September 2010

CT-AIMH Member News

~ Items of Interest from the Connecticut Association of Infant Mental Health ~

Meet Our Endorsement Coordinator

We are delighted to introduce Anne Giordano as our Endorsement Coordinator. Anne will be responsible for promoting and organizing the competency-based endorsement process for infant/toddler professionals in Connecticut.

Ann has extensive infant/toddler work and has been a long-time member of CT-AIMH. She has worked in Birth to Three, Early Head Start, and the Foster Care Clinic. She is a competent trainer and skilled manager. Anne will be working part time in this position and will be going through the Endorsement process in Connecticut.

The Endorsement Coordinator position has been funded with grants from The Children's Fund/The Child Heath and Development Institute of CT, Department of Social Services (ARRA funds), and the CT Workforce Collaborative for Behavioral Health.

Fall Conference Features Dr. Brenda Jones Harden

Mark your calendars for November 18, 2010, from 9-3 at Woodwinds in Branford, CT. Our keynote speaker will be Dr. Brenda Jones Harden, MSW, PhD from the University of Maryland. Her topic will relate to home visiting: relationship building with families who experience many risk factors.

The day will be organized into two breakout sessions and arranged so everyone will be able to participate in both.

Welcome to Our New Board of Directors Member

Patrick "PJ" Ruddy from Tolland has been elected to the CT-AIMH Board of Directors for a three-year term. Patrick is the vice-chair and parent member of the State Interagency Coordinating Council for Birth to Three. Patrick and his family are connected to the Birth to Three and early childhood systems in Connecticut.

We look forward to Patrick's input as CT-AIMH continues to grow.

CT-AIMH Now Has a Home!

Another exciting happening for CT-AIMH is that we will have our administrative home at the Yale Child Study Center. Our address is 230 S. Frontage Rd, New Haven, 06519-1124.

Our email will be: ctaimh@yale.edu

We are appreciative of the efforts that Drs. Fred Volkmar and Linda Mayes have made to provide CT-AIMH a professional home – a home where infant mental health in the state had its beginning with Dr. Sally Provence. We are grateful and excited about taking this next important step in moving infant/early childhood mental health forward in Connecticut.

Watch for our updated website that will continue to be at www.ct-aimh.org.

World Association for Infant Mental Health (WAIMH)

The WAIMH World Congress met in Leipzig, Germany in July 2010. Two new affiliate representatives to the WAIMH Board were selected at the WAIMH Congress in Leipzig: Martin St. Andre (Quebec) and Maree Foley (New Zealand).

Affiliates will soon have greater representation to WAIMH through them. The next WAIMH Congress is scheduled for Cape Town, South Africa, April 17-21, 2012.

Connecticut must maintain at least 10 memberships in the WAIMH to continue our WAIMH affiliate status. Members receive the "Signal" publication. To join WAIMH go to www.waimh.org.

Competency/Endorsement Updates

Connecticut has 11 individuals preparing to become the first to hold the "Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health." These people will become mentors/advisors for Connecticut infant/toddler professionals during their future endorsement processes. The next step is to have Michigan staff come to train two people to administer the exam.

Reflective Supervision

These 11 people are currently receiving a year of reflective supervision from Rebecca Shahmoon Shanok, founding director of the Institute for Infants, Children and Families of the Jewish Board of Families and Children in New York City.

Rebecca has written and presented extensively on reflective supervision. She is guiding us in experiencing and learning reflective supervision so that we can offer it to others in the future.

Committee Work Continues

Committees continue to work to promote the competencies leading to endorsement. Liz Bicio and Kathy Bradley head the training committee.

That committee has developed a training summary for presenters to use to identify audience, content, and relationship to competencies. This will be a helpful tool for those building their portfolios as well as assuring that we make topics available related to all the competencies.

Gratitude to Our Supporters

The CT-AIMH is very grateful to the agencies and programs that have or are supporting our work. Specifically, we would like to thank the agencies/programs that allowed us to bring the Competency Guidelines to Connecticut:

- Building Blocks in southeastern CT
- The Children's Fund/Child Health and Development Institute (CHDI)
- Early Childhood Mental Health Consultation Partnership
- Head Start Collaboration Office
- Graustein Memorial Fund.

Thank you also to CT Workforce Collaborative for Behavioral Health and the Head Start Collaboration Office, who awarded us funds to purchase the license for endorsement from the Michigan-AIMH.

CHDI, the CT Workforce Collaborative and the Department of Social Services (ARRA Funds) are noted for contributions to other activities described in this newsletter.

League of States is Growing

Three new groups have been added to the League, Alaska, Colorado and a large children's service agency in Florida. The League is made up of those states that are offering endorsements in infant mental health following the Michigan process. The total number is now 15.

The next League meeting will be in Phoenix in December 2010. The focus will continue to be on reflective supervision and how to describe or define its essential components.

Upcoming Learning Opportunities

Watch for information later this fall announcing trainings that are competency related, including:

- Introduction to Reflective Supervision
- A two-part series (four sessions in each part) that will cover competency related topics

These trainings are funded through our grants with DSS (ARRA funds) and the CT Workforce Collaborative for Behavioral Health. A post-graduate certificate program in infant-parent mental health is available through UMASS Boston and the fact sheet is available on the following page.

Keeping the Baby in Mind: A good Read

An article, "Keeping the Baby in Mind," by Carla Barron, LMSA, IMH-E®IV, illustrates beautifully how the infant mental health specialist works.

This article was featured in the Summer 2009 issue of *The Infant Crier*, published quarterly by the, and is reprinted in our newsletter for your reading.

Please see pages 5-8 for the article.

UMASS BOSTON

Fact Sheet

DIVISION OF CORPORATE, CONTINUING AND DISTANCE EDUCATION

Post-Graduate Certificate Program in Infant-Parent Mental Health

Now accepting applications for 2010-2011 Boston program

A certificate program for professionals in fields including psychology, psychiatry, pediatrics, social work, nursing, psychiatric nursing, early intervention, speech/language therapy, occupational therapy, midwifery, early childhood education and more...

Please join our highly acclaimed program advancing the quality of mental health services for infants and young children in the context of their earliest relationships. Interdisciplinary Fellows spend 10 intensive, interactive weekends learning from world luminaries and local experts in Infant-Parent Mental Health.

Lecture faculty include:

Ed Tronick (chief faculty), Dan Siegel, Charles Zeanah, Bruce Perry, Peter Fonagy, Tiffany Field, George Downing, Lynn Murray, Peter Cooper, Barry Lester, Gerald Stechler, Kristie Brandt, Kevin Nugent, Connie Lillas, Marjorie Beeghly, Karen Levine, Alice Carter, Joyce Maguire Pavao, Charise Northcutt and more.

Core faculty include:

Ed Tronick, Alexandra Harrison, Marilyn Davillier and Dorothy Richardson.

2010 Program Fellows talk about the program:

"I am taking with me a lot of knowledge I will apply to my work with families and their children."

"Accessible and deeply knowledgeable faculty...Theory, research and practice presented"

"Phenomenal!"

Program Fellows receive comprehensive training in infant and early childhood mental health research and theory, assessment and intervention modalities including:

- Neurodevelopmental models of risk and resilience
- Effects of trauma on early relationships and early brain development
- Up-to-date research and practice with autism spectrum disorders, infant regulatory disorders, early childhood mood and behavior problems, postpartum mood disorders and more
- Therapeutic interventions with infants, young children, and families
- Infant and early childhood assessment tools and measures
- Reflective Supervision and facilitated integration of course material with individuals' practice

For More Information

For more information and to download an application, please visit our website.

Program Director

Dorothy T. Richardson, PhD;
Dorothy@DTRichardson.com

ccde.umb.edu/certificates/infant-parent-mental-health

The Infant Crier is a publication of the Michigan Association for Infant Mental Health. This article is reprinted from the Summer 2009, No. 122 edition with their permission.

Keeping the Baby in Mind

By Carla Barron, LMSW, IMH-E® (IV)

The theme of *The Infant Crier* this year is to think about the ways in which we "keep babies in mind" as we are working with infants, very young children and vulnerable families. As an Infant Mental Health Specialist, it is my job to be aware of the baby who is, along with the family, my "client." I must always remember that if there wasn't a baby in the family, I would not be called in to work with them. It is the baby who brings me to this work; it is the baby who brings me to be with families. However, keeping this baby, my "identified client," in mind is not always easy. How do we keep the baby in mind who is not yet born when we are lucky enough to be referred to a mother during her pregnancy? How do we remain attentive to the sleeping newborn when the family is experiencing financial crises? How do we call attention to the confident eight-month old when the older sibling is acting out his or her own developmental struggles? What about the other babies we carry within us as we work with families? As an infant mental health specialist, I am taught to find ways to pay attention to and hold in mind those babies who call us to work with families, as well as those babies who are ever present and powerful, the babies we carry within us.

Families show us what they need

I recently received the referral of a young mother, Maggie, who has two very young children, Christopher, age 32 months, and Diana, age 14 months, and is pregnant with her third child. She is on her own, recently divorced from her husband and estranged from her mother. Maggie was referred to the Infant Mental Health Program by a social worker at the local Intermediate School District (ISD) who expressed concerns about Maggie's current state of isolation and her capacity to provide for her very young children. The social worker identified a risk of prematurity, as both of Maggie's older children were over five weeks premature and both spent significant time in the neonatal intensive care unit (NICU). During our first meeting, Maggie told me that she expected she would deliver her third baby in the hospital alone, as she had her second child. She said that she expected the baby would need to be taken to the NICU immediately following delivery and that she would have no one there to be with her during her hospital stay.

Both Maggie and the social worker expressed worries about Christopher. At 32 months of age, he has almost no discernable language. He has frequent tantrums and wakes almost nightly from night terrors. He sleeps in the same bed with his mother, as he is unable to calm unless he is touching his mother's skin. Going out to stores or playgrounds, Christopher almost immediately becomes aggressive, demanding, and violent toward other children and his mother.

In our first sessions, I observed that Christopher was unable to play productively with toys; he often roamed the room moving on and off of his mother's lap. After telling me about Christopher, and at my invitation, Maggie talked about her second child, Diana. At 14 months, Diana is not yet crawling or pulling herself to stand. She recently began sitting on her own. She was described by the early interventionists as having "low tone" and is receiving physical, occupational, and group therapy through the local ISD. Diana is able to babble and makes her needs known by crying or waving her hands. She shows limited outward affect, noting her mother's return to the room with only a brief turn of her head In her mother's direction. Maggie was born to a teenage mother and was raised by her maternal grandparents, living in their home from infancy. When Maggie was five years old, her mother married and resumed

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care of Maggie, moving her in with her new family. Maggie left her mother's home when she was 13 years old, stating that she and her stepfather didn't get along. She told me that she believed her mother chose him over her. Several years later, when she was 18 years old, Maggie married her high school sweetheart and gave birth to Christopher shortly after her graduation. During the next three years, this young family lived in four different homes, endured extreme financial hardship, experienced and witnessed domestic violence and finalized divorce after at least two separations.

Bringing to light the baby's experience

Beginnings are not always easy. Maggie and her children presented with many problems. It might have been simpler to identify and stay with case management needs. Maggie talked about several that were identified in our first meetings together. She was insightful, though, and talked about her feelings related to having two very young children and preparing for a third. As I struggled to keep the children and their relationship needs in mind, I remembered that both Christopher and Diana were born early and I asked Maggie to tell me a little more about this. I asked Maggie what Christopher and Diana were like as babies and how they showed their pleasure or dislikes. I wondered about their unique relationships with Maggie. Internally, I wondered why Christopher was unable to explore his world with a sense of awe and pleasure.

I also wondered why Diana was unable to use her body effectively but showed a persistence and drive to explore. I used open ended questions, as well as "tell me more" and "what was that like?" as a way of keeping in mind each child's experience, as well as how it was related to Maggie's own experience. Maggie responded positively to my curiosity about her very early relationships with each of her young children. She began reflecting upon the situations both Christopher and Diana were born into and how they each responded. My gentle questions and explorations such as "How do you suppose Christopher felt about that?" or "Where was Diana when that happened?" led to a focus on each young child's experience. At the same time, I responded to Maggie's concerns.

Upon further reflection together with Maggie, I learned that Christopher was a highly reactive baby, responding to each subtle noise, smell or change. Diana was content to remain in her bassinet and cried only when she needed to. Maggie revealed that she did not pick Diana up unless she needed to be fed or changed and that she experienced a great deal of depression following Diana's birth. I thought about the challenging behaviors Maggie described and explored with her what it was like to be a mother for her children. It was important that Maggie be allowed to explore the feelings she had about being a teen parent to her challenging first baby and her experience of giving birth to her second baby with no family and friends to embrace her. Now again, she would be alone in welcoming her third child into the world, a child whom she was ambivalent about, a baby who was not planned or even wanted at this time in her life.

An empathic response

Although Maggie presented with many strengths and insights, the needs of her family were many. I found myself leaving her home feeling overwhelmed, sad and depleted. I had so many questions, and they had so many needs. How could I possibly tackle them all? How can I help her to keep her unborn child in mind while she struggles with her own isolation and the developmental challenges of two premature children? For that matter, how can I keep in mind this young mother, who is herself a child and alone with no mother of her own?

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With support from my reflective supervisor, I explored the relationship between my questions and concerns and Maggie's struggles, leading me to wonder "How can Maggie possibly tackle all of the needs of her family at one time?" Using my feelings helped me to better understand Maggie's deep sense of being overwhelmed and depleted. She wondered who was going to take care of her. The children, too, were overwhelmed and had the same question, without words, "Who will take care of us?" Armed with these reflections, I arrived at the next home visit better able to listen to Maggie, to observe the children, to support her concerns about the children and show considerable empathy for them all. I kept the unborn baby in mind, waiting for Maggie to feel able to prepare for her new baby, a boy.

The power of being there

Early on in our relationship, I allowed myself to feel what Maggie and her children were experiencing. As an infant mental health specialist, identifying the difficulty I was having "keeping the baby in mind" in the midst of all those competing needs helped me to appreciate Maggie's difficulty in "keeping the unborn baby in mind." While holding each in my thoughts, I was able to partner with Maggie, following her lead, at the same time occasionally remembering to ask about the pregnancy, what plans she was making for the delivery, or what worries she had. It wasn't always easy to do, but I knew it was my responsibility as an infant mental health specialist to hold everyone "in mind." Supporting Maggie while keeping the baby in mind was an important part of our beginning relationship. I believe that this provided a much needed foundation for Maggie to being building her thoughts, feelings and ideas about her very young children and her unborn baby.

Supporting Maggie while keeping the baby in mind was an important part of our beginning relationship

When I first met her, she understood that she was overwhelmed and was not shy about letting me know that she needed support. She asked how often I would come to her home and she was ready to invite me in twice a week. My response was to be consistent, I came when I said I would and I left when I said I would. I brought her concrete assistance that she desperately needed and I offered opportunities for concrete reflection. We began using videotape almost immediately (her idea) and she responded positively. She began to bring her thoughts and feelings out into the open and was beginning to feel less overwhelmed by them.

Guiding reflection

In her article, "Keeping the baby in mind: A critical factor in perinatal mental health (2002), " Arietta Slade talks about reflection and helps us to understand ways to reflect with parents on how to think about their unborn child and how they might welcome this baby into their lives. She describes for us the importance of a mother's capacity for "reflective functioning," which she defines as "a cognitive and emotional process that indicates a capacity to understand the dynamics of an internal and interpersonal emotional life" (p. 11). How a mother is able to keep her baby in mind is connected to her capacity to have an understanding of the baby's emotions and how they may connect to the baby's behaviors. Is the mother able to identify her baby's emotional state or is she clouded by her own emotions? I have often heard a pregnant mother describe her unborn child as "wild" when she feels the baby kicking. I have also heard very young infants described as "angry" or "evil" when they cry. It is our job to establish a trusting relationship with parents so that we can support them in coming to the understanding that they themselves may be angry, not their baby; they themselves may have felt "wild" or "evil" because that is what they were told or what they are feeling about themselves. The relationship we develop over time with parents will provide us with a foundation from which a parent's understanding of and empathy for her baby's experience will grow.

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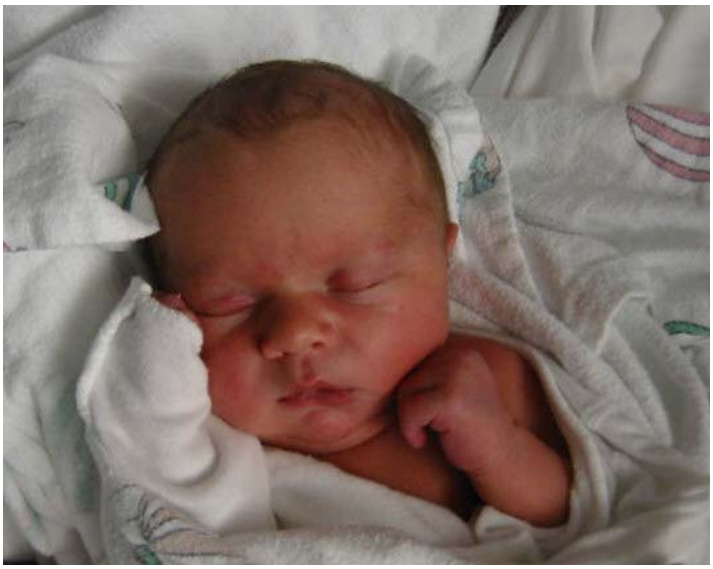
As an infant mental health specialist, I, too, need to have a capacity for reflective functioning in order to understand simultaneously a parent's internal emotional world, an infant's experience within the parent-child relationship and my own emotional response to both. If I allow myself to be led by my own ghosts, I compromise my ability to understand how a parent's emotions connect to their behaviors. I have to be able to understand and have empathy for the parent's experience and the infant's experience so that I can carefully begin to support the parent into understanding her baby's internal emotional world. Beginning with the parent, what they are presenting to me and always remembering to connect it with the baby is a careful and difficult task. I begin with "being with" the family so that they can be with each other.

As an infant mental health specialist, I, too, need to have a capacity for reflective functioning in order to understand simultaneously a parent's internal emotional world, an infant's experience within the parent-child relationship and my own emotional response to both.

Being guided in reflection

In my early training as an infant mental health specialist, I had the opportunity to have weekly individual reflective supervision along with twice a month (that is two times a month!) group reflective consultation. I had the opportunity to learn what it feels like to have someone join with me and allow me to come into my own emotional experience. Through these supervisory relationships, I thought more deeply about my work and was carefully supported to explore the relationship between myself and the infants and families with whom I was working. I was thoughtfully led to wonder about the relationship between my professional work and my personal experiences. Through this relationship, I was open and curious about my feelings, feelings that I was not used to discussing and feelings I wasn't even sure how to express.



The importance of the reflective supervision relationship cannot be understated when thinking about helping a parent bring to life their capacity for reflection. If we are to support the parent's capacity to keep the baby's emotional state in mind, we must also have a relationship that supports our capacity to keep in mind and hold both the parent's and baby's emotional experiences. The reflective supervision relationship provides the infant mental health specialist with a model from which she is able to then establish relationships with parents.

Together, the supervisor and infant mental health specialist learn to explore what has been seen and heard, as well as felt, by the infant mental health specialist when with a baby and family (Weatherston & Barron, in press). This relationship then parallels how the infant mental health specialist and parent together explore what the parent has seen, heard and felt in the presence of her baby. Equally important, the IMH specialist and parent wonder about what the infant's experience might be within the developing parent-child relationship.

References

Slade, Arietta (2002). Keeping the baby in mind: A critical factor in perinatal mental health. Zero to Three, 10-16.
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Connecticut Association for Infant Mental Health

Margaret C. Holmberg, PhD, President
Margaret.Holmberg@ct.metrocast.net

Newsletter Editors:
Kevin J. Sullivan & Margaret C. Holmberg

For Membership Information:

Kareena Duplessis, CT-AIMH Secretary
Child Development Infoline
United Way of CT
1344 Silas Deane Highway
Rocky Hill, CT 06067
Phone: (860) 571-7530
Kareena.Duplessis@ctunitedway.org

Membership Update

Why Join CT-AIMH?
Infants and young children and their givers deserve support and services that encourage nurturing relationships. By joining CT AIMH together we can move forward in creating an infant/early childhood mental health system in CT.

Information about membership is on our website: **www.ct-aimh.org**

Who should Join?
CT-AIMH welcomes the many disciplines that contribute to relationship-focused work with infants and their families, such as educators, including child care providers, therapists, clinicians, home visitors, social workers, nurses, psychologists, physicians and others.

Utilizing Videos to Enhance Parent/Infant Relationships

In the April-June 2010 issue of *The Signal*, the newsletter of the World Association for Infant Mental Health, the feature article by Antoine and Nichole Guedeney is on using video for understanding of and intervention in parent/child relationships. The article gives a comprehensive history of how videos have informed our understanding of infant-parent relationships and how interaction truly develops. The article summarizes "Lessons from the Great Baby Watchers" (Beebe Stern, Tronick, Brazelton and others). Listed are some examples of information we might not know if video had not occurred:

- In secure dyads, even when things are “as good as they get,” the rate of misattunement may reach 50%.
- Being securely attached is working through mismatches, not avoiding mismatches.
- For pairs with too frequent or intense mismatches, frustration or fear of loss may lead the parent to give up the search for attunement.
- Video helps focusing on the baby and on the relationship and helps the parent take the baby's perspective.
- Video shows the big difference between what we, as parents, believe we do and what we effectively do, particularly when stressed.
- Rhythmic coupling at 4 months (turn taking, joining, yielding and tracking) predicts attachment classification at 12 months.
- In mild to major disturbances of relationship, defensive maneuvers in the child get built up quickly (i.e. by 9 months of age).
- Attachment behavior is resistant to change, but there is always room for change.

You receive *The Signa*l with your World Association for Infant Mental Health membership. For an opportunity to learn more about using videos in your work with families, check out this CEED online course. Originally developed as part of the **STEEP™** program, **Seeing is Believing®** is a unique practice that helps parents increase their sensitivity and responsiveness to their babies' cues by using a filming strategy. Through filming and guided viewing, **Seeing is Believing®** promotes perspective-taking by giving parents a chance to see, from the camera’s point of view, what happens between them and their baby. Visit http://www.cehd.umn.edu/ceed/profdev/onlinecourses/sib.htm