Infant Mental Health Home Visitation

Setting and Maintaining Professional Boundaries

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Infant mental health (IMH) home visitors face great challenges in caring for infants and young children in vulnerable families and must balance an array of responsibilities: They must observe surroundings and interactions within the home; assess situations that arise during their visits; and manage a variety of feelings, perspectives, and needs. Home visitors themselves interact with different personalities; in addition to the baby, they may meet one or more parents, grandparents, other extended family members, neighbors, and friends. The baby can easily get lost among the adults, and the baby's needs may get lost among adult needs related to poverty, substance abuse, domestic violence, and other risk factors. The home visitor's desire to prioritize and protect the infant may overwhelm her, interfering with her ability to understand what the family may be communicating through their interactions or their lack thereof. The home visitor's desire to "do" things for the family runs the risk of blurring professional boundaries and distracting from the focus on the relationship needs of the baby and those who have primary responsibility for the baby.

Professional boundaries require that home visitors establish a professional yet caring relationship with families in the context of very personal circumstances. In *How You Are Is as Important as What You Do*, Pawl and St. John (1998) wrote that the manner in which the interventions are delivered is as meaningful as the intervention itself. A nonjudgmental, sensitive, compassionate approach often makes the difference in successful interventions with vulnerable families, as it can support the development of a therapeutic relationship through which the parents can begin to change their understanding of how relationships can be, including, most importantly, the relationship they offer to their baby.

As the home visitor offers the possibility of a relationship with the parents and the parents begins to feel heard, understood, and cared about, an alliance is formed. In this context, it is easy for the professional and personal to get mixed together. If the home visitor aligns completely with the parents, the child's needs may get lost. In fact, much of the art of home visiting involves keeping the needs of the infant or toddler in mind while working to help the parents understand how their overwhelming needs can affect the baby, the baby's development, and the emerging attachment relationship between the parents and the baby.

There is also danger in doing too much for the family. The home visitor who does too much (e.g., spends personal time and money on items for the family, carries too much of the family's emotions) may begin to resent the family when they do not appreciate her efforts or disregard her feelings. Because of hurt feelings, the home visitor may stop taking or returning calls from the family and may begin

Abstract

Relationship-based infant mental health (IMH) home visiting services for infants, toddlers, and their families intensify the connection between the personal and professional. To promote the therapeutic relationship and maximize the effectiveness of the intervention, home visitors must exercise good judgment, in the field and in the moment, to set and maintain appropriate, professional boundaries. In this article, the authors discuss the creation of professional boundaries, encouraging home visitors to apply "best practice" interventions on the basis of thoughtful evaluations of the setting and the nature of the family's needs.

arriving late or canceling sessions. When these things happen, it is a clue that the home visitor has not been successful in maintaining appropriate professional boundaries.

The Home Environment

Delivering services in the home environment has many advantages, but it has disadvantages too; one of its main challenges is the blurring of boundaries between the personal and the professional. During a home visit, the practitioner is expected to perform the duties of a professional, such as observing thoughtfully, assessing capacities and risks, and providing interventions (Weatherston, 2000; Weatherston & Tableman, 2002). At the same time, the practitioner is a guest in the home, and the close relationship between home visitors and family members can feel more personal. Conducting what Selma Fraiberg (1980) referred to as "kitchen table therapy" risks confusing the roles of personal and professional for both the family and the practitioner; interventions offered over a shared cup of coffee or while sitting together on the living room floor may simply feel less professional to both the IMH home visitor and the family members.

However, being in the home offers the IMH home visitor a more intimate perspective than is available to other professionals who never enter the home (Powers & Fenichel, 1999). In the home the home visitor observes personal details such as where family members sleep and with whom, the cleanliness of the home, religious and/or cultural practices, and the nature of the neighborhood. These observations are critical in helping the home visitor formulate an understanding of the infant and family's life.

The following two vignettes illustrate how the intimacy of the home setting gives the home visitor first-hand experience with the families' challenges and the opportunity to provide in-the-moment assistance and support.

Cindy

Cindy visits a family with whom she has been working for approximately 9 months: parents Debbie and Carl Allenton and their children Joey, 6 months, and Lucy, 30 months. As Cindy walks to the door of the Allentons' small trailer, she hears loud arguing. Despite her anxiety about the chaos, she knocks gently and is greeted by Carl, who yells, "Come on in and join the fun! Listen to what I've had to deal with all day!" Carl and Debbie continue their argument while Cindy and the two young children look on.

Debbie has shared with Cindy memories of her own childhood, which included witnessing loud and often violent arguments between her mother and her mother's boyfriends. She often worries that she might scare her own children and acknowledged to Cindy that she does not know how to deal with feelings of anger and anxiety.

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Parents especially need emotional support, guidance, and information during pregnancy and early parenting.

Because Cindy knows Debbie's background and has developed a relationship with Debbie, Carl, and their children, she diffuses the situation by discussing the problems and suggesting possible solutions. She also reflects the children's experience of the argument: she describes her own feelings of apprehension and fear and asks if others in the family felt frightened, too. "You are both feeling angry and discounted. It seems like everyone here is feeling worried and upset, including me, Joey, and Lucy," she says. Cindy understands that Debbie feels hurt and vulnerable, as well as intensely afraid. In a home visit later the same week, Cindy revisits the argument with Debbie and helps her connect those feelings with the children's experience, in a manner that expresses empathy and compassion.

The information a home visitor gains by being intimately engaged with family members in their home is invaluable, and it is unique to the home visiting model. If Debbie and Carl were in couples' therapy in an office setting and simply related the story of this argument, the therapist would get an understanding of their struggle but not the first-hand experience of what it feels like to be in the home when Debbie and Carl are in crisis.

To maintain appropriate professional boundaries in this situation, Cindy first must consider everyone's physical safety and determine if the argument is such that someone might be hurt. If she cannot successfully de-escalate the tension, she will have to call her supervisor, the police, and possibly the local child protection services. Cindy uses her professional judgment, in the moment, to stay and observe. Her observations allow her to learn more about how the family interacts when stressed and to get a sense of how those interactions might feel to the very young children in the home. Because she makes the right decisions, Cindy uses the event to raise both parents' awareness of how their frightening arguments impact their very young children.

The next vignette shows a home visitor offering immediate and concrete assistance in the home setting, which ultimately makes a real difference in the relationship between mother and child.

Rachel

Rachel, an IMH home visitor, visits Stella, a young teen mother who is staying with the father of her baby and his parents. Stella has told Rachel during previous visits that she feels "out of place" at this home and often worries that she and the baby will have to leave. Young, unprepared for the care of a baby, and without the supportive presence of her mother or other family members, Stella is anxious and at considerable risk for mental

health problems.. However, in spite of such risk, she has been able to use the support that Rachel offers through home visiting services and has given her young infant a good start. The baby, 9-month-old Miles, is competent and has reached the developmental milestones expected for a baby his age, smiling often and reserving a special smile just for Stella.

When Rachel arrives for a scheduled home visit, Stella opens the door and quickly walks away. Rachel enters to find Stella hunched over a broken dishwasher. Speaking rapidly and shaking, Stella relates how Miles pulled himself to stand on the open dishwasher, and broke it. Rachel has not seen this mother in such an alarming state. When Miles tries to come near Stella yells at him, which makes him cry pitifully.

Rachel takes off her coat and helps Stella fix the broken dishwasher. Later, they sit together on the couch. Stella says, "I was so scared that this would be it: me and Miles would have to leave." Rachel realizes that she did not fully understand Stella's worry about being abandoned and alone with the enormous responsibility of keeping her baby safe. Rachel gives voice to Stella's worry and panic: "You've been walking on eggshells here. I think I am beginning to understand how worried you are about losing this home for yourself and Miles. It must be so difficult to be so worried all the time. And yet, you've been a nurturing mommy to Miles. You play with him, talk to him, sing to him, and allow him to move about. And Miles is growing so well." Stella then pulls Miles to her and apologizes to him for yelling.

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The intimacy of the home setting gives the home visitor first-hand experience with the families' challenges.

Witnessing Stella's panic and then joining with her to fix the problem that caused it can only happen during a home visit. The IMH home visitor makes a choice to engage in an unconventional intervention, helping to fix the dishwasher. But by doing so, Rachel joins with Stella, acknowledges her fears and worries, and helps her to feel less alone with those worries. Rachel reflects Stella's fear of being alone, yet she also reflects the ways in which Stella has been promoting Miles' social and emotional development under such trying conditions. Rachel's intervention immediately enables Stella to be more emotionally available to Miles.

Perinatal Home Visiting

In his book *The Motherhood Constellation*, Daniel Stern (1995) described the intense psychological changes that occur when a woman becomes a mother. He wrote, "The mother needs and wants to be 'held,' valued, appreciated, aided, and given structure by a benign, more experienced woman who is unequivocally on her side" (p. 183). A mother at risk for relationship difficulties might engage in services with the expectation that the practitioner might fill a maternal role.

According to Weatherston and Tableman (2002), parents especially need emotional support, guidance, and information during pregnancy and early parenting, when the IMH home visitor comes into their lives. Parents with past histories of early relationships that were absent, unstable, inconsistent, or conflicted may treat the IMH home visitor as a maternal figure, or the home visitor may put herself in that role. The parents see the potential to develop a unique supportive relationship, which may lead to positive changes in the way they form a relationship with their infant.

A home visitor aware of a new mother's need for a supportive maternal figure can shift the limits of how she relates to and with the family. Even a home visitor who does not act as a therapist may enter into a relationship that deepens and becomes—for the family—nurturing, an important means of emotional support, and an agent of change. For the parent, this relationship can be essential in negotiating her tasks of mothering. For the professional, however, it may complicate the setting and enforcing of boundaries.

In the following vignettes, the home visitor works hard to strike a balance between her professional role and the unmet "mothering" needs of a young woman during childbirth.

Emily

Grace is 20 years old and 34 weeks pregnant with her third child. Her oldest, Becca, is 4 years old and being raised by Grace's paternal grandmother in another state. Grace's son Chris is 20 months old and lives with Grace in publicly subsidized housing in a crime-ridden neighborhood. The IMH home visitor, Emily, has been providing services to Grace and Chris for 1 year. As part of her services, Emily observes Grace and Chris interact and gives developmental guidance. A developmental screening that Emily and Grace completed together identified a delay in Chris's motor development, so Emily often accompanies them to doctor's appointments and service coordination meetings.

During the length of service, Emily has formed a strong therapeutic relationship with Grace, and she has come to understand the sadness and anger Grace feels toward her mother. When Grace was a child, her mother's boyfriend repeatedly and brutally abused her, yet her mother did nothing to protect her. Grace shared her sense of betrayal with Emily: "She chose him over me. She accused me of lying about what he had done. Then she didn't fight for me when I was sent to live with my grandma." Despite these statements, Grace's behavior seems to indicate a longing for a different kind of relationship with her mother. Grace's apartment is in the same building as her mother's; when Emily asked about this, Grace said only that she wanted her mother to know her grandchildren—she would shut down or change the subject when pressed further.

The arrival of the new baby grows closer, and Emily asks Grace about her plans. "So will William [Grace's boyfriend] take you to the hospital when you go into labor?" Immediately, Grace's affect changes from engaged to flat and sullen. "What do you mean?" she replies. Emily continues, "I was wondering if William would have transportation to get you to the hospital when the time comes. And also, have you thought about who will take care of Chris while you're having the baby?" Grace says, "But I thought you would take me to the hospital. I was going to call you."

At first, Emily tries to explain agency policy and why she can't just drop everything at whatever time of day or night Grace goes into labor, but Grace's angry and disappointed response gives Emily pause. She stops to consider what Grace's expectations might mean. "Grace, I'm sorry if you misunderstood. I have been taking you and Chris to the doctor, so I can see why you thought I might be the one to take you to the hospital. And this will be an exciting and somewhat scary event for you and for Chris. You will need someone you can

count on." Grace remains silent. "I think there is a part of you that wishes you could count on your mom at a time like this." After several silent and awkward moments, Grace asked in a quiet and childlike voice, "But why can't you take me?" It takes a moment for Emily to reply; she herself feels sad and angry about Grace's mother's emotional abandonment of her daughter. Emily feels pulled to say "Yes, I will be the one to take you to the hospital, to support you during labor, to help you welcome this new child," but she knows that doing so will cross a line. Instead she says, "Grace, you and Chris will need someone when the time comes. I am honored that you would choose me to be there for the two of you. And if I can be there, I will. But I might not be available right when you need that help. Let's think about whom else you might be able to call if I'm not available when you go into labor."

The IMH home visitor makes a choice here to acknowledge and respect the importance Grace has given their relationship. She does so being aware of Grace's unstated desire to have her mother available to her and Chris in their time of need, as well as of her own desire to fulfill that "mothering" role for Grace. Keeping those things in mind, she attempts to strike a balance that preserves the therapeutic relationship without letting it become too personal in nature.

Sometimes the home visitor is not so successful in maintaining professional boundaries. Consider how the home visitor in the next vignette becomes emotionally caught up in the situation at hand.

Donna

Donna is an IMH home visitor working with Kiera, a mother of three young children, ages 4 years, 28 months, and 14 months. Each of these young children is placed in a separate foster home. Kiera has been court-mandated to participate in outpatient substance abuse treatment and to find housing before she can be reunited with her children. Under the circumstances, Kiera is struggling and has not been consistently available for weekly visitation with her children at the foster care agency. Donna has been worried about the children and their need to see Kiera and each other. During home visits, they agree to arrange for a visit with the children in the apartment Kiera shares with several of her sisters. Donna spends hours arranging for this special visit, placing multiple calls to the foster care worker and the three sets of foster parents. On the day of the visit, Donna picks up all of the children, but when they arrive at Kiera's apartment, no one is home. After waiting for 30 minutes, it is apparent that the visit will not occur.

Waiting in the home visitor's car the children wonder where their mother is and become increasingly upset . Donna becomes angry with Kiera; she now has to transport all of the children back to their foster homes. She cries along with the children as they protest leaving without seeing Mommy. Donna now has to explain to each foster parent and the foster care worker that the mother did not show up for the visit. Upon her return to the office, she calls Kiera and scolds her for not showing up as planned. She describes how upset the children were and how they cried when they found out they would not be able to see her. Caught up in her own angry feelings, she has little empathy for the mother who did not appear. She expresses no interest in why the scheduled visit was difficult for the mother and has little curiosity about the mother's failure to connect.

Home visitors generally choose their vocation out of a desire to help others to have successful lives and relationships; they want all babies to have caregivers who will support their development and take joy in their existence and accomplishments. Home visitors also often desire to be liked by each family they serve and hope that the families will greet them warmly and benefit from the support they offer. Because the families who are referred for home visiting services are often overwhelmed by the highly charged emotional needs of a new baby and the many factors that place them at risk, home visitors may inadvertently get caught up in fixing or rescuing, in "doing" rather than "being with."

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Professional boundaries require that home visitors establish a professional yet caring relationship with families.

Tools for Decision-Making

Home visitors often encounter situations that require immediate decision making. The following questions and guidelines are designed to assist the IMH home visitor in thinking through a situation in the moment.

Questions to Consider

Why is this bothering me? Answering this question can help the home visitor determine if the situation is personally uncomfortable, a safety risk, or an issue with clinical significance for the infant and family. Whatever the answer, a home visitor would be wise to reflect upon the issue and her feelings in individual or group supervision.

Are there any ethical issues to consider? For example, is the parent asking the home visitor to babysit her children when she goes on a job interview, or is the IMH home visitor being asked to compromise the confidentiality of the family? This question helps the home visitor to assess whether there are ethical issues that place her professional status in some jeopardy. If so, the situation should be addressed with a supervisor prior to proceeding with the family.

Are there alternative courses of action? This question can help the home visitor stop and think about the situation and the ways that she could respond. Again, by sharing her observations and behavior with her supervisor or within a reflective group, the

home visitor has time to explore her concerns with others and consider alternatives. In this way, the home visitor can assess which response will best reflect her own values and the family's values while maintaining her professional role.

Guidelines

Home visitors can use the following guidelines to help create and sustain professional boundaries with children and families:

Take the lead in offering and entering into a professional working relationship with the family. Engaging with families whose past relationships are inconsistent or unstable can be very hard work. Families may be reluctant to trust anyone who offers help; they may be fearful that the home visitor will be hurtful or "turn them in." Home visitors must take the lead in establishing rapport and trust by demonstrating a commitment to the relationship, being consistent in what they do and how they are, and being persistent in their attempts to engage and support the family (Weatherston & Tableman, 2002).

Identify when a breach of trust within the working relationship has occurred. The intensity of the working relationship between a home visitor and a family can blur the boundaries of the professional relationship. A home visitor must be able to identify when she may have overstepped that line and determine how to best repair that relationship. Outside of obvious professional ethics violations, the power of repair cannot be understated. Often, families expect that if a boundary is crossed or a trust violated, the relationship will end. The power of repair occurs when the event is revisited, when the home visitor honestly reflects upon what happened and even acknowledge that she may have done something wrong or offended the family. By working to repair trust the home visitor helps the family experience conflict appropriately, and treating the family with respect and honest deepens the relationship.

Enter into a reflective supervision relationship. An essential part of this service delivery model is providing IMH home visitors the support of a reflective supervisor (Fenichel, 1991; Jones Harden,1997; Kaplan-Estrin & Weatherston, 2005; Scott Heller & Gilkerson, 2009; Weatherston & Tableman, 2002). Reflective supervision allows the IMH home visitor time to sit with another and think deeply about a particular infant and family and their responses and needs. When the IMH home visitor enters into the supervisory relationship, making herself vulnerable and sharing feelings and thoughts that may be difficult, she begins the journey much in the same way as parents and babies. She shares her vulnerabilities with another, experiences a new way of being with another, and maintains respect for herself and her professional growth. The experience is then passed along to the parent, so that the parent can do the same for the infant.

IMH home visitors carry their own early relationships with them, as well as, if they are parents, the relationships they have with their own children. Participation in reflective supervision can help an IMH home visitor better identify and understand the role of her own experiences of mothering and of "being with." Reflective supervision can also offer the home visitor the opportunity to identify and understand feelings she may have about her own choices and journey toward becoming a mother, or not becoming a mother. Being in the presence of a family may evoke for a home visitor feelings related to her own experiences of pregnancy and parenting, the longing for a baby of her own, the loss of a pregnancy or baby, an adoption, or the choice to not become a parent. Reflective supervision can support a home visitor in the struggle to name such feelings and interpret them in a proper context so that they do not inappropriately influence the choices she makes with and about a family she serves.

Feelings of isolation can permeate the work of an IMH home visitor. The infants, toddlers, and families may themselves experience physical, social, cultural, or emotional isolation—moreover, the act of conducting home visits can itself be lonely. The home visitor drives from one appointment to the next, often without an opportunity to touch base with a supervisor or trusted colleague after a difficult session. The reflective supervision relationship can become an internalized companion, combating the realities of isolation when a home visitor is out in the field. Over time, when a reflective supervision relationship has been consistent and protected and when both the IMH home visitor and the supervisor have been fully present and emotionally available, their relationship deepens and the IMH home visitor becomes increasingly aware of the feelings she has in response to her work with infants and families. Increasing self-awareness, both inside and outside the supervisory session, leads to greater confidence. The IMH home visitor explores new insights and trusts herself and her responses. When she is with families, she carries this confidence with her. The IMH home visitor can be with families and at the same time consider her own responses and how she might share these responses with her reflective supervisor. She may even wonder about how her supervisor might respond to her reflections. The reflective supervision relationship can serve as a secure base from which to grow and explore, as well as a safe haven home visitors can return to when they feel vulnerable and insecure (Weatherston & Barron, 2009).

Summary

Most parents want to share their experiences as new parents and their child's challenges and accomplishments with members of their extended family and with their close friends. When families are referred for infant mental health services, the home visitor may become the trusted person with whom to share their experiences with their baby. The home visitor may be the one whom parents greet by proudly showing that their baby has learned to roll over, sit up, or offer a social smile since the last time they were together. The home visitor may also be the one whom parents turn to when their baby rejects them or does not smile or when they reject their baby. When the home visitor can witness achievements and celebrate them, as well as listen openly to the heartbreak and difficulty, parents feel less isolated and take more pleasure in the baby.

Home visiting can be a powerful intervention strategy for many high risk and vulnerable families. It also can be overwhelming and challenging to the home visitor providing the service; taking a relationship-based approach in the intimate home setting can often blur professional boundaries and make them difficult to set

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Publications

Infant Mental Health Services: Supporting Competencies/Reducing Risks.
D. Weatherston & B. Tableman (2002)
Southgate: Michigan Association for Infant Mental Health

Case Studies in Infant Mental Health: Risk, Resiliency, and Relationships.
Edited by J. Shirilla & D. Weatherston, (2002)
Washington, DC: ZERO TO THREE

A Practical Guide to Reflective Supervision.
Scott Heller, S., & Gilkerson, L. (Eds.). (2009)
Washington, DC: ZERO TO THREE

Web Sites

Michigan Association for Infant Mental Health
www.mi-aimh.org/index.php

Best Practice Guidelines to Reflective Supervision/Consultation
www.mi-aimh.org/page.php?id=33

and maintain. Through thoughtful dialogue, processing, and support, usually in the context of a reflective supervision relationship, a home visitor can feel more confident in her decision-making.

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References

Fenichel, E. (1991). Learning through supervision and mentorship to support the development of infants, toddlers and their families. *Zero to Three, 12*(2), 1–9.

Fraiberg, S. (1980). *Clinical studies in infant mental health*. New York: Basic Books.

Jones Harden, B. (1997). You cannot do it alone: Home visitation with psychologically vulnerable families and children. *Zero to Three, 17*(4), 10–16.

Kaplan-Estrin, M., & Weatherston, D. (2005). Training in the 7 languages of infant mental health: The graduate certificate program at Wayne State University's Merrill-Palmer Institute. *Infants and Young Children, 18*(4), 295–307.

Pawl, J., & St. John, M. (1998). *How you are is as important as what you do...in making a positive difference for infants, toddlers and their families.* Washington, DC: ZERO TO THREE.

Powers, S., & Fenichel, E. (1999). *Home visiting: Reaching babies and families "where they live."* Washington, DC: ZERO TO THREE.

Scott Heller, S., & Gilkerson, L. (Eds.). (2009). *A practical guide to reflective supervision.* Washington, DC: ZERO TO THREE.

Stern, D. (1995). *The motherhood constellation: A unified view of parent-infant psychotherapy.* New York: Basic Books.

Weatherston, D. (2000). The infant mental health specialist. *Zero to Three, 21*(2), 3–10.

Weatherston, D., & Tableman, B. (2002). *Infant mental health services: Supporting competencies/reducing risks.* Southgate: Michigan Association for Infant Mental Health

Weatherston, D., & Barron, C. (2009). What does a reflective supervision relationship look like? In S. Scott Heller & L. Gilkerson (Eds.), *A practical guide to reflective supervision.* Washington, DC: ZERO TO THREE.