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Experiences of Infant Mental Health Home Visiting Professionals in Challenging and High-Risk Environments

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Abstract
Partnering With Parents, an infant mental health (IMH) intervention program at Starfish Family Services (SFS), is dedicated to improving social–emotional outcomes, supporting wellness, and strengthening relationships between infants and families. Families served by SFS experience a myriad of societal, community, and relational stressors that can impact the caregiver's capacity to meet a child's developmental needs and the IMH home visitor's capacity to support growth. The authors share vignettes* to elucidate the daily challenges that arise when implementing relationship-based work within systemic barriers, safety concerns, and interpersonal challenges. Their reflective supervisor also reflects on how to best support her team as they work together to consider and strengthen all relationships involved in IMH intervention.

Founded in 1963, Starfish Family Services (SFS) is a private, nonprofit human service agency that serves Wayne County, Michigan, home to the state's largest city, Detroit. SFS has been recognized as a champion for families in Metropolitan Detroit who lack access to essential resources. Serving more than 4,000 children and their families annually, the agency's mission is to strengthen families to create brighter futures for children. SFS provides high-quality programs and services that focus on early childhood development, mental health wellness, and empowering parents.

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Partnering With Parents: An Infant Mental Health Home Visiting Program

Infant mental health home visiting (IMH-HV) is a relationship-based, therapeutic intervention focused on enhancing the social–emotional well-being of infants by supporting families in their home or community (Fraiberg, 1980; Lawler et al., 2017; Weatherston, 2000, 2005, 2007). IMH-HV focuses on the current environment, both physical and emotional, within

* The names have been changed and some of the details of the stories have also been disguised.

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Infant mental health home visiting focuses on the current environment, both physical and emotional, within which the infant is growing

which the infant is growing; thereby working to provide the best possible setting and relationship within which to thrive (Weatherston, 2000; Zeanah & Zeanah, 2009).

IMH-HV programs provide intensive services to families, requiring 4 to 8 hours of home visiting each month. In Michigan, IMH-HV programs are housed within community mental health agencies. Serving families in community mental health settings involves rigorous documentation, lengthy intake paperwork, and a multitude of ongoing assessments. Partnering With Parents (PWP) home visitors work within a framework that includes developmental guidance, resource attainment, advocacy, emotional support, and infant–parent psychotherapy (Fraiberg, 1980; Lawler et al., 2017; Weatherston, 2000; Weatherston & Tableman, 2015). Intervention strategies are tailored based upon the presenting needs of the infant and family, as well as current and potential risk factors.

PWP offers staff members rigorous clinical training, a mentor for peer support, and weekly administrative meetings to learn documentation and agency procedures. PWP home visitors are master's prepared and maintain endorsement from the Michigan Association for Infant Mental Health (MI-AIMH) as an Infant Mental Health Specialist or Infant Family Specialist (MI-AIMH, 2014). SFS is committed to reflective supervision and offers weekly individual and bi-weekly group reflective supervision to their PWP staff.

IMH Work With Families Experiencing High Levels of Risk

Families involved in IMH-HV intervention are experiencing systemic and community risks such as poverty and oppression; as well as interpersonal and relationship risks, such as mental illness, domestic violence, and child abuse and neglect (Jones Harden, 2010; Weatherston & Tableman, 2015). IMH home visitors support families in providing safe environments within which their infants can experience joy, grow, and thrive. They understand the crucial nature of the first 3 years of life in the social–emotional and overall development of a child (Weatherston, 2000, 2005). Yet, the high-risk nature of the families served by IMH, compounded by the urgency of early development, can often elicit strong emotional responses in the IMH home visitor (Jones Harden, 2010; Jones Harden, Denmark, & Saul, 2010; Hinshaw-Fuselier, Zeanah, & Larrieu, 2009; Lieberman & Van Horn, 2008). Working with parents who themselves have experienced inadequate caregiving, violence, poverty, and other stressors can create tension for the IMH home visitor. They have to balance taking time to build therapeutic relationships with parents, addressing the developmental and relationship needs of the child, and managing concrete needs that may be crucial to the family's survival (Fraiberg, 1980; Jones Harden, 2010; Jones Harden et al., 2010; Lieberman & Van Horn, 2008; Weatherston, 2000, 2005).

This article presents vignettes from the perspective of the PWP home visitor. Working with these families evoked a range of emotions and challenges for these professionals and elucidated the multitude of risks they must hold in mind while supporting parents to provide an emotionally and socially rich environment for their babies. These stories also provide a glimpse into the variety of family situations that they work with on a daily basis and paint a picture of what it's like to provide services in this field. Following these vignettes, the reflective supervisor of this home visiting team offers insights into how she works to hold and support her staff, the infants, and their parents.

Integrating an IMH Perspective Into Child Welfare (Michele Hall)

Charles, exposed to opiates and marijuana while in utero, was born 4 weeks early and remained hospitalized for the first month of his life. Hospital staff contacted the Michigan Department of Health and Human Services because of his substance exposure, and Charles was placed into foster care following his discharge. He has developed a positive, loving relationship with his foster parents and sees his birth parents, Jackson and Selena, twice weekly during supervised visits at the foster care agency.

Following Charles' birth, Selena struggled with substance use and experienced brief incarcerations, resulting in inconsistent visitations. With his mother, Charles appeared unsure and distressed during reunions and separations, and Selena had difficulty accurately reading his cues. Conversely, Jackson was always present for visits with Charles, which facilitated a trusting, predictable relationship.

Unfortunately, visitations fell into a disruptive pattern. Charles would arrive and need help transitioning from his foster parents to Jackson and Selena. Selena would attempt to welcome Charles, but her behavior was at times frightening and unclear as she was unable to respond appropriately to his signals. She would often get frustrated and yell at Jackson as he would seek to comfort Charles. Charles would calm in his father's

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arms, which further angered Selena and led to loud arguments during which each parent blamed the other for their situation. It was at those times I would watch Charles shut his eyes and go to sleep. Week after week, argument after argument, Charles appeared to shut down and withdraw.

Difficult Realities

Two years later, Selena's rights have been terminated because she was unable to maintain sobriety or provide Charles with a consistent relationship. Jackson maintained his parental rights and has recently been granted unsupervised visitation. However, the foster parents have formed a strong bond with Charles and want to pursue adoption. Furthermore, the family has had eight different foster care workers throughout their case, thereby increasing the probability of different perspectives and opinions about Charles' needs and delaying permanency planning. Currently, both Charles' birth father and foster parents are struggling to manage the grief that lies ahead when it is decided where Charles will be placed.

IMH in Foster Care

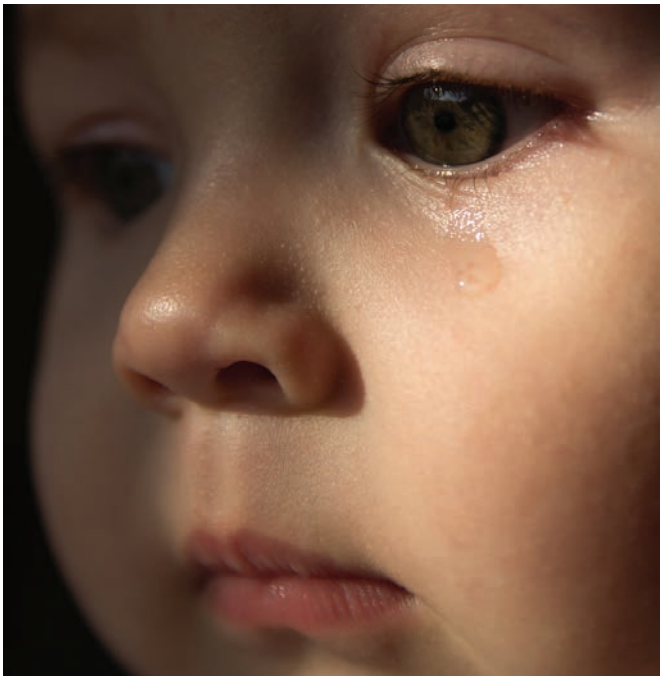
Working as an IMH home visitor within the foster care system can be challenging. Instead of meeting in the parent's home, we meet at the Department of Health and Human Services office during their visitation time. Here, parents often feel they are under a microscope. They may fear revealing their experiences, trauma, and emotions in front of case workers who document their behaviors and make recommendations about their children. At times, the pressures of the foster care system seem in conflict with the IMH-HV model that requires time, pacing, and patience to build an authentic, trusting relationship with a family.

Reflections

I remain in this work because I love what I do and because there are many opportunities for reflective supervision. I have a place to think deeply about Charles and what he means to his parents. I can reflect on my contradicting views and feelings about IMH work within foster care and feel heard. I can think about what is best for Charles and be a voice for him as we continue to work together. It feels powerful to help families slow down, strengthen their capacity to think about how their childhood experiences have shaped them as parents, and reflect upon what it's like to be a parent. My place within my agency and my clinical team has strengthened my perspective of my role and how I play an important part in the IMH home visitation process.

Looking for Ways to Connect (Claire Robinson)

Early in our nearly 2 years of working together, I watched as 18-month-old Gabriel repeatedly slammed his body back and forth in his highchair. I wondered aloud if maybe he was ready to get down, to which his mother, Amanda, replied, "No, it's how he self-soothes. He does it all the time. His doctor said babies will rock themselves to feel better." I carefully replied, saying "Hmm, I've seen that before, but he's hitting the back of the chair pretty hard." She ignored us both, and I immediately felt a kinship with her son as I imagined how often he must get



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Intervention strategies are tailored based upon the presenting needs of the infant and family, as well as current and potential risk factors.

this same response. A few months later, Amanda was telling me about her Native American heritage as she brought out a bundle of sage. I asked about the sage-burning ritual and what it meant to her. She casually dismissed me saying, "It's really complicated, I read a whole book about it; I don't think you'd understand." I was confused and frustrated by her evasiveness. She lit the sage and it appeared as if she had never done it before as she seemed taken aback by the amount of smoke that filled the small home. Gabriel screamed and clung to me as she approached him with the burning sage bundle. I commented that he looked scared by the smoke and she turned to her other son, seemingly ignoring me. As I left the session a short time later, I found myself thinking how I should have felt honored and appreciative of being part of a cultural tradition. Instead, I felt angry because what I had witnessed felt artificial and disingenuous.

The feeling that Amanda was constantly performing to an audience never went away, and I often felt manipulated. I left sessions doubting a lot of things she told me, even when they seemed like part of her real history. I wondered who or what from her past made her feel that she needed to manipulate others to get her needs met and why it seemed as though she never developed a true sense of identity. In turn, I felt like we couldn't build a relationship strong enough to reflect on these thoughts together and achieve some shared clarity, or help her integrate some of these pieces of herself. Without this understanding, I felt like Sisyphus pushing a rock up a hill every time I saw this family, as I realized she might not ever be able to consider and respond to her children's emotional needs.

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Infant mental health home visitors support families in providing safe environments within which their infants can experience joy, grow, and thrive.

Reflections

IMH therapists hold on to the idea that strengthening relationships happens when we can support the reflective capacity of the caregiver. Sometimes this is not possible, so where does the hope for these families lie? For me, it was remembering that I was giving Gabriel and his brother a different experience by responding to them in emotionally supportive ways. Seeking a relationship was foreign to them, and I had the opportunity to offer this thought, free of manipulation and unbalanced emotional burden. This is what I held on to as I entered that home each time, not knowing what Amanda was going to offer, but feeling assured as to what I could offer her and knowing that this may have been the first authentic relationship she had ever experienced.

Struggling With "Good Enough" (Nancy Roycraft)

Rita, 17 years old, entered services when she was 8 months pregnant. She identified as Puerto Rican and Caucasian. Rita's mother died when she was 12 and, having never known her father, she lived in various homes with multiple caregivers. Rita was sexually assaulted and became pregnant while living with her boyfriend's grandmother. She confided in her older brother and his wife, who offered her a place to stay and found her help at SFS.

Rita began her story with her rape and pregnancy. She described experiences of neglect and emotional abuse from her mother and subsequent caregivers. She had to take care of herself, moving from place to place when she felt unsafe, as if she were looking for protection. I often thought about why she had been allowed to live with family members who did not keep her safe and why school counselors had not called proper authorities upon hearing about her living conditions. She talked about her life with an impassive expression; avoiding the emotional toll seemed to be her way of surviving. Yet, the work of processing trauma would be another emotional burden: reflecting on the loss of her mother and the trauma of rape, building self-worth, expressing feelings and needs, and building loving relationships.

At one point, she told me she was dropping the charges against her assailant, and my heart sank. I wanted to encourage her to keep going and tell her not to give up. I felt like I had failed her—I was supposed to support and encourage her to persevere. Even so, I listened when she explained how she felt judged as the officer took her statement and told her that she had no case against her assailant. When she described the officers standing in her living room with exposed handguns and handcuffs, I felt angry that they made her feel intimidated. However, instead of telling her what to do, I validated her feelings and supported her decision. It would not feel right to add to her experience of being judged. When she described feeling intimidated and shamed, her affect was not flat. This time, fear and anger shown on her face as she expressed her emotions, demonstrating a new level of bravery.

We worked to develop her trauma narrative using trauma-focused cognitive behavioral therapy (Cohen, Mannarino, & Deblinger, 2006). At first, Rita chose to share her narrative with her sister in-law, but soon began to express concerns that she was not the right person to hold her story. They were having disagreements about parenting and planning for the baby. Soon after, Rita stated she wanted to end services. She explained she felt "pretty good" and could continue on without them. My heart sank again. I felt flooded with concern and again a feeling of failure. I cried on my drive back to the office; for her and for myself. I worried that she was not ready to be on her own.

Reflections

I had to reflect on my feelings about Rita's decision and realize that, for whatever reason, she was not ready to continue. Although I had different hopes for our ending, Rita felt she had accomplished her goals. Initially I saw it as a continuation of her pattern to leave when feeling vulnerable. However, maybe she was not fleeing, but needed to take a break. With supervision, I realized Rita's ending services was not a failure. As with her decision to drop the rape charges, I again empowered her to express her needs and do what she wanted to do. In our last session, we talked about options for coming back into services. In supervision, I discussed the progress she made and supports still in place for her. Sharing this information helped me to realize that even though this situation was not perfect, as my supervisor put it, it was "good enough" for Rita.

Prevention in the Midst of Chaos (Amber Donahue)

When my phone rang at 8:03 am and Layla's initials flashed across the screen, my heart dropped, and I stared at the phone willing it to stop ringing. I knew it would be bad. Through tears, Layla told me that her boyfriend had assaulted her again. I fought to stay present as she described the beating she endured. I spoke calmly, telling her to breathe—reminding myself to do the same. After she calmed, I asked, "Was she currently safe? Were the kids OK? Did you call the police? How can I help?"

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Later, we met at a park because I wasn't sure the house was safe. When they arrived, 2-year-old West and 3-year-old Nico ran toward me in pajamas with tear-stained faces. Nico climbed onto my lap and said, "Dad hurt Mommy really bad." It felt like I had been stabbed in the stomach hearing those words and looking at his big brown eyes. All I could do was hug them, tell them how scary it must have been, and assure them that for now they were all safe.

As they wandered off to play, I turned to Layla, who had a swollen lip and a bruise forming under her eye. As she talked, I wanted to leave because it was painful to listen. She recounted how that morning her boyfriend accused her of cheating. She described being punched and choked, her children waking up, begging their dad to stop, and 4-month-old Jaz crying in the crib. We talked as the boys ran around us shouting "Look, Mom." When they got no response, they turned to me shouting, "Look, Miss Amber!" and I would offer "That looks fun." The baby sat in her car seat with a bottle propped, as she was so often. I wanted to encourage Layla to pick her up and hold her, but I knew, like many other times, she wasn't capable of it in that moment. While it's not something I typically do, I picked up Jaz and fed her because at least it was something I could do.

It takes a deep commitment to relationships to support infants and families.

Putting Out Fires

I knew that in the following days I'd be supporting Layla to file a police report, create a safety plan, and process this most recent trauma. This was what I did with this family. I managed their crises—domestic violence, food insecurities, eviction notices, child care problems. It often seemed hopeless. I so badly wanted Layla to be present for her kids and to help her connect with Jaz. Instead, we sat in court, in hospital rooms, in line at food banks, and at the housing commission. The kids went with us from place to place, and I tried to find moments to strengthen their relationship with their mother. Layla was able to nurture in those brief moments because she was being nurtured by me. However, the tasks of the crisis would soon take over, and the kids would fade into the background.

Reflections

Every IMH home visitor has their own reasons for doing this work and their own qualities that allow them to remain present for clients during crises. This work is hard. Being with clients during times like this often feels suffocating, as if everything in my body is screaming to flee, yet I stay. What I do know is that I draw on my own experiences and traumatic history which have taught me you are not what happens to you, but everything that has happened shapes who you are. A person's past is not an excuse for poor choices, rather a starting place to understand why they make those choices. I try to develop a sense of what my clients are capable of and slowly make them aware of their abilities. I know the importance of race and culture and that I'm not immune to snap judgements. I don't pretend I don't have these thoughts—I face them head on and make corrections to my thinking. All my clients have something to teach me, and I'm willing to listen. Every day I question why I do this work. But I think I do it because I know I am my clients. The only difference between myself and my clients is I was afforded certain privileges that allowed me to grow despite obstacles and my traumatic past while my clients are just learning that moving forward is even possible.

Providing a Safe Space (Karol Wilson)

I know this work is hard and at times feels unmanageable. I don't have all the answers, but in my role as a reflective supervisor, there are times when having the answers feels urgent. It is my hope that I provide my team with an experience of feeling held, safe, seen, and heard in a space they can depend on to reflect on their work with families and the intricacies of relationships. My presence, reliability, and voice can support them to enter into a similar relationship with parents, whereby that parent can offer the same to their child.

The sense of isolation and trauma in our community can be suffocating. My team and I must be intentional about safety and challenging topics, such as violence and oppression. PWP asks clinicians to go into homes and neighborhoods that may be unsafe. I worry about them constantly. I find myself supporting them to think with families about what safety means. I encourage them to ask, "How do you know when you are safe?" In some cases, safety has become a goal instead of an assessment of the family's experiences. There appears to be no sense of psychological or physical safety for many of these families. How can I help home visitors support exploration with families when there is a lack of safety and so much systemic unrest?

Learning From Attachment Theory

Researchers know that infants explore and learn from their environment when they can rely on their caregiver to be a secure base (Ainsworth & Bell, 1970; Bowlby, 1969, 1988). Infants require a safe haven to return to when they experience a need. Most typically developing children and adults have secure attachment histories (Sroufe, 2005). However, in clinical samples, as high as 90% of maltreated 12-month-olds present with disorganized attachment (Cicchetti, Rogosch, & Toth, 2006). These are the infants and families often seen in PWP. Children who have experienced severe abuse and neglect often depend on things instead of people to regulate their emotions and cope with their experiences (Lieberman & Van Horn, 2008). Their narrative is incoherent, and they are often too flooded with emotions to explore their environment (Gottman, 1993; Lieberman & Van Horn, 2008).

The Supervisor as the Secure Base

I find that I don't always have a clear strategy to reduce feelings of helplessness for my staff. In these moments, I return to the family's story and emotional themes that have been shared with me. I try to be a container to hold the feelings and needs of everyone involved in the family's experience. I sometimes sit

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with my team as they call child protective services, accompany them on home visits to help assess safety or observe the dyad, or just be present and supportive. I ensure that their training needs are met to give them a feeling of professional efficacy, which can be an additional anchor, and remind them to think about their own self-care. I listen when they talk about how sad and helpless they feel, knowing they have comfortable, safe homes to return to; yet their client's families remain in these difficult circumstances.

Reflections

What are the lessons? I re-frame and try to remind my team that they are more than good enough. A trusted colleague of mine, S. Hill, reminds her team that every time practitioners attend a home visit, they leave a piece of themselves behind. Sometimes it's an emotional connection, a toy for a child, or a smile. She then says, "You have given away a piece of yourself to all of your clients this week. How will you put your pieces back together so you will be available to give again?"

Summary

These vignettes illustrate the diverse experiences of families who receive IMH-HV. The IMH home visitors provide unique perspectives of what it is like to bear witness to a family's experience. Self-awareness and an examination of who they are personally and professionally helps them to understand their impact on relationships. Self-awareness is crucial in IMH work, as practitioners cannot ask families to deepen their own reflections if they don't do the same (Thomas, Noroña, & St. John, 2019). Important considerations include how privilege, the injustices of discrimination, and societal risks impact families, and in turn, the capacity to engage in IMH-HV services (Thomas et al., 2019). It takes a deep commitment to relationships to support infants and families. That commitment begins with the supervisor's invitation, and the professional's acceptance of that invitation, to listen, encourage, and be with each other in ways that support emotional growth and wellness in infants and their parents.

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Karol Wilson, LMSW, IMH-E®, is the reflective supervisor for the Partnering With Parents program at Starfish Family Services. Karol has been a part of the infant mental health field for more than 25 years as a home visitor, mentor, program supervisor, trainer, and individual and group reflective supervisor/consultant. Karol provides trainings on attachment, intervention, and diversity. She was one of the first Michigan Association for Infant Mental Health (MI-AIMH) Diversity Fellows and is the first African American to achieve endorsement by MI-AIMH as an Infant Mental Health Mentor.

Claire Robinson, LMSW, IMH-E®, received a master's of social work degree from New York University and is endorsed by the Michigan Association for Infant Mental Health as an Infant Family Specialist. She has been a home visitor for the past 5 years. She spent 2 years working with foster children in the child welfare system in Brooklyn, NY. She is currently employed at Starfish Family Services as an infant mental health therapist and is also rostered in child–parent psychotherapy. Along with providing clinical intervention, Claire is also a coordinator for the Partnering With Parents program.

Amber Donahue, LLMSW, IMH-E®, received a master's degree in social work with a dual-title in infant mental health from Wayne State University and is endorsed by the Michigan Association for Infant Mental Health as an Infant Family Specialist. As a requirement of her dual-title program, Amber completed an internship in infant mental health at Starfish Family Services. A year later she went on to become a full-time infant mental health home-based therapist and has been employed in that work for the last 3 years. Amber works extensively with the Wayne County Baby Court program providing home-based services to families involved in the child welfare system.

Michele Hall, LCSW, IMH-E®, is a licensed clinical social worker and endorsed by the Michigan Association for Infant Mental Health as an Infant Family Specialist. Michele earned a master's degree from Arizona State University with a focus on children, youth, and families. Michele helped establish the Baby Court in Pinal County, AZ, as part of the Best for Babies initiative for children in foster care. Since her employment at Starfish Family Services, Michele completed an 18-month certification in child–parent psychotherapy and works with children birth to 6 years old and their families who have been exposed to trauma, have developmental delays, or have behavioral challenges.

Nancy Roycraft, LLMSW, IMH-E®, earned a master's degree in social work with a dual-title in infant mental health from Wayne State University. Nancy has been working as an infant mental health home visitor with Starfish Family Services for the past 2 years. Prior to completing her master's program, Nancy worked for 3 years as a preschool teacher in a toddler-aged classroom. The desire to work with young children and their caregivers one-on-one sparked her interest in pursuing a degree in the infant mental health field.

Carla Barron, PhD, IMH-E®, is the clinical coordinator for the Merrill Palmer Skillman Institute's Infant Mental Health Program at Wayne State University. She is endorsed by the Michigan

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Association for Infant Mental Health as an Infant Mental Health Mentor and recently earned a doctoral degree in social work. Carla has been involved in the infant mental health field for more than 20 years as a home visitor, individual and group reflective supervisor/consultant, trainer, and researcher.

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