ZERO TO THREE®

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Journal of ZERO TO THREE: National Center for Infants, Toddlers, and Families

Stories From the Field 2013

The Traumatic Consequences of Domestic Violence

Group Therapy for Postpartum Depression

Addressing Challenging Behavior in Child Care Settings

Strengthening Infant Mental Health Through Community Collaboration

Also in This Issue:
Supporting Relationships Between Parents With Disabilities and Their Infants and Toddlers

THIS ISSUE AND WHY IT MATTERS

This third edition of the *Zero to Three* Journal's *Stories From the Field* series continues to highlight the innovative programs, successful collaborations, and unique challenges in providing high-quality services to young children and their families. The authors share their experiences providing services to families with issues of domestic violence, depression, foster care, child behavior problems, physical disability, and other difficult circumstances that put children and families at a high risk for family dysfunction and mental health concerns. The stories illustrate how service providers cultivate and practice enormous patience, creativity, empathy, and respectful collaboration with the support of skilled supervision. The depth of commitment and the passion to make a difference that is reflected in these stories do indeed lead to the "everyday miracles" described in these articles.

Also in this issue, ZERO TO THREE Graduate Fellow Ayelet Talmi provides suggestions for how the stories in this and the previous editions of *Stories From the Field* offer a rich source of information for training and professional development experiences. The articles can be used to support professionals from a variety of settings and roles such as clinical practice, program development, team building, training and supervision, and capacity-building in the early childhood workforce. We would love to hear your thoughts and experiences with using the Journal content for professional development—visit the Journal's Facebook page www.facebook.com/zerotothreejournal to share ideas.

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Note. To protect the privacy of the children and families, all names and other identifying information have been changed unless noted. The photographs are for illustration only and do not depict the families involved.

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Mommy Hates Daddy

A Child–Parent Psychotherapy Story of Engagement, Domestic Violence, and Intergenerational Ghosts

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Abstract
The impacts of violence for young children and their caregivers are multidimensional. The story of 2-year-old Tyronne, his mother, Josephine, and his father, James, illustrates the use of a relationship-focused treatment, child–parent psychotherapy (CPP), in addressing the traumatic consequences of exposure to violence. This family's story exemplifies the complexity of domestic violence by unraveling the source of intergenerational transmission of attachment patterns and unresolved psychological conflict that become internalized, impacting sense of self, safety, and emotional well-being.

The referral arrived in the usual way—in a manila envelope, packaged with about 7 others. They were families that had been on the waiting list from the summer; waiting for fall and waiting for the new year's clinical trainees. Pre-screened and intake information given from the referral source on the current trauma, child symptoms or behaviors, and caregiver's or family's concerns were nicely recorded and ready for green, eager, aspiring clinicians. Two-year-old Tyronne and Josephine, his 32-year-old mother, were referred for treatment because of two recent episodes of violence between the parents that had been witnessed by Tyronne. A relational, dyadic treatment was thought to be optimal because of the child's behavior problems and developmental delays and because of the mother's severe depression. They were an African American family and lived in a neighborhood where community violence, street crime, and drive-by shootings were the norm.

Engagement: Referral to Treatment

Driving through the housing complex brought up a lot of emotions. The reality of the conditions in which the family I[1] was visiting and the other families that called this area home were living was hard to take in. It did not look like a very inviting place or one that stimulates inspiration or motivation. Planted in the middle of industrial and commercial businesses, this area was isolated. It was near a middle class neighborhood yet completely separate from it. The dreariness of it—abandoned cars, telephone wires with dangling pairs of shoes, overfilled garbage cans, barred windows, unnumbered doors, and cement buildings—reeked pain, neglect, and hopelessness. The twisting maze and curvy one-way roads made it clear that there was one way in and one way out. For some, this is all they know, this is "the projects," and this is home.

I parked my car and calculated the door by the small children's clothes drying on the line. Music was blasting as I stuck my hand through the gate's mail slot to knock on the door. Within seconds, Josephine, who had been waiting, answered the door. I introduced myself and reminded her of where I was coming from and she welcomed me in. I entered the house and let her lead the way to the living room. After sitting down I began, "I'm here because I received a referral from your previous service with Healthy Babies. From what I've gathered, they were trying to make your support services accessibly convenient for you. I come from a program that provides mental health services in partnership with your pediatric clinic, where you have already built relationships with Dr. Smith and the staff who are providers for your children's health needs. How did you enjoy working with Healthy Babies?" Josephine replied, "It was okay, fine." I asked, "Do you remember the person you worked with and some of the things you worked on together?"

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[1] *Throughout this article, "I" refers to Markita Mays, who was the clinician working with this family.*

Josephine tried to think for a minute, but was unable to come up with the name of the person. She said, "Honestly, I can't think of her name. I'm sorry. I did work with somebody from there, but I've been working with so many people. They all come and go." I paused, "That must be really hard. How does it feel to have so many people be in your life, coming and going?"

She took a deep breath, smiled, tried to talk and then stopped herself, "Excuse me, let me calm down, I'm getting emotional. . . . I know I need help. I know my children need help. I don't deny we need all the help we can get, but I want people to help because they want to, not because it is their job. I can tell when people are helping me just because it is their job to do so, asking me questions, not focusing on my children. I want my children to get everything they need, but if someone comes and they are here to just do their job I tell them they can go ahead on and leave. Me and my children will be fine."

Markita: "It sounds like, as a mother, you know what's best for you and your children, and you have had a lot of experience with a lot of people. You know good when you see it. That's very insightful of you, and that's very important that you are able to do this as a way of protecting yourself and your children."

Josephine: "Yes, I know when somebody has it in them [*touching her heart*] and if they don't, I let them know they don't need to come back."

Markita: "Well, I want to make sure I don't become one of those people and can become somebody that can support you and your son. That's why I didn't bring any paperwork today. I wanted to just sit down, talk, you get to know me, and I get to know you. Hopefully we will begin to build the relationship that is necessary for the two of us to work together and you can be honest with me about how you feel, and I'll check in with you to make sure you are okay with how things are going." She nodded her head and said thank you. I asked her about her concerns for her youngest son. She stated, "You know he doesn't talk very much. That was one of the things the Healthy Babies person worked with him on. She played with him, brought toys and that stuff. He's talking more now. He fights a lot, too, and he's a very sweet little boy."

Markita: "I don't doubt that he isn't. From knowing a little about your history, it sounds like you and Tyronne have been through a lot. Your little guy has had to see and be around a lot of things that are really hard and tough. Sometimes this affects how children behave and develop. Just growing up in the community in which you do is a lot to deal with on a daily basis. We are products of our environment and situations, and you, him, and everyone else in communities like these have challenges that often get in our way. I want to help you and your children, despite everything, know how to have a loving relationship with each other in the midst of it all. It starts in the home. This is where we teach our kids how to prepare for the world."

Josephine: "Thank you. Nobody has ever explained it like that before."

Markita: "Well, if it's okay, I will come back next week? Same day and time?"

Josephine: "Yes, Tuesday at 10 am will be your time."

Markita: "Okay good. Next week I'll bring the necessary paperwork so we can begin. You've made quite an impression on a lot of people because they were not giving up on you."

Josephine: "Well, I thank them, Dr. Smith too. What's your name again?

Markita: "Markita. Hopefully one you'll remember when we are done."

Josephine: "Markita, Markita, [*smiling*], I got it. Markita."

Engagement serves as the initial, most important step in offering a service and, in clinical treatment, building a therapeutic relationship and alliance. Community mental health providers often face the challenge of developing and building trust with patients who repeatedly experience ruptures because of fragmented systems of care. Having the ability to genuinely and empathetically hold, name, and reflect on family dynamics, barriers (psychological, practical, cultural, or systematic) and desire for change allow for opening "moments of meeting," (i.e. authentic interpersonal connections that reorganize the way patient and therapist know each other; Stern et al., 1998).


Photo: ©iStockphoto.com/Savas Keskiner

Engagement serves as the initial, most important step in offering a service.

Child–Parent Psychotherapy Addressing Domestic Violence

FROM HERE, THE therapeutic journey began. Home visits always started with the same routine. After opening her front door, Josephine would take a key from around her neck to open the gate that gave access to visitors she agreed to see. The house was always dark. Windows were always closed and covered with black sheets. After she and I came into the living room, Josephine would lift a window shade by only a couple of inches to let in some light. She always asked me to excuse the condition of the home as she cleared a space for both of us to sit down. Josephine consistently mirrored the state of her home: disheveled, dressed always in the same dark pajama-style clothes, with a distraught facial expression. Tyronne, at 2 years old, had no words, he made brief eye contact, and spent large parts of the initial assessment sessions burying his head in his mother's chest and staying glued to her lap. Whenever Josephine tried to get up or move away he let out desperate cries and quickly scrambled to wrap himself around her legs as she stood up. Josephine looked desperate, as if trapped in her role. She responded to Tyronne by holding out her arms to pick him up while helplessly crying out his name and begging for some space for herself. She often mentioned that he was not planned and that she did not think she could still get pregnant because there was a 12-year difference

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Driving through the housing projects brought up a lot of emotions. The dreariness of it reeked pain, neglect, and hopelessness.

between Tyronne and his older brother. Tyronne's response was to crawl into a fetal position in her lap and grab her arm to cover up his face.

Child–parent psychotherapy (CPP) starts with an initial assessment that lasts approximately 6 weeks and makes use of clinical interview and structured paper-and-pencil measures to assess the physical and emotional safety of the home environment; the parents' history, mental health and parenting strengths and vulnerabilities; the child's developmental functioning and mental health needs; and the emotional quality of the family relationships (Lieberman & Van Horn, 2008) The concrete needs of this family were so paramount that I also used this time to engage in case management, setting up speech therapy for Tyronne and helping Josephine enroll him in a child care center near their home. When asked about her impressions of Tyronne, Josephine could verbally describe his problem behaviors and developmental delays but could not acknowledge them in the paper-and-pencil instruments. It was as if seeing them written down would make Tyronne's problems too real. When talking about herself, Josephine could only speak in brief generalities, barely touching on her 15-year relationship with her physically abusive husband, James, who she said was now out of the house; her mother smoking crack when she was a child; a father that she did not know much about other than that he had other children and never acknowledged her; and a brother who had been repeatedly incarcerated since he was 14 years old—her older son's age at the time of the assessment. Avoidance was Josephine's primary defense when it came to describing her inner life and her closest relationships, but she eagerly told story after story of seeing multiple murders, drug deals gone bad, high-speed chases that ended in fatality, and physical assaults taking place right at her doorstep. She proudly talked about the key she safeguarded around her neck and the gate that was her family's shield from the chaos that unfolded on the other side. Burdened by a life history marked by chaos, violence, and abandonment and living in a neighborhood that constantly repeated those traumatic events, Josephine had managed to find a small way of keeping herself and her children safe.

The first year of treatment focused on what the mother allowed me to address: Tyronne's speech delays, separation anxiety, and aggressive behaviors. She recoiled from putting into words the domestic violence that Tyronne had witnessed, and pointedly left the room whenever I alluded to it. When she would return, I commented on the link between my mentioning domestic violence and her departure from the room, Josephine replied that she did not want to hear about it and did not want to believe that Tyronne remembered or had been affected by it. She would say, "He was too little. He can forget about it, just like I can. It's over. " When he engaged in aggressive behaviors toward her and others, she was convinced that he knew what he was doing, had control over his behavior, did it on purpose, and knew that he should not do it. Sometimes she referred to him as "catching" a bad gene from his father. When he looked angry, she would say, "He got his father inside." She persistently refused to consider the possibilities that Tyronne responded with aggression when he was scared in order to make himself feel stronger, that Tyronne had learned to hit because children learn by imitation and want to be just like their parents, or that Tyronne's rage came over him suddenly and scared him just as it scared others. She also rejected all suggestions that Tyronne's aggressive behavior could change by helping him make a link between the event that triggered the aggression and his response, following up with containment and redirection. For Josephine, all the men in her life were alike, and that's just the way they were supposed to be. She did not believe she could do anything to change them or her circumstances.

It took a year and a half of weekly home visits before I could get a glimpse of what was really happening in the home. The same key that was used to shield the family from the chaos and violence on the outside was used to imprison them in the darkness of the chaos and violence on the inside. Tyronne began to tell with his body the ongoing family story that his mother could not describe. Both Josephine and I started getting calls from the teachers at his nursery school about alarming behaviors. Tyronne was scratching little girls in the face, leaving marks that would start underneath the eye and extend across the bridge of their nose onto the opposite cheek. He was biting his teachers and peers to the point of breaking skin and leaving an imprint. He was using his finger try to poke others in the eye. He was crying inconsolably for 40 minutes at a time. He was often caught trying to unlatch the outside gate, attempting to run into the street in the direction of home. This was a year after being enrolled in the nursery school, and Tyronne was now 3 years old. No one understood the reasons for the sudden and drastic increase in the frequency and severity of Tyronne's aggressive behaviors. Clinically, Tyronne's behaviors spoke clearly to a toddler's engagement in symbolic fight or flight mechanisms that often is attributed to perceptions of danger (Lieberman & Van Horn, 2005).

I decided to meet individually with Josephine in an effort to trace the roots of Tyronne's increased aggression, but Josephine said there had been no changes in the home and she could not explain why Tyronne had become so aggressive. I persisted, wondering aloud with Josephine about the meaning of Tyronne's behavior and events that might have triggered the current spike in aggression. Josephine responded that she was very upset about Tyronne's targeting of little girls. She said she was overwhelmed by the level of his aggression toward others and felt guilty for the permanent scars he left. She then looked at me, shaking her head and asking, "Where does he get this from? Why is he doing this? I talk to him, I tell him not to do these things, what else am I supposed to do?" I responded with a reflective statement that sometimes we tell our kids one thing but they see other things that don't always match what we say. Instinctively I asked, "How is his dad doing?" This quick question caught Josephine off guard. She stopped, as if trying to think of what to say. Instead of speaking, she used her finger to point upstairs. I nodded my head in acknowledgment.

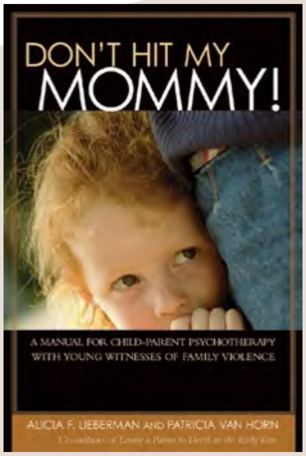
Finally, after 18 months, the unspeakable had been spoken. Josephine whispered, "He's not supposed to be here." I asked her how long had he been back. Continuing to whisper, Josephine answered, "He never left." She then revealed that her husband, James, would either leave out the back door or hide upstairs when people came to the house because he had a restraining order restricting him from having any contact with her and the children. She explained that he had nowhere else to go and added that the kids knew not to talk about him to anybody. I reflected out loud that such a big secret was a lot for anyone to hold, especially 3-year-old Tyronne, before asking, "How is everything between you and him?" Josephine whispered, "He is the problem." I repeated questioningly, "He's the problem?"

I asked Josephine if Dad would be willing to talk, to become a part of their conversation for Tyronne. She shrugged her shoulders and said she would ask him. I encouraged her to ask him only if she was comfortable doing so, and stressed my commitment to work with Josephine in making things safe at home for her and the children.

> For Josephine, all the men in her life were alike, and that's just the way they were supposed to be. She did not believe she could do anything to change them or her circumstances.

CPP Holding Intergenerational Ghosts

THE FOLLOWING WEEK, James answered the door when I arrived. He called out for Josephine so that she could open the gate. She came down, removed the key from her neck, and took a seat at the foot of the stairs while James remained standing. I took a chair out of the kitchen and sat across from them to complete the triangle. I formally introduced myself and described my reasoning for wanting him to be a part of their conversation, saying "Tyronne needs you just as much as he needs his mother, because he learns from both of you how to be in the world." James admitted to "hiding"— he was worried about getting into trouble because of the "situation that happened." He continued talking as if he had not had a chance to express himself in a long time. He talked about all the pressure he was under because of probation, child protective services, and not having a job. He talked about trying to hold all this inside when he was in the house, but the pressure pushed him to go out into the world and drink and then come home and "unload." James referred to himself as a "ticking time bomb" with "skeletons that like to come out." As he talked, his voice was agitated, rushed, and loud. He continued. He professed his love for Josephine and his children. He said he wanted to be there for his family, he just did not know how. He talked about not having a father himself when he was growing up and how he needed to make things right with his sons. He talked about how Tyronne kicked him, raised his hands to hit



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The epidemic of child exposure to violence needs to be met with the acknowledgment that this is a phenomenon where powerful sociological and psychological forces collide.

Learn More

National Child Traumatic Stress Network
www.nctsn.org

They Just Don't Get It: A Diversity-Informed Approach to Understanding Engagement
C. Ghosh-Ippen & M. Lewis (2011)
In J. Osofsky (Ed.) Clinical Work with Traumatized Young Children *(pp.31–52). New York, NY: Guilford*

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A. F. Lieberman (2007)
Infant mental Health Journal, *28(4), 422–439*

Father Hunger: Explorations With Adults and Children
J. Herzog
Book review by K. D. Pruett, (2002) New England Journal of Medicine, *347(19), November 2002*

him, spit at him, and looked at him with mean faces. He talked about how this hurt him but Josephine was OK with it. He talked about his sons having their mother's last name and not his. He talked about being backed up against a wall. As he spoke, Josephine was quiet. When he paused I asked her if there was anything she wanted to say. Josephine shook her head "no," James answered for her, "She wants me out, so I have to leave." Josephine then chimed in, "I got it stuck in my head. I need a break. He's the problem." Dad answered, "See? She doesn't want me here. I don't have anywhere to go. I'm not going back out in those streets. That's trouble. If I can't be here with my family, then I'm going back to my momma." Josephine looked determined, standing her ground: "I need to take care of me and my kids. You need to take care of you."

The room stood still with a heavy silence. I named the unspoken pain that was in the room; the pain that was between the two of them and the physical, verbal, and emotional pain that they inflicted on each other. I spoke about Josephine feeling "stuck" and the fact that they had both been stuck for 15 years, with a lot of acting, reacting, and doing but with no thinking, no reflecting. I spoke about hearing Josephine say that she needed a break, and asked the father whether he could make the most of that break to do some thinking and planning for himself. Josephine nodded her head up and down in a yes. James looked defeated but understanding, "I can do that." He then said he had to leave for a meeting with his probation officer. He thanked me as he walked out the door, saying "I think this is the first time in 15 years we've ever been able to talk to each other. Really hear each other."

I checked in with Josephine, after his departure. She said, "I got it stuck in my head. I'm done. I'm tired. I don't want to try anymore. He's the problem, he's got to go," and then she broke down crying. She let out sobs that bellowed out of her from the deepest part of herself. "I don't take my kids to the park no more. That's how bad it is. I've always been able to make myself leave the house for them, not for me, but now, I can't even go out for them. I don't leave outside of this house. Stuck? That's not even the half of it. I'll get myself ready to go out and soon as I come to this door, something happens. A wall goes up, and I stop and turn around, giving up. Once that wall goes up, that's it. I shut down and I turn the world off. I need help trying to break down this wall so I can turn the world back on. I can't do that with him here. I have to work on me first and I have to focus on my kids. He has to go. That's my plan. Then things will be better." I asked her how she wanted to prepare the kids for her plan. "They aren't going to miss him. They won't even ask about him. I tell them the same thing my momma used to always tell me, 'Daddy might come and go, but Momma will always be here.' My momma told me I don't need no man, not to depend on them. My kids don't listen to him, because I tell them not to. He ain't nothing to them."

After James left, Josephine continued to refuse to speak to Tyronne about his father, but she remained committed to the treatment and never missed a session. During a home visit, I found Tyronne preparing to draw figures representing the members of his family. He first drew Mommy. He then drew himself and his 14-year-old brother. I looked over his drawing, pointing to each person, naming them accordingly, and looking between him and his mother for confirmation. I then inquired about someone who was missing, "What about Daddy?" Tyronne responded with silence, looking down at his picture. Josephine responded by silently shrugging her shoulders while looking blankly at me. I spoke about Daddy moving, no longer living with them, being so far away, and asked Tyronne if he missed his father. Tyronne looked over at Mommy first and then at me, mechanically shaking his head no. Josephine had her all-knowing-mother smile and looked at me with her "I-told-you-so" look. I pressed on, reminiscing with Tyronne about pictures I had seen of him with his father on preschool field trips, how Daddy used to take him to school in the morning, and how Daddy used to cut his hair on the weekends. I wondered out loud about what feelings he might have around trying to understand where Daddy is, missing him, and wondering if he was still a part of their family. I then asked both Josephine and Tyronne if they could make a space somewhere on the paper to represent Daddy being so far away. Josephine got up and excused herself from the room. I wondered out loud again, "What about Daddy?" This time Tyronne looked me in the eyes and responded, "Mommy hates Daddy." It was clear from the look in his eyes that he only had one option about feelings he was allowed to have for his father. Mommy was the most important person to him; she was the one who was still here. *"Daddy may come and go, but Momma will always be there."* Daddy was scary; the bad guy, the man who got angry, the person who had yelled, cursed, and beat his mother. *"They aren't going to miss him. They won't even ask about him."*

Not long after this dyadic session, Josephine got lost behind her wall. She shut down and shut the world off. The immediate cause was the death of her own father, a man her mother taught her not to care about. She said she looked just like him but he never claimed her. She carried her mother's last name, just as her sons did hers. She said her father punished her by not fighting to have a relationship with her when her mother left him. She talked about his other kids and how confused she has always been about why he treated her differently. She did not go to his funeral because she felt he died in her eyes a long time ago. She talked about holding on to this pain and said that even in his death, she was still angry with him. He died and she was left with the unanswered question of why he didn't love her. *"Mommy hates Daddy."* Tyronne's behaviors escalated, exacerbating the mother's withdrawal. For weeks she reverted to her old pattern of not answering the door and not returning phone calls. She did not answer the door when I came for her weekly visits. She later revealed that she only opened her door to either get Tyronne on or off the school bus, made him take naps when he was at home, and was unable to clean her house or cook meals. With the support of weekly reflective supervision, I responded by continuing to call and leave messages, saying I was there for Josephine and Tyronne when she was ready. And one day, she was. She opened the door and was appreciative for not giving up on her. She inquired about my desire to be patient, asking how long would I be able to work with her. What I heard her say was, "Who is going to be there for me, and will you leave me like everyone else? Will I force you to leave me just like I make everyone leave?"

Treatment continued. It involved a delicate dance attempting to increase family communication to bridge Josephine's unresolved ghosts, dad's ticking time bomb skeletons, and Tyronne's behavior as a reflection of his inner life as a mirror of his parents' conscious and unconscious messages. Individual collateral sessions with Josephine became a part of the treatment to address her avoidance and her refusal to grant Tyronne's permission to feel the full complexity of his feelings toward her and his father. During joint sessions with Tyronne and Josephine, I continued to move back and forth between the developmental goals of affect regulation, trust in relationships, and joy in exploration on one hand and, on the other, the huge obstacles that Tyronne faced in reaching these goals—his mother's disavowal of her own and her son's feelings, her physical and emotional withdrawal, the father's comings and goings, the looming shadow of family violence, and the confirmation through neighborhood violence of aggression as a frightening but compelling way of life.

Afterthoughts

OVERT AND COVERT signals throughout the treatment spoke clearly to this family's struggle. There was a consensual code of silence in defense of pain, fear, and loss that acted itself out in aggression, withdrawal, or both. Josephine's inability to tolerate speaking about her own childhood trauma and the domestic violence, getting up and walking out of the room during sessions, assigning her sons her last name, and the dismissal of Tyronne's potential loving feelings for his father were all clear manifestations of her own unresolved conflicts—the "ghosts in the nursery" that engulfed not only herself but her child (Fraiberg, Adelson, & Shapiro, 1975). James' missing foundation of a father in his life, poor regulation skills and coping mechanisms, and the coexistence of violence and victimization in his behavior at home spoke directly to the fear that fueled his violence—the "ticking time bomb skeletons."

At the core of this family's internal drama is the question, "Who is Daddy?" There is a central dichotomy in relation to men. Constructed as perpetrators or offenders, their potential identities as viable fathers remain undeveloped and disavowed. What does this do to the family and to the child? Tyronne is left to decipher his mother's ambivalence, avoidance, anger, and depression while becoming the target of his mother's projections. He constantly asks himself, "Am I like my daddy? Am I a protector or an attacker? Am I lovable or undesirable? Mommy hates Daddy. Does she hate me too? Am I like Daddy? Can I stay or will she send me away too? I can't afford to show anger at Mommy, but it's safe to show my anger with little girls." Hope for Tyronne resides in his mother's ability to recognize his need for identification with a safe father figure and in his father's ability to abide by the goals to become such a figure that he so eloquently articulated in his first meeting with the clinician.

Will this hope be materialized? Families like Josephine's and James' face formidable internal and external challenges. American society often behaves like Josephine, avoiding recognition and resolution of the marginalized and abandoned male's pain and its transformation in anger, which is then responded to with retaliation and social punishment. The epidemic of child exposure to violence needs to be met with the acknowledgment that this is a supra-clinical phenomenon (Harris, Lieberman, & Marans, 2007; Lieberman, Diaz, & Van Horn, 2010) where powerful sociological and psychological forces collide. Recognizing the urgency and national scope of this epidemic, the US Attorney General launched the Defending Childhood Initiative and established a Task Force on Child Exposure to Violence that presented its report in December 2012 (Listenbee et al., 2012) recommending a coordinated approach to change the national dialogue about childhood exposure to violence, making it unacceptable and calling for an effort implemented at the highest levels of the executive and legislative branches of the federal government to create systematic processes for screening, identification, and intervention to address child exposure to domestic violence in every child- and family-serving system—from primary health care to early childhood education, schools, child protection, and the courts. Such a concerted social effort would have enormous repercussions in raising the hopes of families like Josephine's and James' that change is indeed possible and would give impetus to their own efforts on their children's behalf.

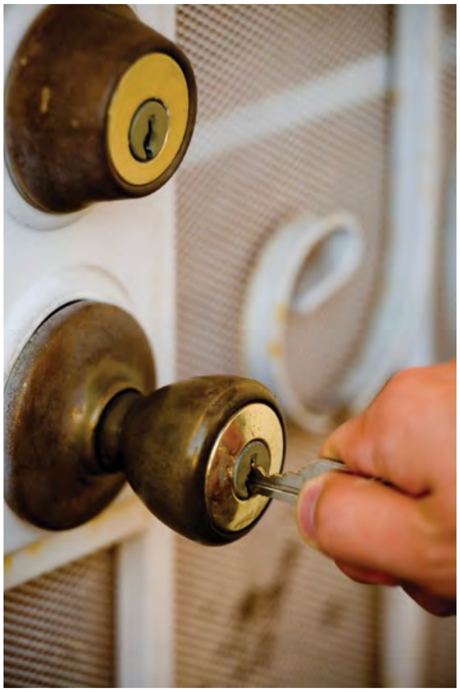

Photo: ©iStockphoto.com/Savas Keskiner

Josephine proudly talked about the key she safeguarded around her neck and the gate that was her family's shield from the chaos that unfolded on the other side.

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Melding Infant Mental Health and Multisystemic Therapy Approaches to Community-Based Treatment

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Abstract

A recent partnership between the Irving Harris Program in Child Development and Infant Mental Health and the Community Based Psychiatry Program at University of Colorado Hospital joined two different approaches to child mental health treatment: infant mental health and multisystemic therapy (MST). This article illustrates the compatibility of these two approaches by detailing the application of both models to the treatment of 4-year-old Noah and his substance-abusing mother, Kim. The authors highlight helpful aspects of each approach, such as using ecologically informed interventions (MST) and reflective practice (infant mental health) to show how openness to contrasting frameworks can ultimately benefit families.

Four-year-old Noah and his mother, Kim, were referred to the Young Child Clinic at University of Colorado Hospital by Noah's pediatrician. Noah was having "tantrums." The Young Child Clinic offers initial psychiatric evaluations, ongoing medication management, and individual and family therapy services to children from birth to 6 years old and their families. In the initial evaluation with the child psychiatry resident, Kim shared that Noah's behaviors had "worsened over the past year." She described Noah as defiant and irritable. He was generally "out of control," and demonstrated "rage episodes" during which he would grab, bite, pinch, kick, and pull Kim's hair, as well as curse and yell. Kim told how she and Noah had been kicked out of numerous stores and restaurants because of the severity of his behaviors.

While discussing Noah's early development, Kim reported complications during her pregnancy with Noah. Addicted to heroin at the time of conception, Kim was placed on methadone early in her pregnancy. Noah was born prematurely at 32 weeks gestation, and required intensive care for the first 2 months of life. Kim reported that even as an infant Noah was easily upset, cried for hours at a time, and was difficult to comfort. She reported that she had never been able to "control him." Kim worried that something was very wrong with Noah.

The resident saw Kim and Noah weekly for 60-minute sessions for 2 months. Noah and his mother often arrived 15–20 minutes late and always appeared to be in crisis. The resident quickly saw Noah's "out of control" behaviors in the office setting. Noah ran out of the resident's office numerous times each session. He'd run down the hallways and giggle uncontrollably. He'd run into other offices and knock down anything in his way. Desperate to control him, Kim physically restrained Noah. He'd slap, hit, or kick back. Kim, very upset, attempted to speak to Noah as if he were a small adult and demanded that he stop acting out. Kim would deliver long, pleading lectures to Noah begging him to behave and promising numerous threats and rewards—none of which ever materialized.

The resident observed Noah's extreme impulsivity and emotionally charged behavior. Therefore, he started Noah on a trial of

Photo: Marketing and Communications Department, University of Colorado Hospital

The Community Based Psychiatry program at University of Colorado Hospital is located in the Fitzsimons Building.

Clonidine in order to reduce the severity of these symptoms. Noah initially showed a mild response to the medication. Feeling that the response wasn't enough, Kim adjusted the dose of medication on her own. This created a significant challenge in treatment as dosing of this medication is very sensitive and needs to be undertaken only by a physician. After a serious discussion with Kim, the medication was continued, but under strict guidelines agreed upon by the resident and Kim. Despite the medication's effects, Noah's behavior grew more unsafe. Kim reported that Noah had one of his "tantrums" on a city bus and was "kicked off." After getting off the bus, Noah ran into the busy street, straight into traffic. Concerned about Noah's safety, the resident recognized that Kim needed more support in order to manage Noah. The resident made a referral to the hospital's Community Based Psychiatry (CBP) program for in-home intervention.

CBP and the Early Childhood Intensive Family Therapy Program

CBP is part of the Outpatient Psychiatry Service at University of Colorado Hospital. Since 1997, CBP has offered three home-based intervention programs: Multisystemic Therapy (MST), which serves adolescents involved with the juvenile justice system; Intensive Family Therapy, which serves children 7- to 17-year-olds requiring concentrated intervention for serious behavioral and psychiatric problems; and Rapid Response, which transitions children from psychiatric hospitalization to less intensive treatment. In 2010, CBP and the Irving Harris Program in Child Development and Infant Mental Health partnered to create the Early Childhood Intensive Family Therapy (ECIFT) program as a fourth CBP program, in order to expand home-based services to children birth to 6 years old. ECIFT provides home-based treatment to young children at high risk for abuse or neglect, who have experienced trauma, and who present with other mental health concerns, such as problems controlling emotions. As early childhood mental health issues often reflect caregiver–child relationship problems, ECIFT serves caregivers who struggle to maintain structure and consistency in the home, or demonstrate inappropriate discipline and ineffective parenting techniques, or both. Like the other CBP programs, ECIFT is a strength-based family therapy intended to stabilize mental health issues to prevent out-of-home placement in psychiatric hospitals or foster care. ECIFT intervention is brief and intensive. Therapists conduct twice-weekly home visits and offer phone support for up to 4 months. However, the ECIFT model is unique in that it infuses an infant mental health perspective into a program where treatment is informed by MST.

MST is an evidence-based intervention for the treatment of antisocial behavior in children and adolescents (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). Theoretically, MST is based on several aspects of Bronfenbrenner's (1979) theory of social ecology, which posits that an individual's entire ecology should be taken into account when considering development. MST theory assumes that a youth's problematic behavior is "driven by the interplay of risk factors associated with the various systems in which youth are embedded (i.e., family, peer, school, and neighborhood)" (Henggeler et al., p. 4). Therefore, MST intervention takes place in all aspects of the youth's environment, such as with parents, family, school, social services (if applicable), mental health services, church, positive peers, extended family, and any other identifiable positive relationships. In addition, MST theory assumes that caregivers are usually the main agents of change (Henggeler et al.). Therefore, intervention focuses on increasing the caregivers' capacity to effectively manage their child. This touches on a major tenant of infant mental health which emphasizes relationship-focused interventions between children and caregivers, toward improved caregiver–child attachments. Infant mental health clinicians use reflective practice to inform thoughtful, emotionally affirming interactions with caregivers (Heffron, Ivins, & Weston, 2005). Similarly, during treatment, clinicians encourage caregivers to take a reflective stance to enhance understanding of the child's emotional experience. When a caregiver conveys understanding of the child's emotions, the child feels validated and relationships are strengthened. Application of both frameworks to clinical work with young children has proven to be quite successful for the ECIFT program.

The Initial Visits

The complimentary relationship between the two models is illustrated further in the story of in-home treatment with Noah and Kim by the psychology fellow from The Harris Program.

An Uneasy Atmosphere

During the first 2 weeks of treatment, the psychology fellow spent time just observing Noah and trying to understand his extreme behavior. Noah was a lively child with an animated face and enthusiastic voice. At the start of each home visit, as the fellow stepped out from his car, Noah would open the front door to the house and exclaim, "Dr. Jay!" But Noah would already have moved to another part of the house by the time the fellow arrived at the door. Noah was always on the go. However, the fellow observed a subtle and important quality to his high activity: Noah seemed less hyperactive and more in a constant state of apprehension. Noah's restless body signaled that things in his world were not safe.

Noah's mother, Kim, shared her son's uneasiness. She was easily distracted and tangential, and required constant redirection to address the topic at hand. When asked about her childhood she didn't share many details but referred to it as "traumatic." She reported that when she was 6 years old her parents

Photo: Marketing and Communications Department, University of Colorado Hospital

An aerial photograph of the entire University of Colorado Anschutz Medical Campus

separated and she moved out of state with her mother, who was a drug addict. Kim described herself as a "damaged and loathsome adolescent." Unbearable feelings of loneliness and shame drove her, in adolescence, into an unrestrained descent with heroin addiction. In her early 30s, with the news that she was pregnant with Noah, she entered a residential substance abuse program for pregnant and addicted mothers. She reported that she has been on daily methadone maintenance for the past 4 years.

Gathering the details of Kim's life story and her early history with Noah was challenging: Kim and Noah's emotions swelled when they interacted with one another, derailing the focus of the sessions. On one occasion, Kim asked Noah if he could play a game on his own so she and Dr. Jay could talk privately. Noah, whose body had been calm, began to rev up. He made silly faces and sounds, and threw game pieces at Kim. Kim became agitated and raised her voice. Noah responded by laughing nervously and kicking her. Kim pleaded with him to stop and tried to grab his legs. Noah began to spit profusely at his mother and the fellow. The fellow coached Kim on setting clear short limits, but Kim was unable to follow these prompts. Overwhelmed by how angry and reactive their interaction became, the fellow firmly told Kim to leave the room. The fellow sat quietly next to Noah and took slow, deep breaths and ignored Noah's spitting and silly behaviors. It didn't take long for Noah to calm. The two sat in silence. After a moment, Noah glanced at the fellow and said, "I couldn't stop acting silly because I had worms in my stomach." The fellow replied, "You feel worried and scared." The fellow left the home disheartened and anxious that Noah and Kim could get so out of control.

Don't Go Away!

When the fellow returned the following week, Kim was not home. Noah's grandfather, in whose home the family lived, welcomed the fellow as Noah quietly watched a movie in his bedroom. The grandfather reported that Kim had been hospitalized over the weekend "for liver problems" and was at a follow-up doctor's appointment. He assured the fellow that she was all right and would be home any moment. The reason for her hospitalization was vague. It seemed strange to the fellow that she was already on the mend, given the serious sounding nature of her condition. The grandfather averted his eyes as he relayed the spotty details of Kim's ailment. Grandfather reported that, 2 days before her hospitalization, Kim had slept most of the day and that on more than one occasion he had found Noah awake, anxiously clinging to Kim while she dozed. The grandfather said that it was not uncommon for Kim to get sleepy in the late afternoon because of all of the medications that she took in addition to her methadone. This was the first the fellow had heard of "other medications."

The fellow became suspicious and concerned, and tried to broach the topic of Kim's substance use. The grandfather appeared uneasy and told the fellow that he "tried to not concern himself with his daughter's business." He was uncertain whether Kim's addiction was the reason he had received a call from the Department of Human Services (DHS) 3 years earlier requesting that 15-month-old Noah be placed in his home. The grandfather tearfully recounted the story of 18-month-old Noah's reunification with Kim. He recalled Noah as initially emotionless and withdrawn. In the days that followed, Noah behaved angrily as he approached Kim; at other times, he was needy and clingy. Then the grandfather shared an important observation: Since that separation, Noah seemed to fall apart whenever his mother went away, whether she physically went away or emotionally "went away" as when she passed out in the afternoon. The fellow thought about the emotional unraveling that Noah had experienced at the end of the previous visit, when Kim had asked Noah to "go away," and wondered if even this going-away of sorts was a painful reminder of how inconsistent and unpredictable his mother could be. As the fellow looked at the clock, he realized that an hour and a half had passed. Kim had never made it home. The fellow thought about the worms in Noah's stomach.

Formulating the Case

AFTER A FEW weeks of visiting Noah and Kim, the psychology fellow became aware of growing discomfort that he was feeling about this family. The fellow looked forward to exploring his feelings in a weekly meeting with the psychologist supervising the case.

Reflective Supervision: A Relational Formulation of the Case

As an infant mental health specialist, the supervisor used a reflective approach in supervision, meaning that she gently inquired about the fellow's reactions toward Noah and Kim. The fellow was expected to observe his thoughts, feelings, and behaviors toward the family as these would be an important source of information that would enrich clinical understanding of the case and guide intervention (Heffron et al., 2005). In the safety of the supervisory relationship, the fellow shared his strong feelings of worry about Noah's well-being and his thoughts of wanting to rescue Noah from Kim. The supervisor helped the fellow understand that his reactions were mirroring Noah and Kim's interactions: Kim's unpredictability poked at Noah's sense of calm and safety. The fellow began to understand that Noah's problems were in direct response to Kim's erratic shifting between emotional over- and under-involvement. On the one hand, when Noah felt upset and began to unravel, Kim became excitable and reactive, kindling Noah's dysregulation and subsequent aggression. On the other hand, Kim's tendency to go away left Noah feeling worried and scared, in a constant state of apprehension.

Like Noah, the fellow felt worried and scared. The fellow finally voiced a concern that had been growing: He feared that Kim was abusing substances in addition to her methadone. The fellow revealed that, although he had had his suspicions for several weeks, he hadn't discussed them with the supervisor. The supervisor helped the fellow understand that he had been minimizing his concerns. By minimizing, he was able to justify his turning a blind eye to a mounting problem. Together, the supervisor and the fellow came to understand that the relationship between the fellow and Kim paralleled Kim's relationship with her father: Like the grandfather, the fellow was doing Kim a disservice by failing to hold her accountable for her addiction. It became clear that Kim's problems with addiction needed to be addressed if her relationship with Noah, and therefore his behavior, were to improve. The reflective process not only helped the fellow cope with his strong feelings of

Photo: ©iStockphoto.com/Blue Orange Studio

Intervention focuses on increasing the caregivers' capacity to effectively manage their child.

worry, allowing for an enriched clinical understanding, but the reflective process also helped guide intervention. The fellow would need to voice his worry to Kim.

MST Supervision: An Ecological Formulation of the Case

When the fellow met with the social worker who supervises the community-based program for MST supervision, the focus was different than that of the reflective supervision. The social worker encouraged the fellow to consider the broader systems that Noah and Kim lived in (e.g., family, peer, school, and neighborhood) to identify the determinants of Noah's problematic behaviors. Within the MST model, identifying the determinant of the presenting problem in terms of the child's full ecology is referred to as a *fit circle* and leads to planned, specific, effective MST interventions (MST Services, 2004). First, the social worker encouraged the fellow to look at the family factors that determined the presenting problem. For example, Kim's lack of adequate substance abuse treatment, led to Noah having angry and anxious feelings that triggered his aggressive and defiant actions toward Kim. This particularly happened when Kim overmedicated or passed out in the late afternoon during what should be their play time. Second, the fellow was encouraged to note broader ecological factors that influenced the presenting problem, such as peer relationships and school. Noah's lack of interactions with same-aged friends led to Noah's inability to play safely and share with others, particularly when Noah was not exposed to peers at preschool who could potentially provide him with models for prosocial behavior. Through MST supervision, the fellow came to understand that factors outside of the parent–child dyad also influenced the presenting problem, including Kim's untreated mental health issues, her inadequate substance abuse treatment, Noah's lack of enrollment in preschool, and the family's disconnectedness from neighborhood and community supports. It became clear that, in order for the family to achieve and maintain improved functioning, the fellow would need to both build a collaborative relationship with Kim and facilitate strong relationships between Noah and Kim and agencies in the neighborhood and community.

Ensuring Safety in Relationships

The atmosphere at the home became tenser. The fellow asked to talk with Kim and the grandfather while Noah played in his bedroom with the door closed.

A Tough Intervention

The fellow expressed his suspicions about Kim's substance abuse—was Kim taking prescription medications more than she should? Surprisingly, the grandfather pressed Kim not only on her increased episodes of "passing out," but also on an incident that had happened the night before. Grandfather reported that Kim was so "out of it" she could barely talk or walk. In her stupor, she obliviously served Noah raw meat and frozen French fries for dinner. Grandfather had kept the plate in the refrigerator: Indeed, the food was cut neatly on the plate—all raw. Kim broke down and revealed honest glimpses into her addiction. She talked about a doctor who (unaware that she was on methadone) prescribed a benzodiazepine medication for her. As benzodiazepines and methadone both have sedating effects on the central nervous system, the two drugs can fatally interact, and for this reasons patients on methadone are rarely prescribed benzodiazepines. This was unbeknownst to the staff at her methadone clinic, which had a strict no-benzodiazepine policy. She collapsed in tears saying she just didn't know if she could take care of Noah any more. However, Kim's honesty was fleeting, and moments later she recoiled. She vehemently refused to sign a release for the fellow to support her in disclosing her prescription medications to the methadone clinic. She sounded terrified as she explained that if she were to come clean, her methadone dose would be lowered and her prescriptions for other medications discontinued. The fellow knew that this information was confidential, but he also knew the home was not safe for Noah. He let Kim and the grandfather know that if Kim could not take the steps to honestly talk with her methadone clinic, he would need to turn to the DHS for help. Again, Kim refused to cooperate. At this point, the grandfather suddenly retracted his story and stood with Kim. Both rose to their feet in anger and told the fellow to leave their home. He was no longer welcome!

Repairing a Ruptured Relationship

Early the next day, the fellow called Kim to let her know that DHS had opened a voluntary case as a result of his reporting his concerns. This meant that a case worker would be out to the home within the next 5 days to meet with Kim and Noah and determine how the agency could support the family. Kim was enraged and tearful. She felt betrayed by the fellow; she reported she was stopping treatment. The fellow acknowledged how scared Kim must be, particularly in light of her previous experiences with Noah being taken from her care. Kim admitted that she was terrified. She feared that Noah would be taken again. The fellow reemphasized that his intention with DHS involvement was to help connect Kim to the community supports that she needed to hold her accountable and to parent more effectively. He acknowledged how he and Kim were at odds, that nothing he could say would help her understand how his intervention was anything other than harmful. Kim agreed. In spite of her anger, he encouraged Kim to hold off on ending treatment until she had time to reflect on her decision. The fellow gently told Kim that although she was upset with him, he was not upset with her. He knew she was scared and worried. He reassured her that he was not going anywhere. Kim agreed to hold off.

The next week, the fellow received a page. It was Kim; she was frantic. The case worker was on her way over to the home. The fellow commended Kim for calling him for emotional support. The fellow gently countered Kim's fears by reminding her of the positive steps she had already taken to be a better mom, such as seeking out and participating in community-based intervention for her and Noah. The fellow advised Kim to "put her best foot forward," and to represent the ways in which she is a good mom, to be forthright and honest about her addiction, and to demonstrate an understanding and responsibility for the ways in which she has not kept Noah safe. The fellow and Kim agreed to meet for coffee the next day to discuss the visit.

Over coffee, the fellow reflected how relieved Kim appeared. Kim thought it was because she chose to be honest and forthright about her addiction with the case worker. The fellow voiced an important observation: Kim chose to be honest. The fellow was frank in telling Kim that the outcome of DHS involvement was entirely up to the choices that she made moving forward. Kim reported that the case worker had told her something similar: If she continued to be cooperative, honest, and open to support, Noah would be safe to remain in her care. This motivated Kim. Kim proudly revealed that she had not only signed releases for the case worker to talk to her methadone clinic and prescribing doctors, but that she requested the case worker not contact anyone until the next day because she wanted her providers to hear it from her. After coffee, she headed to the methadone clinic to talk to her counselor. She asked if she could call the fellow afterward, for support.

Later that afternoon over the phone, Kim remarked on how sympathetic people had been to her disclosure. She had expected punitive responses and instead found kindness and support. She was also beginning to discover something invaluable through her relationship with the fellow: That two people could disagree and still work together. She told the fellow that she had talked with her father. The fellow could return to the home to resume his work with the family.

Connecting the Family With Neighborhood and Community Supports

THE OVERARCHING LESSON learned from this case was just how complimentary infant mental health and MST approaches can be. MST and infant mental health expanded the fellow's repertoire of interventions in treating a complex clinical case, as each framework emphasized different, but equally important, perspectives.

The broad ecological perspective of MST helped the fellow recognize that the strong relationships with organizations in the neighborhood and community were necessary to establish and maintain Kim and Noah's gains in treatment. During treatment, Kim was connected to the Child Care Assistance Program through DHS for respite care so that she could leave Noah in a stimulating learning environment while she attended her increased substance abuse treatment appointments. Kim was reevaluated at her methadone clinic and mandated to attend two substance abuse meetings a week, was subject to weekly urine analyses, and was required to meet daily with her substance abuse counselor. In addition, her methadone clinic began working directly with a psychiatrist and all of her relationships with prescribing doctors throughout the community were terminated. The psychiatrist would oversee Kim safely tapering off her benzodiazepine. Equally important, Kim was connected to and meeting weekly with her own psychotherapist to address the traumatic past that fueled her substance abuse. As for Noah, he was referred to the child evaluation team in his school district for an assessment and placed in a neighborhood preschool. Terminating treatment with solid neighborhood and community supports in place made the fellow feel more assured that the family would continue to maintain the gains they had made.

An infant mental health perspective, on the other hand, placed more significance on improving the quality of Kim's interactions with Noah, and used reflection as a tool. Similar to the fellow's process with the supervising psychologist, the fellow encouraged Kim to observe her thoughts, feelings, and behaviors toward Noah and to contemplate Noah's internal experience. After Kim's substance abuse treatment stabilized, she was better able to reflect not only on her experience but on Noah's. Kim came to understand and appreciate how scary her "going-away" must have been for Noah and came to understand that his anger and defiance (as well as his clinginess) were expressions of his underlying worry. As Kim's understanding of Noah shifted, so did the quality of her responsiveness toward Noah. As a result, over time, Noah's apprehension released and his body quieted. The worms in his stomach were calm.

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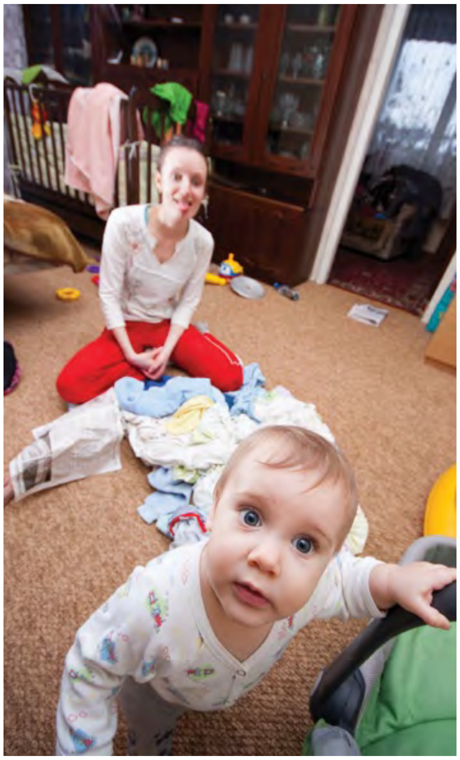

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The reflective process helps guide intervention.

Learn More

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youth in numerous summer camp and volunteer settings.

Marisa A. Murgolo, *LCSW, is the supervisor of Community Based Psychiatry at the University of Colorado Hospital in Aurora, CO. She is responsible for the administrative and clinical management of the four community-based programs: Rapid Response, Multisystemic Therapy, Intensive Family Therapy, and Early Childhood Intensive Family Therapy. Her interest in early childhood development and mental health stems from her prior work in child protection and family preservation, which focused on work with parents with substance abuse problems.*

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Errata

In the article “The Building Blocks for Implementing Reflective Supervision in an Early Childhood Mental Health Consultation Program” by Sherryl Scott Heller, Alison Steier, Rose Phillips, and Leah Eckley in the May 2013 issue, the second paragraph on page 25 should read as follows:

Hiring managers can learn more about what motivates an applicant and about his views on supervision, his approach to working out problems, and his capacity for perspective-taking by asking the applicant how he managed disagreements or disappointments with a supervisor, for example, or by asking him to speculate about what it is like to supervise or be supervised. Such a process offers clues about an applicant’s use of supervision as a secure base and a safe haven, or for his wish that something on that order had been available for support and collaborative problem-solving. Hiring managers also should be alert to signs that applicants show a long-standing preference for autonomy in their work, particularly if there are indications of equating supervision with regressive dependence (e.g., “I go to my supervisor when I have to, but I’m good at figuring things out for myself.” or “My supervisor had an open-door policy, but I didn’t need to go through the door very often.”).

Figuring It Out for the Child Initiative

Fostering Coparenting in Unmarried Expectant African American Parents

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Tanya, 5 months old, slumped in her infant seat, shifting her posture away from her father. "See, she'd rather be doing with you," James said. "She's just tired," Chandra, Tanya's mother responded. "She does that to me too." Chandra tried to reposition Tanya but Tanya was ready to end the interaction, protesting the adjustments.

The parents struggled a bit longer, then finally told Mari, the visit coordinator, "She's just too fussy to do this." "What would you like to do?" Mari replied. Chandra thought for a moment. "Maybe we can try this a different time," she responded. Picking up on her reticence, James chimed in "Yeah, when she gets like this she won't do anything except what she wants." He watched as Chandra removed Tanya, and said "Maybe she'd like her carrier better." "It's over there," Chandra replied. "She needs a nap, I think." Tanya calmed after making contact with Chandra's body and stopped struggling. James fetched the car seat.

A seemingly rather ordinary interaction, just 100 days after Tanya's birth—by a very extraordinary family. James and Chandra are both participants in "Figuring It Out for the Child" (FIOC), one of the nation's first intervention programs designed specifically for unmarried, largely non-co-residential expectant African American parents. Building on lessons from the federally funded Building Strong Families initiative but picking up in places where that project left off, FIOC helps young parents in so-called *fragile families* (unmarried, expectant parents in nonromantic relationships) to plan, practice, and take first steps toward creation of a supportive and sustained coparenting alliance for their child. The road is rarely an easy one. The excerpt that follows is a verbatim rendering of James and Chandra's prenatal intake session just 5 months before their triadic interaction with Tanya; at the time of intake, it was not at all clear whether James would even be around to see his daughter's first smile, rock her to sleep, or become enraptured as Tanya touched his face during en-face play.

It was a dreary late autumn evening. Chandra swiveled about in her chair, intentionally avoiding eye contact with James whenever the chair swung in his direction. James reclined back, body angled away from Chandra, hands clasped behind his head. They had just completed individual intake sessions with male and female assessment team members, and were now taking part in a problem-solving conversation about father

Abstract
Strong, positive coparenting alliances play adaptive functions in a wide variety of family systems. For unmarried, expectant parents in nonromantic relationships, impediments to developing a positive coparenting alliance are formidable. However, these obstacles must be overcome if unmarried fathers are to stay engaged and coparent their child together with their children's mothers. This article spotlights Figuring It Out for the Child (FIOC), a Brady Education Foundation-sponsored initiative for expectant unmarried first-time African American parents. FIOC builds on the expectant parents' often untapped and overlooked desires and resolve to create a positive life for their baby, and it helps them build bridges to communicate, collaborate, and address obstacles to coparenting—whether they are co-resident or not. The authors highlight the travels of one remarkable family through the FIOC intervention in this article.

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Gender-linked concerns over connectedness and autonomy are commonplace, if not universal among women and men during transitions to new parenthood.

involvement after the baby came. The parents had been introduced to the FIOC program by Chandra's Healthy Families worker. The FIOC recruitment specialist explained that during intake into the program researchers would gather background about their histories, lives, and relationship. But now in the throes of that assessment the struggles the parents had been having staying connected during the pregnancy came to the fore.

Chandra had pointedly asked James what his plan was for the family. "To make sure I have everything together and make sure y'all get taken care of," he responded. Chandra laughed sarcastically, "Well, you sure doing a good ol' job." James confessed "I'm not doing a good job right now, I'm trying." But this didn't reassure Chandra. She fired back, "Yea, I know you're not cause you ain't putting no effort into it. James, I done gave you how long? It's been 7 months. I told you and we even confirmed when I was–how many months along? So you had that long to do what you needed to do."

James sat forward. "What you mean? I was working at that time when you told me." Chandra clarified "You wasn't doing nothing though. You knew your job wasn't going the way you wanted it to go. And what you was doing? Sitting on your behind all day. If you wasn't sitting on your behind you was playing basketball or playing the game or you was out and about doing stuff that you don't need to be doing." "Like what?" James asked. "I don't know—you tell me," Chandra responded. "It ain't like you tell me what you be doing. Which you don't."

Clearly agitated, James replied "How about you? You are not always at home. Usually you be out too." Chandra retorted "Where? If I'm not with Sheree and I'm not with my mama and them, where else would I be?" James responded "You usually do your own thing. You always with somebody...." Chandra dug in her heels "Like what, James? You know I don't really go anywhere by myself. Why would I? And you already know who I always be with all the time."

Chandra began demeaning what she saw as James' fruitless routine every day, then upped the ante, "Well, here's how it is. I'm not comfortable with your people watching my baby." James replied in disbelief, "You're not comfortable with my people watching? You have so much trust in your people but you have a big ass issue with mine?" Chandra replied, "I'm not saying that. I'm saying from my point of view, I be hearing things about stuff y'all be doing I don't want my child around..." James interrupted, "What things you be hearing we be doing?" Chandra replied in a mocking tone, "James, what y'all doing? I'm smoking, I'm drinking. Y'all playing video games." James was visibly angry now. "I don't smoke anymore. I haven't smoked in 2 years," Chandra clarified, "But I'm just saying your people do." James told her "That's my little brother and them, so what?" Chandra shook her head "I don't want my child around that. I don't."

James tried one more time "Chandra, I already told them and let them know that, and you know that. So what are you talking about? You can't keep my baby from around my family." Chandra stopped swiveling her chair, "You wanna bet?" James replied incredulously, "Do I wanna bet? Are you serious? Like straight-up really are you being serious?" Chandra made eye contact for the first time "James, I'm fittin'a lay this out right now. The baby fittin'a have my last name. If I'm not around or if somebody else I don't know is around while you got my baby, it ain't even fittin'a go down." "What?" James asked, stunned. "The baby's having your last name?" Chandra replied defiantly, "Yea, oh yea I meant to tell you that." James raised his voice, "Oh, you meant to tell me that, after this whole time that the baby fittin'a have your last name. Like seriously, that's not even cool, dawg, like how you just keep things from me and don't tell me, that's not even cool."

From there, the conversation degenerated further, with raised voices, insults, and a tense exchange around finances that escalated when Chandra brought up the topic of child support. When James said he wasn't going to be put on child support because he planned to be there for their baby, Chandra told him that he had no say in that matter: "You can say you not going to court, but you best believe if Chandra don't get her money by the first of the month, Boo, you'll be sitting in jail."

Building a Coparenting Alliance: The Challenges

Notwithstanding the negative escalation, the early stages of this exchange echoed a common theme for many FIOC participants—and more broadly, many expectant parents regardless of marital status, race, or socioeconomic circumstance. A mother in her third trimester—craving but not receiving desired emotional reassurance and support from the baby's father, worrying if the father would be "there" for her after the baby's arrival. A father, his independence threatened as the birth drew nearer, seeking refuge with buddies, in the comfort and familiarity of video games and basketball, even sometimes through alcohol or recreational drug use. The gender-linked concerns over connectedness and autonomy are commonplace, if not universal among women and men during transitions to new parenthood. The conflict around emotional and financial support and fragility of the overall commitment to the family unit is especially pronounced in relationships like James and Chandra's. Their short and not-yet fully committed acquaintance prior to the pregnancy, lack of positive male role models in their family and social network, and lack of extended family support, coupled with joblessness, poverty, and the threat of potential child support enforcement that could remove father from the picture altogether impairs the expectant parents' ability to overcome these issues and commit to raise their child together. Chandra's threat regarding paternal financial support encapsulates so much of the anxiety and fear of the unknown that circulates around pregnancies in fragile families. That uncertainty effectively keeps fathers at arm's length, sporadically accessible during their babies' first year but not intensively enough involved to forge deep, enduring attachments with their infants.

Immediately following James and Chandra's tense conversation, project team members entered to help restore equilibrium, doing what they could to normalize the conflict and convey respect and encouragement to the parents for seeking an opportunity to address their differences. They then introduced the parents to their mentors, Shavon and Rashid. The mentors spent about half an hour talking to the parents one-on-one. They explained what would happen over the course of FIOC, and made appointments for follow-up one-on-one mentoring sessions before the formal intervention began. The mentors allowed the parents to decide how much to disclose about their personal circumstances during this initial encounter, appreciating that more substance would be disclosed during upcoming mentoring sessions once rapport and trust could be established. Rashid found James very motivated during this initial meeting, despite his stressful exchange with Chandra, and enthusiastic about scheduling a first mentoring session. Shavon found Chandra more reserved and guarded, but dutiful in scheduling an initial mentoring session.

In the coming weeks, the initial impressions the parents gave during the first encounter with the mentors were reinforced. James was an open book, sharing his pride in being a father-to-be, uncertainty about whether he was ready to take on such a role, affection toward Chandra but apprehension about her moodiness and propensity to turn on him and side with her family when they berated him, and hopefulness that FIOC could help them work out some of their frustrations. He acknowledged feeling much more at ease and at home with his brothers and friends, unsure about whether he'd be able to fulfill important aspirations (completing his GED, barber school), and perplexed by the push-pull he felt from Chandra despite his striving to be a stable presence and support in her life. Chandra was more enigmatic, disclosing details of her own family circumstances one day—such as the strained nature of her relationship with her mother and her grandmother's overprotective and dogged "gatekeeping" stance where James was concerned—then the next day denying that these relationship problems affected her at all and asserting that she was her own woman, needing no one. During this mentorship phase, both parents responded to calls or texts received from mentors or project staff within a few hours, further suggesting their commitment to participating in FIOC despite their challenges.

FIOC Intervention

The FIOC intervention, based on McHale and Irace's (2010) Focused Coparenting Consultation (FCC) model, is a three-stage process derivative of structural family theory (S. Minuchin, 1974). It differs from classical structural approaches however, in prioritizing as its first step the raising of parents' consciousness. Whereas insights in structural family therapy often follow from new experiences parents have in enacting different and more effective behavior, FCC aims to promote an active, intentional, and mindful commitment to coparent prior to skill-building and enactment phases. Interventionists help parents cultivate an understanding of the importance of allied coparenting. With the parents, they identify adverse effects of parental bitterness and disrespect on babies' emotional security and well-being, and untoward longer-term effects on child development and adjustment outside the family. Once a mindful awareness and commitment to coparent has increased, parents learn techniques for bringing up and civilly discussing differences, practice talking together about areas of contentiousness in their current relationship (with coaching from their mentors as needed), and finish the work with solidarity-building exercises.


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The opportunity to hear their baby's other parent talk about the meaning of their own father to them has been a bonding experience for many FIOC couples.

Session 1

By the time session 1 arrived, both mentors felt they were beginning to understand these soon-to-be parents a bit better. Despite the relationship contentiousness, Chandra's impulse to hold James at arm's length, and Chandra's family's negative view of James, the mentors had gotten the impression during their mentorship sessions that both parents genuinely wanted to do what was right by their baby. FIOC session 1 is a sit-down dinner, when the mother and father and the male and female mentor come together as a foursome for the first time. Neither mentor was quite sure what to expect in session 1, given the volatile couple interaction at the intake assessment. Following consultation with their FIOC supervisor, they had rehearsed in advance that they would stand ready to actively halt any exchange they saw escalating into harmful name-calling or disparagement. Both mentors would explain that the sessions would instead be a place where James and Chandra could reflect on and talk through their differences, in a calm and empathic manner. But as it turned out, such therapeutic maneuvers were not needed—in the presence of the mentors, both parents were engaged, modulated, even humorous and playful at times. Both Shavon and Rashid picked up on the humor as an asset the parents shared, using humor to lighten (but sometimes also avoid) intense discussions. Humor became a tool the mentors themselves sometimes used in the work. However, they also came to recognize that they themselves had to be careful so as not to join the parents in dismissing important issues by minimizing them through joking.

Session 2

Experiential exercises during FIOC session 2 pointedly address developmental outcomes for African American children without involved fathers. The session included discussions of graphic negative images and accounts of African Americans in the media, a discussion of people the parents know who did and did not have actively involved fathers, and a film in which children discuss how their lives would be different had their fathers been around. These exercises combined to evoke conscious and unconscious sentiments about both the fathers the parents had and the father they can together provide for their own infant. The opportunity to hear their baby's other parent talk about the meaning of their own father to them has been a bonding experience for many FIOC couples.

James found the images powerful and said that they reinforced his own commitment to being there for his daughter. But Chandra

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Coparenting in fragile families is not only possible, but vital, for promoting early family bonds, attachment, and cohesion.

had a different reaction. She found session 2 intense and her response was to close off and declare defiantly that the importance of fathers was over-rated. She had had little father engagement in her life, she pointed out, and she had turned out fine. Rather than challenging her, the mentors reframed her dismissing of the importance of fathers so as not to push on her defenses. They concurred that they too knew many people in the community who had landed on their feet despite not having had fathers around. They commended James on his commitment as a father and pointed out how challenging it was to think about being a dad without having had a father to serve as a role model. This drew Chandra in and she commented that James' father did sometimes make contact with him. She compared James' father to her own and wished that her father would reach out to her in a similar way as James' father had, lamenting that he had not been in touch with her since learning she was pregnant. James took this in, seeing Chandra vulnerable for the first time and, unbeknownst to anyone, formulated an action plan of his own.

Sessions 3 and 4

Sessions 3 and 4 were very challenging for James and Chandra. They mark the transition into FCC Phase 2, the cultivation of communication and problem-solving skills. Parents begin with an exercise in which mentors present several statements parents had rated from *strongly agree* to *strongly disagree* during their separate intake interviews. The parents then guess which items they did and did not agree upon. On an item concerning importance of a strong father for children to thrive, James strongly agreed while Chandra strongly disagreed. Their ensuing conversation bore some resemblance to the difficult exchange they had had at intake, albeit with less volatility. The mentors observed how both parents felt unheard, as an entrée to FIOC's reflective listening exercise. But they struggled mightily to persuade Chandra to partake in the exercise. James too was dubious, for each time it was Chandra's turn to reflect back what she had heard James say, she used the opportunity instead to comment on his failings.

The mentors recognized the pattern and stopped the criticisms each time they surfaced, but James grew annoyed. Noting this, the mentors elected to role play a discussion rather than ask the parents to try again. Rashid also mused that men often needed to seek time for themselves when they feared losing that part of their identity, and Shavon piggy-backed on Rashid's observations, noting she too had seen this in many families she worked with. The unscripted intervention was intended to validate James and to provide Chandra with an alternate perspective on James' behavior besides his lack of caring about Chandra's sensibilities. The parents agreed to try the reflective listening between sessions, but did not.

They struggled similarly in session 4, when the WIN technique (**W**hen you...**I** feel...I **N**eed you to...) was introduced. Again the mentors spent time alternatively defusing conflict, modeling proper use of the technique, empathizing with and validating both parents' experiences, and reiterating the importance of practicing techniques to accomplish the aims they had both established for their child.

Session 5

The parents cancelled session 5. Chandra responded to a reminder call the day of the session by saying she had been sick and did not feel up to coming. She agreed to reschedule for the usual meeting time the following week, and James too agreed to come. The mentors spent time during the ensuing week reviewing the events of the past two sessions, particularly Chandra's reluctance to engage in the communication exercises. They agreed to hold off on challenging her resistance and instead try to get her to attempt the exercise within parameters that felt comfortable and doable for her. FIOC session 5 is supposed to usher in the third stage of FCC, enactments of hot-button conflict issues using the new skills learned, with mentor coaching. But the mentors agreed that Chandra and James had already surged straight into hot-button issue discussions; what they needed to do was slow down to take things one issue at a time. They established an aim for session 5 of having each parent try to reflect back a sentiment they had heard one or more times to let the other know they'd been heard. The mentors would coach the couple through the exercise, actively stopping to intervene any time the parents started veering off track.

Upon returning for session 5, the parents' mood had changed. They were less on edge and more collaborative than in any prior session. This change in dynamic was due in part to James' having reached out independently to Chandra's father to talk to him about Chandra's pregnancy. Without betraying any confidences, James had persuaded the father to be in touch with Chandra, and the father had visited and brought her a baby carrier. This was the first gift Chandra remembered having received from her father, and she had clearly been moved by the gesture. Still, she distanced herself by poking fun at the color of the carrier and making some other mildly sarcastic remarks about James and about her father. But the tone was different and the jokes prompted laughter from James, rather than defensiveness. The parents were minimally successful at carrying out the communication exercises, which Chandra said she had to do her own way. She initially denied that they had practiced any of what they had learned as homework, but James corrected her and said they had at least been talking about things. Chandra did not dispute this.

Session 6

In FIOC session 6 (the final meeting before the birth), the two parents together outline shared goals for their child in written form, with mentors helping only as needed. The session closes with the parents being videotaped as they read a book together to their baby (a copy of which they receive during the FIOC booster session held after the baby's birth, along with a DVD of their book-reading, as a legacy to share with the child). Both parents were subdued during session 6, with the positive energy and collaborative spark of session 5 absent. The mentors were reminded of the ups-and-downs of these young people, and this became a discussion point during the session. The parents did complete the shared goals exercise, agreeing that they wanted their baby to finish high school, have a good life, and stay out of harm's way. The mentors admired again their mutual commitment to their baby and cautioned about more obstacles to overcome. The mentors were left with a sense of sadness as the parents parted, but provided encouraging words and a reminder that they would see them once more at a 1-month postnatal booster session. The parents were also to complete a satisfaction survey with the original intake team as part of a project research protocol.

Rather strikingly, during the satisfaction survey, both parents were introspective and very positive about their experiences in the intervention. Both said FIOC helped them immensely, and that they learned a great deal. Chandra said that it had helped her to hear others cast James' behavior in a different light. The mentors' reflections on how men cope with pregnancies gave Chandra a new way of looking at James and helped her to de-pathologize some of his behavior.

Follow-Up Visits

At the 1-month visit, Chandra and James arrived in separate cabs from their separate residences. Chandra had Tanya in the carrier Chandra's father had bought her. The parents discussed their ongoing issues with James' access to Tanya—Chandra had moved out of her mother's house, and in with the grandmother who did not like James. James had spent relatively little time with Tanya, but Chandra called him regularly, and often put Tanya on the phone at night to hear her father's voice. She also discussed an emergency when she had no one to look after Tanya and had called James. He came immediately, and spent the day caring for Tanya. The mentors observed that Tanya had spent most of the session at Chandra's side, and asked whether she would feel comfortable with James holding the baby. Chandra initially hesitated but took Tanya from her car seat and handed her to James. He held her close to his chest, and within minutes she had fallen asleep. The conversation continued for another 20 minutes before the mentors began to wrap up this final contact with the family. They complimented the parents having kept their commitment, staying in touch, and making sure Tanya knew her father. They encouraged their efforts to coparent, and told them they would be contacted one last time, by the research team, for a 3-month postpartum visit. They shared hugs and an affectionate good-bye.

It was 2 months later now, and Chandra and James occupied the same chairs as several months ago when they had had their heated exchange about father access. James began this time. "So we should talk." Characteristically, Chandra came on brusquely, "OK, so listen. Tanya's too young. She's still too young. Done. There your answer. I'm so tired of repeating myself." James sighed "Well, my answer is, uh… I will cope with that, I will understand but I would like to see her more often …." Chandra softened, slightly "Well you know I try to." James nodded, "Yeah, I know that's one of the things we trying to work on and I know it's the transportation thing." Chandra sat forward "See. See, at least you know I'm trying." "I know," James replied, "At least it isn't like last time because I would have been snapped on by you. 'You ain't seeing your child because I said so.' I would like to see her more often, though, even if we have to do it together." Chandra thought for a moment "I hear you. OK, I understand we got to work together with the baby but as far as you sometimes keeping her all day, that's something we really got to work on though. Like, you can keep her maybe 2 to 4 hours because keeping her all day now is not working, 'cause I'm trying to get this little thing to stop having her mood swings and she has different mood swings. Like if my grandma wasn't trippin', if you was at my house more it would be a different story. So you can understand how she be acting. And you'll know if she be faking, if she really serious." James replied "But that's one of the things I don't know because I'm not around." Chandra concurred, "That's what I'm saying. I said if my grandma wasn't trippin'…." James nodded "But we'll work something out, we'll see."

A decidedly different exchange, Chandra pointing out that James was not yet familiar enough with the baby's rhythms to read her properly, especially for extended periods. James asserting that he wanted to become more sensitive to understanding the baby's signals and that, with more time and experience, he believed this would happen. Both agreed that Grandma presented an impediment they would need to continue to talk about together. Mari, the visit coordinator, soon returned with Tanya, who had been in the next room during her parents' conversation. After spending some time talking with the parents, Mari had them attempt the Lausanne Trilogue Play (LTP) interaction. In the LTP, Tanya was to play first with one parent while the second was just present. Then the parents were to switch roles, with the previously active parent moving into the third-party position. In part 3 all family members were to play together, and in a final part the parents were to engage together with Tanya placed in the third-party position. Tanya negotiated part 1 with her mother adequately, alternately smiling and signaling some fatigue and protest. But part 2 with her father went less well, as Tanya slumped in her seat and shifted posturally away from her father. When James interpreted the signal as Tanya's preference for Chandra, Chandra explained that Tanya was just tired, and that her behavior wasn't directed differentially toward James, "She does that to me too". Together, the parents decided to acquiesce to Tanya's signs of discomfort and prematurely

Learn More

The Interpersonal Context of Early Childhood Development: A Systemic Approach to Infant-Family Assessment
J. McHale & S. Dickstein (in press)
In R. DelCarmen Wiggins & A. Carter (Eds.)
The Oxford handbook of infant, toddler, and preschool mental health assessment (2nd ed.).
New York, NY: Oxford Press.
A new framework for conceptualizing and evaluating coparent and family system dynamics during infant-family mental health assessments.

Coparenting Interventions for Fragile Families: What Do We Know and Where Do We Need to Go Next?
J. McHale, M. Waller, & J. Pearson (2012). Family Process, *51, 284–306.*
A review of the literature concerning earlier efforts that sought to encourage fragile family coparenting, with commentary about needed paths ahead.

Charting the Bumpy Road of Coparenthood: Understanding the Challenges of Family Life
J. McHale (2007)
Washington, DC: ZERO TO THREE.
A detailed summary of the first major research investigation to focus specifically on how coparenting alliances evolve in middle-income two-parent families, from pregnancy through the toddler years. Written in a style appropriate for parents as well as for professionals.

To learn more about the FIOC project, visit:
www.usfsp.edu/fsc/research/figuring-it-out-for-the-child

end the interaction. Clinically, there was much of meaning to decipher from a formal "reading" of the LTP (Fivaz-Depeursinge, Cairo, Scaiola, & Favez, 2012), but most noteworthy to the team was James and Chandra's coparenting decision to assist their baby by settling her in her more familiar and comfortable car seat.

A rather ordinary interaction—but one that may never have eventuated without James and Chandra having come together at a vulnerable point in the pregnancy to begin the process of co-creating a coparenting alliance. Such ventures have been rare in infant–family mental health practice. They are made possible only through practitioners' assumption of a triadic lens (McHale, 2007), view of fathers as equal partners in the baby's life, and conviction that the child's life chances will be improved by a sound and enduring "primary triangle" (Fivaz-Depeursinge & Corboz-Warnery, 1999). We have been struck by the openness and thirst of both mothers and fathers during the pregnancy to "do the right thing" by their child; James and Chandra's evolving story is one that affirms that coparenting in fragile families is not only possible, but vital, for promoting early family bonds, attachment, and cohesion—all harbingers of positive long-term benefits for young children.

James P. McHale, *PhD, is professor and chair of the Department of Psychology and director of the Family Study Center at the University of South Florida St. Petersburg. A family therapist by training, he trained in both Palo Alto and Philadelphia and is a past director of clinical training of Clark University's clinical psychology program. His research studies of coparenting have been funded since 1996 by the National Institute of Mental Health, National Institute of Child Health and Development, and Brady Education Foundation. In 2004, he was the World Association for Infant Mental Health's "Decade of Behavior" lecturer, and in 2007 delivered ZERO TO THREE's special address on coparenting in diverse families at the National Training Institute. He received the Irving B. Harris Award for his 2007 book* Charting the Bumpy Road of Coparenthood, *and his 2011 book* Coparenting: A Conceptual and Clinical Examination of Family Systems *(with Kristen Lindahl) is the field's first comprehensive look at research on coparenting in diverse family systems. Dr. McHale is also past president of the Florida Association for Infant Mental Health and serves as principal investigator for the Figuring It Out for the Child project.*

Vikki Gaskin-Butler, *PhD, MDiv, is instructor of psychology and recipient of the 2012 Clinical Teaching Award at the University of South Florida St. Petersburg. She is co-investigator, clinical supervisor, and project safety officer for the FIOC project, and provides oversight of fidelity monitoring for mentor adherence to the FIOC curriculum, which she codeveloped. A significant portion of her professional practice has been devoted to work with African American individuals, couples, and families, including provision of administrative oversight for clinical operations when with the Samaritan Counseling Center of Northeast Georgia, an interfaith-based counseling center. In preparatory work for the FIOC project, she codirected a research initiative with Mt. Zion Human Services, partner and collaborator on the FIOC project, documenting the prenatal expectancies of first-time African American mothers about postnatal coparenting. Findings from that initiative appeared in a special September 2012 section of the journal* Family Process *concerning coparenting in fragile families.*

Katherine McKay, *PhD, is a clinical psychologist and private practitioner (LLC), and is an affiliate with Bay Pines Veterans Administration Medical Center, and Eckerd College's Leadership Development Institute. She has had extensive experience in working with couples and families, and she serves as a clinical supervisor for the FIOC project. Her work in helping to refine the training of the health educators, pastoral counselors, and paraprofessional lay professionals who serve as FIOC mentors in order that they might effectively blend couples intervention techniques with their (more familiar) psychoeducational and individual counseling skills when delivering the FIOC curriculum has been instrumental in promoting clinically competent delivery of the intervention.*

Gypsy Gallardo *is CEO of The Power Broker Media Group and holds a master in public policy from Harvard University's Kennedy School of Government. Over the course of two decades she has developed and codeveloped leading-edge models that help make measurable progress on issues that disproportionately and stubbornly impact African Americans. Besides her involvement as a lead developer of the initial version of the Figuring It Out for the Child (FIOC) curriculum, she is also codeveloper of an award-winning model for financing commercial development projects in inner-city communities and is founder of The Village Corporation. She also designed a media platform that launched the longest-surviving, most widely-circulated magazine and e-zine targeting Tampa Bay's African American community; co-founded The PACT (People Advocating Change Together), which includes a school-level model for closing the achievement gap, and served as lead organizer of the Seven x 7 movement, which grew to become the largest faith-based coalition ever forged in Pinellas County, Florida. Her contributions in helping to bring word of the FIOC mission and message to African American community leaders and families helped fortify its message and guide many future coparents to learn about the initiative.*

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"Depressia" in Post-Katrina New Orleans

Cultural and Contextual Adaptations to Group Interpersonal Psychotherapy

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This story takes place in post Hurricane Katrina New Orleans where Desiree (names changed) was then a 20-year-old mother of two infants, ages 19 and 2 months. Neither of the girls' fathers was active in their lives, and the father of the newborn was incarcerated on assault charges. Desiree initially came to the Healthy Start New Orleans (HSNO) Clinic looking for housing and employment assistance. The city was still struggling following Hurricane Katrina with a lack of affordable housing, unreliable public transportation, and very few employment opportunities. Desiree and her girls were living with various relatives and friends, typically being told to leave within days or weeks, unsure of to whom they would turn next. Desiree did not complete her high school education and hoped to earn her GED one day. Until then, Desiree was struggling to obtain even a minimum wage position, as such jobs in post-Katrina New Orleans were scarce and she had trouble finding child care so that she could attend job interviews. She was HIV-positive and medically noncompliant with her prescriptions because of a lack of funds, stress, and a chaotic lifestyle. Desiree had a façade of a tough, laissez-faire, and upbeat person, but upon having a chance to tell her story, revealed a deep depression and numerous concerns about the short- and long-term future. Desiree did not seek mental health services, but was referred by her HSNO case manager because of a positive score on a depression screening test. Initially, she had been leery of her counselor, whom she and the other clients referred to as "Ms. Tracy." Desiree stated at termination from therapy that the initial phone call from Ms. Tracy was the first time anyone had asked her, "How are you feeling?" She added, "Not even my mama had ever asked me how I was feeling; why would some lady I've never met care how I was doing?"

Mental Health Care in Post-Katrina New Orleans

At the time of this intervention HSNO served all pregnant and postpartum women (i.e., within 2 years of childbirth) in the Greater New Orleans area. Women were referred to HSNO via their

Abstract

Postpartum depression (PPD) affects a significant portion of women and has serious negative short- and long-term consequences for the woman, infant, and family. This article highlights the feasibility and acceptability of group interpersonal psychotherapy (IPT-G), a manualized approach to PPD treatment, with a high risk and underserved sample of postpartum women in post-Katrina New Orleans. The authors highlight the modifications made to the IPT-G approach for cultural and contextual reasons and consider factors in treatment selection and implementation.

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Clients commonly reported feelings of isolation and lack of social support in post-Katrina New Orleans, where so many in the community were missing the extended family networks they had relied upon for aid, child care, and financial assistance.

friends, family, physicians, or are self-referred via knowledge gained from community outreach programs. The adult clients served by HSNO were over 90% African American women with an average age in the 20s. Many of the clients were unpartnered and most were unmarried. Fathers occasionally attended the program to support their partners or to receive case management services such as assistance with employment or housing. Many of the HSNO clients lived "pillar to post" (i.e., a colloquialism for those living without knowledge of how long they will be able to remain in their current housing or at the home of friends and family). A majority of the clients had less than a high school education (i.e., either currently enrolled in high school when pregnant or postpartum, or having left high school for a variety of reasons, often related to lack of child care). That the intervention took place within 2 years of Hurricane Katrina and its aftermath complicated each of the risks outlined above.

Healthy Start was founded to be a federally funded program, eventually serving more than 100 sites in the United States, that was designed to prevent infant mortality. The program promotes prenatal and postpartum care primarily through a community-based case management model. Each Healthy Start office worked to foster the development of comprehensive interventions for mothers and their infants that address financial, social, emotional, and physical concerns. Specific foci of interventions included reduced rates of negative perinatal consequences (e.g., infant mortality and low birth weight), as well as lessened racial disparities in outcomes. Primary services provided by Healthy Start clinics included counseling to aid the adjustment to parenting, parenting classes, housing assistance, and employment assistance.

Because of the high level of risk in the population served and the lack of general as well as specialized mental health services, the Louisiana Office of Public Health and HSNO collaborated to create the Perinatal Depression Program. This program, which was funded by the Health Resources and Services Administration after Hurricane Katrina, was designed to provide direct services to pregnant and postpartum women who were suffering or at risk for perinatal depression and their infants up to 2 years old. All women were screened for symptoms of postpartum depression (PPD) at the time of entry into the program, using the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987). Those women with EPDS scores greater than the standard cut score of 12 were provided a referral to an on-site emotional wellness counselor, a title used to allay concerns about stigma. Thus, while the majority of HSNO clients were not seeking mental health services when they enrolled in the program, the emotional wellness counselor was described as being part of the range of services available through HSNO. On average, 5 to 12 HSNO clients were referred to the Perinatal Depression Program per week. The identified referral group of HSNO clients was in heightened need of depression treatment and social support because of rampant social isolation and deficient mental health care within their inner-city communities. Prior to the intervention described below, HSNO clients experiencing significant depressive symptoms were offered individual counseling, but manualized or group treatments were not typically provided.

As described in Desiree's case and as observed by the first author, the cultural climate of the clients of HSNO was such that there was reticence to discuss emotional issues and a reluctance to engage with mental health providers and services. Nevertheless, the response of clients to being offered services depended on the process by which the intervention was introduced and on the agency's culture, which imbedded emotional wellness as an important part of the program. As mentioned above, the client's case manager initially screened the client using a simple screen for PPD, the EPDS (Cox et al., 1987). If the client endorsed significant depressive symptomatology or any suicidal or homicidal ideation, the case manager walked the client down the hall to the emotional wellness counselor's office as an introduction. This bridging of services and providers seemed greatly beneficial to clients' interest in and attendance at sessions. Via their already established rapport with their clients, the case managers gave credence to the counselor as a trusted source and to the therapy as a useful service for the clients. When the counselor was unavailable, the client's information was provided to her without a face-to-face introduction, so a "cold call" to the client to discuss services was often warranted. The cold call method was wrought with complications as many clients were reluctant to talk to a stranger about their mental health, well-being, and particularly, their possible depression. The counselor's observations of potential clients' brusque responses to phone calls from a mental health professional (including being hung up on numerous times) sparked her exploration of alternative ways to approach clients regarding their depressive symptoms and overall mental health.

At the time of the intervention, the counselor was the only psychologist on the regular staff and was available 15 hours per week in this setting. As the only Caucasian counselor in the clinic at the time of the intervention, her presence added a significant dimension to the cultural context. Cultural differences were further illuminated because she moved to the area after Hurricane Katrina and had not personally experienced the traumatic event that shaped the city as well as the psyches of the clients. The power and cultural differentials that existed between her and her potential clients were readily apparent. The counselor was acutely aware of her status as a white woman from the North—occasionally referred to as a "Yankee" by clients and neighbors alike. However, as a then-single mother in her 20s living apart from family and friends, she also felt a connection with many of the struggles the women faced and drew upon those similarities to enhance her empathic understanding of their situations.

The Landscape of New Orleans Following Hurricane Katrina

The mental health landscape in New Orleans in the aftermath of Hurricane Katrina was bleak. Following the storm, several studies indicated that the incidence of mental health illnesses doubled in the region. Symptoms were apparent in individuals of all ages, including very young children (Kessler et al., 2008; Scheeringa & Zeanah, 2008; Weems et al., 2007). Posttraumatic stress disorder, depression, and anxiety were the most common presenting problems. The number of distress calls to the New Orleans Police Department's Mobile Crisis Unit was 150–180 calls a month, roughly 5–6 a day, and the annualized suicide rate in New Orleans jumped precipitously. Prior to Katrina, the annualized rate was 9 per 100,000 residents, but following the hurricane, it was 26 per 100,000 residents. Moreover, this figure is likely an underestimate due to some suicides being unclassified or described as accidents (Penix, 2006).

While the need for mental health services doubled, the availability and accessibility of resources were greatly reduced. In July 2007, 50–80% of the city's mental health professionals had left. Outside of university faculty, there were only 22 psychiatrists in private practice in Greater New Orleans, and many of them did not see uninsured or indigent patients (D'Antonio, 2009). One year post-Katrina, only half of the major hospitals that were available prior to the storm were operating. Of central importance, the Medical Center of Louisiana—New Orleans, referred to by locals as "Charity Hospital," which for generations had provided care to the uninsured and indigent population, was shuttered. Prior to Katrina, Charity Hospital had 97 psychiatric inpatient beds and provided care to approximately half of the patients who had psychiatric illnesses in the New Orleans area. One year after Katrina, the city had 60 hospital beds for chronic and severe psychiatric patients, but only 10 of which could be reimbursed through Medicaid (Liu, Fellowes, & Mabanta, 2006) and none of which were available to pregnant women.

Furthermore, parents had fewer resources and available support for caring for their children. The number of child care centers open in Greater New Orleans prior to Katrina was 266; the number of open centers following the storm (in July 2006) was 52; 80% of licensed child care centers had closed (Falgoust, 2007). Thus, the dearth of resources for families with young children, and particularly for single mothers, was alarming. Even so, the absence of traditional services likely enhanced parents' use of alternative programs, including those such as Healthy Start.

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The Intervention

Many of the HSNO clients had significant symptoms of PPD. There were numerous evidenced-based treatments that could have been suitable for use with clients experiencing PPD, however, how malleable these treatments were to the cultural context of the clients and setting varied widely. Once the counselor established a general understanding of the HSNO clinic and clientele, the counselor wondered what approaches to working with depressed women would prove most effective in this context.

Interpersonal psychotherapy (IPT; Klerman, Weissman, Rounsaville, & Chevron, 1984) was a clear treatment choice because of its demonstrated efficacy with major depression and PPD, specifically (Clark, Tlucek, & Wenzel, 2003; Elkin et al., 1989; O'Hara, Stuart, & Gorman, 2000). IPT also emphasized role transitions and social support, and it featured a time-limited course. IPT was developed as an individual treatment approach that focuses on issues pertinent to depression as well as the antenatal and postpartum period (i.e., role transitions, grief or loss, interpersonal sensitivities, and interpersonal disputes). IPT was later modified as a group approach for the treatment of other disorders (Wilfley, Mackenzie, Welch, Ayres, & Weissman, 2000) as well as specifically for use with postpartum depression (Reay, Fisher, Robertson, Adams, & Owen, 2006; Reay et al., 2012).

Clinical observations of the presenting issues HSNO clients faced also weighed heavily on the counselor's therapy selection process. Clients commonly reported feelings of isolation and lack of social support in post-Katrina New Orleans, where so many in the community were missing the extended family networks they had relied upon for aid, child care, and financial assistance. Clients expressed desires for discussions with a here-and-now focus, emphasizing current difficulties, especially social support or lack thereof given changed social structures. The clients also repeatedly expressed the desire to quickly reduce symptoms. The goals of IPT were therefore a good fit for the HSNO women as they included decreasing symptoms of depression first and foremost, improving interpersonal functioning by enhancing communication in significant relationships, resolving acute interpersonal crises, and bolstering social support.

The time-limited nature of IPT was also seen as a benefit as many of the women desired an approach that did not entail long-term follow-up because of numerous barriers to treatment including inconsistent transportation, child care, housing, and other issues. In addition, in IPT the therapist was seen as a client advocate, working with the client who is personally responsible for the direction and nature of change. The


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Following Hurricane Katrina, the dearth of resources for families with young children, and particularly for single mothers, was alarming.

therapist as advocate model seemed one that could empower the clients to enact lasting change in themselves and was therefore seen as a strength to the approach for this population. Finally, the therapist's stance in IPT was active, supportive, directive, and nontransferential in nature, qualities that resonated with the clients at HSNO.

With the treatment modality identified, the counselor began to recruit clients. However, with the high volume of referrals received, she quickly realized that the need would overwhelm her availability. Given the goodness of fit of IPT for our population and the influx of referrals for treatment, we decided to modify a new group form of IPT to be culturally sensitive to our milieu. The group program, IPT-G, was originally created in Australia (Reay et al., 2006; Reay et al., 2012). As outlined by Reay et al. (2006), group treatment provided several potential advantages for postpartum women over and above those of individual treatment approaches including: an interpersonal context which encourages bolstering of women's social support networks, generalization of interpersonal skills developed in therapy, normalization of PPD through discussions with other pregnant and postpartum women, and reduction of the stigma of mental illness or receiving treatment. Of course, group treatment for perinatal women also featured the benefits of being cost- and time-efficient. The group modality fostered more frequent and thorough treatment of a greater number of women than individual psychotherapy could, particularly in a climate of limited mental health professionals and resources (Reay et al., 2006).

IPT-G Structure

Dr. Reay and her colleagues designed their IPT-G approach as an interpersonal laboratory in which members could learn from one another via modeling, social reinforcement, brainstorming, and universality of experience. The structure of the IPT-G approach included two hour-long individual sessions at the time of referral. These sessions were used to more fully assess the client's goodness of fit for the group depending on their symptom pattern, their lack of additional severe mental illness, and their expressed interest in talking about their experiences in a group. The counselor screened potential participants for eligibility using the Mini International Neuropsychiatric Interview (Sheehan et al., 1997), a comprehensive tool used to identify clinically significant symptoms across a number of mental health diagnoses. In order to facilitate group cohesion and enable optimal therapeutic outcome, the Mini Interview was used to exclude women who met criteria for psychotic disorders, bipolar disorders, personality disorders, or a combination of these. Those who were excluded were offered individual therapy instead.

The assessment sessions were also used to obtain genograms (i.e., family trees) and Interpersonal Inventories (Klerman et al., 1984), which painted a picture of the client's closest relationships, lack thereof, or interpersonal strains in their support systems. The Interpersonal Inventory gleaned the client's account of her current difficulties in relationships, including examples of problematic interactions, communication problems, and resolution of problems. It also facilitated the therapist's understanding of the client's expectations for her relationships. During the Interpersonal Inventory, the therapist attended to the client's communication style (e.g., abrupt, expansive), clarity, focus and ability to self-reflect, and typical patterns of interactions with others as well as the content of the responses. By the end of the Interpersonal Inventory, the therapist and client agreed on the interpersonal issues that would be their foci in the group sessions. Individual sessions therefore set the stage for the group treatment as well as provided an ideal opportunity for the therapist to establish rapport and to get to know each woman, her strengths, and her presenting complaints, prior to the group session.

The IPT-G approach set forth many ideal conditions for provision of treatment. The IPT-G format of services included eight 2-hour long group sessions. In composing the group, the counselor attempted to gather participants who shared a common complaint (e.g., PPD). An ideal number of group members was described as being between 6 and 10 so that each client would have time to speak during each session. The clients also ideally started the group together and committed to all eight sessions in order to maintain cohesiveness among the participants.

IPT-G delineated four stages to the approach, each with different foci and goals. In phase one, engagement, the focus was described as establishing the group's common purposes and encouraging a collaborative approach to addressing the clients' concerns and symptoms. The counselor's job during engagement was to construct a space where confidentiality was established and to create a structure where appropriate self-disclosure was encouraged. The remaining stages were described as when much of the interpersonal work of the group was accomplished. Phase two, differentiation, was defined as when individuals' issues emerge, conflicts occurring within and outside the group are processed, and roles develop within the group. The counselor's role was to help group members understand how these dynamics unfold both in and outside the sessions. Phase three, interpersonal work, was designed to be when individuals' area(s) of focus are delved into deeper and when group members learn from one another via modeling, social reinforcement, and role-playing. During interpersonal work, the counselor would facilitate connections between group members and support attempts at change.

Termination, the final phase, was defined as when the clients' senses of loss and potential increases in symptoms would be discussed. The counselor's role was to summarize individual and group progress, highlight tools to be used in the future, and provide support and psychoeducation around termination.

Lessons Learned

Throughout the planning and implementation of the IPT-G approach within HSNO our team frequently discussed how to make the treatment more culturally relevant and accessible to clients without hindering its effectiveness. We considered the limitations and areas of poor fit for the HSNO population and made relevant revisions when appropriate. We also encountered a number of practical barriers that required creative responding in a timely manner.

Client Engagement

A foreseen challenge to therapeutic investment and progress during the engagement phase was how to introduce and discuss in-depth the concept of depression. Cold calls to potential Healthy Start clients often ended abruptly when the counselor mentioned the word "depression." It was interesting that, following the individual sessions in which depression was discussed openly and demystified as being a name for what the women were already experiencing, the topic of getting to know depression was broached early in treatment and the group appeared ready to discuss it at length in fascinating ways. The IPT-G manual suggested introducing the concept by drawing a diagram of a woman on a board and having clients write the signs and symptoms of depression on the diagram where they are felt (i.e., sadness might be drawn on the heart, head, or both). The women in the group really took to this exercise and named their diagrammed woman "Depressia." By talking about how Depressia was feeling they were able to depersonalize the experience enough to first identify a variety of physical, cognitive, and emotional symptoms of depression. The group members then discussed which symptoms they had each experienced.

As mentioned above, one of the counselor's primary jobs during the engagement phase was to promote appropriate self-disclosure through maintenance of structure and boundaries. This proved difficult with the HSNO group, as many of the women had no prior experience with therapy. The discussions often slid into casual conversation and left the counselor wondering how to bring back the focus without hindering group process and rapport. For example, women would frequently discuss relationship issues with their partners that were fruitful and on-topic, but at times these discussions would deteriorate into heated disparagement of men in general. The counselor had to gauge when the discussion was becoming unproductive and when it was appropriate to intervene in a manner which did not chastise, harm rapport, or hinder continued disclosures.

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Practical Barriers and Attempted Solutions

The group faced difficulties with fidelity, including missed appointments by members, withdrawals prior to attending, and women referred once the group was in progress. Unfortunately, we could not be sure of the reasons why some women withdrew from the group prior to attending, as these women were extremely difficult to contact or connect with. For those enrolled, one consistent reason for poor or scattered attendance was difficulty getting downtown to the clinic, as all of the group members and most of the HSNO clients lacked reliable transportation. The women relied on cab vouchers provided by HSNO or on public transportation that was unreliable at best in the years following Hurricane Katrina.

There were additional barriers to engaging the HSNO clients in IPT-G. One was a pervasive difficulty contacting women throughout the duration of the group sessions. In post-Katrina New Orleans, many low-income individuals, including our clients, were living with whoever could take them in that night or week, and they changed cell phone numbers frequently. Therefore, secondary and tertiary contacts often had little knowledge of how to contact the women when their cell phones were disconnected. Difficulty connecting with clients between sessions therefore complicated confirming appointments and arranging transportation, likely contributing to inconsistent attendance.

Given that referrals continued to be made after the first group session, some by the group members themselves, we decided to include women who entered the group within the first two sessions, providing them with an overview of what they had missed during extended individual sessions. This approach went against the recommendation of the manual to close the group after session one. It also proved to be less than ideal, both for the individuals who had missed some information and for the group who had begun to establish a cohort. However, within this context, it was a solution to the increasing demand for group entry once word spread among social workers, case managers, and clients alike. Despite the potential drawbacks, no long-term negative effects on the individuals or the group were noted, and they quickly established a rapport.

As a third complication, none of the women had access to reliable child care for their infants or older children, so we enlisted undergraduate student volunteers to provide child care. The volunteers were generally reliable, but also overwhelmed by the number of children present or the varied age ranges of the children. The volunteers were occasionally so overwhelmed that the children needed to join the group in session, which, although informative from the perspective of being able to observe parenting, was also distracting to the group's dynamics and went against the manual's recommendations.

Finally, the group also struggled with employment conflicts to attendance. This barrier was seen as a double-edged sword as so many of our group members had an initial goal of employment. For example, after one of the clients obtained employment, her new boss was unwilling to allow her to attend weekly sessions that conflicted with her work hours. As a testament to her commitment to the group, she scheduled her break for our group time and called in on her cell phone from a work restroom. However, not all of our clients were so enterprising or inventive and had to miss sessions when they conflicted with work schedules.

Modifications to the Manual

There were various points at which we deemed it necessary to diverge from the IPT-G manual because of cultural considerations. The IPT-G program was developed in Australia with a predominantly middle or upper-middle class, well-educated, Caucasian sample. Many exercises and clinical examples in the manual needed to be rephrased or edited to reflect the experiences of our African American, low socioeconomic status, unpartnered, urban New Orleans group of women. For example, an exercise in the manual posed a situation to the group in which a mother is initiating a role transition via obtaining a promotion at work. For most of our women, employment was something they were striving toward or could not imagine achieving because of their other responsibilities. Therefore, we deemed it necessary to alter the exercise to that of a role transition in which a woman was obtaining employment for the first time since having her child. In this manner, we sought to make the exercises more accessible to our group, with the goal of facilitating rather than possibly stunting communication and learning among members.

A particularly salient example of cultural variance came in the form of a partners' evening that was included within the manualized treatment, designed to enhance the partners' understanding of PPD. As many of the women in the group did not have identified or stable partners, we invited any significant other the woman chose as a parenting partner, including sisters, mothers, cousins, and closest friends. Despite numerous attempts to schedule this evening for the broader group of identified parenting partners, the majority of invitees declined for various reasons, further emphasizing the lack of social support and difficult circumstances these women and their family and friends faced. Instead, a "termination celebration" for the women was an agreed-upon substitution for the partners' night.

As an additional complication not addressed in the IPT-G manual, the stressors experienced by women in the group consistently went above and beyond their depression symptoms. Over and above relationship difficulties with loved ones, these women were struggling with trauma-related grief and adjustment issues post-Katrina (all six women); unemployment (five women); parenting partners' imprisonment (two women); positive HIV status (one woman); lack of financial, emotional and child care support (all six women); as well as extreme isolation (all six women). In addition, one woman disclosed current domestic violence during session six of the group. The counselor sought supervision around how to handle this disclosure through the group process, as IPT-G does not specifically address domestic violence. The counselor and her supervisors decided to stray from the manual's next session format in order to include psychoeducation around domestic violence and safety. In so doing, we decided that the heightened degree of severity of our cases and the atypical circumstance of working with PPD in a severely traumatized region required adjusting the foci of the sessions such that they took into account the women's experiences. We also began to look at IPT-G as a first step of treatment that for many of our clients would require additional, more intensive therapeutic services after group completion. For relationship-fragile clients such as ours with numerous barriers to seeking and remaining in therapy, a positive experience such as a supportive group could be thought of as an important step toward seeking services for themselves or their children later.

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Learn More

Postpartum Support International
www.postpartum.net
Information about postpartum mood disorders as well as resources and referrals.

Interpersonal Psychotherapy and Training Opportunities
http://interpersonalpsychotherapy.org/

Interpersonal Psychotherapy: A Clinician's Guide
S. Stuart & M. Robertson (2012)
London, UK: Edward Arnold
For in-depth information regarding IPT as a treatment approach.

Recalling that many of the women faced primary concerns of social isolation and lack of support, it was remarkable that a few of the clients learned that they lived within blocks of one another. Plans for caring for each other and each other's children, sharing transportation, and meeting socially outside of the clinic began to emerge. Although group member contact outside of sessions was discouraged in the IPT-G manual, a modification seemed culturally and situationally important for this group, as the therapist's having stepped in to inhibit contact between members would not likely have been understood nor welcomed, thereby potentially harming rapport and trust. In addition, the decision not to intervene proved beneficial to the treatment in this case, as women often shared transportation to sessions, reminded one another of upcoming appointments, and provided emotional and physical support to one another.

The termination process for our group represented an especially salient deviation from the original IPT-G program. The counselor was moving out of the state after the group's end. As termination approached, she gave reminders about the upcoming end of the group and her move. Remarkably, given the initial lukewarm and often guarded reception to the counselor and the therapy, the women asked "Ms. Tracy" to extend the group until she left town (i.e., three additional sessions) as well as to include a graduation session/party to say good-bye. The counselor agreed to conduct the additional sessions, in part because all but one client had missed sessions and she saw the extended sessions as an opportunity to summarize and review the main points many women may have missed. This extension meant the group met 11 times for therapy and one time for the graduation party. At graduation, the counselor found it especially touching that the clients joked about renting a bus to come to where she would be for the group and planned for how they would continue to get together.

Outcomes and Reflections on the Group

As initially hoped, using a group approach was observed to be especially effective in reducing the stigma of depressive symptoms and diminishing the social barriers between the counselor and clients via the inclusion of other community women. This benefit began as early as the initial recruitment meeting or phone call when the counselor was able to describe the group as an opportunity for the client to discuss her situation with other new mothers from the community. Clients responded with enhanced interest in speaking with the therapist and, in particular, in learning about the group.

Unfortunately, because of the clinical nature of the group and clinic, as well as the lack of research funding available, little empirical data were obtained and Institutional Review Board consent for research was not applied for. As a summary of group progress, we could state that all but one woman improved to the point of no longer screening positive for depression on the EPDS by the end of the group. The woman who continued to endorse depressive symptomatology in the at-risk range had learned just prior to rescreening that her boyfriend (the father of her children) had been arrested on rape charges, therefore it is understandable that she would screen in the significant range at that time. Each member's progress in other areas of functioning during group treatment was arguably more important than the reduced depression scores. Women obtained employment (three women), became compliant with medication regimens (one woman), obtained housing (two women), made healthier relationship decisions with significant others in their lives (all six women), and felt support from other women in the group (all six women). Further, their demeanors during group went from those of being overwhelmed, sad, frustrated, and skeptical to being open-minded, lighthearted, and at ease.

As for Desiree, she obtained stable housing via support from HSNO early in her involvement in the group. After a few unsuccessful job interviews, she found stable employment in a local restaurant and had enrolled in GED courses by the time of the group's termination. Desiree secured stable child care with a relative who wanted to support her successful employment. She sought medical care and was taking her HIV prescriptions with increasing consistency. Her tough demeanor cracked on a number of occasions when sharing her story or listening to those of her group members. At least in the confines of our safe group space, she presented as more lively, friendly, and open than she had initially.

Desiree's story echoed those of the other courageous women from the group. Despite having left New Orleans and the group more than 4 years ago, the women and city remained in the counselor's daily thoughts. Perhaps their lasting influence on their counselor was due to the women representing personalized depictions of what their city was going through—depression, marginalization, isolation, neglect, trauma, and mistrust of outsiders. However, an equally likely alternative was of quite the opposite tone: that the women in this group, their commitment to self-improvement, resilience, and support for one another, embodied the spirit of rebirth in their city.

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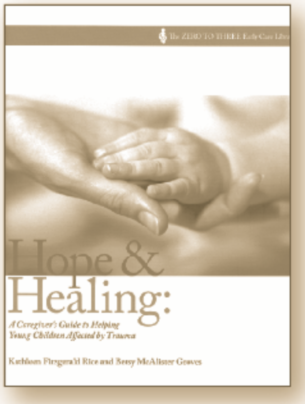

Everyday Miracles

Supporting Parents of Infants in Foster Care

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Abstract

This article describes a model for supporting parents and their infants during separations due to temporary foster care. Using a case example, the authors describe a model for visit coaching, including their process for assessment and strategies used for intervention. The lessons learned are: (a) that individual parents can present very differently when contextual risk factors are properly addressed; (b) that interventions need to target specific risk factors such as untreated mental health problems, unemployment, or housing problems before attachment-based interventions can be effective; and (c) attachment theory and practice has significant utility in supporting mothers and their infants in foster care.

The authors were enlisted to provide visit coaching to a mother, Sandra, 24 years old, and her 16-month-old daughter, Bonnie, who was in temporary foster care. Visit coaching (Beyer, 2008) is an increasingly popular approach that is frequently used with parents who have children who are in foster care. Visit coaching is fundamentally different from supervised visits because, instead of being confined to observing and reporting on the visit, a visit coach is actively involved in helping the parents demonstrate their best parenting skills (Beyer, 2008). We have found that the visit coaching model is equally effective in helping the parents of young children build or maintain a healthy attachment during separations or periods of infrequent contact that are often associated with stays in foster care. The goal of visit coaching with parents of infants in foster care is therefore twofold: (a) to help the parents overcome the parenting deficits that necessitated the child's removal, and (b) to preserve the primary attachment relationship during temporary foster care and thereby enhance the likelihood of successful family reunification.

The caseworker requested visit coaching because she was concerned that the visits were not going well; Bonnie was unusually irritable during visits with her mother, and Sandra had difficulty managing her own distress when Bonnie was upset. The caseworker was frustrated that little progress had been made on the issues that prompted Bonnie's removal and placement in foster care despite providing the mother with a range of services and supports over the previous year. The caseworker wondered if the mother was capable of caring for her baby full time if she couldn't cope with Bonnie and keep her calm for a short visit. Bonnie was reaching the court-imposed time limits for infants in foster care, which meant that soon a decision needed to be made regarding her permanent care. The looming deadline was causing the worker and Bonnie's mother to feel some pressure and urgency.

History

Bonnie was placed into foster care when Sandra was admitted to an in-patient mental health program for a week following a personal crisis (the breakup of Sandra's relationship with the baby's father). Sandra was discharged after a week with a referral for community counseling. Bonnie remained in foster care because Sandra was not stable—she was not coping with employment, was repeatedly getting evicted for nonpayment of rent, and was

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Individuals with a full balanced view of the child and of their relationship with the child are more likely to provide a detailed and coherent description of the child.

“couch surfing” with the baby (sleeping on friend’s couches).

A parenting assessment did not identify cognitive deficits that would preclude parenting. The report from the parenting assessor noted that the mother was anxious but not to an extent that should prevent her from parenting her baby. Sandra seemed motivated, yet the efforts to reunite her with her baby were stymied by one crisis after another. The child welfare worker said, “She just can’t seem to get her act together long enough for me to return the baby to her.” The worker and foster mother reported her concern that Bonnie was easily dysregulated during visits, meaning that she was easily upset, cried excessively on visits with her mother, and was difficult to soothe. The foster mother reported that Bonnie was much calmer and more manageable at the foster home, except following visits with her mother. She stated that Bonnie’s behavior, weight, and health improved during a 2-week period when visits were cancelled because of the mother’s hospital admission.

A community mental health counselor was counseling Sandra for anxiety, but Sandra’s instability was interfering with appointments and the therapist found her counseling sessions were diverted to address the latest crisis. Visits were a problem, too. Sandra’s job changes and evictions caused schedule changes that interfered with the visit routine. Sandra was cancelling at least one visit per week. The baby’s excessive crying elevated Sandra’s anxiety because she feared that visit supervisors and the foster mother were giving negative reports back to the child protection worker. Consequently, every time the baby cried, Sandra became extremely anxious and could not be a source of comfort for the baby. At the time of the referral the child welfare worker had set court dates to apply for permanent custody of Bonnie.

The Intervention

The authors were asked to provide visit coaching (see box Steps to Visit Coaching) to evaluate the problem further, to try to understand why this mother was having so much difficulty, and to see whether some of the concerns could be addressed with support during visits. We provide a visit coach who is in the room with the parent and a clinical supervisor who observes coaching sessions from behind a one-way mirror.

STEPS TO VISIT COACHING

Many experts have noted that parent skills and parent–child relationships do not improve simply by ensuring regular contact during foster care stays. Haight and colleagues (2003), for example, found that, without specific intervention, the quality of parent–child interactions during visits varied widely and the effect of visits on parent–child relationships also varied (Haight et al., 2003). At the same time, they noted that the attachment relationship is stressed by the separation itself. Careful assessment and intervention planning is therefore an essential first step in the coaching process.

Stance Toward Infants and Families

1. Gather social history—reason for coming into foster care, parent caregiving history, context of parent, family and community risk and protective factors.
2. Working Model of the Child Interview (WMCI; Zeanah & Benoit, 1995)—the WMCI yields rich clinical data on parental mindset and attitude toward the child and their relationship with the child.
3. Gather information on child vulnerabilities such as congenital risks, developmental status, or temperament. Developmental screening—Use the *Ages and Stages Developmental and Social Emotional Questionnaires* (Squires & Bricker, 2009) to screen for possible developmental delays and to identify social–emotional concerns.
4. Observe parent and child interaction—it is helpful to watch a comforting or nurturing moment, an interaction in which the parent must support the child to complete a task, and a “take charge” moment, or a moment when the parent must assert authority. Examples: Try to observe the parent when the child is hurt, ill, or distressed. Watch the parent assist the child with a task that is beyond the child’s ability and observe a task that requires compliance and cooperation between the parent and child such as a clean up activity (when age-appropriate).
5. Identify the goals of coaching and identify the expected parental behaviors.
6. Develop strategies to improve parenting skills. Some examples:
   a. Deficit: cue reading. Strategy: the coach can speak for the child (i.e., wonder aloud what the child is thinking or feeling).
   b. Deficit: parent is intrusive or frightening. Strategy: child lead play or learning to follow the child’s lead in play (Wieder & Greenspan, 2003). The coach can encourage the parent to let the child direct the play and wait for an invitation to join the play; the coach can help the parent minimize rules or interference.
   c. Deficit: parent has difficulty creating structure and predictability to visits. Strategy: the coach can help parents plan routines for greeting and leave-taking; the coach can teach parents to give predictable cues that alert the child to an impending transition.
   d. Deficit: parent cannot manage difficult behaviors. Strategy: the coach can introduce tactics for calming and soothing, or help parents to have consistent and clear expectations; the coach can teach parents to reduce the demands on the child or anticipate problems before they arise (Greene, 2009).
7. Provide a written summary of the social history, child strengths and areas of concern, family and community context (risk and resiliency factors), observations, visit coaching goals and activities, clinical impressions and findings, along with suggestions for further intervention where appropriate.

The Assessment Process

The process starts with gathering social history and the Working Model of the Child Interview (WMCI; Zeanah & Benoit, 1995) to understand the relationships that are central to the child and life stressors that might interfere with those relationships. The WMCI is a structured interview that is used to arrive at a clinical opinion on the individual's internal representation or mindset toward a particular child. The purpose of the interview is to reveal in as much detail as possible the individual's perceptions, feelings, motives, and interpretations of the child and that adult's relationship with the child. The interview is recorded, and then the clinician interviewer reviews the recorded interview in detail. The interview is evaluated for the following criteria:

- Richness of detail (i.e., how well does the parent seem to know the child)
- Openness to change (i.e., is the parent flexible and able to accommodate the child's changing needs)
- Intensity of involvement (i.e., how engaged or disengaged the parent is in the relationship with the child)
- Coherence of narrative (i.e., is there a well-organized and logical flow of ideas and feelings about the child)
- Caregiving sensitivity (i.e., does the caregiver recognize the child's feelings and have empathy for the child's distress)
- Acceptance (i.e., is the caregiver able to accept the demands and challenges that the child imposes)

The individual's responses on the WMCI provide rich clinical data on the likelihood of attachment security or insecurity in the offspring (Benoit, Zeanah, Parker, Nicholson, & Coolbear, 1997). Specifically, individuals with a full balanced view of the child and of their relationship with the child are more likely to provide a detailed and coherent description of the child that is supported by many examples. They are able to reflect on the child's experiences and feelings and to demonstrate empathy and concern for the child's distress. Individuals who exhibit these characteristics are more likely to display parenting behaviors that support a secure attachment. Individuals who respond on the WMCI with a disengaged or distorted view of the child and of their relationship with the child may overlook or misinterpret distress cues; they may minimize the child's suffering and may fail to recognize the impact of their parenting on the child, all of which serve to undermine attachment security. The parent responses on the WMCI along with observation allow the coach and clinician to quickly identify parental attitudes and behaviors that should be targeted and plan a focused intervention.

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No measurement tool perfectly predicts attachment security or insecurity; and attachment security alone does not perfectly predict child outcomes later in life.

Like any clinical assessment tool the WMCI (Zeanah & Benoit, 1995) has limitations when used in the child protection context. No measurement tool perfectly predicts attachment security or insecurity; and attachment security alone does not perfectly predict child outcomes later in life. Clinical impressions should not be based solely on the WMCI. Rather, the WMCI offers rich clinical data that can be added to other information to gain insight into the parent–child relationship. The findings from the WMCI can add to the clinical picture of risk and protective factors that are known to predict outcomes in children at risk. Specifically, information should be gathered regarding risk and protective factors in the following domains: parental competence, child characteristics (temperament, health, and development), family and community context (housing, employment, practical and emotional support), and parent–child relationship factors (attunement; Greenberg, 1999). Sandra's profile on the WMCI suggested that she had a full and balanced view of her child, a view that would support a secure attachment, but she found Bonnie more difficult than would be expected, and Sandra's responses suggested that she was distracted from her relationship with Bonnie by other life stressors.

The WMCI (Zeanah & Benoit, 1995) is followed by an observation of the parent and child interacting during a visit. The coach and clinician watch for the following:

- How well does the parent read the baby's cues, interpret them correctly, and respond sensitively?
- Are the visits calm or chaotic? Does the parent need help learning how to provide structure and a predictable routine during the visit, such as: a greeting, play activity, snack, and good-bye routine?
- Can the parent be a secure base and safe haven for the baby? Is the parent able to regulate the baby during times of distress and support exploration? If not, why?
- Can the parent take charge when necessary to ensure safety and to support appropriate behavior?
- Is the environment supportive of positive parent–baby time? Is there too much stimulation (e.g., lighting, noise), poor selection of age-appropriate activities, adequate space, comfortable seating? For example, one visit site had a large, flat screen television that dominated the visit room.
- How is the baby transported to visits? Is there a different driver each time? How is the infant prepared for the transition by the foster parent?
- Are there variables in the context that are interfering with attachment (e.g., parental stress, social isolation, or mental health problems) that need to be addressed alongside the coaching?

Any of these areas may be the focus of visit coaching. Having identified areas where the visits could be improved, the coach then offers some positive verbal feedback and one or two suggestions to establish rapport with the parent and evaluate the parent's attitude and receptiveness to coaching. The focus of the feedback is on parent strengths, so the

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The *Ages and Stages Questionnaires* provide a friendly way to help recognize capabilities and challenges, and to learn about what other children of the same age are expected to do.

feedback emphasizes the things the parent did well. One suggestion that might help the infant is offered in this initial session to see how it is received. The parent is then given information on the coaching process and is asked whether he wishes to participate. The coach explains that the coaching will take place over eight sessions at which time a report will be submitted to the child protection worker. The first coaching session typically begins with a developmental and social–emotional screening using the *Ages and Stages Developmental Screening Tools* (Squires & Bricker, 2009). After that, sessions are designed around the priorities the parents and coach identify together.

The social history revealed that Sandra was born into a family that had multigenerational child protection intervention. She was removed from her birth family when she was 4 years old and placed for adoption with a family that she describes as emotionally distant and with a mother who was critical and abusive toward her. As an adult she was utterly alone, having cut off contact with her family and having broken off her relationship with Bonnie's father. She had few friends because she was constantly moving and changing jobs.

Sandra was living in a women's shelter at the time of our initial involvement, and supervised visits with Bonnie were taking place four mornings a week in the community. These visits typically involved Sandra taking her then 12-month-old daughter for walks in the downtown area, occasionally stopping in a park or going to a coffee shop. Bonnie's development was beginning to show signs of delay around this time with no weight bearing or verbalization and a very low level of self-regulation. One minute she seemed content and the next she would shriek at the top of her lungs (enough to make passersby stop and stare). The noise and stimulation of the busy downtown streets appeared too much for Bonnie, causing her to cry excessively and be difficult to soothe, making the visits stressful for both mom and baby.

Visits were further complicated by Sandra's significant anxiety and fears about losing custody of her baby as well as very low confidence in her ability to parent. This was due in part to negative feedback from the foster mom about the baby's distress following visits, as well as poor visit reports. Her lack of confidence, her anxiety, and the negative reports created an escalating cycle whereby her anxiety fed the problems and interfered with positive parent–child interactions, and the negative feedback from visit supervisors and the foster mother increased Sandra's anxiety and fear of losing permanent custody of her child. Sandra coped with these pressures by making impulsive and expensive purchases for the baby—such as toys or treats that she could ill afford.

After an initial session with Sandra, it was clear that her anxiety was debilitating and significant enough to impair her ability to work or to engage in coaching sessions. We determined that the visit venue was completely inappropriate and had to be changed. Furthermore, we felt that Sandra was not going to progress with visit coaching until she had secured affordable housing that she could rely on. Visit coaching was suspended until these instrumental issues were addressed, but we saw a need to help this mother by advocating on her behalf and helping her organize community supports.

With some advocacy from the authors, Sandra was able to access a psychiatrist for a formal mental health diagnosis and was put on antianxiety medication to complement her counseling. The formal diagnosis allowed her to qualify for temporary financial assistance based on a medical diagnosis of severe anxiety disorder. She applied for long-term financial assistance as a disabled person. Her caseworker helped her to secure subsidized housing based on her disability. A home visitor helped her learn how to budget and pay bills. After a few weeks a case conference was held and was attended by the visit coach, the clinical supervisor, the mental health therapist, Sandra's caseworker, and the home visitor. The team reported improvement in Sandra's anxiety level and the home visitor reported improvement in her ability to handle everyday living skills.

Visit Coaching

Without the stress of trying to hold a job while trying to cope with an untreated anxiety disorder, Sandra was able to stabilize her life and was now fully engaged in mental health counseling for her disorder. She was missing fewer counseling sessions and was able to keep a predictable visit schedule. With her living situation more stable, visit coaching was reinstated twice a week, and the coaching session were relocated from the child welfare office to Sandra's home. Visit coaching resumed, and the first session focused on completing the developmental screening using the *Ages and Stages Developmental and Social Emotional Screening Questionnaires* (Squires & Bricker, 2009). The Questionnaires provide a friendly way to help Sandra recognize Bonnie's capabilities and challenges and to learn about what other children of the same age are expected to do.

Following the initial session and with Sandra's input, visit coaching focused on teaching Sandra strategies for rebuilding the attachment relationship with Bonnie, calming and soothing techniques for dealing with Bonnie's sensory integration and self-regulation issues, positive discipline strategies, and strategies for building a predictable routine and consistency into the daily schedule.

As a child, Sandra had had few opportunities to play with a caring adult so one of the primary attachment-based activities we coached the mother on was child-led play. This strategy involved getting the mother and baby on a mat and supporting the mother to watch the baby carefully to read her cues of interest or disengagement, wait for a gesture or cue of joint attention or interest (e.g., eye contact, gesture, facial expression, bringing an object of interest to the parent), and then follow the child's interest by responding to the cue. Despite her anxiety and childhood deprivation, Sandra proved to be quite adept at child-led play. While some parents struggle to let the baby lead the play, Sandra quickly responded to suggestions to let the child initiate the interaction and she needed minimal coaching to read Bonnie's cues of interest, disengagement, or distress. We introduced activities for quiet time such as books, puzzles, rhymes, and finger plays. We helped Sandra to learn table activities such as play dough and coloring. Sandra demonstrated an ability to accept suggestions and implement them in the moment, and we noted that she generalized new strategies to subsequent sessions. For example, when we suggested that each visit follow the same pattern—greeting, activity, snack, quiet time, and good-bye routine—Sandra came to subsequent sessions with a plan that incorporated these phases.

Calming strategies was the area of greatest concern because of the dynamic between the mother and child that quickly escalated the baby's distress rather than calming her. Some of the calming and soothing techniques we taught were: use of redirection or moving to other activity; modifying the environment to prevent upsetting situations (e.g., removing items from view that baby cannot have such as pens, phones); and cuddling and using a soothing, reassuring voice when she is upset. This strategy required us to help Sandra manage her own anxiety; something we were able to do by offering frequent reassuring messages and focusing on parent strengths. The coach's therapeutic rapport with the mother was an important factor here.

Many upset situations arose around feeding. Sandra frequently resorted to using food as a soothing device. When she became stressed or upset, Bonnie would scream and cry for food or her sippy cup. Sandra quickly complied to end the screaming—she told us she felt enormous pressure to keep the baby quiet. With the coach's encouragement, reassurance, and support, Sandra began to replace food and offer herself as a soothing device. She was encouraged to cuddle the baby and use reassuring and soothing tones when the other strategies (e.g., redirection or removing frustrations) didn't work.

Sandra needed a lot of help to take charge of the situation when Bonnie was noncompliant. Not only had Bonnie learned to self-soothe rather than turn to her mother for comfort, she had also learned to control the parent–child interactions by screaming loudly. We helped Sandra to implement positive discipline strategies such as kind and firm interactions, consistent rules, and expectations followed by clear, appropriate consequences. Sandra used a time-out mat for significant outbursts or very negative behaviors (e.g., throwing food, hitting). Bonnie initially responded very poorly to any type of negative direction such as: do not touch, or no. She would immediately scream and become very distraught. Sandra and the visit coach began to follow up the negative direction with something Bonnie could do instead. For example, "Don't pull the kitten's tail, pet it nice like this," or "No more snack—can you bring me your book so we can read it?" This focus on talking about something she could do seemed to help Bonnie to get over the upset and move on to a positive interaction without the complete meltdown.


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No single event, even ones as important as early attachments or foster care separations, will tell the whole story of a child's future prospects.

The visit coach and clinician noted that with her anxiety under control, Sandra was increasingly excellent at reading the baby's cues and was consistently responding with empathy. We noted that despite her regulation challenges, the baby showed preference for her mother over strangers (us) and sought her mother out for comfort. With some coaching, Sandra came to each visit with a healthy snack and appropriate activity. She implemented a good-bye routine to cue the baby of the transition. As suggestions began to pay off (the baby was happier and more settled during visits, supervisor reports were increasingly positive) Sandra became eager for more ideas and suggestions. Her confidence grew and her parenting was increasingly consistent and predictable.

The team met again and determined that it was time to begin transitioning Bonnie home. Considering that a few months earlier the

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Child Welfare Information Gateway: Parent Child Visits
www.hunter.cuny.edu/socwork/nrcfcpp/downloads/PHProgramsvisiting.pdf
Lists state and local therapeutic visitation programs in the U.S.

Visitation With Infants and Toddlers in Foster Care: What Judges and Attorneys Need to Know
M. Smariga (2007). American Bar Association.
www.ct.gov/ccpa/lib/ccpa/birth_to_three_and_visitation_aba_child_law_center_doc.pdf

plan had been to apply for permanent custody of Bonnie, we considered this to be a major turnaround for this mother and child. The team created a plan that included 3 hours per week of visit coaching and 1 hour per week of attachment counseling for the coming month. Over the 3 months that followed, visit coaching decreased while parenting time increased until Bonnie was in Sandra's full-time care. During the transition period, the home visitor increased her availability to help Sandra find community support and to help her cultivate a social network with other mothers with babies. The clinical supervisor helped Sandra complete a Ulysses Agreement , which is an agreement or plan designed for parents with a mental illness to help them anticipate mental health crises and plan for the care of children (British Columbia Schizophrenia Society, 2013). Sandra continued with weekly individual therapy sessions to learn strategies to manage her anxiety. The accelerated support was put in place to increase the odds of a successful reunification.

Sandra has begun to understand her own mental health and is working to address issues that negatively impact her health and her parenting. Sandra is learning to parent Bonnie in a supportive and caring way that builds on her own strengths and addresses her daughter's development concerns. Sandra and Bonnie have been reunited with a combination of professional and natural supports in place to maximize the opportunity for success.

Lessons Learned

There are three components to effective service provision for infants in foster care if they are to be reunited successfully with parents. (a) The interventions need to target multiple risk factors. (b) Because a range of interventions is usually needed to address multiple risk factors, appropriate staging of interventions is as important as the intervention selected. In Sandra's case the visit coaching could not be effective until her housing and employment issues were addressed. The housing and employment issues were the consequence of an untreated anxiety disorder. (c) Because children present differently with different caregivers, the intervention should target the parent–child relationship not the individual parent or the child.

Once Sandra's mental health issues and her living situation were stabilized, the visit coaching model and the visit coach appeared to be a good fit for Sandra. She was increasingly cooperative, comfortable, and forthcoming in the sessions. Sandra attended the once-weekly sessions with a willingness to learn and with an ability to generalize that learning to other visits with her daughter. She was able to ask questions, express concerns, and engage with the visit coach. Although the visit coaching was making a difference in the visits, it was not enough. Sandra was struggling with anxiety, which made it impossible for her to maintain a job, secure permanent housing, continue with the regular visit schedule, or follow through on tasks required of her by her caseworker. These risk factors strengthened the case for permanent removal of Bonnie and negatively impacted visit reports which in turn increased Sandra's anxiety level and reduced her ability to cope with daily living. Without a multidisciplinary team to address the myriad of issues faced by this mom, reunification would not have been possible. Positive parenting strategies, good mental health, secure income, and stable housing were individually not enough. All these factors needed to be in place at the same time for Sandra to succeed.

Conclusion

Child development is complex and involves the interaction of a number of past and current life events and risk factors. Adaptation or pathology are the result of developmental history and current circumstances, never either alone (Sroufe, Carlson, Levy, & Egeland, 1999). Attachment experiences, according to Bowlby (1973), are not immutable and are not independent of the context and subsequent experiences. No single event, even ones as important as early attachments or foster care separations, will tell the whole story of a child's future prospects. The goal of visit coaching is to use attachment-based strategies to preserve and enhance the primary attachment relationship during temporary foster care and thereby enhance the likelihood of successful family reunification. Like many families we have supported however, we found that we could not achieve successful reunification in a vacuum. Until the other risks and impediments were addressed in a staged process, the mother–infant attachment could not be supported by visit coaching alone.

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Families in the Legal Enforcement System

A Case Example of Blending Infant Mental Health and Family Partner Services

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Abstract
Public enforcement agencies such as criminal justice, child welfare, and immigration directly or indirectly impact children and families, often through mandated requirements and forced separations. As a result, families involved with these agencies can be wary of trusting early childhood home visitors and mental health providers. Through case description, including the mother's own words, we present an intervention model that pairs a family partner with direct experience in the criminal justice system as an intervention partner with an infant mental health specialist in order to create increased trust and a safety net of services around the family. Specifics about the model and lessons learned are shared to promote best practice in programs offering services to this vulnerable population of families.

Families that have been involved with public enforcement agencies, including criminal justice, child welfare, and immigration face a unique set of circumstances related to trusting service providers—including infant mental health clinicians—that can impact their willingness to use services on behalf of their young children. Most of these families have suffered punitive and traumatic experiences, including arrest, investigations, removal of children, deportation, confinement, and the breaking up of their families, making it difficult to trust any provider with information about ongoing family struggles and strategies for survival. Referrals for early childhood mental health services often come at a time when parents are facing reunification or re-entry challenges as they transition back into the community and into their families. Speaking the truth about their circumstances to service providers comes with the very real risk of further reporting to authorities and the fear of further punitive consequences in the name of safety and protection. In some communities, involvement with and evasion of these law enforcement institutions are seen as commonplace, normative, and a fact of life. Still, experience dictates that it is often safer not to trust and not to tell. Unanswered phones, unreturned calls, and missed appointments can lead either to protracted periods of "wooing" by therapists eager to offer help but unable to make regular and consistent contact, or elimination of engagement efforts completely under an agency's pressure of waiting lists and limited funding. In this article we describe a partnered intervention model that blends more traditional infant mental health services with the Real-Talk Family Partner model as a strategy to more effectively reach these families.

With historical roots in early intervention and developmental disability, our Early Intervention Services (EIS) program at Children's Hospital & Research Center Oakland has employed parents with direct experience receiving intervention services for many years, initially in the form of "parent professionals"—mental health providers who were also parents of a child with disabilities. The use of parent professionals revealed how personal experience and self-disclosure can often be a port of entry (Stern, 1995) and a fast track to intervention when carefully and thoughtfully used (Pawl & Milburn, 2006). We had learned, too, how someone with direct personal experience, embedded in our staff and representing a parent's point of view, could further shape our understanding not only about families but about ourselves

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In some communities, involvement with and evasion of law enforcement institutions are seen as commonplace, normative, and a fact of life.

and the way we and our work are perceived in homes and in the community. We had experience working not only with parent professionals in early intervention, but with peer counselors in residential drug treatment programs and with parent advocates in our own county child welfare system (Frame, Berrick, & Knittel, 2010).

Using Family Partners: The Real-Talk Model

Alameda County Behavioral Health Care has a System of Care grant from the Substance Abuse and Mental Health Services Administration (Early Connections). EIS was one of six early childhood mental health agencies in the county to add a family partner position to our staff in March 2011. The family partner effort in our county championed adding the family voice and the use of personal experience to the governance, implementation, and delivery of all early childhood mental health services funded by the Early and Periodic Screening, Diagnosis, and Treatment program. The family partners are creating parent partnerships to expand the reach to all families, especially those families who seem hard to engage. EIS serves an urban, culturally diverse population (38% African American, 32% Latino, 14% mixed race or other non-white) targeting children (birth to 6 years old) who have social–emotional, developmental, and medical vulnerabilities. In our program, hard-to-reach families are often families with multiple children who are also involved with criminal justice (e.g., jail, prison, probation, parole), child protection, immigration, or a combination of these; many are families in transition needing concrete help with reunification and re-entry efforts, often related to housing, income, employment, and other daily survival efforts associated with poverty.

In spite of our previous experience with parent professionals, we were initially unsure of how to use these new family partner services in our early childhood mental health program. As trained infant mental health specialists, we believed in our skills at engaging families. We were accustomed to providing a blend of developmental guidance, concrete services, advocacy, emotional support, and infant–parent psychotherapy to address relationship impasses (Fraiberg, 1980). As clinicians we were skeptical about how to work with a partner who was going to use personal experience and self-disclosure as a primary method of intervention. The relationship between mental health and family partner perspectives was not yet clear. This would emerge and clarify in our work with Carime and Santiago, and enable us to develop our own version of a family partner model to be used when enforcement system experience was central.

Carime and Santiago

Carime and Santiago were referred to our EIS program by an early childhood health coordinator at the local county hospital because of concerns about Carime's postpartum depression and Santiago's poor weight gain. Santiago's father had been detained by police 5 days after the birth, and was in the process of being deported to his native Guatemala. There were four other children at home to be taken care of, and the hospital staff had grave concerns regarding Carime's ability to attend to the needs of her newest son. Carime had revealed her diagnosis of bipolar disorder, but was noncompliant with her medication. There were also strong indicators of chronic posttraumatic stress disorder.

We knew that "getting in the door"—being seen on the first visit as someone who could help, not continue to hurt this family—was the immediate goal (Seligman & Pawl, 1984). Carime had many reasons not to trust us. She had experience with all of the public law enforcement institutions including two previous child protective services (CPS) referrals, time in jail, and a partner in the process of deportation. But we had not yet learned how these experiences could place limits on our intervention efforts and did not consider the importance of starting with our family partner. We believed that Cecilia, a bilingual and bicultural clinician strongly identified with her Latina culture and a trauma-trained infant mental health specialist, could engage Carime and help her reach her now-vulnerable infant.

Infant–Parent Psychotherapy in the First Year

Santiago was 2 months old when home visits started. Carime was very cautious, slow to warm up, distant, and very depressed. Sometimes this took the form of being unable to rouse herself from the couch to open the door. This lethargy and immobility was mirrored by Santiago, who was also quiet, sometimes too quiet, and most frequently asleep. When he woke up, it was with extreme fussiness, and feeding became the only strategy used to calm him. Carime was trying to breastfeed, which felt so effortful that she supplemented with a bottle, often propped. Within 6 months, there were concerns about Santiago's development. To lessen expenses, there was an additional roommate living with the family of six; a teen mother with her own 2-month-old baby boy and nowhere else to go. This would be the first of many mothers and their young children who would pass through Carime's home for a few days to a few weeks as they fled domestic violence or were faced with eviction. Santiago's father, plagued by alcohol addiction, would reappear over the next year, often increasing domestic incidents of conflict and tension.

Concrete survival needs were interfering with Carime's ability to be with her baby, and were, of necessity, the first port of entry for any hoped-for therapeutic work. Engaging the family required a flexible approach that would grow to include meeting Carime where she wanted and supporting her directly in any effort she made to improve her situation. Carime took every occasion to hand her baby to others, including Cecilia, every time she visited. Santiago's siblings (the eldest, 11 years old) were taking care of the baby and doing the chores. Cecilia's efforts in the first year were attempts at "mothering the mother" in her own therapeutic relationship. Cecilia accepted Carime's thinking and emotions, and used a gradual approach, providing support for basic survival needs while pacing her therapeutic interventions to match Carime's own tolerance for the work. Cecilia was able to use her presence and relationship with the mother as a vehicle to contain Carime's anxiety, becoming a stable and predictable figure who could help her manage and regulate her impulses. This was something Carime had sorely lacked in her own experience. In the context of her visits, Cecilia searched for moments to speak for Santiago—becoming his voice, bringing his experience into the session—and helping Carime see her importance to her son, while she listened to the disjointed stories of Carime's own traumatic history. Although this created a tentative foothold into the "ghosts" in Santiago's nursery (Fraiberg, Adelson, & Shapiro, 1975), the continual effort at meeting basic needs left little opportunity for more direct therapeutic interventions that could focus on the impact of her complex trauma. Cecilia struggled to maintain regularity with the family, and she used reflective supervision to think about her own role and relationship with the family and to contain her own feelings that the chaos in the family evoked. It didn't seem like enough.

Slowly, we began to ask ourselves whether our infant mental health approaches were sufficient. Could we use a family partner who, as a mother of young children, had direct personal experience with law enforcement agencies and service providers, to break down barriers of trust, build collaborative relationships, help with concrete services, and teach us something about the family's experience? Would it help Carime and Santiago, and other hard-to-reach families, if they could see the face of someone who had made it through?

The Second Year: Introducing Shawny and the Real-Talk Model

Physical proximity in the workplace became the catalyst for family partner service expansion, relationship building, and the development of our own partnered intervention model with this family, and in our own program. Cecilia, whose desk was near Rashawnda's (Shawny), began consulting with her about housing issues. Carime's landlord was being unresponsive to the insect infestations that threatened the health and comfort of the family, and there was an imminent threat of eviction. Carime's ongoing depression left her with little motivation to move and no energy to advocate for her needs, clean, or organize her household. Santiago was developing medical symptoms, including asthma and rashes. Given the level of need in the family, it began to feel like having an additional provider—an intervention partner—who could know the family directly and who could relate to Carime's experience as a peer—was essential and would ultimately maximize our intervention efforts. Carime was in need of emotional support, systems navigation, and help with meeting concrete needs. And her relationship with Santiago was still very much in jeopardy. Carime had rejected additional providers before, including a previous family partner who was both bilingual and bicultural. Would she accept a family partner who was a match to her other culture? Someone with personal experience with legal enforcement systems and from the community? In supervision, we questioned what it would mean to add an English-speaking African American family partner as a service provider for this family. We thought carefully about what Shawny's role could be and how it might work to support the family, Cecilia, and the relationship work that Cecilia was trying to do. Cecilia introduced the idea to Carime. Her reactions were mixed but her situation felt desperate and she was willing to try.

Cecilia introduced Shawny as the family partner, and shared that she might be able to help Carime with her current housing crisis. Shawny first disclosed that she had direct experience working in property management, hoping that she could offer Carime something of direct value given her current circumstances. Then she shared her story in a nutshell. "I am a formerly incarcerated single mother of three children, one of whom has had mental health challenges. I am originally from Oakland, and I grew up in 'little Tijuana,' a neighborhood not far from here. I was homeless at a point in my life with my children, and I know what it means to even think about having to know where to go with your kids. Look, I know where you are at; I've been there myself and I want to help you get back on track."

Carime would later describe the first time she met Shawny: "I was getting evicted and was desperate. She was African American, but a mom like me. She was a single mother with three kids who had struggled and now was giving back to her community. That first day we connected like a magnet, and I told her, 'You're hired.' "

An early episode would help us to see how using our Real-Talk partnered model would be helpful. Carime's children came home from school with lice. She told Shawny, but did not want Cecilia to know, feeling vulnerable about being judged. The "ghosts" of the enforcement systems that had judged her were present. Shawny accepted her position, but talked about why she thought it was important for Cecilia to know. In doing so, Carime gave her permission to talk with Cecilia on her behalf. Shawny spoke with Cecilia about the very real fear Carime felt about what Cecilia might do, given her experiences with incarceration and CPS. Cecilia was then able to explore Carime's feelings and concerns about how she might be perceived, linked with her previous history of CPS involvement due to untreated ringworm in her children. Cecilia was able to normalize Carime's experience with the lice and help reduce her anxiety.


Photo: ©iStockphoto.com/Reynardt Badenhorst

Carime was very cautious, slow to warm up, distant, and very depressed. Sometimes this took the form of being unable to rouse herself from the couch to open the door.

Shawny's capacity to be the bridge between Carime and Cecilia facilitated the creation of a therapeutic space for reflection and exploration about potential triggers given her history.

With the addition of Shawny as an intervention partner providing concrete and emotional support to the family, Cecilia was more able to provide her therapeutic interventions around the relationship with Santiago. In the second year of treatment, Cecilia continued with a more in-depth approach—working to create a narrative that would start to integrate Carime's fragmented and chaotic trauma history, helping with self-regulation, developing strategies for managing Carime's anxiety, monitoring Santiago's development, and promoting positive parent–child interaction and attachment (Lieberman & Van Horn, 2008). Shawny continued with direct parent support, helping Carime to regulate her anxieties through hands-on support and availability; providing her with resources; and supporting her ongoing experiences with landlords, medical appointments, and service providers. Her methods became the foundation of the Real-Talk Family Partner Model shown in Table 1. The term "Real-Talk" is borrowed from street culture and language and indicates first-hand knowledge of the neighborhood culture while emphasizing trust, honesty, and transparency. This direct experiential knowledge, especially of the impact of involvement with enforcement systems, afforded Shawny a path unavailable to Cecilia or other providers to help Carime. Shawny, by her very presence, provided Carime with a constant reminder of the capacity to change her life course. She carefully tailored her use of personal experience to address crises, offered encouragement, and remained a bridge to trusting other providers. Cecilia and Shawny now had regular "check-ins" to consult, collaborate, and provide ongoing support to one another. The improvement was dramatic.

Impact and Change Over Time

At 2 years 5 months old, Santiago is now a happy, well-developing youngster, becoming talkative in English and Spanish. Carime's depression and immobility have lifted, and she feels more capable, independent, and resilient. She is able to recognize more readily when things are not safe, and the safety of her children has become her priority. Concerns about Carime's relationship with Santiago have resolved, and the level of anxiety in the home is considerably reduced. Carime reports that she is able to focus more on Santiago and knows now how to read his cues and offer him support. She states that now she knows how to be a better mother; she knows how to coo and play and read books and be there for her children. There are still crises and needs for support, and she is active in reaching out for continued help.

Carime helped us to think about our partnered model by offering her own insights about Cecilia and Shawny's roles:

Cecilia is never judgmental. And she inspired me a lot. I wanted to enroll in community college and had asked others for support. They would hand me a resource and wait for me to do it myself. Cecilia helped me register for classes; she encouraged me, helped me with homework and was right there with me. And I will graduate next May, the first person in my family to go to college. She made me feel special, smart. Cecilia has been more focused on Santiago, on parenting and on my relationships in the family. There have been times when things were difficult with us. I remember when she told me about being a mandated reporter. Santiago was learning to walk and falling down a lot at the time, and I got mad at her and thought she didn't trust me, that she thought I was hurting him. I didn't want her as our therapist and at the same time I didn't want her to go. I know there are limits with Cecilia; professional limits. I don't know much about her personal experience, but she is a good listener and a thinker.

Shawny is like Cecilia but more hands on. I can connect more to Shawny because of her life experience. She has helped a lot with diapers, housing and medical appointments. They both will meet me anywhere it is convenient for me, *not for them. Shawny is always spot on for date and time. She is always there when she says*

Table 1: Real-Talk Family Partner Model for Families With Enforcement System Experience

Goals	• Help empower parents to re-establish their own sense of agency and control over their lives and the lives of their children • Help parents to trust and use other services and providers on behalf of themselves and their children
Foundational principles	• **Trust:** importance of confidentiality; holding parent's confidence, discussing mandates for reporting, gaining permission to share information with others each time it comes up • **Honesty:** saying it like it is; being direct about consequences, difficulties, known barriers through a relationship of support • **Transparency:** self-disclosure and maximizing and using life experience as it applies to the family's circumstance and situation
Ports of entry	• Concrete needs and immediate daily crises faced by family • Parent support needs
Intervention methods with families	• Use of working street knowledge of neighborhoods, schools, housing, and other resources that is informed by lived experience and being a member of the community • Use of parent's language, including street talk, slang, profanity, and culturally acceptable attitude and body language to show through verbal and nonverbal means that you understand their experience • Use of self-disclosure in answering direct questions • Sharing of knowledge and information • Acceptance of family's current values and perspective • Thinking with parents, not for them • Staying in the here and now • "Translating" understanding between families and providers
Collaboration methods with providers	• "Translating" the family's experience to providers • Partnering with providers in joint service delivery and mutual support • Consulting around resources and case management needs • Respecting the boundaries and limitations of each other's work • Maintaining regular communication and "check-ins"

she will be. And she helps to calm me down. I will call her or text her, even after hours when things upset me about my children, my husband or my landlord. I always hear back from her and she reminds me to relax, to take a breath. She shows me how to be a mother. I saw a rash on Santiago and was afraid to take him in to see the doctor. I was afraid of CPS. Shawny encouraged me to take him in and to talk with Cecilia. She helped with a letter to the landlord about the mold, with housing applications, and with calling the asthma clinic. She told me about her own experience; her felony, her faith, her daughter. She makes me feel not so alone.

Cecilia, Shawny, and EIS

The benefits of our partnered intervention model have extended beyond the families we serve to our own staff. Cecilia has learned about this family's perspective and is more attentive and informed about the survival strategies of street life, and the very real fears about trust that are regularly evoked given Carime's experience with various enforcement agencies. Shawny's presence as a coworker provides intervention partnership and support to Cecilia in sharing the celebrations and challenges of working with this family, complementing a more targeted use of reflective supervision.

Shawny, as the lone family partner in our agency, is increasingly involved with families, programs, and services. She is learning to share the language of mental health while she simultaneously questions it from a parent's perspective. She is regularly involved now with all families who are referred with previous incarceration or child welfare experience, and we are starting to use her as a first contact for family navigation and the building of trust. She is fully embedded in our program, receiving internal referrals and partnering with our clinicians to provide consultation, perspective, and direct services, including a parent support group to previously incarcerated mothers.

Lessons Learned

In the EIS early childhood mental health program, our commitment to serving hard-to-reach families who have enforcement system experiences, and our belief in incorporating a parent voice and perspective, have led to a blended infant mental health and family partner model. Although early in the process, we believe this has been beneficial for families, staff, and our community. Our lessons to date include the following:

Power Dynamics

Families referred by others and considered to be at risk because of a history with legal enforcement agencies bring a unique set of engagement challenges to early intervention providers. Often these are families who have been disrupted or displaced because of confinement, deportation, or child removal. Always, they are families vulnerable to the power dynamics associated with authority, often a traumatic reminder of arrest, legal investigation, or actual incarceration. The difference in power dynamics between a parent and a provider can itself be a potent reminder of enforcement agency experiences, giving rise to repeated difficulties with trust. Using Shawny and the Real-Talk model has allowed us to create a successful bridge for understanding and remedying the power differential between parents and providers and for more quickly engaging with families whose understandable chronic fear and anxiety is an impediment to receiving services.


Photo: ©iStockphoto.com/Deborah Cheramie

Families considered to be at risk because of a history with legal enforcement agencies bring a unique set of engagement challenges to early intervention providers.

Partnered Intervention: Families

Although many intervention models use a team approach (Slade, 2002) we have often relied on relationship-based intervention strategies delivered by one clinician, concerned that multiple providers can be overwhelming to vulnerable families receiving many services. Many families facing reunification or re-entry from system-enforced separations such as foster care, deportation, or incarceration have enormous challenges with stabilization. They often have housing-, employment-, medical-, and income-related needs that overshadow any relational concerns they may have about their children. The chronic stress and anxiety that accompany the uncertainty about basic survival and further scrutiny can result in the most needy families making the least contact and receiving the fewest services. We have learned that using a teamed model with a family partner who has personal experience with re-entry or reunification can work effectively for families, broadening both the range of services and the range of support.

Partnered Intervention: Staff

Partnered intervention is not just peer support to the family, but a therapeutic bridge and support to the provider. Although supervision creates a reflective space for considering therapist response, client need, relational factors, and interventions, it is not a substitute for an intervention partner who can share the direct experience of being with the family. Our experience suggests that this is best practice for supporting staff to serve families with high stabilization needs, complex trauma, and a history with enforcement agencies. With monthly meetings and regular check-ins between partners, it can be an effective adjunct to reflective supervision.

Learn More

Working Well Together
http://workingwelltogether.org

National Federation of Families for Children's Mental Health
www.ffcmh.org

California Mental Health Advocates for Children and Youth
www.cmhacy.org/index.html

The Real-Talk Family Partner Model and the Use of Self-Disclosure

The Real-Talk Family Partner model that we have described has many features that overlap with infant mental health practice. Confidentiality, building trust, and seeking to gain the parent's perspective are building blocks of a strong working alliance, as is developing reflective capacity around use of self (Heffron, Ivins, & Weston, 2005). But even judicious use of self-disclosure is often considered a compromise to good therapeutic practice, which emphasizes a focus on the parent, child, and their relationship, rather than the provider. We have learned that with some families, carefully and thoughtfully delivered self-disclosure by the family partner can be a powerful intervention and cement a family's commitment to services. Real-Talk additionally emphasizes the careful and well-thought-out use of culturally congruent verbal and nonverbal communicative strategies as indicators of understanding. We use a reflective supervision model to think through the elements and methods of the model, and monitor our challenges and successes.

Effective Leadership in Integrating a Family Partner Model

The early childhood direct service landscape is populated by a variety of disciplinary providers. Family partners and parent advocates, with direct and personal experience with service systems, are the most recent addition to this landscape. In our experience, integrating multiple perspectives in the infant–family field is both imperative and enriching but requires organizational support, commitment, and reflection. Questions that have arisen for us include how and when to use self-disclosure and personal experience, how to partner with clinical providers, how to find a mutual language of understanding, and how to support individual and collaborative service partnerships with existing funding sources. We have used our clinical leadership and supervision to effectively address these questions and others as we continue to embed family partners in our early childhood mental health programs.

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We would like to thank Carime, who, in wanting to help other families, generously allowed us to use her story and her words in writing this article. The writing of this article represents an example of the partnership between staff and family in implementing the foundational principles of trust, honesty, and transparency included in the Real-Talk Family Partner model.

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Rashawnda Lee, *CFP, is a certified family partner, Early Intervention Services at Children's Hospital & Research Center Oakland. For more than a decade Rashawnda worked in the private business sector before transitioning her career to support families with young children coping with mental illness. In her current role as a professional family partner, Rashawnda provides direct service to families, consultation, advocacy, parent engagement, and supportive services by using her living experience as both the parent of a child with mental health illness and a previously incarcerated parent and survivor, along with her children and family, of the impact of incarceration. In collaboration with Alameda County's postincarceration MOM's program she facilitates a support group for parents and caregivers of young children of incarcerated parents. Rashawnda's lifelong passion since release has been to utilize her life experience to help others realize that survival and change in their lives are possible, and that, ultimately, being empowered with knowledge and a voice in partnership with supportive mental health services can improve a young child's quality of life.*

Cecilia Reus, *MA, licensed MFT, is an infant mental health specialist, Early Intervention Services at Children's Hospital & Research Center Oakland. Cecilia was trained and practiced as a clinical psychologist in her native Chile, with a focus on early childhood and the importance and impact of culture in the process of attachment formation. She became a licensed MFT when she immigrated to the USA. She has been an infant mental health specialist in the Early Childhood Mental Health program at Children's Hospital & Research Center Oakland since 2006. Cecilia has also done extensive work as a mental health consultant at preschools, has co-facilitated parenting groups in the community, and has provided trainings. As a bicultural and bilingual clinician, she is interested and committed to providing services integrating culture, immigration, and trauma, and attending to the impact of these in the early years.*

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Early Intervention in a Child Care Setting Using Play and Family Therapy

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Abstract

At an alarming rate, preschoolers are being expelled from child care centers because of disruptive behavior, and elementary schools are dealing with social–emotional behaviors that affect the entire classroom. The authors share the story of a child who would have been one of those expelled from child care and at risk in the elementary school classroom if he had not been referred to an early intervention program. Through the use of individual play therapy, group play therapy, and in-home family therapy, the child and his family were able to learn coping skills, improve the parent–child interaction, and increase self-awareness, all which benefited the family system as a whole.

The increasing number of children less than 5 years old who have social and emotional challenges is documented by the increase of very young children who are expelled from child care because of disruptive behavior (Gilliam, 2005; Wheatley, 2001). Elementary schools are also reporting difficulty in classrooms because of young children unable to attend to activities, calm themselves, and interact appropriately with others (Gilliam, 2005; Wheatley, 2001). Would early intervention services have allowed these children to remain in preschool and experience healthier social and emotional development?

The child and family in this article illustrate the importance of early intervention programs in the child care setting and the involvement of the family in the therapeutic process. I[1] worked as a mental health consultant and therapist in a child care center and worked with this family for more than 2 years. The story highlights the importance of understanding the child's behavior through the context of the family therapy and highlights the power of play as an intervention. The case details have been changed to protect the client family's confidentiality.

Early Intervention and Family Therapy

Early intervention refers to an array of services implemented to enhance the development and functioning of a young child (Ramey & Ramey, 1998). When considering early intervention for children, the family system must be addressed as there is a constant flow of information and influence between parents and children (Gammer, 2009). Young children are often the symptom bearer for family problems as they are not as complex in their thought process and less able to self-regulate or understand the rules of the system as the older family members (Lund, Zimmerman & Haddock, 2002). In addition, influence of the family history and the social environment

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[1] *Throughout this article, "I" refers to Rebecca Matte.*

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I first met MJ after he hit a peer during a struggle over a toy car in his classroom.

can also impact a child's behavior and how a parent may conceptualize or understand that behavior (Bricker, Schoen Davis, & Squires, 2004; National Research Council & Institute of Medicine, 2000). Also, young children affected by stress, trauma, violence, and neglect may respond by displaying behavior such as withdrawal, crying, difficulty with self-regulation, changes in eating and sleeping, and problems engaging with others (Hill & Solchany, 2005; ZERO TO THREE Policy Center, 2007). Thus, a clinician must take many factors into consideration to understand the meaning of the child's behaviors in the context of the family system (Favez, Frascarolo, Keren, & Fivaz-Depeursinge, 2009; Lieberman & Van Horn, 2009).

Assessment and Family Engagement

I first met MJ after he hit a peer during a struggle over a toy car in his classroom. He was referred for services by his teacher at the child care center; she reported that MJ was very active, physically aggressive toward his peers, and had a difficult time following directions. As a mental health consultant at the child care center, I was able to offer mental health services to the children, family, and staff at the center through a grant-funded program which delivered services through classroom support, parent workshops, psychotherapy peer play group, and family therapy.

MJ was referred when he was 30 months old. He was an African-American toddler living in an apartment with his mother, father, and younger sibling in a lower socioeconomic urban area of south Florida. MJ was observed in the classroom, and he appeared to be on track developmentally for cognitive functioning, gross motor skills, and communication. I also observed MJ playing happily with his peers. He did appear to be more active than the other children in the classroom; going from one center to another without finishing his previous activity. Throughout the observation, I noted that the teacher constantly reminded MJ of the classroom rules and needed to redirect him. MJ did interact with other children in the classroom but struggled with sharing toys, and the interactions tended to end with MJ becoming physically aggressive. I recognized that some of his behavior was age appropriate however MJ demonstrated a much higher level of aggression and distraction in the classroom. For that reason, I decided to make contact with the parents and offer early intervention services through the child care center.

I introduced the program to the father, and he initially was reluctant about the services. I followed up with the father a few days later and he did agree to meet and start the process for the services to begin. During the initial meeting, I completed multiple assessments to better understand MJ. I reflected to the father that he was very aware of his child and that both parents were working hard to provide for the family. The father seemed willing to engage, however, little connection was made with this family at that time and I knew that I had to work to understand the family more clearly and determine how to develop a relationship with the parents in order to help MJ.

I talked with the parents about their concerns. The father reported that MJ had a hard time following directions from his mother, but was able to follow directions when he gave them. When asked why, the father explained, "He knows that I don't play." This statement helped me to begin understanding the dynamics of the family. Both parents had witnessed MJ being physically aggressive toward his younger brother and with other children in his classroom at the child care center. They admitted that they were concerned that MJ would be a bully when he got older.

It appeared that MJ was on track developmentally for communication, gross motor skills, and problem solving. However, in the areas of fine motor skills and personal social skills, MJ was delayed. On the Social Emotional version of the *Ages & Stages* (Squires & Bricker, 2009) his scores showed concern in attachment issues, high activity level, difficulty in self-soothing, and physical aggression. MJ was just the type of child for whom this early intervention grant program was designed; these behaviors could be precursors for future problems with attention deficit hyperactivity disorder or even conduct disorder. Through early intervention, we could help MJ make changes in his behavior, develop communication and coping skills, and potentially avoid future problems which could adversely impact his social–emotional well-being and his education.

Play Therapy

MJ started grant program services within 2 weeks of my meeting with the father. Initially MJ had two individual play sessions and then moved into peer play groups with one or two other children from his classroom who had similar concerns in developmental ability, presenting issues, or family background. The therapist played a facilitator role; modeling and encouraging positive behavior. The goal was for MJ to be able to display self-control and cooperative play skills and to increase social skills by the end of the group intervention. Play would allow the child to act out and organize his thoughts and feelings about his experiences (Gammer, 2009; Lieberman & Van Horn, 2009; Tyndall-Lind, Landreth, & Giordano, 2001).

For the first year of services, MJ participated primarily in the peer play groups. I checked in with the teacher and parents separately at least once a month to talk about progress and provide strategies to help with behavioral concerns. Initially, and for an extended period of time during peer play groups, MJ displayed a chaotic, unorganized style of play. MJ often become frustrated and hit his peers or had a temper tantrum. Typically, MJ fell on the floor crying when a peer took a toy that he had been playing with earlier but was no longer playing with at the time. MJ was able to use words to tell about his toys and what he wanted to do with them, but struggled with verbal communication when he was upset. As the sessions went on, MJ showed an increase in temper tantrums, had a difficult time following play group directions, and struggled with the transition back to class. During the first year of services, I struggled to understand how to engage MJ's mother and father in the services. I still felt that I did not have a real connection or relationship with the parents, which is critical for the therapeutic process to be successful (Duncan, Hubble, & Miller, 2007; Reiter, 2013; Seligman, 2009).

Family Engagement

Both parents worked full-time, which made it difficult to schedule meetings with them. At the start of services, the parents reported that everything was "good" at home. However, there seemed to be a disconnect between what was reported happening at home and what happened at school. Over the year, because of the father's change in work schedule, I started to interact more and more with the mother and she developed enough trust that we were able to schedule the first family therapy session in their home. On my first visit to the home, I observed MJ interact with his mother and was able to open up a discussion with her about MJ's behavior, developmental ability, and needs. I observed that MJ's play was as active and chaotic in the home setting as it was at the child care. The mother seemed shy and unsure, and reluctant to set limits. I provided her with tools to help with development and modeled limit setting. I was curious about her interactions with MJ and the meaning of her reluctance to intervene in his behavior.

Around the time of the first home visit, MJ had moved from the 2-year-old room to the Junior Pre-K classroom at the child care center, requiring that new assessments be completed. On a tool that identified protective factors MJ showed typical behavior for self-control, which was a huge step for him. MJ scored in the concern range in all domains for behavior concern: withdrawal/depression, emotional control problems, attention, and aggression. The new teacher reported that MJ struggled with following classroom rules, participating in classroom activities, and was physically aggressive towards classmates. The teacher also noticed that he tended to prefer solitary play and only interacted with peers when he wanted something from them, which usually ended up with MJ becoming aggressive. I discussed this new information with the parents, who agreed to have family therapy sessions every other week. Everyone involved was concerned about MJ and how to help him increase his skills and develop appropriate behavior in the classroom and at home. I was beginning to make progress with the parents; slowly we were developing a relationship.

Around the same time, the father and mother got into a fight that led to the local police being called to the home and protective services becoming involved with the family. One day, as he dropped MJ off at school, I observed that the father had a black eye. At the following home visit, the mother shared that as she and the father had been talking, things escalated to the point where she got so mad she hit the father. I was concerned about MJ and his younger brother witnessing what had happened, yet the mother insisted that the children were both at the paternal grandmother's house (which is just downstairs). During the family session, I talked with the mother about the effects on children when violence is in the home. Mom appeared to listen, however, she continued to maintain that the children were not present. When the children later joined the session, I noticed that MJ actively sought interaction with me more than he did with his mother. The child's needs were being met in the interaction with me but it was difficult for his mother to understand his cues. In order to help MJ with his behavior, I needed to help the mother first. I continued to work on developing a trusting relationship with the family in order to learn more about what was happening in the home.


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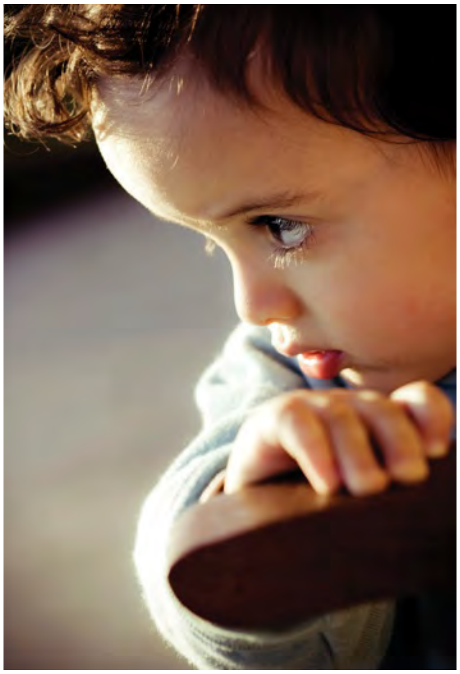
Early intervention refers to an array of services implemented to enhance the development and functioning of a young child.

In the family therapy sessions, I continued to reflect about MJ's behavior at school and in the peer play group. MJ was spending most of the day in time-out because he was not following directions and was being aggressive in the classroom. In the peer play groups, MJ continued to participate mostly in solitary play with only brief moments of peer interaction. The parents also struggled with joining MJ in play at home. The father was able to set limits but did not give MJ time to process the choices before he would put his son in time-out. The mother tended to follow the father's lead both on setting limits and lack of involvement in play. When I asked about how the family played, the father reported that "We play video games together." I praised them for spending time together, but stressed the importance of play without electronics in order to increase the one-on-one interaction between the parent and child. The mother reported it was difficult for her to have play time with the children because of work and her family responsibilities of making dinner and getting the children ready for bed. The father did not seem to want to play in any other way with his children. Professionally, I struggled with the lack of quality time the parents had with MJ, which I have learned to be the key to parents really learning about their child. However, I understood the importance of accepting the family's limitations and building on their strengths. We continued with every-other-week family therapy sessions and weekly peer play groups for the second year of services.

I was frustrated that MJ was not progressing despite the intervention and felt that there must be more happening in this family of which I was unaware. The mother and I had developed a stronger relationship, yet although I was still earning her trust, I could sense that there were things she did not tell me. With the father, I felt that he consistently put on appearances during the sessions, trying to say the "right" answers instead of what was really happening at home. I realized that I needed to slow down and not try to pull them along faster than they were willing or able to go; then perhaps I could see more of what was going on with the parents.

By the time the end of that year approached, MJ's teacher reported that he was less aggressive with peers and followed directions more often, but he still struggled in many ways. In the peer play group, he also continued to be challenged with self-control. However, any progress made in the classroom behavior was left behind when he then transitioned into the Pre-K classroom. MJ had a very difficult time transitioning and in the first months he spent increasing amounts of time in time-out or sitting by himself because of physical aggression with his peers. The new teacher was also concerned about his learning experience; MJ seemed to not be able to complete classroom activities. His latest assessment showed a decrease in protective factors from the previous year—the results showed concern in all areas; both protective factors and behavioral concerns. I spoke with MJ's mother about the



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Young children are often the symptom bearer for family problems.

assessment results and transition difficulties. This became a high priority because in a year MJ would be moving into kindergarten but he did not yet have the skills to do so successfully. His mother agreed to move MJ into a higher level of services, which meant that he would continue with weekly peer play groups and would also participate in weekly individual therapeutic sessions and with the every-other-week family therapy sessions.

Now that we were meeting more often, I felt that the mother and I had developed a more trusting relationship, as she seemed to tell me more about her feelings and concerns. She reported that MJ "whined and cried a lot" for what he wanted and was physically aggressive with his sibling daily. The mother was frustrated and shared that she had been quite young when she gave birth to MJ and, 13 months later, to his younger brother. She realized now how different and more challenging it was to be a mother than it was when she was just "helping out" with other children. I felt like we had made a real connection; and that I understood this mother more fully than before. Her concerns for MJ in the home were the same as those expressed by teachers in the classroom. I could see that the mother now was engaged in the services, and wanted to help her child succeed; but just did not know how to do it.

Making Progress

For about 3 months, MJ participated weekly in a peer play group, an individual therapeutic session, and in a family therapy session. In the individual therapy session, I concentrated on providing a safe play space where he felt unconditionally accepted through a child-centered approach of therapy. Through play he learned new ways to communicate and different ways to solve problems. At times he wanted to engage in the more aggressive play. He would say things such as, "Do it this way" (showing the dolls hitting one another), or "No, that's wrong." Throughout the session, it was important for MJ to be in close proximity to me. When it came time for peer play groups, he had to learn to share not only toys but me, as the therapist. I acknowledged to MJ that I realized he wanted my full attention, but that I needed to play with everyone, which frustrated him. However, over time his coping skills increased, allowing him to accept the limits and join the peer play.

During the last year of services, the family sessions were more frequent and more work was able to be completed. The mother was engaged and more willing to learn new ways of working with and parenting MJ. She started to spend more time with MJ and his sibling during the session. Throughout family sessions, I encouraged the mother when she engaged in the play and would bridge play moments between the child and mother by handing toys to the mother to share with MJ, or I made reflections to help the mother become aware of her child's cues. The mother was able to feel more comfortable and started to set limits when MJ or his sibling were fighting over toys. Both children began to use their words and cope when they were not getting what they wanted. The mother, who had appeared reluctant to set limits in the beginning, was now parenting more effectively and enjoying it. Her children were also responding to her involvement, which she enjoyed as well. I felt honored to be a witness of the parent and child having mutually enjoyable interactions.

The peer play groups continued throughout the last year; it was in these groups that it all seemed to come together for MJ. He showed an increase in social skills through asking peers to play, allowing peers to join his play, and using his words when he needed something from his peers. The progress was noted not only in the play groups by me, but also by the teacher in the classroom.

MJ was now able to participate in more classroom activities. He would still sometimes struggle with following directions and physical aggression with peers; however this was a significant improvement in behavior for MJ. He also appeared happier, with more consistent behavior. At home, the mother also reported that MJ was much less aggressive with his sibling. The services began to decline in intensity, with weekly peer play groups and the family therapy sessions rotating with the individual sessions. Even with the decline in services, MJ continued to show constant improvement.

During the graduation ceremony at the end of the school year, I noticed that the mother and father were sitting separately from one another. At the next family session, the mother reported that she had decided to separate from the father because of his infidelity. I supported the mother and acknowledged the strength it took for her to make such a difficult choice. We talked about how to tell the children about the separation. I was able to also observe the mother correcting MJ's inappropriate behavior, setting limits, and helping him to join back in play. This mother had come a long way in her skills and in understanding herself and her children. In the following sessions, we talked about helping the children move into a new place and preparing MJ for kindergarten.

The last few family sessions were in the new apartment where the boys were living for the first time without their father. The mother talked about the changes she had noticed in MJ's behavior; he displayed less physical aggression toward his sibling and peers at school. The mother also noticed that MJ was using his words more. I wondered and reflected with the mother whether the difference in his behavior may have been related to MJ no longer being exposed to violence. We talked about the fact that children often match their behavior to their surroundings; MJ now lived in a calmer environment.

MJ's teacher continued to report improvement in his behaviors; she stated that although MJ still got frustrated, he showed increased coping skills and use of verbal communication and was an active participant in classroom activities. It was interesting that the teacher also noticed a big change in the mother, stating "The mother cares a lot about her children and does her best, always." This involved mother was different from the mother the teacher had met at the beginning of the year.

At discharge, MJ's transition into the kindergarten setting has been fairly successful. The mother's growth and strength as a parent was evident when she was able successfully advocate for her son while he was having a difficult time in school with a specific teacher. MJ still has some struggles in the classroom but has shown marked overall improvement in behavior. The last time I saw MJ, he was able to pause and give me a hug before running out the door to play with his friends; just a typical 5 year old.

Using multiple modalities for intervention led to the success of this intervention. The combination of family therapy and play therapy increased the parental support for the young child. Critical to the process was helping the mother establish her authority as a parent and understand how her behavior impacted her child's behavior. As a result, the mother was able to interact more purposefully and positively with her children. MJ's negative behaviors decreased, which had a positive effective for him socially, emotionally, and academically. The changes in the mother and the child increased the strengths, resources, and resiliency for the family system.

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Using *Stories From the Field* for Professional Development

"How-To" Guidelines From Reading to Reflection and Practice Integration

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Case studies provide numerous opportunities for professional development and can be particularly helpful in transdisciplinary training. Below are suggestions for how to use the Zero to Three *Journal's* Stories From the Field *series of articles across a variety of settings and roles such as clinical practice, program development, team building, training and supervision, and capacity-building in the early childhood workforce.*

Stories From the Field (Powers, 2011, 2012, and this issue) journals present a collection of articles focused on how professionals who work with infants, toddlers, and their families are making a difference. The stories highlight both the successes and the challenges of working with young children and their families, and they offer a powerful opportunity for professional growth and development. For clinicians, team members, and program administrators, each issue of *Stories From the Field* can be used for reflection on clinical work, team functioning, and systems building. The stories might also fuel practice change and offer pathways to deeper understanding of the work. For educators, trainers, mentors, and supervisors, *Stories From the Field* present real-world clinical cases and programs that can be used when training transdisciplinary professionals.

Below are some general guidelines for using *Stories From the Field*, followed by "how-to" suggestions for clinical practice, team building and program development, teaching and supervision, and workforce capacity building efforts. The suggestions can be readily adapted for use with a variety of audiences and for different purposes.

General Guidelines

Recognize the potential of the stories. The articles in the *Stories From the Field* Journal issues were written by and for professionals who work with babies, young children, and their families. These collective stories reveal the experiences of professionals working with young children and, beyond this, the experiences of the young children and families they serve. Stories provide opportunities to share trials and tribulations, challenges and barriers, learnings, and ultimately, to build collective wisdom.

Identify the gems within the stories. As you consider each article or story, look for the gems—moments of connection, opportunities, challenges, and barriers. Consider the lessons learned and what you might have done differently or the same under similar circumstances and why.

Read reflectively. Before you begin a story, create a space for reflective reading. Set aside the time both to read a whole story and to think about its significance. Read the story with intentionality. Pause as often as you like to consider a particular section, statement, or case. Reread the story—either immediately or at another time—and consider how your thoughts, reactions, and take-home messages have changed. Capture your reactions to what you read with notes or highlights.

Reflect on what the stories mean to you, your colleagues, and the young children and families you serve. Consider the perspectives offered in a story and how they relate to your everyday work. How do the cases, teams, and processes differ from what you are doing? On the basis of these reflections, consider the changes you would make to your practice, your programs, and systems.

Clinical Practice

Clinicians rely on their clients' stories and the narratives they cocreate during treatment to inform and guide their work. Depending on the setting in which you practice and type of work you do, you may find that you are the only infant and early childhood mental health clinician within a program, an agency, or a particular geographic locality. In community-based private practice, you may, indeed, be the sole infant mental health provider. *Stories From the Field* demonstrate that, as a clinician, you are not alone.

- Use the stories to identify other clinicians, professionals, and providers who are doing similar work in similar settings with similar populations.
- Use *Stories From the Field* as a reflective tool to create self-awareness about your own practice. You may want to ask yourself: (a) who you serve, (b) what you do, (c) what the opportunities and challenges are, and (d) where you get support and sustenance to continue to engage in your work?
- Create a peer consultation group or journal club where you use articles from *Stories From the Field* for discussion. Talk about different stories at each meeting, setting the frequency of meetings at a manageable interval for your group.
- Write your own *Stories From the Field*. Whether you enjoy writing or find it challenging, capturing your story by writing it down can enhance your conceptualization of a particular case and offer another avenue for self-reflection on the work you do. If you are a member of a peer consultation group or journal club, consider having members share their own story at your meetings.

Team Building and Program Development

Stories *From the Field* provide ideal material for discussion at team meetings, group supervisions, retreats, and other gatherings. Careful examination by a team of its own functioning is often challenging and fraught with feelings, investment, and ego that interfere with transformation and progress. Using the stories, team members can examine how other programs work, gaining insight into how to improve their own services.

When using *Stories From the Field* with teams, establishing expectations and guidelines is essential. First, agree as a team that everyone will read the selected story for a specific meeting. Second, select a facilitator who will be responsible for guiding the story discussion. Last, create a space and allot enough time to discuss the story at the designated meeting. The story discussion should not be an afterthought or left for discussion only if there's time at the end of the meeting. The facilitator is responsible for ensuring that the agenda includes adequate time for discussion.

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The articles in the *Stories From the Field* Journal issues were written by and for professionals who work with babies, young children, and their families.

At the start of your meeting, have the facilitator set the agenda and begin the discussion with a reflective question that invites team engagement. The facilitator will maintain conversation flow, being mindful that everyone has an opportunity to comment or engage as they wish. The facilitator is also responsible for closing the discussion and following up on action steps or team decisions. Consider designating another team member to take notes or minutes that briefly document the discussion, capture the thoughts and feelings of the team members, and record any action items.

- Create team "table talk" by selecting a story that describes work related to your team's work. Consider the similarities and differences, reflecting on what your team can learn from the story and how your team can enhance its functioning.
- Read stories that illustrate a particular struggle for your team, whether it's a specific type of client, a programmatic barrier, or another dynamic that interferes with your work. Create a space to discuss challenges and what they might mean in your own work.
- Refresh and change group dynamics by bringing in new voices in using the stories. The perspectives of others may reinvigorate or help clarify your mission and vision.

Teaching and Supervision

Stories, whether one's own or others', are powerful teaching tools. In teaching and supervising professionals in your own and other disciplines, you can use these stories to illustrate the work in which you engage.[1]

- Select *Stories From the Field* related to the content of your workshop, seminar, or training. Participants in your training can read the stories in advance or you can use excerpts from the stories throughout your presentation.
- Use stories for training about a particular approach, program model, or population (e.g., integrating mental health services into pediatric primary care, working with caregivers who are substance abusers).

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[1] *For permission to reproduce and distribute the articles, go to www.zerotothree.org/permissions*

Practical Tips and Tools

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Capturing your story by writing it down can enhance your conceptualization of a particular case and offer another avenue for self-reflection on the work you do.

- Select a story to read and discuss in supervision. Other people's stories provide new material and alternative perspectives in the context of supervisory relationships and can often help when clinician's feel "stuck."
- Develop case-based learning opportunities using *Stories From the Field*. Consider regularly incorporating case-based learning into existing seminars and courses for early childhood professionals and creating new opportunities for such learning.
- Use stories to share the work of infant and early childhood professionals with professionals in other fields and settings. Many of the stories describe innovative, transdisciplinary, and cross-systems approaches to early childhood services. They can be used to demonstrate the potential of building collaborative relationships and working together to improve the lives of young children and their families.

Building Workforce Capacity and Creating Systems Change

While professionals rely on data, evidence, and science to drive decision-making, it is often the stories that drive them to create solutions and compel them toward action and, ultimately, change. In a diverse and dynamic field like infant and early childhood mental health, stories can serve as bridges across disciplines, systems, and purposes.

- Use *Stories From the Field* when training transdisciplinary professionals to create connection to and identification with your content area. Ask professionals to identify where they would fit into the story, what their roles might be, and what actions they would take. Ask them to reflect on the perspectives of other professionals and of the families in the story.
- Consider the services and programs described in the stories. How did the setting or type of service impact the providers, families, and children described in the story? What systems, procedures, or institutional supports were necessary to make the program work? What was missing and how could you improve upon the work described?
- Advocate for change using *Stories From the Field* and your own stories. The real-life experiences documented in the stories provide compelling material that can be used to advocate for improvements in early childhood services and systems. Share successes and identify opportunities to transform care on the basis of lessons learned in *Stories From the Field*.

Use *Stories From the Field* as a reflective tool to create self-awareness about your own practice.

The "how-tos" described above are by no means exhaustive. The articles in the *Zero to Three* Journal's *Stories From the Field* series can be used in countless ways to support, promote, and enhance your work on behalf of young children and their families. Be creative and go beyond reading the stories to using them as an opportunity to explore how theory, research, and training are put into practice to create meaningful change in the lives of infants, toddlers, and families.

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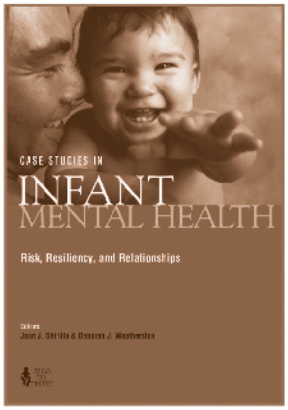
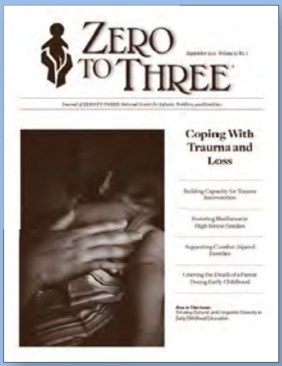

CASE STUDIES IN
INFANT
MENTAL HEALTH
Risk, Resiliency, and Relationships


ZERO TO THREE
Improving the Lives of Infants and Toddlers in Foster Care


ZERO TO THREE
Coping With Trauma and Loss


ZERO TO THREE
Coping With Separation and Loss


ZERO TO THREE
Improving the Lives of Infants and Toddlers in Foster Care

Joining Hands With the Judicial System

Community Collaboration to Support Infant Mental Health in Kansas

ALICE EBERHART-WRIGHT
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For more than 40 years I have worked in the field of early childhood mental health, starting the first therapeutic preschool in Kansas at a state mental hospital in the late 1960s and soon realizing that services had to start much earlier than 3 years old. Although I was trained as a child development specialist, I realized that I had to understand adults and mental health and that my work needed to focus on relationships. I have always considered myself a person who walks back and forth across the bridge from education to mental health and back again. Soon there were new bridges to cross as I realized that I had to deal with community, collaboration, and communication. Each bridge led to a new fascinating village—a village that required joining hands to understand one another's culture. The judicial system is the village that is currently fueling my passion.

My work for all these years has been subject to court decisions that either support healthy child development or create traumas that may affect a child for a lifetime. The work has evolved to include the child welfare cases in which children may need foster care as well as children of divorce whose parents and extended family fight for visitation and custody, lacking the kind of education and support to help them ensure protection for young children's needs and recognition of children's signals for help from toxic stress.

Many years ago, when I was part of a national infant mental health forum, one of our members said, "The babies are crying." Her words have been my mantra as I have seen babies split between two homes, sometimes spending alternate weeks or months in completely different environments with different caregivers who have no understanding how upsetting that can be. Or when I have seen babies moved as if inanimate dolls by various transporters among an assortment of places or returned to an unstable biological home after becoming attached to foster parents who nursed them through very difficult beginnings to their second year or beyond. (See box Essential Components and Challenges.)

The Kansas Story: A Work in Process

I HAD BEEN involved in formulating and working on the Kansas Early Childhood Strategic Plan and found one other colleague who agreed to work with me on reaching out to the judicial system. I spent several years reading many law journals, talking to the editor of *Family Law Quarterly*, and writing a paper based on the research I had done. As I recognized that each judicial system in Kansas operated differently, I was not sure how to go about developing individual relationships. My colleague and I were stuck. As I talked with friends around the country about how we communicated with other important disciplines to build a basic knowledge about infant mental health, we repeatedly heard the question, "What is infant mental health?" On a conference call, one of our ad hoc team members came up with the term, Consortium to Change the World. Why not think big?

When Kansas decided to purchase the Infant Mental Health endorsement system from the Michigan Association for Infant Mental Health, the Kansas Association for Infant and Early Childhood Mental Health (KAIMH) became part of a network known as the League of States that stretched from coast to coast. At the time, Kansas was the seventh state. At annual meetings, our designated participants learned about the work of each of those states and formed relationships that have continued to grow through email and regular phone calls; there are now 14 states that have entered into an agreement with Michigan or are in preparation. In 2012, as a result of these relationships, I decided to attend a conference in Phoenix because of their wonderful work in establishing a system that had four Baby Judges committed to focusing on the needs of infants and toddlers in the child welfare system. They had formed a model collaborative network, had reflective supervision available for specially trained Court Appointed Special Advocates (CASAs) who would deal with infants and toddlers, and offered an annual conference for continuing education. In the current economic climate, child welfare services must be creative and rely more on well-trained volunteers to reach out to increasing numbers of families who require extra service.

The Turning Point

When personal issues arose, preventing me from going to Phoenix, I mentioned my sadness at having to miss this learning opportunity at a KAIMH board meeting, which resulted in the turning point for the judicial initiative. A new board member had resources and an interest in pursuing this herself. She attended in my place and met one of the Baby Judges and one of the coordinators of Arizona's Best for Babies program. Best for Babies is modeled after the ZERO TO THREE Safe Babies Court Teams Project (ZERO TO THREE, 2013) and is a collaboration between Prevent Child Abuse Arizona and 14 of the 15 court jurisdictions in the state.

Board members generally have different resources at their disposal, and our conference participant had a University of Kansas job that handled grants and evaluations around the state. New energy for the judicial work began to grow on the KAIMH board. Although I wanted to focus on my community, my state board membership compelled me to look beyond Topeka. I decided to encourage other Board members to do the same in their areas of the state. We could stay in touch through email and periodic conference calls to share ideas.

Finding an interested judge was critical. It just so happened that an endorsed KAIMH board member from across the state had a sister who had just become the Topeka judge presiding over a caseload of children in the child welfare system. Through that connection, the Shawnee County Judicial Team had our judge who agreed to help with the cause and work with us on how to focus in a more intense and sensitive way on children less than 3 years old. I had become active on a Citizen's Review Board (arm of CASA) to hear cases and make recommendations to the judge. Through my work there along with getting some requests to do "Bonding Assessments," which I relabeled "Attachment Assessments" for the court, I have been able to understand more of the challenges for the court system as well as the need for education for the judicial system and CASA. In the last few months, I have begun offering reflective

ESSENTIAL COMPONENTS AND CHALLENGES

As I grew professionally in my infant mental health career, then reached out to the judicial community to create a mutually beneficial partnership, I realized that I needed to both teach what I knew and learn what I didn't know. I see these principles as important tools to remember and use. They materialized from multiple experiences over many years.

Essential Components for Consideration by the Judicial Community

1. Infants and toddlers communicate through crying and behavior. Persistent crying and challenging behavior can include sleep, eating, and toileting issues as well as either aggressive or withdrawal symptoms. These are signals for help.
2. Relationships are critical. Infants and toddlers require relationships that are ongoing, sensitive, and responsive. Nurturing foster parents can be miraculous interventions for young children. Frequent visits with biological parents both motivate parents to comply with their case plan and help children to keep the parents in mind. Research on the importance of secure attachment has been documented in thousands of studies around the world for at least 20 years. Attachment is an ongoing process that begins at birth and goes through stages that follow a predictable developmental pathway. It is more complex than bonding, which refers to the adult's initial attachment to a baby, usually at birth.
3. Changing the child's placement, especially more than once, is detrimental to development of relationships, which are so critical to young children. Changes threaten the child's sense of security and attachment.
4. Collaborative communication should include all caregivers in a young child's life working together to ensure protection and coordination of regular, predictable schedules that take into account developmental stage and individual needs.
5. Adult wishes or convenience should not take precedence over a child's best interests.
6. Infant and early childhood mental health specialists should be consulted to understand infant and toddler needs. Development changes markedly over the course of childhood, and the earliest developmental stages require specialists for this nonverbal period of life.
7. Toxic stress does great damage for a lifetime.
8. Environment and nurturing relationships are essential, with secure attachment to a few primary relationships a critical component.
9. What a child experiences in the first few years of life largely determines how his brain will develop and how he will interact with the world throughout his life.

Challenges for Infant Mental Health Specialists

1. Recognize the lack of understanding of the judicial system: its standards, the need for education and training, overwhelming numbers of cases requiring decisions, and a culture that may rely on an adversarial rather than collaborative approach.
2. See that becoming involved in the judicial system requires one to learn tricks of the trade: meaningful assessment and report writing skills, willingness to testify in cases where attorneys may see their job as "winning" the case for their client as opposed to thinking about the best interests of the child, setting aside time to build collaborative teams, and finding the resources that provide the best resource material for each situation.
3. It is important to obtain reflective supervision for oneself while also being able to provide it for others because the work is so challenging.
4. It means developing skills to reach out to key people in one's own community to form cooperative teams that support the needs of young children in the court systems.

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What a child experiences in the first few years of life largely determines how his brain will develop and how he will interact with the world throughout his life.

Learn More

Child-Centered Practices for the Courtroom and Community: A Guide to Working Effectively With Young Children and Their Families in the Child Welfare System
L. Katz, Judge C. Lederman , and J. Osofsky (2011)
http://forms.brookespublishing.com/store/books/katz-70731/index.htm

A Developmental Approach to Child Welfare Services for Infants, Toddlers, and Their Families: A Self-Assessment Tool for States and Counties Administering Child Welfare Services
www.zerotothree.org/public-policy/state-community-policy/professional-resources.html

Webinar on Judicial Work in Arizona
www.keccs.org/~eccs/webinar_resources.shtml
Handout and recorded session

Courts, Child Welfare and Infant Mental Health: Improving Outcomes for Abused/Neglected Infants and Toddlers
B. Tableman & N. Paradis (2008)
www.mi-aimh.org/products/publications/courts-child-welfare-infant-mental-health

Michigan Association for Infant Mental Health Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health
www.mi-aimh.org/endorsement

sessions for all CASA volunteers who want to come, as well as training on child development for new CASA volunteers.

Moving Across the State

Meanwhile, other endorsed board members continue to search for partners in their areas of the state. Through regular email communication among all interested parties, the KAIMH steering group is building a network of resources, sharing lessons learned, and setting up a variety of training opportunities. For example, the Arizona program sent us their PowerPoint presentation about the Phoenix work that had been presented at a recent national CASA conference, and our local judge wants to work on a set of resources for the court system. The board member who visited Phoenix set up a webinar conducted by Best for Babies, which gave more than 100 participants detailed information about how their system works. The webinar is now available on a website as a resource for others.

Lifelong Learners

Another important piece is one's own continuing education. Child advocates and other professionals must learn from those in the judicial system about the standards they must uphold, what limitations they have, and what kinds of reports they need to guide their decisions. Working within the broader legal system (including attorneys, mediators, court services workers), it is important to understand how to deal with an adversary, how to communicate, and what materials are most helpful. Working within the child welfare system, infant mental health professionals need to understand their service model, intervention models, and key features. It is important to include medical providers; and Early and Periodic Screening, Diagnostic and Treatment providers; and, providers of mental health, dental, behavioral, and Part C services in all that is done for this age group. Because of the focus on parent and child together, the parents' issues are just as important. It is necessary to voice the wish to learn from everyone and create systems for how to do this, both formally and informally.

Building Community Teams

As members of KAIMH looked at their own communities, they decided which players need to be approached. Here in Shawnee County, individual members of the steering group individually talk with potential partners (any agency or service dealing with families with infants and toddlers who may get into the court system). The hope is to build coordinated collaborative services that expedite infant and toddler permanency in families that best meet their needs. By instituting the Michigan Association for Infant Mental Health Endorsement System for Infant Mental Health 5 years ago, there is a set of standards that ensures state services of culturally sensitive, relationship-focused practice from a growing field of professionals. However, the team may add other clinicians who have not chosen the endorsement route but have a reputation for being experts with this population. It is important not to be too rigid and exclude clinicians who have an established track record.

It was surprising that some of my most exciting connections have evolved from talking about my work in coffeehouses and community events with individuals in social settings. Since everyone is interested in living in a well-functioning society, the topic of infant mental health and brain development becomes fascinating. Soon I have names of people who should be involved from places all over the state that I can pass on to my colleagues in those locations. I realize that my passion has moved this initiative forward by unconventional means. I just needed to listen and empower interested individuals to try out a new idea and share the results. The common denominator with each of the KAIMH ambassadors is our core knowledge of infant mental health and its focus on connecting the pieces of the puzzle.

Tips for Your Journey

As I progress down the once unfamiliar judicial and child welfare path, these are my own lessons learned. You may find others.

- Become familiar with your own judicial system through observing courtrooms, through your own direct experience, and through stories from supervision and colleagues.
- Talk about your new interest everywhere you go, searching for a network of colleagues, important issues, and ideas for moving the process forward.
- Build relationships with supportive judges and court workers through networking with everyone you know.
- Search the web for resources, learning about the judicial system as well as infant mental health principles that are particularly important for you to know and practice.
- Become active in an infant mental health organization such as ZERO TO THREE or international and state branches of the World Association for Infant Mental Health.
- Find a mentor through ZERO TO THREE's Policy network or some of the resources listed in this article to guide you on your journey.
- Find a way to use your own talents and ideas, such as making talks; showing PowerPoint presentations; or using photographs, DVDs, and stories. The Robertsons' (Robertson, J., & Robertson, J., 1967–1973) powerful films from the 1960s revolutionized procedures that had caused infants and toddlers significant distress in foster care. They are still incredible examples to show the intensity of young children's trauma with separation. The Safe Babies Court Teams (ZERO TO THREE, 2012) DVD is a rich, compelling guide to bring together community players who can make a difference in their community.
- Reflect on progress, challenges, lessons learned, and next steps.


Photo: ©iStockphoto.com/mocker_bat

Attachment is an ongoing process that begins at birth and goes through stages that follow a predictable developmental pathway.

Alice Eberhart-Wright, *LCMFT, IMH-E IV, is an infant mental health specialist and licensed clinical marriage and family therapist who has specialized in children less than 6 years old. She has done extensive writing, speaking, and consulting on multiple mental health issues dealing with children and families on an international basis. Her Child Development Center at Topeka State Hospital in the late 1960s and early 1970s dealt with a wide range of families, many of whom had mental health issues, generations of dysfunction, and failures to find success in raising their children from birth to 6 years old. She has worked on a National Institute of Mental Health adolescent parenting research project with Joy Osofsky at Menninger in Topeka and a National Institute of Child Health and Human Development project focused on working with low-income families to develop parenting skills at the University of Nebraska. She was the first regional infant family specialist with Early Head Start in Region VII. She was the last program director for Menninger's Preschool Day Treatment Center. She and Abbey Griffin developed Focus and Reflect, a camcorder strategy to capture and build on beautiful moments in adult–child interaction. She has a published book of children's songs* (Swinging on a Tune: Songs for the Very Small and Very Tall) *and a chapter on multiple caregivers in* Infant and Toddler Mental Health *(edited by Martin Maldonado). She is currently on the board of directors for the Kansas Association for Infant and Early Childhood Mental Health.*

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Be a Court Appointed Special Advocate for a Baby

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I love being a Baby Court Appointed Special Advocate (CASA)!

A CASA is appointed for a child in foster care. According to the national CASA organization, CASA volunteers are appointed by judges to represent the best interests of children who have been removed from their homes because of abuse or neglect. CASA volunteers are everyday citizens who have undergone screening and training with their local CASA program (National CASA Association, 2013a). CASAs generally take one case at a time, visiting with the child and foster parents, attending medical appointments, talking with teachers or child care providers, and observing how the child and biological parents relate. CASAs also write up their observations, opinions, concerns, and recommendations for the child prior to every court hearing. CASAs attend each hearing to update the judge and to answer questions about the child (National CASA Association, 2013c).

To date, most CASAs have been involved with children of at least school age; verbal children who can walk down to the park to play catch, go to the movies, or out to eat.

Why Be a CASA for a Baby?

Nationally, nearly one in four foster children enter care less than 1 year old. These children are more likely to be adopted and are vulnerable to developmental delay leading to risks for failure in school and life (Wulczyn, Ernst, & Fisher, 2011). In Arizona, infants less than 1 year old are the largest age group to enter care, they remain in care longer, and they more often (1 in 5 children) return to foster care after reunification with parents because of re-abuse (Arizona Department of Economic Security, 2012).

The period from birth to 5 years old is a sensitive period for all children, and four important bodies of research inform policy and practice for children in this age group: brain development, child development, adverse childhood experiences, and economic investment in early care and education.

1. Neuroscience documents the tremendous growth of the brain during the first 5 years of life. Brain development affects growth and development in all other domains. Trauma from abuse or neglect, as well as separation and loss of familiar caregivers, dramatically alters brain development (Center on the Developing Child at Harvard University, 2012).
2. Child development research reveals how babies learn and how parents can facilitate that learning, or not. Safe, stable, nurturing relationships are key to maximizing the child's capabilities (Center on the Developing Child at Harvard University, 2010).
3. Adverse childhood experiences (events that happen before a child is 18 years old, e.g., physical, sexual, or emotional abuse or neglect, maternal depression, incarcerated parent, domestic violence), have demonstrated serious consequences for adult health and well-being and can be a factor in intergenerational abuse and neglect (Felitti et al., 1998).
4. Economists have solid research supporting investment in the early years as the most effective return on investment for society (Heckman, n.d.). Savings range from $4-$17 for every $1 invested, depending on who's calculating and how deeply the cost benefits dig into education, crime, welfare, productivity (CED, 2012).

All of this exploding research combines to strongly suggest that paying attention to the growth and development of infants and toddlers at this critical developmental stage of life is a cost-effective investment in American society. Child maltreatment is most often intergenerational. There is an opportunity to halt that intergenerational cycle by investing in the children most vulnerable to abuse and neglect, the babies. Creating positive childhood experiences for children in the child welfare system can provide them with healthy, nurturing relationships that form the basis for a positive model for parenting their future children.

What Does a Baby CASA Do?

As described on the National CASA Association website (2013b), a CASA volunteer spends time with the child, getting to observe her likes/dislikes, abilities/

difficulties, and what she is learning about her world. The CASA uses the information gathered to inform judges and others what the child needs and what will be the best permanent home for her.

When the assigned child is a preverbal infant or toddler, the CASA's work is necessarily with the child and caregiver(s). How do the caregiver and child relate to one another? Is the child learning to trust that the caregiver will protect and comfort him? Does the caregiver allow the child to use his muscles and explore his world? Can the CASA help the caregiver to sensitively interpret baby behavior?

It may be easiest to explain with an example. Let's meet Katie.[1]


Photo: ©iStockphoto.com/Zhang Bo

The period from birth to 5 years old is a sensitive period for all children.

Katie was born drug exposed (meth, alcohol, and tobacco) and placed in foster care upon discharge from the hospital, as had two older siblings, of different fathers, who were subsequently adopted into other families' care. Their mother, Leah, 18 years old when the first baby was born, had a serious substance abuse history, and because she could not safely or adequately meet the needs of her babies, she lost parental rights to them soon after Katie was born. She said of Katie at the time she was removed, "The drugs are winning. I don't want this baby girl."

I was assigned as Katie's CASA 2 weeks after her birth. Katie's guardian ad litem (or attorney) asked why a CASA was needed on this case; it looked like her mother's rights would be terminated and she would also be adopted. However, a CASA could be a valuable advocate for Katie while she remained in the custody of Child Protective Services (CPS).

My first step was to review the state case file at CPS. Leah had been in the foster care system since she was 7 years old, never graduating high school or earning a GED; her own mother had been in and out of prison for substance abuse. Katie's father, Leo, who is 10 years older than Leah and is also the father of two gradeschool-aged girls, had been imprisoned for 9 years for his involvement in a murder, with multiple entries prior to that for juvenile offenses. He was a heroin addict and dealer and had been jailed for the 95 days just prior to Katie's birth for nearly strangling Leah. Both Leo's father and mother had prison records, as did his older brother and sister-in-law—who were also the foster parents of his two daughters. He completed a GED while in prison. He has never held a job.

This is a case of intergenerational trauma. Poor parenting skills and insecure attachments have dealt Leah and Leo dysfunctional models for coping with life, and especially for parenting Katie. Such inadequate parenting puts Katie at risk to repeat a life of abuse, neglect, lack of education, and potential crime. The effects of adverse childhood experiences are obvious for these parents, leading them to engage in risky behaviors which are showing up in drug abuse, depression, and the inability to hold a job. People working with this family need to view them through a trauma-informed lens, asking "How are these adverse life experiences affecting you?" not "What's wrong with you?"

Katie was initially placed for the first month of her life with the foster mother who has adopted Katie's middle sister, but she cannot adopt Katie. Katie's father, Leo, requested that Katie be moved to his brother and sister-in-law, who are also caring for his two other daughters born prior to his prison term. The Court agreed.

I visited Katie and her new foster family every other week. The foster mother, Sarah, now a grandmother, had not cared for a newborn in a long time. She was loathe to put Katie on her tummy, which limited Katie's opportunities to stretch her muscles. She was either held or put on her back in a portable bed. Katie's development was worrisome. Although Katie was not an irritable baby, she appeared to have problems with her muscle tone, consistently stuck her little tongue out like a snake, and spit up a lot, all consistent with prenatal drug exposure. I requested a visit from the child development/early intervention specialist to assess her for any delays. Both the specialist and I introduced play activities to Sarah to help Katie strengthen her muscle tone and practice using her muscles. We both encouraged Sarah to take Katie to the pediatric clinic for immunizations and anticipatory guidance as well as treatment for frequent colds. I urged the specialist to continue routine visits with Sarah and Katie to assess the baby's progress and to update activities for the foster mother and teenage half-siblings to use in their play with Katie.

It was gratifying to put knowledge about early brain development and child development right to work to help the foster parent recognize her role as the child's first and best teacher.

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[1] *The names in the case example have been changed as required to protect the confidentiality of all children and families in the dependency system.*

Photo: ©iStockphoto.com/StudioStella

During the first 2 years of life, babies learn which people in their lives are their very important people.

I teamed with the social worker and Katie's attorney to make a home visit. We jointly recommended that Sarah talk to the pediatric clinic about the abnormal amount of formula Katie spit up and her near constant respiratory problems. The pediatrician conducted a swallow test (x-ray) and prescribed a thickening gel for "silent aspiration"—another probable result of prenatal drug exposure.

Leah and Leo, the biological parents, had been ordered to provide random urine tests and attend substance abuse treatment sessions. It was clear that Leo intended to keep Leah clean in order to comply with these court orders so that they could get Katie back with them. Other court orders for the parents included domestic violence counseling and couples counseling. Parents must show the court that they can and want to be good parents to their child by complying with all court orders before the judge will grant parent–child reunification, placing the child back in the parents' home.

Working Toward Reunification

When reunification is the plan, a best practice to improve outcomes for infants and toddlers in foster care is to ensure that the biological parents and children see each other frequently. In one study, researchers found that for every additional visit per week, reunification is 3 times more likely (Potter & Klein-Rothschild, 2002).

The court had ordered supervised visits between Katie and her biological parents for 2 hours twice a week. It took a while for the state-contracted Parent Aide services to start, so Leah and Leo visited her twice a week in the CPS office, then in the Parent Aide contractor office because they did not have their own home. In order to increase the amount of time they could see their baby, now 4 months old, the parents attended the same church that the foster family attended. I also attended church so that I could see how Leah, Leo, and Katie were interacting and relating to one another. During one of these visits at church, the foster family, biological parents, and I all sat down to talk about how things were going and how to create a safe, stable environment for Katie. It was during this visit that Leo said he was very uncomfortable with the Parent Aide who was supervising visits twice a week at the Parent Aide office. Leo felt the Parent Aide was watching him as if he were a felon. And it turns out the Parent Aide in a previous job had indeed been a prison guard. The discomfort Leo felt was interfering with his interactions with Katie. I urged him to request a change in Parent Aide. He did. Subsequent visits went much better. Leo got a job, which led to renting an apartment, and Katie could visit her parents in their home, still supervised.

When the CASA believes it is in the child's best interests, she can take the opportunity to listen to parents and encourage them to advocate for themselves in support of reunification with their baby. I offered a relationship to Katie's parents, encouraging them to seek and use community supports and resources to help them to continue to be "good enough" parents to their adorable little girl.

Facilitating Positive Relationships

A Baby CASA's primary responsibility is to observe the baby in an effort to understand what life is like for her, to figure out whom she can trust to contingently respond to her needs for not only food and comfort, but also for emerging recognition of who she is. During the first 2 years of life, babies learn which people in their lives are their very important people (VIPs). Ideally, these are the people who will protect them, keep them safe, and encourage them to explore their world. Very young children need skin-to-skin contact with their VIPs. They do not yet have the memory skills to keep their VIPs in mind when out of sight. As Urie Bronfenbrenner said,

> *...in order to develop normally, a child requires progressively more complex joint activity with one or more adults who have an irrational emotional relationship with the child. Somebody's got to be crazy about that kid. That's number one. First, last, and always* (National Scientific Council on the Developing Child, 2004, p. 1).

When appropriate, the CASA can advocate for frequent and regular visits with the biological parents, in natural settings if possible, so that the child can experience the touch, voice, smells, and faces of his parents, to hopefully experience "an irrational emotional relationship" between parent(s) and child.

The CASA also has an opportunity to encourage foster parents to fall in love with the baby, to be the day-to-day person who is "crazy" about her. Research by Zeanah and colleagues (2009), studying placement of Romanian orphans in community-based foster homes with foster parents capable of positive emotional investment in them, showed that children placed prior to being 18 months old can develop secure attachments and make up lost ground in physical, cognitive, and emotional domains.

One day, I got a call telling me that Katie had been abruptly removed from the foster home she had been in for 5 months and placed in a new foster home. CPS felt she was unsafe there. An older child in the foster home had been harmed, so CPS removed Katie. Katie, at 6 months old, lost the foster parents who had provided her with secure and stable care and had to adjust, for the third time, to new surroundings and a new "mothering" figure.

I was worried that this move would be hard for Katie— that she would get sick again, that the small gains she had made developmentally might stall. It is a testament to the resilience that can be engendered by safe, stable care of an infant—even if for only 5 months—that Katie could experience minimal outward disruption in her eating and sleeping schedules when she was placed in the new foster home with a foster mother who was crazy about her. The only clue that I could see in Katie's behavior was reluctance to approach me when I visited in her new foster home. She and I had seen each other nearly weekly over the past 5 months and she was beginning to enjoy sitting in my lap or giggling when we played peek-a-boo. Now she wanted to stay in her foster mother's arms.

Fortunately, Katie's new foster mother, Jane, was a responsive, nurturing young woman who gave Katie lots of physical affection as well as daily routines for eating, sleeping, and exploring. At the new foster home, Katie played with two other children just 1 and 2 years older. There were many toys and more people to interact with her. Given the positive structure of this household, I could see Katie begin to turn to Jane for comfort and reassurance.

But while Katie was learning to trust that Jane would protect and support her emerging exploration, I was feeling anxious about how to best advocate for Katie in the reunification process with her biological parents, Leah and Leo. Given the substance abuse and violence experienced by and between her parents, would reunification be best for Katie? Jane's household was providing a good place for Katie to be safe, healthy, and encouraged to get back on track with developmental milestones. On the other hand, research says children do best long term when returned to their birth parents. Could Leah and Leo learn to be "good enough" parents?

Reflective Supervision

Fortunately, I had the opportunity for reflective supervision with an experienced clinician, Lillian, who could think with me about the options for Katie and for exploring my own feelings about Katie and about her parents. I had observed how Katie fussed when her foster mother was out of her sight, and how she quickly quieted when back in Jane's arms, ready to go back to playing with the toys. I had observed how Leah seemed to try too hard to get Katie's attention on visits with her biological parents, while Katie snuggled right into her father's shoulder when he picked her up. Lillian helped me to identify my own emotions as I observed Katie and to recognize how my feelings were likely similar to Jane's as well as Leah's and Leo's. Is Leah sad that she has already lost two daughters and could lose Katie as well? Is she feeling incompetent? Is Leo concerned that he might not get to parent this baby as she grows into her teen years? Does Jane share my concern for Katie's safety as well as the less than optimal opportunity for having fun if she returns to her parents?

Meanwhile, supervised visits occurred twice weekly at the biological parents' apartment. I accompanied Katie on one of these visits. It was very clear that Katie liked to be with her father, who appeared comfortable and responsive to her. She was less enthusiastic about being with her mother. Leah was intrusive, sometimes shaking a toy in Katie's face and bouncing her vigorously. Katie would fuss and turn away. Leah said poignantly, "Katie doesn't like me." I worried about both of them. I worried about Katie because her mother had such a difficult time responding appropriately and often misread Katie's cues. I worried about Leah because she appeared emotionally shut down, anxious, unable to hold or offer emotional support to her baby girl. I wrote this into my Court Report, encouraging more social and emotional support for them both (Bandy, Andrews, & Moore, 2012) through a home visiting or Early Head Start program.

The Permanent Placement Decision

The case had been in dependency court since Katie was born and placed in the first foster home, which was now 12 months ago. By law, for children less than 3 years old, the judge seeks a permanent placement decision within 12 months.[2] Overnight visits with Katie's biological parents had been occurring twice a week, with only pop-in supervision for the past month, and with the Parent Aide reporting no safety issues. In the eyes of the court, Leah and Leo met the definition of "good enough parents." The persons responsible to monitor parent–child interactions reported no safety concerns for the child, the biological parents had shown the ability to provide adequate food and shelter, and they had complied with the services in the case plan (i.e., substance abuse testing, counseling). The judge at the permanency hearing agreed to family reunification, with strong recommendations for Leah and Leo to agree to participate in family support programs such as a voluntary home visiting program and, if available, enrollment in Early Head Start.

Learn More

Best for Babies, Prevent Child Abuse Arizona
www.pcaaz.org
The Best for Babies (B4B) program in Arizona is modeled after the ZERO TO THREE Safe Babies Court Teams. B4B is a project of Prevent Child Abuse Arizona and is funded by the Court Improvement Project of the Arizona Administrative Office of the Courts and First Things First.

ZERO TO THREE Safe Babies Court Teams
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ZERO TO THREE created the Safe Babies Court Teams to increase awareness among those who work with maltreated infants and toddlers about the negative impact of abuse and neglect on very young children and to change local systems to improve outcomes and prevent future court involvement in the lives of very young children. The Safe Babies Court Teams works toward these goals by training professionals, providing resources, encouraging collaboration between existing community service providers in Court Teams sites, and increasing parent-child contact, mental health capacity, and placement stability in the Court Team sites.

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[2] *Arizona Revised Statutes, Title 8 Children, Section 8-862. Permanency hearing.*

When the judge asked for my comments as a Baby CASA, I urged both parents to accept help in developing positive supports within their community. I spoke directly to Leah to encourage her to allow someone to continue to support her in her relationship with her little girl. She had lost two other daughters; her grief about those children was apparent in her reluctance to fully commit to Katie; there was a great deal of emotional support needed to help them reconnect (Bandy et al., 2012). I encouraged Leah to complete her GED so she could better support Katie when she's in school. I spoke directly to Katie's father about his nurturing way with Katie and how important he was to her continued health and growth. I encouraged him to support his wife to become the best mother she could be for Katie.

I called the foster mother to tell her that Katie would be returned to her parents' care. Although she also had reservations about Katie's return—were the parents ready? Would their care be "good enough?"—she shared my support of the judge's decision. Katie and her parents had a place in our hearts and minds. We understood that our involvement as foster mother and Baby CASA, respectively, had helped Katie to feel secure in her foster care placement and in her visits to her biological parents' home, giving Katie a storehouse of resilience to draw on as she grows, and had helped her parents' confidence that they could provide "good enough care."

There were other feelings, too, as I said good-bye to a baby I had come to care about. I felt fortunate to be assigned to this case that was originally thought to be an automatic termination of parental rights and Katie's subsequent adoption. Perhaps my involvement helped all parties understand Katie's needs and led to the best possible outcome for Katie. That thought is tempered by the fear that the unresolved intergenerational violence and dysfunctional parenting models in her biological family, unless supported to change, could lead to future problems. However, I am comforted knowing that in my role of CASA, I helped all the parties—the foster parents, the biological parents, the early interventionist, the CPS worker, and the judge—to gain insight into Katie's needs and facilitate their efforts to find a safe, stable, and loving permanent home.

Author's Note

This article is written by Dr. Mary Warren, as an individual, and does not represent the views of the Arizona Supreme Court, the Arizona Judicial Branch, or the Arizona Supreme Court CASA Program. Confidential documents and information have not been disclosed. The views stated herein are the views of the author, in her individual capacity, and are not the views of the Arizona Supreme Court, the Arizona Judicial Branch, or the Arizona Supreme Court CASA Program.

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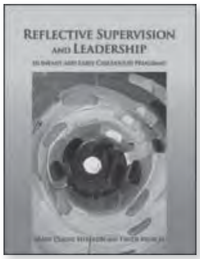

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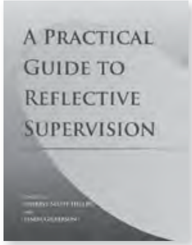

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Adaptations Supporting Relationships Between Parents With Physical Disabilities and Their Infants and Toddlers

MEGAN KIRSHBAUM
Through the Looking Glass
Berkeley, California

At least 6.1 million children, 9.1% of children in the United States, have parents with disabilities. More than 4.1 million parents with children less than 18 years old, 6.2% of parents, have reported they have at least one disability (Kaye, 2012). In addition, there are many parents and primary caregivers who do not identify as disabled although they experience functional difficulties that affect baby care such as pain and fatigue. There has been a rapid increase in the number of grandparents in parenting roles, cited as 2.6 million for 2008–09 and estimates of disability in these parenting grandparents has ranged from 25% to 50% (Kaye, 2012; Minkler & Fuller-Thomson, 1999).

This prevalence of parenting with a disability is obscured because systems at the local, state, and national levels seldom identify parents with disabilities in their data collection. The resultant lack of identification of need has limited the development of resources, expertise, and systems change to support families.

As the newly released report *Rocking the Cradle: Ensuring the Rights of Parents With Disabilities and Their Families* by the National Council on Disability (2012) pointed out, parents with disabilities and their children face ongoing multisystem social obstacles, including housing, transportation, personal assistance, custody, and assistive technology. They frequently have to pay out-of-pocket for extra expenses associated with being a parent with a disability despite family incomes that are approximately half those of parents without disabilities (DeNavas-Walt, Proctor, & Smith, 2012; Kaye, 2012).

A Disability Culture Perspective

Disability culture's contextual view of disability as socially constructed shifts the emphasis from the differences that reside within the individual to an emphasis on social and environmental obstacles. A social or cultural perspective regarding disability focuses on transcending obstacles through access: the elimination of barriers whether due to attitudinal bias, lack of expertise, lack of resources, communication, environment, or public policy (Kirshbaum, 1994; Olkin, 1999).

Abstract

This article focuses on a disability culture-based organization's process of addressing baby care adaptation issues of parents with physical disabilities and their babies and toddlers. The author describes the role of teamwork between infant mental health specialists and occupational therapists, application in custody situations, and public policy change efforts relevant to baby care adaptation. Baby care adaptations can have a profound effect on the relationships between parents with physical disabilities and their young children.

Speaking from the perspective of people with disabilities and their family members, pragmatic ingenuity about adaptation is needed to achieve access—to make family life work in the face of everyday obstacles (Kirshbaum, 2000).

Through the Looking Glass

Through the Looking Glass (TLG) grew out of the independent living or civil rights movement for people with disabilities. As such, the organization has had a cultural rather than a medical model of disability—with a commitment to decreasing social obstacles through supporting better practice and more resources nationally, through adapting services, and through developing parenting adaptations to reduce functional obstacles associated with disability. Since its founding in 1982 TLG has served families with disability in parent or child, combining infant mental health, family therapy, and early developmental intervention with practical adaptive disability solutions. TLG has been the primary organization, nationally and internationally, focused on baby care adaptations for parents with physical disabilities and their young children, serving thousands of these diverse families. Over the years TLG has found that baby care adaptations can have a profound effect on the relationships between parents with physical disabilities and their babies and can impact the outcomes of child custody cases.

This article focuses on the process of addressing baby care adaptation issues of parents with physical disabilities and their babies and toddlers, including the role of teamwork between infant mental health specialists and occupational therapists, application in custody situations, and public policy change efforts relevant to adaptation.

Documenting Natural Infant–Parent Adaptation

As initially described in *Zero to Three* (Kirshbaum, 1988) TLG conducted a groundbreaking research project from 1985 to 1988 that sought to expand the working sense of the range of "good-enough parenting" to include physical difference in parents. The project videotaped, monthly, how mothers with physical disabilities cared for their babies from birth through toddlerhood in basic areas of care (e.g., feeding, bathing, diapering and dressing, lifting, carrying, and moving). Without intervention or adaptations being introduced by service providers, most mothers developed ingenious solutions to disability obstacles. A natural reciprocal adaptation process unfolded over time in the mother–infant dyads. Videotape analyses mapped this gradual mutual adaptation process as it developed between parent and infant during interaction. Babies adapted to their mothers' disabilities as early as 1 month old.


Photo: Hunter Lewis Wimmer

At least 6.1 million children, 9.1% of children in the United States, have parents with disabilities.

For instance, a one-month old infant would curl up like a kitten and remain very still and compact during lifts by his mother with paraplegia. This adaptation was elicited by the mother positioning the baby on his back and signaling him by tugs on his clothes, pausing to evaluate his readiness before lifting, then lifting by holding on to the front of his clothes with one hand. The mother demonstrated how she had very gradually been working on developing the baby's ability to hold up his head during the lift. One month later, at two months of age, videotaping documented that despite his increased physical ability the baby didn't do his part of the work as effectively when he was drowsy—letting his head fall back more, moving too much and becoming less compact during lifts. His mother explained that he needed to be aware of her signals to cooperate. (Kirshbaum & Olkin, 2002, p. 72)

Subsequent work with families involved with the child welfare system revealed interruption of the mutual infant–parent adaptation process associated with out-of-home placement and infrequent visitation. It became clear that families in these situations had a heightened need for assessment and intervention regarding baby care adaptations.

A parent with significant cerebral palsy was videotaped by child protection workers while diapering her baby—without any adaptations being provided and after a long period of out-of-home placement which interfered with the natural reciprocal adaptation process between parent and child. This tape was cited in court as evidence for her parental incapability, despite the similarity to long diaperings by high functioning mothers with cerebral palsy in the community. (Kirshbaum & Olkin, 2002, p. 74)

In response, the TLG infant mental health therapist, familiar with disability adaptations, began introducing parenting adaptation as part of her evaluations in child welfare cases.

For example, in a child welfare case involving a mother with significant cerebral palsy, the psychologist conducting the evaluation speculated that the lack of mutual gaze between mother and baby was likely due to the intrapsychic pathology of the mother. However, no one had set up a physical situation in which the

Photo: Through the Looking Glass

Parents with disabilities and their children face ongoing multisystem social obstacles, including housing, transportation, personal assistance, custody, and assistive technology.

> *mother and baby were comfortably located face-to-face at an appropriate distance from one another to allow mutual gaze to develop. The disability specialist simply attached a laptop tray to the mother's motorized wheelchair and positioned the baby on a pillow on the tray (with pillow and baby secured by a wide Velcro strap); mutual gaze between mother and baby began immediately.* (National Council on Disability, 2012, p. 175)

Such situations led to the conclusion that one cannot evaluate parental capability and the potential of a relationship between a parent with a significant physical disability and a baby without first providing whatever adaptive techniques and equipment reduce stress during parenting or even make it possible for interaction to occur and the infant–parent relationship to develop. Without doing so one is evaluating the mismatch of the environment with the parental disability, not the parenting.

Baby Care Adaptation Research and Development

These experiences motivated the addition of occupational therapists to TLG's infant mental health staff, so that baby care adaptation development could be a focus. TLG began a series of three research and development projects funded by the National Institute on Disability and Rehabilitation Research (NIDRR) and conducted by a team of infant–family mental health specialists and occupational therapists. These projects designed, fabricated, and provided individualized baby care adaptations to parents with physical disabilities and their babies in order to reduce obstacles at the outset of parenting. The equipment was informed by the inventions of mothers documented in the 1985–1988 study. For instance, several of those mothers who needed to lift with one hand grasped their babies' clothing during lifts. Lifting harnesses were developed as a more dependable and secure version of that strategy. The adaptations also included accessible cribs; baby care trays and seats for wheelchairs; four-wheeled walkers with baby seats; accessible diapering surfaces and high chairs; positioning supports for breastfeeding, holding, and carrying; as well as accessible childproofing. Adaptive techniques (e.g., one-handed diapering and dressing) and facilitation of cooperation in the infant (e.g., teaching them to lift their bottoms during diapering) that were based on the solutions of parents with disabilities were included in the intervention. Illustrations were provided through publications with photographs (DeMoss, Rogers, Tuleja, & Kirshbaum, 1995; Vensand, Rogers, Tuleja, & DeMoss, 2000) and a videotape.

The disability cultural perspective was reflected in the emphasis on *environmental mismatch*, "the barriers or physical elements in the environment which fail to match the functional abilities of the parent are seen as the problem rather than the parent's physical limitations" (Tuleja & DeMoss, 1999, p. 72). Focusing on what is conducive to change is the point—changing a diapering surface to accommodate a wheelchair—rather than focusing on a mother who can't stand as the problem.

Videotapes of interaction were analyzed before and after provision of baby care adaptations to assess outcomes. These research projects found the baby care adaptations to be inherently empowering, decreasing environmental barriers and increasing parents' functional baby care abilities and involvement, decreasing fatigue and pain. By reducing the physical demands of care the equipment appeared to prevent secondary injury. Occupational therapists had observed mothers, without baby care adaptations, overstressing their own bodies and developing repetitive stress or back problems, in an effort to avoid stressing their babies during care. In some situations, the equipment helped resolve maternal depression that was associated with postnatal exacerbations of disability, such as in multiple sclerosis. As baby care tasks became easier, parents tended to be less preoccupied with the physical demands of the task and engaged in more positive interactions with their babies (Tuleja & DeMoss, 1999; Tuleja, Rogers, Vensand, & DeMoss, 1998).

Next, a national survey of 1,175 parents with disabilities was conducted for TLG's National Center for Parents With Disabilities, documenting the many social obstacles these parents experienced (Toms-Barker & Maralani, 1997). Parents noted the unavailability of adaptive parenting equipment or information about it and the lack of public or private health funding for it, necessitating out-of-pocket payment. Of the 717 parents who answered how adaptive parenting equipment could have improved their lives 53% said it would have made them more independent or less tired, 51% said it would have made things take less time, 49% said it would have made them feel more secure about their child's safety, and 42% said it would have caused less pain.

A subsequent survey of 89 couples in which mothers had disabilities and nondisabled partners documented happy marital relationships and high satisfaction with their division of child care, household tasks, and family decisions. However, a majority of the mothers with disabilities rated improved availability of funding for adaptive equipment as likely to increase their satisfaction with the division of family labor (Abrams, Jans, & Kirshbaum, 2001; DeMoss, Jans, & Kirshbaum, 1998).

Encouraging National Baby Care Adaptation Practice

Since the establishment of TLG's NIDRR-funded national centers for parents with disabilities and their families in 1993, requests for technical assistance and information have indicated an unmet need for occupational therapy services for parents with physical disabilities and a related need for occupational therapist training regarding baby care adaptations. TLG responded by developing a curriculum to train occupational therapists in academic settings (Tuleja, Rogers, & Kirshbaum, 2002). TLG is currently developing an online course regarding baby care adaptations to meet the needs of practicing occupational therapists.

Developing Tools to Support Baby Care Adaptation Practice

During the national centers' technical assistance and training, a need had been identified for tools to guide baby care assessment and intervention practice. TLG completed the *Baby Care Assessment for Parents With Physical Limitations or Disabilities: An Occupational Therapy Evaluation* (BCA; Tuleja, Rogers, Kirshbaum, & Abrams) in 2005 as a NIDRR Field-Initiated Development Project. It has been primarily used to guide intervention and to train occupational therapists since then. The breadth of the assessment has also proved to be very effective for clarifying the physical functioning of parents involved in custody cases.

The BCA tool (Tuleja et al., 2005) was based on extensive clinical experience assessing and addressing parents' baby care strengths and challenges, analysis of existing performance measures, and TLG's research projects involving development and analysis of the impact of baby care adaptations. The tool reflects development by a team of infant–family mental health specialists and occupational therapists, including those with personal and family disability experience. The BCA includes a Parent Baby Care Self-Assessment, Occupational Therapy Baby Care Performance Analysis, and Parent-Child Relationship Referral Guide. The domains included in the Baby Care Performance Analysis are:

1. Holding,
2. Positional Changes,
3. Carrying and Moving,
4. Nursing,
5. Bottle Feeding and "Sippy" Cup,
6. Spoon Feeding,
7. Diapering,
8. Dressing,
9. Nap and Bedtime Routines,
10. Bathing,
11. Hygiene,
12. Going Places,
13. Comforting,
14. Interactive Play,
15. Providing Developmental Experiences, and
16. Discipline/Limit Setting/Cooperation.

TLG has already established that the BCA (Tuleja et al., 2005) performance analysis ratings have strong content validity and high inter-rater reliability among TLG occupational therapists. External content validity was established through training and use by occupational therapists in several institutions. Current research focuses on whether performance ratings made by occupational therapists who were not involved in the development of the tool are adequately correlated with TLG ratings, to ensure that the BCA has sufficient inter-rater reliability when used with occupational therapists outside of TLG.

Ensuring validity of the tool is particularly important because it is increasingly being used to generate evidence in child welfare and family court custody cases when the physical functioning of a parent with a disability is alleged to negatively impact the well-being of their child. A TLG vignette included in the National Council on Disability report on parents with disabilities and their children illustrates such use:

Photo: Through the Looking Glass

Baby care adaptations can have a profound effect on the relationships between parents with physical disabilities and their babies.

> *Paul's story demonstrates the gravity of the situation faced by many parents with disabilities who are involved in the family law system. Paul was a father with quadriplegia and a stay-at-home parent for his three-year-old son Leo. He had spent 20 years as a police officer and became quadriplegic when he was shot on the job. Although Paul used walking canes, his active son was safe in his care. He had door alarms on the doors and bookcases in case Leo tried to climb or leave the house. An ingeniously installed alarm system triggered if Leo tried to leave the yard. Leo had never been hurt or gotten away as a result of Paul's disability. Then Leo's mother filed for divorce, moved out, and filed for full physical custody. She asserted that quadriplegia rendered Paul unable to care for Leo.*
>
> *Despite uncontested testimony that Paul had always been the primary parent, the Georgia family law court awarded temporary custody to the mother, with severely limited visitation to Paul. Twenty-four-hour supervision was required during the visitation periods, and Paul was ordered to hire a professional nanny to supervise visitations. Over the next two years of litigation, Paul went through a significant portion of his disability retirement fund paying for attorneys, private nannies, interim child support, and assessments.*
>
> *He and his attorney concluded that the only way to show parental capacity was with an Adapted Baby Care Assessment. No occupational therapist was able to do the assessment in their area, so a therapist from TLG flew to Georgia, conducted the assessment, completed and submitted a court report, and appeared in court to defend it at trial. Paul won half custody of Leo with no requirement of supervision. While grateful, he was sad that he had missed a great deal of his son's life. Both he and Leo experienced tremendous grief during the long periods of court-ordered separation.* (National Council on Disability, 2012, p. 148)

TLG has also been modifying the BCA (Tuleja et al., 2005) for use to predict adaptation needs and potential functioning when current performance in baby care cannot yet be observed. One example of this is use of the BCA in home studies that precede adoption. Another TLG vignette from the National Council on Disability's report regarding parents with disabilities and their children illustrates this:

> *For instance, a woman with a physical disability experienced difficulty during the home study required for adoption. The social worker said she had serious reservations about the woman's ability to parent, especially that she might drop a baby or be unable to catch a toddler who ran off. The woman—a leader in the independent living community—assumed that it would not be wise to express her dismay about the social worker's speculations. Rather, she contacted a national center that provides technical assistance regarding custody issues of parents with disabilities. The center conducted a baby care adaptation assessment, using weighted dolls and adaptations that have proved helpful to other parents with disabilities. The mother provided the adoption agency with the assessment report, documenting capabilities and solutions to potential difficulties, as well as the center's video and publication illustrating such adaptations in use by other parents. She successfully adopted a baby.* (National Council on Disability, 2012, p. 179)

Photo: Through the Looking Glass

Once parents experience the use of the adaptations, they have voiced that the "can-do" attitude implicit in the baby care solutions opens up hope and possibilities.

As a disability culture-based tool, the BCA (Tuleja et al., 2005) has an empowerment orientation; the development of adaptations is guided by the parent's expertise and choices about role and care options. Teamwork between parents and occupational therapists is integral to the process.

Teamwork Between Infant Mental Health and Occupational Therapy Practitioners

Teamwork and mutual support between infant mental health and occupational therapists is crucial when serving the most stressed and vulnerable families. Parents with disabilities are not immune to the problems that are familiar in infant mental health practice and that complicate the formation and course of the infant–parent relationship. They may have had childhood histories of abuse and neglect and may have had multiple out of home placements. Having grown up in an era of inadequate support for families of children with disabilities, their relationships with their own parents may have been affected by unaddressed parental grief and depression.

In addition, women with disabilities are more vulnerable to abuse and violence than women without disabilities. Social isolation and dependence on others for personal and household assistance increases this risk. Research documents that some women with disabilities stay with partners who are potentially dangerous to themselves and their children when the women depend on the partners for care and are concerned they will lose custody of their children without this assistance (Millberger et al., 2002; Nosek, Robinson-Whelan, & Hughes, 2006). Recall that TLG's research indicated that baby care adaptations can increase the parenting role; therefore they can reduce dependency on assistance.

Parents with disabilities may be vulnerable to depression due to isolation; poverty; history of dependency, abuse, or exploitation; environmental barriers; barriers to health care; and health disparities. Depression is often unidentified and unaddressed in parents with disabilities, and the results of depression are often conflated with the impact of the disability. Women with disabilities experience a particularly high rate of depression with 30–59% being affected (Nosek et al., 2006). Screening for postpartum depression is advisable because a history of previous depression is a predictor of postpartum depression (Beck, 2001).

When women experience disability onset or worsening during pregnancy or postpartum they can be expected to experience reactive depression and grieving. Yet TLG's research has documented the role of baby care adaptations in resolving maternal depression in such situations.

> *A mother with a post-natal exacerbation of multiple sclerosis became extremely depressed. She relied on her able-bodied husband to provide the infant care to such an extent that the baby was not forming a relationship to the mother and the father was becoming overwhelmed. Baby care adaptations helped alleviate her depression, increasing a balance of functioning in the couple and allowing the relationship between mother and infant to flourish.* (Kirshbaum, 2000, p. 17)

As Jeree Pawl has said about working with babies and families in general: "Pulling together the threads of hope and the evidence of possibility is our task" (Pawl, 2000, p. 5). Applying the infant mental health idea of "parallel process," if we support one another in positive and empowering perspectives about families, we are more likely to support hope and problem-solving in the families we serve.

The Importance of an Early Focus on Adaptations

When serving particularly stressed parents with disabilities, it's crucial to begin addressing parenting adaptation solutions concomitantly with psychosocial issues, establishing teamwork between infant mental health and occupational therapists from the outset. With the most stressed parents, the concrete, enlightening potential of baby care equipment and the new hope it brings about the parenting role can motivate addressing other problems, such as substance abuse or domestic violence. Unfortunately, records of custody cases of parents with disabilities seldom reflect consideration of adaptive issues (Kirshbaum, Taube, & Baer, 2003; National Council on Disability, 2012). A TLG vignette from the National Council on Disability report illustrates such a situation:

> *A young African-American mother with quadriplegia had had her baby removed at birth after testing had shown prenatal substance abuse. The social worker described the mother as forming no relationship to her baby despite weekly visitation. She thought the mother was psychologically incapable of forming a relationship with her child. In the six months since the baby had been born the mother had been provided no assistance in order to make it possible for her to hold or care for her baby in any way. Everyone, including the mother, just assumed this was impossible. The able-bodied grandmother did the care or left the baby in a playpen during the visits. During the first visit I saw a depressed mother who indeed appeared estranged from and disinterested in her baby. But when I showed her videotapes of parents with disabilities and their babies—images of possibilities—she asked if I could help her hold and feed her baby. So in the second visit, with a variety of frontpacks and pillows, she was able to hold her baby for the first time. She tenderly nuzzled and murmured to her, caressing with her lips, greeting her baby for the first time as mothers do immediately after giving birth.* (National Council on Disability, 2012, p. 177)

When occupational therapists are included in intervention, they usually bring familiarity with how people with physical disabilities can live independently in the community; their practical problem-solving orientation is helpful even if they lack experience with parenting adaptations. Both parents and mental health providers, often unfamiliar with baby care adaptations, have difficulty predicting their potential impact. TLG's occupational therapists have explained that both parents and providers lack a repertoire of "visual histories," accumulated images of care by parents with physical disabilities as well as care incorporating baby care adaptations. For providers, this may lead to exaggeration of the difficulty, even disbelief in the possibility of care, precluding the development of solutions. Parents may apply patterns of "disability accommodation," soldiering through the disability obstacles, as they have learned to do in other areas of their lives. Mothers can feel pressured to be "supermom," wary about expressing needs or divulging difficulties out of concern about attitudinal bias and judgments (Rogers, Tuleja, & Vensand, 2004; Tuleja et al., 1998). As noted earlier, TLG has found that mothers with physical disabilities tend to overstress their own bodies during care in order to avoid stressing their babies. Mothers' overuse of their bodies can result in secondary injury, such as repetitive stress or back problems. In turn, this can limit their parenting role and even result in separations due to hospitalization. The early introduction of baby care adaptations can reduce supermom pressures and prevent secondary injury repercussions on the infant–parent relationship.

Once parents experience the use of the adaptations, they have voiced that the "can-do" attitude implicit in the baby care solutions opens up hope and possibilities. One mother with quadriplegia from a neuromuscular disability said she had assumed she would just be a passive observer of others taking care of her baby. With a range of baby care adaptations she was able to be the primary caregiver.

There are also practical timing reasons to establish adaptation teamwork early. Ideally, the teamwork should begin during pregnancy. There are often shifts in the assistive technology needs of the expectant mother due to weight and balance changes during pregnancy, for example, the need to begin using a walker, or manual or motorized wheelchair. Such equipment can also support care once the baby is born. It takes time to develop an adaptive nursery; it can even require a move to other housing or modification of the home. Parents with multiple stressors or lacking independent living experience will require plenty of time to integrate the use of the scarce community resources which can be mobilized.

Clarifying Infant Mental Health Issues Through Adaptations

The early introduction of baby care adaptations, even piloting them during assessment, helps to guide infant mental health intervention. Once parents experience the effect of the baby care equipment, it is typically integrated smoothly into daily routines. However, sometimes addressing the physical baby care obstacles clarifies underlying relationship issues that can be addressed in infant mental health intervention. After a mother with significant cerebral palsy acquired an adaptive nursery, easing her physical care, her difficulties with empathizing with her baby's experience were highlighted. Providing another mother with an adapted frontpack for holding her baby surfaced her aversion to physical closeness and her history of childhood abuse. Addressing the physical disability obstacles can be clarifying for parents, too. Once baby care adaptations were in place and care was physically possible, one highly stressed mother involved with the child welfare system, faced with the reality of the emotional commitment, relinquished the baby for adoption.

Teamwork Regarding Family Systems and Cultural Issues

Introducing adaptations can draw attention to family, role, or cultural issues that need consideration and can benefit from teamwork when addressing the parent's functioning in baby care.

Baby care adaptations can produce extremely rapid change in the functioning and role of the parent with a disability.

Infant mental health practitioners are familiar with entering the whirl of infant–parent and family life during home visiting. However, parental physical disability adds additional elements to the picture. Parents with disabilities may have personal assistants addressing their personal or household needs and involved with their children. One often sees a complex interplay of parent assistive technology within a home that may or may not be conducive to access and may or may not facilitate the presence of baby care adaptive equipment. The baby care adaptive equipment is often combined with adaptive techniques, and the dance between parent and child often involves natural reciprocal infant–parent adaptation and collaboration. Meanwhile parents, family members, and personal assistants may be working around the disability issues in the household, affecting the role of the parent with the baby.

A parent with a long-term stable physical disability is more likely to have integrated adaptations and developed skills and assertiveness while navigating this household teamwork. If the parent has a new or newly worsened disability, a disability complicated by cognitive difficulties or depression, or patterns of long-term dependency, working out household parenting roles and integrating adaptations can be more challenging and time-consuming.

Baby care adaptations can produce extremely rapid change in the functioning and role of the parent with a disability. Occupational therapists are often introducing the adaptations at the already change-laden transition to parenthood. Most parents and families flourish in the face of such changes. Sometimes the process is more difficult and results in rejection of adaptations the occupational therapist worked so hard to provide.

Occupational therapists can benefit from support from mental health practitioners who are familiar with homeostasis in the face of change in family systems. The transition to parenthood is understood to be a time of disequilibrium and role reorganization in couples and families when added changes, as from adaptations, could be difficult to integrate (Kirshbaum, 1997).

> *For example, in one family the non-disabled grandmother's role, before babycare equipment intervention, was to diaper and spoon-feed the baby. With intervention, which included adaptive babycare equipment, the mother was able to perform these tasks independently. The grandmother no longer felt necessary in her role of care taking. In response, the mother used the equipment less often so the grandmother would continue to be more concretely involved with care of the baby.* (Tuleja & De Moss, 1999, p. 72)

More consideration of cultural issues is especially important because of the ethnic diversity of parents with disabilities; for instance, analysis of the American Community Survey indicated that 13.9% of American Indian/Alaska Native parents, 8.8% of African American parents, 6% of White parents, 5.5% of Latino/Hispanic parents, and 3.3% of Asian/Pacific Islander parents have a disability (Kaye, 2012).

Always, family and cultural issues, including child care practices, are the background and foreground of the family caregiving dance.

> *A Samoan mother with hemiplegia, concerned about her ability to care for her newborn baby, requested an adapted crib. Once provided she only used the crib to store toys because it didn't fit with her family's infant care practices.* (Kirshbaum, 1997, p. 25)

Learn More

Web Sites

Through the Looking Glass & its National Center for Parents with Disabilities and Their Families
www.lookingglass.org
3075 Adeline St., Ste. 120
Berkeley, CA 94703
Phone: 1.800.644.2666 (VOICE)
TTY: 510.848.1005

The National Center for Parents with Disabilities & their Families: The Legal Program
www.pwd-legalprogram.org

Publications

Adaptive Baby Care Equipment: Guidelines, Prototypes & Resources
Vensand, K., Rogers, J., Tuleja, C. & DeMoss, A. (2000). Berkeley, CA: Through the Looking Glass.

Rocking the Cradle: Ensuring the Rights of Parents with Disabilities and Their Children
National Council on Disability (2012). http://www.ncd.gov/publications/2012/Sep272012/

Disability cultural issues need consideration as well. Parents who identify with disability culture may have a strong preference for providers with disabilities or who are part of the independent living disability community. They may not be willing to reveal needs and difficulties to cultural outsiders, out of concern about attitudinal bias.

Custody Situations

Recent TLG research has particularly targeted child welfare and family court practice with parents with disabilities and their children, documenting the prevalence of inappropriate practice (Callow, Buckland, & Jones, 2011; Fife, 2010; Kirshbaum et al., 2003; National Council on Disability, 2012). Rarely do professionals conducting assessments or providing services in these situations consider the need for an occupational therapist evaluation or the relevance of baby care adaptations.

Inappropriate removals can have devastating consequences for children, as another TLG vignette for the National Council on Disability report reflects:

> *Bobby's story illustrates the trauma endured by children when a family is wrongfully separated. In Kentucky, Louise, a grandmother in her early 60s, has arthritis and uses a walker. She has had custody of her two-year-old grandson, Bobby, since his birth. When Bobby's mother was arrested, she was asked if she had any children. She explained that her son lived with her mother. Social workers came to Louise's house and explained that they were removing Bobby but he could stay three more weeks, until his third birthday, since there was no immediate need for removal. The social worker added that it is "textbook" that Bobby would be better off with a young, healthy family than a grandmother who is "old and handicapped."*
>
> *Louise did her best to explain the unexplainable to Bobby—that child welfare was taking him and she didn't know for sure when he could come home. Bobby was removed just after he turned three, and he engaged in developmentally appropriate protest for an extended period. The social worker viewed this as pathological; she repeatedly physically dragged Bobby away from Louise at the end of visitations, threatening to end contact if he did not "behave." Eventually, she acted on her threat: Citing how "upsetting" visitations were and Louise's poor choice in feeding him candy on a visitation (she brought a marshmallow "Peep" to an Easter visitation) the social worker severely curtailed the visits.*
>
> *At that point, Bobby became despairing and detached quite quickly. He refused to eat, and when he did eat, he vomited. Child welfare sent him for barium treatments to see if he was physically sick; he wasn't. He was then hospitalized for an injury sustained in foster care. Louise was not allowed to visit, and his foster parents chose not to. Bobby spent his hospitalization alone in a crib with a top to prevent him from getting out, surrounded by IVs and other invasive equipment. Bobby was then labeled as "willful" and considered a "high-needs, difficult child." This label was used as another reason not to return him to Louise. Bobby was eventually adopted; thankfully, the adoptive parents kept some contact with Louise. Her knowledge of his foster care history helps Bobby's adoptive parents understand the psychiatric work he requires to deal with his reactive attachment disorder, claustrophobia, and ongoing nightmares.*
>
> *Efforts to move the court to acknowledge the discrimination and its effects met with complete truculence. The trial judge stated from the bench, "For the record, disability has nothing to do with this case.* (National Council on Disability, 2012, pp. 125–126)

Addressing Baby Care Adaptations in Public Policy

In 2001, I wrote an article for *Zero to Three* describing my first tentative experiences in public policy advocacy, which were encouraged as a fellow in ZERO TO THREE (Kirshbaum, 2001). The public policy role of TLG has evolved considerably since that time, resulting in the passage of legislation regarding parents with disabilities in Idaho and Kansas, and regarding baby care adaptations in California. The Idaho and Kansas legislation addressed baby care adaptation in assessment and intervention, even requiring such adaptations in custody situations (Callow et al., 2011).

Recently TLG has had a substantive role in advocating for, planning, and writing the National Council on Disability's extensive report, *Rocking the Cradle: Ensuring the Rights of Parents With Disabilities and Their Children*, submitted in October 2012 to President Obama. My chapters for this report specifically focused on adaptations in intervention and parenting evaluations. Included in the report are drafts of state and federal legislation, developed by TLG's Ella Callow, which also addressed baby care adaptation issues. The following finding and related recommendations of the report highlight adaptation issues:

> *FINDING 4: Parents with disabilities who are involved in dependency or family proceedings regularly face evidence regarding their parental fitness that is developed using inappropriate and unadapted parenting assessments. Resources are lacking to provide adapted services and adaptive parenting equipment, and to teach adapted parenting techniques.* (National Council on Disability, 2012, p. 311)

Following this finding the report recommends that:

> - *States must mandate training for custody evaluators on parents with disabilities and their children;*
> - *CMS [Centers for Medicare and Medicaid Services] must expand the definition of durable medical equipment (DME) to include adaptive parenting equipment*
> - *States should establish adaptive parenting equipment reuse and loan programs.* (The National Council on Disability, 2012, p. 312–313)

TLG has been honored to channel its many years of research and intervention experience to this major public policy effort. It is hoped that the result will be significant reductions in the obstacles facing parents with disabilities, their babies and toddlers, and the service providers who support families with disabilities.

Megan Kirshbaum, *PhD, has a doctorate in psychology and has been an infant–parent and family therapist in the disability community since 1974. She founded Through the Looking Glass in 1982 and is its executive director and co-director of its National Center for Parents With Disabilities and Their Families. She is the recipient of national awards and is a graduate fellow of ZERO TO THREE. She has served as an expert witness in court proceedings regarding parents with disabilities in 10 states. She has personal and family experience with disability.*

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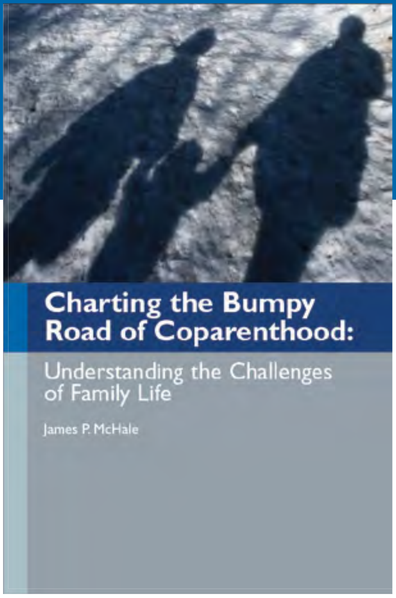

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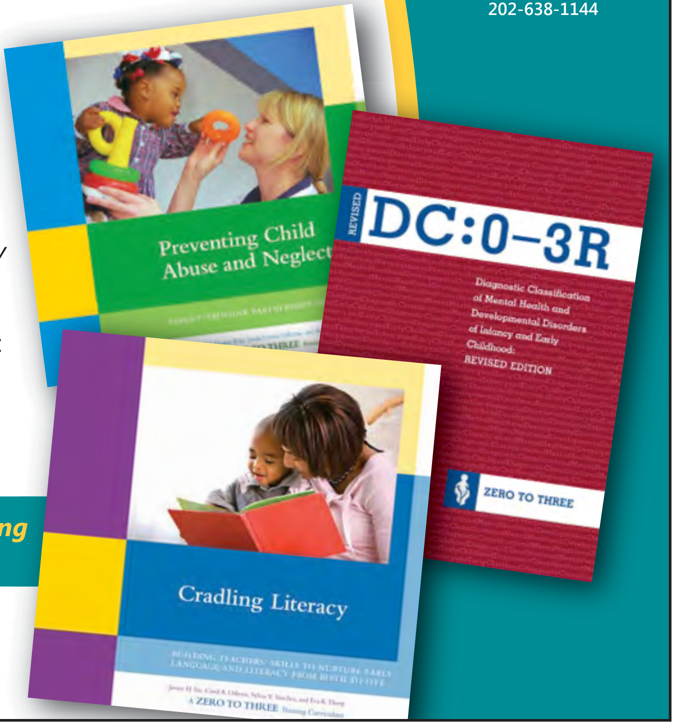

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Jargon Buster

Given the multidisciplinary nature of our work with infants, toddlers, and families, we often come across words or acronyms that are new or unfamiliar to us. To enhance your reading experience of this issue of *Zero to Three*, we offer a glossary of selected technical words or terms used by the contributing authors in this issue. Please note that these definitions specifically address how these terms are used by the authors in their articles and are not intended to be formal or authoritative definitions.

Phrase	What it means
Baby Care Adaptations	Baby care adaptations refers to devices or techniques that allow parents with physical disabilities to manage caregiving tasks, such as bathing, diapering, and feeding. Adaptations might include accessible cribs; trays and seats for wheelchairs; four-wheeled walkers with baby seats; accessible diapering surfaces and high chairs; positioning supports for breastfeeding, holding, and carrying; as well as accessible childproofing. (Find it in Kirshbaum, page 62)
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program	The EPSDT program provides comprehensive and preventive health care services for children less than 21 years old who are enrolled in Medicaid. States are required to provide comprehensive services and provide appropriate and medically necessary services on the basis of certain federal guidelines. (Find it in Eberhart-Wright, page 52; Ivins, Lee, and Reus, page 37)
Figuring It Out for the Child (FIOC) Program	FIOC is a Brady Education Foundation-sponsored initiative for expectant unmarried first-time African American parents. FIOC builds on the expectant parents' often untapped and overlooked desires and resolve to create a positive life for their baby and helps them build bridges to communicate, collaborate, and address obstacles to coparenting—whether they are co-resident or not. (Find it in McHale, Gaskin-Butler, McKay, & Gallardo, page 17)
Real-Talk Family Partner Model	The Real-Talk Family Partner model provides parent professionals who use their own life experiences and self-disclosure to engage hard-to-reach families. The term "Real-Talk" is borrowed from street culture and language and indicates first-hand knowledge of the neighborhood culture while emphasizing trust, honesty, and transparency. (Find it in Ivins et al., page 37)
Visit Coaching	Visit coaching (Beyer, 2008) is an increasingly popular approach to working with families whose children are in foster care. The goal of visit coaching with parents of infants in foster care is twofold: (a) to help the parents overcome the parenting deficits that necessitated the child's removal, and (b) to preserve the primary attachment relationship during temporary foster care and thereby enhance the likelihood of successful family reunification. (Find it in Wotherspoon & McInnis, page 31)
	Beyer, M. (2008). "Visit coaching: Building on family strengths to meet children's needs," *Juvenile and Family Court Journal, 59*(1), 47–60.

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