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Responsibility for Children under the Age of Three Years

Recommendations of the German-Speaking Association for Infant Mental Health (GAIMH) for the care and teaching of infants and toddlers in daycare centers

By GAIMH Board of Directors, Karl Heinz Brisch, Maria Mögel, Heidi Simoni, Barbara von Kalckreuth, Katharina Kruppa (with the assistance of Anna von Ditfurth and Jeremy Hellmann)

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About the development of the GAIMH recommendations

These recommendations have been approved and published by the board of GAIMH. The basis for these recommendations are the result of work done in April 2008 during an intensive day-long session involving invited experts and members of GAIMH internal working groups. This session involved intensive interdisciplinary discussions of findings and experience from the research and practice of invitees from GAIMH's member countries -- Germany, Austria, and Switzerland -- based on international studies on the development of infants and toddlers.

The recommendations are directed at all of those who share responsibility for the care and raising of infants and toddlers: parents, politicians, preschool management, teachers, and therapists involved from birth to preschool, governmental authorities, pediatricians, child psychologists, psychologists, child psychiatrists, and journalists.

Only part I – The GAIMH Recommondations - is published in the Perspectives in Infant Mental Health, the full text with part II is available at www.waimh.org

Preliminary remarks

The present text consists of two main parts:

I GAIMH recommendations on the quality of supplemental care for infants and toddlers in daycare centers.

II Comments and explanations to the GAIMH recommendations.

The second part consists of the following sub-items:

-- Chapters 8 through 10 formulate the concerns, basic positions, and issues important to GAIMH (as an association concerned with emotional health in early childhood) with regard to the requirements for care of infants and toddlers outside the family.

-- Chapters 11 to 15 derive the requirements for self-understanding, conceptualization, and organizational implementation of supplemental care outside the family from the developmental and relational needs of infants and toddlers.

-- Chapters 16 and 17 deal with issues of teaching policy and the overall societal framework for daycare centers, and discuss the scope of future research.

GAIMH recommendations on the quality of supplemental care for infants and toddlers in daycare centers

In addition to private networks, families with infants and toddlers need social resources that provide relief, encouragement, and a sense of belonging to both adults and children.

Because of this, GAIMH welcomes the encouragement and support for centers outside the family as an opportunity for all infants and toddlers to experience age-appropriate care, teaching, and relationships outside of but with the close cooperation of their own family. However, this requires that the centers be

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attuned to the special needs of this age group. This also means that preschools should not simply be open to one- and two-year olds. In their basic concept, they must be adapted structurally (in smaller groups, more personnel, age-appropriate environment and procedures) and in terms of content (trained personnel with an understanding of early childhood developmental psychology and pedagogy) to the learning needs of infants and toddlers.

1. Recommendations for dealing with basic needs

1.1 Responding to and satisfying physiological needs

Caregivers must have adequate time and the professional knowledge to provide support on an individual basis (!) for the sleeping-eating-waking rhythms of infants and toddlers, to document this, and to transmit this information to the parents and other caregivers (cf. also the recommendations in the white paper of the Gesellschaft für Sozialpädiatrie un Jugendmedizin [German Association for Social Pediatrics and Youth Medicine], Horacek et al., 2008).

1.2 Security through attachment

Affect regulation and impulse control in infants and toddlers must still be supported by trusted persons in the immediate environment. Even in daycare centers, infants and children need -- and choose! -- one primary caregiver and other familiar caregivers who are reliably available at a glance in critical situations to help the children regulate their emotional states, needs, and impulses. This presupposes that these caregivers are able to assess appropriately the situational stress that the infant or toddler is under (Papoušek, 2006; Papoušek et al., 2008). Because of this, the training of staff must include attachment theory so that they recognize the attachment needs of toddlers, as well as the need to assist in affect regulation and avoidance behavior, and to respond to the children appropriately.

Daycare centers and their staff must recognize the importance of the parents for each child as a trusted and safe base in frustrating or fear-inducing situations through a careful, and if needed, repeated process of familiarization and ritualized support in separation situations. Good care aims at continuity. Changes in groups or caregivers should be avoided during the first three years, that is during the sensitive phases in which the child constructs identity, relationship, and attachment. This must be taken into account in forming children's groups, and speaks against groups that are strictly segregated by age during the first two years of life. Because of this, staffing should remain as constant as possible.

1.3 Stimulation and regulation

The daycare center and its staff must structure the day for each child in such a way that both overstimulation and understimulation -- and the potential resultant disorders of behavioral and emotional regulation -- are largely avoided. The staff should be well grounded in the behavioral organization of infants (Als & Butler, 2008), and be sensitive to the individual needs and sensitivities of the children placed in their care. They should be able to create a stimulating environment for the group and the individual child, as well as spaces for retreat and withdrawal. They recognize the child's overload signals, and are able to adjust the care setting to each child's needs.

1.4 Exploration and self-efficacy

In order for children to explore their environment, be open to engagement with adults and children, and experience self-efficacy, the space in which they are doing their exploration must be easily understandable, the routine predictable, and the level of stimulation moderate. For infants or toddlers this means that their daycare center group should be small, and the staffing levels large (cf. recommendations for structural and procedural characteristics of quality of care in daycare center and Chapter 13.1). The daily routine should be designed with these needs in mind, that is, provide a stimulating and a protective environment. Both daycare center management and their staff must be able to protect the children in their care from confusing circumstances such as frequent rotation of caregivers, avoidable changes in the group, or from loss of or disrespect for objects that have meaning to the child.

Even very small children are interested in other children and are especially fond of learning from older children whom they trust. As a result of their "teaching activity," these "older children" also acquire valuable social competence (K. Grossmann, oral communication, 2008). This is why mixed-age groups are integral to an environment that invites exploration and makes it possible for the child to experience self-efficacy. Mutual exploration, imitation, and action are possible for infants and toddlers only in the presence of reliable primary

caregivers and other trusted children. They also need places to which they may withdraw when they are tired, fearful, or frustrated (Hellmann, 2009).

1.5 Coordination and cooperation between family and daycare center

Coordination between family time and time spent at the daycare center must be directed primarily at the individual needs of the child and the structural guidelines for quality of care in daycare center (see Chapter 13.1 and the following " recommendations for structural and procedural characteristics of quality of care in daycare center"). The child should be able to reconcile the time spent at the daycare center and in the family, and to benefit from both. The care of infants and toddlers requires sensitive, supportive work with the parents that is available on a daily basis. It takes into account that the parents' identities develop as part of a process along with the developmental steps taken by the child, as they resonate to his critical steps and advances. For this reason, parents easily subject to uncertainty. The management of the daycare center and the child's primary caregivers in the daycare center must make room for the concerns of parents, assume various functions in work with the parents, and maintain limits counseling the parents.

2. Recommendations for good-quality teaching process

The familiarization or settling in period, that is, the time in which the infants and toddler experiences separation for the first time and begins to get used to her new primary caregiver or attachment figure in the new environment of the daycare center, is crucial for integrating and infant or toddler into the daycare center, and for his well-being (Ditfürth, 2009).

A trusting relationship must develop between caregivers and parents, in which emotions, expectations, and fears are appreciated and can be discussed and clarified.

The staff must understand the significance of and forms and conditions under which infants play, foster those conditions, and lend support to the children. The appreciation of the each child as an individual and as a member of the group requires individualized group teaching methods that satisfy the various individual and age-dependent needs of the children.

Infants and toddlers should be cared for in mixed-age groups because such groups provide opportunities for many different types of experience, and because both the younger and older children gain necessary competence.

3. Recommendations for an adequate structural quality

Infants should be cared for in small mixed-age groups (6 to 8 children).

The general caregiver staffing ratio (number of caregivers in relation to the number of children cared for) should be closer to 1:2 than 1:3, and should not be confused with the ratio of adult caregivers and children in actual everyday situations.

A staffing ratio of one teacher to 2 to 3 toddlers is viewed as developmentally advantageous according to international studies, and is viewed as high-quality.

The recommended ratios between caregivers and children in actual everyday situations should be met in order to protect the children from overstimulation, understimulation, and stress (cf. the results of the NICHD study, Watamura et al., 2003; Friedman & Boyle, 2009).

The time that children and caregivers spend together should be coordinated and structured such that the children have continuous relationships with trusted caregivers and other children. The acceptance of children with large differences in the times during which they are in daycare is to be avoided.

Small mixed-age groups should have three connected rooms available to them in which concentrated play, loud activity, gross motor movement and recuperative withdrawal or sleep are possible simultaneously. Interestingly structured places for play should enable children to engage in suitable activity. Easily accessible external spaces complement the group rooms.

4. Recommendations for operational quality and professionalism

Quality of the day facility in terms of structure, process, and guidance should ensure that the developmental needs of the children and the needs of the parents are supported. The fulfillment of this task presupposes child-centered management that permits staffing that is both well trained and adequate in number, and a protective atmosphere that is both stimulating and friendly in which the child may develop in collaboration with the parents.

Teaching should be supported by both staff and case supervision. The qualification to lead such a center should be based on educational studies or equivalent professional experience and be acquired through deepening of educational qualifications. The management of daycare centers should not only be capable of handling day-to-day teaching and organizational requirements, but also recognize situations that may endanger the child and the potential need for expert consultation and interdisciplinary support.

5. Recommendations for children and families with special needs

Good institutional daycare may promote the developmental opportunities of all children because it makes social integration possible.

Children and families with special needs may find in daycare centers opportunities for social networking and peer belonging, which increase the chances for healthy development. However, these specific integrative tasks that daycare centers are called upon to fulfill are associated with challenges that require commensurate conceptual, professional, and personnel resources.

For infants and toddlers with an migrational background, daycare centers assume the function of a transitional space between the family and the surrounding culture. The experience of belonging based on meaningful relationships decreases parents' fears and makes it easier for children to acquire a second language, which facilitates later integration into school (cf. also Chapter 14.1).

Infants and toddlers from at-risk families benefit from daycare center care that stimulates them, shields them from the effects of neglect, and fosters social integration. For the parents, childcare that supplements the family may facilitate economic integration and support their own parenting competence. Risks to the child and the associated conflicts between family and daycare center occur frequently when caring for these children. The handling of these complex situations requires that the daycare center management be well integrated into an interdisciplinary network including youth welfare services, have specialized knowledge, and a pedagogical approach that defines institutional responsibilities, possibilities, and limits, and which is

supported by the trustees or sponsors and the staff.

Infants and toddlers from families with emotional risk factors benefit from ongoing alternative relationships in daycare centers. The parents get both relief and encouragement, which in turn supports their own parenting competence. However, incomprehensible and impulsive behavior on the part of parents and child may trigger fears in both the caregivers and other parents, and strain the day-to-day routine. Psychotherapeutic supervision and support may help the parents, children, and staff avoid becoming overwhelmed.

Infants and toddlers with special developmental risks that would likely not be adequately dealt with in remedial facilities may benefit from the available teaching and peer groups in daycare centers. However, such integration is possible only with additional staffing and consultation with child support services based on the individual needs of the child and her family, and the composition of the child's group. It is important that the children themselves and the group in which they are integrated be shielded from overstimulation.

6. Compensatory care as prevention and opportunity

The availability of daycare care facilities outside the family may contribute in important ways to primary and secondary prevention of abuse and neglect.

If resources are inadequate -- in terms of staffing, training, group size, networking among centers --, GAIMH considers supplemental care outside the family to be harmful to the infants and toddlers themselves and an additional stress for the parent-child relationship.

7. GAIMH policy recommendations for educational and institutional frameworks of daycare centers

Societal interest in the quality of teaching in daycare centers for infants and toddlers has also stimulated discussion across the board about the educational tasks in young families and the care and learning needs of infants and toddlers in general. This interest has demonstrated what young parents accomplish on a daily basis and shown that both families and daycare centers are dependent on protection, support, encouragement, and discussion for the fulfillment of their caring and educational tasks. These are needed to ensure that infants and toddlers are supported in their early childhood development. In this sense, the upgrading of early childhood care and education strengthens all young families.

7.1 Education in early childhood

The family is the most important site of learning and socialization for infants and toddlers. When parents entrust their infants and toddlers to daycare centers, they must be certain that their children receive the individual attention they need in terms of overall learning needs and age-appropriate stimulation that neither over-challenges or under-challenges them. Because of this, GAIMH recommends that overall educational plans for early childhood proceed from learning processes of infants and toddlers, and that these plans make early childhood education relevant to the developmental stage of the individual child. These overall educational plans should contain specific recommendations for educational processes and goals in early childhood, facilitate the transition to subsequent educational systems, and decrease barriers to access to high quality educational and care opportunities.

7.2 GAIMH recommendations and questions for future research

Research in the area of early childhood care and education can still be expanded and networked more effectively. In the areas of basic and applied research, gaps in our knowledge with respect to early childhood learning processes, particularly in group situations, and social exchanges among infants and toddlers in multi-person settings must be closed. Quantitative and qualitative longitudinal and case studies can yield important knowledge about the significance of daycare outside the family for child development, about risk assessment and indications, and about how educational approaches work.
A national and/or regional statistical database should be created in all three countries that would enable us to obtain clear information about the status of quantitative and qualitative care at daycare centers, which can then be used for policy and professional planning.

7.3 GAIMH recommendations for mandatory supervision of daycare centers

The qualification and supervision of centers that provide care outside the family cannot be left to the management of daycare centers, or to the trustees or financial sponsors. Rather, they must be held up to measurable standards of structural quality and embody professional knowledge and standards for the assessment of procedures and guidance. As a result, in the interest of the children and to ensure quality in daycare centers, GAIMH recommends the mandatory establishment of specialized oversight agencies under the aegis of state-run youth welfare services. These oversight bodies must have knowledge in the areas of developmental psychology of early childhood and of early-childhood education, and examine the structure and work of daycare centers based on scientifically established standards and criteria. In addition, GAIMH considers the elaboration and establishment of overarching pedagogical quality management for infants and toddlers to be indispensable in all three countries. GAIMH recommends that the state expressly stress the importance of quality in all competitive bidding by providers.

The full recommendation with a list of the participants in the GAIMH internal working group is available at http://www.gaimh.org/publikationen/betreuung-in-krippen.html

In this paper, the term "daycare center" [Krippe] was used uniformly for institutions or facilities that care for small children outside the home, in the full knowledge that different terms are used in Germany, Austria, and Switzerland as well as in other countries.

From the Editors

By Deborah Weatherston and Hiram E. Fitzgerald, Editors, Michigan, USA

Dear colleagues:

During the past 50 years infant mental health has emerged as a significant approach to the promotion of social and emotional wellbeing in infancy, as well as a preventive-intervention approach to treatment when significant risks to the infant or young child, the parent and the relationship are identified. Within this same time frame, the infant mental health movement has expanded to a global network of professionals from many disciplines, research faculty, and policy advocates, all of whom share the common goal of enhancing the quality of relationships that infants and young children have with their parents and other caregivers. The global reach of infant mental health demands attention to the cultural context in which a 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.

We invite all members of the World Association for Infant Mental Health and all members of its 50 international Affiliates to contribute to WAIMH's international publication, newly named by the WAIMH Board, «Perspectives in Infant Mental Health,» where views about infant mental health can be shared, discussed, and indeed, even debated. We welcome your articles, brief commentaries, case studies, program descriptions, and descriptions of evidence-based practices.

Articles will be reviewed by the editors and members of the Editorial Board, all of whom are committed to identifying authors from around the world and assisting them to best prepare their papers for publication.

In the spirit of sharing new perspectives, we welcome your manuscripts,

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President's page

By Miri Keren, WAIMH President, Israel

«The Signal» has a new name: «Perspectives in Infant Mental Health.» Giving a name, is, as we know very well from our clinical work, a port of entry into our wishes, conscious as well as unconscious. Indeed, the idea of changing the name of our Newsletter from "The Signal " to «Perspectives in Infant Mental Health,» reflects our- conscious - wish to make the name fit the changes that have gradually occurred in the last years, i.e from an information-based Newsletter to a more scientific format with emphasis on the collection of clinical studies, program descriptions and sharing of experiences in the field.

This present Issue is indeed a collection of various aspects of infant mental health all around the world, from Pakistan to Germany, with a special emphasis on the complex interplay between societal changes, such as father's role in the family in Pakistan and our clinical practice. The GAIMH recommendations for ensuring good enough quality of Day Care is also an expression of our members' deep commitment and active involvement in their own society. This document, as well as Catherine McGuire about the position paper on Infant Mental Health Policy in Ireland (see previous Issue), are very helpful for our in-process task to prepare the Infant's Rights document. I strongly encourage any one of you who are involved in this kind of activity to send us your thoughts and recommendations.

The Infant's Right to grow up in a good-enough family, sounds so obvious. Still, the more we work with infants, the more we are facing high- risk families, where exposure to trauma and major parental psychopathology create a tough dilemma between the adult's best interest and the infant's, as it is vividly described in this Issue. Countertransferential issues are major, our own feelings of failure are difficult to handle, and one is often tempted to give the therapeutic trial up. Ethical and clinical issues are numerous and must be dealt with among ourselves. Cross-cultural adoptions, recomposed families, same-sex parenthood, single parenthood, financial adversities and parental unemployment are issues that involve many professional fields - sociology, anthropology, social work, education, as well as psychology and psychiatry. As a professional association, WAIMH has the task of formulating guidelines to help all of us make clear recommendations on behalf of babies and families to health and social service policy makers and family courts.

Intensive work is going on around the preparation of our next WAIMH congress in the UK. As announced in Capetown, the theme will be around Babies in Families. Though we still have time ahead of us, please start thinking about your presentations!

Very cordially to all of you.

Major Mental Illness Complicating Reunification Following Maltreatment

By Tessa Chesler and Devi Miron, Tulane University School of Medicine, Louisina, USA

In the United States, termination of parental rights is an extreme legal intervention, requiring proof that the parent is "unfit;" that is, that they are not now nor in the foreseeable future able to provide safe and appropriate care for their child. The complex issue of whether it is in the best interest of the child to sever the parent-child relationship is a key issue in these cases. When a mother has major mental illness, such as schizophrenia, the issues become even more intricate.

We begin by considering pregnancy and parenting n women with schizophrenia. Then, we describe a case vignette to highlight key issues and challenges in determining the best interests of a child in foster care whose mother has schizophrenia. We also consider potential interventions for mothers with schizophrenia.

Mothers with Schizophrenia

One of the biggest fears of mothers with schizophrenia is that they are going to lose custody of their children. These fears are not unfounded since about half of mothers with schizophrenia do, at some point, lose custody of their children, usually to family members (Seeman, 2002). The number of mothers with schizophrenia who are having children is growing. In North America, about half of women with schizophrenia are mothers, and in Great Britain, about 63% of women with psychosis are parents. Losing custody of their children not only increases the stress of these mothers, but also has lasting negative impacts on the children (Seeman, 2002).

The number of women with schizophrenia who are having children seems to be increasing as services and treatments for schizophrenia evolve. Schizophrenia is being increasingly treated in the community in outpatient clinics rather than in inpatient facilities. Typical antipsychotics, which once were standard treatment, had a side effect of raising prolactin levels, making conception difficult. Some newer atypical antipsychotics have less effect on prolactin because of their transient binding to D2 receptors, which could increase the likelihood of getting pregnant (Bassett, Lampe & Lloyd, 1999).

Half of mothers with schizophrenia are raising at least one of their children. Ritsher found that 44% of these women are single and over two-thirds needed help with child care (Ritsher, Coursey & Farrell, 1997). Even though half of mothers with schizophrenia retain custody, Joseph found that only 12% were the primary caregivers of their child (Joseph, Joshi Lewin & Abrams, 1999). If a mother with schizophrenia is not single, there is a 9% chance that the significant other also had a serious mental illness (Hearle, Plant, Jenner et al., 1999). Thus, assortative mating complicates a small but meaningful number of cases.

Bassett et al. (1999) assessed mothers with schizophrenia and their infants using the Global Rating Scales of Mother-Infant Interaction and interviews. Children raised by mothers with schizophrenia showed more avoidant behaviors. Negative symptoms of schizophrenia and the medications used to treat schizophrenia can severely affect the mother-child interaction as the mothers appear more emotionally remote, insensitive, and unresponsive. Although the interaction between mothers and their children may appear compromised, mothers with schizophrenia expressed definite benefits of being a mother during interviews about parenting. They cited that they had a purpose, identity, love, and support. However, these benefits were complicated by the fears that these mothers had about losing their children or of their children also suffering from a mental illness. If they did lose custody of their children, they often suffered long lasting anger and grief.

Case Vignette

Ms. Hanson1 was court-mandated to an intervention program that serves children less than 5 years old who are placed in foster care and their caregivers. She provided information during an intake evaluation, a parent-child relationship evaluation, and a psychiatric evaluation.

1 Please note that the names used in the article are fictitious.

Ms. Hanson is a 32-year-old female from the southern United States. Ms. Hanson's parents divorced when she was very young, and she was raised by her mother and maternal aunt, along with two older sisters. She is very intelligent, and she skipped 3rd grade. She became pregnant at 18 years old and had an abortion. She disclosed this first pregnancy during evaluation of her partner violence experiences. However, she declined to discuss whether this pregnancy was the result of an abusive situation.

Ms. Hanson began college away from home, and stopped attending after one year because she struggled academically. Her maternal aunt described Ms. Hanson as unstable and very moody during this time. In fact, Ms. Hanson moved around to several family members' houses because she easily became violent, and subsequently was asked to leave. This instability occurred for several years as she struggled to maintain employment in various food service venues.

Ms. Hanson became pregnant again when she was 29 years old during a single encounter with a man whom she claimed to not know. She said that she did not know that she was pregnant until she was eight months gestation. At the time of her evaluation, Ms. Hanson was unemployed.

Ms. Hanson's family members called Child Protective Services 15 months after Ms. Hanson delivered her child, Luke. The family members stated that Ms. Hanson was locking Luke in the closet, not feeding him properly, and not getting the medical care that he needed. Child Protective Services began its investigation of this case after three calls from the family members. After investigation, Luke was placed with his maternal great aunt. Luke's mother became so upset and violent when Luke was taken away that the police took her to jail, and later to a psychiatric hospital. The Court ordered Ms. Hanson to participate in the services provided by a team of infant mental health specialists who assess the ability of parents to care for their young children, provide intervention, and make recommendations to child protection services and the Court.

During Ms. Hanson's initial interview, it became clear that she did not have insight as to why Luke was removed from her custody. She said she felt that she was

protecting him from others by keeping him in the closet. She explained she would bring him out at night so that she could spend time with him. Her guess as to how she could regain custody of him was to "give him bigger toys – remote control cars."

Ms. Hanson participated in a Working Model of the Child Interview a semi-structured interview designed to assess the parent's perception of his or her child (Zeanah & Benoit, 1995). Examples of Ms. Hanson's responses are below:

> Examiner: "What is your favorite story about Luke?"
>
> Ms. Hanson: "When he was firstborn and he would sleep in his bassinet, I would tell him, 'I'm staring at you, I'm watching you.' He would look back."
>
> Examiner: "What do you like about that story?"
>
> Ms. Hanson: "I don't know, it's kind of nice, pleasant, dear to the heart."
>
> Examiner: "What are your feelings on having a boy?"
>
> Ms. Hanson: "It was a bit of a relief especially with the cleaning aspects. I couldn't imagine a girl – not to be gross – how are you going to clean that out? Thank God you're a boy!"

Ms. Hanson and Luke (then 20 months old) also participated in a parent-child interaction procedure modified from the procedure developed by Judith Crowell and colleagues' procedure (Crowell & Feldman, 1988; Crowell, Feldman & Ginsberg, 1988). Luke appeared anxious and unsettled during the evaluation. In fact, he refused to remain with his mother, and his great aunt was asked to remain silently in the room to act as a "secure base" for Luke. With his great aunt present, Luke was relatively more comfortable to explore and interact with his mother. However, he continued to maintain distance from her; resisting her efforts to hold him on her lap. The dyad exchanged limited positive affect. Ms. Hanson showed some strengths during the procedure, including maintaining interest in engaging her son and talking with him. However, she had trouble following his lead during play and reading his cues.

Ms. Hanson was referred for a psychiatric evaluation because of concern about disorganization in her thought processes. During the psychiatric evaluation, Ms. Hanson reported memory problems, and said that her heart was "differentiating." She had several neologisms, and was guarded and paranoid throughout the interview. Although she denied any psychiatric treatment, she reported she had been taken to a psychiatric hospital when Luke was brought into care. She was prescribed an antipsychotic medication at that time. Ms. Hanson reported to the evaluator that the medication was just a "suggestion" and she didn't have to take it. It was clear during the interview that she had a thought disturbance. Careful history from her and her family made clear an insidious deterioration in functioning over a several years. Ms. Hanson was diagnosed with Schizophrenia, paranoid type.

After the evaluation, the Court ordered Ms. Hanson to obtain psychiatric treatment. However, she did not follow up with these recommendations. She had been granted weekly visitation with Luke in his great aunt's home until one night she attempted to take Luke from the home. On that night, Ms. Hanson was out of control and violent as she forcibly pushed her way into her maternal aunt's house and angrily demanded her son. The maternal aunt called the police, and Ms. Hanson was transferred to an inpatient psychiatric facility against her will. She was started on an antipsychotic medication, and slowly, she began to improve. After her discharge from the hospital, Ms. Hanson began to go to psychoeducation groups, individual therapy, parenting sessions, and joint sessions with her maternal aunt. Slowly, therapeutic, supervised office visits with Luke were re-introduced. Ms. Hanson became stable and consistent with treatment, and her relationship with Luke improved gradually over several months. For example, over time, Luke chose to sit on his mother's lap and the two enjoyed playing together.

Over the course of approximately one year of intervention, the infant mental health team continued to monitor Ms. Hanson's individual progress and the progress in her relationship with her son. Although Ms. Hanson's stability improved, she continued to have poor insight into Luke's physical, developmental and emotional needs. She also failed to gain a full understanding of the circumstances under which Luke came into care. Her difficulty sustaining attention in general; and specifically to Luke's cues also put Luke at a significant risk. As Luke's ambulation increased, Ms. Hanson's anxiety increased as well. She continued to prefer confining Luke to a small area in the visit room where he had little freedom to explore. Because of Ms. Hanson's inability to discern dangerous situations and her problems with attention, the team determined that she was at very high risk for recidivism of neglecting Luke should he be returned to her care. Child protection staff and the judge agreed and care was transferred to her maternal aunt. Ms. Hanson was able to maintain a relationship with Luke through regular visitation.

During one of Ms. Hanson's last interviews, she discussed her feelings about schizophrenia. She stated, "It's held me back a lot. Just from the stigma feeling to not show my feelings. I feel trapped inside…. My family – I think, 'Do you just see me as this crazy person sometimes?' I feel they'll blame it on the schizophrenia if I do something. I want to express my emotions but I feel a little held back."

Recommendations

To conclude, we present recommendations to assist mothers with schizophrenia and their young children.

System collaboration. Unfortunately, women with schizophrenia often have a mistrust of legal and mental health services, and consequently, many times care for these mothers and their children is not initiated until after the child comes into custody of the State. The reasons for this are complicated. The mistrust these women have of the systems available to assist them due to factors associated with psychosis (e.g., distorted thought process, paranoia) and the reluctance to accept diagnosis or treatment, coupled with the inconsistency in availability, quality, and access to services offered by the systems seem to be some of the deterrents to helping mothers with schizophrenia (Bassett et al.,1999; Seeman, 2002. Collaboration between legal, mental health, and child protection systems is important to ensure that the needs of the child and mother are being met. This sentiment is echoed by the women with schizophrenia in Bassett's focus groups, who stated that they wanted support, information, better access to community services, and therapeutic programs and family planning.

Family planning and prenatal and postnatal care. Although it would be preferable to begin family planning education before pregnancy, many mothers with schizophrenia do not obtain prenatal care. Many times these mothers are single and are at low socioeconomic levels, which may make access to medical

care difficult. The risk of premature delivery and low birth weight for mothers with schizophrenia is 50% greater than for mothers without the illness (Nilsson, Hultman, Cnattingius, Olausson & Lichtenstein, 2008). Proper prenatal care can reduce risk for problems in the infants and mothers. after the child is born, continued postnatal care is necessary to provide the child with proper medical management. Nilsson et al. showed that children with mothers and fathers who have schizophrenia are at an increased risk of medical problems (Nilsson, et al.,2008). They hypothesized that smoking by mothers with schizophrenia increased the risk of medical problems. Further, infant mortality has been shown to be increased in children whose fathers have schizophrenia, and more studies are needed to determine why this increase exists (Crowell & Feldman, 1988). These children require early interventions such as early developmental screening. Mothers can benefit from in home parenting instructions on caring for an infant. Therapeutic child care can aid the child and provide needed social supports and peer interaction (Seeman, 2002).

Child protection assessments. When a mother and her young child come to the attention of child protection services, a parenting assessment is needed. It is important to conduct parenting assessments with mothers with schizophrenia and their young children at different intervals to ensure accuracy. These assessments should include evaluations of safety and risk factors for abuse and neglect, quality of the relationship and attachment, and parenting capacities. Early parenting assessments can identify any immediate dangerous situations which need to be addressed, and they can guide the examiner in determining what supports are needed. When conducting evaluations, it is essential to consider that the postpartum period is a sensitive time because psychiatric symptoms can increase. During this time, the mother's functioning should be carefully assessed and interventions should be implemented when necessary. Mother-infant interaction may look very different a few weeks after birth. Later parenting assessments usually involve evaluating the developmental functioning of the child. It is sometimes difficult to ascertain if developmental delays are due to parenting deficits or to genetics or to other factors. It is known, however, that regardless of the etiology of the delays, these children will benefit from extra stimulation and an enriched environment, and these can be provided through child care centers. The need for extra stimulation alone does not justify taking the child's custody away from a mother with schizophrenia.

Following assessment, a comprehensive plan should be put into place with the goal of keeping the mother and child together. Mental health providers can play a key role not only in assessing and treating the mental health of mother and child, but they can aid in bringing together the different services to create a cohesive team. This team should include the mental health care workers, family workers, legal services, child protective services, case workers, obstetricians, and pediatricians. Ideally, services should be in place prior to the birth of the baby. This team can provide appropriate medical and psychosocial interventions (Seeman, 2002). As the team collaborates and communicates, the best interests of the child can be adequately determined by considering strengths and concerns of the parent's ability to care for her child safely and effectively. Many mothers with schizophrenia may find that with the support from her team, she is able to care for her child. After a complete assessment, it might become clear that the mother with schizophrenia is not able to adequately meet her child's needs, as in the case described above. With a comprehensive plan in place, however, mothers with schizophrenia may still be able to remain meaningfully involved in their children's lives when this involvement is in their interest.

References

Bassett, H., Lampe, J., & Lloyd, C. (1999). Parenting: experiences and feelings of parents with a mental illness. Journal of Mental Health, 8, 597-604.

Crowell, J. A., & Feldman, S. S. (1988). Mothers' internal models of relationships and children's behavioral and developmental status: A study of mother-child interaction. Child Development, 59, 1273-1285.

Crowell, J. A., Feldman, S. S., & Ginsberg, N. (1988). Assessment of mother-child interaction in preschoolers with behavior problems. Journal of the American Academy of Child and Adolescent Psychiatry, 27, 303-311.

Hearle, J, Plant, K, Jenner, L, et al. (1999). A survey of contact with offspring and assistance with child care among parents with psychotic disorders. Psychiatric Services, 50, 1354-1356.

Joseph, J. G., Joshi, S. V., Lewin, A. B., & Abrams, M. (1999). Characteristics an perceived needs of mothers with serious mental illness. Psychiatric Services, 50, 1357-1359.

Ritsher, J. B., Coursey, R. D., & Farrell, E. W. (1997). A survey on issues in the lives of women with severe mental illness. Psychiatric Services, 48, 1273-1282.

Seeman, M. (2002). Women with schizophrenia as parents. Primary Psychiatry, 9(10), 39-42.

Nilsson, E., Hultman, C., Cnattingius, S., Otterblad Olausson, P., & Björk Lichtenstein, P. (2008). Schizophrenia and offspring's risk for adverse pregnancy outcomes and infant death. The British Journal of Psychiatry, 193, 311-315.

Zeanah, C. H., & Benoit, D. (1995). Clinical applications of a parent perception interview in infant mental health. Child and Adolescent Psychiatric Clinics of North America,4(3), 539-554.

Urban Fathers' Involvement in Early Childhood Development: A Case Study from Pakistan

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Introduction

Fathers' role traditionally has been considered as a bread earner and role model for practicing moral values in a family. However, in these changing times the role of the father has diversified especially in urban areas and metropolitan cities. Since the growing needs, the rise of solar families (mother, father and children only) and increase in education levels have influenced changing practices of fatherhood to a great extent. Hence, today's fathers are relatively more involved in their children's development than before (Palkovitz & Palm, 2009; Bronte-Tinkew et al., 2008; Manlove & Vernon-Feagans, 2002). This has been widely reported by various researchers and parenting organizations across a range of urban settings..

According to Ball, Fatima and Chakma (2012), "These changes have impacted the composition of families {often from extended families to more nuclear families}, increased participation of women in the labour force, increased out-migration of mothers while fathers may remain at home, and in some cases, changing ideas about gender roles and about children's socio-emotional needs" (p.1). A renowned sociologist has presented reflections on the traditional perceived role of the fathers, when the fathers were considered 'second adults in the family' and has argued that fathers who are involved can benefit children as no other adults can (Popenoe, 1996).

Researchers from the West have studied the impact of the father's involvement on the optimal development of young children through a wide-range of quantitative studies. The lived experiences, perceptions and beliefs of the fathers have been discussed in several qualitative studies.

Fatima's (2012) fatherhood study in Pakistan emphasized the importance of exploring fathers' involvement and its impact on very young children. She argued that "researchers are now calling for an expansion of research to address aspects of father involvement that assess(es) both quality and quantity and that examine(s) direct and indirect forms of father involvement in children's lives" (p.5).

A growing body of research has investigated the significant role of fathers noting that many child development agencies place primary focus on mothers and their children, thereby paying little or no attention toproviding fathers access to the parenting program interventions (Cowan, Cowan, Pruett, & Pruett, 2005).. Because many research studies have indicated a significant positive relationship between fathers' involvement and children's optimal development in the early years of life (Perry, Harmon & Leeper, 2012), greater emphasis needs to be given to involving fathers in prevention efforts. While, the importance of fathers' involvement appears to be a vital aspect of child development it is important to explore how involvement is defined.

Involvement, in principle, means participation, association, interaction and a bonded relation. Likewise, parental involvement in infancy and early childhood means responsive or proactive care of the children. Hence, an involved caregiver is the one who is responsive to the child's needs, interacting with the child, providing care and nurture. The University of Virginia (2011) in one of its projects 'celebrating babies and tots' has given an insightful definition of responsive care and involvement: conducive environment and caring adult.

Forgarty & Evans (2009) describe fathers' involvement as a "direct interaction between a father and a child, accessibility, or how available a father is to his child when needed, responsibility or managing and providing resources for a child, and building of social capital or how fathers provide a support network for children as they grow up to contribute to society" (p.1). In early childhood, fathers' role and involvement target development that facilitates children's emotional support, physical exercises and cognitive activities (Bronte-Tinkew et al., 2008). Pleck (2004) expresses the view that fathers who are involved in their children's development are more satisfied and also have children who are more social than children with less paternal involvement.

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There are several research studies that provide evidence of strong association between fathers' involvement and children's developmental outcomes. Stratton (2006) showed that a father's presence in the family in and of itself had noticeable impact on the conduct problems in young children. The research study targeted 30 families who received training on managing their child's conduct problems and later were divided into families with fathers and without fathers. The results of the study established that the families without fathers appeared to be less receptive to the intervention than the families with fathers.

Many investigators have postulated an association between children's cognitive development and fathers' involvement. The studies have demonstrated that children whose fathers are involved in the early years of life have shown higher academic performance in their schools than the ones whose fathers were less involved. Moreover, the children of involved fathers have shown greater interest in the schools, activities and have less school readiness issues. Moreover, children of involved fathers have score higher on IQ tests and are less likely to fail in exams (Astone & Rivera, 1999;

Furstenberg, & Weiss, 2001; National Center for Education Statistics, 1997; William, 1997).

Researchers who have investigated the emotional wellbeing of young children have argued that the children whose fathers are involved in their development have higher self-regulation. Equally, fathers' involvement studies accentuate that children of involved fathers have fewer coping and competence issues, self-management problems, and behavioral problems. These children are better in handling stress and new situations and are found to be more resilient (Veneziano, 2000). In addition, quite a few studies have shown a significant correlation between fathers' involvement and children's overall life satisfaction (Dubowitz et al., 2001; Flouri, 2005; Formoso et al., 2007; Schwartz & Finley, 2006).

Many research studies have focused on discovering the relationship between fathers' involvement and social development of young children. (Kato, Ishii-Kuntz, Makino, and Tsuchiya (2002). Children whose fathers were closely involved in their early years of life had more positive peer relationships, were better liked by others, were team builders and participated well in social events.

The physical health of young children and its association with fathers' involvement has been a growing interest for the researchers involved in early childhood programs. Fathers' involvement in early childhood protects children from getting involved in drug abuse later in life (O'Connor, Davies, Dunn, &Golding, 2000). Studies have shown that children who reside with their fathers have relatively fewer health problems than the ones who do not.

The relationship and presence of fathers in early childhood also help to decrease negative developmental outcomes of young children. Children who feel close to their fathers and are demonstrably given responsive care appear to have less involvement in criminal activities, delinquencies and anti-social behaviors.

Accordingly, the current study is an initiative towards providing insights to this phenomenon. The study brings forward three noteworthy practices of urban fathers from Karachi, Pakistan. The voices of fathers from non-Western cultures are drastically absent from the corpus of literature accumulating from studies in Western societies. The voices of these Parkistani fathers are significant because they are culturally authentic and contextually appropriate in ways that may help frame studies of larger samples of fathers from developing countries. This study focuses on exploring beliefs, practices, challenges and constraints of the fathers who are involved in the developmental health of their young children in urban settings.

Method

Study Design

This qualitative inquiry followed a case study method with three cases of involved fathers in Karachi, Pakistan. The intention was to expand in-depth understanding of urban fathers' involvement, roles, beliefs, practices and challenges. The research employed purposive sampling to recruit the participants for the study.

Participants

As for the selection of the cases, the researcher has recruited three involved fathers of different socio-economic backgrounds from Karachi. To recruit the fathers who were involved in their children's development, the researcher went to the community and inquired from the people and after many suggestions chose the fathers that best fit the criteria. This included their willingness to participate in the study; a minimum of two to four hours on an average each day spent with the child and the fact that they have children less than three years of age. The three fathers were selected from economically affluent-class, middle-level -class and less privileged-class.

Khalid (pseudonym) was the father selected from an affluent socio-economic background. Khalid's family lives in an affluent area and is well established in a family business. He manages the business by himself and returns home early in the evening. Once Khalid is back home he often dedicates all his time to his only child, a two-year-old son.

Kabir (pseudonym) was the father selected from middle socio-economic background. . Kabir is a chartered accountant and is employed by a multinational company. He works twelve to thirteen hours a day. He is also preparing for a higher education degree and studies at home. Once he is back home he ensures spending at least two to three hours with his seven-month-old son.

Kasim (pseudonym) was the father selected from an economically underprivileged class. He is a government servant, works seven hours a day and is a father of a one and half year old girl. He lives in a community where there is a lack of appropriate child care facilities and also lack of awareness of educating girls. Kasim, once home, assures giving five hours to his daughter on an average in a day. He says during this time he plays two roles; a father and a teacher.

Measures

The source of data collection for this study was in-depth contextual interviews and observations. The in-depth interview was conducted with a semi-structured interview guide and three days observations were taken in the home setting of the fathers in the study.

Procedure

After the data collection, it translated in English, then again in Urdu and then again in English to ensure its reliability. Moreover, thematic analysis was performed to explore the key emerging themes from the data.

Findings and discussion

The findings of this study revealed many commonalities and individualities of the involved fathers and their practices of fatherhood. The analysis from the data revealed two major findings of the beliefs, roles, practices and challenges that the three fathers have in common:

1. Becoming a Father: Roles and Responsibilities
2. Fatherhood: Involvement, Practices and Challenges

Henceforth, given is the explanation of the two common themes that emerged from the data.

Becoming a Father

All three fathers expressed their feelings of becoming a father differently. However, all three stated that it is a kind of feeling that cannot be expressed in words. While fathers expressed how they felt, their eyes were shining and one father even started crying (Field Notes, p.1, 2012). Khalid expressed that he had planned to have a child with his wife after a few years of marriage. However he got the news of his wife's pregnancy after only a couple of months of marriage. He mentioned:

> "We had planned sometime after marriage but when I heard this news I was surprised and excited…it was a feeling of happiness and thought now what next to do. Only thought was to live better as my exciting life starts now. Even thought that whatever and however I am living

> I should move on. It was great and unexpected situation for me. It was my baby. Then slowly one by one family started given best wishes so I felt it's not dream as it's a fact of my life. Those moments with my wife and my baby were evergreen moments of my life" (Khalid, 2012).

It can be seen in Khalid's description that although he was happy to be a father, he lacked readiness to becoming a father. Jordan (1989) explored factors that determine readiness of fathers and gathered data from 56 expectant fathers. The study revealed that recognition of being a father was significantly associated with men's acceptance of pregnancy. Many fathers in various urban settings subsist with a similar kind of state of mind that may influence their level of acceptance in becoming a father. Thus, keeping in mind Khalid's case where he was content but not ready, agencies working on parenting interventions can develop capacity building of such expectant fathers.

In Kabir's case his baby was a planned and he was well prepared. He mentioned that it was his first time ever to hold a newborn baby. He expressed his feeling by narrating:

> "When nurse gave me my child in my hands and when I held the baby, I felt so good but on the other hand sense of responsibility strongly touched me and thought came that now finally I have become a father. A very unique and unexpressible feeling was there at that time. Never thought of it, in fact I never picked any newborn baby in my hands and when I held my own baby, a fear was there in my heart, a fear that if I drop my child…. Even feels good as well but also a fear that will I be able to fulfill all his needs or not but happiness also was there as new member came in our life" (Kabir, 2012).

Pruett (1997) mentioned that most men experience carrying babies in their arms for the first time when they have baby of their own. Kasim's experience was unique amongst the other two with an influence of the cultural practice. In his culture fathers are not allowed to see their newborn for the first ten days. Philosophizing this he mentioned:

> "Almost when I came to know that I am going to be a father so I felt very happy that baby which is going to come in this universe is bringing so much happiness. I cannot tell you that how much money I have spent on these tasks and problems. It has been almost 10 days; there are some requirements when a baby is born. Generally, baby comes in father's hands quickly but here it takes 10 days when a father gets to hold his baby in his hands. So after 10 days I held my baby in my hands so I felt so emotional from inside and felt so good and it was my own baby in my hands and I felt an unusual feeling inside me. And how I can express you that what my feeling was when I held my baby first time in my hand" (Kasim, 2012).

The expression of feelings of becoming a father is widely influenced by the culture, norms, and communities that men live in. Hence, a man's emotions in several societies are known as self-controlled and economically focused (Doucet, 2007; Shields, 2002). Therefore, it is vital to provide a platform for the expectant fathers to share their feelings. All three fathers have given insights to their childhood, how their own fathers behaved and the roles and responsibilities of their fathers. Fathers have related practices of their fathers in their childhood to their own current context and practices. Kasim mentioned that he had lovely memories of his childhood and likewise, he wants to maintain similar experiences with his child.

Whereas, Khalid mentioned that his life was dependent on his father's decisions and that his mother also played a caring responsive part. Therefore he allows his wife to be on the decision making side with him. To him, it is healthy for child development if both parents make decisions for their children. On the contrary, Kabir lacked care, support and facilitation in his childhood and on this he mentioned:

> "Basically child grows by observing his father because father is a role model for him. He wants to be like his father although I never wanted to be like my father. But I want my child to be like me. So I have to be very responsible and careful in every step of my life. In past years people were not aware about all these things as my father gave priority to his shop but now a days awareness is coming slowly in the society… people are more conscious about higher education and discipline" (Kabir, 2012).

All the fathers have given different views on roles of fathers and several patterns were observed in their responses. Kasim's view of fathers' responsibility is to act like a role model for his young children. To him, a father needs to change a lot once they enter into fatherhood, their life styles, practices, and approaches in relating to other people change. These changes are required to support children to learn social skills from their fathers. Kabir's view was that fathers' role should be as a friend who teaches psycho-social norms to a young child. On this, Kabir mentioned:

> "Major role is as a guide and help him to know the difference between good and bad. We have to be patient and calm while dealing with kids. Build trust between father and child so that child feels comfortable and share every step of his/her life with his father and if face any problem always come to father to resolve it" (Kabir, 2012).

Likewise, Kasim mentioned that it is vital for a father to first explore the social dynamics of the gender of the newborn. The role model practices are customized for male and for female children. He thinks gender sensitivity is vital since the relevant context has predefined different roles for a female and a male child. To him, father is the one who provides gender awareness to young children. This phenomenon of fathers' facilitation in gender development of young children has been found to be consistent with literature in the West.

According to Stern & Karraker (1989), fathers' and male members of the family characterize children as strong and hardy if it is male and delicate and soft if it is a female. Likewise, similar instance and phenomenon can be observed in developing nations where gender roles are usually predefined. Consequently, it can easily be determined that fathers' perception of their role as a father is associated with their own context and belief system.

Regardless of different perceptions of roles and responsibilities, all three fathers strongly accentuate father's core responsibility of building a stable career and providing lifelong financial security for their young children from day one.

Fatherhood: Involvement, Practices, and Challenges

An expanding literature indicates that fathers' involvement in child development does contribute to the developmental health of their young children (Pleck & Masciadrelli, 2004; Sandberg & Hofferth, 2001; Bianchi, 2000). All three fathers in this study on an average spent two to four hours interacting, playing, baby sitting and teaching their young children every day. Although their educational background and family context are different as to their structures and life patterns, all three fathers assured spending quality time with their children every day.

Khalid was found to participate more often in all daily routine activities with the child. He believes that the father's involvement is not restricted to giving a specific number of hours to a child but generally participating in routine activities of the young children. He said he is involved with his child since morning (before going to business) till the time they all go to sleep. So, he participates in changing diapers of his child and other routine care giving. While he does that he closely interacts with the child. Moreover, he has a routine of playing physical games with his child before the child goes to sleep. To him, facilitating play and involvement in the physical activity of young children is vital for their development. Furthermore, he always accompanies his wife when his child has a health care appointment. In addition, he believes that it is significant that fathers take their children out of the house to socialize, as he does. He mentioned that every weekend he takes their child out to a park or a society club to enable him to learn social skills. Likewise, Kabir is of a similar view and says that young children need care and love. Hence, all activities that Kabir does with the child focus on routine interaction and playing with him.

On the other hand, Kasim is much focused and involved in cognitive development activities of his child. He is more concerned in carrying out activities with his daughter that focus on her intellectual development. He believes in giving a concentrated and specially allocated time to young children. To him, young children learn better if the father is participating in their cognitive and numeracy skills.

This phenomenon has been found consistent in the study of Fagan and Iglesias ( )where they have found a positive association between fathers' involvement in early years of life and high scores in mathematics. Moreover, Kibria (2009) states "According to both parents, activities that fathers might do to enhance their children's development includes helping out during meal times, taking their children to school, helping with washing hands, going for outdoor visits, playing, increasing bedtime routines and toilet training. On the other hand, both parents were less supportive of increasing fathers' activities in storytelling, bathing, clean-up, reciting rhymes, making toys and singing activities" (p.3).

> As Khalid mentioned, "Every night for about half an hour or 45 minutes we play together like hide and seek or flat race as these kind of games help in physical as well as cognitive development of a child and this also is his favourite game as well and as he enjoys a lot. Yes, like daily massage. Before wearing pampers his mother used to do massage. During massage I use to play and he enjoyed and felt relaxed. Even to develop his cognitive skills we used to play colors game to pick colors etc. Rarely do we see TV shows but yes some time baby watches TV that I use to put on as some time when child is not ready to eat so I use to switch on baby TV channel and he used to sit and eat. Even if any there was an informative program then I use to facilitate. Other than this we used to play different home based games and even book reading" (Khalid, 2012).

Fathers being involved in the development of their child also face numerous challenges and issues. A study was conducted in Singapore to explore the public perception of fatherhood. A sample of 2220 was recruited to administer the survey. The findings of the study revealed that work responsibilities were the most challenging for fathers. After work responsibilities, financial constraints, lack of parenting resources, lack of knowledge of parenting skills, society view and pressure were the variables rated as a few other challenges fathers face.

In the current study, all three fathers stated "work responsibilities" and "work pressure" as major challenges that they faced. Khalid finds it difficult to manage his work related frustrations and thinks that because of his work many times the child gets neglected. He mentioned that often he cannot participate in bathing the child because at that time he is in office. Likewise, Kabir said he is a student and the pressure of work and studies does not allow him to spend the time he wants to spend with the child. Whereas, Kasim mentioned:

> "Look, a man grows and becomes adult and gets married, till this stage there is no problem but after a year when he becomes a father he has to face many challenges. Just like as I am an officer, I have to deal with many problems and I have to work with officers so there are many ups and downs in office. Feelings with which I used to work have to change now. This is the biggest challenge for me to maintain my feelings at home with my young daughter" (Kasim, 2012).

These narrations of the three fathers reflect that they find it complex to balance work requirement and their fatherhood practices at home. All three fathers expressed their helplessness in this respect. The findings give insight to the corporate and developmental sector to promote day care facilities for working fathers as well. This will allow the fathers to spare a few hours from their work and cater to the developmental needs of the young child. The presence of children might also acts as a motivational factor for the fathers. As Khalid mentioned

> "When I enter home the word "Daddy" comes from his mouth that makes me relaxed and I start playing with my child" (Khalid, 2012).

There has been a recent development in the Western context that now allows new fathers to bring their babies to work as well for day care support. This allows working fathers to stay in contact with the baby as like mothers. Likewise, knowing the importance of the early years of life many countries have introduced paternity leave systems (Ray, Gornick, & Schmitt, 2009).

Conclusion

Hereafter, it can be concluded that fathers' involvement in early childhood development is significant and brings positive influence later in life. This study aimed at exploring case studies of the fathers who are involved in the developmental health of their young children, their practices and their lived experiences of fatherhood. Since the study was restricted to urban setting and focused on limited number of cases it cannot be generalized to a wider audience. Thus, there is a need to study this phenomenon both quantitatively and qualitatively to facilitate a reaching a larger population in a similar context. The findings of the study might aid programs, agencies and educational institution in designing programs for fathers of young children. Furthermore, it might contribute to bridging the gap of information in developing nations and parenting practices.

References

Amato, P. R., & Rivera, F. (1999). Paternal involvement and children's behavior problems. Journal of Marriage and the Family, 61 (2), 375 – 384.

Ball, J., Fatima, I. & Chakma, S. (2012). Supporting Positive Father Involvement in the Care and Development of Children in the Asia Pacific Region. ARNEC: Retrieved from http://www.arnec.net/ntuc/slot/u2323/e-discussion/Father%20Involvement%20E Discussion%20Synopses_final-web.pdf

Bianchi, S. M. (2000). Maternal employment and time with children: dramatic change or surprising continuity? 'Demography 37(4): 401-414.

Bronte-Tinkew, J., Carrano, J., Horowitz, A., & Kinukawa, A. (2008). Involvement among resident fathers and links to infant cognitive outcomes. Journal of Family Issues, 29, 1211–1244.

Bronte-Tinkew, J., Carrano, J., Horowitz, A., & Kinukawa, A. (2008). Involvement among resident fathers and links to infant cognitive outcomes. Journal of Family Issues, 29, 1211–1244.

Cowan, C. P., Cowan, P. A., Pruett, M. K., & Pruett, K. (2005). Encouraging strong relationships between fathers and children. Working Strategies, 8(4), 1-11.

Doucet, A.(2007). Do Men Mother? Toronto: University of Toronto Press.

Dubowitz, H., Black, M. M., Cox, C. E., Kerr, M. A., Litrownik, A. J., Radhakrishna, A., English, D. J., Wood Schneider, M. , & Runyan, D. K., (2001). Father involvement an children's functioning at age 6 years: A multisite study. Child Maltreatment, 6, 300-309.

Fagan, J. and Iglesias, A. (1999). Father involvement program effects on fathers, father figures, and their Head Start children: A quasi-experimental study. Early ChildhoodResearch Quarterly, 14, 243-269.

Flouri, E. (2005). Fathering and child outcomes. West Sussex, England: John Wiley & Sons Ltd.

Forgarty, K. & Evan, G. (2009, November). Being an involved father: What does itmean?.Retrieved May 26, 2012, from http://edis.ifas.ufl.edu/pdffiles/HE/HE14100.pdf

Formoso, D., Gonzales, N. A., Barrera, M., & Dumka, L. E. (2007). Interparental relations, maternal employment, and fathering in Mexican American families. Journal of Marriage and Family, 69, 26-39.

Furstenberg, F. F., & Weiss, C. C. (2001). Intergenerational transmission of fathering roles in at risk families. Marriage and Family Review, 29 (2-3), 181 – 201.

Jordan, P. (1989). Laboring for relevance: Expectant and new fathers. Western Society for Research in Nursing. Salt Lake City: UT.

Kato, K., Ishii-Kuntz, M., Makino, K., & Tsuchiya, M. (2002). The impact of paternal involvement and maternal childcare anxiety on sociability of three-year-olds: Two cohort comparisons. Japanese Journal of Developmental Psychology, 13 (1), 30-41.

Kibria, G. (2009). Role of father's to enhance children's development during early childhood. ARNEC.

Manlove, E.E. & Vernon-Feagans, L. (2002). Caring for infant daughters and sons in dual-earner households: Maternal reports of father involvement in weekday time and tasks. Infant & Child Development, 11, 305–320.

MCDYS. (2009). Fatherhood public perception survey. Ministry of Community Development, Youth and Sports. Retrieved from: http://dadsforlife.sg/images/stories/dfl/SINGAPORE_FATHERHOOD_PUBLIC_PER EPTION_SURVEY_2009.pdf

National Center for Education Statistics. (1997). Fathers' involvement in their children's schools. Washington, DC: U. S. Government Printing Office.

O'Connor, T., Davies, L.,Dunn, J., & Golding, J. (2000). Differential distribution of children's accidents, injuries, and illnesses across family type. Pediatrics, 106, November, 68.

Palkovitz, R., & Palm, G. (2009). Transitions within fathering. Fathering: A Journal of Theory, Research, and Practice, 7, 3–22.

Perry, A., Harmon, D., & Leeper, J. (2012). Resident black father's involvement: A comparative analysis of married and unwed, cohabiting fathers. Journal of Family Issue,s 33(6), 686 714.

Pleck, J. H. & Mascaidrelli, B. P. (2004). Parental involvement: levels, sources and consequences' In M. E. Lamb (ed.) The role of the father in child development. New Jersey: John Wiley and Sons. 4th Edition.

Pleck, J.H., & Masciadrelli, B.P. (2004). Paternal involvement by U.S. residential fathers: Levels, sources and consequences. In M.E. Lamb (Ed.), The Role of the Father in Child Development, 4th Edition (pp. 222–271). Hoboken, NJ: Wiley.

Popenoe, D. (1996). Life without father: Compelling new evidence that fatherhood and marriage are indispensable for the good of children and society (p. 163). New York, NY: The Free Press; Stanton, G. T. (2003). How fathers, as male parents, matter for healthy child development [On-line]. Available: http://www.citizenlink.org/FOSI/marriage/A000002226.cfm

Pruett, D. (1997). How men and children effect each other's development. Zero to Three Journal. 18 (1).

Ray, R., Gornick, J., &Schmitt, J. (2009). Paternal leave policies in 21countries: Assessing generosity and equality. Center for Economic and Policy Research. Washigton: DC.

Sandberg, J. F. & Hofferth, S. L. (2001) Changes in children's time with parents: US 1981 1997.' Demography 38(3): 423-436.

Schartz, S. J., & Finley, G. E. (2006). Father involvement, nurturant fathering, and young adult psychosocial functioning: Differences among adoptive, adoptive stepfather, and nonadoptive stepfamilies. Journal of Family Issues, 27 (5), 712 – 731.

Shields, S, E. 2002. Speaking from the Heart. Gender and the Social Meaning of Emotion. Cambridge University Press.

Stratton, C. (2006). The effects of father involvement in parent training for conduct problem children. Journal of

child psychology and psychiatry. 26 (5), pp. 801 – 810. DOI: 10.1111/j.1469-7610.1985.tb00593.x

Stern, M. . & Karraker, K. (1989). "Sex Stereotyping ofInfants: A Review of Gender Labeling Studies." Sex Roles 20 (1989):501-522. Retrieved from: Gender-Role Development – The Development of Sex and Gender - Boys, Girls, Male, and Roles - JRank Articles http://social.jrank.org/pages/272/Gender-Role-Development.html#ixzz1w4ApGFJ9.

Virginia, 2011. Celebrating babies and tots. The University of Virginia. Retrieved from: http://vachildcare.org/index.php?option=com_content&view=article&id=49&Itemid=53

Veneziano, R. A. (2000). Perceived paternal and maternal acceptance and rural African American and European American youths' psychological adjustment. Journal of Marriage and Family, 62 (1), 123-132.

William, M. V. (1997). Reconceptualizing Father Involvement. Unpublished master's thesis, Georgetown University, Washington, DC.

Affiliates Corner

September 2012

Facebook

By Maree Foley and Martin St-André

It is autumn and spring. This shared geographical reality captures something of the experience of creating, of growing, and of consolidating as a WAIMH affiliate. Being a WAIMH affiliate is a dance between working locally while sustaining connections with other affiliates, and to WAIMH. As WAIMH affiliates we are paradoxically part of an international family; while we co-create evolving local WAIMH Affiliate families. In turn, we straddle a plethora of relationships with WAIMH, the Affiliates Council and our Affiliates. Further, each group reflects a unique stage of development as an organisation whereby each group brings unique needs and offerings to the relationship/s. Consequently, amidst grass-roots living, it is a challenge to hold the interplay of these relationships in mind.

To support our experience of being and becoming a WAIMH family we have been working on ways to keep in mind our connectedness with each other. As a result, we are in the early stages of piloting the use of Facebook. Facebook offers us a unique opportunity to experience our connectedness in a new way; and to reflect on this experience of social engagement. That is, Facebook is a technological form of social engagement, and social engagement is of interest to us in our day-to-day work with infants and their families.

A team of council members, including Catarina Furmack (Nordic Affiliate) and Lynn Priddis (Australia) are currently working on a project, initially aimed at the leadership teams of each affiliate as a way to bridge their connections with each other. We will provide updates as this pilot programme develops.

Finally, the creation of the Affiliates Council provides a rich opportunity for Affiliates to have a real input into WAIMH's activities and projects. As a result, the Affiliates Council is "becoming" a lively place for generating ideas and actions within infant mental groups. Thank you to all WAIMH members and presidents for your ongoing participation in our "spring-autumn WAIMH family".

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Reflections on WAIMH Congress Cape Town, South Africa

By Maree Foley, New Zealand

It is September and spring is winging its way here via the Tui's who have re-turned, and who are now nesting and relishing in dawn song. Their singing accompanies ever-present memories of the WAIMH congress in Cape Town, captured in part by a photo, pinned onto my office wall. The photo was taken at the WAIMH congress dinner in the Nyanga Arts Centre, in the Nyanga Township. I am standing with WAIMH friends, and three women, referred to as "the mama's" who are each dressed in bright orange. These three women are artists, chefs, and cultural ambassadors for their township.

I have looked into this photo often. It brings such warming and joyful memories, and it unsettles me. Amidst the blissfully unaware cheer of her visitors, one of the mama's in orange seems saddened, perhaps weary? I project this affect onto her, knowing nothing about her, her story, or her dreams; it is just what I see: a complex picture of joy and weary wrestlessness.

This photo captures my experiences of the WAIMH congress where I was simultaneously uplifted and disturbed by what was on offer. For example, Professor Mark Tomlinson, presented a harrowing statistic: approximately 21,000 children died, every day, in 2010, with expected current statistics to be even more harrowing. This is an unbearable statistic requiring courage to hold in mind. In my endeavours to do so, the picture of the "mama in orange", returns. Her presence intertwines with the stark statistics, keeping me awake. Awake with mindfulness of a global picture of infant mental health: of life and death and all that lies between health and struggles for our global infants and their families. It's challenging, it's uncomfortable, yet their collective message is clear and strong.

Alongside Professor Tomlinson and the "mama in orange", Dr Astrid Berg presented a snapshot of her work with local colleagues, in the Townships. This is the work and life of every-day saints. Dr Berg's capacity to hold the tension of multiple paradoxes with patience, generosity and efficacy, was extraordinary. It was a lesson for me from a voice-lived. These lessons tend to linger in consciousness over time as they soak into ones bones.

I thank Professor Tomlinson and the "mama in orange" for keeping discomfort close-by and my complacency somewhat at bay; Dr Berg and colleagues for their raw inspiration; and I acknowledge and treasure the deep friendships forged with WAIMH members, who are such good company to journey with, in the field of infant and family mental health.

By Elizabeth Tuters, Ontario, Canada

When I reflect on the WAIMH Congress in Cape Town, I think about beautiful weather, luscious flora and fauna, the azure sea and the wide blue sky. I think of the ambiance and the atmosphere of delegates across the globe coming together in a part of the world once ripped apart by the horrendous years of Apartheid, whereas now there is a sense of hope, of working together, of reconcilliation. All of this was reflected in the Opening Ceremonies through the oration of the speakers, and the voices of the choir rich with the diversity, rhythm, and harmony of the place we were visiting.

The committed work of the WAIMH Affiliate Local Organizing Committee was evident everywhere throughout the Congress. The elegant, state-of-the-art venue provided space and time to meet others during the breaks and the luncheons. The congress program offered a rich variety of choice from a menu of clinical practice in the field of infant mental health, and current infant research.

All of this being said, I also was aware of the inequities in South Africa that were very evident as we visited different places. It is our human nature that we must become aware of the full range within our sensibilities. We also must become aware of these inequities within our WAIMH family of Affiliate organizations. Some of our WAIMH Affiliates have significantly fewer resources than others, especially those in the emerging and developing countries. In 2009 I had an opportunity to go on a professional visit to South Africa. Astrid Berg took me to Khayelitsha. I was impressed to see how under these severly disadvantaged conditions so much effective and innovative work was being done.

We must do our best to work with these emerging Affiliates, as we now have the new By-Laws to include the Affiliates within the governance of the WAIMH structure. We now have two elected Affiliate Presidents who sit as voting members of the WAIMH Board of Directors. At the WAIMH Cape Town Congress we had a social event for the WAIMH Affiliate Representatives to meet each other. This was organized by our two Affiliate representatives elected by the Affiliate presidents in the Leipzig WAIMH Congress in 2010. The elected representatives are Martin St. Andre and Maree Foley, who chaired their first meeting of the Affiliate Council in Cape Town. This was attended by representatives of the global WAIMH Affiliates, who were encouraged to engage in active participation in the structure of the WAIMH Affiliate Council.

I look forward to the outcomes of this enthusiastic Affiliate meeting, and the interest generated in the members to participate in the development of initiatives between economically established countries and between emerging countries. The primary focus was on communication, sharing of resources and training within the context of the countries. I left feeling hopeful that we have developed a family of Affiliates who can engage in creative dialogues with each other and assist in further development of WAIMH's vision and aims, brings us all to the crossroads of culture, science, art, creativity, and most importantly mutual respect.

Reflective Supervision: Discoveries of an Accidental Tourist

By Robert F. Weigand, Arizona State University, Arizona, USA

ZERO TO THREE Corner

Reflection is essential to the professional development of those working with young children and their parents. It is a deeply personal process that requires a commitment to and assurance of safety for the supervisee. This article (Zero to Three, Volume 28, Number 2) recounts the author's personal and professional journey through reflective supervision he received as a teacher of toddlers in an early childhood center. He describes the reflective process and the qualities of the supervisory relationship that contributed to the professional growth that it supported. Copyright ZERO TO THREE.

Author's Note

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I stumbled accidentally on, and then into, reflective supervision. I had not been seeking it; in fact, I had no idea what I might be getting into. This accident has been the most helpful and meaningful aspect of my professional development. Reflection is a uniquely individual and personal process, and therefore so is what we call reflective supervision. For some it might involve a recollection and close inspection of "What I did" or "How I am." It might be an opportunity to safely say aloud all that one thinks and feels about a parent, child, or family. It might be a place to share the burden of responsibility that one inevitably bears when working intimately with children and families. For some, reflection is simply a sharing of hypotheses about a child's behavior, a parent's caregiving patterns, or a family's relationships and rituals; a thinking aloud or exchange of ideas about how to proceed. Whatever its aim and process, it must be freely chosen.

My initial experience with reflective supervision began a number of years ago when, early in my career as a preschool teacher and teacher educator, I had begun to reconsider the skills required to be a good teacher and caregiver of toddlers and preschool children. My struggles with the group I was teaching at that time—16 children who were 2 and 3 years old—compelled me to doubt the adequacy of many of the skills I thought I had mastered. One incident in particular provoked me to question the adequacy of my repertoire of management techniques, tricks, and gimmicks for helping children learn appropriate social behavior. It occurred very early in the school year when Amy, a slight, blond 3-year-old, was dropped off abruptly as her father dashed off to work. She stood silently just inside the door, her face impassive, but tears were just beginning to well up behind her plastic glasses. I bent close to her with my hand on my knees and cheerfully said good morning. She responded by kicking my right shin. Although taken aback, I managed a smile and advised, "It's not OK to kick at preschool." Her expression did not seem to change as she cocked her foot and kicked me a second time. I continued to "smile" and repeated in a somewhat less friendly voice, "Amy, it's not OK to kick." Her third kick was perfectly aimed.

I was paralyzed. I was overwhelmed with a simmering stew of emotions: anger, frustration at my incompetence and failure, and guilt and remorse for even feeling angry at a child so small and vulnerable looking. Fortunately, a classmate ran over to greet Amy and led her off to the play dough table. He rescued both of us from the next missteps I was likely to make.

The emotions that these and various similar experiences evoke are typical for those working with young children. They ebbed and flowed regularly in my work with this group of 2- and 3-year-olds. I began to notice how they sometimes impaired my ability to see clearly the child before me, and to respond in a way that was appropriately sensitive to this child in this moment. Although the strategies and techniques I had learned and the advice and suggestions offered by my supervisor often proved effective in managing behavior, I had a growing and uncomfortable sense that these young children needed more or better than my "teaching and guiding" was providing. Something was missing from my repertoire of professional skills that would enable me to be more present and supportive.

I wondered if preschool teachers might use some of the same skills with young children that "helping professionals"—counselors, psychologists, and social workers—used with their clients. I learned that this idea was not new to the early childhood field (e.g., Rogers, 1983), but I nevertheless decided to create, at least for my own use, a catalog of "helping skills" for use with very young children and to solicit feedback on this list from appropriate members of the faculty at the university where I was teaching at the time. I wanted to be certain that my taxonomy was comprehensive. Most offered helpful suggestions, and I revised and refined my list of skills.

I was generally satisfied and pleased with my scheme when I visited CR, the last faculty member on my list. He studied the pages for a few minutes. "This category here that you call, 'self-awareness,' I wonder what that means to you," he said. "I see what you have written here, but have you ever taken the time to consider what this is really about?" He suggested a shift from considering knowing what to do to knowing how you are. After some further discussion, I cautiously accepted his offer of regular meetings to explore this aspect of my work with young children. Not fully convinced of the importance of this endeavor, I intended to approach this as a sort of tourist—this would be a short trip just to get the idea.

Promoting and Supporting Reflection

We began supervision with a general agreement that we would focus our work together on the effects of my feelings on my relationships with the toddlers in my care. This focus was similar to the supervisory work that CR had done with students preparing to be family therapists and consistent with the "self-awareness" groups he conducted for mental health professionals and teachers. He had a doctorate in counseling and training, and supervising therapists was a primary professional interest.

CR never set or followed a predetermined agenda. From the outset, a striking feature of our time together was that the process was essentially mine. Supervision was about me and my experience with my young clients. I was free to determine the general direction of our work and the specific tasks and focus for each session. He took few notes, but seemed to hold in mind where I had been and the questions and issues with which I seemed to be wrestling. His guidance consisted mostly of recollections from previous sessions, mirroring my immediate feelings, thoughts, and intentions in order to help me "hold my place"—that is, to recall for me where I had just been on this reflective journey and where it seemed I might be heading. He occasionally asked questions or offered tentative suggestions to help me sort through my own confusion or uncertainty. All of it felt supportive. His interest in learning more about my experience was genuine. My reflection was essentially a shared process in which he provided a safe and compassionate kind of mirroring. Although there was no predetermined structure to our process together, at least none that I could initially discern, in retrospect our work consisted of three fundamental reflective tasks: relating and reexperiencing emotionally significant events in my relationships with children; examining and evaluating the meaning of the feelings, thoughts, intentions, and actions evoked during those events; and considering how I might use this understanding for my professional growth and development.

Emotionally Significant Events

My description of specific relationship experiences with a child made up the initial substance of supervision. These were stories of events that elicited in me strong emotional reactions. They were typically about incidents with a child whose behavior challenged me; who kept me awake at night; or who brought to the fore my attitudes, feelings, and behaviors that I considered to be most unpleasant and unattractive. When with a child such as this, I felt ineffective and incompetent. I told these stories when I could muster the courage. Sometimes I dodged, hedged, glossed over, or deflected while CR waited patiently for me to settle in.

During this phase of supervision, I carefully reflected on exactly what happened during these episodes with children. The details were important: what specific behaviors occurred, when and under what circumstances did they occur, what preceded or precipitated the behavior, and what exactly and specifically each of us (the child and I) experienced.[1] CR's patient, engaged listening with sensitive, careful questions about specific details helped to elicit an increasingly rich and accurate story. The following brief excerpt offers a taste of how such a description began:

> RW: Michael was whining at me that his boot was stuck. It wasn't like he was scared or worried or even that frustrated. He just didn't feel like doing it himself. He's like that a lot. Nicole really needed help with her boots, they're tough and she's much younger. I had to help her instead, and told him he'd just have to wait. Of course, he whined even louder, and then threw his boot at me.
>
> CR: That Michael must really be hard, especially during times when it seems he's whining for no good reason or when he gets aggressive. What does he do then, like with the boot? What happens exactly?
>
> RW: Well, he gets frustrated easily, we all know that! And then he loses it, and is really hard to calm down because he won't listen at that point. I guess we all try to avoid him in those situations. Like with the boot thing I was thinking, "Oh great, here we go!"
>
> CR: So, what's it like to be in that moment with him—that time with the boot?
>
> RW: Frustrating, obviously. I mean, I guess I get a little mad, and the whining bugs everyone. I know he's going to whine and get upset, and I know nothing I do will help. In fact if I say or do anything, it will likely make it worse. No matter what, I'll end up looking like I'm mean, or like I'm a bully or something. Or incompetent—like "Why can't I make this kid calm down and behave."
>
> CR: He traps you. You can't escape feeling either like a bully or like a failure.
>
> RW: Right! I shouldn't get mad. He is only 3, after all. No matter how it goes I end up feeling bad about myself.
>
> CR: How do you protect yourself from that?

Two aspects of this "phase" of our supervisory process are noteworthy. First, I was very timid about self-disclosure of any kind. Remembering and narrating events, the "facts," as they occurred, seemed relatively nonthreatening. I could "feel out" my supervisor and his process, and proceed gradually and tentatively. It allowed us to get acquainted. He allowed me to set the agenda, to freely decide what story or experience to relate, and how intimately I wished to disclose the details. He allowed me to wander with no particular or apparent destination in mind. I was, after all, simply a tourist. This introduction helped to build my confidence in the security of our relationship and to muster the courage for whatever might lay ahead. It was a safe way to begin. During this phase of our work I gradually came to recognize and then trust his nonjudgmental stance and his commitment to our alliance.

Second, attending to the details of my experiences proved over and over again to be a rich source of information about me and my work with children. Much happens inter- and intrapersonally during these interactions with children (Stern, 1995, 2004). Feelings, thoughts, and intentions erupt and subside. Some of these I act on consciously and with a clear

1 Daniel Stern (2004) describes at length the nature and clinical significance of examining the specific details of interactive moments.

sense of purpose. Some I quickly repress, especially when I fear their outward expression will cause harm either to others, as with an outward expression of anger, or to myself if my behavior might lead to unpleasant feelings such as mortifying embarrassment. Some emotions find their way to unconscious and subtle expression even as I struggle to repress the inappropriately negative feelings and potentially damaging intentions. Before any attempt to understand why specific feelings, thoughts, and intentions emerge, they must first be identified and acknowledged. Rather than a simple narrative history of the events that transpired, the careful and unhurried recounting of emotion-laden experiences with children can yield a richer "reexperiencing" of the interaction. Examining the emotions that were evoked, expressed, or suppressed can lead to a better understanding of the events that followed.

Understanding My Reactions

Reexperiencing emotionally significant interactions with children provided an opportunity to carefully examine the emotions, thoughts, and intentions that accompanied and motivated my behavior. Under gentle but careful scrutiny, the meaning of my interactions and reactions came to light. For example, Michael clearly needed assistance and support at least as much as Nicole, probably more so. I soon recognized that my "turn to" Nicole, was, in fact, more a "turn away" from Michael to avoid the risk of professional embarrassment that interactions with him often entailed. Attending to Nicole was a device, a gimmick I used to give myself permission to pass over a more difficult caregiving task. Nicole would typically cooperate and warmly smile her gratitude. With Michael, no matter how carefully I proceeded, there was always the risk of an unpleasant battle in which both he and I would sink into a power struggle, his cries of protest and discontent calling everyone's attention to my inability to manage his behavior. As long as Nicole needed help it was acceptable to rebuff Michael. I dismissed Michael covertly and gently so as to go unnoticed to all, including me. Michael, of course, noticed; but I was saved from the pain of embarrassment and frustration that accompanies professional failure—real or imagined.

But Michael was 3-years-old. How much harm could he really cause me? How much damage could he do? Is it really he who would label me incompetent and judge me to be failing as a teacher? Despite episodes of noncompliance and assorted other struggles with Michael, I never truly believed that he did. Reflecting on these episodes with Michael exposed this paradox: I felt frustrated, inept, and humiliated by a small 3-year-old 3-year-old. My recognition of this paradox and of the full range and intensity of the emotions that this and similar episodes evoked prompted CR to ask, "If not he, then who? Who else, whether or not actually present, is in the moment with the two of you?" We came then to the point of exploring the why of my feelings during interactions: Why this feeling, this thought, with this child, at this moment? The lens through which I filtered these moment-to-moment experiences began to become apparent. It was made up of feelings, thoughts, and tendencies to react to others in certain characteristic ways that I had unconsciously carried forward from childhood experiences. Then and there the "ghosts" that Selma Fraiberg (Fraiberg, Adleson, & Shapiro, 1980) described so eloquently emerged from the shadows to make their presence, essence, and power, apparent. These "visitors from the unremembered past," as Fraiberg described them, had faces. It was not any and all childhood experiences that influenced my interactions with children, it was experiences with another that I was carrying forward that mattered. It was my childhood others—or more accurately, my representations of their attitudes and behavior toward me and my emotional

Consumer's Guide to Reflective Supervision

When choosing a supervisory relationship for the purpose of reflection I consider four qualities: presence, commitment, reverence, and mutuality. All are essential, for without them my reflective work will certainly sputter and stall.

Presence. Reflection is a deeply personal process. It can get to the very core of who I am and its effect on my work. Sharing this process with another is most intimate and requires considerable trust. My supervisor must be fully present and engaged in this process with me and not distracted by his or her own personal or professional agenda. This is about me and my work, and I need full attention about what I am feeling and thinking.

Commitment. Reflection is the most important aspect of my professional development. If it goes well, nothing will have a greater impact on my relationships with children and families and my capacity to help. If I am to venture into reflective supervision, then I expect to work hard at it, especially when the discoveries are painful or frightening. I will prepare myself for supervision and the work we will do together. I need a supervisor who will fully commit to this process as well. It must be a priority. Postponing, replacing, or interrupting reflective supervision with administrative tasks, "teaching," goal setting, or performance evaluations feels dismissive. Unless these tasks are left for another time and place, my reflective work will be guarded, tentative, and halfhearted.

Reverence. I look for a supervisor who has a profound respect for the intra- and interpersonal processes fundamental to the work of reflective supervision. Self-examination—looking inward—proceeds at a pace and in a manner that is unique to each individual. Neither of us really knows in advance what we will explore together or what we will discover. Change will not likely be linear or orderly with consistent and clearly identifiable markers of progress. My growth will proceed in fits and starts. I will occasionally become stuck. The process of my reflection must nevertheless be respected and supported. The relationship contract offered to me must therefore be "How can I help?" not "I know what you need and I have the expertise to bestow it."

Mutuality. My demands of a supervisor are high, and it's unreasonable to expect that anyone can meet them without fail: To err is inevitable. Breaches between us are likely, and our work together will surely provoke strong emotions. Mutuality in our relationship means first that my supervisor recognizes that reflective supervision is as necessary for him or her as it is for me. I am wary of the supervisor who is "above" supervision. Second, mutuality involves a willingness to own inevitable mistakes, acknowledge them, and work collaboratively, as equals, to resolve them.

responses to them—who influenced my relationships with children. These were my ghosts, and together CR and I made their acquaintance.

Talking about my work in a relationship characterized by a sense of security promoted this careful and deeper exploration of my emotions and behaviors. More importantly, this kind of supervisory relationship invited careful reflection of even those feelings and reactions that I considered to be unattractive and had worked so hard to suppress. My experience was never judged to be good or bad, right or wrong, appropriate or inappropriate. It simply was. CR actively listened but never offered advice nor gave directions. He never suggested that I would "do better next time" or that my experiences or feelings were common to others in my field.

The Possibility of Change

Acknowledging the existence and potential influence of my ghosts, or the experiences from my past that may be influencing my current relationships, marked the beginning of a third phase of supervision: a gentle invitation to know them better, to explore the full range and depth of their influence on my work, and to learn how to coexist peacefully and comfortably with their inevitable presence.

I characterize this phase of our process as "considering a possibility of change" because I was never made to feel that I was inadequate and therefore should change in any way. Reflecting on my interactions with children had helped me to become more attuned to children's reactions to me as a caregiver and, more importantly, to my own periodic feelings of fear, anger, inadequacy, and so forth. I realized that they did not simply act, they reacted to me! I then began to see more clearly and accurately how I was with children. I wanted to explore the possibility of change. I wanted to feel more comfortable and confident in my own work and to do better for the children entrusted to my care. Together CR and I recognized that we had come to point in our work together when it was permissible for him to ask, "What (or who) keeps you from being the teacher you wish to be?" "What (or who) keeps you feeling inadequate or incompetent?" Who are these ghosts and what is the nature and effect of their hold on you?

Addressing these questions requires the most personal form of reflection and therefore the most intimate form of supervision. It can be uncomfortable at times, even scary. My initial reaction was ambivalence, despite the alliance we had forged and my admission that it was now appropriate and important to address these questions. I expressed this by periodically "needing" to cancel an appointment, or by bringing to supervision unrelated other "important" issues or events to discuss. During some sessions I delayed and dodged, using "small talk" that rambled on until our time ran out. I tried to forget about the ghosts. I tried telling myself that simply knowing they existed was sufficient, and they would now just leave me to my work. CR waited patiently. Eventually, but initially only periodically and very tentatively, I gathered my courage to advance. Each time I did so he was there waiting and accepted that I must have needed to leave or retreat, at least for a while. The process was mine after all.

Our approach to supervision required that we negotiate, and periodically renegotiate, the boundaries of our work together. At times, the boundaries that demarcate the line between supervision and therapy seemed flexible or appeared to blur. To me, my safety was far more important than specifying the exact nature and location of that boundary. Throughout our time together, my feeling safe was paramount to us both, and that determined the boundaries of our work.

In time we came to know something of these ghosts, their methods and their motives. These insights, and an eventual realization that the ghosts were human with ghosts of their own, helped me to begin to live a little more comfortably with their influence.

The Result of Reflective Supervision

I must admit that change was inconsistent, variable, and sporadic. Some sessions yielded little or nothing in the way of personal or professional growth, at least that I was able to discern or feel. Periodically, though, what transpired during our time together rocked me to the core and offered a flood of insight. At such times I felt a veil lifted, allowing clarity of vision into who and how I was in my relationships with children, and a deepening understanding about why I am so. This new-found clarity and understanding spawned ideas and plans for trying to be different and better in my work. Perhaps most important, I began to better tolerate my own inevitable mistakes and shortcomings. This, in turn, precipitated a gradual increase in my tolerance for even the most exasperating characteristics of my young clients and an improved capacity to be calm, available, and supportive during the most difficult interpersonal episodes with them.

Several capacities relevant to my work as a caregiver of toddlers and preschool children began to change. I am referring here not to my ability to manage, change, or control children's behavior but instead to my ability to empathize with children.

For example, I became more sensitive to my own emotions evoked by specific behaviors and during interactions with children. I was more likely to recognize and label for myself these specific emotions, including those that were conspicuously aroused and obvious and those that were less apparent, more subconscious. I was more acutely aware of the feelings that would compel me to "turn away from" a child such as Michael. While these feelings often floated beneath the surface, they nevertheless always pushed for release or expression even if through subtle or covert behaviors. They were always present and operating. Now they were more visible and conscious. I also became more aware of and paid increased attention to the expression of those feelings: even subtle expressions such as increased muscle tension, small changes in posture, and slight changes in facial expression and tone of voice.

I was more conscious of what a child might be seeing, hearing, or otherwise sensing from me, and better attuned to how that might affect their thoughts and feelings. I gradually became able to sense more fully what was transpiring between a child and me during an interaction and more attuned to my contributions to the interaction, even during episodes of noncompliance and conflict. I was able to better manage, if not completely control, the effect of my emotions on my responses to children and gradually their influence began to fade. My reactions became more appropriate to the real child before me.

I became more comfortable with my own limitations and imperfections as a teacher. Not that I didn't feel the need to learn and improve; rather I came to accept reality of the work as difficult and messy. Mistakes with 2-year-olds are an unavoidable fact of life. They will from time to time make me look and feel incompetent, ignorant, impotent, and silly. Even on my good days. I will misread them. I will do and say the wrong thing. There will be breaches in the harmony of even the best of my relationships with children. My interpretation of the seriousness and magnitude of such episodes became more legitimate, and the emotional burden that typically accompanied missteps and mishaps became more commensurate with their actual consequences. I became less preoccupied by remorse and self-criticism over my mistakes and more tolerant of the

inevitable unpredictability of children's behavior and of the ebb and flow our emotions and interactions.

I began to feel an improved ability and willingness to sense, recognize, and examine my more pervasive attitudes toward individual children. In every group there is at least one child, and often two or three, whom I find to be especially challenging. The behavior and affect of these children provoke in me feelings of frustration, aggravation, impotence, incompetence, rejection, and anxiety. The desire to disengage and drift away from these children can be a powerful force—one that if regularly acted on, leaves children to their own devices to struggle alone with the challenges of group care. My disengagement could be subtle and go unnoticed by everyone in the room—except that particular child. Strategies such as classroom housekeeping, attending more to "easier" or more gratifying children, or assigning supervision of a challenging child to an assistant enabled me to look and feel like a "good teacher" even as a child entrusted to my care struggled to connect. As I became more conscious of my impulses to avoid or dismiss a child while acknowledging the underlying feelings that drove those impulses, it became easier to muster the courage and energy necessary to engage the child.

The most important change was my increasing ability to be psychologically present "in the moment" with a child. I became better able to focus more exclusively and clearly on what he was doing, feeling, intending, and thinking. Being present in this way, whether it is with a toddler as he explores a novel toy or with a child during episodes of purposeful noncompliance, is an essential teaching and caregiving function. The occasions when I can support such engagement and exploration without intruding are when I am best able to support a child's development. This is not simply a matter of accurately observing what a child is doing and correctly guessing what he might be thinking. It involves momentarily letting go of one's need to manage, control, or even teach. The capacity to appropriately let go of my needs and worries to simply be with the moment became more reliable.

Being present and available to a child in this way entails being simultaneously more present to myself—that is, being similarly aware of my own feelings, thoughts, intentions, and needs. In emotionally charged interactions with young children, caregivers must regulate and soothe both the child and themselves. It is inappropriate to expect a toddler to share responsibility for regulating the interaction. There is, then, no one else. For this to go well, the caregiver must be fully aware of both child and self and be sufficiently present to care for both.

What Sticks?

Although my initial experience of reflective supervision occurred many years ago, much from that experience sticks with me. I do, of course, remember some especially useful and poignant supervisory experiences and the most significant (for me) discoveries about "how I am" in my work. More importantly, I have carried forward attitudes, beliefs, and expectations about reflective practice and supervision.

The Necessity of Reflection

I now have an unshakable belief in the importance of reflection as a key focus of professional development for anyone working with children and parents. Using supervision as a mirror for self-reflection is invaluable. For me it is a necessity. My "ghosts" accompany me wherever I go in this work. They exert powerful influence over who I am and how I am. Knowing them better is helpful. The supervision I received enabled me to see that my feelings and reactions are not necessarily demons to be exorcised. They are tendencies to feel, think, and act in utterly human ways—albeit sometimes for better, sometimes for worse. Understanding my feelings helps me to see myself more clearly and thus more accurately sense a child's needs.

Reflection does not ensure that I consistently and effectively recognize and resist the untoward influence of my past experiences or that I always use them effectively. Sometimes I do; often I fail. Regular reflection helps me to recognize what has happened and its effect on those for whom I work.

Trepidation and Resistance

There have been times when the discoveries made in supervision were disconcerting, a few even painful. Some of my ghosts I don't at all like. Some of them are ugly and scary. I still resist acknowledging their existence and prefer to shy away from their presence. Most disquieting is how much they remind me of me, especially when I see them in my own reflection as I interact with toddlers, preschoolers, and their parents. I prefer to look away at those times. Therefore, I sometimes (often, in fact) prefer to busy myself with other duties in order to avoid the "mirror" that reflective supervision presents. "No time for this," I tell myself. So despite my recognition of the importance of reflective practice and supervision, I sometimes resist its intrusion into the comfort of my emotional and professional status quo. I settle into and enjoy the myopia. All the while, though, I'm trying to muster the courage to push forward to take another, closer look. Remembering the fortifying security that supervision provided in the past has often helped to quell my anxious reluctance just enough to return to the process.

Supervision Is Never Over

The feelings and tendencies to act in ways that I had come to understand and manage years ago occasionally resurface, catching me by surprise. "I dealt with this!" I exclaim to myself when tied into the inevitable emotional knots that young children provoke. I have come to realize that whatever I had hoped to achieve through supervised reflection—personal and professional growth, mastery, self-awareness, self-acceptance—is fluid and elusive. It comes and goes. It is resilient in the face of some personal and professional circumstances but vulnerable to others. For me, the stability and vigor of what I think I have achieved requires ongoing support or it erodes. Sometimes a specific child will prove especially challenging; sometimes the dynamics of a particular group of children will overwhelm me. Reflection still does not come easily or feel natural. It has not become automatic. It requires practice still.

Quality Supervision

Reflection is a very personal and potentially difficult process, and we are likely to flourish only if we have a safe and trusting supervisory relationship. My supervisor provided a reliable alliance that gently encouraged me take a careful and critical look at my relationships with children. He allowed me to proceed at my own pace. He occasionally offered his own vision and experience, though not as an expert or one with "superior vision," per se, but as one who had done some of this work himself. He was a companion who went with me, maybe a few steps ahead from time to time, but never pulling or pushing me along. His accompaniment was critical to my realization that my struggles were real, legitimate, and human. (See sidebar A Consumer's Guide to Reflective Supervision for suggestions on choosing a supervisor for the purpose of reflection.)

Conclusion

My accidental encounter with an opportunity for reflective supervision led to personal and professional discoveries about the nature and importance of this process. My "tour" included a close inspection of my feelings and representations about myself as a caregiver and about the children I taught. Reflection offered an introduction to my own "ghosts from the nursery" and their influence on my relationships with the children and parents I served. My supervisor and I spent a considerable amount of time with these ghosts, and I gradually learned how to coexist more peacefully with their presence and even to use them for professional advantage. Through reflective supervision, I experienced the very sort of respectful, understanding, and supportive relationship I hoped to provide to children and their families. I experienced firsthand what a potent agent of change this kind of relationship can be.

References

Fraiberg, S., Adelson, E., & Shapiro, V. (1980). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. In S. Fraiberg (Ed.), Clinical studies in infant mental health: The first year of life (pp. 164–196). New York: Basic Books.

Rogers, C. (1983). Freedom to learn for the 80s. Columbus, OH: Charles E. Merril.

Stern, D. N. (1995). The motherhood constellation. New York: Basic Books.

Stern, D. N. (2004). The present moment in psychotherapy and everyday life. New York: W. W. Norton.

From the Kauppi Campus -News from WAIMH Central Office

By Pälvi Kaukonen, Kaija Puura, Leena Kiuru and Minna Sorsa, Finland

Dear WAIMH members,

The new Perspectives in Infant Mental Health is a double issue ending WAIMH year 2012. The year was exciting and busy from the perspective of the WAIMH Central Office.

The WAIMH members started the eventful year by electing a new WAIMH Board member. The candidates were Astrid Berg, Karlen Lyons-Ruth, Nancy Suchman and Jean Wittenberg. Karlen Lyons-Ruth was elected to the WAIMH Board of Directors for a four-year period.

Next, the WAIMH members were asked about their opinion for guiding the election of the future WAIMH President-Elect. The candidates were Campbell Paul and Kai von Klitzing. The result of this tentative enquiry supported Kai von Klitzing, who was then unanimously elected by the Board of Directors as the new President-Elect. He will start his term of Presidency in 2016. Miri Keren started her WAIMH 2012-16 Presidency during the Cape Town Congress, and we want to thank Antoine Guedeney for his efforts and leadership as the President 2008-12 and now as the Past President of WAIMH.

Until April the WAIMH Office was busy arranging the 13th World Congress in Cape Town, South Africa. The collaboration with the hard-working Local Organizing Committee, the Program Committee and the Onscreen Conferences-Congress Bureau worked well. The program, facilities, and arrangements were all abundant and beautiful. At this stage we are also happy to inform you that the congress in Cape Town was a financial success. We especially want to thank Astrid Berg and the Local Organizing Committee, and Deborah McTeer and Jolandi Ackermann in Onscreen Conferences for this success!

The planning for the next WAIMH World Congress in Edinburgh in 2014 is already well under way, with Professor Jane Barlow from Warwick chairing the Local Organizing Committee. To avoid overlap with other congresses occurring at the same time we had to change the initial dates for the congress. Please note that the new dates are 14-18th June, 2014. Mark this in your calendars and inform your friends and colleagues of the change!

In addition to these tasks the Central Office has been involved in cooperation with Martin St-André and Maree Foley in the intense development of the collaboration between WAIMH and the WAIMH Affiliates.

We also constantly develop the WAIMH web-page (www.waimh.org). There is a page including Resources and Links. Take a look! The web-page is crucial for our members, because the membership applications and renewals are done online. Remember to renew your WAIMH membership (see more guidelines on page 22 in this journal)!

WAIMH wants to globally promote the development of research and services for infants. Please support your colleagues in developing countries by letting them know they can apply for a WAIMH Beacon Club scholarship. This is a free one-year membership of WAIMH including the subscription of the Infant Mental Health Journal and is intended for people from developing countries. The value of the scholarship for one person is 132.50 USD yearly. The application is filled in electronically at the WAIMH website.

Next year, 2013, will involve lots of activities in the organization. The preparations for the 14th WAIMH World Congress (2014) continue, and the Call for Papers will be sent out to you during spring 2013. There will be changes in the WAIMH Board of Directors as the four-year term of some Board Members is ending. The Office continues to develop ways to collaborate more with the Affiliates via the Affiliate Council, Martin St-André and Maree Foley. WAIMH is also about to face the modern world, as new initiatives and possibilities for utilizing the web and social media are being presented to us. Remember that each of you can also contact us with your ideas for improving our organization.

Thank you for year 2012, and may you all have a Successful and Happy New Year!

WORLD ASSOCIATION FOR
INFANT MENTAL HEALTH
www.waimh.org

WHAT IS WAIMH?

The World Association for Infant Mental Health (WAIMH) is a non-profit organization for scientific and educational professionals. WAIMH's central aim is to promote the mental wellbeing and healthy development of infants throughout the world, taking into account cultural, regional, and environmental variations, and to generate and disseminate scientific knowledge.

Why become a WAIMH member?

- To promote principles of infant and child health, development and mental health.
- To become part of a global learning community and professional network that speaks for infants, young children and families around the world.
- To have access to resources that promote infant mental health.
- To learn from world experts about the health, mental health and optimal development of infants, toddlers and their families across cultures and around the world.
- To expand your professional, social network.
- To exchange of information about infants and infant-family programs.
- To contribute to the protection of health and well-being in infancy, early childhood and parenthood on a global level.
- To get opportunities to keep pace with new findings and innovations in scientific, clinical, and educational research and programs involving infants and their caregivers.
- To contribute to a professional global learning community: WAIMH.

WAIMH AFFILIATES

WAIMH encourages individuals in geographic regions (states, provinces, nations, multi-nations) to develop Affiliate Associations to improve its international network of communication, and to allow individuals to focus on relevant local issues. Currently, there are 57 affiliates spanning six continents.

Affiliate Council Chair: Martin St-André

Affiliate Council Representative: Maree Foley

THE BEACON CLUB

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

Beacon Club donations:

- Extend the influence of infant mental health to countries now developing new approaches to issues of infancy.
- Make it possible to build capacity for promoting the well-being of infants and their families.

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

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

CONGRESSES

WAIMH hosts a World Congress every two years, each in a different country. Our 14th World Congress will be in Edinburgh, Great Britain, 14-18 June, 2014. WAIMH also hosts Regional Conferences.

E-mail: congress@waimh.org

PUBLICATIONS

Infant Mental Health Journal

The Infant Mental Health Journal publishes peer-reviewed research articles, literature reviews, program descriptions/ evaluations, clinical studies, and book reviews that focus on infant social-emotional development, neurobiological correlates of emotional development, caregiver-infant interactions, contextual and cultural influences on infant and family development, and all conditions that place infants and/or their families at risk for less than optimal development. The journal is dedicated to interdisciplinary approaches, including diverse theoretical views, to the optimal development of infants and their families. Special emphasis is given to high risk infants and very young children and their families.

Editor: Hiram E. Fitzgerald
E-mail: fitzger9@msu.edu

Perspectives in Infant Mental Health

Perspectives in Infant Mental Health, WAIMH's quarterly newsletter, gives members an opportunity to share research of interest, provides a forum for the exchange of news and views from around the world, and informs members of upcoming events and conferences.

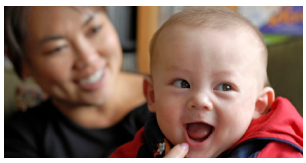
Editor: Deborah Weatherston
E-mail: dweatherston@mi-aimh.org

BECOME A MEMBER

- You can subscribe the scientific journal, the Infant Mental Health Journal, at a greatly reduced member rate. The subscription fee includes the access to the Wiley database of the electronic journal.
- You can upload Perspectives in Infant Mental Health (formerly The Signal), WAIMH's quarterly newsletter from WAIMH's website. This major interdisciplinary, international communication link for infant mental health professionals is an open access publication.
- You'll get reduced registration rates for regional conferences and for WAIMH's World Congresses.
- You'll have access to WAIMH database, an information network for infant mental health professionals.

The Professional membership rate is $75.00 annually. Student members pay $45.00. The membership fee is a yearly cost (Jan-Dec).

Both Professional and Student members may receive the Infant Mental Health Journal at an additional cost. The additional cost of the journal subscription are: $45 (USA), $47.25 (Canada, including $2.25 tax), or $57.50 (International orders).



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