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Abstract

This qualitative study explores infant-family mental health experts' perspectives and experiences regarding the inclusion of infants in the family therapy setting. Infant socioemotional development is relational in nature and evolves in the context of both dyadic attachment relationships and broader multi-person co-parenting systems. Given this, we sought to understand why family therapy interventions involving families with infants rarely include the infant in a triangular or family systemic approach. Interviews were completed by clinical and/or research experts whose work integrates tenets of both infant mental health (IMH) and family theory and therapy. All interviewees brought at least 5 years of expertise and were actively engaged in the field. Interviewees expressed consistent beliefs that infants have a rightful and helpful place in family therapy approaches. They maintained that infants' innate social drive and communicative capacities position them to make meaningful and clinically significant contributions within family and systemic psychotherapy contexts. Noting that infants have remained on the periphery of these practices, experts advocated expansion and greater integration between IMH and family therapy, while preserving each field's distinctive identity. Experts reported that the interplay between IMH and family therapy fields has been uni-directional as family systems concepts are embedded within IMH approaches, but few IMH premises are incorporated in

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mainstream family therapy practices. The disconnect was attributed to multiple factors, including graduate and professional training and theoretical, clinical, research, and sociocultural barriers, which were mutually reinforcing. Experts also identified clinical gains for both infants and family members when infants were meaningfully included in family interventions. Common ground was identified between the disciplines, with a belief that relationally distressed young children and parents are best served by clinical engagement with their network of relationships. Results call for greater collaboration between disciplines to challenge existing traditions and to more fully include infants in mainstream family therapy. Recommendations for integration of family therapy and IMH in clinical, theoretical, research, training, and sociocultural domains are offered.

KEYWORDS

early childhood mental health, family therapy, infant mental health, intervention, reflexive thematic analysis, systems approach

Key points

- Using a qualitative methodology, this study gathered the perspectives of infant–family mental health experts on the inclusion of infants in mainstream family therapy settings.
- Experts consistently underscored the importance of including infants in mainstream family therapy, highlighting their inherent social capabilities and contributions to family dynamics and family therapy sessions. Challenges include a need to embed infant mental health principles within mainstream family therapy, akin to the existing inclusion of systemic perspectives within the infant mental health stream.
- Factors hindering the integration of infant mental health approaches into mainstream family therapy included issues in graduate and professional training, theoretical differences, clinical practices, research biases and sociocultural barriers. These barriers were seen to be mutually reinforcing, serving as a negative feedback loop working against integration.
- Findings call for greater collaboration between disciplines to challenge existing traditions, with a view to more fully include infants in mainstream family therapy.
- Recommendations for the integration of family therapy and infant mental health approaches in clinical, theoretical, research, training and sociocultural domains are presented.

INTRODUCTION

From birth, infants possess remarkably advanced capacities to engage with those around them, suggesting an innate propensity for social interaction and connectivity (Stern, 1985; Trevarthen, 1979). For over 40 years, developmental psychologists have heralded infants' astounding communicative capabilities. Though the word *infant* itself has its roots in the Latin *infans*, meaning 'speechless,' this is a misnomer. Babies exert observable influence through both verbal and non-verbal channels (Stern, 1985; Trevarthen, 1979). Among their abilities are an aptitude for navigating multi-person relationships, referred to as the child's 'triangular capacity' and a capacity for 'collective intersubjectivity' or dawning awareness of the 'mind' of multiple others (Fivaz-Depeursinge et al., 2010; Iles et al., 2017; McHale et al., 2008; Trevarthen & Aitken, 2001). Likewise, infants possess a 'shared narrative awareness'



(Trevarthen & Aitken, 2001) wherein the infant can lead relational interactions highlighting their capacity for intentionality, independence, and initiation. Observational studies reveal that infants affect the course of family interactions in real time. For example, they use strategies that defuse tension between parents by undertaking an active participatory role (Fivaz-Depeursinge & Philipp, 2014).

Despite infants' capacity to interact with multiple others, most clinical practice in the field of infant mental health (IMH) focuses predominately on mother–infant dyadic interventions (Philipp, 2012). There are a number of evidence-based dyadic therapies, such as child–parent psychotherapy (Lieberman et al., 2015). By contrast, there is a dearth of evidence-based interventions extending beyond parent–infant dyads to engage broader family systems – a province of the field of family therapy. The dyadic emphasis of IMH has been attributed to cultural mother–infant tropes, endemic to the disciplines that shaped IMH in its formative years – especially psychodynamic psychotherapy (e.g. Stern, 1985; Winnicott, 1965). Additional restrictions are attributable to the bias in many modern therapy settings to focus on just two people in most sessions (Kirman, 1998). Although dyadic conceptualisations and interventions are themselves systemic in one sense, the IMH field's overriding focus on dyadic interventions is surprising given the established influence that the broader constellation of carers and relationships exert on infant development (McHale & Lindahl, 2011). Such constellations themselves take on different configurations as a function of culture and social organisation (Favez et al., 2009; McHale, 2009).

Dyadic approaches are indicated in circumstances where infants have suffered relationship trauma or disruption with their primary caregiver. Yet they can also be limiting in other respects. For example, by focusing intensively on the child's relationship with their mother or any single caregiver within the family system, the therapist may fail to recognise protective or harmful contributions from children's other significant attachment figures, such as a father or grandparent. As most of the world's children grow up with the ongoing presence of more than one parent or carer (McHale, 2007a; Pew Research Centre, 2018), the contributions of other adult family members who spend regular time with the child are important, especially in the face of risk or adversity. Thus, as argued by P. Minuchin (1985), 'studies of the parent–child dyad ... do not represent the child's significant reality' (p. 296). Infants co-parented by more than one adult construct caregiver-specific relationships, interactions, and attachment organisations that can differ markedly between caregivers (Dagan et al., 2022). Hence, limiting the therapeutic focus to a single relationship can overlook other emotional supports of critical relevance to the child and dyad. Dyadic approaches can easily miss important relationship dynamics that define the infant's full family constellation, including adult–adult relationships centred around the child (i.e., co-parenting) and the everyday protective relationships which can develop with older siblings (Murphy et al., 2017).

While there are numerous schools of family and systemic psychotherapies, as a discipline, the broad church of family therapy is committed to the strengthening of familial relationships through recognition of unhelpful patterns of emotional and behavioural communication, including across generations, and the promotion of more adaptive ways of being. As such, family therapy practices may be expected to provide a context that fosters improved outcomes for infants. Depending on the conceptual model, and the practitioner's orientation, training, and treatment goals, family therapy also attends to individual members and subsystems (such as child–parent or adult–adult) within the family. Numerous authors have advocated expanding clinical practices and research work to move beyond the dyad. For instance, McHale and Phares (2015) wrote that 'changing the focus from dyads to family systems truly would be a bold and transformative new direction' (pp. 4–5). Yet, the major schools of family therapy generally have not included a core developmental perspective, and with that, inadvertently created little place for infants, either clinically or conceptually. Indications from research involving older children and their parents auger well for a downward extension, including needing less tertiary service system engagement over the longer term (Hopkins et al., 2016; Westwater et al., 2020). It would be of significant value to establish whether similar benefits could be realised from the implementation of family therapy interventions involving infants.

A relatively small number of interventions have appeared in the literature directly involving the infant or young child in family sessions. The IMH field, albeit slowly, has gradually begun showing a

recognition of the existence of such interventions. The most intensively studied of these approaches involve clinical applications of the Lausanne Trilogue Play (LTP; Fivaz-Depeursinge & Corboz-Warnery, 1999) and Lausanne Family Play (LFP; Fivaz-Depeursinge & Corboz-Warnery, 1999). Other examples include mentalisation-based treatment for families (MBT-F; Asen & Fonagy, 2021), reflective family play (RFP; Philipp et al., 2023, this issue), and triadic child parent psychotherapy (Iwaoka-Scott & Lieberman, 2015). For the most part, the expositions of existing interventions are triadic only (e.g., triadic CPP); few models have expanded to incorporate work with grandparents, siblings, same-sex couples, or various other family configurations.

Though IMH and family therapy would seem ‘natural partners’ (Sved-Williams, 2003), when family therapy approaches overlook the infant, they inadvertently silence the infant's voice and minimise their potential contribution (Opie et al., 2023, this issue). The assumption that infants would be minimal, or even non-contributors, to family therapy sessions distorts the influences infants uniquely exert (Opie et al., 2023, this issue). Leading infant–family scholars tend to agree that ‘family work is the next frontier in IMH’ and ‘where the field needs to put our collective efforts’ (A. Lieberman, personal communication, 15 August 2022). More pointedly, ‘family therapy without a developmental perspective is an inherent contradiction’ (E. Fivaz-Depeursinge, personal communication, 23 July 2023).

During the 1990s, there were constructive dialogues between object relations family therapists and IMH clinicians that led to the formation of an ‘interfaces study group.’ That group met together for several years under the auspice of the World Association for Infant Mental Health (Byng-Hall, 1998; Fivaz-Depeursinge et al., 1994). They chose the LTP procedure, at that time an emerging new paradigm, to explore the triadic interactions and relationships of one baby from 3 to 12 months of age. They chose a non-clinical family and examined the data from their very different theoretical perspectives. Respectfully, they also included the family and their feedback in this process of exploration. The group considered three major domains in this ongoing family interaction: intrapsychic, interactional, and intergenerational domains. The work of this group inspired other IMH clinicians to work systemically with the infant and at least both parents and other family members. One contributor, Ann Morgan, who was a paediatrician and IMH clinician working in a family-oriented paediatric hospital setting, was among those who advocated seeing things through the infant's eyes, as a person who is part of a threesome (at least). This approach is consistent with that to be explored in the data below, in which experts comment on the importance of directly hearing the baby's voice when conceptualising the problem confronting the infant within the family (Paul, 2015; Paul & Thomson-Salo, 2013). Among the early insights coming from the early work of those pioneering triadic assessments and interventions was a recognition that therapists can understand not just the infant's presenting symptoms and problems, but in the context of working with the whole family deliberately aiming to address the baby as well, paying attention to the baby's active communications signalled through gaze, vocalisations, or body movements (Fivaz-Depeursinge & Corboz-Warnery, 1999).

The time seems ripe for a shift in which family therapists reflect on their own developmental attunement and stances regarding the issue of infant inclusion (Zeanah & Lieberman, 2016). To stimulate such reflection, the current study sought expert commentary from IMH practitioners who work from family perspectives regarding both the current state of inclusion (or lack thereof) of infants within family therapy and facilitators and challenges to greater inclusion. Of particular interest was whether IMH experts believed that family therapy approaches, which rely heavily on verbal dialogue, could accommodate the infant's capacity for non-verbal communication as a contributor to the family narrative, thereby influencing family development. The infant's non-verbal contributions within the family, and in the family therapy context, were one specific focus in the line of questioning used in this study. Overall, the line of questioning was structured to better understand (i) the degree to which IMH and family therapy are now integrated and (ii) whether there might be a greater place for the infant in family therapy.



METHOD

Study design

A qualitative methodology was used. Qualitative research methodology is most appropriate when examining a new realm of inquiry and seeking to determine emerging themes of key relevance within it (Corbin & Strauss, 2008).

Participants

Recruitment

Purposive snowball sampling was employed. Professional networking and recommendations, augmented by web searches, were used to identify additional study participants possessing both IMH and family systems expertise. Participants were invited via email by the first author (JO) to join the study. This email invitation included the rationale for the study and background information. A study participant information statement and consent form were then emailed to interested participants and an interview time agreed via email. Demographic data were also collected. Later, a calendar invitation was sent to participants with a video conferencing software (Zoom) link, including the interview questions. Participants were therefore familiar with the interview questions beforehand and were briefed on the reasons for this research.

Participant selection

To be eligible for the current study, participants were required to have at least 5 years of IMH and family clinical and/or research experience, be currently working in a clinical and/or research setting and be able to read and write in English. No geographical restrictions were imposed. Participation was voluntary and required informed consent.

Sample size

In total, 29 experts in both IMH *and* family therapy were invited to participate. Seven individuals did not respond to the invitations, and two others were unable to participate due to scheduling constraints.

Sample characteristics

Study participants included 20 IMH and family therapy expert researchers and/or clinicians (6 male, 14 female). Participants were from Australia, Canada, Israel, England, Sweden, Switzerland, the United Kingdom, and the United States. Demographic data are presented in Table 1. Years of clinical and/or research experience in the field ranged from 5 to ≥ 30 years ($M = 24.53$).

**TABLE 1** Aggregated participant characteristics.

	All participants (<i>N</i> =20)		Australian participants (<i>n</i> =12)	
	<i>N</i>	%	<i>n</i>	%
Gender				
Male	6	30	4	33
Female	14	70	8	67
Age				
30–39	2	10	1	8
40–49	4	20	2	17
50–59	5	25	3	25
60–69	9	45	6	50
Country				
Australia	12	60		
Metropolitan	11		11	92
Regional	1		1	8
Canada	2	10		
Israel	1	5		
Italy	1	5		
Switzerland	1	5		
United States	3	15		
Role				
Psychiatrist	4	20	3	25
Psychologist	1	5	-	-
Psychotherapist	1	5	1	8
Academic	2	10	-	-
Dual academic/clinical roles	12	60	8	67
Years' experience				
5–10	4	20	3	25
11–15	4	20	2	17
16–20	1	5	1	8
21–25	2	10	-	-
26–30	3	15	3	25
30+	6	30	3	25
Institutional affiliation				
University	4	20	2	17
Hospital	1	5	1	8
Multiple institutional affiliations	15	75	9	75
Highest education				
Ph.D.	9	45	4	33
MD	3	15	1	8
PsyD	1	5	-	-
Masters	3	15	2	17
Bachelors/Grad Dip	4	20	4	33
Dual academic/clinical qualifications	1	5	1	8
Employment status				
Full-time	14	70	8	67
Part-time	5	25	3	25
Other	1	5	1	8

Abbreviations: Grad Dip, Graduate Diploma; MD, Doctor of Medicine; Ph.D., Doctor of Philosophy; PsyD, Doctor of Psychology.



Procedure

Ethics and consent

Ethical approval was granted by La Trobe University's Human Research Ethics Committee (HEC22159). The study adhered to the Australian National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, 2007). All participants provided written, voluntary, and informed consent. A copy of the participant information statement and participant informed consent form was attached to the calendar invitation and sent separately in the confirmation email. Consent forms were completed via soft copy and emailed to the first author. Before the interview recording began, participants were given time to ask questions. The interviewer (JO) provided a study overview and reminded participants of their voluntary participation and their right to withdraw at any time. Participants consented to the interview being recorded and transcribed.

Data collection

Interviews

Individual semi-structured interviews were conducted, allowing participants to expand on areas they viewed as significant. All interviews were conducted in English. Each participant was interviewed once by the first author (JO), who is an IMH postdoctoral research fellow. The interviewer had no prior relationships with the 15 participants and maintained a professional relationship with five participants. Semi-structured interviews allowed for the establishment of commonly organised, but very complex, narrative content. All questions were open-ended, allowing participants to co-guide the interviews. All interviews were video and audio recorded for later transcription. Data collection occurred between September–November 2022. The interview length averaged 51 minutes (range: 35–74 minutes).

The interview schedule is outlined in [Table 2](#).

The audio- and video-recorded semi-structured interviews were transcribed verbatim using the artificial intelligence software, Otter.ai. The first author, JO, reviewed all transcripts for accuracy and completeness.

Qualitative approach and justification

As we were interested in the meaning experts ascribe to the integration of IMH and family therapy, and the infant's place in family therapy, interviews were analysed qualitatively using reflexive thematic analysis (RTA; Braun & Clarke, 2021a; Clarke et al., 2015). RTA is an interpretivist paradigm wherein prominence is placed on the individual participant's subjective experience. The methodological rationale for selecting RTA was its alignment with our aim to examine and interpret patterns of meaning from within a dataset by reiteratively discovering themes and making connections between them (Braun &

TABLE 2 Semi-structured interview schedule.

Interview schedule	
(i)	Tell me about your experience in this area.
(ii)	In your experience, does IMH work typically extend beyond the dyad to include other family members? If so, how often have you seen this? If the proportion is low, should it be different?
(iii)	What are the frameworks/principles for IMH and family therapists to draw on? Are these frameworks accessible and/or well-established?
(iv)	What are the benefits, if any, associated with working with multiple members of the infant's family?
(v)	What are the challenges, if any, that come with working with multiple members of the infant's family?
(vi)	Where do you see the future of family work in this space?



Clarke, 2021b). Thus, this was the most suitable framework for analysis as the aim was to generate patterns of meaning and experience from the data set. Moreover, RTA allowed thematic examination of the construction of meaning and experience through participant narratives. Notably, RTA also acknowledges and embraces the research analyst's subjective perspective, perceiving this as an analytic asset.

Importantly, as RTA is flexible and does not impose structured methodological parameters, we were not limited by a theoretical framework to make meaning of the data (D'Souza et al., 2020). Consequently, three core theoretical assumptions informed our analysis: (i) that IMH is a field unto itself, with its own frameworks and theories; (ii) that family therapy is a field unto itself, with its own frameworks and theories; and (iii) that the fields of IMH and family therapy might represent a degree of theoretical and practical overlap.

We followed Braun and Clarke's (2021a) six iterative steps to reflective thematic analysis: (i) transcript familiarisation; (ii) coding transcripts; (iii) generating initial themes; (iv) revising themes; (v) defining and finalising themes; (vi) writing up. Aligning with the study's exploratory research questions and aims, the coding process was predominantly inductive, with themes generated as the dataset was analysed.

Interviews were first coded at the semantic/overt data level wherein we identified what was apparent in the interview transcripts and collective dataset. These semantic/overt codes were then converted into thematic and sub-thematic categories, which extrapolated and extended upon what was reported upon in the codes. This was the point where the research analyst's interpretation entered the analytic process.

Our coding process was predominantly inductive. The research team commenced the analytic process with no preconceived codes, but rather developed codes as the dataset was analysed. Thus, researchers sought to maintain an open mind to let the data shape the evolving themes. This aligns with the study's exploratory research questions and aims. We allowed the data to generate hypotheses and guide the generation of study codes, themes, and sub-themes. However, deductive elements to the work were also included, such as the research questions (Braun & Clarke, 2021b).

Data analysis and rigour

To ensure clear, standardised, and rigorous reporting of results, we adhered to the Consolidated Criteria for Reporting Qualitative Research 32-item checklist (Tong et al., 2007). All identifiable material from transcripts was removed prior to coding to maintain participant confidentiality. All transcripts were double coded. Specifically, independent coders extracted and coded transcript data using a standardised coding table. Following this, the two coders of each transcript came together to discuss and refine codes. The final themes were collaboratively generated by all coders.

The data were analysed by JO, AB, LR, FP, EH, and JMH. To further ensure rigour, JO followed a semi-structured interview schedule when conducting all interviews. Regular team meetings were held to co-develop codes, themes, sub-themes, and recommendations to embed not only the rich data from the collected dataset, but to include the research, clinical, and theoretical wisdom of the research team. The study team who further contributed to the results comprised researchers and researcher-clinicians, all trained in IMH, developmental psychology, infant-inclusive family therapy, and/or qualitative research methodologies.

RESULTS

Generated themes

We found four overarching themes common to all participants:

1. Family practitioner awareness of the infant in family therapy.
2. Interconnectedness of IMH and family therapy.



3. Divergence and barriers impeding inclusion of the infant into family therapy.
4. A feedback loop between the fields perpetuating the exclusion of infants.

These themes and their subthemes are discussed in further detail below.

1. Family practitioner awareness of the infant in family therapy

1a. Shared guiding principles

Participants held the common view that it was important and valuable to afford infants a place in family therapy. In this way, infants were seen as a 'North Star' guiding their work. All valued infants as unique individuals capable of experiencing complex emotions, mental health, and mental ill health, in attunement with their social contexts. The main premise was that *'infant development is inherently relational in nature'* (#2), unfolding not just in the context of dyadic relationships with primary caregivers, but within their full contextual environment. Participants asserted that infancy was *'a critical developmental period not to be overlooked'* (#19) as it is the foundation upon which all subsequent development will rely, organising relational development throughout the life span.

Proper timely attention to the family context was seen as paramount for changing trajectories, both in the life of the infant and in the development of family challenges. In terms of the infant's place in clinical family therapy, there was unanimous recognition of the infant's robust communicative capacity, meaningful therapeutic presence, and value-adding contributions to family sessions. In sessions, the infant's presence and contributions can be expected to evoke – or fail to evoke – responses from individual family members of dynamic significance. Such exchanges can be underscored and drawn to the attention of the older family members, elevating mindfulness and opening the door to the charting of new relational patterns. Further, the child's emotional reactivity, signs of disinterest or discomfort, and other verbal and non-verbal signals are all part of the flow of family commerce. These are signals that provide meaningful targets for potential therapeutic intervention if therapists take note of and integrate them into the flow of the work. In short, the very young child's behaviour and affective displays were seen as important non-verbal communicative bids to be decoded and explored in family therapy. There was also strong opinion among participants that there was an important moral imperative – that *'the infant has a right to be an active participant'* (#3).

1b. The invisible infant

All participants reported that in their experience, the exclusion of infants from family therapy services was commonplace. Such exclusion was believed to cut across diverse family therapy service settings including private practice, non-government organisations, and government-run organisations. This belief was reflected in the observation that *'traditional family therapy is not well set up to involve non-verbal and non-mobile infant participants ... the infant's voice is greatly underrepresented in the family therapy field'* (#4). Relatedly, many voiced that mainstream family therapy services do not prioritise the infant, observing that *'infants are often invisible, silent, and forgotten in family therapy settings'* (#14). Others believed that family therapy lacks a central focus on early development. Infants are overlooked in family therapy because they are viewed as non-participants with minimal contributions of merit to offer, sometimes seen but rarely heard: *'often practitioners talk about the very young child but seldom to the very young child'* (#16). Participants felt this bias resulted in parents' own perspectives, experiences, agendas, and representations being privileged in a manner that failed to adequately recognise or integrate the infant's experience. Others lamented, *'IMH is not well understood outside of IMH'* (#1). Overall, the view that babies were invisible in family therapy, whether their invisibility was intentional or unintentional, was widely held and cited as a major missed opportunity.

1c. A prevailing sense of frustration with the unjust exclusion of the infant

Participants also reported personal frustration about the exclusion of the infant from family therapy, some on the verge of exasperation. One asserted: *'you can't call family therapy "family therapy" if you're*



not actually working with the whole family ... they don't see the baby and don't privilege the baby's experience' (#4). Another stated, 'the fact that most family therapists don't know about IMH is surprising and disappointing ... the need for IMH in family therapy is not only necessary but obvious' (#12). Such frustrations were based on well-established scientific evidence heralding the unparalleled importance of development during the infancy years for life-course development and the belief that such evidence was being ignored or trivialised, undermining the very efficacy infant–family work would be positioned to achieve. Others' frustration cited ethical injustice in excluding infants: 'excluding the infant is a human rights issue' (#3), 'infants have the right to join a family session, particularly when decisions made in the session directly impact them' (#5). There were observations that blatant exclusion of a verbal child would not be tolerated by systemically oriented professionals at any developmental period. For some, their degree of frustration led to ambivalence and doubt about any possibilities for change; one participant acknowledged, 'I don't know if IMH will ever be fully immersed in family therapy' (#15). However, for others the frustration prompted advocacy – 'it's my job to keep babies safe and give them a voice ... while most privilege the voice of the adult, I privilege the voice of the infant' (#4).

1d. A potential for clinical impact when infants are included

Participants reported that in their own practices, involving infants in family therapy sessions could lead to transformative, clinically meaningful outcomes and the revision of family scripts. As an example, participants pointed out that the intensity of care the infant requires, as well as novel demands and pressures associated with welcoming a new infant, served as a stressor for the family, which depleted parents' internal resources. Transitions to parenthood, accompanied by revisions in parental identity, self-efficacy, and agency, can exacerbate underlying familial tensions. Hence, the needs of infants can serve as one potential 'port of entry' to prompt examination and even enactments of the family's style of handling conflict and addressing multiple needs. One participant explained,

You can watch the dynamics right before your eyes, who the infant turns to, who they're most comfortable with, who's most responsive to them, you can see whether there is perhaps conflict or jealousy ... there's so many things you can see in the room that tells you volumes about how the family functions. (#6)

Participants asserted that such clinical interchanges provided concrete data that could be helpful in articulating the infant's, parents', and family's clinical presentation and in assessment and case formulation. They evoked the well-known family therapy mantra that *'the whole family is more than the sum of its parts'* (#19). Participants gave examples of triangular familial patterns they had observed within therapeutic settings where infants were involved. For example,

Seeing which of the two parents the child goes to when they start crying can start a conversation about the triadic relationship, but also the kind of quality of the dyadic relationship that the child has with each of them. And this you can see only if you see the three of them together, when the child has the choice between the two caregivers. (#10)

Numerous participants reported on the profound impact of infants in motivating parents to actively engage in therapeutic processes, fostering an elevated sense of hope and the belief in the possibility of positive change. For some practitioners, the therapeutic work with infants proved particularly invigorating, as observable, demonstrable changes in the infants' affect and behaviour would often manifest rapidly within a matter of just weeks. This specifically pertains to a therapeutic approach that is congruent, truthful, integrated, and spontaneous. Additionally, the energy and playfulness that an infant exudes during a session were noted as having therapeutic benefit, instilling a sense of possibility, healing, and rejuvenation in the therapeutic environment. Participant reports collectively shed light on the significant and multifaceted role that infants assume within the therapeutic context, acting as catalysts for transformation and sources of inspiration for positive change.



Participants reported that during sessions with both parents and the infant, therapists have natural openings to discuss ties to the parents' personal histories and the past. Infants draw attention to both intergenerational and within-generational patterns of relating. In so doing, they can potentially draw attention to and thereby influence transgenerational trauma patterns and the possibility of healing within the family unit. Additionally, infant–family work done well can enliven parents' own mindfulness about their infant's mind which, in turn, can enhance parental sensitivity and reflective capacity and permit the infant to enjoy more positive mirroring interactions. Another strength of such approaches includes opening a door to important subsystem familial work. More specifically, family therapy involving the infant/young child can allow for nuanced observation and understanding of the interactions of not just the full family but also of subsystems if multiple family subsystems (e.g., co-parent, parent–infant, infant–sibling) were present together. Finally, family therapy involving the infant can accommodate a wide range of diverse family constellations, such as unmarried couples, multigenerational families, or same-sex families, in which infants may not have a single predominant 'primary' caregiver but where caregiving is shared and distributed.

2. Interconnectedness of IMH and family therapy

Participants believed that IMH had thoughtfully embraced family therapy principles. They also felt that IMH professionals had shown widespread acceptance of family therapy principles and that many had made important interconnections improving their approaches to families.

2a. Existing integration

Some interviewees portrayed IMH and family therapy as integrated and overlapping fields. For example,

While IMH and family therapy are often put into separate categories of thought, they are already married discourses in my mind because I've been trained in both ... it's about which discourse you are paying attention to. If you strip it back, we're all orbiting around the same clinical material, but our reference points are different in terms of who are the theoretical ancestors we draw from. (#5)

Participants who voiced such positions were those trained in both approaches and they expressed comfort and confidence drawing on elements from both theoretical traditions, as called for, in their work. They highlighted the synergistic influence of both ways of working, citing the intersection between IMH and family therapy, with emphasis on the relational nature of infant work. According to one interviewee, *'one of the interesting and unique aspects of IMH practice is that it's never one client that you're working with. If you're interested in supporting an infant, you have to be interested in supporting the caregiver'* (#9). Equally, however, despite their conviction that IMH had taken pains to integrate principles from family theory and therapy, they believed such integration had not been reciprocated.

2b. Synergies with integration

Several participants reported having felt pressure early in their careers to focus on either IMH or family therapy. For example, *'I felt pressured to pick a side. I didn't want to choose IMH over family therapy or family therapy over IMH'* (#16). Only with experience, knowledge, skill, and confidence did they become comfortable eschewing this needless dichotomy. Some felt that closing off family therapy to infants was a clinical disservice. One interviewee claimed, *'it's not about either or, family therapy or IMH, but about what works best for whom'* (#2). Another advocated moving past questions of whether IMH and FT were distinct, arguing *'we need to look beyond the black and white and inject shades of grey into this work ... you need a foot in both camps to hear the message and work effectively'* (#15).

There was widespread agreement that there is a need for continuing integration so a broader family therapy audience could see the intersection and place of IMH in family therapy work. For some, such



integration was viewed as a commonsense advance, as *'integration of the IMH perspectives into the family systems field is a logical next step'* (#1) and *'the field of family therapy needs to do much more to embrace all that we've learned about the infant'* (#20).

Fuller integration was seen as viable because there had historically been intersections between IMH and family therapy. Some participants recalled that in prior decades the infant had been far more visible through the work of specific family therapists, prior to the more recent integrative regression. One participant said, *'family therapy and early psychodynamic psychoanalytic work were inextricably intertwined at the beginning of family therapy methodology, practice, and theory, but this is often lost now'* (#3). Another recalled *'going back to the 80s and 90s, when I trained in family therapy, there were great thinkers, like John Byng Hall and Mary Sue Moore, who actively worked toward bringing the infant's voice into the family session.'* These participants drew hope from this history that a movement towards infant inclusion could be reinvigorated.

Participants voiced confidence that family therapists' existing clinical skills and systemic theoretical knowledge made them well-suited to engage in IMH work. Readily translatable skills included creation of a calming presence for highly stressed families, adoption of a neutral stance, utilisation of circular questioning, demonstration of curiosity about (the infant's) experience, meeting the family at their current level, and considering intergenerational beliefs within the family dynamic. Some maintained that the infant's very presence in the room facilitates systemic approaches of circularity and curiosity, which the family therapist is well-equipped to draw on.

3. Divergence and barriers impeding inclusion of the infant into family therapy

Simultaneously, perception of a disconnect between family therapy and IMH was present for all participants, who viewed IMH as not embedded within family therapy. For many, the fields were distinct paradigms, which resulted in the infant being overlooked in the family therapy setting. The divide was attributed to a belief that *'family therapy has lacked a central focus on early development and the non-verbal communications of the infant'* (#2). Another reported, *'how much is family therapy currently developmentally informed ... presently it's remarkably un-developmental'* (#14). One respondent lamented that family therapists were not expressly interested in infant experiences, *'unfortunately, I think family therapists aren't even at the point of thinking about the infant'* (#15). Participants proposed numerous reasons why the infant has remained on the periphery in family therapy, as reported below.

3a. Antiquated myths and misconceptions about infancy

Participants believed that failure to include the infant in family therapy was driven by persistent unfounded myths and misconceptions about babies. One stated, *'it doesn't help that we have this cultural concept that the infant does not remember, they're not aware, they don't know what's going on, and they can't be impacted by family dysfunction'* (#18). Others cited additional falsehoods about infants such as *'babies do not have mental health, babies can't contribute to a family session'* (#10). One participant sarcastically stated, *'infants have mental health? What!'* (#11). These views were perceived as troublesome when families, and some family therapists, presumed infants are protected from conflict, which is unfortunately not the case (#17). Others felt therapists had trouble holding in mind that babies are highly attuned to others (#11).

3b. The decontextualised infant and the need to contextualise

Among the participants who themselves employed IMH interventions, most used dyadic therapies, which decontextualised the infant from their broader social ecology. *Even so*, participants emphasised the clinical imperative of conceptualising infant emotional development in its broader social context: *'children grow up in multi-caregiver environments the vast majority of the time'* (#9). They maintained that fully assessing child experiences in the family leads to more accurate, complete, and comprehensive case formulations with better understanding of the family system. Participants felt that context was key in understanding behavioural and affective content. According to one participant: *'therapeutically, we cannot*



consider infants outside of the network they are embedded in as that's not reflective of their life where these problems play out' (#9). Practices that decontextualised the infant were viewed with exasperation. One interviewee said, 'I mean, nobody develops within the context of just one other person!' (#6); another wondered 'whatever happened to that old African proverb "it takes a village to raise a child"?' (#12). Participants pointed out that cultural erosion of family systems meant that many children's 'villages' now by necessity included extra-familial co-parental supports, including parents' friends, nannies, and daycare providers.

3c. A relentless dyadic bias

Participants cited historical biases in viewing infant experience as concentrated within the context of a single 'primary caregiving' relationship with one influential caregiver, usually the mother. This bias existed in both clinical and research settings. Infant assessments and interventions have primarily been conducted at the dyadic level with attention lavished on one major carer in a family group. One expert pointed out that the '*majority of the treatments out there are still just mother–baby dyad: circle of security, parent–child interaction therapy ...*' (#18). Another reported, '*there's a strong gendered aspect to IMH, particularly in Western cultures ... where more and more focus has been given to the role of the mother ... so it's a cultural thing and it's a gender thing*' (#9). Some underscored gendered sociocultural norms of the 1940s to 1960s, the time at which IMH and attachment theory began drawing breath as new fields in their own right. Participants reported that this was an era of stricter gender roles. Minimisation of father influence during infancy was compounded by the proliferation of attachment research drawing on cultural norms and assumptions; the strange situation procedure itself unwittingly obscured broader familial influences affecting the baby. The explosion of interest in these fields served to reinforce and encourage theory, research, and practice reifying the cultural confines.

Participants observed that even following notable sociocultural movements, IMH clinical and research realms were slow to move beyond the dyad. Nearly all spontaneously stated that a dyadic focus fails to do justice to the complex interpersonal realities of most infants today. For example, '*dyadic attachment relationships do not exist in isolation of other relationships*' (#9). Many observed that in many cultures, caregiving has increasingly become a shared responsibility with diversification of family structures. One participant reflected that '*we need to consider what holds the attachment relationship ... what are the other relational structures that support the mother and infant's relationship?*' (#14). Remarking on dyadic biases that persist, an interviewee noted '*when we bring only one parent, we bring only one piece of the puzzle*' (#12). Another lamented, '*for the non-attending parent [to the therapy session] any understandings, interpretations, advice, guidance, is secondhand*' (#5), and some likened the second-hand treatment of the non-attending family member(s) as a '*trickle down economy*' (#16, #18). Another issue raised was that because attachment relationships are dyad-specific, the child's relationship with the privileged caregiver attending sessions can be very different than the relationship the child shares with the non-attending attachment figure. Relatedly, observation is pivotally important in IMH work, in part because observations are useful when a parent's reports and interpretations are sullied by limited self-awareness. Observation of dyads only is insufficient. Collectively, dyadic biases hamper clinical work, obfuscating family-level dynamics and related relevant issues.

Perhaps not surprisingly then, some participants highlighted that men and fathers were often sceptical about and, hence, less likely to engage in family treatment, even if invited. Their scepticism can often be directly traced to feelings of not being welcomed by services they (often accurately) perceive to be gendered. Interviewees also felt that fathers often view emotional work with the baby as the province of mothers, holding outdated beliefs that it was not a father's place to attend IMH services. Many fathers also do not wish to interfere with relationships developing between the mother and her service provider, and men often intuitively recognise when a provider accustomed to working solely with mothers and infants is not fully comfortable engaging with fathers or with seeing multiple adults simultaneously.

Despite the challenges with outreach to men and fathers, interviewees emphasised the imperative of continuing to welcome fathers to service settings. One participant pointed out that,



We know that whether you intervene with a dad or not, he's still going to be in the baby's life. So, looking away and not taking the opportunity to do what you can to strengthen co-parenting is really not in the baby's best interest ... we talk about best interests all the time, but the reality of the best interest is making sure that what's happening on the ground is as positive, safe, collaborative, and reflective of reality as it can be. (#20)

Participants maintained that father-inclusive work was essential if the aim was to understand triadic and co-parenting relationships, which are a context for early child development. Father-inclusive work also takes the brunt of responsibility off the mother's shoulders and shifts the focus to the co-parents. Participants felt the IMH field had seen a slow, progressive shift away from dyadic, mother–infant oriented approaches, but highlighted that more work is needed to truly embrace a systemic approach.

3d. *Overlooking cultural considerations*

Several interviewees commented that it was important to differentiate what was universal regarding family development contexts for infants, and what elements were culturally specific. Most echoed the sentiment that *'the need for connection, interaction, emotional regulation, and attachment is universal'* (#4). Despite this, many highlighted the necessity of considering the infant and family within the cultural context where families are situated.

Participants noted that the existing practice of family therapy, including those involving infants, was limited in cultural perspectives. Concerns were raised about a lack of multicultural influence in current training and treatment approaches. Concerns were also raised that most therapeutic traditions evolved in white Anglo-Saxon contexts, culminating in a dominant western perspective. Interviewees noted that applying western models without considering cultural differences and local understandings was insufficient and a poor cultural fit. For example, *'you can't take westernised practice models, in my view, and just apply them as if they should work, or as if people should just understand what we do, because they don't'* (#2). Participants remarked that the inadequacy of certain treatment approaches is evident when cultural factors, such as diverse family structures and gendered parenting roles in different cultures, come into play.

Professional training was discussed with respect to degree of focus on cultural groups and differences, such as multi-generational families. Most felt training approaches generally lacked sufficient opportunities for practitioners to engage with diverse cultural groups. Others reported the rich learning that can be found when engaging with more collectivist cultures relative to individualistic westernised cultures. Participants also highlighted that the role of the infant changes within different cultural contexts, reporting unique understandings and representations of the infant in eastern compared to western cultures. For example:

The meaning of the infant changes according to context ... in our western context the baby of rape is often ambivalently regarded by the mother. So, from the perspective of the mother, "When I look at him, I can only think about the rape"; "I hate him and I love him." Whereas some women from places like Sierra Leone say to me, "it's not the baby's fault, it's the fault of the people who are ruining our country." (#2)

3e. *A lack of research investment*

Participants reported on the dearth of empirically published family therapy research involving infants. For example, *'most people agree that early experiences are really important, but we don't come around to owning that in terms of research and funding'* (#14). Expanded research will be pivotal in validating and demonstrating clinical efficacy, justifying the most impactful trainings and building integrative momentum: *'the real proof of the benefit of family and triadic therapies will come from empirical studies that show dyadic therapies are less effective in improving the infant's symptoms than triadic/family ones'* (#13). Another participant stated,



Working with the family is going to be ultimately more effective than not including the family, my hope is that that's borne out empirically, and then we can surely get on with legitimising family work in this space. (#14)

Despite widespread recognition of the great need for expanded research, interviewees acknowledged the challenges of designing, funding, and conducting high-quality research. One expert attributed the lag in research to the reality that *'funders want to back proven models ... IMH is flexible and individualised currently without a central framework'* (#16). Others reported that IMH's psychodynamic assumptions did not readily lend themselves to empirical evaluation, manualisation, and standardisation. Hence there are attendant difficulties with embedding such approaches into mainstream family therapy contexts. Others attributed the scarceness of whole-family empirical research to logistical and methodological research design complexities including cost and the time-consuming nature associated with developing, collecting, and analysing data on whole families compared to dyads or individuals.

3f. Theoretical pluralism

For some, the chasm between family therapy and IMH was attributed to the fields' distinct theoretical emphases. Some felt family therapy's narrative therapeutic emphasis, underlying the creation of meaning through linguistic communication, essentially excluded preverbal infants. For example:

As family therapy got enamoured with narrative work, it left some of its roots in systemic work, Milan family therapy principles, and structural family therapy behind, and as it did that, it forgot about the very young child ... not understanding that narrative might be expressed in different ways to voice. (#14)

Another participant elaborated on the contrasting theoretical positions,

You've got two different paradigms, or ways of approaching clinical issues. One, the family therapy tradition, if you look historically, is very much about the skilled unravelling of many complicated dynamics and often how meaning is created through language. Infant interventions and IMH come from a rather different tradition, which is more psychoanalytic. It is focused largely on the primary carer and the infant, looking at the intricacies of early self-development ... IMH tends to focus on individual psychopathology – either the infant's or a parent's – often at the expense of what's happening in the broader system. One has a more external communicative focus, the other is centered on an intrapsychic model. (#2)

Others attributed the disconnect to IMH's psychodynamic tradition and tendency to focus on individual psychopathology in the form of mental representations – either the infant's or the parent's – at the expense of characteristics of the broader familial system. One participant maintained that in psychodynamic approaches the infant is 'inside' the parent, in either memory or fantasy, and so it is inconvenient to have an actual infant physically present in the room. This participant contrasted this orientation with many family therapists' behavioural leanings, which seldom attend to the infant's inner world or representations. However, other interviewees countered this notion, noting that family therapists do draw on a range of theoretical approaches, including psychoanalysis. For example, *'the early beginnings of family therapy were inextricably intertwined with early psychodynamic psychoanalytic theory and practice ... this is still observed today, but to a lesser degree'* (#3).

Some participants thought there were invisible constraints to overcome, related to the historical prestige attributed to psychotherapeutic interventions. One interviewee cited a principle of inverse proportionality, wherein the smaller the therapeutic system, such as in psychoanalysis, the higher the prestige associated – a prestige commensurately associated with higher remuneration. As therapeutic systems expand, prestige diminishes, as does relative remuneration. Given that participants in this study



represented several different countries, it is possible that this professional divide in prestige may be more significant in the service system for families in some nations than in others.

Others attributed the theoretical disconnect to family therapy and IMH both being multidisciplinary fields; each representing a merging of many well-established theoretical orientations, disciplines, and professions. For example, 'IMH is informed by developmental pediatrics, psychology, psychoanalysis, attachment theory, family systems theory, etc.' (#16); similarly 'family therapy is always a secondary degree, you can come to it from psychiatry, psychology, social work, occupational therapy, speech pathology ...' (#1). While such disciplinary diversity allows professionals to approach clinical issues from varying clinical perspectives, some felt it was this diversity that led to the lack of consensus on how to unify IMH and family therapy and a lack of established standards, policy frameworks, and ethical guidelines for family therapy involving the infant. Some felt this diversity partially explained the absence of stand-alone frameworks or models for family therapy to include the infant. One participant stated, there is 'no central guiding framework and no proven model ... current models do not include the 0-to-6-year developmental period.' Another reported 'we need guidelines for when to choose dyadic therapy, when to choose a triadic therapy etc.' (#12). In the absence of unifying theories, models, frameworks, and guidelines, participants felt that family therapy work involving infants lacked a clear guided path. Others worried that certain family therapists might be so entrained in the dogma of their preferred theoretical approach that they were not able to see value beyond their present methods. This was seen as stultifying not just for clients but for the field itself, encapsulated in the comment, 'family therapists were trained in the model that they were trained in ... it's locked in, it's what they do instinctively' (#20).

3g. Absence of the infant from family therapy training

Participants unanimously agreed that 'family therapists have not had the requisite training to understand the language of the infant and to appreciate it as expressive, clear, and contingent' (#3). Another highlighted that:

They're not trained in engaging and involving little kids in their therapy, so that's a blind spot for family therapists ... working with little kids is messy and complex and they don't know how to do it, they didn't get enough training and supervision in graduate school. (#20)

In response, participants called for specialised IMH training for new family therapy graduate students. One participant underscored this by stating, 'if you want family therapists to be more interested in the infant, you have to train them to be more interested in the infant' (#5). However, realistically this was reported as challenging as graduate family therapy programs, globally, do not typically include content on IMH or early childhood development. The exception to accessing such training was if students, or interested family therapy professionals, independently sought out such specialist IMH training. However, there were concerns raised with accessing such independently sourced training. For example, one participant (#2) reported that 'the whole attachment privatisation of bodies of knowledge is controversial. Over the years I've quite literally spent tens of thousands in training' (#2).

Participants reported impediments encountered in the realistic pursuit of IMH professional development for family therapists. The consensus was that IMH training was an investment of considerable magnitude, both in terms of time and finance. Additional constraints included the scarcity of such trainings and their predominance to be based in the United States, particularly attachment-specific training. Participants further reflected upon the constraints tied to current IMH training content. They identified a substantial gap in the provision of post-training assistance and opportunity for practical application of learning, an omission of which frequently resulted in clinicians grappling with uncertainty and feeling inadequately equipped, despite having acquired new knowledge and skills. This was reported to inhibit translation of the training content into clinical practice. In addition, participants reported criticism of the prevailing dyadic trainings, narrowly focusing on the parent-child dyad. Participants argued that excluding contextual elements, such as the father, siblings, and culture, resulted in a decontextualised approach to therapy. Collectively, these obstacles raised concerns of whether such training could be realistically embedded into family therapists' professional development journey or active practice. Still, participants stressed the necessity for such training given its unique, experiential, and primarily



observational nature. They emphasised that observational training is an important, immersive form of learning. One participant explained:

It's different to training the intellect. IMH is about embodied relationships with an infant in a family ... so, you can train your intellect, and I can articulate the four different attachment classifications of secure, avoidant etc., but actually being in a room and watching an infant sleep, hit, vomit it's a different part of your brain that gets activated and trained. (#5)

3b. Necessary clinical skills for including infants

This theme described the sophisticated clinical skills and extensive experience necessary to conduct family work involving an infant, described by participants as challenging to achieve. All participating clinicians commented on this theme. For example:

This is a steep learning curve beyond typical family therapy trainings ... it requires a more challenging therapeutic position ... the skills required from the therapist are more complex, because they need to listen, to observe, and to feel what's going on with people in the room. (#12)

When commencing family therapy including the infant, participants believed there may be concerns and apprehension related to the clinical complexities involved. There may be anxiety owing to concerns about confidence and competency in this specialised domain. Thus, exclusion may be exacerbated by clinician discomfort. One specific concern may be apprehension about infants injecting spontaneity and chaos into therapy sessions, hindering session planning and control. One participant reported 'I didn't want my agenda going out the window' (#16), reflecting worry associated with infant inclusion and their unpredictable affect and behaviour. Thus, some concerns were with infants 'derail[ing] the session' (#8). There were sentiments that therapist training in both IMH and family therapy approaches help clinicians to embrace whatever emerges during sessions and to use it to guide the work, letting go of more structured, 'safer' therapeutic explorations; however, there were also beliefs that flexible spontaneity is unusual and dependent upon clinicians' own preferred therapeutic stance.

Unpredictability as a source of anxiety when conducting family therapy involving the infant was also associated with suspending predetermined therapeutic approaches to be therapeutically present and congruent with the whole family. Some participants highlighted that the focus of the work is dependent on the specific baby and family present, as different symptoms or presentations require different explanatory models and therapeutic flexibility. This integrated way of working requires that the therapist closely observe and respond to what is happening in the therapeutic space, without relying on a uniform therapeutic style. Several clinicians emphasised synergistic clinical benefits of drawing upon both family therapy and IMH approaches in a session.

Participants also highlighted questions about 'who's the client?' (#9) in the context of conducting family work involving infants, parent-child dyads, co-parent-child triangles, and the full family system. This uncertainty regarding prioritisation and accountability prompted further anxieties, according to participants. Given the many inherent complexities, many clinicians understood why so many prefer individual or dyadic work, which provides a greater sense of control and organisation.

All clinician participants agreed that there is a need to develop infant observational non-verbal skills: 'we need to know how to talk with very young children, through play, and have a family conversation about it, rather than talking about the child' (#16). Many commented that non-verbal dialogues with an infant and hearing the baby's 'voice' require a sharp skillset, for infants communicate via expression, behaviours, gaze, body orientation, and play, all of which reveal the complex inner world of the infant.

Participants commented that family therapists may encounter challenges in adopting a representational way of working, which is inherent to IMH and centres on identifying and understanding how each carer uniquely perceives the infant. This approach was identified as diverging significantly from pathologising or history taking of the caregiver as an individual.



Participants emphasised the significance of infant observation in developing these advanced skills. Such training teaches respondents to see that which is 'hidden in plain sight.' As one interviewee explained, *'my infant obs[ervation] taught me to talk less, watch more, and to be curious about what I see in the presence of families ... I learned to be comfortable with infants. It blew my mind because things I would never have noticed before I noticed'* (#16). Despite clear benefits, drawbacks were also noted as training is time-consuming, emotionally tiring work. However, all participants reported that the payoff was worth it given clinical benefits for the infant, family, and practitioners themselves.

4. A feedback loop between the fields perpetuating the exclusion of infants

Participants described the confluence of obstacles inhibiting advancement of the dialogue between IMH and family therapy as a feedback loop. The situation was described as *'a catch-22'* wherein integration was needed to harness the numerous reported benefits offered – but was inhibited by an array of barriers. Barriers were likened to a *'domino effect.'* For example:

It's frustrating actually because it's a vicious cycle. There aren't many people doing this kind of work, which results in very little research, which results in few validated interventions. So, it's a kind of loop ... the cycle starts by [IMH] training focusing on working with two [people], not three. This makes you more comfortable with dyadic work, so you continue doing and teaching that. You're less experienced working beyond the dyad so you don't do it and you don't teach it. (#12)

This situation was not seen as easily resolvable given the systemic, widespread nature of barriers that occur at training, theoretical, clinical, research, and sociocultural levels. Participants agreed that such barriers arose from overlooking the infant and non-verbal infant communications, instead privileging the narratives family therapies more commonly focus upon. These barriers precluded integration, resulting in a mutually reinforcing process of disconnection (see [Figure 1](#)).

DISCUSSION

Findings indicate that exclusion of infants from family therapy is seen as a widespread and concerning phenomenon, in the eyes of infant-family mental health experts. Concurrently, the same experts believed there was a merited, natural position for the infant within a range of family therapies. Participants enthusiastically advocated expansion and integration of a dialogue between IMH and family therapy. Common ground was also identified, with those interviewed recognising that professionals in both disciplines serve children best when including the child's total network of relationships to fully understand and resolve relational issues.

The introduction of a new infant into an existing relationship system was characterised as a potential therapeutic turning point, creating new emotionally charged relationships that instigate systemic changes and can spark reflection among senior family members. The infancy period was perceived as an ideal time for family therapists to explore change processes via the infant joining in the therapeutic journey. Integrating the baby's communication gave a meaningful opportunity for therapists to support reflective capacity in parents around attachment needs, in real time. For family therapists, attention to the infant's challenges are particularly important in situations where the family system is not fully attentive to the baby's needs. The opportunity to see the family and baby together enables family therapists to better ascertain when dyadic intervention or models of trauma responsive care should be introduced to foster attunement and attachment. The aim would never be to transform family therapists into infant psychotherapists (or vice versa). Rather, important growing points would seem to include mutual elaboration, an iterative process of developing integrated



models of therapeutic change and having clearer perspectives on matching therapeutic modality to family challenges.

Both family therapists and IMH practitioners seem to agree that the infant's developmental, emotional and relationship course is influenced by the family structure, social networks, childcare practices, and cultural models of parenting. While normatively the infant has a strong role in shaping the dynamics of the family system, the impact of within- and outside-the-family stressors and of perturbed inter-adult and family dynamics can disrupt the infant's development. For these reasons, incorporating the infant and addressing the infant directly within-the-family therapy intervention – always in an attuned, interactive way – stands to have a profound therapeutic effect for the baby and for the family as a whole.

While those interviewed shared many perspectives, interviewees also expressed some differences in points of view. One common shared view was recognition that any infant's developmental course occurs in relational contexts influenced by family, social networks, and cultural models of parenting, childcare, and infancy. Another was that the current level of interdisciplinary dialogue and efforts to date at creating a rapprochement between IMH and family therapy has been largely unidirectional. With respect to differences in perspectives, some commentators believed that family therapy principles were ingrained in and critical to IMH work, while others disagreed, drawing attention to IMH's historic dyadic emphasis – only slowly being revised – which had often decontextualised the infant–caregiver dyad from its broader social ecology. Interviewees did agree that even though **IMH and family therapy share a relational focus, neither family therapy training programs nor clinical family therapy practice attend much to IMH principles**. As a result, such principles have not had material influence on the practice of family therapy. Relative exclusion of the infant may also owe to a move away from privileging

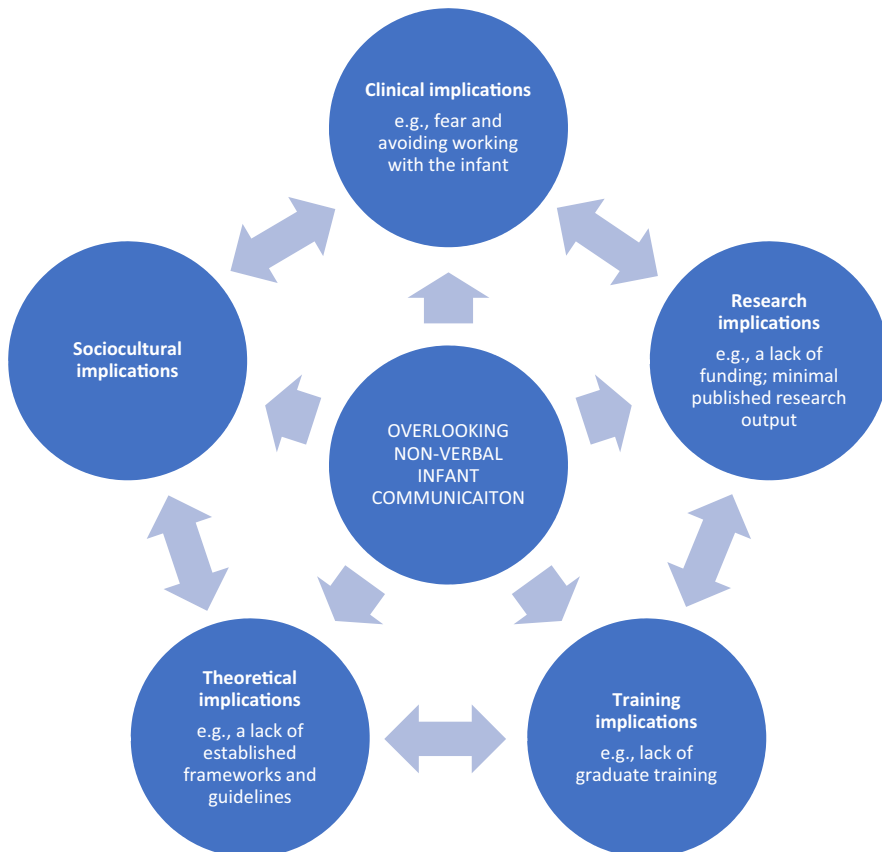


FIGURE 1 A feedback loop precluding the meaningful inclusion of the infant into family therapy.



non-verbal communication and preferences towards narrative frameworks and techniques. Overall, participants identified barriers at training, clinical, research, theoretical, and sociocultural levels as to why the infant has remained on the periphery of family therapy practice.

The minimisation of non-verbal communication, human beings' basic first language of relationships, is unfortunate. Affect and affect attunement has been highlighted by Stern (2008) and Damasio (1994) as particularly relevant, with 70–90% of early relationships negotiated through non-verbal communication. Non-verbal communication remains fundamental not only to communication post-infancy, but to all relational communications across the lifespan. As a universal language humans engage in from birth, affective communication is a foundation upon which verbal language is built. Through non-verbal narrative, parents communicate with their infants by simply drawing on their own innate abilities (i.e., intuitive parenting behaviours; Papousek & Papousek, 1987). They form the dialectic counterpart to the infant's preadapted competence as they progressively co-construct the integration of verbal into non-verbal language with their children. Creating space for non-verbal communication may be particularly important in families where the infant and/or others have unique communication styles or preferences, as with neurodiversity, or various forms of cultural meaning.

Conceptually, though both disciplines have certainly been influenced by multiple theoretical traditions (McHale & Sullivan, 2008), IMH interventions have been shaped by psychodynamic thought ('ghosts in the nursery'; Fraiberg et al., 1975), more so than family therapy. Indeed, family systems work developed in part from a rebellion against psychoanalytic dominance in clinical treatment, with sentiments that too much influence was ascribed to unresolved conflicts of infancy and early childhood. As a result, distinct clinical, training, and research agendas followed. Given the differing perspectives and priorities, each field ascribed distinct relevance to the infant within a family system setting. However, the two fields can mutually and synergistically complement each other, leading to integration – without necessitating a reduction to a singular model. Both IMH and family therapy pioneers anchored methods in non-verbal communication and ethological methods of observation. In developmental science and IMH, pioneers included Stern, Trevarthen, and Bowlby, while in family approaches, Scheflen, Kendon, and Bateson were instrumental in their systems thinking. Yet afterward, methods evolved separately: IMH embracing the psychodynamic approach, intergenerational effects and deep dynamics within a mother–infant dyad and family therapies pursuing work with couples and families of older children drawing on narrative techniques. The emphasis in family therapy on verbal mediation, with less reference to non-verbal context, has moved afield from the original pioneers' perspectives. Verbal dialogue in modern family therapy can and should be contextualised by the non-verbal context, as the same dialogue (or trilogy or multilogy) can take on different meanings depending on the non-verbal context.

There are complex issues involved in the integration of these two fields. One challenge is in maintaining the integrity and focus of each approach, while building a shared recognition of the infant's capacity and influence on relationships. Family therapy and psychodynamic therapy are not incommensurable frameworks, though they focus on different elements. The divide between dyadic and systemic approaches should not be overstated, as both provide insights towards understanding early psychosocial development and transgenerational themes and functioning. Both also present therapeutic opportunities at a critical period of family adaptation when parents are reworking models of their own childhoods (Fraiberg, 1980).

Despite barriers inhibiting the infant from contemporary family therapies, infant-family mental health experts held confidence that cross-field dialogue would benefit both disciplines. Benefits included more complete case formulations as a function of highlighting system-level risk or resilience undetected in dyadic observations of the parent–infant or couple. Similarly, including infant communications may lead to more nuanced observation and understanding of interactions of both full family dynamics and of subsystems, when multiple family subsystems are present. Infant inclusion affords a potential port of entry for examining enactments of the family's style of handling conflict and addressing multiple needs. Collectively, infant-inclusive family work can be an enabling tool for the



meaningful revision of family scripts (Dallos et al., 2023). Overall, the strong rationale for expanding family therapies to involve infants is clear, commensurate with the growing recognition of co-parenting and family-level dynamics within the IMH field since the late 1990s (McHale & Cowan, 1996; McHale & Fivaz-Depeursinge, 1999).

Recommendations

To address obstacles to integration of IMH and family therapy, our findings suggest several connected paths forward, across clinical, training, theoretical, research, and sociocultural domains. These recommendations include potential implementation timeframes (i.e., short, medium, and long term).

Clinical

Short term:

- (i) Establish and evaluate co-therapy approaches wherein IMH and family therapy practitioners concurrently work with a single family. Such collaboration may not only support the family but also provide bidirectional on-the-job training for each practitioner. We believe that the financial and resource-intensive costs of this approach are justified by the likely longer-term efficiency and therapeutic enrichment that would result.
- (ii) Equip family therapists through training to better recognise and embrace the unique forms of communication and the spontaneity that infants bring into therapy sessions. Viewing the infant's unguarded spontaneity as an asset rather than a liability is of fundamental importance. Being attuned to the infant's spontaneous expressions and interaction bids enables family therapists to tap into relationship data that may not emerge without the infant's presence.
- (iii) Family therapists trained to work with older children possess transferable skills well suited to infant work. However, to best provide interventions for vulnerable families of infants, both family therapy and IMH intervention skills will be needed (Carr, 2019). In the short term, those trained in family therapy might consider concentrated infant-family mental health graduate training courses or certificates, until such a time as there are widespread expansions of training curricula.

Training

Short term:

- (i) We encourage graduate family therapy training curricula, professional development, mentoring, and supervision structures to embed a developmental and life-course approach. Adapting student learning objectives so that family therapists are equipped to provide comprehensive and effective care to all family members, including infants, is an important step. For graduate training programs, a new norm where infant inclusion is the expectation rather than the exception will situate future family therapists to honour the needs of all family members, including infants. We further recommend training and supervision involve those who straddle the two fields of IMH and family therapy.

Medium term:

- (i) As infants are infrequently meaningfully included in family therapy sessions as many family therapists lack the skills for engaging therapeutically with families containing infants, the curricula of



training programs and continuing professional development courses for systemic therapists would cover IMH intervention skills and the application of theoretical knowledge to clinical practice.

- (ii) Training in the essentials of attachment theory and child development theory would optimally become core requirements for all therapists. Relevant content includes the impact of a new infant on a family, parental transition to co-parenthood, and expectable challenges encountered throughout this period (McHale, 2007b). To teach about parent–infant interaction and highlight the value of observational skills development, an introduction to observational screening instruments, such as the Maternal Behaviour Q-Sort (Pederson et al., 1999), the Emotional Availability Scale (Biringen, 2008), and/or the AMBIANCE measure (Bronfman et al., 2009–2014), can be emphasised. Opportunities to observe infants allow clinicians to gain a profound understanding of both the baby and their interactions with their parent(s). Inclusion of an infant-family observational element may allow trainee family therapists to observe the voice of the infant in action. The importance of observation lies in learning to observe systematically and in minute detail (i.e., microanalysis). Such skills are needed to understand communication (non-verbal and verbal) within the family and between the family and therapist. Similarly, observing a therapist in action, one who specialises in both family therapy and IMH or observing co-therapy sessions co-led by both IMH and family therapy experts is recommended. We view such expert observation to be as important as observing the infant and the family. For those working with families with very young infants, consider training in the newborn behavioural observation (NBO; (Nugent et al., 2007)) system.
- (iii) Introducing pertinent semi-standardised observational tools, such as the LTP paradigm (Fivaz-Depeursinge & Corboz-Warnery, 1999; McHale et al., 2018; Tissot & Favez, 2023), could impose structure and reduce the complexity and perceived uncertainty about the flow of family therapy that includes an infant. It would further facilitate the learning of systematic observation. This calls attention to the value of video recording to facilitate observational learning, for it provides an opportunity for video feedback. While video recording is useful in therapist training, it is also an effective intervention tool (Philipp & Hayos, 2015). Studies suggest video feedback shows benefits in reducing symptoms (Fukkink, 2008; Juffer et al., 2019), enhancing the therapeutic alliance, and reducing treatment times (Zelenko & Benham, 2000) and enhancing compliance in treatment recommendations (Mazzoni & Lubrano Lavadera, 2013). Capturing and then presenting a parent's struggles on video is a powerful tool that allows parents to see themselves and feel heard. It acts as a mirror, allowing them to observe their own behaviours that might require modification. Further research is needed to more fully understand applications of video feedback in the context of co-parenting and broader family contexts (Fivaz-Depeursinge & Philipp, 2014).

Long term: Develop standalone specialised certificate programs that encompass both family therapy *and* IMH. This would produce practitioners skilled in both fields.

Research

Short term:

- (i) Co-design with IMH specialists the inclusion of reliable methods through which the infant can share their own feedback on the problem situation and outcomes of treatment, through interest, affect, and behaviour. This allows for the infant to share their narrative and does not rely solely on the caregiver to tell the infant's story, as these may not always be aligned. Tap into the expertise of scientist-practitioners who bridge clinical and research domains and straddle IMH and family therapy fields, to steer relevant research efforts.



Medium term:

- (i) Much as the LTP paradigm has offered an evidence-based approach, established research and clinical tools and/or new validated semi-structured instruments should be available to assess family dynamics. Family dynamics are in evidence from observations of the entire family group. Non-verbal behaviours allow for infant as well as for family member inclusion and interactions of specific family subsystems using a semi-standardised situation can also be completed. Operational criteria should consider the specificities of the infant's developmental stage.

Long term:

- (i) Recent writings from infant-family mental health experts (McHale et al., 2023; Oppenheim et al., 2023) offer some valuable leads in approaching infant-inclusive family therapy. This work offers examples of what a unified developmental systems perspective can contribute to family assessment and intervention – if not (yet) therapy. This work and the present study underscores the significance of and ongoing need for research that involves observations of whole family interactions that include fathers and non-primary caregivers, towards enhancement of every family members mindfulness about their role in caregiving.

Theoretical

Short term:

- (i) Increasing opportunities for cross-disciplinary dialogues and discussions could identify common ground and new insights. Transitions are likely to be gradual. The experiences and feedback of the experts interviewed for this report could seed future integration efforts and strategies. For example, working groups could collaborate on creating frameworks and policies that revitalise the field. By fostering dialogue and cooperation between the fields, a collaborative approach would help to solidify integration and promote acceptance and recognition.

Medium term:

- (i) Any theoretical model related to family therapy involving infants should emphasise that the quality of family interactions and functioning can be predominantly evaluated through observational methods, including non-verbal interactions.
- (ii) Merging theoretical bridges and imposing structure is required to formalise the integration between IMH and family therapy. A pivotal part of this initiative would involve the development of innovative integrative models of care that fuse the principles of IMH and family therapy. These models must encompass a comprehensive approach to address the diverse needs of families. Furthermore, crafting developmental support statements, protocols, and guidelines that delineate best practices in the field is a critical undertaking. Such directives provide a reliable and potent foundation for professionals working with families and for conducting associated research. Simultaneously, the creation of standards, policy frameworks, and ethical guidelines are indispensable in elevating the field to a professional level and driving efforts towards integration. Such guidelines would provide a structured approach to welcoming infants into family therapy, addressing the current lack of clarity in this area. For example, higher-level overarching frameworks can be proposed to guide this work, offering a non-prescriptive but supportive structure that allows for both flexibility and clinical individuality, both crucial elements in conducting work with infants. These frameworks could guide subsequent work, enabling family therapists to



navigate the complexities of involving infants in the therapeutic process with a well-defined and ethically grounded approach.

Long term:

- (i) Ideally, the skills of professionals providing interventions for vulnerable families would be grounded in an ecological, multisystemic, developmental, and relational theoretical framework. This approach would consider the multiple nested systems involved, as well as account for the development of individuals from infancy to adulthood within these multiple systems. These are systems that actively involve the infant, acknowledging their interconnectedness within the family unit and the broader community context, while recognising and appreciating infant individuality.
- (ii) Work towards a unified developmental system perspective, including a theory of alliances at all levels and at all developmental stages of clinical groups. A framing party (e.g., parent, therapist) interacts with a developing party (e.g., infant, couple) to facilitate the latter's autonomy: from the parent–infant dyad to the triangular co-parent–infant/child/adolescent triad or to the whole family, to the therapist(s) – client(s) groups as well as to networks of professionals. Taking this perspective, there could be fuller integration of IMH and family therapy in their developmental and systemic dimensions. A developmental system model of alliances, as proposed in the LTP paradigm, applies first at a theoretical level in any group, be it a family, a team, or a therapeutic one. Any alliance requires coordination between all members to reach a given goal, such as solving a problem or playing together (Fivaz-Depeursinge & Corboz-Warnery, 1999).

Sociocultural

Short term:

- (i) Father inclusion is increasingly the norm in family therapy practice and so too it should be in IMH practice. To promote inclusion, optimally in both domains, an expectation of the father's attendance would be established and communicated from the first interaction with the family. Such attendance should be the expectation in both the IMH and family therapy fields. Encouraging and normalising the presence of fathers in family therapy and IMH sessions can create an environment that fosters greater family engagement and support, likely resulting in more comprehensive and effective therapeutic outcomes.
- (ii) In many families and cultures, other carers besides mothers and fathers are everyday, engaged co-parents responsible for the care of and upbringing of children. Family therapies have long been structured around the key importance of cultural context and are well placed to incorporate the infant's contributions to cultural traditions within the therapeutic setting.

Strengths, limitations, and future research

The present study's strengths include a moderately sized sample ($N=20$) that spanned six developed countries. Expert participants were diverse in terms of professional positions, comprising clinicians, researchers, and clinician-researchers. Despite these strengths, findings were likely influenced by the stance and inquisition strategy used by the authors. This approach can be viewed as both a strength and a limitation. Qualitative research is always shaped by the position of the researchers, as acknowledged earlier, which can be seen as both a strength and limitation. However, because participants included only experts in infant-family mental health, missing was the voice of mainstream family therapists. Hence, future research is needed to explore family therapists' own views on infant-inclusive therapy, including benefits, barriers, and practical considerations, to compare their insights with findings from the present study.



CONCLUSIONS

This study drew attention to the baby in systemic thinking and to reinstating the infant within family therapy paradigms. It highlighted existing elements of integration and offered recommendations towards promoting further integration. Therapeutic gains that can result from these two disciplines collaborating more closely with and learning from one another are unquestionable. Equipping practitioners with more specialised, and integrated, infant observational skills during training programs can enhance the effectiveness and efficiency of therapy. Families can potentially derive greater clinical benefit from engaging with one integrated therapist rather than having multiple interactions with different kinds of practitioners who may not see or integrate the full picture. We hope this article inspires mutually respectful and beneficial discourse between the two fields, with equal benefit to families, where the unified goal is one of infant-led relational learning and healing.

ACKNOWLEDGEMENT

Open access publishing facilitated by La Trobe University, as part of the Wiley - La Trobe University agreement via the Council of Australian University Librarians.

CONFLICT OF INTEREST STATEMENT

The authors have no conflict of interests to declare.

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How to cite this article: Opie, J.E., Booth, A.T., Rossen, L., Fivaz-Depeursinge, E., Duschinsky, R., Newman, L. et al. (2023) Initiating the dialogue between infant mental health and family therapy: a qualitative inquiry and recommendations. *Australian and New Zealand Journal of Family Therapy*, 44, 412–439. Available from: <https://doi.org/10.1002/anzf.1569>