COMMENTARY

Including the infant in family therapy and systemic practice: charting a new frontier

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Abstract
This position paper from a core group of infant mental health academics and clinicians addresses the conspicuous underrepresentation of the infant in mainstream family therapy. Despite infants’ social capacities and clear contributions to family dynamics, they remain largely overlooked within this therapeutic context. We suggest that family therapists have moral and professional responsibilities to support the participation, protection, and well-being of all family members, including the infant. Here, we emphasise the importance of including the infant in the family therapy setting. By highlighting their frequent omission, we aim to amplify infants’ often unheard ‘voice,’ role, and contributions to family development, especially recovery from distress. A shift towards infant inclusion as the rule rather than the exception represents a new frontier of integration. We first highlight the relational nature of infant development with a focus on the infants’ psychosocial capacities and vulnerabilities. We then consider reasons why the infant may be overlooked in family and systemic therapies and offer a rationale for inviting the infant into these settings, illustrated through the use of a clinical case vignette. We conclude by encouraging shifts in family therapy research, training, and practice to better incorporate and understand the unique contributions of the infant to family life.

KEYWORDS
family therapy, infant, infant communication, infant mental health, infant participation

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COMMENTARY

INCLUDING THE INFANT IN FAMILY THERAPY AND SYSTEMIC PRACTICE: CHARTING A NEW FRONTIER

The turn of the 20th century saw renewed calls to invite children into the family therapy setting (Carr, 1994; Korner & Brown, 1990; Miller & McLeod, 2001). While such child advocacy efforts served to reinvigorate family therapy’s history of including verbally expressive children as therapy participants, a similar commitment has yet to be made to preverbal, particularly not yet mobile, infants. Recognition of the infant’s non-verbal communications within family therapy sessions can be found in scattered publications dating back to the 1970s, addressing infants’ non-verbal expressions of intention and the dysfunctionality of unilateral decisions by parents that ignore infant signals (e.g., Murphy, 1979). There has also been occasional advocacy for family therapists to better equip themselves for infant–parent therapeutic work (Jones, 2007). Still, no major movements within the family therapy field itself have heretofore taken up this important mission in a coordinated manner. When relevant interventions have been offered in the family therapy literature, they have tended to portray interventions incompletely and generically (e.g., Fosson & Wilson, 1987).

This is unfortunate because, as discussed throughout this special issue, infants themselves are vibrant and active social processors and participants, not merely passive recipients of the goings-on around them (Reddy & Trevarthen, 2004). They wish to know and be known in truthful experiences. They influence not only dyadic but also family-level dynamics through contributions that would have significance and meaning if actively attended to in the therapeutic process (Schögler & Trevarthen, 2007). Their contributions reflect considerable social capacities, extensively documented in research throughout the past half century (Murray et al., 2016). Yet despite clear evidence that babies are contributors to family processes, a practice–research translation divide exists and preverbal infants remain on the periphery in most mainstream family therapy settings.

This article is concerned with this widespread non-inclusion of preverbal infants from family therapy settings, asserting their social right to meaningful inclusion, participation, and non-discrimination from the newborn period forward. Even the youngest of children express their interests, feelings, and intentions non-verbally, and all have a right to be heard, accepted, and respected in the family therapy setting. We maintain that it is vitally important for family therapy practice boundaries to be expanded to include the infant voice. We make a case for this change in practice by elucidating the relational nature of infant development, highlighting the unique abilities and vulnerabilities of the prelinguistic infant.

Key points

- Family therapists have moral and professional responsibilities to consider the participation, protection, and well-being of all family members, including the infant.
- Despite evidence highlighting the significant contributions of preverbal infants to family dynamics and therapy sessions, infants have been largely overlooked in mainstream family therapy.
- This article challenges this oversight, addressing the need to recognise and include infants as active participants with valuable social inputs, and advocates for their meaningful inclusion in family therapy settings from the newborn stage onwards.
- In addition, this article offers background knowledge on infant development, capacities, and vulnerabilities as a rationale for their inclusion in family therapy.
- The text subsequently provides a series of guidelines stressing the significance of acknowledging and appreciating infants within the family therapy context. It also champions change in family therapy research, training, and practice to better accommodate and understand the infant.

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and illustrate how integrating the infant in family therapy practices can lead to clinical benefits. We also call for family and systemic psychotherapists to acknowledge the infant as an autonomous individual with unique perspectives, emotions, and needs, beyond their relational ties with their caregivers. We advocate a paradigm shift, retiring outdated views of the infant as a liability or a distraction in family therapy and supplanting that view with one of the infant as an essential contributor and asset to the therapeutic process (Opie et al., 2023, this issue). We conclude by offering an accounting of infant-inclusive guidelines in the family therapy setting.

This guidance is directed to family therapists who encounter situations where infants accompany their family unit to therapy sessions but are not themselves a central subject of discussion. We do recognise that not every family therapist can be expected to possess extensive expertise in infant mental health (IMH). Equally, we believe all therapists can mindfully consider the infant’s active role and how the family dynamic may be influenced by their presence and communicate this value by welcoming the infant to the therapy setting.

INFANT DEVELOPMENT

IMH experts have a responsibility to share with other mental health colleagues, including family therapists, an understanding of the infant’s development, capacities, and vulnerabilities. This provides a strong rationale for including and engaging with the baby in the family therapy setting.

The relational nature of infant development

From birth through age 3, infant development proceeds largely within a relational framework comprised of attachment relationships and caring bonds, typically with multiple individuals inside and often outside their natal family. These relationships guide infants’ self-organisation and emotional regulation (Stern, 1985). Infants are born with innate proficiencies for social interaction that form a basis for early intersubjectivity (Paul & Thomson-Salo, 2018). Their early relational interactions help them develop a sense of self, express themselves, form close relationships, and explore their environment (Stern, 1985; Zero to Three Infant, 2001). Eventually, relational contexts will come to shape the child’s expectations of self, others and the world at large (Bowby, 1969/1982). Hence, early infant–caregiver relationships can mitigate or intensify the development of later socioemotional outcomes (Sroufe, 2005). While babies are born equipped to socialise, it is the nature of relationships in family environments that shape their sense of self. However, babies are not only shaped by their social ecology but they themselves alter the pre-existing social network they are born into, through a continuous process of bidirectional influence. This is especially well acknowledged and celebrated in First Nations cultures (Elliott et al., 2023; this issue).

Capacities of the infant

Infant is derived from the Latin infans, meaning ‘without speech.’ Yet infants possess powerful capacities for articulation and communication (Nagy et al., 2017; Trevarthen & Delafield-Butt, 2014). Born ready for relationality, infants possess a sophisticated repertoire of affects and behaviours to engage, primarily through non-verbal channels, using multiple sensory modalities to communicate (Trevarthen, 2011). Their senses allow them to interpret and navigate the dynamics of social relationships; discern and adapt to the complexities of social rules; and detect disruptions in social interplays. Guided by an implicit relational knowing, infants develop expectancies in relation to caregivers and the surrounding environment and are pained when expectancies are violated. After several months, infants become increasingly conscious and intentional, but purposeful and deliberate actions can be seen even in the earliest weeks of life (Thomson-Salo & Campbell, 2014).
Infants demonstrate autonomy, agency, independent interests, and desires. Contrary to inaccurate views evident from the lay public to the judiciary, infants do feel emotions and build and retain memories from their earliest moments (Lieberman & Van Horn, 2009). Their complex internal world is characterised by diverse and independent emotional states, including humour and fear, and they manifest practiced habits and behavioural preferences beyond what most parents may recognise (Mitsven et al., 2020). As they approach the toddler years, they demonstrate imagination, imitation, attunement, and pretend play. In short, the infant is a unique individual with a developing mind separate from, yet deeply entwined with, their caregivers through relational connections that shape their early experiences.

The vulnerable infant

Despite these capacities, the altricial state of infancy requires ongoing advocacy and recognition. Infancy is a time of disproportionate vulnerability, and infants represent some of our most markedly helpless societal members. They are physically dependent, easily hurt (physically and psychologically), and not yet able to fully regulate emotion. Yet despite their vulnerability, they often receive inadequate attention and care. Dependent as they are, infants are especially vulnerable to trauma within their close primary relationships. Much infant trauma is relational with trauma typically occurring in the context of primary relationships and is therefore inescapable for the infant. Infants cannot speak about struggles or verbally request help, and as a result, prolonged traumatic experience often becomes embodied. Unaddressed vulnerabilities often lead to compromised early social and emotional development, which itself has great potential for compromising long-term life course trajectories (Zeanah & Zeanah, 2019).

The massive body of research on the negative effects of adverse childhood experiences (ACEs; Asmundson & Afifi, 2020; Hays-Grudo & Morris, 2020) for physical and mental health problems and on the protective value of secure attachments in infancy (Cassidy & Shaver, 2016; Duschinsky, 2020) provide a strong rationale for very early family intervention. It is particularly important to address the needs of vulnerable families at risk of non-optimal parenting, child abuse, domestic violence, mental health problems, addiction, separation, and divorce. While the infancy period reflects a time of heightened vulnerability, it is at the same time a pivotal window for intervention and support for children and their parents and caregivers.

THE INFANT IN FAMILY THERAPY

Understanding the infant's absence from family therapy

Infants may be excluded from family therapy for several reasons. Most forms of family therapy, especially in the narrative tradition, prioritise verbal constructions, leaving the non-verbal communications of infants unattended. Because the infant lacks speech and is often not given credit for social capacities and contributions, there is bias towards engaging only parents or more verbal children. Privileging the parents' narrative and agenda loses sight of the infant and the caregiver becomes the storyteller for the infant, regardless of the accuracy of their account. Moreover, in the family therapy setting, the voice and needs of the older verbal siblings can sometimes overshadow the infant's expression (Fosson & Wilson, 1987). This learning, which marginalises the preverbal infant's ‘voice,’ is likely to be amplified when the therapist has not had training in early child development and infant observation, a missing component in many family therapy training programs.

For the clinician, the preverbal child's rapidly oscillating emotional and behavioural states can be complex and confusing, as when the child appears simultaneously loving and chaotic. For some family therapists, there may be uncertainty and fear about the drama and intensity of transitory infant state changes and in-the-moment needs. Others may inadvertently lose sight of quieter infants even if they
are in the room. Therapists may even consciously or unconsciously perceive them as a liability and a distraction during sessions, rather than seeing the value of the authenticity and spontaneity they invite into a family session. Any one or more of these factors may result in family therapists neglecting the potential for including the infant in family sessions.

Humans have historically held inconsistent views about infants. On the one hand, there are romanticised or idealistic views of infants who can do no wrong and suffer no wrong, impervious to the effects of trauma, adverse experiences, and family dysfunction. This view fails to see the baby as an autonomous being with a mind and intentions of their own. On the other hand, humans have also harboured negative attributions about infants, sometimes even scapegoating them as the genesis of familial troubles (Cowan & Cowan, 1988; Fraiberg, 1980), despite the baby's incapacity for hostile intent.

Perceptions that infants have not yet developed enough to warrant inclusion may flow from a view that infants lack capacity to communicate, understand, and remember. Because adults often privilege the infant's overt behaviour, in so doing they can overlook the infant's subjective experience and intentions (Benziman, 2013). A perception of infants as acquiescent and not socially competent is also likely to perpetuate infant exclusion from the family therapy therapeutic conversation.

**Championing for the infant in family therapy**

Champions of the rights of very young children have documented compelling rationales for infant inclusion. These include the United Nations Convention on the Rights of the Child (1989), the World Association for Infant Mental Health Position Paper on Rights of the Infant (2016), and the World Association for Infant Mental Health Position Paper on Infants' Rights in Wartime (Keren et al., 2019). These statements address the imperative to safeguard rights of infants, acknowledging their vulnerability and intrinsic value as members of society. This said, concerns with infant rights most typically centre on physical, rather than relational, social and psychological experiences and needs. Physical safety is always of paramount importance, but once safety has been assured, there is rarely a parallel degree of concern with the infant's related experience of psychological safety and security.

Such concern is clearly called for. Making the case on a global scale, Trevarthen (Delafield-Butt et al., 2019; Trevarthen, 2018a, 2018b) explain the far-reaching consequences of neglecting care and companionship of babies and toddlers. He cautions of negative impacts not just on children's mental and physical well-being, but on economies, cultural values, and foundations of how infant learning, growth, and psychological development are supported. Våpenstad and Bakkenget (2021) weigh in that ‘grownups should get to understand that infants are not indifferent, but highly intentional and meaning making creatures, wanting to have their opinion heard and legitimized’ and point out that ‘the discourse around children's rights and participation has usually been about what can be done or how can authorities intervene on behalf of children’ (p. 3; Våpenstad & Bakkenget, 2021).

**Clinical contributions of the infant**

The infant's interactions with their family speak to the family's state of being as a secure base, especially its capacity to maintain safety and sensitive response to its members in the face of challenge. Affording infants a genuine place in a therapeutic dialogue not only supports and protects infant well-being but also facilitates new entry points into family dynamics. Making room for the real presence of the infant has numerous benefits, such as infusing greater immediacy and urgency into family sessions. In addition, infants can play a pivotal role in fostering hope and motivation and in facilitating positive familial change (Paul, 2015; Salo, 2007).

The infant can bring life and joy to a therapy session, through shared gaze, directed smiles, and collaborative play. Equally, the infant's protest, anger, and irritability are transparent signals of
distress, inviting responses from all around. The shape of those responses can be telling of sources of relational stress in the here and now, as well as historically. The authentic experience of facing down strong emotions can elucidate underlying familial tensions. The infant’s unfiltered expressed affect may evoke well-worn patterns, sequences of behaviour, and family ‘solutions.’ In these ways, both ‘positive’ and ‘negative’ contributions of infants can be clinically useful, revealing more than what would otherwise be accessible without the infant's presence. The emergence of real-time conflicts in the therapy session also allows family scripts to be explored and addressed in the moment (Byng-Hall, 1986, 1990). So, too, infants can feel understood and supported when a therapist notices their signals and communications and also when the baby can see their parents being attended to sensitively by the therapist.

LISTENING TO THE INFANT

What has the infant to say to us about who they are, and the difficulties they can face within their family, of all diverse forms?

Listening to and understanding all that the non-verbal infant might have to say may seem a grand task for systemic psychotherapists who may not be IMH trained. Nonetheless, all family therapists practice and inspire a reflective stance and curiosity. Adopting an IMH perspective means holding comparable curiosity to the infant as a distinct individual player within the family drama. Therapists need not be infant experts in order to notice the infant's spontaneous communications, and positive and negative emotions; to make note of parental reactions; or to ask parents about their own meaning-making, constructions, and responses. The many arms of this rationale lead us to firmly encourage the family therapist to value and include the infant's voice.

Steps to enhance inclusion can encompass:

• Direct engagement, meeting the baby as a person, as someone to build a relationship connection with, as well as seeing them as part of a broad family collective – helping the baby feel present, included, and perceived as an equal contributing partner.
• Making time to consider the baby's perspective and experience whenever the baby attends a session.
• Adopting a reflective stance and cultivating curiosity and openness about what the infant might have to say (e.g., what the baby sees, thinks, and feels); this is complex as therapists can never really know what is in the mind of anyone. Utilising one's own reflective functioning as a therapist and fostering that of parents during the session is key (Slade, 2005).
• When asking a baby anything, therapists genuinely direct attention to them with gaze, voice, and playful interaction.
• Embracing a contemplative perspective while fostering curiosity and openness to understand how the baby's interactions both impact the family and invite the family to reflect on the nature of its secure base functioning.
• Considering cultural variability in the definition of the infant's family (e.g., nuclear versus multigenerational or extended families) and taking each unique family constellation into consideration when planning whom to include in family therapy consultations and sessions (McHale & Dickstein, 2019).
• Adopting a strengths-based posture to promote parental self-efficacy, capacity, sensitivity, and responsivity. Validation, normalisation, commendation, and empathetic engagement with parents about their affective responses, behaviours, and lived experiences is supportive and in turn indirectly supports the infant.
• Welcoming and accepting unpredictability and spontaneity brought by the infant's presence in a family session. Reframing the infant's unexpected emotions and behaviours as a useful window into family dynamics rather than an inconvenience and session distraction.
GUIDELINES TO INFANT-INCLUSIVE FAMILY THERAPY

Collectively, we have underscored the rights and experiences of infants, their intrinsic value as contributors to their families, and hence, by extension, their deserved role and place in family therapy theory and practice. In the family therapy context, infants will necessarily require special consideration given their vulnerable status. We underscore and affirm the following World Association for Infant Mental Health (2016) Position Paper declarations:

• The Infant is to be considered as a vital member of his/her family, registered as a citizen, and having the right for identity from the moment of birth.
• The Infant has the right to have access to professional help whenever exposed directly or indirectly to traumatic events.

Guidelines for infant-inclusive family therapy practice include:

1. Participation:
   a. That infants be respectfully included in a family therapy session.
   b. That infants be valued and viewed both as an equal partner in the family therapy setting and as an essential family member, while also being recognised and appreciated as an individual with a unique perspective and contributions.
   c. That infants be given voice, to ‘speak’ and be heard, for instance by attending to infants' interactional behaviour and communications within the family.
   d. That infants be acknowledged by the therapist as a person in their own right, possessing their own capacity for communicating their experience.
   e. That infants receive the family therapist's sensitivity, curiosity, responsivity, and inclusive stance.

2. Non-discrimination:
   a. That infants be afforded the same consideration as older children who possess verbal language, allowing them to participate, contribute, and be heard in a family therapy setting.

3. Protection:
   a. That infants have protection from any further harm when the child and family have experienced trauma or early adversity.
   b. That infants receive age-appropriate measures to mitigate vulnerability and distress, in relation to both within or outside-of-family factors.

Concepts into practice: a clinical case vignette

Principles are often easier to see when presented in a clinical case. We hence examine application of the guidelines in a clinical case vignette:

John, aged 3 months, was admitted to the paediatric hospital from the Emergency Department where his very anxious mother, Maria, had brought him. Maria and Maria's Greek-born mother, Alexis, were fraught with worry about his poor feeding and significant weight loss. John was the first child to his 38-year-old mother and his 35-year-old carpenter father. He had a 10-year-old brother born of his mother's first relationship. John was accompanied to hospital by the maternal grandmother who remained by his side almost constantly when in hospital. The grandmother, out of anxiety, insisted on vigorous bottle feeding and it was hard for John's mother, or his nurse to feed him. The paediatrician determined that even though John consumed small volumes when fed by his anxious
grandmother, his growth was medically sufficient. However, given John's difficulty feeding and the intense family anxiety, a referral to IMH was made.

The therapeutic team used a model wherein the whole family was very much involved in the mental health assessment and care, and arranged for a screening session with John, his mother, and his grandmother. Unfortunately, John's father could not attend the first IMH session, and his brother was at school, though they participated in subsequent sessions. Maria seemed skeptical about the role of IMH for her feeding-averse son but came along with us. The therapist talked with each of the people present, John's mother, his grandmother, and John himself asking the adults what concerned them most, and similarly directly addressing John who looked out from over his mother's shoulder as she held him close. John listened as the therapist spoke tracking him with his eyes and turning his face towards him when he spoke in a playful, lilting manner, asking “How are you… What do you think?” The therapist asked John's mother if he could speak to him some more, and perhaps hold him. The therapist said, “May I meet John?” His mother with a very wry smile, and vocal mockery addressed John and said “Sure! Sure! John this is the doctor, you can talk to him!” and to the therapist she said playfully “Doctor, this is John! You talk with him!”

John was held in the therapist's arms and on his lap looking directly into his eyes listening, next with a smile, and then tracking the therapist's face as he moved from side to side softly asking John “Your mother and grandmother have been worried … What's been wrong …?” John was an active partner in this lively conversation, looking eye to eye, speaking with his own gentle hand movements and soft vocalisations. His mother was clearly astonished by this.

Then John coughed and stilled for a short moment. His mother was suddenly frightened and perplexed and asked “What happened?! Is he okay?” Maria explained to her mother, Alexis, in her native Greek language what was happening. Alexis herself then asked to speak, and Maria translated into English sentence by sentence. Alexis said how she had a son in Greece, who died tragically at the same age with a coughing illness, when medical care was not available. This disaster happened when Maria herself was a little girl. Maria said her mother yearned for her dead baby so much it was as if Alexis had taken over Maria's baby and in a state of protective grief, claimed John as her son. Through this John directed his deep gaze alternately to his mother and his grandmother, offering both sad and smiling facial expressions. They were both moved to tears by his intense gaze and responsiveness. Maria thanked her mother for sharing her sad story and for her support, but Maria said it was time for her to reclaim her son as her own.

In this vignette, the active emotional communications of baby John effected a major shift in the family structure, with his mother, Maria, firmly re-claiming him as her son. She embraced her mother and acknowledged her mother's 30 years of grieving but said ‘He is my son now. Thank you for caring.’ John seemed to empower his mother, who had been burdened over the past 10 years by the shame of having her first child as a teenager, out of wedlock. Maria gracefully but firmly claimed her role as mother, and she was the one who then came in each day to feed John before he returned home – feeding and healthy – 3 days later. John as a real person, with attuned and active participation in the IMH-family therapy intervention, triggered a shift in the family mythology, enabling Maria to claim with pride ‘You are my baby now.’ In a subsequent family session, Maria explained to her husband about her mother's tragic grief and how her own shame about her first pregnancy had left her feeling distant and powerless in relation to baby John. His addition to the family and attendant feeding refusal had destabilised the whole family system but also allowed access to trauma and reparation (Minuchin, 1985).
Patricia Minuchin (1985) likewise championed including very young children into therapy. Using an example of a 2-year-old boy who knocked over a box of chalk, eliciting anger from his parents, she argued that proper analysis of the incident ‘would require the equal inclusion of all three participants.’ Though power in the family seemed to reside with the parents, P. Minuchin suggested going beyond ‘second-order effects’ to consider in real time the toddler's own thoughts, wishes, and experience of the family interaction. Contrast this example with a scenario described by Salvador Minuchin (2018) in his work with a couple whose 2-year-old toddler was separated from them on a kibbutz. In this case, the toddler was not able to be physically present to speak for himself regarding his experiences and feelings of having been separated from his parents. Even when adults are invited to speak on behalf of absent children, the parents' representation may or may not accurately reflect the young child's own perspective.

**CLINICAL RESOURCES**

In 1989, in Lugano under the auspice of the World Association for Infant Mental Health, an international study group formed to look at ‘the interfaces between intrapsychic, interactional, and transgenerational domains of family life’ bringing together understandings of infant development, attachment theory, and family systems therapeutic work (Byng-Hall, 1998; Fivaz-Depeursinge et al., 1994). There have been significant examples since of successful melding of family systems, attachment theory, and IMH leading to clinical cross-disciplinary work with troubled families and infants, for example, Lausanne Trilogue Play (Byng-Hall, 1998; Fivaz-Depeursinge et al., 1994) and Reflective Family Play (Philipp, 2012) interventions.

There are several primers and tools which are helpful in therapeutic work with infants and both parents and other family members. For example, the newborn behaviour observation (NBO; (Nugent et al., 2007)) is a structured way for a clinician to meet a newborn infant in the first few months of life and to share the infant's capacities for self-regulation with (sometimes amazed) parents. The NBO, though a brief intervention, can build a bridge between IMH interventions and family therapy with very young infants. It gives the baby a lively voice and helps parents to understand and respond to the baby's behaviour. It is a concrete means to help the baby become, fittingly, a respected active partner within the evolving family romance – a family player in their own right. These are some of the joint research and clinical activities which demonstrate the real value of collaboration between family therapy and IMH clinicians and researchers.

**CONCLUSIONS**

Based on the considerations outlined in this position paper, we encourage and indeed call upon the fields of family and systemic practice to ready the path for consistent inclusion of the infant into the family therapy setting, including research. It is our intention and our fervent hope that the guidelines included in this paper will steer policy and practice advances in this space. The infant-family mental health guild stands as a ready and willing partner and collaborator in these efforts.

**AUTHOR CONTRIBUTIONS**

Study conceptualisation was done by JO, CP. Manuscript drafting was done by JO, JM, CP. Revision of manuscript and final version approval was done by all authors.

**ACKNOWLEDGEMENTS**

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

**FUNDING INFORMATION**

This study received no funding.
CONFLICT OF INTEREST STATEMENT
The authors have no conflicts of interest to declare.

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https://doi.org/10.1002/anzf.1567