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Contents

How Refuge provides 'refuge' to Infants: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing family violence

This article by Wendy Bunston (PhD), Australia, is a summary of her doctoral research on infants' experiences of refuge while in Refuge crisis accommodation with their mothers. This PhD thesis can be fully accessed and downloaded by visiting: http://hdl.handle.net/1959.9/55917.

By Wendy Bunston, Australia

Infants under 12 months are more likely to be killed or harmed than any other age group in childhood (AIFS, 2010; AIHW, 2012a; Brandon et al., 2008; Frederico, Jackson, & Jones, 2006; Zeanah & Scheeringa, 1997). These risks are increased for the infant who lives with family violence. These infants are often present or nearby during incidences of familial violence within their home and make up the highest cohort of children to enter women's Refuges[1] (or alternatively, shelters/crisis accommodation) with their mothers after fleeing family violence (AIHW, 2012a, 2012b; Shinn, 2010). However, as a vulnerable population, infants experiences of violence and subsequent entry into women's refuges with their mothers to escape family violence is the least reported, thought or written about, and responded to of any age group in childhood (Bunston, 2017; Bunston, Franich-Ray, & Tatlow, 2017; Lieberman, Chu, Van Horn, & Harris, 2011).

1 Refuge with a capital 'R' refers to the physical place or accommodation provided and refuge with a lowercase 'r' refers to the emotional and social feeling of being.

The purpose of the research

The purpose of this PhD was to attempt to understand the experience of the infant in Refuge, and what was provided to them. There was no discernible research available regarding what occurred 'in-house' for infants who, with their mothers, become homeless as a result of family violence (David, Gelberg, & Suchman, 2012). High risk and transient populations such as these are often excluded from research as they are difficult to access, hard to engage and challenging to track (Booth, 1999; Thompson & Phillips, 2007). My interest was in what occurred in the Refuge setting to provide the infant with the experience of feeling that they had found refuge, and was that refuge experienced as a 'place', as a 'feeling of safety', or both? Six general questions were developed. These aimed to both guide this research overall and to set the parameters for collecting data regarding the infant, the mothers and the Refuge itself. Specifically:

- What is experienced as 'refuge' for the infant?
- How are the needs of the infant met within Refuge in order to make them feel safe?
- How are the infant/mother attended to in order to bring the infant into an emotionally regulated and healthy state?

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Perspectives Outreach
Calling all Infant Mental Health Professionals!

It is especially thought provoking to understand that every infant and family is affected by forces far beyond their reach - forces that may strengthen or hinder social, emotional, and relational health. A truly global organization, WAIMH invites professionals from around the world to contribute to its quarterly, open-source publication, WAIMH Perspectives, offering insights into the ways of seeing and being and working in diverse contexts, cultures and communities with infants, very young children, and their families.

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Double spaced

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APA, 6th edition for style

Articles of varying length are welcome. However, length should not exceed 10 pages, word format

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- How does entry into Refuge impact on the infant/mother relationship?
- How does the infant experience safety ('refuge') in a refuge environment?
- What knowledge do both staff and mothers have in relation to the needs of infants entering the Refuge?

The scope of the research

In 2014 I visited eight women's refuges in three countries; Australia, England and Scotland. I undertook collecting data from ten infants, interviewed ten mothers, and thirteen staff. I endeavoured to capture something of the subjective experience of the infant; first and foremost. This was done through using infant observation techniques I had been trained in as an infant mental health practitioner. The research methodology was purposefully 'infant led' (Bunston, 2008, 2016; Paul & Thomson-Salo, 1997), contextually sensitive and unobtrusive and drew from the concepts of intersubjectivity using a constructivist grounded theory research methodology (Charmaz, 2014).

Infant Observation as the starting point

It was necessary to first engage and build trust with each Refuge before I could gain entry. This led to staff recommending me to mothers, and mothers then meeting me for a preliminary outline of the research and to gain informed consent. Data collection began with undertaking an hour of observation with each infant (depending of accessibility I had one to three infant observations sessions with each of the ten infants involved in the study). I used traditional infant observation techniques (Bick, 1964; Datler, Datler, Hover-Reisner, & Trunkenpolz, 2014; Rustin, 1997), seeing this as the most discreet and ethical method to collect data directly from the infant in such a sensitive setting.

Immediately following each observation, I either spoke my process notes into an audio-recorder (which I then transcribed later) or wrote lengthy process notes. Once this data was collected I then proceeded with interviewing mothers, and later followed this with staff who were representatives of the three different countries in which I visited the Refuges. My two PhD supervisors and a critical friend (a teacher of infant observation methods) acted as the 'seminar group' within which the raw infant observation data was presented and nuances of the data could be explored (Bick, 1964; Caron, Sobreira Lopes, Steibel, & Schneider Donelli, 2012; Caron, Sobreira Lopes, & Schneider Donelli, 2013; Datler et al., 2014; Rustin, 2009; Waddell, 2013).

Infant led research

My research focused on the preverbal infant (12 months and under). Processes were in place to terminate sessions should the research process cause any distress to baby or mother, and post-observation and/or interview support for all participants was made available. The ethics of including infants in this research was weighted up against the importance of the research, the need to include the experience of the infant and that infants have a right to be included in research which directly concerns them (Pinheiro, 2006). I deliberately commenced with collecting data from the infant before any other and undertaking my analysis of the infant data before any other. This ensured that the experience of the infant served as the foundation upon which all other data was analysed to ensure the infant was front and centre in all aspects of the research process. This commitment worked to embed the infant's presence and experience into this methodological approach, intentionally honouring the potential to more actively include their voice in this research. This was to ensure, as much as was possible, that what might be the experience of the infant was included and to protected. To not do so risked "the elimination of an important category of knowledge, namely the knowledge of the child" (Schmidt Neven, 2007, p. 202).

Findings

Specific to the infant I found that whilst the majority of the infants sought out their mothers for refuge (as a place and to feel safe) they did not necessarily experience what they received as feeling like refuge. There were few other choices for the infant other than to turn to their mother; when the assurances they sought were left unsated some infants actively self-soothed, shut down or accommodated what was needed in order for them to gain proximity. As the observer I experienced varying levels of distress, anxiety and sadness as I watched a number of infants floundering and in only two instances experienced observing a sense of joyful exchange, reciprocity and playfulness between the infant and their mother.

Overall, I found that Refuges, like many other settings, are predominantly 'adult-centric'. Women's Refuges and shelters were originally created by members of the women's liberation movement in the 1970's to provide safe accommodation for women and their children experiencing violence in their home (Schechter, 1982). The belief then, and still today largely centres on supporting the mother which, by osmosis then supports the infant. However, these often highly traumatised mothers are not always available to tend to their infants. Not because they are bad, or do not care, but because they are themselves distressed and/or dysregulated and not able to quickly recover and/or know how to make themselves available to their rapidly developing infant.

The staff themselves did not feel adequately trained nor supported to confidently respond to the infants' needs and it appears that only when an infant is obviously unwell or distressed is direct assistance for the infant sourced, and then this is from outside, specialist help. In remote areas such support is not actually available. Workers do not generally directly engage with or consider the experience of the infant. This does not appear to result from a lack of compassion but acts as a means of self-protection. It is too painful for both staff and mothers alike to fully immerse themselves in a sympathetic response to the distress and trauma experienced by the infant. Therefore, the infant is lost from view in the Refuge setting, often not finding refuge, and on occasion, appearing to feel less than safe in this setting.

An important finding of the research was that all mothers involved in the study were motivated to leave the violent relationship because of their concern for their infants' welfare. This motivation to protect their infant was far greater than their desire to leave the relationship for the sake of their own safety. Their entry into refuge appeared to attend to the physical requisite for safe shelter, but less so to supporting their emotional need for reassurance about their role as parent and anxiety about their ability to manage their relationship with their infant. What Refuge might offer them other than accommodation was left unsaid but appeared as a yearning for guidance and support in their parenting role and for securing their infant's future.

Truly experiencing refuge after violence

The setting of Refuge has the potential to offer amazing opportunities to engage with and provide important therapeutic support to vulnerable infants and their mothers. Refuges are, however, poorly resourced and often isolated from other services which could and should provide relevant and critical early intervention programs. Staff within Refuges are highly committed but poorly paid. They deal with complex presentations and support highly

traumatised families. Other services, such as mental health – for adults, children and infants – need to work alongside Refuges, given the strong correlation between the impact of family violence and mental health difficulties (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008; Kemp, Green, Hovanitz, & Rawlings, 1995; Tolman & Rosen, 2001; WHO, 2013). Mental health services would also have much to learn about the intricacies of addressing family violence and the complexities of attachments formed in such contexts by engaging with the infants, families and staff who make up Refuge.

Conclusion

It is no longer acceptable to say that family violence is not 'core' business for other service providers in mental health, community health and maternal child health, and multiple others. To bring the infant relationally alive, to fan the hope derived from this new relationship and to support the infant's wellbeing, physically and emotionally, a commitment is now required to support a setting which, for decades, has been protecting our most vulnerable. For as long as family violence remains endemic, the Refuge environment remains a necessity and intervention programs "must consider the dyad-context system to better address particular needs and to tailor intervention services" (Mingo & Easterbrooks, 2015, p. 480).

Refuge for the infant needs to be less about the building and equipment and more about people and relationships. This is as true for the mother as it is for the infant. Refuge workers need to be encouraged to act as a community of carers for the infant and their mother and be supported in doing so. This is through adequate funding and a community of service providers working to support them and recognising that refuge is as much a critical emotional space for the infant as a building which provides shelter. Infant mental health services, as with Child and Adolescent Mental Health Services (CAMHS), could begin now by offering regular reflective supervision sessions and consultations to local Refuges and crisis accommodation services. It is time to build active partnerships between infant mental health and family violence services if we are to bring about opportunities for repair which may truly have the power to interrupt intergenerational familial violence.

Summary of Key Findings

1. The infant is not understood to possess their own subjectivity and therefore is often lost from view within the Refuge setting.

2. The mother, not the Refuge, is expected to be the refuge for her infant.

3. Only when the infant is in obvious need do they receive specialist, 'outside' help.

4. It is too painful for the adults in Refuge to see or think about the subjectivity of the infant, or of the infant having their own traumatic memories.

5. The infant is the catalyst for mothers to seek Refuge and it is this relationship which provides the hope for the creation of a different future.

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This PhD Thesis can be fully accessed and downloaded by visiting: http://hdl.handle.net/1959.9/55917. In late 2016 the author was a recipient of the 'Nancy Millis' award for excellence in research.

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