Minding the Baby®
home visitation program

TREATMENT MANUAL

Intervention and Training Guide

Fifth Edition

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Dedicated to the mothers, babies, and families who have taught us so much, and in loving memory of Katrina H. Clark, who believed in us from the very beginning.

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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This treatment manual provides a thorough introduction to the basic components and protocols of the *Minding the Baby®* (MTB) clinical model, including specific treatment and intervention training guidelines. It is to be used in tandem with training provided by MTB National Office faculty and staff at Yale University. Specific training and on-going consultation are necessary for replication projects and full implementation of the MTB model.

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TREATMENT MANUAL
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PART ONE
THEORETICAL AND HISTORICAL PERSPECTIVES: GENERAL AIMS AND ASSUMPTIONS

CHAPTER ONE: OVERVIEW AND INTRODUCTION

Introduction

The purpose of this manual is to guide clinicians and their supervisors in delivering *Minding the Baby®* (MTB), a home visitation program for infants and their families. MTB grew out of an interdisciplinary collaboration among clinicians and researchers from the Yale Child Study Center, the Yale School of Nursing, and the Fair Haven Community Health Center. It was designed to integrate nursing and mental health approaches to home visiting in order to address the multiple and complex health, attachment, and mental health needs of vulnerable families in a coherent, holistic way (See Ordway, Sadler, Holland, Slade, Close, & Mayes, 2018; Ordway, Sadler, Slade, Close, Dixon, & Mayes, 2014; Sadler, Slade, Close, Webb, Simpson, Fennie, & Mayes, 2013; Slade & Sadler, 2018; Sadler, Slade, & Mayes, 2006; Slade, Simpson, Webb, Albertson, Close, & Sadler, 2017; Slade, Sadler, Close, Fitzpatrick, Simpson, & Webb, 2017; Slade, Sadler, & Mayes, 2005; Slade, Sadler, deDios-Kenn, Webb, Ezepchick, & Mayes, 2005).

This manual is organized into two sections. Part I (Chapters 1-4) provides a general overview of the theory and history underlying the model, as well as a description of MTB's primary goals and assumptions. Part II (Chapters 5-11) provides an overview of the structure and format of the intervention, as well as a consideration of the general process and function of the individual home visit. The specific content of nursing and mental health visits are also discussed, as are procedures for managing a range of clinical concerns, and the vital role of supervision and team support. Finally, the procedures for monitoring fidelity are outlined. A glossary of terms is included in Appendix IV.

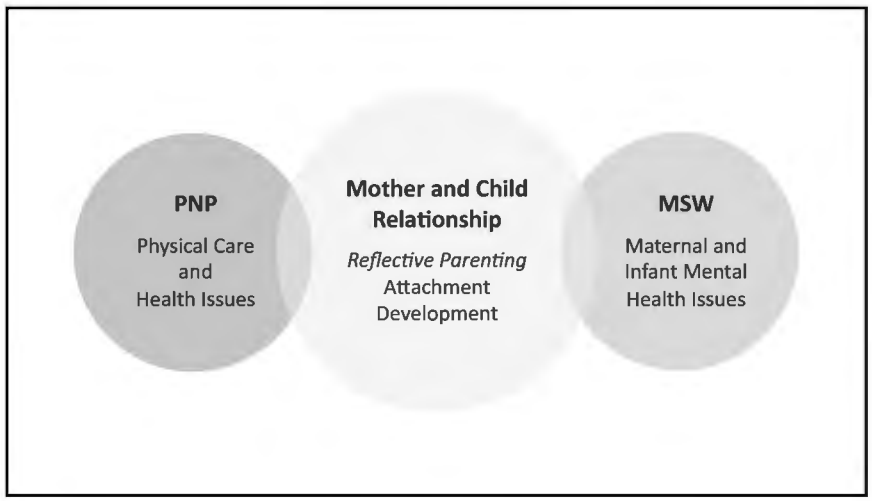
We recommend that clinicians and supervisors read Part I at the beginning of training, and return to it as needed as they become more deeply immersed in the program. Part II will be most useful to clinicians once they begin their day-to-day work with families, and to supervisors in overseeing this work. Chapter 9 is specifically geared toward supervision.

Overview of *Minding the Baby®*

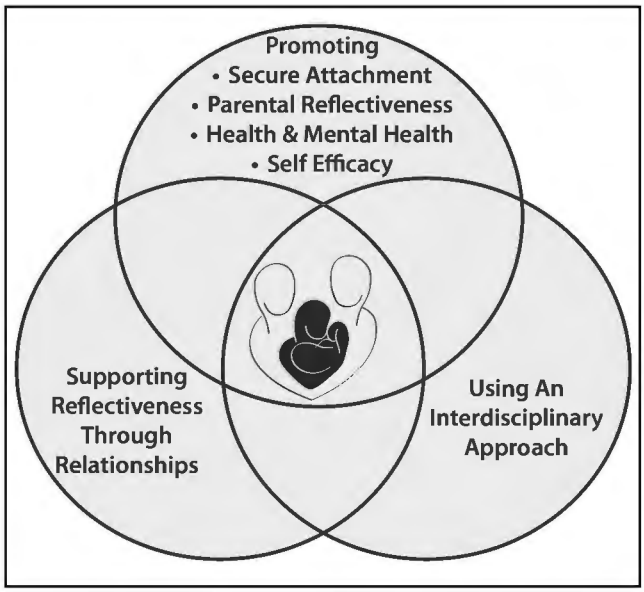
The model

MTB is an interdisciplinary, relationship-based home visiting intervention that aims to promote positive health, attachment, mental health, and life course outcomes in infants, mothers, and their families. As we will elaborate throughout this manual, MTB is unique in two primary ways. First, it is interdisciplinary. Each family is seen by a team that includes a nurse and a licensed social worker[1]; while each member of the team provides a particular kind of care, they share a series of principles, goals, and techniques, and work in a layered, highly reciprocal way throughout the intervention (See Chapter 6). MTB is also unique in its emphasis on the role of parental reflective functioning (RF) or mentalization (Slade, 2002, 2005, 2006) in facilitating the development of a range of positive outcomes (See Chapter 3).

[1] The intervention is typically delivered by nurses with at least one year of pediatric or family experience, or equivalent combination of experience and education. Likewise, the mental health component of the program can be delivered by a social worker, psychologist, or other professional with training appropriate to this role.



MTB services begin when mothers are pregnant for the first time, and continue until the child turns two. Clinicians alternate visits on a weekly basis until the child turns one. After the child turns one, clinicians alternate visits on a biweekly basis until the child is two. This alternating pattern of nurse and social worker visits allows us to continuously monitor and respond flexibly to the complex needs of the child, the parent, and the extended family. We believe that positive health and mental health outcomes, secure attachment, parental reflectiveness, and maternal self-efficacy are made possible by the relationship formed with the nurse and the social worker over the course of the intervention, both of whom endeavor to maintain a reflective stance in all aspects of their work.



The population

The individuals who are served by this intervention can be considered "at-risk" for many different reasons. They may suffer the many ills coincident with social and economic disadvantage. Many of the mothers are young, without stable and supportive partners, and often without adequate family, social, and community support. In addition, trauma exposure is common in our families (See Chapter 4). Many mothers and fathers experienced sexual or physical abuse in childhood, or were neglected in a variety of ways. Some of the parents were themselves placed in foster care during their own childhoods; others find themselves in

abusive relationships, and suffer ongoing relationship violence. Finally, the effects of substance use and crimes related to substance use affect parents at the individual, family, and community level.

Theoretical Underpinnings

The success of any home visitation program depends upon the articulation of a strong theoretical core that unifies and drives the intervention (Olds, Kitzman, Cole, & Robinson, 1997; Olds, Sadler, & Kitzman, 2007). The MTB intervention is grounded in attachment, mentalization, social ecology, and self-efficacy theories. We will briefly review these and provide several key references as resources describing each more fully.

Attachment theory

The basic premise of attachment theory is that the child's early relationships with caregivers powerfully affect a range of developmental, health, social, interpersonal, and cognitive outcomes (Sroufe, Egeland, Carlson, & Collins, 2005). While temperamental, genetic, and community factors also play a role in whether development proceeds smoothly and fully, attachment theory focuses on the influence of the parent-child relationship, particularly the degree to which the child both feels secure in the parent's availability at times of threat or need, and supported in his autonomous explorations of the world. Children who feel that they can safely seek comfort when in need, and that the range of their feelings (joy, sadness, anger, and fear), and their interests (curiosity, exploration) can be recognized and responded to by the caregiver are those most likely to be secure in relation to attachment. By contrast, those who feel unsure of their parent's emotional availability – either because the parent ignores or rejects the child's needs, or becomes activated and inconsistently responsive – are likely to become insecurely attached. That is, they will be classified in the Strange Situation Procedure (Ainsworth, Blehar, Waters, & Wall, 1978) as either avoidant or resistant in relation to attachment. Children who are avoidant tend to favor autonomy over the expression of their needs and emotions, whereas resistant children tend to maintain closeness at the expense of autonomy. These are considered *organized* insecure strategies. Some parents appear to be frightened by or frightening to the child in their efforts to gain proximity and comfort (Main & Hesse, 1990; Lyons-Ruth, Bronfman & Parsons, 1999; Lyons-Ruth & Jacobvitz, 2016). These responses leave the child in a state of "fright without solution", as their source of comfort (the parent) is also a source of alarm (Main & Hesse, 1990), and lead to the behavioral disorganization, confusion, and disorientation that are the signs of *disorganized* attachment (Main & Solomon, 1990). Both parental histories of loss and trauma (Lyons-Ruth, Yellin, Melnick, & Atwood, 2005; Main & Hesse, 1990) and socioeconomic risk (Cyr, Euser, Bakermans-Kranenburg, & van IJzendoorn, 2010) have been linked to disorganized attachment. The trauma histories and socioeconomic risk status of parents in MTB put their children at high risk for disorganized attachment. The sequelae of disorganized attachment are considerable in terms of long term social, emotional, and relational development (Carlson, 1998; Lyons-Ruth & Jacobvitz, 2016).

Additional resources: Carlson & Sroufe, 1995; Cassidy & Shaver, 2016; Karen, 1998; Holmes & Slade, 2018; Slade & Holmes, 2013; Sroufe, Egeland, Carlson, & Collins, 2005

Mentalization or reflective functioning theory

What leads some mothers to behave sensitively, and others to respond insensitively? How does trauma shape their responses? Fonagy and his colleagues (Fonagy, Steele, Steele, Leigh, Kennedy, Mattoon, & Target, 1995; Fonagy & Target, 1997) suggested parents differ in their capacity *to*

envision/imagine/recognize/reflect upon the child's desires, beliefs, intentions, thoughts, and feelings. Parents who see their child's behavior in light of these feelings and thoughts (He's hitting me because he's mad at me) are more likely to respond sensitively than are parents who respond only to behavior (He's hitting me because he's bad and he just has to stop.) In other words, parents *behave* differently, i.e., more or less sensitively, because they vary in the ability to make sense of the child, to understand what, in essence, makes him tick. Fonagy and his colleagues refer to the psychological processes involved in making sense of one's own or another's thoughts and feelings as *mentalization*, and the manifestation of mentalizing processes in an adult's conscious thoughts and narratives as *reflective functioning* (or RF). **We use these terms interchangeably in this manual.**

Parental RF has been defined as the parent's capacity to "keep the baby in mind," to make sense of the baby's internal states, emotions, thoughts, and intentions, as well as his/her own (Slade, 2002, 2005). Reflective functioning allows the parent to regulate the baby's states of arousal and affective experience, and is at the heart of her/his ability to insure the child's physical health and safety, setting the stage for the development of secure, reciprocal, and flexible attachment relationships.

It is much harder for a parent to be reflective when s/he has had traumatic or disrupted early relationships with their primary caregivers. These assaults interfere with the development of reflective capacities, and lead to chronically dysregulated and disrupted development. As a result, mothers have difficulty regulating their own needs as well as those of their children, and are often overwhelmed by the physical and emotional demands of parenthood. It is for this reason that the enhancement of reflective functioning in this population seems especially crucial.

Additional resources: Fonagy, Steele, Steele, Leigh, Kennedy, Mattoon, & Target, 1995; Fonagy & Target, 1997; Allen, Fonagy, & Bateman, 2008; Slade, 2002, 2005, 2006

Social ecology theory

Social ecology models help to explain the multiple layers of influence that individuals and families experience in living their daily lives. In particular, social ecology helps us to remember the many complex relationships and forces that affect the health and development of our young parents and children. Each parent-child dyad lives within a dynamic set of nested systems that include family and partner relationships, as well as work, school, peer, and neighborhood contexts, all of which reside within a larger set of contexts that include community characteristics, local, state, and national agencies and overarching social and cultural influences (Bronfenbrenner, 1994). Within this framework, it is important to note that for individuals and parent-child dyads, proximal processes (e.g., the influences and interactions that take place within the household or immediate family) are usually more powerful than more distal processes (e.g., programs that are part of the larger community or region) (Tudge, et al., 2009).

This framework helps home visitors to understand the many competing demands that young parents often face as well as the relative influence of family members versus outsiders in developing or changing attitudes or behaviors. For example, there may be many compelling reasons that parents choose to cancel a home visit in favor of family obligations or responding to a neighborhood crisis. Conversely, as home visitors become truly engaged with a young mother and are seen as trusted helpers, their scope of influence on the young family may indeed increase. Thus, from the perspective of this framework, enhancing early attachment relationships must be accomplished at both the individual and contextual level, at the level of

singular relationships and at the broad level of relationships to the family and community. Without attention to these diverse levels of influence, change is impossible.

Additional resources: Bronfenbrenner, 1994; Bronfenbrenner & Evans, 2000; Tudge, Mokrova, Hatfield & Karnik, 2009; http://www.cdc.gov/ViolencePrevention/overview/social-ecologicalmodel.html

Self efficacy theory

Self efficacy theory describes the ways in which individuals think about or believe in their ability to make things happen in their lives; to assume agency or mastery over what happens to them (Bandura, 2000). This theory provides a useful framework to organize the ways in which MTB helps young mothers to understand the reasoning, learn the skills, and learn the specific parenting and self-care attitudes and behaviors important for promoting good health and well-being in both generations (parent and child). Home visitors provide much information to young families, and also serve as role models for self efficacy, especially related to health care and parental competence and confidence.

Skills and tasks (e.g., making appointments for health visits; planning for contraception before a pregnancy scare crisis) are presented, modeled, discussed, and often rehearsed between home visitor and parent. The program aims for mothers to be able to – with practice over time – gain in their sense of confidence and self efficacy as they are able to accomplish more and more of these daily life tasks and parenting competencies with less input from home visitors. By graduation, we hope parents will feel that they can manage their life responsibilities and tasks independently or be able to identify how to find help when it's needed.

Additional resources: Bandura, 2000; Olds, Kitzman, Cole & Robinson, 1997

CHAPTER TWO: KEY ELEMENTS OF THE MTB MODEL

Introduction

There are many elements of the MTB model. In this chapter, we will address the following: MTB is a *relationship-based, interdisciplinary program, implemented during the transition to parenthood. It is typically implemented in partnership with community care providers, and delivered in a flexible and intensive fashion, guided by parental competencies and limitations and committed to culturally sensitive practice*. Finally, MTB is *mentalization-based and trauma-informed*: the core principles of MTB's reflective parenting approach are described in Chapter 3, and our approach to trauma in Chapter 4.

Relationship-based

We see the development of the relationship between home visitors and the mother, father, baby, and other family members as key to the success of the intervention. From the earliest contact, home visitors approach parents with an eye to forming a relationship; that is, with compassion, curiosity, warmth, and openness. The parent-clinician relationship serves as the bedrock for both interdisciplinary and reflective practice. In addition to being a primary agent of change, the relationship between the clinician and the parent serves as a model for the developing parent-child relationship, one in which there is trust, respect, and curiosity on both sides.

Relationship building begins from the very first day of contact with the family. Because their life experiences have often led them to avoid closeness and healthy dependency and made them unwilling to trust others or turn to them for help, many of the young women recruited for MTB have a good deal of difficulty establishing positive close relationships. This means that the MTB team may have to work especially hard and very consistently to establish trust and develop open communication. This is often an ongoing struggle that requires skill, patience, and sensitivity on the part of the home visitor.

When the relationship falters, which can stem either from something that triggers the mother, something that the clinician has said or done, or other external factors (such as living with dysfunctional family members, having low income jobs with shifting work schedules, etc.), restoring it is the place to begin. With some families, clinicians must return to this point many times. Whatever the challenges in providing layered care and concern, the ability of the home visitor to maintain the relationship, to repair ruptures, and to remain available even through periods of significant disruption (i.e., mother "disappears") is absolutely crucial. Even the most relationally adept of home visitors need the ongoing and crucial support of team members and supervisors to manage the multiple layers of system failure, chaos, upheaval, and disruption that are far too typical for many of our families (See Chapter 9).

This brings up the crucial issue of *rupture and repair*. Ruptures are inevitable in any relationship, and the same is true for the clinician-parent relationship. The clinician may misunderstand something the parent has told her, may miss an important communication, get exasperated, or disappoint the mother. More significantly, she may have to report the mother to child protective services, or take some action that is very distressing to the mother. Ruptures can come from the parent's side as well. She can disappear, refuse a visit, shut out the home visitor's concerns. *All of these provide opportunities for repair*. That is, we can't prevent ruptures, but we repair them. We can return to a disappointing moment and discuss it, we can apologize for being short-tempered, we can take a step back and acknowledge that we went too far. Even when we gravely threaten the mother (as in a child protection referral) we can be present to process this with her, reassuring her of our underlying concern.

In MTB there are, of course, two clinicians, and thus two mother-clinician relationships, two baby-clinician relationships, and two mother-baby-clinician relationships. We see the demands of managing these various different but overlapping supportive relationships as providing a level of developmental and relational *complexity* that is both beneficial and growth-promoting to mothers.

A range of other relationships must be nurtured as well: those with community partners, including care providers, support staff, and administrators, those with the broader community of educators, social service providers, and child protection workers interacting with the family. The relationship between the clinicians and their supervisors is also critical, for it is these relationships that allow the clinician the "secure base" she needs to fully engage with the work. These relationships (see Chapter 9) sustain and nurture the clinicians and protect them – at least to some extent – from the emotionally eroding and painful aspects of the work.

Interdisciplinary

An interdisciplinary model is crucial to meeting the complex needs facing our families. Nurses often the most ready access to families, who can be suspicious of mental health workers in general, and social workers in particular. In addition, nurses are able to provide a level of care and knowledge that young, first-time parents needed. Social workers provide other levels of desperately needed 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. In addition, there is usually tremendous overlap between health and mental health concerns: few mothers have health care problems without emotional distress, and toxic stress and trauma leave a long shadow on the body and on an individual's capacity for self-care. Even public health outcomes as "simple" as breastfeeding, contraception, and subsequent childbearing patterns are entirely bound up in a mother's feelings about herself, her body, and her sense of autonomy and self efficacy. Thus, we try to insure a true integration of the two disciplines by providing joint training and supervision, and by the continuous sharing of information and insight between team members.

There is today a great deal of research that makes clear the close relationship between physical and mental health. The best example is Anda and Fellitti's Adverse Childhood Experiences Study (Felitti et al., 1998), which documented that adverse childhood experiences, (childhood abuse, neglect, family dysfunction), are strongly associated with a number of negative health and mental health outcomes in a sample of 17,000 adults. (For more information about the study, and links to numerous related publications, see https://acestoohigh.com.) The ACES findings also provide powerful support for the stress regulation model (Shoukoff, 2012) which suggests that severe and ongoing traumatic or toxic stress has long term negative effects on a number of systems in the body and in the brain.

Caring and sensitive parenting can significantly buffer the effects of toxic stress. Some children, despite having suffered an accumulation of ACEs, have had parents (or other caregivers) who are able to provide a safe nurturing environment, and maintain stable family relationships, which together help the child feel loved and protected. Additional – more distal – protective factors include parental employment, stable housing, and access to health care (Garner, 2013). Thus, the MTB interdisciplinary team works to promote resilience by helping parents maintain physical and emotional wellness in themselves and their children.

Transition to parenthood

MTB is implemented during the "transition to parenthood", a sensitive period for the rapid physical, neuroendocrine, neurobiological, emotional, and social reorganization that readies the "parental brain" (Feldman, 2015) for its work ensuring the child's literal survival and their entry into the human, social world (See Slade & Sadler, 2018 for a review). This includes the activation of both neuroendocrine (and specifically oxytocin) systems that ensure attachment and bonding and regulate stress (Feldman, 2015; Toepfer et al., 2017), and dopaminergic reward centers in the brain that insure pleasure in the early mother-child relationship (Strathearn, Montague, D'Amico, & Fonagy, 2009). Both maternal early life stress (ELS) and stress during the prenatal period itself (acute environmental or internal stressors) affect "fetal development as well as the quality of postnatal dyadic mother-child interactions" (Toepfer, et al., 2017).

These multiple biological and environmental processes dramatically impact the pregnant woman's ability to imagine, represent, and ultimately develop a relationship with her soon to be born child. The father too is undergoing enormous psychological changes as he prepares for parenthood. During pregnancy, MTB practitioners aim to provide resources (i.e., health information about pregnancy, the delivery, and infant development) that can help to alleviate some of the sources of prenatal stress in both parents. They also work with the mother-to-be, the father-to-be and other immediate family members to address other potential sources of distress, dysregulation, and ongoing trauma. They work to bring the baby alive for the mother and father in a variety of ways, from imagining the infant in utero, anticipating the delivery, to planning for life after the baby is born, focusing both on their capacity to reflect on the infant's internal experience, and to develop positive representations.

Embedded in Community Agencies

MTB is not an "independent" program, but one sanctioned and even encouraged by the health, mental health, and social service providers working in community settings. Every single community partnership is a *relationship* that must be nurtured, and must be mutually beneficial and respectful if it is to sustain complex demands and system pressures. Each new site has required adaptation and adjustment on all sides. This is not to say the model itself has changed, but details of how families are approached, how records are obtained, and how information is conveyed across professions differ from site to site. It is hard to overemphasize how crucial these processes of building and sustaining relationships are if community partnerships are to flourish and thrive. In most implementations, the program is completely voluntary. In those settings where the program is mandated or less than fully voluntary, the relationship between the families and the care providers is more complex.

Flexible and Intensive Service Delivery

While MTB has specific aims, and is based on a developmental model, with a number of distinct stages and intervention procedures, the program itself is best implemented in a flexible, individualized way, responsive to the needs of individual parents, babies, and families. Thus, while this manual presents a number of frameworks to think about the program, each of these frameworks is interpreted by the clinicians in the way that makes clinical sense to them and their partner within the context of the individual family. There is no prescription for each session, or each stage of the intervention, but rather a set of goals and strategies and principles that guide each home visit. This permits clinicians to focus on the things they feel are most important, but within the context of a set of overarching aims and goals.

In MTB, we are flexible abont where visits are condncted. Visits can be schednled at the clinic, at a relative's home, at the local library, or even in a local park if the weather permits. Contact is the important thing. Visits may on occasion be qnite long and intensive (in the case of an emergency, for example), or – if the mother is only willing to have brief contact – visits may need to be short and focnsed. Sometimes mothers "disappear" for a while, often, for example, right after the birth of the baby, when their families have gathered around to offer support. Sometimes they are too overwhelmed to make use of us after the birth. They may disappear for emotional reasons. At times, mothers need more visits from the nurse or social worker. They may not be ready to "transition" to biweekly visits when the baby is one year, or to graduate at two years. While we try to stay as close as possible to the MTB timetable, we also try to remain responsive to the individual needs of each family. To the degree that it is possible, we try to maintain contact and keep in touch in whatever way is possible, paving the way to a return to the normal "dosage." When families choose to leave the program before their second birthday, we try to discuss all options with them, and support whatever decision they ultimately make. In any case, we don't give up on them. We do not terminate a family unless the parent states that she wants to withdraw from the program.

Guided by Parental Competencies and Limitations

No program is right for everyone, and certainly our families vary greatly in their level of cognitive, social, and emotional competency. It is not uncommon for some of our mothers to be limited cognitively, or severely learning disabled (although if there are severe intellectual limitations, MTB may not be a good "fit" for mothers). We tailor the program in whatever way is necessary to provide the level of service they need, while at the same time enconraging their antonomy and development. Likewise, we have mothers who are very bright and ambitions, and who take on many responsibilities within their families. We tailor onr services to them, too, trying to provide them opportnnity and snpport for their development.

Culturally Sensitive Practice

The cnltnre, class, and racial differences that often exist between a home visitor and the family she is serving pose a particnlar set of challenges. The development of a therapentic relationship depends npon these being handled with sensitivity and care. Awareness of, cnriosity abont, and respect for cnltnral differences in the experience of family, the expression of emotion, the comfort with strangers, and the willingness to be vnlnerable is a critical part of the home visitor's work. For instance, in some cnltnres it wonld be considered an insnlt to refnse a mother's offer of a cnp of coffee and cookies. In others, certain kinds of inqniries are experienced as intrnsive and improper. Thns, it is important to enlist the mothers in teaching the home visitors about their culture

CHAPTER THREE:
WHAT IT MEANS TO BE A MENTALIZATION-BASED, REFLECTIVE PARENTING PROGRAM

Introduction

One of MTB's primary aims is to enhance a mother's capacity to mentalize, or reflect upon the baby's experience, and thus appreciate that the child has thoughts, feelings, desires, and intentions that are different from her own. We also aim to help parents be able to describe *their own* thoughts and feelings, and to soften the defenses that protect them from strong and unmanageable emotions. Therapeutic relationships with the nurse and social worker make possible moments of exploration and contemplation, and provide a reflective space for the mother so that she can eventually begin to wonder about and make sense of her baby, first with the clinician's help and eventually on her own.

To this end, both clinicians endeavor to work – as much as possible – in an "RF way". RF work is not a "separate" part of this work; it provides an approach that frames all of what we do: drafting a labor plan, resolving a housing crisis, or responding to a mother's depression. It is a process we engage in as much as we can throughout the work, not something we assess as an outcome or that we try to "change", per se. Here are some basic assumptions of what it means to work in an "RF way" (see too Allen, 2012; Allen, Fonagy, & Bateman, 2008; Bateman & Fonagy, 2004, 2006; Fearon, Target, Sargent, Williams, McGregor, Bleiberg, & Fonagy, 2006; Holmes & Slade, 2018).

Working in an "RF way"

When we meet parents, they do not typically have the words or even a framework to make sense of their thoughts and feelings; rather, they are at the mercy of feelings and thoughts they cannot recognize or regulate. Thus, we would describe most of the parents we see as having low or even quite low RF when they begin the program. This can be manifest in a number of ways: they can be emotionally inaccessible and shut down, prone to episodes of dysregulation and impulsivity, or they can seem dissociated and emotionally disorganized. In many of the families we see, open emotional expression and self-reflection are rare, and indeed strong emotions are threatening and thus must be denied, dissociated, projected, or expressed in action.

MTB aims to provide a context for reflecting on thoughts and feelings. This requires that clinicians maintain a *reflective or mentalizing stance.* A reflective stance is one that acknowledges that unrecognized or unnamed thoughts and feelings underlie behavior. In effect, we do not take behaviors *at face value* (mother is manipulative and aggressive) or *try to change them*; instead, we approach problematic behavior as indicative of underlying feelings and thoughts that we have to *discover*. Discovering and naming thoughts and feelings is key to modulating them and ultimately changing behavior. Thus, for example, just as we would hope that mothers might respond to their child's tantrumming by first wondering "What might be going on? What's got him so upset?", we respond to parents' difficulties by wondering the same thing. MTB parents can only begin to consider their feelings and thoughts when they feel safe, and understood.

This process evolves over a long period of time; in some instances, very little progress is possible. The development of RF is buttressed by both a caring relationship, and ongoing concrete support. With these supports in place, we can begin to imagine what emotions and thoughts might underlie a parent's defenses, and what their childhood emotional experiences might have been. Based on what we know about her and

her history, we try to imagine what the mother might be thinking and feeling and try to put it in language that she can understand. We put ourselves in her shoes. Likewise, based on what we know about the infant and his history, we try to imagine what the infant/toddler might be thinking and feeling and try to put it in language that she can understand. We can then begin to imagine and perhaps frame for the parent what s/he can't. We offer these imaginings tentatively, speculatively; this is our way of giving voice to what the parent cannot. This serves to make some of their experience understandable and coherent, even if they are only listening.

"Wondering" or being curious about a parent's internal experience does not necessarily mean that we ask her what she is feeling; this can feel violating or shameful. It has been adaptive for them for them to shut others out, and defenses against sharing internal experiences are safety mechanisms. So, we try to be cautious in our inquiries about thoughts and feelings, if we inquire at all. We want to soften, not inflame, defenses (like avoidance, denial, aggressiveness, panic, etc.) There is a time for wondering out loud, but at first we try to be emotionally present and *internally* wondering. When we feel they can hear it, or perhaps even when they can't, we can begin to wonder out loud, and offer our hypotheses about the causes of their distress or maladaptive behavior. Feeling understood rather than invalidated and criticized will help parents feel safe. Even so, they may see clinicians as threatening and intrusive, and their defenses may be readily activated. We wonder in ways that are speculative and open to modification, and we watch for small incremental changes in their openness to having even brief discussions about their thoughts and feelings. We keep it simple and grounded in observations of behavior.

It is often necessary for the home visitor to focus on the mother's experience first, even at the expense of the child's, in order to create the space for the mother to wonder about her child. For her to attend to the baby and become aware of and curious about his experience, the mother must herself be held and nurtured by her relationship with the home visitor. This may require the home visitor to set aside her concerns about the baby while she attends to Mom, with the ultimate intention of helping the mother quiet down enough to make room for the baby.

If the home visitor skips the step of keeping the mother in mind, and turns directly to the child (perhaps out of her own concern or anxiety), she has not nurtured the mother's capacities to keep the baby in mind, but has taken over her role for her (in some instances, of course, this may be absolutely necessary). What we are ultimately trying to do is to create enough safety for the mother that she can listen to her baby (Close, 2001). One of our favorite sayings is Sally Provence's reminder: "Don't just *do* something. Stand there and pay attention. Your child is trying to tell you something!" When mothers can pay attention, and listen, the child will flourish.

A few caveats:

- Try to think of reflection not as an *outcome* (i.e. something mother must do), but a *process* that *the clinician* takes the lead in. If the clinician can remain reflective, hopefully the parent will eventually follow. Don't worry about evaluating or improving a mother's reflectiveness. Instead, try to stay reflective yourself.
- Try to use non-threatening, basic observations of a mother's emotional state; imagine what it might be like to be her or the baby and put that in the simplest language for her; always take this stance that your hypothesis is just that: a hypothesis (not a certainty). "I wonder if it feels kind of scary to think about doing this all on your own." "I could be wrong, but did that make you kind of angry?"

- YOU are the one putting words to her experience; if she could, she would. Try to avoid asking her to do what she probably can't. That is, if mother is having trouble describing her feelings, do not press her to. Offer gentle suggestions instead. When she can name her feelings, applaud it!

Strategies for Enhancing RF

Listed below are some of the basic strategies of a reflective clinician.

Build the relationship:

1. Support, be empathic, reassure
2. Highlight and praise competencies (in RF and others areas)
3. Highlight mother's and baby's connection

Maintain a reflective stance:

1. Model and encourage curiosity and wondering ("not-knowing") about own and others feelings or thoughts
2. Use "what if?" stance—encourage family members to play with new ideas
3. Validate mother's experience before offering alternatives
4. Generate multiple perspectives—what else could be going on?
5. Use humor judiciously; be playful when it feels right
6. Ask moms to clarify and elaborate; gently challenge them when useful
7. Link feelings to behavior in mother and in child
8. Reflect the mother's feelings back to her; work to identify and label hidden feeling states
9. Speak for the mother—sometimes mothers have limited feeling vocabulary or little practice putting their own feelings into words
10. Speak for the baby—verbalize baby's perspective, talk to the baby, describe baby's world and experience to the dyad
11. Stay in the moment—Stop, listen, look, stop, rewind, explore

Using your own experience:

1. Know yourself - pay attention to your own reactions and feelings
2. Make use of yourself as a clinician, your own feelings, and your experience
3. Share your feelings when therapeutically useful
4. Acknowledge when, as clinician, you do not know what to say or do
5. Acknowledge mistakes when they arise; pay attention to ruptures in the relationship
6. If overwhelmed with affect or content, step to the surface; put your feelings and thoughts into words

Self assessment

Working reflectively can be very difficult, as the pull to *doing* can be so powerful. Home visitors must master the "dance of reflecting and directing", finding the right balance over and over again. One of the ways to help home visitors remain reflective is to encourage routine self-assessment, using the following guidelines, which are adapted from Allen, et al (2008).

At all times:

I take a stance of not knowing what the mother's or the baby's experience is, and I am interested in finding out.

Example: "Tell me more. I'd like to understand what that was like for you and what you were thinking."

I ask questions to promote exploration and clarity, rather than taking answers at face value or not following up or assuming I understand.

Example: "How do you understand it when she cries and falls to the floor? How do you understand that behavior?"

I encourage curiosity.

Example: "What do you think he made of that big crash?"

I validate the mother's experience before I offer alternative perspectives or reframing.

Example: "Wow! It sounds like reading her comments on FaceBook made you furious."

I always try to keep the baby in mind, even if s/he never enters our conversation in a given session. When I can, I try to bring the baby into the conversation. When I can't, I respect the fact that, for the moment, the mother needs my undivided attention.

I highlight and praise competencies in reflection and other areas.

Example: "You really figured out what she needed and now I see her smiling and relaxed!"

I help the mother to imagine "What if?"

Example: "What if you brought him with you into the kitchen while you're cooking?

I ask the mother how she understands the motivations of her child, or her family members.

Example: "Why do you think she did that? What do you think she's feeling when she does that?"

When I can, I try to speak for the mother, putting a complicated experience into words.

Example: "So when your mother said the baby was crying because he was hungry, and your Aunt went to buy formula, it sounds like you were worried about your milk supply, and the baby not eating, and things were happening so fast it was hard to think about what the baby really needed right then."

I try to speak for the baby if the mother makes misattributions or isn't engaged, or when I am observing behaviors.

Example: "Oh mommy, I'm crying so hard because you left the room and I didn't know where you went!"

I try to elaborate in moments when mother can consider alternative perspectives.

Example: "Ah… It seems as though you were wondering if his cry meant he really was hungry or did it mean that he was trying to tell you something else. What else did you think the crying meant right then?"

I reflect mom's feelings back to her in a modified form, i.e., in a regulated, contained, and organized way.

Example: "The baby's crying can be so hard to handle! That cry just gets to you and you get worried, frustrated, and upset all at the same time. It's hard to know what to do when you have so many feelings at one time."

I frequently highlight mother's and baby's bond.

Example: "Look! He is really looking into your eyes. When you look back at him he seems so loving and peaceful!"

I use humor judiciously and I try to be playful when it feels right.

When mothers are resistant or negative:

When a mother can only see things in one way, or in a negative way, I try to generate multiple perspectives.

Example: "Can you imagine other reasons why she cries so hard?"

I try to re-frame the mother's perceptions of the baby or of herself.

Example: "Do you suppose we can think about that in a different way? I wonder, when he makes that face and he looks like he is mad, I wonder if he is actually feeling sad."

I gently challenge a mother's beliefs about me or herself or others.

Example: "In your experience with other social workers it seemed they just wanted to be in your business. Are you wondering if I will be the same way?"

I stay in the moment and with the mother's current thoughts and feelings.

Example: "You seem really angry." "That sounds like it feels really scary to you."

I stay away from complex explanations for her and her child's feelings. I tend not to bring up her past history as an explanation for her current reaction.

*Example: I **avoid** saying things like, "Oh, the reason you are feeling so mad at your child is because your Mom used to feel mad at you."*

When a mother is seeing things in black or white and with absolute certainty, I do not confront her but use techniques like exploration, considering alternatives together, and attending to current emotions.

Example: Mother says, "My sister is a brat. She always gets what she wants and I hate her." I reply, "How does that happen? How does your sister get what she wants?"

During an emotional outburst, I maintain our dialogue, and I don't comment on the reasons behind the outburst. I try to clarify what the mother is feeling without interpretation.

I only consider underlying causes when mother is no longer acutely upset.

I try to identify triggers in recent interpersonal experience, including interactions with me.

When things get too "hot," I try to stop, look, listen, rewind, explore.

Example: "You just got so upset…can we stop a minute and think about what happened there?"

In supporting myself as a clinician to pay attention to my own experience:

I pay attention to my own reactions and feelings, especially when I am upset during a home visit.

I pay attention to ruptures in my interaction with the mother and try to sort out, from both of our sides, what led to the rupture.

Example: "Perhaps you were trying to tell me that you didn't want to talk about that issue anymore, and I wasn't understanding what you were telling me."

I use my own experience in the home visit to help me imagine what the mother or baby might be feeling.

I share my feelings when it is therapeutically useful.

Example: "I'm worried about you. If you decide to go beat up that girl who made you so angry you could get hurt, or arrested, or even go to jail."

I acknowledge when I do not know what to say or do.

When I feel overwhelmed by affect or content I put my feelings and thoughts into words.

Example: "This is really hard to talk about. It brings up so many feelings. Let's take a breath and talk about what would help you feel supported.")

Some of the Challenges of Working in an "RF Way"

There are a number of intense and recurrent challenges inherent in working with individuals who have difficulty mentalizing, or – as is often the case – are prone to being reactive, impulsive, and out of touch with their emotional life. These defenses have been essential to emotional survival for the parent.

Thus, survival mechanisms are not going to yield quickly or easily, and in fact clinical progress often means that they shift just a little. We often remind clinicians to "cherish small shifts" because while parents may graduate from the program as only fleetingly able to name feelings and contain their behavior, these are enormous steps forward for their own and their babies' development.

One of the concepts that is useful in thinking about what can so easily happen clinically is what Fonagy and his colleagues call "cycles of non-mentalizing interactions" (Fearon et al., 2006).

An example of a mother-child non-mentalizing interaction

The mother is trying to get her toddler to go to bed. He wants more contact, and after fussing for a while gets out of bed and comes back out to the mother. In that moment, she experiences an intense emotion, "I need some time for myself after a long day with two jobs, no support, and I do not want to see you at all!"

When her son comes into the room, she gets angry, cannot imagine why he might be up again, and what he might need in this moment. She reacts instantly and without reflection (i.e., she does not think, "He hasn't seen me all day, maybe he just needs a little more attention, maybe I put him down too quickly because I'm so exhausted and I need to stay with him a little bit and soothe him, etc.") and shouts at him to get back into bed. She may move toward him sternly and demand that he leave the room. She may grab him forcefully. The child, whose wish for contact has been unrecognized (and in fact denied) now likely feels a series of powerful emotions himself: fear (she is threatening him), anger, sadness, etc. And he likely feels out of control.

As a result, he is compelled to action, and drops to the floor screaming. He is (as a toddler) not thinking about his mother's need for a little down time, and his efforts to control the mother through his behavior leads to a further escalation and to a coercive, distressing, and frightening interaction. It is easy to imagine that both mother and child are highly dysregulated and aroused by now. Sleep for the child and peaceful solitude for the mother are now quite impossible.

One of our main goals clinically is to short circuit the move from powerful emotion to coercive interaction, to encourage parents, in that highly aroused moment, to wonder "What does he need? How can I get him back into bed and settled down and get myself the down/alone time that I need?" In other words, what is he trying to tell her?

We also find the concept of non-mentalizing interactions to be highly relevant to the mother-clinician interaction.

An example of mother-clinician non-mentalizing interaction

The clinician (either the nurse or the social worker) and mother having a discussion about the mother's return to a violent boyfriend. The mother has just told the clinician that she spent the weekend with the boyfriend and brought the child along. This despite the fact that there has been intervention by the authorities and a requirement that the mother keep the child away from the father. In that moment, the clinician is likely going to feel both frustration and fear, for the mother and child, and concern about the legal ramifications should this become known to child protective services.

The clinician herself is a mandated reporter and she has to consider whether this incident is reportable. She has reviewed this so many times with the mother. And now the mother is back with the boyfriend. At that moment, the clinician may (as clinicians are human!) start reminding the mother how dangerous this is, tell her she's done a risky thing, used bad judgment, put her baby at risk, etc. All of this may in fact be true. The mother, hearing the clinician's tone, has already stopped listening. She feels coerced and judged, and begins to shut down. The opportunity to get her to wonder about what it is that draws her back into the relationship, and to wonder about the impact of this relationship on the baby, is lost. In her (totally understandable) anxiety, the clinician has lost sight of what is likely very true for the mother: she is attached to this man, probably for all sorts of unfortunate reasons, but she is attached.

This too is a non-mentalizing interaction, with both parties trying (implicitly if not explicitly) to control and coerce the other: the clinician is trying to get the mother to "see the light" and the mother is trying to push the clinician's as well as her own concerns for her and the baby's safety out of her mind. A rupture ensues in the clinical relationship.

As will be described more fully below, there are a number of techniques that can be used to help a mother reflect on her life choices *without* taking a stance that makes Mom feel lectured to, judged, controlled, or puts her in conflict with her partner's wishes and demands. The clinician wants to give her the space to see all the options and to explore her own wishes and needs.

Many times parents' urgent problems make us feel that we must fix things. Other times we feel that we must respond to their demands, even if these are distinctly anti-reflective (i.e., we are responding to and thus reinforcing their impulses). While there are of course many times when urgent situations must be addressed, and we must respond to mother's demands, it is so important not to abandon a reflective stance, even when we are doing something very practical.

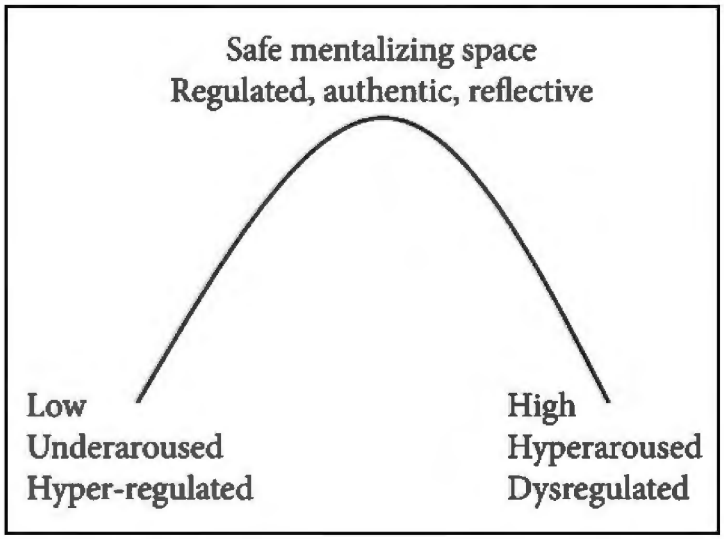
To alter Sally Provence's words just a little: "Don't just *do* something. Stand there and pay attention. The *mother/father* is trying to tell you something." That is, we try (and it is often very difficult) to remain attuned to what might be going on for parents, what they are being triggered by, and whether the triggers are in their childhood or the immediate present. When we fail to keep the parent's mind in mind at these moments, but instead respond to their impulses (and our own), we may well repeat and even reinforce maladaptive patterns of relationship and interaction.

Mentalization and Threat

The capacity to reflect is most helpful in moments of strong emotion. It allows some distance, perspective, and helps in regulation. Thus, in the example above, if the mother can keep her child's needs in mind even when she is annoyed and overwhelmed, she will likely be able to stay reasonably regulated and not escalate the situation. And he will feel understood. Yet, moments of strong emotion, and in particular moments when traumatic experiences are triggered, are those in which it is most difficult to mentalize.

For mothers who have difficulty reflecting in moments of strong emotion, who feel the threat of anger, sadness, and other potentially traumatic triggers, defenses are activated quickly. Thus, a mother will shut down and become emotionally distant and lose sight both of her own mind and the mind of the other (deactivated), become activated and emotional (hyperactivated), or disorganized and potentially frightening or dissociated. These defenses are understandable safety operations that are readily activated by threat. Reflection provides the mother with another way to regulate threat. It is for this reason that it is particularly important to remain attuned to evidence that the parent is feeling threatened and defended, and to try to stay as close as possible to the parent's experience in these moments.

As noted above, the only way parents are going to develop the capacity to reflect in a difficult moment, rather than react, is first if they feel they can trust us to provide a safe context for difficult feelings, that we can hear these feelings, name them, and tolerate them. They must also trust that we will not react by becoming threatening ourselves: judging them, fearing them, wanting to control them, at which point we become triggers, too. But of course many elements of the work can be highly activating and threatening for clinicians too: fear for a parent's safety, for a baby's safety, for a mother's health or a baby's health. Clinicians can also feel threatened when parents defy them, or fail to change in the ways clinicians wish they would or feel they should. When a clinician is threatened, she too can become defensive, controlling, focussed on teaching or "doing", or non-reflective. When both the clinician and the parent are threatened, ruptures are inevitable. What is most important is that the clinician realize and acknowledge when she has been activated, and to step back and try to re-establish her own reflectiveness.



What we are striving for (and what can often be so difficult to achieve) is for the parent to stay, as much as possible, in a reflective space, where she can experience her feelings, but at the same time think about and regulate them, in a playful, authentic way.

CHAPTER FOUR:
WHAT IT MEANS TO BE A TRAUMA-INFORMED PROGRAM

Trauma and MTB

Trauma exposure

Many of the families we see in MTB, including mothers, fathers, and grandparents, have significant trauma histories, or high levels of trauma exposure, including sexual and physical abuse, abandonment, parental substance abuse, foster placement, and other forms of family disruption. In addition to multiple forms of trauma exposure in childhood, many MTB families also live in traumatizing environments; this can mean that mother is in a violent relationship with her partner or her family, struggling with domestic or intimate partner violence, or is living with family members who are active substance users or involved in criminal activity (which raises yet another level of trauma, namely the threat of having one's child removed by child protective services.) The impacts of psychosocial adversity and poverty are also felt at every level of parents' lives (Shonkoff, 2012). Whether it manifests in the absence of food, clothing, housing, acceptable educational programs, or other crucial resources, or in the rates of community violence, or in pervasive classism and racism within social and community systems, MTB families have very difficult lives. They are often isolated socially and geographically and may have few options for obtaining basic services.

Resilience factors

There are a number of protective or resilience factors that can ameliorate the long-term impacts of trauma. A crucial and central protective factor is the availability of a loving, caring attachment figure who makes the child feel loved, supported, and important. Lieberman and her colleagues Lieberman, Padron, Van Horn, & Harris, 2005) refer to these figures as "'angels in the nursery', key childhood figures with whom mothers had experiences of safety, intimacy [and] joy" (2005, p. 506-7). Other important factors include having a cohesive family structure in which boundaries are clear and flexibly maintained, loyalty to loved ones is central, communication is open, and family rituals are observed and celebrated. Other researchers have emphasized the importance of dispositional factors such as intelligence or an easy temperament, relational factors such as an ease with people and an ability to seek out friends and helping mentors, as we; as flexibility, perseverance, and creativity, and attitudes like hopefulness and faith. We see these in MTB families as well, and work to create benevolent childhood experiences (Narayan, Rivera, Bernstein, Harris, & Lieberman, 2017) in the lives of MTB infants, even if their parents did not experience these directly. (See too Davies, 2010; Walsh, 2002).

Trauma symptomatology

Parents' exposure to trauma is distinct from the way such exposure affects their functioning. Trauma exposure, per se, does not necessarily equate to symptomatology or psychopathology; rather, it is the depth and breadth of exposure that is associated with more severe symptoms, and more impairment of functioning. For many years, the psychopathology of trauma was poorly understood, and in fact the only trauma-related diagnosis in the DSM-5 or ICD-10 was Post-Traumatic Stress Disorder or PTSD. We found, from the outset, that this diagnosis did not adequately describe the difficulties we were seeing in our families. Rather, the diagnosis of Developmental or Complex Trauma Disorder (C-PTSD) is much more useful (see Courtois, 2004; Courtois & Ford, 2013; Slade et al., 2017; van der Kolk, 2014).

Courtois's (2004) review paper on complex trauma in adults should be required reading for any MTB practitioner, as it eloquently describes the struggles of traumatized parents. Courtois defines *complex* trauma as "a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts. [The term] extends to all forms of domestic violence and attachment trauma occurring in the context of family and other intimate relationships. These forms of intimate/domestic abuse often occur over extended time periods during which the victim is entrapped and conditioned in a variety of ways." (2004, p. 412) Such exposure disrupts development at the level of the mind, the body, and the brain, and deprives mothers of the kinds of experiences they need to build strong foundations for later learning, relating, and regulation, across multiple domains.

The symptoms of complex trauma are distinct from "simple" PTSD, which is typically defined as a response to an acute trauma or series of linked traumatic events. This in contrast to "individuals exposed to trauma over a variety of time spans and developmental periods", who suffer "from a variety of psychological problems not included in the diagnosis of PTSD, including depression, anxiety, self-hatred, dissociation, substance abuse, self-destructive and risk-taking behaviors, revictimization, problems with interpersonal and intimate relationships (*including parenting* [emphasis added]), medical and somatic concerns, and despair." (2004, p. 413). This vividly describes many MTB parents.

Courtois makes the point that all of these symptoms are NOT symptoms of a range of different, co-occurring disorders (i.e., the Mom has anxiety *and* depression *and* an impulse disorder); rather, each is a symptom of underlying "complicated posttraumatic adaptations." (2004, p. 414) The posttraumatic adaptations include alterations in 1) the regulation of affective impulses (impulsive acting out), 2) attention and consciousness (tendency to dissociate), 3) self-perception (extreme shame, guilt, and self-hatred), 4) perceptions of the perpetrator (seeing the self as bad and the perpetrator as justified), 5) relationships (inability to see others as trustworthy), and finally 6) a tendency to express through the body what cannot be tolerated emotionally or expressed verbally.

What must be addressed in both the diagnosis and treatment of complex trauma are these *posttraumatic adaptations*, not simply depression, anxiety or even PTSD, per se. Unfortunately, elements of the posttraumatic adaptations that Courtois (2004) describes are often misdiagnosed (and treated) as – for example – depression or anxiety, when they are more accurately seen as part of a larger series of adaptations that must themselves be the focus of treatment.

Trauma assessment

MTB parents typically do not enter MTB seeking treatment for their trauma; rather, they enter MTB for support during the transition to parenthood. Thus, even while parents often have significant trauma histories, it can take months and sometimes years to determine the nature of the parent's trauma exposure, which can be complex and multi-generational. Even when clinicians have access to trauma history through case records, it often takes a very long time for parents to feel safe enough to talk about what happened to them. In our experience, disclosure often comes in spurts, or in the least likely moments. It can come as the mother approaches graduation, and the opportunities for shame are minimized. In some instances, mothers will disclose to neutral research assistants collecting data around the time of graduation. Sometimes it is not disclosed at all, and we are left to wonder, with many, many hints, but no proof. We often realize the extent of their trauma not through what they tell us, but through how they *are*, their behavior, their withdrawal, their frightening attributions of the baby, their fragmented states of consciousness. We can also observe it

in their relationships to their bodies, which can often serve as the vehicle for trauma symptoms. As van der Kolk has so aptly observed (2014) in his work on trauma, "the body keeps the score."

In addition, because traumatic experiences can be defended against so strongly, parents will often deny that an obviously terrifying event (being sexually abused by their own parent) had any impact at all. It is important to remember that one of the most profound legacies of trauma is that thinking, feeling, and remembering can be quite distorted; cognition and memory can be fragmented, illogical, and chaotic, and feelings can be dampened, dysregulated, or completely inaccessible. With the current popularity of assessing ACEs, it is important to remember that disclosing both events, and the feelings and thoughts around them, can be a very complex process. It is for this reason, that both exposure and symptom assessments must be handled with great care, for they can trigger great distress and shame in respondents, who may never have divulged their secrets to anyone, and yet suffer gravely from their after effects. It is very important to watch for any ruptures that stem from such discussions, and to address them immediately.

The Legacy of Trauma

Insecure attachment histories

Many, though not all of the parents seen in MTB have suffered disruptions in their early caregiving relationships; few had mothers and fathers who were consistently available to them and able to provide a safe, predictable, and loving environment in which they might flourish. In some instances, this has taken the form of separation and abandonment, whereas in others it has taken the more malevolent form of physical or sexual abuse. Most MTB parents also grew up in circumstances of significant socioeconomic risk, which is also highly associated with insecure attachment (Cyr, et al., 2010).

Many (but not all) MTB parents would likely be classified as "insecure" in relation to attachment, and of these, many would be classified as disorganized or unresolved in relation to attachment. Insecurity comes in three forms: avoidance (where strong affects are denied), preoccupation (where the individual is preoccupied with their negative attachment experiences), and – most seriously – disorganized attachment. Disorganized attachment is thought of in 2 ways in adults: Unresolved or Helpless/Hostile representations of attachment. Unresolved attachment shows up in fragmented, chaotic, eulogistic speech around the trauma, loss of a sense of time and space and orientation, and lapses in monitoring of discourse and fluency; this can often make it very, very difficult to get a sense of what actually happened. Hostile/helpless representations show up as early as pregnancy (Terry, 2018) in identifications with a hostile or helpless caregiver, manifestations in the narrative of fear, laughter at pain, blocking, and the inability to reflect on childhood trauma (See Lyons-Ruth et al., 2005).

Both signal the likelihood that the mother-child relationship will be disrupted. When one has a trauma history, the intense emotions and longings evoked by becoming a parent are likely to trigger detachment and disengagement, neediness and dependency, or disorganized, and dysregulated efforts to regulate connectedness. These are all so difficult for children. It is so important for clinicians to be aware of these strategies, and the ways they impact the work with families.

The mother's relationship to her body and her physical health, as well as to her child's, is also profoundly impacted by her early attachment experiences. While this typically receives little attention in the attachment literature, insecure attachment, which begins in the bodily relationship between a mother and infant, has a profound effect on the adult woman's capacity to listen to her body or to recognize her child's bodily needs

and cues. Trauma likewise distorts the relationship to the body and its "language." When the body is, as one mother put it, "the scene of the crime", it is no longer a part of the self, the source of so much self-knowledge and self-sense, but rather a sign of the enemy and of great danger. Thus, the trauma victim can lose or struggle to develop the capacity to listen to the body and its signals. Insecure adults often have complex relationships to physical illness and health care, reporting, for example, multiple physical problems, but finding little satisfaction in the search for care, which they may in fact actively thwart (Slade, 2004; Slade, et al., 2005b). Somatic or physical complaints become the only way that intolerable or dangerous needs and wants can be expressed.

Challenges in relationships

Depending on the types of trauma one has experienced, establishing and maintaining safe, loving interpersonal relationships can be very difficult. Thus, we often see that many of the parents we work with are in active conflict or completely estranged from the father of the baby, have unsatisfying and often destructive relationships with partners, and find little solace or comfort from their families of origin. Some have taken on the role of caretaker in their own families, and have to work long hours to provide for housing and food for a number of close and distant relatives.

This does not bode well for their ability to provide a secure base for their children's needs for both closeness and autonomy. Parents who have had traumatic attachments are more likely to frighten or withdraw from their children, to mock their distress, or to reverse roles, forcing their child into a caregiving role. Imagine how difficult it would be to find security and safety from a parent who was dissociating, affectively dysregulated, self-hating, and removed from their bodily experience?

A history of insecure attachment and particularly traumatic attachments also has a noticeable impact the mother's capacity to develop therapeutic and trusting relationships with the home visitors. Living with the chronic threat posed by attachment trauma makes it especially difficult for parents to engage in a consistent way with home visitors, and may lead to episodes of disengagement, suspicion, splitting, overdependency, and entanglement. These can be very stressful for clinicians and must be regularly addressed in supervision (see Chapter 9).

Toxic stress

One of the most potent effects of ongoing trauma 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) (Shonkoff, 2012). A lag in the development of higher cortical functioning means, among other things, that parents will have difficulty learning, attending, reading social cues, thinking through their decisions, and developing emotional control. One model used to describe these impacts is the toxic stress model (Shonkoff, 2012). This model distinguishes 3 levels of stress and environmental response: positive stress (a healthy and normal part of development, accompanied by a supportive environment), tolerable stress (severe and longer lasting stressors that are nevertheless buffered by helping adults), and toxic stress (strong and frequent/prolonged adversity without adult support). Within this model, adversity includes not only personal trauma but community or societal trauma as well, both of which leave the individual chronically stressed. Prolonged toxic stress profoundly impairs the development of stable mechanisms of stress regulation, and leaves sufferers in constant states of under or over arousal, either heavily defended, shut down, and even dissociated, or dysregulated, highly agitated, labile, and at the mercy of their strong

emotions. These shifts between under and over-arousal expose parents to the deleterious effects of chronically high levels of circulating cortisol and other biological indicators of the stress response. The study of stress biomarkers allows researchers to track the impact of stress on biological systems, as well as the effectiveness of interventions in lowering the impact of stress and its deleterious effects on emotional and cognitive functioning (Johnson, Riley, Granger, & Riis, 2013).

Trauma and the MTB intervention

Here are the basic components of MTB's trauma informed approach:

1. **We work to help the parent feel safe in relation to us.**

Bessel van der Kolk (2014) is one of the world's leading trauma theorists. In his view, a two-pronged approach is necessary for the treatment of trauma. The first of these is the establishment of a trusting therapeutic relationship. One of the most entrenched legacies of trauma is the lack of a basic feeling of trust in others. This stems from the fact that intimate others and family members, as well as a range of educators and providers, have in fact behaved in threatening and frightening ways. Thus, vigilance for potential threats is essential.

The first phase in addressing any traumas is the establishment of trust and safety. While we may see ourselves as inherently trustworthy, this is not necessarily parents' experience of us, and until they begin to deeply experience the relationship with us as safe, no therapeutic work is really possible. As Courtois notes, this can take years. In MTB, establishing safety may be all that can be accomplished in 27 months' work with the parent. For some parents, this alone is an enormous step forward in their experience of themselves and others. Hopefully it will also open them up to other positive life experiences in the years to come and increase their willingness to explore their openness to later exploration of their traumatic experiences.

2. **We work to help parents develop ways of relaxing systemic hypervigilance by relaxing the body.**

The second arm of van der Kolk's two-pronged approach is developing strategies to relax the body and become more attuned to bodily sensations. This is an essential step in helping parents regulate states of hyper and hypo arousal that preclude cognitive and emotional processing. In line with this, we help parents in the use of a range of mindfulness and mind-body techniques to focus sensation and aid relaxation (See Chapters 7 & 8.)

3. **If we are aware of traumatic experiences in the parent's history, but do not hear about them from the parent, we bring them up only when we can assure the parent's emotional safety. We appreciate that she may nevertheless choose not to discuss them further.**

It can be very frustrating to have information about a mother's or father's history, only to find that the parent is unwilling to talk about it or never even brings it up. Our job is (to return to #1 above) to do all we can to ensure her emotional safety, and then gently see whether (under these conditions) the parent is more open to telling the story. But this may simply never occur.

Unfortunately, there can be too much emphasis in the trauma literature upon the importance of bringing a parent's trauma narrative to light. This is sometimes a *last step* in MTB. As we mentioned earlier, mothers do not necessarily see discussing their traumas as what MTB is "about". From their perspective, in fact, they may not even see discussing their traumas as relevant to their experience as parents. While we might wish them to arrive at that point, they are not necessarily there at all when they begin.

4. **We appreciate that her "story" will likely emerge in ways that may confuse us or make little sense. Dissociation, blocking, and panic are natural defenses to managing unspeakable pain.**

Trauma sufferers naturally do whatever they can to block the pain and terror that such experiences bring. In effect, they "scramble" their experiences in whatever ways they can so that they are not as live and threatening. The younger they were when traumatic experiences occurred, the more confusion will be evident. What we see are primitive defenses, irrational thoughts, denial, incoherent stories and inconsistent remembering. We must remember that these are self-protective strategies that have their very own function and meaning in managing great suffering and are not willful or conscious diversions. Trauma victims often have a great deal of difficulty seeing the "big picture", because to do so would be to be confronted with intolerable feelings and anxieties. Thus, life is lived in the moment, at a concrete level; impulses must be acted upon, and frustration tolerance is hard won. Defenses that would permit higher levels of organization and regulation are either absent altogether, or function tenuously and intermittently.

While the parent's way of managing feelings can be very distressing to clinicians (mother's failure to respond to texts or calls for weeks after a difficult visit), these are the ways mothers (and fathers, etc.) survived their childhoods. While we work to soften these defenses and help the mothers trust in us and in their own feelings, we cannot lose compassion for the reasons behind their fears of our benign presence in their lives, and their fears about what they (and the baby) think and feel.

5. **We stay vigilant for signs of the posttraumatic adaptations that are common to complex trauma sufferers, and try to address these (rather than, for example, feeling that we must address the trauma directly). That is, even when access to the traumas are blocked or denied, we remain sensitive to their manifestation in other forms and attempt to respond to these clinically.**

When a parent cannot tell her story (and thus we don't know it), or when the story is only fragmented and diffuse, we have many ways to watch for the effects of traumatic experience. We do not need explicit stories to know there have been traumas. We can observe the posttraumatic adaptations described by Courtois above. When parents dissociate, become massively dysregulated, feel as if they cannot move or are drowning in despair, idealize their abusive partners or family members, or see themselves in the light in which their perpetrators see them (i.e., worthy of abuse), we see them as signposts of trauma. Often, while we cannot engage with the traumas themselves, we can work to soften the adaptations to them that are so problematic and damaging.

6. **If the parent is willing and able to talk about her traumatic experiences, we appreciate the enormity of her doing so, and proceed with caution, openness, and respect.**

This point should be self-evident, but sometimes is not. Even when events have taken place in the distant past, discussing them with another can be very, very difficult, both because of the pain that comes with allowing buried affects to come alive, and because of the fear of humiliation that so often accompanies revealing shameful and dark elements of one's past.

7. **We understand that even when a trauma narrative has been put into words, the parent's capacity to think about her story and reflect upon her emotional experiences may be quite limited. When possible, the process of returning to this narrative over time will bring about relief.**

Putting one's experiences into words, telling the story in as clear a way as possible, is an enormous accomplishment. But it is only one step in a lifelong process. Over time, and with retelling, the feelings and

memories associated with critical childhood events, often with key attachment figures, slowly emerge and the story begins to make sense in a deeper way. Only then can the parent begin to reflect upon its impact on her parenting, and on other central relationships in her life. We know that mothers who have experienced trauma as children have often been told by others, "get over it, don't think about it, forget it, get out of your feelings" or "you are crazy". They need our permission and the safety of the therapeutic relationship to explore it.

8. We stay vigilant for the ways traumatic experiences are repeated in relation to the baby.

The infant mental health movement began when Selma Fraiberg made the following observation: "In every nursery there are ghosts. They are the visitors from the unremembered past of the parents, the uninvited guests at the christening. Under all favorable conditions the unfriendly and unbidden ghosts are banished from the nursery, and return to their subterranean dwelling place. The baby makes his own imperative claim upon parental love and, in strict analogy with the fairy tales, the bonds of love protect the child and his parents from the intruders, the malevolent ghosts" (Fraiberg, Adelson, & Shapiro, 1975, p. 387).

The authors describe a range of intrusions, from the mild ghosts who appear when normal developmental issues trigger old conflicts, and are readily resolved, to the far more serious ones, who threaten not only development, but safety. When this occurs, the infant is seen, not as an individual in his own right, but through the lens of the ghosts in the mother's past. Tragically, the mother brings the past, in all its horror, into the present. The tragedy is repeated, in large part, because mothers have disavowed their childhood feelings, which were simply too intense to hold or acknowledge. They may vividly remember the past, but none of the feelings that accompanied it, notably fear. This old fear comes alive in the relationship with the baby, however, with the mother "identifying with the aggressor", eliciting affects in the child that she could not feel herself (Fraiberg et al., 1975). She becomes the abandoning mother, her baby the lost and lonely child, or the terrifying mother, her baby the terrified child (Lyons-Ruth, Bronfman, & Atwood, 1999).

In our experience, many of the families in MTB are grappling with frightening ghosts from the past that have powerfully inserted themselves into the nursery. Whether or not we know the story, there are clues to what some of the ghosts might be and how they might manifest themselves. The clinician must keep them in mind, returning to it again and again in whatever way she can, either through slowly unraveling the story with the mother, or simply attending to it herself, noting its presence in mother's everyday life.

This provides a way of thinking about the *meanings* behind a mother's feelings about herself, her baby, and others close to her. "Why" does this mother turn away from her baby, "why" does she feel she has no choice but to have another baby, etc. The answer to "why" will often make no rational sense (i.e., she feels she has "no choice" but to stay with her violent partner), but at the same time makes deep *psychological* sense (i.e., why should I be entitled to live a life different from the one my mother lived, even though it is something I never wanted to do?)

9. Even when current relationships are manifestly dangerous to parents, we appreciate the complexity of their ties and try to understand them. If we directly threaten these relationships, we risk damaging the therapeutic alliance.

Parents are often involved in domestic and relational violence. In these circumstances (which may not be disclosed when it is happening or may only be disclosed when a situation has become extremely dangerous) the clinician's goal is to protect both the mother and the baby (or, in some instances, protect the

father and baby). As a result, the clinician may feel strongly that the mother should leave her partner. In these cases, the clinician's perception can conflict with the mother's attachment (however insecure and dangerous) to her partner or another family member, and her hopes for family life. Home visitors' alarm and even insistence that the mother distance herself from her abusive partner can subtly drive the mother toward her partner unless her feelings of attachment to the partner, and her feelings of unworthiness and hopelessness, can be addressed. Deep down, she may well not be able to imagine any other kind of attachment or see herself as deserving anything better. The absence of hope and the feelings of despair that stem from chronic upheaval and danger are the long arms of family disruption.

10. We stay vigilant for the ways traumatic experiences are repeated in relation to both the nurse and the social worker.

How do the traumas from the past affect the clinician-parent relationship? How do representations of attachment and attachment trauma affect the parent's ability to form what might best be called a therapeutic alliance? Clearly, as we mentioned earlier, parents may find it difficult to trust us. But often there are other, more subtle impacts of the past on the clinician-parent relationship. Parents may fail to ask for help, become suspicious, exploitative, angry, divisive, etc. These kinds of beliefs about the clinician – hopefully transitory – are what psychodynamic therapists refer to as transference. Any helping person in a caregiving role is likely to be seen through a variety of lenses, many of them a function of past experience. The more a clinician is prepared for this, and can recognize it as a meaningful communication from the parent and not a personal insult or willful subterfuge, the better. When the clinician responds to these communications as "real" rather than an echo of the past, the therapeutic alliance and clinical work is at risk. Such occurrences must be addressed in supervision.

11. We recognize and affirm signs of resilience and strength.

While MTB families often have difficult lives, there can be reservoirs of hidden strength and resourcefulness to be found in each family. These are reflected in a myriad of ways, from the courage with which young mothers return to work and school, free themselves from destructive partners, and – perhaps most significantly – welcome the home visiting team into their homes and their hearts. Their involvement in the program, which is completely voluntary, deepens and broadens with time, activating more positive representations of being nurtured and cared for, "angels in the nursery" (Lieberman, et al., 2005). Thus, "the recovery and integration into consciousness" of positive parental (or grand parental or extra-parental) experiences within the context of treatment provides a "growth promoting force that is as important to therapeutic work as the containing, taming, and exorcising of ghosts" (p. 506). And so we listen for angels and ghosts, both, in whatever form these may be manifest in relation to the child.

PART TWO:

STRUCTURE AND FORMAT OF THE INTERVENTION

CHAPTER FIVE:
PHASES OF THE INTERVENTION AND CONDUCTING A HOME VISIT

Overview of the Intervention

In this chapter, and in the chapters that follow, the MTB intervention is presented from a variety of vantage points: the structure of the intervention, and the process of both the intervention and an individual home visit. It is important to bear three things in mind in reading this section. First, there is no recipe for a particular home visit. As will be obvious throughout the following chapters, the home visitor must remain flexible in her expectations and in her goals. It is this flexibility that will allow her to provide the most appropriate and sensitive care for the family.

Second, while there are goals going into a home that are derived from what the home visitors know about the family and the child *at this particular time,* these goals are continuously revised as the actual situation in the home is addressed, and issues that must be addressed immediately are prioritized. Thus, this manual does not contain prescriptions, but rather guidelines for addressing a range of problems and circumstances.

Finally, and this cannot be stressed enough, assessment is a constant across all visits. Home visitors are always assessing the parent's strengths and areas of conflict, developmental progression and regression, potential risk and potential benefit. It is this attitude of watching and listening that is vital to providing care that will be most directly beneficial and helpful to mothers, and that will be most protective of the child and his or her development.

Recruitment

Clinicians contact the mother after a referral to the program has been made. If mothers indicate a willingness to learn more about MTB, the clinicians make an appointment with her (and potentially her partner). This first appointment is attended by both home visitors, who together describe the program in more detail and answer any questions that the mothers or other family members may have. Most future visits will take place with individual home visitors, but meeting both members of the team for the first visit conveys the unified nature of the intervention. It is at this visit that first impressions as to the nature and focus of the intervention will be formed.

As part of the recruitment process, home visitors provide information and materials that mothers find helpful, giving them a sense of what MTB has to offer. For example, books or flyers on pregnancy, getting ready for the baby, and safe sleep are offered in a binder for families to keep. Once mothers have agreed to participate, individual consent forms are signed.

Initial engagement and assessment

This phase typically lasts about five visits, although components of the social work assessment may continue up to birth. The first visits by the nurse are aimed at conducting a health assessment of the mother (See Chapter 7; refer to the Operations Manual for sample forms). The visits conducted by the social worker are aimed at obtaining a psychosocial history (See Chapter 8; also Appendix I for a sample form).

On about the third to fifth visit, the Pregnancy Interview (PI) is administered by the social worker and observed by the nurse practitioner. When these visits have been completed, the intervention formally begins. While the overt focus of this phase is upon the assessment of the health and mental health status of the mother, this is also considered an important first step in engaging families, and in giving them a sense of the home visitors' ability to help them and take care of their various needs. This is the clinicians' chance to communicate interest and presence in a way that is the first step to developing therapeutic and trusting relationships.

Confidentiality and consent

While they are in MTB, families are almost always receiving other services in the community: health care, social service assistance, etc. During the engagement and assessment phase, the clinicians need to understand what other services the family is receiving, so they can partner *with the family* to collaborate with health providers and community agencies. MTB never contacts other providers without informed, written consent from families; our commitment to protecting the confidentiality of families is made clear to them from the very first contact. Discussing concerns with the family and the need to gather more information along with obtaining informed written consent to communicate with the identified provider or agency is the first and most important step to inter-agency collaboration on behalf of MTB families.

Families need to know who the clinician will speak with, what sort of information will be exchanged, the purpose or reason for the exchange, and the potential outcome. Families must also be assured that their information will not be shared with anyone other than the person(s) they have given the clinician written permission to communicate with. In times of crisis or emergency when police or child welfare intervention is warranted and written consent is not feasible, MTB clinician teams still *partner with the family* to arrive at the best possible outcome. Clear, but compassionate communication about safety, interpersonal violence, child maltreatment, or any other concern indicating imminent danger is essential to protecting the clinician team-family relationship. (See section on **Child Protective Services**, page 36.)

Phases of the Intervention

The prenatal phase

Families are seen on alternate weeks by the home visitors; thus, they see the nurse on Week 1, the social worker on Week 2, the nurse on Week 3, and so forth. The frequency of either health or mental health visits may be increased as necessary. It is very helpful to the process of engagement to see mothers at least once a week during this period. As labor and delivery approach, visits may increase as anxiety builds. Mothers may need very specific kinds of help from home visitors, such as labor planning and concrete services.

The delivery and postnatal phase

If possible, the MTB clinicians visit the hospital once the baby is born. This is a brief friendly visit with a baby card and small gift. Assessments are done at this time concerning any needed support for breastfeeding, neonatal or maternal health issues, emergency clothing, baby supplies, etc.

Continuing support and visits are warranted if the baby is in the Newborn Intensive Care Unit. This is especially true if the mother is discharged from the hospital before the child. She may need help figuring out how to get to and from the hospital to visit the baby. She may also need emotional support, as well as information to prepare for the discharge of a premature or medically fragile baby. She may need help communicating with the medical staff so that she can best understand her baby's medical situation.

Both home visitors try to visit the family at home during the first week post discharge from the hospital. In the immediate postpartum period, clinicians assess how much care the new mother and family need. Some parents desire private time with their families and prefer not to have lots of home visits. In this case, the clinicians sometimes need to find ways of re-engaging with families after the initial settling-in period.

The first-year visits

Families are visited weekly throughout the first year of the child's life. The nurse and social worker alternate visits, and thus each typically sees the mother twice a month. However, the frequency and type of visits is routinely assessed and adjusted to meet the needs of the family. If there is a medical crisis, nursing visits are increased, although this does not necessarily mean that mental health visits are decreased. Likewise, if there is a mental health crisis, social work visits can be increased. All of the decisions are made on a case-by-case and week-by-week basis.

The transition phase

Several months before the baby turns one, the clinicians assess the appropriateness of shifting a family to biweekly visits. The decision is made on the basis of resources and of the readiness of the individual family. When the number of home visits is reduced, each clinician changes her visits from twice monthly to once monthly visits. The timing of this shift is individual; some parents are clearly ready to make the switch when their babies are a year old, whereas others remain in some level of crisis and require that the intensive schedule of the first year be maintained for several months or more. For example, there may be medical or developmental instability in the baby, or the mother may be too fragile emotionally or socially to manage the transition. The team makes this decision in an on-going way, and if they find that shifting to every other week seems to have left a mother with less support than she needs, weekly visits are resumed or another arrangement to provide more contact is made.

The second-year visits

Families are typically visited once every other week during the second year, seeing the nurse and social worker each only once a month. Texting is used to remind mothers of the new every-other-week schedule and who will be visiting with her the following week.

The goodbye phase

The aim is to graduate families just after the second birthday of the child. Families are reminded of the upcoming graduation *three to four months before the graduation date*, so they will have adequate time to say goodbye to each of the home visitors. The goodbye phase occurs over a number of sessions, during which the many steps the parent has taken and changes she has made are reviewed in an ongoing and positive way. This is a time for each home visitor to create bridges for and with the family, reinforcing the insights they have made, and underscoring the burgeoning and increasingly complex understanding of their child. The home visitors review the many and rapid changes that have occurred in the child's development, from newborn to blossoming child. Both home visitors come together for the last visit. It is always important to remember that they have likely become very important to the families they are seeing, and thus that the period of saying goodbye can be very difficult for parents, particularly those who have struggled with attachment losses and disruptions.

Basic Components of the Home Visit

There is a basic structure and process to all home visits, whether they are nursing, social work, or joint visits. The general outline for home visits follows four stages that include preparation, engagement, conducting the home visit, and ending the visit. In the following sections, a general template for home visits is described.

Preparation for the visit

In preparation for the home visit, clinicians consider the developmental stage of the child and parent with whom the visit will take place. This is followed by a review of the probable health, safety, child development, and parenting themes relevant to those developmental stages. Depending on the focus of the visit (nursing or mental health/social service), this review also includes health needs, mental health issues, family and household issues, and any special concerns that have been previously assessed and defined for the family.

Materials used in home visits

While MTB does not rely on a particular curriculum, handouts and props and other teaching materials may be used throughout the intervention when appropriate. These are only supplements to work with the family. Choosing handouts takes time and thought. Consider the literacy level and attractiveness of the handout. Color diagrams and pictures are helpful in explaining new concepts. Interactive videos or questionnaires can break up the sameness of your time together. Parents are busy people and wordy handouts may never be read. At times the clinicians may need to develop their own materials. Check the literacy level for different materials so you are sure they are readable. Be sure to use caution and reputable sources when gathering information from the web.

Materials given to the families

Books and toys are given to families throughout the intervention.

- To mark special occasions such as baby showers, births, and birthdays
- To encourage interactions between parent and child
- To demonstrate the baby's increasing abilities, such as shaking a rattle, throwing a ball, or turning pages in a book
- To encourage exploration and experimentation with the objects brought to the home
- To encourage reading, from birth.

It is helpful to give toys that are sturdy and not too expensive or fancy, and that can be left out for the child to use on a regular basis.

Toy bag

In addition to materials given to families, clinicians bring along their own toys to use with the baby during the visit. Usually, home visitors carry these in a large, brightly colored bag large enough to accommodate toys and other materials the home visitors will need for the visit. As babies grow into toddlers, they begin to identify this toy bag with enjoyable activities and toys. Sometimes parents will want to play with the toys too; in these situations it can be useful to bring duplicates. Again the toys serve many purposes: to engage a crying baby, encourage expressive and imaginative play, occupy a toddler while the parent tells a long story about a recent family incident, and demonstrate a child's new skills. Some parents are influenced by the program's choices and purchase a toy similar to one the clinician has brought to the home.

The contents of the toy bag typically include:

- stacking rings
- nesting cups
- a baby doll and bottle
- plastic animals and people
- puzzles
- blocks
- books
- plastic cups and food
- cars and trucks

Other considerations are the toy's safety, age-appropriateness, cost, and ease in cleaning with 10% bleach solution or in a dishwasher after each use. For these reasons, it is necessary to frequently replenish toy supplies.

Location of visits

While the majority of home visits take place in the homes of MTB families, there may be circumstances when parents do not wish home visitors to come into the home (i.e., when there are visitors or the family is in a temporary housing situation). In these instances, the visit may be at public setting such as the children's playroom of a public library, a coffee shop, or other neutral location negotiated with the family. When mothers are particularly busy and have difficulty scheduling home visits, clinicians can be creative in meeting mothers 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 toward the mother. Typically, the extenuating circumstances are temporary (often job schedules change or housing situations improve or change) and so the regular visits in the home setting can then resume.

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 mother to an appointment, or assist with making phone calls to access resources or schedule appointments. There are instances when a home visitor may be asked to drive a mother to a medical appointment, pick her up at school, or give her a ride to an appointment around social services. Families may lack access to cars and live in neighborhoods where there is little public transportation. Thus, providing transportation can be a normal and appropriate part of the intervention, and indeed some sessions take place entirely around a trip to the clinic, and the like. Traditional training perspectives may perceive these engagement strategies as enabling. However, we have found that assisting mothers in what may seem like menial tasks is an integral part of the clinical work and is a concrete way of building the parent's trust. It is also necessary role modeling and life-skills training that prepares parents for increasing independence and self-efficacy.

When the parent isn't home

Four common periods of time have been identified when families may need to be re-engaged.

- Toward the end of the pregnancy, many mothers experience irritability and a desire to turn inward and 'nest'.

- Directly after the baby is born when mothers go home from the hospital is a pivotal time. Families may wish to experience the first few weeks with their baby as a private time. If contact begins to be lost during either of these two periods, a positive connection to the program can be made by making short visits, acknowledging feelings, and bringing useful items. After a few weeks, regular home visits can usually be re-established.
- When bimonthly visits are first initiated, families may again be hard to engage. There are numerous reasons for this, ranging from changes in the parent's life to the difficulty some families have establishing any new routine.
- Finally, around the time a child turns 18 months, clinicians may need to rethink their relationship with the family. Mothers may return to work or school to finish programs put on hold because of their pregnancy, and this can make regular appointments very challenging. Clinicians work to continue to see the family so as not to cut the intervention short or be unavailable to help them keep their relationship with the baby in mind during this busy time.

It should not be assumed that a mother is unavailable simply because she does not answer her phone or return a text. An attempt to make a home visit should still be made.

There is a fine balance between advertising the clinician's availability and reliability and being intrusive. Sometimes giving the mothers a short 'vacation' from MTB is all that is needed. Sometimes the mother's desire to continue with the program is unclear. After a reasonable amount of time it can be helpful to send her a text message to say the clinicians are thinking of her and remind her of clinician phone numbers.

If a continuing trend of missed visits is noted, the clinicians and supervisory team evaluate possible causes and solutions. MTB does not drop families because of no shows. Often these missed appointments are caused by extenuating circumstances related to a chaotic family life, and once contact has been re-established the mothers are thankful to have a chance to discuss what has happened and to refocus on the work done together with the home visitors. If a parent states that she no longer wishes to participate in MTB, of course, we honor her wishes.

Duration, schedule, and attendance of 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 mothers are being accompanied to a medical or social service appointment by the home visitor. By contrast, some families find an hour "too much" in which cases they may require shorter, and possibly, more frequent drop-ins. Despite this apparently variable and fluid schedule, home visitors find it most useful to schedule "regular" appointments with mothers. This allows the family to count on the time (and thus develop a concrete sense of the home visitors' reliability) and allows the home visitors to create a reasonably coherent and regular schedule.

Schedules are challenging for many MTB parents. Parents who are working or going to school reschedule or cancel frequently because their schedules may not be under their control. Another consideration is the experience a parent may have in making and keeping appointments. Parents may have difficulty understanding how a change in their plans affects the home visitor. It can be useful to help parents set up a calendar, or alerts on their phone, to remember medical and other appointments as well as home visits.

Sometimes a parent may miss appointments for emotional reasons, including fear of abandonment or rejection by the clinician team or embarrassment about a recent crisis. Thus, missed appointments, no-shows, cancellations and rescheduling are regular and common. The notion of consistency, while of vital importance in engaging these families, must always be balanced against flexibility, which the complexity of their needs demands.

Contact between home visits

At times parents will call the home visitors between visits. There may be questions or they need advice. Clinicians might also call or text to follow-up on an issue that came up during the last home visit. Staying in touch provides concrete evidence that home visitors are present and available. While home visitors carry their work cell phones so they may be reached easily, MTB does not provide 24-hour coverage. It is important to inform parents of each clinician's work days and hours, and provide families with the appropriate way to contact their medical home or other resources when clinicians are not available. Appropriate use of the Emergency Department is part of the life skills training for each family.

Conducting the Visit

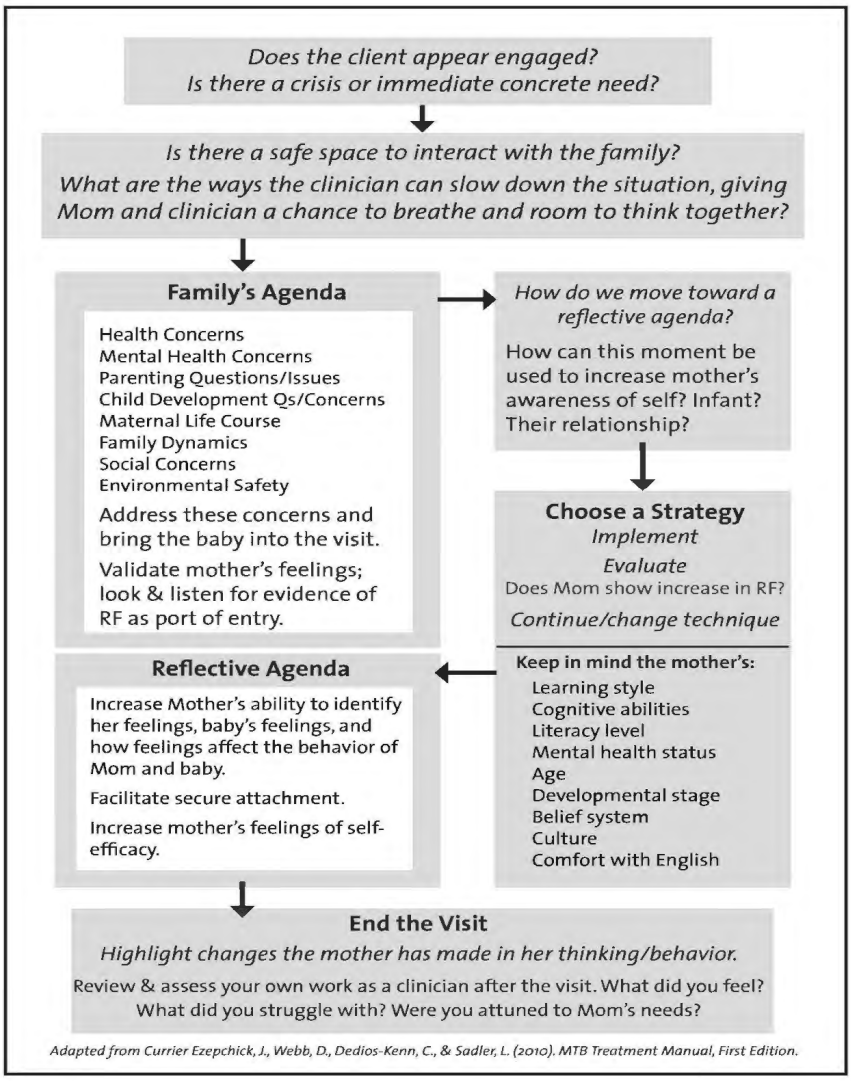
Home visitors dress neatly and professionally but without noticeable jewelry or handbags. Cell phones and car keys are readily available in a pocket. Handbags are left in the trunk of the car partly because this reduces possible problems for visitors, but also because handbags often have small items and medications that can be dangerous to young children. A hand sanitizer should be kept in the car and used before and after the home visit. In addition, gifting the family with hand sanitizer for all visitors to use before greeting or holding a newborn is recommended.

Safety is always a consideration. A clinician should always be aware of her surroundings and never put herself in a compromising situation. Knowing where to park and whether or not the doorbell works are also important safety measures to take. MTB home visitors place a large sign on the front dashboard of their cars when they visit families and wear name badges with the program logo and title as well as the name of the agency one works for, so they are readily identified as health visitors in the community.

Engagement, clinician and family agendas

The visit begins with a social greeting that is sensitive to the cultural and social demands of an individual family. Typically, after she has greeted everyone in the room, the home visitor begins with questions about how the family is doing this week. Listening to the mother's own concerns at the start conveys that she is important as a person as well as a mother.

The home visitor's goal for each visit will vary tremendously in content. At the same time, the overarching goal of helping mother keep herself and her baby in mind – whether from the standpoint of health, development, mental health, or plans for the future – does not vary. As illustrated below, the first step towards realizing these goals is assessing whether or not the family is open to engaging in the visit. The mother's ability to engage with the clinician is central to the success of the visit, because the relationship is a primary vehicle for change. Is the mother ready to attend, or is she overly tired? Is she on the telephone? Is she angry or upset at the clinician or about some crisis that may have just occurred? Is she watching TV? Is she calm enough to listen and concentrate, or is she too anxious and agitated?



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

The clinician must then assess whether there is a therapeutic or reflective "space" in which she can engage with the mother and baby. By "space" we mean both a literal space – somewhere reasonably quiet and, ideally, private – and a metaphorical space in which the mother can be open and ready to engage with the home visitor.

If there is not a therapeutic space in which to work, the clinician tries to create one. Is there is a safe place for the mother, child, and clinician to work and play together? The clinician may need to do things as basic as helping the mother child-proof the room for the baby or as complex as negotiating with older relatives or non-family household members to temporarily leave the room so that the mother and child are not overly distracted during the visit. There may frequently be loud music playing, many teenagers present, or the TV blaring. The home visitor works with the mother to decide how these distractions may be modified or if the visit needs to be rescheduled for a quieter more productive time or moved to a different space.

The home visitor begins to assess the clinical situation. Is her "plan" for the visit feasible? Is the mother ready to think about her own physical health or emotional experience, about the baby and about the relationship? Is she open to the materials and the issues the home visitor is hoping to raise? Is there an issue that overrides all those the home visitor had in mind? Once the clinician has gauged "where" the visit will

begin and where she hopes it will go, she works to enhance and elicit the mother's attunement. This involves watching for cues from the mother regarding her interest in and the relevance of the topic. There can be a tension between the home visitor's assessment of the clinical issues and the family's agenda.

The clinician follows the mother's lead, and tries to engage her around what is pressing to her at that moment, modifying the plan as needed. It may take much of the visit to get the mother to think about the baby at that moment, but even this small shift of attention is an enormous accomplishment. The home visitor looks for ways to increase the mother's awareness of herself, her infant, or the relationship.

- Is there a crisis that can be "used" to help the mother be more reflective about herself, her baby, or their relationship, or must it be attended to in its own right?
- Is there a concrete need on the part of the mother that should not be ignored?
- Is there a way to help the mother play with and enjoy her child while enduring the tedium and humiliation of a visit to the welfare department?
- Is there a way to help the mother notice her child's developing frustration tolerance while the home visitor and mother talk?

There is no "one size fits all" curriculum for mothers; individual adaptations must be made on an ongoing basis. The assessment of engagement continues throughout the visit. When the time is up, or when the mother no longer seems able to engage, the home visitor must move to end the visit.

The relationship between the home visitors and the child

During the course of home visits, clinicians are also interacting individually with the babies and establishing relationships. Babies have experiences with MTB home visitors that may be quite different than any other relationship they have with another adult. Home visitors are engaged, speak quietly and reflectively, and describe their feelings, actions, etc. They see the children as individuals with their own needs and feelings. They try to pay consistent attention to their cues.

Babies greet and initiate interactions with home visitors from an early age. These interactions change as the baby becomes a toddler. At first the baby may pull at the home visitors' ID badges. As they touch the home visitors' earrings, catch their hands in their hair, etc., they learn about the home visitors as individuals. Later on, they enjoy exploring the MTB home visit toy bags, emptying them or carrying them around, imitating the clinicians and looking for their approval.

As babies become toddlers, they are more demanding of the clinicians' time and attention during a home visit. Often they try interrupting the conversation between the home visitor and mother with a new game or, if all else fails, deliberately pushing all the limits to pull the mother's attention back to them. This is one way they test the home visitors – are they consistent? Have they kept them in mind? Other tests emerge if a child hits a clinician or if a limit needs to be imposed (e.g., no throwing eyeglasses). Again this may be a new experience, where the child (and mother) experiences a quiet, sensitive, and consistent form of discipline.

Working with family members

Essential to MTB's work with mothers is the clinical ability to navigate the family system within which MTB mothers live. The clinicians can be seen as a boon or an obstacle to mother's partner, grandparents, aunts, uncles, and friends. Sometimes the view of the clinician can fluctuate between positive and negative

from week to week depending on a family member's belief system or fears. Family members have many reasons for sitting in on a home visit. Paying attention to the other family member's purpose for attending the visit will help guide the clinician. Sometimes a family member is asking for attention for herself—she may need social services or doesn't feel well. Once in a while, someone will try to provoke the clinician, teasing and testing to see her reaction. As with the mothers themselves, acceptance grows when family members feel heard and reassured that the MTB clinicians are in their homes to support the emotional and physical health of the baby and parents.

Ending the visit

When the clinician decides it is time to end the visit, clinicians often use the ending and "saying goodbye" process as a way to model or demonstrate how the parent could handle transitions with the child. Ten or so minutes before the visit actually ends, the clinician signals it is time to wind down the visit. Toddlers have a harder time at the end of a home visit. They are frequently very tired because they have played extra hard during the visit. They protest goodbyes, wanting to be held by the home visitors, or they might want to walk out the door alongside them (hoping Mom will come too). Again, this provides us with a wonderful (although sometimes noisy and tearful) opportunity to model behaviors and healthy routines, such as goodbye rituals, that are sensitive to the child's underlying feelings. This too models for the mother how important it is to acknowledge sadness and anger, even (or especially when) these feelings are disruptive.

As the visitor is packing up to leave, it is helpful to think back on the visit together, to summarize what was accomplished and make note of its positive moments. The home visitor should then review any task that the mother may need to accomplish, for example making a medical appointment or trying a new behavior. It is helpful to remind the parent about next week's visit both in terms of who the home visitor will be and when the visit will take place.

After the Visit

Self-assessment

After a home visit, the clinician takes a few minutes to think back and review the time spent with the family. This is a chance to sit quietly and assess the work you did together. It is also a good idea to regularly review the self-assessment materials described in Chapter 3 (pp. 11).

Meeting with your partner

At the next weekly meeting between clinicians, each home visitor updates her partner on particular family issues or problems that emerged during the home visit and a plan is made together as to next steps. In addition, there may be a need for the home visitor to consult with a clinician from the community health center or with another social or health agency.

Using supervision

After the conclusion of some particularly difficult visits, it may be necessary for the visitor to also consult with clinical supervisors for questions or decision-making about clinical problems. Some home visits are stressful for clinicians, as they are witness to and containers of severe trauma, chaos, and other stressors within the family or the child. For these and other reasons, regular clinical supervision sessions are very important, not just for the quality of clinical work, but also for purposes of stress reduction and prevention of burn-out among clinicians (See Chapter 9).

Child Protective Services: The clinical dilemma of being MTB clinicians *and* mandated reporters

Almost all professionals working across children and family service sectors are mandated reporters (i.e. professionals who are legally required and ethically trained to notify local social or child protective service agencies of suspected child abuse or neglect). There are varying reports in the literature regarding how consistently pediatric clinicians make child protective service reports if they may suspect child maltreatment (Flaherty et al., 2006; Herendeen et al., 2014; Levi et al., 2015;; Levi & Crowell, 2011; Sege et al., 2011). For home visitors in particular, having intimate contact with families in their home or community setting offers an opportunity to observe the unique relationship dynamics, challenges, risks, and strengths inherent within a family system. This adds an additional layer of complexity to working with vulnerable children and families that is very different from working in an outpatient health or mental health setting.

At times, home visitors may be reluctant to report suspicion or evidence of child maltreatment or neglect because they fear violating the trust established in the therapeutic relationship, or losing the relationship altogether (Levine & Doucek, 1995). Additionally, home visitors may have their own professional and/or personal experiences with child protective services that did not yield positive outcomes. Therefore, they may not feel child protective services would be useful or helpful to a family at risk. There are other instances in which home visitors may also be at risk of reporting suspicion of maltreatment and neglect prematurely because of misunderstandings and assumptions made about the family's intentions or actions. A premature report to child protective services may not only compromise the therapeutic relationship, but also add further trauma and chaos into the life of an already vulnerable family. Therefore, integrating the role of MTB clinician with mandated reporter to social or child protective services, and knowing when reporting suspected abuse or neglect is likely to be in the best interest of the family, is a high-stakes balancing act.

Although having professionals in the home may result in more reports of suspected child abuse and neglect, otherwise known as surveillance bias (Chaffin & Bard, 2006), earlier detection may result in fewer serious reports, injuries, and removal of children from parental custody (MacMillan et al., 2005; Olds, Henderson, Kitzman, & Cole, 1995). Additionally, when reports of suspected maltreatment and neglect are made thoughtfully and in partnership with the family, the therapeutic relationship can be preserved with the potential for collaborating with the child protective services agency as a supportive rather than punitive agent in the family's life.

When an MTB clinician is faced with the decision of whether or not to report suspected child maltreatment or neglect, it is important to consider the following:

- Safety of the child
- Safety of the mother/father/family
- The relationship between the home visitors and the mother/family
- The clinician's mandated reporting requirement and legal requirements
- The family's level of crisis and need

- If time and safety concerns allow:
  - Call your clinical partner to discuss and begin to formulate a plan
  - Call your supervisor to discuss your concerns
  - Present the case to team members in team meeting

- If you are unsure about what constitutes child maltreatment or neglect:
    - You may be able to call your local social or child protective services office anonymously to verify need and risk
- If a decision is made to notify CPS
    - Consider how to do this in the least traumatic way possible while ensuring the child's (mother's/family's) safety
    - Work through the plan report and maintain the helping relationship with the family during and after the reporting/investigation, and if the family remains under surveillance for an extended time period

In almost all cases, MTB clinicians notify the family *before* making the report, and in many cases, the clinician team will invite the family to make the report with them. This demonstrates to the family that they are not being punished for being "bad parents" and that the clinical team will continue to support the family even through a difficult time.

There are a few essentials to "having the conversation" with families where concerns for risk are intense enough to make a report to a social or child protective services agency:

- Explain concerns
- Underscore the importance of the family partnership
- Use an empathic not a punitive tone
- Continue to acknowledge and highlight the family's benevolent intentions
- Preserve the relationship
- Explain legal responsibilities
- Explain how the caring relationship will not come to an end
- Reassure the family of the program's ongoing help and support
- Educate about the role of social and child protective services as a supportive vs. policing agent
- Repair, as needed, the clinical relationship and Mother's/family's anger/fear after CPS referral.

Reports to child protective services can raise very strong feelings in both the family and the clinician team. It is critical for clinicians to get the support they need in reflective supervision to acknowledge their own fears and triggers so that they can contain and hold the family's fears and potential feelings of betrayal in order to continue the work. (See too Chapter 9.)

The following is an example illustrating how a MTB clinician approached informing a mother of the need to refer her for child protective services investigation:

> ***Clinician:*** *We know how hard this has been for you and we have been working with you these last few weeks to help you keep you and your baby safe.*
>
> ***Mom:*** *Yeah.*
>
> ***Clinician:*** *It looks like after what happened last night, (a second intense physical fight with the baby's father) that you are really struggling and we worry that you're at a point right now where you are no longer able to keep the two of you safe.*
>
> ***Mom:*** *I'm just so tired (tearfully).*

Clinician: *We mentioned a couple of times that we are mandated reporters which means that if we are concerned that a mom and child are in danger, we need to contact DCF (social or child protective services) and make a referral to see if they can help.*

Mom: *Oh God! Not them, they'll take my baby! (crying more)*

Clinician: *We completely understand that many people think of DCF only as people who take children away from their parents. But that really is a very small part of what they do. Their goal is actually to keep families together and they offer programs and resources to help children stay with their parents. DCF will also appreciate that you are participating in MTB on your own (voluntarily) because you know it's a good thing for you and your baby.*

Mom: *Really? Ok.*

Clinician: *Yes really. We are not making this call to punish you or because we think you are a bad parent. We know you love your baby and want to be the best parent you can be. If we all work together we can help make that happen. We would like to make the call with you and then when someone is scheduled to come and talk with you, we can be here to support you and share our concerns.*

Mom: *I really don't want DCF (social/child protective services) in my life but I guess it's better coming from you guys than if a neighbor or somebody else ends up calling anyway.*

Clinician: *That's a really good point! You don't want someone who doesn't know you or understand your situation making this kind of a call. We know you and care very much about you and your baby. We will continue to work with and support you.*

CHAPTER SIX:
INTERDISCIPLINARY PRACTICE: SUPPORT FOR CHILD DEVELOPMENT, ATTACHMENT, AND PARENTING

Interdisciplinary Practice

One of the defining features of MTB is that it is interdisciplinary. While each clinician works from a specific knowledge base and skill set unique to their chosen professions, the guiding principles of the MTB model *blend* these perspectives and provide the clinical base for the intervention. The team's success will depend on not just how well they implement their "part" of the intervention, but on how well they are able to *synchronize* their approach to families with the other member of the team. The nurse and social worker are equal partners and work closely together in a variety of ways. They share a set of principles and values, goals, and range of techniques. They consistently work together in a layered, mutually supportive and reinforcing way.

Thus, while families receive two distinct kinds of care – nursing and mental health/social service – there are many ways in which the roles of the nurse and social worker overlap. (See figure on page 2.) As team members get to know each other and develop a rhythm of collaboration, their roles become more shared and overlapping. For many practitioners this new way of working may feel awkward and confusing at first. However, over time, clinicians find the work becomes richer as they share their valuable perspectives and learn from each other.

Each profession has its area of expertise and may cover similar topics from a different perspective, as many topics are interdependent in nature and build on each other. Each clinician looks for a point of entry to integrate her work with that of her partner. While building on family strengths both clinicians also assess for potential risks for maltreatment. Similarly, both home visitors remain attuned to indices of domestic violence, and are prepared to take steps to help parents under such circumstances.

This sort of complicated layering of the work is discussed and planned in the weekly face-to-face meetings between partners and in the weekly whole team meetings. Communication between team members is essential to interdisciplinary collaboration. In addition to weekly meetings important information is shared through phone calls, texts, and emails as needed: updating one's partner on the current home situation, the communication focuses on the family's openness to work with the clinicians, reception to a certain topic, and observations regarding the parent's demeanor and mood and child's health and development.

The work of the social worker and nurse becomes intertwined over the course of the intervention. Home visitors build on their partner's efforts, layering their care in a way that both supports the previous visit and elaborates on it. Thus a team member looks for a port of entry and picks up on a thread from her partner's last visit, using the metaphors that are appropriate to her own profession and style. This approach contributes to a seamless experience of care by the parents. Both clinicians may work on the same 'issue' in a mutually supportive and complimentary way.

Shared principles

Home visitors share these core principles:

- All families have a "story." There is value in listening to this story, bearing witness to its hardships, validating its effects, and assisting in its integration into present day life experience.
- It will take time to get to know this story, and the work progresses slowly and in stages.

- Within each family there will be distinctive themes that dominate the clinical work. The themes will provide an essential backdrop of the intervention.
- A non-judgmental, accepting, and reflective approach is essential.
- Reflective moments need to be highlighted and validated as they occur.
- Each home visitor (as well as supervisor) will be affected by their experience in the home and their relationships with family members. This experience needs to be processed and understood.
- The cultural issues that influence parenting need to be sensitively understood and explored within the context of the intervention.
- There is more than one method of overcoming any barrier. Continued assessments and family feedback make it possible to explore alternatives.

These shared perspectives create a sense of coherence for both visitors and families, and help them to experience their complex relationship to MTB in a unified and integrated way.

Shared goals

The home visitors share a number of goals with respect to families and babies: promoting reflective functioning, supporting a positive parent-child relationship and secure attachment, providing developmental guidance, helping parents articulate and realize their life goals, including considerations of family planning and avoiding rapid subsequent childbearing, and assessing family needs.

Promoting reflective functioning

Both the nurse and social worker focus on enhancing reflective functioning, helping parents become increasingly aware of the child's body and physical states (reading the baby's physical cues), and the child's mind and mental states (reading the baby's behaviors in light of intentions and mental states). While working to develop parents' reflective capacities in different domains, clinicians aim to find ways to think about, organize, and regulate the parents' and child's thoughts and feelings. (For a fuller description, see Chapter 3.)

Supporting the parent-child relationship and promoting secure attachment

Home visitors strive – in a variety of ways – to support the parents' positive interactions with and observations of the baby. Clinicians value the baby as a partner in their efforts to use "teachable moments" during a home visit to demonstrate positive parenting skills through instruction, repetition, and modeling. These kinds of interventions are crucial to parents' developing capacities to read their babies' cues and intentions. However, clinicians are careful not to take over for the parent unless she needs help, and readily reinforce positive moments between parent and child to intentionally support the parent's emerging sense of competence and mastery. Success in interacting positively with their babies often comes as a result of the reawakening of the parents' "angels" rather than "ghosts" in the nursery; that is, in remembering, through their developing relationship with the clinicians, benevolent care-giving experiences they might have had in their own childhoods (Lieberman, et al., 2005; Narayan, et al., 2017).

Both clinicians observe and comment upon the attachment behaviors of the infant, such as the newborn's interest in gazing at mother's face, or the child's checking back to his father when he crawls away. As the baby grows, clinicians 'translate' the baby's attempts to seek proximity and maintain contact, framing these in a positive light so the parents can understand their importance to the baby. In this way, clinicians explain stranger anxiety, separation anxiety, and other developmental stages from the baby's point of view.

Much of the team's work in the first half of the first year (and likely beyond) concerns helping the parent regulate the baby. The most obvious and consistent concerns surround feeding and sleeping. Struggles for control are often quite tangible, and parents need help in both being flexible and in understanding the child's changing needs. The clinicians work hard to convey the idea that development occurs in phases, and that the understanding of a baby's particular developmental needs makes the whole relationship seem more manageable and comprehensible.

Another way to support a secure attachment used by both clinicians is encouraging breastfeeding. Breastfeeding is an excellent source of nutrition for babies, as well as a wonderful means to promote closeness, intimacy, and child attachment. For mothers who choose not to breastfeed or who may have concerns about their body (perhaps related to sexual abuse), home visitors work to help them feed their babies in a way that will promote bonding, encouraging them to hold the child closely and affectionately, and to maintain good eye contact during feedings.

Developmental guidance

The development of parental reflective functioning is inherently intertwined with a basic understanding of the child's development. When the clinicians are working to help parents accurately read their children's behaviors and mental states, they are also using ongoing parent-child interactions as opportunities to teach the parent about development. Ideally, both home visitors have extensive knowledge of infant and toddler development that they use to provide developmental support and anticipatory guidance. In cases where this knowledge base isn't as strong, it is important to consider collaborating with pediatric healthcare providers and pursuing training opportunities that will enhance understanding of infant and toddler development. Areas in which these issues become especially relevant are those of temperament, discipline, safety, and play.

Supporting co-operative parenting

Co-operative parenting, or co-parenting, is a concept that both clinicians discuss with parents beginning prenatally. This idea is not meant to imply that both parents divide responsibility equally but that mothers and fathers work together to find common ground and make decisions based on what is best for their child. Learning to co-operate as parents is important whether or not parents live together.

While this manual has used the term 'father' throughout, it is important to note that someone other than the biological father may fill this role. 'Social fatherhood' (Coley, R, 2001) describes the various members of family and society who may fill the traditional role of father: a new boyfriend or husband, a same sex partner, grandfather or other family, friend, or community member.

The goal of co-parenting is not that parents agree on every aspect of child rearing. Parents may worry that a baby can only attach to one person and need to be reassured that they are both important to the child. Babies quickly learn that parenting styles differ and generally are not confused that mother and father play, console, or show affection differently.

The clinicians can support the co-parenting roles by encouraging the mother and father to share stories about their childhood: who was important to them, what are their family traditions and values, what would it look like for their child to be happy and well-adjusted. The social worker may administer the Pregnancy Interview to the co-parent (as well as the mother) in order to understand his perspective and his expectations as a new parent. The three wishes from the interview can be used in the same way as with the

mother: as gentle reminders of parental hopes and goals, reinforcement of certain principles, and challenges to consider the child's and other perspectives. This can be a fruitful format for beginning many discussions between parents.

Barriers to co-operative parenting are the fatigue and isolation common to the early months of parenthood, lack of knowledge of how to co-parent, competition regarding who is the better parent, and gatekeeping by a family member who keeps one parent, often the father, away from the child. The clinicians can address these barriers by pointing out the mother and father's common beliefs, modeling attentive listening, negotiating compromises and respecting differences of opinions. The social worker and nurse repeatedly bring the parents back to consider how their actions impact the baby.

Promoting self-efficacy

Parents who participate in the MTB program are often managing competing developmental tasks as they juggle adolescence or emergent adulthood with the transition to parenthood. Both the nurse and social work home visitors often play a key role in modeling and assisting parents with building basic life skills such as: financial budgeting, grocery list and meal planning, phone etiquette, scheduling and cancelling appointments, gathering and storing personal records, and accessing community resources. Many families, perhaps due to past negative experience and inaccessibility of larger systems (healthcare, education, social service, employment, etc.) are hesitant to make a phone call on their own or visit an office in person to get information. The MTB clinician team can be instrumental in facilitating a greater sense of autonomy in families, which in turn, builds a sense of confidence and competence. Developing and promoting self-efficacy during the prenatal period sets the stage for parents to become more able to navigate complex systems and to be good advocates for themselves and their children.

A word about "enabling": Many traditionally trained health and mental health professionals are taught that promoting self-determination and autonomy in the client is essential to best practice. This is true on a number of levels and every individual who participates in the MTB Program has a different level of independent functioning capacity. It is important to remember that the majority of families served by the program are emergent adults with limited role models for adaptive life-skills; helping them develop skills is not enabling them. Families may need clinicians to provide more hands-on assistance with making phone calls, scheduling and attending appointments, and accessing resources. In the early stages of intervention, a family might most benefit from the clinician "doing for", modeling a particular task (calling the health provider, scheduling a pediatric appointment, etc.), with gradual progress to "doing with" (the clinician and parent complete a task together), to the final goal of "doing on your own." It is not unusual for families to move through these stages over the 27 month-course of the intervention as they learn to navigate systems in society that we as professionals may assume they already understand. Hence what and how much we do ***for*** families are determined by the individualized needs of the family, clinical and ethical guidelines, and program policy.

Supporting parental life goals

At the same time that home visitors provide support for parents' efforts to know and understand their baby, they also provide support for the realization of their own personal goals and ambitions. Many parents have the desire to complete their schooling, to develop healthy and productive relationships with their partners and families, to find meaningful work, and to function as productive members of society. The road to such goals can be very complex for many parents who have often received little concrete or emotional support

for such ambitions within their families of origin. Clinicians try, within the framework of both nursing and mental health visits, to define and begin to realize these goals, recognizing that a father's and mother's capacity to do so will not only enhance their sense of self-worth and competence, but will have enormous and far-reaching positive effects on the baby as well.

Delaying subsequent childbearing

Research has amply demonstrated that delaying rapid subsequent childbearing is essential to the health, mental health, and well-being of both the mother and baby (Klerman, 2004). Waiting to have a second child can be a complex decision for many mothers. There can be pressure from family members or from internal pressures and wishes, another manifestation of "ghosts in the nursery." Clinicians try from the beginning to help mothers think about their wishes for the future, and to anticipate what it would mean to have a second child, both in terms of their ability to care for another infant, as well as their own life plans and goals. The clinicians help parents think deeply about family planning in respectful ways that consider cultural and religious norms with the understanding that it is ultimately the mother's choice to bear a second child. The nurse works on this issue directly by continuously emphasizing the importance of birth control, and working with the mother to make sure she avails herself of all available resources. The nurse also reviews the Reproductive Life Plan materials (Collier, Rosenthal, Harris, & Morrison, 2013), which provide a guide for thinking through life goals including the timing of further children. The social worker works on the various emotional aspects of the issue, including partner and family pressures and expectations, and the ways these impact the young mother and her feelings about herself.

Shared techniques

Home visitors use a variety of cross-disciplinary techniques to achieve their shared goals. They share the mentalization-based techniques described in Chapter 3, and focus on maintaining and supporting the relationship with the parents and the child. Other techniques include the following:

- Increasing parent's observational skills through:
    - *Direct instruction/psychoeducation*: "Babies this age are just learning how to control their grasp and movement. Maybe if he had something less breakable to play with, he'd pay less attention to your inviting and colorful collection of statues." "A lot of parents feel blue after they give birth. It's really hard. What are the blues like for you?"
    - *Repetition*: "Let's revisit what you were trying last week when you saw how she enjoyed playing with you more when you followed her lead. Could we see what would happen if we made a game of it?"
    - *Helping parent to hold mutual, reciprocal gaze so that she can experience pleasure in relation to the baby:* "Oh look, how he settles down when you look at him. And now he's smiling! Doesn't that feel so nice?"
    - *Encouraging parent to learn and use relaxation techniques* "Let's take one minute for a few deep breaths and see how we feel."
    - *Brainstorming:* "OK, let's see if we can think of some reasons he might be waking up and crying at night."

Some of the Challenges of Interdisciplinary Work

While clinicians share a culture of working with parents in a reflective, supportive way, they also have different trainings, vocabularies, paradigms, and scopes of practice. The discovery of a common language with mutual respect and support is essential. Some barriers to working well as an interdisciplinary team are:

- Seeing different behavior or hearing different 'stories' and believing only one clinician has all the correct information
- Overwhelming one's partner with reactivity to events
- Competition 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?
- Clinician's own counter transference or the feelings families may evoke in clinicians
- Difference in personal boundaries, e.g., clinician believing both clinicians should share the same comfort level and boundaries when this may not be the case
- Avoidance of expressing differing ideas and opinions
- Client trying to play one clinician against another
- Taking a judgmental stance or blaming the clinical partner when difficulties arise in a family

The process of collaboration becomes easier as both clinicians grow in knowledge and confidence in their own and each other's skills and abilities. Continuously attending to these issues is important.

Interdisciplinary Practice Across the Intervention: Layering the Health and Mental Health Work

Making room for the baby

Home visitors continuously assess parents' emotional and physical readiness for the baby. What is their understanding of what it means to have a baby? What do they imagine it will be like to care for a baby? How realistic are these expectations? How will the mother and father parent together? What kind of support can be expected from the extended family? Clinicians use active listening to make these assessments and help parents anticipate what their needs will be once the baby is born. Thus, home visitors view helping the parents "make room for the baby" as one of their major goals during this period of the intervention. This takes place in a number of ways.

Making room for the baby is physical and psychological. Babies need a place to sleep, to play, and to feel safe. Home visitors help create a space that is physically safe and as free as possible from environmental intrusions. They help obtain whatever is necessary to assure clean air and physical surroundings, preferably insuring a smoke-free environment for both baby and mother. Many parents-to-be have trouble thinking about what a baby will need upon coming home for the first time. They are given information about cribs and car seats and sometimes need direct help in obtaining these items. Becoming informed about cultural preferences regarding traditions before and after the birth will help the clinicians in their work.

Parents have various kinds of expectations about parenthood. For some who are have little experience with babies, expectations can be vague, diffuse, and idealized. These parents may have little real sense of what it will mean to be a mother or father, and require support to begin to experience themselves as parents-to-be. Others, by contrast, have had a great deal of experience with babies (siblings, cousins, etc.), and thus have a more textured view of the complexities and demands of childrearing.

One of the ways that home visitors begin creating a psychological place for the baby is addressing these expectations directly. Clinicians begin to imagine with parents what it might be like during the baby's first

days and weeks, and to think about what will be most important and meaningful to them during that time. Clinicians might wonder with the family: What are their thoughts about childcare, breastfeeding, sleeping, and self-care? How do they see the baby fitting with their own goals and ambitions? The clinicians work to help parents develop more realistic and complex views of their new babies and the demands that they will bring.

As they progressively come to "own" parenthood, mothers and fathers begin to feel more self-confident, recognizing that they will play a vital role in shaping the baby's life. These are steps in coming to see oneself as a parent. The development of a real sense of the baby, as well as a beginning capacity to "own" parenthood is greatly aided by information about newborns and their particular needs. This knowledge is conveyed experientially and home visitors show pictures of newborns, help parents bathe and dress a newborn baby doll, and help them imagine what they will feel like when the baby is crying or wakeful. The home visitors also begin teaching parents about newborn development; e.g., how to help infants sleep more soundly and learn to self-soothe. The clinicians introduce ideas like reading the baby's cues and following the baby's lead, slowly acclimating the parent to the idea that the baby will be a person with his or her own mind and feelings, and the fundamental role the parent has in shaping the kind of person the baby will become.

Adjustment to parenthood

Once the baby is born, the clinicians each ask to hear about the parents' experience of labor and delivery. Mothers may show great pride in the way they handled labor and the baby's birth. This positive self-assessment is a wonderful experience to examine and build upon. Clinicians can point out the strength and inner resources that the mother exhibited during labor and use this example when new challenges occur. Some mothers may express disappointment about the labor experience, telling the team in a variety of ways that they feel let down by the baby or unhappy with themselves. If they have required a Caesarean section, for instance, they may feel that they have "failed" as a mother. If the baby was jaundiced, or premature, a mother may likewise imagine him or her to be damaged or particularly vulnerable. These situations require careful attention by both members of the team so that they can facilitate the beginning of an optimal attachment between the mother and her child. When babies are born medically fragile or have chronic medical conditions, the clinician team plans interventions that are highly individualized according to the family's needs.

The first six weeks of life present a unique set of demands and challenges, and this is typically a very stressful, exciting, and tiring time for parents. The major developmental task of this period is the establishment of homeostatic regulation: the regulation of sleep, eating, elimination, the establishment of day/night differentiation, and the emergence of distinct states of consciousness (from sleep to full alertness). The baby's capacity to become regulated grows as the infant matures and is aided by the care-giving environment as parents establish consistent routines and patterns during this period.

The clinicians help the parent begin to understand and regulate the baby in a variety of ways, by encouraging them to adjust their expectations of the baby in accord with the infant's state of awareness (e.g., the baby must attain some degree of alertness before s/he can attend to eating or be social). Some mothers and fathers seem appropriately preoccupied with their newborns and are attuned to their signals. Others need help to recognize the baby's basic signals for food, for sleep, and for satiation, and find ways to calm and soothe the baby. The team also addresses regulation in terms of the baby's environment,

teaching parents about appropriate levels of touch and sound (loud volumes of television or music are examples). All of these simple interventions serve to normalize the baby's appearance and behavior for the parent.

The team also attends to the parents' needs during this period. Are they getting enough rest? Is the mother eating appropriately? How is the father adjusting to the new needs of the family? How are the parents adjusting as a couple? This is often a time of significant adjustment for parents, and the team continuously assesses physical and psychological health, watching for signs of risk for postpartum depression, inter-partner violence, or an increased risk of child abuse such as Shaken Baby Syndrome. Plans made during pregnancy regarding these situations are reviewed. The clinicians re-introduce simple stress reduction techniques and encourage the help of family members if and when appropriate.

Growth

The first year is a time of extraordinary growth and change. Both clinicians spend significant time teaching parents what to expect of their baby at different stages. The baby gradually becomes more responsive and sociable, begins to smile, clearly knows her caregivers, and responds differentially to the significant people in her life. There is also the emergence of regulated patterns in sleep, eating, and elimination, and reciprocal engagement becomes possible and pleasurable to the baby. From the perspective of social and emotional development, the first year is the time when enduring patterns of attachment and relatedness are established. This is a time of enormous physical development as well. Children turn over, crawl, and may be walking by twelve months. They have usually started to use single words, to point, and indicate that they are thinking, feeling, and becoming autonomous people in their own right. The challenges posed by the need for consistency, regulation, and reciprocity on the one hand, and for increasing support for autonomy on the other, are enormous. Both clinicians are alert to any developmental delays and work with families to increase a child's skills and make outside referrals if needed.

Play

Many parents have a difficult time understanding the value and meaning of play to the infant and toddler. They may find it threatening to abandon themselves to the simple pleasures of play, or reject it as a 'waste of time.' They may have grown up in environments that precluded them from having the time or place to play and explore. Yet play is crucial to a range of the cognitive, affective, and social developments MTB seeks to promote (Close, 2001; Slade, 1994). Helping parents learn to play, and appreciate their babies' play, is central to the work of both home visitors. Clinicians do this by helping mothers and fathers recognize opportunities for play, modeling play and playfulness, encouraging floor time, bringing toys to home visits, addressing safety concerns, and making sure that there is a play space for parent and child. The parent's capacity to play is encouraged, as even infants derive obvious pleasure from social games and engagements. These are rich opportunities for interpersonal exchange and most importantly shared fun and pleasure.

Autonomy and exploration

As children approach their first birthdays, they express their desire for autonomy in increasingly clear ways (at the same time that they express their equally strong desires for closeness), posing a range of contradictions and complexity for parents. Some parents are quite threatened by their children's autonomous strivings and must wrestle with cultural beliefs that either overvalue or undervalue autonomy, and require specific and sometimes punitive responses to what can be perceived as "disrespect" or – conversely –

passivity. The team uses developmental principles to reframe and normalize these behaviors, and to highlight the pleasure and expansion of self that comes from the baby's free explorations. Baby-proofing as a preventative measure and early form of guidance is introduced to the parents. This will help ensure that clashes over the baby's exploration will be minimized, and the parent can pleasurably and reciprocally meet his explorations. If there are constraints due to living in another person's home or a shelter, the clinicians then explore ways to negotiate and compromise in the current living situation.

As the baby becomes mobile, issues regarding discipline come to the forefront of many home visits. Parents' efforts to discipline their children often stem from their own childhood experiences, and less upon an accurate reading of the child's intentions. The interpretation of "mis"-behavior and the need to correct such behavior often result in disruptions in the parent-child relationship. Discussions with the parents give them time to reflect on their role as a model to a young child who learns through imitation. Often parents have not had the opportunity to discuss and critique their own upbringings, or to formulate appropriate behavioral goals for their children's development.

Discipline or guidance has both historical and cultural contexts for families, and thus poses a set of challenges that must be managed against the backdrop of their own, sometimes very strong, feelings. If they do not discipline, are they "spoiling" the baby? If they frighten the baby, isn't that what he needs to learn? All of these issues must be explored, keeping in mind the developmental knowledge, cultural beliefs, and childhood experience of the young parents. Many MTB parents were harshly disciplined as children, and they need support to link the fear they felt with the fear their babies feel in the present.

Thus, clinicians are continuously linking future goals with current caretaking practices, and helping mothers and fathers reframe their responses to their infants and toddlers in light of developmental knowledge and understanding while helping them balance their own needs with those of the baby.

In the section below, we present an example of how practitioners work together to address a postpartum mood disorder. The approaches used are listed after the case material.

Interdisciplinary practice: Postpartum mood disorder

Janice, 22, and her husband Hector, 25, looked forward to the visits by both clinicians. They were eager to learn and understand as much as they could about parenting before their daughter was born. When Janet was asked to name three wishes she had for her baby, she said she hoped her child would be healthy, have a 'real' childhood and that she would always feel that her mother was there for her. Along with other prenatal education regarding the transition to parenthood, both the social worker and the nurse spoke to Janice and Hector about perinatal mood disorders. Information was given about typical hormonal changes post birth and the effect of lack of sleep. Risk factors, symptoms and symptom management were explained, noting that postpartum depression and anxiety are common and not an indication of being a bad parent. Janice was interested in creating a labor plan with the nurse but was unable to elaborate on her concerns other than stating that her family told her she shouldn't use an epidural because it wasn't good for the baby. The parents hoped their child would be breastfed as they felt it was an important way for their daughter to grow strong and healthy. During the history gathering by the social worker Janice disclosed that her mother was often absent due to substance addiction and it was her grandmother who raised her and with whom she was very close. When Janice was 15 her grandmother passed away and Janice became depressed.

Tiffany was a healthy full term baby and the birth went well, although Janice reported that she had asked for the pain control as soon as labor began, as the pain was too much. Janice stopped breastfeeding after a week saying she felt her daughter "didn't like her milk." The clinicians watched the baby grow and explore her world. At one home visit the social worker observed that Tiffany seemed at ease and playful with her father but averted her gaze when her mother picked her up. This seemed a marked change from the mother-child relationship of the first months postpartum. During their weekly meeting the social worker shared her concerns with the nurse. Together they wondered about the severity of the mother's symptoms and possible causes, including health concerns. They ruled out safety concerns for mother and child including domestic violence and thought about the availability of other caregivers and support networks for the whole family. During clinical supervision the team discussed their concerns and all agreed that more frequent visits were appropriate. The supervisor considered the impact of increasing the intensity of the team's work with Janice and Hector to their caseload and stress levels. She reminded them of all they had already accomplished with this family and encouraged them to remember to care for themselves during this worrisome time. The team made a plan to do individual assessments of the family and reintroduce the topic of postpartum depression in a caring way. The family welcomed the extra support and Hector was able to step in as the primary caregiver for their daughter during Janice's recovery. Initially Janice was not interested in medication so the team agreed to try non-pharmacological methods, including individual therapy sessions with the social worker.

While the nurse and social worker both addressed the mother's depression from their profession's perspective, each looked for moments where they could integrate the other's work during the home visit. When the nurse helped Janice and Hector think about ways the mother could get more sleep, exercise and sunlight, the social worker would then follow up at the next visit asking about the mother's sleep patterns and introduce a short mindfulness exercise for both parents. Each home visitor suggested reassuring routines and play experiences Hector could provide for the baby to foster optimal development. Both clinicians offered support to Hector reminding him that he also needed to look after himself as well as Tiffany. After weeks of work together Janice was interested in meeting with her primary care provider to discuss medication and the nurse helped connect her to her medical home. Over time Janice's mood stabilized and she slowly began to enjoy the time she spent with her daughter. The little girl became more engaged with the mother as Janice's mood lifted and Hector continued his important role as a support to his wife and loving, playful father to his little girl.

Approaches used:

- Caring for the whole family as a unit
- Regular meeting times and communication between partners
- Use of supervision
- Flexibility to increase frequency of home visits
- Looking for a port of entry to your partner's work
- Use of relaxation techniques with the family
- Respect for the family's role as partner in the intervention (medication was considered by not imposed on the mother until she felt ready)
- Connecting parent with the medical home

PART THREE

INTERDISCIPLINARY AND DISCIPLINE SPECIFIC ROLES

CHAPTER 7:

NURSING APPROACHES

General Principles: Nursing "MTB Style"

The nurse's main role in MTB is to assess and teach parents about their own health and the health and development of their children. This includes integrating health related information, safety and anticipatory guidance for child-rearing into the home visit to enhance child development and maternal-child attachment.

It is important to note that the nurse home visitor from MTB is not the only health care provider for the family. However, because of the frequency of visits and flexibility of time spent with the family, the nurse has the unique opportunity to provide additional support and information for the family's overall health and well-being. Depending on the nurse's scope of practice, if a parent presents with a complaint of his or her own or a concern regarding the child's health or development, the nurse consults with the primary care clinician or refers the family to their medical home. It is important to keep the connection between the family and their own health care providers strong.

There are many ways to help parents become attuned to their baby's physical and developmental needs and cues, and thereby improve a sense of parental competence and self-efficacy. The nurse does this by careful listening, assessment, modeling behaviors, motivating parents to make healthy choices, and health teaching. An assessment is done of the parents' learning styles and cognitive abilities to aid the nurse in presenting health information. A judicious number of handouts on health and safety concerns, mentioned in the chapter on interdisciplinary teamwork, are presented to parents by reading important sections aloud. The nurse may also supplement these materials by adding illustrations, showing videos and drawing pictures. The MTB nurse also has ample opportunity to translate professional jargon used by other health providers. She helps the family understand medical terms and concepts, leading the parents to feel confident in their ability to care for their child and advocate for the family's health needs.

In the sections below, the nurse home visitor will find useful guides regarding health competencies, care plans, approaches and themes to use in this work. Following this section are several common themes and vignettes illustrating the nurse's approaches to working in the home.

Nursing competencies

MTB nurses, as home visitors, are involved in many aspects of each family's well-being. The MTB nursing competencies were developed to help new clinicians assess which areas they need to learn more about as the work begins. These competencies, with suggested readings and web sites, can be found in Appendix II. In addition, the nurse is expected to stay current with evidence-based guidelines for common health issues including nutrition and obesity, sleep recommendations, delayed childhood development, failure to thrive, asthma, allergies, and migraines as well as education regarding medication use, side effects, and changes to be made in the home for safety.

Nursing care plans

The nurse's work in the MTB program is consistent with the overall goals of *Bright Futures* (Green & Palfrey, 2008):

- Health promotion of the child and family
- The importance of developmental and longitudinal care, assuring the family has a regular source of health care
- Promotion of family/clinician partnerships for optimal care
- Integration of care with community and cultural needs and preferences
- Linkages for the family with other needed resources in the community

Pediatric health care for the new family includes assessment of the strengths, needs, and health status of the parent and child as individuals, as a dyad, and within the family context. A family assessment includes becoming aware of their unique strengths, supports and any needs regarding information, health care, social services or other basic needs. These assessments inform the nurse as she develops an individualized care plan for each family. Nursing plans (See Appendix I) outline the topics to be discussed over the course of the intervention. A checklist is provided to help the nurse keep track of what she has discussed and what plans she will make. To allow for flexibility of delivery these checklists are broken into three-month increments (e.g., prenatal, 0-3 months, 3-6 months).

The reflective approach to nursing and health education

Home-based work – with its frequency and intensity – is different from traditional forms of nursing practice. The gathering data and imparting information usually occurs at a slower pace, allowing for more depth of understanding. Visits are usually conducted in the family's home and adaptations are made for the comfort of the parents. In addition, the MTB nurse usually develops a close partnership with the family, as the twice monthly visits allow sufficient time to get to know the family's history over time. The slower pace and flexibility may feel uncomfortable at first. In addition, and in contrast to office-based practice, checklists are rarely used in the home, notes are generally made after leaving the home, not during the visit, and assessments can be paced in accord with the family's needs.

Happily, the nurse beginning her training and home visiting work in MTB will find many of her previous skills transferable. Nurses are typically excellent observers, teachers, and advocates, with experience in developing a therapeutic alliance with patients. The home visit is an excellent setting in which to learn from families. Each household is a blend of traditions, culture, and spiritual beliefs. These inform feelings and expectations of parenthood and help the family and clinician better understand and work with each other. Nurses often discover that useful information is more likely to be gathered when visits happen in a more informal manner, allowing trust to build over time.

The family is the unit of care in a very tangible way. We are working in the family home, and the key to conducting successful visits is for nurse home visitors to accept that often various people or family members may enter and exit various parts of a visit. Some topics become useful conversations for everyone to hear at once, particularly around illness and injury prevention. Other topics may be more difficult to manage. Families are often given misinformation about health and parenting by well-meaning family and friends. The nurse becomes an 'askable clinician'; a person to go to for factual information about nutrition, normal infant or toddler behavior and development, etc. Parents may also receive conflicting advice on how to parent their child. New mothers and fathers may wish to explore ways parenting that may be different from the way they were brought up. This calls for tact on the part of the nurse home visitor, to avoid creating conflict within the extended family. Respectfully answering their questions, acknowledging

different traditions, and responding to concerns can ease tension. The open discussion among all family members together often provides the new parents with many things to think about in the months to come.

The use of the reflective stance in educating parents about health matters and health information is a complex skill and becomes easier over time. This attachment-based approach highlights parents' expertise, promotes perspective taking on the part of the parent, and conveys the notion of reciprocity between parent, child and home visitor. Using the many techniques described in Chapter 3 – helping parents articulate their concerns and wishes, modeling constructive parent-child interactions, being the voice of the baby, etc. – helps the nurse promote health and positive parent-child interactions. The nurse may use a discussion of the child's temperament to encourage parents to take the baby's point of view and thus provide more sensitive and responsive parenting. Or, when a parent is asked about their hopes, dreams, and goals for their child during the Pregnancy Interview, the nurse utilizes this information as a way to connect a parent's desire to have a healthy baby with information about nutrition and feeding choices.

When a health or safety topic is urgent, however, the nurse may need to change tactics, and use a more directive approach. For example, if a parent is mixing formula incorrectly, direct instruction is needed. It is then possible to return to a more reflective discussion about the parent's desire to nourish her baby and watch her grow and be healthy. Further useful practices to integrating a reflective approach are listed below.

Nursing Approaches

This list of didactic and theoretical approaches, presented in alphabetical order, is not meant to be exhaustive but is included to give a sense of how the nurse conceptualizes the work during home visits. While these approaches are not unique to the MTB program, they are especially useful in nurturing parental reflectiveness in new mothers.

Anticipatory guidance and foreshadowing

Much of the nurse's role is in preparing parents for normative change and growth in their children by providing anticipatory guidance that is timely, appropriate, and relevant (Hagan, Shaw & Duncan, p.263). For instance, a parent who knows beforehand that a child's growth slows after the enormous changes of the first several months of life will be less concerned over the child's reduction in appetite. Consequently, the parent can be guided to pay attention to the child's cues of satiation and is less apt to push the child to eat when he is not hungry.

The use of foreshadowing can help reinforce a totally new concept. Foreshadowing involves educating the parent about developmental changes of normal childhood long before the child has reached that developmental stage. The benefit is that the parent hears about this new idea or information several times before the child reaches the age when the information is useful. For instance, when a baby is just born, the nurse and parent discuss the many milestones the baby will reach in the next year. Mothers and fathers often express a desire to see their child learn to walk. The nurse introduces the amusing idea that a baby will actually wake herself up at night to practice walking at about a year of age. When the parents wonder why the child is suddenly waking several times a night, pulling up in her crib to walk along the railing, the parents can be reminded with some empathy and humor that "the time you've looked forward to has arrived! Your child is showing signs that she will soon be walking." This helps reframe the child's waking as a new skill that the parents have been anticipating. Foreshadowing also helps to introduce parents to new

ideas about newer or different child-rearing practices before they are actually in the midst of making choices. An example of this is when the nurse discusses normal infant crying patterns and ways to respond to crying, shortly before the child is born. Then when the parent encounters infant crying and hears conflicting advice from family members about letting babies exercise their lungs, the nurse can reflect back on the discussion they all had about attending to and soothing crying babies.

Case management and referrals

MTB families may have numerous needs involving many agencies and professionals in the areas of health, mental health, or life course goals. As part of a holistic philosophy of care, the nurse often has the responsibility of facilitating and coordinating referrals to medical providers, early interventionists, dentists, physical therapists, day care providers, high school counselors, etc. Integration of these services within home visit discussions helps families to obtain the care that they need and also helps them experience better continuity for primary and specialty health care and social services. Often both MTB home visitors work with the same agencies or professionals, communicating and coordinating the work as needed for the family's benefit. This coordination is integral to the interdisciplinary work of planning for the family's well-being.

Developmental screening

The nurse assesses cognitive, gross and fine motor, social-emotional, language, and behavioral development in a natural manner during each home visit. A developmental assessment is performed on a periodic basis by completing the Ages and Stages Questionnaire® (Squires & Bricker, 2009) with the parent and baby. If there are slight delays the parent can be instructed to make changes in her interactions with the baby leading to improvement in language, cognitive, or motor skills. For example, an infant's lag in motor development could be related to lack of experience because the parent has been uncomfortable playing with the baby on the floor. The developmental screening helps the parent see the need for more 'tummy time' and the nurse can help the parent think of ways to make this a pleasant activity for the whole family. Referrals are made to appropriate medical or early intervention agencies if the child needs diagnostic evaluation or intervention of a more formal nature.

Neonatal assessment

The nurse may adapt Brazelton's *Neonatal Behavioral Observation Scale®* (Brazelton & Nugent, 2011) to show the skills of the newborn to the new parents. This technique of newborn behavioral observations provides a wonderful opportunity to dispel the commonly believed myth that a newborn cannot see or hear, or its obverse, that children are highly capable. For example, a parent might misattribute the meaning of a 5-day-old infant's fingers becoming tangled in the parent's hair as aggressive behavior.

Labor plan

Mothers-to-be often worry about labor and delivery as the pregnancy progresses. For some women these common worries become fears exacerbated by post-traumatic stress disorder (PTSD) or complex trauma symptoms related to histories of sexual abuse. Women who have not been abused may have suffered other traumas throughout their lives related to poverty and violence that may have left them feeling powerless and violated. As labor and delivery approaches, these feelings can resurface. Simkin & Klaus (2004) developed an approach to help mothers cope with these fears as they plan for their birth experience. See Appendix I for an adaptation of this approach that includes detailed information on creating labor plans. This format gives the nurse an opportunity to explore pregnant women's feelings and concerns, to provide concrete information about the hospital and birth experience

while allowing the mother to make choices about those aspects of labor that can be individualized. This gives women a sense of control during a time when many aspects of life feel out of control. The labor plan can be given to her support partner and to the birth attendant during the actual labor and delivery.

Motivational interviewing

Motivational interviewing provides a way of helping parents make difficult changes in their lives. Even though clinicians have a great deal of knowledge about – for example – diet, sleep, parenting skills, or high-risk behaviors, sharing this knowledge with parents is not usually sufficient to produce change in behaviors and outcomes. Parents may feel ambivalent, seeing both the positive and negative effects of making the change. The nurse uses motivational interviewing techniques to acknowledge that making a change is a personal decision. Otherwise the parent may feel coerced to make a change that can feel threatening and potentially violate trust between the nurse and the parent. The nurse can ask parents, on a scale of 1 to 10, to rate their readiness or motivation to change a particular behavior before offering information for such issues as smoking cessation, weight loss, or changes in parenting behavior. Open-ended questions and active listening encourage mothers or fathers to articulate personal goals, which helps them to feel understood and supported as they consider making changes.

Helping a parent take ownership of a decision

The nurse observes a parent giving her 18-month-old a pacifier each time he is upset. The parent has expressed her wish that the child use more language; the nurse suggests weaning the child from the pacifier as a way of encouraging the child to speak. The mother states that she wants the child to stop using the pacifier but can't get the baby to calm down without it. The nurse suggests various ways to help the child learn to self-soothe, but the mother has an objection to each suggestion.

At this point the nurse might note that this doesn't seem to be the time to make this change but she is certain the mother will make a decision when she is ready. A month later the mother says she is tired of having the baby ask for pacifier all day and she has been unsuccessfully hiding the pacifier from the child. The nurse might then ask questions regarding the mother's readiness to help the child wean from the pacifier, which then leads to listing the pros and cons of the change, and eliciting the mother's ideas of how she might make this change work for her and her child. This discussion shifts the decision and the approaches to make the changes onto the mother, and this engaged process usually results in outcomes that are more likely to be successful.

In situations that directly influence the child's health and safety – for example, when mothers or fathers smoke – the nurse continues to provide education to reduce the harm of second hand smoke to the baby, while simultaneously assessing the parents' motivation to stop smoking for their own and their child's health benefits.

Promoting self-efficacy

As described in Chapter 6, promoting self-efficacy is a key element of what MTB practitioners do. During the first weeks after the baby is born, the nurse assesses the parents' knowledge of their baby's needs, as well as the mother's health, her level of fatigue, her feelings of competence, and ability to cope. If the mother, for example needs help with breastfeeding, the nurse helps the mother with problems such as sore nipples and blocked milk ducts, helping to provide a positive breastfeeding experience. Women are also encouraged to keep track of the baby's output (number of wet and soiled diapers per day) to evaluate

adequate intake. This also gives them a record to bring to the pediatric visit. Frequently new parents are surprised and a bit overwhelmed by the number and types of questions the pediatric provider asks during well-baby visits, and this record gives them confidence as they learn to give a medical history for their child. Health promotion and illness prevention education adds to families' well-being and also increases parents' *perception* that they have the skills to keep their child safe and healthy.

Throughout the intervention the nurse may observe areas in which parents need information and coaching to master these and other life skills. What may appear as non-compliance or forgetfulness might actually be lack of knowledge, sometimes accompanied by embarrassment or shame. Simply giving a parent a phone number to call the pharmacy is often not enough at first. Simplifying the task by listing the steps, offering to demonstrate, and then offering support as the parent tries a new skill leads to increased confidence and competence. As the intervention comes to a close, the nurse can review the families' learning and the new skills they have acquired so that they feel positive about their accomplishments and strengths.

Providing concrete resources

MTB clinicians, because they are in the home, are likely to observe families' needs for resources. A lack of food, a tiny apartment with little or no furniture, an incomplete or broken car seat, or unsafe living conditions become apparent during home visits. Any time a concrete need becomes evident, the nurse has an opportunity to further assess the parent's understanding of her child's health, safety and development, as well as the family's situation within the community.

When a parent appears unable to obtain a particular health related item for any reason (financial, lack of transportation, disorganization, inadequate understanding of need) the nurse may deliver the resource to the family and demonstrate the use with scheduled follow-up visit to evaluate the parent's understanding of its use. For instance, when a parent does not follow medical directions for her child, the nurse has a chance to evaluate finances, literacy, family systems, health beliefs, parent-child dynamics, and the parent's cognitive abilities. This information can then inform her as she helps the parent keep the baby in mind. As with case management, the nurse and social worker always discuss and collaborate on the family's needs.

Stages of Change or Transtheoretical Model

Taking into account parents' health belief systems and readiness for making lifestyle changes allows the nurse to formulate plans to improve healthy behaviors and self-efficacy in families. In addition to using motivational interviewing techniques, the nurse assesses barriers to making changes, provides support during change, and reframes relapses using the steps from the Transtheoretical Model of Change (Prochaska & DiClemente, 1986). This model depicts changes in a circular framework with the steps along the circle including precontemplation (not ready), contemplation (getting ready), preparation (ready), action (beginning the change), maintenance (continuing the decision), and termination (either change is made or choosing not to continue). In speaking with parents about making changes, it is often helpful to draw out the circle for them beginning with precontemplation as the entry point to the circular process. This helps to make the Stages of Change process more concrete and understandable for the parent.

For example, a parent may express a desire to make a change, perhaps wanting to lose weight, but does not know where to begin or states that he has tried before and 'failed.' The parent can often point to the stage he is currently in and, with the nurse's help, list what he might do next. The parent might feel he wants to make use of basic nutritional information needed; together he and the nurse can discuss reading food labels, portion sizes, grocery shopping, and so on. He might decide to simply read the new information and not

makes any changes, or he may go ahead and buy healthier food. The nurse later follows up with more discussions about nutrition and may ask the parent how he feels about changes he is making.

Stress reduction techniques

Mindfulness and stress reduction are similar concepts. Mindfulness techniques help parents slow down and become aware of their thoughts, urges, and feelings (Kabat-Zinn, 2011). This awareness can lead to an understanding of the reactions to triggers that cause stress. Often, providing a simple diagram of the body systems and organs affected by stress helps to describe the fight or flight response. (There are many sample diagrams available online.) This approach also may help parents understand the physical and emotional sensations they may have when they are scared or very stressed. Parents can learn to identify bodily symptoms of stress such as headaches, muscle tension, or a racing heart. Mindfulness exercises can help parents notice when their body begins to tense, what preceded the symptom, and how they reacted. With practice parents may choose healthier responses to stress or the triggers they identify in their daily lives. As an example, if a mother feels stressed when her child is crying inconsolably, the nurse asks the mother to describe how her body feels and wonders out loud how the baby interprets the tension in her arms as she holds him. The baby usually calms when the mother is able to take a few deep breaths, relaxes her body, and holds the baby in a more relaxed fashion.

Mindfulness techniques may be introduced to parents as part of their prenatal care in the medical home or by the nurse home visitor. Relaxation techniques such as yoga, breathing, body scans, etc. can be used with both parents. The nurse begins by demonstrating and practicing pursed-lip breathing during visits in later pregnancy. She asks women to use this technique during Braxton-Hicks contractions and note the change in muscle tone as they relax. These exercises are also useful during difficult times as a parent, in school or work situations, or when there is conflict between family members. Parents are given information about their infants' reactions to stress and how their presence, soothing, and reassurance may protect children from the adverse effects of chronic stressors of daily life (see Chapter 8).

Teachable moments

MTB nurses use **teachable moments** throughout home visits and their work with families (Zuckerman & Parker, 1997) to enhance parents' understanding of their children. For example, in preparation for a home visit, the nurse plans to discuss the child's language development with her mother. During the visit, the nurse notices that the child, when hungry, has learned to point to what she wants. This is an ideal moment to bring up how the mother can verbally label items in the child's home and world as a way to develop vocabulary.

Health Related Domains

In the US, the pediatric health content of the MTB program is consistent with the components of developmentally oriented pediatric practice with evidence-based pediatric health guidelines, and with Bright Futures (Hagan, Shaw & Duncan, 2017). MTB programs in different countries will follow local evidence-based practice MTB clinicians organize the clinical work into several broad domains that are consistent with the overarching goals of the program. Within any particular home visit, one or more of these domains are addressed as is suggested in the monthly care plan content, and as the families' specific needs become known. During visits, the nurse assesses priority areas that she and the family focus on during their time together, and areas to be planned for future visits. Common themes in the nurse's work are discussed below.

Maternal health

Pregnancy

Home visits that take place during the prenatal period focus on the mother and her health, labor and delivery, and planning for the arrival of the baby. Prenatal education includes topics such as maternal nutrition, normal physical and emotional changes during pregnancy, signs and symptoms of pregnancy complications, prevention and recognition of pre-term labor, feeding choices for the infant, mindfulness methods for reducing stress, and preparing the family and household for the newborn. The nurse helps women identify normal symptoms of pregnancy as well as the signs and symptoms of pregnancy complications, and this is a discussion that usually helps to elicit many questions so that the nurse may address any parental concerns. During visits, the woman and her labor support person are informed about the approaching labor and delivery process and are prepared for the childbirth experience. The woman is encouraged to attend the frequently scheduled prenatal appointments. Often the nurse may have to facilitate these appointments, sometimes accompanying the woman if there are particular concerns, or helping her to reschedule any missed appointments.

Early in the home visiting process, the first assessments conducted by the nurse involve the mother's current health, high-risk behaviors, and how the mother understands her pregnancy and fetal development. Beginning assessments should be non-threatening, and often it is helpful to start with a nutritional evaluation. A food diary is a good way to explore the mother's possible nutritional deficits, but to be useful this should not be simply a list of foods eaten in the past week. The conversation should also include her food likes and dislikes, learning who shops and cooks, as well as with whom and where the mother eats. The nurse can then better understand the family's interactions, hierarchy, dietary traditions, and culture before making suggestions regarding dietary changes. These sorts of changes are difficult and take time. If the pregnant woman is not the person who shops or cooks in her household, then the nurse needs to consider how to include other family members into the nutritional discussions. During pregnancy, (foreshadowing) parents are also asked to think about their diet in terms of role-modeling healthy dietary patterns for their future child.

Depending on the level of trust that develops during the early visits, the nurse might assess cigarette smoking or use of alcohol and illegal drugs by the mother and close family members. The hazards of exposing the developing fetus to these toxins are reviewed, and the nurse works to facilitate reductions in substance use through behavioral change strategies and referrals to cessation or treatment programs in the medical home. It is common for these issues to be downplayed or concealed until women know the nurse better, so the nurse may need to provide education around these topics in a more general way. Choices regarding the method of feeding the newborn are also discussed prenatally including evidence of the value of breastfeeding. The nurse gives the mother information so that she is successful with her personal choice of feeding her child. If the mother prefers to bottle feed, the nurse discusses ways to encourage eye-to-eye contact between mother and child so feeding is a time to bond. These approaches are also encouraged with fathers. Many mothers express a desire to breastfeed but may not know anyone who has breastfed or fears that the baby will not be fed adequately. This can be a barrier for the mother in her ultimate feeding decision, but may also signal to the nurse that this is a mother who needs extra support in the early days of learning to nurse her infant. The nurse discusses barriers and fears, as well as advantages of breastfeeding, and may role-play various scenarios to help prepare the mother. Using these proactive approaches has helped many mothers in MTB to have satisfying and successful breastfeeding experiences.

Postpartum

The parents may need frequent reminders to care for themselves in the early weeks after the baby's birth. If the mother's birth experience was difficult there may be a number of health-related concerns. Those mothers who are recovering from a Caesarian-section may need reminders to limit lifting and climbing stairs. As they learn to care for the baby it is important for the home visitors to help new parents understand the importance of also taking the time to care for themselves.

Addressing parental sleep needs is important for parental health, but is also important as prevention for child abuse. Sleep deprivation adds to parental stress, feelings of being overwhelmed, and may impair parents' judgment and responses to newborn needs or crying. Other family members and friends can be encouraged to give the new parents time to rest. The concept of sleep hygiene may be new to many parents. Within the realities of caring for a newborn, it may be helpful to suggest basic approaches such as reducing caffeine intake in the afternoon and evening, and curtailing late night social activities and screen time, so that at least while the baby is sleeping, they can also be sleeping.

Parents may feel a sense of disappointment when they first see their newborn. In their mind's eye they may have envisioned a 3-month-old, like the model in a baby magazine advertisement. It helps parents to know that 'falling in love' with their baby does not always happen right away. Women also often find that their emotional and sexual relationship with their husband or boyfriend has changed and may be strained. The nurse, by bringing up these topics, gives the parents an opening to discuss these feelings and ways to negotiate some of the changes and solutions. At times it is necessary to assist the mother in reconnecting with a primary health care provider, especially after she has her postpartum visit.

Reproductive health and family planning

Many women have inadequate information regarding their risk of infection during pregnancy, or infection risk and subsequent pregnancy after the delivery. The nurse assesses and continually reinforces the need for safer sex practices and birth control options/proper use. Family and life-course planning are also fruitful discussions with fathers as they enter their new parental roles. Another helpful area to discuss is preconception health and nutrition if the mother thinks she would like to have another baby. The health of another baby will depend on many factors under the mother's control and she is encouraged to think ahead about her weight, her eating habits, her oral health, and her high-risk behaviors.

Parental mental health

Pregnancy, giving birth, parenting, and changing relationships bring up complex feelings for both mother and father. These issues are discussed in more detail throughout the manual, particularly in Chapters 4 and 8. As described in Chapter 8, the social worker provides therapy and counseling to mothers and their families.. While not usually trained as a clinical therapist, the nurse does participate in assessment of many mental health conditions and provides a caring relationship for the family, while coordinating specific mental health needs with the social work home visitor.

Mood disorders

The pregnant woman experiences many physical and emotional changes related to hormonal fluctuations that can be uncomfortable, disturbing, or even frightening. Common reactions and feelings before and after giving birth are discussed with both parents. The signs and symptoms of postpartum depression and anxiety, which may be experienced in both the mother and father.

Both home visitors discuss available treatment for perinatal mood disorders within the MTB treatment model and when/if additional resources are needed. While medication for depression may be refused by mothers, early diagnoses may be treated with non-pharmacological methods (getting enough sleep, exercising, spending time outdoors) at first, and then followed closely by the social worker, nurse, and medical. Both home visitors work to avoid negative postpartum situations by advising mothers to rest when the baby rests and accept help when offered.

Child health and development

Newborn behavior

Preparation for the baby includes helping parents to understand common newborn characteristics that are often worrisome for new parents, such as noisy breathing, crying, skin appearance and care, sleep cycles, eating patterns, and how to determine whether the baby is receiving adequate milk. The nurse uses life-size pictures to point out the appearance of the navel cord, infant's color, and skin/appearance that the newborn will have in the delivery room. The nurse makes use of information from many sources to describe how babies and adults are different. For example, young infants have tiny stomachs and experience hunger as pain that comes on suddenly. This knowledge allows the mother to respond to the newborn's cry upon waking with more understanding, and may reduce her negative attributions ascribed to the baby's crying behavior.

Early postpartum home visits can be used as teachable moments for the nurse to normalize the newborn's appearance and behavior. During these early postpartum visits, both home visitors admire the baby and may meet members of the extended family. Often home visitors will hear the story of giving birth and make note of the mother's inner strengths. Assessments are done concerning any needed support for breastfeeding, neonatal or maternal health issues, and any urgent needs for emergency clothing or baby supplies. This assessment informs both home visitors about the frequency, as well as the timing, of needed home visits during the weeks following discharge from the hospital.

The nurse asks questions about the infant's feeding, elimination, sleep, and behavior. At the same time, the nurse assesses the baby's general health and development by observation. When there is any question about physical growth or development, the nurse can do a basic screening, asking more specific questions and setting up simple, enjoyable tasks for the child to check developmental areas and observations. The nurse tries to encourage the mother to hold and attend to the baby during the visit so that the nurse can comment on the baby gazing at the mother or her response to baby's needs. As the baby grows older and is awake and comfortable, the nurse interacts more directly with the baby, remarking on his/her appearance, generally enjoying the child and modeling play or conversations with the infant

The nurse provides continuing support and often has extra visits if the baby is ill or pre-term and is admitted to the Newborn Intensive Care Unit. Nurses can help the family understand complex medical issues, NICU treatments, and prepare for a complicated discharge home. The nurse is an important liaison for the mother with the medical staff who make rounds on the hospitalized neonate. For instance when one MTB newborn was re-hospitalized several days after birth for hyperbilirubenemia the nurse home visitor visited the mother and child in the hospital. The mother felt helpless and scared, with little family support. The nurse was able to help interpret the lab work and reason for phototherapy, helping the mother to relax, and continue to breastfeed her child.

Reading cues

Learning to identify the states of awareness, sometimes called states of consciousness or states of arousal, in a newborn helps a new parent successfully read an infant's cues of hunger and discomfort, as well as the baby's interest in socially engaging the parents (Nugent & Morell, 2011). This skill increases parents' sense of competence and decreases stress levels, allowing for more positive interactions between parent and child. Parents can be helped to 'read' their own baby's cues, by practicing with photos of babies in the quiet alert, active alert, upset, drowsy, active asleep, and quiet asleep states. Each behavior is a clue as to the child's readiness to eat, sleep, be comforted, or be given time to rest from stimulation. Parents are usually amazed and delighted to learn how their newborn baby seeks to communicate with them from the beginning (See Nugent et al., 2007). For parents who may have more difficulty with the concept of reflective parenting, this early practice with reading infants' cues and states of awareness may be one way to help parents make the connection with concepts of reflective parenting and "wondering" about the infant's mental states.

The period of time between approximately 6-12 weeks of age is known as the period of developmental crying. This is a normal developmental stage when a baby will cry, sometimes for hours, and be difficult to console. After ruling out illness or injury the nurse can help the family find ways to manage what can be a very stressful few weeks. Anticipatory guidance around crying, consoling, and coping is needed to help prevent Shaken Baby Syndrome or other types of maltreatment. Parents who are helped to understand that developmental crying is a transient physical state may be more tolerant of the baby's distress, versus worrying it is a sign of their incompetence or that the baby is 'bad'.

Sleep

Since infants usually do not consolidate their sleeping patterns until about 6 months of age, parents need to be counseled about young infants' needs for night time feedings and patterns of awakening, but even before that time parents can begin to use approaches that help infants to return to sleep and learn to fall asleep more independently (Paruthi, Brooks, & D'Ambrosio et al., 2016).

Parents are reminded that a baby should always be put to sleep on his or her back for naps and at night. Many cultures value co-sleeping and the nurse needs to respectfully discuss and educate parents about the safety concerns of sharing a bed with an infant. American Academy of Pediatrics (AAP) recommendations include having infants sleep in the same room with parents ideally up to age 12 months (https://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/Preventing-SIDS.aspx). Education regarding Sudden Infant Death Syndrome (SIDS) or Sudden Unexplained Infant Deaths (SUID) starts prenatally and continues into the post partum period (https://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx). It is strongly suggested that the infant sleep in the same room with parents through the first year. Education regarding Sudden Infant Death Syndrome (SIDS) starts prenatally and continues into the post partum period. The nurse assesses and helps families to prepare safe sleeping environments for infants regarding cribs, bassinets, or other sleeping choices: portable cribs cradles, baby "boxes", etc.).

A newborn may sleep up to 20 hours a day, divided into naps of a few minutes or longer periods of several hours, waking only to feed. There is no real pattern to the wake-sleep cycles, although many newborns have their days and nights 'mixed-up' and may have more wakeful periods during the night (much to parents' dismay). After 3-4 weeks the baby becomes alert for longer periods of time. It is then that parents

can begin to help the baby learn day from night by interacting with him during the day and attending to diapering and feeding at night in a quiet, kind, but less playful way. Slowly the moments of sleep coalesce and the baby tends to sleep longer at night. Sleep experts recommend 12-16 hours per day for infants 4-12 months of age, including naps. Often infants (6-12 months) will not sleep 'through the night' consistently, while some may be able to accomplish this in the second half of their first year.

When discussing the sleep needs of the older infant the nurse works with parents to develop a regular bedtime routine that will help both the parents and baby relax. It is not unusual for an older baby to still wake once or twice a night. The nurse and parents can think together about why this may be happening and how best to help the baby back to sleep. Sometime during the second year of life a baby's sleep needs decrease to an average of 11-14 hours a day. This includes one or two long naps. The nurse assesses sleep patterns on a regular basis. If parent reports that the baby snores, an evaluation should be done by the pediatric provider for possible obstructive sleep apnea. Night terrors and fear of the dark are common issues as children become older toddlers.

Nutrition

Continued breastfeeding is encouraged for as long as the mother is able- ideally 12 months. A cup is introduced in the second 6 months of infancy with cautions regarding offering juice and sweet liquids. The importance of not propping bottles or allowing the child to sleep with a bottle is reviewed both in terms of prevention of dental caries (tooth decay) as well as prevention of choking and ear infections. Feeding discussions as the infant becomes older, include safe feeding practices and safe versus unsafe finger foods for the older infant who is learning to self-feed.

Nutrition for older infants and young toddlers is an area that receives much attention from the nurse. Nutritional teaching can be accomplished by timing the home visit with a feeding session, planning out menus for the older infant and toddler, and practice reading food labels. Sometimes trips to the grocery store are especially helpful for the nurse and parent to select and discuss foods and healthy nutritional choices within the family's ethnic traditions as well as budget and food availability. The nurse can also discuss the many benefits for toddlers and older children of eating meals with family members gathered together.

Child development

As the infant grows, the content of the home visit changes. Pediatric anticipatory guidance concerning safety, health promotion, and problem-solving around feeding, sleeping, and common minor ailments are introduced and reinforced at a comfortable pace using a conversational style. As infants grow older it is useful for the nurse and parent to sit on the floor with the baby and play together, finding ways for the nurse to demonstrate the child's growing motor, language, and problem solving skills. The nurse can watch for the baby to look at her parent for reassurance and refueling, pointing how important the parent is to the child. The developmental stage when the baby begins to drop objects as an invitation to play or to discover what will happen next can be hard for new parents to understand, since they may find the interaction boring and messy. The nurse can discuss the child's new motor skills of grasping and letting go of objects and reframe the throwing behavior as that of a curious and intelligent baby exploring the world and asking her parent to come play. This re-framing allows the nurse to then praise the parent for raising a child who wants to interact with the environment with such determination, noting how this trait will be valuable in school and later in life.

Safety

Some home safety issues become apparent to the nurse home visitor before the infant is born. The nurse addresses these issues (smoke detectors, open non-screened or gated windows, missing railings on the stairs) early on, as the addition of a newborn into the home may be powerful motivation for family members to make necessary changes. Safety counseling also includes a reinforcement of how parents need to protect the child from second hand smoke or third hand smoke. In addition, issues surrounding lead and toxic exposures, falls, burns, and choking are reviewed. Emergencies and first aid skills are also discussed.

Infant mental health

Both practitioners work to promote infant mental health. For a full description of the mental health and social work approaches to promoting infant mental health, please see Chapter 8. Listed below are some of the ways the nurse promotes the parent child relationships and its pleasures and challenges.

Attachment relationship

Throughout the intervention, the nurse makes observations regarding the child's social-emotional development; watching the child's cues, the parents' response to his cues, the parents' use of language, the parental beliefs systems (cultural, family, and spiritual beliefs), and the appropriateness of parental expectations. The nurse, as well as the social worker, will focus on promoting a positive and nurturing parent-child relationship, as both home visitors are partners in this developmentally oriented relationship-based practice.

Promoting pleasurable moments

The nurse actively coaches the parent in developmentally appropriate and enjoyable ways to play with her child. Routines such as diapering, bathing, and feeding are opportunities for the parent and child to interact in order to know and understand one another. The nurse helps the parent recognize the baby's invitations to play and desire for proximity as positive healthy components of parent-child interactions. As the child becomes more mobile and wishes to explore the environment, the nurse can explain the child's need to have the parent delight in her new skills and be the secure base she returns to in times of concern.

Discipline

Eliciting the parents' personal goals for their child, as well as the family values they wish their child to learn, is a good starting point for a discussion about discipline. It is helpful to ask the parents how their baby will learn these values, how they themselves were disciplined, and how they feel these methods worked for them. This information, and an acknowledgement of the parents as the experts on their baby, provides the nurse with insight about how to approach many parenting topics, especially the potentially charged topic of discipline.

As the baby turns one, anticipatory guidance is provided regarding delaying toilet training to a more appropriate age, preventing and managing temper tantrums, development of toddler fears, biting and hitting, and the beginning of representational and imaginative play and its value (Hagan, Shaw & Duncan, 2017). As a child grows in his desire to become more autonomous some parents will feel rejected or enter into a power struggle with their child over who is in charge. Many parents will express concerns about children becoming demanding and spoiled during the phase of toddlerhood. Parenting techniques are offered so that the parent can engage a child's cooperation in an age-appropriate and thoughtful manner. An equally important reminder at this time is for the nurse to review with parents all the lessons in trust they

have taught their baby in the past year. All opportunities are used to demonstrate the child's continuing need for parents to be the secure base- for the child to explore the larger world. This approach often helps to counteract inappropriate expectations of the toddler and serves as a wonderful reminder to parents about how important they are to their young children.

Case Vignettes: Health Related Home Visits

Breastfeeding

Suli had expressed a desire to breastfeed her baby. She knew from the midwives how valuable breast milk would be for her newborn, but she was concerned because her own mother had been unsuccessful with breastfeeding her. "My mother says I didn't like it, probably because she couldn't make enough milk, and I was hungry." The nurse went over basic breastfeeding techniques and discussed breastfeeding as something mother and baby learned to do together, a process that takes practice. The nurse felt the anticipatory guidance around breastfeeding would give Suli a strong basis to build upon once the baby was born. To reassure Suli concerning her fears about not having enough breast milk, the nurse talked about the newborn's normal weight loss during the hospital stay, the reserves the infant has while waiting for mother's milk to 'come in', the nutrition value of colostrum in the first few days of life, and how to evaluate adequate intake by counting diapers. After Suli demonstrated comfort and confidence in the different positions to hold the baby (using a baby doll) while nursing, the nurse began exploring the possible social and emotional barriers to breastfeeding that Suli might experience. The nurse reviewed mindfulness and stress reduction techniques for Suli to use to care for herself. The nurse role-played several scenarios to prepare Suli for potential concerned reactions after the baby was born. She pretended to be a worried Aunt: "You're starving the baby! Listen to her cry. I'll go buy some formula." Suli laughed and said that sounded just like her family. "But I'll tell them—'Babies cry for lots of reasons. Look—she's healthy and has lots of wet diapers.'"

When Suli's daughter was born 6 weeks later, she was ready for the barrage of concerns from well-meaning family members. She told the nurse, "It's just like we talked about. The baby couldn't find the nipple at first and her head went back and forth like she was saying, 'No! I don't want to do this.' But I knew she just needed help learning. My mother gets worried that she isn't big enough, but every time the baby is weighed she's bigger. I can see with my own eyes that she's OK. She's beautiful!"

Approaches used:

- Anticipatory guidance given regarding normal newborn growth and development
- Assessed barriers and family beliefs of breastfeeding; foreshadowing of possible family responses
- Promoted self-efficacy through role playing possible scenarios

Safety

When the nurse first began visiting Maria and George she mentioned Shaken Baby Syndrome, which Maria had heard of on television. The young couple was appalled that anyone would hurt their child and couldn't imagine ever feeling that way. The nurse had witnessed Maria's low tolerance for interruptions and wondered how she might react to a baby's constant needs in the first months. The nurse was worried but took a deep breath and thought to herself about approaches to use to reduce the

risk of child maltreatment. She decided to wait for a teachable moment to discuss newborn behavior and 'parked' her concern. Over the following visits the nurse spoke about a newborn's cry as a form of communication and ways to console a baby. The nurse also discussed the period of normal developmental crying and planning for moments when the couple might be sleep deprived and overwhelmed.

Maria's baby was not always easy to console and did not sleep for long periods of time. Maria was very tired and felt fortunate to have strong support from her mother-in-law who gave her numerous breaks. Maria worried that she didn't know what her baby wanted and that she was not a good parent. The nurse reviewed the baby's states of awareness, and Maria started to identify her son's cues and predict what he needed. She then felt she had some control in regulating the baby, and her sense of competency grew.

Several months later Maria admitted to the nurse that she had had "one of those days." The baby had been crying for two hours. The young mother had tried every trick she knew to comfort him to no avail, and she was afraid that she would lose her temper and "do something (harmful) to my baby." She recounted how she had put the baby safely in his bassinette, knowing he was fine even though he was crying inconsolably. She went to take a shower to calm herself. Soon after her husband came home to find the baby was crying in the bedroom and his wife was crying in the shower. "At first he was mad at me for leaving the baby alone. But then he saw what was happening. He knew he needed to help out more and give me a break."

Approaches used:

- Anticipatory guidance given regarding developmental crying and newborn sleep habits
- Normalized new parent feelings of inadequacy
- Nurse self-regulated and 'parked' her concern, waiting for a teachable moment
- Helped parents read infant cues and plan for stressful moments, raising sense of self-efficacy

Encouraging interactions with the baby

At a home visit with Keisha and her 5 month old, the nurse observed Keisha propping a bottle up with a blanket and walking to the other side of the room. This was a surprise as the mother was usually warmly attentive to her daughter. The nurse wondered what had happened while waiting for an opening to mention her concern. Keisha spoke with pride of the baby's ability to 'hold' her own bottle and then told the nurse about the argument she'd had with her on-again/ off-again boyfriend. The nurse recalled that the mother mentioned during her Pregnancy Interview that it was important for her daughter to learn to be independent as she might end up doing everything on her own "just like I have to do."

The nurse listened thoughtfully to the young mother's feelings of sadness and anger about parenting without much support from her partner or family. The nurse asked about the mother's mood but the mother denied any symptoms of depression. When the baby started fussing the nurse asked if she could place a blanket on the floor to see how the baby was developing. Keisha asked a question about teething, and the nurse talked about oral care for the baby. The mother mentioned her own dislike of the dentist, which gave the nurse an opportunity to discuss the prevention of baby bottle caries. This included anticipatory guidance regarding introduction of a cup and

limiting juice intake. Without criticizing Keisha for propping the bottle, the nurse was able to use this moment to discuss the small motor skills the child was learning, including holding onto items and bring them to her mouth.

After the visit the nurse contacted her MTB partner and discussed her concerns about Keisha's mood and her difficulty attending to the baby. The social worker made a plan to visit the family and assess the mother for a perinatal mood disorder while the nurse thought about non-pharmacological approaches to alleviate some of the stress Keisha and the baby were feeling.

On the following visit Keisha wanted to discuss becoming more physically fit now that the baby was almost 6 months old. The nurse had brought along pictures of yoga stretches that mom and baby could do together, hoping to help the mother relax and enjoy time with her baby. As Keisha and the baby did the first set of yoga exercises together the baby laughed, anticipating her mother's movements. Keisha and the nurse agreed that a few simple routines might benefit both mother and child. Over the next few months, as the social worker supported the mother around being a single mother, the nurse helped Keisha think about her health and how her well-being impacted her child.

Approaches used:

- Used the parent's Pregnancy Interview goals linked parenting choices to child's growth and development
- Anticipatory guidance given regarding child health and development using a teachable moment
- Offered relaxation exercises to relieve stress
- Offered activities to increase pleasurable moments between parent and child
- Partnered with social worker to address mother's mood

CHAPTER EIGHT:
MENTAL HEALTH/ SOCIAL WORK APPROACHES

General Principles: Social Work "MTB style"

The MTB social worker wears many hats, often at the same time. Like the nurses, MTB social workers support healthy parenting and secure attachment, reciprocity in the infant-parent relationship, and provide a range of information and guidance concerning child and parent development. In addition, MTB social workers offer support for both mothers' and infants' mental health and social service needs (which are often intertwined). The *mental health* component of the program is multifaceted and multimodal, and includes a flexible combination of ongoing dynamic and diagnostic assessment, individualized treatment of the dyad (infant-parent psychotherapy) or mother, individual psychotherapy, supportive counseling, crisis intervention, family intervention, and referral as needed to outside providers. The *social work* component includes the provision of a range of social supports, including resources for immediate concrete needs, immediate safety, financial support, housing, and education.

"Social work, MTB style" is a complex and challenging role. One MTB social worker, reflecting on the uniqueness of her role as a home visitor commented: "So many social workers aren't trained to think about the relationship…and in the beginning, I felt so 'on my own,' it's really different from working in a clinic." The MTB social worker takes a reflective stance, always theorizing about the meaning of things that are happening. Rather than try to fix them, we wonder: "How did it get to be that way?" "What's going on behind the 'curtain'?" Of course, some mothers are not ready for this kind of work. For one mom, it would mean just focusing on the baby's crying, for others it would mean talking about the past. Hence, we tailor approaches to fit the needs of each individual mom and family.

Social work competencies

Due to the multi-faceted nature of the social work role within the MTB model, there are a variety of core competencies that serve as foundational to effective clinical practice as an MTB clinician. The social work competencies are detailed in Appendix II, as well as the Operations Manual. Generally, these include the ability to form a therapeutic alliance, a familiarity and comfort with working reflectively, experience working as part of an interdisciplinary team, grounding in infant and toddler development, infant mental health, and parent-child work, familiarity with adult mental health and treatment approaches, and – finally – a strong working knowledge of community resources, social service agencies and practices, and legal guidelines for working with families and children.

Social work, mental health, and reflective practice: A delicate balance

In the sections that follow, we have divided the "therapeutic or mental health" work from the "social" work. In practice, however, they are often intertwined. Thus, for example, while MTB operates from a dynamic, reflective perspective, it may be a long time before mothers are able to work dynamically, to discuss their trauma histories, or reflect on their experience. They may have to learn from our consistent presence, and our ability to be helpful with providing concrete support and resources that we can be trusted with the "deeper work." It is the social worker's ability to think reflectively regardless of the type of support she is providing that will allow for the mother's reflective abilities to emerge. For example, if the social worker has arranged a more suitable schedule of high school classes for a teenage Mom, only to find that she is still truant and missing classes, then she begins to wonder what might be keeping the mother

away from school. Why can't the mother make use of these resources? It is important to reiterate (see also Chapter 3) that maintaining a dynamic, reflective focus can be difficult given the multiple challenges of mothers' lives.

The Mental Health Component

The mental health component of MTB is based in psychodynamic theory, which means that we try to understand mothers in light of their own histories and, in particular, their relationships with primary caregivers. The mental health component is also geared toward assessment, treatment, and disposition of psychiatric conditions.

Assessment during pregnancy

The first step in becoming acquainted with mothers is to – over a series of sessions – get to know the mother's history and begin to assess her psychological functioning and experience of pregnancy and impending parenthood. This includes collecting a psychosocial history and creating a genogram, and administering the Pregnancy Interview. *There must be a therapeutic alliance before any of this information can be gathered*. Collecting any historical or clinical information requires asking about complex, difficult material, and we cannot expect the mother to share any of her story until she feels some trust and comfort with the clinician. Therefore, it may (and usually does) take weeks (or more) before the clinician has gotten a reasonably full picture of the mother's history and functioning. This process should not be rushed, *as the major overarching goal during this period is to get to know the mother before she gives birth*, and of course assessment continues once babies are born. Many of the mothers are not used to undergoing formal psychiatric assessments, so throughout the interview, the tone should be set to convey warmth, interest, and empathy. As the program is voluntary, and mothers do not typically agree to participate because they are seeking mental health services, the social worker cannot leap into a typical psychosocial assessment with pen and paper in hand delving into deeply personal questions.

During the 3-4 months before the birth, the social worker begins by administering the first part of the psychosocial interview, then creating a genogram, then collecting the PI (ideally with the nurse present), then finishing up whatever remains of the psychosocial interview. Decisions about when and how to administer any assessments should be guided by what is going on with the mother, and the strength of the alliance. We do urge that every effort is made to administer the PI before birth (to both parents if they are interested). There is a post-birth version, but this is much less valuable clinically than a pre-birth assessment.

The psychosocial assessment

The psychosocial history (See Appendix I) can be framed as "getting to know the family story." The interview is framed in an informal manner, conversational in tone, and free of judgment. It is helpful to invite the mother to talk openly about her past and present by first highlighting the usefulness of the psychosocial interview to the forthcoming work. "I would like to ask you to walk through the past a bit, as if you were telling your life story. It is important because this is the story that has shaped your experiences, and it will help me understand who you are so that we can work together better." An important part of learning the mother's story is understanding her cultural identity and how it has impacted her past and present experience. It may be helpful for the clinician to disclose her level of familiarity with certain

cultural beliefs and customs as a means gaining the mother's trust. The same is true about disclosing one's experience working with mothers.

It is helpful to think of the administration process in three phases: the alliance building phase, diagnostic phase, and the closing phase. As we described above, during the alliance building phase, the clinician and mother are essentially getting to know one another better. It is a time for developing a trusting relationship and a sense of confidence in the clinician's ability and her level of willingness for self-disclosure.

During the diagnostic phase, determining whether there are potential signs of previous psychiatric problems such as depression, anxiety or personality disorders can guide decisions about further exploration of current symptomatology prior to or co-existing with the pregnancy, family history of mental illness, or substance abuse. Tying in deeper exploration of social and educational history adds to the diagnostic picture. The mother's ability to recall a narrative of her life, past trauma, her style of discussing emotionally laden material and an assessment of her ego strengths, insight, judgment, impulse control, etc., are all valuable impressions that form a base for her as she evolves into her mothering role.

During the closing phase of the psychosocial interview, the mother is allowed time to reflect on the experience of the assessment itself. The closing phase dovetails into further discussion about upcoming visits such as initial treatment planning, i.e., mental health intervention, contacting social services, and consulting with the nurse or the midwives as needed. The issue of confidentiality is reinforced for the mother to continue trust building. The psychosocial assessment consists of the following domains, roughly divided between history taking and assessment.

History taking and alliance building phase:

- Comprehensive developmental history
- Educational/vocational history
- Family history
- Psychiatric history
- Creating a genogram

The diagnostic phase: assessment, formulation, and treatment

- Mental status exam
- Diagnostic impressions using the 5 axes of the DSM-V (if applicable)
- Impression of global assessment of functioning
- Impressions/strengths, concerns re: the meaning of pregnancy for the mother and her new role as a parent, what the baby might mean or represent for the mother, social support networks, any signs of trauma history or mental impairment that may impact functioning

The closing phase: treatment planning

- Goals of the parent-infant dyad and treatment goals

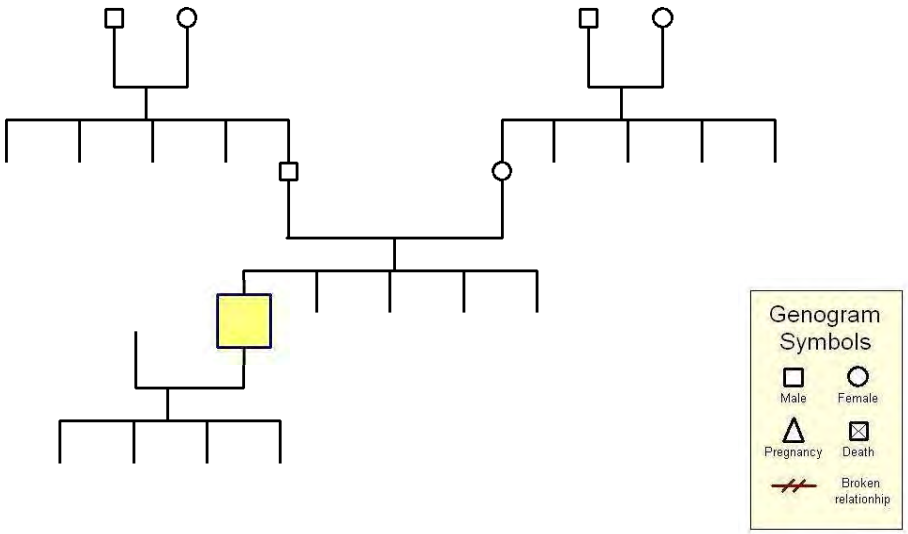
The genogram

Once she has completed the history taking part of the psychosocial assessment, the social worker works with the mother (and father) to create a genogram. The formulation of a three-generational genogram of the mother's family and the father's family is the second reference point in the initial assessment period. For many families, there are themes that recur across multiple generations that are not obvious until they are given voice and "made true" through the construction of the genogram. Often mothers are surprised to take

a "bird's eye" look at their family because it reveals both to themselves – as well as the social worker – patterns, trends, and discrepancies in their family history. It is critical to understand the affect that accompanies their telling of family events. The meaning the mother gives to certain family relationships, what she downplays and emphasizes all play a role in formulating an understanding of the mother's own attachment system and internal world. Ultimately, such understanding will help the clinician recognize such patterns as they recur in the mother's developing relationship with the child.

The genogram also helps guide the treatment formulation. It makes evident factors that are likely to influence the baby at some level, such as psychopathology in the family, major events in the family such as parental divorce, separation, parental absence, remarriage, or death. It highlights important socio-economic and cultural patterns of the family's lifestyle – i.e., adolescent pregnancies, immigration, chronic unemployment – and can reveal issues that may have vital impact upon potential problems that can impact the mother, father, dyad, and infant. Completion of the genogram is often framed as a family diagram or family tree with the purpose of understanding important health and relationship history that will help the MTB clinician team understand the family better.

Genogram template example (www.genopro.com)



Once the social worker has completed as much of the first part of the psychosocial assessment as she feels is possible (this will vary from mother to mother) and completed the genogram, the social worker administers the PI. The nurse is present for this visit if at all possible.

The Pregnancy Interview

The Pregnancy Interview – Short Form (PI; Slade, 2003) is a 20 item, open-ended clinical interview that is designed to assess a woman's emotional experience of pregnancy, her feelings about upcoming parenthood, as well as the nature of her developing relationship with her baby. She is invited to think about her partner's and her family's response to her pregnancy, as well as to describe the ways she thinks about her baby and imagines her relationship to the child, both during pregnancy and once it is born.

On the one hand, the content of the interview is very important and key to understanding what the pregnancy has meant to the mother and her family, and whether the mother is emotionally ready for this new relationship. What was going on in her life when she became pregnant? How did this pregnancy alter key relationships, and her planned life course? Is it viewed as a welcome developmental step, or as a

profound disruption and source of anxiety and fear? Does she have an idea of how to prepare for a baby? Can she imagine a relationship with the baby now? Can she imagine taking care of the baby's emotional needs after it is born? What is her representation of the baby? Is it positive, negative, or ambivalent? Does she express hostility to the unborn child? Is there evidence of her projecting malevolent intentions onto the child?

Clinicians are looking for signs of a burgeoning attachment, positive representations, and some capacity to "engage" with the reality of having a baby. And, importantly, they are evaluating the degree to which she is aware of her experience of having been parented, and of the ways she wants to repeat or transform these experiences in this new relationship. Often, the core themes that are introduced in the PI turn out to be the core themes in the work with mother. Here is often where the team really gets a sense of the "ghosts" in the nursery (Fraiberg, et al., 1975).

Just as important as content is the *way* the mother responds to the interview. Is she open, fluent, and emotionally engaged or is she shut down and unavailable? How able is she to reflect upon her experience of pregnancy, and upon her experiences of having been parented? Is she able (see Chapter 3) to name some of what she is feeling, or are emotions absent from her narrative? The mother's responses to the PI questions also offer insights into how well she will be able to regulate the intense feelings that are part and parcel of new motherhood. Will she avoid them or will she be overwhelmed by them? Will she be able to manage complexity and thrive? Although the PI was originally intended for expectant mothers, the clinical interview has been modified for administration to expectant fathers. Gaining fathers' perspectives as they transition into parenthood can be valuable in understanding the father's "ghosts in the nursery" (Fraiberg, et al., 1975) as well as be useful in helping clinicians anticipate what issues may arise for the couple as they begin their new roles as parents.

The mental status exam

1. Appearance - included facial expression, grooming, dress, gait, etc.
2. Orientation - includes awareness of time and place, events, etc.
3. Speech Pattern - describes the speech, i.e., slurred, pressured, slow, flat tone, calm, etc.
4. Affect/Mood - describes mood as evidenced in both behavior and client's statements, i.e. sad, jittery, manic, placid, etc.
5. Impnlsive/Potential for Harm - assesses impnlse control with special attention to potential suicidality and/or harm to others.
6. Judgment/Insight - describes client's ability to predict the consequences of her/his behavior, to make "sensible" decisions, to recognize her/his contribution to her/his problem.
7. Thought Processes/Reality Testing - describes client's thinking style and ability to know reality, including the difference between stimuli which are coming from inside herself/himself and those which are coming from outside herself/himself. Statements about delusions, hallucinations, and conclusions about whether or not the client is psychotic would appear here.
8. Intellectual Functioning/Memory - a description of level of intelligence and of recent and remote memory functions.

Source: http://www.naswma.org/

Completing the psychosocial assessment

Once the PI is completed, the diagnostic and treatment planning phases of the psychosocial assessment can be finalized as the social worker is better able to develop a comprehensive clinical formulation highlighting the mother's strengths, her goals as a parent, and areas for targeting intervention. The information gained from the psychosocial assessment is used to make preliminary diagnostic formulations, identify the mother's core personality structure, social and relationship history, and assess cultural identity and affiliation. After completing the interview, the social worker writes a narrative summary of the interview. This summary ideally integrates the multiple strands of data obtained during the assessment, and allows for the identification of what are likely to be the core issues in developing a treatment plan for the mother.

Mental health intervention during the pregnancy and the postpartum period

During pregnancy, home visits are focused on assessing the mother's needs and supporting as much stability (financial, relational, emotional) as possible. As psychosocial history is gathered and the PI is completed, the mental health clinician assists the mother in making mental, emotional, and physical space for her baby. This may start at the level of the body. How does the mother interpret the common aches and pains of pregnancy? What are her concerns as her body rapidly changes? Does she have intense fears of giving birth? How might the physical symptoms of pregnancy impact the mother's feelings about her growing baby? The social worker partners closely with the nurse to ensure that the mother is receiving adequate prenatal care and nutrition. The social worker and nurse also work together to educate expectant mothers about the risks of neglecting dental care during pregnancy.

Both the body and mind undergo significant changes during pregnancy. For adolescent and young adult women who are often undereducated about how their bodies work, and may also have sexual trauma in their childhood history, pregnancy can mark the onset of mental illness or augment pre-existing mental health disorders. Additionally, the multiple stresses associated with unintended pregnancy, and the emotional yearnings and wounds that may be uncovered, make it particularly important for the social worker to emphasize her role as a source of emotional support for the expectant parent. Ruling out potential diagnosable disorders is an integral piece of gathering psychosocial history. The social worker is also responsible for consistently attending to the mother's mental status (see above) at every contact. Psychoeducation about the impact of pregnancy on moods and emotions is also critical at this time because it can help mothers identify what they might be experiencing with a reduced sense of shame and self-blame once they understand that emotional and mood changes are common and expected.

During the postpartum period, a smooth recovery following birth is the goal. The social worker may need to help the mother reconsider her expectations of herself in terms of resuming household and family responsibilities too soon after the birth. Bearing witness to the birth story can also be an empowering experience for the mother as she is invited to share her experience of a profound life change. Although the family may be inclined to miss a few visits during this "cocooning" period, it is important for the social worker to stay in touch - perhaps via phone or text and check in regularly with the mother for any physical or mental changes. (More will be said about perinatal mood disorder in the maternal mental health section below.) Another important consideration postpartum is the family's plans with regards to spacing of children and contraception. The social worker explores with the mother (and sometimes mom's partner) what their goals are in terms of growing a family; and other life course milestones like completing school, employment, or home ownership. There are also emotional and attachment considerations that the social

worker explores in terms of how a rapid subsequent pregnancy might impact finances, other life stressors, and partner/parent-child relationships.

If mothers receive a diagnosis of a chronic illness while in the program, like Type I or Type II diabetes, the social worker plays a key role in helping the mother through her grief process and adjustment to managing chronic illness as well as supporting lifestyle changes and coordination of medical care.

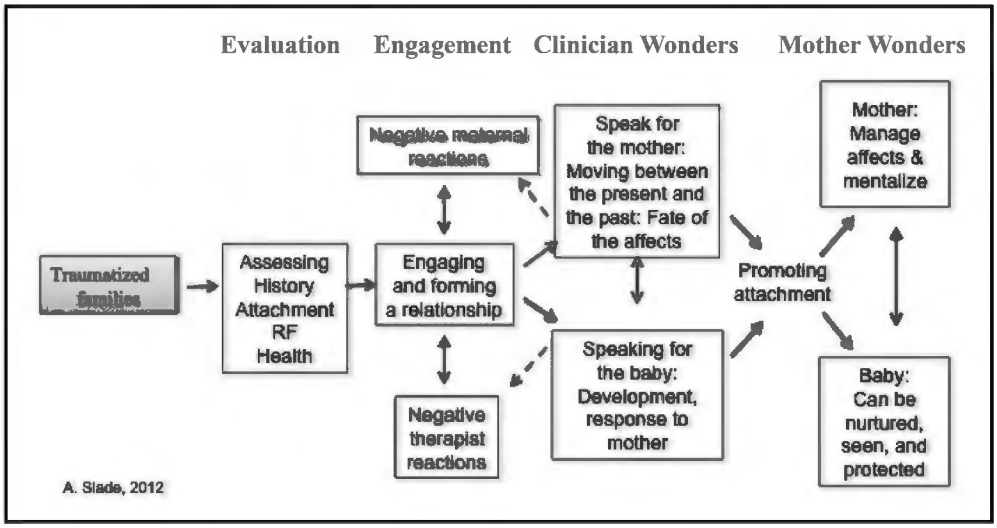
Treatment approaches throughout the intervention

A number of the treatment approaches used by the MTB social worker will be described below. Throughout the intervention, regardless of the treatment approach used, it is integral to continually look for opportunities to reflect with the mother about change and progress (where she started, how far she has come, what was really hard for her that has now become easier), to encourage the mother to advocate for her child and to support her positive instincts.

In the sections below, we include clinical vignettes to exemplify how we implement various of the treatment approaches in a reflective way. We have bolded the clinical strategies used. See Chapter 3, pp. 17 for a full list of strategies used to enhance maternal reflective capacities.

Psychotherapy in the kitchen (or on the bed, or in a coffee shop)

Fraiberg (1980) aptly termed what she and her colleagues were doing in their initial forays into infant-parent psychotherapy "psychotherapy in the kitchen." While she was primarily referring to infant-parent work, the techniques she described included forms of individual psychotherapy, supportive psychotherapy and even family counseling. The MTB clinician wears all these hats (and more) at various points in her work with the mother, baby, and family. "Psychotherapy in the kitchen" captures nicely the flexibility of the MTB approach in technique, location, and frequency. There are times when the social worker (in consultation with the nurse) decides to increase social work visits in response to a crisis of some sort. This can go on for as long as the team – in consultation with supervisors – deems it necessary. At the same time, it is also not unusual to then lose track of her for two months. The "door is always open" policy of the MTB model facilitates continued engagement. However, the work of the "therapeutic process" is often disrupted and clinicians must grow accustomed to picking up where they left off, starting fresh, or starting all over again with the same initial presenting concerns.



As Fraiberg (1980) noted, transference, countertransference, and resistance are particularly useful in framing certain aspects of the work with mothers and babies, despite the fact that the work is quite distinct from office-based, dynamic psychotherapy. Mothers will have feelings about the home visitors, and home visitors about the mothers that don't objectively "belong" to that relationship. And mothers will avoid topics or visits because they are too difficult, "resisting" exposure of feelings they cannot bear. This may be one way of understanding a mother's "disappearance or non-compliance."

Another important part of "psychotherapy in the kitchen" is the concept of therapeutic boundaries. In MTB, the maintenance of boundaries is important if the therapeutic relationship is to have the power that it can. Yet, if boundaries are too rigid, the mother will not feel safe. This often comes up with respect to self-disclosure. Many mothers want to know a bit about their home visitors as they get to know each other. Although this can feel somewhat unsettling for the traditionally trained clinician who typically avoids giving clients personal information, it is important to consider the appropriate use of self-disclosure in an effort to connect with families and create safety in the therapeutic relationship.

Infant-parent psychotherapy

Pioneered over forty years ago by Selma Fraiberg and her colleagues (Fraiberg, Adelson, & Shapiro,1975; Fraiberg, 1980; Lieberman, Silverman, & Pawl, 2000; Lieberman & Van Horn, 2008), infant-parent psychotherapy is one of the central approaches used by the social worker. Well described in the literature, the most crucial component of infant-parent psychotherapy is the direct involvement of both mother and child. Infant-parent psychotherapy is used to target a wide range of relational and attachment disruptions between mothers and infants starting from birth onward. The focus is to understand the link between the mother's past history and the present difficulties with her child. As parents are helped to recognize how their own experiences can be unknowingly played out with their baby, they can become freer to experience their baby in a more contingent and responsive manner, less hindered by the entanglements of the past.

Many of the techniques described throughout this manual (speaking for the baby, speaking for the mother, developmental guidance, attention to trauma), as well as the reflective approach that is at the heart of MTB are central components of the infant-parent psychotherapy approach. The fundamental tenets of infant-parent psychotherapy and Lieberman and Van Horn's child-parent psychotherapy are well described in Fraiberg (1980) and Lieberman and Van Horn (2008). These are required reading for home visitors.

Infant-parent psychotherapy in the first year

Isabel greeted the clinician and showed off her newly bathed, pristinely dressed 3-month -old girl, who was nestled in an infant seat. The house was impeccably clean, floors shone, carpets vacuumed, toys put away. Isabel spoke for quite some time about how well she was doing now that the father of the baby and her younger siblings were "back out in the world," creating the strong expectation that she cook, clean, and take care of the house (as well as the baby) on her own. This sense of mastery and pride as a homemaker was important to Isabel, as it was of great value to her partner. It took much time for her to tend to the numerous hours of domestic work, giving her little room to rest or play with the baby. The infant lay quiet, almost still in her infant seat, making only occasional whimpers when she would catch the mother's eye.

Isabel did not pick up or let the baby out of the infant seat for what seemed to be an unusually long time, given the age of the baby. The mother and baby would signal with their eyes and voices, but the

baby's vocalizations were minimal and mother's responses were always tinged with a hushing, quieting tone that appeared to further push the baby into stillness. "She's so difficult at times, especially when she squirms out of the seat." Isabel used many rattles, mobiles, music boxes and the "vibration mechanism" on the seat to calm the baby while she completed her endless chores. When the home visitor inquired about floor-time or play with the baby, Isabel seemed certain that she had "enough time" when the baby would be allowed to lie on the parents' bed for a few minutes before bedtime. Isabel seemed uncomfortable with allowing the baby to create mess as well, and kept most of the baby items out of sight for most of the visit. "I can't stand clutter."

Isabel also spoke about her housekeeping as a primary duty and seemed to place the baby's need for closeness, physical mobility, or play second. Over the course of the visit, it became clearer that Isabel saw herself as the "golden child" in comparison to her brother, who was reckless in his drinking and womanizing.

Clinician: "It must be good to be thought of in that way, but I can also imagine it coming with a lot of expectations." **(empathy, hold conflicting affect)**

Isabel: "No, it's not a problem. Except that his rudeness and lack of respect for my father and others makes my father so depressed, that I am sometimes worried."

Clinician: "Could you tell me about what that is like for you?" **(ask for elaboration)**

Isabel went on to detail numerous incidents in the recent weeks that escalated the general tension between herself, her brother, and her father.

Isabel: "I'm in the middle. The peacemaker. It pains me to see how upset my father is and my brother just seems to do bad things to get our attention." She described one recent incident in which the brother called her to "rescue" him from a recent arrest. Isabel looked visibly shaken when recounting the incident and spoke about how she felt unable to set limits with her brother.

Clinician: "It sounds clear why he's the messy one in the family. It also is certain that this must affect you a lot." **(validation, reflect mother's feelings back to her)**

At this point the baby began to squirm, and mother put a pacifier in her mouth. The squirming continued as the infant spat out the pacifier. Isabel then began rhythmically rocking the infant seat with her hand, trying to hush and soothe the baby. Then the baby began to cry. Isabel got a bottle of milk and tried to place it in the baby's mouth. Again, the baby shook her head. Isabel tried to turn on the vibration mechanism on the seat but the baby kept on crying.

Clinician: "What do you think she's telling you?" **(model and encourage curiosity)**

Isabel: "This is what I mean," she exhaled, with an exasperated shrug, "when I say she's difficult."

Clinician: "Sometimes babies, like grown-ups, get bored of being alone. Perhaps she wants some company and some space to play." **(use "sometimes" statements, linking feelings to behavior in the child, generate multiple perspectives)**

Isabel took her daughter gingerly out of the infant seat and put her in her lap stiffly. The clinician said to the baby, who was now wide eyed and observant: "Well hello there. Things sure look different from up there." **(speak for the baby: verbalize baby's perspective and describe baby's world and**

experience) *As the baby remained on the mother's lap, the clinician asked the mother if she could spread a blanket out on the floor and place some toys around. The mother briefly noticed how her baby's eyes brightened. She then continued to speak in a narrative tone about the distress she felt having to deal with her brother's manipulative behavior. "He always gets away with everything."*

*Clinician: "Do you think that there might be some other ways to handle times when he surprises you with crises he wants you to become involved in?" (***validate mother's experience before offering alternatives)**

*Together, the clinician and Isabel discussed ways to better set boundaries with her brother and not get "swept away" into having to feel sorry for him for the situations he would create. After some time, Isabel's automatic smile changed to reveal a wider range of emotions, from confusion to anger. The clinician spoke about the meaning of "messiness" in terms of the household, (***ask for clarification)** *the mother's family and the baby's growing emotional and physical exploratory repertoire.*

*Clinician: "It is hard to be in the middle, but as we have discussed, you have rights to set limits, and in the same way, don't have to feel there is only one way you can respond to situations." (***affirmation, encouragement)**

The thread of the discussion carried into more discussion about allowing the baby to play more, have more floor time with the mother and understanding the baby's normative developmental needs.

Individual psychotherapy

Dynamic approaches to psychotherapy are used throughout the intervention; this means that the social worker tries to deepen the mother's understanding of herself, and to better understand her life story and the history of her relationships. Without access to the mother's internal world, there is limited access to the baby's world. To some extent, access to the mother's thoughts and feelings are provided by infant-parent psychotherapy. But there are multiple instances when mothers may need time with the social worker to work through concerns that cannot readily be addressed within the context of joint psychotherapy. These may occur while the child is sleeping, or playing nearby, or may require that the mother and home visitor meet in a coffee shop without the baby. These approaches are essential, especially for mothers who may be struggling with perinatal mood disorders, traumatic history, or relationship difficulties in their primary support group. There are also many times when techniques borrowed from cognitive-behavioral therapy, and other evidence-based modalities can be applied in useful and appropriate ways in any given situation. It is very rare for MTB mothers to seek psychotherapy outside of MTB, and thus it becomes the social worker's job to recognize when such interventions – as distinct from infant-parent approaches – are necessary.

Supportive psychotherapy and developmental guidance

Intrinsic to most dynamic approaches is an element of support, provided by the therapist's caring presence. Generally speaking, supportive approaches differ from dynamic approaches in that they are more direct and focus on the mother's conscious feelings, and take the place of more intensive dynamic work when current issues require immediate attention. They may involve working in the moment to help the mother develop concrete steps towards alleviating particular negative patterns, and can be a powerful way of helping the mother feel listened to and, in turn, supporting her to move forward in owning her feelings and becoming

responsible for her behaviors. The following is an example of the social worker providing support for the mother while supplying developmental information and guidance.

Support, developmental information and guidance

Yolanda and her 16-month-old, Jasmine, sat in their living room and within minutes Jasmine began emptying blocks from a container by hurling them across the room in all directions. Yolanda took Jasmine's hand and sharply slapped it with two fingers while letting out a loud, "NO!" Jasmine pulled her hand away, waddled a few steps away to pick up another block and without looking at her mother, threw it. Yolanda had been exhausted by her day's work as a housekeeper. She said, "She doesn't listen. I don't know what to do. Everything is no, no, no. I might as well call her "no."

The home visitor saw that Jasmine's throwing was not aimed at distressing her mother, but was a new skill she had discovered since the previous several visits.

Clinician: "I know it must be annoying to you to see her doing things that she hadn't done before, like, throwing things. But in some way, it does seem like she might be playing a game. **(empathy, reflecting mother's feelings back to her, validation before offering an alternative)** *Would you like to see what might happen if we tried to get into her game?"* **("what if" questions, experimenting and reframing with humor)**

Yolanda: "Why not. It doesn't work when I try to tell her not to anyway. It can't hurt," Yolanda grinned in humorous surrender.

The clinician got on the floor to fill and dump the blocks for Jasmine, who watched with intent. Then, giving Jasmine the blocks, Yolanda watched as Jasmine did the same, however, scattering the blocks with more fervor. Yolanda continued to discuss how she felt ineffective and possibly at risk of spoiling her baby because of the manner in which Jasmine was determined to repeat her activities, such as block-throwing. The clinician entered into a discussion about normative developmental needs, specifically around the emergence of independence, determination and preference in the toddler years. **(psychoeducation, normalizing)** *The conversation led the clinician to ask Yolanda about her upbringing in Puerto Rico, how her cultural beliefs enforced by her parents, affected how she saw herself as a mother.* **(model curiosity, ask for elaboration, use of autobiographical narrative: connecting own past childhood to child's experience)** *Yolanda was pleased to talk about how her parents' strictness resulted in their own children becoming respectful and obedient. Her own mother used "hand hitting" or "spanking" to control her young children, and that she advised Yolanda to do the same with Jasmine.*

Yolanda was able to discuss the differences between her own life situation and that of her mother's, i.e., her mother had much familial help and rarely was away from the home. Yolanda was also able to enter into a description of how she judged her efficacy as a mother and was able to accept that she did have different expectations of her daughter given that it was her firstborn. "I am confused about what I should tolerate and what I should not. Is she acting spoiled?"

The clinician then invited mother to play on the floor with the blocks, and noted the dyad's positive interaction. It was at this point that the clinician gently introduced the concepts of mastering a new task via repetition, using past incidents such as banging on the tray at mealtime, as an example. **(reframing, offering baby's perspective)** *Yolanda brought forth that she truly missed being in Puerto*

Rico and felt in "limbo" trying to parent in the city environment in a drastic contrast to her more rural environment of her hometown. The themes of bringing together culture, dislocation from one's place of origin, family expectations and the mother's formation of an identity as a mother together with the new behaviors of the strong-willed toddler allowed the mother to gain insight into how her own feelings affected her baby's behavior and thinking. **(linking feelings and behaviors)**

Family or couple intervention

The mental health intervention is geared toward progressive change at multiple levels of the mother-infant dyad's world. The family of origin plays an integral role in determining to what extent the family system will enhance or discourage growth in the dyad. For many of the mothers in the MTB intervention, the family can be a source of added stress, due to limitations in their ability to model resiliency, security, and consistency for the dyad. In others, the family can be a source of support. Where appropriate, family systems change is incorporated throughout the work.

Family sessions can be held for various clinical reasons when appropriate, i.e., to work through problems between the mother and her parents, to safeguard against possible problems in the mother's care-giving or to assist in the multiple chronic social problems facing the dyad. In many instances, however, the family becomes part of the intervention because one or more members have needs that require attention and may or may not be directly affecting the dyad. In this instance, the therapist must make clinical decisions as to how to navigate providing direct services to other family members while being faithful to the treatment by maintaining a focus on the mother and baby's needs. The clinician communicates that intervention with the family is important, but that the focus of the intervention remains on the dyad.

Working with psychiatric disorders

Diagnosis and care

Given the life circumstances and family histories of many of the mothers in MTB, we find that a fair proportion will manifest some form of "diagnosable" psychiatric disorder. This can range from what are referred to in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (2014) as anxiety and depressive disorders, to more severe disorders such as PTSD, bipolar disorder or other forms of major psychiatric disorder. Many of the mothers also show signs of personality disorders, including antisocial, narcissistic, and borderline personality disorders. As was noted in Chapter 4, many of these can present as part of a general clinical picture of Complex Trauma Disorder. While it is not a primary job of the MTB social worker to formally diagnose DSM 5 disorders, it is important to be able to recognize the signs of psychiatric disturbance, so that we can take steps to obtain more support for mothers when needed.

MTB is often the first course of treatment in these circumstances. As has been discussed throughout this manual, the establishment of a safe, trusting relationship with a mentalizing clinician can be enormously helpful to mothers, both in managing their own emotional lives, and developing loving, intimate, and secure relationships with their babies. In this sense, the supportive, dynamically oriented work of the home visitors, particularly the social worker, is a *primary* treatment for both the mother's emotional pain as well as her psychiatric problems. And together with the nurse, social workers have many techniques available to help mothers manage their anxieties through deep relaxation, meditation, and breathing. Some social

workers feel the need to refer mothers out in these situations; while this can be appropriate, it is also important to remember that the care we provide is therapeutic and very helpful.

Clinicians often feel that they do not have the skills to treat psychiatric problems. They feel they should be providing, for example, cognitive behavioral therapy or trauma therapy, or they may worry that anything outside of targeted treatment is of little value. But many "evidence-based" protocols have not been tested on samples like ours. More importantly, families, due to cultural values and beliefs, or distrust in the healthcare system, have difficulty engaging outpatient psychiatric care providers. Although there are certain circumstances where mothers need to be referred out, this does not diminish the value of what MTB has to offer. It is easy to lose sight of the fact that there is both power and great worth in talking about one's pain with a safe and trusted clinician. As has been emphasized by so many theories of psychotherapy, and is made explicit in Courtois's work on complex trauma (2004), the provision of a safe and containing therapeutic relationship is the first step in any mental health treatment. Stabilization must occur before further treatment, and MTB clinicians are very good at establishing relationships, wondering, and listening which are key elements of stabilization.

At the same time, attention to the signs of clinical depression (including postpartum depression), disabling anxiety, or emerging psychotic process may signal a need for another layer of care, notably a psychiatric intervention and evaluation for medication. Ideally, when there is a need for medication or psychiatric evaluation, the home visitors will be able to link the mother and family to outside psychiatric services, and focus primarily on what they have to offer as MTB providers. In these circumstances, the social worker will often increase her visits and increase the intensity of her therapeutic work allocating equal time for the mother individually and the parent-infant dyad.

For some mothers, graduating from MTB means both losing MTB, as well as losing a layer of crucial psychiatric support. MTB clinicians facilitate a referral to outpatient treatment at this point in hopes that the mother can transfer her positive therapeutic experience to an outpatient provider. However, finding a good therapeutic match for many of our mothers can be difficult and often leaves them feeling abandoned and clinicians feeling guilty and frustrated.

Psychiatric crisis intervention

The emergence of a psychiatric crisis rapidly shifts the focus of the intervention towards symptom stabilization, safety planning, and possible collaboration with the medical and/or outside psychiatric providers as needed. Psychiatric crises may include perinatal psychosis during or around the time of delivery, postpartum depression, or the emergence of other DSM-5 disorders during the two-year course of involvement with the mother. Psychiatric crises are handled by first obtaining an accurate diagnostic impression, which requires that a psychiatrically oriented interview be administered to the mother and other family members/friends who have observed the mother and might be in a position to support her. If safety evaluations show that the mother is at a critical point, in terms of either harming herself, her baby or others, steps to provide the highest level of safety would be taken. This might include contacting the local emergency department or psychiatric mobile crisis intervention.

Things to consider when assessing for risk for suicide or homicide:

- History of previous attempts (this is the most correlated with risk of future attempts)
- Client age (adolescents and elderly males are at highest risk)

- Client gender (males tend to have higher rates of completed suicides)
- Client ethnicity (White and Native American)
- Marital status (divorced, separated, recently widowed)
- Access to weapons/means
- Lack of social support
- Negative religious or cultural beliefs about sexual orientation/identity
- Ongoing feelings of hopelessness
- Recent significant stressors (fired/laid off, expelled from school, loss of a loved one)
- Family history of suicide (or a close relationship with someone lost to suicide)
- Perfectionism and low self-worth
- Substance use

Protective factors to include in assessment:

- Being married or a parent
- Religious beliefs discouraging suicide
- Cultural beliefs discouraging suicide
- Good social support
- Good coping skills, ability to problem-solve and history of managing behaviors
- Pets
- Hope for the future
- Sense of personal control
- Access to appropriate healthcare

Source: https://www.socialwork.career/2016/12/suicidal-ideation-how-to-document.html

If the mother does not require hospitalization or a higher level of psychiatric care, a treatment contract is made with the mother and/or other family members; the mental health aspect of the intervention is intensified, with more frequent visits made by the social worker focused on symptom alleviation, couple and/or family counseling and when necessary, further referrals to mental health providers in the community are made. In both perinatal or postpartum depression, steps are taken to 1) provide close monitoring of symptoms and intensified supportive counseling by more frequent visits by the mental health home visitor and/or the nurse, 2) make referrals, if applicable, to outside psychiatric care, and 3) collaborate fully in treatment planning with the nurse home visitor, the midwifery or obstetric team, as well as the mother's primary care provider in order to monitor and assess the mother during the course of the crisis.

Individual psychiatric crisis management and family supportive counseling during the first year of intervention

Delores, whose son Jacob was 8 months old, was feeling overwhelmed by her inability to control many external stressors: her boyfriend's unemployment, a lack of family support, and poor relationships with her co-workers. She presented with outbursts of irritability, which were marked by loud cursing and fighting with her mother. On occasion, she would storm out of the house, sometimes overnight. The social worker reviewed all of stresses bearing down on Delores and wondered with her about how her ability to function and parent might be affected. **(showing empathy and modeling curiosity)** *Delores reported having raging episodes in the presence of her 8-month-old son Jacob, who was beginning to show signs of anxiety, depression, and anger. The social worker suggested to Delores*

that additional support from the MTB team and her community health center might improve her symptoms and help her feel better. **(direct instruction, psychoeducation)** *She assured Delores that although asking for help might feel like a sign of weakness, it is perfectly normal for new parents to be stressed, and it would be impossible for someone experiencing her current life stressors to manage without help.* **(validation of experiences, affirmation)** *The social worker consulted with her nurse partner to develop a more intensive plan of care. Both the nurse and social worker assessed Delores to rule out post-partum mood disorder, and a major depressive episode. A risk assessment was also conducted to rule out suicidality and homocidality. Delores received more frequent home visits with the MTB clinical team for a period of several months to help her address the sources of her thoughts and feelings and to develop strategies to improve sleep, nutrition, stress management, and increase pleasurable moments with Jacob. Although she was initially reluctant, with the education and support of the MTB team, Delores agreed to meet with the psychiatrist at her community health center. A full psychiatric evaluation was conducted, and psychiatric medication was prescribed to help Delores control her labile affect as well as her persistent irritability and depression.*

In addition, Delores, her mother, and boyfriend met together (without the baby) to work through long-standing conflicts so as to reduce conflict and focus on the emotional impact of their negative relating styles upon the baby. **(bringing family back to the baby)** *Over time, the baby's aggressive, irritable, and irregular behavior softened. He played more with his mother, who was more open to allowing exploration without judging it as an affront to her authority. She continued to take in the support and non-judgmental interventions that aimed to emphasize her ability to recognize her son's thoughts, feelings and inner states. Slowly, she learned to tolerate and regulate her own at times tumultuous internal world. Her rages diminished and she made strides in protecting her son from overt outbursts through an improved ability to verbalize* **(labeling feelings and expanding emotion vocabulary)** *rather than act out her feelings of anger, sorrow, and isolation. Delores thrived when the social worker and nurse would point out the changes she made in managing her stress and interacting more gently with Jacob.* **(incremental praise, encouragement)** *The parents' ability to manage conflict between one another also improved, which gave them glimpses of improved relating for the future.*

Environmental crisis intervention

Social workers must often address non-psychiatric crises, such as those regarding child safety, parent crisis, domestic violence, and the involvement of child protective services. This is where good clinical judgment, assessment skills, and consultation with one's partner, the team, and clinical supervisors are critical. At such times, mental health crisis counseling and direct service provision can be useful in helping reduce the impact of the stress on the mother-infant dyad. It is important to note that when working with outside agencies, the social worker must often be very explicit about what her role in MTB is. It must be made clear that her relationship with the mother is a therapeutic one, and that her primary role is to protect and support her relationship with mother. She is not a child protection worker, a domestic violence worker, but the mother's primary clinician.

Ultimately, unless there is imminent risk of harm to the mother or baby, it is up to the family to accept assistance. Clinicians can facilitate, give information, and make linkages, but cannot resolve the crisis. It is also important to remember that *MTB is not a crisis-intervention, on-call, 24-hour program. Clinicians should turn their phones off when not working.*

Video feedback

While not a treatment approach, per se, video feedback can be a useful way to promote the mother's ability to observe herself, her baby, and their interaction. It is not necessarily suitable for all families, but when mothers are open to being taped, observing the videotape together can be quite eye-opening and transformative. The social worker can use her phone, or, if it is available, a video recorder. Some sessions will require planned videotaping if specific interactions or routines like feeding are being observed. However, there are moments when spontaneously filming a particularly meaningful interaction can help a mother take a step back and see her best qualities or think about what she might like to do differently to enhance her relationship with her child. If filming is planned, advanced warning is a good idea – some mothers like to be camera-ready!

Typically, the mother and social worker review these tapes later in the session, or in a subsequent visit. Such review provides a lively way of helping moms reflect on how their child has changed and grown, what they have enjoyed most about their baby and motherhood, and what goals they may have for the future. It also allows mothers to think about their responses to the baby within the context of the safe relationship with the social worker.

After watching a taped interaction together with the social worker, the mother is first asked to provide a narrative of the experience; she is asked what she was intending, thinking, feeling, responding to, and noticing in her baby. She is then asked to provide a parallel dialogue about what her infant is "saying" to her via his gaze, his body tension, his vocalizations, and his general bodily activity. She is asked to draw as vivid a picture as possible of her and her baby's experience of one another. Next, the mother is asked to answer a series of questions geared towards becoming more acutely aware of their experiences of the interaction: 1) What parts of the interaction did you enjoy the most? 2) Which parts did you enjoy the least? 3) In which parts did you feel most effective in terms of relating to your baby? 4) In which parts did you feel least effective?

In a non-critical tone, the social worker guides the mother to view her competencies and her experience of joy with her baby, while at the same time, allows for room for discussion of where the mother and baby "had a harder time joining one another." The exercise reinforces the mother's growing ability to read her baby's signals and opens discussion regarding discovering the baby's experience of the mother. The social worker conveys in a non-judgmental way that the video is meant for the mother to explore and discover her interaction with her baby in a reflective way. The aim is to engage the mother in a dialogue about what she thought were positive and negative aspects of her efforts to elicit engagement.

For example, if a mother says that she did not feel effective in holding the baby's attention, the social worker can ask open-ended questions such as, "What do you think the baby felt when you withdrew because you couldn't get him to look at you?" or "What could you have done differently when he kept looking away?" The mother's ability to look back at the tape and comment on observations about herself can also promote a source of material about developmentally appropriate behavior and engages the mother in an ongoing discussion about discovering the baby's internal world. This enhances the mother's ability to take the baby's perspective and witness their interaction as a mutual exchange of cues, signals and shared emotion.

Videotaping in an infant-parent session

During a videotaping session designed to observe infant-led play and interaction, the social worker noticed that Laura's face to face interaction with her three-month-old daughter Annie was perfunctory and task-based. There was little vocalization and infrequent eye contact, and Laura's communication with Annie was mixed: she interspersed a chain of kisses with sarcastic teasing, and then told her daughter to "shut up" several times. Laura at first offered little about her internal world, and seemed disinterested in thinking about the baby. Instead, she focused on her ongoing and troubled relationship with the father of the baby. She reported that she had recently physically attacked the father of the baby and destroyed his property. She had previously revealed other angry attacks during her pregnancy. The social worker inquired about Laura's thoughts just before **(curiosity)** *she launched into her attack of the father of the baby and helped her explore how her feelings of rage are linked to other feelings not so evident in the drama of the altercation.* **(linking feelings to thoughts/actions)**

While watching Annie explore and mouth a rattle, Laura pensively reviewed moments of disappointment, abandonment, and rejection from the father of the baby and began to own her aggressive behavior (as opposed to outwardly blaming the father of the baby for "making her do these things to him"). As the social worker pointed out Annie's response to Laura's less-intrusive play "Look at how curious Annie is about that rattle! You are really giving her a chance to explore it," **(verbalize baby's perspective and experience)** *she began to draw links between Laura's ways of experiencing and expressing anger to her own mother's use of physical punishment towards her as a child.* **(linking the past with the present)**

Several weeks later, the social worker and Laura reviewed the video together to discuss how Annie's sense of exploration and desire for social interaction was changing. Laura was able to recognize her anger with her baby, and was able to imagine how the baby experienced her mother's states of anger. **(alternative perspective-taking)** *Laura also verbalized that she was feeling less irritated by Annie's bids for play and connection, realizing that it's natural for her baby to want to be close to her sometimes. Laura's past and present hurt was thus separated from the baby. She could now pause when she felt mad at the baby and talk about it freely.* **(use of words to identify feelings and mental states)** *Her previous distance from the baby began to grow into a more spontaneously caring presence. Laura was able to talk about wanting to protect her baby from the experiences she herself had as a child.* **(exploring and expressing intentions)**

Stress management

The social worker partners closely with the nurse to help parents develop stress management skills where they recognize physical and emotional signs of stress and develop strategies to address the symptoms. Mindfulness, problem-solving, reality-testing, and desensitization can be valuable components of a stress management plan for young expectant parents (refer to Chapter 7).

Other areas of emphasis

Life skills, education/employment

Life course issues are always a work in progress based on what is going on in the mother's life. Many mothers return to work by the time the baby is one year old. Some go right back to work immediately after the baby is born, while others seem content to stay home with their children until they enter preschool despite not having completed high school. MTB clinicians constantly walk a fine line of supporting

mothers' efforts to build their self-efficacy while also helping them to keep their babies in mind as they juggle multiple demands of work, education, and motherhood.

Infant mental health

Infant mental health is defined as the developing capacity of the child from birth to age 5 years to form close and secure adult/peer relationships, manage and express a full range of emotions, explore the environment, and learn. Informing families about the importance of healthy social and emotional development in infancy and toddlerhood, and supporting positive, nurturing parenting practices is an integral piece of the MTB intervention for both the social worker and the nurse. The social worker pays special attention to parent-child interaction from the earliest days following birth through the first 2 years. Encouraging sensitive parenting behaviors, mutual enjoyment, and a secure attachment through exploration of emotions, play, videotaping, and helping families develop emotional vocabulary to identify what they and their baby might be feeling, are some key strategies the MTB social worker uses to promote infant mental health.

Parenting, child health and development

Part of developing positive, caring parenting practices is understanding child development so that parents have age-appropriate expectations of their child. The MTB social worker encourages parents to think about their own childhood experiences of being parented and what it means to feel safe and loved, the meaning of discipline, and intergenerational parenting practices or relationship dynamics they wish to pass on to their children, as well those they want to change. The social worker relies heavily on the benevolent intentions stated by the parent in the Pregnancy Interview to offer gentle reminders about the wishes parents have for their child. These wishes can be key tools in helping parents consider alternative viewpoints about discipline and appropriate infant and toddler behavior. The social worker consults frequently with the nurse about the baby's health in terms of managing common illnesses, changing nutritional needs, growth, and timing of developmental milestones.

The Social Work Component

Social support and community resources

Resources for immediate food and shelter

Housing utilities such as heat, electricity, water, pest control, providing an adequate living space for the baby, shelters, etc. are all examples of resources that need to be available for the dyad's physical well-being in the immediate present. Fully assessing these needs during the initial psychosocial interview and following through with a service plan is crucial. Ensuring that there is adequate food and equipment for the baby, i.e., bassinet, clothes, medicine, transportation to the hospital, must also be fully considered for the immediate physical well-being of the dyad. When appropriate, the mental health home visitor uses donation services, such as food pantries, churches, and community resource centers to obtain the necessary baby items. In cases where the mother has no telephone service or transportation available to her, the clinician will coordinate with resources in the community to obtain the necessary equipment or items for her, especially during the immediate postpartum period, when she is recovering from the delivery. In many cities, medical transportation to appointments is available for families receiving public health insurance. Having access to general phone info-lines for community resources and getting to know what is available for expectant and new mothers of infants and toddlers within the community is essential to the MTB social work role.

The social worker also evaluates the need subsidies available to the new mother and baby. The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is activated during the mother's pregnancy. The mother may need help in applying for and maintaining appointments. Special concerns by the team about the infant's weight or missed appointments by the mother require collaboration with WIC case managers as well as close assessment of the home situation. In the event of food insufficiency, the mother is helped to find local food pantries and in some cases, emergency food is provided by the team. Once again, the hallmark of the work of securing access to or actual food is that the food and providing nourishment is such an essential facet of mothering. Problems with maintaining enough food in the home can be diagnostic of other latent social or psychological issues, or may be indicative of deep poverty.

Public housing and supportive housing can be very important for many mothers who are not able to afford the market rates for apartments. Despite the chronic shortage of affordable housing, mothers can be helped to take action towards becoming eligible for housing waiting lists. Application for public housing is typically a long process (wait lists are anywhere from 6-36 months long) and should not be considered an immediate short-term solution, but rather part of a plan for more long-term, stable housing. The social worker may also connect a mother to local resources for supportive supervised housing if there are needs for more on-going, concrete help with daily living, financial planning, and other life skills due to mental or intellectual disability.

Resources for family finances

Becoming a mother for the first time brings with it enormous financial pressures. For many MTB mothers, having a baby marks a point in which she is quickly introduced into a new role of being legally responsible for herself and for another human being. Having to face the duties of managing the household finances can be a chronic strain upon the time a new mother has to care for her baby. Building a sense of competency through supporting mothers in positive and effective interactions with outside agency representatives affords them the opportunity to learn how to navigate complex, multi-level social service systems.

For many pregnant women living below the poverty level, welfare can play a major, on-going role in providing assistance to the new mother and baby. The work-for welfare-initiatives currently in place in many states determine that the client can usually depend on cash assistance for around 18 months to two years, a period that is parallel to the duration of the MTB intervention. The MTB mental health worker advocates vigorously to help the mother secure and manage her accounts for state assistance, sometimes writing letters, calling the caseworkers *often with the mother present and participating*, or transporting mothers to their appointments. These steps provide a means to help the mother work through frequently arising issues around recertification and eligibility determination. In addition, helping the mothers understand their rights and options with respect to applying for welfare cash assistance and state assisted health insurance can be a critical piece of securing their own and their baby's financial picture. More importantly, it can become a way for the mother to think reflectively about long-term planning and budgeting for the family's long-term survival.

The goal of providing such heavily focused advocacy is to secure effective services, explain and help the mother interpret confusing laws and regulations, and eventually strengthen the mother's ability to become more proactive and gain competence in her own case management. The overarching benefit of being able to successfully manage this complex web of service needs is that the mother develops the capacity to

understand the powerful impact of financial uncertainty on her life and on her baby, and can develop the tools necessary to manage her circumstances to the fullest extent possible.

Social Security Disability can be a needed entitlement for mothers and/or babies who meet medical eligibility criteria for a physical or psychiatric disability. Similar to welfare, securing applications, explaining the federal regulations, as well as providing close advocacy becomes a part of the treatment. Central to the use of disability assistance is a continuous dialogue between the social worker and mother about financial planning, budgeting, and adjusting resources when the disability assistance ends. Depending upon the severity of the baby's diagnosis and the mother's emotional reaction to the disability, she may also need help processing the meaning of the label *disability*. The clinician may need to help the mother through potential, sometimes unanswerable questions about her baby's well-being, while at the same time continuing the work around attachment building and reflectiveness.

Legal matters and court appearances

Paternity and child support can be sensitive topics for some mothers, especially if there is uncertainty about paternity or conflict or estrangement with the father of the baby. We help mothers develop a visitation plan that is consistent and predictable if the parents are separated. Helping them talk through and process their concerns (even down to writing out what their ideal plan would be, what they don't want, and what they are willing to negotiate) can be empowering. Also having some understanding of the court hearing process helps clinicians to be more supportive.

Environmental health and safety

Resources for immediate safety

Not uncommonly, MTB families have had experience with legal, protective, or criminal agencies at some point in their recent past or in their childhoods. Understandably, MTB clinicians understand that these prior experiences can make families unwilling to expose their lives or trust outside authorities. Nevertheless, there are times when child protective services or police intervention may be needed, for example in the event that there is excessive instability in the living conditions of the dyad due to the parent's or other family members unsafe behaviors, i.e., active drug activity in the home or domestic violence by the mother's partner against the mother. Useful resources involve obtaining a 911 cell phone (typically from domestic violence shelters) to give to the mother to call authorities in emergencies, filing protective or restraining orders, developing safety plans, giving her emergency numbers to shelters and crisis hotlines; as well as reviewing warning signs of potential outbreaks of violence.

Safety of the child

As a mandated reporter, the clinician must report suspected cases of child abuse or neglect to child protective services. Steps to thoughtfully assess risk and harm are made by the entire team, and further collaboration is made with the medical providers of the mother and baby. There is a potential for anger and the mother's leaving the program, and in this vein, it is strongly recommended that the home visitor process and explain the reasons for concern to the mother and make the call with the mother whenever safe and appropriate. The clinician must emphasize to the mother the necessity of outside monitoring for the sake of the baby's safety. Delicacy, straightforward explanation, and offering to support the family through the investigation process can act as a buffer against the potential disruption in the treatment.

Family crisis and domestic violence

Many of the mothers in home visiting programs may be involved in what we would consider unhealthy romantic relationships where infidelity, emotional and physical conflict, and ambivalence about remaining in the relationship are the norm. Communication and negotiation skills are often lacking. Additionally, partners often have expectations of one another that are strongly influenced by cultural forces but may not always seem reasonable, particularly when the clinician's emphasis is on helping the couple keep the baby in mind. Ultimately, the best the clinician can do is help each party to feel heard, and direct their intentions toward the best interest of the baby. Sometimes this means seeking more specialized intervention to protect the relationship and family system, or ending the relationship.

A family violence situation, whether chronic or acute, between mother, father, and/or other household members may place the adults as well as baby at serious risk for harm. The steps for action in cases of imminent danger call for a full assessment of the frequency, intensity and duration of the episode(s), the perpetrator's proclivity towards violence, the role of substance abuse/use, an assessment of the history for escalating violence, and the mother/family members' ability to de-escalate or manage the physical violence. When these situations place the mother, baby and/or other household members at immediate physical risk, steps must be taken to reduce the conditions aggravating the violent situation, removing the members at risk for harm from the violent environment, alerting authorities, local police, domestic violence shelters, and child welfare authorities. Furthermore, focusing on providing support, concrete services, and post-traumatic counseling are key elements in the treatment with the social worker.

Working collaboratively with mothers around domestic violence can be fraught with clinical issues such as the reluctance to disclose actual events out of fear of involvement with legal enforcement agencies. Often family violence plays a significant part in the mother's own childhood history, making the mother perceive it as the norm in family life. In these instances, getting the mother to understand the realities of the violence – its physical and emotional impact on her baby and on herself – is a large part of the immediate crisis work. Preventing repeated incidents of violence through more in-depth counseling while improving the mother's ability to disclose the degree of violence in her and the baby's lives are continual strands of the treatment in these instances.

Sadly, it is often the case that – despite our repeated efforts to help mothers disengage from violent partners – the pull to return can be overwhelming. This can be very difficult for home visitors, who often cannot fathom the extent and depth of mothers' attachment to their partners. It is only by respecting these attachments and their power (power that may well operate through fear) that we can truly help mothers understand and hopefully relinquish them. If clinicians take a stance of "Throw the bum out!" they will not get very far, and conversely, encourage mothers to hide their complex feelings for their partner. Unfortunately, this is the stance of many domestic violence treatment programs, which limits their effectiveness for many mothers.

Conclusion

As stated at the beginning of this chapter, the social work role within the MTB model is rich and multi-faceted. Therapeutic work and case work go hand-in-hand, often simultaneously. The psychological and basic needs of families are almost always interwoven. Flexibility in thinking, the ability to find compassion for every family, a sense of humility and reliance on the nurse home visitor as a true partner, and a sense of competence in foundational clinical practice are essential qualities for successfully managing this challenging and dynamic role!

CHAPTER NINE:
THE CLINICIAN'S EXPERIENCE:
VICARIOUS TRAUMA, SUPERVISION, AND SELF CARE

Introduction

Being a *Minding the Baby ®* clinician can be very stressful, at times. It is for this reason that teamwork, supervision, self-assessment, and self-care are such essential components of the MTB model. In order to set the stage for considering each of these issues, we begin with the text of an email written by an experienced nurse to her supervisor, an email that describes more eloquently than we possibly could just how hard the work really is.

> *Dear Denise:*
>
> *Yes... I'm on vacation. :-) But, as you can see, since I'm sending you this email at 3:05 AM, sleeping is not always my forte. I've been grappling with how to handle the stresses of the job that I will be returning to next week after my vacation...been thinking a lot about vicarious trauma and just wanted to share something that hit me as a truth because maybe this will help someone else struggling as I am.*
>
> *So, I'm realizing that part of the vicarious trauma for me is not only feeling and experiencing the pain of what these girls endure and/or have endured in the past. For me, it's also that working with them has increased my own awareness of life's realities, and of the potential for traumatic events in everyday life. So, it's given me a heightened awareness of my own vulnerability to the horrible things that can happen...to me, to my baby, to my family. This makes me feel helpless and fearful and contributes to my nightmares, which often lead me to being awake at 3:05 am. :-) The "what if's" of life have increased dramatically for me. Staying away from the news used to work for me, but now, this job IS the daily news! We go into the areas with the shootings and the poverty and hunger, and they're sharing those stories with us. Sometimes, they share things my mind never knew existed. I can't change the channel.*
>
> *Also, the girls we work with have not only been through awful individual life experiences, but they also live everyday lives of just mere existence and poverty. So, I'm also realizing that seeing the daily despair just does something to me, and it's then a struggle to not bring that sense of despair and hopelessness into my own personal life.*
>
> *Thanks so much!*

The Clinician's Experience: Vicarious Trauma

Within the MTB model, our ability to promote change and recovery in parents depends upon our ability to *care* for them, and thus provide a secure base for them in the journey of becoming a parent. Our capacities for empathy and reflection on the one hand, and for warmth, openness, and kindness on the other, are key. Often, we must do this against the backdrop of hearing about and holding horrific stories of trauma, and sit with parents who are troubled, angry, frustrating, and so sad they are frozen. We hold these feelings for the parents, calm ourselves enough to help parents regulate and attend to their babies. We aim to do this with compassion and non-judgment. At the very same time, we are formulating appropriate responses, making observations, assessments, and decisions. We leave home visits trying to remember what we've observed,

planning next steps, and sorting through our responses to what we have experienced. We work long hours and sometimes feel overwhelmed by parents' demands. This is often difficult and tiring work.

Selma Fraiberg (1980) proposed that when infant-parent work enables a mother to experience the affect associated with traumatic childhood experiences, it acts to prevent further recurrence of these patterns. In order to help mothers experience these affects, clinicians must hold and feel the trauma too. Indeed, it is often the case that mothers cannot experience the affect, but instead project it onto the clinician. By taking this in, and bearing witness to multiple stories of trauma, pain, and violence, (and often current danger and violence) the clinicians experience the feelings the mother could not: a childhood sense of overwhelming danger, rage, rejection, and helplessness. These can swamp the clinician at times, and lead them to feel unsure of themselves and their ability to protect the child. At these times, clinicians (like mothers) run the risk of becoming distracted by severe and real life crises, which may in some ways be easier to keep in mind than the mother's negative affect in relation to the baby, which can be so palpable in her treatment of the baby, and so distressing for home visitors.

There are costs to such witnessing. Among them are similar but different phenomena: *burnout, compassion fatigue, and vicarious trauma*. Vicarious trauma is defined as "the cumulative transformative effect on the helper of working with survivors of traumatic life events" (Saakvitne et al., 2000). The clinician's caring awareness of the prevalence of trauma and its devastating impacts can become traumatizing for the clinician, who begins to experience some of the sequelae of trauma exposure: preoccupation with the mother's trauma, helplessness, fear, re-experiencing, or emotional numbing. This can lead to a range of difficulties inside and outside of work. These may include over or under working, exhaustion or illness, free floating irritability or anger, rejecting closeness, sleep difficulties (including nightmares), over or under eating, disrupted relationships with friends. Likewise, they can lead practitioners to question their identity, to a change in world view, to feelings of uncertainty, emotional numbing, depression, anxiety, and despair. We see so much of this in the poignant clinician letter, above.

There are some known risk factors for vicarious trauma. Clinicians who have not been trained to work with trauma or who do not have adequate supervision and support are more likely to suffer its effects. Likewise, a caseload that is too heavily weighted with high trauma cases is ultimately untenable. A lack of training, supervision, and attention to workload are all indications of a lack of awareness at an agency level of the power and reach of vicarious trauma. Unsurprisingly, there are personal factors as well. Clinicians who themselves have histories of trauma are also vulnerable to vicarious trauma, as the circumstances of the families they are working with resonate too deeply to maintain clear boundaries and regulate one's own emotions. Clinicians who are overwhelmed by demands in their own lives – especially when they themselves are caring for small children – are also more vulnerable to complex trauma.

There are several crucial antidotes to vicarious trauma: teamwork, supervision, and self care.

Teamwork

One of the sequelae of vicarious trauma or compassion fatigue can be a failure or unwillingness to collaborate with clinical partners. Communication seems so difficult. But in fact, one's clinical partner is the person who knows more about the trauma of the work than anyone else. Thus, sharing, problem-solving, anticipating, and experiencing together the pain of a family's situation can be enormously helpful. It allows the clinician much needed perspective on distressing and hopeless clinical situations, and helps

her "let go" of client suffering and of her guilt at living an easier life. This is not to say that the clinician distances herself; rather, she gains a perspective that allows her not to drown in or overly identify with her clients' suffering. The families desperately need this perspective.

Additional layers of support to the clinical pair also include local managers and clinical supervisors, all of whom provide the layers of holding necessary to keep clinicians able to mentalize and empathize with deep layers of pain and trauma. We see the clinician's letter above as a clear example of turning to supervisors to process trauma exposure.

Supervision

As has been noted throughout this manual, supervision – which encompasses support, consultation, and guidance – plays a critical role in MTB. Indeed, we view the fact that clinicians receive far more supervision than is typical of other home visiting programs as one of the strengths of our program. Supervision is critical for a number of reasons, chief among them being that it provides a means to deepen and broaden the clinician's understanding of the mother, the baby, and herself. When the enormous complexities of this work are not processed, however, they interfere profoundly with the work.

Clinicians receive one hour of discipline-specific supervision per week (the social worker is supervised by the mental health supervisor, the nurse by the nurse supervisor), and one hour of interdisciplinary supervision every other week (each team is supervised jointly by either the nurse supervisor or mental health supervisor, typically on an alternating basis). They are also expected to participate in weekly team meetings, at which one case is typically discussed in depth, and various urgent matters, updates, and "gems" (moments when the parent takes a big leap forward, often in her ability to reflect) are also discussed. In addition, they are expected to be in close, daily contact with their clinical partner, and to sit down and review their joint caseload at least once every week or so.

One of the functions of supervision in MTB is to maintain the interdisciplinary focus of the program. Because the two home visitors are supervised together within each discipline, they are privy to both types of input and thinking about the cases. This exposure to layers of expertise, and of joint problem-solving, creates a set of checks and balances within the clinical case discussions such that one position or perspective is always balanced by the other. This is crucial to helping home visitors keep the "whole" child in mind, in all his complexity. It is also crucial to helping the home visitors work together to provide the "seamless web of care" (Lieberman, 2003) described above, using supervision to resolve differences in language and approach, and to maintain a unified focus on the enhancement of reflective functioning.

Within the framework of supervisory meetings, there are three different types of supervision: administrative, clinical, and reflective supervision. Administrative supervision takes up relatively little time in the larger scheme of things, but it is important to review clinical status (active/inactive) and required paperwork, dosage patterns, update family contact information, and discuss upcoming research visits with program administrators. The rest of the time in supervision is devoted to clinical and reflective supervision. Clinical supervision refers to case review, which has different meanings within nursing and mental health frameworks, includes discussing areas of difficulty, considering what the options are for resolving these difficulties, and addressing some of the dynamic reasons behind them.

As an example, the social worker and nurse presented the case of a mother whose anxiety was so extreme that she was waking the infant up at hourly intervals to "check" him. In addition, she was obsessed, in a

very worrisome way, with stories of infants dying and would comb the internet for the most outlandish stories and present them to the home visitors as proof of her need to be vigilant. Her presentation was chaotic and disrupted and she herself was physically quite dysregulated, unable to sleep. The team was concerned about postpartum OCD. The house was very chaotic, with everyone up half the night, the TV blaring, etc.

In supervision, the home visitors first had to make sense of the extent of the mother's anxiety, and begin to think both of what might be causing it, and what strategies might be employed to regulate it, including bringing the larger family in to support the mother. They also had to assess her mental health status and potential need for medication. The first route the home visitors took was to discuss their concerns with the family. The father was coached to help the mother allow the baby to sleep as long as she would, and not wake her. This allowed the mother a less disrupted sleep as well and she began to function better. At the same time, the social worker tried to help mother think about why she was so frightened about the baby's safety, which led to important dynamic work.

In another instance, the social worker reported having transported a family to advocate for entitlements. After listening to her describe the details of the crisis, the supervisor asked a simple question: "How was the Mom with the baby in the waiting room?" This allowed the clinician to refocus on the baby, and to attend to other aspects of the situation. In yet another instance, the nurse was extremely concerned about growth retardation and motor delays in one of the families. She was focused on obtaining the tests necessary to properly diagnose the problem. The child was losing weight, and the mother seemed unable to comfortably and successfully feed her. The supervisor supported the nurse in her concerns and efforts to help obtain the necessary tests to rule out any medical problems. The conversation between supervisor and nurse then focused on helping the nurse look at the mother-child interaction and how she might guide the mother to notice the baby's hunger cues, muted though they were. While this did not solve the very real medical crisis, it allowed the mother to gain a sense of competence and confidence in nurturing her baby, at a time when she most needed it.

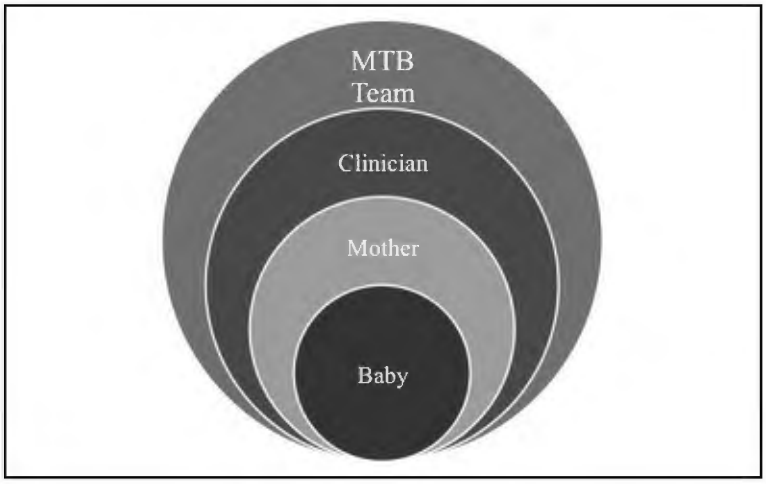
Reflective supervision is often a critical part of clinical supervision, but here the focus is on the clinician and her experience. Its aim is to provide clinicians with a safe environment to explore anxiety, doubt, fear, anger, and frustration, and is a critical piece of helping them manage the emotions that may get in the way of being able reflect upon mothers' experiences, so that they can remain in the "playful, reflective space." As Weatherston and Barron (2009) put it, it is a time for "shared exploration of emotional content of infant and family work as expressed in relationships between parents and infants, parents and practitiouers, and supervisors and practitioners."

The assumption underlying reflective supervision is that the clinician needs a safe place in which to reflect, just as the mother does, to identify blind spots, misunderstandings, empathic and reflective failures, and – broadly speaking – what are sometimes termed countertransferential responses. These can include intense negative feelings such as anger and frustration; these feelings are often so difficult for "helpers" to acknowledge, and yet their effects can be powerful and insidious. For example, a clinician may find herself judging the mother or avoiding her. Within this process, supervisor and clinician may not always feel aligned with each other, and they may in fact re-enact the clinician-mother dynamic in subtle (or not so subtle!) ways. The reflective supervisor encourages the clinician to tell the story, remains gentle, aware, and curious, and allows time for reflection. She pays close attention to how the clinician's emotional

reactions are affecting the work, and provides a safe, reflective space in which the clinician does not feel judged, and a place to process her emotional reactions.

Reflective supervision can be used as a lens or frame to use with administrative and clinical supervision. The main goal is to explore affect and understand how it might enlighten us about the mother/the baby/ourselves. Safety and containment are so important here to allow the clinician to maintain or return to a reflective stance and to grow her clinical skills.

Mutual trust is so important in the supervisory relationship. The degree to which the clinician feels understood and supported by the supervisor will have a profound impact on the degree to which she is able to regulate and contain the mother, the baby, and their relationship. Supervision is at the apogee of a number of parallel processes; the supervisor holds the supervisees and the complexities of the work in mind; as a function of this holding, the clinicians are then able to hold the mother, as well as the baby, in mind, which in turn allows the mother to hold her baby in mind. This is graphically represented in the figure to the right.



Self care

For reasons that should be very clear by now, the work of MTB can be depleting for clinicians. This makes self-care all the more important. While individual clinicians need to take care of themselves, Supervisors must also try to keep an eye on how well clinicians are taking care of themselves, and help them take time off or recharge when it is necessary. It is also important for the implementing agency to encourage and support self-care; in this way, the atmosphere of care extends across all levels of the program.

Listed below are suggestions for self care, compiled by home visitors:.

- Try to make reasonable limits on the times you are available to mothers, in person and by phone.
- Sometimes saying 'no' is the right answer.
- Drive carefully.
- Find a routine that allows you to decompress after home visits.
- Take quiet time to reflect.
- 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.

- 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 lifelong process. Remember that being a "good enough" parent supports the development of secure attachments.
- 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.
- Remember that being a "good enough" parent (and clinician) supports the development of secure attachments.
- 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.
- If you become ill, don't visit pregnant women and infants.
- If you find you are feeling ill tempered and impatient, perhaps you are in need of a break of some sort.
- 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.

CHAPTER TEN:

MTB TREATMENT FIDELITY MONITORING: INTERVENTION DELIVERY SELF ASSESSMENT

Introduction

As a federally designated evidence-based home visitation model, MTB is most is most likely to have the desired effects when clinicians are faithful to the MTB model; this is termed *maintaining fidelity to the* model, and it is achieved by following the procedures and approaches described in this manual. It is important to consistently monitor clinical work with young families so that clinical fidelity is ensured within the realities of constantly changing clinical and community environments.[2] For replication purposes, MTB treatment fidelity is measured, monitored, and enhanced across 4 domains (design, training, delivery, and receipt/enactment), as described more fully in the MTB Replication Operations Manual. The following framework is intended for use in ensuring clinicians' and supervisors' fidelity, including the procedures involved in delivering the intervention and elements of family engagement, observation, assessment, discipline-specific content, interdisciplinary teamwork, clinical approaches, and supervision.

These lists of procedures and approaches are intended for use as a part of a self-assessment process for clinicians, as a means to hone clinical skills and deepen understanding of MTB clinical roles. It is helpful to think about how regularly or consistently each of these actions or approaches is undertaken. This framework may also be useful to clinicians in raising questions or issues during supervision. Many of the procedures and approaches listed below are shared across both the mental health and nursing role, as noted, while some are more discipline-specific.

For those replicating the MTB model, the "Treatment Fidelity: Intervention Delivery Checklist" forms (provided in the Replication Operations Manual) should be completed by each clinician for selected families on a regular basis (at least twice per year) beginning three months after the first families are enrolled into the replication program, as well as the accompanying "Supervisor Self-Assessment Form" by each supervisor. One of each of these forms is to be submitted to the MTB National Office by each team member (clinicians and supervisors in both disciplines) on an annual basis.

Intervention Procedures ***(All Clinician Home Visitors)***

Structure of work with families

- Follow protocols for informed consent, intake, obtaining psychosocial and health history, and home visit documentation (including use of the Home Visit Process Variables form)
- Schedule regular individual home visits with families on an alternating basis
- Complete joint visits for consent signing, 1-year transition visit, and graduation visit
- Discuss and prepare for graduation with family three months before the child turns two

Clinicians as partners

- Meet weekly face-to-face to discuss families
- Work together in layering clinical work
- Assess families and their goals and needs prior to the transition visit, determining together when to transition to fewer visits in child's second year
- Discuss and prepare to make referrals for wrap-around care as family nears graduation

[2]McGuire DB, DeLoney VG, Yeager K, et al. (2000) Maintaining study validity in a changing clinical environment. *Nursing Research;* 49:231–235.

Family Engagement ***(All Clinician Home Visitors)***

- Build a therapeutic alliance[3] by providing a warm supportive presence
- Create a 'safe place' in the home to meet and talk
- Balance attention paid between child and parent(s), and the relationship(s) among them
- See mother-infant relationship as focus of treatment and psychotherapeutic intervention
- Hold the baby in mind and bring the mother back to holding the baby in her mind
- Recognize the mother's individual needs for care unless there is a safety concern (sometimes mom is "the baby")
- Understand the family system of the mother and who she identifies as her family
- Show awareness of personal boundaries and appropriate use of self-disclosure
- Understand role as a guest in the home
- Pay attention to the power dynamics between self and family: professional, cultural differences, etc.
- Acknowledge the family as experts of the child
- Respect cultural and family beliefs
- Observe the physical surroundings of the home and assess for concrete needs
- Demonstrate ability to use concrete service needs as a "port of entry" when needed[4]

Observation & Assessment ***(All Clinician Home Visitors)***

- Assess for safety risks
  - Bodily (especially partner violence)
  - Relational (especially interpersonal violence)
  - Environmental (community, home, child proofing, etc.)
- Screen for normal child development
  - Milestones
  - Appropriate play and behavior for age and developmental level
- Assess social supports and concrete resources
  - Living circumstances of the mother
  - Relationship status with father of baby, father figure, and/or significant other
  - Familial/friendships connections
  - Family strengths
  - Housing stability
  - Food security or insecurity
  - Utilities, clothing, basic baby supplies
- Observe maternal-child attachment system
  - Consider attunement[5] and reciprocity[6]

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[3]*Therapeutic Alliance: a relationship between a healthcare professional and patient or client in which engagement and trust are central to working towards beneficial change for the patient or client.*

[4]*Port of Entry: a point in an intervention whereby change is possible in the mother-infant dyad; a point at which to engage mother or family in building a therapeutic relationship.*

[5]*Attunement: bringing or being in harmony, evidenced between parent and child when mutual delight or pleasure is demonstrated and the child's needs are anticipated and met.*

[6]*Reciprocity: the "give and take" in a relationship, can also be viewed within the context of "serve and return" exchange in which the infant learns to initiate and respond to interactions with the caregiver.*

- Parental capacity to support exploration, provide a secure base, and support regulation of emotions
- Parental sensitivities around separation, esteem, and connection
- Temperamental goodness of fit between mother and child
- Affect, motor, and emotional activity/regulation of mother and infant
- Monitor for perinatal mood disorders in the transition to parenthood and the mothering role
- Monitor child growth, and overall development (including relational capacities)
- Monitor mother-child relational system and any risks

- Observe other caregiving relationships available to the child as optimal, or potential risk or protective factors

Nursing Role ***(Specific to Nurse Home Visitors)***

- Coordinate mother's prenatal and primary care (including reproductive health), baby's pediatric/primary care, and any needed specialty care for both
- Apply the concept of "dyadic" work[7] in MTB nursing
- Obtain maternal health history and status
  - Health assessment of the parents
  - Mother's prenatal care
  - Labor Plan
- Individualize and prioritize content for each family
- Assess for barriers to care plan implementation for family
- Use nursing approaches as described in Chapter of 7 of the MTB treatment manual
  - Anticipatory guidance[8] and foreshadowing[9]
  - Developmental screening
  - Motivational interviewing
  - Transtheoretical model (Stages of Change)
  - Stress reduction/mindfulness techniques
- Evaluate and consider the following when discussing health concepts
  - Health literacy[10]
  - Developmental age[11]
  - Comfort with language
  - Learning style
  - Stress level and stress management
  - Cognitive abilities
  - Families interests and personal agendas for the home visits

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[7]*Dyadic work: clinical intervention addressing the relationship system existing between two individuals.*

[8]*Anticipatory guidance: used by pediatric health care providers to address predictable childhood behavior and give developmentally appropriate advice to families.*

[9]*Foreshadowing: a clinical approach that builds on the concept of anticipatory guidance in which the clinician describes usual childhood behavior far in advance of the child's current developmental age to give parents the opportunity to learn about and look ahead to new stages.*

[10]*Health Literacy: the ability to obtain, process, understand, and discuss basic health information and services,*

[11]*Developmental/Emotional Age: refers to the recognition that a parent's chronological age may not reflect his or her developmental level or emotional self-regulatory skills.*

- Document health education, health problems, approaches, and need for further care
- Assess child's physical health and development

Mental Health/Social Work Role ***(Specific to Mental Health Home Visitors)***

- Communicate with nurse partner regarding content of mental health work with intention of layering roles appropriately, meeting weekly face-to-face
- Obtain maternal mental health history and status
  - Psychosocial history
  - Diagnoses (rule out or assign)
  - Trauma history
  - Developmental and emotional age versus chronological age
  - Genogram
  - Pregnancy Interview
  - Internal or individual strengths
- Individualize and prioritize content for each family
- Be prepared to use a variety of intervention strategies in dealing with trauma, anxiety, domestic violence, etc.
- Assess barriers to treatment plan implementation for families
- Apply MTB clinical approaches (Detailed in Chapter 8 of the MTB Manual):
  - Psychodynamic-trauma informed (mentalization-based, exploring ghosts in the nursery, linking mom's autobiographical narrative to present experience of parenthood, and intentions and challenges in the parenting or mothering role)
  - Supportive counseling
  - Parent-infant psychotherapy (incorporating play, videotaping, forming a coherent narrative for the mother, helping mother to see and hear herself and her baby)
  - CBT techniques
  - Mindfulness approaches
  - Couples' and family counseling
  - Family therapy/counseling
  - Case management
  - Advocacy
  - Assist with navigating the social service system
- Document mental health history, problems, and approaches

Interdisciplinary Teamwork ***(All Clinical Staff)***

Case conceptualization and development of multiple perspectives

- Communicate with partner(s) in other discipline(s), checking in regularly
- Build a trusting relationship by valuing others' perspective and experience
- Understand roles and knowledge base/scope of practice of partner
- Arrange face-to-face meetings weekly, with adequate time to discuss families in depth
- Coordinate home visiting appointments to alternate between clinicians, understanding that flexibility will be needed
- Coordinate joint visits as needed

- Share observations: What did I see? What did I hear? What did I feel? What do I think the parent felt? Why do I feel that way? What in the parent's history might have influenced this situation? Where was the baby? What was happening in the dyadic relationship?
- Consider the "voice" of the baby in terms of affect, motor activity, and regulation (are there significant changes?)
- Share perspectives, wondering together; remember each partner only has a snapshot of the family so no one person completely understands what is happening
- Explore where partners' perspectives converge and diverge
- Understand the role of debriefing from difficult home visits, and venting vs. reflecting on why the clinician might have those feelings
- Acknowledge and coordinate work with partner in overlapping professional domains
- Coordinate and collaborate with clinical partner and family's medical home in any additional health needs, including:
- Acknowledge shared goals of MTB partners
- Use MTB approach to goal setting
    - Consider how concrete goals/needs vs. goals to increase parental reflective functioning can work in tandem
    - Take a reflective stance vs. focusing solely on problem solving/fixing
    - Consider family strengths and importance of giving hope
    - Use family's goals stated in the pregnancy interview, through discussion with family and clinical observation
    - Consider collaboration needs with medical home and referrals to other agencies
    - Reassess goals for family at one year; discuss what is reasonable to accomplish
    - Plan for resources and wrap around care needed at graduation

<u>Clinical Approaches</u> ***(All Clinical Staff)***

Developing parental reflective functioning

- Be present and authentic, not distracted
- Maintain a reflective, wondering stance
- Hold the perspectives of both parent and child
- Speak for the baby with the goal of promoting parent's understanding of the child
- Speak for the parent with goal of promoting understanding of own feelings and behavior
- Help parent understand child's behavior as communication
- Acknowledge the family's experience without trying to immediately change it; "being with" or "joining" with the family[12]
- Listen, use silence, pause, and slow down the conversation
- Acknowledge that there is more than one way to understand or accomplish a goal
- Link parental goals for child with child-parent behavior and relationship
- Reframe[13] negative conceptions and circumstances

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[12]*Joining: to align oneself with the client's experience (or an aspect of the experience) or to find common ground on which to connect with the client in the process of building a therapeutic alliance, while maintaining neutrality and professional boundaries.*

[13]*Reframing: a way of viewing events, ideas, concepts, and emotions to find more positive alternatives.*

- 'Park' issues until they can be discussed
- Recognize hyper-arousal (the feeling of being revved-up, panicked, ready to take flight or fight) or hypo-arousal (the feeling of being disconnected, low energy, non-reactive) in parent and self
- Help to soothe and organize a family's emotional experience; "containing" or "holding"[14]
- Use mindfulness techniques for self, and the family, to reduce hyperarousal
- As the mother is able to make sense of her feelings and those of her child, create a more nuanced, complex narrative of her and her baby's experience
- Notice and highlight small shifts in family perspectives
- Work to increase pleasurable moments between parent and child
- Understand that repetition and rephrasing helps parents grasp new concepts

Use of Clinical and Reflective Supervision ***(All Clinical Staff)***

Clinicians

- Protect regularly scheduled time for supervision and be prepared with case material
- Be present, open, curious, and ready to share and explore thoughts and feelings
- Be open to multiple explanations/perspectives
- Be able to access own thoughts, beliefs, values, emotional responses, and subjective experiences
- Explore impact on the therapeutic relationship in particular and the work in general
- Recognize parallel process[15]
- Articulate the family's story
- Provide a clinical formulation: how do you understand the situation from a dynamic perspective?
- Provide a diagnosis if/when appropriate

Supervisors

- Protect regularly scheduled time in a quiet, private space
- Create an environment of emotional safety that facilitates authenticity
- Be present, open, curious, calm, and non-judgmental stance
- Demonstrate ability to hold clinician, mother, and baby in mind
- Explore clinician's triggers, beliefs, values, etc. and their impact on the work
- Recognize own triggers, beliefs, values, etc. and their impact on the supervisory process and relationship

[14]*Holding: maintaining a safe, boundaried, consistent presence in the therapeutic relationship so that clients feel safe enough to explore and express difficult or intolerable emotions. This is an emotional process and doesn't often involve physical holding. The main ingredients are trust, consistency, a non-judgmental tone, acceptance, and emotional safety, e.g., when a mother can feel safe revealing a traumatic personal event to the clinician because of the clinician's ability to be non-judgmental, active listening, and able to make the mother feel emotionally safe. For additional information, see: http://relational-integrative-psychotherapy.uk/chapters/holding-containing-and-boundarying/*

[15]*Parallel Process: consciously connecting the lived experience of individuals and their relationships with the lived experience and relationships of others.*

CHAPTER 11:
CONCLUDING THOUGHTS

An interdisciplinary, collaborative, community-based home visiting program serving at-risk first-time parents in an urban setting in Connecticut, *Minding the Baby®* (MTB) has garnered interest from around the world to implement program elements and replicate the applied research model. In sum, the goal of MTB is to enhance the physical health, mental health, and development of infants and their mothers, and to develop sustaining and healthy attachments among mothers, children, and extended families.

This treatment manual was designed as an intervention guide and training tool for new clinicians working for MTB at Yale as well as for those receiving training on similar reflective home visiting programs in other parts of the country and the world. After reading this manual, the reader should have a better understanding of the theoretical underpinnings of the model as well as practical implications and considerations of working as MTB clinicians. While current and ongoing research will help evaluate changes over time and the contrasts between groups for this program, the positive outcomes we have reported are likely associated with the following: relationship-building with home visitors; RF coaching and delivery of mental health services in the home as needed; regular safety checks and teaching in the home; encouragement of breastfeeding and limiting second-hand smoke exposure; and pediatric anticipatory guidance with the family. Our research findings suggest that this intensive relationship-based home visiting program may be crucial to helping high-risk families for whom significant attachment and relationship disruption preclude response to other less intensive interventions. Ongoing evaluation will continue to provide information about the effectiveness of the program and the many potential benefits of this preventive model with young families.

It is important to keep in mind that such an intensive model requires specific training, provided by faculty at Yale Child Study Center and Yale School of Nursing, as well as collaboration with the MTB directors and program coordinators at Yale. The training institute currently provided at Yale provides a thorough introduction to the basic constructs and techniques of the program model and is designed for clinicians such as registered nurses, advanced practice nurses, social workers, and psychologists; program directors; and researchers. Further training and on-going consultation are necessary for replication studies and full implementation of the MTB model and research component. This manual is a supplement to the training institute, in addition to the Quick Reference Guide for clinicians and the MTB Operations Manual. We close with words from MTB mothers upon graduation:

- *"When you are aware about yourself, it's easier to be aware of your child."*
- *"They changed my framework of thinking about my daughter. They helped me to think things out…and to think about her personality when I talk to her."*
- *"They give you pieces of their hearts."*
- *"They help you to help you."*

APPENDICES

APPENDIX I: Assessments and Forms

Maternal Psychosocial History Form

For Use By Official MTB Replication Sites/Implementing Agencies

ID: _____

Completed by: _____ **Date:** _____

Identifying data & current living situation (FOB & family):

Household members:

Attachments:

Pregnancy history

Number of pregnancies: _____

☐ Abortions: ☐ Miscarriages: ☐ Stillbirths: ☐ Planned: ☐ Unplanned:

Labor support partner(s):

Strengths:

Past psychiatric and/or substance abuse history:

Childhood, educational, and developmental history:

Internal world (fantasies/preoccupations, current/past pregnancies, recurrent themes/unresolved conflicts, trauma, losses):

Self care vs. neglect (sleep, meal routines, appetite, eating problems, exercise, leisure)

Attachment concerns for dyad & infant (fantasies of the baby; problem: denial of any emotional connection to baby, inability to hold an image or idea of baby in her mind, images of how baby will change daily life):

Mental Status Exam

Appearance:

Behavior:

Speech:

Mood & affect:

Thought process:

Thought content:

Cognitive:

DSMIV-TR Diagnosis

I.

II.

III.

IV.

V.

Initial Treatment Plan (Goals for mother/couple/family/mother-infant dyad)

The patient identifies the following goals:

Mother:

Baby:

Mother/infant dyad:

Other areas of focus for treatment include:

Sample Labor & Birth Plans

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

Many of the young mothers-to-be in MTB are snrvivors of physical and sexual abuse. Those who have not been abused have suffered various other traumas throughout their lives. In these situations the women have felt powerless and violated. Most are worried about the pain of labor and have been told horror stories from family and friends or watched television shows about emergency births. The prospect of delivering a baby can retrigger these feelings. 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 home visitor paces the discussion and questions according to the woman's reactions. Emphasis is put on feelings and fears concerning pain and pain relief as mothers-to-be often focus on this. The nurse can integrate the mindfulness skills the midwives have taught in the prenatal classes 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 the Midwives 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. In addition there needs to be flexibility for the Midwives to make decisions to provide the best and safest care for the laboring woman and the baby. 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 Midwives.

The mother has the opportunity to read and make changes before the final copy is put into her medical chart. The Midwives at the community clinic have approved the format of the plan and keep a copy in the womeu's medical chart that goes to the hospital at the time of admission.The initial questions 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 smaller steps and makes a concrete pictnre 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 act a certain way and how to ask for support.

Labor Plan Beginning Questions:

1. 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?
2. 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?

See the following pages for a sample chart to use in writing a labor plan, followed by a sample birth plan that is also often used with MTB mothers. The Birth Plan format was adapted from a form prepared by Carla Reinke, RN, MSN, CNM, for Virginia Mason Medical Center, Seattle WA.

Description of the labor experience

EXPERIENCE	RESPONSE	COPING STRATEGY
Changed appearance (hair, clothing)		
Nakedness around others		
Secretions: blood, amniotic fluid, stool		
Body positions such as on hands and knees or on back and exposed		
Reactions to hospital sounds, smells, doctors and nurses		
Reactions to having blood drawn		
Reaction to idea of IV insertion		
Reaction to vaginal exams		
Possibility of being connected to BP cuff, baby monitors, IV bag, O_2 mask, etc.		
Restriction to bed		
Pain related to labor		
Pain-related behavior: panic, loss of control		
Expressions of pain: facial, vocal, body		
Pain medication pros and cons		
Use of non-pharma-cological pain reduction techniques		
Feelings regarding the midwives who will care for you		
Others who might assist in the delivery whom you will not meet beforehand		
Issues with family and friends who will be at birth, or who want to be there against your wishes		

EXPERIENCE	RESPONSE	COPING STRATEGY
Procedures that might be needed that are unpredictable: vacuum delivery, cesarean delivery		
Feelings about seeing the baby born, emerging from the vaginal canal		
Sounds you might make while working to give birth		
Holding the baby during or after infant is cleaned up		
Nursing the baby right after birth		
Cutting the umbilical cord		
Postpartum care: delivery of the placenta, stitches if necessary, fundal massage		

Note: Adapted from Simkin & Klaus, 2004.

The information obtained from this discussion is summarized and put in the following format for the medical chart:

Name, estimated due date, names of support people.
An introduction: Information regarding being a first -time parent, first time hospital experience, etc.
Important issues: Often information regarding the support people.
Pain control preferences: Would or would not like to try birth without medication.
Issues around medical interventions: Particular fears around blood draws, vaginal exams, etc.
Positioning: What is the woman willing to try? Modesty issues.
Pushing efforts: Concerns over loss of control, messiness, desire to see birth with mirror.
Other issues: Does the mother need the CNM to tell her everything that is happening because mother is very fearful? Does she need reassurance? Does the mom want to hold the baby right away?

References

Simkin, P. & Klaus, P. (2004). *When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women.* Seattle, WA: Classic Day Publishing.

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

Minding the Baby®
Sample Birth Plan Format*

Birth Plan for _____

My primary caregiver is _____ and my due date is _____

My support people will be _____

I will give birth at _____

Introducing ourselves:

Important issues, fears, concerns:

Labor preferences:

- Controlling pain

- Medical interventions

- Positioning

- Pushing efforts

Other important items regarding labor and birth:

Unexpected labor events

- Complicated or prolonged labor or fetal problems

- Cesarean delivery

Post-partum for mother

- I plan to feed with: ☐ Breastmilk ☐ Formula

- Concerns, questions, needs, feelings about visitors

- Controlling pain

- Follow-up after discharge

- Educational needs

*Acknowledgement: This Birth Plan form is adapted from the form prepared by Carla Reinke, RN, MSN, CNM, for Virginia Mason Medical Center, Seattle WA

My Family Life Plan

My FLP is about taking care of me, my baby and my body!

My Current Age:_____

How Many Children I Have Now:_____

How Many Children I Want to Have:_____

I want My First/Next Baby: ___Now ___Years ___Never

My Goals Before Having A Baby:

Write in: _____

Choose all that apply:

- ☐ Prepare to have a healthy pregnancy
- ☐ Improve my health
- ☐ Get more education
- ☐ Get child care
- ☐ Improve my relationship
- ☐ Get a job/career
- ☐ Save money
- ☐ Prepare to be a parent
- ☐ Find a partner/get married
- ☐ Get different housing/move
- ☐ Quit/get treatment for a habit

I Want a Baby Now or Someday

	Yes	Not Yet
Taking folic acid	☐	☐
Healthy weight	☐	☐
Not smoking	☐	☐
Not drinking/using drugs	☐	☐
Have family support	☐	☐
Have child care	☐	☐
Can get healthy food	☐	☐
Have financial support	☐	☐
Have healthy teeth/gums	☐	☐
Partner is ready for a baby	☐	☐
Partner & I are able to communicate with each other	☐	☐

If "Not Yet" to any see 'Places for Help' p.2

I *Don't* Want a Baby Now or Someday

Birth control I/my partner plan to use:

_____

Where I/my partner will get birth control:

_____

I can **get** this birth control without a problem.

Yes ☐ Not Sure ☐

I can **use** this birth control without a problem.

Yes ☐ Not Sure ☐

I **understand** how it works, how long it lasts and what to expect.

Yes ☐ Not Sure ☐

If "Not Sure" to any see 'Birth Control Help' p.2

Adapted from: C. Collier MD, MPH, MHS and M. Rosenthal MD, MPD– Yale Robert Wood Johnson Foundation Clinical Scholars Program.
K. Harris and L. Morrison –New Haven Healthy Start, The Community Foundation of Greater New Haven

PREPARE BEFORE PREGNANCY

Having a baby is a very special experience. Having a baby can also be difficult or stressful if you are not ready. Making a Family Life Plan will help you prevent unplanned pregnancies and help you be healthy and prepared when you want to become a parent.

PLACES FOR HELP – NATIONAL

Online Family Planning Resources

www.plannedparenthood.org

www.bedsider.org

Folic Acid & Preconception Health

Take at least 400mcg of Folic Acid Daily.

Start before you become pregnant.

www.marchofdimes.com

Quit Smoking

Quit Line for Help: 1-800-Quit-Now

www.quitnow.net

Domestic Violence

Natl Domestic Violence Hotline: 1-800-799-7233

http://www.thehotline.org/

PLACES FOR HELP – LOCAL

Please write in any relevant local resource for your client/patient.

Social Services & Resources	Phone #
Medicaid/CHIP	Phone #
Parenting Help	Phone #
WIC Nutrition Assistance	Phone #
Medical/Reproductive Care	Phone#

BIRTH CONTROL HELP

There are lots of birth control options! Pick the right birth control for you or discuss these options with your partner.

Long-Acting Birth Control

Skyla Intra-Uterine Contraception/IUD

- Works up to 3 years
- Medical provider places & removes
- Smaller size than other IUDs

Mirena Intra-Uterine Contraception/IUD

- Works up to 5 years
- Medical provider places & removes
- Helps make periods lighter

ParaGard Intra-Uterine Contraception/IUD

- Works up to 10 years
- Medical provider places & removes
- No hormones

Nexplanon Arm Implant

- Works up to 3 years
- Medical provider places & removes
- Only one small rod in arm

Permanent Birth Control

Essure/Tubal Occlusion

Tubal Ligation/Tubes Tied

Vasectomy (Male sterilization)

Daily to Monthly Birth Control

Depo Provera Injection

- Works for 3 months
- Medical Provider gives injection

NuvaRing Vaginal Ring

- Each ring lasts 3 weeks
- You place ring in vagina

Ortho Evra Patch

- Each patch lasts 1 week
- You place on skin

Pills

- Must take one pill every day
- You take pill by mouth every day

Emergency Birth Control

Plan B—Effective up to 72 hours after unprotected sex. Buy at pharmacy. Call ahead for availability.

Infection Protection

Condoms—Use every time to prevent STDs.

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Step 1. ASK you client their ideas about children and family.

1. *Would you like to have (more) children in the future? What about your partner?*
2. *How many children would you like to have?*

   -If Client says 'I don't know' Ask:-

   What is the smallest/largest number of children you think you would be happy having?

3. *When would you like to have your first (next) child?*

   -If Client says 'I don't know' Ask:

   Would you be happy having a child or another child right away? If no, why not? Discuss spacing pregnancies: How far apart in age do you want your children to be?

Step 2. ADVISE about the importance of having a FLP and planning pregnancies.

- Discuss benefits of planning pregnancies and using a family planning method consistently.
- Discuss the impact unplanned pregnancies can have on health, relationships, finances, etc.

Step 3. ASSESS areas of critical importance for client when planning a family.

Age	Health Conditions	Employment	Smoking
Finances	Food Security	Family Needs	Drugs/Alcohol
Relationships	Housing	Education	Violence

- *How would you want to prepare yourself before having (more) children?*
- *What are the most important things you want for your life before having a (more) children?*
- *Discuss how having (more) children would affect vulnerable areas in clients life.*

Step 4. ASSIST client with making a plan to prevent unintended pregnancies.

Review the basic birth control categories by effectiveness and effort required. Provide resources.
Help client complete the 'My Family Life Plan' Tool

- *What family planning method would you or your partner like to use until you are ready for a child?*
- *Have you or your partner used birth control or a method to prevent pregnancies before?*
- *Do you think you or your partner may have problems getting or remembering to use that method?*

Step 5. ARRANGE a preconception or family planning appointment with a clinician.

- Provide resources about where birth control can be obtained.
- Schedule appointments with a clinician for family planning or preconception care.
- Document the client's Family Life Plan in the medical and program record.
- Follow-up to assess progress towards established goals, barriers to care and need for additional help.

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CONTRACEPTIVE GUIDANCE

You can help your client prepare for using contraception by providing resources and helping her/him consider how using contraception will fit in her/his life.

- **What methods have you or your partner tried before?**
- **Do you think you or your partner may forget to use this method?**
- **Do you think you or your partner may have problems accessing this method?**
- **Is the cost of this method a possible problem?**
- **Is it possible she or her partner will use it incorrectly?**
- **Is privacy about the method you choose a concern for you or your partner?**
- **Is it possible you or your partner will regret using a permanent form of birth control?**

Reliable Online Resources

www.plannedparenthood.org
www.bedsider.org

Contacts for Family Planning in your local area: (write in local resources)

Name of Agency/Provider **Phone #**

QUICK BIRTH CONTROL REFERENCE

Permanent Contraception

Essure—Tubal Occlusion
- Medical provider inserts in office
- No hormones

Bilateral Tubal Ligation
- Medical provider performs surgery using laproscopy or small incision

LongActing Reversible Contraception

Skyla Intra-Uterine Contraception
- Works up to 3 years
- Medical provider places & removes
- Smaller size than other IUDs

Mirena Intra-Uterine Contraception
- Works up to 5 years
- Medical provider places & removes
- Helps make periods lighter

ParaGard Intra-Uterine Contraception
- Works up to 10 years
- Medical provider places & removes
- No hormones

Nexplanon Arm Implant
- Works up to 3 years
- Medical provider places & removes
- Only one small rod in arm

Intermediate- Acting Contraception

Depo Provera Injection
- Works up to 3 months
- Medical provider gives injection

Short- Acting Contraception

NuvaRing Vaginal Ring
- Each ring last 3 weeks
- You place ring in vagina

Ortho Evra Patch
- Each patch lasts 1 week
- You place on skin

Pills
- Must take one pill every day
- You take pill by mouth every day

Non-Prescription Hormonal Methods

Plan-B Emergency Contraception
- Effective up to 72 hours after unprotected sex
- Buy at pharmacy. Call ahead for availability.

Adapted from: C. Collier MD, MPH, MHS and M. Rosenthal MD, MPD– Yale Robert Wood Johnson Foundation Clinical Scholars Program.
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MTB Nursing Care Plans

Prenatal Care Plan

1. Mother's health
    - ☐ Nutrition; supplements; pica; mercury exposure; food sufficiency
    - ☐ Rest/exercise
    - ☐ Myths and misconceptions
    - ☐ Dental care
    - ☐ Safe sex
    - ☐ Signs and symptoms of complications; Pre-term labor prevention
    - ☐ Fetal growth and development/brain development
    - ☐ Body changes/moodiness
    - ☐ Flu shot
    - ☐ Domestic violence
    - ☐ Postpartum care
2. Labor & delivery education
    - ☐ When to call midwife
    - ☐ Coping; mindfulness tapes/techniques; visualization
    - ☐ Labor plan; pain management
    - ☐ Baby's gender, appearance, personality
3. Newborn care
    - ☐ Hospital care
    - ☐ Breastfeeding/formula preparation/no cereal in bottle
    - ☐ Non-nutritive sucking
    - ☐ Infant senses
    - ☐ Breathing sounds
    - ☐ Feeding patterns; weight loss & gain; stools
    - ☐ Crying: recognizing types/comforting techniques
    - ☐ Sleeping patterns
    - ☐ Jaundice/skin appearance and care
    - ☐ Cord care/Circumcision/Fontanels
    - ☐ Vaccinations; well baby visits
    - ☐ Illness prevention; how to use a thermometer; when to call the clinic
4. Safety
    - ☐ Smoking
    - ☐ Car seat
    - ☐ Back-to-sleep; crib safety; co-sleeping
    - ☐ Never shake a baby
    - ☐ No microwave/propping bottles
    - ☐ Sun exposure

- ☐ Burns/hot liquids
- ☐ Bathing/water temperature
- ☐ Necklaces/jewelry
- ☐ Other children/pet adjustment
- ☐ Fire alarms
- ☐ Stairs/railings
- ☐ Walkers as shower gifts

5. Parenting/adjustment

- ☐ Preparation for baby: equipment, clothing, room
- ☐ Decision making: feeding, circumcision, etc.
- ☐ Cultural and religious traditions
- ☐ Pediatric primary care physician (PCP)
- ☐ Visitors; unwanted advice; support
- ☐ Expectations; feelings of competence
- ☐ Coping; stress reduction
- ☐ Postpartum depression
- ☐ Brazelton's concept of three babies; imagined parent
- ☐ 'Spoiling'

6. Life course

- ☐ Time for self
- ☐ Relationship with the father of the baby (FOB)
- ☐ Birth control
- ☐ Housing
- ☐ Spiritual & health beliefs
- ☐ Returning to work/school

Postpartum Care Plan: First 3 months

1. Mother's health
    - ☐ Rest; help and support
    - ☐ Nutrition
    - ☐ Body changes
    - ☐ Normal feelings after giving birth; falling in love with baby over time
    - ☐ Baby Blues/depression
2. Infant health and development
    - ☐ General baby care/routines
    - ☐ Hand washing
    - ☐ Skin care
    - ☐ Thrush; plastic nipple cleaning
    - ☐ Constipation
    - ☐ Humidifier
    - ☐ Healthcare; well child visits; vaccinations
    - ☐ Signs and symptoms of illness; demo thermometer use; med dosage
    - ☐ Breast/bottle feeding; delaying solids
    - ☐ 'Tummy time'/ flattened head
    - ☐ States and regulation
    - ☐ Crying/colic
    - ☐ Temperament
    - ☐ Cognitive, motor, and social development
3. Safety
    - ☐ Review all above concerns
    - ☐ Overdressing
    - ☐ Cotton clothes/blankets
4. Parenting/adjustment
    - ☐ Stimulation/playing with baby
    - ☐ Spoiling/discipline
    - ☐ Reading cues
    - ☐ Infant massage
    - ☐ Expectations; disappointment
    - ☐ Competence
    - ☐ Coping; stress; child abuse prevention
5. Life course
    - ☐ Review all concerns from previous stages
    - ☐ Birth control
    - ☐ Childcare

Postpartum Care Plan: 3-6 months

1. Mother's health

- ☐ Nutrition; dieting; weight loss; soda and juice intake
- ☐ Multivitamins; medications/remedies
- ☐ Exercise
- ☐ Rest/fatigue
- ☐ Realistic goals
- ☐ Mood; mindfulness techniques
- ☐ Menstrual periods
- ☐ Birth control; safe sex; sexual relations

2. Life course

- ☐ Continued breastfeeding
- ☐ Relationship with FOB/ partner
- ☐ Work/school
- ☐ Friends
- ☐ Time for self
- ☐ Own primary care physician
- ☐ Health beliefs/spiritual well-being

3. Child's health

- ☐ Child watching others eat
- ☐ Continue to hold child when giving bottle
- ☐ Food and drug allergies
- ☐ Overfeeding/juice intake
- ☐ Continued colic/reflux
- ☐ Solids: when, what, and how
- ☐ Food to avoid/ signs and symptons of allergies
- ☐ Teething/oral health
- ☐ Growth spurts
- ☐ Changes in patterns of eating and sleeping
- ☐ Immunizations/well baby visits
- ☐ Signs and symptoms of illness/ear infections

4. Child development

- ☐ Brain/cognitive development/storage
- ☐ Baby's vision and hearing
- ☐ Motor development (gross): rolling, sitting
- ☐ Motor development (fine): grasping, bubble blowing, thumb sucking, hand-to-mouth
- ☐ Exercises with baby
- ☐ Language development: reading to baby, conversations, singing
- ☐ Emotional development; infant massage; comfort with touching; confidence

- ☐ How to play: games while diapering and bathing; stimulating environments
- ☐ Baby's distractibility and interest in everything

5. Safety

- ☐ Accidents: falls, burns, choking
- ☐ Gentle play; dislocated shoulder and elbow
- ☐ Car seats
- ☐ Second hand smoke
- ☐ Bathing: never leave alone
- ☐ Baby-proofing the house
- ☐ Small objects/appropriate toys
- ☐ Back-to-Sleep
- ☐ Fire alarms/escape plan
- ☐ Hand washing/illness prevention
- ☐ Dosing medicine

6. Parenting

- ☐ Temperament/personality
- ☐ Attachment
- ☐ Predicting baby's responses
- ☐ Baby's demands/spoiling
- ☐ Expectations/discipline versus punishment
- ☐ Support; baby sitters
- ☐ Mother's feeling of competence
- ☐ Father's role/engagement
- ☐ Grandparents
- ☐ Establishing routines
- ☐ TV watching: influence on child's behavior

Care Plan: 6-9 (or so) months

1. Mother's health

- ☐ Nutrition/food sufficiency
- ☐ Exercise
- ☐ Domestic violence
- ☐ Daily routine
- ☐ Mood/stress reduction; time for self/rest
- ☐ Birth control/safe sex
- ☐ Own and FOB's PCP; yearly physical: thinking ahead

2. Life course

- ☐ Relationship with FOB/new relationship
- ☐ Family planning
- ☐ Work/school
- ☐ Other interests; getting out of the house
- ☐ Finances
- ☐ Child care/baby sitters/emergency numbers

3. Child's health

- ☐ Well child appointments/vaccinations
- ☐ Growth curve
- ☐ Illness prevention/ when to call clinic
- ☐ Teething myths/oral care
- ☐ Routines/regular nap time
- ☐ Nutrition/food proportions
- ☐ Weight gain
- ☐ Self-feeding/spoons/mess/play
- ☐ Avoiding battles/mealtime as social time
- ☐ Introducing cups
- ☐ Fever care

4. Safety

- ☐ Baby-proofing expectations/normal exploration/scientists
- ☐ Outlet covers; appropriate toys; plastic bags
- ☐ Walkers
- ☐ Second hand smoke
- ☐ Sun exposure
- ☐ Car seats
- ☐ Shaken baby/gentle play/dislocated elbows and shoulders
- ☐ Burns: bath, liquids, stove
- ☐ Falls; gates for stairs; children who climb
- ☐ Fire escape plan/recheck alarms

- ☐ Dosing meds; common OTC meds and safe usage
- ☐ Poisons/locking up vitamins/purses

5. Child development

- ☐ Cognitive
  - Brain development; stimulating environment
  - Expanding world/child as scientist.; learning through exploration, imitation, repetition, sensory experiences
  - Object and people permanence
- ☐ Physical
  - Gross: rocks on hands and knees, pulls to stand, sit from standing, crawls
  - Fine: toys in and out of containers, pincer grasp, transfer
- ☐ Language
  - Communication through body language
  - Frustration
  - Babbling: promote turn-taking/dialog; adults give babble meaning
  - Promote with conversation, description, songs, books
  - Knows own name
- ☐ Emotional
  - Adults to read and label emotions; regulation
  - Baby's emotions change quickly; self-calming
  - Predictability; trust/security; transition objects; leaving child
  - Fears/stranger anxiety
  - Sense of self/autonomy/driven from inside
  - Effect on areas of sleeping and feeding

6. Parenting

- ☐ Expectations for self; prioritizing/choosing appropriate battles
- ☐ Temperament
- ☐ Goals for baby/goal of self-control far in the future
- ☐ Family values: how are they taught
- ☐ How children learn: modeling (family and TV); giving directions; repetition
- ☐ Discipline/punishment
- ☐ Using distraction/substitution
- ☐ Positive and negative attention/reinforcement
- ☐ Trying limits through exploration; testing to evoke a response: what's OK or not
- ☐ Internalizing what was once unknown happens over time

Care Plan: 9-12 months (or more)

1. Mother's health
    - ☐ Nutrition/food sufficiency; weight control/exercise
    - ☐ Daily routine/rest
    - ☐ Mood/stress reduction; time for self
    - ☐ Safe sex/STDs
    - ☐ Own/FOB's PCP; yearly physical
    - ☐ Domestic violence
2. Life course
    - ☐ Relationship with FOB/new relationship
    - ☐ Birth control/family planning
    - ☐ Work/school; goals for next year/finances
    - ☐ Getting out of the house; other interests
    - ☐ Child care/baby sitters/emergency numbers
3. Child's health
    - ☐ Well child appointments/vaccinations/PPD/Hgb
    - ☐ Lead toxicity prevention
    - ☐ Iron deficiency prevention/no cow's milk/formula intake
    - ☐ Bottle weaning; weaning from the breast
    - ☐ Illness prevention/ when to call clinic; antibiotic use
    - ☐ Teething/molars; prevention of dental caries
    - ☐ Routines: mealtimes; family times, naps
    - ☐ Nutrition: likes and dislikes; healthy snacks
    - ☐ Finger foods; appropriate proportions; avoiding battles at mealtime
    - ☐ Weight gain/triple birth weight by 12 months; slowing of growth
    - ☐ Preventing obesity; junk food/juice intake/exercise
    - ☐ Food allergies
    - ☐ Choking hazards; how to respond to choking
    - ☐ Flat feet and bowed legs
4. Safety
    - ☐ Review all above topics
    - ☐ Heating food in microwave; safe food storage
    - ☐ Walkers
    - ☐ Emergencies: when to call 911; ER use; First Aid

5. Child development

- ☐ Cycles of organization and disorganization: irritability and negativism
- ☐ Prepare for tantrumming and aggressive behaviors
- ☐ Review temperament: How does baby approach the world?
- ☐ Review how babies learn/ explore
- ☐ Cognitive
  - Person permanence
  - Follows simple commands
  - Stacking and knocking over; looks for dropped object; causality
  - Bangs objects together
  - Understands use of everyday objects (brush)
  - Water play/containers; learning and exploring body parts
- ☐ Physical
  - Gross motor: cruises, crawls up and down stairs, walks with support; Walking/push and pull toys/balls
  - Fine Motor: pincer grasp, pointing, waving goodbye, throwing/dropping to let go; removing shoes & clothes
  - Toileting
- ☐ Language
  - Articulation
  - Vocabulary growth/bilingual children
  - Describing your day: laundry, cooking, shopping opportunities
  - Turn taking: imitate and interpret babble
  - Songs: finger plays, dance, rhyme, rhythm; Books: keep them available
  - Pointing to communicate
  - May shake head 'no'
- ☐ Emotional
  - Confidence/self-esteem
  - Social referencing
  - Development of more complex emotions/giving words for feelings
  - Expectation of success or failure/looking for approval
  - Stranger/separation anxiety; transition object/sense of security
  - Dependence versus independence; regression

6. Parenting

- ☐ Parenting styles: parent's struggle for control versus baby's agenda and effect on sleeping and eating
  - Responding versus reacting
  - Permissive; authoritarian; authoritative
  - Nurturing: gentle and supportive, encouraging
  - Smothering: self-defeating messages
  - Structuring and protecting: setting limits teaches skills
  - Criticizing: blaming and shaming
- ☐ Discipline strategies for babies: child-proofing versus constant supervision and teaching
- ☐ Issues to consider:
  - Effect of child's temperament, baby's purpose, safety issues, need for limits, limited memory & sense of time
  - Parents as a team, set the examples
  - Appropriate expectations; few/simple rules; mixed messages
  - What physical punishment teaches (e.g.. pulling child's hair)
- ☐ Actual strategies:
  - Being pro-active: predicting baby's behavior.
  - Eye contact/non-verbal communication
  - Consistency; importance of repetition
  - Distraction/substitution
  - Reinforcements: not food; ignoring 'bad' behavior/; picking your battles
  - Time outs: when they work
  - Time outs for parents

Care Plan: 12-24 months

1. Mother's health

- ☐ Health risks; chronic health issues; medication: OTC and herbal drugs
- ☐ Substance abuse/smoking
- ☐ Weight control: juice & soda intake; reading food labels; food sufficiency; 5-a-day veggies & fruit; exercise
- ☐ Mood; mindfulness; stress reduction; time for self
- ☐ Birth control/safe sex
- ☐ PCP/dental care
- ☐ Domestic violence

2. Life course

- ☐ Relationship with FOB/new relationships
- ☐ School/ work/childcare
- ☐ Life goals/other interests
- ☐ Finances/housing

3. Child health

- ☐ Well child appointments: prepare toddler by acting out the visit
- ☐ Vaccines/PPD
- ☐ Lead/Pica
- ☐ Illness prevention; signs and symptoms of illness; medications; home remedies
- ☐ Six URIs per year within normal limits; antibiotics: use and misuse
- ☐ Eye and ear care: vision 20/60; hearing
- ☐ Slowed growth: decrease in appetite; respecting child's cues; examining own behavior
- ☐ Nutrition: picky eaters; food 'jags'; junk food; juice; appropriate proportions
- ☐ Whole milk only; intake; anemia prevention; cup use; weaning from bottle
- ☐ May go from 2 naps to 1; promoting good sleep habits
- ☐ Mealtime: independence in feeding; avoiding battles; socialization
- ☐ Dental care: 6-10 new teeth
- ☐ Reducing pacifier use

4. Safety

- ☐ Choking & suffocation: food, plastic bags, balloons, cords on clothes, jewelry, small objects, appropriate toys
- ☐ Burns: irons, hot stoves
- ☐ Falls: windows and stairs; crib versus bed
- ☐ Motor vehicle accidents: passenger and pedestrian; car seats
- ☐ Water safety: bathtubs and pools
- ☐ Poison Control Center; house plants
- ☐ Sun safety
- ☐ Insect repellent
- ☐ Guns

5. Child development

- ☐ Energy level norm; curiosity
- ☐ Motor
  - Gross Motor Skills: gets to feet unaided, maneuvers around object, tries to run, crawls up and down stairs, throws, carries toys
  - Fine Motor Skills: turns pages of book, whole arm movement with crayons, upside down spoon at first, 3-piece puzzles by 2 yrs.
  - Toilet Training
- ☐ Language
  - Learning nouns first; two-word sentences; speech articulation
  - Identifies three body parts by 2 years
  - Uses pointing, pulling, or gestures to direct adult attention
  - One step requests
  - Self-centeredness: MINE!; sharing; play with other children: solitary/parallel
  - Beginning of empathy towards others
  - Separation: healthy protests; hide and seek
  - Transitions: security object; self-soothing behavior: thumbs, masturbation, etc.
  - Fears: new situations and people, bathtubs, loss of physical balance, clothes covering eyes, the dark
  - Negativism; stubborn behavior
- ☐ Cognitive
  - Storage of three objects; block stacking: up to 4 blocks by 15 months; causality
  - Teachable moments; imitation: tries to wash self
  - Less oral
  - Play and pretending = learning/problem solving; representational/symbolic Play: how to encourage

6. Parenting

- ☐ Autonomy; desire for self-mastery
- ☐ Children need more 'yes' than 'no'/ How to say 'no'
- ☐ Giving child appropriate choices
- ☐ How to talk so child will listen
- ☐ Tantrums as inner struggle; prevention/therapeutic hug
- ☐ Biting, hitting, scratching: accidentally reinforcing the behavior
- ☐ Making mistakes as a parent and repair work: How we learn to parent
- ☐ Different relationship with each parent, grandparents, and other family
- ☐ Interaction with child: walks from a child's point of view, examining objects at child's height
- ☐ Individual differences among children
- ☐ Supporting child's feeling of confidence
- ☐ TV influence and parental responsibility
- ☐ Structured bedtime routine; bedtime requests; night light

APPENDIX II: Clinical Orientation & Competencies

Clinical Orientation for MTB Home Visitors & Supervisors

Clinical orientation for MTB clinicians and supervisors is aimed at familiarizing team members with the MTB approaches and philosophy. Orientation and training should be done in a timely fashion, shortly after hire, with an appropriate amount of time allotted for these activities prior to seeing families. MTB team members review the following general requirements as part of the initial orientation process, conducted in conjunction with the MTB Introductory Training and careful review of the MTB Treatment Manual, MTB Operations Manual, and the discipline-specific competencies that follow.

- Clinician Documentation
  - Both disciplines: Home Visit Process Variables (HVPV)
  - Mental health: Psychosocial History and Social Work Notes
  - Nursing: Health History and Nursing Notes
- Collaborative approach with healthcare providers: goal of creating a seamless plan of care for the family
- MTB model fidelity: importance of utilizing the materials provided by the MTB National Office, including using nursing care plans and following the model with regard to implementation factors such as timing and addressing individual needs
- On-going training: importance of continual review of competencies specific to MTB and general discipline-specific training to keep up-to-date with health and mental health information
- Development of appropriate materials to use in the home for health education or other work with the families as needed

Competencies for MTB Social Workers/Mental Health Clinicians

MTB mental health home visitors are responsible for understanding the content that follows, first assessing current knowledge and then identifying topics with which the clinician may need to become acquainted.

General Skills & Abilities

Ability to:

- Work within a community health setting
- Understand the basics of service delivery in the home (vs. clinical settings)
- Work on a multidisciplinary team
- Hold multiple perspectives (Mother, baby, clinician, service providers, etc.)
- Manage interdisciplinary dyadic team dynamics (capitalizing on strengths, avoiding pitfalls)
- Develop collaborative relationships with human service agencies and systems

Strong foundation in:

- Infant mental health
- Infant, child, and adolescent development
- Work safety as related to working in the community and home visiting
- Mandated reporting in the context of the therapeutic relationship
- Resources in the community: housing, nutrition, insurance, childcare, family-focused programs
- Custody law, child support enforcement, restraining orders, legal aid resources
- Infant-parent and child-parent psychotherapy
- Working from a strengths based perspective and promoting self-efficacy
- Psychotherapeutic and behavioral theories of change
- Cultural competency and sensitivity: respect cultural contexts impacting family beliefs about childrearing
- Knowledge of trauma and its effects on infants and young children
- Trauma assessment

Recommended resources:

- *For Our Babies* by Ronald Lally
- *Don't Hit my Mommy!* by Alicia Lieberman, Chandra Ghosh-Ippen, & Patricia Van Horn
- *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment* by Alicia Lieberman & Patricia Van Horn (2008)

Mother's Health, Mental Health, and Safety

General knowledge of:

- Adolescent & adult mental health (MSE, assessing for mental health crises, screening for substance use)
- The physical and psychological changes related to being pregnant, giving birth and becoming a mother
- Ways to support mothers through this transition
- Assessment for peri- and post-natal depression

- Domestic violence assessment; familiarity with available resources
- The latest research on adolescent and emerging adulthood
- Mentalization-based dynamic psychotherapy
- Couples' therapy
- Mindfulness meditation practice for self-care and client intervention
- Cognitive-behavioral approaches

Recommended resources:

- *Promoting Maternal Mental Health*, NCAST, Katherine Barnard, website: www.ncast.org
- http://www.postpartum.net/
- *Down Came the Rain* by Brooke Shields

Infant/Toddler Health, Mental Health, and Development

Familiarity with:

- Attachment styles and indicators
- Reflective functioning
- Newborn experience
- Infant and toddler health indicators (when to refer to nurse)
- Breast feeding
- Prenatal and infant brain development research
- Developmental guidance and surveillance across all domains
- Observation skills specific to parent-child interactions, attunement, and reading cues
- Using video as a clinical intervention
- Promoting parental competence
- Assessing for disturbance/disorders of infancy/in the caregiving system
- Use of toys, books, media, activities to promote secure attachment, parental reflective functioning, early literacy
- Attending to parental trauma, loss, and autobiographical narrative as it impacts the attachment relationship and parental reflective functioning
- Understanding the role of play in development and how to use play to promote attachment

Recommended resources:

- State or National Infant Mental Health Association Chapters (www.waimh.org)
- Zero to Three (www.zerotothree.org)
- *What's Going on in There?* by Lise Eliot
- *The Emotional Life of the Toddler* by Alicia Lieberman
- *The Baby Book* by Dr. John Sears & Martha Sears
- *Women's Ways of Knowing* by Mary Field Belenky, Blythe McVicker Clinchy, Nancy Rule Goldberger, & Jill Mattuck Tarule
- *Your Baby is Speaking to You* by Kevin Nugent & Abelardo Morrell
- *Raising a Secure Child* by Kent Hoffman, Glen Cooper, and Bert Powell
- *Assessment and Therapy of Disturbances in Infancy* by Selma Fraiberg
  (This is her original book on infant mental health, still available through third party sellers on Amazon.)

Professional Skills

- Collaborating with others (service providers, clinical team)
- Building and maintaining relationships at multiple levels (working with community and systems providers, community health center, social service systems, child welfare), within the family system and the team
- Conflict resolution
- Supporting/mentoring others
- Active listening
- Effective verbal and non-verbal communication
- Clear, concise writing with the appropriate style (notes, reports, correspondence)
- Analyzing information/situations
- Problem solving
- Sound clinical judgment
- Planning and organization of tasks
- Recognizing and understanding parallel processes
- Knowing when and how to utilize reflective supervision

Recommended Journals: *Infant Mental Health Journal, Clinical Social Work Journal, Traumatology, Zero to Three*

Personal Qualities

- Warmth and empathy
- Curiosity
- Sensitivity and emotional openness
- Self awareness
- Capacity to reflect
- Capacity to connect with others

Competencies for MTB Nurses

MTB nurse home visitors are responsible for understanding the content that follows, first assessing current knowledge and then identifying topics with which the nurse may need to become acquainted. The books and web sites indicated are places to begin and the nurse may wish to explore other sources of information as needed. A list of cited references follow below.

General Skills & Abilities

- Health literacy
  - literacy level of materials and vocabulary when doing health education
  - information regarding anatomy and physiology, use of healthcare systems, etc. (See www.ihs.gov/healthcommunications.)
- Using evidence-based information, keeping up-to-date with new guidelines for common illnesses and treatments; medical home concept (See www.medicalhomeinfo.org.)
- Cultural competency and sensitivity (St. John, Thomas, & Norona, 2012)
  - Infant Mental Health Professional Development: Together in the struggle for Social Justice (*Zero to Three* and www.nccc.georgetown.edu)
- Family-centered care
- Case management and advocacy for families
- Enfolding reflective functioning into a home visit (See chapters 3, 7, 8 of MTB Treatment Manual, www.aap.org/ebcd, Ordway et al., and www.pediatrics.aappublications.org - search for 'Incorporating recognition & management of peri and postpartum information into pediatric care')
- Interdisciplinary work/layering the work (See MTB Quick Reference Guide page 24)

Mother's Health

- Prenatal health:
  - preterm labor s/s and other complications
  - nutrition
  - oral care (Baby Basics, page 38)
  - anatomy: women's and infant
  - fetal development
- Labor and delivery
- Sexually transmitted infections
- Contraception, using a teen friendly approach (See Teen C.A.R.E. and Collier et al., 2013, Reproductive life plan: Tools for social service professionals.)
- Postpartum health
  - Nutrition (See www.choosemyplate.gov)
  - Weight concerns (See www.nhibi.nih.gov and search public resources for 'Healthy Hearts, Healthy Homes: Do you need to lose weight?')
  - Sleep hygiene (See www.sleepfoundation.org/sleep-tools-tips)

Adolescent Development

- Adolescent development (See Bright Futures pages 731-799.)[16]
- Brain development (See www.AAP.org and search for 'early brain and child development' – also www.nimh.nih.gov and search for 'The Teen Brain: Still under construction.')
- Assess for high-risk behaviors (See www.aap.org/connectedkids - appendix C.)

Mother's Mental Health (See Bright Futures pages 283, 318-319, 396-397, 419-420.)

- Assessing for peripartum depression and other mental health disorders and treatment options (See MTB Quick Reference Guide page 72.)
- Adjustment to parenthood (See Touchpoints pages 35-36.)
- Relationship issues
- Assessing for domestic violence (See www.futureswithoutviolence.org)
- Stress reduction (See www.mindfulnessforteens.com and www.goamra.org - search for 'pregnancy.')

Mother's Life Course

- Returning to school/work

Parenting

- Parenting skills
- Discipline (See Bright Futures pages 89-98 and Touchpoints pages 119-121, chapter 19.)
- Routines (See www.zerotothree.org - search for 'social routines.')

Infant/Toddler Health[17]

- Neonatal appearance (prenatal handout)
- Infant needs and behavior (See Bright Futures p 77-93 & MTB Quick Reference Guide p 68-71)
- Illness prevention
- Signs of illness in infants and young children: URIs, gastroenteritis, fever in infants & toddlers
- Vaccinations (See www.AAP.org.)
- Skin care/common rashes
- Breastfeeding (See www.womenshealth.gov and Bright Futures pages 174-177.)
- Nutrition, transition to solid foods and food allergies (See www.uptodate.com - search for 'starting solid foods during infancy' and Bright Futures pages 182-185.)
- Elimination, toilet training (See Bright Futures pages 95, 551.)
- Sleep (See Bright Futures, chapters by age.)
- Oral care & dental visits (See Bright Futures pages 205-216.)

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[16] *For additional detailed information see the chapter that focuses on a particular age, pp. 517-574*

[17] *For additional detailed information see the Bright Futures chapter that focuses on child's age, pp. 255-417*

Child Development

- Infant brain development (See www.zerotothree.org and search for 'brain development FAQs.')
- Toddler development (See Bright Futures, chapters by age.)
- Normal language development (See www.reachoutandread.org.)
- Fine and gross motor skills, social-personal, and cognitive abilities; red flags (when developmental milestones are not met) (See www.CDC.gov regarding screening for autism.)
- Anticipatory guidance (See Bright Futures, chapters by age.)
- Play (See Bright Futures, chapters by age.)
- Temperament (See www.zerotothree.org and search for 'temperament.')

Infant Mental Health

- See Bright Futures pages 115-130; search for 'still face' on YouTube; www.aap.org/connectedkids
- Infant Mental Health concept of dyadic work (See MTB Quick Reference Guide p 3-4.)
- Attachment theory & attachment styles (See Bright Futures pages 119-120; search YouTube for 'Circle of Security.')
- Toxic stress: trauma, brain changes, and prevention (See www.developingchild.harvard.edu working papers 1-13; www.theounce.org; www.cdc.gov/violenceprevention/acestudy)

Safety

- See Bright Futures pages 235-258 and TIPP: The injury prevention program from the American Academy of Pediatrics
- Car seat use (See www.healthychildren.org; www.safercar.gov/parents.)
- Safe sleep (See Safe to Sleep campaign www.nichd.nih.gov.)
- Lead, other toxic substances (See Bright Futures, individual chapters by age.)
- Prevention of child abuse: shaken baby, developmental crying (See Bright Futures page 83; www.dontshake.org; www.purplecrying.info.)

Competencies for MTB Supervisors

General Skills & Abilities

Ability to:

- Discern among administrative, clinical/problem-solving and reflective supervision frameworks
- Develop and sustain the capacity to listen carefully
- Give positive before negative feedback
- Use *reframing* rather than corrective comments about clinical approaches
- Give supportive comments even while reframing a case or clinical approaches
- Constantly use tolerance, compassion, and self-reflection
- Stay gentle, calm, non-judgmental, aware, curious
- Allow time for reflection
- Be curious about how emotional reactions affect the ongoing work
- Be organized, predictable, and reliable
- Resist the temptation to dwell upon the minute details of a case with a home visitor, except when necessary for safety or important clinical questions/decisions
- Know when you don't know and refer to resources as needed

Understanding of:

- The importance of collaborative discussions and working relationships with other supervisors and clinicians
- The concept that we all learn from each other; we all teach one another
- The importance of maintaining a sense of humor

Supervisory Competencies (Interdisciplinary)

Ability to:

- Establish and maintain good relationships with other supervisors on team
- Highlight and integrate health issues (pregnancy, maternal, child) with parenting and other family, mental health, social, or situational crisis issues (health issues sometimes get buried by other crisis oriented work)
- Be helpful with clinical care but also think about and apply (when appropriate) structural, attachment/Reflective Functioning, developmental, family, or social ecology frameworks
- Balance theoretical principles with the practical challenges clinicians face in real time
- Comfortably balance reflection, clinical problem solving, and administrative mandates
- Support and expand upon mental health discussions from health and/or developmental perspectives

MTB Nursing Supervisor Credentials & Competencies (Discipline Specific)

- Minimum education: Bachelors of Nursing (BSN) with substantive clinical experience
- Preferred education: Masters or PhD in nursing, public health, or other relevant field
- Experience in pediatric nursing, family health, or nurse midwifery
- Two to four years of experience with clinical supervision, clinical leadership, or teaching
- Ability to maintain the balance between reflective parenting help and health related issues for mother, father, child, and other involved family members

- Ability to maintain child development knowledge base, work with adolescent parents, the transition to parenthood, infant & toddler development, and brain development
- Ability to maintain current knowledge base for health care:
  - Prenatal care, contraception, STIs, and current practices
  - Neonatal, infant, and toddler pediatric primary care; adolescent primary care and women's health
- Current knowledge of child maltreatment signs and symptoms, clinical assessment/decision-making, and legal issues/mandated reporting requirements
- Experience using a reflective stance with clinicians regarding organizing/pacing visits and difficult issues

MTB Mental Health Supervisor Credentials & Competencies (Discipline Specific)

- Minimum education: Masters in Social Work or related mental health field
- Preferred: Licensed Clinical Social Worker or PhD in psychology (if other degree, equivalent training)
- Two to four years of experience with clinical supervision
- Background in dynamic theory and practice, infant-parent psychotherapy or child-parent psychotherapy, parent and early child development, trauma, attachment, reflective functioning
- Comfort helping clinicians to make dynamic formulations and relate these to practice
- Ability to create a calm holding environment that makes it possible for supervisees to take chances, ask questions, and explore how they feel about the work.
- Experience and training in reflective supervision
- Infant Mental Health Endorsement® (or equivalent) encouraged (See http://mi-aimh.org/for-imh-professionals/endorsement/ and http://www.waimh.org/)
- Current knowledge of child maltreatment signs and symptoms, clinical assessment/decision-making and legal issues/mandated reporting requirements
- Understanding of the clinician's role as a mandated reporter while maintaining investment in protecting the therapeutic alliance
- Comfort with psychiatric diagnosis; when to recommend medication or psychiatric consultation
- Comfort balancing dynamic approaches with supportive approaches, crisis intervention, and case work
- Comfort managing clinicians' countertransference
- Comfort holding clinician's anxieties, fears, and range of strong emotions with an ability to process and explore how these feelings connect to the work (integration)

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APPENDIX III: Clinical Protocols

Off Hours Clinical Coverage

Minding the Baby® (MTB) is a supportive home-based intervention. MTB is not designed to provide continuous care 24 hours per day and 7 days per week; MTB clinicians work in collaboration with a health clinic/facility that does have 24/7 on-call availability for emergent situations beyond daytime and early evening hours.

- During working hours, MTB families have access to clinicians by phone.
- Due to the flexibility of working schedules among MTB clinicians, early evening hours may be available for families to call, but this is not always the case.
- Part-time MTB clinicians are not expected to make or return calls during the hours/days when they are not working for the MTB program unless there is an extreme emergency.
- Protocols for consultation among the clinicians are as follows.
    - If the nurse has a mental health or case management question:
        - Call the mental health home visitor who shares the case.
        - If this home visitor is not available, call the covering clinician to develop a plan.
        - If neither is available, call the MTB supervisor(s) and the clinic for help to develop a plan.
    - If the mental health home visitor has a health issue question:
        - Call the nurse home visitor.
        - If the nurse is not available, call the child's or mother's primary care clinician.
        - If neither is available, call the MTB supervisor(s) and the clinic's on-call person.
    - Clinicians may wish to provide laminated cards with their hours listed for MTB families. These hours should also be included in outgoing voicemail greetings, along with instructions for families to access off-hours coverage.
    - During regular hours, families are instructed to call their assigned MTB clinicians with questions/concerns.
    - On weekends or after hours, families are instructed to call the clinic or healthcare facility on-call number for health or mental health questions.

With unusual circumstances (e.g., premature birth, hospitalized child, etc.), some after hours contact between MTB clinicians and families may be needed. This is at the discretion of the home visitors, and such contact should be discussed with team members and supervisors.

MTB clinicians do not routinely attend family events such as children's birthdays, christenings, showers, etc., but a card may be sent from the MTB team if appropriate.

Cross-Discipline Clinical Coverage

MTB home visitors work closely with health care providers and clinicians from the collaborating health clinic(s) or other healthcare facilities. As such, they take on a variety of roles as they work with families, other MTB clinicians, and clinic providers. Good communication and collaboration among the mental health clinician, nurse, and healthcare providers are key to working successfully in these roles as well as in providing cross-discipline coverage for one another as needed. The following are typical scenarios wherein such coverage is necessary. This is not meant to be a complete list of the variety of situations that occur. For the purposes of these scenarios, the mental health role is referred to as social work/Social Worker (SW) and the nurse role is referred to as a Registered Nurse (RN).

1. For health-related questions that arise during a social work home visit, the SW assesses the seriousness and urgent nature of the issue, deciding whether to a) call provider(s), b) call the RN during the home visit, or c) leave a message for the RN to call the mother. A few examples are as follows.

- Mother of a 3-month-old asks if the baby's spitting up is dangerous. Baby looks well and is playful. After the home visit, the SW calls the RN and asks if she could give the mother a call to speak with her about the issue.
- Mother of a 1-month-old says the baby feels warm. SW helps the mother while she takes the infant's temperature and stays with her while she calls the provider or clinic to report a fever of 101.
- Just as the SW arrives for the home visit, the mother reports that her 7-month-old has rolled off the bed and hit her head on the bare floor. Baby is crying and has a bump on her head, but there is no cut. Mother is very anxious. RN is called so she can assess the fall right away.

2. For health-related concerns that arise during a nurse home visit, the RN makes a decision to diagnose, confer, refer, educate, follow up, or report to Primary Care Physician (PCP) if warranted. A few examples are as follows.

- A 6-month-old has a rash on her cheeks. The RN does a history and limited physical examination, diagnosing a mild case of atopic dermatitis. Education is provided regarding treatment and prevention with follow-up information provided.
- A young woman in her 8th month of pregnancy is reporting increased swelling of her face and feet. She is experiencing some blurry vision. The RN takes her blood pressure in the home and calls the healthcare office right away to arrange for her to be seen by her provider for possible pregnancy induced hypertension.
- Over the course of the past several home visits, the RN and SW conclude that a 10-month-old has motoric delays. The clinicians spend time assessing the mother's concerns and understanding of the child's development, then confer with the pediatric provider. A phone call can also be made to the early intervention team with the mother during a home visit, allowing her to be part of the referral process.

- During a home visit, the RN notices the mother is not able to follow through with the medication instructions given by the pediatric provider for her child with an ear infection. After educating and devising a system to help this mother, the RN reports to the PCP that the mother appears to have some learning difficulties and writes a note in the child's chart that the mother will need future instructions written down, in simple language.

3. For phone calls regarding health related issues, the clinician either triages the issue (during work hours), or leaves an outgoing phone message greeting with a phone number for healthcare emergencies and noting unavailability during off-hours.

4. For mental health-related questions that arise during a nurse home visit, the nurse rules out imminent risk to the safety of mother and baby and then assesses the urgency of the issue and decides if the SW should be contacted during the home visit or if the mother has a counselor or therapist outside of MTB, deciding with the mother if it would be more appropriate to contact her therapist directly. In less urgent cases, the nurse may encourage the mother to either share concerns with the SW by phone, schedule a visit with the SW sooner than planned, or address the concern at the next scheduled social work home visit. The RN either leaves a message for the SW regarding the concerns raised during the visit or discusses it with the SW at their weekly meeting. Some examples are as follows.

- The mother of a newborn admits to wondering if she is suffering from post-partum depression (PPD) and reveals that she has intense feelings whenever her baby cries for prolonged periods of time. She expresses fear that she may hurt the baby out of frustration. The RN assesses for risk of harm to mother and baby and could diagnose the mother with PPD after interviewing the mother about her symptoms, nutrition, sleep patterns, and degree of support available to help care for the newborn. If there are no safety risks, the RN could develop a safety plan with mother and contact the SW after the visit and have the SW follow up with the mother to offer more supports.
- A teenage mother of a 4-month-old is unable to obtain her prescribed medications following a psychiatric evaluation because her insurance eligibility is unexpectedly terminated. The RN contacts the SW either during the visit or right after the visit so that the SW can contact the family to gather information and assist with investigating the cause of termination and actions needed for re-instatement.
- A mother of an 11-month-old reveals during the nurse's home visit that the home she rents is in foreclosure and she has several months to look for a new place before she needs to move out. The RN may explore with the mother what her options are regarding living with family or friends, applying for section 8, or considering a shelter in an emergency. The RN would likely leave a message for the SW to contact the mother or follow up on the housing issue at her next visit.

5. For mental health concerns that arise during a social work home visit, the SW makes a decision to listen, observe, assess, diagnose, confer, refer, educate, follow-up, advocate, or make direct linkages when necessary. A few examples:
   - A mother of a 2-month-old complains of frightening perceptual disturbances, particularly at night and when she is alone. The SW reviews the mother's mental health and cultural history and explores any additional complaints that the mother has. The SW assesses for suicidal ideation and risk of self-harm and harm to baby. SW and mother call her healthcare provider together to triage mother's concerns with a therapist and arrange to schedule a psychiatric evaluation for the mother.
   - A married teenage mother of an 11-month-old reveals that she has been physically abused by her husband for several months. The SW assesses for safety of mom and baby and existing supports. She listens and helps the mother contain difficult feelings of guilt, shame, fear, sadness, and loss. She explores options with the mother as she is ready regarding counseling, domestic violence community resources and supports, and ways of protecting her positive relationship with her baby. The SW also contacts the PCP and RN during the visit if the mother is complaining of physical injuries or other somatic symptoms.
   - A mother of two infants who has struggled with depression and has been receptive to treatment expresses her desire to complete her college education. She recognizes that she will need childcare and requests the support of the SW and RN with applications and selecting programs. In collaboration with the RN, the SW educates the mother about existing infant-toddler programs in her community, provides the mother with parent-friendly information about how to look for quality programs, assists the mother with obtaining and completing applications, may teach her how to use the local child care information, referral, and resource system either by phone or on-line, and educates her about financial assistance available (care-4-kids, tuition scholarships, etc.). When the mother is ready to visit different programs, the RN, SW, or both accompany her as needed.

Transfer of Family to New Clinician

Staff transition is inevitable in home visiting. In addition to turnover, there are times when a staff member is out for an extended period of time (e.g., for medical, family, or maternity leave). It is essential that these transitions be planned for carefully whenever possible. This protocol provides guidance, considerations, and steps for such transitions.

General Considerations

One major concern when transitioning a family from one clinician or team to another is protecting the therapeutic relationship. This may involve helping families manage feelings of loss as they say goodbye to someone who has supported them and to whom they likely have grown close. In addition, support should be provided for the clinicians who continue working with the family who may be losing a clinical partner, and the clinician(s) who may be new to the family and/or program.

Family Support

For many families enrolled in MTB and other home visiting programs, relationships can be threatening. A family's experiences in relationships – those both intimate in nature as well as those involving helping professionals – will naturally affect their expectations of the MTB Clinical Team. The MTB team enters a family's life at a particularly fragile, precious time and the relationships that are built hold meaning on many different levels for both the families and the clinicians. When a family must form a new relationship with a new clinician due to a leave of absence or turnover, they must once again open themselves to being vulnerable and having to re-tell some of their story.

The family is also dealing with the loss of the former (or temporarily absent) clinician, who may well have become very important to them. It is critical for the new clinical team to keep the relationship with the former team alive for the family. This conveys a message that acknowledges 1) the clinician(s) and the relationship(s) meant something to the family; and 2) the relationship with the family was also meaningful for the clinician(s).

Whenever possible, it is ideal to notify families about a change in clinician(s) approximately six weeks in advance, allowing for relaxed introductions to new clinicians and adequate time for family to process their feelings about saying goodbye to current clinician(s). If there is less time before a new clinician begins work with a family, the procedures described below should be instituted immediately. The goal is to have the family feel both comfortable enough to continue the work with the new clinician(s) and also to have their relationship(s) with the leaving clinician(s) valued and processed.

It is important to consider that saying goodbye to a home visitor can be a reminder of past goodbyes and the family may have many complex feelings about a change in home visitors. All clinicians, old and new, should make an effort to think together with the family about their losses in past relationships, how they happened, and the feelings elicited by the goodbye with the clinician(s).

The following types of home visits should ideally occur at least once each before the final/temporary goodbye, or more if the clinicians feel it would be helpful for the family.

1. The leaving clinician(s) notify the family in person of the impending change/transition.
2. The current clinical team introduces the family to the new clinician(s).
3. The new clinician(s) meet with the family on their own once.
4. The leaving clinician(s) has a goodbye visit with the family.
5. The new clinician(s) take over the case.

When a clinician is out temporarily on an extended leave, the remaining clinician may well need support from a home visitor of the opposite discipline. If a home visitor's leave extends longer than 6-8 weeks, it is recommended that efforts be made to bring on a temporary replacement. Efforts should be made as described above to attend to the family's feelings about a new clinician, the temporary loss of the known clinician, and then – potentially – the family's feelings about resuming with the original clinician. It will of course be necessary to obtain the mother's agreement and permission before introducing a substitute clinician.

Clinical Support

Clinicians who are newly transitioning to a family or clinicians who have lost a clinical partner will also require some additional support. It is critical to acknowledge the loss that may be felt by the non-transitioning clinician, in the case when just one team member is leaving, as well as implications surrounding distribution of workload, forming a new relationship with the covering clinician, and absorbing the family's potential feelings of loss and ambivalence about forming a relationship with someone new.

Additionally, new clinicians should be provided with a safe space to explore their potential feelings and anxieties about working on a new team, fears of being rejected by transferred families, and the challenge of allowing the family to miss the former clinician while simultaneously trying to hold a place as the new clinician in the family's mind. Making time and space to assess the variety of relationship roadblocks that may occur during this time helps to ensure a smoother transition for both the clinical team and the family.

Record Review

Whenever possible, both current/leaving and new clinicians should be given time to discuss the families being transferred, as well as to review the following together.

- Pregnancy Interview
- Psychosocial History Form
- Genogram
- Health History Form
- Labor Plan
- Health Problem List
- Clinical Transfer Form
- Oral summary of family situation and past experiences
- Any other relevant documentation

APPENDIX IV: Glossary
Glossary of Clinical Terms in Nursing and Mental Health

Anticipatory guidance: used by pediatric health care providers to address predictable childhood behavior and give developmentally appropriate advice to families.

Attunement: being in harmony, evidenced between parent and child when mutual delight or pleasure is demonstrated and the child's needs are anticipated and met.

Clinical Formulation: at the end of a period of assessment, the clinician integrates what she has learned about the mother (and the infant and family, if appropriate) and formulates an understanding of the clinical situation. If relevant, she may also arrive at one or more diagnoses. She is guided in her formulations by theories that help make sense of the clinical picture. These formulations guide treatment planning, using best practices or evidence-based practice guidelines to form the initial care plan for a patient or family. The formulation and treatment plan can be modified as often as new information leads either to new understanding or new treatment approaches.

Containment: This is a concept that comes out of the object relations tradition. It initially referred to the parent's capacity to regulate feelings that the child finds overwhelming or intolerable; in this way, the child learns about his or her internal experience in a safe way, and can then begin to regulate them him/herself. This term can also refer to the ways the clinician regulates or *contains* the parent's intense emotions. Containment (also referred to as holding) takes place within the framework of a safe, caring, consistent relationship. For additional information, see: http://relational-integrative-psychotherapy.uk/chapters/holding-containing-and-boundarying/

Countertransference: This refers to a clinician "transferring" feelings onto a parent or into the clinician-parent relationship that have to do with the clinician's own issues and triggers. Thus, for example, a clinician might become judgmental and critical of a parent who she perceives as abandoning because the mother evokes strong feelings about the clinician's own experiences of abandonment in childhood.

Defense: This refers to a way of thinking or behaving that is designed to ward off intolerable or unacceptable feelings (which are usually unconscious). This is often demonstrated in the behaviors of parents, e.g., in home visiting when mothers become indignant, change the subject, text or play on their phones, and/or are consistently unavailable for appointments. Defenses may also be evident in splitting (for instance, seeing one home visitor as 'bad' and the other as 'good', denying having feelings of anger or any intense emotion at all, or blaming others.

Developmental/Emotional Age: refers to the recognition that a parent's chronological age may not reflect his or her developmental level or emotional self-regulatory skills. The developmental or emotional age of a parent may present as younger than chronological age due to cognitive impairment, lack of exposure to developmentally appropriate experiences and responsibilities, trauma, any combination thereof, or all of the above.

Developmental Guidance: helping a parent to understand the child's needs from a developmental framework considering physical, social, communicative, cognitive, and social growth, using a non-didactic approach.

Dyad: something that consists of two elements or parts (e.g., a couple, parent and child).

Dyadic Work: clinical intervention addressing the relationship system existing between two individuals.

Ecology of Relationships: examining relationships across multiple levels, i.e., mom and baby, mom and clinician, clinician and clinical partner, clinician and supervisor, etc. This is done in supervision and can also be done with families when mapping genograms or gathering psychosocial history.

Foreshadowing: a clinical approach that builds on the concept of anticipatory guidance in which the clinician describes usual childhood behavior far in advance of the child's current developmental age to give parents the opportunity to learn about and look ahead to new stages.

Health Education: health knowledge imparted and designed to help promote, improve, maintain, or restore a person's health.

Health Literacy: the ability to obtain, process, understand, and discuss basic health information and services, enabling the patient to make informed decisions regarding their diagnoses, treatments, prescriptions, and other health related services.

Holding: This does not refer to physical holding, but instead to emotional holding, to providing a safe, boundaried, consistent presence in the therapeutic relationship so that parents feel safe enough to explore and express difficult or intolerable emotions. The main ingredients of holding are trust, consistency, a non-judgmental tone, acceptance, and emotional safety, e.g., when a mother can feel safe revealing a traumatic personal event to the clinician because of the clinician's ability to be non-judgmental, active listening, and able to make the mother feel emotionally safe. For additional information, see: http://relational-integrative-psychotherapy.uk/chapters/holding-containing-and-boundarying/

Hyperarousal: This refers to a parent's becoming over-excited and highly aroused. This typically results from the activation of the sympathetic nervous system; signs of hyperarousal include irritability, aggression, impaired self-regulation, pressured speech, hyperactivity, and lack of focus. Hyperarousal is a common symptom of PTSD and complex trauma; both clinicians and families can become hyperaroused. For additional information, see: www.ptsdupdate.com/treatment-hyper-arousal-symptoms/

Hypoarousal: This refers to being under-aroused or disengaged, a common state in victims of violent or sexual trauma that may include motor weakness, attention deficits, dissociation, and/or an impaired capacity for both emotional and cognitive processing. Parents may present as unfocused, distracted, lethargic, or uninterested when in fact they are experiencing a state of hypoarousal in the face of a triggering event.

Joining/Join: to align oneself with the parent's or child's experience or to find common ground on which to connect with the client in the process of building a therapeutic alliance, while maintaining neutrality and professional boundaries.

Parallel Process: Parallel process "describes the interlocking network of relationships between supervisors, supervisees, families, and children" (Heffron & Murch, 2010), and refers to situations in which dynamics between the clinician and parent duplicates a dynamic from the therapist's or parent's own life. For example, a clinician who is micromanaged by her supervisor and discouraged from trusting her clinical instincts may then take an authoritative stance with a parent, not allowing the parent to honor his or her intuitions in caring for the child.

Port of Entry: coined by psychologist Daniel Stern, refers to a point in an intervention whereby – because of its emotional valence – the parent is open to change or engagement. For example, a baby's crying may be a port of entry at which point the work can begin, because it is a flashpoint for mother, opening her up to suggestions and connection.

Psychodynamic Perspective: This is a perspective that assumes first that an individual's past experiences, particularly in key attachment relationships, exert a tremendous influence on their view of themselves, relationships, of others, and the world. Thus, understanding the present with families often involves understanding parents' early childhood experiences, many of which have been forgotten or pushed away.

Reciprocity: referring to the "give and take" in a relationship, can also be viewed within the context of "serve and return" exchange in which the infant learns to initiate and respond to interactions with the caregiver, contingent on caregiver response to bids for connection.

Reframing: a way of viewing and experiencing events, ideas, concepts, and emotions to find more positive alternatives. For example, reframing a situation in which a mother is upset with her baby for hurting her by saying, "maybe the baby thought your shiny earrings were interesting and wanted to touch them instead of just pulling your earrings to hurt you on purpose."

Repair: addressing and resolving disruption in the therapeutic relationship. For instance, if a clinician inadvertently offends a mother, she would bring this up in a subsequent visit and try to repair the rupture by clarifying what happened and validating the mother's experience.

Rupture: A break in the therapeutic relationship that has the potential to affect the parent's capacity to trust the clinician. These are not uncommon, but should be attended to and repaired as quickly as possible.

Self-efficacy: coined by psychologist Albert Bandura, belief in one's own ability to succeed in specific situations or to accomplish a specific task. Thus, maternal self-efficacy is a mother's sense of competency as a parent and her ability to accomplish life course goals educationally, emotionally, financially, etc.

Splitting: a common defense mechanism evidenced in families where there is a lack of ability to integrate complex ideas and feelings; everything is seen as "black and white." This is problematic when families attempt to align with one clinician versus the other, or if clinicians compete for the affections of the family.

Therapeutic Alliance: also referred to as "helping alliance" or "working alliance," this refers to a relationship between a healthcare professional and patient or client in which engagement and trust are central to working towards beneficial change for the patient or client. For more information see: http://ct.counseling.org/2014/08/connecting-with-clients/

Transference: This refers to the parent's experiencing emotions in relation to the clinician that actually 'belong' to another relationship. Thus, a mother who does not feel anyone can care for her because she was consistently rejected by her mother throughout her childhood might experience the clinician as rejecting and unfeeling.

Use of Self: the clinician's integration of his or her professional training, orientation, and identity with his or her personal beliefs and value system and ability to recognize how each impacts relationships with families, and the work in general.

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