Vol. 33 No. 2 | Summer 2025

Perspectives in Infant Mental Health

Professional Publication of the World Association for Infant Mental Health

Contents

From the Editor-in-Chief,
J.Barlow.....1

From the Desk of the President of WAIMH,
A. Berg.....4

WAIMH Executive Director Corner,
K. Puura.....5

Research Papers

Tūhono - First We Connect: Attachment Through Indigenous Kaupapa Māori Research Methodology - Transforming Infant Mental Health,
A. Mikahere-Hall, D. Wilson and P. Perehama Pou.....6

Clinical Papers

Reclaiming intergenerational wellbeing for First Nations families through Birthing on Country,
R. Coddington and M. Briggs.....13

The Sankofa Infant Mental Health History Project,
M.-C. Condon, A. Subramaniam, N. Pérez Byars, E. M. Shivers, N. Isarawong and G. Walteros.....18

Rethinking Infant Mental Health Through Proximal Care: Decolonizing Developmental Models of Social Engagement,
E. E. Little.....23

Marram Ngala Ganbu- ('We are one'): A First Nations led, trauma-informed approach to Children's Court hearings for Child Protection Matters on Wurundjeri and Yorta Yorta Country, Australia,
A. Morris and N. Milburn.....25

Honouring the voices of First Nations minya ones and their families through Wakwakurnaku Kumangka Pudnanthi family support group,
G. Foster, J. Cockatoo-Collins and B. Turner.....27

Professional Development

Decolonizing Infant and Early Childhood Mental Health Consultation Professional Development,
E. Catherine, J. Mulitauopele, D. F. Perry, L. Rabinovitz, L. Hepburn and N.Horen.....29

Relational Principles for Collective Wellbeing: Multigenerational Indigenous Frameworks Informing Infant Mental Health Revitalization,
D. Charlot-Swilley, M.-C. Condon, A. Little Victory, H. Shawky, S. Barclay Hoffman and Y. Edmond.....34

Continued on next page

Special Issue: Decolonizing IMH Research, Practice & Intervention

From the Editor-in-Chief

By Jane Barlow (United Kingdom)

While the colonising practices of the West have changed significantly over the past few decades, the long-term consequences of such practices continue to be felt by the people living within colonised communities. For example, the evidence shows that Aboriginal children are still much more (ten times) likely to be placed in out-of-home care than non-Aboriginal children and that this disparity starts in infancy (O'Donnell et al 2019). Furthermore, the intergenerational trauma that is a significant part of the adversity experienced by many Aboriginal families, relate to earlier colonial practices regarding the forced removal of Aboriginal children. So, in Aotearoa New Zealand, 33% of babies removed in 2019 were from mothers who had been in care themselves, 69% of whom were Māori (Keddell et al 2022). The loss of traditional ways of caring in many indigenous communities, alongside the ongoing failure of practitioners from Western cultures to recognise the value of such traditional practices or to question the appropriateness of Western IMH concepts and methods of assessment, serves to perpetuate this colonial legacy when working with First Nations people.

So, there is much still to do in terms of the decolonisation of IMH, and this special issue of Perspectives focuses on some of the innovative work that is currently being undertaken to 'revitalize' IMH concepts and practice, through the recentring of ways of working that are important to colonised and indigenous communities.

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

WAIMH Central Office
Tampere University, Faculty of Medicine and Health Technology, Arvo Ylpön katu 34, 33520 Tampere, Finland
Tel: + 358 44 2486945, E-mail: office@waimh.org, Web: www.waimh.org

Opinion Pieces/Policy/Advocacy

Decolonising infant mental health: an anthropological provocation from Southern Africa,
F. C. Ross.....38

Digital Colonisation and Infant Mental Health,
M. McCaleb.....40

Book Reviews

Book Review of WAIMH Handbook of Infant and Early Childhood Mental Health: Addressing Decolonization and Cultural Context,
M. du Plessis.....44

News from WAIMH

Call for Papers: WAIMH 19th World Congress 2026 Toronto, Canada,
.....46

Editorial Staff

Perspectives in Infant Mental Health is a quarterly publication of the World Association for Infant Mental Health. ISSN 2323-4822.

Our **research paper** by Alayne Mikahere-Hall, Denise Wilson, and Pita Perehama Pou, sets the scene with a report of an investigation of Māori perspectives on secure attachment relationships, and the development of a culturally grounded framework for transforming infant mental health practice through Indigenous knowledge systems. The Tūhono framework is a transformative paradigm that that is playing an important role in influencing international Indigenous attachment scholarship.

The need for a move away from Western paradigms is the focus of our first two **clinical papers**. In, *Rethinking Infant Mental Health Through Proximal Care: Decolonizing Developmental Models of Social Engagement*, Emily Little proposes a shift away from a focus on evaluating the parent-infant relationship through the assessment of variation in face-to-face interactions to a focus on more proximal aspects of caregiving (i.e., body-to-body contact through infant carrying, bed-sharing, and long periods of sustained physical contact), which she suggests are widespread, developmentally meaningful, and represent an enriching caregiving context.

In, *Reclaiming intergenerational wellbeing for First Nations families through Birthing on Country*, Rebecca Coddington and Melanie Briggs, describe the emergence and operation of the 'Birthing on Country' movement, which includes maternity services that have been designed and delivered for and by First Nations women. This care encompasses connection to Country, integration of cultural knowledge, and provision of care by Aboriginal midwives and Aboriginal Health Practitioners with a focus on community and kinship.

Three further clinical papers describe the way in which IMH practice is being realigned with the cultural values of indigenous communities through storytelling, and the use of culturally sensitive approaches. In *The Sankofa Infant Mental Health History Project*, Marie-Céleste Condon and colleagues, describe how this project supports revitalization by inviting diverse Storytellers to share stories and perspectives that are at risk of being left behind; recording them; and creating an archival resource for revitalizing relationships, IMH discourse, workforce development, practice, and policies.

In, *Marram Ngala Ganbu ('We are one'): A First Nations led, trauma-informed approach to Children's Court hearings for Child Protection,* Ashley Morris and Nicole Milburn, describe a First Nations led, culturally sensitive approach to adjudicating matters for First Nations families involved in the Children's Court of Victoria, Australia, where infants are over-represented compared to both non-First Nations families and older First Nations children.

In, *Honouring the voices of First Nations minya ones and their families through Wakwakurnaku Kumangka Pudnanthi family support group*, Geneva Foster and colleagues describe how the Strengthening Early Years (SEY) team, aim to increase the self-efficacy and self-determination of First Nations families to better support their minya one's in the first 1000 days by ensuring transparency with the families, including them in all decision-making, and adapting this approach to create culturally safe spaces.

Our two **Professional Development Papers** address the way in which professional development opportunities can be used to advance the revitalization process. In, *Decolonizing Infant and Early Childhood Mental Health Consultation Professional Development*, Evandra Catherine and colleagues

argue that a decolonized approach to professional development recognizes that mainstream models of IECMHC PD often fail to fully account for the lived experiences of historically marginalized communities. They argue that professional development is central to decolonization because it creates spaces where consultants are supported in deep self-reflection, and where they are encouraged to challenge assumptions and provided with opportunities to practice new ways of working.

In our second Professional Development piece, *Relational Principles for Collective Wellbeing: Multigenerational Indigenous Frameworks Informing Infant Mental Health Revitalization,* Dominique Charlot-Swilley and colleagues, describe how dominant approaches to IMH often prioritize individualization while neglecting the relational and communal contexts fundamental to wellness and thriving. Drawing on the practices of three indigenous communities - Ubuntu, Lakou, and Etuaptmumk - their paper supports revitalisation through a return to relationship-based frameworks that nurture collective wellbeing across lifespans.

Our two **Opinion Pieces** continue these themes. In *Decolonising infant mental health: an anthropological provocation from Southern Africa*, Fiona Ross draws on her anthropological expertise to offer some provocative thoughts about decoloniality in IMH; and in *Digital Colonisation and Infant Mental Health*, Miriam McCaleb examines the fresh wave of colonisation that is underway with regard to the digital revolution and the way in which for-profit agents distract us from the key issues and harvest our data.

And we conclude with a **book review** by Michelle du Plessis that focuses on several issues with regard to culture and decolonization selected from the WAIMH Handbook of Infant and Early Childhood Mental Health – Cultural Context, Prevention, Intervention, and Treatment, Volume 2 (Osofsky et al., 2024).

We would be very pleased to receive any further thoughts or commentaries on this topic or indeed the individual papers in this special issue, which we will publish in the next issue of Perspectives.

References

O'Donnell M, Taplin S, Marriott R, Lima F, Stanley FJ. Infant removals: The need to address the over-representation of Aboriginal infants and community concerns of another 'stolen generation'. *Child Abuse Negl.* 2019 Apr;90:88-98. doi: 10.1016/j.chiabu.2019.01.017. Epub 2019 Feb 12. PMID: 30769191.

Keddell, E., Fitzmaurice, L., Cleaver, K., & Exeter, D. (2022). A fight for legitimacy: reflections on child protection reform, the reduction of baby removals, and child protection decision-making in Aotearoa New Zealand. *Kōtuitui: New Zealand Journal of Social Sciences Online, 17*(3), 378–404. https://doi.org/10.1080/1177083X.2021.2012490

From the Desk of the President of WAIMH

by Astrid Berg (South Africa)

Dear WAIMH Colleagues

I am writing this in difficult times. Who would have thought that when we started the "Infants in Crises" Working Group in 2024, just after the start of the war in Ukraine, we were at the beginning of global events not imaginable before. It seems that humanity has taken a few steps back, regressed to early psychological ways of functioning of splitting and projection – are we, as a species, losing our human capacity for caring about the other and, how do we as a World Association position ourselves in these nightmarish times?

The only answer we may have is that we must do what we are doing with even more energy and commitment. We must continue to care for all infants and their families – they, more than any other group, bear the consequences of wars and withdrawal of aid and food. WAIMH has joined the call from UNICEF, WHO, and ICRC for immediate aid access and an end to civilian suffering. https://waimh.org/news/703136/Infants-in-Crises--statements-from-the-WAIMH-Presidency.htm We are also aware of the devastation caused by climate change – the most recent example being the catastrophic floods in Texas.

It is in the very nature of the work with infants, young children and their families that our guiding principles are, namely inclusion, equity and diversity. We cannot and will not abandon these, they are the key foundations on which we stand. It was in this spirit that the decision was made to keep the strong title of the October 2026 WAIMH Congress in Toronto "Harmony in Diversity – Nurturing the Youngest Minds around the World". This is what we stand for and will celebrate. I would like to urge you to consider attending the Congress – it will be a warm and welcoming occasion and provide us with the opportunity to make connections and support one another.

In keeping with this theme, the current Special Edition on "Decolonizing infant mental health research, practice and intervention" has provided us with a timely reminder of the long-term consequences of the actions of dominant nations on other nations and national groups with different practices to their own. It has also provided an exciting opportunity to explore and think about the contexts and cultures of the parts of the world where the majority of infants and their families live. We have much to learn from each other – mutual understanding and respect for our diverse ways of being can only be enriching. I thank the *Perspectives* Editorial Team for this important initiative.

I want to thank the many colleagues in the Infants in Crises Group for having been so responsive to requests and suggestions. I hope that we can draw from these and have a lively symposium or two at the Congress in Toronto. We want to hear from those on the coal face, on the frontlines, what they experienced and how they dealt with these traumatic situations.

I want to particularly thank my colleagues in the Middle East, who have not shied away from communicating with each other and working together. When the task is the wellbeing and safety of an infant, a young child and a family, then we move beyond splitting and projection, and do what we can do.

On an organizational level there is an increasing interest coming from WAIMH membership to help to think about infant mental health topics of interest and importance, such as ethical dilemmas and concerns about screen use in the early years. In order to streamline these contributions, members of the Executive Committee are in the process of drafting guidelines for establishing such interest groups. Once agreed upon, these guidelines will be made available.

In the meantime, my thoughts are with all the infants, young children and their families who are suffering from physical and mental trauma, caused by conflict and wars and natural disasters. Let us know how we, as a World Association, can help you even from afar.

Photo: Astrid Berg

WAIMH Executive Director Corner

By Kaija Puura (Finland)

Dear colleagues and friends,

This issue of *Perspectives* addresses how we need to rethink and reshape the field of Infant Mental Health by identifying and addressing various biases in existing theories, research, and interventions. This includes questioning the long-standing dominance of Western perspectives and ensuring that knowledge systems from various other cultures are valued and integrated into the existing knowledge base. What I believe quite many of us have already experienced and understood is that infant mental health is necessarily influenced by cultural contexts. This means that, in order to successfully promote Infant and Early Childhood Mental Health, we need to understand and respect the diverse ways in which different cultures approach parenting, caregiving, and child development. Developing interventions that are tailored to the specific needs and contexts of local communities is key to this goal and can only be achieved by working closely with community members to create culturally relevant and effective mental health services for young children and their families.

In the current geopolitical situation, we hear daily news from various parts of the world about how nationalistic ideas are gaining strength, and how interest in and respect for people from other cultures and backgrounds are not encouraged but instead considered a weakness. From history, we know—or should know—that cultural and ethnic diversity is actually a force that helps populations develop, stay healthier, and thrive. Here in Tampere, Finland, we currently have an interesting exhibition at the Vapriikki Museum called *Ancient DNA: A Key to the Past*. We Finns have long thought that we are a genetically homogenous group of people. However, already during the Stone Age, different groups lived in Finland, among which the exhibition highlights the hunter-gatherers of the Cambrian culture and the herders of the Late Bronze Age culture. In the Bronze Age, new traditions arrived in Finland from the East, and in the Iron Age from the South. It is now known that the genetic background of modern Finns is a diverse mix of groups of people who arrived at different times and from different directions, and that this diversity has helped our populations grow. All in all, it seems really short-sighted not to celebrate diversity—even if we just think about our genetic constitution, not to mention cultural enrichment.

The theme of the WAIMH 19th World Congress in Toronto, October 2–6, 2026, is *Harmony in Diversity*. It could not be more fitting for this *Perspectives* issue and for our current world. I had the honor and pleasure of going to Toronto this April for a site visit and to take part in the *Expanding Horizons* Congress organized by our Local Organizing Committee Chair Chaya Kulkarni and her great team, including Program Committee member Warren Kapashesit. Canadians are warm and welcoming people and are looking forward to hosting us all. An essential part of Canadian hospitality is that all congress guests will be served a warm lunch in addition to morning and afternoon refreshments, so I ate really well at *Expanding Horizons*—and so will every delegate at the 2026 Congress.

Toronto is also a very traveler-friendly city. It has a well-functioning public transport system, and from the international airport, you can take the UP Express train, which takes you to the city center in 20 minutes. The compact city center also makes it easy to walk around, if you wish to take a break and leave the Congress site at the Sheraton Centre Hotel on Queen Street. A popular site for taking selfies is the City Hall, located just across the street from the Sheraton, and a fun fact is that it was designed by Finnish architect Viljo Revell.

Toronto is also a very suitable site for our World Congress, being one of the most multicultural cities in the world, with over 250 ethnic groups and 170 languages represented. I encourage you all to bring your own unique clinical or scientific contribution to our wonderful diversity of presentations and people. The submission of abstracts is open until December 1st, so you have plenty of time to submit. Together, we can make a difference—and make the world a bit better for infants, young children, and their families.

Photo: Kaija Puura

Tūhono - First We Connect: Attachment Through Indigenous Kaupapa Māori Research Methodology - Transforming Infant Mental Health

By Alayne Mikahere-Hall[1], Denise Wilson[1], and Pita Perehama Pou[2] (Aotearoa New Zealand)

[1]Taupua Waiora Research Centre, Auckland University of Technology, Auckland, New Zealand

[2]Community Elder and Cultural Advisor, Mangakahia, New Zealand

Funding: Health Research Council of New Zealand

Ethics Approval: Approved by the Auckland University of Technology Ethics Committee (AUTEC) on 10 January 2018, AUTEC Reference number 17/363.

Background: This research, beginning with doctoral work in 2015, developed the first comprehensive Indigenous alternative to Western attachment theory. When this work began, Indigenous perspectives on attachment were virtually absent from the literature. The Tūhono framework has since influenced emerging international Indigenous attachment scholarship.

Objective: To investigate Māori perspectives on secure attachment relationships and develop a culturally grounded framework for transforming infant mental health practice through Indigenous knowledge systems.

Methods: Kaupapa Māori research methodology was utilised with 65 participants across Aotearoa New Zealand, employing culturally appropriate qualitative methods and the Te-āta-tu Pūrākau analytical framework. Participants included kaumātua, key informants, and whānau (family) constellations representing diverse family systems.

Results: Five interconnected themes emerged: (1) Whakapapa as a continual thread connecting children across generations; (2) Te reo Māori as a healing language; (3) Whānau constellated caregiving systems; (4) Ūkaipō-Kainga as nurturing environments; (5) Mahi Tūhono and Mahi Pāmamae as trauma-centered healing approaches.

Conclusions: The Tūhono framework offers a transformative paradigm that has influenced international Indigenous attachment scholarship. Recent studies reaching similar conclusions validate this pioneering work's foundational contributions to decolonising infant mental health practice globally.

Keywords: Tūhono, Indigenous attachment, Kaupapa Māori, whānau (family), decolonising practice, infant mental health

Introduction

When this research began in 2015, Indigenous children worldwide faced disproportionate removal from families, yet Indigenous perspectives on attachment were virtually absent from academic literature. In Aotearoa New Zealand, recent government reporting has highlighted the disproportionate representation of Māori children in Aotearoa New Zealand's state care system, along with troubling evidence of abuse. According to the Independent Children's Monitor (2024), Māori comprise roughly one-third of the child population yet make up two-thirds of those in state care and three-quarters of youth justice placements. In 2023, 9 per 1,000 tamariki Māori were in care, compared to 2 per 1,000 non-Māori, with Māori children comprising 50% of all reports of concern to the Oranga Tamariki -- Ministry for Children. The Disparities and Disproportionality Report by Oranga Tamariki (2023) further found that 82 out of every 1,000 tamariki Māori were reported to Oranga Tamariki, compared to 24 per 1,000 non-Māori.

This pattern of overrepresentation has persisted for more than a decade. Findings from the Royal Commission of Inquiry into Abuse in Care (2024) revealed that Māori survivors reported higher levels of physical, psychological, and cultural abuse than other ethnic groups. Tamariki Māori were more likely to be institutionalised, targeted with racism, and denied access to te reo, tikanga, and whānau connections—factors contributing to intergenerational trauma and Treaty breaches.

Te Tiriti o Waitangi - The Treaty of Waitangi

Te Tiriti o Waitangi, signed in 1840 between Māori rangatira (chiefs) and representatives of the British Crown, is widely acknowledged as the founding document of Aotearoa New Zealand. It was intended to establish a mutually respectful relationship, where Māori would retain authority (tino rangatiratanga) over their lands, people, and tāonga (treasures), while allowing the Crown to exercise governance over its own people.

Two versions were signed—one in English, and one in te reo Māori—but the meanings diverge significantly. The Māori text affirms Māori sovereignty and self-determination, while the English version has often been interpreted as a cession of sovereignty to the Crown. This dissonance has created decades of conflict and ongoing efforts to reconcile historical and contemporary breaches.

Rather than framing obligations solely through Crown-derived principles like partnership, protection, and participation, many Māori scholars and communities advocate a return to the original intent and authority of Te Tiriti grounded in mana motuhake (autonomy), honouring whakapapa and upholding tikanga Māori (Māori protocols). These perspectives emphasise Māori-led approaches to wellbeing, justice, and care. In the context of child and adolescent mental health, recognising the place of Te Tiriti means more than cultural inclusion—it calls for structural transformation, where Māori knowledge systems, healing practices, and self-determination are central rather than supplementary.

Research Genesis

This research emerged from doctoral work in 2015 investigating relationship dynamics between Māori mothers and their tamariki when exposed to partner violence (Hall, 2015). That foundational study revealed the inadequacy of Western attachment frameworks for understanding Indigenous experiences, establishing an urgent need for culturally grounded alternatives. The concept of tūhono—meaning to connect, attach, or bond—offered a foundation for exploring Māori perspectives on secure relationships extending beyond individual parent-child dyads.

Study Aims

This study aimed to: (1) investigate Māori perspectives on secure attachment relationships; (2) identify traditional and contemporary practices supporting healing; (3) develop a culturally grounded framework positioning Indigenous knowledge as primary; and (4) contribute to global Indigenous movements toward decolonising child welfare systems. The research addresses three critical gaps: lack of Indigenous theoretical frameworks, insufficient understanding of traditional practices promoting secure relationships, and absence of community-led models positioning Indigenous communities as authorities over their children's wellbeing rather than subjects of external intervention. LeVine (1974) understood the important links between cultural values, and the influence of child-rearing practices, indeed Ainsworth was critical of the over reliance on the Strange Situation laboratory investigations into attachment noting the lack of fieldwork research (Ainsworth & Marvin, 1995).

Research Agenda - Epistemic Sovereignty

Centering Indigenous research methodologies is an act of resistance; it challenges colonial frameworks, asserts epistemic sovereignty, and uplifts knowledge systems that have sustained Indigenous peoples despite centuries of erasure. Framed as a positive assertion of epistemic sovereignty, resistance through Indigenous research methodologies disrupts colonial knowledge hierarchies and reclaims space for relational, place-based ways of knowing (Cunneen et al., 2017). Epistemic justice calls for the dismantling of entrenched hierarchies that privilege Western epistemologies as the default standard of legitimate knowledge. This dominance has historically marginalised Indigenous, Black, and Global South ways of knowing, often relegating them to the periphery of academic discourse. As Maleku (2025) argues, achieving epistemic justice requires more than inclusion; it demands a fundamental reorientation of knowledge production that centres pluralism, relationality, and community-rooted epistemologies. Resistance, in this context, becomes a generative force: a deliberate pushback against epistemic dominance that reclaims space for diverse intellectual traditions and affirms the right of all peoples to define, validate, and transmit their own knowledge systems. Bishop's (2010) assertion that Kaupapa Māori research is controlled by Māori for the empowerment of Māori aligns with the foundational principles articulated in Smith's (2012) *Decolonizing Methodologies*.

Methods

Kaupapa Māori Methodology

This research employed Kaupapa Māori methodology, prioritising Indigenous knowledge systems and community self-determination (Smith, 2012). A Pūrākau narrative inquiry data collection method was used in the research (Lee, 2009). Central to this framework is whakapapa—genealogical connections linking individuals to ancestors, descendants, and natural world. The methodology ensures consistency with a Māori worldview and enables whānau to identify key family members in the care-giving system (See Mikahere-Hall, 2017, 2019). Te-āta-tu Pūrākau, a five-step Indigenous analytical method was utilised in the research, which provided the analysis framework (see Mikahere-Hall, 2019). This method captures the narrator or storytellers' ability to move through different aspects of their pūrākau (narrative), where analysis involves a search for themes under groupings: (1) Social circumstances; (2) Relational dynamics; (3) Emotional content. Two further steps were included (4) Interpretive analysis and (5) Wairua or Wairuatanga (Spiritual content). Pūrākau are traditional Māori oral histories that carry cultural knowledge and wisdom. Life events both past and present, relationships and connections to people and places are deeply interconnected. Pūrākau have traditionally served to transmit histories and experiences while conveying nuanced meanings that Māori whānau draw upon for guidance and understanding.

Pūrākau are well-established as both a narrative inquiry method in research and an educational pedagogy among Māori Indigenous scholars in Aotearoa New Zealand (Pouwhare, 2023; McLachlan et al., 2017; Lee, 2009). As a research methodology, Pūrākau and Te āta tu Pūrākau are complimentary and represents a Kaupapa Māori approach that captures participants' narratives in culturally appropriate ways, increasingly utilised in educational and social services contexts. This methodology serves as an expression of decolonising practice, reclaiming Indigenous oral accounts of experiences and perceptions as a legitimate form of inquiry that counters colonial misrepresentations that have historically portrayed these narratives as simple mythology or homogenised accounts.

Researcher Positionality

All members of the research team identify as Indigenous Māori, bringing lived experience and cultural understanding that fundamentally

shaped our research design. Our positioning as Indigenous researchers means we approach this work not as external observers, but as cultural insiders with deep connections to the knowledge systems, worldviews, and communities central to this research. This insider positioning enables us to engage authentically with Kaupapa Māori methodology and methods recognising the spiritual, relational, and cultural dimensions embedded within these approaches as legitimate and essential components of knowledge creation. Our shared Indigenous identity provides us with cultural competency to interpret nuanced meanings within participants' narratives and to understand the broader sociocultural and sociopolitical contexts that inform their experiences such as the on-going impacts of colonisation.

As Indigenous researchers, we acknowledge our responsibility to conduct research in ways that honour our cultural protocols, benefit our communities, and contribute to the broader project of Indigenous knowledge sovereignty. We recognise that our cultural positioning both privileges our understanding of Indigenous ways of knowing and creates accountability to ensure this research serves Indigenous peoples' interests.

Our collective Indigenous identity also means we bring particular sensitivities to issues of colonisation, cultural misrepresentation, and the importance of self-determination in research processes. This positioning informs our commitment to Kaupapa Māori principles and our resistance to research approaches that would extract knowledge from our communities without reciprocal benefit.

We acknowledge that within our Indigenous identities, we each bring unique tribal affiliations, personal experiences, and professional backgrounds that further shape our individual and collective perspectives on the research.

Participant Recruitment

Whanaungatanga (extended relationships) served as recruitment method, utilising existing networks to engage participants while maintaining cultural accountability.

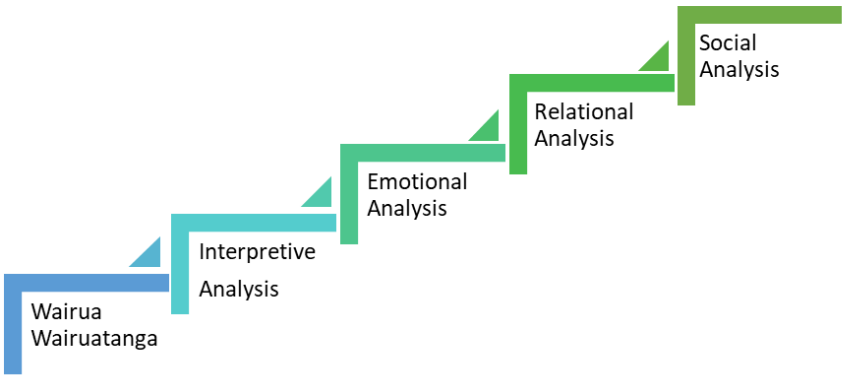

Figure 1. Te-āta-tu Pūrākau five step analysis method (Hall, 2015; Mikahere-Hall, 2017).

Participants and Data Collection

Sixty-five participants were involved across three domains: kaumātua (elders, n=6), key informants (n=6), and whānau constellations (n=25 groups). Whānau represented diverse contemporary configurations including mixed-ethnicity partnerships, single parents, same-sex couples, whāngai arrangements, whānau hauā (disability whānau), and grandparents raising mokopuna. Pūrākau (Mikahere-Hall, 2019; Lee, 2009; Hall, 2015) provided the primary data collection method, gathering family and traditional knowledge through culturally appropriate narratives. All research participant data was recorded and transcribed for data analysis purposes. Pūrākau are central to the research design and as Mehl-Madrona (2007) observes, "What we have are collections of stories that make sense to members of the cultures who tell them" (p. 5). This understanding is fundamental to Kaupapa Māori-driven research, which is purposefully undertaken by Māori with Māori participants to generate culturally grounded, 'insider' (Lee-Morgan, 2019) oriented insights. This approach eliminates the problematic outsider perspectives and misinterpretations that can arise when research is conducted without appropriate cultural understanding and positioning. Smith's (2012) cautionary explanation attests to the importance of getting the story or stories right, generating knowledge from the inside for solutions orientated outward for community benefit. As Lee-Morgan (2019) suggests engaging with pūrākau from the "inside-out" (p. 151)

Data Analysis

The analysis method Te-āta-tu Pūrākau was developed by Hall (2015) as a systematic and philosophical approach to support the analysis of Pūrākau inquiry. Te-āta-tu Pūrākau shares similarities with thematic analysis where themes emerging from data help identify key insights however it differs fundamentally in its ontological foundation. Unlike Western research paradigms that typically focus on observable phenomena, Pūrākau methodology recognises spiritual insights, ancestral wisdom, and intuitive understanding as valid sources of knowledge alongside empirical data. This worldview acknowledges transcendent, intuitive, and esoteric knowledge as existing and as a naturally occurring accessible human function. The analysis recognises spiritual beliefs as intrinsic to the narrator and therefore preserving their integrity rather than reducing them to secular interpretations.

The analysis process identified recurring patterns of meaning within the Pūrākau and coded these within the four specific domains detailed in the five step Te-āta-tu Pūrākau analysis method (see Figure 1.). Beginning with the Social Analysis step working down to step five with the purpose of delving deeper into the data. The fourth step recognises the researcher as an active participant and receiver of the pūrākau, acknowledging that receiving these narratives involves active sense-making processes. This step focuses on the researcher's interpretive analysis, examining how meaning is constructed through the interaction between the narrative and the researcher's understanding. The fifth step observes how spiritual beliefs are engaged, considering how foundational worldviews and cultural

beliefs contribute to the meaning-making processes. Te-āta-tu-Pūrākau organises the raw narrative data into five interconnected related domains to produce the foundational themes and sub-themes.

Ethical Framework

Ethical approval was granted following important Health Research Council Māori ethical guidelines and research principles as set out in Te Ara Tika (Hudson et al., 2010). The principles helped inform and guide participant recruitment and data collection processes in an acceptable manner from both cultural and health research perspectives. The principles are values-based and embody manaakitanga (care) to guide the quality and structure of processes from which engagement between researcher and research participants unfolds (Mikahere-Hall, 2019).

Safe tikanga values and practices guide the nature in which researchers and research participants engage in the research study. The guiding Māori principles include tika (correctness), pono (integrity) and aroha (compassion). Rangatiratanga (leadership), manaakitanga (respectful regard), kaitiakitanga (guardianship) and wairuatanga (spirituality) are also embraced as respected Māori ethical principles fundamental to this Kaupapa Māori research project (Mikahere-Hall, 2019).

Results

Under each of the five overarching themes, a number of sub-themes were identified. These sub-themes provided further nuance and insight into how these core ideas were enacted, understood, and experienced in diverse whānau contexts. For example, within *Whānau constellated caregiving systems*, sub-themes reflected varied caregiving roles taken up by extended whānau members and the fluidity of relational responsibilities. Similarly, *Mahi Tūhono and Mahi Pāmamae* included sub-themes such as narrative healing, Te Oro Tapu (sacred prayer song), reconnection with whakapapa, and expressions of intergenerational resilience. Together, these themes and sub-themes formed an integrated framework that highlights Māori ways of knowing, being, attaching and healing in the context of child wellbeing and protection. While a number of sub-themes emerged within each category, this article presents only the overarching themes due to word count constraints. Sub-theme analysis will be explored further in future work due for publication in 2025.

Theme 1: Whakapapa

Whakapapa emerged as the foundational connection linking children to ancestral past, present relationships, and future generations. Unlike Western attachment's focus on individual relationships, whakapapa provides inherent belonging transcending circumstances. As stated by one kaumatua (elder):

> There is only one of me there is only one of you but we descend from and we have decadency. So how to remain as mātua tupuna (ancestors) do we extend and expand that. We are not talking one generation here we are talking thousands of generations nē (isn't it). It is the preservation of our ira (gene).

This kaumatua spoke of whakapapa as central to the rituals concerning death, where making ancestral connections to the deceased are recited for the benefit of the living. Acknowledging the important contribution the deceased has made to the continuity of whānau and the footprints left behind in the form of tamariki (children), mokopuna (grandchildren) and the potentiality for future generations to quote:

> "Those gatherings are important exposure to your understanding of your evermore whakapapa (genealogy)"

This genealogical framework ensures children's worth exists independently of individual relationships, providing security through collective identity rather than dyadic bonds. One female kaumātua explained:

> You could say that it takes a valley to bring up a child and it can go from the bottom of that road; ...to the end of that road. As the children are growing in that valley they have always got someone that's watching out for them, being protective of them. So, by the time someone gets from the beginning to the end of that road everybody's looking, watching and thinking "Oh yeah there goes P---he's okay he's safe, he's going home or he's going the other way, or he's going wherever he's going. So, the protection [of the child] was the whole valley being involved."

Whakapapa challenges Western individualistic assumptions by positioning collective responsibility as fundamental to child development.

Theme 2: Te Reo Māori (The Māori Language) as a Healing Language

Te reo Māori emerged as a transformative healing language, shifting from deficit-based terminology to concepts promoting connection. Participants consistently described how English language pathologised their experiences while te reo Māori offered healing alternatives. When explaining the importance of the Māori language several kaumatua talked about the spiritual ethos of the language and the importance of karakia (incantations/ prayer) mihimihi (acknowledgements).

> It is hard for us to hear sometimes, when you use our reo [language] it is not harsh it doesn't talk about disorders it thinks about all things having connection and relationships be it good or be it bad

This linguistic transformation challenges Western diagnostic frameworks that label Indigenous children and families as problematic. The shift from "attachment disorders" to "tūhono" (connection) and "tūhonotanga" (connectedness) reframes challenges as opportunities for strengthening bonds.

Theme 3: Whānau Constellated Caregiving

Whānau constellated caregiving systems encompassed grandparents, siblings, and extended networks beyond nuclear family models. This collective approach distributes caregiving responsibility across multiple relationships and affirms the centrality of communal care in Māori child-rearing practices.

> I think that really ideally, we want all our Māori children to grow up with secure identities, with knowing who they are and to have those connections as wide as possible...that buffer of whānau around them.

This quote speaks to the importance of *identity and belonging* as outcomes of expansive whānau support. The metaphor of a "buffer" suggests both protection and emotional grounding, highlighting how secure cultural identity is shaped through multiple, relational threads.

> The belief is in them; it is in them. A lot of people think I want to go and do this or I want to go here, but no, you have to believe in your children and the moko [abbreviation for grandchild] you are there for them. It's like We! We are going to do this; it is not an 'I' thing. We are a very tight family.

This expression of shared belief and collective action affirms how caregiving is framed not as an individual task, but as a coordinated whānau endeavour. The emphasis on "*we*" over "*I*" underscores a deep interdependence and a values-based commitment to uplift tamariki as a shared responsibility. One key informant described:

> The task is not for every hand, yet no hand at all but for many hearts to gather around the tamaiti, so that in the giving, both the tamaiti and the village grow.

This whakataukī (proverb) inspired reflection beautifully captures the reciprocity embedded in caregiving: as tamariki are nurtured by the collective, the collective itself is enriched. It illustrates a philosophy where care is relational, continuous, and spiritually grounding. Together, these insights reveal whānau constellated caregiving as a dynamic and culturally grounded model, in which caregiving is not only about protection, but also about empowering identity, collective resilience, and the growth of the entire community.

Theme 4: Ūkaipō-Kainga as Nurturing Environments

Ūkaipō-Kainga represents nurturing environments including spatial and spiritual connections to ancestral lands. Security emerges from place-based connections extending beyond human relationships.

> In terms of the bond or attachment, in most cases, whānau, I think are awesome, because breast feeding is something that they chose to do,...you know it's the intergenerational thing, we are breast feeders, we are ūkaipō [mother's sustenance], you know ūkaipō how we all connect to Papatūānuku [mother earth], this connection to our tūpuna whenua [ancestral land]. It reminds us to nurture our babies, ourselves and our environment.

This theme challenges Western attachment's focus on human relationships by incorporating environmental and spiritual dimensions of security. Connection to place provides grounding and identity that supports attachment relationships.

Theme 5: Mahi Tūhono-Mahi Pāmamae

Mahi Tūhono-Mahi Pāmamae integrates trauma-centered healing approaches including waiata (song), oriori (prayer-song), and aroha as intentional healing behaviors. As one of our guiding research elders promoted in her life's work "*We have to sing the soul back into being*" Hinewirangi Kohu-Morgan (10/12/1947 – 15/02/2023). Traditional practices become therapeutic interventions promoting security, with a key informant research participant stating:

> Aroha, is always part of healing, it is intentional life-giving behaviour, the cohesive bond, when this is missing our babies our mokopuna learn to know the nothingness

This integration of cultural practices with trauma healing demonstrates how Indigenous approaches address both individual and collective healing needs, providing alternatives to Western therapeutic interventions.

Discussion

Western attachment theory, whilst valuable in many contexts, emerged from particular cultural assumptions about nuclear family structures, maternal responsibility, and individual psychological development (Keller, 2017; Vicedo, 2017). When applied universally without cultural adaptation, these frameworks can pathologise Indigenous caregiving practices and justify ongoing colonial interventions that separate children from their communities (Choate et al., 2019). The predominance of Western theories in infant mental health practice represents what Indigenous scholars identify as epistemic injustice—the systematic devaluation of Indigenous knowledge systems in favour of Western academic paradigms (Smith, 2012). The Tūhono research study is not a dismissal of the important infant-mother relationship; however, it is a shift toward the whānau and the key members that make up this constellation of people there to support, nurture and grow the expanding whānau and to protect the mother, infant child and children.

International Validation

The Tūhono framework's core insights have been validated by recent international scholarship. Waters et al. (2024) reached remarkably similar conclusions about expanding beyond dyadic relationships, while Wright et al. (2025) identified epistemic violence in attachment theory applications—issues the Tūhono framework addressed previously. This convergence may suggest the framework's foundational influence on emerging Indigenous attachment scholarship and it is imperative that this work continues to develop. The convergence of conclusions demonstrates the framework's prescient identification of Western attachment theory's limitations for Indigenous populations.

Theoretical Contributions

The Tūhono framework offers three key theoretical contributions: First, it positions Indigenous knowledge as primary rather than supplementary to Western frameworks. Second, it demonstrates how cultural practices function as therapeutic interventions. Third, it establishes community-

led models positioning Indigenous communities as authorities over their children's wellbeing rather than subjects of external intervention.

Practice Implications

The framework provides immediate applications for transforming infant mental health practice. Assessment approaches must incorporate whakapapa connections, whānau constellation caregiving, and place-based relationships. Intervention strategies should integrate traditional healing practices and prioritise cultural language over diagnostic terminology. Training programmes require fundamental restructuring to centre Indigenous knowledge systems. This includes understanding collective caregiving models, recognising cultural practices as therapeutic interventions, and developing greater cultural understanding and responsiveness in Indigenous worldviews to increase safety. Child welfare systems need systemic transformation to honour Indigenous ways of understanding secure relationships while addressing contemporary challenges.

Conclusion

The Tūhono framework, developed through a pioneering decade-long research investigation has established Indigenous attachment research as a legitimate field and influenced international scholarship. Its validation through recent international studies reaching similar conclusions demonstrates the framework's transformative potential for infant mental health practice globally.

The Tūhono framework offers essential foundations for decolonising child welfare systems while revitalising traditional practices promoting secure relationships and healing from intergenerational trauma. Future research should focus on implementation strategies, cross-cultural applications, and measuring outcomes using Indigenous evaluation frameworks. The framework's influence on emerging scholarship indicates growing recognition that Indigenous knowledge systems provide sophisticated, complete alternatives to Western paradigms. This work contributes to global Indigenous movements towards epistemic justice and community self-determination in child welfare.

Glossary - Māori Terms

1. **Aroha** caring, affectionate, compassion
2. **Aotearoa** Māori name for the country known as New Zealand
3. **Iwi** extended kinship group, tribe, nation, people, nationality
4. **Kāinga** (as part of Ūkaipō-Kāinga) home, settlement, village
5. **Karakia** prayer, to recite prayer chant, incantation ritual
6. **Kaumātua** elder, elderly man, elderly woman, person of status in the family
7. **Kaupapa Māori**Māori approach, Māori topic, Māori customary practice, Māori institution, Māori agenda, Māori principles, Māori ideology - a philosophical doctrine
8. **Mahi** to work, do, perform, make, accomplish, practise,
9. **Mahi Pāmamae** intentional work focus on healing painful experiences
10. **Mahi Tūhono** intentional work focus on attachments and connections
11. **Mana motuhake** autonomy, self-determination, independence, sovereignty, control over one's own destiny.
12. **Manaakitanga** generosity, kindness, support
13. **Mātua tupuna** mātua -grown-up, adult, parental – tupuna -ancestor, grandparent
14. **Mihi / Mihimihi** to greet, to acknowledge
15. **Moko** grandchild abbreviation for mokopuna
16. **Mokopuna** to be a grandchild, a descendant
17. **Oriori** prayer song, lullaby
18. **Pāmamae** traumatic, upsetting, distressing, painful, to feel hurt, trauma
19. **Papatūānuku** earth mother, primordial mother
20. **Pono** be true, valid, honest, genuine, sincere.
21. **Pūrākau** narrative, storytelling
22. **Rangatahi** young person, adolescent, youth
23. **Rangatira** to be of high rank, leader
24. **Rangatiratanga** chieftainship, right to exercise authority, chiefly autonomy, leadership
25. **Reo** language, reference to Māori language (as part of te reo Māori)
26. **Tamariki** children
27. **Tamaiti** child
28. **Tāonga** treasure, gift, special gift
29. **Te Ara Tika** Correct path – relating to ethical conduct
30. **Te Oro Tapu** sacred sound
31. **Te reo Māori** The Māori language
32. **Te Tiriti o Waitangi** Treaty document signed in Waitangi in 1840
33. **Te-āta-tu Pūrākau** the emerging dawning narrative used to metaphorically capture what arises from a state of unknown (darkness) into the light (clarity) because of narrative content analysis. Te āta (the dawn) tu (rise) Pūrākau (Pū -root source, rākau -tree)
34. **Tika** to be correct, true, upright, right, just, fair, accurate, appropriate
35. **Tikanga Māori** Māori protocols and values
36. **Tino rangatiratanga** esteemed authority, autonomy
37. **Tūhono** to join, attach, bond connect-
38. **Tūhonotanga** attachment
39. **Tūpuna** ancestors, grandparents
40. **Tūpuna whenua** ancestral land
41. **Ūkaipō** mother, source of sustenance, nurture
42. **Ūkaipō-Kāinga** places of belonging, belonging to, home, nurturing
43. **Waiata** song, to sing
44. **Wairuatanga** spirituality, beliefs
45. **Whakapapa** table, lineage, recite genealogies, layers-upon layer as in generations
46. **Whakataukī** proverb
47. **Whāngai** to feed, nourish, bring up, foster, adopt, raise, nurture, rear

48. **Whānau** to be born, give birth, born into family, kinship group

49. **Whānau hauā** disabled whānau

50. **Whanaungatanga** relationship, kinship, sense of family connection - a relationship through shared experiences and working together which provides people with a sense of belonging

References

Ainsworth, M. D. S., & Marvin, R. S. (1995). On the shaping of attachment theory and research: An interview with Mary D. S. Ainsworth (Fall 1994). *Monographs of the Society for Research in Child Development, 60*(2-3), 3-21. https://doi.org/10.2307/1166181

Bishop, R. (2010). Effective teaching for Indigenous and minoritized students. *Procedia-Social and Behavioral Sciences, 7*, 57-62. https://doi.org/10.1016/j.sbspro.2010.10.009

Choate, P. W., Kohler, T., Cloete, F., CrazyBull, B., Lindstrom, D., & Tatoulis, P. (2019). Rethinking Racine v Woods from a decolonising perspective: Challenging the applicability of attachment theory to Indigenous families involved with child protection. *Canadian Journal of Law and Society, 34*(1), 55–78. https://doi.org/10.1017/cls.2019.8

Cunneen, C., Rowe, S., & Tauri, J. M. (2017). Fracturing the colonial paradigm: Indigenous criminological perspectives. In A. Deckert & R. Sarre (Eds.), *The Palgrave handbook of Australian and New Zealand criminology, crime and justice* (pp. 385-400). Palgrave Macmillan. https://doi.org/10.1007/978-3-319-55747-2_26

Durie, M. (2006). *Measuring Māori wellbeing* [Paper presentation]. New Zealand Treasury Guest Lecture Series, Wellington, New Zealand.

Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford University Press.

Hall, A. (2015). *An indigenous Kaupapa Māori approach: Mother's experiences of partner violence and the nurturing of affectional bonds with tamariki* [Doctoral dissertation, Auckland University of Technology]. AUT Research Repository. https://hdl.handle.net/10292/9273

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te Ara Tika: Guidelines for Māori research ethics: A framework for researchers and ethics committee members*. Health Research Council of New Zealand.

Independent Children's Monitor. (2024). *Te aroturuki i ngā whakahaere – Experiences of care in Aotearoa: Annual report 2024*. https://www.icm.org.nz/reports/annual-report-2024/

Keller, H. (2017). Attachment. A pancultural need but a cultural construct. *Current Opinion in Psychology, 15*, 59–63. https://doi.org/10.1016/j.copsyc.2017.02.003

Keller, H., & Otto, H. (2009). The cultural socialization of emotion regulation during infancy. *Journal of Cross-Cultural Psychology, 40*(6), 996-1011. https://doi.org/10.1177/0022022109348576

Lee-Morgan, J. B. J. (2019). *Purakau from the inside-out: regenerating stories for cultural sustainability Decolonizing Research: Indigenous Storywork as Methodology*.(eds JA Q'um Q'um Xiiem, JBJ Lee-Morgan and J. De Santolo) pp, 151-170.

Lee, J. (2009). Decolonising Māori narratives: Pūrākau as a method. *MAI Review, 2,* 1-12.

LeVine, R. A. (1974). Parental goals: A cross-cultural view. *Teachers College Record, 76*(2), 226-239.

McLachlan, A. D., Wirihana, R., & Huriwai, T. (2017). Whai tikanga: The application of a culturally relevant value centred approach. *New Zealand Journal of Psychology* (Online), 46(3), 46-54.

Maleku, A. (2025). Toward epistemic justice in social work research: (Re) imagining global knowledge production. *The British Journal of Social Work, 55*(2), 613-620. https://doi.org/10.1093/bjsw/bcaf052

Mikahere-Hall, A. (2017). Constructing research from an indigenous Kaupapa Māori perspective: An example of decolonising research. *Psychotherapy and Politics International, 15*(3), e1428. https://doi.org/10.1002/ppi.1428

Mikahere-Hall, A. (2019). Tūhono Māori: A research study of attachment from an Indigenous Māori perspective. *Ata: Journal of Psychotherapy Aotearoa New Zealand, 23*(1), 61-76. https://doi.org/10.9791/ajpanz.2019.07

Oranga Tamariki. (2023). *Report on disparities and disproportionality experienced by tamariki Māori in the care and protection system*. https://www.orangatamariki.govt.nz/about-us/research/our-research/report-on-disparities-and-disproportionality-experienced-by-tamariki-maori/

Pouwhare, R., & Steagall, M. M. (2023). The Māui Narratives: from bowdlerisation, dislocation and infantilisation to veracity, a Māori practice-led approach. *LINK PRAXIS, 1*(1), 243-285.

Royal Commission of Inquiry into Abuse in Care. (2024). *He Purapura Ora, he Māra Tipu: From redress to puretumu torowhānui: Final report*. https://www.abuseincare.org.nz

Smith, L. T. (2012). *Decolonising methodologies: Research and Indigenous peoples* (2nd ed.). Zed Books.

Statistics New Zealand. (2013). *Te Kupenga 2013*. http://archive.stats.govt.nz/browse_for_stats/people_and_communities/maori/kei-te-pewhea-to-whanau-2012/new-approach-measuring-whanau.aspx

Vicedo, M. (2017). Putting attachment in its place: Disciplinary and cultural contexts. *European Journal of Developmental Psychology, 14*(6), 684–699. https://doi.org/10.1080/17405629.2017.1289918

Waters, S. F., Richardson, M., Mills, S. R., Marris, A., Harris, F., & Parker, M. (2024). Beyond attachment theory: Indigenous perspectives on the child–caregiver bond from a northwest tribal community. *Child Development, 95*(6), 1829-1844. https://doi.org/10.1111/cdev.14127

Wright, A., Gray, P., Selkirk, B., Hunt, C., & Wright, R. (2025). Attachment and the (mis)apprehension of Aboriginal children: Epistemic violence in child welfare interventions. *Psychiatry, Psychology and Law, 32*(2), 175-199. https://doi.org/10.1080/13218719.2023.2280537

Reclaiming intergenerational wellbeing for First Nations families through Birthing on Country

by Rebecca Coddington[1], R.M., B.Mid (Hons), PhD, and Melanie Briggs[2], R.M., B.Mid, M.Mid (Australia)

[1]Birthing on Country Research and Implementation Coordinator, Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation

[2]Minga Gudjaga and Birthing on Country Manager, Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation

Photo: Birthing on Country Manager and midwife Mel Briggs and Waminda midwives Lulu Littler and Jess Baird with a mum and baby at their Minga Gudjaga Gunyah clinic in Nowra, NSW. Credit: Tace Stephens

Australia is considered one of the safest places in the world for a woman to give birth with universal access to publicly-funded maternity care, robust healthcare infrastructure and a highly skilled and regulated health workforce (COAG Health Council, 2019). Yet, despite this, First Nations women and babies currently experience significant disparities in health outcomes when compared with their non-First Nations (Australian Government Department of Health and Aged Care, 2021). These disparities include higher rates of maternal mortality (14.4 deaths per 100,000 vs national average of 4.8), higher perinatal mortality rates for babies born to First Nations mothers (17 deaths per 1,000 births, vs 9.6 per 1000 for non-First Nations babies) (AIHW), higher rates of preterm birth (14% vs 8% born before 37 weeks' gestation) and a greater number of First Nations babies born at a low birthweight (12% vs 6% <2500g) (Australian Institute of Health and Welfare, 2025a). Although the deficit discourse surrounding First Nations peoples attempts to locate these disparities as arising from an intrinsic *lack* or *risk* situated with First Nations Australians themselves, a more truthful appraisal points to both a *lack* of culturally appropriate services and the *risk* of women experiencing racism within mainstream maternity services (Adams et al., 2018; Macedo et al., 2020; Sherwood, 2013; Simmonds et al., 2012). Despite countless Australian government initiatives over the past two decades aiming to 'Close the Gap' in health inequities (Commonwealth of Australia, 2023), White healthcare systems remain unsafe for Blak[1] bodies.

Prior to colonisation, Firs Nations women were generally healthy and well-nourished (Webb, 2009). They experienced birth in the context of deep connection to Country, culture and community (Adams et al., 2018; Roe, Yvette et al., 2024).

> *Indigenous women have been birthing since time immemorial, when the lands were pure, and the dreaming stories were a reality. Birthing is the first ceremonial journey we go through to leave the spirit world to come into the physical world. Our connection to our ancestors and our culture provides our people with a sense of belonging and grounds our ways of knowing, being and doing (Briggs, 2022).*

Post colonisation, however, the Western healthcare system was used as a tool of control and assimilation where First Nations people experienced medical neglect, denial of treatment and dehumanisation (Dow & Gardiner-Garden, 1998). As such, a deep mistrust of mainstream healthcare services persists amongst First Nations communities, acting as a barrier to health equity (Freeman et al., 2022; Gatwiri et al., 2021). For this to change, it is vital that we recognise these disparities as not merely health 'gaps', but rather a reflection of the systemic inequality embedded in healthcare structures (Gatwiri et al., 2021).

Colonisation, it seems, is bad for your health (Sherwood, 2013). The colonisation of Australia by British settlers from 1788 until the present day involved dispossessing First Nations people of land, language and culture, enacted in part by forcibly removing First Nations children from their families and placing them in government or church-run institutions (Human Rights and Equal Opportunity Commission, 1997). The main period of forcible removals, known as the Stolen Generations, occurred from 1910 until the 1970s as part of the Australian government's attempt to 'assimilate' First Nations people into White Australian society, with the aim of erasing culture and identity (Human Rights and Equal Opportunity Commission, 1997; Read, 2006). Australia's violent colonial past initiated a domino effect of intergenerational trauma that continues to have far-reaching detrimental impacts on the social and health determinants experienced by First Nations people today (Human Rights and Equal Opportunity Commission, 1997; Kairuz et al., 2021; Sherwood, 2013). In many ways, the colonial project persists to

[1]The term 'Blak' is a deliberate re-spelling of 'Black', removing colonial associations tied to this word and reclaiming an Indigenous-defined identity grounded in pride and solidarity.

this day with First Nations people living with daily experiences of racism in interpersonal, systemic and internalised forms (Jones, 2001; Kairuz et al., 2021; Watego, 2021).

Despite sustained attempts to decimate First Nations peoples, First Nations people continue to persist and resist. From the early 1970's in Australia, a movement established to develop health care services that are designed, delivered, and governed by Aboriginal people for Aboriginal people (National Aboriginal Community Controlled Health Organisation (NACCHO), 2020). Aboriginal Community Controlled Healthcare Organisations (ACCHOs), work to empower communities to shape services that meet their unique needs, grounded in the principles of self-determination and the provision of culturally safe, holistic care (National Aboriginal Community Controlled Health Organisation (NACCHO), 2020). In the maternity care sector, First Nations communities are fighting for birthing sovereignty, calling for the funding of First Nations-led solutions to perinatal health inequities (Hickey et al., 2021; Sherwood, 2013). This movement is known as 'Birthing on Country', which refers to maternity services designed and delivered for and by First Nations women that encompass connection to Country, integration of cultural knowledge, provision of care by Aboriginal midwives and Aboriginal Health Practitioners with a focus on community and kinship (Australian College of Midwives et al., 2016; Roe, Y. et al., 2020).

At the forefront of the Birthing on Country movement in Australia is an ACCHO called Waminda South Coast Women's Health and Wellbeing Aboriginal Corporation (hereafter Waminda). For the past 40 years, Waminda have been providing culturally safe and holistic health and wellbeing services to women and their Aboriginal families on the unceded lands of the South Coast of New South Wales (NSW). Waminda was established in 1984 as an Aboriginal Women's Health Centre known as 'Jilimi', in response to the local Koori[2] community's concern about the lack of culturally safe health services available for women and their families (Waminda, 2025). Waminda operates from a foundation of culture and employs a firmly strengths-based approach, pushing back on the deficit narrative that permeates most mainstream healthcare services. The organisation

Photo: Waminda's Chief Executive Leadership Team, (left to right) Lisa Wellington, Cleone Wellington, Kristine Falzon and Hayley Longbottom. Credit: Tace Stephens

is community driven, led, connected and informed, overseen by a Board comprising of seven local Koori women elected by the local community at their Annual General Meeting each year. Waminda's community-centred approach includes taking guidance from the Women's Elders Group and Cultural Committee who ensure Aboriginal ways of knowing, being and doing are incorporated into all aspects of the service.

Waminda has developed a distinctive Model of Care that is deeply rooted in Aboriginal culture, community leadership, and self-determination (SNAICC, 2023). The service supports reclamation of intergenerational wellbeing for women and their Koori families through the provision of high-quality, holistic care that addresses the social determinants of health. This is achieved by offering comprehensive 'wrap-around' services, where internal referral pathways provide women with seamless access to non-judgemental care from numerous Waminda programs including; primary healthcare with doctors, nurses and Aboriginal Health Practitioners; maternity and sexual health services; counselling and psychology services; family preservation and restoration casework; domestic violence prevention and support; chronic disease management and prevention through nutrition and exercise; and youth programs, all provided within a holistic, culturally safe, and trauma-informed framework.

Within the Australian maternity care sector, the upscaling of Birthing on Country is fundamental to reclaiming intergenerational wellbeing for First Nations families. It is well recognised that a mother's mental health has implications for her infant's development, with poor maternal mental health having potentially long-term adverse effects on children's mental and physical health, and their cognitive and socio-emotional skills (Feldman, 2015; von Hinke et al., 2022). At present, 97% of all births in Australia occur in hospital labour-ward settings (Australian Institute of Health and Welfare, 2025a), yet these institutions continue to contribute to unacceptable, harmful healthcare experiences for First Nations women (Hickey et al., 2021; Macedo et al., 2020). This has flow on effects for families, as women who experience traumatic births commonly report difficulty bonding with their infant, experience less secure attachment and report parenting as more stressful (Fameli et al., 2023; Hairston et al., 2018; McDonald et al., 2011). The 2024 NSW Parliamentary Inquiry into Birth Trauma revealed the extent to which Australian women were being traumatised by their birth experiences with over 4000 written testimonials detailing a lack of informed consent, inadequate pain relief, and experiences of disrespect and mistreatment (NSW Parliament, 2024). Research demonstrates that 1 in 3 women report their births as traumatic and between 3-15% are estimated to develop Post Traumatic Stress Disorder after childbirth (Grekin R. & O'Hara M.W., 2014). While specific national statistics on birth trauma rates among First

[2]Koori is a term used by Aboriginal people from southeastern Australia, particularly in parts of New South Wales and Victoria, to refer to themselves. It is a self-chosen, culturally specific identifier, as opposed to a general term for all Aboriginal and Torres Strait Islander peoples (Australian Indigenous Health et al., 2022).

Nations women are limited, evidence of racism experienced within mainstream maternity care systems combined with higher rates of complex life stressors make it likely that birth trauma rates are much higher among Indigenous women (Kairuz et al., 2021; Macedo et al., 2020). Waminda are determined to disrupt this cycle of trauma.

At Waminda, Birthing on Country is a metaphor for the best start to life for Koori babies, ensuring a safe passage for Mingas (Mothers) and Gudjagas (Child) through supporting a healthy transition to motherhood for women by strengthening family capacity and cultural connection. A key strength of Waminda's Birthing on Country service is that it is anchored within their broader community-controlled, wrap-around services. Maternity care is provided at Minga Gudjaga Gunyah[3] (Mother and Child Home), a community clinic based in the Nowra CBD. Care can also be provided at the woman's home or any location in community that she chooses. Minga Gudjaga is Aboriginal Health Practitioner (AHP) led, meaning that women see an AHP as their first point of contact in pregnancy, and continue to have regular AHP visits alternating with antenatal appointments with their primary midwife throughout pregnancy. AHPs are registered healthcare practitioners who specialise in providing culturally and clinically safe care, supporting the social and emotional wellbeing of women and their families. Waminda AHPs are known and trusted members of the local community, which helps women feel safe in accessing the service. For women experiencing complex life stressors, Waminda's provision of culturally-informed, individually tailored, strength-based care reduces Koori families' interaction with government child protection agencies, decreasing the risk of child-removal.

First Nations children are significantly overrepresented in out-of-home care (OOHC) systems, making up 43% of all children in OOHC and only 4% of the national population (Australian Institute of Health and Welfare, 2025b). In mainstream maternity care services, First Nations families with complex trauma are more likely to be reported to child protection services than they are to receive family support in pregnancy (Chamberlain et al., 2022), with the risk of child removal a major barrier to parents asking for and receiving the help they need (Newton, 2020). To protect women from the risk of child-removal, Waminda's Birthing on Country team work closely with Nabu, an internal family preservation and restoration program, which aims to keep Koori families together. Nabu evolved in direct response to community concerns that too many Koori children were being removed from their families. To combat the epidemic of child removal, Nabu focuses on local solutions and contextualised activities to engage and strengthen participating families and achieve the best outcomes for all involved (SNAICC, 2023). Nabu's intensive support includes the provision of counselling and intensive parenting support, and advocacy for families who are navigating the education, housing and legal systems (SNAICC, 2023).

Photo: Members of Waminda's Birthing on Country Team, (left to right rear) Fiona Reid, Patricia Deaves, Melanie Briggs, Tanya Williamson, Carly David, Lulu Littler, Jedda Outten, Xaviera McGuffin, Bec Coddington. (left to right front) Kathleen Taylor, Zoe Goddard, Teagan Brown, Tahlia Avolio, and Jessica Baird. Credit: Tace Stephens

For decades, First Nations communities have sought to reclaim birth, endeavouring to ensure the best start to life for future generations. At Waminda, this is achieved through the application of Aboriginal governance and safety strategies to support maternal, infant and family health and wellbeing within a holistic Model of Care. Waminda's Birthing on Country program answers the call from local Koori women for a safe space to birth their babies, that

[3]Gunyah is a Dhurga word signifying a home. It represents a place for our community to feel welcome, safe and where they belong (Waminda, 2024).

integrates culture and decolonises healthcare delivery. Preventing birth trauma and supporting women to heal from the trauma of previous births or adverse life experiences gives women and their Koori families the best start to life, supporting them to reclaim their right to intergenerational health and wellbeing.

References

Adams, K., Faulkhead, S., Standfield, R., & Atkinson, P. (2018). Challenging the colonisation of birth: Koori women's birthing knowledge and practice. *Women and Birth, 31*(2), 81–88. 10.1016/j.wombi.2017.07.014

Birthing on Country position statement. (2016). https://indigenousmidwives.org.au/birthing-on-country-position-statement/

Australian Government Department of Health and Aged Care. (2021, June 30). *Status and determinants of Aboriginal and Torres Strait Islander health*. https://www.health.gov.au/topics/aboriginal-and-torres-strait-islander-health/status-and-determinants

Australian Indigenous Health, InfoNet, &. (2022). *The Australian Indigenous HealthInfoNet guidelines for Aboriginal and Torres Strait Islander terminology*. https://healthinfonet.ecu.edu.au/healthinfonet/getContent.php?linkid=675466&title=The+Australian+Indigenous+HealthInfoNet+guidelines+for+Aboriginal+and+Torres+Strait+Islander+terminology&contentid=44676_1

Australian Institute of Health and Welfare. (2025a). *Australia's mothers and babies*. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/about

Australian Institute of Health and Welfare. (2025b). *Child protection Australia 2022–23*. https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2022-23

Briggs, M. (2022, Feb 21). *Birthing on Country is a Sovereign Right for Indigenous Parents*.

Chamberlain, C., Gray, P., Bennet, D., Elliott, A., Jackomos, M., Krakouer, J., Marriott, R., O'Dea, B., Andrews, J., Andrews, S., Atkinson, C., Atkinson, J., Bhathal, A., Bundle, G., Davies, S., Herrman, H., Hunter, S. A., Jones-Terare, G., Leane, C., . . . Langton, M. (2022). Supporting Aboriginal and Torres Strait Islander Families to Stay Together from the Start (SAFeST Start): Urgent call to action to address crisis in infant removals. *Australian Journal of Social Issues., 57*(2), 252–273. https://doi.org/10.1002/ajs4.200

COAG Health Council. (2019). *Woman-centred care: Strategic directions for Australian maternity services.* https://www.health.gov.au/sites/default/files/documents/2019/11/woman-centred-care-strategic-directions-for-australian-maternity-services.pdf

Commonwealth of Australia. (2023). *Briefing book: Key issues for the 47th Parliament. Parliament of Australia*. https://www.aph.gov.au/-/media/05_About_Parliament/54_Parliamentary_Depts/544_Parliamentary_Library/Research_Papers/2023-24/Briefing_Book_key_issues_for_the_47th_Parliament.pdf

Dow, C., & Gardiner-Garden, J. (1998). *Aboriginal and Torres Strait Islander Health: Historical Overview*. Australian Parliament Library.

Fameli, A., Costa, D. S. J., Coddington, R., & Hawes, D. J. (2023). Assessment of childbirth-related post traumatic stress disorder in Australian mothers: Psychometric properties of the City Birth Trauma Scale. *Journal of Affective Disorders, 324*, 559–565. 10.1016/j.jad.2022.12.123

Feldman, R. (2015). Sensitive periods in human social development: New insights from research on oxytocin, synchrony, and high-risk parenting. *Development and Psychopathology, 27*(2), 369–395. 10.1017/S0954579415000048

Freeman, T., Townsend, B., Mackean, T., Musolino, C., Friel, S., & Baum, F. (2022). Advancing Indigenous self-determination and health equity: Lessons from a failed Australian public policy. *SSM - Qualitative Research in Health, 2*, 100117. 10.1016/j.ssmqr.2022.100117

Gatwiri, K., Rotumah, D., & Rix, E. (2021). Black Lives Matter in Healthcare: Racism and Implications for Health Inequity among Aboriginal and Torres Strait Islander Peoples in Australia. *International Journal of Environmental Research and Public Health, 18*, 4399. https://doi.org/10.3390/ijerph18094399

Grekin R., & O'Hara M.W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: a meta-analysis. *Clinical Psycholgy Review, 5*, 389–401. 10.1016/j.cpr.2014.05.003.

Hairston, I., S., Handelzalts, J.,E., Assis, C., & Kovo, M. (2018). Postpartum bonding difficulties and adult attachment styles: the mediating role of postpartum depression and childbirth-related PTSD. *Infant Mental Health Journal: Infancy and Early Childhood, 39*(2), 198–208. 10.1002/imhj.21695

Hickey, S., Roe, Y., Ireland, S., Kildea, S., Haora, P., Gao, Y., Maypilama, E. L., Kruske, S., Campbell, S., Moore, S., Maidment, S., Heinemann, K., Hartz, D., Adcock, A., Storey, F., Bennett, M., Lambert, C., Sibanda, N., Lawton, B., . . . Sherwood, J. (2021). A call for action that cannot go to voicemail: Research activism to urgently improve Indigenous perinatal health and wellbeing. *Women and Birth, 34*(4), 303–305. 10.1016/j.wombi.2021.03.011

Human Rights and Equal Opportunity Commission. (1997). *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. https://humanrights.gov.au/our-work/bringing-them-home-report-1997

Jones, C. P. (2001). Invited commentary: "Race," racism, and the practice of epidemiology. *American Journal of Epidemiology, 154*(4), 299–304.

Kairuz, C. A., Casanelia, L. M., Bennett-Brook, K., Coombes, J., & Yadav, U. N. (2021). Impact of racism and discrimination on physical and mental health among Aboriginal and Torres Strait islander peoples living in Australia: a systematic scoping review. 21, 1302 (2021). *BMC Public Health, 21*(1) https://doi.org/10.1186/s12889-021-11363-x

Macedo, D. M., Smithers, L. G., Roberts, R., M., & Jamieson, L. M. (2020). Racism, stress, and sense of personal control among Aboriginal Australian pregnant women. *Australian Psychologist, 55*(4), 336–348. 10.1111/ap.12435

McDonald, S., Slade, P., Spiby, H., & Iles, J. (2011). Post-traumatic stress symptoms, parenting stress and mother-child relationships following childbirth and at 2 years postpartum. *Journal*

of Psychosomatic Obstetrics & Gynecology, 32(3), 141–146. https://doi.org/10.3109/01674822X.2011.596962

National Aboriginal Community Controlled Health Organisation (NACCHO). (2020). *About NACCHO*. https://www.naccho.org.au

Newton, B. J. (2020). Aboriginal parents' experiences of having their children removed by statutory child protection services. *Child & Family Social Work, 25*(4), 814–822. 10.1111/cfs.12759

NSW Parliament. (2024). *Select Committee on Birth Trauma - Report No 1 - Birth trauma*. NSW Parliament. https://www.parliament.nsw.gov.au/lcdocs/inquiries/2965/FINAL%20Birth%20Trauma%20Report%20-%2029%20April%202024.pdf

Read, P. (2006). *The stolen generations: The removal of Aboriginal children in New South Wales 1883 to 1969*. NSW Department of Aboriginal Affairs.

Roe, Y., Briggs, M., Buzzcott, C., Hartz, D., Kildea, S., & Sherwood, J. (2020). Returning birthing services to communities and Aboriginal control: Aboriginal women of Shoalhaven Illawarra region describe how Birthing on Country is linked to healing. 5(1), 58–71. https://journalindigenouswellbeing.com/journal_articles/returning-birthing-services-to-communities-and-aboriginal-control-aboriginal-women-of-shoalhaven-illawarra-region-describe-how-birthing-on-country-is-linked-to-healing/

Roe, Y., Allen, J., Haora, P., Hickey, S., Briggs, M., Wilkes, L., Nelson, C., Watego, K., Coddington, R., Ireland, S., Kruske, S., Gao, Y., & Kildea, S. (2024). Enabling the context for Aboriginal and Torres Strait Islander Community Controlled Birthing on Country services: Participatory action research. *Women and Birth, 37*(2), 368–378. 10.1016/j.wombi.2023.11.007

Sherwood, J. (2013). Colonisation - it's bad for your health: the context of Aboriginal health. *Contemporary Nurse, 46*(1), 28–40. 10.5172/conu.2013.46.1.28. PMID: 24716759.

Simmonds, D. M., West, L., Porter, J., Davies, M., Holland, C., Preston-Thomas, A., O'Rourke, P. K., & Tangey, A. (2012). The role of support person for Ngaanyatjarra women during pregnancy and birth. *Women and Birth, 25*(2), 79–85. 10.1016/j.wombi.2010.12.007

SNAICC. (2023). *Early intervention profile: Waminda – South Coast Women's Health and Welfare Aboriginal Corporation*. https://www.snaicc.org.au/wp-content/uploads/2023/09/220201_7_Early-Intervention-Profile-Waminda-1.pdf

von Hinke, S., Rice, N., & Tominey, E. (2022). Mental health around pregnancy and child development from early childhood to adolescence. *Labour Economics, 78*, 102245. 10.1016/j.labeco.2022.102245

Waminda. (2024). *What does 'Blak Cede Gunyah' mean?* Retrieved June 4, 2025, from https://blakcede.com.au/news/what-does-blak-cede-gunyah-mean

Waminda. (2025). *Waminda's History: From Jilimi to Waminda*. https://waminda.org.au/history/

Watego, C. (2021). *Another day in the colony*. University of Queensland Press.

Webb, S. G. (2009). *Palaeopathology of Aboriginal Australians: Health and disease across a hunter-gatherer continent*. Cambridge University Press.

The Sankofa Infant Mental Health History Project

By the Sankofa Project Steering Collective:

Marie-Céleste Condon[1]*, Aditi Subramaniam[2], Natasha Pérez Byars[3], Eva Marie Shivers[3], Nucha Isarawong[4], and Germán Walteros[5] (United States)

[1]Reflective Consultant & Researcher

[2]Massachusetts Society for the Prevention of Cruelty to Children

[3]Indigo Cultural Center

[4]Barnard Center for Infant and Early Childhood Mental Health, University of Washington School of Nursing

[5]Private Consulting

*Corresponding author: marie.celeste.condon.phd@gmail.com

Key Words: Sankofa, Decolonization, Revitalization, Infant Mental Health History, Storytelling, Healing Justice

Funding: Irving Harris Foundation and the Academy of ZERO TO THREE Fellows

The authors have no conflicts of interest to declare.

This manuscript has not been published elsewhere and is not under consideration by another journal.

Abstract

Conceptualizations of relational health, and infant mental health (IMH) have largely centered on the perspectives of White theorists and professionals. Often untold and less-centered less-central are the stories and contributions of culturally and racially diverse peoples who have supported, led, and labored on behalf of children and families for generations, despite harms perpetrated on their communities. The Sankofa IMH History Project supports revitalization by inviting diverse Storytellers to share stories and perspectives that are at risk of being left behind; recording them; and creating an archival resource for revitalizing relationships, IMH discourse, workforce development, practice, and policies. Symbology, QR codes, art, and reflective questions are used to prompt perspective-taking and collective reflection. Authors integrate text, oral tradition, spiritual, embodied, and cerebral wisdom, as means of engendering and transmitting knowledge, sustaining cultures, and informing revitalization and social change. The Sankofa Project is a love letter to our field.

Introduction

The Sankofa Infant Mental Health History Project (Sankofa Project) is an ongoing effort led by Indigo Cultural Center and co-held, co-dreamt, and co-created with the Steering Collective for the purpose of revisiting the history of infant mental health (IMH) and expanding our understanding of relational health.

The conceptualization of IMH in the United States has largely centered on White theorists and professionals and infant-parent (usually mothers) dyads. Often untold and less-centered central are the stories and contributions of people and communities of color who have supported, led, and labored on behalf of young children and families for generations; the links between self, family, and community wellbeing that cultures worldwide have understood as inextricable; and how power and privilege have impacted the professional field's development and directional focus through the decades. The Sankofa Project features the stories, wisdom, and contributions of IMH practitioners and scholars, illuminating the interconnected nature of workforce development, practice, and policy – much like the Möbius strip in Figure 1.

The Sankofa Project aims to support revitalization in IMH by inviting diverse storytellers to share stories at risk of being buried, left behind, unintegrated, or glossed over. Through recordings and archived resources, we aim to prompt pivots towards reimagining transformative relationships and possibility-creating (Ginwright, 2022).

Figure 1. Möbius Strip: A metaphor for interconnection (Credit: Steering Collective).

The Sankofa Project invites revitalizing ways of knowing and cultural practices –the cornerstones of replacing oppressive systems with systems that nurture healing and possibilities in communities. Figure 2. explains the significance of Sankofa.

Sankofa originates from the Akan people of Ghana, serving as a reminder to go back and retrieve what is important from the past as we move forward to the future. One popular interpretation is "go back and get it."

Figure 2. Sankofa.

History

The naissance and development of psychiatry 1650–1850 (Kendler et al., 2022), family studies in the early 1900s (Burgess, 2022), and pioneering work in IMH in the 1970's (Policy Equity Group, 2023) coincided with European and United States imperialism and colonization (NIH, 2022). As language, cultures, and relationships were colonized often to the point of extinction, a knowledge vacuum about relational wellbeing was created. Not surprisingly, scholars and practitioners who saw the need to understand IMH health and develop evidence-based interventions in post-colonial societies were influenced by the colonialist, manifest destiny, eugenic, and White supremacist discourses of their times. We are deeply grateful to ancestors who persevered and kept language and knowledge about collective wellbeing alive through waves of genocide (Voce et al., 2021; NABS, 2020), so future generations might know, sustain, and pass forward healing practices rooted in abiding, relational principles that enabled cultures and communities to thrive for millennia (Richardson, et al., in press).

Key Concepts and Guiding Principles

"*While we can create good ideas and put them into words, there's no assurance that these language-based symbolic representations will work for people who do not rely on verbal representation to express ideas. Sometimes, words, language- or number-based frames limit what is possible in terms of… mutual understanding between people (p. 4, Watanabe & Maharaj, 2024).* With this expansive approach in mind, the Sankofa Project's Key Concepts are defined in Figure 4.

Trees Holding Hands: "Only when knowledge is conditioned by respect can it be truly shared."

— Charles Labrador, Acadia First Nation (1997)
— Basma Kavanagh, Artist

Colonization. Colonization devalues, marginalizes and cripples the sovereignty, language, cultures, worldviews, wisdom, histories, and social order of colonized peoples. Even when a People manage to survive, racial imbalances in knowledge, knowledge production and agency are perpetuated (Dudgeon et al., 2024).

Appropriation erases the identities of people and cultures who generated knowledge. Imbalances in privilege, social status and rank perpetuate colonizer-colonized dynamics; reinforce inequalities and stereotypes; and strip principles and practices of their authenticity and sacredness. Origins, sacredness, true meaning and purpose are lost.

Decolonization is the process of reversing control, reclaiming sovereignty over one's body, relationships, principles, knowledge production, and practices. Colonialism including extractive capitalism is deeply embedded in our society and systems (Sanchez, 2019; 2022). Like insidious invasive weeds, it would require gargantuan effort, resources and revolution to eliminate it in our society. Revitalization and Indigenization are effective alternatives.

Revitalization is about reclaiming, sovereignty, worldviews, cultural practices, traditions, language, and other facets of life that were suppressed or lost during colonization. Revitalizing relationships with people of diverse cultures and positionalities opens pathways for reversing power dynamics, promoting healing and social change.

Figure 4. Key concepts.

The Steering Collective is two years into its commitment to ongoing critical, reflective dialogue, discovery of diverse cultural guiding principles, and ways of living those principles. Combining principles and teachings from our own ancestors and those illuminated by Sankofa Project Storytellers, we hope to influence ways of being and being with among people who engage with the Project. QR Code 1, "Guiding Principles" features two elders revisiting principles that emerged while witnessing stories that inform the Sankofa Project, and engaging in critical reflective dialogue about the revitalization of IMH history. Along with centuries-long tradition of oral history, the video offers images and excerpts from their dialogue. We invite you to turn your phone camera on and scan the code below.

QR code 1. "Guiding Principles".

Colonization affects both colonizers and colonized in profound ways (Memmi, 1965). Revisiting what we "know" as professionals elicits many questions: What stories have not yet been illuminated about the history of our field? Are we working with fragmented truths that serve some, while harming others? What non-dominant sources of wisdom have been overlooked? What has been appropriated, exploited, and commodified, exacerbating harm? What did ancestors teach about relational and collective wellbeing? How might humility and resourcing community efforts (as opposed to outsider efforts) create new possibilities for healing in relationships and IMH workforce development, practice, and policy?

Land. Root. Seed. Culture. Community. Storytellers. Learners. (Methodology)

The need for revitalization has not been felt or dreamed by Indigo staff alone. There have been reverberations from many – particularly professionals of color – calling for change, truth-telling, and reckoning within our collective fields. Indigo partners with a small steering collective of IMH professionals who inspire and advise the design, process, and dissemination phases of the Sankofa Project. Each steering collective member brings a part of themselves, their stories, and their histories to how we see, think, and create together.

The Sankofa Project is a qualitative, emergent design endeavor featuring decolonizing methodology (Smith, 2005), on-going reflexivity, and theoretical sensitivity (Glazer, 1978). The primary means of collecting information are interviews with culturally and racially diverse IMH professionals. The Steering Collective began by generating a list of 20 people that could contribute to constructing a fuller history of IMH that centers the contributions of individuals and communities of color. Table 1 shows selection criteria, storytellers' names, and examples of interview questions. In the end, we, the Steering Collective, also contributed reflections to the first Sankofa Project video, *Part One: Land. Root. Seed. Culture. Community.*

At each interview, two to three members of the Steering Collective ask broad and exploratory questions to capture concepts and meanings. Interviewers explain their intent to reverse typical power dynamics by positioning interviewees as Storytellers, and themselves as witnesses and learners "at the feet of Storytellers" (Condon et al., 2022; Charlot-Swilley et al., 2024). Storytellers are asked to speak to the future, past, and present; their cultural context; IMH history; and their hopes for the field. Emergent themes are a basic building block of inductive, qualitative social science research. Themes are derived from the participants, not the researchers. Steering Collective members use a priori coding to analyze data generated in response to questions in interview guides and emergent coding for other data. (Charmaz, 2006; Saldaña, 2021).

Table 1. Criteria. Storytellers. Questions.

Criteria	♦ Work and lived experience reflect a priority area of practice context focus: therapeutic supports for early relationships, home visiting, perinatal health and birthing, IMH consultation, reflective practice, and fatherhood ♦ Has a way of storytelling that embodies decolonization and revitalization ♦ Can deeply contribute to the Sankofa Project's overarching questions regarding identifying harms within IMH, illuminating traditional healing ways, and revitalizing caregiving practices
Storytellers	♦ Haruko Watanabe ♦ Dr. Hisako Watanabe ♦ Dr. Janina Fariñas ♦ Dr. Marva Lewis ♦ Sankofa Project Steering Collective
Questions	♦ Who are you and where do you come from? ♦ Who has influenced the way you do and think about your work? ♦ What are some of the cultural ways of knowing, wisdom, and approaches to healing that are missing from existing IMH interventions/frameworks? ♦ What harms have been perpetuated by the mainstream, dominant IMH field?

The EPICURE agenda (Stige et al, 2009) is used to decolonize and structure methods of investigation and generate accurate, credible, and useful results. Figure 5. shows connections among agenda elements.

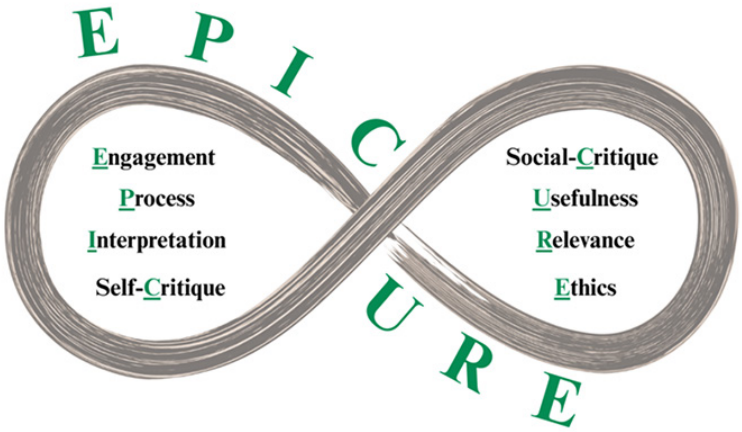

Figure 5. EPICURE.

The first part of the acronym – *EPIC* – addresses issues of process, highlighting the importance of reflective dialogue and self-critique in collaborative qualitative participatory action investigations. The second part – *CURE*– addresses the social implications of the work.

Implications: Integration, Innovation and Revitalization

The past lays the groundwork for things to come. What we know and understand about history influences who and how we are and what and how we do things in the present, and impacts the future. James Baldwin writes, "*The great force of history comes from the fact that we carry it within us, are unconsciously controlled by it… History is literally present in all that we do*" (Baldwin, 1965). He also offers, "*If I love you, I have to make you conscious of the things you don't see*" (Baldwin, 1989).

Many current IMH policies – including funding, eligibility, programming, workforce development, etc. – are influenced by dominant versions of IMH history and practice. Yet, being in relationships is indigenous and endogenous to every human being. A historical accounting that acknowledges that our relatives and ancestors understood indigeneity and endogeneity in relationships informs a significantly different frame for IMH practice, policy, workforce development, and beyond.

Practice. In Table 3, we offer reflective questions based on the Sankofa Project's initial findings and themes, to invite readers to practice critical reflection and dialogue about what care looks and feels like as we co-journey with families and young children. Critical reflection and dialogue lead to healing justice-informed actions in service of 'right' relationships with families.

Policy. Major implications and recommendations that flow from this work relate to co-creating and revitalizing the infrastructure, networks, and conditions of our field. A revitalized IMH future must center and integrate an understanding of diversity, oppression, community assets, historical racial trauma, equity, and collective wellbeing (Irving Harris Foundation, 2028). We must acknowledge harms resulting from our past tendencies to *not* center the voices, traditions, ways of knowing, and worldviews of Indigenous, Black, Brown, Asian, and other People of Color. Elevating examples of policies informed by traditional wisdom and revitalizing ways of knowing will enable us to move beyond aspirations into realizing healing justice. Necessary, tangible movement forward must include sustained funding for the development of durable, cross-system infrastructure and workforce pathways that are based on expansive, expansive, anti-racist, revitalized, liberatory worldviews of IMH history.

Workforce Development includes the education and ongoing development of those who formally and informally support children and caregivers, prenatal to age five. Laying inclusive and revitalized historical groundwork in IMH, while partnering with and honoring the cultural wisdom and practices of communities, will support efforts to recruit, educate, train, and sustain a diversified workforce. The Sankofa Project's efforts to document a re-storying of the history of the IMH field can contribute to supporting and growing the workforce into future generations and creating a more resonant and relevant IMH field for communities and families.

However, inclusion and revitalization only partially address the challenges and barriers to workforce development. Our accounting must acknowledge and address the systemic influence of historical and present-day enactments of power, privilege, marginalization, and oppression within individuals, relationships, and systems, as well as the mechanisms by which these are perpetuated and reproduced. Otherwise, it will be impossible to retain and sustain a diversified IMH workforce. Education and training efforts should align with expansive, revitalized worldviews – including approaches that extend understanding of relational contexts beyond self and other humans, to include earth, flora and fauna, spirit and divinity.

Table 3. Reflective Questions for Revitalizing Practice.

- What can we learn from the families and communities we serve about what 'healing' means to them?
- How can our current service delivery models integrate spirituality, embodied arts, and collective practices of relational wellbeing?
- How can we more keenly understand and interrupt the pathologies of failing systems instead of restricting our identification of dis-ease to individuals, families, and communities?
- How do we understand and repair chasms between rich cultural and Indigenous ways of 'being with' one another and the people we aim to serve, and forces of modernity that engender isolation, commodification, and othering?

Such an expansive accounting invites and revitalizes buried or forgotten routes to healing and wellbeing not destroyed – impossible to destroy – because they live within relationships endogenous and indigenous to every human being. A diversified workforce needs a multitude of culturally rooted pathways to healing within their work, from secondary and vicarious trauma, and from societal and workplace harm and oppression.

Conclusion

It is possible to reach back and access cultural and indigenous routes to healing and wellbeing. It will involve changing not just what we do, but '*how we be*' with one another, communities, families and children. Barbara Holmes inspires us, "*There's a point in our healing journey when we realize it is no longer personal. Our pain, the pain of our ancestry, is the pain of the world, and vice versa. Our healing is for humanity* (2021). It will also involve looking at ourselves and our beloved field more fully and clearly –at both treasured contributions and harms. To be effective, decolonization and revitalization must be an authentic collective effort with commitment to sustained dialogue. We invite YOU, dear reader, to join us in going back, retrieving, studying, and passing on wisdom.

Our first video, *The Sankofa Infant Mental Health History Project, Part One: Land. Root. Seed. Culture. Community*, will be released in the fall of 2025. QR code 2 is a link to its webpage.

References

Baldwin, J. (1965, August). The White Man's Guild. *Ebony*, Vol. XX No. 10, 47.

Baldwin, J. (1989). *Conversations with James Baldwin*. University Press of Mississippi, 156.

Burgess, N.J. (2022) *Why Family Science? Because it shows us how families can thrive*. NCFR website https://www.ncfr.org/about/what-family-science/why-family-science-cossa

Charlot-Swilley, D., Thomas, K., Mondi, C., Willis, D.W., & Condon, M-C. (2024). A Holistic Approach to Early Relational Health: Cultivating Culture, Diversity, and Equity. *International. Journal of Environmental Research & Public Health, 21*(5), 563.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Sage.

Condon, M-C., Charlot-Swilley, D., & Rahman, T. (2022). At the feet of storytellers: Equity in early relational health conversations. *Infant Mental Health Journal,* 1–20.

Ginwright, S.A. (2022). *The four pivots: Reimagining Justice, Reimagining Ourselves*. North Atlantic Books.

Dudgeon (Bardi), P., Milroy (Palyku), H., Selkirk (Noongar), B., Wright (Nunga), A., Regan (Wongi and Noongar), K., Kashyap, S., Agung-Igusti, R., Alexi, J., Bray, A., Chan, J., Chang, E.P., Cheuk, S.W.G., Collova, J., Derry, K. and Gibson (Gamilaraay), C. (2024). Decolonization, Indigenous health research and Indigenous authorship: sharing our teams' principles and practices. *Medical Journal of Australia, 221*: 578-586.

Holmes, B.A. (2021). *Crisis Contemplation: Healing the Wounded Village*.

Irving Harris Foundation. (2028). Diversity-informed Tenets for work with infants, children and families (available in English). Principios Informados en la diversidad para trabajar con bebés, niños, niñas y familias (y en Español) Date accessed: July 13, 2025.

Kendler, K.S., Tabb, K., & Wright, J. (2022). The Emergence of Psychiatry: 1650–1850 *American Journal of Psychiatry* (179).

Labrador, C. (1997). Trees holding hands. Oral Presentation. http://www.integrativescience.ca/Principles/TreesHoldingHands/

Memmi, A. (2016). *The colonizer and the colonized* (H. Greenfeld, Trans.). Souvenir Press.

National Native American Boarding School Healing Coalition (NABS) (2020). *Healing Voices: A Primer on American Indian and Alaska Native Boarding Schools in the U.S. 2nd Edition*. https://boardingschoolhealing.org/education/us-indian-boarding-school-history/

NIH National Genome Project. (2022). *Eugenics and Scientific Racism*. NIH website https://www.genome.gov/about-genomics/fact-sheets/Eugenics-and-Scientific-Racism

Policy Equity Group. (2023). *Thinking bigger to transform Infant and Early Childhood Mental Health*. https://policyequity.com/thinking-bigger-to-transform-infant-and-early-childhood-mental-health/

Saldaña, J. (2021). *The coding manual for qualitative researchers* (4th ed.). SAGE Publications Ltd.

Sanchez, N. (2019). TED Talk: Decolonization is for everyone. https://www.youtube.com/watch?v=QP9x1NnCWNY

Sanchez, N. (2022). TED Talk: Re-thinking who we are through a decolonizing lens: Sisa Quispe. https://www.youtube.com/watch?v=zgdzdV-I3EY

Stige B, Malterud K, Midtgarden T. (2021). Toward an Agenda for Evaluation of Qualitative Research. *Qualitative Health Research*. 2009. 19(10):1504-1516.

Voce, A., Cecco, L., & Michael, C. Cultural genocide: the shameful history of Canada's residential schools – mapped. *The Guardian*. https://www.theguardian.com/world/ng-interactive/2021/sep/06/canada-residential-schools-indigenous-children-cultural-genocide-map

Watanabe, H., & Maharaj, S. (2024). Discovering the meaning of 'Amae' and its use in Infant Mental Health work and Beyond. *Perspectives in IMH. 32* (1).

Rethinking Infant Mental Health Through Proximal Care: Decolonizing Developmental Models of Social Engagement

by Emily E. Little, PhD (United States)

Early relationships with caregivers are the foundation for infant mental health. Yet the study of parent-infant interaction has been almost exclusively shaped by Euro-American caregiving norms emphasizing visual face-to-face interaction, verbal responsiveness, and positive emotional display as core indicators of early relational health. Most tools used in assessment and clinical practice reflect these assumptions. These frameworks represent only a small portion of how infants are raised globally. In many caregiving environments around the world, infants are held close to the caregiver's body, and communication unfolds through movement, breath, posture, and rhythm.

This paper proposes a shift in how infant mental health is conceptualized. Rather than framing variation from face-to-face interaction as divergence or risk, I highlight proximal caregiving (i.e., body-to-body contact through infant carrying, bed-sharing, and long periods of sustained physical contact) as a widespread, developmentally meaningful, and enriching caregiving context. I highlight findings from randomized trials, cross-cultural comparisons, and observational studies to demonstrate how touch-based engagement supports early co-regulation, emotional expression, and caregiver sensitivity.

Much of the current literature on infant social development relies on tools that measure visual and vocal interaction. The Still-Face Paradigm (SFP) is among the most widely used of these tools. It is designed to examine infants' expectations for contingent interaction by assessing their responses to a temporary pause in face-to-face engagement (Tronick et al., 1978). Standard measures include gaze aversion, facial affect, and vocal protest. The pattern observed in urban U.S. samples (i.e., reduced positive affect and increased distress) is often used as a benchmark. However, research in global contexts challenges these conclusions. In a cross-cultural study, Bolivian infants, who were raised in proximal care environments characterized by near-constant physical contact, showed no significant change in behavior during the still-face episode while U.S. and Fijian infants displayed the expected signs of distress (Broesch et al., 2022). These findings suggest that infants develop expectations for social interaction based on their cultural environment. What appears as disengagement through the lens of Western paradigms may instead reflect self-regulation or relational trust.

This is supported by observational data comparing infant-caregiver object exploration in the U.S. and Vanuatu. Caregivers in Vanuatu engaged infants through physical positioning and touch, rather than through pointing or verbal explanation (Little, Carver, & Legare, 2016). The structure of interaction reflected a relational model in which infants learn through physical proximity and shared movement. A follow-up experimental study (Little, Legare, & Carver, 2022) found that U.S. parents randomly assigned to wear their infants in soft carriers were more responsive during interactions than those who used stationary infant seats. Physical contact increased parental sensitivity without requiring changes in instruction or training. In carried positions, caregivers can detect subtle shifts in temperature, breath, or body tone and infants learn through alignment with caregiver rhythms, often appearing calmer and more observant. These patterns have physiological benefits: in a randomized controlled trial, caregivers who received infant carriers were significantly more likely to continue breastfeeding at six months and reported fewer symptoms of postpartum depression (Little et al., 2021: 2023). These outcomes suggest that infant carrying has benefits that extend across the caregiver-infant dyad to shape key health outcomes.

Despite these findings, most clinical assessments remain based in assumptions about eye contact, emotional expressiveness, and vocal interaction. Infants who regulate through quiet body awareness or who express engagement through touch may be labeled as withdrawn or at risk. Moving toward a more inclusive model of infant mental health will require changes in both research and practice including new tools to assess caregiver-infant interaction through physical contact, body orientation, and rhythm. Observational protocols must be expanded to account for the relational cues present in touch-based communication. In clinical settings, infant mental health professionals should be trained to recognize diverse expressions of emotional connection. Interventions that promote infant

carrying and other forms of embodied care should be made accessible and community-driven, especially in health systems that have historically pathologized global majority caregiving practices.

The models and tools that shape infant mental health assessment and promotion are not neutral. They are shaped by the cultural norms from which they emerged. When those norms are assumed to reflect universal development, they exclude the ways infants and caregivers build relationships in the majority of the world's communities. Infant carrying, and the broader set of proximal caregiving practices it reflects, offers a developmental context that is relational, protective, and rooted in deep cultural knowledge. By recognizing these practices as central to healthy development, infant mental health can become more inclusive, accurate, and responsive to the diversity of global human development.

References

Broesch, T., Little, E. E., Carver, L. J., & Legare, C. H. (2022). Still-face redux: Infant responses to a classic and modified still-face paradigm in proximal and distal care cultures. *Infant Behavior and Development, 68*, 101732.

Little, E. E., Legare, C. H., & Carver, L. J. (2019). Culture, carrying, and communication: Beliefs and behavior associated with babywearing. *Infant Behavior and Development, 57*, 101320.

Little, E. E., Bain, L., Hahn-Holbrook, J., & Legare, C. H. (2021). Infant carrier intervention and breastfeeding duration: A randomized controlled trial. *Pediatrics, 147*(6), e2020049717. https://doi.org/10.1542/peds.2020-049717

Little, E. E., Bain, L., & Hahn-Holbrook, J. (2023). Randomized controlled trial to prevent postpartum depressive symptomatology: An infant carrier intervention. *Journal of Affective Disorders, 340*, 871-876.

Little, E. E., Carver, L. J., & Legare, C. H. (2016). Cultural variation in triadic infant–caregiver object exploration. *Child Development, 87*(4), 1130-1145.

Mesman, J., van IJzendoorn, M. H., & Bakermans-Kranenburg, M. J. (2009). The many faces of the Still-Face Paradigm: A review and meta-analysis. *Developmental Review, 29*(2), 120-162.

Tronick, E. Z., Als, H., Adamson, L., Wise, S., & Brazelton, T. B. (1978). The infant's response to entrapment between contradictory messages in face-to-face interaction. *Journal of the American Academy of Child Psychiatry, 17*(1), 1–13. https://doi.org/10.1016/S00

Marram Ngala Ganbu- ('We are one'): A First Nations led, trauma-informed approach to Children's Court hearings for Child Protection Matters on Wurundjeri and Yorta Yorta Country, Australia

by Ashley Morris[1] and Dr. Nicole Milburn[2] (Australia)

[1]Gunditjmara man and former Manager Koori Services and Programs

[2]Private practice

The authors acknowledge the traditional owners of the lands and waters throughout Victoria, and pay our respects to Elders Past and Present.

> 'For First Peoples in Victoria there is an unbroken connection between their experiences with colonial child removal practices and their experiences with the current Victorian Child Protection system. These traumas, historical and contemporary, continue to impact First Peoples families and communities' (Yoorook, 2022).

This paper describes a First Nations led, culturally sensitive, approach to adjudicating matters for First Nations families involved in the Children's Court of Victoria, Australia, where infants are over-represented both compared to non-First Nations families and older First Nations children. The approach has been implemented in 2 regions, one metropolitan and one regional, and has made a substantial difference for families involved in the current system. Nonetheless, learnings have been that decolonising from within the colonial system has, by definition, been limited and a new, First Nations led, system needs to be developed.

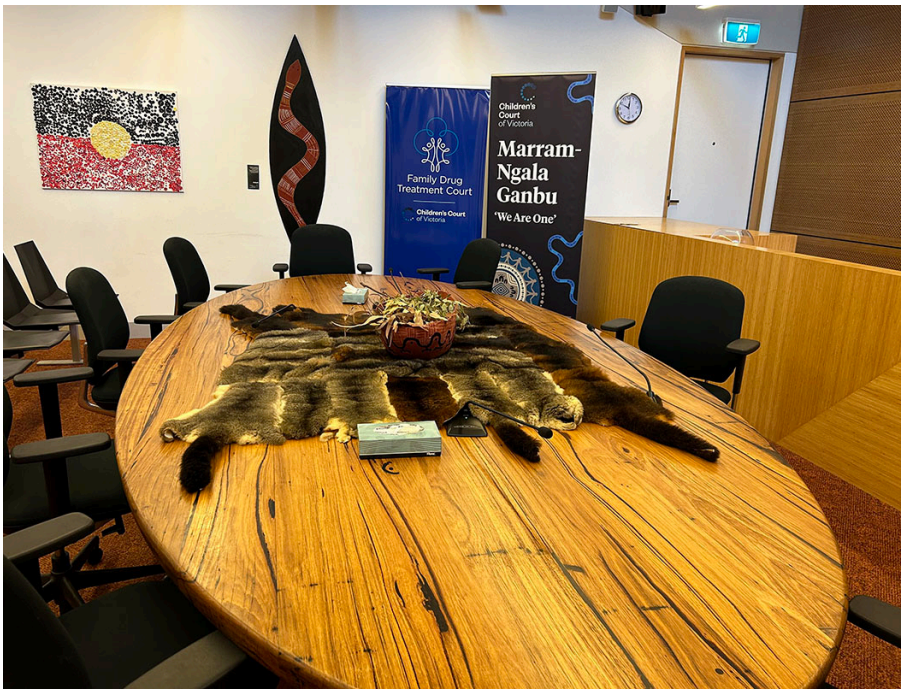

Photo: Bar Table covered by a possum skin cloak made by the local Aboriginal community. Credit: Nicole Milburn

At 30 June 2022, when compared to non-Aboriginal children, Aboriginal children in Victoria were:

- 5.7 times as likely to have a report made to Child Protection
- 7.6 times as likely to have a finalised investigation by Child Protection Services
- 8.5 times as likely to be found 'in need of protection' by Child Protection Services
- 27.7 times as likely to be in out of home care (Yoorook, 2022).

Decisions about the protection of children are made in the colonial adversarial system of law.

First Nations people in Victoria called for the development of a specialist Koori Hearing Day in the family division of Children's Court that is conducted as a solution focused, family led approach, embedded in culture. Their calls resulted in a pilot program that was established in 2016.

Marram Ngala Ganbu (MNG) is a Woiwurrung word for 'we are one', given to the program by the local traditional owners. When applied to Protection matters it calls to mind Winnicott's

Photo: Coolamon filled with leaves, crafted by a young person in care. The Coolamon is a symbol of care and nurturing. Credit: Nicole Milburn

phrase of 'there is no such thing as a baby' (1960), immediately addressing how impossible it is to put babies and toddlers against parents in an adversarial system.

Most aspects of the proceedings have been adjusted to be inclusive and respectful of Aboriginal families' kinship and culture, within the confines of the Child Youth and Families Act (2005). Some key aspects are described below.

In MNG the hierarchy of magistrate on the bench, lawyers at the bar table and family in the gallery has been removed. All parties including family, extended family, elders and support services sit at an oval bar table to have a conversation with the Magistrate. The conversation happens between the magistrate, family and Child Protection with help from the lawyers.

The bar table itself (see image) is embedded in culture. It is covered by an enormous possum skin cloak made by the local Aboriginal community that people hold, particularly when stressed. In the centre is a coolamon filled with leaves. The coolamon, crafted by a young person in care, is a symbol of care and nurturing, and traditionally carried life-giving water as well as babies themselves. All eyes are drawn to the coolamon in the centre of the table, reminding of the focus on the baby.

Key team members ensure there is enough time for each family and are responsible for building relationships with service providers and communities, opening the door to say this is the safe place to come and do the business we need to do. Historically, for Aboriginal people, courts were a place where you have your children removed or go to jail. The team's difficult task is to break down these barriers.

There is direct support throughout, such as making sure families know who the lawyers are and what their role is; when their Court hearing day is; what to expect on that day; where to sit, walk; and to make a cup of tea and have a debrief. Where appropriate, families are contacted months before the hearing day to lower the anxiety that comes with going to court for Aboriginal families.

A Child Protection Practice Leader mirrors the role with the family for the Department; for example, making sure actions from the court hearing are followed up. This ensures things progress within the 12–24-month timeframe for reunification or permanency required under the Act in Victoria (2005; revision 2016). It's very difficult for Aboriginal families to wipe 230 years of colonization in 12 months, so there is much focus on supporting progress.

One magistrate follows the life of the case, which means there is nowhere to hide in terms of accountability for the families, service providers, and Child Protection.

Outcomes have been more Aboriginal children staying with family, and greater culturally sensitive therapeutic jurisprudence throughout the Children's Court (Arabena et al, 2019).

Key learnings from MNG have been that to truly decolonise, band-aid fixes in colonial systems need to give way to large-scale transformation. Victoria is embarking on a Treaty between the First Nations and the Victorian Government, which, combined with the findings from the Yoorook Truth and Justice Commission (2022), are paving the way for a First Nations led practice.

References

AIHW (2025). *Child Protection in Australia*. https://www.aihw.gov.au/reports-data/health-welfare-services/child-protection/data

Arabena, K., Bunston, W., Campbell, D., Eccles, K., Hume, D., & King, S. (2019), *Evaluation of Marram-Ngala Ganbu*, prepared for the Children's Court of Victoria. https://www.socialventures.org.au/wp-content/uploads/2024/10/Evaluation-of-Marram-Ngala-Ganbu-November_SVA-Consulting.pdf

Children, Youth and Families Act 2005 (Vic)

Winnicott, D.W. (1960). The Theory of the Parent-Infant Relationship. *International Journal of Psycho-Analysis, 41*, pp. 585-595.

Yoorook (2022). https://www.yoorrook.org.au/focus-areas/child-protection

Honouring the voices of First Nations minya ones and their families through Wakwakurnaku Kumangka Pudnanthi family support group

By Geneva Foster (Badhu Island, Zenadth Kes), Jasmin Cockatoo-Collins (Yupungyathi, Gangallida, Kuku Yalangi, Goa), and Bec Turner (non-Indigenous) (Australia)

Terms from our First Nations languages and/or Australian Aboriginal-English have been intentionally used as a decolonising practice in representing the Cultural language that we use in honouring the diversity of First Nations Cultures in our work.

Nunkuwarrin Yunti of South Australia is an Aboriginal community-controlled health organisation (ACCHO) based on the traditional lands of the Kaurna people of the Adelaide Plains, providing culturally safe, health and community services to First Nations people across South Australia. Through our Strengthening Early Years (SEY) team, staff aim to increase the self-efficacy and self-determination of First Nations families to better support their minya[1] one's in the first 1000 days (Australian Human Rights Commission, 2023). This is achieved through ensuring transparency with the families, including them in all decision-making, and adapting our approaches to create culturally safe spaces.

The SEY team have developed a voluntary family support group model that is complimentary to other Nunkuwarrin Yunti perinatal services, and co-created resources that are informed by the lived experiences of families who attend the group. This work was undertaken in collaboration with project partners, local Aboriginal cultural consultant Dana Shen and Emerging Minds. The co–created resources are informed by the Replanting the Birthing Trees online resources for practitioners working with First Nations families and minya ones from pregnancy up to 5 years old. These resources include a 'Welcoming Our Little Ones' booklet and 'Letter from your corka[2] bub [3,4].

The families who attend the support group chose the Kaurna name Wakwakurnaku Kumangka Pudnanthi (WKP) which translates to *Children's Gathering Place*. The families felt that this best reflected what the group means for their minya ones, themselves and other significant family members within their cultural kinship structures. This includes extended family members who are equivalent to immediate family including siblings, Aunties, Uncles[5], nieces, nephews and grandparents.

The weekly routine of WKP is continuously shaped by the families who attend the group. The key focus is to provide an environment in which they can freely use their own culturally informed parenting practices, or in some cases explore what this may look like for the first time with their families. WKP is about providing a safe and nurturing space where families can come together and connect with their bubs in a meaningful way and honour traditional First Nations child rearing practices, whilst feeling free to be able to parent without judgement (SNAICC, 2011).

All aspects of WKP have a cultural lens that honours First Nations identities, belonging, and ways of learning and passing down knowledge. Our yarning circle, Acknowledgement to Country sung with the minya ones, 'mob mapping'[6], singing in First Nation's languages, and our Corka Connections through minya massage routine, all help the families and bubs to identify and learn where they fit within their own cultural identity and the wider world. It also allows space to share stories and pass on knowledge to one another. By having the opportunity to explore traditional First Nations practices such as bush rub making, smoking ceremonies and cooking with traditional ingredients, families and minya ones feel connected and learn why First Nations cultural practices are important.

Even though WKP embeds evidence-based practices such as Marte Meo (Marte Meo, 2025), Cue-based infant massage (Emerging Minds, 2023), and Circle of Security (Circle of Security, 2025), being recognised as 'Aunties' by the families, as well as practitioners, enables us to share special moments as they happen in an more connected way. Families have reflected how they feel more connected with their culture due to simple things, such as being able to decide what they eat as well as bringing other family members to the group. Families are naturally encouraged to keep the minya ones in the forefront of their minds, and to understand that their bub is engaged in continuous learning and that the ways that families respond are key to helping build and shape their developing brain. Through the incorporation of educational topics based on the families' input, families are empowered to understand age-appropriate contextual information that supports their minya one's health

[1] little
[2] beautiful
[3] referring to someone younger than you
[4] Inspired by AAIMH *'Letter from your baby'*
[5] Titles are intentionally capitalised as an act of respect within First Nations' Cultural contexts e.g. Aunty, Uncle, or Elder
[6] Identifying which Country people belong to on the Indigenous map of Australia

and development, as well as making decisions and life choices that align with their families' values and visions for their futures.

The learning made throughout WKP's journey has highlighted to need for a number of team roles, including a Coordinator, a Child Health Nurse, and importantly a unique Elder or 'Aunty' position that supports the families' cultural exposure and understandings. It has also led to the development of a toolkit to help inform and guide practitioners seeking to decolonise their practice and honour minya ones and their families' voices in the delivery services for First Nations families.

References

Australian Human Rights Commission. (2023). *Self-determination and Indigenous peoples*. https://humanrights.gov.au/our-work/aboriginal-and-torres-strait-islander-social-justice/self-determination-and-indigenous

Ashton, A., Hawting, J., & Harrison, J. (2011). *Growing up our way*. SNAICC.

Marte Meo. (2025). *About Marte Meo*. https://www.martemeo.com/en/about-marte-meo/

Rolbusch, N. (Host). (2023, June 2023). Using cue-based infant massage to support infant mental health [Audio podcast episode]. In Emerging Minds. https://emergingminds.com.au/podcasts/using-cue-based-infant-massage-to-support-infant-mental-health/

Circle of Security. (2025). *What is The Circle of Security*. https://www.circleofsecurityinternational.com/pages/what-is-the-circle-of-security

Decolonizing Infant and Early Childhood Mental Health Consultation Professional Development

By Evandra Catherine, Jordyn Mulitauopele, Deborah F. Perry, Lauren Rabinovitz, Lisa Hepburn, and Neal Horen (United States)

Introduction

Decolonizing infant and early childhood mental health consultation (IECMHC) professional development (PD) requires rethinking how we conceptualize, train, and support consultants in the field. A decolonized approach recognizes that mainstream models of IECMHC PD often fail to fully account for the lived experiences of historically marginalized communities. This gap reinforces Western cultural norms and overlooks the historical and political forces shaping the well-being of Black, Indigenous, and other marginalized children and families. PD is central to decolonization, as it creates spaces where consultants are supported in deep self-reflection, encouraged to challenge assumptions, and provided opportunities to practice.

While this paper focuses primarily on decolonizing PD in the U.S. context, we acknowledge the importance of expanding these insights to a global context. Reflective practice models, especially those rooted in Western frameworks, may not align with the relational norms, communal values, or historical realities of other cultural settings (Killian, 2018; Westerberg, 2016). For decolonization to be meaningful globally, efforts must be guided by local communities and culturally grounded epistemologies. In some countries, this may mean embedding IECMHC within collective caregiving systems or aligning consultation with spiritual and ancestral traditions of well-being.

In the United States, decolonizing PD and reflective practice are particularly urgent. Persistent racial inequities in early childhood systems, such as higher rates of expulsion and exclusionary discipline for Black children, reflect the lasting impacts of systemic racism and bias. Despite growing calls for equity, traditional PD models have often failed to equip early childhood professionals with the skills needed to critically examine and disrupt these patterns.

Consequently, there is a pressing need for approaches that center relational practices, historical awareness, and critical self-reflection. Decolonizing IECMHC PD is not only an idea but a necessary approach to transform the relationships and systems that affect marginalized children and families.

The purpose of this paper is to present research findings that informed the development of PD framework for anti-bias IECMHC (COE, 2025a), along with an accompanying resource outlining five essential elements (COE, 2025b) necessary for consultants to engage in and embody anti-bias IECMHC practice. The framework emphasizes the critical role of the trainer in fostering deep reflection among consultants and creating opportunities for them to practice navigating difficult conversations. As trainers engage in this work with consultants, a parallel process is set in motion: consultants embody these practices with their own consultees. Through the parallel process (Figure 2), consultants create IECMHC experiences that offer consultees opportunities for reflection and practice, ultimately strengthening their capacity for anti-bias practice and enhancing their reflective functioning. Parallel process refers to the idea that experiences in one relationship can be transmitted to, and shape, interactions in other relationships (Heller & Gilerson, 2009; Parlakian, 2002). The framework also emphasizes the need for PD environments where relationship-building and emotional safety are prioritized to foster optimal growth. These opportunities are best supported within professional learning communities, such as Communities of Practice (CoPs), reflective supervision (individual and group formats), and ECHOs (Project Extensions for Community Healthcare Outcomes) that bring consultants together for ongoing, connected learning. Therefore, the next section reviews the growing evidence supporting IECMHC as a promising strategy to disrupt bias in early care and learning settings for marginalized children and families.

Evidence Positioning IECMHC as an Anti-Bias Approach

Over the past two decades, research consistently demonstrates that IECMHC disrupts bias, improves child outcomes like social-emotional development and teacher-child interactions, and reduces exclusionary disciplinary practices disproportionately impacting Black and Brown children (Fabes, Quick, et al., 2020; Gilliam, 2005; Silver et al., 2023). More recently, racial equity scholarship has positioned IECMHC as an anti-bias approach in early childhood education (ECE) and other child-serving systems.

Researchers such as Eva Marie Shivers and Annie Davis-Schoch have significantly contributed to this field. Their studies show that IECMHC

disrupts implicit bias, reduces racial disparities in discipline, and strengthens teacher–child relationships (Davis, Shivers, & Perry, 2021, 2022). Gilliam and colleagues (2016) found that educators watched Black boys more closely when anticipating misbehavior, even when none occurred. Building on this, Davis and colleagues (2022) introduced a framework (Figure 1) illustrating how consultants disrupt bias through reflective questions, creating holding environments, addressing race and gender, cultivating cultural awareness, and exploring context. Shivers et al. (2021) further showed that racial bias contributes to teachers' perceptions of conflict with Black boys, even before consultation begins, underscoring the need for PD that promotes deep conversations about race, bias, and systemic inequities.

Beyond child outcomes, research has clarified the mechanisms driving change. The Center of Excellence for IECMHC's Theory of Change (COE, 2021) highlights the importance of a strong, culturally responsive consultative alliance (CA), reflective supervision, and engagement with core consultation activities. Davis et al. (2018) found that the CA is strengthened when consultants bring expertise in cultural diversity or share racial/ethnic backgrounds with consultees. A strong cultural lens not only fosters better relationships but also disrupts bias, particularly for boys of color.

Building on this, Davis and colleagues (2022) emphasize that culturally responsive, reflective relationships are essential levers for advancing equity in IECMHC. Reflective supervision supports consultants in developing anti-bias

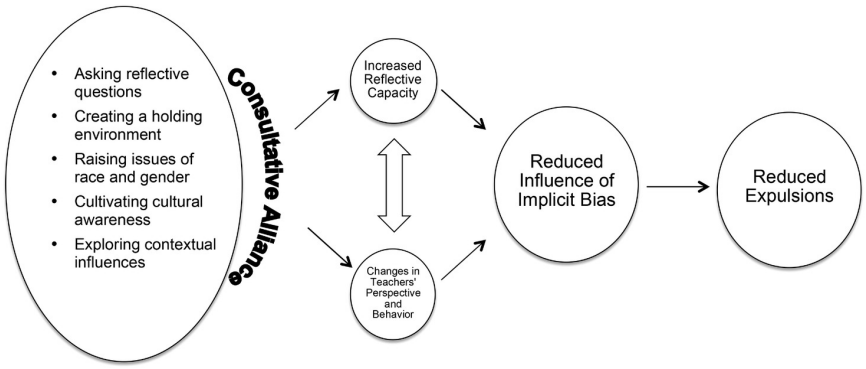

Figure 1. Expulsion prevention: Framework for the role of infant and early childhood mental health consultation in addressing implicit biases (Davis, A. E., Perry, D. F., & Rabinovitz, L., 2020).

practices, underscoring the need for professional development that explicitly addresses issues of race, culture, and gender. Consultants consistently report that equity-centered PD and reflective supervision are critical in preparing them to navigate the complexities of anti-bias work (Catherine, Davis-Schoch, Rand, & Perry, 2023; Catherine, 2024). However, implementing reflective supervision in developing contexts presents unique challenges, including limited time, inadequate resources, and a shortage of trained facilitators. Additionally, cultural norms, stigma surrounding mental health, and hierarchical organizational structures may hinder open reflection and emotional vulnerability. To be effective, reflective models must be adapted to reflect local values, relational norms, and systemic realities (Killian, 2018).

Given IECMHC's demonstrated potential to interrupt systemic bias, PD systems must move beyond traditional technical training. A transformative approach must incorporate decolonizing processes: shifting beliefs, exploring positionality, supporting critical reflection on equity, and building capacity for courageous conversations about race and oppression (COE, 2025b). Centering these elements is essential for preparing consultants to foster equitable outcomes for marginalized children and families. The next sections describe the five essential PD elements needed to build strong anti-bias practice and propose a framework to achieve them.

Toward Anti-Bias Consultation: Essential Elements and Framework

To fully realize IECMHC's potential as a disruptor of bias, consultants must be intentionally prepared through PD grounded in racial equity and decolonizing practices. As the field has evolved to more diverse populations, such as families in home visiting, pediatric, and childcare settings, PD must move beyond passive

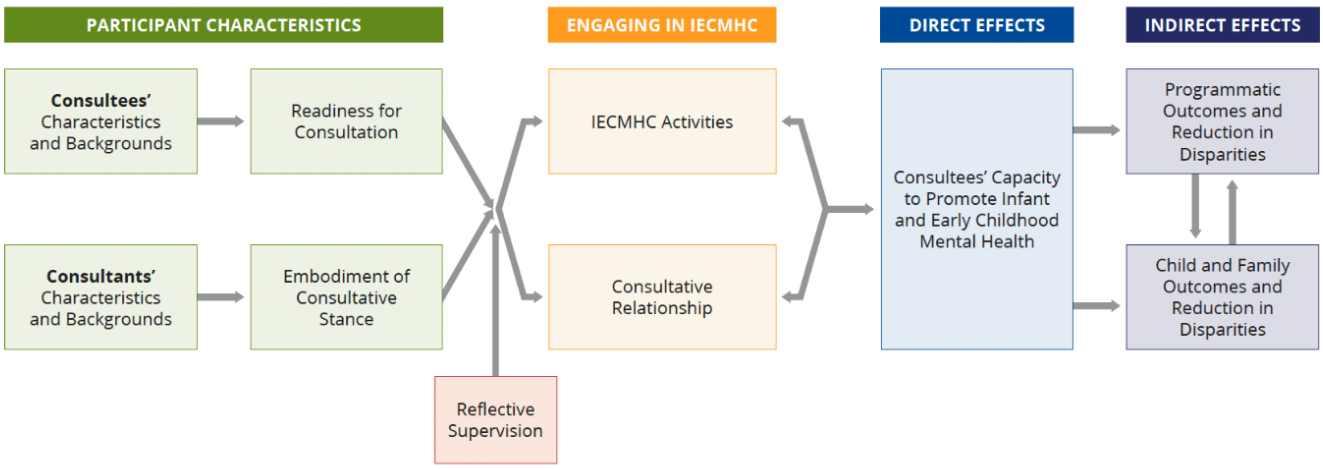

Figure 2. Center of Excellence for Infant & Early Childhood Mental Health Consultation's Theory of Change for Infant and Early Childhood Mental Health Consultation (Center of Excellence for Infant and Early Childhood Mental Health Consultation, 2021).

acknowledgment of diversity. It must actively confront bias and structural inequities by equipping consultants to recognize, name, and address how racialized experiences shape IECMHC outcomes. This work requires PD systems to create intentional spaces where consultants engage in ongoing reflection, challenge Western assumptions about child development and caregiving, and practice difficult conversations about racism and bias. Research confirms that effective PD is not simply about transferring knowledge; it must foster critical consciousness, cultural responsiveness, and relational, contextual thinking (Hardy & Bobes, 2017).

However, not all consultants experience PD equitably. Black and Latino consultants report feeling less comfortable than their White peers in raising race and culture concerns in supervision (Shivers, Janssen, et al., 2022). Additionally, consultants of color often prioritize training grounded in non-dominant knowledge systems, which is frequently undervalued by White consultants (Shivers, Janssen, et al., 2022). These disparities highlight the need for PD to not only acknowledge racial differences but actively respond to them by diversifying content and methods. To move from acknowledgment to dismantling inequities, PD must center decolonizing practices. This requires more than content revisions; it demands a fundamental reshaping of how consultants are trained to recognize, challenge, and dismantle inequitable systems. Achieving this requires grounding PD in five essential elements, developed through semi-structured interviews with key equity informants in IECMHC research, evaluation, technical assistance, training, and PD. These Five Essential Elements (COE, 2025b) offer a roadmap for embedding decolonization into PD, equipping IECMHC consultants to advance equity both in mindset and practice. When integrated, these elements cultivate a culturally responsive workforce committed to equity and justice for all families.

Five Essential Elements for PD

1. **Shifting Beliefs and Thinking**: Encouraging continuous learning and unlearning by engaging with perspectives traditionally excluded from IECMHC training.
2. **Exploring Positionality**: Fostering self-awareness of how consultants' identities, privileges, and biases shape their work.
3. **Reflecting on Equity Topics**: Providing structured opportunities to deepen understanding of systemic barriers impacting Black, Indigenous, and other families of color.
4. **Practicing Difficult Conversations**: Creating safe yet courageous spaces to navigate conversations about racism, discrimination, and bias with cultural humility.
5. **Embodying Anti-Bias Practice**: Moving from theory to tangible action, ensuring policies and interventions dismantle rather than perpetuate harm.

For consultants to develop the skills necessary to produce positive outcomes for marginalized families, PD systems must embed the five essential elements (COE, 2025b). Embedding these elements allows consultants to continuously reflect on dominant norms and their influence on bias and practice. Therefore, it is crucial that PD systems are grounded in the parallel process and recognize the trainer's critical role in modeling anti-bias practices that consultants can embody with their consultees.

PD Framework: Building Learning Communities

This section will describe a PD framework based on a qualitative study with 16 IECMHCs from a southwestern state. Participants were purposefully selected from a program focused on addressing race, equity, and bias in training. The sample included consultants with 1 to 10+ years of experience, and diverse racial and ethnic backgrounds, including White, Hispanic, Native American, and Asian participants, with a majority holding a Master's degree and an average age of 39.

Findings from the study highlighted critical features for PD systems that support anti-bias consultation. Consultants emphasized the need for time to build trust and psychological safety within these environments. When consultants feel safe and comfortable, they are more likely to internalize anti-bias principles and apply them through the parallel process with their consultees, ultimately fostering equitable outcomes for young children and families. Participants also stressed the importance of equity-focused anti-bias PD occurring within relationship-focused and content-based models, such as Communities of Practice, Professional Learning Communities, and ECHOs. These settings allow consultants to engage with difficult topics in a supportive, safe environment, in contrast to traditional one-time trainings. Finally, consultants noted the necessity of opportunities for deep reflection and practice in navigating challenging conversations within these safe communities, leading to embodying anti-bias practice.

Based on these findings, the author, in collaboration with Georgetown's Center of Excellence for Infant and Early Childhood Mental Health Consultation, co-developed a Professional Development Framework for Promoting Anti-bias Practice (COE, 2025a). This framework challenges dominant Western models that have historically shaped the field and addresses the need to recognize and dismantle the impacts of racism, anti-Blackness, and systemic inequities within IECMH. The framework

Figure 3. Professional development framework for promoting anti-bias practice (Center of Excellence for Infant and Early Childhood Mental Health Consultation, 2025).

(Figure 3) illustrates the relationship between the trainer, the IECMH consultant, and the IECMH consultee through a visual diagram of three overlapping circles, each representing one role, with arrows showing the flow of interaction and learning between them. The left circle, labeled "Trainer," highlights the importance of "Relationship-Focused and Content-Based PD," reflecting consultants' expressed need for ongoing learning opportunities rather than isolated, one-time trainings. Arrows connect the Trainer to the IECMH Consultant (center circle), showing that the trainer provides opportunities to practice anti-bias strategies and to engage in deep reflection, leading to increased reflective functioning. In turn, the IECMH Consultant applies these same approaches with their consultees (right circle). Arrows forming a continuous loop among the circles illustrate the parallel process at the heart of PD (COE, 2025a).

Discussion

In the United States, children of color—particularly Black, Indigenous, and Latino children and boys across racial groups face systemic inequities in early childhood settings, including disproportionate rates of expulsion, harsher discipline, and fewer opportunities for positive developmental support (Gilliam, 2005; U.S. Department of Education, 2016). IECMHC has emerged as a promising strategy to address these disparities by strengthening adults' capacity to create equitable, culturally responsive environments. Research shows that IECMHC improves both child and adult outcomes and helps disrupt implicit bias, leading to reductions in exclusionary practices and stronger caregiver-child relationships (Duran et al., 2009).

However, for IECMHC to sustain these gains, a fundamental shift in PD is needed. Traditional PD models in the U.S. often emphasize technical skills or surface-level cultural competency, while overlooking the deeper work of addressing systemic power dynamics, privilege, and internalized bias. Decolonizing IECMHC PD requires intentionally designed learning environments where consultants are supported to critically reflect on their beliefs, positionality, and biases, and are equipped to challenge inequities at both personal and systemic levels. Globally, these efforts must also contend with distinct challenges. Barriers to implementing reflective practice across international contexts include limited time, insufficiently trained facilitators, organizational resistance, and cultural factors such as mental health stigma, language differences, and differing expectations of psychological support (Killian, 2018; Westerberg, 2016). These realities underscore the need to adapt reflective models to local relational norms and community-led frameworks, rather than Western models. Reflective capacity remains central to this work. Consultants must be supported to navigate discomfort, engage in deep self-reflection, and build the skills necessary to confront issues of race, power, and oppression in contextually responsive ways (Stroud, 2012). Moving forward, PD systems must be both content-rich and relationship-focused to prepare consultants for the complex, transformative work that authentic equity demands.

The qualitative study was approved by Arizona State University Institutional Review Board (IRB). Approval number: STUDY00014679. Approved 02/28/2022.

References

Brennan, E. M., Bradley, J. R., Allen, M. D., & Perry, D. F. (2008). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. *Early Education and Development, 19*(6), 982–1022. https://doi.org/10.1080/10409280801975834

Catherine, E. (2024). *Advancing anti-bias practice through infant and early childhood mental health consultation*. SRCD Anti-Racist Developmental Science Summit. Panama City, Panama.

Catherine, E., Davis Schoch, A., Rand, J., & Perry, D. (2023). *Promoting anti-racist practices in infant and early childhood mental health consultation.* Society for Research in Child Development (SRCD). Salt Lake City, Utah.

Center of Excellence for Infant and Early Childhood Mental Health Consultation. (2022). *Status of the evidence for infant and early childhood mental health consultation (IECMHC)*. https://www.iecmhc.org/documents/CoE-Evidence-Synthesis.pdf

Center of Excellence for Infant and Early Childhood Mental Health Consultation. (2025) *Professional development framework for promoting anti-bias consultation*. https://www.iecmhc.org/wp-content/uploads/2025/04/CoE_PDSuite_FrameworkDocument_FNL-508-2.pdf

Center of Excellence for Infant and Early Childhood Mental Health Consultation. (2025). *5 essential elements of effective anti-bias professional development for mental health consultants*. https://www.iecmhc.org/wp-content/uploads/2025/04/CoE_PDSuite_Checklist_FNL2-508.pdf

Center of Excellence for Infant and Early Childhood Mental Health Consultation (2021). *Theory of change for infant and early childhood mental health consultation*. https://www.iecmhc.org/documents/CoE-Theory-of-Change-Descriptions.pdf

Davis, A. E., Perry, D. F., & O'Kane, M. (2022). Expulsion prevention: Framework for the role of infant and early childhood mental health consultation in addressing implicit bias. *Infants & Young Children, 35*(2), 122–138.

Davis, A. E., Barrueco, S., & Perry, D. F. (2021). The role of consultative alliance in infant and early childhood mental health consultation: Child, teacher, and classroom outcomes. *Infant Mental Health Journal, 42*(2), 246-262

Davis, A. E., Shivers, E. M., & Perry, D. F. (2018). Exploring culture, race, and ethnicity in early childhood mental health consultation: The role of the consultative alliance. *Perspectives, 3*(2), 24.

Downer, J. T., Maier, M. F., & Witherspoon, D. P. (2020). Teacher-child racial/ethnic match within pre-kindergarten classrooms and children's early learning: Exploring variation across racial/ethnic groups. *Early Childhood Research Quarterly, 52*, 74–84.

Duran, F., Hepburn, K., Irvine, M., Kaufmann, R., Anthony, B., Horen, N., & Perry, D. (2009). *What works? A study of effective early childhood mental health consultation programs*. Georgetown University Center for Child and Human Development.

Fabes, R.A., Quick, M., Musgrave, A., Meek, S., & Catherine, E., (2020). Exclusionary discipline in U.S. public pre-K programs: An initial look at the 2017-2018 CRDC data. *The Preschool (and Beyond) Exclusionary Discipline Project: Research Brief (Issue 1)*. Tempe, AZ: Arizona State University

Gilliam, W. S., Maupin, A. N., Reyes, C. R., Accavitti, M., & Shic, F. (2016). Do early educators' implicit biases regarding sex and race relate to behavior expectations and recommendations of preschool expulsions and suspensions. *Yale University Child Study Center, 9*(28), 1-16.

Gilliam, W. S. (2005). *Prekindergarteners left behind: Expulsion rates in state prekindergarten systems*. Foundation for Child Development.

Hardy, K. V., & Bobes, T. (Eds.). (2017). *Promoting cultural sensitivity in supervision: A manual for practitioners*. Taylor & Francis.

Heller, S. S., & Gilkerson, L. (Eds.). (2009). *A practical guide to reflective supervision.*

Killian, B. (2018). The challenges of reflective supervision in developing contexts. *Infant Mental Health Journal, 39*(1), 37–46

Meek, S. E., & Gilliam, W. S. (2016). *Expulsion and suspension in early education as matters of social justice and health equity*. NAM Perspectives.

Perry, D. F., Allen, M. D., Brennan, E. M., & Bradley, J. R. (2010). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing child outcomes. *Early Education and Development, 21*(6), 795–824.

Parlakian, R. (2002). *Reflective supervision in practice: Stories from the field*. Zero to Three Center for Program Excellence.

Shivers, E. M., Janssen, J. A., Subramaniam, A., Parker, A. L., Noroña, C. R., Lara, C., Best, D., Yazzie, D. A., Cimino, J., Kohchi, J., Fitzgibbons, S. (2022). *Digging Deeper: De-Colonizing Our Understanding and Practice of Reflective Supervision Through a Racial Equity Lens: First-Wave Findings*. Prepared by Indigo Cultural Center for the Alliance for the Advancement of Infant Mental Health. With funding from Perigee Fund.

Shivers, E. M., Faragó, F., & Gal-Szabo, D. E. (2022). The role of infant and early childhood mental health consultation in reducing racial and gender relational and discipline disparities between Black and white preschoolers. *Psychology in the Schools, 59*(10), 1965-1983.

Silver, H. C., Davis Schoch, A. E., Loomis, A. M., Park, C. E., & Zinsser, K. M. (2023). Updating the evidence: A systematic review of a decade of Infant and Early Childhood Mental Health Consultation (IECMHC) research. *Infant Mental Health Journal, 44*(1), 5-26.

Stroud, B. D. (2012). *Intentional living: Finding meaning through reflective practice*. ZERO TO THREE.

Westerberg, D. (2016). Reflective supervision across cultures: Challenges and lessons learned. *ZERO TO THREE Journal, 36*(3), 19–25.

Relational Principles for Collective Wellbeing: Multigenerational Indigenous Frameworks Informing Infant Mental Health Revitalization

By Dominique Charlot-Swilley[1]*, Marie-Celeste Condon[2], Arla Little Victory[3], Hoda Shawky[4], Sarah Barclay Hoffman[5], and Yanique Edmond[6] (United States)

[1]Department of Pediatrics, Georgetown University School of Medicine

[2]Independent Reflective Consultant

[3]Taratibu Youth Association, Inc.

[4]Noorture, LLC

[5]Children's National Hospital

[6]University of Maryland Global Campus

*Corresponding Author: dc1203@georgetown.edu

Key Words: Revitalization, Community Health Workers, Community Doulas, Ubuntu, Lakou, Etuaptmumk

Abstract

The enduring legacy of colonization continues to shape the field of Infant Mental Health (IMH), and professional development (Pro-D) spaces. Conventional approaches often prioritize individualization while neglecting the relational and communal contexts fundamental to wellness and thriving. This article advances revitalization: a deliberate return to relationship-based frameworks that nurture collective wellbeing across lifespans. Weaving Ubuntu, Lakou, and Etuaptmumk into IMH Pro-D offerings is a step towards revitalizing the field. Three exemplars Ubuntu, Lakou and Etuaptmumk, illustrate how revitalization creates possibilities for transformative relationships between professionals and those they serve.

Introduction

The legacy of colonization continues to shape professional development (Pro-D) in the field of Infant Mental Health (IMH). Historically, there has been a strong emphasis on evaluating, problematizing, stigmatizing, and treating individuals rather than addressing the broader relational contexts that support wellness. Colonization can narrow our understanding of health; reinforce deficit-based narratives; and isolate individuals from collective sources of healing that many cultures have long recognized. Revitalization can disrupt this pattern. Revitalization is a deliberate return to communal, relationship-based ways of knowing and being. We explore how Indigenous frameworks such as Ubuntu, Lakou, and Etuaptmumk offer pathways to more expansive IMH Pro-D. By grounding our practices in revitalization, we begin restoring relational ecosystems that foster thriving for children, families, and communities (Bundick et al., 2010). We take a multigenerational perspective, recognizing that a vision of nurturing wellbeing from pregnancy across the entire arc of life serves children and families best.

Reimagining professional development: Revitalization rooted in relational frameworks

Ubuntu, a Bantu African philosophy, "*I am because we are*," and "*a person is a person through other persons*" emphasizes interdependence (Ngomane, 2014). Ubuntu teaches that children belong not just to their parents but to the entire community. This creates a shared responsibility for nurturing, where multiple adults contribute to a child's development through collective caregiving practices. Within Ubuntu-inspired communities, children learn relational skills through immersion in multigenerational interactions. Early development is not a series of individual milestones to be achieved, but a process of becoming integrated into collective care and responsibility.

Lakou is a communal living system found in the rural provinces of Haiti. Historically, the term "Lakou" refers to clusters of homes where families of African descent reside, embodying an extended family structure that is prominent in Haitian and other Caribbean and African cultures (Edmond et al, 2007). Members of a Lakou work cooperatively to support one another financially and in other ways (LaRose, 1975). Raising children is viewed as a collective responsibility, where children and mothers benefit from interacting with a broad network of people who share wisdom, responsibilities, and resources (Ambert,1994). Lakou enables Haitian mothers to fulfill traditional roles, while emulating successful parenting models. Every member of the community contributes to children's care and development. Within the Lakou, children are valuable assets. Each child's success contributes to the Lakou's wellbeing. Research indicates that as children age, they fulfill additional

supportive roles by caring for younger siblings and connecting families, clans and villages with the larger community (Cayemittes et al,1995; Institut Haitien, 1989; Vimard, et al, 1991).

The deeply embedded roles children play in collectivist systems, which extend beyond those of children in nuclear families, align with broader relational values and worldviews of their culture. Ubuntu and Lakou recognize the centrality of relational networks in shaping collective wellbeing across the lifespan. By centering community-based, relational approaches to nurturing, both challenge the reductionist, individual-centered approach evident in Western frameworks, where IMH is often addressed separately from social and cultural contexts.

Etuaptmumk, (Two-Eyed Seeing) and its corollary, Trees Holding Hands, are guiding principles (IISH website, 2025) that Mi'kmaq First Nations Elders in Northeastern North America embody and teach through stories beginning when children are very young (Marshall et al., 2023; Iwama et al., 2009; Labrador, 1997). Children and youth learn to practice mindful noticing, cultivate mutual respect, and recognize the existence of different worldviews. They learn to recognize and respectfully integrate strengths from different ways of knowing for the good of all. Etuaptmumk-inspired pedagogies help researchers, educators, and therapists unlearn white supremacy; pivot towards non-judgmental witnessing (Ginwright, 2022); and, how to reverse colonist-colonized power dynamics in relationships with one another, families and communities (David, 2024). Etuaptmumk is a path forward for those who aspire to implementing The Tenets (Irving Harris Foundation, 2012) and advocate for revitalization, and healing justice (Chang & Bryant, 2024; Charlot-Swilley et al., 2024). Mi'kmaw Spiritual Leader, Healer and Chief, Charles Labrador of Acadia First Nation, encouraged his people to believe in people:

> "It's not we and them. It's us. Trees hold hands. We as people need to do the same. [Then], walking forward together in good ways, we can share knowledge that has been conditioned by mutual respect." (IISH website)

Ubuntu, Lakou, and Etuaptmumk represent holistic frameworks for emotional, social and relational wellbeing that are cherished by Indigenous cultures around the world. These pedagogies foster community-centered care by emphasizing interdependence and cultural relevance. Revitalizing IMH Pro-D must involve revising curricula to integrate Indigenous knowledge and multigenerational perspectives that augment professionals' capacity for self-reflection, cultural humility, and compassionate curiosity. It's not the family's responsibility to adapt to oppressive systems; but rather the professionals' responsibility to practice radical listening; yield power; adapt to and honor the family's culture and expertise. IMH Pro-D efforts are called to advance equity, inclusion, restorative justice, and healing. To meet this call, professionals committed to revitalizing systems and practices can be guided by three core principles that promote healing, social change, and thriving.

Community-Rooted Healing and Wellness utilizes culturally specific modalities —movement, music, ritual, and storytelling— to develop emotional expression, self-regulation, and interpersonal connection. These practices serve as vital pathways for transmitting values, reinforcing belonging, and fostering thriving through shared experience —principles deeply relevant to community bonds and early relational health. When integrated into Pro-D frameworks, these approaches provide teams with experiential learning structures that revitalize individual and collective capacity while embedding mindfulness principles, Indigenous relational frameworks, and the healing potential of collective experiences.

Multigenerational Support recognizes that child development does not occur in isolation, but is deeply rooted in extended family and community structures, cultural heritage, and ancestral knowledge. Communities hold wisdom about healing practices that enables them to endure and transcend historical trauma through meaningful multigenerational engagement. Wisdom is passed forward and relationships are sustained across time. Integrating multigenerational perspectives into Pro-D strengthens professionals' capacity for humble witnessing; expands understanding of caregiving networks; strengthens family-provider partnerships; and honors Elders and extended kin as essential contributors to child and community wellbeing.

Re-Claiming Identity centers storytelling and narrative as tools to affirm belonging, identity, and heritage while dismantling colonial myths that have othered, pathologized, and harmed communities. This principle invites professionals to reflect on their social-cultural identities, positionality and privilege to engage with families in ways that honor families' lived experiences and cultural pride. Embedding radical listening and identity-affirming practices into Pro-D helps decolonize care models; fosters cultural humility; and establishes responsive, healing-centered approaches to supporting young children and caregivers.

Multi-relational Continuum: Pregnancy, Infancy, Childhood, and Youth

While much of mother/newborn dyad care continues to be provided by grandmothers, aunties, neighbors, sisters, two-spirit relatives, community healers and midwives around the world, in the United States many of these roles are fulfilled by community-based doulas. They are non-clinical providers of physical, emotional, educational and practical support to mothers and birthing families throughout the perinatal period (Bey, 2019). These doulas and the people they serve are usually members of the same communities, often comprised of Black, Brown, and other People of Color. They share an intimate understanding of social and structural barriers to optimal health (Johnson, 2024). Doulas' reassuring presence not only promotes healing, rest, and bonding, but their culturally affirming practices contribute to the passing down of meaningful traditions central to families' beliefs, identities, and values.

Studies have demonstrated the protective effects of doula care, recognizing them as a crucial part of the relational wellbeing workforce (Wint, 2019). Community-based doula care reduces stress, negative birth experience, and rates of postpartum depression (Bey, 2019). They actively engage partners in the pregnancy and birth (Falconi 2022), and leverage established trusting relationships to help clients access basic needs (Bruner, 2021). Community-based doulas

embody the first universal relational health principle: community-rooted wellness and healing.

A noteworthy example is Hummingbird Indigenous Family Services in Washington State, which provides culturally responsive programs for Native American, Alaskan Native, Native Hawaiian, and Pacific Islander families. Their Indigenous BirthKeepers doula program connects families to doulas with shared culture who incorporate traditional knowledge to strengthen parent-community bonds. Their Pilimakua (*pili*, the 'Ōlelo Hawai'i word for connection, and *makua*, the Native Hawaiian/Kānaka Maoli tradition of parenting and caregiving as a whole generation) Family Connections Program include home visiting, parent groups, emotional peer support, and community connection events founded on principles of shared knowledge, cultural reclamation, sustainability, and self-compassion. Multigenerational perspectives are manifest in community-centered activities that recognize collective responsibility as Indigenous resiliency. Storytelling, music, dance and workshops connect families across generations to create books, blankets, and lullabies that lift up shared cultural identity. All three Relational Principles are represented in Hummingbird's statement,

> "We tell these stories first and foremost for us, for the people. To remember to call back, to sing back, the vitality and the immeasurability of the worth and value of Indigenous mamas and children". (Hummingbird website, 2025)

Community health workers (CHWs) —trusted individuals who also have strong ties to their communities — are emerging as vital contributors to the IMH field. They help expand access to mental health (MH) services by bridging gaps in services; providing culturally responsive support; connecting families to resources; and promoting wellbeing through education and advocacy (Robertson et al., 2023; Barnett et al.,2018). Trusted CHWs create healing spaces that reduce stigma, improve access to care, and foster health literacy (Cohen & Andujar, 2022; Barnett et al., 2018). They are especially effective in early childhood settings, where they support families in homes, early learning programs, clinics, and communities (Robertson et al., 2023; Barnett, et al 2018). Their work strengthens relational health and helps ensure MH services are community and culture focused.

A powerful example is the Infant & Early Childhood Mental Health (IECMH) Family Leadership Certificate Program at Georgetown University, which exemplifies a revitalizing approach to service delivery and workforce development. This nine-month program, requiring no prior degree, builds CHWs' competencies with a specialization in family and IECMH. Co-created with families and community leaders, the curriculum honors lived expertise and strengthens upstream prevention, early intervention, and attention to social determinants of health. It also opens professional pathways for community members, expanding the workforce across sectors serving young children.

A revitalizing approach to IMH centers community-led, culturally grounded practices by pivoting from deficit-based models towards models that recognize community knowledge, traditions, and strengths. Through trusted relationships, CHWs help support families in re-claiming identities that affirm their cultural heritage. Their work represents a holistic, culturally attuned, community-centered practices that honor families' vitality. CHWs offer relational, home-based support; lead family empowerment programs; conduct community-based screenings; and foster peer support networks. These are revitalization activities because they place relationships, culture, and healing justice at the center.

Connection —the primal task of humanity— is a thread that extends from pregnancy through infancy, childhood, youth, adulthood, and elderhood. Ubuntu: "*I am because we are. A person is a person through other persons*" does not have a defined beginning or end. Ubuntu is relevant to MH across the arc of life. Taratibu Youth Association (TYA), a community-based performing arts organization rooted in Ubuntu and in the Circle of Courage framework (Brendtro et al., 2005), is another exemplar of a program that fosters positive, multigenerational mental health. It brings together youth, their young siblings, parents, and community elders. Adults make deposits in TYA children and youth by intentionally holding space with them; being fully present to their feelings and experiences; singing, dancing, exchanging stories and ideas with them (Greenfield, 2009). Youth internalize these ways of being with one another and pass it forward when they become parents. In this way, relational health extends beyond early childhood, offering IMH professionals a vision of positive parallel process from one generation to the next. Clearly, development does not occur in isolation. It is rooted in multigenerational caregiving, ancestral knowledge, and relational continuity. We invite you to scan our QR codes for additional information about in TYA.

Wawa Aba is the Ghanaian Adinkra symbol for toughness and perseverance.

Conclusion

Revitalization offers more than an alternative to traditional Pro-D in IMH. It represents a necessary reclamation of ways of being that honor relationality, interdependence, and community-rooted healing. By centering Indigenous frameworks such as Ubuntu, Lakou, and Etuaptmumk, and by learning from community-based exemplars like Community Doulas, CHWs, and TYA, we are reminded that wellbeing is not an individual achievement, but a collective practice. Revitalization is the reweaving of enduring wisdom into contemporary systems to foster emotional, social, and relational thriving. As we reimagine Pro-D through this lens, we create the conditions for infants, young children, and families to flourish, and for

communities to heal, regenerate, and lead from their strengths and histories. Revitalization of IMH "*must not just heal, liberate, and empower individuals and communities, it must also… heal and improve a broken, sick society*" (David, p.74).

References

Barnett, M.L., Gonzalez, A., Miranda, J., Chavira, D.A., Lau, A.S. (2018). Mobilizing Community Health Workers to address mental health disparities for underserved populations: A systematic review. *Administration & Policy in Mental Health. Mar;45*(2):195-21.

Bey, A., Brill, A., Porchia-Albert, C., Gradilla, M., & Strauss, N. Advancing birth justice: Community-based doula models as a standard of care for ending racial disparities. (2019). *Every Mother Counts*. NY, 2019. https://everymothercounts.org/wp-content/ uploads/2019/03/Advancing-Birth-Justice-CBD-Models-as-Std-of-Care-3-25-19.pdf

Brendtro, L., Brokenleg, M., & Van Bockern, S. (2005). The Circle of Courage and positive psychology. *Reclaiming Children and Youth, 14*(3), 130-136.)

Bundick, M.J., Yeager, D.S., King, P.E., & Damon, W. (2010). "Thriving across the life span" in *The Handbook of Life-Span Development, Vol. 1: Cognition, biology, and methods*. Lerner, R.M. & Overton, W.F., (Eds.) John Wiley & Sons Inc.

Cayemittes, M., Rival, A., Lerebours, G., Barrere, B. (1995). Haiti survey on mortality, morbidity and utilization of services 1994/95. *Summary Report*. Petion-Ville, Haiti, Institut-Haitien de l'Enfance, (22).

Chang, D.F., & Bryant, L.L., Eds. 2024). *Transforming careers in mental health for BIPOC: Strategies to promote healing and social change*. NY: Routledge.

Charlot-Swilley, D., Thomas, K., Mondi, C. F., Willis, D. W., & Condon, M.-C. (2024). A Holistic Approach to Early Relational Health: Cultivating Culture, Diversity, and Equity. *International Journal of Environmental Research and Public Health, 21*(5), 563. https://doi.org/10.3390/ijerph21050563

Cohen, J., & Andujar, P. (2022). *Infant and Early Childhood Mental Health (IECMH): Laying the groundwork for all future development*. Infant and Early Childhood Mental Health Technical Assistance Center. https://gucchd.georgetown.edu/Docs/iecmh/IECMH%20-%20Laying%20the%20Groundwork%20for%20All%20Future%20Development.pdf

David, E.J.R. (2024). Decolonizing research: Some tips to heal the damages of a sick world. In *Transforming careers in mental health for BIPOC: Strategies to promote healing and social change*, D.F. Chang & L.L. Bryand (Eds.). Routledge. pp. 71-80. DOI: 10.4324/9781003309796-8

Edmond, Y.M., Randolph, S.M., & Richard, G.L. (2007). The Lakou system: A cultural, ecological analysis of mothering in rural Haiti. *Journal of Pan African Studies, 2*, 19-32. http://www.jpanafrican.org/docs/vol12no11/TheLakouSystem.pdf.

Falconi, A.M, Bromfield, S.G., Tang,T., et al. (2022). Doula care across the maternity care continuum and impact on maternal health: Evaluation of doula programs across three states using propensity score matching. *eClinical Medicine*, 50:101531. https://doi.org/10.1016/j.eclinm.2022.101531

Ginwright, S.A. (2022). *The four pivots: Reimagining justice, reimagining ourselves*. North Atlantic Books.

Greenfield, P.M. (2009). Linking social and cultural factors to child development: A cross-cultural perspective. *Journal of Child and Family Studies, 18*(4), 401-410.

Hummingbird Indigenous Family Services: https://www.hummingbird-ifs.org/

Institute for Integrated Science & Health: http://www.integrativescience.ca/Principles/

Institut Haitien de Statistique et d'Informatique: Division d'Analyse et de Recherche Demographique (1989). *A study of the relationship between population and regional development in Haiti*.

Irving Harris Foundation (2012). *The diversity-informed tenets for work with children and families*. https://diversityinformedtenets.org/download-the-tenets/

Iwama, M., Marshall, A., Marshall, M. & Bartlett, C. 2009. Two-Eyed Seeing and the Language of Healing in Community-Based Research. *Canadian Journal of Native Education, 32*: 3-23. http://www.integrativescience.ca/Principles/TwoEyedSeeing/

Johnson, K., Shawky, H., & Willis, D. (2024, April). Community-based doulas and early relational health: The role of public policy and financing. *Nurture Connection*. https://nurtureconnection.org/resource/community-based-doulas-policy/

Labrador, C. (1997). *Mi'kmawey: Advancing Mi'kmaq scholars and scholarship*. Presentation at Cape Breton University, NS.

Marshall, A.D., Zimanyi, L., & Kewageshig, E. (2023). *Walking Together*. Toronto, CA: Annick Press.

Ngomane, M. (2020). *Everyday Ubuntu: Living better together, the African way.* Harper Design.

LaRose, S. (1975). The Haitian Lacou, Land, Family and Ritual. In *Family and Kinship in Middle America and the Caribbean*. Marks, A. & Romer, R. (Eds.). Willemstadt/Curacao, Institute of Higher Studies, Curacao. 482–501.

Robertson, H.A.; Biel, M.G.; Hayes, K.R.; Snowden, S.; Curtis, L.; Charlot-Swilley, D.; *American Public Health Association: Community Health Workers*, available at: https://apha.org/apha-communities/member-sections/community-health-workers

Taratibu Youth Association: https://www.taratibu.org/

Vimard P., Guillaume, A., Quesnel, A. (1991). Modifications of costs and benefits of children supported by parents: socio-economic differentiation and its impact on fertility: Evolution of fertility and the role of children in rural West Africa. International Union for the Scientific Study of Population [IUSSP] Committee on Comparative Analysis of Fertility and University of Zimbabwe Seminar on the Course of Fertility Transition in Sub-Saharan Africa, Harare, Zimbabwe.

Wint, K., Elias, T., Mendez, G., Mendez, D., & Gary-Webb, T. Experiences of Community Doulas Working with Low-Income, African American Mothers. *Health Equity*. 2019; 3(1): 109-116.

Decolonising infant mental health: an anthropological provocation from Southern Africa

by Fiona C. Ross (South Africa)

Anthropology

University of Cape Town

ORCID: 0000-0001-9642-3670

As an anthropologist working in the field of infant mental health in South Africa, a field heavily dominated by psychology and psychiatry, I'm interested in how disciplinary apparatuses take hold and how concepts, theories and analytic frameworks produce subjectivities, norms and social effects. Forged in the crucible of Europe's violent world-making and its enduring legacies, Anthropology has long been (justifiably) accused of being colonialism's handmaiden. The construction of 'the Other' was critical in structuring colonial hierarchies that continue to shape global suffering. It was responsible for the emphasis on difference that grounded apartheid. For decades, anthropologists have grappled with our imbrication in colonial knowledge formations (e.g. Asad 1973; Harrison 1991). I draw on this decolonial intellectual work to offer some thoughts about decoloniality in IMH.

Disciplines institute and govern specific knowledge formations. Decolonisation involves recognising that knowledge is implicated in inherited systems of power that may be exclusionary and damaging and may replicate harm. It involves understanding that what is taken for granted in our disciplines and our methods may be premised on specific ways of being and arranging the world and imagining relations (Tuhiwai Smith, 1999). For example, what we call 'western' models of the world imagine it as a resource available to augment human life - or at least, the lives of some. Yet, most indigenous peoples have a different model of the world, seeing humans as a component in a network of delicate human and non-human relationships, and emphasising harmony and balance. At the same time, it is easy to reify and romanticise these ideas. We need constantly to be vigilant about our knowledge formations and the work they do. As bodies of knowledge practices, disciplines have the power to influence social fields. Sometimes they become resistant to critique. Recognising and remedying this, requires a reflexive stance, oriented to generativity, inclusion and non-harm.

Does IMH need decolonisation? This is an open question. Its scholarship is powerful, but its evidentiary base is narrow and may not reflect the richness of human experience. Its presumptions about relationship may be limited. The journal is to be commended for opening this opportunity to assess its premises, tools and methods critically.

As an outsider, I offer five provocations.

While acknowledgement of the **WEIRDness of psychology's evidence base** is important, more research on its implications is required. A three-pronged approach would be useful: consideration of the historical and cultural underpinnings of concepts taken to be universal (including the idea of universality itself); a wider evidentiary base, drawing from a broader range of disciplines, transdisciplinary approaches, and including wider wisdoms; critical attention to how knowledge shapes practice and with what effects.

Increased focus on **how diverse relational ties are made and sustained**, especially where possibilities have been diminished by colonialism and contemporary curtailments. Here, I am gesturing to the ways that humans are encouraged into relations with others - human and non-human - more broadly, and with how those relations are imagined. Majority world relational ontologies (e.g. the idea of ubuntu in southern Africa) offer important cues. This does not replace a focus on maternal dyad but should prompt attention to the wider networks that sustain flourishing, and which are often made invisible by our disciplinary presumptions. Such attention will become increasingly important as the Anthropocene jeopardises well-being globally.

An anti-racist stance. Presumptions about otherness easily slip into naturalised notions of racialised difference. These have powerful and detrimental effects. Here is a recent example. Kohlhoff et al (2024) examine maternal depression, oxytocin, sensitivity and adult attachment style, and infant temperament in an 'ethnically diverse' sample of 106 mostly married, mostly well-educated Australian mothers. The study found that 'non-Caucasian identity' rather than depression or oxytocin levels predicted difficult infant temperament (p. 1; 2; 9-10). 'Non-Caucasian' is a post hoc descriptor that glosses 'Asian..., Indian… and Arabic backgrounds' (p.3). It conflates a landmass, a nation-state and a language category into an 'Other' to 'Caucasian'. 'Caucasian' is not an Australian census category. Its mobilisation here produces a racialised framework. Although the authors

note (p.9) that 'non-Caucasian' may be a proxy for other forms of difference, including language, marginalization, lower socio-economic status etc., none of these are explored. Instead, a recommendation for future research examining ethnicity and attachment is offered. This produces a pernicious racialised othering and normalises whiteness as the baseline for measurement.

'Epistemological allyship' and beyond. Seth Oppong (2023) developed this idea to invite wider networks of collaboration between psychology's centres of power and excluded majority world academics in that discipline. I extend the notion here to suggest that we need to draw on other disciplinary formations and wisdoms not held in universities. One reason is that our disciplinary apparatuses can make us resistant to critique. Another is that our concepts can become closed and ineffectual, or worse, can be put to work in ways that might harm. Engaging with other bodies of knowledge, in both other disciplines and external to academia, could limit the echo-chamber expertise that sometimes bedevils disciplinary scholarship, and open productive questions of flourishing and well-being. There are already important examples of this in the IMH journal (e.g. Richardson et al. 2025).

Finally, a cheeky suggestion. For an outsider coming to the field of IMH, the significance of the **concept of attachment, and particularly of maternal-infant attachment**, is striking. It has the quality of a sacred object. Anthropologists have long observed that the current model of attachment is predicated on specific cultural values (including those relating to degrees of autonomy and dependence) and that a wide range of other models exist in majority world settings (e.g. LeVine 2014; Keller and Bard 2017; Vicedo 2017). Universalist presumptions about how and with whom infants form relations may miss critical and formative dimensions of infant experience. It might be worth asking what work the attachment to attachment is doing and what it might mask. For example, in many contexts in southern Africa, a key axis of well-being has to do with the infant's relation with their ancestors; a form of attachment that has not been adequately acknowledged in the psychological literature and yet which can become pressing at various points in an individual's life. Disregarding this disavows a vital dimension of social life, precluding attention to how absent-yet-present forces shape the worlds of infants. What other influences, modes of attentiveness and role players are rendered invisible when we attend too closely to the maternal dyad/primary caregiver? Who else might be in infants' social worlds, playing important but under-recognised roles? What might the effect of these be on infant mental health? At what point does attachment cease to be an adequate explanation of infant experiences or for how they will come to relate?

As ideas about 'optimal' infant development circulate ever more widely through global organisations like UNICEF and WHO, it behoves us to think about the social, political and ethical effects of our precepts and concepts, and the evidence bases on which they are built. I have offered these comments in the spirit of scholarly conviviality (Oppong 2019; Nyamnjoh 2024) and with gratitude for the opportunity to do so.

References

Asad, T. (Ed.). (1973). *Anthropology & the Colonial Encounter*. Ithaca Press.

Harrison, F. (Ed.). (1991). *Decolonizing Anthropology.* American Anthropological Association, Arlington, Virginia.

Keller, H., & Bard, K. A. (Eds.). (2017). *The Cultural Nature of Attachment*. MIT Press.

Kohlhoff, J. L., Karlov, M., Dadds, B., Barnett, D., Silove, D., & Eapen, V. (2024). Maternal antenatal depression, oxytocin, and infant temperament: The roles of ethnicity and adult attachment avoidance. *Infant Mental Health Journal, 1*(13). https://doi.org/10.1002/imhj.22129

Levine, R. A. (2014). Attachment theory as cultural ideology. In H. Otto & H. Keller (Eds.), *Different faces of attachment: Cultural variations on a universal human need* (pp. 50–65). Cambridge University Press. https://doi.org/10.1017/CBO9781139226684.005

Nyamnjoh, F. (2024). *Incompleteness, Mobility, and Conviviality*. Langaa RPCIG.

Oppong, S. (2019). Overcoming obstacles to a truly global psychological theory, research, and praxis in Africa. *Journal of Psychology in Africa, 29*(4), 292–300. https://doi.org/10.1080/14330237.2019.1647497

Oppong, S. (2023). Epistemological Allyship: *Psychology and Developing Societies. 35*(1) 69 –86. https://doi.org/10.1177/09713336231152301

Richardson, M., C. Waubanascum, S.F. Waters, M Sarche. (2025). A decolonial perspective on Indigenous infant and early childhood mental health: Reclaiming Indigenous ways for the next seven generations. *Infant Mental Health. Vol 46*(4): 361-375. https://onlinelibrary.wiley.com/doi/10.1002/imhj.70000

Tuhiwai Smith, L. (1999). *Decolonizing Methodologies: Research and Indigenous peoples*. Zed Books.

Vicedo, M. (2017). Putting attachment in its place: Disciplinary and cultural contexts. *European Journal of Developmental Psychology, 14*(6), 1–16. https://doi.org/10.1080/17405629.2017.1289838

Digital Colonisation and Infant Mental Health

by Miriam McCaleb (Aotearoa New Zealand)

Human (Māori) settlement in my country (Aotearoa | New Zealand; ANZ) around 800 years ago resulted in some burning of forests, inadvertent species extinctions, and introduction of flora and fauna that had not been here before. European colonisation some 650 years later resulted in massive deforestation, masses of unintentional species extinctions, and unfettered introduction of flora and fauna resulting in ongoing threats to native forests and birds.

European colonisation has also left injuries on those people who were here first – known locally as tangata whenua (people of the land). Colonisers showed complete disregard for patterns of traditional food gathering and land allocation, while actively suppressing Māori culture, language, and healing knowledge.

Descriptions of traditional Māori caregiving behaviours (Jenkins & Mountain Harte, 2011) align with those as defined within the Evolved Developmental Niche (Narvaez et al., 2013). Rather than the colonisers learning and adapting, these childrearing models were eschewed in favour of the enforced belief system of the Victorian colonisers. It was a time of 'spare the rod, spoil the child', where the difference between discipline and abuse may have simply been the frequency of physical punishments (Rayner, 2008).

While some of the hangovers of our colonial past have been redressed – for example, physical punishment of children is no longer legally allowed (Debski et al., 2009) – other tensions remain. For example, Census data reveals that merely 4% of the total ANZ population speak te reo (the Māori language); (Statistics New Zealand, 2024). Colonisation leaves a long shadow.

As if that were not worrisome enough, here I argue that there is a fresh wave of colonisation underway, of particular importance to infant mental health. The current technological movement – in which for-profit agents deliberately take our attention and harvest our data – can be understood as digital colonisation, recognised as a particular menace to those of us in the global south (Kwet, 2019).

People's ubiquitous use of smartphones and their affordances have led to habits which have reduced our attention spans (Zimmerman et al., 2023), and contributed to a "cognitive miserliness" (p. 473) in which we outsource thinking to our devices (Barr et al., 2015). Our collective experiences with technology, especially social media, point to an uptick in mistrust of public health agencies and experts of all kinds (Schluter et al., 2023), and this perhaps includes such organisations as WAIMH. All of this is occurring within an extractive economy in which people and their families are the product (Birch et al., 2021). With these colonisers, it is not our slow-growth forests being pillaged, but our data, and our attention.

For parents of infants, the fracturing of attention means that smartphone use during caregiving is associated with reduced maternal sensitivity (Tharner et al., 2022). This lessens the likelihood of a parent's ability to respond to an infant's cues in a timely and comforting manner. Use of the smartphone during infant care is an example of 'technoference', a phenomenon in which technology use interferes with in-person relationships. For infants, parental technoference has negative associations for relational health (Golds et al., 2025), language development (Corkin et al., 2021) and socioemotional regulation (Lederer et al., 2022). The digital colonisers extend their influence into our every waking hour, without regard for whether infants are present or not.

In the case of new parents, whose need for support, information, and reassurance is both legitimate and understandable, the evolutionary mismatch being exploited by social media platforms (Sbarra et al., 2019) and the persuasive design strategies being used by big tech (Fogg, 2009) point to the scale of this challenge. For an individual family grouping, it becomes increasingly difficult to live peacefully without the influence of the colonisers – be they those arriving by boat in the 19th Century, or those traveling on undersea cables and wireless networks today.

Colonisers have long understood the need to assert influence in even the most intimate arenas, with writing from 1905 declaring it "out of the mouths of babes and sucklings that the strength … (of) first rate Imperialism … is ordained" (Macnamara, 1905, p. 248). Thus, it may be unsurprising that smartphone use during the intimate care routine of feeding is common (Nomkin & Gordon, 2021). This colonial overreach risks displacing opportunities for shared gaze, insightful wondering, and grooming touch, as smartphone use stills the faces of caregivers (Stockdale et al., 2020), creates a state of "absent presence" (Aagard, 2016, p. 223), and busies the hands of the parent during infant feeding (McCaleb, 2024).

Meanwhile, the very timing of that feeding routine may be predicated on the instruction of a parent's smartphone, due to the rise of so-called 'baby tracking apps' (Pangrazio et al., 2025). These tell a new parent when to feed a baby, and when to put them to bed, inviting artificial intelligence (AI) to circumvent an insightful serve-and-return interaction. Tracking apps even tell a nursing mother which side she should use this time, risking a damping down of her bodily awareness, or interoception.

Given the relationship between maternal interoception and sensitivity to infants' physiological and emotional states (Suga et al., 2022), the commercialised confidence as offered by tracking apps risks weakening a new parent's emerging skills to join their baby in attuned, bespoke, caregiving choreography. This algorithmic imperialism poses risks to the optimal functioning of the dyad.

Further, in an example of the power of digital colonisation, I cite an otherwise excellent working paper recently co-published by the Australian Government titled "Baby Apps: Mapping the issues" (Langton, 2024). While it raises salient points about data security, feminist tensions, and digital childhoods as relates to menstruation, fertility, and baby tracking apps – it is silent in considering the impact of such apps on the subjective experience of the infant, on parent-child relationships, or on child development. I suggest that even those of us with concerns about the unfettered use of baby apps also live under a system of digital colonisation and cannot account for every issue – let alone map them all.

The popularity of baby tracking apps is just one example of technochauvinism, a term coined by Madeleine Broussard (2019), which describes a belief that a technological solution is superior to an analog – or human – solution. In this case, the confidence and assurances as projected by a baby-tracking app are sold as being preferable to learning to read an individual baby's cues for tiredness and hunger, and responding to them.

This move toward parenting a 'datafied' child (Lupton & Williamson, 2017) creates opportunities for the digital colonisers to commodify parental vulnerability. In one example, a new mother describes being inundated with advertisements following an online search: "…sleep doctors and this sleep guru and this is the system and they've all got a price tag to it" (McCaleb, 2024, p. 195).

Meanwhile, those who use period trackers are participating in a so-called 'FemTech' industry (McMillan, 2024), said to be worth more than US$50 billion by 2025. Gilman (2021) writes, "these profits do not flow to menstruators, rather, they enrich private businesses" (p. 101), another example of extraction by the offshore digital colonisers. Further, such apps can predict a pregnancy and share this information with third-party advertisers even before the app's user knows they are pregnant (Mascheroni & Siibak, 2021). Thus, they may be targeted with promotion of products and services for pregnancy and parenthood even before they have lived experiences of either stage. This may include free versions of the aforementioned tracking apps, even as such apps can "contribute to feelings of inadequacy and self-doubt" (Hall et al., 2023, p. 1).

This is not the only way that technochauvinism impedes on new parenthood. Babies can be rocked by mechanical swings which are cued by the sounds of babies' distress (Kumar et al., 2022), while elsewhere researchers describe an "automated carer room" (Srividhya et al., 2023, p. 412) doing away with the apparent inconvenience of infant care altogether.

The digital colonisers seem to see babies as a problem to be solved, and as such seem to disrespect the social synapse – the relational space between people (Siegel, 2020), or as we in the South Pacific may call it: *the va* (Muliaumaseali'i, 2020). The problems that trackers, rockers, and automated carers set out to solve with purchasable commodities and downloadable solutions are only problems because of the loneliness and isolation of so many new parents.

It is an unfortunate irony that the ways people lived in this country before European colonisation (collectively, where a new mother would be surrounded by kin and non-kin, helping her as she became used to her new role) would have made them less susceptible to the wiles of today's digital colonisers. Non-western knowledge systems are not the only thing at risk in a system which uses algorithmic asymmetry to tilt thinking, with the code underpinning the tech we use every day written within a "tech bro culture of mirrortocracy" (Nguyen, 2021, p. 17).

The colonisers' enactors – those who write the code and enforce the imperial algorithms that keep us distracted (Thomas & Wilson, 2024) – are overwhelmingly male, and by no means represent all the cultures of the world. Americanisation of media and technology leads to children affecting accents during play, and word processing software which longs for me to use this spelling: decolonization. Further, given that they enforce a business model which demands attention above all else, while requiring no ethics training from their coders (Dash, 2018), biases are inevitable, and undeclared.

Those of us who understand the value of responsive caregiving on infant mental health must take seriously our role as the filter between the extractive economy of the digital coloniser, and our babies. For us lies the challenge of attempting to embrace the useful aspects of the colonisers' offerings (be they hot running water or rapid communication) although we cannot control the negative and unavoidable effects on the other side of the ledger. Such negativities include historical examples like influenza on an unexposed population, as well as contemporary challenges such as technoference. Today's families must raise their babies in an era of normalised smartphone use, where they encounter gameified and addictive affordances on a daily basis. Infant care occurs under the gaze of the shiny overlords held in the palms of our hands, where the developmental stakes are high, and the distraction is deliberate.

Such a climate is especially challenging for the altricial infant, who is especially vulnerable to the harms of colonisation. Writing in 1820, before mass settlement by British colonisers, the missionary Samuel Marsden observed: "There can be no finer children than those of the New Zealanders. Their parents are very indulgent, and they appear also happy, and playful, and very active." (Marsden & Elder, 1932, p. 283). Knowing the injustices inflicted on Māori by the Victorian colonisers, and the challenges foisted upon all of us by the digital colonisers, it is questionable whether such descriptions would still apply.

Note: The author is a Pākehā New Zealander, of European ancestry. The author identifies as tangata tiriti, that is: belonging to this land because of the Treaty of Waitangi (1840).

References

Aagard, J. (2016). Mobile devices, interaction, and distraction: A qualitative exploration of absent presence. *AI & Society, 31*(2), 223-231. https://doi.org/10.1007/s00146-015-0638-z

Barr, N., Pennycook, G., Stolz, J. A., & Fugelsang, J. A. (2015). The brain in your pocket: Evidence that Smartphones are used to supplant thinking. *Computers in Human Behavior, 48*, 473-480. https://doi.org/10.1016/j.chb.2015.02.029

Birch, K., Cochrane, D., & Ward, C. (2021). Data as asset? The measurement, governance, and valuation of digital personal data by Big Tech. *Big Data & Society, 8*(1), 7-16. https://doi.org/10.1177/205395172110173

Broussard, M. (2019). *Artificial unintelligence: How computers misunderstand the world*. MIT Press.

Corkin, M. T., Henderson, A. M., Peterson, E. R., Kennedy-Costantini, S., Sharplin, H. S., & Morrison, S. (2021). Associations between technoference, quality of parent-infant interactions, and infants' vocabulary development. *Infant Behavior and Development, 64*, 101611. https://doi.org/10.1016/j.infbeh.2021.101611

Dash, A. (2018). *12 things everyone should understand about tech*. Retrieved 2 November, 2023 from https://www.anildash.com/2018/04/07/12-things-everyone-should-understand-about-tech/

Debski, S., Buckley, S., & Russell, M. (2009). Just who do we think children are? New Zealanders' attitudes about children, childhood and parenting: An analysis of submissions on the bill to repeal Section 59 of the Crimes Act 1961. *Social Policy Journal of New Zealand*(34).

Fogg, B. J. (2009). *A behavior model for persuasive design*. Proceedings of the 4th International Conference on Persuasive Technology, Claremont, CA.

Gilman, M. E. (2021). Periods for profit and the rise of menstrual surveillance. *Columbia Journal of Gender and Law, 41*, 100-113.

Golds, L., Gillespie-Smith, K., & MacBeth, A. (2025). Exploring the relationship between maternal wellbeing, infant development, smartphone use, and mother-infant responsiveness. *Infancy, 30*(1), e70005.

Hall, J., Hiebert, B., Facca, D., & Donelle, L. (2023). 'Putting all my eggs into the app': Self, relational and systemic surveillance of mothers' use of digital technologies during the transition to parenting. *Digital Health, 9*, 20552076221150742. https://doi.org/10.1177/20552076221150742

Jenkins, K., & Mountain Harte, H. (2011). *Traditional Māori parenting: An historical review of literature of traditional Māori child rearing practices in pre-European times*.

Kumar, V. S., Pullagura, L., Kumari, N. V., Pooja Nayak, S., Devi, B. P., Alharbi, A., & Asakipaam, S. A. (2022). Internet of things-based patient cradle system with an Android app for baby monitoring with machine learning. *Wireless Communications and Mobile Computing, 2022*, 1140789. https://doi.org/10.1155/2022/1140789

Kwet, M. (2019). Digital colonialism: US empire and the new imperialism in the Global South. *Race & Class, 60*(4), 3-26.

Langton, K. (2024). *Digital child working paper, Baby Apps: Mapping the issues*. Brisbane, Australia: ARC Centre of Excellence for the Digital Child

Lederer, Y., Artzi, H., & Borodkin, K. (2022). The effects of maternal smartphone use on mother-child interaction. *Child Development, 93*(2), 556-570. https://doi.org/10.1111/cdev.13715

Lupton, D., & Williamson, B. (2017). The datafied child: The dataveillance of children and implications for their rights. *New Media & Society, 19*(5), 780-794. https://doi.org/10.1177/1461444816686328

Macnamara, T. J. (1905). In Corpore Sano. *Contemporary Review, 87*, 238-248.

Marsden, S., & Elder, J. R. (1932). *The letters and journals of Samuel Marsden, 1765-1838: Senior chaplain in the colony of New South Wales and superintendent of the mission of the church missionary society in New Zealand* (J. R. Elder, Ed.). Otago University Council.

Mascheroni, G., & Siibak, A. (2021). *Datafied Childhoods: data practicies and imaginaries in children's lives*. Peter Lang.

McCaleb, M. A. (2024). *"a new guilty thing you're aware of but you don't change"– Seeking supportive smartphone habits for new mothers at the transition to parenthood: A mixed methods study* University of Canterbury]. Christchurch, New Zealand. https://ir.canterbury.ac.nz/items/46902716-3488-4b93-aaaf-39e70079b9f2

McMillan, C. (2024). Gender, health and technology: The rise of femtech - periods, profit, and power. In J. Gideon & S. Hawkes (Eds.), *A Research Agenda for Gender and Health* (pp. 87-106). Edward Elgar Publishing. https://doi.org/10.4337/9781802209228

Muliaumaseali'i, M. (2020). *Teu le Va (nurture the space) in-between intersectionality*. ServDes 2020 Conference, RMIT, Melbourne, Australia.

Narvaez, D., Gleason, T., Wang, L., Brooks, J., Lefever, J. B., Cheng, Y., & Centers for the Prevention of Child Neglect. (2013). The evolved developmental niche: Longitudinal effects of caregiving practices on early childhood psychosocial development. *Early Childhood Research Quarterly, 28*(4), 759-773. https://doi.org/10.1016/j.ecresq.2013.07.003

Nguyen, X.-T. (2021). # MeToo innovators: Disrupting the race and gender code by Asian Americans in the tech industry. *Asian American Law Journal, 28*(17), 17-56. https://digitalcommons.law.uw.edu/faculty-articles/837

Nomkin, L. G., & Gordon, I. (2021). The relationship between maternal smartphone use, physiological responses, and gaze patterns during breastfeeding and face-to-face interactions with infant. *PLoS One, 16*(10), e0257956. https://doi.org/10.1371/journal.pone.0257956

Pangrazio, L., Langton, K., & Siibak, A. (2025). How the family makes itself: The platformization of parenting in early childhood. In J. Sefton-Green, K. Mannell, & O. Erstad (Eds.), *The platformization of the family: Towards a research agenda* (pp. 47-68). Springer Nature Switzerland. https://doi.org/10.1007/978-3-031-74881-3_4

Rayner, H. J. (2008). *A darn good hiding or the naughty step?: Ideas on child discipline in New Zealand 1890-2008* Massey University.

Sbarra, D. A., Briskin, J. L., & Slatcher, R. B. (2019). Smartphones and close relationships: The case for an evolutionary mismatch. *Perspectives on Psychological Science, 14*(4), 596-618. https://doi.org/10.1177/1745691619826535

Schluter, A. P., Généreux, M., Landaverde, E., & Schluter, P. J. (2023). In the COVID-19 pandemic, who did we trust? An eight-country cross-sectional study. *Journal of Global Health, 13*. https://doi.org/10.7189/jogh.13.06036

Siegel, D. J. (2020). *The developing mind: How relationships and the brain interact to shape who we are*. Guilford Publications.

Srividhya, S., Manasa, S., & Mrudula, A. (2023). Smart cradle for baby monitoring. *International Journal of Intelligent Systems and Applications in Engineering, 11*(3), 412-416. https://ijisae.org/index.php/IJISAE/article/view/3182

Statistics New Zealand. (2024). *Aotearoa New Zealand as a village of 100 people*. Retrieved 24 April from https://www.stats.govt.nz/infographics/aotearoa-new-zealand-as-a-village-of-100-people/

Stockdale, L. A., Porter, C. L., Coyne, S. M., Essig, L. W., Booth, M., Keenan-Kroff, S., & Schvaneveldt, E. (2020). Infants' response to a mobile phone modified still-face paradigm: Links to maternal behaviors and beliefs regarding technoference. *Infancy, 25*(5), 571-592. https://doi.org/10.1111/infa.12342

Suga, A., Naruto, Y., Maulina, V. V. R., Uraguchi, M., Ozaki, Y., & Ohira, H. (2022). Mothers' interoceptive sensibility mediates affective interaction between mother and infant. *Scientific Reports, 12*(1), 6273. https://doi.org/10.1038/s41598-022-09988-y

Tharner, A., Mortensen, A. H., Holmsgaard, E. M., & Væver, M. S. (2022). Mothers' smartphone use and mother-infant interactive behavior in the postpartum period. *Pediatric Research*, 1-4. https://doi.org/10.1038/s41390-021-01451-4

Thomas, D., & Wilson, C. L. (2024). Imperial algorithms: Contemporary manifestations of racism and colonialism. *American Journal of Community Psychology, 73*(1-2), 7-16. https://doi.org/10.1002/ajcp.12744

Zimmerman, A., Janhonen, J., & Saadeh, M. (2023). Attention span and tech autonomy as moral goods and societal necessities. *Digital Society, 2*(2), 23. https://doi.org/10.1007/s44206-023-00053-3

Book Review of WAIMH Handbook of Infant and Early Childhood Mental Health: Addressing Decolonization and Cultural Context

by Michelle du Plessis (South Africa)

Department of Psychiatry

Stellenbosch University

This review focuses on a number of issues with regard to culture and decolonization within selected excerpts from the *WAIMH Handbook of Infant and Early Childhood Mental Health – Cultural Context, Prevention, Intervention, and Treatment, Volume 2* (Osofsky et al., 2024).

The global focus of this volume creates an interconnected, tapestry of approaches to IECMH, in which each cultural thread and each family's story, contributes to the richness and strength of the whole. The reader is sensitized to the necessity of weaving a global fabric in terms of IEMCH care, thereby addressing concerns that theory and practice have been formed for too long using only the single thread of research sourced from Western countries (Puura, 2024, Chapter 1). While valuable, this Western-centric thread has failed to capture the diverse spectrum of human experience and relationships, as the majority of infants and children globally live in the non-Western world (Dawson et al., 2024, Chapter 4), where indigenous communities have their own deeply relational practices and intergenerational care systems, based on knowledge that has been passed on through storytelling, ceremony, and language (Keren, 2024, Chapter 10; Wesner et al., 2024, Chapter 15).

Jointly, these chapters are underpinned by a recognition that colonialism has torn indigenous families from their culture and culturally informed practices of caregiving, and replaced them with models of caregiving based on Western culture. For instance, in the Japanese context, rapid Westernization led to disruption of traditional child-rearing approaches (Watanabe, 2024, Chapter 5). Over time, Western approaches have come to be seen as culturally intrusive, leading to a movement to reinstate culturally congruent methods such as deep listening and interdependent, non-verbal affective communication (Watanabe, 2024, Chapter 5).

Similarly, in South Africa, traditional African patterns of caregiving, with their emphasis on physical closeness, prompt responsiveness, and extensive family and community involvement, form protective relational patterns within the community fabric (Dawson et al., 2024, Chapter 4) that have been undermined by the forced introduction of Western practices.

Difficult historical tears left by colonialism and apartheid, now need to be carefully addressed by examining their impact on indigenous caregiving practices, and the extent to which programmes and practices that have been imported from the West are congruent with practices based on local values and wisdom.

Similarly, assessment of the wellbeing of infants and their families requires careful reflection with regard to the extent to which any Western measures being used are based on assumptions about the parent-infant relationship that do not pertain in non-Western settings. Assessment tools and frameworks developed from a Western paradigm may lead to a 'measurement disjuncture', whereby the tools can be irrelevant, invalid, and unreliable when applied to non-Westen and Indigenous communities (Keren, 2024, Chapter 10; Wesner et al., 2024, Chapter 15). The handbook calls for the development of culturally grounded measurements and interventions that includes a continuum of approaches, either developed from scratch or by adapting existing measures to address the cultural and community-defined concepts and values (Wesner et al., 2024, Chapter 15).

The handbook highlights the need for a proactive approach to the identification of culturally incongruent approaches. Diversity-informed practice requires that we understand and critically reflect on our own cultural background, values, biases, assumptions, and the influence of oppressive systems, with critical self-reflection ultimately leading to new perspectives (Ross-Donaldson et al., 2024, Chapter 13). The *Diversity-Informed Tenets for Work with Infants, Children, and Families*, are presented as a foundational framework for decolonizing practice, stressing the necessity for critical self-reflection (Spicer et al., 2024, Chapter 2; Ross-Donaldson et al., 2024, Chapter 13). Practitioners are encouraged to be aware of their own power and privilege, how they might be perceived by families with histories of oppression, and to question how their methods might perpetuate inequities (Spicer et al., 2024, Chapter 2; Ross-Donaldson et al., 2024, Chapter 13).

Diversity-informed reflective supervision, within a social and racial justice framework, is similarly highlighted as a vital space for examining the processes related to culture and practice, and thereby contributing to the making of a globally represented IECMH field (Spicer et al., 2024, Chapter 2; Meuwissen et al., 2024, Chapter 25). Historically Eurocentric reflective supervision models, need to explore racial inequities and racialized experiences by amplifying the voices and lived experiences of practitioners who have been historically excluded from shaping IECMH theories (Ross-Donaldson et al., 2024, Chapter 13; Meuwissen et al., 2024, Chapter 25).

Essentially, the selected excerpts from the *WAIMH Handbook of Infant and Early Childhood Mental Health, Volume 2*, challenge the biases and dominance of Western-centric knowledge in IECMH, advocating practices that are culturally relevant, equitable, and co-developed with the communities being served. It calls for a critical examination of existing theory and practice, and a targeted effort to incorporate diverse worldviews and cultural practices in order to create a tapestry of IECMH approaches to practice, that truly support all infants, young children and their families globally.

References

Osofsky, J.D., Fitzgerald, H.E., Keren, M. and Puura, K. (Eds.). (2024). *WAIMH Handbook of Infant and Early Childhood Mental Health - Cultural Context, Prevention, Intervention, and Treatment. Vol 2*. Springer Nature. https://doi.org/10.1007/978-3-031-48631-9

Authors of chapters included in WAIMH Handbook of Infant and Early Childhood Mental Health Vol 2 review:

Puura, K. (2024). Cultural Context of Parenting and Infant Mental Health: Overview. (Chapter 1, pp. 3-6).

Spicer, P., Korfmacher, J., and Sarche, M. (2024). Justice and Care in the Ethics of Infant Mental Health. (Chapter 2, pp. 7-14).

Dawson, N., Lachman, A., Voges, J., Berg, A. (2024). Developing Culturally Sound Infant Mental Health Practice for the South African Context. (Chapter 4, pp. 39-56).

Watanabe, H. (2024). Reviving the Inner Nurturing Capacities of Families in the Unpredictable World: A Japanese Perspective on Infant Mental Health. (Chapter 5, pp. 57-74).

Keren, M. (2024). Infancy and Early Childhood Mental Health Assessment: Overview. (Chapter 10, pp.153-156).

Ross-Donaldson, S., Noroña, C.R., Dickson, A., and Kronenberg M. (2024). Diversity-Informed Practice for Parent/Caregiver Relationship Assessment. (Chapter 13, pp.187-206).

Wesner, C.A., Handeland, T., Martin, L., Asdigian, N.L., Barnes-Najor J., and Rumbaugh Whitesell N. (2024). Advancing Equity Through Engaging Communities to Address Measurement Disjuncture in Indigenous Infant and Early Childhood Mental Health. (Chapter 15, pp.227-246).

Meuwissen, A., Shea, S.E., Eaves, T., Parker, A., Barron, C.C., and Paradis N. (2024). Reflective Supervision: The State of the Field and Future Directions. (Chapter 25, pp.393-412).

WAIMH 2026
19TH WORLD CONGRESS | TORONTO, CANADA

The World Association for Infant Mental Health

19th WORLD CONGRESS

TORONTO, CANADA

Sheraton Centre Toronto Hotel

October 2-6, 2026

With the theme:
Harmony in Diversity — Nurturing the Youngest Minds Around the World, this international event brings the world's top voices in infant mental health together. Dive into new thinking, inclusive solutions, and global collaboration—live from vibrant Toronto!

Scan to Learn More

contact us via waimh.congress@sickkids.ca

HOSTED BY

Infant and Early Mental Health Promotion | SickKids

IEMHP is a national organization advancing lifelong outcomes by applying early mental health science in pregnancy, infancy, and early childhood.

www.iemhp.ca

ORGANIZED BY

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

WAIMH is a not-for-profit organization for scientific and educational professionals.

www.waimh.org

WAIMH 2026
19TH WORLD CONGRESS | TORONTO, CANADA

CALL FOR PAPERS

Join us at **#WAIMH2026** in Toronto to explore the diverse and interconnected world of infant mental health.

KEY DATES

- **Abstract Submission Opens**
  Jun 02, 2025 | 01:00 UTC
- **Registration Opens**
  Oct 15, 2025 | 01:00 UTC
- **Abstract Submission Closes**
  Dec 01, 2025 | 15:00 UTC
- **Acceptance Notification**
  Mar 31, 2026
- **Presenter Confirmation**
  Apr 30, 2026 | 15:00 UTC
- **Congress Dates**
  Oct 02 - 06, 2026

SUBMISSION TYPES

- Clinical Abstracts
- Scientific Abstracts

PRESENTATION FORMATS

Available for Individual or Group Submissions

1. Brief Oral Presentation
2. Poster Workshop

   Available for Individual Submissions Only
3. Poster Presentation
4. Interactive Workshop

   Available for Group Submissions Only
5. Symposium

Scan to Submit or Learn more

Early Submission Incentive

Be among the first 50 abstracts submitted to secure exclusive* early bird pricing not available to the public.

* Applies to presenting authors only. Abstract must be accepted by PC.

WORLD ASSOCIATION FOR INFANT MENTAL HEALTH

Infant and Early Mental Health Promotion | SickKids

WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH
www.waimh.org

PERSPECTIVES IN INFANT MENTAL HEALTH

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

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

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

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

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

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

Invitation to contribute

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

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. Ethics (max 3000 words, including references)
e. Community Voices (max 800 words, including references)
f. Letters (max 800 words, including references)
g. Opinion pieces/Policy/Advocacy (max 1000 words, including references)
h. 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

CONTACT

WAIMH

Tampere University

Faculty of Medicine and Health Technology

Arvo Ylpön katu 34

Arvo Building

33520 Tampere

Finland

Tel: + 358 44 2486945

E-mail: office@waimh.org

Web: www.waimh.org

www.waimh.org