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Infant-led Practice: Responding to Infants + Their Mothers (and Fathers) in the Aftermath of Domestic Violence by Wendy Bunston in

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CHAPTER 9

Infant-led Practice

Responding to Infants and Their Mothers (and Fathers) in the Aftermath of Domestic Violence

Wendy Bunston

The inclusion of infants in the minds as well as the work places of practitioners engaged in addressing domestic violence is a recent phenomenon. In part, this has resulted from neuroscience demonstrating conclusively what many have always believed: that what happens in childhood lasts a lifetime (Carrion, Wong and Kletter 2013; Schore 2003b; Shonkoff 2010; Siegel 2012; Solomon and Heide 2005; Teicher 2002; Teicher *et al.* 2003). When violence occurs during infancy and early childhood, it is no longer a question of whether it impacts on neurobiological, social and psychological development rather it is how much and in what way (Schechter and Willheim 2009). Just how the infant is included in our work to address the impacts of domestic violence is informed by what is known as 'infant-led' practice (Bunston 2008a, 2008b; Thomson Salo 2007). This approach asks the worker to consider the infant as possessing their own subjectivity and agency and not to be seen simply as an extension of their parent (Thomson-Salo and Paul 2001). The infant is experienced as a new and emerging human being, dependent on as well as shaped by their caregiving environment, and capable of shaping that caregiving environment in return (Stern 2003). Further still, 'infant-led' work sees the infant as an active participant, offering possible entry points for creating therapeutic change in caregiving systems that have become unworkable (Thomson-Salo *et al.* 1999).

This chapter will explore how this important advance in our thinking has enhanced practices of working towards disrupting the impact and

describe clearly what 'infant-led practice' involves, how research on infant development informs practice and will offer examples of how this has been undertaken with mothers in individual family work as well as within group work. It will also touch on work that has included fathers. Critical to 'infant-led' work in any area of practice, but particularly so in the area of addressing domestic violence, is ensuring the safety of the infant. Further examples will be included which illustrate the issues involved in keeping infants safe in mind and in practice.

Infant-led practice within a context of family violence

At first glance, the concept of 'infant-led' practice appears straightforward and can be simply interpreted as placing the infant front and centre in the practitioner's thinking and ensuring that their needs are met. For example, in order to work successfully with older children and young adults, we have learnt that we must first engage and then collaborate with them. Our dominant vehicle for negotiating this exchange is verbal. 'Infant-led' practice is more nuanced than this. This work largely remains in the preverbal domain. It is not about filling up the therapeutic space by just talking about the infant with the caregiver, but about truly working towards 'being with the infant' over 'doing things to' the infant (Bunston 2008b; Jordan 2011; Paul and Thomson-Salo 1997). Engaging with an infant involves demonstrating a gentle curiosity about them and inviting their participation. It is respectfully addressing the infant and awaiting reciprocal cues from the infant.

The infant responding to your smile, returning your gaze, a small hand extended: these may all be cues that an infant has registered your interest and is curious about you in return. We can all interpret meanings behind language, the intonation of speech, facial expressions and body language. Infants are highly attuned to their environments and are careful observers of those around them. They can also clearly signal their distress, their comfort or discomfort in the presence of others. Morgan (2007) suggests that infants need the therapeutic space to be safe, reliable and truthful. 'Safety' refers to the infant feeling safe within their internal world, 'reliability' to providing a relationship over time and 'truthfulness' to being available to what the baby thinks and feels. We may know much about infant work and parent work, but as Morgan notes:

> We know nothing about this baby, we know nothing about this mother and this father, but we give them our full awareness, our thinking, our knowledge, so that something new can emerge for all of us who are involved in the work, for the baby, the mother, the father and for the therapist. (Morgan 2007, p.13)

The neuro-biology of trauma

Where the infant has been exposed to family violence, additional complexities come into play. Depending on the length, severity, type of and exposure to the violence, and the capacity or incapacity of the caregiving environment to protect or mediate the impacts of the violence, the infant may well have had been forced to rely on their own immature and very limited defences. Immediately post-birth, infants are particularly reactive to stress and within the first two years they are highly dependent on their caregiving system to co-regulate their emotional states as they begin learning to do so for themselves (Rifkin-Graboi, Borelli and Enlow 2009; Schore 2001). The younger the infant and the more frequent the exposure, the more likely the defence will be to shut down and disappear into a frozen, dissociative state (Schore 2003a).

Infancy is a time of immense neuro-biological development and all energy and resources at the infant's disposal are directed towards growth. In circumstances of severe stress, with no available or adequate safe haven, the infant literally needs to hide, to shut down and conserve energy should it be needed to respond to danger. The need to safeguard and to conserve energy leads to an under-stimulation or under-use of important synaptic connections that are rapidly developing to shape the form and function of neural development (Siegel 2001). We are still coming to understand more fully the adverse effects of intimate partner violence on the baby in utero (Quinlivan and Evans 2001; Sarkar 2008). Rifkin-Graboi *et al.* (2009) suggest that the newborn has limited memories of extreme stress and in novel experiences stress reactivity is 'likely to be driven more by evolutionarily based predispositions and other individual characteristics of the infant' (p.60).

It is when traumatic and frightening experiences are repeated, however, that the infant comes to expect certain responses, behaviours or interactions from their caregiving environment and adapts their responses, behaviours and interactions accordingly:

> The generally held belief in neural science is that the patterns of neuronal connections determine the ways in which the brain functions and the mind is created… It is in this manner that interpersonal experiences directly shape the genetically driven unfolding of the human brain. (Siegel 2001, p.72)

Repeated early exposure to trauma and violence influences neural pathways and, ultimately, the hardwiring of the brain. As Perry *et al.* (1995) note, accumulative emotional states brought on by trauma become 'personality traits' over time. As Arvidson *et al.* (2011, p.38) explain:

> For young children, traumatic experiences may occur prior to the acquisition of expressive language skills. Young children may lack a specific, identifiable traumatic event and do not have the skills necessary to process trauma through a coherent, sequential, verbal narrative. Trauma processing with young children often occurs in the moment when a child experiences heightened physiological reactions. The restoration of internal safety happens when the child's distress is identified, validated, and modulated by a caregiver.

The caregiving environment is the incubator within which infants grow their capacity to communicate what they are feeling. How well this 'caregiving incubator' functions depends to a considerable extent on the experiences, past and present, that shape the relational world of the caregivers.

Practice implications

It is often not only the infant who is overwhelmed by ongoing violence. Both infant and mother may be traumatised, compromising the ability of both to effectively process their emotions. Further, each may even act as a trigger for the other (Schore 2001). What we might effectively offer is ourselves as something of an intermediary. No matter the support role we offer (i.e. counsellor, group facilitator, family support, refuge worker), we can learn to be more available and present to both mother and infant. We offer our mind, our relationship and our presence to sit with both infant and mother in order to facilitate communication. We, for that moment, become part of the caregiving system and add something new. We can 'be with' (contemplative) their world rather than 'do' something to it (reactive).

Notwithstanding the importance of 'doing', particularly in instances of immediate crisis or danger, making space 'to be' can leave workers feeling unprotected and powerless (Bunston 2011; Bunston and Sketchley 2012). Our ability to recognise and sit with such powerful feelings (to think about our feelings and theirs) may provide real and invaluable insights into what the infants and mothers we work with are feeling. Taken a step further, sometimes our timely ability to sensitively put words to those feelings, not as givens but as gentle questions, may bring out in the open a feeling state that can then be processed (tolerated and thought about) together.

Ironically, a 'doing' developmental activity associated with infancy is the importance of learning routines, such as quickly settling an infant into sleeping and eating patterns. This is something seen as even more critical for an infant exposed to family violence (Arvidson *et al.* 2011). The safety of creating respectful routines is to be encouraged as long as one is cognisant of the fact that exposure to relational violence also creates its own routines. Infants shutting down can replicate the infant 'going to sleep'. Just placing a traumatised infant in a cot and away from their caregiver may be countertherapeutic. They may need instead to be near a soothing presence, rather than left alone to manage such overwhelming and frightening feelings. Within a refuge setting, for example, should the mother herself be highly agitated, it may be the most calm, responsive and comforting person present who can offer immediate relational and physiological relief to that infant, whilst also remaining a calming presence for the caregiver.

Infants can become quickly attuned to the signals of 'what is to come'. We need to endeavour to learn from the infant what their own unique routines have involved, and to pick up on the signals they might give us about what they have come to expect from their world. This involves waiting, watching and wondering about what might be happening for the infant (Cohen 2006). For example, certain smells (alcohol), sounds (slamming doors), sights (broken toys) or relational triggers (mother pulling back as their infant approaches) can all arouse a cascade of sensory and physiological memories. More important than our desire to set up a new routine for them is to first come to know the infant and understand what triggers their stress and what alleviates it. Following a routine

should not take precedence over coming to understand their world and exploring what allows them to feel safe and encourages their growth and exploration. Even if we get it wrong, or if their mother misses the mark, growth occurs when we genuinely seek to get it right and together strive to repair relationships (Tronick 2007).

'The principles of regulation theory that apply to the mother–infant relationship also apply to the clinician–patient relationship' (Schore 2005, p.211). They apply to all relationships which are significant to us as we exist and are shaped in relationship to others, and none more so than in infancy (Cozolino 2006). Our being with this infant and this mother therapeutically is not about educating: it is about learning, ours and theirs. We can offer relational capacity building by relating to the infant in the context of their relationship with their mothers, and fathers, leaving an imprint of difference in how to be with each other. This is what we strive for, to enhance and support thinking and relating to support what 'good enough' caregiving can offer (Winnicott 2005).

> Coordinated visual eye-to-eye messages, auditory vocalizations, and tactile and body gestures serve as channels of communicative signals that induce instant emotional effects… Attachment communications, therefore, are 'built into the nervous system', inducing substantial changes in the developing brain. (Schore 2005, p.207)

Importantly, this approach is not intended to exclude the urgent imperatives of what an infant needs physically. If we see that an infant is 'at risk' through lack of adequate care, physically and/or mentally, we also need to be able to act quickly and respond accordingly. The five-week-old infant who is losing weight, or is not regularly bathed and covered in sores, or who is put down to sleep in unsafe bedding or left unattended for hours, needs our minds to recognise that this infant is suffering. As committed as we are to the mothers and fathers, who may themselves present horrific backgrounds of trauma, who may seem little more than youngsters (particularly teenage parents) and who may still be 'at risk', the infant is fully dependent on the care of others. It is sobering to acknowledge that infancy is when we are most vulnerable, with the risk of death greater than at any other time during childhood and adolescence (AIHW 2012; Brandon *et al.* 2008).

Applying what we know to our practice with infants

This section is intended to illustrate how the theory and approaches described above can be used in practice. Space allows for the following case examples to be cursory only, providing a strand of what occurs in the work overall, but each aims to illustrate critical elements of the work undertaken. Building on the ideas of offering an available, reflective mind and calm and attuned presence, these examples will explore how to be with infants and their mothers. This is illustrated both within a group and individual context and is drawn from work undertaken within a child and adolescent mental health programme based at a children's hospital in Melbourne, Australia. A two-tiered group work programme, PARKAS (Parents Accepting Responsibility Kids Are Safe), was originally developed to address the impacts of domestic violence on children and their mothers (Bunston 2001, 2002). It soon became apparent that both the children and the mothers themselves had experienced violence from early childhood and a much earlier intervention response was needed. A community-based infant/mother group work intervention called the Peek-A-Boo Club was soon developed along with a refuge-based programme called BuBs on Board (Bunston 2006, 2008a; Bunston and Glennen 2008).

It is also important to note that infant-led work in the context of domestic violence can often be very time limited, particularly where a mother and her child or children have become homeless as a result of leaving the relationship. Whilst this work should not be rushed, this does not mean that it cannot be respectfully bold and open to offering opportunities to avert and begin to process trauma from the very first contact. How well this is done comes with confidence, practice and, most importantly, by accessing good supervision (Bunston 2013a; Bunston, Pavlidis and Leyden 2003).

Case Study: Darcy

Mary had left an extremely violent relationship some six weeks before I met her. She and her two children Darcy (16 months) and Matilda (30 months) had engaged with a family support worker who was worried about what the children had witnessed and wished to refer the family to an infant/mother group. Mary was very reluctant to attend a group but agreed to an initial one-off session for herself and the children.

The referring worker offered to wait in the reception area but it was very apparent that the whole family wanted her to participate in the session and the worker, subsequently, became a very important player in the work. A total of six sessions were completed with this family as transitional housing was found for them in a different region two months after the work commenced.

Darcy was not yet walking unaided and tended to crawl around the room. Every so often he would suddenly become stiff and, facing head down with his legs together and resting on his toes, he would balance on his elbows in a plank position. He would remain in this position for some 60 to 80 seconds then just as suddenly resume his crawling. On other occasions Darcy would appear to suddenly get cramp and he would curl up and become very agitated and distressed. After these two things occurred, I asked Mary what she thought was happening for Darcy. Mary explained that she had taken him to see a doctor and a specialist who felt his difficulties were bowel-related but that tests had not been able to prove anything conclusively.

When Darcy cramped up, Mary would attempt to comfort him, asking what was wrong, but this had little success and she would then look towards me helplessly as if to say, 'what can I do?' The hypothesis held by his mother and specialist was that Darcy was most likely constipated so they were endeavouring to treat these symptoms by attending to his diet. Whilst it was clearly important to undertake a full medical assessment of Darcy, there did, however, appear to be little capacity to contemplate that there might be a psychological explanation for Darcy's symptoms. Mary had told the two children that they were on holiday, not that they had left their father or why. Matilda would often ask after her daddy and when they would see him. Mary avoided answering this question and would endeavour to distract her or change the topic.

It was very difficult for this family unit to talk about what had happened to them and particularly to talk about the father. This work was conducted on the floor, sitting on cushions and with toys and space for the infants to explore. When Darcy moved into his 'plank position', I lay next to him and wondered aloud if it was hard not to see his dad, and hard for the family to talk about some of the painful and frightening things about their dad. I wondered if perhaps it was so painful for Darcy that it made him feel stuck inside. Words were eventually found to begin to talk about some of the fear, sadness and trauma they had all experienced. Mary remained

very reluctant to share too much, particularly in relation to her own past, but she began to talk to the children about why they were no longer living at home and why they were not returning home. Their worker used what occurred in the sessions to continue making space for this family to give words to what they might be feeling outside of the sessions.

This description of the work undertaken intends to give a flavour of what was involved in trying to 'be with' and make meaning out of what Darcy might be communicating, rather than 'doing to' Darcy. Darcy's symptoms did abate and Mary and the children experienced something new – the idea that these two infants had very powerful emotional material and responses (to what had happened at home and to losing their father) that were not being processed. My curiosity about her infants in turn led to Mary being curious about me, what I was doing and why. This resulted in her becoming more contemplative about their internal rather than their external worlds. The family support worker was very effective in bringing this same level of thoughtfulness into her own work with the family, and although this did not 'cure' or resolve their trauma, it perhaps made it a little more bearable.

Case study: Pia

Pia, 14 months old, had been removed from her parents' care and was residing with another family. Child protection services wished to explore partial reunification with her mother, Arna, and referred the two to our infant/mother group. Arna presented herself as a very loud and sometimes frightening figure. We undertook a thorough assessment session with Pia and Arna (and asked the child protection worker to sit out of this session) before accepting Pia into the group. As with all our assessment sessions, we spoke honestly and clearly about our mandate (and commitment) to report if we found an infant was 'at risk' of harm. We made it very clear to Arna and the child protection worker that we would not proceed with Pia in the group if we felt her mother's presence proved too overwhelming for her, given their lengthy separation from one another. We also made it very clear to Arna and the worker that we were not there to assess their relationship for the courts and we would not meet separately with the worker (as child protection had requested) to emphasise that they, Pia and Arna were our clients, not child protection services.

Arna possessed a very engaging sense of humour and was a very big presence in the group. She was very vocal about Pia's father's violence and about how she would not tolerate his 'rubbish', often giving him 'as good back'. Pia was a very self-possessed little girl, and whilst it was evident that she recognised her mother, she did not use her, or any other mother, for social referencing or support and seemed able to cue very quickly into the facilitators as the more reliable caregivers in the room. As the dynamics of the group settled into their own rhythms, we were able to observe how Pia and Arna related to one another, how Arna would rush at Pia and then back off, offended at her approach not being reciprocated. We were also able to pick up Pia's very tiny cues, how she would circle around her mother, occasionally look at her and, when Arna failed to notice, move on to somewhere else.

We offered some reflections out loud when we started to 'catch those moments' and expressed our curiosity about how this little family might begin to 'safely' get to know each other again. A significant moment occurred in the group some three weeks in when Arna began to criticise Pia's father, using very colourful and offensive language. One of the facilitators (who had formed a very positive relationship with Arna) boldly jumped in and very genuinely stated that she found that language too much, that it was not OK to speak like that in front of the infants, the mothers or the facilitators. She also reflected that it put Pia in a really tough place as she had regular supervised access with her father, and by all reports this was positive. This did not discount the violence Arna had experienced nor absolve Arna of the violence she had exposed Pia to herself.

Much discussion was had in supervision later that day about 'that moment' and the facilitator's anxiety that maybe she had said too much and perhaps lost Arna from the group. It would appear that it did the reverse: there was a marked change in Arna from that moment on and we were able actively to help Arna within the group to 'self-regulate' and reflect on what she did that made it easier for Pia to make her tentative approaches towards her, and what pushed her away. Arna was still able to talk about her distress over Pia's father but in such a way that it did not frighten Pia (or anyone else). There was a marked shift in their

relationship and the beginning of a 'getting to know' one another within the group, with Pia even taking to sitting in her mother's lap. Placing Pia's needs and safety as central, building a strong rapport with Arna by not partnering with child protection services but by partnering with Arna and Pia as a dyad, and then negotiating an open relationship with child protection services brought in new ways of being with each other.

Case study: Benny

Benny was a little over two when I started to see him and his mother, Jenny, for individual work. He struggled with some developmental delays and had seen his father physically assault his mother on numerous occasions. His father, John, had a diagnosed mental health difficulty and could be erratic in taking his medication. Jenny still loved John but felt she had to leave him in order to create some stability for herself and Benny. I had been seeing Benny and his mother for over 12 months and Jenny was reporting that there had been much improvement in the relationship between Benny and his dad, in part due to her setting firm limits around when he could visit and clear expectations about how he should behave with Benny. It appeared that John loved Benny very much and was keen to comply with Jenny's expectations and form a positive relationship with his son.

Alongside this work, I had been developing and running a group work intervention for fathers (who had been through a men's behaviour change programme) and their infants (Bunston 2013b). I had previously worked jointly with some fathers and children (Bunston 2001, 2008b) and had some positive outcomes, so I was keen to explore how to bring fathers, who were motivated to change, safely into the therapeutic space. I had previously discussed with Jenny the possibility of including John in a session even though John had not attended any counselling for himself. Despite Jenny's scepticism and an initial refusal, John did eventually agree to attend a session. I was introduced to John by Jenny, and Benny very excitedly showed his father around the room, the toys he played with, and tried to engage his father in one of the regular games we played together.

John began to play with one set of toys, then moved on quickly to something else and then another, a pattern Benny had displayed when first beginning counselling, but which had decreased with him showing a much greater attention span and depth of imaginative play over the past six months. The session seemed to proceed a little awkwardly but well enough, until I began to ask more direct questions of John and about his childhood. As I focused on John, I missed seeing Benny's cues and his warnings. I could see John tensing up and not liking my questions, but it was not until Benny came up to me and hit my arms, saying 'don't talk to my daddy', that I realised how anxious Benny had become and that he had been showing me how acutely he was cued into his father's moods and ability to become volatile. I backed off from where I had been taking the session and returned to taking my lead from Benny.

That was the first and last session I had with John (he made it clear that he would not return) and I have spent much time reflecting on the implications of this session. There is much that can be taken from this session, discussed and questioned: was it right or wrong for me to have included his father? I was concerned that I had made unsafe a space which had become very safe for Benny and his mother, and I was much relieved when Benny bounced into the next session and greeted me with his usual enthusiasm. We discussed what had happened and I suggested that I had perhaps put my interest in including John ahead of what Benny and Jenny needed or wanted. On reflection, I think I lost sight of Benny in my mind and in the room. This does not mean that I want to dispel the thought of fathers who have been violent out of the counselling space, as such rigidity is not helpful for the infant, mother or counsellor. Fathers are and remain critical figures who can ideally be integrated in a healthy way into the emotional world of the infant, psychologically if not in person. It does mean that this work needs to be approached cautiously, and with greater consideration than I showed in this instance.

Bringing 'Dads on Board' in our work with infants

A much more positive example of including fathers in the therapeutic space has comprised the development of a groupwork programme for fathers after their involvement in a men's behaviour change programme (Bunston 2013b). This involved two eight-week pilot projects for fathers which involved both the infant and, in all but one case, the mother of

the infant. This work saw the fathers better equipped to move into more self-reflective work. These fathers had made a public commitment to address their violent behaviours and had become accustomed to the structure which accompanies participating in a groupwork process. When fathers have not been willing or available or it has clearly not been appropriate to involve them in this work, it has been important to bring the capacity to think and talk about the infant's father into the therapeutic space in order to think about their meaning and significance for the growing infant. This can enable the infant to derive some goodness from that relationship and tolerate that which had been destructive (Jones and Bunston 2012).

Fathers, as with mothers, are a reality in the infant's life, although for some fathers this may be only through their role in the infant's conception. Whether the father lives with or has court-ordered access with their child, or through the growing child's imaginative creation of their father and how this real or imagined relationship is internalised, this shapes the person that the child grows into. Our job is to work with infants, children and their families to find ways to bring honour safely to the significance of these attachments, irrespective of how we may judge them.

Conclusion

'Infant-led' work operates in the realm of discovery. It replicates the conditions applicable to enabling an infant to grow and develop safe relationships with their caregiving environment and with their sense of self. The key, integral ingredients needed include: providing a safe base, ensuring the infant comes to no harm and being available, through relationships, to discover and make meaning. The presence of violence, often predating these ingredients, means that infant-led work in the context of violence requires a greater sensitivity to and thoughtfulness about ensuring that both the external world and internal world are safe to enter and work in. It is about facing the infant's truth, with its often overwhelming complexity, and not running from the complexity. Instead, holding still and offering something of ourselves that is reliable and reflects back something new and nourishing to the infant and in their relationships with their mother and father.

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