treatment and referral options, and by sharing assessment information (with the client's consent) to facilitate warm handover of care between services.

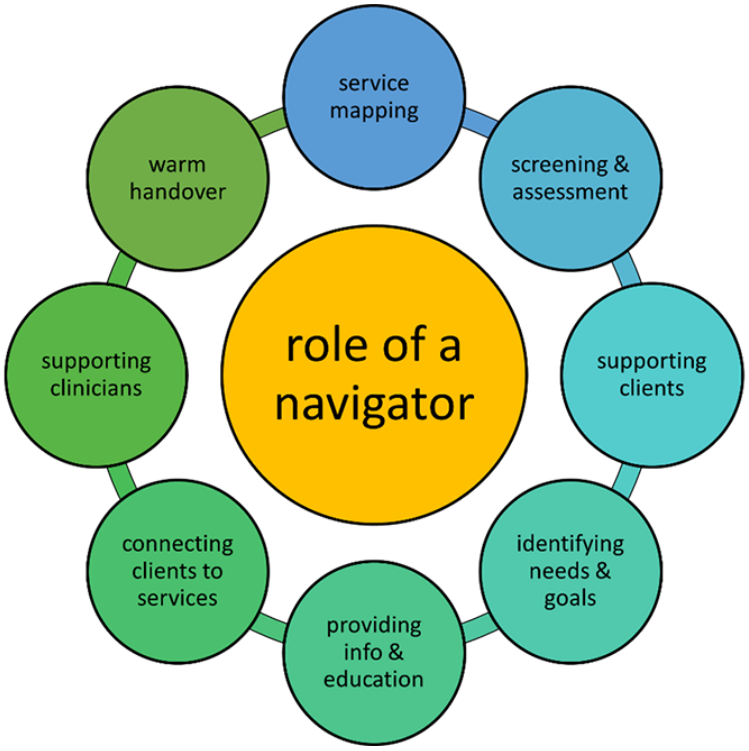


Figure 1. Role of a ForWhen Navigator, adapted from Harris et al. (2024)

***Case Study 1: Linh***. *Linh was initially ambivalent about seeking mental health support, but once connected with Navigator Sara[2], she felt a sense of relief. Linh was struck by Sara's ability to listen and understand her situation, and that she remembered details of Linh's story each time they spoke, so she never had to repeat herself. Sara supported Linh with strategies to improve her son's sleep and better communicate with her husband, to put in boundaries and open up about her needs. Linh was eager for resources about motherhood and parenting, so Sara shared articles and podcasts relevant to Linh's situation. These resources and psychoeducation provided by Sara gave Linh a language to understand some of the things she was going through. Meanwhile, they worked on getting Linh connected to the right perinatal mental health support. Linh needed access to a no-cost service, but there was a 4-6 week wait. Sara helped Linh get the referral organised and was able to check in and support her until her first appointment.*

***Case Study 2: Callum***. *"Sara immediately felt like the first person who understood absolutely everything I was going through, and everything I needed in that moment", recalls Callum. Sara recognised that Callum needed space to unload and debrief about what he and his family were going through. She listened to his story, validating his feelings and experiences. She talked with Callum about setting boundaries and reassured him that it was okay to focus on his own family and to limit visitors – this was crucial advice for Callum, who went out of his way to accommodate others. Sara also provided psychoeducation on bonding and attachment, addressing his anxieties about Emma's ability to bond with Eli, especially since breastfeeding was a challenge due to her illness. As a ForWhen Navigator, Sara maintained links with psychology practices and was able to organise a timely appointment for Callum with a perinatal specialist. With Callum's consent, Sara's psychosocial assessment was shared with this provider for a more seamless transition of care. Over the next few weeks, Sara continued to check in with Callum, offering emotional support and practical parenting advice, until he felt he had the support in place that he needed.*

***Case Study 3: Brooke***. *When Brooke called ForWhen and disclosed thoughts of harming herself and her baby, Sara helped Brooke to safely explore these thoughts and feelings. Sara worked to identify immediate risks to mother and baby, as well as what protective factors were present. Sara worked with Brooke to create a safety plan and over the following week, she checked in with regular phone calls to make sure they were okay. Sara normalised and validated Brooke's feelings and encouraged her to talk to her family about what was going on in her mind. Doing this was a huge turning point for Brooke. Living in a small town three hours away from the closest hospital, Sara's support felt like a lifeline. Sara advocated to get Brooke into a mother-baby unit, a place where*

[2]For the purposes of this article, we have used a single Navigator pseudonym. Clients are connected to a local Navigator based in their state/territory.

*she could receive inpatient mental health treatment and have her daughter there with her. Thanks to Sara's communication with the unit and her advocating for Brooke's need for immediate support, Brooke and her baby were admitted quickly, where they received the care they desperately needed.*

***Case Study 4: Alex.*** *Alex was immediately struck by Sara's ability to listen carefully and "demystify" his concerns. He was eager to understand how his own experiences of being parented impacted his role as a father and his connection with his son. Sara sent him resources specifically designed for fathers, which he found helpful. They discussed the impact of stress and sleep deprivation at home, and strategies to improve sleep quality and communication. Within days of his initial call with Sara, Alex and his partner had made dramatic changes in their lives, opening up conversations about family dynamics and the support they needed from each other. Sara also connected him to a Circle of Security program, which helped him better understand his baby's needs. Alex felt Sara was "in the trenches" with him, providing emotional and practical support during a difficult period.*

## Benefits for families

A recent evaluation of the ForWhen service has shown that after engaging with a ForWhen Navigator, clients experience significant reductions in psychological distress, and improvements in parental self-efficacy and parent-infant bonding (Kohlhoff et al., forthcoming). In interviews and focus groups, clients and health professionals have highlighted the way in which Navigators are able to support families who might otherwise miss out on essential services (Harris et al., forthcoming). The case studies reported here enrich these findings, by illustrating the outcomes of the ForWhen service for four clients and their family members, with positive impacts on mental health, family functioning, and overall wellbeing.

***Case Study 1: Linh.*** *For Linh, the trust and rapport built with Sara was key: "I felt like tonnes of weight had been removed from my shoulders after each conversation, and I could breathe better, and see better." Sara taught her to be more compassionate with herself as a parent, and to show her child it's okay to feel emotions and not bottle them up. Linh reflected on how these transformations in herself had helped her whole family: "It's not just my life, it's a ripple in the water. It helps my husband; it helps my baby."*

***Case Study 2: Callum****. Before contacting ForWhen, Callum had tried reaching out to a couple of services but encountered long hold times and waitlists. He lacked the time and energy to pursue these options, and also felt lost as to which service might be most appropriate for him. Reflecting on how hard it was to try and access support, Callum said: "I had no time or energy to get a referral and navigate that system when I've got a screaming baby I'm caring for on my own". With Sara's support in identifying his needs and locating services that were appropriate and available to him, Callum transitioned to seeing a perinatal psychologist. Although immensely challenging, Callum felt that their early postpartum experiences had strengthened his relationship with Emma, as Sara's advice to practice self-compassion and prioritise their family helped them navigate this difficult period together.*

***Case Study 3: Brooke****. Today, Brooke's daughter is 14 months old and thriving. Reflecting on her experience, Brooke believes that the ForWhen service achieved exactly what it was meant to do – to navigate her through the darkest period of her life. She feels that Sara's reassurance, encouragement, and advocacy was crucial in getting her and her daughter the level of support they needed. Brooke told Sara, "I think you may have just saved my life."*

***Case Study 4: Alex****. Alex's experience of new fatherhood highlights the fact that with the arrival of a baby, fathers are often juggling workload and work-life balance, financial pressures, sleep deprivation, and shifting relationship dynamics. Yet Alex felt that there is still the prevailing assumption that parenting is all mums' responsibility. Alex believes ForWhen could greatly benefit more men by providing targeted support and normalising perinatal mental health challenges amongst fathers and non-birth partners – because "you need to support fathers as well, to create an effective team".*

These cases are a testament to the transformative power of tailored and compassionate mental health support in addressing the unique challenges faced by families during the perinatal period. Navigators work with parents to understand their concerns, help them identify available strengths and supports, and normalise difficult thoughts and feelings they may encounter in the journey of new parenthood. Clients have reported that the support of Navigators helped to build their parenting confidence, improve their relationship with their partner and infant, and reduce the stigma associated with perinatal mental health challenges. By providing holistic care, addressing individual needs and circumstances, and reducing barriers to care access, navigation services like ForWhen can offer a lifeline to parents, to ensure timely support and promote early intervention and long-term benefits for parents, infants, and families.

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# Diagnostic Classification and Intervention in Infant Mental Health – A comment on guidelines for classification and treatment

by Susanne Hommel, Barbara von Kalckreuth, and Margret Ziegler (Germany)

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The recently published German AWMF guideline, 'Mental Health Disorders in Infancy, Toddlerhood, and Preschool Age' represents some advancement in the diagnosis and treatment of mental health in children up to the age of five, particularly since the internationally widely used DC 0-5 (2016) has not yet been included as the standard for under fives into German diagnostic classification systems.

The German AWMF system provides evidence-based guidelines for diagnostic and treatment developed by the Institute for Medical Knowledge Management (IMWi) and the Association of the Scientific Medical Societies (AWMF). It is similar to the internationally reknowned NICE guidelines, developed by The National Institute for Health and Care Excellence (NICE) in the UK. NICE provides several guidelines pertinent to Infant Mental Health, focusing on the social and emotional wellbeing of children under five (2025). These guidelines provide evidence-based recommendations for professionals involved in early years' care.

This commentary describes the major changes to the guidelines, a brief description of ongoing limitations and perspectives for a future revision.

## The AWMF Guideline on Mental Health Disorders in Infants, Toddlers, and Preschool Children

The AWMF guideline on mental health disorders in infancy, early childhood, and preschool age focuses on children aged 0 to 5 years and 11 months. It provides evidence-based recommendations for the diagnosis and treatment of mental health disorders in young children. The primary aim is to offer a practice-oriented approach for all professionals working with this age group, including child and adolescent psychiatrists and psychotherapists, pediatricians, midwives and family nurses, physio-, occupational and speech therapists etc.

The guideline emphasizes the importance of early detection and intervention to prevent chronic conditions and long-term impairments. It considers the high developmental dynamics in this age group and the crucial role of primary caregivers. Recommendations cover both diagnostic procedures and therapeutic approaches tailored to the specific needs of children under six years of age. Unfortunately there is no English translation nor an English summary.

This newly published guideline is an update of the 2015 published version and was developed through an interdisciplinary process involving diverse professionals working with under fives and is based on recent scientific evidence.

The preamble and those chapters particularly relevant to very young children, such as Relationship Disorders, Regulatory Disorders (as separate from Sensory Disorders), Early Childhood Feeding and Eating Disorders were revised in order to secure a more relational focus on development, classification and treatment of disorders from 0 – 3 years of age:

- A new developmental-phase-specific order of disorders was introduced and chapters on specific disorders were restructured.
- Relationship Disorders as a Central Chapter in the very beginning of the guidelines: The guideline dedicates a separate chapter to relationship disorders, highlighting the importance of early parent-child interactions for the child's emotional and psychological development and integrating a relationship-focused understanding of disorder development and treatment—especially for children aged 0–3 years.
- Early Childhood Regulatory Disorders as an Independent Category: Regulatory Disorders as described by Asmussen et al. (2023), Chatoor (2005, 2009), von Hofacker (1998), Papoušek (2004), Ziegler et al. (2023) such as excessive crying, sleep disturbances, and feeding difficulties are recognized as a distinct category of disorders and a chapter of its own, enabling more targeted diagnostics and treatment. This is of outmost clinical relevance as regulatory disorders tend to generalize and affect several

regulative capacities as well as persist, and are therefore highly disturbing for parents. The critical revision placed great importance on ensuring alignment with DC:0-5 (2016, 2019) and current clinical research, while also preserving the German concept of Early Childhood Regulatory Disorders and distinguishing it from the internationally widely recognized diagnosis of 'Sensory Processing Disorders'.

- The chapter on eating disorders was renamed 'Feeding and Eating Disorders', and the clinically and therapeutically relevant classification of early childhood feeding disorders by Irene Chatoor (2009), which used to be included in the DC:0-3R (2005), was reinstated in the diagnostics, classification, and treatment recommendations. Irene Chatoor's classification of feeding disorders has proven to be highly useful in clinical practice as Chatoor identifies different types of feeding disorders, including infantile anorexia and sensory food aversion, and provides specific diagnostic criteria as well as therapeutic approaches for each category. This differentiation allows professionals to develop a precise understanding of the psychosomatics and psychodynamics in order to develop individually tailored interventions.
- The inclusion of psychodynamic interventions to working with parents and infants.

## Limitations of the Guidelines

The revised German guidelines now provide users working with infants, toddlers, preschoolers and their parents with insight into some of the relational and psychodynamic aspects with regard to disorder development, diagnostics, and treatment. However, unlike the NICE guidelines on 'Social and Emotional Health' and 'Promoting Wellbeing' the German guidelines focus by definition on the impairment of health and wellbeing and on defining disorders instead of focusing on supporting health and wellbeing and the development of a positive bonding and attachment relationship. This is partly due to the different wording in English and German languages but also a focus on to Mental Health and wellbeing in English speaking countries and on mental disorders in German speaking countries.

## Future Perspectives

There is still a long way to go until not only the German guidelines but also healthcare, social services and early education really focus on the relational nature of the Early Years. The lack of attention to the family system and, in particular, to the infant during this key developmental phase ultimately leads to exorbitantly high follow-up costs for both the healthcare system and social security systems (Campbell et al., 2014; Heckman, 2005). Even more so against the backdrop of existential crises that urgently require early intervention.

At least for the first 1001 days from pregnancy to the child's second birthday a timely, individually tailored, multi-level classification and intervention for the baby and parents is not only urgently needed (NICHD, WHO, WAIMH, Young Minds) but also cost-effective (Heckman, 2005). An intervention that takes into account the child's uninterrupted brain development, the attachment process completed by the end of the second year, and the parents' mental health.

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# Book Review: The Politics of Potential: Global Health and Gendered Futures in South Africa by Michelle Pentecost

by Salisha Maharaj (South Africa)

Michelle Pentecost critically examines the concept of the first-1000 days of life, a programme designed to optimize nutrition and healthcare from conception to age two. The book explores the concept of intergenerational responsibility, highlighting how the health and well-being of future generations are influenced by the health of mothers and children during the First 1000 Days.

The book features an ethnographic account of her fieldwork, providing a moving account of the experiences of the lives of fifteen South African woman as they journey through the first-1000 days of their babies lives. Pentecost puts into sharp focus the insidious burden placed on these women by this intervention programme. She takes the reader to international conferences, government offices and healthcare facilities, providing examples from a system that places on this generation of women, the responsibility for reshaping the future of the next generation following historical political, social, and medical injustices. She also examines the science in terms of the intergenerational transmission of health, disease, and human capital, highlighting the gendered and racialized aspects of intergenerational responsibility in South Africa.

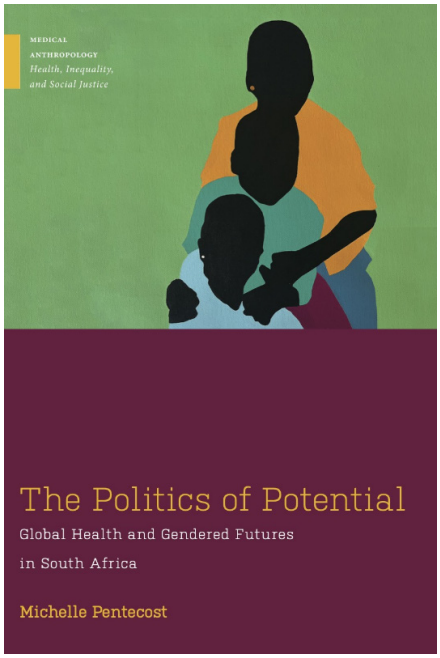
## Reviewer commentary

As a Clinical Psychologist working in a public health care facility in Cape Town, South Africa my experience of the First-1000 days initiative is that it has been widely promoted as a critical window of opportunity to improve physical and mental health outcomes of future generations, including being accepted and adopted into national and local healthcare programmes (https://www.westerncape.gov.za/first-1000-days/about-1). Its message is clear and simple: good nutrition and a healthy, loving and safe environment are key components for healthy development across the lifespan. In South Africa, the economic benefits may also be significant: "research shows that children who benefit from essential First 1 000 Day outcomes, can earn up to 20% more as adults versus their counterparts; and are more likely to have healthy families themselves" (https://www.westerncape.gov.za/first-1000-days/about-1). Pentecost's book: *The Politics of Potential* highlights the hidden inequity within an 'ideal' intervention in terms of the historical socio-political context in which the burden of redress for inequities now fall on a generation of women who are the most severely disadvantaged in apartheid South Africa. Pentecost provides an important lens with which to examine the systemic factors that reinforce gendered and racial prejudice.

Overall, Pentecost's book provides a rich tapestry of ethnographic fieldwork, and a critical lens of the first-1000 days programme and the systems that support it.

***Michelle Pentecost*** is a South African physician-anthropologist. She completed her medical training at the University of Cape Town and her doctorate in anthropology at the University of Oxford. Michelle has a decade of work experience as a clinician in South Africa and her research and publication record reflects her interest in the interdisciplinary domains of clinical medicine, anthropology, science and technology studies and the medical humanities. Her work has been funded by the UKRI, the British Academy and the Wellcome Trust.

More about Michelle Pentecost and her work can be found here: https://michellepentecost.net/.




Book Cover: Pentecost, M. (2024). The Politics of Potential: Global Health and Gendered Futures in South Africa. New York: Rutgers University Press.

Reference

Pentecost, M. (2024). *The Politics of Potential: Global Health and Gendered Futures in South Africa*. New York: Rutgers University Press

# The WAIMH History Archive has launched


## We are thrilled to announce the launch of the WAIMH History Archive!

Emeritus Professor of Psychiatry, Robert Emde, presented the history and development of the field of Infant Mental Health in a plenary lecture at the 15th World Congress of WAIMH in Prague in 2016. His presentation was titled Infant Psychiatry and the origins of WAIMH – Early Contributions that Energized the Field.

This plenary took us on a journey of 'reverberating memories'; of our founders, of infants, families, practitioners, and of WAIMH as an organization. A journey following the evolution of our field from the early frontiers of recognition of infant suffering, to considering the impacts of infancy beyond infancy and the importance of moral development, always reflecting on translation to meaning – psychological, relational and community meaning.

The presentation provided an insight into the passion and dedication of the pioneers in our field who have laid the foundations for infant mental health as a field of practice and for WAIMH as an organization to represent and advocate for it. Many of today's practitioners and those to come will not have the good fortune to learn directly from these pioneers in infant mental health.

The WAIMH History Archive is a response to reflections on how the voices of the pioneers and leaders of our field could be archived and recorded to ensure that all infant mental health practitioners have the opportunity to understand WAIMH's foundations, incorporate it into their present work and be enabled to contribute to a better future for infants, young children and their families. In this way it is hoped that infant mental health and the work of WAIMH will continue to reverberate across generations.

As the History Archive grows, it is hoped that you will be energized by the 'reverberating memories' of the past, challenged to consider new frontiers, inspired to translate your findings to clinical meaning, grow a deeper self-reflective moral stance in your work and consider ways to achieve more together, in cooperation and collaboration with parents, families, communities, colleagues and as an organisation in a global context.

**WAIMH members enjoy a 20% discount on all content on the History Archive.** Members can find the discount code in the WAIMH member portal. Join WAIMH or renew your membership to access the member portal.

## Now Available:

Presentations from the WAIMH 2024 Interim World Congress, including:

- 3 x Pre-Congress Institute presentations
- 4 x International keynote presentations
- 4 x Invited speakers from the Nordic region
- 2 x Invited symposia

## Coming Soon:

Presentations from earlier WAIMH World Congresses

Podcasts featuring pioneers in infant mental health

**Visit the WAIMH History Archive at:**
https://waimh.vhx.tv/

# World Infant, Child and Adolescent Mental Health Day 23rd April 2025

This year marks the 4th celebration of the World Infant, Child & Adolescent Mental Health Day (WICAMHD).

In 2022, WAIMH connected with IACAPAP (International Association for Child and Adolescent Psychiatry and Allied Professions), WPA-CAP (World Psychiatric Association Child and Adolescent Psychiatry Section), and ISAPP (International Society for Adolescent Psychiatry and Psychology) to initiate the World Infant, Child & Adolescent Mental Health Day on 23 April annually.

The specific aims are to:

1. Recognize the global importance of infant, child, and adolescent mental health, and
2. Advocate for the promotion of mental health and prevention of mental illness in infants, children, and adolescents.

The theme in 2025 is "Bridging Worlds: Mental Health Support for Displaced Children and Families".

This theme underscores the importance of comprehensively understanding and addressing the mental health challenges encountered by displaced children and families as a result of crises, while simultaneously promoting inclusion and fostering understanding between displaced individuals and host communities.

You can participate in many ways:

## Join the WICAMHD 2025 Symposium

The WICAMHD 2025 Symposium will be held on April 29th as part of the Turkish Association of Child & Adolescent Psychiatry (TACAP) annual national conference, the 34th National Congress of Child and Adolescent Mental Health and Illnesses. The hybrid symposium will be available both online and in-person at the Pine Bay Holiday Resort Hotel in Kusadasi, Türkiye.

**Date:** Tuesday, April 29, 2025

**Time:** 2:00 PM Istanbul | 1:00 PM CEST | 11:00 AM UTC | 7:00 AM EDT

**Duration:** 3 hours

**Format:** Hybrid


The symposium is open to the public. Virtual participation is free with registration. In-person attendees will incur an external participation fee.

For more information and to register, please visit the event website.

### Invited Speakers & Panellists

- **Associate Prof Campbell Paul**, Past President of WAIMH; Consultant Infant Psychiatrist, Royal Children's Hospital Melbourne, the University of Melbourne; Royal, Women's Hospital and Murdoch Children's Research Institute, Australia
- **Dr Chiara Servili, MD MPH PhD**, Technical officer, Child and Adolescent Mental Health, Department of Mental Health, Brain Health and Substance Use, World Health Organization
- **Daniel Fung Shuen Sheng, MD**, CEO, Institute of Mental Health Singapore; Adjunct Associate Professor, Lee Kong Chian Medical School, Nanyang Technological University; Yong Loo Lin Medical School and DUKE NUS Medical School, National University of Singapore, Singapore
- **Dr. Füsun Çetin Çuhadaroğlu**, President of ISAPP, Honorary President of the Turkish Assoc. for CAP, Founding Chair of the Policy Division of ESCAP, Turkiye
- **Dr Matthew Hodes**, Honorary Clinical Senior Lecturer in Child & Adolescent Psychiatry, Division of Psychiatry, Imperial College London; Member of IACAPAP, United Kingdom
- **Anthony P. S. Guerrero, M.D**, Professor, Chair, and Residency Program Director, Department of Psychiatry, University of Hawai'i John A. Burns School of Medicine; Chief of Clinical Program, Psychiatry, Chief of Psychiatry (Medical Staff), The Queen's Medical Center, United States

## How to Support WICAMHD

Share the WICAMHD logo widely.

Use social media to spread your message about the importance of mental health in the young.

Please involve your communications teams and do it on all websites and social media platforms you are on.

We suggest the following hashtags:

#WICAMHD

#WICAMHD2025

To download the WICAMHD logo, marketing flyer, or social media tool, please visit: https://iacapap.org/events/world-infant-child-and-adolescent-mental-health-day/wicamhd-2025.html

## More information

For more information, please visit: https://iacapap.org/events/world-infant-child-and-adolescent-mental-health-day/wicamhd-2025.html


# Call for Applications – Editor-in-Chief, Infant Mental Health Journal: Infancy and Early Childhood

INFANT MENTAL HEALTH JOURNAL
Infancy and Early Childhood

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Michigan Association for Infant Mental Health
Learning and growing together.

The *Infant Mental Health Journal: Infancy and Early Childhood (IMHJ)*, the official publication of the World Association for Infant Mental Health (WAIMH), is seeking applications for its next Editor-in-Chief. The *IMHJ* is owned by the Michigan Association for Infant Mental Health (MI-AIMH) and published by Wiley. To support the journal's continued success, MI-AIMH partners with the Alliance for the Advancement of Infant Mental Health to coordinate efforts to sustain its impact.

We extend our deepest appreciation to Dr. Holly Brophy-Herb for her exceptional leadership and dedication as Editor-in-Chief. Under her guidance, *IMHJ* has expanded its focus to include both infant and early childhood mental health, enhanced its impact in the field, fostered a focus on diverse perspectives in infant and early childhood mental health, and embraced new strategies for engaging a broader audience. Dr. Brophy-Herb will continue in her role through Volume 46:5, with the newly appointed editor joining her in September 2025 to support a transition period before assuming full responsibilities in October 2025.

## About the Role

The Editor-in-Chief of *IMHJ* holds a pivotal role in shaping the journal's content, ensuring its academic integrity, and advancing the field of infant and early childhood mental health. The Editor-in-Chief leads a dedicated editorial team, oversees the peer review process, and engages with an interdisciplinary global community of researchers, clinicians, policymakers, and practitioners.

The new Editor-in-Chief will be appointed for a five-year term (2025–2030) and will receive a stipend for the editorial office. Details will be discussed during the interview process.

## Key Responsibilities

- **Editorial Leadership**: Develop and uphold journal policies, maintain high publication standards, and oversee the editorial board.

- **Manuscript Oversight**: Manage the peer-review process to ensure timely and rigorous evaluation of submissions that align with *IMHJ*'s mission.
- **Collaboration & Promotion**: Work closely with the Journal Publishing Manager, editorial office, and production team at Wiley, as well as MI-AIMH, the World Association for Infant Mental Health, and the Alliance for the Advancement of Infant Mental Health, to promote the journal, acquire high-quality content, and engage in professional outreach, including conference participation.
- **Strategic Direction**: Identify opportunities for special issues, emerging research themes, and interdisciplinary collaboration to advance the field.
- **WAIMH Board of Directors**: Represent *IMHJ* on the WAIMH board of directors.

## Qualifications

The ideal candidate will have:

- A broad and strong interdisciplinary knowledge base in infant and early childhood mental health, including research, policy, clinical practice, and intervention strategies.
- Leadership and organizational skills to manage an international editorial team and sustain strong relationships with diverse professionals.
- Prior editorial experience, such as serving as a Senior Associate Editor, Associate Editor, or Editorial Board Member, with familiarity in online manuscript submission systems.
- A strong research background, including an extensive publication record and recognized expertise in the field.
- A commitment to engaging technological innovations in academic publishing and dissemination.
- High professional and ethical standards in scholarly publishing.

## Application Process

Interested applicants should submit the following materials via email to Ashley McCormick, Chair of the IMHJ Search Committee (asmccormick@allianceaimh.org):

1. A one-page vision statement outlining their vision for *IMHJ* and its future development.
2. A letter of interest, detailing relevant experiences, qualifications, and leadership approach.
3. A current CV or resume including contact details (mailing address, email, phone).
4. Contact information for two professional references familiar with their editorial, research, or leadership work.

*IMHJ* is committed to fostering diverse perspectives in research and editorial leadership. We encourage applications from candidates of all backgrounds, particularly those whose work advances equity in IECMH.

## Application Timeline

- Call for the new Editor-in-Chief released by March 15, 2025
- Applications due by June 15, 2025
- Finalist interviews July 7-18, 2025
- New Editor-in-Chief announced by August 1, 2025
- New Editor-in-Chief begins transition period on September 1, 2025
- New Editor-in-Chief assumes full editorial responsibilities on October 1, 2025

For inquiries about the position or application process, please contact Ashley McCormick, Chair of the IMHJ Search Committee at asmccormick@allianceaimh.org.

We look forward to identifying an Editor-in-Chief who will continue the strong legacy of *IMHJ* and further elevate its contributions to the field of infant and early childhood mental health.

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www.waimh.org

# PERSPECTIVES IN INFANT MENTAL HEALTH

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

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

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

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

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

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

## Invitation to contribute

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

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 63 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: Infancy and Early Childhood 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.

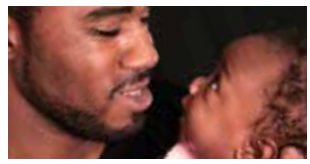
Editor: Jane Barlow
E-mail: perspectives@waimh.org

# BECOME A MEMBER

- You can subscribe to the scientific journal, the Infant Mental Health Journal, at a greatly reduce 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 journal subscription is $40. The subscription is easily completed through the WAIMH Online Store: www.waimh.org/store



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