Minding the Baby®

Home Visitation Program

Clinician's Quick Reference Guide

Second Edition

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Minding the Baby® (MTB)

Clinician's Quick Reference Guide (QRG)

This quick reference guide provides just that – a quick reference to the basic components and protocols of the *Minding the Baby*® (MTB) clinical model. It is intended for use by clinicians who have received the clinical training provided through the MTB National Office at Yale University. Specific training and on-going consultation are necessary for replication studies and full implementation of the MTB model.

Yale University
School of Nursing
Child Study Center
New Haven, Connecticut
January 2019

Minding the Baby® (MTB) began as a collaboration among the Yale Child Study Center, Yale School of Nursing, Fair Haven Community Health Center, and Cornell Scott–Hill Health Center in New Haven, Connecticut.

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The MTB National Office was developed through the support of our generous funders and is currently supported mainly by private donors and foundations including The FAR Fund, WK Kellogg Foundation, and Grossman Family Foundation. Original MTB training materials were developed in 2010 with generous support from Pritzker Early Childhood Foundation and Seedlings Foundation. Additional funding support has been provided through replication training and consultation contracts with the National Society for the Prevention of Cruelty to Children in the UK; Florida State University in the US; and the Center for Mentalisering, Frederikshavn Center for Families, and Metodecentret in Denmark. A complete list of funding sources is available on our website at www.mtb.yale.edu.

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Introduction: How to Use The QRG

This Quick Reference Guide (QRG) is to be used in conjunction with MTB replication training provided through the ***Minding the Baby®*** (MTB) National Office, as well as the MTB Treatment Manual (Slade, Sadler, Webb, Simpson, & Close, 2018). The purpose of the QRG is to provide easy access to material that will help clinicians prepare for home visits, think of useful strategies for particular situations, tune-up on reflective responses, and consider where both child and parents are developmentally. The suggestions in this guide are not meant to be used in a prescribed way, but should be applied flexibly in line with the needs of an individual family. For fuller descriptions and background, please refer to the Treatment Manual. Information regarding training for replication of the model can be found at www.mtb.yale.edu.

Chapter 1: Getting Started

The family unit as defined by the parent(s)

Families are made up of parents, grandparents, siblings and others. The pregnant woman defines who is in her family and who she wishes to be involved in the MTB program; this may change over time. While the mother is frequently the family member most involved in MTB, clinicians should anticipate her partner's interest and wish to be involved. The transition to parenthood impacts both partners and their relationship, and co-parenting or co-operative parenting is highly beneficial to the child's development. An infant can and does attach to more than one person, and when parents cooperate, they both keep the baby's best interest in mind. In this respect, we aim to educate parents about the stress babies experience when there are conflicts between them, and encourage parents to learn about each other's background. In this way, they can share

their values, beliefs about parenting, and hopes for their child. This allows the clinician to point out commonalities and model respectful ways to disagree.

Fathers

Traditionally, home-visiting interventions beginning prenatally tend to focus primarily on the mother. MTB practitioners continually challenge themselves and each other to be intentional about engaging fathers with the goal of anticipating father participation rather than simply inviting it (Kyle Pruett, personal communication, March 2017). This means that health and psychosocial history data are gathered for fathers as well as mothers and the Pregnancy Interview is administered to expectant mothers and fathers. Whenever possible, fathers are participants in the therapeutic relationship that develops. MTB home visitors must also consider their trauma history and complex needs as they transition into parenthood.

Relationship building and rebuilding

In MTB, we see the clinicians' ability to establish caring, open, and trusting relationships with the parent(s) and the parent-infant dyad as crucial to the success of the intervention, and to the parent's ability to "keep the baby in mind." These relationships will serve as a model for the developing parent-child relationship (Slade, et al., 2018; Slade, Sadler, Close, Fitzpatrick, Simpson, & Webb, 2017). So, from the first time we meet the parents, we focus on relationship-building. When faced with the enormity of a family's needs, clinicians often want to help by making suggestions on how to change or 'fix' a situation. We recommend Sally Provence's (one of the founders of the Child Study Center at Yale) excellent advice: "Don't just do something. Stand there and pay attention. The (family) is trying to tell you something."

It is important to remember that there is an inherent power differential between the professional clinician and the family. This can feel intimidating to the parents. Questioning and probing for feelings can be threatening. Building a trusting, safe relationship is the first step in developing a positive working connection with all family members. So:

- Be present.
- Be mindful.
- Show up.
- Be consistent.
- Be kind.

A "family centered" approach

Family centered visits require that a clinician be able to listen and observe in a way that allows her to discover what is foremost on the parent's mind, with the eventual goal of bringing the parents "back to the baby." This often starts with the parent's agenda; attunement to parents' thoughts and feelings is of primary importance during each home visit. The clinician should use open-ended questions to make sense of parents' concerns, and then choose strategies that will help them reflect upon their role as parents and the effect they have on the baby. Using the family's vocabulary and giving them time to process and articulate their thoughts is essential.

It is helpful to remember that the parent's agenda for a particular home visit may not be the same as the clinician's. Take the time to learn what the family finds most important or urgent to discuss.

Chapter 2: MTB Key Ingredients

MTB aims to promote parental reflective functioning (RF); secure attachment; the health and mental health of the parent and child; and the parent's self-efficacy. This is done using an interdisciplinary approach, mediating change and supporting growth through relationships built among the home visitors and family members. (See the MTB Treatment Manual for more detail.)

Reflective parenting

One of the broad goals of MTB is the enhancement of parental RF (Slade, 2005). Parental RF refers to the parent's capacity to reflect upon the baby's experience, and to appreciate that the child has thoughts, feelings, desires, and intentions that impact their behavior. It also refers to the parent's capacity to describe their own thoughts and feelings, understand how these affect their behavior and are different from the child's. Parental RF forms the basis of healthy and secure attachment relationships, and is vital to fostering feelings of self-efficacy in the parents.

MTB is a reflective parenting program; this means, simply, that we help the parent to "keep the baby in mind" (Slade, 2002). Clinicians work to facilitate the parent's development into a more reflective parent, one who recognizes his or her own mental states (even in times of stress), the mental states of the baby, and the interplay of those mental states through a developmental and behavioral lens. The baby's internal life is taken as something real and meaningful from the beginning. Developing reflective capacities allows the parent to modify and shift approaches to the baby's changing needs, development, and behavior in a nurturing, caring, supportive way.

Infant mental health and secure attachment

Infant Mental Health (IMH) refers to the child's developing capacity to experience and regulate emotions, form secure relationships, and explore and learn, within the context of their family, community, and cultural background (www.ztt.org).

Responsive, nurturing, and predictable caregiving by primary attachment figures lays the foundation for mental health and healthy emotional regulation in the developing infant and toddler (Zeanah, 2018). IMH and secure parent-child relationships begin in pregnancy, as parents-to-be ready themselves for parenthood (Slade & Sadler, 2018). They are essential to the child's socioemotional development and school readiness (Jones, Greenberg, & Crowley, 2015), and reduce risks for adverse outcomes later in life, including dependency on the welfare system, chemical dependency, involvement in the criminal justice system, and early parenthood (Campbell, Conti, & Heckman, 2014).

A secure relationship lays the foundation for a child's emerging abilities to explore his world, manage new and difficult feelings, and develop interpersonal relationships with others (Powell et al., 2013). Infants and their primary caregivers, usually their mothers, are engaged in a delicate "dance" from the very start of their relationship.

That dance involves the infant learning what he can come to expect from relationships based on how the parent responds to the infant's initially very basic needs for food, warmth, closeness, and sleep; and how parent and infant continue to adapt to one another as the child's more complex needs for exploration, trust, guidance, and emotional organization develop and evolve (Stern, 1977).

The Circle of Security framework (Powell, Cooper, Hoffman, & Marvin, 2013) captures the essence of what a secure relationship looks like with three main principles:

- The parent is always "bigger, stronger, wiser, and kind" with a proper balance of all four qualities.
- The parent whenever possible follows the child's need.
- The parent whenever necessary takes charge.

For further information and helpful resources, refer to the Circle of Security website (http://www.circleofsecurity.org) .

A key theoretical framework underlying parental reflective functioning is the concept of mentalization, which refers to the capacity to envision mental states in the self and others (Fonagy & Target, 1997). The parent's ability to connect their own inner experience to their attitudes and behavior, coupled with their understanding of their baby's inner world allows the parent to regulate their child's behavior and affect, and to help the child make sense of his or her world (Slade, 2005).

Hence, an emotionally regulated parent is able to care for their child in a responsive, nurturing way which enables the child to experience predictability, security, and a model for self-regulation. Imagining and being curious about the needs, intentions, and desires of their infant from the earliest moments following birth is a fine-tuned skill that underlies parental reflective functioning. Reading and responding to infant cues, following the baby's lead both in feeding and diapering routines, as well as in play, and pausing a moment to watch a child and wonder what he may be thinking and feeling, are all elements of regulated parenting.

An interdisciplinary team

In MTB, care is provided by a nurse-social worker team. The complexities inherent in working as a team are discussed in

Chapter 3. This interdisciplinary approach is crucial to meeting the complex needs facing MTB families. Nurses often have the most direct access to families, and are able to provide a level of care and knowledge that young, first-time parents need. Social workers provide other levels of care: specific attention to the after effects of trauma and loss, including depression, anxiety, and relationship problems, as well as case work and concrete support for housing, food, and education. Both practitioners provide support for the developing parent-child relationship and for both parent and child development.

The transition to parenthood

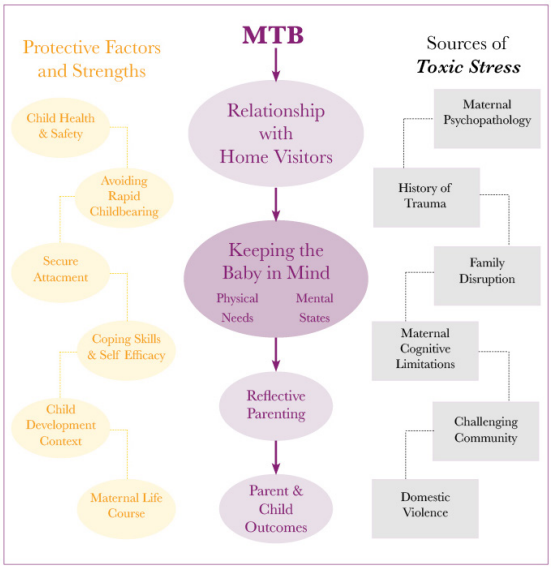
MTB is delivered during the *transition to parenthood*, a sensitive period for the rapid physical, neuroendocrine, neurobiological, emotional, and social changes that are part and parcel of parenthood. (See Slade & Sadler, 2018 for a review.) Thus, beginning in the second trimester of pregnancy, mothers and fathers-to-be are encouraged to safely explore their feelings about becoming a parent, to imagine who their baby might become, and to think about the kind of parent they hope to be.

Trauma-informed

Adverse childhood experiences including chronic poverty, interpersonal and community violence, and all forms of child maltreatment (physical, emotional, sexual, and neglect) have profound and far-reaching effects across generations (Garner, 2013; Lieberman, Ghosh Ippen, & Van Horn, 2015). These include a range of traumatic adaptations in parents, many of these sequelae of complex developmental or attachment trauma (Courtois, 2004; Slade, Simpson, Webb, Albertson, Close, & Sadler, 2017; van der Kolk, 2014). In engaging and building relationships with expectant families, we focus first on establishing safety in the therapeutic relationship, and in helping parents develop ways to manage intense stress responses.

Finally, we work to address their traumatic experiences in ways that are respectful and supportive. Related to the question of trauma is the newly-emerging science of toxic stress, which is defined as strong and frequent prolonged adversity without adult support (Shonkoff, 2012). One of the most potent effects of ongoing trauma to parents and young children is the chronic elevation of stress hormones, which can lead to a range of physiological, neurobiological, hormonal, and epigenetic changes, and impair the development of higher cortical functions (because, in effect, the body is always under siege). On-going, high stress situations can impede a parent's ability to be aware of and respond sensitively to their child's needs, including protecting the baby from these same stressors. Figure 1 below illustrates the protective factors MTB promotes to help mitigate toxic stress in the child.

Figure 1. MTB & Protective Factors Mitigating Toxic Stress



Culturally informed

Culture gives every person a framework within which to interpret the world. Family and community accomplish this for children through socialization. Cultural values and mores are taught, often in an indirect and unconscious way, through parenting, using activities in the home as well as verbal and nonverbal communication. How clinicians understand and respect the differences in values between ourselves and the families we work with can affect the relationship clinicians develop with families in MTB.

Parental goals in most cultures are similar though they may be prioritized differently. Parents typically wish their children to be happy, healthy, respectful, intelligent, and able to follow instruction. Some cultures place great significance on getting along with family, emphasizing interdependence and valuing obedience and loyalty. Some cultures highly value self-sufficiency and critical thinking with the goal of giving their children the skills to be creative and, eventually, independent from the family. As clinicians, we wish to promote sensitive parenting by helping parents understand their child's needs and perspective within their own cultural context.

The clinicians take the stance of a student, sincerely interested in the ways parents teach their children about important issues. A clinician may need to ask the meaning of words or phrases that seem used in an unusual way. Talking openly and thoughtfully about differences helps young parents become consciously aware of their own values. When the hopes, values, vocabulary, and goals of the family are clarified, the clinicians can use this knowledge to work together with parents with less confusion and misunderstanding. The use of a genogram can be helpful in understanding various elements of a parent's family background, in terms of medical and mental health as well as

cultural differences. A very helpful key and sample genogram is provided in the Waters, Watson, and Wetzel (1994) article, also available on-line:
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2380035/pdf/canfamphys00096-0076.pdf

Strong links to the community

Given the multiple needs of high-risk families, it is crucial to link MTB to other systems of community health care and social services. MTB clinicians develop relationships with health, mental health, social service, and other providers throughout the community. The alliance between the home visiting program and community resource agencies provides a cohort of professional colleagues with whom clinicians can share the challenges of working with families and their numerous physical, medical, and mental health needs. Developing effective methods of communication among the home visitors and community resource agency staff prevents the intervention from being derailed by multi-need complex families playing one well-meaning clinician against another.

Chapter 3: Enhancing Parental Reflective Functioning (RF)

As detailed below, there are various strategies the clinical team utilizes to facilitate development of the parent's reflective capacities in order to build a secure attachment relationship, which is central to optimal infant mental health.

Maintaining a reflective stance

Clinicians try to maintain a reflective stance at all times (which can be very difficult). Often this means centering oneself before a visit before entering the home. The clinician's ability to reflect allows the parent to experience herself as reflected upon by a caring person, namely the clinician; this, of course, is how we hope the child will eventually experience the parent.

The reflective clinician:

- thinks about behavior in terms of mental states (feelings), making connections, and modeling curiosity and openness about mental states in the child, the parents, and oneself
- encourages the parents to pause and reflect by trying to slow down the situation and look at what is happening, facilitating wondering
- understands reflection is a new skill for the parent and can be challenging, especially when feelings are strong
- attempts to break cycles of non-mentalizing interactions (Fearon, et al., 2006)
- cherishes small shifts in parental thinking and behavior
- makes many decisions during the home visit, trying out one approach, assessing the parent's reaction, trying a different strategy, and evaluating the overall effectiveness of these attempts

- resists the urge to do something in response to the parent's distress or one's own triggered reactions
- recognizes that a persistent need to problem solve may reflect the clinician's own difficulties with emotion regulation

Speaking for the baby

This approach helps bring alive the baby's needs and desires, as well as the parent's thoughts and feelings (Carter et al., 1991). This can help to reframe the baby's intentions and normalize the baby's behavior. Ways to speak for the baby include:

- Wondering aloud/brainstorming. For example, "I wonder if the baby is making that face because he was confused when you pulled the bottle away?"
- Using "sometimes statements." For example, "Sometimes mothers feel surprised that they don't feel they love their baby when s/he is born. Sometimes it takes getting to know the baby before parents fall in love with their child."

Speaking for the parent

This approach helps give voice to the mother's experience of herself as a parent, encouraging her to express feelings about impending childbirth or her own developmental/psychological history (e.g., "I wonder how this feels to you…"). It is important to recognize, however, that traumatized parents or those who aren't verbally expressive may become dysregulated when asked to talk about their feelings. In these instances, the clinician may want to take a guess (e.g., "Some mothers feel a little frightened when they think about the delivery, I know it can sound pretty overwhelming…").

Actively listening, observing, and questioning

- Observe aloud and elaborate on parent's affect
- Disrupt the escalation of negative patterns or interpretations of family members by reframing in neutral words
- Clarify parent's use of words/ vocabulary
- Ask parents to explain their beliefs about children and parenting
- Ask parents help in understanding their view of the situation
- Ask probing questions. For example, "Why do you think your baby reacted that way?" "What else might be going on?"
- Challenge parents in a playful, friendly manner. For example, ask, "Have you found that yelling has stopped the baby from touching things?"
- Be mindful that even curious questioning may at times be interpreted as prying or invading their privacy. This is particularly true if the parent has had little experience with this type of attention.
- Informally review the changes and gains over the past weeks, months, etc.
- Help the parent develop a narrative or story of his or her life, becoming a parent, etc.
- Verbalize the parent's strengths
- Play out a situation: this can be done by role-playing potentially difficult situations with the parent

Managing the parent's stress

- Reframe the parent's expectations
- Observe and discuss physical responses to stress

- Create a labor plan in advance of the delivery (Simkin, 1992)
- During times of stress, normalize the stages of change (Prochaska & DiClemente, 1986)
- Use mindfulness and relaxation techniques to develop the parent's capacities to reflect and contemplate

Helping parent read the child's cues

Beginning when the baby is born, the parent watches and listens for clues to the child's needs and feelings; these clues are found in the baby's facial expressions, body language, and cries, and greatly help a parent get to know their child. Observing the child's cues and following their lead helps the parent learn about her infant's needs and fulfill them in a timely fashion, and gradually builds a sense of competence.

A clinician can use the infant's behavior and the parent's response to the baby as a port of entry to ask probing questions or speak for the baby and thus enhance the parent's capacity to make sense of the baby.

Following the child's lead

Clinicians regularly model following the child's lead, as means to help parents do the same. This involves watching, waiting, and wondering (Cohen, et al., 1999); MTB clinicians approach the child with curiosity about his or her wishes and intentions in care-seeking as well as in play.

Instead of doing something, the clinician's biggest task is to do nothing and allow the child to invite us into his experience. This means taking pause and observing the child; being with him in a different more thoughtful way and then contemplating a response based on observations of his actions, behavior, and emotions.

Filming parent-child interactions

We suggest that clinicians film parent-child interactions when possible, typically using an iPhone or iPad. This can be done in an informal, relaxed way; films can then be reviewed by the clinician and parent together. Reviewing interactions together allows the clinician to:

- Help parents slow things down, pause and reflect on themselves, the babies and how they interact together. This can serve as a parent's "time out" to think about and focus on the baby, despite the busy distractions all around.
- Engage parent in reflecting about their exchanges with the baby – encourages parents to be curious, to observe and notice, to name thoughts and feelings, and imagine those of the baby
- Respond to parent's comments (positive & negative)
- Make suggestions for the interaction as you watch together, e.g., "maybe he's grabbing your earrings because they are bright and shiny and so interesting to him."
- Point out when the parent does well: "Look how comfortable she feels trying something new because she feels safe with you nearby."

Helping parent attend to the child's play

Building play skills in both parents and toddlers is a central focus of the home visitors' work during the second year of intervention. The capacity to play is rooted in the parent-child relationship (Slade, 1994). Play is a vehicle children use to express feelings, manage conflict, try out different points of view, and assimilate difficult experiences. MTB parents often have very busy lives and are challenged by making play an integral part of their relationship with their children. Many have not

had play experiences during their own childhood and therefore lack an appreciation for the value of play.

The role of the home visitor is to introduce to the parent different ways of engaging the baby that are playful and create space to enjoy her baby. The use of books, songs, finger plays, and simple toys that are developmentally appropriate aims to expose parents to the developmental, social, and emotional functions of play as well as provide opportunities for the developing toddler to explore and utilize their evolving cognitive, motor, and language skills as they begin to make sense of their experiences. The clinician uses play to:

- Model for parents who may have lacked play/playfulness in their own backgrounds
- Demonstrate and explain the evolution of play as child becomes a toddler who uses more imitation and pretend aspects in play
- Show that play has meaning by playing with the child.
- Model how to play with the baby or toddler
- Show how to use simple toys in play
- Point out baby's skills and intentions; e.g., use a developmental explanation to shed light why a child knocks over the block tower the parent just built

Using floor-time

The concept of floor time allows a semi-structured, finite point in time where perhaps for ten minutes a day a mother or father can spend time on the floor with the baby and enter the child's world as a spectator and potential playmate (Greenspan, 1992). In this instance the child is allowed to "take the lead" and show the parent what interests him or her and initiate a playful interaction without being directed. When parent, baby and clinician are playing together, clinician uses this time to help parent:

- Follow the baby's lead
- Imitate the baby's behavior as a way of taking the child's perspective
- Read baby's cues
- Increase parents' observation skills
- Reinforce and shape parent behavior
- Address misinterpretations and misattributions
- Make non-judgmental observations regarding attachment behaviors

Being playful with the family and enjoying the baby

Playfulness – in the clinician, in the parent, and in the child – is so important, and often the key to authentic communication and closeness. Thus, the clinician is encouraged to:

- Find ways to be playful with the family
- Include other family members or family pets
- Include a good-natured sense of humor towards one's own mistakes; for example, when locking keys in car, stepping in a puddle, etc.

The parent's capacity to truly enjoy the baby is also key. Clinicians encourage parents to:

- Hold the baby
- Sing to the baby
- Feed the baby on demand
- Feed the baby face-to-face with good eye-contact
- Smile and hold the baby's gaze
- Design a comforting and predictable routine
- Talk and describe the baby's world to the baby
- Massage the baby

Additional approaches

Additional approaches to enhance the parent-child relationship include:

- Continually find ways to bring the focus back to the baby
- Maintain focus on the parent-child relationship in the midst of chaos
- Increase the parent's awareness of disruption and overstimulation of the baby
- Acknowledge the mother as the expert on her own baby
- Teach effective parenting skills
- Use anticipatory guidance and foreshadowing
- Think about the parent and baby's temperament and goodness of fit
- Draw parallels between parent and baby's desires and feelings
- During separations ask, "What did it feel like for the baby? For you?"
- Encourage the parent to think about his or her own needs and self-care
- Help the parent to problem solve by:
    - Prioritizing
    - Planning step-by-step for the future
    - Brainstorming
- Give the parent concrete reminders of the program to reinforce the messages of the home visitor, such as:
    - Books and handouts for mothers to keep and pass along to siblings, cousins, friends, etc.
    - Emergency supplies when needed (diapers, clothing, etc.)

- Highlight progress by noticing, reinforcing, and celebrating:
  - Parents' efforts to learn new ways of thinking and/or acting
  - Movement (even incremental) toward the family's goals
  - For example: "*Wow! Remember when that was really hard for you? Look at how different it is now!"* or *"You are really opening yourself up to a new way of trying this!"*

Self-assessment after the home visit

MTB clinicians are encouraged to regularly check in with themselves about their level of reflectiveness during the visit. Here are some useful questions. Please also see the MTB Treatment Manual for a self-assessment tool.

- Was I able to maintain a reflective stance?
- Was I attuned to the parent's and baby's needs?
- Do I have a sense of the relationships between mother and child, father and child, father and mother, and each family members' relationship with the home visitor?
- What did I struggle with?
- Was I able to bring the parents back to the baby?
- What do I need to communicate with my partner/supervisors?
- What are the next steps?

Chapter 4: Interdisciplinary Practice: Coordination and Integration of Care

Multidisciplinary teamwork is similar to cross cultural work. Each discipline has its own domains, language, and strengths, and sees the world through a particular professional lens. For each clinician there can be a degree of vulnerability in accepting new perspectives, and in tolerating the pace of the work or the overlapping roles of the clinicians. Curiosity, authenticity, compassion, and a measure of humility toward mothers and colleagues are critical to the work of MTB.

Nursing approaches

Listed below are some of the didactic and theoretical approaches the nurse home visitor uses in her work with families. This list is not meant to be exhaustive. These approaches are not unique to the MTB program, but the intent when using an approach is to draw out and nurture parents' RF. Taking a reflective stance is an essential aspect of the nurse's role. Further explanation and examples are found in the MTB Treatment Manual, Chapter 7.

- Anticipatory guidance and foreshadowing
- Case management and referrals
- Developmental screening
- Individualized treatment plan
- Labor plan (See Appendix I)
- Neonatal assessment
- Stress reduction techniques

Mental health approaches

The mental health component of the intervention is aimed at supporting expectant parents psychologically and emotionally as they prepare for the transition to parenthood. MTB

clinicians rely upon a range of well-established therapeutic techniques such as: psychosocial history gathering (including the use of genograms to diagram family relationship dynamics of both parents), infant-parent psychotherapy, insight-oriented and supportive counseling for parents, video feedback, and family and crisis intervention.

The Pregnancy Interview (Slade, 2003) is also administered to both the mother and the father to explore their intentions, thoughts, and wishes about becoming parents. The 3 wishes parents make for their baby at the end of the interview often inform goal and treatment planning and are incorporated to guide the focus of the mental health approaches. Post-partum mental health assessment is on-going for both parents with the understanding that perinatal mood disorder symptoms may present differently in mothers and fathers due to hormonal fluctuations and socialization based on gender.

Finally, direct social service support is provided to meet the immediate financial and concrete needs of the family. Concrete resourcing is often a key "port of entry" to family engagement and relationship building. The aim is to balance service needs and reflective work.

Team communication: "Layering" the work

One of the most important elements of the work is the clinicians' capacity to communicate with one another, and to build on each others' work in a thoughtful, ongoing way. Some key tenets of layering the work are as follows.

- Each profession has its area of expertise and both clinicians may cover similar topics from a different perspective (i.e., maternal health, maternal life course, child health and development, parenting, parental mental health, infant mental health, and social support).

- Many topics are interdependent in nature and build on each other.
- Each clinician looks for a point of entry to integrate their work with their partner's work, keeping RF in mind.
- The team and the supervisors need to provide ample opportunities for communication and create a safe environment for case conferences and discussion.
- There needs to be at least weekly communication, preferably face-to-face, between various sets of team members; this should be protected time.

The value of two clinicians

Aside from the fact that the nurse and mental health clinician bring different skills and perspectives to the work, there is great value in having two clinicians regularly interacting with families, typically in alternating, but sometimes in joint, visits. Among the benefits are:

- Session by session communication about the dynamics, life events, observations, and impressions of the dyad during weekly one-on-one meetings
- Linking interventions; following up the other's visit in a common flow
- Recognizing and resolving splitting
- Families learn to use clinicians each for their field of expertise
- As clinicians discuss and clarify their roles, clinicians are less likely to feel in competition or sole "ownership" of families
- Clinicians grow in knowledge and confidence about own and team member's abilities
- Clinicians learn to be each other's safe sounding board

Barriers to interdisciplinary teamwork

Teamwork can be very complex. Thus, it is important to be aware of the following potential challenges to working together.

- Families may try to play one clinician against another.
- Clinician may see different behavior or hear different 'stories' and believe that they each have all of the correct information.
- Clinicians may overwhelm their partner with reactivity to events.
- A clinician may be judgmental and/or blaming.
- There may be a failure to discuss countertransference reactions, or strong feelings about families.
- Competition may occur between clinicians; e.g., Who does the client like best? Who is 'most helpful' to the client? Whose professional training or life-experience is more valuable?
- There may be a failure to appreciate differences in personal boundaries; clinicians often will have different comfort levels with certain boundaries and these should be respected.
- Clinicians may avoid the expression of differing ideas and opinions.

Chapter 5: Working with Adolescent Parents

Adolescent mothers face many simultaneous developmental demands as they seek to merge their adolescent developmental tasks and behaviors with the new roles that emerge in pregnancy and early parenthood (Moriarty Daley, Sadler & Reynolds, 2010; Sadler & Cowlin, 2003). Some key developmental issues arise, as the demands of adolescence often conflict with the demands of new parenthood. See Table 1 on pages 26-29 for more on these developmental conflicts.

Helping adolescent parents

Remember when working with adolescent parents that they were teenagers first, before they became parents. Sometimes their behaviors or reasoning might appear puzzling. In these cases, thinking about Adolescent Development may help you sort out what might be going on.

Brain development is a work in progress, with the emotion-focused amygdala part of the brain predominating, while the prefrontal cortex (executive functioning) is still developing. This helps to de-mystify some of the decisions teens make or the ways in which they might misinterpret facial expressions (fear for anger, for example), or misattribute their infant's developmentally normal responses.

You can help teens make progress with their cognitive development by modeling and helping them to use rational decision making processes, problem solving, and planning for their child's needs and changing abilities.

Adolescents often lead complex lives and respond well to authentically interested and caring adults; indeed, they are more open than older parents to new ways of thinking about their parenting roles and about their young children.

Many teen parents have trauma exposure and some have sexual abuse in their own life histories, prior to becoming pregnant. They also may have struggled with academics, peer relationships, and finding diverse role models in their lives prior to pregnancy.

Helping teen parents with their own development and life course plans (especially delaying rapid subsequent childbearing and completing education) adds to the value we bring to these young parents. It also shows them that we are interested in them as individuals as well as parents.

Clinical approaches

Within the home visiting process there are often clinical issues that are specific to teen parents and their infants and young children. In general, teaching and coaching regarding health, development, and parenting issues should be as concrete as possible, with hands-on approaches, use of video (of the dyad) when possible, and helping to foreshadow parenting issues that are likely to come up in the relatively near future (vs. 6-12 months or years away).

Including the child's father in home visits depends on the nature of the couple's relationship and also how well the maternal family is able to get along with the baby's father. There is a wide range of involvement from fathers, and in some cases the teen mother may have a new partner who wishes to become involved in the raising of her child.

Teen mother/father dyads often require or benefit from couple's counseling, since their relationships are often crisis-oriented, and may not be permanent romantic relationships although contact between the father and child may continue. Helping the young couple keep the child's best interests at the center of their decisions about their own relationship is the focus of much of the counseling.

Table 1. Developmental Conflicts of Adolescence and Motherhood
(Adapted from Sadler & Cowlin, 2003)

	ADOLESCENCE
Identity Issues	Role experimentation
	Time with peers
	Greater need for sleep
Independence and Individuation	Relaxing of dependent ties with parents/family
	Desire for more time with friends; mobility
Adolescent Cognitive Development	Concrete, present-oriented reasoning; brain is not finished growing yet
	Egocentric focus on own issues/needs
	Parent and child undergoing critical periods of brain development
	Teen's maternal brain; relying more on amygdala vs. pre-frontal cortex; misinterprets emotions/facial expressions; capacity for empathy still developing

MOTHERHOOD	EXAMPLES
Specific parental roles and responsibilities	Taking babies out to clubs/parties
24/7 job description	Realization of the need to plan and thank/reciprocate for help
Sleep deprivation	
Increased dependence on family for economic and child care support	Experience sometimes described as "life-saving"; restoring daughter back into family
Tied to home and family more because of baby	2-year window of co-residence with maternal familly seems critical (delayed subsequent childbearing and high school completion)
Confusion between own thoughts/reasoning and baby's; difficulty seeing child separate from self	Mother/child tantrums; "He's a brat just like me" (3 month old baby); "She should know better than to fall off the bed. It's her own fault."
Maternal role requires future planning, thinking about consequences, anticipating child's behavior (safety)	Issues of discipline; issues of spoiling infants

	ADOLESCENCE
Sexual Development	Adjustment to physical changes of puberty; may be uncomfortable and relatively uninformed about sexuality despite sexual activity
Attachment Issues	History and ongoing issues of attachment with own parents/ caregivers; pregnancy highlights relationship/feelings about mother Family cycles of teen parenthood with other family members having raised the teen mother Unresolved attachment issues between teen and her biological mother

MOTHERHOOD	EXAMPLES
Adjustment to physical changes of pregnancy, post-partum period, and breastfeeding	Reactions to idea of breastfeeding as "nasty"— need to help it become "okay" though this depends on family attitudes/practices. Never push/insist.
Confronting return to fertility/need for contraception	Denial of need for contraception despite recent pregnancy
	Sexual pressure; exploitation by partners
Gradual & ongoing coaching about parental reflective functioning for enhancement of infant attachment	
Learning about infant's mental states; emotions & individual needs; taking into account the teen's cognitive style & perspective; video recordings can be analyzed together; modeling, speaking for the baby help with this	

Teaching adolescent parents

When teaching adolescent parents, keep the following techniques and topics in mind.

- Use concrete, simple, present-oriented information; teachable moments/demonstrations, modeling.
- Communicate basic information; watch for professional jargon; ask for questions.
- Demonstrate child development when possible.
- Safety and discipline are hot issues.
- Ask about feeding and breastfeeding patterns and any needed interventions.
- Assess and help support the adolescent's contraceptive plan at frequent intervals.

Chapter 6: Practical Aspects of Home Visits

Families are often coping with multiple and simultaneous stressors related to basic needs, housing, family or community violence, as well as individual mental and physical health issues. These compelling issues and problems often run the risk of distracting clinicians from their primary focus.

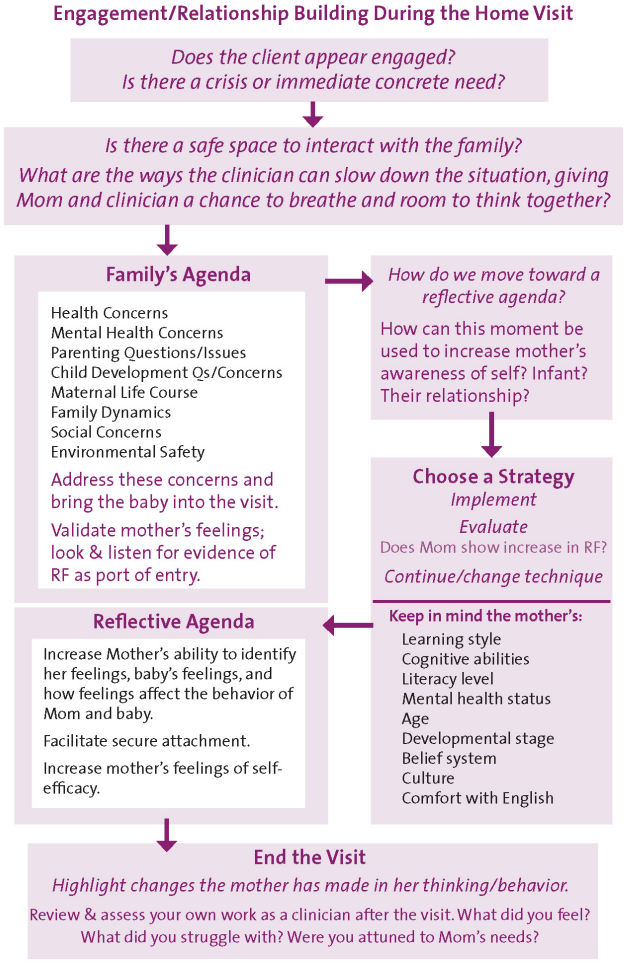
Clinicians, along with parents, are constantly assessing, reassessing and making decisions about which sets of problems to attend to and in what order. The challenge for clinicians is to keep relating all conversations back to the mother-child relationship, all the while managing one's own feelings. It is completely normal to have strong feelings about what is observed and heard.

Some of the many complexities in the clinical context are illustrated in the figure on page 32, displaying the process and structure of a home visit as the clinician discovers and explores the parent's agenda and makes choices to interweave MTB goals into the home visit.

MTB intervention timeline

TIME PERIOD	FREQUENCY OF VISITS
Prenatal	Weekly (clinicians alternate weeks)
Around Baby's Birth	Joint visit to congratulate the family
First Year of Child's Life	Weekly (clinicians alternate weeks)
Transition Visit at 12 months	Joint visit with both clinicians
Second Year of Child's Life	Every other week (each clinician sees the family monthly)
Graduation Visit	Joint visit with both clinicians

Figure 2. Structure of a Home Visit: A Decision Tree



Adapted from Currier Ezepchick, J., Webb, D., Dedios-Kenn, C., & Sadler, L. (2010). MTB Treatment Manual, First Edition.

Scheduling home visits

Home visits typically last about an hour. There are instances, however, when home visits can last several hours or may be cut short. Longer home visits are obviously required when there is a crisis or when parents need to be accompanied to medical or social service appointments by the home visitor. By contrast, some parents find an hour "too much" in which cases they may require shorter, and possibly, more frequent drop-ins. It may feel hard to leave after an hour if there are many family concerns, however it is difficult for the family and clinician to stay attentive for more than 60 minutes and a longer visit may not be productive.

Location of visits

While the majority of home visits take place in the homes of MTB families, there may be circumstances when parents may not wish the clinicians to come into the home. The visit setting may be negotiated with the family for another acceptable place. This may be a public setting such as the children's playroom of the public library, a coffee shop, or an empty room in the community health center.

When parents are particularly busy, visitors can also be creative in meeting parents during a lunch break at work or school, or conducting the visit while driving the mother to an appointment or home from work or school. These types of visits can serve as helpful and trust-building outward demonstrations of commitment on the part of the program towards the parent. The extenuating circumstances are usually temporary (often job schedules change, or housing situations improve or change) and then regular visits in the home setting can resume. If a parent continues to need transportation, the clinicians should help her find other resources.

Suggested toys to bring to a home visit

Clinicians bring toys to use with the baby during the visit, but these toys are not left at the home. It is useful to have a brightly colored washable tote bag that accompanies the home visitor and is large enough to also accommodate any resources and teaching materials. As babies grow into toddlers they begin to identify this bag with enjoyable activities and toys. The clinician may use several bags in a day.

The toys serve many purposes including distracting a crying baby, occupying a toddler while a parent tells a long story about a recent family incident, or demonstrating a child's new skills. Some parents are influenced by clinician choices and purchase a toy similar to one the clinician has brought to the home. Knowing this, it's important to try to stay away from toys advertising a movie or cartoon show, those that are overly busy with lights and sounds, and those that do not encourage a child's imagination. Age appropriate and safe toys are chosen.

The contents of the toy bag typically include:

- Stacking rings
- Nesting cups
- Blocks
- Plastic animals and people
- Puzzles
- Balls
- Books
- Cars and trucks
- Large pop beads

Safe household objects, such as clean deli containers and lids, also encourage parents to think creatively about what children find interesting to explore. The types of toys offered change as the child grows.

Toy safety and sterilization

Children under the age of three often mouth objects as a way of exploring their world. As clinicians enter homes, it is important to be certain that the toys brought as gifts or to use for play do not pose choking hazards or spread germs. Check your toys for loose or broken parts on a regular basis.

A toilet paper roll can be used to find toys of an appropriate size for infants and toddlers. The size of the opening in the roll is similar to the size of a child's throat. If you can rotate the toy and fit it through the roll at any point, the toy is too small to use as a gift or during a home visit.

Keep hand sanitizer in the car to use before and after the home visit. In addition, clinicians should wash their hands in the home before greeting or holding a newborn.

Since cloth books and wooden toys cannot easily be cleaned, plastic toys are used. To sterilize toys, use regular household bleach in a solution of 1 part bleach to 10 parts water. Dip the toys in the solution and then allow to air dry. This is an important step. After toys are dry, they can be rinsed in water if there is still the odor of bleach on them. Bleach solution loses is ability to sterilize quickly so prepare when needed and do not store. A sanitizing wipe can be used for cleaning off board books and puzzles.

Choosing and using handouts

Choosing handouts takes time and thought. Topics must be relevant to the mother. She is an adult learner and is rarely looking for abstract theory. A reasonable guideline is to use only a few handouts per home visit. A comprehensive list of topics to discuss at different time periods during the MTB intervention is included in the Treatment Manual. Using this list the nurse can look for appropriate handouts to use with parents.

Some government agencies and health care centers have well designed handouts that can be ordered for your use.

Consider the literacy level and attractiveness of the handout. Color, diagrams and pictures are very helpful in explaining new concepts. Mothers are busy people and wordy handouts may never be read. Less can be more! After all, they are receiving this information as a supplement to the education you are doing with the family.

It is useful to read the handout with the parent, pointing out, underlining, and crossing out particular information you want or don't want them to remember. This helps to reinforce the information as the parent has heard and seen the material. Consider the parent's learning style. Perhaps a video or simple demonstration will work better with some parents. Some interactive handouts or questionnaires can break up the sameness of your presentation.

Some useful handouts can be printed from the internet, but be cautious and use only reputable sources. Often this material is at a literacy level beyond our client's current education level. Some may need to be re-worked to make them accessible to parents.

Clinician safety

Clinicians should be aware of their surroundings and not put themselves in a compromising situation. Visits can always be rescheduled or a different location found to meet families if a particular setting or situation does not feel safe.

Other important safety tips and considerations include the following.

- Trust your feelings and instincts about safety during home visits; it is often useful to discuss these incidences with the team in order to support one another in this effort.

- Consult a map or GPS device before leaving for a new location.
- Know where to park and whether or not the doorbell works.
- Place a large sign with the program's logo on the front dashboard of the car.
- Wear a name badge with the program logo and title so clinicians are readily identified as health visitors in the community.
- Dress neatly and professionally but without noticeable jewelry or handbag.
- Leave handbag in the trunk of the car; this reduces possible problems for visitors and is also a safety measure since handbags often have small items and medications that can be dangerous to young children. If this is not possible consider bringing only the necessary items into the home.
- Keep cell phones and car keys readily available in a pocket.

Chapter 7: Common Challenges

When other family members are home

Typically, the mother and potentially the baby's father participate in home visits. However, other family members often sit in on a home visit, for a variety of reasons. It is worth the clinician's time to explore these. Some family members may be uncomfortable with strangers in their home, teaching new ways to parent. As with the parents themselves, acceptance grows when family members feel heard and reassured that MTB clinicians are in their homes to support the emotional and physical health of the baby and parents.

Some subjects are too private to be broached with an audience, but other topics may be interesting to introduce for discussion by the whole family. For instance, discussing baby proofing as a discipline method can help mothers, fathers and other family members understand their differing points of view

Missed appointments

Missed appointments, no-shows, cancellations, and rescheduling are regular and common. MTB does not penalize for missed appointments, nor do we assume that they reflect a parent's lack of commitment to the program (although of course they can). In general, we assume parents are interested in the program and that other concerns have caused them to miss their appointment. Unless the parents inform the program that they no longer wish to be part of the program we are open to their returning.

Schedules are challenging for many parents. MTB clinicians strive to be maximally flexible in these situations, although there are times when the inconsistency has to be addressed directly for the sake of preserving the treatment relationship. The notion of consistency must be balanced against flexibility.

Some families live in the moment and have difficulty understanding how a change in their plans might affect the home visitor. It is appropriate for the clinicians to help parents think about ways to use their phone calendar or alerts to remember appointments and to help them feel comfortable making phone calls to schedule and reschedule appointments.

Contact with a parent by phone or text to confirm an appointment can be unpredictable and other methods may need to be used. It should not be assumed that a parent is unavailable simply because she or he does not answer the phone or return a text (although texts are typically most reliable). An attempt to make a home visit should still be made. If no one answers the door, a note should be left indicating that the clinician is sorry to have missed the family and will try again soon.

Clinicians may need to go to the home several times hoping to catch the parent at home. Phones are lost or broken, families move suddenly, work and school start and stop without advanced notice. The more insidious issues of violence, injury, illness, and the inability of many young parents to structure their lives to keep appointments are additional barriers. Sometimes giving the family a short 'vacation' from weekly visits is all that is needed.

Retaining and re-engaging families

MTB has had good success in retaining families that have been difficult to contact or keep engaged. This success is due in part to the program's flexibility and in part to our acceptance of the enormous barriers to such relationships that these families face.

The tenacity with which the clinicians strive to keep these connections with young parents can cause many strong feelings in the clinicians. It is hard not to feel rejected or annoyed after many missed appointments. Clinicians worry they have said or done something to upset the family. They wonder what to do

with their time when a cancellation changes their schedule at the last minute. While this level of persistence can feel awkward to the clinician, the family often appreciates it.

Outreach with no response can be stressful and draining for clinicians. With some families who are difficult to engage or have multiple no shows, clinicians may also benefit from a short break from pursuing a mother.

Attributing blame does not enhance the relationship with our families. The clinicians' task is to model compassion and curiosity and hope the parents will demonstrate a similar understanding with their baby when conflicts, last minute changes, misunderstandings, or mistakes are made. MTB has found the following four common times when clinicians may need to re-engage families. Being sensitive to the family's needs at these times is the first step towards re-engaging them in the program.

- The first time period when clinicians may notice parents less available to meet is towards the end of the pregnancy when many mothers experience irritability and a desire to turn inward and 'nest.'
- This may happen again directly after the baby is born. Families may wish to experience the first few weeks with their baby as a private time. If clinicians begin to lose contact with parents during either of these two periods, they keep a positive connection to the family by making shorter visits, acknowledging their experiences as new parents, and bringing them useful items. After a few weeks the clinicians can usually re-establish regular home visits.
- After the child's first birthday, when clinicians first initiate biweekly visits, parents may, again, be hard to engage. There are numerous reasons for this, ranging from changes in the family's life related to work or school, to the difficulty of establishing any new routine.

- Finally, when a child turns 18 months, the clinicians' time with the family may need rethinking. The mother's successful return to work or school can make regular appointments very challenging. While clinicians are extremely happy these mothers are doing so well in their life course choices, the clinicians want to be available to help families keep their relationship with the baby in mind during this busy time. Clinicians try to accommodate these changes by staying in touch and being flexible with appointment times.

Managing resistance

"Resistance" can be manifest in many different ways. Parents can "go missing", or –within the home visit itself – make phone calls, change the subject, get very sleepy, turn up the TV, end the visit suddenly, etc. In managing resistance, it is important to assess what this family can tolerate at a given moment. If the subject being discussed brings up difficult feelings or is no longer about the baby and parent's relationship, bring the focus back to the baby. Other tips and strategies include:

- Give emotionally difficult subjects a rest and return to them at another home visit. Notice these barriers to the parent's ability to work with you. File this information away to consider what you can change and what you have to accept. Be aware of your own values, concerns, and anxieties being expressed during the time you spend with the parent.
- Look for the family's strengths.
- Show faith in family's ability to continue thinking about the issue in an open-minded way.
- Go back to shared goals for the child: 'I want you and your child to do well. I'd like to share some things I have learned that might be useful to you.'

- Observe what you do that is 'containing' for the paent; what boundaries are helpful and build trust. Maybe having a consistent time to visit or being flexible with an unusual work schedule is helpful. Perhaps a calm demeanor or forgiving missed appointments allows the parent to relax and focus on the visit.
- Remember that all of the decision-making -- your own and the parent's -- is on-going. This isn't the final word.
- Ask about the other family members' feelings, opinions, and traditions.
- Break goals down into tangible reasonable steps. Help the parents build a road map for themselves. It is tempting to either praise the parents for their ambition or hope they can be successful, or to warn them that their expectations are overly optimistic. These approaches can be helpful, but in and of themselves may not help the family achieve their goals.
- Do a 'spell check' on yourself. Are you using unfamiliar words, idioms, or concepts? Rephrase and check to see if the parent has grasped your meaning. Do this by asking for an example or using an open-ended question.
- Know that you are probably being misinterpreted more often than you imagine. Even if the words you use are in the parent's vocabulary it may take time to process them. If you have moved on with the conversation, the parent may be lost and embarrassed to stop and ask for clarification. Watch for eyes glazing over, subject changes, restlessness.
- Remember that it is normal for adolescents and young adults to test limits. They need to know you are there for

them even if they act out. They will try to shock you. They will miss appointments. They will forget to follow-up on a promise. If we are teaching the parents not to be harsh or punitive or show obvious frustration with their children, then we need to model this calm patient approach with them.

- Remain hopeful and humble. Remember that 'help' and 'change' can have different meanings to different people.
- When a family or parent is particularly difficult to engage or work with, try viewing them through a trauma lens and remain curious about what experiences may have lead to their current interpersonal difficulties.

"Doing for" families is not necessarily "enabling"

Many of the ways that clinicians engage and build relationships with MTB families are not traditional clinical engagement strategies. It is not unusual for a clinician to accompany a parent to an appointment or assist with making phone calls, or completing application forms to access resources or schedule appointments. Some of the things done for and with the parent may lead the clinician to feel we are working counter to the goal of enhancing self-efficacy in the family.

Clinicians often grapple with the question of how much to do for families. It is difficult to establish a broad-reaching program policy regarding how much we do or don't do for families because each situation is unique in terms of individual capacity to access resources, understanding of systems as well as simple processes, and motivation for change. Therefore, an individualized approach is applied to each situation with on-going assessment of the development of self-efficacy for each parent.

Case management

Assisting families with navigating social service systems in order to access resources like housing, health insurance, food, medical care, legal matters, and other basic needs can be a key component of the mental health intervention. It is important for mental health clinicians to be aware of community services and resources available to families. Understanding factors like: eligibility criteria, the application process, length and scope of services, and the location of agencies relative to where families live is essential to effective partnership with agency providers and families to ensure that their case management needs are met.

Things to remember

- Social Service and other systems can be extremely difficult to navigate as well as intimidating.
- Families often need modeling and support to initiate access to resources.
- Model (Do For), Practice (Do Together), & Plan (Do Independently): What steps can be put in place so that the parent feels confident to try on their own the next time?
- Celebrate baby steps – sometimes simply calling to cancel a home visit ahead of time or calling a medical cab for an appointment are great signs of progress.
- It is not the clinician's responsibility to provide, but rather to support, assist, and connect families with resources.
- Even the best-laid plans fail. Despite the best possible efforts, sometimes families don't get connected to resources for a plethora of reasons. Don't assume personal failure for this.
- Finally, consulting with clinical partners, in supervision, and with the team is important in any situation that seems unclear. Clinicians should do all they can to clearly express their concerns.

Chapter 8: MTB Guiding Values

MTB home visitors share the following set of guiding values and beliefs about the work that supersede the differences in their approaches and disciplines.

- Clinician authenticity, curiosity and compassion are cornerstones of a reflective stance. Efforts are made to understand and accept the families for who they are and where they are. All families have a "story" to tell. Listening to this story, bearing witness to its hardships, validating its effects, and assisting its integration into present day life experience will help parents make meaning of their lives.
- The cultural issues that influence parenting need to be sensitively understood and explored. Care is taken to explore and understand cultural belief systems and how these beliefs shape the family's parenting.
- Clinicians assume parents are doing the best they can with what they know within their capacities. Clinicians are mindful of providing praise not only for outcomes but also for efforts made by the parent.
- Within each family there will be distinctive themes that dominate the clinical work. Clinicians address 'in the moment' issues and listen for overarching themes that may be used to help the parents better understand themselves and their child.
- Clinicians must have both discipline and flexibility to know when and how to use one's self in the relationship. This requires an ability to acknowledge and process strong feelings. Use of the self also calls for a solid knowledge base, and intuition and creativity in thinking about problems.
- An increase in reflective capacities will occur within the ongoing process of home visits. All reflective moments should be highlighted and validated as they occur.

- Home visitors (as well as supervisors) will be affected by their experience in the home and their relationships with family members. This experience needs to be processed and understood.
- There is more than one method of overcoming any barrier. Continued assessments and family feedback make it possible to explore alternatives.
- The nature of relationship building is cyclical: reach out, connect, disengage, and reach out again. Repeat as needed.

Chapter 9: Supervision

MTB supervision includes discussion and problem solving for both administrative and clinical tasks. In addition, time is regularly devoted to exploring the thoughts and reactions of the clinicians to the intensity of the work. This approach is often described as reflective supervision.

As clinicians care for families, keep them in mind, provide a holding environment in which they can safely share and explore their thoughts and feelings about themselves and their baby, the clinicians' relationship becomes a crucial factor in a parent's felt security, as well as the ability to begin to reflect on inner experience as well as the baby's experience.

Clinicians need the same kind of trusting relationship to depend on while navigating the challenges of this work. They too need predictability and a holding environment in which they can explore their reactions to the work with the families to avoid becoming overwhelmed and depleted.

Practical aspects of reflective supervision

When practicing and participating in reflective supervision, it is critical that the following tenets are followed consistently.

- A regular time and place and ample time to discuss issues
- No distractions
- An agenda that allows for reflection
- A collaborative exploration of thoughts, feelings and reactions connected to the ongoing clinical work with the parents and babies

Important points to remember

- Clinicians need to feel safe enough to explore a range of intense feelings: helplessness, hopelessness, sadness, vulnerability, anxiety, doubt, fear, anger, and frustration. These are the same reactions they are helping the parents with.
- A reflective supervisor wants the clinician to tell the story.
- A reflective supervisor must be gentle, aware, and curious and allow time for reflection and constantly question- how do emotional reactions affect the ongoing work?

Chapter 10: Compassion Fatigue, Secondary Trauma, and Clinician Self Care

Compassion fatigue

As a result of holding a great deal of difficult feelings and trauma history presented by families, it is not unusual for clinicians to find themselves feeling overwhelmed and depleted. Compassion fatigue is often a residual of burnout and may be long-lasting if not addressed.

Common symptoms of compassion fatigue are: avoidance of clients with a trauma history, social withdrawal, communication problems, lack of motivation, and staff conflict. If clinicians are experiencing any of these symptoms, it is essential that they seek support from supervisors, peers, and/or personal resources, i.e., friends, family, community, counseling, spiritual guidance, etcetera.

Vicarious or secondary trauma

Defined as: "cumulative transformative effect on the helper of working with survivors of traumatic life events" (Saakvitne et, al., 2000), vicarious trauma can be a result of prolonged compassion fatigue and changes the helper's worldview and sense of meaning. Although vicarious trauma, sometimes known as secondary trauma, is a common occupational hazard associated with helping and healing traumatized populations, clinicians with specific risk factors are more likely to experience vicarious trauma.

Clinicians who have not been trained to work with traumatized clients, do not receive adequate supervision or support, have unresolved trauma themselves, work in organizations that are uninformed about the effects of trauma, and have many personal life demands are at greatest risk for experiencing

vicarious trauma. Clinicians suffering from vicarious trauma may experience: depression, anxiety, questioning one's identity, disruption in one's beliefs, emotional numbing, and changes in self-esteem. Knowing one's self, being educated about vicarious trauma, recognizing symptoms, practicing regular self-care, and seeking support from peers, supervisors, and personal/social connections are effective ways of preventing vicarious trauma.

Self care

As clinicians care for parents and their babies, it can be easy to forget about their own self care. Be sure to keep these important reminders in mind.

- Eat healthy meals and snacks even on busy workdays.
- Try to make reasonable limits on the times you are available to families, in person and by phone. It can be tempting to be on call 24/7. This can lead to burnout.
- Sometimes saying 'no' is the right answer.
- Drive carefully. Traffic or an unexpectedly long home visit may make you late for an appointment. Don't rush or text while driving. It is better to begin your next visit late but safe and in a positive mood.
- Find a routine that allows you to decompress after home visits: listen to music or audio book in the car between visits, stop at a park or coffee shop to do paperwork, walk, meditate—whatever works for you.
- Think very carefully about what you disclose about yourself to the families. You may care for them and they probably really appreciate your support, but they are not there to be your friend.
- Know yourself. Work to understand how your own history and temperament impact your work and relationships.

- Understand your own limits and boundaries.
- Find someone who is able to listen to the difficult experiences you encounter. Not everyone can tolerate these stories, but that doesn't mean they don't care about you and your work. Remember confidentiality.
- Use your team members and supervisors to get a new perspective.
- In the beginning, learning about RF and attachment may make you question your own parenting. This can be quite disconcerting. Don't be too hard on yourself. Learning about oneself and parenting is a life-long process.
- Sitting in the car, floor, and couch all day is part of the job. Put aside some time to walk or exercise in your favorite way.
- When you have a day full of no-shows, don't take it personally. Remember it is part of the work with a population that is facing many stressors.
- If you become ill, don't visit pregnant women and infants. Take care of yourself.
- If you find you are feeling ill tempered and impatient, perhaps you are in need of a break of some sort. A short visit to get a snack, a personal day or a vacation can help you regain some balance between work and life away from work.
- Be gentle with yourself. You may not feel you are making a difference in a family's life, yet you may never know which small helpful act or kind words may have had an influence.

Appendix I: **Labor Plan**

The Labor Plan format used in MTB is modified from Penny Simkin and Phyllis Klaus' (Simkin, 1992; Simkin & Klaus, 2004) work on strategies for specific triggers during labor with women who have experienced sexual abuse.

Many mothers-to-be in MTB are survivors of physical and sexual abuse. Those who have not been abused have often suffered various other traumas throughout their lives. In these situations the women have felt powerless and violated. The prospect of delivering a baby can retrigger these feelings. Most are worried about the pain of labor and have been told frightening stories from family and friends or watched television shows about emergency births.

Penny Simkin and Phyllis Klaus have written articles and questionnaires for mothers on this subject, which we have adapted to help the mothers in our program.

Discussing the different aspects of the experience of labor and birth, and immediate postpartum care for mother and infant, can take 2 to 3 home visits. Much of the content is potentially new and emotionally charged, so the nurse paces the discussion of a possible trigger according to the woman's reactions. The nurse can integrate the mindfulness skills to relax the woman during the discussion and as practice for labor itself.

An overview of the stages of labor is given, including the first signs of labor, when to call their birth provider and what measures can be taken to provide comfort. The mother-to-be is then asked if she would be interested in making a birth plan.

The nurse explains that this plan that can be changed at any moment--even during labor. She also reminds the family that there needs to be flexibility for the providers to make decisions to give the mother and her baby the best care. After the mother

has had a chance to express her wishes regarding the birth the nurse takes the information home and writes a summary that can be easily referred to by the birth attendant. The mother has the opportunity to read and make changes before the final copy is put into her medical chart.

The initial questions, below, ask the woman to think about what makes her feel safe and how she typically handles pain and fear. The nurse then breaks down the labor experience into small steps and makes a concrete picture for the mother to imagine herself in the situation.

For example, young or abused women may have particular feelings about how they appear to others. In asking about appearance during labor the nurse might say, "It's impossible to tell when a baby will be born! Imagine its 2 a.m. and you've been awake for the last 10 hours in the early stages of labor. Maybe you've been walking and taking a shower to relax. Now you call the midwife because your contractions are getting longer and stronger. She says it's time to go to the hospital! You might be in your robe and you probably haven't combed your hair. How would you feel about going to the hospital like that?"

If the question elicits an emotional response, the woman's exact words are written on the form and the nurse asks the woman to think about ways to cope with that feeling.

In the above example, one woman might state that her appearance doesn't matter to her as long as she is physically comfortable. Another might be appalled and choose to have her hair braided the week before her due date so it will look nice in the pictures after the baby is born.

While the labor plan is the final result of the process, the conversation itself is often enlightening to the women and the clinicians. After doing the labor plan women have commented

that the experience made the pregnancy and birth more 'real' and helped her think about why she might respond in certain ways and how to ask for support.

Beginning Questions

The following questions may be helpful to ask as you begin the labor plan process with the parent(s). Refer to the MTB Treatment Manual for more details and sample forms.

- What makes you feel comfortable and safe when you are in a new situation?
- Have you ever been in a hospital?
- Were you there for yourself or visiting someone else?
- Are there things or people you would like to have with you when you go to the hospital?
- Think of a time when you were afraid or in pain. How did you cope with the situation?
- Can you think of ways to help yourself, or ways others can help you, if you become scared?

Appendix II: **Child Development**

Anticipatory Guidance and Foreshadowing

Early childhood providers in several fields have found the act of offering parents a glimpse into their child's next stage of development helpful to prepare them to support their child's growth. Excellent resources are the AAP's ***Bright Futures, 4th edition*** (Hagan, Shaw & Duncan eds, 2017) and Dr. Barry Brazelton's ***TouchPoints*** (Brazelton, 1994). The anticipatory guidance is broken down into information appropriate to help parents at each well baby appointment.

In MTB, a similar technique is used that we call "foreshadowing." In this case, parents are offered information about what their child will be able to do and how he or she might experience the world—both in the near future and in the months and years to come. This gives the parents an opportunity to see how stages come and go, building on skills learned at each stage.

The hope is that this larger context will help parents understand and be patient with some of the more challenging but temporary stages of childhood, and celebrate the meaning behind the milestones. A simple example of foreshadowing is discussing normal developmental crying during pregnancy rather than waiting to talk about increased crying between the ages of 6–10 weeks at the two-week or one-month checkup.

States of Consciousness of the Newborn

Researchers Dr. Peter Wolff and Professor Heinz Prechtl studied infants and found 6 common levels of awareness. Learning to identify these 'states' of wakefulness and sleep helps the new parents learn about infant needs and the ways newborns communicate (Wolff, 1987).

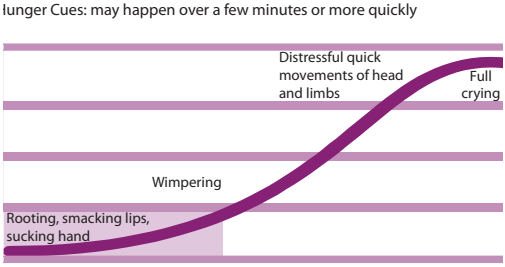
- **Quiet Sleep:** A deep sleep when infant looks completely relaxed.
- **Active Sleep:** Period when infant begins to move head and limbs, but is asleep. Eyes may move under lids.
- **Drowsy:** The state when child may have eyes half open and half closed. Heavy lidded eyes. May either fall asleep or awake more fully after being drowsy.
- **Quiet Alert:** Baby is fully awake, quiet, with eyes are wide open. This is the ideal time to be face-to-face with infant as baby will watch and respond to parent's face and voice. Also the best time to feed infant as s/he is settled and can easily find the nipple, suck, and swallow.
- **Active Alert:** Baby may be becoming uncomfortable, hungry, or over-stimulated. Needs help to settle to eat or sleep.
- **Crying:** Clearly distressed. Hungry and can't find the food source, over-stimulated or very tired.

Early and Late Hunger Signs

Informing parents and observing their reaction to a baby's cues of hunger is important. Sometimes there is a misunderstanding that one should wait to feed a baby until a child cries for food. Crying is actually a late sign of hunger and can be frustrating for parents and baby because a crying baby can be hard to settle and feed. In addition the baby may gulp air and become uncomfortable during or after the feed.

Remember that the baby's stomach is very tiny during the first weeks of life. Breast milk and formula are quickly digested and the baby is hungry as often as every 90–120 minutes. Over the next few months the baby's stomach slowly grows and some children can go as long as 3–4 hours before becoming hungry. Each child, however, is different and there are no hard and fast rules about when to feed.

A parent who learns to answer the baby's need for food by reading the early signs of hunger is teaching the baby that his or her needs are important and mother is there to help. This is an important aspect to forming a secure attachment.

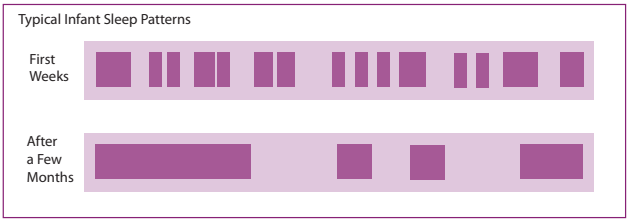


Normal Infant Sleep Patterns

A newborn may sleep up to 20 hours a day, but this sleep is split up into short catnaps of a few minutes or somewhat longer periods. There is no real pattern to the sleep and wake cycles, although many babies do have their nights and days 'mixed up.' For the first several weeks the baby's main purpose is to grow.

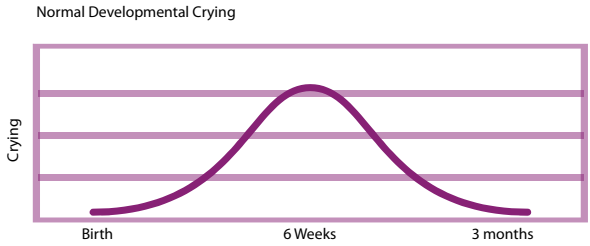
This can mean the infant falls asleep while eating and wakes shortly thereafter to feed again. After 2–3 weeks the baby becomes alert for longer periods of time. At this time parents can help the baby learn day from night by interacting with the child during daytime and attending to the diapering and feeding at night in a quiet and kind, but less playful way. Slowly the moments of sleep coalesce and the baby tends to sleep longer at night and stay awake longer during the day.

Again there is a wide range of normal in terms of how much sleep each baby needs and some children will not sleep 'through the night' for many months to come.



Normal Developmental Crying

All around the world, babies cry. In fact, all around the world, babies tend to cry more often and for longer periods of time between 6–10 weeks of age. Research has shown that, during this time period, babies have happy moments and crying moments each day. The crying periods can go on for 20 minutes or for several hours. However, unless the baby shows signs of illness or injury, this crying seems to be a normal part of development. An extremely useful web site about normal periods of crying and how to prevent child abuse has been developed by The National Center on Shaken Baby Syndrome at www.purplecrying.info. Additional information about crying is available at www.dontshake.org.



A note about "colic" – unfortunately, the word "colic" has been used in ways that have resulted in confusion and misinterpretation. Colic is not a medical condition but is sometimes used to describe a baby who cries more often and for longer periods of time than most infants. If a family believes their child cries more than usual, it is important to have the health care provider do a physical exam to rule out anything serious. If the child is healthy, reassure the family that this stage of crying will pass between 3 and 4 months of age, and work together on ways to cope and maintain a relationship with the infant.

Developmental Milestones

There are many books and articles with more detailed lists and discussion regarding normal development and red flags when development is delayed. Development is generally observed in the following areas:

- Large Motor (muscles)
- Fine Motor (muscles)
- Language
- Cognitive (problem solving skills)
- Social/ emotional (interpersonal skills)

Noting milestones can be educational and enjoyable for clinicians and parents, and is also important in assessing the child's growth and development. The Ages and Stages Questionnaires (ASQ) consists of a series of parent interactive questionnaires. (See ***www.agesandstages.com***.) The questions ask parents to observe and help their child demonstrate a variety of skills, noting that the child may have already accomplished the skill, demonstrates the skill sometimes, or has not yet learned this

skill—suggesting that this skill is one to look for in the near future.

While this measure can be used to evaluate a child who does not seem to be meeting the appropriate milestones, it is also a wonderful educational activity for parents who may be unaware of their child's changing abilities. It is a way to both celebrate what the child can do and what the parent can do to encourage the child to try a new skill.

For the child with mild delays the clinicians can show the parent activities to encourage skill development. For instance, a child who is not lifting her head may not have sufficient 'tummy time' to practice this skill and build muscle strength.

The clinician can explore ways to make tummy time a part of the family's routine and reassess the baby's abilities over the following weeks. For more concerning delays a first screen may help the clinician and parent decide on the appropriateness of referring for early intervention services.

The CDC has a user friendly app called CDC's Milestone Tracker. Other good resources for developmental milestone checklists include:

- www.CDC.gov/development
- www.healthychildren.org
- The Bright Futures Pocket Guide 4th edition (Hagan, Shaw & Duncan, 2017)

Reading to Young Children

Reading to children at a young age has been shown to increase vocabulary and comprehension, enhance their interest in reading on their own as they get older, and create soothing and pleasant moments between parents and children.

Parents may feel awkward or self-conscious when asked to read to their child. It is helpful to model reading and coach parents to try different books and approaches to engage their child. Encourage the parent to take their child on their lap in a comfortable place for both of them. Try to find a place with few distractions, although this may be difficult to do in a busy home and should not keep a parent from reading.

Offer the family age-appropriate books: board books and bath books that can be mouthed and tossed around. Introduce the parent to good childhood literature, classics that are not written for television characters. Offer a variety of books: picture books, poetry, books of songs, simple pictures of children and animals.

Make reading fun for the family by suggesting they use funny voices. Skip words if the child is most interested in turning pages. Point at pictures. At young ages, infants simply enjoy the experience of being held and listening to the sound of mother's voice, as well as looking at bright, colorful pictures; or having a tactile experience with books that offer different textures.

Appendix III: Comprehensive Assessment: Tools & Clinical Observation

Assessing for Perinatal Mood Disorder

When assessing for depression, it is important to first rule out diagnostic criteria. It is normal for expectant parents to feel an enormous range of emotions during pregnancy, and knowing when to be concerned and when to help normalize feelings is key. Frequent consultation with the parents, the MTB nurse, clinical supervisors, midwives, and other providers involved; and keeping up with current research about the management of perinatal mood disorder and psychopharmacology during pregnancy can help make the fuzzy lines clearer. (Refer to Postpartum Support International at www.postpartum.net.) Don't forget to trust your own clinical judgment as well.

On-going Mental Status Exam, Risk Assessment, and Safety Contract Planning

Taking stock of parents' mental status at every visit is essential. Ask these questions:

- Are they oriented to time and place?
- Do they have racing or recurrent thoughts that are distressing?
- Are there changes in grooming or appearance?
- Is there drastic weight gain or loss?
- How is attention span, flow of thought, and concentration?
- How is alertness and lucidity? Orientation to time and place?
- Are they making any bizarre or unusual attributions to the baby?

The Edinburgh Postnatal Depression Scale (***Bright Futures Mental Health Tool Kit***) is a helpful tool available in the public domain. It is very short and easy to administer and is used widely in the U.S. and across the world.

Other screenings have also been validated for the first year and beyond (Chaudron, 2004). The U.S. Preventive Services Task Force provides screening recommendations at: ***http://www.uspreventiveservicestaskforce.org/uspstf/uspsdepr.htm*** and lists the following two particularly helpful screening questions:

- Over the past 2 weeks have you been down, depressed or hopeless?
- Have you felt little interest or pleasure in doing things?

It is important to note that fathers may not identify as feeling down or hopeless. They may identify as feeling annoyed or irritable and having a desire to leave the house and go out often.

Assessing for Suicide Risk

If parents are having thoughts of harming themselves or the baby, carefully consider the following questions.

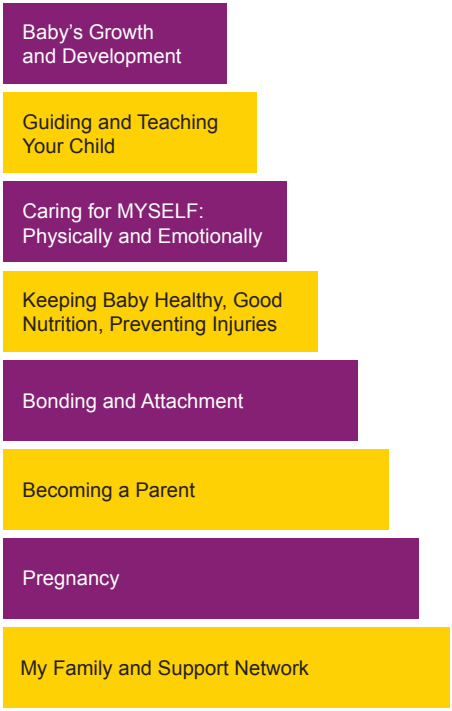
- How often and intense are these thoughts?
- Do they have a plan?
- Are they willing to accept help?
- Have they created their own solutions or tapped into natural supports?
- Are they able to care for themselves and the baby?
- Are they willing to contract for safety and agree to take concrete steps to ensure safety including seeking help or assistance when needed?

Appendix IV: Key Home Visits

Transition Visit at Baby's First Birthday

Transition visits provide a rich opportunity to mark the passage of time. Home visitors review and reflect upon the many changes, challenges, and growth the mother and child have undergone. The chart below, inspired and modified from Bright Futures (Green & Palfrey, 2002) mentions a number of broad categories that help frame this discussion between the parent and both clinicians.

Transition Visit at 12 Months



Modified from Green, M.& Palfrey, J. (2002). Bright futures: Guidelines for health supervision of infant, children & adolescents: Second Edition, Revised. Arlington, VA: National Center for Education in Maternal & Child Health.

The mother is invited to retell the story of the past year; about the times she found to be the happiest, most difficult, and most surprising. The clinicians wonder with her how she felt about these moments and invite her to imagine what these times were like for her baby. Articulating such understanding reinforces the mother's positive feelings of attachment to and pride in the baby as well as identifying her own growth as a parent.

Saying Goodbye: Graduation from MTB

Saying goodbye to MTB parents is a carefully planned ritual. The intention is that parents internalize that they are cared for and held in the hearts and minds of the clinicians. The hope is that over time they will transfer this caring to their own babies and 'keep them in mind.'

At best, the goodbye phase comes at a time when the dyad is ready to move ahead. In instances where there are pressing needs for ongoing connections with other agencies, such as social service, psychiatric or daycare, those referrals can be put into place to link the family as they move forward in their development. Depending on the parents' capacities for reflection, their investment in the program and their ability to cope with endings, the goodbye phase can bring up clinical issues that are indicative of most losses. There can be at once a shared feeling of expectation and hope as well as loss and sadness on the part of the family, baby, and the clinicians.

The clinician must consider that it would not be unusual for the parents to "act-out" in response to having intense feelings about the impending transition. Anger, denial, minimizing the significance of the relationship, avoidance, expressing feelings of betrayal, development of new crises, and attempting to continue the relationship on a personal level are some examples of ways that MTB parents struggle with changing or ending the therapeutic relationship.

Due to the intense nature of the therapeutic relationship, saying goodbye can also evoke strong feelings in each clinician.

When needed, endings can be discussed in the team meeting where clinicians can receive support to make useful decisions about when to say goodbye.

Steps in Preparing for the Goodbye

- Remind parents of the upcoming goodbye beginning 3-4 months ahead of time.
- As a team (clinicians and supervisors), choose the approximate date of last visit in consultation with parents.
- Encourage parents to process feelings of ending and separation as well as feelings of hope for the future.
- Invite parents to decide how they would like to mark the significance of ending the program.
- Reflect together (clinicians and parents) on accomplishments, bumps in the road, and their development as a parent over the last two years.
- As a team, implement steps towards referrals, evaluations, appointments as needed.
- Encourage parents' active role in following through on future plans, including pre-school plans as the child enters the 3rd year of life.

The Final Home Visit

Clinicians present the family with an acknowledgment of MTB Graduation, and a book for the family is carefully chosen to underscore specific themes present throughout the parent-infant relationship. Clinicians choose an appropriate present for baby and prepare a Memory Book that includes:

- Poems
- Photos of dyad & team taken throughout the intervention
- Quotes extracted from clinical interviews as gentle reminders to parents of their intentions to be the best parents they can
- Handwritten message from each home visitor highlighting the strengths and hopes for the parents and baby

Appendix V: Health & Mental Health Resources

Maternal and Infant Mental Health

- Futures Without Violence: www.futureswithoutviolence.org
- Zero to Three: www.zerotothree.org
- Postpartum Support International: www.postpartum.net
- World Association for Infant Mental Health: www.waimh.org

Child Health and Development

- www.brightfutures.org
- www.NAPNAP.org
- www.NICHD.nih.gov for Safe Sleep information
- www.dontshake.org
- www.agesandstages.com
- www.healthychildren.org
- www.AAP.org
- www.cdc.gov
- www.reachoutandread.org
- www.developingchild.harvard.edu/

References

Brazelton, T.B. (1994) Touchpoints: Opportunities for preventing problems in the parent-child relationship. *ACTA Paediatric Supplement,* 394, 35–39.

Campbell F., Conti G., Heckman J.J., Moon, S.H., Pinto, R., Pungello, E., Pan, Y. (2014). Early childhood investments substantially boost adult health. *Science, 343,*1478-1485.

Carter, S., Osofsky, J., & Hann, D. (1991) Speaking for the baby: A therapeutic intervention with adolescent mothers and their infants. *Infant Mental Health Journal,* 12, 291–301.

Chaudron, L., Szilagyi, P., Kitzman, H., Wadkins, H. & Conwell, Y. (2004). Detection of postpartum depressive symptoms by screening at well child visits. *Pediatrics,* 113, 551–558.

Cohen, N., Muir, E., Lojkasek, M., & Muir, R., Parker, C.J., Barwick M., & Brown, M (1999). Wait, watch, and wonder: Testing the effectiveness of a new approach to mother-infant psychotherapy. *Infant Mental Health Journal. 20,* 429-451.

Courtois, C. (2004). Complex trauma, complex reactions: Assessment and treatment *Psychotherapy: Theory, Research, Practice, Training, 41*, 412-425.

Daley, A.M., Sadler, L.S., & Reynolds, H.D. (2013). Tailoring clinical services to address the unique needs of adolescents from the pregnancy test to parenthood. *Current Problems Pediatric and Adolescent Healthcare.* (43), 71-95.

Fearon, P., Target, M., Sargent, J., Williams, L., McGregor, J., Bleiberg, E., Fonagy, P., Allen, J. (2006) Short-term mentalization and relational therapy (SMART): An integrative family therapy for children and adolescents. In Fonagy, P. (Ed), *The Handbook of Mentalization-Based Treatment* (pp. 201–222). Hoboken, NJ: John Wiley & Sons.

Fonagy, P. & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology, 9*, 679-700.

Garner, A. (2013). Home visiting and the biology of toxic stress. *Pediatrics, 132, Supp2,* S65-S73.

Green, M.& Palfrey, J. (2002). *Bright futures: Guidelines for health supervision of infant, children & adolescents:* Second Edition, Revised. Arlington, VA: National Center for Education in Maternal & Child Health.

Greenspan, S. I. (1992). *Infancy and early childhood: The practice of clinical assessment and intervention with emotional and developmental challenges.* Madison, CT: International Universities Press, Inc.

Hagan J.F., Shaw, J.S., Duncan, P.M. (2017). *Bright futures: guidelines for health supervision of infants, children, and adolescents [pocket guide].* Elk Grove Village (IL): American Academy of Pediatrics.

Jones, D., Greenberg, M, & Crowley, M. (2015). Early social-emotional functioning and public health: The relationship between kindergarten social competence and future wellness. *American Journal of Public Health, 105,* 2283-2290.

References

Lieberman, A.F. & Van Horn, P. (2008). *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment.* New York: Guilford Publications.

Lieberman, A.F., Ghosh-Ippen, C., & Van Horn, P. (2015). Don't hit my mommy!: A manual for child-parent psychotherapy with young children exposed to violence and other trauma. Washington, DC: Zero to Three.

Ordway, M.D., Sadler, L.S., Holland, M.L., Slade, A., Close, N., & Mayes, L.C. (2018). A home visiting parenting program and child obesity. *Pediatrics, 141(2),* e20171076.

Powell, B., Cooper, G., Hoffman, K., & Marvin, R. (2013). *The circle of security intervention: Enhancing attachment in early parent-child relationships.* New York: Guilford Publications.

Prochaska, J. O. & DiClemente, C. C. (1986). Towards a comprehensive model of change. In Miller, W.R. & Heather, N. (Eds.), *Treating addictive behaviors: Processes of change.* (pp. 3–97). New York: Plenum Press.

Sadler, L. S., & Cowlin, A. (2003). Moving into parenthood: A program for new adolescent mothers combining parent education with creative physical activity. *Journal of Specialists in Pediatric Nursing,* 8, 62–70.

Shonkoff, J.P., Garner, A.S., Siegel, B.S., & Dobbins, M.I. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics,* 19, 232-249.

Simkin, P. (1992). Overcoming the legacy of childhood sexual abuse: The role of caregivers and childbirth educators. *Birth,* 19, 224–225.

Slade, A. (1994). Making meaning and making believe. In *Children at play: clinical and developmental approaches to meaning and representation.* A. Slade & D. Wolf, eds. New York: Oxford University Press, 81-107.

Slade, A. (2002). Keeping the baby in mind: A critical factor in perinatal mental health. In A. Slade, L. Mayes, & N. Epperson, Eds. *Special Issue on Perinatal Mental Health*, *Zero to Three*, June/July 2002, 10-16.

Slade, A. (2003). The Pregnancy Interview. *Unpublished manuscript.*

Slade, A. (2005). Parental reflective functioning: An introduction. *Attachment and Human Development, 7(3),* 269–281.

Slade, A., Holland, M.L., Ordway, M.R., Carlson, E.A., Jeon, S., Close, N., Mayes, L.C.,& Sadler, L.S. (in press, 2018). *Minding the Baby*®: Enhancing parental reflective functioning and infant attachment in an attachment-based, interdisciplinary home visiting program. *Development and Psychopathology.*

Slade, A., & Sadler, L.S. (2018). Pregnancy and infant mental health. In C.H. Zeanah, Ed. *Handbook of Infant Mental Health, 4th edition,* pp. 25-40. New York: Guilford Press.

Slade, A., Sadler, L.S., Webb, D., Simpson, T.E., & Close, N. (2018). *Minding the Baby*® *Treatment Manual.*

References

Slade, A., Sadler, L., Close, N., Fitzpatrick, S., Simpson, T., & Webb, D. (2017). *Minding the Baby*®: The Impact of threat on the mother-baby and mother-clinician relationship. In S. Gojman de Millan, C.Herreman, & L. A. Sroufe, Eds., *Attachment across cultural and clinical contexts*, pp. 182- 205. London: Routledge.

Slade, A., Simpson, T. E., Webb, D., Albertson, J., Close, N., & Sadler, L. (2017).

Minding the Baby®: Developmental trauma and home visiting. In H. Steele and M. Steele, Eds., *Handbook of Attachment-Based Interventions,* pp. 151-173. New York: Guilford Press.

Sroufe, L. A., Egeland, B., Carlson, E. A., & Collins, A. (2005). *The development of the person: The Minnesota study of risk and adaptation from birth to adulthood*. New York: Guilford Press.

Stern, D. (1977). *The first relationship: Mother and infant.* Cambridge, MA: Harvard University Press.

Waters, I., Watson, W., & Wetzel, W. (1994). Genograms: Practical tools for family

Wolff, P. H. (1987). *The development of behavioral states and the expression of emotions early infancy*. University of Chicago Press: Chicago.

van der Kolk, B. (2014). *The body keeps the score.* New York: Penguin Books.

Zeanah, C.Z. (2018). *Handbook of infant mental health, 4th edition.* New York: Guilford Press.

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