How Refuge provides ‘refuge’ to Infants:

Exploring the ways in which ‘refuge’ is provided to, and experienced by, infants entering crisis accommodation with their mothers after fleeing family violence.

Author
Wendy Bunston
BSW., MaFT., GCOrgDyn., GDInfMH(Eqiv)
wendy.bunston@bigpond.com

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School of Allied Health, Department of Community and Clinical Allied Health
La Trobe University, Victoria, Australia

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ABSTRACT

This research is concerned with the ways in which refuge is provided to, and experienced by, pre-verbal infants who enter into women's refuge accommodation with their mothers as a consequence of fleeing family violence. The literature reveals a certain amount of information specific to the infant affected by family violence and homelessness, but little research on infants within the refuge setting or their experiences in such a setting. This study involves ten infants, ten mothers and thirteen staff and key informants from eight women's refuges within Australia, England and Scotland. To ensure that the infant remained at the fore of this enquiry, an 'infant-led' qualitative research approach was undertaken. This approach utilised an inter-subjective approach through infant observation techniques, and drew on a constructivist grounded theory methodology in its implementation and analysis (Charmaz, 2014). This offered an ethically sound, non-intrusive, yet flexible means to access not only the world of the infant, but the largely hidden world of women's refuges.

This research found that infants in refuges are not seen as being capable of possessing their own subjective experiences, and consequently are often lost from view. The provision of refuge to the infant was considered, by both staff and the mother herself, to be the mother's responsibility. However, the capacity the mother possessed for this was affected by her own past and current trauma. Only when the infant was observed to be experiencing obvious difficulties was assistance given, and this came from outside, specialist workers. The adults in refuge appeared to find it too painful to see or even think of the infant as having their own subjectivity or traumatic experiences. Furthermore, the significance of the now 'absent' father was discounted, leaving no place for processing this complex relationship. The catalyst for every mother entering refuge was, however, the potential relationship this afforded between them and their infant, a relationship which gave mothers the greatest hope for creating a different future. A key finding of the study is that greater attention to the needs of the infants is required if they are to benefit from their experience of refuge.

DOCTOR OF PHILOSOPHY DECLARATION

Statement of Authorship

Except where reference is made in the text of the thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis submitted for the award of any degree or diploma. No other person's work has been used without due acknowledgement in the main text of the thesis. This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

Signature

Wendy Christina Bunston

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PART ONE

CHAPTER ONE

Introduction

When a mother and her children leave home in order to escape family violence, they are effectively moving away from what most would consider their safe haven and into the great unknown. This is neither a holiday nor an adventure, but an act of escape. This decision reflects the opposite of what most people consider the norm – that home is where you feel safe. These mothers make the difficult decision that it is safer for themselves and their children not to remain at home. For some, this decision is literally in order to save their lives. Many of these mothers do not have family or friends on hand to assist with their departure, and have no choice but to seek crisis accommodation. It is the infant who is the most vulnerable in these families, and infants who make up the largest cohort of children entering Refuge with their mothers. By virtue of their dependency, the infant is also highly likely to have been present, held, or nearby when the mother has experienced violence.

It is not possible to be present and observe what happens to the infant during a violent altercation within their family. This research explores what transpires for the infant post-violence on entering those environments created specifically for women and children who are escaping family violence. The number of infants entering women's refuges with their mothers is high. The impact of what happens in the infant's early life lasts a lifetime. Infants are the most urgently in need of reassurance, are the most responsive to lively engagement and the most open to relational reciprocity. This research enters the hidden world of refuges to discover what happens for the infant within these crisis accommodation settings.

Area to be researched

There is a need to provide space for those most at risk to be seen and to be heard. Mothers and infants accessing refuge are particularly vulnerable. They have received little attention in the literature. This is despite the fact that "their members share characteristics or attributes that make it important for the health and human services to have information about them to inform service planning, policy, and delivery" (Thompson & Phillips, 2007, p. 1292). The infant is regarded as the 'accompanying child' who is considered attended to by virtue of attending to their mother (Glennen, 2011). McIntosh (2002) notes that society is so informed by 'adult-focused' theoretical and philosophical attitudes to service delivery and recovery that it remains to be asked:

> What happens to the child? In the face of a preoccupation with parent's rights and needs, what happens to the rights of a child to heal from trauma when a parent cannot for good reasons be the chief instrument of their recovery? (p. 232)

The purpose of this exploratory study is to understand the experience of the infant in refuge and what is provided to them. Currently, there is no discernible research available regarding what occurs '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). Although much has been written about the detrimental impacts of ongoing relational trauma on the developing infant, there have been few attempts to explore the perspective of the traumatised infant, or to recognise those infants most clearly 'at risk' and needing refuge in times of crisis.

Studies undertaken of children in refuge (rather than infants) have been inconsistent in study design, definitions, settings and participation (Rog & Buckner, 2007). Where studies regarding homelessness have directly involved children, the emphasis has largely been on measuring the impact of homelessness on their growth, development and functioning, with a tendency to rely on standardised quantitative measures rather than to seek their feedback (Bassuk & Rosenberg, 1988; Buckner, 2008; Drake, 1992; Gewirtz, Hart-Shegos, & Medhanie, 2008; Huntington, Buckner, & Bassuk, 2008; Samuelson, Krueger, & Wilson, 2012; Shinn et al., 2008). Other research has excluded children altogether, relying solely on the account of the mother (Lindsey, 1998). Research into the effects of family violence on children (including infants) has similarly focused on measuring impacts rather than inviting their participation (Levendosky, Bogat, & Martinez-Torteya, 2013; Levendosky, Huth-Bocks, Semel, & Shapiro, 2002; McFarlane, Nava, Gilroy, Paulson, & Maddoux, 2012; Schechter & Willheim, 2009; Van der Kolk, 2005; Widom, 1999; Wolfe, Jaffe, Wilson, & Zak, 1985). Once again the voice of the child has been excluded in many studies regarding the impact of family violence on children (Buchanan, 2011; Insetta et al., 2015; Izaguirre & Calvete, 2015; Mbilinyi, Edleson, Hagemeister, & Beeman, 2007). Research demonstrates clearly that infants are affected by trauma (Bosquet Enlow, Egeland, Blood, Wright, & Wright, 2012; Levendosky et al., 2013; McIntosh, 2003; Osofsky, 1999; Schechter & Willheim, 2009). Even at this early stage, "violence witnessed as young as 2 months old is held vividly in non-declarative memory, and if untreated can be expressed in fragmented form throughout the child's life" (McIntosh, 2002, p. 234).

The purpose of the research

The intention of this research is to explore how the infant experiences their stay in refuge. This involves what is done with, and for, the infant within the refuge environment, and the consideration of what constitutes the experience of 'refuge' for infants in this setting. This includes what precisely occurs for the infant to facilitate their experience of feeling safe following

their departure from a violent relationship and/or their familiar surroundings, when both mother and infant have been, or perhaps still are, traumatised. It attempts to understand if the infant experiences a feeling of safety simply by moving with their mother into another setting that has been created to be free of violence. Furthermore, this research is concerned with giving a voice to someone whose voice is least acknowledged in our society: the pre-verbal infant. As such, infants aged 12 months and under are of specific interest.

The questions of the research

What occurs in the Refuge setting to provide the infant with the experience of feeling that they have found refuge, and is that refuge experienced as a 'place', as a 'feeling of safety', or both? As will be explored, simply being with their caregiver does not guarantee that they will experience safety. The nuances of what is felt to be a place of refuge (ie., the physical presence of the caregiver) and how this is qualitatively different in providing the feeling of safety (the emotional presence) is important to consider. In order to create an operational framework for understanding as well as exploring what might constitute 'refuge' for the infant, 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. The concepts underpinning these are explained in Chapter Two. These questions specifically explore:

- 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?
- 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?

Importance of the research

Intervening with infants who have been traumatised by exposure to violence and/or the challenges of homelessness is urgent work. This is because infancy is a crucial formative stage in the life of a child. The most rapid period of brain development occurs in infancy. Trauma left unaddressed during this period has significant and far-reaching detrimental consequences for development across the lifespan (Lieberman, Van Horn, & Ippen, 2005; Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Schore, 1996; Schore, 2005; Schwerdtfeger & Goff, 2007; Shinn et al., 2008; Shonkoff & Phillips, 2000; Siegel, 2012; Thompson & Phillips, 2007; Thomson-Salo et al., 1999; Thomson Salo, 2007). The literature demonstrates that both infants and mothers who experience familial violence and require the use of crisis accommodation services are often negatively impacted by these distressing events (Benoit, Coolbear, & Crawford, 2008; David et al., 2012; Fantuzzo, Boruch, Beriama, Atkins, & Marcus, 1997; Gustafsson, Cox, & Blair; Lieberman et. al., 2005; AIHWb, 2012; McCoy-Roth, Mackintosh, & Murphey, 2012; Rog & Buckner, 2007; Rosen, Seng, Tolman, & Mallinger, 2007; Swartz, Graham-Bermann, Mogg, Bradley, & Monk, 2011; Tailor & Letourneau, 2012; Zeanah & Scheeringa, 1997). The literature also clearly demonstrates that Intimate Partner Violence (IPV) and refuge use due to homelessness are linked (AIHW, 2012b; Anooshian, 2005; Spinney & Blandy, 2011; Waxman & Reyes, 2007).

Ongoing family violence and homelessness have also been demonstrated to harm mothers' perceptions of their infants. This subsequently increases the risk of infants developing insecure attachments with poor self-regulatory capacities, leading to potentially significant internalising and externalising behavioural difficulties (Bogat, Garcia, & Levendosky, 2013; Huth-Bocks, Levendosky, Theran, & Bogat, 2004; Levendosky, Bogat, & Huth-Bocks, 2011; Levendosky, Bogat, Huth-Bocks, Rosenblum, & Von Eye, 2011; Malone, Levendosky, Dayton, & Bogat, 2010). The cohort of infants and mothers who are forced to use women's refuges have endured many of the challenges described above. This makes it critical to understand this distinct setting and how it

functions in relation to the infant and their mothers. Undertaking a study of the infant in refuge offers a rare opportunity to capture their experience at a time when they are particularly vulnerable and, importantly, the opportunity to discover what might help or hinder their recovery.

The vulnerability of the infant: By virtue of their age and stage the infant is vulnerable, and this is no more so than in the first year of life. Children are reported to be at greater risk of harm, injury and even death in infancy than during any other period in childhood and adolescence (AIFS, 2010; AIHW, 2012a; Brandon et al., 2008; Frederico, Jackson, & Jones, 2006; Zeanah & Scheeringa, 1997). A review of child deaths in England found that family violence was a notable contributor to child deaths (Brandon et al., 2008). Child protective services within Australia identify family violence as a leading cause of, and reason for, the substantiation of harm, abuse and neglect in infants 12 months and under (AIHW, 2012a; AIHW, 2013). There are two criteria for entry into women's refuge according to Barca (2013) are: 1. that the "women and/or their children are at the 'highest' risk of harm and homelessness"; and 2. that this is "as a result of the threat of family violence" (Barca). It can be safely assumed that the majority of infants who come into refuge with their mothers have been exposed to or have experienced significant harm, either to themselves and/or to their mothers.

Needing refuge: Mothers and children who use crisis accommodation are generally highly vulnerable and will access refuge, often repeatedly, as they have no other options available to them (Spinney, 2012). The research regarding the profile of the mother entering refuge suggests she herself may be highly traumatised, much of this trauma being cumulative. She may not always possess the internal resources or capacities to deal with this trauma, nor know how to respond to or recognise her infant's distress (Ahlfs-Dunn & Huth-Bocks, 2014; Bassuk, Buckner, Perloff, &

Bassuk, 1998; Bassuk et al., 1996; Peled & Dekel, 2010; Peled & Gil, 2011; Weinreb, Buckner, Williams, & Nicholson, 2006). While a refuge can provide an environment safe from harm, the traumatised infant, like the traumatised mother, also requires caregiving that is attuned to their emotional states, is able to assist with physiological regulation and is reciprocal, responsive and relationally healing. As infants make up the highest cohort of children entering crisis accommodation with their mothers (AIHW, 2012a, 2012b; Shinn, 2010), it is of strong concern that they are the least researched or written about in the area of family violence. Further to this, in seeking refuge accommodation mothers are effectively bringing their infants, themselves and their relationship to a place where they can potentially receive enormous opportunities for early intervention. The act of leaving is in itself a huge step towards redressing the harm that has led to such a decision in the first place. What occurs next is crucial to understand.

Approach taken

This research seeks to understand the subjective experience of 'the infant in Refuge'. An exploratory qualitative research approach is congruent with this purpose, over a quantitative approach being employed to measure or test a certain hypothesis (Alasuutari, 2009; Baker, 2005; Ferraro, 1983; Jenney, Alaggia, Mazzuca, & Redmond, 2006; Lindsey, 1998; Mullender et al., 2002; Rhode, 2004; Rustin, 1997; Urwin, 2011). This enables the gathering of perspectives about, and from, the multiple sources that contribute to this interpersonal phenomenon. In addition to this, such an approach needs to respect, and be sensitive to, the nature of women's Refuges and the primary reason for their existence. This preferences a non-intrusive, flexible and 'infant-sensitive' method of enquiry (Denzin & Lincoln, 2003; Denzin & Lincoln, 2013; Hingley-Jones, 2011; Reddy & Trevarthen, 2004; Rustin, 2006; Scheeringa, Zeanah, Myers, & Putnam, 2003; Urwin, 2011; Vliegen, 2006). Consequently, a constructivist grounded theory methodology was used to inform the collection and subsequent analysis of the data. This was because the interpretive nature of

this methodology favours and indeed respects the emergent confluence of multiple social realities and perspectives (Charmaz, 2014).

Allowing the Infant to lead: Being 'infant-led', an approach taken in this research and one which will be explained more fully later, was crucial to ensuring that the experience of the infant was central. This is achieved by acknowledging that the subjective experience of the infant is co-constructed between mother and infant, and infant and others (Trevarthen & Aitken, 2001). Similarly, this recognises that meanings are co-constructed through interpersonal processes such as the conducting of interviews, collecting data and the interpretation of the data itself (Bryant, 2003; Crotty, 1998; Medico & Santiago-Delefosse, 2014). Important to constructivist grounded theory is the priority to develop 'theoretical usefulness' over 'meticulous accuracy' in order to build knowledge that can make a valuable contribution to practice (Charmaz, 2014). In this instance, this is to both make known and gain some understanding of the infant's experience in Refuge. This enables the experience of the infant to be considered as important as the experience of the mother, shining a spotlight on an area neglected within research into early childhood trauma. This research also endeavours to add new knowledge to what is currently known about infants who would be considered at higher risk than the general population. The current and most relevant research, literature and knowledge offering a foundation through which to begin to address the questions of this research will be reviewed in the next two chapters. However it is important to recognise, and make transparent, the voice of myself as researcher and the influences I bring to this inter-subjective approach before proceeding further.

My Voice as researcher

What bearing does our past have on our future? I am the third biological child of my parents but the fourth of five children. I was the only unplanned child. My mother had experienced serious

complications when giving birth to my two older brothers, and she proceeded with the pregnancy against medical advice. My older sister had been fostered at the age of four months by my parents as 'the little girl they always wanted' and then formally adopted at the age of 22 months, when I, 'the unexpected girl', was four months old. My mother tells me that she was so convinced she was going to have another son that she asked the nurses to check again upon their announcement that she had had a girl. My mother lost her mother shortly before I was conceived and suffered a nervous breakdown as a result. She was diagnosed with depression and did not recover until I was around 12 months of age. I was nine when my parents permanently fostered my youngest brother, aged four. He has spina-bifida and, though not wheelchair-bound, has experienced life-threatening complications at various times throughout his life as the result of early surgical procedures. My siblings and I each faced different circumstances and challenges early in our lives, the consequences of which seem to be reflected in our lives even to this day. My parents remain married, with a strong commitment to one another and to their family. Do these early events and the experiences of my siblings influence my life now, the choices I make and my interest in infant mental health and the impact of relational trauma?

I came to infant work relatively late in my professional social work career. It feels, however, that I would not have been ready for it any earlier. It is almost as though the more I progressed in my understanding of my work, the further back I learnt to look. As a new graduate I worked with 'at risk' adolescents and their families. Each stage of my career revealed greater complexities and greater traumas. As I grew in my experience and knowledge, so too did my capacity to sit with the enormity of people's stories. I moved from working predominantly with youth into a dual role within adult, and child/adolescent, mental health (CAMHS). As such, I worked with two ends of the developmental spectrum. In my role with adults I quickly became accustomed to the long shadow cast by early childhood experiences of violence – sexual, physical and emotional.

In my work with children, it regularly seemed to be the adults in their lives who deemed them to be the 'problem', as though how these children presented in life was quite separate from the relationship they had with them. Just as my work with adults revealed the significance of their experience of being parented, my work with children revealed the complexity of engaging in work with the adults who parented them. In some extreme instances this proved ineffectual, and it seemed more pressing to explore ways in which to ameliorate the impact of the given child's experience of being parented.

Following an eighteen-month period working as a team leader in child protection, I returned to the familiarity of a CAMHS setting. I remained there for 16 years. During that time I was afforded the privilege of developing a group work intervention for children and their mothers (and some fathers) who had been impacted by family violence. This work taught me that familial violence rarely started later in the lives of children but began earlier and often in utero. I began to learn about infant mental health and how to invite the infant into the therapy room. The more I worked with infants, the more they taught me. I am not a parent myself. I have, however, been touched by the lives of thousands of children throughout my career. I overcame my fear of what the infant could not tell me through speech to discover the enormity of what they could tell me when I related to their subjectivity. This discovery confirmed my belief that it is never too early to work towards addressing the impacts of family violence – or to create healthy relational opportunities which may not only alter the infant's developmental pathway but loosen the hold of familial violence on future generations. My impetus in undertaking this thesis is the hope that it may make a contribution to our understanding of how this transmission of violence within families can be brought to an end.

Thesis structure

This thesis has been set out in four parts:

Part One: This section focuses on the purpose of undertaking research into the experience of the infant entering Refuge with their mother within the unique environment of refuge. Chapter One introduces and identifies the area to be researched and the questions this research seeks to answer. The chapter argues why this area of research is important and, of equal importance, the approach taken. Chapter One also situates me as the researcher within the landscape of what is to be studied. Chapter Two provides definitions important to the research including 'what is refuge' and how the term 'family violence' is understood and applied in this thesis. Chapter Two also provides the historical and contemporary context of women's Refuges in Western society. Chapter Three then moves on to providing more fully the rationale for undertaking this research, and builds an extensive review of the literature pertinent to this inquiry. The areas reviewed include the impact of family violence and homelessness on infants and their mothers, infant development, impacts of trauma, the development of primary relationships, infant communication, and the emergence of the subjectivity of the infant through the inter-subjective experiences of mothers and children in Refuge. It concludes with the ethical considerations involved in conducting this research.

Part Two: Contains Chapter Four only, providing an in-depth description of the way in which this research was undertaken. The epistemological foundations and methodology utilised in keeping with an approach described as 'infant-led' are explained. Ensuring that the infant remains at the forefront of this research determined how this different way of conducting research with infants was approached, and which methods were employed. This fourth chapter explains why respecting the subjectivity of the infant through the use of infant observational methods was as important as honouring the perspective of their mothers and the Refuge accommodation staff who participated in this study. The concept of an infant-led qualitative research approach is

explained, together with the way in which this concept knits together a new method of guiding and informing the unfolding of a process of data collection and coding. This then draws on a constructivist grounded theory methodological (GMT) frame informed by 'inter-subjective' thinking in order to direct this research. This frame is in keeping with the largely mutual creation of experience, meaning-making and inter-subjectivity which is integral to the dependent infant's development. It also honours and makes transparent the interpersonal and emotional implications inherent in any enterprise which attempts to research human nature and our shared inter-connectivity. This chapter also introduces the research participants, and explains the important mechanisms built into the research process to ensure the integrity, reliability and trustworthiness of the findings.

Part Three: This focuses on the findings of the research and is divided into three chapters. Part Three commences with an introduction that provides examples of the coding process that brings transparency to the logic of thinking, the interpretations informing the analysis and the subsequent conclusion reached. The focus of Chapter Five is then on the infant, presenting the key experiences that emerged from the analysis of the infant observation data. Chapter Six moves to the perspective of the mothers. This chapter presents what the mothers expressed as their key insights into their infants' experiences of finding refuge and being in Refuge, and explores the ways in which these merge with, or diverge from, those of the infants. Chapter Seven offers the third and final tier of the findings arising from this research. This chapter provides the perspective of the Refuge itself, and is taken from interviews with the Refuge worker groups and key informants. Each chapter purposefully builds upon the previous one, offering a depth and richness of dimension not possible had any of one these three crucial perspectives – that of the infant, the mother or the Refuge – been withheld.

Part Four: The fourth and final part of the thesis presents the concluding chapter of this research. Chapter Eight presents a comprehensive discussion regarding what this research has found. It explores where these findings sit within the broader context of the research and literature pertaining to infants, crisis accommodation and homelessness, and family violence. It recognises the limitations of this research, and offers suggestions regarding what has been learnt from undertaking this study and what is still to be understood. This chapter then brings this thesis to its conclusion. It draws together the essence of what this research has to offer, providing a summary of findings as well as its limitations. The implications of these findings, for both policy and practice within the sector of crisis accommodation are presented and what these might mean for the family violence field to embrace as a new way of thinking about, and responding to family violence.

CHAPTER TWO

In order to afford clarity around the major terms and concepts that will be used in this thesis, a brief, over-arching definition of family violence is provided. Following this a more nuanced exploration of what constitutes 'refuge' generally, and then more specifically for the infant, is examined. The remainder of this chapter is then dedicated to describing the context within which this thesis is set through an exploration of the historical and contemporary aspects of women's refuges today.

Family violence defined

The term 'Family Violence', for ease of use within this thesis, encompasses such terms as Intimate Partner Violence (IPV), Domestic Violence (DV) and Family Violence (FV). Within Australia, 'the Family Law Act' (Section 4AB) came into effect in June 2012 and defines family violence as "threatening or other behaviour by a person that coerces or controls a member of the person's family (the family member), or causes the family member to be fearful" (FCA, 2013, p. 4). This includes behaviours which involve physical and sexual assault, stalking, derogatory taunts and acting with intention to do so, damaging property, causing death or injury to an animal, depriving financial support, isolating family members or depriving them of their liberty. For the purposes of this Act, a child is exposed to family violence if the child sees or hears family violence or otherwise experiences the effects of family violence" (p.4.). Essentially, "family violence presupposes a relationship between those involved … Regardless of age, violence between family members is more common than violence between acquaintances or strangers" (Tolan, Gorman-Smith & Henry, 2006, p. 559).

Defining refuge

There are two separate, but not mutually exclusive, meanings of the word 'refuge'. In exploring the literature, the word 'refuge' is used interchangeably with the words 'sanctuary' and 'asylum' and refers to a process – that of 'seeking refuge' – as well as a destination – that of 'finding refuge' (Fontaine, 2015; Jordan, 2011; Schabel, 2008; Shapiro, 2013). Derived from the Latin word *refugium*, it refers to a place of safety and is used today to mean both a place and/or a state of being (Stevenson, 2010). That is, these two strands of meaning point to refuge as either an 'entity' (a building or shelter) and/or refuge as a 'subjective experience' (feeling protected and safe from harm). The entity of refuge (as something provided from 'with-out') and the 'experience' of finding refuge (as something that is felt 'with-in') are inextricably linked but are not always simultaneous, and within this study in particular the nuances of what constitutes 'refuge' are inherently more complex than this. The place of Refuge, and the state of refuge, will be described before moving on to what is understood as 'refuge' for the infant, together with the reasons for its provision being so important.

Note: From this point onwards, in order to delineate between refuge as an emotional state and refuge as a place, refuge *not commencing with a capital letter will refer to the 'emotional state'.* Refuge *commencing with a capital letter refers to Refuge as the physical place within which the infant and mother are residing.*

The physical place of Refuge and 'feeling safe'

The concept of 'Refuge' as a place usually refers to a 'dwelling' or 'location' away from harm. It may provide physical distance from the cause of the harm, but to feel safe or a sense of comfort from harm or distress is not simply a physical sensation but a psychological and visceral experience (Schore, 2003b). Seeking refuge is by no means a recent phenomenon. Rabben (2012) argues that providing strangers with Refuge is an ancient custom that has been practised

throughout history, and just as humans have been characterised by their capacity to work together, so too have they been observed to possess a capacity for conflict and exclusion. 'Sanctuaries' during Ancient Greece were physical dwellings or locations imbued with a sacred purpose and, whilst they existed in many shapes and forms, they fulfilled a largely religious function, serving many purposes including the provision of a place in which protection could be sought (Pedley, 2006). This infusion of Refuge as both a 'place' and a psychological 'state' is evident throughout the Old Testament of the Bible. Refuge is referenced as both demarcated cities where mercy could be afforded (Browning, 2009; Cohn & Elon, 2007) and through the odes sung to God that extolled the blessings, protections and shelter given by vowing oneself to God in prayer: "for you are my refuge, a high tower where my enemies can never reach me" (Psalms 61:3). The latter, as a spiritual 'state', implied infinite accessibility but not without constant prayer, as those "refusing to worship God will perish, for he destroys those serving other gods" (Psalms 73: 27).

The tradition of Refuge: From as early as the fifth century, Refuge was often given temporarily and to those who may have transgressed in some way but were deemed to be deserving of protection over punishment (Brewers, 1952/1977). Over centuries, the provisions of Refuge to those who had transgressed, or the acceptance of strangers who came from foreign lands, demanded a moral decision that would allow them to be received, according to Rabben (2012) – a decision that came with conditions; "Thus in many societies sanctuary is only temporary or is hedged with restrictions" (Rabben, 2012, p.47). Notwithstanding the brutalities wrought by warring nations in biblical times, in modern society the numbers seeking Refuge (as Refugees escaping civil war or women escaping violence) continue to outweigh the provision of Refuge by those countries and/or communities who are in a position to offer it. Within many fields of enquiry, the contemporary usage of the term 'Refuge' simply refers to a place or dwelling of safety and protection (Allaby, 2010; Gorse, Johnston, & Pritchard, 2012; Military, 2002) whilst others

explore more complex manifestations (Bowker, 2000; Curl, 2006). Environmental psychology and architectural design has, for example, proposed that humans are biologically driven to seek out the right balance between Refuge (enclosure) and prospect (outlook), a theory known as 'prospect-refuge theory' (Appleton, 1998), which manifests in a "human behavioural and psychological need for places that allow a person to observe without being seen" (Dosen & Ostwald, 2013, p. 232).

The emotional state of 'refuge' for the infant

What makes an infant feel safe, and in a place specifically created to offer shelter, is at the core of this enquiry, as is understanding what occurs specifically for the infant in order to provide them with 'refuge'. The infant actively seeks out and/or maintains ready access to a familiar person, most often their mother, in order to feel secure and protected in case of an emergency. This is something which Bowlby (1988) believes serves a biological purpose and is "an integral part of human nature" (p. 26). Safety for an infant is by necessity relational and physiological, and felt within the context of a responsive and attuned caregiving environment. When frightening things happen the caregiving environment, in ordinary circumstances, steps in and protects as well as soothes, using the relationship to bring calm to the place of distress. Winnicott (1960) offered a realistic appraisal of how the infant typically finds safe refuge in their mother's response. However, the response does not have to be perfect, as seldom will the mother provide exactly what the infant needs exactly when they need it and nor is it useful for them to do so. Simply being 'good enough' provides the infant with a sense that when things feel overwhelmingly unsafe, the primary caregiver will step in and shield them from harm. They will do this well enough and often enough to allow the infant to feel as though they are reliable (Tronick, 2007; Winnicott, 1960).

Learning how to manage stress is a developmental process which begins in infancy according to Rifkin-Graboi, Borelli, and Enlow (2009). They contend that the neonate is totally dependent on their caregiver, whilst the infant engages in dyadic regulation and the pre-schooler moves towards self-regulation. The infant's experience of being safe and sheltered from harm is derived from their relational experiences within their caregiving system. The way in which infants experience danger and difficulty depends on the danger itself, the meaning they give to that danger and their previous experiences in their short lives to date (Rifkin-Graboi et al., 2009). When the infant is exposed to ongoing danger, the level of harm accumulates (Bromfield, Gillingham, & Higgins, 2007). Of interest to this study is what happens for the infant when they are removed from what many would consider to be the ongoing danger of living with violence and placed in the refuge space.

Trauma: Within this research the emphasis is largely, but not exclusively, on what is referred to as 'relationally' created trauma – that which occurs within the context of primary relationships (Schore, 2001). The unique and subjective responses that determine why an interaction and/or event is experienced as traumatic by one infant, child or adult and not another are still the focus of much enquiry. Studies into what constitutes trauma and how trauma impacts upon the individual incorporate the consideration of multiple variables, including temperament, genetics, culture, attachment, environment and neurobiology (Baibazarova et al., 2013; Clark et al., 2013; Davis, Glynn, Waffarn, & Sandman, 2011; Murgatroyd & Spengler, 2011; Perry, Mackler, Calkins, & Keane, 2013; Pratchett & Yehuda, 2011; Gopnik, 2004; Schechter, 2009; Trevarthen, 2001; Tronick, 2007). Trauma to the mind, body and spirit involves a rupture of some sort that overwhelms that person's normal everyday coping capacities (Van der Kolk, 2003). Herman (1992) describes the need for the developing child to have a secure sense of connection, and through the more powerful caregiver a respected sense of their own autonomy. Furthermore, Herman contends that this sense of control is violated by traumatic events and that what is lost

is “the autonomy of the person at the level of basic bodily integrity” (p. 52). Restoration and healing of trauma requires not only its cessation but the act of being comforted, validated and building trust, as well as the ability to speak of, and tolerate, that which has been felt as unspeakable (Abrahams, 2010; Herman, 1992; Schore, 2003b; Van der Kolk, 2014). Should the ill-equipped and still rapidly developing infant be left alone to manage traumatic events, their emotional responses, including ‘shutting down’, risk becoming their permanent default position whenever they are highly or even mildly distressed (Perry et al., 1995; Perry & Szalavitz, 2006).

Subjectivity and inter-subjectivity: This research is concerned with coming to know the experience of the infant and what is provided within Refuge to offer them refuge. This understanding of their experience is gained through a recognition of the infant’s subjectivity within their inter-subjective relationships. The subjectivity of the infant is described by Stern (2003) as the possession of a “global subjective world of emerging organization … it operates out of awareness as the experiential matrix from which thoughts and perceived forms and identifiable acts and verbalised feelings will later emerge” (p. 67). Infants organise their sensory perceptions as part of a “process of formation, and it is a sense of self that will remain active for the rest of life” (Stern, 2003, p. 38). The ‘emergent self’ exists from birth, gathering progressively the sense of the ‘core self’ and the ‘subjective self ‘until the ‘verbal self’ begins forming from fifteen months and the ‘narrative self’ thereon after. These evolving ‘selves’ remain in a fluid dynamic with the others throughout life and are “constructed from the patterned experience of self in interaction with another (Stern, 2003, p. xv). Furthermore, Stern (2003) argues that these “early forms of inter-subjectivity exist from almost the beginning of life” (p. xxii).

The idea that infants have experiences, feelings and responses of their own is a notion that has perhaps eluded many professionals, even those directly working with infants (Reddy & Trevarthen, 2004; Schmidt Neven, 2007). Humans are, from birth, vulnerable. They remain

dependent on others for their existence, and for a longer period than any other living species. It is also known that an infant's development is shaped by biological, neurological and genetic factors (Burgess, Marshall, Rubin, & Fox, 2003; Fishbane, 2007; Gunnar & Quevedo, 2007; Luijk et al., 2011; Mc Dermott & Cobham, 2012; Murgatroyd & Spengler, 2011; Sprangers et al., 2009). These converge with their environment and are formed during their most significant and earliest relationship experiences (Perry et al., 1995; Schore, 2001; Schore, 1996).

The subjectivity of the infant emerges only through their inter-subjective experiences with others. "We live our life from its very beginning with the other … Congruently, our brain-body system begins taking shape and, immediately after, starts developing its lifelong encounter with the world through the mutual relationship with another living human being" (Ammaniti & Gallese, 2014, p. 1). Research demonstrates that even in the earliest stages, infants possess moments of what Stern (2003) calls 'primary consciousness', which involves the unfolding of a self that emerges at a sensory level, with relational experiences being organised into some sort of meaning for the developing infant. How the self develops is not pre-ordained, but is understood to be increasingly complex. As Schore (2005) notes, "nature's potential can be realized only as it is facilitated by nurture" (p. 205). It is perhaps useful to make an analogy here to the elements inherent in what provides refuge – as subjectivity essentially refers to what happens 'with-in' (the internal emotional experience) and 'inter-subjectivity' to what happens between and 'with-out' (the physical manifestation expression of the emotion) – and how their caregiving world interact with that emotion. Furthermore, for the infant, the interplay between their subjectivity (with-in), and their inter-subjectivity (with-out) will significantly impact the way in which the infant subsequently develops (Ammaniti & Gallese, 2014).

Responding to fear: When the infant feels alarmed, they seek out refuge in their primary caregiving relationship. How the emotional or sensory experience of finding refuge is determined by the infant is both subjective and inter-subjective. That is, the infant is motivated to retain proximity to their caregiver, for better or worse, in order to feel safe. However, simply being with their caregiver does not guarantee that they will experience safety. The quality and nature of what the infant internalises as 'feeling safe' (their subjective experience) occurs within the context of their repeated (inter-subjective) experiences within their primary relationships. These experiences are implicitly coded, organised and stored in the first year of life, creating formative patterns that are internalised within the implicit memory "which has a special regulatory function that acts in an automated and unconscious way" (Ammaniti & Gallese, 2014, p. 131). Schechter & Willheim (2009) explain that it is the response of the caregiver over time that leads to the infant having the experience of 'felt security'. This refers to the infant being provided with an adequate level of constancy in their relationship, which results in them feeling safe. Conversely, in the midst of violence, they argue that there will be instances when the infant's caregiver, themselves the victim of violence, will be unavailable to them, at which time the infant's experience could be conceived of as 'felt anxiety'. Repeated experiences of 'felt anxiety' impact on the infant's relationship with their caregiver. Is simply coming into what is deemed to be a safe place with their mother – that of the refuge – enough to provide the infant with the experience of 'felt security'?

The need for the infant to feel safe

There are two final elements worth expanding on with regards to the infant's need to feel safe and the developmental purpose this fulfills. The most significant task during early infancy is to find physiological regulation, and this is achieved for the infant only through "the mutual exchange of social behaviours" (Stern, 2003, p. 43). Refuge for the infant occurs from with-out, as in their challenge to have their needs sufficiently met they are absolutely dependent on others.

The needs of the infant: In order to ensure their healthy development, an infant's needs extend well beyond being adequately housed, clothed and fed. Just as crucial as the quality of the physical and nutritional care given to the infant is the reliability of the emotional care and responsiveness provided (Bowlby, 1952; Stern, 2003; Trevarthen, 2001). The physical and emotional are, of course, intimately intertwined; the way in which the infant is physically held, touched, engaged with during feeding and nappy changes, and played with and bathed all transmit messages about the quality and assurance of their care (Bowlby, 1951; Holmes, 1993; Lieberman, 2007; Winnicott, 1970). The need for ongoing emotional care enables:

> the build-up in the infant of memories of maternal care beginning gradually to be perceived as such. The result of healthy progress in the infant's development during this stage is that he attains to what might be called 'unit status'. The infant becomes a person, an individual in his own right (Winnicott, 1960, p. 589).

'Needs' serve a developmental purpose, and should not be dismissed merely as a whim, or as something the infant simply wants. Meeting social, emotional as well as physical needs enables healthy neurophysiological and psychological growth, particularly for the infant. The needs of the infant which are focused on in this study are those that are socio-emotional and pertain to their arousal states. Whilst arousal states are largely physiological, the infant still needs help to down-regulate when distressed and up-regulate to engage in social pleasure, discovery and safety as this serves as the foundation to all later developing social behaviour (Van der Kolk, 2014). It is the way in which these needs, physical and emotional, are met which protects the infant from that which they are not yet ready or capable of traversing, i.e., how the outside world (their environment) impacts on their internal emotional world (which is not purely or primarily physiological) and then, from within, to their outside world (Bürgin, 2011).

Emotional regulation: The infant moves from being completely dependent on the caregiver to manage their physiological regulation to acquiring the ability to self-regulate as an essential developmental progression towards healthy growth (Rifkin-Graboi et al., 2009). The physiological sensation of feeling safe within their internal world occurs well before this sensation is able to be developmentally recognised at a cognitive level or articulated as their language skills advance. Van der Kolk (2014) explains that infants are "at the mercy of the alternating tides of their sympathetic and parasympathetic nervous systems, and their reptilian brain runs most of the show" (p.84). The caregiving relationship is pivotal in aiding the infant to manage their autonomic nervous system and in particular the still-developing ventral vagal complex (VVC), which dictates how effectively this is managed. The VVC is engaged through social connection, in times of play and 'conversation', and when the infant is feeling threatened or overwhelmed and turns to others for help in seeking comfort. When this support is given, the VVC sends signals to their regulatory systems (i.e., heart and lungs) enabling the infant to feel safe and to settle (Porges, 2007; Van der Kolk, 2014). Should this call for support fail, the 'fight/flight' response is activated. In the very young infant, this second response may simply involve looking or turning away as they have very few alternative options at their disposal (Stern, 2003). When the infant remains in an overwhelmed state, they have no recourse but to move to a dissociative state and to 'freeze' or shut down (Porges, 2007; Schore, 2003a). This immobilised state is the antithesis of growth-enhancing conditions that promote resilience and robust emotional and behavioural functioning. Where there is relational violence, the very young infant is susceptible to the co-occurrence of traumatic responses. The infant reacts to the terror of the mother when she is assaulted, creating a 'shared trauma'. This involves the mother then being unlikely to make herself available to regulate the infant's response and "higher-cost endocrine responses are especially likely, and may be expected to have ramifications well past the cessation of the traumatic experience" (Schechter & Willheim, 2009, p. 65). Just as infants need someone, and somewhere to go to in times of overwhelming duress, so too do women fleeing violence.

The context of women's Refuges

That women and children are deemed to require a place of Refuge in society today speaks to a larger and more complex set of social issues than this thesis could hope to attend to (Arnold & Ake, 2013; Lehrner & Allen, 2009; McFerran, 2007). However, a brief overview about what has been a largely gendered debate about the rights of women and children to be kept safe is at least warranted, as this goes some way to explaining how the environment under consideration came to exist in the first place.

Historical background

The provision of crisis accommodation specific to women fleeing violent relationships is only a recent phenomenon. The first of such services was established in the early 1970s and was driven by the Women's Liberation Movement (WLM) (Schechter, 1982). Records suggest, however, that women seeking accommodation for themselves and their children is not new (Walsh, 1997). A 'Melbourne Ladies' Welfare Society' report published in 1974 states: "From our past reports we find that deserted wives were as prevalent in the last century as they are today … During the 1830's women with children were drifting about seeking a roof to cover them. At this critical period, the Society decided to rent a nine-roomed house in Fitzroy Street, Fitzroy, to protect the homeless women and children" (Women's Liberation Halfway House Collective, 1976). What was different in the 1970s was the recognition that women and children who were homeless were largely so because of society's tacit approval of men battering women in their own homes. The Women's Liberation Movement challenged an ideology which blamed the homeless woman for her predicament and politicised men's violence towards women, making public something that had previously been deemed private and hidden from view (Schechter, 1982, Theobald, 2009; Theobald, 2012).

The first women's Refuges: Often cited as the first such Refuge to open and one that quickly attracted much publicity was Chiswick Women's Aid, which opened in 1971 in West London, England (Pizzey, 1975). However, Brzuzy and Lind (2008) note that since 1964, Haven House had been 'quietly' operating in Pasadena, California in the USA. Within a decade of the first Refuge opening in Britain more than 200 Refuges in the United Kingdom (UK) had opened up, including those associated with Scottish Women's Aid (Pahl, 1985). Canada opened its first shelters in 1973 (Tutty, 1999). In 1974, Australia's first women's Refuge was established in Sydney (McFerran, 2007), with New Zealand's first Refuge established in Christchurch in the same year (Turner, 2007). In Australia throughout the 1980s, Victorian women's Refuges argued that women fleeing domestic violence were in fact not homeless but rather "have been forced to abandon their homes because of violence and abuse" (Theobald, 2009, p. 13). This emphasis on having to flee the home both politicised and distinguished the nature of women's and children's homelessness.

Whilst the history of women's Refuges in western countries is relatively short, it is a powerful one. The aspirations behind creating women's Refuges invoked what Rabben (2012) described as the notion of a moral decision in offering Refuge to another. However, it was also clearly politically motivated by women and for women, as "a place where women may come and be safe, amongst other sympathetic women, while they recover from the shock of physical or emotional trauma, and they learn something about themselves and their own oppression" (Women's Liberation Halfway House Collective, 1976, p. 174). They also operated from a clear belief that mothers should reclaim their right to make decisions about their children (Pahl, 1979). The intention was to offer personal Refuge (initially physical) whilst simultaneously offering political empowerment, enabling women who came into Refuge to liberate themselves from the shackles of male patriarchy and sexual subjugation.

Women's Refuges are interchangeably known as half-way houses, havens, safe houses and shelters (Mizrahi & Davis, 2008) and, within the UK, as Women's Aid (Harris & White, 2013). Refuges are considered one of the main 'crisis accommodation' options specifically for women and children who are leaving violent relationships and have nowhere else that is safe to go. These women and children are considered to be experiencing 'primary homelessness', which is considered the most extreme form of homelessness. Chamberlain and MacKenzie (2008) define 'primary homelessness' as encompassing those who live on the streets, in cars and in other unconventional locations.

Women's Refuges today

'Women only' Refuges are 'only' for single women, and mothers and their children escaping family violence (Scottish-Women's-Aid, 2013). In order to survive financially, most Refuges currently require some level of government support to exist. With this support has come an expectation of 'professionalising' over politicising the nature of Refuge work (Arnold & Ake, 2013). Refuges themselves have now been critiqued in some quarters for imposing conditions similar to those that these women were originally attempting to escape, with rigid and prescriptive organisational cultures imposing punitive rules in order to monitor the women's behaviour (Koyama, 2006). Women's Refuges, however, largely still operate within a 'feminist' model which precludes employing men as staff within Refuge or allowing older adolescent male children entry, and with the fundamental purpose of empowering 'battered' women (Harris & White, 2013; Pierson and Thomas, 2010).

Feminism: As feminism remains the dominant ideology within women's Refuges (Sullivan et al, 2008), the presumption of men's 'ownership' of women along with an inequality between the sexes continues to be challenged within these environments (Murray & Powell, 2009). Debates

within feminism about what constitutes the oppression of women have, however, become more complex. This includes considering multiple tyrannies, such as structural and racial inequalities and the treatment of women marginalised in the community for their sexual orientation or disability (Arnold & Ake, 2013; Sokoloff, 2004). In order to cater for the increasingly diverse populations accessing Refuges, staff have needed to become much more aware of the cultural and structural issues facing their residents (Sokoloff & Dupont, 2005). This is particularly important as inequity and violence towards women are understood to stem not only from attitudes towards gender but from other forms of discrimination, meaning that some women will be affected in multiple ways. Woman of colour, together with those from migrant communities and minority groups, are now being given a voice in a movement that was once dominated by white, middle-class women (Arnold & Ake, 2013). The movement itself is calling for self-analysis and change, as four decades after its inception it challenges itself against "simply devolving into another 'tier of the social service industry'" (Lehrner & Allen, 2009, p. 675), calling for a re-invention of the movement without losing sight of its core values and goals.

Changes in models of Refuge accommodation: Models of accommodation are slowly changing over time. Some of the first women's Refuges established in suburban houses are being converted into purpose-built facilities, with transition houses through to supported, sole-occupancy housing also being offered (McFerran, 2007). While Refuges were always intended to provide short-term assistance only, today it is recognised that many women are likely to be repeat users presenting with high-risk factors such as substance abuse and mental health issues, in addition to the effects of family violence. This transience is stressful for mothers and children alike, as many return to a state of homelessness following their contact with emergency accommodation services (Spinney, 2012). These very services provided to women and their children were built on the premise that women escaping family violence could enter safe accommodation during a time of crisis and find Refuge (Grossman & Lundy, 2011). The intention of this type of crisis accommodation was to act

as a ‘stepping stone’ that would empower women to move from unsafe homes towards new lives free of violence (Srinivasan & Davis, 1991).

Context-sensitive research: The setting of Refuge itself is highly sensitive, with the location usually kept secret as “the address is only disclosed on a 'need to know' basis” (Barca, 2013). Research in such a sensitive environment involves substantial ethical consideration. Historically, and still today, the locations of women’s Refuges are hidden, and they vary in the provision of low- through to high-security. This emphasis on secrecy and security arose from a demonstrable need to protect and provide sanctuary to women and children from the perpetrators of the violence (Harding & Helweg-Larsen, 2009; Postmus, 2003; Wilson, Baglioni, & Downing, 1989). Essential to the provision of safe housing to women and children fleeing family violence has been the commitment to policies that ensure confidentiality, adequate security and support. In addition, the Refuge milieu itself is often busy, chaotic and distressing. Families frequently arrive with very few possessions, sometimes being escorted to venues by police or community workers they barely know, or transported by taxi from the women’s services facilitating their escape. Victoria, Australia, like many other regions, has the precautionary policy of placing women and their children ‘out of region’. As a result, families are not only negotiating new living arrangements but often totally new locations. Respecting the sensitivities inherent in needing to use Refuge in the first place is critical to conducting ethical research within such settings.

In Summary

The necessity for refuge from violence and persecution has been evident throughout history. Within the literature, those seeking refuge are usually individuals and/or groups who have transgressed the rules of society, and/or been forced to flee their homelands due to war, persecution or environmental disasters. The need for physical, as well as emotional refuge from

harm is critical to survival. This is no more so than in infancy. The infant is dependent on others to keep them safe from harm. As they grow, their capacity to develop skills in self-care, emotional regulation and healthy relational reciprocity form. These skills provide the foundation for each individual child's subsequent development. Public recognition that some infants, children and women specifically require refuge not from outside sources, but within their own families, and most predominantly from men, is a relatively recent phenomenon.

It can be seen from the short history of women's Refuges that violence against women and children has been a long-standing issue, but one not overtly challenged or politicised until the women's movement created the very first shelters for battered women. During the past forty years, and despite the best efforts of feminism to advocate for far-reaching structural and political change, the need for Refuge for women and children unfortunately remains. Furthermore, the women's movement itself has identified the need for a greater analysis of the more complex power differentials that operate within and between women themselves. This research aims to highlight the fact that infants have not been afforded a place in discussions concerning 'more complex power differentials' and perhaps can add to this analysis through an inclusion of the way in which children, and specifically infants, are also impacted by societal inequalities and tyrannies not currently acknowledged in relation to family violence and its aftermath. The next chapter reveals what knowledge is currently available regarding the impacts of family violence and homelessness on the infant and mother. It then examines the research on infant development, communication and subjectivity/inter-subjectivity before considering what is known about the experience of children and mothers in Refuge. The chapter concludes with a discussion regarding the ethics of including infants in research.

CHAPTER THREE

Review of the literature

As there has been so little research regarding the infant in Refuge, a broader sweep of what is relevant to the experience of the infant who presents to Refuge, including the impacts of family violence and homelessness, will be examined. Further to this, a review of the literature on infant neurobiological and relational development will be considered, as will the impact of trauma on infant development and how this trauma can be repaired. Infant communication, subjectivity and inter-subjectivity within the context of their primary caregiving relationships is also addressed. As there has been some interest in the experience of older, verbal children and mothers in Refuge, this research will be presented. The final section of this chapter turns then to how research can give voice to the experience of the pre-verbal infant and the ethics of doing so. The areas identified as particularly important to review are:

- What current knowledge is available?
- What is understood to be the experience and impact of family violence on the infant - in utero and from birth – and on their mother?
- What is understood to be the experience and impact of homelessness both on the infant and their mother?
- What is important to understand about infant development, relationships, trauma and repair?
- What do we know about how the pre-verbal infant communicates to others about their subjective world, and why is this important?
- What can we take from the knowledge available on the experiences of mothers and older verbal children in Refuge?
- What makes it important to give voice to infants in research, and how can this be ethically undertaken?

Searching the literature: The first step I took in searching the literature involved using electronic document retrieval systems, specifically search engines such as 'CINAHL' (Cumulative Index of Nursing and Allied Health Literature), 'ProQuest Social Science journals', 'Biomed Central' and 'Taylor and Francis online journals'. I used the key words "family violence, domestic violence, intimate partner violence AND refuge, crisis accommodation, shelter, emergency accommodation, homelessness AND intervention group work AND infant baby OR infant mental health AND mother". I also registered to receive regular 'EBSCOhost Alert Notification' results regarding the publication of any new research and regularly utilised Google Scholar when tracking down specific areas of interest regarding infant development or generally relevant areas to this research.

Overall, these searches yielded incomplete results specific to this research. This led to a need to undertake a comprehensive manual search of the literature. This involved following up articles and materials found in the reference list of substantive articles that relate more broadly to the women's movement, infants at risk, early childhood trauma, and in key journals (ie., *Infant Observation*, *Infant Mental Health Journal*, *Journal of Interpersonal Violence*, *Violence Against Women*, etc.) and national domestic violence clearing-house sites within different countries. Government websites and international organisations such as UNICEF, the United Nations and the World Health Organisation provided useful information on prevalence and profiles surrounding populations at risk of violence and homelessness. Also helpful were reference books including the *Encyclopaedia of Sociology* and specialist dictionaries produced by the Oxford University Press. Grey (non-peer reviewed) literature and reports from women's organisations, a small number of unpublished theses, and books, particularly those containing historical information about the women's movement and Refuges, were especially helpful in fleshing out the contextual picture of Refuge. That these sources of information were found through an

extensive internet search, and often in non-academic locations, attests to the fact that this knowledge appears to have been obscured and marginalised.

Current available literature: There is no research regarding the experience of the infant within women's Refuges, let alone how they experience finding refuge within this setting. This is despite the large numbers of infants who, with their mothers, enter Refuge each year (AIHW, 2012a, 2012b; Shinn, 2010). What is described within the literature is limited to specific therapeutic work with individuals or groups of women and infants who reside in Refuge but attend outside services (Groves, 2002; Jones & Bunston, 2012; Lieberman & Van Horn, 2004, 2008), or to interventions delivered in-house to enhance the relationship between the infant and mother (Bain, 2014; Bunston & Glennen, 2008; James & Newbury, 2010; Keeshin, Oxman, Schindler, & Campbell, 2015). The information found in the literature does not, however, go within the Refuge itself to explore what happens in the everyday life of the infant who resides there. What occurs within Refuge for the infant, particularly those aged 12 months and under, can only be inferred by exploring what the 'related' research and literature have to offer. Important to note from this particular experience of the infant is that during this stage of their lives, they are developing more rapidly than they will at any time thereafter. What happens before entering Refuge and once in Refuge - be it for weeks, months, or, for some, a year or more of their young, immature yet rapidly developing lives - will be remembered, albeit implicitly, and may risk leaving the infant "vulnerable to triggers of their traumatic memories" (Schechter & Willheim, 2009, p. 204).

The gap in knowledge: There is a gap in the knowledge between what we have begun to understand about infants exposed to family violence and infants who, with their mothers, escape into Refuge following exposure. Leaving a violent relationship does not simply erase all the memories associated with that trauma, either for the infant or for their mother (Schechter, 2004;

Schechter & Willheim, 2009). The infant who enters Refuge continues to have needs. They may enter the Refuge in a traumatised and dysregulated state. If there is not an available and attuned adult to help them move into an emotionally safe and regulated state, they will remain unsettled. Understanding how the needs of the infant entering Refuge are met on a day-to-day basis in a setting that is created for escape from violence warrants attention.

When violence begins for the infant

Family violence can impact infants from birth and even for a long time before they are born (Ahlfs-Dunn & Huth-Bocks, 2014; Quinlivan & Evans, 2001). It might be surprising to consider that some infants may never have known a life without violence. That is, some infants are the product of rape within the couple's intimate relationship and their exposure to violence thereafter continues to grow as they grow (Lathrop, 1998; Sakar, 2008). Some infants may first be impacted in utero, whilst others are not exposed to violence until post-birth. It is important to recognise that the impacts of exposure to violence at different developmental stages can have different consequences for the infant, and for the infant/mother relationship (Levendosky, Leahy, Bogat, Davidson, & von Eye, 2006; Rifkin-Graboi, Borelli, & Enlow, 2009; Rigterink, Fainsilber Katz, & Hessler, 2010; Schechter & Willheim, 2009).

Conceived through violence: The prevalence of rape and non-consensual sex in intimate adult relationships is less acknowledged, and its impacts less understood, than other abuses that occur within family violence (Thomson Salo, 2010). "Knowing that her resistance will ultimately result in violent rape, a battered woman may submit to unwanted sex to avoid physical harm" (Lathrop, 1998, p. 26). How many infants begin their lives as a result of non-consensual sex within the context of family violence is difficult to ascertain (Senanayake, 2012). This may be due to the fact that the question is not being asked of women, in part because of the uncertainty of what

constitutes consensual versus non-consensual sex and the ambivalence some woman undoubtedly hold about wanting a baby (Pajulo, Helenius, & Mayes, 2006). Sarkar (2008) found that violence from partners significantly affected women's reproduction and pregnancy outcomes, and concluded that women's mental and physical health was significantly compromised by this violence, as was their control over sexual reproduction. In a large-scale study undertaken in the United States, it was found that many women who experienced violence also had 'rapid, repeat pregnancy' (Scribano, Stevens, & Kaizar, 2013). This description refers to women falling pregnant within 12 months of the birth of the previous child. The investigators speculated that this may fit with other emerging research suggesting that perpetrators of violence towards their partner may 'coerce' them into falling pregnant. Such studies suggest that 'pregnancy coercion and birth control sabotage' are another form of partner control (Miller et al., 2010). The implications of a forced pregnancy on the relationship of the mother with the resulting infant are considerable, as the infant risks acting as a constant and negative reminder of the violence. Furthermore, "if the infant is experienced as an alien object invading her body there may be a transgenerational transmission of trauma" (Thomson Salo, 2010, p. 294).

Violence in utero: Violence towards the mother during pregnancy has been found to result in miscarriage, lower birth weights for the infant, smaller brain size, premature delivery, neonatal death, breast-feeding difficulties and other adverse outcomes for both infant and mother (Asling-Monemi, Pena, Ellsberg, & Persson, 2003; Coker, Sanderson, & Dong, 2004; McFarlane, Campbell, Sharps, & Watson, 2002; McFarlane, Parker, & Soeken, 1996; Quinlivan & Evans, 2005; Quinlivan & Evans, 2001; Sarkar, 2008; Taft, Watson, & Lee, 2004). Schwerdtfeger and Goff (2007) found that a history of trauma is more likely to have an impact on an expectant mother's prenatal bonding with her infant when that trauma has been interpersonal. Even when the experience of family violence is not current but has been experienced by the mother herself as a child, there are potential impacts for her infant (Fraiberg, Adelson, & Shapiro, 1975; Lieberman, 2007). Malone

et al. (2010) found that "regardless of the presence or absence of childhood maltreatment, the effects of domestic violence concurrent with pregnancy impact the way a mother thinks of her child. The emergence of a distorted prenatal representation in pregnant women in abusive relationships may be driven primarily by the concurrent violence from their partner" (p.446).

Increased risks of violence during pregnancy: Pregnancy has been identified as a time of increased risk of violence from partners (Adesina, Oyugbo, & Olubukola, 2011; Chhabra, 2007; Gazmararian et al., 2000; McFarlane et al., 2002; McGee, 2000; Menezes-Cooper, 2013; Richardson et al., 2002). It has been suggested that this increase in violence has a dual intention of hurting both mother and the infant in utero. Humphreys & Houghton (2008) argue that this represents "the most serious forms of child abuse and the risks posed by these perpetrators to both women and the unborn child" (p.10). McFarlane et al., (2002) concluded from their research into abuse during pregnancy that violence which occurs during pregnancy should be considered "as a sign of a particularly dangerous batterer … Abuse during pregnancy should be seen as an important risk factor for attempted or completed femicide" (p.33).

Post-birth violence: In some instances it may be that the infant is seen by the mother to be more impacted by violence post-birth than before they are born. An Australian study looked at the incidence of violence before, during and post-pregnancy (Gartland, Hemphill, Hegarty, & Brown, 2011). These researchers found that the majority of women who reported feeling fearful of their partners before and during the pregnancy remained feeling fearful of violence 12 months past the birth of the infant. This fear post-birth corresponded in some degree to a reported increase in women leaving their partners by the time their infant was 12 months old (Gartland et al., 2011).

Infants & mothers living with family violence

The post-birth impact of violence on infants has been easier to report than the prenatal impact. These impacts have been demonstrated to occur in their neural, social, cognitive and emotional development and in their primary relationships, and ultimately are found to increase the likelihood of the transmission of violence across generations. Research into the impacts for the mother herself has suggested a negative effect on their sense of self-worth and their relationship with their infant; however, some studies indicate that with adequate social and systemic support, this trajectory can be reversed.

Neurobiological development: Infants' neurobiological development is negatively impacted by the trauma of living with family violence (Schechter & Willheim, 2009; Schore, 2001; Solomon & Heide, 2005; Van der Kolk, 2014; Van der Kolk, 2005). The infant brain is at a critical stage of development, and adverse events in early childhood risk "structural modifications in neural networks as well as long-term changes in the synthesis and release of neuromodulators (including neurotrophins), thus allowing for fast-acting biochemical switching in response to appropriate stimuli"(Cirulli, Berry, & Alleva, 2003, p. 80). Schechter and Willheim (2009), in their review of the literature on the impact of violence on early childhood development, were unequivocal:

> There is no longer any question that experiences of violence and maltreatment adversely and enduringly alter neurobiological development, psychological and social functioning, and subsequent expectations from the environment (citing Kaufman, Plotsky, Nemeroff & Charney, 2000). The questions that remain are to what degree and in what ways is early development affected by violent experience and maltreatment (p. 197).

High levels of exposure: What further compounds the imperative of these neurological concerns is the contention that children from birth to five years-of-age experience exceptionally high levels of trauma compared to older children, yet are under-represented in the trauma literature and under-serviced in the community generally (Lieberman, Chu, Van Horn, & Harris, 2011). Infants exposed to any forms of violence, be it in their community, the media or in their most intimate relationships, are affected (Zeanah & Scheeringa, 1997). Whilst some trauma occurs outside the family, most trauma (about 80%) begins at home (Van der Kolk, 2005).

Interpersonal impacts: What potentially sets the occurrence of violence within the family so insidiously apart from other forms of violence for the developing infant and young child is that the source of the violence occurs within – and within the relationship that created them (Intimate Partner Violence), at the hands of the people who care for them, and in the context of their learning how to be with others and how others deal with them (Jones & Bunston, 2012; Osofsky, 1995; Schore, 2001; Thomson Salo, 2007; Zeanah & Scheeringa, 1997). They may experience their caregiver as both the source of their fear and the source of their comfort, creating an intolerable dilemma of where to go to for safety and protection (Hesse & Main, 2000; Siegel, 2012). Holt, Buckley, and Whelan (2008) examined the literature from 1995-2006 that was specific to domestic violence and its impact on children and young adults. They found that whilst protective factors can offset the damaging impacts of living with family violence, affected children are nevertheless at increased risk of experiencing emotional, physical and sexual abuse, and of developing emotional and behavioural problems which increased the likelihood of other adversities in their lives. A study of 206 children in the U.S. from infancy to early school years measured intelligence quotient, language and academic progress across three points (Bosquet Enlow et al., 2012). A significant association between family violence and decreased cognitive capacity was found, with the greatest impairments evident in the cohort exposed to family violence from birth to two years. Similarly, a study involving 47 children (7-16 years) used

multiple standardised measures to assess their cognitive functioning concluding that family violence inhibited executive functioning, and increased impulsivity and distractibility (Samuelson et al., 2012).

Relational insecurity: Maternal depression is noted to be high in mothers experiencing family violence (Martin et al., 2006). Commencing with a cohort of over 200 mothers during pregnancy, a 10 year longitudinal study in the U.S. found violence in the couple relationship negatively impacts maternal representations (how the mother perceives her infant), which in turn influences how the infant attaches to the mother (Bogat, DeJonghe, Levendosky, Davidson, & von Eye, 2006; Levendosky, Bogat, & Huth-Bocks, 2011; Levendosky, Bogat, Huth-Bocks, Rosenblum, & Von Eye, 2011). Pre-screening measures were utilised to determine eligibility to participate in the study, with multiple standardised measures and questionnaires administered over different developmental periods with both mother and infant. The study found that high levels of maternal depression and negativity towards the infant were present. This negativity increased the likelihood of an infant, by the age of one, being insecurely attached to the mother. If the violence continues, by the age of two the infant's insecurity in their attachment to their mother is further exacerbated. In turn, this interferes with the mother's availability to help her infant manage their emotions, leading to behavioural difficulties. Conversely, this research found that where the mother leaves the perpetrator following the child's birth, more positive maternal feelings are present and by age 4 the mother-child attachment is more likely to be secure (Levendosky, Bogat, & Huth-Bocks, 2011; Levendosky, Bogat, Huth-Bocks, et al., 2011; Levendosky et al., 2006; Malone et al., 2010).

Inter-generational trauma: Women who experience family violence are more likely to have histories of inter-generational trauma (Ehrensaft et al., 2003; Renner & Slack, 2006). Many are

also diagnosed with Post Traumatic Stress Disorder (PTSD), experience high rates of mental health difficulties and poor physical health, lack social support, receive less formal education and utilise extensive support services (Gilroy, Maddoux, Symes, Fredland, & McFarlane, 2015; Helfrich, Fujiura, & Rutkowski-Kmitta, 2008; Kemp, Green, Hovanitz, & Rawlings, 1995; Tolan, Gorman-Smith, & Henry, 2006; Tolman & Rosen, 2001). Renner & Slack (2006) found support for the theory of 'learned helplessness', contending that victimisation through abuse or witnessing family violence during childhood had a strong correlation with women becoming victims of family violence in adulthood. Ehrensaft et al. (2003) found that solely witnessing the violence in childhood increased the likelihood of re-experiencing this in adulthood.

The capacity of mothers: Overall, the picture painted of women and mothers who have experienced significant family violence is grim. However, mothers can diminish the impacts of violence on their children, and both mothers and children do demonstrate resilience, resourcefulness, coping skills and strategies for seeking out support (Anderson, Renner, & Danis, 2012; Martinez-Torteya, Anne Bogat, Von Eye, & Levendosky, 2009; Masten, 2011; Papoušek, 2011; Sabina & Tindale, 2008; Weatherston & Fitzgerald, 2010). The keys appears to be the cessation of the violence as well as the accessing of support. Samuelson et al. (2012) found that mothers' emotional functioning and parenting style has an impact on children's neurocognitive functioning, and contends that interventions supporting mother-child interactions have the potential to enhance the cognitive abilities of children who have lived with family violence. A picture of hopefulness, growth and resilience was captured in a study that used a mixed methods approach to examine 37 women who had come through a violent relationship:

> For the women in this study, their lives did improve as a result of the many internal and external resources they were able to access and develop. In addition to tangible resources, positive social support can provide opportunities for survivors to speak the unspeakable,

> receive affirmation and validation, along with reviewing and even rewriting their life stories (Anderson et al., 2012, p. 1295).

Sarkar(2008) concluded that women who experienced family violence wanted health care workers to ask directly about possible violence. They found the risk of sexual assault dropped substantially where women did report violence to police and/or took out a protective order.

Impacts of homelessness on infants, children & mothers

Significant numbers of infants, children and mothers who have experienced family violence have also, at different times, experienced homelessness (Anooshian, 2005; Buckner, Bassuk, & Zima, 1993; Edalati, Krausz, & Schütz, 2015; Wenzel, Leake, & Gelberg, 2001). Infants and mothers who enter into crisis accommodation are classified as 'homeless'. Some of those infants will not have experienced family violence in addition to homelessness, however the literature, where predominantly referring to mothers and their children who enter generic crisis accommodation (as opposed to women only Refuges), does not tend to delineate between these two different cohorts other than to report that high levels of family violence are associated with homelessness (Bassuk et al., 1996; Cowal, Shinn, Weitzman, Stojanovic, & Labay, 2002; Edalati et al., 2015; Wenzel et al., 2001). Bassuk et al. (1996), pioneers in early research into homelessness used the definition of being homeless as "more than seven consecutive nights in a shelter, or a car, abandoned building, public park, non-residential building, or other non-dwelling" (p. 641).

The homeless infant: Reporting on figures within the United States, Shinn (2010) contends that "infancy is the age at which shelter (Refuge) use is highest" (p.25). These statistics echo Australian figures, with children under the age of four making up the largest group of 'accompanying children'; within this group, family violence was cited as one of the main reasons for 'seeking assistance' (AIHW, 2012a, 2012b). Similarly high figures are recorded in the UK (Webb,

Shankleman, Evans, & Brooks, 2001; Women's Aid, 2014). The homeless infant is more likely to be born premature and underweight (David et al., 2012). The transient nature of homelessness is more likely to compromise the infant's developing self-regulatory capacities, leading to poor educational outcomes.

The homeless child: Where the homelessness has been chronic, children are more likely to have mental health difficulties, particularly in relation to internalising (ie., withdrawn, anxious, sullen) behaviours (David et al., 2012). Where their mother has experienced both past trauma and homelessness, the child is less likely to enjoy a positive parent-child relationship (Perlman, Cowan, Gewirtz, Haskett, & Stokes, 2012). Children who are homeless have less access to medical and dental care, encounter significant barriers to learning and demonstrate higher class-repeat rates. Time, resources and capacity limits enrolment numbers for pre-schoolers, with some parents who are homeless fearing "that their children will be removed from their care, if their homeless status becomes known" (McCoy-Roth et al., 2012, p. 5).

A 2005 review of research into children's experiences of homelessness suggested children exhibited high levels of aggression as a result of exposure to violence within their families as well as within homelessness settings (Anooshian, 2005). They also experienced higher levels of social rejection and isolation, enjoyed little privacy and had punitive parent-child relationships. This then led to the "double crisis'' of homelessness for families, demonstrating that the very factors that led to them becoming homeless (e.g., poverty and family violence) also added further to the pressures on the parent (Anooshian, 2005). "For many homeless families, threats to effective parenting are further intensified by Refuge living. The chaotic social relations within Refuges erode the mother's confidence in parenting and leave children overwhelmed with multiple and unpredictable standards of behaviour" (Anooshian, 2005, p. 136).

Associated risks for children: Homelessness in itself is not always the biggest risk facing children. A comprehensive U.S. study undertaking a comparison of developmental outcomes for infants and young children who were homeless with low-income housed infants and young children found no major differences in scoring on infant development (Coll, Buckner, Brooks, Weinreb, & Bassuk, 1998). Both groups demonstrated high developmental scores at 18 months of age and under; however, scores dropped significantly for homeless children over 18 months. The authors of this study suggested that homelessness in itself was not detrimental to developmental outcomes; rather, of greatest concern were the high-risk conditions shared by both groups (including single parenting, poverty, and exposure to violence, maternal depression and substance abuse). Their findings indicated that as these children grew older they continued to fall behind normative developmental expectations, demonstrating the cumulative harm of living with poverty and other high-risk variables (Coll, et al., 1998).

A small Australian intervention program conducted in five women's Refuges used a worker-scored global assessment scale to assess the quality of the relationship between 22 infant/mother participants. All but two of these dyads fell well below the 'adapted' (optimal) range in the infant/mother relationships. Further, the majority of infants were observed to display considerable developmental delays, "most notably in relation to language acquisition, sequential reasoning and social referencing" (Bunston & Glennen, 2008, p. 16). Smolen (2003) powerfully and evocatively argues that the homeless infant is born into loss, leaving behind the perfect and protected environment of the womb:

> From the beginning of life these babies encounter an unbearable cycle of nowhere to go, no place to call home, no safe sanctuary, only the feeling of 'falling forever' … The infants to whom I am referring are rarely held. Their mothers' gaze looks outward, searching for a place to sleep for the night and concentrating on finding their next meal. These mothers

> avoid looking into their infants' eyes because they will see only a reflection of their own inadequacy. These mothers are unable to gaze upon their newborns because they were invisible to their own mothers and that reminder is intolerable. Women in this position must protect themselves from re-experiencing excruciating pain (p.250).

The homeless mother: The profile of the homeless mother that commonly emerges in Western countries is of a women in her mid to late twenties with two children, one or even both of whom are under the age of six (Bassuk et al., 1996; David et al., 2012; Rog & Buckner, 2007; Waxman & Reyes, 2007). International studies suggest that minority ethnic groups are generally more likely to experience homelessness (Shinn, 2010). This same profile applies to mothers (Rog & Buckner, 2007). Within Australia, however, it is the Aboriginal and Torres Strait Island population who are over-represented in the figures of those accessing specialist homelessness services, or who are classified as homeless (AIHW, 2012b; DFHCSIA, 2008).

Compared to mothers living in stable housing, the homeless mother is also more likely to have been in foster care when she herself was a child (Bassuk et al., 1996). Additionally, mothers in Refuges are more economically disadvantaged, have fewer social supports and the severity of their physical and sexual abuse is greater than that of their contemporaries not in Refuge (Bassuk et al., 1998; Bassuk & Weinreb, 1993; Bassuk et al., 1996). In addition to poor health, mothers who are homeless are said to be more likely to smoke, use substances (Bassuk et al., 1996; Coll et al., 1998; Rog & Buckner, 2007; Wenzel et al., 2001) and suffer from depression, PTSD and mental health difficulties (Bassuk & Weinreb, 1993; Buckner et al., 1993; Edalati et al., 2015; Zabkiewicz, Patterson, & Wright, 2014). Exposure to early childhood trauma themselves also features prominently in the lives of homeless women (Anooshian, 2005; Edalati et al., 2015; Wenzel et al., 2001).

Additional risks for women: A large proportion of young homeless women were found to have fled from the parental home to escape violence or conflict only to face further physical and sexual abuse through being homeless, according to Crawford, Trotter, Hartshorn, & Whitbeck (2011). Their study found that rates of pregnancy amongst young homeless women were considerably higher than those of their peers, and of the 90 women in the study who had children, only half reported that their children remained consistently in their care, while a fifth reported having no contact with their children. Additionally, these young, pregnant and homeless women were isolated and regularly went hungry. They also suffered from high levels of stress and were often already the victims of crimes, including the circumstances surrounding their child's conception. This study contended that the circumstances of their pregnancy, in turn, robbed these young women of the time and support through which to prepare themselves psychologically for their imminent role as mothers, which impacted on the subsequent maternal representations they formed of their babies (Crawford et al., 2011). Women reduced to living on the streets often endure considerable and ongoing adversity, face ongoing sexual and physical victimisation, are more exposed to risk and are noticed by society only when they make trouble (Jasinski, Wesely, Wright, & Mustaine, 2010; Salomon et al., 2004).

Infant development

Developing relationships: One of the most important elements over and above the essential physical and nutritional aspects that contribute to healthy infant development is the quality of the relationship formed between the infant and their primary caregivers. The nature of this infant/caregiver relationship has been described using terms such as 'maternal' or 'parent-infant bonding' (Johnson, 2013; Swain, Lorberbaum, Kose, & Strathearn, 2007), 'social seeking behaviour' (Clark et al., 2013), 'interactive behaviours' (Jung, Short, Letourneau, & Andrews, 2007) and 'maternal sensitivity' (Perry et al., 2013). Most commonly, however, this relationship

is conceptualised in terms of the quality of the attachment the infant develops with their primary caregiver, as this is seen to directly impact the infant's neurological, physiological, psychological and emotional development (Beijers, Risken-Walraven, & De Weerth, 2013; Madigan, Atkinson, Laurin, & Benoit, 2013; Raby et al., 2012; Schore & Schore, 2008; Siegel, 2012). Breidenstine, Bailey, Zeanah, & Larrieu (2011) state that "central to this conceptualisation of attachment are observable, biologically driven behaviours, which Bowlby referred to as attachment behaviours" (p. 275) and which are motivated by the drive to seek protection from harm, particularly in infancy. The child with a secure attachment will seek out their parent as "a safe haven in times of distress" (Fishbane, 2007, p. 401). Physiological responses such as heart rate, cortisol and neural activity have been measured, along with examining temperament and genetics, in order to elucidate the relationship between the infant's development and their attachment experiences (Fox & Card, 1999; Burgess, Marshall, Rubin, & Fox, 2003; Calkins & Fox, 2003; Mundy & Fox, 2003; Szewczyk-Sokolowski et al, 2005). This has provided evidence that early relationship experiences, be they positive or negative, are important as they have potentially enduring physiobiological implications for the developing infant's health, growth and future development.

Developing emotional self-regulation: Pre- and post-natal maternal stress can lead to the infant developing regulatory difficulties, indicating that it has negative impacts on infant physiological and psychological health and the mother-infant attachment. Where a mother is greatly overwhelmed by her own feelings of stress she can become compromised in her ability to not only recognise, but be available to help, her infant to become calm or find comfort when they, too, are overwhelmed by distressing events or emotions. This leaves the infant in a physiological state of dysregulation, which then impinges on the ability of both mother and infant to relate to each other in a healthy and reliable manner (Baibazarova et al., 2013; Burgess et al., 2003; Davis et al., 2011; Huizink, Robles de Medina, Mulder, Visser, & Buitelaar, 2003; Talge et al., 2007). Studies such as these have been able to incorporate sophisticated scientific techniques to

measure physiological responses, and on occasion have combined these techniques with standardised attachment measures such as the Strange Situation procedure and/or Adult Attachment Interview (Burgess et al., 2003; Swain et al., 2007). The rigour involved in conducting, as well as committing to, such studies, however, often precludes the 'high risk', 'vulnerable' and often 'hidden' mother-infant population who experience both family violence and homelessness. Nevertheless, retrospective studies have provided powerful evidence of severe early childhood relational trauma impacting across the life span (Carpenter et al., 2009; Elzinga et al., 2008; Murgatroyd & Spengler, 2011; Teicher, 2002; Teicher et al., 2003; Teicher et al., 2004). Infant studies within stable families clearly demonstrate that even small amounts of stress in normal caregiving environments affect an infant's cortisol system (Beijers et al., 2013; Tollenaar, Beijers, Jansen, Riksen-Walraven, & de Weerth, 2012).

Relationships and attachments

Theories of attachment: Current research concerning infant development is typically dominated by what is known as attachment theory (Beebe & Lachmann, 2014; Cassidy & Shaver, 1999; O'Sullivan & Ryan, 2009; Salter-Ainsworth, Blehar, Waters, & Wall, 1978/2014; Schore, 2005; Schore & Schore, 2008; Tryphonopoulos, Letourneau, & Ditommaso, 2014; Van der Kolk, 2014; Zeanah, Benoit, Hirshberg, Barton, & Regan, 1994). It is widely considered that the quality of the relationship the infant has with their primary caregiver is pivotal to their development (Arvidson et al., 2011; Bowlby, 1952; Bretherton, 1991; Cyr, Euser, Bakermans-Kranenburg, & Van Ijzendoorn, 2010; Fonagy, Luyten, & Strathearn, 2011; Johnson, 2013; Salter-Ainsworth, 1991; Schwerdtfeger & Goff, 2007; Siegel, 2012). This relationship is actualised through interactional behaviours. An important contributor to the research concerning the importance of the quality of an infant's developing relationship, or 'attachment' to their carer, was Mary Main (Main, 1999). She stressed that 'attachment' is technically defined as the child's attachment to their parental figure. When the attachment system is activated (for example, by a familiar figure

leaving or unfamiliar person arriving), it leads to proximity-seeking behaviours by the infant. This is usually with the attachment figure(s) who is most likely to provide them with safety and survival when they perceive situations as 'life-threatening'. Further she writes:

> All infants who have had the opportunity to form an attachment are attached, whether the attachment is secure or insecure. The related fact that an infant becomes definitively as attached to a battering parent as to a sensitively responsive one (Bowlby, 1958) is astonishing to some new audiences (Main, 1999, p. 847).

Attachment Theory, as it is largely known today originated in Britain midway through the twentieth century (Bowlby, 1969/1982, 1988; Bretherton, 1992; Holmes, 1993; Main, 1999; Salter-Ainsworth & Bowlby, 1991). The origins of attachment theory are attributed to British Child Psychiatrist John Bowlby (1969/1982) and his chief collaborator, American psychologist Mary Salter-Ainsworth (Salter-Ainsworth & Bowlby, 1991). Bowlby argued that we are all born as proximity-seeking creatures, biologically endowed with characteristics designed to pull others towards us, unless experience teaches us otherwise. "Attachment researchers, building on Bowlby's attachment theory, identify secure attachment as the child seeking proximity to the parent, the parent offering a safe haven in times of distress" (Fishbane, 2007, p. 401). Salter-Ainsworth (1969) explains that "attachment refers to an affectional tie that one person (or animal) forms to another specific individual. Attachment is thus discriminating and specific" (p. 970). Further still, "once formed, whether to the mother or to some other person, an attachment tends to endure" (Salter-Ainsworth, 1969, p. 970). Bartholomew, Henderson and Dutton (2001) argue that this is even more so when the attachment has been developed within an abusive relationship. Thus, while attachment patterns are formed in infancy they persist across one's lifespan (Salter-Ainsworth, 1991). The need to feel safe and secure, in whatever form this takes, lies at the heart of theories of human relationship and human development, and operates at all stages and ages. How we understand the science of human development today is credited by

multiple authors (Bakermans-Kranenburg, van Ijzendoorn, Caspers, & Philibert, 2011; Cirulli et al., 2003; Clark et al., 2013; Luijk et al., 2011; Meaney, 2010; Papageorgiou & Ronald, 2013; Perry et al., 2013; Riem, Bakermans-Kranenburg, van Ijzendoorn, Out, & Rombouts, 2012; Schechter et al., 2012; Schechter & Willheim, 2009; Shonkoff, 2010; Siegel, 2001; Siegel, 2012; Swain et al., 2007) to the early ethological and naturalist observational research work of Bowlby and Ainsworth undertaken midway through last century (Bowlby, 1951; Bowlby, 1952; Bowlby, 1969/1982, 1988; Salter-Ainsworth, Blehar, Waters, & Wall, 1978/2014; Salter-Ainsworth, 1969; Salter-Ainsworth, 1979; Salter-Ainsworth & Bowlby, 1991).

Behaviours and their relational meaning: Attachment is seen largely as a behavioural system motivated by the goal of finding security for self through our relationships with others. What can be observed in the infant (crying, gazing, vocalising, posturing and hesitating) provides clues about what they may be experiencing. This 'attachment behaviour system' is activated by threat, distress and/or separation from an attachment figure, and from being in new situations. How the attachment (caregiving) figure responds when these behaviours are activated is seen to directly impact on the infant's developing attachment style (Crowell & Treboux, 2006). This then has implications for the "representations" or "working models" of attachment, these terms referring to a dynamic which is internalised and organises our pattern of relating to others (Salter-Ainsworth, 1969; Schore & Schore, 2008). An adult's individual attachment style is understood to derive from their early childhood attachment experience, which acts as a prototype for later intimate relationships. Furthermore, these prototypes and how they influence behaviour are believed to be largely handed down from one generation to the next. Once developed within the individual, these patterns of relating generally remain consistent over time (Crowell & Treboux, 2006).

Secure attachment: Attachment is categorised as *secure* and *insecure*. An individual operating from a secure working model of attachment exhibits a robustness and confidence in exploring their environment (this includes both their internal and external world), safe in the knowledge that loved ones will remain available to support, guide and nurture them. For the infant, this experience of attachment enables "an external ring of psychological protection which maintains the child's metabolism in a stable state, similar to the internal physiological homeostatic mechanisms of blood pressure and temperature control" (Holmes, 1993, p. 66).

Insecure attachment: An insecure working model arises when the caregiver's behaviour generates, rather than reduces, anxiety in the infant. The infant's innate need to maintain contact with their caregiver, even in the face of unpredictable, rejecting and possibly even harmful responses from the caregiver, leads to the internalising or organising of working models of attachment that involve coping strategies of *avoidance* or *ambivalence* (Main, 1991). An *insecure avoidant* strategy involves the infant minimising the need for contact in order to avoid painful feelings of rejection while simultaneously remaining watchful and aware of their caregiver, albeit from a distance. Feelings of neediness are minimised and relegated to the unconscious. Conversely, an *insecure ambivalent* strategy involves the infant maximising contact with an inconsistent caregiver, exhibiting submissive behaviours or even demonstrating a reversal of roles where they take on caring for the caregiver (Main & Solomon, 1990).

Disorganised attachment: A third insecure strategy identified later in the literature on attachment – *disorganise*d – appears to be less common in the general population and emerged as a third, discrete classification as a result of ongoing research into children's attachment behaviours (Main, 1991; Salter-Ainsworth & Eichberg, 1991). This strategy involves more severe and chaotic coping mechanisms that include bizarre and confused responses as well as 'freezing'

or unusual movements (Holmes, 1993). This category involves the infant failing to find a strategy with which to cope with attachment-related stress (Main, 1991). Significant support for this third category of 'insecure attachment' resulted from a study conducted over 30 years with 200 mothers. The Minnesota study involved mothers considered to face potential challenges in their role as parent, largely because of living in poverty:

> Consistent with the theorizing of Main and Hesse (1990), we found that disorganization was strongly predicted by caregiver intrusiveness and by maltreatment, including physical abuse and psychological unavailability. While intrusiveness (doing things to the baby for which the baby was not prepared) and physical abuse likely would be frightening and therefore disorganizing, emotional unavailability might be viewed as making it difficult for the infant to organize attachment behavior in the first place" (Sroufe, 2005, p. 356).

Criticism of Attachment Theory: Not without its critics, Attachment Theory was initially treated with great suspicion by the psychoanalytic colleagues of Bowlby, who described the approach as "mechanistic, and devoid of regard for that which cannot be measured or observed" (Fonagy & Target, 2007). In return, Bowlby was quick to see the areas of weakness in psychoanalysis, in particular its lack of empiricism or inclusion of context (Fonagy & Target, 2007; Holmes, 1993). This early dissonance has receded considerably, with both perspectives extending to incorporate some important elements of the other whilst respecting remaining areas of difference (Beebe et al., 2011; Bretherton, 1992; Fonagy, Target, Steele, & Steele, 1998; Main, 1991, 1999; Stern, 2003; Tronick, 2007). Criticism remains, however, regarding its cultural bias. The theory was developed and applied largely to white, western societies and it has been seen to fail to translate appropriately to other racial groups, cultures and customs (Neckoway, Brownlee, & Castellan, 2007; Neckoway, Brownlee, Jourdain, & Miller, 2003; Rothbaum, Rosen, Ujiie, & Uchida, 2002). Additionally, it has been seen as a theory which does not recognise gender

inequities, particularly with regard to family violence, and fails to see behaviours deriving from the motivation of the mother to protect her infant (Buchanan, 2011; Buchanan, Power, & Verity, 2013).

Research with infants

Research into infant development has been heavily influenced by attachment theory. Considered the 'gold standard' in measuring the attachment between the infant and mother is the 'Strange Situation Procedure' (SSP) (Main & Solomon, 1990; Salter-Ainsworth et al., 1978/2014). This takes place within a laboratory setting where a level of stress is 'induced' by separating the infant from the mother, and the 'attachment behaviours' triggered by the separation from, and then reunion with, the mother are measured according to standardised measures. Other techniques involve filming sequences of behaviour between infants and their caregivers and then coding and analysing these according to particular 'emotional availability' scales (Biringen, 2000). Another research method involving filming uses a specific technique of microanalysis to slow down the interactions in order to describe the interactional patterns (Beebe, 2006). Filming allows the laboratory to visit the infant rather than requiring the infant to attend the laboratory (Puckering et al., 2011; Puckering, Evans, Maddox, Mills, & Cox, 1996). Questionnaires filled in by mothers about their infants' behaviour have also featured strongly in infant research (Briggs-Gowan & Carter, 2007; De Wolff, Theunissen, Vogels, & Reijneveld, 2013). These research methods seek to quantify and measure interactional behaviours and/or focus exclusively on the infant/mother relationship. More recently 'infant observation', used in the study of infant development, has been utilised as a research tool, and is seen to provide less intrusive and more 'infant-sensitive' opportunities to discover the emotional world of the infant (Datler, Datler, Hover-Reisner, & Trunkenpolz, 2014; Reddy & Trevarthen, 2004; Rustin, 1997, 2006; Urwin, 2011).

Relational trauma

There is now considerable evidence that the rapidly developing infant can become, and may remain, physiologically dysregulated as a consequence of their being overwhelmed by the volatility and/or inattention of a violent care-giving environment (Schore, 2003b; Schore & Schore, 2008; Shonkoff, 2010; Siegel, 2012; Zeanah, Benoit, Hirshberg, Barton, & Regan, 1994). The infant's natural developmental trajectory is forward, and overwhelming emotional, physiological and physical trauma is believed to impede development. When left without a relational buffer, the infant moves from a hyper-vigilant response to shutting down, summoning all the internal resources they have at their disposal to hibernate until it is safe to emerge (Rifkin-Graboi et al., 2009). Knowing when it is safe to emerge is highly dependent on a reliable, protective and safe caregiver ushering them back from hibernation. A highly effective primitive defence involves an infant shutting down during times of extreme danger, thus stalling growth. With repetition, the exposure to danger risks turning heightened 'emotional states' into ongoing, problematic and easily triggered 'personality traits' as the infant brain develops (Perry et al., 1995). Failure to provide the infant with a safe, emotionally containing and responsive relationship leads to an infant defending themselves against "the catastrophic anxiety of falling-into-space" (Bick, 1986, p. 299). This leads to the development of what has been described by Bick as a 'second skin', which is similar to Winnicott's concept of the 'false self' (Winnicott, 1965). The infant then fends for themselves, however this involves what is effectively a "pseudo-independence, and a substitute for this container function is created" (Pretorius, 2004, p. 71). Attachment theory offers one means through which to measure attachment behaviours, which are seen to be formed within the caregiving system and speak to how the emotional states of the infant are being adequately regulated or, alternatively, left to the infant alone to manage (Schore, 2005; Schore & Schore, 2008).

The developing brain: Infancy is understood to be the time within which the individual's neural scaffolding is laid down, developing pathways not just between the right and left hemispheres, but from lower to higher order brain functioning (Perry et al., 1995; Schore, 2001; Teicher, 2002). Experience is believed to shape the brain, particularly within the formative stages of infancy (Cozolino, 2006; Rifkin-Graboi et al., 2009; Schore, 2005; Siegel, 2012). The infant's right brain, believed to be responsible for the emotional self, begins its rapid growth in the first two years of life and is exquisitely sensitive to the infant's caregiving environment. This environment, namely that of the relationship between the primary caregiver and the infant, co-constructs the affect (emotional) regulation system within the infant's developing right brain (Schore, 2001). Ongoing failure within this relationship to 'interactively regulate' both negative and positive states within the infant risks impacting on the infant's mental health.

An infant experiencing early relational trauma and adversity that is not mitigated by their caregiver is left to self-regulate. This results in the release of powerful stress-inhibiting chemicals within the brain in a quest to regain some emotional equilibrium. The immature brain is assaulted with a cascade of neuro-chemical reactions which may "persistently alter the expression levels of key genes by epigenetic marking thus initiating adjustments in behaviour, neuroendocrine and stress responsivity throughout later life" (Murgatroyd & Spengler, 2011, p. 582). From thereon in, the most primitive and earliest forming part of the brain retains its influence throughout the life of the individual as our physiological response to the world reacts more quickly than our cognitive response (Cozolino, 2008). Neuroscientist Paul MacLean (1990) researched the way in which lower-order brain functioning continued to exercise considerable influence throughout the individual's life as "forebrain mechanisms underlying prosematic forms of behavior … emotional mentation, a form of cerebration that appears to influence behavior on the basis of information, subjectively manifest as emotional feelings" (p.12). What this means is that the physiological self, and what we feel, absorbs information more quickly than what we think and can give words or

narrative to. The more skilled we are in self-regulation through our experiences of secure early caregiving – particularly with regards to stress – the better we are at moving to higher-order brain functioning and thinking about and describing what it is that we feel (Cozolino, 2006; Gunnar & Quevedo, 2007; Schore, 2001; Schore, 2005; Siegel, 2001; Siegel, 2012).

Relational repair

Just as the quality of the relationship an infant has with their caregiver can cause the infant harm over time, so too is the infant readily available and able to recover through relational repair (Jordan & Sketchley, 2009; Masten, 2011; Schore, 2003b; Tollenaar, Beijers, Jansen, Riksen-Walraven, & De Weerth, 2011). Research reveals the ways in which 'relationships can heal'. Infants are neurologically 'wired to connect' and innately seek out proximity with others, even when those others may also be a source of harm (Fishbane, 2007; Schore, 1996; Schore, 2003; Siegel, 2001; Siegel, 2012). Emotional affect regulation occurs in the context of safety, as does the capacity to experience relational repair (Johnson, 2013; Siegel, 2001; Siegel, 2012; Spangler & Grossmann, 1993; Tronick, 2007). "Feeling felt" is important in all interactions and "empathy soothes us and makes us feel safe" (Fishbane, 2007, p. 403). Oxytocin, a neuro-regulator in the brain, increases dramatically in mother and infant (and father) during and after childbirth and is involved in positive feedback mechanisms, social approach, bonding and building trust (Kemp & Guastella, 2011; Kimura, Tanizawa, Kensaku, J, & Hiroto, 1992; Kosfeld, Heinrichs, Zak, Fischbacher, & Fehr, 2005). Clark et al. (2013) found that "infants with higher CSF OT (Cerebral Spinal Fluid Oxytocin) levels appear to actively seek parental social interaction for soothing, and have a greater interest in social interaction as measured at 6 months of age" (p.1210).

Safety is understood in the first instance to involve the experience of physical holding and care for the infant, and impacts on the evolving psyche of the baby and the integration of body and mind:

> As the baby takes in milk, he also takes in the experience of an interaction, a carer motivated to feed him by her concern for his growth and well-being. The feed constitutes, at a somatic level, an experience of the capacity to take inside physical nourishment but also an experience of feeling thought about and attended to" (Elfer, 2011, p. 228).

A dual ingestion process occurs at an emotional and physical level, and is what provides the infant with their experience of 'containment'; that of feeling held physically and mentally (Bion, 1985), which Fonagy (2010) asserts leads to the ability to 'mentalise'. The ability to mentalise involves the capacity, as the infant matures into later childhood, to develop a "reflective self, the internal observer of mental life, the dialectical complement of the experiencing self (Fonagy, Steele, Steele, Moran, & Higgitt, 1991, p. 202).

Capacities for growth: There is an enormous capacity for triggering endogenous opiates in the infant's developing brain through mirroring systems that promote healthy attachments through mutual gaze, building in pleasurable states for the mother and infant and the capacity to recognise each other's feeling states (Schore, 2003b, p. 15). The more the infant experiences pleasurable and attuned interactions during this early formative stage, the greater the influence on the neural pathways being formed. Interactive representations are seen to become encoded by the end of the first year of life, with an "expectation of being matched by and being able to match the partner, as well as 'participating in the life of the other'" (Schore, 2003b, p. 15). Infants undergo significant maturational changes in the prefrontal cortex by the end of their first year, and this area is identified as important for infant self-regulatory behaviour and attachment. Important neural configurations are occurring in this 'convergence zone', which ultimately acts as the control

centre for autonomic, emotional processing. What is stored in the infant's early forming procedural memory comes directly from "regulated and unregulated affective experiences with caregivers" (Schore, 2003b, p. 20). Schore (2003b) advocates that the continuity of this experience lays the groundwork for the infant's own capacity to potentially achieve a 'reflective self' by 18 months of age, and, throughout the second year, the formation of a 'theory of mind' whereby the infant can ascribe meaning to the behaviour and mental states of others and of self. By the middle of the second year, when the normal child has some 15 words he/she can utter, the orbital frontal cortex matures. The foundation has been laid, and the "core of the self is thus nonverbal and unconscious, and it lies in patterns of affect regulation" (Schore, 2003b, p. 22).

Supporting intuitive competencies: Papoušek (2011) argues that "nature has paved the ground for a precious resource embedded in the parent–infant system by providing the infant with extraordinary capacities and the parent with complementary and supportive, intuitive competencies for preverbal communication" (p.42). Early intervention can provide critical opportunities for promoting those 'extraordinary capacities' and 'intuitive competencies'. Letourneau et al. (2015) contend that infants, toddlers and young children exposed to early relational trauma can find 'corrective attachment experiences' within their environment which may offer them security, with direct infant/mother work offering reparative opportunities. Their meta-analysis of seven mother-infant intervention programs focussing on maternal sensitivity and/or maternal reflection found that "compared to infants who did not receive the attachment intervention, infants who received the intervention were nearly three times as likely to be securely attached" (p.383).

The findings from a recent exploratory study suggest maternal sensitivity and responsiveness may ameliorate some of the impacts of violence on infant development as mothers attempt to

compensate for the violence endured. The study involved 51 toddlers who had been exposed to family violence within their first 12 months, using video observational measures, standardised scales and semi-structured questionnaires (Letourneau et al., 2013). The act of leaving a violent relationship takes enormous courage and strength, and is a step towards recovery for many mothers which is further bolstered when combined with access to inter-personal support (Anderson et al., 2012). This can spill over to the infant, and as research suggests, children too possess some levels of resilience in the face of adversity (Martinez-Torteya et al., 2009; Masten, 2011). A study by Letourneau et al. (2013) found that infants themselves seem able to bring compensatory aspects to mother-infant relationships impacted by violence, facilitating improvements in those relationships.

The subjective infant

That infants may be capable of bringing something to their relationship demonstrates that infants possess their own self and, as such, 'subjectivity'. This opens the door to an examination of what infants themselves bring to not only therapeutic work but to infant research. "We view the baby as having a mind and an intentional self from birth, who very early recognises his or her own body and feelings as different from those of others and who has capacity for empathy" (Thomson Salo, 2007, p. 183). Viewing the baby "as a subject, in his or her own right" (Thomson-Salo & Paul, 2001, p. 14), as well as an entry point for facilitating change, is a seismic shift in thinking for many professionals (Bunston, 2008b, 2011; Thomson-Salo, 2012; Thomson-Salo et al., 1999). Jones (2007) in her eloquent paper on the 'hospitalised' infant argues that the infant has an "equal right to participation in the therapeutic process" (p.146). She builds on the work of others who are promoting the need to not only recognise, but work with, the subjectivity of the infant (Morgan, 2007; Thomson-Salo & Paul, 2001; Thomson-Salo et al., 1999).

Recognising that the infant offers something to the relationship with their carer does not discount what attachment theory brings to our understanding of infancy but rather enhances it (Stern, 2003). It speaks to the capacity of the infant to bring something of themselves, as embryonic as it is, to their relationship with others. This perspective was influenced by the pioneering work of Winnicott (Winnicott, 1960; Winnicott, 1970; Winnicott, 1971/2005) and other influential thinkers who recognised the need to involve the infant in their work with families in order to avoid becoming steeped, along with the parent, in perceptions of the infant that were potentially problematic (Fonagy et al., 1991; Stern, 2003; Trevarthen, 2001; Trevarthen & Aitken, 2001). It is seen as imperative for the infant to be included in therapeutic work that concerns the infant; without this inclusion, "something that is not faced in the mother is not faced in the baby. It gets repeated in the baby and this leads to the intergenerational transmission of difficulty" (Thomson-Salo & Paul, 2001, p. 14).

The baby makes a difference: Involving the infant as a crucial and very active participant in work with families utilises a subjective 'infant-inclusive' approach. (Morgan, 2007). This approach recognises that the baby makes a difference, and changes the dynamics within the couple relationship. While Morgan appeared to be working with families where there was no overt violence, the perturbations caused by the anticipation and arrival of a new baby will equally apply to those families where there is. The inclusion of infants and subsequent engagement of them in the therapeutic process makes a difference. This is seen to be the case because every family member is considered equally. 'Coming to know' the infant can be revelatory in the therapeutic setting, creating an awareness where something new can emerge, "and what can emerge may be a thought, an opportunity to feel there are other ways of being" (Morgan, 2007, p. 12). Morgan is referring to the therapeutic arena. However, the same view can be applied to research.

Researching the 'subjective' infant: Research into the mother-infant relationship can eschew the perspective of the infant, essentially relying on that of the parent/s, or further still that of the researcher interpreting the material of the parent (Buchanan, 2011; Peled & Gil, 2011; Weinreb et al., 2006). Research into the mother - infant relationship may risk collusion with the mother by privileging her perspective, largely by assuming that the infant has none. Opening up possibilities in research, which invites the perspective of the infant, may open up a space in which new information can emerge. This approach challenges the adult-centric thinking that dominates western cultures in both service delivery and in research (McIntosh, 2003; McIntosh, 2002). Thomson Salo (2007), in her direct work with infants who have experienced family violence, argues that it is about not treating the infant as peripheral to the proceedings by 'talking about' them or 'distracting' them with a toy, but rather 'tuning in' to the sometimes 'terrified' feeling states. This includes viewing the baby's "expressions as having meanings" (p.186).

Infant communication

Infants are social beings, seeking out various kinds of engagement with others. By the age of three months infants are able to work out their primary caregiver's communication patterns and attribute significance to these (Stern, 2003). The relationship centres on interpersonal satisfaction, and when these expected responses are disrupted infants possess the agency and motivation to communicate "distress and protest at the unnatural break-down in contact" (Murray, 1996, p. 368). "Winnicott concluded that young infants were remarkably sensitive, not merely to the physical parameters of their environment, but to higher-order personal qualities" (Murray, 1996, p. 365). The intricacies of infant communication, emotional capacities and feeling states has attracted much interest, with research clearly demonstrating that infants possess cross-modal sensory capacities from a very early age – capacities which are exhibited when their normal patterns of interacting with their caregiver are disrupted (Carpenter et al., 2009; Doom, Cicchetti, Rogosch, & Dackis, 2013; Stern, 2003).

The physiology of infant communication: The infant provides many physiological clues to our understanding of their feeling states. They relate to their environment through their ability to engage in, or disengage from, reciprocal gaze, and by touch, vocalisations, crying, sleeping and eating. Infants can arch their backs when distressed, can freeze, smile or flop (Liddle, Bradley, & McGrath, 2015; Murray, 1996; Spietz, Johnson-Crowley, Sumner, & Barnard, 2008). Bowlby, drawing on ethological concepts, proposed:

> several instinctual responses that mature in the course of the first year, namely sucking, clinging, crying, following, and smiling, become organised into attachment behaviour focused on a specific mother-figure during the second half of the first year (Bretherton, 1991, p. 17).

Just how often, or how seldom, certain behavioural responses are exhibited provides us with very powerful indices to the emotional world of the infant (Rifkin-Graboi et al., 2009). While infants rapidly absorb information from the 'outside in', within their first year of life they are equally preoccupied with the 'inside out', activating innate proximity-seeking behaviours to summon their caregiving environment to assist in regulating the slew of challenges they face physically in managing their physiological and affective states.

Recognition of others: An infant at two months can discern their mother's voice and by seven to eight months be guided by her emotional expression, as well as being able to follow the gaze of another (Fonagy et al., 1991). By nine months, infants will follow their mother's cue when witnessing how she interacts with a stranger, and can recognise when their affective states are at odds with what is being reflected in the face of another. By the infant's second year, they can demonstrate visual curiosity about another's feeling states and increasingly match this with verbalisation. They want to know about and understand what causes the feeling states they see

in others. Infants can, by three years-of-age, recognise that others have feelings and intentions that are distinct from their own. They can verbalise their own and others' feelings and "take into consideration the mental state of the other in planning and structuring of actions" (Fonagy et al., 1991, p. 204).

The language of infants: Another way in which infant communication has been conceptualised is through what is known as the 'Keys To Caregiving (KTC)' (Spietz et al., 2008). KTC was developed over two decades ago and has drawn on the research and literature to assemble a study guide on infant communication, creating an intervention program for parents that allows them to learn:

> … the 'language' of the young infant and their varied individual differences; how vocal, gestural, and bodily behaviors come together to signal what the baby wants and doesn't want; how to console or modulate infant state to enhance quality of mother-infant interaction (Jung et al., 2007, p. 201).

The work of KTC has specifically identified behaviours which correspond to six states of consciousness for the infant: sleeping states, levels of alertness, engagement and disengagement cues, and hunger as well as feeding. KTC incorporates The Barnard Model (1978) cited in Spietz et al. (2008), which describes a reciprocal relationship between the parent and infant with the parent holding the responsibility of responding to the cues of the infant in order to alleviate their distress, while the infant responds in turn, with each adapting their behaviour to accommodate the other.

Discordance in communication: When the infant's caregiving environment is not, however, in tune with the infant, it can be experienced by the infant as dismissive or even hostile. Fraiberg (1982) proposed that in order to protect themselves from such situations, infants behaviourally

respond with whatever capacities they have at their disposal. These include: *avoidance,* involving averting their gaze from that of their caretaker as painful mental representations are evoked by their image; *behavioural reversals,* where self-harming diverts aggression away from their caregiver to themselves, ie., pulling their own hair, banging their heads; *immobilisation,* involving dissociation and shutting down; and *fighting*, by directing their aggression towards their caregivers and exhibiting emotional collapse. Two week-old infants have been noted to show organisational behaviours intended to protect themselves when their caregivers have failed to do so (Groves, Lieberman, Osofsky, & Fenichel, 2000 cited in McIntosh, 2002).

Appleyard & Osofsky (2003) report that infants and toddlers who have been exposed to either family or community violence display erratic mood swings, separation anxiety, developmental regression and sleep problems. The child's behaviour was particularly impacted by violence in the home, to the extent that they were less likely to play or explore, smiled infrequently, appeared to become dazed, avoided contact with others and lacked an interest in self-mastery of their environment. The infant possesses a subjective self which engages with their relational environment, even when using measures to protecting themselves from it (Schore, 2001; Zeanah & Scheeringa, 1997). Deciphering meaning from events does not happen in isolation for the infant, but through their relationship with others.

Inter-subjectivity

From the very beginning, the infant requires interaction between what is their emerging subjectivity and the subjectivity of others, usually their caregivers. Stern (2003) makes the delineation between 'primary inter-subjectivity', which he originally referred to as the sense of a core self (from birth) to a domain of core-relatedness (two to six months of age) where the infant recognises the mother is distinct from themselves, and 'secondary inter-subjectivity'. He believes

the latter to occur at around nine months, at which age the infant is able to match or read, as well as misread, the mental states of others depending on the continuity and quality of the caregiving relationship. However, he acknowledges that these delineations are somewhat artificial, as so much more research that contests the boundaries of what we thought we knew about the interpersonal world of the infant emerges. There is no contention within the boundaries of what we do know, however, that the construction of meaning about self and about others takes place through interactions. Infants begin to ascribe meaning to the behaviours of their caregiver as they accord with their biological needs and the way in which these are responded to (Stern, 2003).

Information is taken from the outside in, as infants organise their sensate experiences of caregiving responses, and from the inside out, as the infant matches and mixes these within their intimate relationships. Their experience of this interaction is then:

> … finally reinternalized in the infant's (and the caregivers') internal world … In other words, intersubjective interactions as observable behavior are modified by the intrapsychic representations of the protagonists, but the intrapsychic representations, too, are modified at the very same time by the actual intersubjective interactions (Bürgin, 2011, p. 111).

With-in, with-out and in-between: Inter-subjectivity begins, but does not end, in infancy. Interpersonal patterns repeat, re-shape and re-invent themselves throughout the individual's entire life depending on who comes into and out of their lives, and when and how (Ammaniti & Gallese, 2014; Bürgin, 2011). The individual is impacted by their own emotional state as well as the states of others, and interactively this happens together (see 'Inter-Subjective Constructivism' p. 87 for a more comprehensive explanation). The individual manages their internal world whilst evaluating the emotional states of others. This creates the inter-subjective processes that operate

with-in, with-out and in-between each other. Each person benefits from healthy and constructive exchanges throughout life, as "these processes of self and interactive regulation are simultaneous, complementary, and optimally in dynamic balance, with flexibility to move back and forth" (Beebe & Lachmann, 1998, p. 481). Accumulative stress, relational trauma and early childhood abuse do not support optimal balance and reciprocity in relationships. "Even highly competent parents can become destabilized under the impact of illness, loss, or other traumas" (Beebe, 2005, p. 8). 'Other traumas' would certainly seem likely to include such things as becoming homeless as a result of fleeing family violence.

Mothers and children in Refuge

The outcomes of research regarding the capacity of Refuges to provide refuge to the women and children who enter their doors have been mixed, with success most often equated to assisting them to not return to the perpetrator (Abrahams, 2010; Bell, Goodman, & Dutton, 2007; Davies, 2008; Gondolf, 1988; Gordon, Burton, & Porter, 2004; Horton & Johnson, 1993; Meyer, 2012; Postmus, 2003). Levendosky et al. (2002), suggest that:

> women who live in violent homes may never have the chance to recover while they remain in these physically and/or psychologically abusive environments. One would also expect that children living in domestic violence situations would struggle with similar cognitive and affective responses to the trauma of witnessing serious harm to their mothers (p152).

However, it is simplistic to think that leaving a violent partner/home and entering a Refuge ameliorates all of the harm caused by the violent situation. The fear of poverty, loneliness and having little support, together with the capacity for forgiveness, are what keep many women from leaving, and are the reasons for many returning (Davies, 2008; Gondolf, 1988; Gordon et al., 2004;

Horton & Johnson, 1993). As has already been noted, there are also high rates of repeat occupants in Refuges, suggesting limited options for mothers who leave the family home (Spinney, 2012). Additionally, recent trends have seen women and children encouraged to exercise their right to feel safe and remain at home, with interventions being developed to instead assist with the removal of the perpetrator (Spinney, 2012; Spinney & Blandy, 2011). However, it has been observed that just as entering Refuge does not remove all trace of the past traumas of family violence, neither does remaining in the home where these traumas took place (Bunston & Glennen, 2015).

When Refuge feels 'unsafe': Entering a shelter or a Refuge is seen as a last resort when no other accommodation is available. However, even then it may not necessarily provide 'refuge' for the child or their mother. One obstacle to mothers using Refuge is a fear that their children will be removed (Anooshian, 2005; McGee, 2000). Those entering shelters have experienced high levels of violence (Grossman & Lundy, 2011; Mertin & Mohr, 2002). Perlman, Cowan, Gewirtz, Haskett, & Stokes (2012) found that shelter life can often be experienced as over-stimulating, as in some services accommodation is shared with others, and mothers report feeling that they have little control over their surroundings. The sense of urgency in attending to their children, as well as to their own concrete needs, can supersede their capacity to be emotionally available, reflective and responsive to their infants. In such surroundings, mothers are having to parent in front of others and can feel judged or hampered in their attempts (Perlman et al., 2012). Similarly, children with difficult behaviours, or who may simply push what many consider to be 'normal' boundaries, might trigger negative emotions in the mothers, challenging their capacity for reflective functioning (David et al., 2012). Upon leaving the shelter, conflict can arise "as children finally feel safe enough to express emotions they have contained while living in the shelter " (Lindsey, 1998, p. 250).

Refuge as repair: Conversely, many homeless mothers prioritise their children and seek support by accessing crisis accommodation in a desire to provide their offspring with a better future and childhood than they experienced (Crawford et al., 2011; David et al., 2012). Tischler, Edwards, and Vostanis (2009), reviewing a number of studies exploring the impact of homelessness on mothers, identified that some women in fact experienced 'post-traumatic growth', developing new networks and exhibiting great strength and resilience. Within high-risk populations such as those that experience homelessness, there will also be those families who present as robust and capable of weathering the stresses of transience and poverty inherent in unstable housing (Gewirtz, DeGarmo, Plowman, August, & Realmuto, 2009). Refuge stays provide an opportunity for recovery and allow many women and children to receive services in-house, as well as to link into further service systems and assistance post-departure (Lyon, Lane, & Menard, 2008). Grossman, Lundy, George, and Crabtree-Nelson (2010) in their analysis of 70 DV services in Illinois found that "shelters do offer shelter" and:

> are an essential component of the service system for women who are victims of violence. Although their role as a place of respite and safety is critical, the findings suggest that they meet significant additional needs and continue to do so for many women after they have left. It seems imperative, given the scarcity of resources for women who are victims of domestic violence, to consider the ways in which shelter programs can better assist the women who use them (p.2087).

Mothers: Rather than proving to constrain the mothering role, the entry into crisis accommodation settings may be able to support the emotional sensitivity of the mother by assisting her to manage her own emotional distress. A growing number of researchers and clinicians concerned by the increase in the number of families experiencing homelessness are calling for flexible, therapeutic and integrated support services to be provided to these families (Brinamen, Taranta, & Johnston, 2012; Perlman et al., 2012; Tischler et al., 2009). "It is

conceivable that shelters can do much to support child-centred environments that support the caregiver in the parenting role" (Brinamen et al., 2012, p. 5). McGee (2000) found that Refuge staff were considered to be critical to women rebuilding their lives post family violence, with the women themselves frequently reporting that "they had received more support from Refuge workers than from any other source, including family and other professionals" (p.163).

Young children: Young children residing in Refuges or shelters can experience the presence of others as comforting and encounter, perhaps for the first time, just what a secure environment can feel like (Abrahams, 2010; Bunston & Sketchley, 2012; Jarvis, Gordon, & Novaco, 2005; McGee, 2000). For some families, the parent-child relationship may grow stronger during periods of Refuge stay, and that closeness may extend after the family moves into a home of their own. The caregiving environment in Refuge can be positive and it can be negative; either way, infants are hungry for relationships with others. Infants are highly available to engaging in relationships, with all interactions contributing to the emerging personality and development of the infant (Johnston, 2005). Most critically, opportunities for early intervention work abound in mother-infant work. The birth and early stages of an infant's life are periods of rapid change and development, for both infant and mother.

Crisis accommodation settings are a unique setting in which the caregiving environment – comprising both the staff and the mothers themselves – can offer healing and positive relational experiences (Brinamen et al., 2012; Keeshin et al., 2015; Lyon et al., 2008). Infants are biologically endowed or, as it is sometimes now termed, 'hard wired' (Siegel, 2001), to connect with their caregiving environment, and the neuroplasticity of the brain in these formative stages allows for remarkable opportunities for neural repair to occur, particularly in the first 12 months of life (Shatz, 1992). At the very least, infants entering crisis accommodation have been traumatised

through living and growing in potentially toxic and frightening caregiving environments, and, at the most, through their own direct experience of being harmed or caught in the middle of violent altercations within their family. How a Refuge service and the staff who work there offer the infants and mothers who enter their doors the experience of 'feeling felt' (ie., that another person is aware of and sensitive to how you are feeling) and 'feeling safe' is critical to offering refuge – the first imperative step towards healing and trauma recovery (Lyons-Ruth & Block, 1996).

Giving children their own voice

The research and literature on the impacts of family violence and homelessness on children clearly demonstrates that these impacts are often adverse and ongoing. These impacts may also be inter-generational and capable of being carried into their future lives as parents and the lives of their children. While much research has been undertaken 'on' children, less has been undertaken 'with' children. Children living with family violence are often identified as 'silent witnesses' (Jenney et al., 2006; Laing, 2000; McIntosh, 2003). Upon entering Refuge, children are further silenced as they are then hidden away from all that they know - their friends, school and local community (Barron, 2007; Women'sAid, 2015). McGee (2000) found that whilst children wanted to focus on their future after leaving violence, they were also extremely open to talking about their past experiences of violence and actually possessed amazing recall of violent events that occurred when very young. Children have been increasingly invited to participate in research that concerns them, sharing their stories about living with violence and what they have found helpful in their recovery post-violence (Baker, 2005; Barron, 2007; Jenney et al., 2006; Jouriles, Vu, McDonald, & Rosenfield, 2014).

It is no longer acceptable to exclude the voice of children in the very research that concerns them. It may not always be possible to include certain vulnerable groups, however, "sensitivity to the issue of including these groups in research, when possible, will help to prevent their under-representation in the scientific literature" (Moore & Miller, 1999, p. 1035). Children are now recognised as important contributors to our understanding of the complexities of relationships within family violence (Baker, 2005; Jenney et al., 2006; Jouriles et al., 2014; McGee, 2000; Morris, Hegarty, & Humphreys, 2012). This needs to be extended further to include the voice of infants. Those children 'accompanying' their parent/s are largely thought of as pre-school or school-aged rather than as infants. "The verbal (older) child receives a response because they can articulate their needs; the infant response is mostly limited to physical relief needs, such as food and clothing" (Glennen, 2011, p. 36).

Conducting ethical research with infants

Research into children has tended to operate from a deficits model, looking at what children cannot do rather than what they can, despite the enormity of the adversities facing them (Tay-Lim & Lim, 2013). Children have also been excluded from research that affects them directly. A young participant in a study conducted into 'Institutional Abuse in Australia' remarked: "I'm sad that they haven't talked to kids and only adults who were abused when they were kids, because it's probably still happening and kids now need a say too" (Moore, McArthur, Noble-Carr, & Harcourt, 2015, p. 69). *The United Nations Study on Violence against Children* (Pinheiro, 2006) urges researches to include the voice of children. They acknowledge that, as yet, there are no international agreements on just how this can be ethically achieved. In reviewing the literature, however, they found consensus around ensuring consent, confidentiality, privacy and protection from harm, as well as payment for participants.

The right to be heard: To remove the voice of children is to remove their perspective, as "the silencing of the child in effect constitutes another level of the elimination of an important category of knowledge, namely the knowledge of the child" (Schmidt Neven, 2007, p. 202). The *UN Charter on the Rights of the Child* is unequivocal: children have the right to be protected and kept safe from violence (UN, 1989). They also have the right to be asked about their experience of violence. The *UN Report on Violence against Children* recommends that research be specifically carried out with groups of children where they are identified to be most at risk of violence (Pinheiro, 2006).

In summary

The literature demonstrates that infants and mothers who are exposed to family violence and homelessness are detrimentally impacted. The implications of such exposure within the infant's first year of life are particularly far-reaching and profound, involving not just the negative effect that this exposure has on the infant's relationship with their primary carer but a probable negative impact on the infant's growing sense of self, both separate to and in relation to others. Further still, while the potential for long-term difficulties exists for the still developing infant, so too there is great potential for relational repair. Women's Refuges act as one of the major frontline services in supporting women and their infants escaping family violence. Women's Refuges also offer a unique setting within which to explore what the experience is like for the infant and mother who have left a violent home in order to seek safety with a crisis accommodation setting. Part Two of this thesis explores the way in which infants can be ethically and respectfully included in research that so immediately and intimately involves what is offered to them within such settings.

PART TWO

CHAPTER FOUR

Placing the experience of the infant at the centre of this study is the first and foremost priority. The research process seeks to look to the infants themselves in order to understand what provides the infant with the experience of 'finding refuge' within a context that is Refuge. This involves an exploration of what occurs for, with, and to the infant to facilitate feelings of safety. The focus is on the infant whose voice is least acknowledged in our society: the pre-verbal infant aged 12 months and under. The six general questions guiding this research enquiry, and presented in part on p.13 of this thesis, are:

- 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?
- 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?

Chapters One and Three addressed the importance of the infant having their emotional needs met over and above those needs that are predominantly physical, as these two spheres are critically linked (Winnicott, 1965, 1970). How the infant is attended to, engaged with and thought about in relation to their physical care is imperative for their healthy growth and development (Beebe, 2006; Beebe & Lachmann, 1998; Bowlby, 1951; Fonagy, Gergely, & Target, 2007; Fonagy et al., 1991; Hesse & Main, 2006). Where an infant has experienced significant trauma such as family violence, this imperative is much greater. These questions intend to flesh out what is understood

about what an infant needs from their mother and from the Refuge settings after departing the experience of family violence, and how these needs are attended to. This might involve the ways in which the infant is included in interactions, spoken or not spoken to, and how they are put at ease in an unfamiliar setting (Herman, 1992; Morgan, 2007). The distinction between "refuge" as an emotional state and, for the infant, ultimately a relational experience, and the Refuge as an environment, is also of importance to the research (Bowlby, 1988; Rabben, 2012; Rifkin-Graboi et al., 2009). This includes when the infant feels distress, or already has a heightened anticipation of frightening events or interactions, what is done to bring them to a physiologically settled and relaxed, rather than defensive, state (Van der Kolk, 2014). Finally, what enables an infant to experience safe refuge and how is this shaped by what both their mother and the Refuge staff provide?

As discussed in Part One, in order to illuminate the world of the infant their subjectivity needs to be honoured. To actually understand the experience of the infant, they must be seen in the context within which they are functioning. This is the means by which voice can be given to their perspective. This is expressed through the inter-subjective relationship that is co-created with their mother as well as others, and which communicates their experience of finding refuge within Refuge. Five key criteria were developed to safeguard the subjective perspective of the infant alongside the mutuality of experience and meaning created through the other key players crucial to the provision of refuge. These 'key players' are, of course, their mothers, together with those who operate as the human fabric of the Refuge – the workers, managers and other key personnel. The criteria below also acknowledge the voice of the researcher. These criteria are:

1. The experience of the infant is paramount and needs to remain so

2. Ethically sound methods sensitive to both the infant and Refuge setting are imperative

3. The context of Refuge can be understood through the collection of data from the multiple sources that constitute Refuge

4. Knowledge about how the infant makes meaning is integral

5. The voice of the researcher needs to be made transparent

The development of the first four criteria emerged directly from the comprehensive review of the literature undertaken in Chapter Three. The fifth criterion recognises that embedded throughout the entire thesis is the interpretive nature of what is researched and how this is then presented through the voice of the researcher. The privileging of the 'experience' of the infant within research requires what Reddy & Trevarthen (2004) argue is crucial: that as researchers working with infants "we have to engage with them, allowing ourselves to feel the sympathetic response that the other's actions and feelings invite" (p.9). It is this that enables the researcher access to what provides the greatest amount of information about their world. This last point needs to both be made overt and appreciated for the 'inter-subjective' value it brings to the process of respecting the 'subjective' experience of the infant involved in research.

This fourth chapter will explain what an 'infant-led' research methodology is (Bunston, 2008b; Paul & Thomson-Salo, 1997). The new synthesis draws on "constructivist grounded theory method" (Charmaz, 2003, 2008; Charmaz, 2014) to bring forth the perspective of inter-subjectivity inherent in striving to remain infant-led. What this offers is a way of understanding the perspective of the infant within the environment of Refuge. This current chapter informs the reader of an epistemological connection between inter-subjectivity and constructivism in order to provide an effective framework for guiding the methodological approaches and subsequent methods selected in meeting the key criteria of this study. The epistemology, methodology and methods utilised will be detailed. The chapter then moves to provide evidence of the way in which

the data was coded and analysed before concluding with a summary of the steps involved in ensuring rigour and trustworthiness throughout this process.

Epistemology

Meaning-making is relational

An infant builds knowledge not in isolation but through their interactions and emotional engagement with others. This is not to say that infants cannot make meaning by themselves:

> but self-organized, coherent meaning-making is limited; they cannot sustain it for long periods. Without the provision of external resources, their ability to self-regulate attentional and affective states diminishes and their capacity for meaning-making flounders" (Tronick & Beeghly, 2011, p. 109).

Essentially, the 'making of meaning' for the infant is co-constructed and needs to be understood within that context. Of course, every other player in Refuge – the mother, the worker and the manager - also make meaning of what they experience. As with any exploration into human phenomena, making meaning of what is experienced is highly relational, representing as it does that "which cannot be known except through another subject; in this case the researcher" (Hollway & Jefferson, 2000, p. 4).

It is important to acknowledge one of the most dominant theoretical and research constructs widely used in, and integral to, an understanding of infant development: that of attachment theory (Bowlby, 1969/1982; Bowlby, 1988; Main, 1991; Main, 1999; Salter-Ainsworth, 1991; Salter-Ainsworth, 2014). The procedures used to measure attachment styles are not appropriate to the sensitivity of the Refuge setting, nor is measuring the infant's attachment the actual purpose of this study. Nevertheless, this research will remain cognisant of both the attachment

styles that may be indicated within the observations and interview sessions with the infant and the mother. The greatest attention will be directed towards what it feels like to engage with the emotional world of the infant, and what inferences can be made from this (Caron, Sobreira Lopes, & Schneider Donelli, 2013; Ingram, 2015; Morgan, 2007; Reddy & Trevarthen, 2004).

There are many theoretical perspectives concerned with 'making meaning'. Within a research setting, the sociological perspective of 'symbolic interactionism' calls for the researcher to truly capture the social phenomena of the individual/s being studied and the meanings attributed to them by the researcher (Crotty, 1998). This belongs within a branch of social research known as an interpretivist approach, which is particularly concerned with meaning-making and privileges both culture's impact on the person as a social being and how this social being learns to think in relation to others. For many researchers who use an interpretive approach, dialogue is seen as the discourse necessary to interpret as it is definitively human (Mininni, Manuti, Scardigno, & Rubino, 2014). Whilst this hermeneutic approach sees language as crucial, knowledge about the capacities of the preverbal infant is better situated in a framework which values not what is thought or spoken about, but what is seen and felt (Reddy & Trevarthen, 2004). This research is interested as much in the emotionality of the infant as in the infant's behavioural world, as in essence, one informs the other.

An inter-subjective approach

Privileging what is seen and felt in the process by which infants make meaning has been used to inform the way in which this research is undertaken and consequently understood. This honours a space in which to make meaning and to discover what may be happening for the infant, without pretending that this meaning is absolute. This is in preference to assuming that we already know the answer, as can happen when making an assessment of behaviours measured against pre-

existing templates or validated scales of assessment. Non-verbal infants are understood to engage in proto-conversations, motivated by companionable engagement and developed through the creation of a cooperative inter-subjectivity with their caregivers (Trevarthen, 2001). Where this research approach differs to other interpretive approaches is in its recognition of the inner world experience and its mutuality of construction, particularly in reference to the infant. 'Making meaning' for the infant is pre-symbolic, and despite evidence of their amazing cross-modal capacities just days after birth, "it is radically different from the representational meaning made by older children and adults, but it is meaning nonetheless" (Tronick & Beeghly, 2011, p. 107).

Beebe and Lachmann (1998) identified the need for infant research to recognise that the 'inner' and the 'outer' worlds are co-constructed, and thus are not separate domains. "We distinguish between the two domains, but see them as fundamentally coordinated. By not privileging 'inner' or 'outer', and by emphasizing their reciprocal co-construction … we defined a dyadic systems view integrating self and interactive regulation" (p.280/1). Beebe's research work, amongst others, has kept its lens firmly trained on the interactional world of the mother-infant dyad and how this translates to other relational dyads such as therapist/patient work (Beebe, 2006; Beebe et al., 2011; Stern, 2003; Tronick, 2001). It is this interactive regulation that co-constructs the infant's emotional self, and is a major developmental task in early infancy.

Constructivism: This research is drawing on a body of knowledge particular to the co-construction of meaning between the infant and their mother. This sits within a broader landscape of meanings constructed by multiple others, specifically the Refuge workers and key informants, and further still, that of the researcher. Constructivism incorporates the researcher within the picture and Charmaz (2014) argues that "researchers, not participants, are obligated to be reflexive about what we bring to the scene, what we see, and how we see it" (p.27).

Constructivism is generally applied to qualitative research approaches. As will be explained more fully later (see 'Inter-subjective Constructivist Grounded Theory', p. 91 of this research), this type of approach complements the interpersonal nature of this research. To take one perspective alone diminishes not only the credibility of the research but its capacity to offer a comprehensive picture of what is a complex social and emotional manifestation. Medico and Santiago-Delefosse (2014) argue that there cannot be scientific validity within qualitative research "without explicitly acknowledging subjective and intersubjective processes, as well as the specific contexts in which researchers generate and analyze data" (p.350). They refer to the 'phenomenon of resonances' which calls for clarity around the processes researchers undertake in the interpretation of their data. Providing transparency around what you have done as a researcher involves an ethical component, whilst being deeply etched in a recognition of the subjectivity we each bring to our work as researchers. In line with this commitment to transparency, this chapter will not look at what was intended but what was actually undertaken in order to reach its final conclusions.

Inter-subjective constructivism: Bringing 'inter-subjectivity' and 'constructivism' together makes explicit the different contexts of relatedness which are active in, and relevant to, this study. This is important for all participants, but particularly so for the infant's dyadic development in relation to their mother. 'Inter-subjective constructivism' also recognises the infant's inner and outer world, together with the inner and outer world of the other participants involved in the research, including the researcher. In order to make explicit the 'inter-subjective system' as defined by Medico & Santiago-Delefosse (2014) within the context of this research, the acknowledgement of the researcher role and the subsequent choice to use a constructivist framework to make sense of the landscape being explored is important. This is in recognition of a belief that what is taken from the data is not simply discovered but co-constructed, and that this co-construction is derived from "past and present involvements and our (the researcher's)

interactions with people, perspectives and research practices" (Charmaz, 2014, p. 17). What remains then is how to purposefully keep the experience of the infant paramount within this 'inter-subjective constructivist' approach.

Infant-led research

The notion of conducting infant-led research has been directly influenced by adapting the clinical practice of being infant-led. This clinical practice recognises:

> the baby as having a mind and an intentional self from birth, who very early recognises his or her own body and feelings as different from those of others and who has capacity for empathy (Thomson Salo, 2007, p. 183).

This considers the "baby as a subject, in his or her own right" (Thomson-Salo & Paul, 2001, p. 14) and involves seeing the infant as "the entry point" for facilitating change in the therapeutic domain (Bunston, 2008b, 2011; Thomson-Salo, 2012; Thomson-Salo et al., 1999). Placing the infant at the forefront of our research achieves three things. Firstly, it affirms that the infant does indeed have something to say. Secondly, it involves a deliberate choice to collect the data, as much as is possible, from the infant before collecting it from their mother or the workers. This also includes undertaking the analysis of the infant data first. Thirdly, in the final analysis of the infant data the key themes then emerge, acting as the foundation for all others (mother and Refuge staff/key informant interviews). The subsequent analysis of all other data then either collapses into these foundational themes or is significant enough to 'stand-alone' (see Diagram 1., p. 123). These steps are taken purposefully so that the infant's subjectivity will not get lost in a sea of other more dominating, competing, yet equally essential subjective perspectives. As the infant is totally dependent on others for their survival, they are the most vulnerable participants in this study. Keeping the infant 'front and centre' gives their experience better odds of becoming known. This allows the least powerful voice to take precedence and create "dialogue about vulnerability

from the perspective of the person experiencing it … Because persons who are vulnerable are at greater risk of not being heard" (Hall Gueldner, Britton, & Terwilliger, 2012, pp. 125-126).

Methodology

There are no road maps available on how to navigate this new area of research. Using the guide posts provided by the criteria outlined above, an approach on how to enter this new terrain needed to be flexible, sensitive and trustworthy. It is not only the infants in this study who are vulnerable. Their mothers also face considerable disadvantage. They have experienced significant trauma as a consequence of having fled not only a violent relationship but their home. Many will often have arrived with little more than what they could carry or load into their car. Similarly, working in Refuge is not without its drawbacks. Comparably speaking, staff in Refuge enjoy considerably less job security, income and status than their colleagues in other parts of the family violence and/or welfare sector (Haldane, 2010; Srinivasan & Davis, 1991). Furthermore, the locations of Refuge are predominantly kept secret to prevent violent partners from arriving to 'forcibly' remove partners and children. Circumstances where a violent ex-partner has discovered the location of a Refuge and attempted to forcibly enter, harm and/or even kill is not an unfamiliar occurrence in these settings (Patton, 2003; Theobald, 2014). As such, gaining entry into such locations required proof that the researcher was trustworthy. This included being flexible, sensitive and responsive in the choice of the methodological approach without compromising its veracity.

Qualitative Research: The choice to use a qualitative approach was deliberate. Whilst quantitative research approaches are invaluable in testing hypotheses, focusing as they do on the minutia and measuring, quantifying and either confirming or disproving hypotheses, they do not allow for discovery of unchartered territories (Denzin & Lincoln, 2003). In fact, the use of

mechanistic approaches with fixed data collection methods may inhibit and even risk distressing the participants in this study. What is being encouraged here is an actual study of what is a relational, as well as an experiential, process. This means embracing participants' personal interactions, and no more so than with the infants. Murray (1996) argues that using quantitative approaches in infant research comes at a cost : "What is problematic, however, is that in the cause of scientific rigour a reductionist account of infant interpersonal relations was produced, and indeed almost as many questions were begged as were answered" (p.364). This research aims to open up and discover what has, until now, been largely unknown. It is too soon to look towards narrowing down this area of enquiry when so much needs to be revealed. Srinivasan & Davis (1991) used a participant observation approach to study in detail the organisational environment of one particular shelter. They argue strongly that a qualitative approach was the most conducive to understanding such a setting, as it was within the listening and observation stages that they were able to compare and distil "the subtleties in the verbal and nonverbal communications" (p.55).

Qualitative research offers a naturalistic approach, studying as it does activities that can seek to preserve the phenomenon of interactions within that particular environment (Silverman, 2013). Importantly, this means using an approach that does not impinge on an already sensitive setting. Methods of collecting material for analysis are subjectively orientated, privileging the meanings given by those who are the subject of the study. Denzin and Lincoln (2003) propose that the qualitative researcher extracts intricate, studied representations from multiple sources within a specific setting, viewing the subject of the study as interactive and impacting on an audience, rather than objectifying the subject under the scrutiny of the social scientist's gaze. These multiple sources allow for triangulation, providing credibility by deriving findings from alternate sources that affirm, as well as enrich, the depth of the outcomes of the research overall. This then provides flexibility in entering a particular setting that possesses its own history, culture and purpose, and

aligns the rich texture of differing perspectives, voices and circumstances to come together as a whole (Denzin and Lincoln, 2013). Most important was the selection of an approach that was "not beholden to methodological dogma" and which allowed a 'tailoring' of what is appropriate to the context being entered "without sacrificing methodological integrity" (Stern & Porr, 2011, p. 14). The following section describes the type of qualitative approach that was used.

'Inter-subjective' constructivist grounded theory method

Charmaz (2014) argues that in using Grounded Theory Method (GTM), "concepts can travel within and beyond their disciplinary origins" (p.14). Developed by Glaser and Strauss in the 1960s, this qualitative approach was seen to draw on the strength of empirical rigour in data analysis. Furthermore, this occurred without a discarding of the input of existing knowledge and accepted interpretive understanding and meaning to further extend conceptual theory (Charmaz, 2003). GTM originally contended that the researcher could retain distinct objectivity, thus allowing the data, rather than the researcher's interpretation of the data, to dictate the emergent theory (Bryant, 2003; Tolhurst, 2012). In GTM the collection of data slowly builds and is methodically coded, compared and analysed in order to enable patterns to emerge under themes and clusters that lead to concept development (Bryant & Charmaz, 2007). GTM within a constructivist paradigm acknowledges the subjectivity of the researcher's interpretation of the data. Constructivist GTM is adaptable and organic:

> When constructivist grounded theorists enter research sites and engage their data, their perspectives may grow and/or change, and thus permit the structure of inquiry, as well as its content, to be emergent. Researchers who treat grounded theory as consisting of a few flexible yet systemic guidelines create the conditions to define emergent categories (Charmaz, 2008, p. 161).

This enables a flexibility which is congruent with, and enables an unencumbered flow to unfold within, human systems of inter-acting and functioning. This places the onus on the researcher being able to adapt to the Refuge environment, not the Refuge environment being required to adapt to the researcher.

Four basic principles of GTM

The rigour of GTM rests within its commitment to four basic principles (Stern & Porr, 2011). These are as follows:

Principle One: The first principle is characterised by the undertaking of an inductive rather than deductive process, replacing the need to verify positivisms with the need to explore and uncover meaning straight from the data. There is not an already-deduced hypothesis which is being tested; rather, there is the opportunity for the data itself to directly generate new theory. Charmaz (2014) acknowledges that there are finer nuances at play here than the data simply being interpreted and analysed free of any existing biases or perspectives. Just as the participants in qualitative research possess inside information about the world seeking to be discovered, so too does the researcher bring existing knowledge and questions. The way in which this is accounted for and made transparent is important (Medico & Santiago-Delefosse, 2014).

Principle Two: The second principle is concerned with the explanations that make meaning out of what these explorations reveal, providing rich and thick descriptions which then explain this meaning-making process (Stern & Porr, 2011). More than this, however, it is important to make overt the abductive reasoning involved in the data collection and analysis process. The onus is on the researcher to make clear their perspectives, influences and processes, but further to ensure that a substantive logic is provided in order to explain the way in which the findings were

discovered. All possible interpretations of the data need to be considered before arriving at the most likely explanation, which "relies on reasoning – making inferences – about empirical experience" (Charmaz, 2014, p. 201).

Principle Three: The third principle involves trusting that this 'meaning-making' will emerge from the intimate relationship the researcher forms with the exploration of the data. This exploration requires due diligence – simultaneously collecting and analysing data and then providing a clear pathway to indicate just what was done, what meaning was made of it, how this meaning came to be made and where this took the research next (Charmaz, 2014). The sensitive nature of this research made the issue of 'where to look next' in the search for anomalies in theoretical sampling difficult. This is because the data that could be collected was dependent on which Refuges allowed me entry, and, once inside the Refuges, which mothers were willing and available to be involved in the study. However, the 'logic' of theoretical sampling was applied nevertheless, through the application of the final principle. This involved going back to the data in order to re-examine the categories as an emergent process before returning to gather more data – not to find saturation, but to "subject [your] new theoretical interpretations to rigorous empirical scrutiny" (Charmaz, 2014, p. 201).

Principle Four: The final principle adhered to was the 'constant comparative method'. As described by Stern & Porr (2011): "This recursive overlap of data collection and in-depth scrutiny is at odds with linearity and leaves you, the grounded theory detective, not knowing what might be around the corner" (p.44). What distinguishes this approach is the preparedness to look around that corner and to then explain what you see. In moving onto the task of outlining the methods used in the data collection process, the commitment to ensuring that the infant remained central to this research will also be described.

Methods

No documented research has been carried out on the experience of infants in Refuge. What small amount has been undertaken in relation to infants and domestic violence has, in my opinion, relied on the use of methods neither suitable nor ethical for this study. One study involving infants exposed to family violence relied on a laboratory procedure which deliberately induces moderate stress in the infant to measure their attachment to their mother (Levendosky, Bogat, Huth-Bocks, et al., 2011). I believe this is neither ethical nor appropriate for infants who are already highly likely to be stressed coming into Refuge. Another study omitted the presence of the infant altogether by solely reporting the mother's account (Buchanan, 2011; Buchanan et al., 2013). Understanding what is provided to the infant coming into a Refuge setting should not occur in isolation of the infant themselves. Relying on the measurement of responses to contrived situations and/or relying on mothers' reports is common in research with infants and children. Another method, as already noted (p. 60), is the filming of mothers and their infants (Beebe, 2005; Hoffman, Marvin, Cooper, & Powell, 2006; Tronick, 2007). This, however, risks impinging on the already constrained space for the infant and mother, the privacy of others and the replication of the 'monitoring' experience many women have already endured from their partners. Incorporating filming in this research would also have required a level of organisational consent that was likely to have created even further obstacles to my being allowed access. More importantly, the reliance on the equipment required to adequately capture and film the experience of being with the infant would also have potentially served as the greatest inhibitor to making myself, as researcher, fully and totally present. Unobtrusive, flexible methods which were sensitive to the circumstances that brought these infants and mothers to Refuge were required. Furthermore, sensitivity in negotiating with the Refuge system itself was imperative.

The implementation of the research

Gaining access to infants within this setting was, in the first instance, dependent on gaining entry into the Refuge. The secret and guarded world of Refuge was only able to open up to the implementation stage of this research through the use of existing networks and my tenacity in creating and following up a range of opportunities.

Opportunistic sampling: Refuges are typically accessed through considerable gate-keeping processes, often involving an umbrella service or peak body. It would be accurate to describe the means of gaining access to women's Refuges as purposefully shrouded. Screening processes are intended to protect the locations of accommodation in order to ultimately protect the women, children and staff from both perpetrators and voyeurs arriving unexpectedly. This meant that I needed to use the opportunities I had at my disposal to gain access to researching this hidden world. This could also be considered as using 'convenience sampling', where the emphasis is on accessibility (Marshall, 1996). The first two Refuges that initially agreed to be involved did so only because of an existing relationship I had with them. A visit to a state-wide meeting for women's services to speak directly about my research, and a follow-up email to all Refuges within the state, failed to elicit any interest in involvement in the research. A further two Refuges I approached directly would not grant access. The manager of one, rather than the workers themselves, felt concerned that the study's findings could be used to adversely criticise women's Refuges. The other Refuge manager was suspicious of my interest and the person who gave me their contact details was only cursorily known to her. A third Refuge that agreed to participate did not subsequently have any infants in their Refuge during the ten-month period of my data collecting. A fourth Refuge did not reject being involved, but put in place numerous impediments that made it difficult to gain access to the service in a timely manner.

Going further afield: In all other instances, personal introductions through established professional relationships with colleagues who could vouch for my trustworthiness were the key to recruiting a sufficient number of Refuges for the study. This involved using collegial networks considerably further afield than what I had originally intended. These contacts served as intermediaries. Once a Refuge indicated interest, contact was made with the Refuge itself. I sent information about my research, consent forms and my ethics approval paperwork to the specific Refuge so that they could discuss my entering their Refuge with either their management and/or board of management. Changes were made to these forms as appropriate to the different countries or regions in which the Refuge was located, and new ethics approval sought where necessary. No Refuge was chosen for any specific reason other than through the contacts I had and the location in which the Refuge was based. Rather, it was the Refuges which chose to allow me entry. In some respects, gaining entry to Refuges further afield than those based locally was easier. Three Refuges in the UK were able to be visited in conjunction with an already planned trip. Visiting two Refuges in remote Western Australia was possible due to a previous work colleague's move to this new location some time before I commenced the research. It could be suggested that overall, the willingness of Refuge staff to allow an unknown yet credible university-affiliated researcher into their Refuge increased the further away that researcher was based.

Communal Refuges: All eight Refuges were communal-based but varied in size and capacity. This means that all of the accommodation consisted of communal areas shared by all residents. The smallest Refuge allowed for two families at any given time, while the largest was a purpose-built facility with twenty-one independent units. No Refuges could guarantee at any given time that there would be any infants residing in the Refuge, as the nature of being a crisis-based accommodation service means that tenancy is unpredictable. Once in the door, the sampling was 'purposive' (Marshall, 1996), targeting infants under 12 months and their mothers, as well as

workers and key informants within, or associated with, those Refuges. At every juncture, this relied upon the ability to prove myself trustworthy, ethical and flexible.

The staff as gatekeepers: The potential for participants to be identified and then asked to participate in the study occurred only when the researcher was deemed 'trustworthy' by staff. The potential to communicate with staff occurred only once the researcher had been vetted by their managers within the Refuge, and in some instances further above them, by their operational managers. The researcher was required to fit in with the schedule of the infants and mothers as well as Refuge workers, ensuring that the research did not impinge on the day-to-day functioning of the Refuge. Visits were rescheduled when this appeared imminent. No research was undertaken until consent forms (see Appendix One) had been sent ahead to Refuges, and their boards of management or operational managers had given approval. No research was conducted with participants until information and consent forms were read, understood, questions asked and forms signed, including their right to withdraw. The researcher remained in touch with Refuge personnel and made contact details available to all involved. In order to gain access to the infant, I first needed to engage with the Refuge system and then their mother, as illustrated by Figure 1., below. Once the Refuge system allowed entry, the infant was able to remain at the forefront of the research, as is captured in Figure 2.

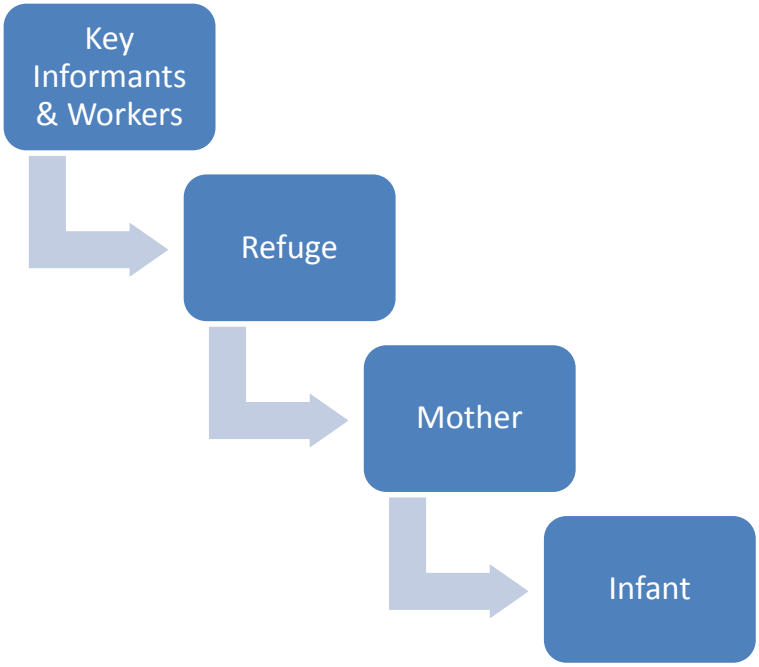

Figure 1: Steps towards gaining access to the infant

Data Collection methods and analysis

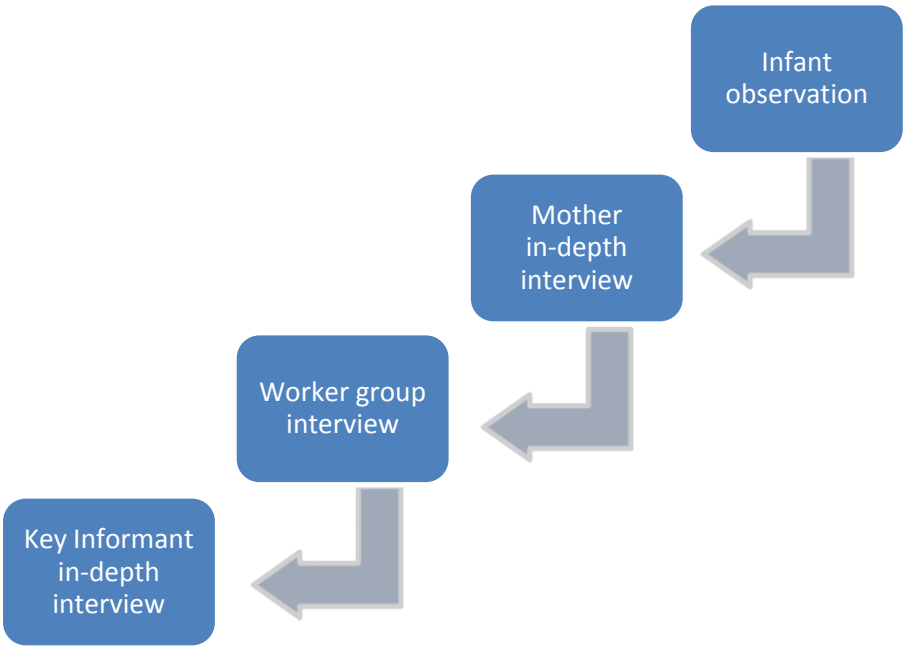

Figure 2: Data collection and analysis sequence

The Data collected

Surrounding the infant/mother dyad in this setting were the workers, managers and key personnel who provided the system of Refuge within which this study is based. The data collected, as will be explained, consisted of 15 separate 'infant observation' sessions involving 10 infant participants. 10 mothers were individually interviewed, 7 workers participated in two group interviews and 6 key personnel supporting the Refuge system were interviewed. Overall, a total of 33 participants were involved in this study. Eight Refuges were included across three different countries.

Infant observation

'Infant Observation' is a training method used in infant mental health to collect data in order to give prominence to the experience of the infant (Bick, 1964; Blessing & Block, 2009; Caron, Sobreira Lopes, Steibel, & Schneider Donelli, 2012; Monticelli, 2014; Rustin, 2009; Vliegen, 2006). The method of infant observation has a rich psychoanalytic tradition, where "seeking to access internal emotional states as well as the meanings of external behaviours, can be seen as giving expression to the 'voices' of the youngest children including babies" (Elfer, 2011, p. 225). This method of observation involves scrutinising behaviour in preference to analysing self-reports that offer attitudes (Abrahamson, 1983). The pre-verbal infant communicates through behaviour and engagement, and as such unobtrusive observation offers the most congruent way through which to collect data. Indeed, Caron et al. (2013) argue that in the arena of the infant, "verbalisation has no meaning" (p.170). Within mother-infant interactions, the way in which they relate to one another is of greater significance than what is spoken. Furthermore, the imperative of research within psychoanalysis is that the observer "repeatedly allows him/herself to be affected by the experience" (Caron et al., 2012, p. 229).

The observation of infants as a 'systematic discipline' was developed by Ester Bick in 1948 at John Bowlby's request, as part of his child psychotherapy training course at the Tavistock Clinic in London. Psychotherapy students of the centre were required to undertake infant observations and write up detailed process notes in order to "conceive vividly the infantile experiences of their child patients" (Bick, 1964, p. 240). More than sixty years later, this method of learning about others is still considered a highly developed and respectable line of inquiry (Rhode, 2004; Rustin, 2009). It has also been adapted to elucidate an understanding of other groups who are not language-dependent (including the elderly and the disabled) and is now widely applied to other settings and used by a range of professions, and in particular social work (Adamo, 2008; Briggs, 1999; Davenhill, Balfour, Rustin, Blanchard, & Tress, 2003; Dearnley & Hartland-Rowe, 2009; Diem-Wille, Steinhardt, & Reiter, 2006; Fleming, 2004; Hingley-Jones, 2011; Hughes & Heycox, 2005; Maliphant, 2008; McKenzie-Smith, 2009; Ng, 2009; O'Dwyer, 2008; Rhode, 2004; Shuttleworth, 2008; Trowell & Miles, 2004; Walker, 2008; Wilson, 1992; Zago, 2008).

Rustin (1997) suggests that infant observation as a research tool fits within a heuristic framework of knowledge generation. This involves capturing dense accounts of the infant/mother and other interactions that occur in Refuge. Furthermore, in order to learn about infants, Reddy and Trevarthen (2004) propose that the study of any system's behaviour requires the scientist to be engaged with that system and is akin to "Malinowski's celebrated method of 'participant observation' for the study of human communities and customs in unfamiliar lands" (Reddy & Trevarthen, 2004, p. 1). This ethnographic flavour, inherent in a participant observation approach, resonates with infant observation in its endeavour to:

> relate 'surface observations' to a deeper level of theoretical explanation, seeing observed cases as instances of a theoretically consistent model of behaviour, or enabling the latter to be elaborated according to the process described by Glaser and Strauss (1967) as the generation of 'grounded theory' (Rustin, 1997, p. 98).

'Infant Observation' calls for the researcher to be fully "present in the moment" and "open to perceiving as much as possible" (Rustin, 2009, p. 30). This has the dual emphasis on what is seen as well as what is felt. The observer does not take notes during the session as "this helps the observer to immerse herself in the emotional experience, while strictly respecting the setting, and, at the same time, being fully engaged in registering every event and indication of life and emotion" (Caron et al., 2012, p. 222). Immediately following each (approximately) one-hour session, I audio-recorded a meticulous and detailed process account of the session as an "untheorised narrative description of what was observed" (Rustin, 1997, p. 95). In every instance, this occurred within 10-30 minutes of the observation so that I could offer as accurate an account as possible, and in a private space well away from the infant, mother and staff. Included in this account was a record of the impact of the observation on the researcher and how the researcher was "affected by what took place" (Rhode, 2004, p. 284). I then transcribed these audio notes in verbatim at a later date. It is certainly acknowledged that the presence of the researcher in the room did not go unobserved, nor was it unfelt by the infant. As Reddy & Trevarthen (2004) argue, neither should the presence of the researcher remain 'unfelt'. This is the very essence and 'inter-subjective' nature of what creates this approach to researching the infant. Being actively, but quietly, present, and as a researcher formally qualified in 'infant observation' methods, this form of data collection centred around how to be in the presence of the infant and mother and "be receptive rather than [to] 'interfere" (Rhode, 2004, p. 284). This required the capacity to immediately be a moderating presence when necessary in order to put the infant and mother at ease. Additionally, this enabled the flexibility to accompany the mother and infant wherever they needed to go, should they need to move from room to room or go outside.

In-depth interviewing with mothers

In addition to the infant observation was the task of meeting each mother for an in-depth interview. This allowed each mother the opportunity to give her perspective on her infant's experience of being in Refuge, and what she considered gave her infant refuge. As the other key player in the primary dyadic system of mother-infant, her perspective was vital to understand. Ethically, the inclusion of the mother's voice both respects and recognises that neither perspective, hers nor her infant's, can be fully understood in isolation of the other. Building trust over time is an important element in the interviewing of hidden populations where sensitive and painful material may be involved (Booth, 1999). Unfortunately the luxury of time was not always available. However, in each case some preliminary evidence of my trustworthiness had been built through my earlier connections with the staff in order to gain entry, as a result of which the staff would then be more likely to vouch for my credibility. A pre-meeting with mothers to explain the research, and the familiarity that developed between us throughout the infant observation session, consolidated this further. Each mother participated in one interview only. All mothers had read to them, and/or were emailed a copy, of the interview, which was transcribed from an audiotape (two mothers who declined to be audiotaped were shown written process notes) "to verify their accuracy" of the interview (Carlson, 2010, p. 1105).

These interviews used semi-structured questions and acted as a guide only, in order to remain present in the conversations and not become distracted. Booth and Booth (1994) argue that good in-depth questioning ensures the participant feels in control and that recording methods, audio or note-taking do not dictate or interfere with the comfort levels of the participant, either consciously or unconsciously. It is important that the researcher adapts to the interviewee's environment, rather than stage-manage the process for their own benefit. In each interview, these key areas were covered:

- What circumstances brought you and your infant to Refuge?
- What previous experience have you had of Refuge?

- Did you experience family violence in your own (childhood) background?
- What do you feel provides your infant with a sense of refuge?
- What do you think your infant is making of their experience of being in Refuge?
- What do you think Refuge has provided for your infant and for you?
- What did you imagine Refuge would offer your infant and offer you?
- What more might Refuge offer your infant and offer you?

While these areas remained central in the questioning, they were not rigidly adhered to. Judgement and sensitivity was required, as the process involved entering the meaning-making and personal worlds of the mother and her infant (Minichiello, Aroni, Timewell, & Alexander, 2008). In circumstances where engagement is crucial to discovery, Minichiello, Aroni, Timewell, & Alexander (1990) argue that:

> It is more useful to see this method being employed as part of an exploratory study where the researcher is attempting to gain understanding of the field of study, and to develop theories rather than test them (p. 101).

Remaining flexible also allowed the capacity to drill down and follow the lead of the mother's answers, creating a more organic flow whilst retaining some ability to collate some general themes for consideration within the analysis. With the exception of one mother's interview, all of the infants were present with their mother whilst she was being interviewed. While my focus was primarily on the mother during the interview, this also provided me with another opportunity to witness interesting interactional dynamics between the mother and infant.

Worker group interviews

The workers are those who bring a Refuge alive. They make up the very essence of that which sets Refuge apart from simply offering a family a hotel room or an emergency housing commission property. Apart from offering an economy of time and resources (Minichiello et al., 2008), the group interviews conducted as part of this study respected the busy schedules of the Refuge staff and the small window of opportunity available to interview the workers as a group. Notwithstanding the politics of any given workplace, these workers were rostered on, and operated as, a group in their provision of services to the infants and mothers involved in this study. They are the caregiving environment for the caregiving system of the mother and infant. They had, as a group of staff, formed a particular working relationship which contributed significantly to the culture and dynamic of the experience that offered refuge within the Refuge. The inclusion of a group interview, where this was possible, offered a useful forum through which each group could reflect on what they believed refuge for the infant to involve, while also providing the research with a particular reflection from each distinct group. This allowed comparison and cross-referencing to occur across both of the groups that represented two of the three different countries. The interview formats remained flexible in order to allow an unstructured space within which group members were encouraged to feel they could control the direction taken, language used and meanings given to' refuge' (Liamputtong, 2007).

Key informant interviews

Whilst not initially considering the introduction of any further players, it became apparent that there were specific individuals who offered a unique perspective on this study by virtue of their longevity in the Refuge sector and/or position in relation to the state of play of a particular Refuge or the Refuge sector. These individuals included women who had occupied key positions of power regarding the ways in which Refuges provided care, and offered an historical, as well as contextual, perspective otherwise unavailable through the worker interview groups alone. In one instance, this included a worker who had previously been a resident of the Refuge in which she

now worked. A mother of two young infants while residing in the Refuge, this woman offered a unique perspective. Using an in-depth interview approach once again, I used these meetings to 'mine' for rich data regarding the prevailing and historical cultures that had, from their perspectives, informed the way in which Refuges had previously, and currently, operated.

The participants

A total of 33 people participated in this research. Ten of these were infants; however, 11 infants are referred to, as will be explained. Eleven mothers are represented in the data, but only ten were interviewed. Eight Refuges participated, three in Melbourne and two in the Kimberley region of Western Australia. The remaining three Refuges were based in London, England (one) and in Glasgow, Scotland (two). Five workers and four key informants were from the UK (London and Glasgow), while two workers and two key informants were from Australia. Information about the infants and mothers will be presented first (see Table 1 below). The participants are named via numbers rather than pseudonyms, as this is how I kept all of the data non-identifiable and clear in my mind throughout.

DESCRIPTION OF INFANT & MOTHER STUDY PARTICIPANTS *Table 1.*

INFANT'S AGE (months)	NUMBEROF OBSERVATIONS	NUMBER ASSIGNED TO EACH MOTHER	MOTHER'S AGE	CULTURAL IDENTITY*	NUMBEROF OFFSPRING	LENGTH OF STAY (days)	NUMBER OF ADMISSIONS
3	2	1	23	Australasia	1	4	1
4	3	2	40	Australasia	3	30	2
3wks	2	3	26	Asia	1	7	2
16	1	N/A	35	Africa	2	21	1
8	2	5	24	United Kingdom	2	352	1
11	2	6	33	Europe	1	90	1
4	2	7	32	The Americas	1	3	1
7	1	8	29	Africa	1	186	1
4	1	9	30	United Kingdom	1	5	1
6	2	10	28	Indigenous	4	3	5+
8	0	11	33	Australasia	4	30	2

* The cultural identities of the participants have been broadened to increase anonymity.

Infant & mother study participants

Three infants were observed only once, six were observed twice, and one was observed three times, totalling 18 different infant observation sessions. For all but one infant, this was their first admission into a Refuge. One infant had been in the same Refuge on two occasions. One infant was born whilst in Refuge and another arrived at Refuge two-and-a-half weeks post birth. Eleven mothers participated in the study but only ten were interviewed. The mother of the fourth infant chose not to proceed beyond her infant's observation. This appeared to be due to some conflict arising with the Refuge itself. The infant of the 11th mother was not awake when I arrived at the Refuge, so we proceeded with the mother's interview first. This was the only occasion on which the mother's interview occurred first. An appointment for the infant observation was then

rescheduled; however, illness within the family then prevented any further contact from taking place.

By virtue of being assessed as meeting the criteria for entry into Refuge, all 11 mothers and infants in total were classified as 'homeless'. Previous experience with the intransigence of living in multiple and not always adequate accommodation, which is also seen as a form of 'homelessness' (Chamberlain and MacKenzie, 2008), was indicated by six of the mothers. Seven of the mothers said that this was the first time they had been admitted to a Refuge, while one of these seven had been in multiple Refuges as a child. Three mothers had had one previous admission into Refuge, and one mother had had multiple admissions. The length of admission as noted in the table above was at the time of the last observation or interview. The infants ranged from three weeks to 12 months in age, with one 16 month-old also included. While the intention of the study was to focus on infants 12 months and under, there was confusion by a staff member about the age of an infant she believed was aged 12 months but was actually 16 months, a fact revealed in the observation session itself. Nevertheless, this observation proved very powerful and I felt that its inclusion offered something to the study.

The Infants

In total, five girls and five boys were observed. The infant of the 11th mother was a girl. The number of observations undertaken (approximately an hour each), and length of time between observations was determined by what opportunities presented themselves, both for the participants and myself. Only one infant was observed on three occasions, and this over a time period of one month. Six infants were observed on two occasions, with three of those at different times and in different settings on the same day. The remaining three observations occurred within the first week of these infants' stay. The infants who were observed just once were two

infants for whom the opportunity for only one visit was possible, this observation then being followed by an interview with the mother. The last infant to be observed just once, was the infant whose mother chose not to proceed further. In addition to this, all of the infants were present during the interviews conducted with their mothers except for the infant of the 11th mother.

The mothers

There was a diverse cultural mix amongst the participants. Of the 11 mothers, one was indigenous Australian and four were native-born (two Australian, two from the UK) to the country where the interview was conducted. The remaining five mothers were immigrants, with one mother on a visitor's visa. Five women were of colour - one Asian, one Northern European and four Anglo-Saxon. The strong ethnic presence could align with a commonly held perception that immigrant and black communities experience a greater prevalence of family violence than white western communities. Sokoloff and Dupont (2005) suggest, however, that racial and cultural differences diminish when socioeconomic considerations are take into account, and not least with the "high and extreme levels of poverty in Black communities" (p. 48). Furthermore, many studies have failed to appreciate the complexities and challenges inherent in migrating to another country (Vaughn, Salas-Wright, Cooper-Sadlo, Maynard, & Larson, 2014). This could equally apply to dispossessed indigenous populations.

Nine of the ten mothers interviewed confirmed that they themselves had experienced family violence in their childhood. The remaining mother's father had been a soldier killed in battle before her birth. Two mothers had tertiary qualifications and one mother had obtained a certificate in her chosen industry. The biological fathers of nine infants referred to in this study were reported by the mothers as the perpetrators of the violence. The remaining perpetrator was the father of the sibling of one of the infants, rather than the infant's biological father. Two

mothers required the use of an interpreter, but only one of these was subsequently interviewed. The interpreter services were supplied in both instances by the Refuge, once by phone and once in person.

Two mothers opted not to have their interviews audiotaped, but accepted and approved the subsequent written account of their words. The remaining eight mothers' sessions were audiotaped and the interviews transcribed and sent to them. Five of these transcripts were approved via email, two verbally, and the remaining mother failed to respond to any emails or text messages. All mothers were given their transcripts to read. All gave full written and verbal consent to be involved. No mother involved in the study withdrew consent. All data concerning the infants and mothers were transcribed by the researcher. All mothers were given a copy of their interview transcripts.

Workers & key informants

The Refuge personnel in this study were represented by seven workers from two separate group interviews run in two different countries. A further two additional key informants from each of the three countries (a total of six) were also involved in separate interviews. Thus, a total of 13 participants represented the perspective of Refuge. Of these seven group interview members, six were workers and one a manager. Two of the key informants were Refuge managers, another was the director of the agency that ran a number of Refuges and other services for women impacted by family violence, and the fourth was the children's program manager for this same agency. The remaining two key informants were: a senior advocate working within a leading women's family violence service, with over 30 years' experience in the sector including experience working within Refuges; and the previously mentioned Refuge worker (see p. 103/4). All of these interviews were audiotaped and transcribed by an external, university approved and

professional transcribing service, with the exception of one interview which was conducted by Skype. This was the only internet interview conducted, and I transcribed it immediately following its conclusion, given that it was a Skype recording and the quality of the audiotape was poor.

The Refuges

As already noted in the implementation of the research (p.94) and the description of participants (p.104/5), the study occurred within eight Refuges. The capacity of the Refuge accommodation varied. Three were medium-to-large purpose-built Refuges, three were former homes that had been converted into Refuges and extended to accommodate a number of families, and two were small, typical suburban homes accommodating no more than two families. The latter two did not have staff on site. The average length of stay varied from Refuge to Refuge, with the Australian sample generally being short-term residents. The Scottish and English Refuges tended to house the infants and mothers for considerably longer periods due to severe housing shortages in those two countries. In order to gain entry into the Refuge, all women and their children were assessed as being at risk of harm due to family violence and with no other safe or viable option available to them. The locations of all of the Refuges were secret; however, in the small, remote Australian areas visited in the study, the locations of the Refuges were known to the local community. Six of the eight Refuges provided medium-to-high security.

Data analysis

The organic as well as opportunist nature of this study resulted in four discrete collection phases. These were demarcated literally by the physicality of travel involved in collecting data from the four distinct locations visited within the three countries in which the Refuges were located. In essence these subsequently operated as timelines, with each of these phases seeming to correspond, on the whole, to marker points for developing the emergent codes. These codes were,

however, by no means the final ones. What occurred within the first three phases will be described, together with a description of how the final phase unfolded. As will be seen, this fourth phase moved towards a consolidation, and in-depth exploration, of the completed data sets. This marked a move from the completion of initial coding to a more in-depth analysis. This journey of data collection and its implications for subsequent analysis resonates with the statement made by Charmaz (2014) who notes: "our data collection methods flow from the research question and where we go with it" (p.27). The analysis of this data not only flowed from the research question but from the methods required to collect the data.

Emergent methodology

A fundamental commitment of this study was to privilege the experience of the infant in order to understand what gave them the feeling of having found refuge in the Refuge setting. This was, however, dependent on what was provided to them. Although infants are active participants who possess their own active subjectivity, this subjectivity is co-constructed with others due to their formative developmental stage (Fonagy et al., 2007). To keep the infant as the focus, and the recipient of refuge provided by the Refuge, new methodological ground had to be traversed. Whilst constructivist GTM provided the framework, applied equally to this research was the inter-subjective nature of the way in which the nuances of the methodology itself needed to emerge to honour this assurance. As such, it is important to make transparent not what was intended to be done, as this was not exactly known prior to the study, but what unfolded, how and why. The need to remain infant-led was revisited constantly throughout the process, and adherence to this requirement evolved into what eventually transpired. This allowed the study to remain consistent with the inter-subjective, as well as constructivist, principles that are so powerfully germane to the research of the developing infant.

The core method of data collection used to infer the experience of the infant was infant observation. Caron et al. (2012) suggest that it is the emotional resonance so vital to research through infant observation which also creates its greatest difficulty:

> It is especially challenging when such writing involves an element of translation of an intimate experience, which must be both recognised as personal and validated as communicable, while helping in the formulation of new ideas and new theoretical constructs (p.239).

Explaining this challenge as it happened – rather than describing what was planned, when there were no rigid plans – will be presented throughout the following stages. This methodological application emerged with due diligence, constant peer checking and rigour, bending to the need for the infant to be heard rather than the need for the infant to be sublimated into the voice of their mother, the Refuge setting and the researcher. This next section therefore describes the process as it transpired.

The beginning: Ethics approval was granted in December 2013, and two months had passed before the first recruited Refuge had an infant and mother who were admitted and also willing to participate. It took three months to recruit another two Refuges. One of these Refuges agreed to only limited involvement, as an infant and mother already participating in the study had been transferred into their service. When a Refuge had a mother and infant who agreed to be involved in the study, I needed to respond quickly as their likely length of stay in the Refuge was not always known. In two of the Refuges this was even more urgent, as they generally offered short-term stays. The recruitment process directly impacted on the coding process. It was a priority to transcribe the observations (audio-recorded immediately after each session) and interviews quickly in order to ensure that the emotional life of the data was captured. This was a task I undertook. This also aided me in maintaining a close and ongoing relationship with the data of

the recently-met infants and mothers whilst continuing to meet new participants. It also minimised any feelings of being overwhelmed by the amount of data to transcribe, as well as minimising impingement on the critical process of being directed by the data. As a result, these discrete phases could only involve preliminary coding processes; however, they allowed for an iterative process of contrast and compare to occur (Charmaz, 2014). As will be described, within each of the first three phases some preliminary coding was undertaken. In order to offer some transparency in how this process unfolded, and to not disrupt the flow of this section, some examples taken directly from the data coding and analysis process will be provided at the beginning of the next chapter (see p.127).

Phase One: This data set was collected over four months (February – May 2014) and from Melbourne Refuges. A total of eight (audio-recorded) infant observations and three interviews with mothers were transcribed. Beginning codes were developed, commencing with the infant. The infant as the starting point represented a structural attempt to give their perspective prominence. These codes were simple and captured actions that were developed into topics. Charmaz (2014) notes: "[the] actions of your respondents preserves the fluidity of their experience and gives you new ways of looking at it. These steps encourage you to begin analysis from their perspective. That is the point" (p.121). These codes commenced with my perceived perspective of the infant. I did, however, find myself struggling with a pull towards the more dominating presence and actions of the mother, ie. her behaviour, conversation, when interacting with her infant, failing at times to be fully "present" to emotional states of the infant. That less recognition was given to what it felt like to be with the infant, and the impact of their emotional experience in the Refuge space, was perhaps something of a learned response. I continued to operate more from a preference for what I could see than from initially trusting what I could feel.

The observation material was regularly reflected upon under supervision with my two PhD supervisors. Additionally, a colleague who specialised in infant mental health and was a teacher of infant observation methods acted in the role of 'critical friend', meeting to review the infant data and the thesis overall. These two different but complementary reflective spaces enabled the emotional aspects of the research to remain important in the interpretation of the data being collected and to be fed back into the overall coding and analysis (Ingram, 2013). These reflective spaces critically aligned with a crucial component in the discipline of infant observation work which is scrupulously adhered to – that of regularly meeting with a 'seminar group' to present and explore the nuances of the data collected (Bick, 1964; Caron et al., 2012; Caron et al., 2013; Datler et al., 2014; Rustin, 2009; Waddell, 2013). It is this space which "produces a fertile ground where ideas/seeds have a place to germinate, when fertile, or remain in a dormant state, when sterile… And so the group carries on, spiralling upward, sharing and constructing new ideas" (Caron et al., 2012, p. 228). I was also able to re-listen to the audio material and revisit the emotional aspects captured in my voice. This revisiting became an important aspect of immersing myself in the emotional flow of the data collected. Together, these ideas sat percolating in my mind as I undertook the second phase of the data collection process overseas, in the UK (England and Scotland.

Phase Two: The subsequent reiteration of codes within the next phase evidenced a shift further towards capturing the active subjectivity of the infant so integral to infant observation work. Still-evolving in the coding process was the inter-subjective nature inherent in infant observation work. This is described by Datler et al. (2014) as the researcher needing to "use their subjective response as further data in trying to consider what might have been going on in the 'inner world' of the subject of the observation" (p.199). What the second phase of the data collection and coding process provided was the development of more refined questions around certain ideas and codes (Charmaz, 2014).

This data was collected overseas within a three-week period (June 2013). Five infant observations, interviews with five mothers, one group interview and two key informant interviews were undertaken. Transcribing the audio-recorded data from this collection phase occurred upon returning to Australia in July. Most of these infant observation and mothers interview transcriptions were completed before the commencement of the next phase. It became apparent that certain key ideas were emerging as a result of the preliminary coding in Phase One. The ongoing reflective presence of the supervision group input evidenced a shift in the bringing of the infant more clearly into frame. The themes in this phase took on more depth and resonance, offering a more sophisticated account of the infant's subjectivity. Remaining infant-led required a continuous, rigorous attention to and concentration on the infant's data rather than simply seeing this as collecting, transcribing, coding and analysing their data first. It actively required privileging that space where "verbalisation has no meaning" (Caron et al., 2013).

Phase Three: The lack of success in recruiting Refuges locally led to me using my collegial networks to visit a further two Refuges in remote Australia for which I had gained ethics approval. I undertook a one-week trip interstate (mid-August 2014). This resulted in one further infant observation, one interview with a mother, one group interview and two key informant interviews. Soon after returning to Melbourne, a further, sole interview followed with a 'mother alone'. The details of this are summarised earlier in this chapter. The infant was asleep when I arrived so I made the judgement to proceed with the interview with the mother, only to subsequently have no opportunity to later conduct an infant observation. These sessions had been scheduled to occur some time before the visit to remote Australia, but the Refuge requested that it be rescheduled. As arrangements had already been set in place by the Refuge and the participant was keen to be involved in the research, this 'rescheduled', final session proceeded, with illness in the family of the infant preventing any further contact. This third phase garnered further, more

nuanced extensions of the preliminary codes as they began to transform into themes. In addition, what emerged clearly was the way in which the 'process of being asked questions' about the infant had an impact. In the interviews with the mothers and the staff there appeared to be times when they were emotionally caught 'off guard'. These moments revealed the emotional and visceral responses evoked by 'making space for the infant' – not physically, but emotionally. This shift appeared to parallel the difference in how I, as researcher and observer, became more in-tune emotionally during the collection and interpretation of the data.

Phase Four: The preceding three stages give some insight into how the analytic direction of this work was beginning to unfold. A considerable amount of data had been amassed by this stage. Whilst transcribing and coding the infant observations and mothers' interviews remained an important researcher task for me, it was timely to stop and work in a more focused manner with all of the differing data sets. In order to 'keep on top' of the transcribing, all of the staff group interviews and key informant interviews apart from two (one key informant did not want to be recorded and I transcribed another) were sent to an external professional transcribing service. Despite this, I still re-listened to the audio recordings of these worker/key informant interviews. Phase Four saw a more structured and formalised coding process take place. An openness to what might emerge from this data remained, and tracking the ways in which to interact with the different forms of data became more important to make transparent so that my logic, and how I was arriving at my conclusions, could be clearly demonstrated as I moved between collecting and analysing the data (Bryant, 2003; Charmaz, 2008; Charmaz, 2014).

There were two components needing attention. The researcher takes the "opportunity to deal with the data in a more speculative fashion: to think about 'what it means' for the participants" (Larkin, Watts, & Clifton, 2006, p. 104). Further to this, to make clearer the experience of not just

what the data means but also to describe the emotions experienced while collecting the data, I was, as researcher, required to remain attentive to the 'inter-subjective' layers of meaning that are being extracted from the data, together with any emotional reverberations these might produce. As described in the epistemological section of this chapter (p.83), meaning-making is relational. To best understand the infant, their emotional world needs to be engaged with, as "emotions are intensely shared, because it is in the nature and function of emotions to stir up sympathetic responses in others" (Reddy & Trevarthen, 2004, p. 11). This same analytic approach was taken to interpret all data sets, but in each instance commencing first with the data from the infants. This more intense attention to the data can be explained in the work as undertaken in two stages (as will be described below). This work led to the creation of a specific space in which to capture the depth and nuances of each of these perspectives individually, the accompanying emotions in relation to the infant observation material (see Appendix Two) and the foundation upon which all else, once coded, would be systematically analysed (see Appendix Three).

Commencing with the infant

The first criterion identified at the beginning of this chapter was: that the experience of the infant is paramount and needs to remain so (see p. 81). Building a methodological approach for the collection of data, and a structure for the analysis that commenced with the infant, ensured that this commitment was honoured. This final stage of the analysis began with, but did not end with, the infant, as honouring the inter-subjective nature of this enquiry meant adhering to the third criterion identified. This was: that the context of Refuge can be understood through the collection of data from the multiple sources that 'make up' Refuge (see p. 82).

Stage One – Step One

The analysis process began with each individual infant observation (see Figure 2, p.98). This was irrespective of having conducted just one observation, or more than one observation, with the individual infant over time and where circumstances allowed (as on four occasions). After this, I analysed their mother's interview. When this was completed, sequentially, I moved onto an analysis of the data of the next infant/mother to participate – eg., Infant One and then Mother One, Infant Two and then Mother Two, and so on. A thematic coding process was utilised, starting with reading the written observation notes of the infant as well as re-listening directly to the audio material. This involved what Charmaz (2014) described as generating an 'interactive analytic space'. As already mentioned, listening to the audio-notes in addition to relying on an interpretive reading and re-reading of the transcribed data facilitated both an emotional and intellectual response to the material collected. Essentially, the re-connection with the emotional content of what was observed became more vividly alive with each re-listening as the immediacy of each of the audio-recorded dialogues captured not just the material of each observation but the nuances of my speech, tones and emotions. In the transcriptions, each line was numbered. Meanings were then attributed to certain interactions or events as they were read through, and the audio material listened to again. Small passages of lines were coded in which a particular event, interaction or emotional response were elucidated. The meanings that were constructed from these passages were then coded, as the interpretations indicated what might be emerging as a theme.

Stage One – Step Two & Three

Once the thematic coding of all of the dyads was completed (the infant observations first, followed by their mothers' interviews), the process repeated itself again from a slightly different angle. Starting afresh, and with fresh eyes, my focus shifted to looking at all of the 'infant observations only' as one complete data set, ie. using the same process as described above but from scratch.

Once this was completed, the same process was once again used with the entire set of the 'Mothers only' interviews. Step Three involved becoming more focused, and comparing and contrasting the themes and codes extricated from the different angles used in re-analysing the infant observation and mother interviews.

Table 2. Coding process

Step One		Step Two (Repeat)			Step Three (Focused)
Infant then Mother Data Sets	Initial Coded Themes (1)	Infants Only Data Sets	Mothers Only Data Sets	Coded Themes (2)	Compare & Contrast Coded Themes (1 & 2)
Step Four (Repeated)		Step Five (Repeated)		Step Six (Focused)	
Workers' Group Interview	Initial Coded Themes & Re-code (3)	Key Informant Interviews	Initial Coded Themes & Recode (4)	Compare & Contrast Coded Themes (Combined 1 & 2) with (3 & 4) and review of field notes	

Stage two- Step four & five

This stage used the same process of both listening to, and re-reading, the transcripts of the group and key informant interviews. The two parts in Steps Four and Five involved the coding and recoding of the worker group interview data and the key informant data. As there was not necessarily a dyadic relationship between the 'worker groups' and 'key informants', such as with the infant and their mother, this data was subjected to a re-coding process 'by location' to maintain consistency and rigour across the analysis of the four data sets of infant, mother, worker

and key informants. These were coded sequentially, in the order in which the data was collected. Once all worker group interviews and the key informant interviews had been initially coded, a second round to revisit the data occurred in order to tease out further themes and codes anew, and to track the thought processes involved in interacting with the data. Returning to the data in this manner allowed space to undertake "theoretical playfulness", which:

> allows us to try out ideas and see where they may lead … Grounded theory coding is flexible; if we wish, we can return to the data and make fresh coding. We can move forward to writing about our codes and weighing their significance" (Charmaz, 2014, p. 137).

Stage Two – Step Six

This last step involved sorting through a large amount of data to determine which themes appeared in greater frequency and/or significance (Charmaz, 2014). This was the last step in the development of a more focused framework within which to create the more conceptual elements that emerged directly from the data. Charmaz (2014) contends that "focused coding requires decisions about which initial codes make the most analytic sense to categorize your data incisively and completely" (p.138). The coding procedure is about 'essence capturing', whilst the categories which then emerge 'form patterns' when clustered together, creating the story of the research (Saldaña, 2009).

Resonances: It is the 'inter-subjective' element in this analytic process that is important to revisit, as well as making this final stage clear and transparent. 'Essence capturing' is imbued with 'subjective' resonances, as this is what captures the attention, the emotions, the interests and the imagination of all of the players who have contributed to this thesis, and particularly the researcher. Medico & Santiago-Delefosse (2014) strongly argue that:

> Within a constructivist perspective, which considers subjectivity (that of participants and that of researchers) as multiform and, more importantly, dependent on relational elements, this "interpenetration, this knot of subjectivities" is situated not within the individual but rather at the intersection, in the encounter, in the intersubjective system … interpretation must be understood as existing within a spiral relationship that is part of a complex history, in a specific moment and place, embodied and situated within the moment of the interview, in the observation, and in the analysis; it is always the product of a specific relationship, a specific encounter (pp.360-61).

Substantive significance: These resonances are inherently located within the themes for analysis that are generated through particular steps which include: becoming conversant with, and reflexive about , the data; creating initial codes; seeking out themes; reappraising the themes; outlining and identifying the themes; and collating these into a report for analysis (Braun & Clarke, 2006). The 'substantive significance' of certain themes to emerge comes not so much from their frequency but from "the consistency of a theme across and within study participants" (Longhofer, Floersch, & Hoy, 2013). The range of perspectives available through the data available for analysis allowed it to be context-sensitive and, most importantly, infant-inclusive, as the infant in fact carried the 'insider knowledge' (Strøm, Kvernbekk, & Fagermoen, 2011). That is, gaining an understanding of what provided refuge to the infant required the study to keep the infant's experience both paramount, as far as possible, and held within the rest of the other significant perspectives.

The researcher: Reviewing additional field notes was deliberately addressed at this later stage rather than at an earlier one. This was so that these personal reflections did not carry as much weight as the primary data from the participants, though to exclude them altogether was to deny

the obvious presence and filter of the researcher throughout the study. As this process was being undertaken, it was important to acknowledge that there were decisions made regarding which links and themes emerged in the data. They did not just miraculously appear, and as recognised by Braun & Clarke (2006) "the theoretical framework and methods match what the researcher wants to know"(p.80). My field notes were an important reflection on my perception of the overall contextual experience when directly within the Refuge context. As Glaser (2002) noted, 'all is data', and the field notes and my personal memos could not simply be dismissed as they possessed influence and were, as such, reflected upon in the final analysis. I reviewed these notes/memos in order to establish if I had missed anything of value or that might usefully extend the data set. Where these notes add contextual depth to what is to be described in the following 'findings' section, they are identified as my *field notes*. My presence as the researcher and as a participant (even when in the role of observer) had a bearing on the setting, all of which contributed to the creation of an encompassing picture of the Refuge context (Abrahamson, 1983).

'Infant-led' comparative recoding: As already noted, each individual infant observation, mother interview, worker group interview and key informant interview were coded twice and the outcomes reviewed for consistency. The themes for each were then collapsed into major categories which were 'led' first from the infant observational data, overlaid with corresponding themes arising from the mother, then overlaid again with the worker/key informant interviews (see Diagram 1., p.123). Any outstanding themes to emerge from the mothers and worker/key informant interviews were then collapsed until these were exhausted (Minichiello et al., 2008).

Significant 'standalone' themes remained. These were themes identified as important in elucidating the meaning that was being created in order to better understand the context of

Refuge and the experience of refuge. Each level of coding/recoding and then the final integration of coding across the three domains of the infant, mother and worker/key informant data was undertaken in close consultation with both PhD Supervisors. The logic of how these codes evolved and then remained as the final, 'stand-alone' findings was dissected comprehensively within the supervision space. Further to this, the coding of segments of infant observational data was reviewed by an external 'infant mental health' expert. This additional measure was taken as a safeguard, ensuring the experience of the infant retained its centrality in the coding and interpretation of the data.

'Infant-led': Beginning with the infant, data was sorted under the main headings and, where themes applied to more than just the infant, they were extended to include other participant groups. For example, the first and clearest theme to emerge appeared to be true not just for the infant but for the mother, as will be discussed later (and shown in Appendix Four). The mothers experienced a sense of refuge through holding their infants. The construction of the key themes emerged from, and rested firmly in, a foundation that was led by the data taken from the infant. The infant as the starting point laid a foundation that was blatantly intended to favour the infant's perspective as much as was possible, given that these themes were constructed by the researcher. These constructions could only exist, however, in the realm of 'inter-subjectivity', with meaning made through what all involved brought to its creation (Beebe & Lachmann, 1998; Charmaz, 2014; Medico & Santiago-Delefosse, 2014; Trevarthen, 2001). What emerged, however, was the shared humanity of all of the participants. As illustrated in the theme of 'feeling safe' (Appendix Four), this corresponds with what most would feel when being respectfully held by someone familiar, trusted and/or loved.

Consolidation: The themes to ultimately emerge commenced with those drawn from the analysis of the infant data, laying the foundation for, but not completing the process of, the final analysis. The next layer involved collapsing the major themes arising from the mother's data with those that had resonance with the infant's themes, either for the infant, themselves, or both. Significant themes remained as 'stand-alone' themes for the mothers. The same process occurred for the worker and key informant data analysis. The themes to emerge from this third tier of exploration were assessed for resonance between the infant themes and then those resonating with the mothers, and again, themes that remained of significance for this third tier were left as 'stand-alone' themes. The final tier was the recognition of the resonances as related to me, the researcher. This tier was reflexively appraised and re-appraised by, and within, the two different supervision groups (and on a single occasion when the two groups were able to organise coming together as one). A representation of this analysis process is illustrated in the diagram below:

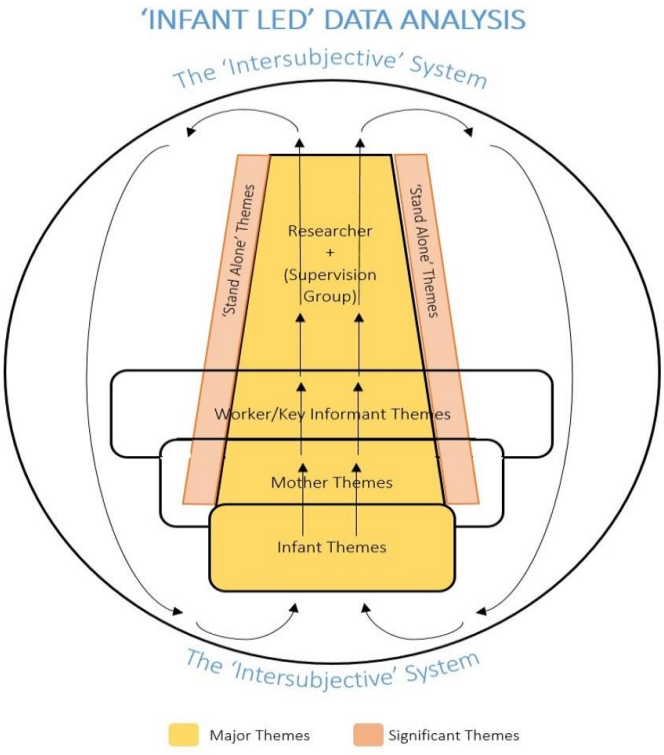

Diagram 1. Infant Led Data Analysis Model

Rigour and trustworthiness

The analysis as described above carries little weight unless rigour and trustworthiness is evident. Booth and Booth (1994) contend that the best procedure for data validation lies with comparisons between differing subjects, "as one account confirms another, stores accrete, regularities emerge so it becomes less likely that individual narratives are the product of one person's family and more likely that they show structural features in the lives of the subjects" (p. 421). It is the differing voices within mother-infant caregiving systems, as well as other players within Refuge, that attest to the trustworthiness built between each tier of inquiry. Validity within qualitative research differs from that of quantitative research in that it is not about the "ability to generalise from the research sample to the population" but is concerned with the quality of the findings, and notions of "credibility, accuracy of representation, and authority of the writer" (Krefting, 1991, p. 215). The unique nature of any social setting under inquiry in qualitative research does not lend itself to be replicated fully in another, similar setting; however, the ability to provide amply descriptive material will allow the findings of this research to have transferability to such settings.

Trustworthy: Credibility of the findings within this research comes from the emergence of the themes and patterns across the analysis of the four tiers of data collected. The fourth tier being recognised in this research is the researcher's field notes and subjective interpretation, supported by reflective space created by the supervision group and permeating all levels of data collection and analysis. This credibility is demonstrated by providing evidence as to why, and how, themes became themes (Braun & Clarke, 2006). The four strands of data collection – 1. infant observation, 2. in-depth interviewing with the mother, 3. key informant interviews and worker group interviews, and 4. the researcher perspective, offered four distinct vantage points from which to assess levels of consistency within the findings, providing methodological triangulation and a crystallisation of the multiple facets on display in the social world of the Refuge (Janesic, 2003).

In describing the data coding and analysis procedures undertaken, these processes have been made transparent as far as possible. This has involved 'unpacking' the different steps taken, and the rationale behind the 'infant-led' perspective argued in order to indicate the thoroughness and quality of what has been carried out at each stage of this research process (Letourneau et al., 2013). This clarity is intended to both demonstrate the integrity of the findings to be presented and to provide another researcher undertaking a similar study with a valuable road map. It is hoped that such a road map, guiding further research within the same setting and with a similar population, might "find consonance in the assignment of the same or similar themes to respondent answers" (Longhofer et al., 2013, p. 48).

Reflexive resonances: More importantly, this study has used another method to enhance the integrity of these findings. Consistent with the 'inter-subjective' application of a constructivist methodology, the depth of the coding and analysis has been enhanced by the reflexive space created through regular meetings with the two experienced qualitative research scholars supervising this study's implementation (Bigby, 2015). This was achieved in conjunction with an expert in infant observation acting as a 'critical friend' and who was involved in reviewing segments of the infant observation data, the infant coding and analysis, as well as the writing process. This reflective interpersonal space is important to acknowledge. It provided a refuge of sorts to the researcher. The 'subjective' resonances evoked within interpersonal research, especially within an area that is purposefully exploring the emotional experience of those who occupy a particularly vulnerable position in society, is a rich element of the meaning-making process that needs to be made transparent. Medico & Santiago-Delefosse (2014) contend that:

> these resonances are thus crucial in the meaning-making process. They may be at the basis of new interpretations and choices concerning categories that do not seem evident at first in the text or that are not visible in a purely grounded theory application (p.355).

Using an inter-subjective approach, and drawing on a constructivist grounded theory methodology, what the researcher finds compelling is particularly important as this accesses a part of the story that is activated through "significant intersection zones" (Medico & Santiago-Delefosse, 2014, p. 354) of emotions, and within the relational interactions that occur within the study itself.

In summary

This chapter has explained the process that evolved through honouring the voice of the infant in structuring the data collection, analysis and peer review mechanisms which operated within the supervision process. It has also introduced both the participants involved in the research and the settings within which the interactional world of these participants operate. The next three chapters will present what they had to say. Commencing with Chapter Five, the key findings to emerge from the infants will be presented. Chapter Six then introduces the voices of the mothers, followed in Chapter Seven by voices of the workers and the key informants. The perspectives of the mothers and of Refuge offer the opportunity to compare and contrast that which was drawn from observing the infants with the reflections of the mothers and other adults – ie. workers and key informants –on what they believed had impacted on the lives of these infants whilst in the Refuge setting.

PART THREE

This section presents the findings from all three tiers of enquiry, dedicating a chapter to each: the infant, the mother and the Refuge. Each chapter begins by presenting the key findings of each tier before moving on to provide a more comprehensive analysis of these findings, supported by excerpts from the data and relevant literature. This first chapter differs from the subsequent two only in that the data presented is descriptive and captures the nuances of the interactions, behaviours, emotions and milieu of the infant's world as observed by myself as researcher. This data is not dependent on the language of the participants but on my description of their behaviours, unlike the next two chapters. As such, Chapter Five commences with an introduction which makes explicit the processes involved in how the observation data foremost, and the interview data subsequently, have been analysed in order to reach the conclusions presented overall in this section on the findings of this research. This introduction is followed by the key findings relevant to the experience of the infant.

CHAPTER FIVE (The Infant)

Introduction

As with all research endeavours in the social sciences, a specific and often significant journey occurs along the path which leads to the final destination. In order to provide some grounding in, and transparency about, the interpretative process that I undertook within the data coding and analysis, I will briefly revisit the first three phases mentioned in the previous section (Chapter Four) and give direct examples of how I began to code the data I was collecting. The purpose of this is to explain the iterative progression I moved through as I 'interacted with the data' (Charmaz, 2014). I am purposefully including these examples, which are taken directly from my data coding. I am providing these here rather than within the previous chapter as this is not about

the methodology of the research so much as the evidence of the steps that made up the logic of my thinking, my abductive reasoning and my ultimate interpretation of what I had collected, particularly with regards to the emotional experience of being present to the infant. Each phase produced a different round of analysis, which fed back into the data collection process itself. This was a usage of theoretical sampling which is particular to grounded theory and which, with each round of coding, builds depth and rigour into the process of reaching plausible explanations for what did "not fit under existing interpretive rules or earlier inductive generalisations" (Charmaz, 2014, p. 201).

This introduction offers a sense of how I came to the conclusions I have within what are then presented as three penultimate chapters on the findings of the fourth and final phase of my analysis (see Table 2. Coding Process p.118 and Appendix Two, Three and Four). Each chapter pertains to each perspective most relevant to this research. PLEASE NOTE that I have chosen to present all of the data excerpts (and coding examples in this introduction) in *italics* throughout the next three chapters. I believe this helps to clearly identify the raw data and codes and, most importantly, enables the potency of this data to then stand out.

Phase One: As previously explained, my initial codes were rudimentary in Phase One (see p.112) and occurred during the first four months of data collection. I found that I focused too much on the mother and, perhaps like the infant, took my lead from her rather than trusting myself. These very early codes are based on the first two infant observations and captured the mother as the most active participant, as the example below demonstrates. The Refuge, as can be seen, was effectively on the peripheral. This example is taken from my initial coding of themes, which involved only the small amount of data that had been collected by this early stage (2nd April 2014):

INFANT	*MOTHER*	*REFUGE*
Mother as the focus	*Baby as the focus*	*Provision of shelter*
Mother as the comforter	*Being a 'good' mother*	*Provision of necessities*
Mother as the stimulator	*Television as companion, comforter*	
Mother as nourisher		
Mother as 'home'	*Where is home?*	*Providing a house*

Phase Two: Within the next phase (as previously described, see p.113) a subtle shift was evident in my coding process, revealing more depth and complexity in my analysis of the data, particularly with regards to the meaning of the infant in the lives of the mothers. For example, I held a more sophisticated appreciation of the infant's role as a provider of refuge. In this phase I began to move away from an assumption I initially began with – one which I shared with the mothers and Refuge staff – that the infant was simply a recipient of refuge. This theme is explored in more detail later in this, and the following, chapter. The excerpt below offers a sense of how I was beginning to expand on my analysis of what was becoming one of the key 'emerging' themes.

> ***How the infant provides refuge to mothers (29th July 2014)***
>
> *There is a presumption that by looking after the mother, the infant is also being cared for. This research is suggesting that infants, by virtue of responding to their mothers and being the motivation for their departure from their partner, as well as the reason to go on – the infant provides purpose – add meaning to their lives. That is, the infant gives the mother psychological and emotional refuge as they navigate their life away from their partner, the parent of their child.*

This particular analysis explores the way in which the infant is a powerful motivator in the mind of the mother, as well as a participant who engages with them and offers co-constructed meaning. This was an important strand to capture; however, it also reflects the fact that my focus is still mother-biased. It considers what the infant means to the mother, and what the infant gives her rather than what they experience in being with her, and what they receive from their experience in Refuge.

Phase Three: This third phase (see p.114) occurred during the last period of data collection prior to embarking on Phase Four: the final and most lengthy stage of analysis of all of the completed data sets. The excerpt below is taken directly from the data being collected, with coding notes created at this point. This excerpt provides examples of a number of themes that are beginning to take prominence. Further examination was needed in relation to how to remain committed to the criteria developed and described earlier (see p. 81). Crucial to this commitment was the need to keep the subjectivity of the infant paramount, in amongst other competing voices. The smallest sentence, highlighted in yellow *("making space for baby")*, held the greatest significance. I needed to ensure that the infant was given a prominent space within what would be the final and most comprehensive phase of my analysis:

> ***Emerging Codes – (In Red): (15th December 2014)***
>
> *(Baby as Refuge)- What are these babies offering the mother? In all instances the babies are the catalysts for coming into Refuge, predominantly as a choice made by the mother to ensure her safety and her baby's safety; but in two instances these babies are placed with their mother in Refuge because of child protection concerns.*
>
> *Emotionally, what do these babies represent for the mothers? Much is hoped for, for these babies, chiefly a new start – giving them a different future to what they have experienced in their pasts, their reason for going on, perhaps even their reason for living.*

Making space for baby

(The business and busyness of Refuge)- The busyness of what occurs within Refuge and how needs are prioritised. Needs of the adults are prioritised over needs of the children and infants. In the busyness of the business of Refuge it appears that very few needs are actually met. When the surroundings are chaotic and dysregulated, so too is the infant.

(The impact of being interviewed)- The process of being asked questions about their baby and about the baby's experience of being in Refuge took on a dimension all of its own, surprising me and perhaps surprising the Refuge system that I entered.

(Example: Manager at Refuge No. Seven).

What words do mothers use to describe fathers? – partner/ex - partner-father etc. Who brings him up first – me or mother?

The infant was still being lost, or at least proportionately so, amongst the competing perspectives of the adult participants. What did emerge more clearly, as mentioned in the previous chapter, was the way in which the *"process of being asked questions"* about the infant impacted the mothers and staff, through *"making space for baby*" – not physically, but emotionally and reflectively. This same process paralleled the experience I was going through in my supervision sessions. I too, was being asked questions which focused my attention on the infant and facilitated my reflection on the experience of being present to the infant. As I revisited the data and re-listened to the audio-tapes of my observations and the interviews (in which all the infants except one where present), emotional memories were evoked and I revisited what it felt like in each of these data collection sessions.

Phase Four: This phase involved the most comprehensive and final analysis of the complete data sets as was described in detail in the previous chapter (see p115). This chapter now moves to presenting the findings of Phase Four.

How the infant finds refuge in Refuge

The predominant themes extracted from the infant observation data are encapsulated in four major headings as presented below. Within each heading, the nuances inherent in each theme will be explored. These are:

1. I (the infant) come to you (the mother) for refuge and to feel safe

2. I (the mother) take refuge from what you (the infant) give me

3. I (the infant) do not come to you (the mother) for refuge

4. I (the infant) am lost from your (the mother's) view

The first heading encapsulates the finding that it is largely the mother, rather than the Refuge, who provides the infant with refuge. The next theme of **'I (the mother) take refuge from what you (the infant) give me'** actively includes the mother's voice to capture the essence of the ways in which mothers express the very real power of the infant's presence in their lives, and the profound reciprocity of this relationship. The third heading, **I (the infant) do not come to you (the mother) for refuge,** illustrates a presentation that was significant, if not dominant. This explores the very real vulnerability of the infant to their mother, which may be so strong that the infant senses it may in fact be safer to manage alone. The last heading, **I (the infant) am lost from your (the mother's) view,** speaks to a theme which was the most prevalent. This consisted of a pattern which appeared in a myriad of different variations throughout most of the observations - that the subjectivity of the infant appeared to disappear from the mother's view. This

disappearance in part, seemed to be linked to a larger mindset in relation to what is sufficient for the infant.

The Infant's experience of 'refuge' revisited

It is useful here to recap briefly on the salience of refuge for the infant as discussed in Chapter Two. Refuge was recognised as being experienced as either 'a place' – ie. a physical entity – and/or a 'state of being' – an emotional experience (Hornby, 2010; 2010). In Chapter Three the distinction between 'being safe' and 'feeling safe' was explained, with the latter being imperative to healthy neurophysiological development in infancy (Schechter & Willheim, 2009; Siegel, 2012; Van der Kolk, 2014). Infants usually seek proximity with their caregivers when feeling threatened, even in circumstances in which the threat itself may emanate from the caregiver (Main & Solomon, 1990). The infant who feels safe in their relationship with their caregiver will approach them directly for comfort, whereas the infant who feels unsure may use overly clingy or, conversely, evasive behaviours to maintain physical proximity (Main, 1999). The infant who feels unsafe in their relationship demonstrates a more conflicted approach to accessing reassurance, as the need for proximity overrides the sense of fear. Salter-Ainsworth and Eichberg (1991) explain that "this results in a conflict between two quite incompatible behaviours – to seek proximity to the attachment figure and to also avoid proximity to her" (p.162). The following point explores the way in which the infants in this study appeared to experience seeking and finding refuge and safety.

1. I (the infant) come to you (the mother) for refuge and to feel safe

The most consistent theme evident in all but two observations was that the infant predominantly approached their mother and/or expressed a need for refuge from her above any other person. That the mother might be the person most familiar to the infant, as well as consistently nearby, is important to acknowledge. That the infant did not, however, in every single instance go to the mother is also important, and will be addressed in the third point. The fact that the same infant exhibited different experiences of what provided refuge in different circumstances is also important to acknowledge. What this first theme explores is just how when the infant approached their mother, they did this, and what was provided. As referred to earlier in this thesis, synchronicity between infant and mother is not always present, but simply needs to be 'good enough' and 'often enough' to provide the infant with a sense of feeling understood and thus safely responded to (Tronick, 2007; Winnicott, 1960). This theme speaks to the dimensions of refuge that the infants in this study sought from their mothers, and what they received. Typically, the seeking of refuge involved the infant instigating the request for contact, either through using physical or vocal cues, with their mothers. Often, though not always, this resulted in the mother reciprocating. This is consistent with the premise within attachment theory that infants are generally 'proximity seeking', and when their attachment system is triggered, most often they seek out their primary attachment figure, usually their mother (Main, 1999).

What differed across 16 of the 18 observation sessions undertaken with the ten infants was the quality of, and the extent to which, the infant found safety within the refuge their mother provided. Some infants' experiences of safe refuge were consistent, while others less so. Still other infants' experience of refuge appeared to involve remaining near their mother rather than directly engaging with her, either physically or emotionally. Conversely, one infant appeared to experience the opposite, that of too much attention from her mother. This appeared to impinge on the capacity of the infant to express their own subjectivity. Those infants who appeared to

derive enough of a safe constancy in their experience of their relationship with their mothers expected a certain reciprocity. This resulted in the infant being relaxed enough to explore new ways of being with their mother, as well as showing curiosity about the world around them. It is this experience of finding refuge, as well as safety, that will be explored first.

Finding safety in the refuge of mother

The process of the infant seeking refuge with their mother and then subsequently feeling safe in that refuge was demonstrated through different infants' presentations. The infant appeared most likely to find safety within that refuge when held, most often physically but also interactionally. This was evidenced through a certain ease and mutual attentiveness within the mother and infant relationship. It involved more than having their basic needs met. Both partners were comfortable with one another. The mother could respond to the signals of her infant and work with them to find solutions when they became distressed. The infant sought and received comfort, companionship and reassurance. The infant also often showed curiosity, and was vocal and engaged (Stern, 2003; Trevarthen, 2001; Trout, 2011). In addition, I as the observer found myself sharing a congruent emotional response, deriving simultaneous pleasure from observing the infants and using this awareness in how I interpreted such data. While the range of responses could change over time and in different circumstances, the experience of finding safety in the refuge their mother provided essentially demonstrated that both the infant and mother had given, and received, enough interactional cues to constitute establishing a relationship which provided physical as well as emotional support for the infant (Tronick, 2007).

The infant finding both refuge and the experience of feeling safe within that refuge was observed in both of my observations with Infant 1 (3 months old). She was able to ask for, and take comfort from, her mother. In the first observation I recorded that:

> *The mother was very responsive to her infant, returning her gaze, smiling at her, talking to her, and the infant was chatting quite a lot, so lots of vocalising and again the mother was asking her questions and having a conversation with her and telling her "what a lovely girl she was" and "what an interesting girl she was" and how "she had lots that she wanted to say" and the infant drank this all in as she looked into her mother's face.*

During the second observation with this dyad, a minor miss-cue occurred between the couple. The mother misread the meaning of the infant's frustration at not being able to reach a hanging mobile toy as she: "*did not seem to see this and responded by taking her out of the rocker altogether, which seemed to make the infant even more upset".* This dissonance was minor, and the infant felt free to protest and also prepared to attempt her mother's solutions, which included trying to feed her and then rocking her. However, the two were able to work through this and return to finding an enjoyable equilibrium:

> *The mother went and got two storybooks from the bookcase in the corner of the room and sat down next to the infant and read her the books. The first one was the story of "the wheels on the bus". The infant looked up at the book, which was open, and the mother proceeded to read the book to her and sang the song: "the wheels on the bus go round and round" … The infant remained very engaged in the process, watching her mother's face all the while, and through this whole process was holding up her little legs and grabbing at her feet through the end of the jumpsuit* (2nd Observation – Infant 1, 3 months old).

This mother and infant worked together until they found a mutual solution and, together with repeated interchanges of mutual enjoyment and verbal exchanges in both observations, this suggested a 'good enough' relational history between mother and infant (Winnicott, 1960). Where there were moments of discord, they were short-lived and quickly repaired. This infant

appeared to feel 'free to be playful', both with her mother and with herself, and is evidence of an important and necessary developmental experience as described by Thomson-Salo et al. (1999).

A similar devotion between mother and infant was also on evidence with Infant 10, whose mother was able to recognise that her infant was distressed by entering the Refuge environment only the day before and was able to make herself available to her infant in a manner which attended to his distress. The mother of this six month - old infant appeared to recognise that her infant had a subjective response to this different environment, and helped the infant to manage his responses by keeping him close. When she did attempt to have her oldest child hold the infant so that she could eat her lunch, the infant protested. When he started crying:

> *she took him back. When interviewing she had handed him to her sister so we could talk but he would not settle. He came back to her and was grizzly (upset). Eventually she breastfed him which quietened him a little but not for long, and then changed breasts. He seemed to settle a bit, then at the end of our talking became upset and his mother walked around with him, rocking him* (1st Observation).

His mother, who had four children with her, presented as enjoying all four, watching and laughing with the older three as they played. The next morning I saw Infant 10 again.

> *Mother 10 was holding her baby and he seemed much calmer and much more settled than yesterday. She said he was getting more used to their surroundings and after a couple of days he calms down. He gave me good eye contact … was much more contented than yesterday, happy just in mum's arms* (2nd Observation).

This infant was quick to protest when he was away from his mother's arms. Each time he did, his mother responded quickly. This suggested an expectation that his mother would regularly and reliably provide comfort. Whilst an alternative interpretation might suggest that this infant was

actually clingy and unable to be reassured, even when he was with his mother, it was only their second day in this new environment. When the 2nd Observation took place on the second day, the difference in his presentation was considerable. He was much more settled, available to engage with his environment and enjoyed the attentions of his older sister while resting in his mother's arms. His preferred relationship was obviously that which was offered by his mother. She did not interpret his behaviour as clingy, attention-seeking or demanding, and neither did I. She appeared aware of his need to transition into this new environment, in some ways more than any of the other mothers had seemed able to do. In her interview (which she requested to be written up – not audio recorded - and which was subsequently read back to her), this mother indicated an ability to hold this baby in her mind as well as in her arms:

> *"Mother thinks her baby knows this is a different place. That he hears different voices, sees different things and smells different things. She sees him looking around. This is not home for him"* (Interview Notes, Mother 10).

This infant and mother, like Infant 1 and her mother mentioned above, demonstrated the capacity to work together well enough to find emotional balance (Tronick, 2007). The availability of the mother to be attuned to their infants' needs provided them with refuge that felt safe. This safe haven was not observed to be so readily available for other infants. In order to maintain proximity with their mothers and retain some semblance of what offered refuge, or at least shelter from other potential dangers, these infants appeared to learn that it was better to acquiesce to the needs of their mother.

Losing, and finding, safe refuge in Refuge

Not all infants received the same offer of ongoing safety from their mothers. In some instances, the actions of the Refuge itself exacerbated this loss of access to safe refuge by inadvertently

creating or failing to attend to the need of the infant to have ready access to their mothers. Nevertheless, when these infants were held, engaged with actively or both, the infant in most circumstances demonstrated a ready willingness and ability to actively receive this (Thomson-Salo, 2012). When the access to refuge is lost, and worse still, prevented, the infant is forced to find other, inadequate and ultimately damaging ways to manage their distress. When this distress is ongoing the overwhelmed infant has no choice but to shut down altogether (Porges, 2007; Schore, 2003a). All the energy at the infant's disposal is directed purely towards survival. The ventral vagal complex (see p.32) is compromised, and development as well as social engagement disappears (Porges, 1995; Rifkin-Graboi et al., 2009; Schechter & Willheim, 2009; Van der Kolk, 2014). A number of infants were not often offered safe refuge, but when they were, the shift in their demeanour was as palpable as when access to finding refuge was lost. The following scenarios illustrate when this occurred, and involve two infants in particular.

The first example is of Infant 2 who, with his mother, had had a harrowing day prior to their entry into Refuge that evening. They had been separated from one another for four hours, with Infant 2 removed earlier in the day by Child Protective Services and both required to then attend court. He was returned to his mother after she agreed to enter Refuge. I met this dyad an hour after their arrival to find them in their allocated room:

> *The mother was sitting on the bed with her baby on her lap, he was looking out towards myself and the Refuge worker … little Infant 2 was in a jumpsuit. He had very bright blue eyes and was looking curiously at me and the Refuge worker. He appeared alert and interested in his surroundings. Infant 2 seemed to be a smallish baby and was exactly 4 months of age, had very little hair and seemed bright and curious,* (1st Observation).

This infant sat in his mother's lap and appeared to have made a significant recovery from what had been reported as a very distressing day. This was the first and last time I saw him curious,

settled, responsive and calm in this session. He had lost his safe refuge through a series of events which saw the Refuge 'unthinkingly' rob him of access to what, for him, was his refuge: his mother. This first occurred when the other family sharing the unit arrived, bombarding him with friendly intentions which this already fragile infant found overwhelming: *"The infant looked like he was upset, scrunching his face up, almost like, to me, like he was about to cry… his little left hand clutching his mother's long black hair. He was hanging on for dear life"* (1st Observation).

An awkward politeness was given preference over shielding this infant and mother from any further intrusions. The business of Refuge was the next priority over this infant remaining where his refuge was. They were moved from the safety and warmth of his mother's embrace into the cold of the night so that his mother could choose her food from two fridges in the main house. The infant, much to his distress, was put in a coat, and handed onto strangers while his mother selected her food. He was then strapped into a pram when his mother decided to walk (or escape) to the local shops "*to buy a real coffee*". I accompanied the pair, pushing the pram for her mother as she had a cigarette. I saw and felt the desolation of the infant:

> *I could see the infant's little face when we would pass under each streetlight. And it was a pained little face. He had a little frown and he was looking intently at me and I think trying to figure out who I was and where he was … I was trying to reassuringly talk to him and I just felt like, it was almost like I could see it had been an horrific day. He was exhausted and he was just looking at me intently and frowning. There was no friendly curious engagement, it was like, just frozen, and I felt very teary, and feel teary recalling it and writing about it* (1st Observation).

The observation ended with our return to the Refuge and to their small room, which lacked the original warmth it had seemed to possess. His mother left him in the bassinette, which had previously sat within the pram but was now placed in the middle of one bed while she sat on a

bed opposite, believing her son would drift off to sleep. By the time he returned from the walk he was:

> *Staring off into space with a glazed look … I could not (now) see into the basket from where I sat and wondered if Mother could either. I stood up to look over the bassinette and saw that he was in fact not asleep but simply quiet, his eyes not wide but little slits, simply staring,* (1st Observation).

The coldness of the evening, or the sheer exhaustion of this infant may well have contributed to his presentation, however, this seemed to fail to fully explain what I saw, and what I felt. Kestenberg (1985) wrote about the way in which infants can move into 'dead spots' where, with nowhere else to go, and no sufficient emotional refuge provided by others, they experience effective numbness. As Schore (2001) describes, this involves a process of dysregulation in which the infant disappears into themselves and "the child disengages from stimuli in the external world and attends to an "internal" world. The child's dissociation in the midst of terror involves numbing, avoidance, compliance, and restricted affect. Traumatized infants are observed to be staring off into space with a glazed look" (p. 211). Infant 2 appeared to have moved into a 'dead spot'. The walk to the shop was not in itself a trauma. Put in the context of the multiple separations from his mother, and the intrusions of unfamiliar places, faces, sounds and smells that he had experienced that day, his capacities to cope were depleted, as were those of his mother). Ultimately, it seemed, they had both disappeared into themselves. The refuge they had found in one another at the very beginning of the observation had been lost, and in some respects the Refuge itself had contributed to this.

A similar experience appeared to occur for Infant 7 (4 months old) when I observed her for the first time. This infant and mother had been in the Refuge only three days. It was their first attendance at a large, staff-run house meeting. The infant appeared overwhelmed by the space,

and the social interactions foisted upon her. Her mother left her sitting in her pram and found an empty space to sit, which was at the furthest end of a row of women sitting on a couch. Eventually the woman closest to Infant 7 picked her up, chatted to her, then passed her along to the next woman. The infant was passed to the next before eventually being handed to her mother. Infant 7: *"had a serious little face, I didn't see her smile, looking at others, but not a lot of smiles"* (1st Observation). When she reached her mother: "*she just sat on her mum's knee, with her back against her mum's chest, looking out towards everyone else but no gesturing, no chatting or talking, just observing, basically*".

My second observation with this same pair began with the infant staring at me in a manner not dissimilar to the way in which she had stared in the meeting at others, but with much less intensity. We were now alone in their private unit and: "*Mum was at the stove cooking, so I just sat there watching the baby who looked back at me, was interested in me, but not smiling or responding".* Eventually her mother came and sat down with her and: *The baby became increasingly vocal from this point and was very focused on her mother. Midway during the interview session there was a lovely, reciprocal exchange between infant and mother, with them talking to each other* (2nd Observation – Infant 7, 4 months old). This infant, I had observed, was not confident enough to instigate communication with her mother, perhaps because she was not used to doing so. She was, however, able to quickly respond to her mother's invitations, and moved from what at the beginning of the observation could be interpreted as a dysregulated, almost dissociative state into finding a state co-regulated with her mother.

This dyad appeared to become more at ease with one another, gazing lovingly into each other's faces and talking with great animation and pleasure as the session progressed. The deepening of their rapport with one another seemed to herald a move within the infant which indicated a

greater sense of emotional safety and intimacy in the relationship. During this observation, a shift in the baby – in proximity and behaviour – occurred when her mother shifted. This shift coincided with the interview stage of the session. The act of the observation, my curiosity about her infant and the interview questions focusing on her infant seemed to contribute to this mother's interest in considering her infant's point-of-view:

> *The mother was fully engaging with her baby – "yes my love, yes", talking to her baby who was responding and vocalising. "Yes, "oh my goodness, is that what happened when you were sleeping, all that stuff? I can't believe it". The mother was laughing and speaking back to infant about what she thought her infant was telling her* (2nd Observation).

The ability of the mother to consider the infant's perspective and respond according to the infant's emotional and developmental needs is integral to the infant feeling safe and secure (Bretherton & Salter-Ainsworth, 1974). This was clearly seen here with Infant 7 in the second observation, as well as in the observations of the first two infants (1 & 10) referred to earlier. This was indicated by the dyads' mutual enjoyment, the mothers' capacity to think about the subjective experience of their infant and the liveliness of their encounters together. This is what brought these infants to life. These responses support what Trevarthen (2001) suggests are mirroring processes critical to creating co-constructed meanings for the infant. These meanings make it possible to "sustain mutually supportive companionship in experience and purposes" (p.99). Companionship with, and enjoyment of, the other is able to occur only when the infant is feeling safe.

I become what you need me to be

A further dimension of the infant finding refuge demonstrates how some infants appeared to accommodate to the needs of their mothers to ensure that, at a minimum, they were guaranteed proximity. This was evidenced in relationships that appeared to enjoy less collaboration and

more compliance on the part of the infant. That is, they seemed to have learnt to become what their mothers needed them to be. This kept them close enough to draw some level of refuge from the relationship. How safe they may have felt with this refuge appeared tenuous, but it was what they were familiar with and provided something over nothing at all. These dyads were not often in synchrony with one another, nor did the infants approach directly, instead remaining nearby so as to remain connected (Main, 1999). This appeared to leave the infant with a certain wariness, and presenting with a greater self-sufficiency than the infants previously introduced. They presented with a pseudo-independence which ensured that they could still feel the safety of their mother's presence without making too many demands that risked severing that connection. This was achieved through demonstrating an inordinate amount of patience and self-management, being able to be quickly pacified and not exhibiting any real signs of protest.

In order to minimise disharmony and to help "to reduce this anxiety the infant's behaviour comes to fit or complement the attachment figure's behaviour, in other words, it is adaptive or strategic within that relationship" according to Crowell and Treboux (2006, p. 295). Minimising rejection to maintain connection comes at a significant cost, subjugating what the infant needs to feel truly safe. It is safer to ask for too little. However, both are left unsatisfied emotionally, albeit remaining in familiar relational and, thus, recognisable and safe territory. This interactive sequence could be seen as what Beebe et al. (2011) describe as working 'too hard' and who "interpret 'low coordination' as 'inhibition' or 'withdrawal,' where metaphorically each partner is relatively 'alone' in the presence of the other" (p.177). There were numerous examples of the infant's compliance, as will be demonstrated through the following three examples:

Making do: Making do with what you can get was in force for all three infants in the examples that follow. One particular infant, however, over the course of three separate observations in four

weeks, demonstrated a decrease in the demands he made of his mother. In Infant 2's first observation he made his distress clearly known, but when they were not met he eventually gave up (see p. 141). In his subsequent two observations he was much calmer, with his environment making considerably less demands of him. He was, however, infrequently held by his mother. At the time of his third (and final) observation he was 5 months old. When I arrived at the Refuge I was shown in by staff who then left me alone with Infant 2, who was lying on a rug in the back lounge room. He seemed to be entertaining himself and together we remained waiting for his mother, who was outside having a cigarette. I spoke to the infant and he reciprocated. When his mother returned she greeted me and her infant warmly, then sat on the couch next to his rug. While this mother interacted verbally with her infant, she mainly directed her conversation towards me. The infant remained on the rug for some further 30 minutes after his mother sat down.

During this observation session, and as was evident in the previous two, this infant did not have a great deal of physical contact with his mother. When he did, it was generally to serve a function, eg. she would give him a drink or something to eat, or change his nappy or clothes. I noted in this third session that: *"a couple of times I wondered where he was disappearing to. I could see that he got that stare"* (3rd Infant Observation). That 'stare' I was referring to had been one I had observed in the first two observations, when he simply seemed to emotionally disappear. Given his otherwise generally happy demeanour, I could have put this stare down to his concentrating on passing a motion, something it would later be revealed he had done when his mother changed his nappy before putting him down for his nap. Fighting going to sleep, or perhaps being unable to settle himself enough to do so, had been evident in the two previous observations and was now evident in this one as we came to the end of the session. His mother placed him in his cot, leaving him alone with his soft toy bear for company:

> *he seemed to really hug that (soft toy bear) for a bit, then let it go and was a little bit grizzly (agitated) and mum said, "I usually just leave for about 10 minutes and then I come and check on him." She explained that she knew the difference between when he was crying and distressed and when he was just grizzling and on the way to getting to sleep* (3rd Observation).

I was left wondering, for this infant and others, if their mothers did always know the difference, even though these particular mothers spoke with such certainty about what was happening for their infant. It appeared that many infants exhibited behavioural responses which seemed to stave off any overwhelming and potentially frightening responses from their mothers. Conversely, it may be that these infants felt unable to manage their own overwhelming feeling states with little help from others. Infant 2 began fussing (crying) towards the end of this session and his mother left him to warm him up some milk. I remained and bent down to him on the rug. I began talking to him, and as he was kicking about his feet:

> *I started to push at the bottom of his feet and he seemed to enjoy pushing against my hands so that stopped him crying and he seemed to enjoy my involvement and then when Mum came back with the bottle. She picked baby up and gave him a bit of a cuddle and put the bottle to his lips but he didn't take the milk. She did this a few times and he let her know fairly clearly that he didn't want the bottle, so she said to him, "Maybe you need to have your nappy changed," so we went upstairs* (3rd Observation).

On numerous occasions throughout the three observations undertaken, Infant 2 was most settled when he was held by his mother and not for any other purpose than simply being held

Asking for little: A further example of what appeared to be learnt compliance is powerfully demonstrated in the way in which the next infant, Infant 6, knew how to behave in the manner

her mother needed from her (that is, to not demand too much) in order to get what she needed, which was to stay in close range). At 11 months, Infant 6 demonstrated astonishing self-sufficiency. She kept in contact with her mother, but avoided impinging on her space until finally, overwhelmed, she started to decompensate. When I arrived the infant was in her cot, awake, alert, playing with her toys and looking from me to her mother:

> *Her mother interacted with her at different times, gently laughing at things that she did and seeming to enjoy her. The infant was chatting away, making a 'doo' 'doo' noise and quite industrious in her play and chatter within the cot. In all, she remained there very patiently for over twenty minutes with the first, very short hint of protest at about 16 minutes, then back to play, a round of very intense chatting just on twenty minutes, then at 21.30 minutes beginning to cry and this becoming increasingly loud. It wasn't until the little girl started to cry that she was pulled out of the cot. She gave a very sudden cry and then Mum picked her up and she stopped crying very quickly and I said, "Was that her cry to get out of the cot?" and she said, "Yes" and she sat the infant on her lap and told her to shh; she did, then mother placed her on the floor and she was crawling around the unit, very vocal, entertaining herself again very patiently.* (2nd Observation – Infant 6, 11 months old).

This infant lasted an extraordinary amount of time before making any protest. She remained in contact with her mother (Mother 6) without imposing too much. It was 45 minutes into the session before I discovered that my arrival had interrupted their meal time. This infant girl had become increasingly frustrated and eventually succumbed to crying, but stopped immediately at her mother's request. It was at that point that I asked what they would be doing if I were not in the room. *"We were going to eat"* (Interview Transcript). The mother effectively acquiesced to my demands, putting aside the task of feeding herself and her daughter in order to privilege what I wanted: an interview.

The push and pull of wanting to be close without demanding too much felt like a feature of this infant's and mother's lives. It was as though in order to maintain some sort of 'safe enough' equilibrium, there was something perfunctory and minimalist in this mother/infant relationship. While the mother certainly enjoyed her daughter, and was proud of her achievements, there was little demonstrable contact between them. There was a strong yet brittle self-protective veneer about these two individuals, both separately and together. Such behaviours would fit with Main & Solomon's (1990) description of an 'anxious-ambivalent' attachment. This is where the infant develops a strategy of remaining close enough to take comfort from, but not too close to be rejected by, the caregiver.

My first observation of the infant of this mother occurred in the house meeting at their Refuge. I noted that *"the mother and the little girl felt like they are a bit on the outer"* in the group. Nevertheless this infant (Infant 6), whom I was sitting close to, seemed interested in me but wary of making an approach. This mother who, with her infant, had been at the Refuge for three months, sat by herself on one couch whilst four mothers (one of whom was Mother 7 and had arrived only three days earlier) sat on the opposite couch. Mother 6 "*had made the cake and that was to be shared with everyone*" (1st Observation, Infant 6). This gesture of the cake- making seemed to resonate with a desire to be included without demanding it, that is: I want connection but will not ask for it for fear of being left with nothing.

Learning Quickly: A pattern of inconsistency in availability can establish itself very early. The interactional pull in favour of the obviously more powerful mother and her needs was illustrated with Infant 3, who was only three weeks of age. This was the youngest infant involved in the study and, while the communication was more subtle, certain patterns already seemed present. Stern

(2003) points to research supporting the newborn's capacity to take in external events and the way in which the tasks of regulation, such as eating and getting to sleep, consisted of "the mutual exchange of social behaviours" (p.43). Trevarthen & Aitken(2001) argue that the infant possesses "innate intersubjectivity – that the infant is born with awareness specifically receptive to subjective states in other persons" (p.4). While pleasant, this mother-infant interaction, not unlike the interactions observed in the previous example, was somewhat goal-directed. The social exchange was lovely, but the interactions were time-limited and appeared to operate within the service of outcomes. This infant had learnt quickly how to stay connected:

> *She (the mother) was feeding him and then he seemed to slow down and he was getting slower and slower and she was pumping at her breast, I think to keep him eating. He started, I think, to go to sleep at the breast and she looked up at me and said, "He eats and he goes to sleep, he eats and he goes to sleep," and after a while when it was evident that he was not continuing to suckle she removed him from her breast and put him up on her left shoulder and was patting on his back and remained doing that for a little while, just patting his back gently, and his head would sort of flop back and she'd have to push back with her hand and then raise him up higher on her shoulder and then she said, "If he doesn't eat fully then he doesn't go to sleep, he goes to sleep softly"… after patting on his back for a little while she put him back to the breast and started to encourage him to eat again, which he did, not as ferociously as the first time but he did seem to start to suckle again* (2nd Observation).

Once the infant is sated, he wants to return to sleep. His mother, also keen for some rest, wants him to remain awake until he is fully satisfied, as this enables him to sleep longer. Putting her own needs first is not problematic in itself, and for a very tired new mother it is understandable. Over time, however, this may become problematic. In my first observation of this dyad, the staff member said that if a mother and baby were resting, she would normally leave them alone to rest. This is what she did. A different staff member during my second observation visit told me she was

leaving mother and baby alone as she, the staff member, had a cold. In and of themselves, both responses by the workers seemed very appropriate. In this context, and as will be discussed in more depth later, leaving the mother alone and, in effect, losing sight of the infant and of the mother may unintentionally ensure that the infant has little choice but to acquiesce. In this instance, should the mother continue to awaken and force-feed this infant, this may lead to his developing a problematic sleep cycle over time (Whittingham & Douglas, 2014).

Am I separate to you?: The infant acquiescing to the needs of the mother may also be illustrated in a very different way. Their dynamic seemed to present with a sense of 'all or nothing', with anything more or less too difficult to navigate. Rather than "the infant's behaviour (shifting) to fit or complement the attachment figure's behaviour" (Crowell & Treboux, 2006, p. 295) through too much distance, the infant can be given too little. This next relational dynamic saw this infant's identity at risk of potentially fusing with that of her mother. Where the mother is not being somewhat remote, she is being overwhelming, giving too much before the infant asks for or even wants it. The following example is of a mother/infant relationship where the dynamic appeared to be very engaging but almost excessively so. The dilemma for this infant was perhaps not understanding how she was separate from her mother. The excerpt is taken from an infant observation of Infant 9, who was 4 months old and living with her mother in a shared transitional house with one other family. It was their first week in Refuge, and the mother had made the decision to flee with her daughter. She had inadvertently discovered that the infant's father was making plans to 'kidnap' their daughter and return to his home country overseas. This segment provides some sense of how I saw this mother to be working very hard to 'jolly' her infant up during the observation:

> *Mother had been feeding her daughter and trying then to get her to go to sleep … I wasn't quite sure that she was ready to go to sleep … then she moved her onto the little play mat which had a number of toys that dangled down … It was a lovely period of extended play but*

an element of it was about distracting her infant from being in this new and strange place. The infant would anticipate her mother coming down when she was playing a game with her where she would do like raspberries (blowing) on her stomach and was shaking her hair in front of her infant … they a really strong sense of engagement, but there was just an edge of there being some level of mismatch in the sense that it felt like the infant wasn't really determining that it was her play period, that it was probably something more orchestrated by Mum as a distraction and to make sure she remained happy … there were smidges there where the infant was getting ready not to be happy and mum worked really hard to bolster her up. (1st Observation).

I had only one opportunity to observe this infant. The observation alone did not imbue me with enough confidence to hypothesise that this infant and mother evidenced an anxious attachment. However, within the context of this mother's interview I found other indicators giving some support for such an idea. Mother 9 revealed that when she was 16, she had given her own mother an ultimatum between her and her mother's then violent partner: "*I did ask my mum to choose between him staying in the property or me, and unfortunately she chose him, because I don't think she believed I would have left, but I did"* (Interview Transcript). When Mother 9 was speaking in her interview about the impact that the past week had had on her infant she declared: "*she is not fazed by it in the slightest … Because everything is basically, other than her surroundings, is the same, she's been brilliant … she is content and always smiling, laughs away".* This mother recognised that her baby had been '*quite tired*' over the last few days, but put this down to the weather being unseasonably hot. As for herself, at night when her daughter was asleep she would cry and '*let herself go*' so as '*not to think about it during the day while she is awake'.* Despite this mother's account, and the protestations about her infant's happiness, this assurance did not feel entirely convincing. The trajectory of this mother-infant pair risked developing into an interactional pattern where one sublimated their needs for the other:

"She is my world, yes she is my world. I live for her, I don't live for myself, everything I do is for her, she is everything (talking to infant) aren't you princess, you are my wee poppet aren't you?" (Interview Transcript)

Her infant is her princess-poppet and her whole world. This creates quite a burden for one so small - particularly when she, the infant, may feel grumpy, angry and not at all like a princess. There seemed a risk leading to this infant acquiescing to the needs of her mother, not through few demands but by actively meeting all of her demands and thereby failing to express her full range of emotions and her subjective self. In this instance, it seemed possible that the infant 'appearing happy' at times for the sake of her mother was potentially something she was learning to anticipate, or had learnt already. Infant 9 was very social and would reciprocate my smiles when she looked my way. She and her mother presented as a unit very much in love with each other. What separated this exchange from those that appeared to offer greater safety was that there seemed to be such a strong sense of the infant needing to be happy, not for her sake but rather for her mother's.

Overall this first theme essentially found that most infants gave clear indications of feeling most content when held by their mothers or in close proximity to their mothers. This was demonstrated through their use of their mother as their preferred caregiver, generally seeking her over any other person who was also in proximity and potentially available to them. The mother, as the primary partner in their infant's life, did not just serve the role as provider, however; these mothers gained something significant for themselves from this relational exchange. Just as important to capture in the inter-subjective world of meaning created between infant and mother is what the mothers appeared to take from their infants. This next theme

examines what might be considered the other side of the coin: how the mother takes refuge in their infant.

2. I (the mother) take refuge from what you (the infant) give me

The infant as refuge

It is perhaps assumed that the conditions for creating safety in a parent/child relationship are uni-directional: from the parent down. What emerged from the infant observation data, and was confirmed through the mother's interviews, was the amount of refuge the mothers derived from their relationship with their infant. All ten mothers interviewed identified the infant as the catalyst for coming into Refuge. Two of these mothers were referred to Refuge by child protection, and both chose the safety of their infant over remaining with the partner/father who was violent. The relationship with the infant offered some level of repair and compensation for the violence experienced within what had been their other most intimate relationship, that with their now ex-partners. One mother had even held out hope that the infant's birth might change the father, as he would: *"see my baby and he will look at himself and get treatment for himself to get together and change to improve himself"* (Mother 3).

The infant appeared to represent, for many mothers, hope, purpose and the incentive to create a safe and different future. The very experience of relating to their infant helped to 'make good' and even offer a feeling of security not previously experienced. The early childhood experiences of the majority of the mothers suggest that a sense of emotional safety was not often present in their own family when they were growing up. The presence of the infant in their lives appeared to offer a chance to re-dress disappointments and hurts from their pasts. Accordingly, just as this study found that **I (the infant) come to you (the mother) for refuge and to feel safe,** it also found

that **I (the mother) take refuge from what you (the infant) give me**. That said, what the infant represented for the mother was not always straightforward nor always realistic.

The Infant as 'refuge' from the mother's past

Holding their infant, either in their arms, in their minds or both, may compensate for early childhood experiences which left these mothers feeling unsafe. All but two of the mothers had witnessed and/or experienced parental violence in their own childhoods, though other significant challenges were present for those two mothers. These early experiences of violence appeared to generate an additional imperative to ensure that their infants did not have to endure what they had endured. Their own experience of being subjected to, and growing up with, violence as a child was the motivating factor for leaving their infant's father. That is, some of the mothers had not considered leaving for themselves but they were prepared to leave for the benefit of their infant. Ostensibly, the possibilities of this new relationship with their infant appeared to offer a great deal of refuge from old hurts and harm caused by their own parents.

The literature suggests that early relational trauma experienced by the mothers themselves impacts on their attachment experience, and often results in the mother going on to form negative representations of herself as a mother, and of her child (Flykt et al., 2012; Huth-Bocks et al., 2011; Lieberman & Van Horn, 2009; Main, 1999; Stern, 2003). This study would suggest that at this very early stage in the infant/mother relationship, the mother finds strong incentives to create positive future relational differences. This is evidenced in the first instance by taking the step to leave what they experience as a detrimental relational context for their infant. That is, the infant represents an opportunity for reparation. Mother 1, for example, had seen her father physically, sexually and mentally abuse her mother. She explained that the reason for her now leaving her abusive partner of five years was that she *"didn't want infant 1 (3 months old) growing up thinking*

that's okay" (Interview Transcript). The desire to give her daughter something different offered this mother refuge from a past she could not change and a future that she could change. The nuances of how to find refuge in Refuge were more complex than the act of simply leaving a violent relationship. This alone did not magically produce the feeling of refuge, nor refuge which felt safe, but it did represent a journey towards doing so.

Seeing and feeling that which is 'unsafe': Most of these mothers were very accustomed to seeing events that left them feeling 'unsafe'. A history of early childhood family violence was outlined by numerous mothers. Mother 6 described witnessing reciprocal violence between both parents growing up. "*When I was little my father punching my mum as well. I saw it. So it was like I don't want that she (the Infant) saw everything like this,* but she then added "*Ohh my mum is as well domestic violence", "my father is, yep from my mum"* (Interview Transcript).

The background of Mother 8 was more complex, as she described not only growing up with violence but being left behind "*because I know my mum left when I was three months"* and her father re-partnering. "*What I can remember is my dad hitting us too and my stepmum … it was actually my stepmother that causes everything, so … So she would be like, "I told her to do this and she is not doing it", just bam bam bam (pointing a finger like she is in trouble). Sometimes you'd be starved"* (Interview Transcript). This resulted in Mother 8 feeling like she "*still didn't have the connection"* with her mother as a result of having been left, and adamant that "*I'm not letting anyone take care of my child. I'm going to take care of my child myself*" (Interview Transcript). Mother 9 recounted her sense of abandonment over her mother choosing her partner over her and Mother 10 explained that she was brought up by her grandmother as her "*mother was too busy with alcohol to look after her"*.

When your own mother is experienced as 'unsafe'

It was the feminist movement that exposed the prevalence of men's violence towards women (Freeman, 1973; Gayford, 1975; Lehrner & Allen, 2009; Santana, Raj, Decker, La Marche, & Silverman, 2006; Women's Liberation Halfway House Collective,1976). The feminist movement was also responsible for the creation of Refuges exclusively for women (Freeman, 1973; Pahl, 1979, 1985; Theobald, 2014; Tutty, 1999; Women's Liberation Halfway House Collective, 1976). The complexity for some of these mothers was that not only did they witness or experience their fathers' violence but also experienced their mother as 'unsafe', as a result of her failing to protect them and, in some cases, also proving to be violent. They were determined not to do the same. Mother 1, for example, spoke of feeling that both of her parents had let her down, her mother in particular: "*we grew up with that and mum stayed with him, and wanted to have a family with him and everything like that"* (Interview Transcript). A feminist paradigm contends that the mother, particularly in times past but still in evidence today, is disempowered by a culture that privileges men's control and ownership of women (Davies, 2008). Further exacerbating Mother 1's experience was the fact that her mother had suffered from a mental illness: "*she had psychosis … she was eventually hospitalised and then me and the boys (her younger brothers) kind of had to fend for ourselves"* (Interview Transcript).

This mother's (the mother of Mother 1) ongoing battle with mental illness coupled with managing the demands of mothering was likely to have been overwhelming (Nicholson, Sweeney, & Geller, 1998) in addition to living with a violent partner. Gender inequality and other disparities were apparent in most of the mothers' backgrounds. The mothers in this study did not conceptualise their experiences of feeling abandoned by their mothers or fathers through a gender, cultural or societal lens. This distress was expressed at a much rawer and more guttural level:

> *My mum was so off the rails … I remember dragging my brothers around a corner to run over to my dad and jump up and down on his leg and beg him to please, please, please stop*

> *hurting my mum. And him just smashing her head through the front window … I had nowhere to go and moved into a hostel and she (her mother) ended up following me down and I moved back thinking she is trying and all that stuff and after that she ended up a bit worse … my brothers started getting on bad paths because there was no food at home and they were young. And mum was hocking their stuff to go and get her own stuff* (Interview Transcript, Mother 1).

This example, as do those provided by Mothers 6, 8, 9 and 10 mentioned above, speak to the experience of some of the women finding their own mothers not only unable to provide them with reliable caregiving, but at times putting them at further risk.

Nowhere to hide: When, as children, they had needed protection, these mothers had had nowhere to hide. Their experience, justified or not, was that their primary love object, their mother, did not care for, protect or privilege them. Less appeared to be expected or desired, whether justified or not, from their fathers. It is imperative to acknowledge the broader gender, cultural and societal discriminations that impinge on the individual if we are to increase understanding of how we, as humans, operate. However, it is equally disrespectful not to also hold in mind the pure relational angst and hurt that permeates the lives of many individuals who feel betrayed and unwanted by the very people who gave them their life in the first place. Fairbairn (1952), a pioneer in the theory of personality development, wrote that for a child to feel absolute safety they need to feel that their parent authentically loves them for who they are as a person. In return, this parent needs to genuinely accept their love. For this not to occur creates an unparalleled level of trauma in early childhood. This sense of rejection can last well beyond the early years. Mother 5 spoke of still feeling abandoned by her mother and father (now separated) who lived in different countries and offered her no support. She described her mother, in particular, as a '*holiday Nanna',* "*really not that interested in the children but more interested in herself".*

The presence of the infant, the relationship they offered the mothers and the possibilities for change featured large in many mother's minds. Mother 3 explained: "*it is really sad to leave my home but now I have the baby and I just look at the baby and that helps me to feel better"* (Interview Transcript). Mother 7 stated: *"So yes, she give me this, and hope … (Looking at baby) she put other goals in my life … I was empty so she is filling up where I was empty"* (Interview Transcript). Many of the mothers in this study had not found refuge in their relationships with their mothers or their fathers, and certainly had not found refuge in their relationship with their partners. In fact, in most instances, these were the very people creating the fear and trauma from which they hoped to escape. This had left a void which their infant, for better or worse, was now in a position to fill. The infant, despite their incontrovertible need to be cared for, risked being burdened with enormous expectations of caring for, or even 'saving', their mother.

3. I (the infant) do not come to you (the mother) for refuge

Theme 1 explored the infants' propensity for going to their mothers in preference to others. The most unusual presentations in the study were those infants who appeared to find it safer not to remain in connection with their mother, as occurred with two infants within three separate observations. No refuge was found with their mothers, but some semblance of refuge appeared to be gained through remaining disconnected from them. These infants' presentations were complex, and I found myself experiencing considerable feelings of anxiety when observing them. I interpreted my 'sympathetic response' as a direct indication of how both infants were likely to be feeling apprehensive (Reddy & Trevarthen, 2004). There are particular 'approach and withdrawal' behaviours in the mother and the infant that have been described by Beebe (2006): "These distressed mother-infant interactions must be viewed within a mutual regulation model of interaction, in which both partners contribute moment-by-moment to the exchange, although

not necessarily equally or symmetrically" (p.151). This appeared to be how the anxiety and ambivalence felt by both infant and mother were managed. It is an approach that is demonstrated in the following scenarios.

It is safer to manage alone

Where the infant displays behaviours which suggest that they may feel safer in trying to manage their feeling states alone rather than seek out their mother, an 'anxious avoidant' attachment style may be in play. This does not involve compliance nor acquiescence. Contact with their mother is actually kept to a minimum. Infant 8 was one of only two infants (see p. 162 regarding this other infant) who appeared to keep their mother at a distance as a strategy for managing their overwhelming feelings, seemingly triggered by being too close to their mothers. What set Infant 8 apart was the lack of alternative options for finding other and perhaps more positive inter-subjective experiences. During and after this session, I felt particularly anxious about the welfare of this couple and felt that what this infant displayed was significant. When I arrived, the mother had been feeding Infant 8, who was 7 months old. He was refusing to eat and making a mess of his food:

> *She got increasingly frustrated with him … At one point she became quite sharp with him and said, "Enough!" which gave me a bit of a fright when she said it, so I imagine gave her baby a little bit of a fright* (1st Observation).

After this confrontational interchange the mother removed herself to the kitchen in the room next door, leaving the infant in his walker, and alone with me. This dyad had been in this transition house for six months and were now living by themselves, as the other resident had recently moved on. No Refuge worker had been to visit them for two weeks, according to the mother: "*Normally she comes every week, so I think she is busy or something"* (Interview Transcript). When his mother left the room, the infant moved himself in his walker towards the television but got

lodged between the wall and television cabinet. This meant he had to twist his neck back awkwardly around to see the television, and proceeded to do so more than a dozen times over a ten-minute period, turning back when he could no longer bear the discomfort and then twisting around again. Finally he let out an angry cry. Throughout this whole time I sat in front of him. Not once did he make any overture towards me for help. Did he not expect any help? Bowlby (1988) suggested that for the infant who is "in extremity and with no one else available, even a kindly stranger may be approached" (p.27). This infant appeared to have learnt to rely on himself.

This mother's withdrawal may have functioned as a means of managing the stress, or perhaps even aggression, created by the relationship. The most authentic exchange in these two excerpts seemed to be when this infant's mother told him "enough". This then honestly matched his angry emotional state, ending the dissonance and heralding withdrawal. Later, a similar pattern played itself out again. First she removed herself to find a tangible object (a muslin comforter) to offer her crying son rather than offering herself. Next, she physically held him tightly until he collapsed into sleep, appearing exhausted, or perhaps finding the ultimate withdrawal. The use of a muslin cloth as his comforter had begun in the hospital soon after his birth: "*He was putting it (the muslin cloth) over his face, she said that he been doing that since he was a baby and she wondered if that was to do with the violence, if he covered his face when there was screaming"* (1st Observation).

The muslin cloth remained over his face as he slept, appearing to serve as a barrier between the two, protecting each from returning the other's gaze and perhaps the trepidation of what might be seen in each other's face. A perceived level of threat seemed to operate between this dyad, with the mother ultimately the more powerful (though perhaps not feeling this) of the two. This is perhaps suggestive of a dynamic referred to by Hesse and Main (2006) in which "the parental behaviour inevitably places the infant in a behaviourally irresolvable situation in which the

attachment figure simultaneously becomes both the haven of safety and the source of the alarm" (p.310). This mother seemed fatigued and overwhelmed, as did the infant. Both felt abandoned, and stranded within their relationship with each other and in their environment, and as I noted some hours later in my field notes, "*I felt uncomfortable many times … loss and loneliness seemed to permeate this interview and observation.*"

The words of Hesse and Main (2006) again seem to capture well an essence of this dynamic:

> It is important to stress again that these subtle, non-abusive yet untoward FR (frightened and frightening) outcomes of parental fright may occur in the absence of direct maltreatment … we are concerned the infant has obviously not "lost" the parent, nor ordinarily experienced abuse, its disorganization can be viewed as a second-generation effect of the parent's earlier trauma (p.310).

There was no evidence of any direct abuse, but rather a feeling state that perhaps wished harm (from both mother to infant, and infant to mother), and which possibly left this dyad immediately overwhelmed by the enormity of these aggressive feelings. This mother appears to have experienced multiple traumas and systematic abuse through childhood, together with her own mother leaving when she was 3 months old. She was desperate not to replicate such traumas for her infant. The dynamic operating between this mother-infant may have carried the hallmarks of developing into a disorganised attachment where 'flight, attack and freezing behaviours' are evident (Hesse and Main, 2006). What makes this particular infant's presentation so important to note is that the level of vulnerability and risk to the infant alone, and to the mother and infant relationship together, is considerable and is not aided by leaving this dyad with so with little external support at such a critical time.

The second infant who did not appear to find either safety or refuge with her mother was Infant 5, who was 8 months old. She was one of a small number of infants present at this particular Refuge's large monthly house meeting during the first observation. This little girl had been passed around to different mothers but appeared very comfortable and familiar with her surroundings, unlike Infant 7 (Theme I, p.143):

> *She was stood on the table and they laughed at her chubby little legs, and she seemed quite relaxed being moved from the other to the other to the other, and eventually ended up with a worker, who turned out to be her mum's key worker … there almost seemed be a stronger relationship between the baby and the worker … she (the worker) was about to leave the room and the baby started crying and I noticed that the mother pushed the baby out towards the worker saying, 'Take her. You can have her, you can keep her.' And the worker did end up taking the baby, saying, "I'll hold her"* (1st Observation).

It may be argued that the worker undermined the mother, even embarrassing her in front of the other mothers when her infant appeared to cry over the worker leaving the room. Perhaps this reflected the infant's preference for the worker over the mother. Perhaps the mother confused the infant, by actively passing her over to others and reducing the infant's connection with her.

This infant was actually born in Refuge and had lived there her entire life up to that point. It was initially hard to identify which mother this infant belonged to. In this instance, it appeared that this infant had access to other potential caregivers in this setting and, as a result, alternative relational opportunities that may have been compensatory. Conversely, perhaps this served to actually confuse the infant and undermine the mother's primary relational role. This risk of having potentially diluted, or disrupted, the bond with the mother was particularly pertinent to this infant as she was soon to leave the Refuge with her mother and brother to live in their own accommodation. Her mother worried about the impact of having "*started her life in Refuge*" as

"*there was lots of picking up other people's babies and talking with them"* (Interview Transcript). She wondered what would happen when it was just the three of them. I too wondered what might have happened had the infant and the mother – who was also close to the worker mentioned above – not had these early relational opportunities. Might these foundational experiences have afforded the infant, at the very least, some protective factors which could be built upon by other future and forthcoming relationships (Eriksson, Cater, Andershed, & Andershed, 2011).

The withdrawal from her mother continued during the second observation visit, but this time the infant did not protest. They were in their private unit within the Refuge, with the mother the infant's primary and only caregiving option:

> *She (the infant) started to get grizzly (agitated) at one point and mum said, 'Whoa', made this 'sort of 'Whoa' noise and she immediately stopped … The infant was holding the bottle by herself and drinking away and as she neared the end, she was starting to let the bottle fall down because she was starting to get sleepy and eventually she dropped the bottle and fell asleep, sitting in the bassinette in the middle of the bed* (2nd Observation).

This infant was seldom held by the mother in this observation other than when the mother dressed her in readiness for her impending weekend access handover to the biological (non-perpetrator) father. She was left sitting on the bed in her carry basket and was expected to feed herself and to get herself off to sleep. Her one protest was met with a swift verbal reprimand to which she acceded. Then she got on with the business of looking after herself. This was very different to her first observation, where she had quite freely protested but to an alternative caregiver with whom a very different relationship was apparent. She had not been directly punished by her mother for this earlier protest, but her mother had nevertheless made her disapproval known. Where this infant was, and who she was with, appeared to determine how

she responded. In the privacy of their room, it appeared that it was safest for this infant to withdraw. Ultimately, as with Infant 8, she was vulnerable to her mother, depending on the environment she was in. While this response was suggestive of an avoidant style designed to manage her anxiety, this infant also displayed what is referred to as the infant capacity to exhibit a 'hierarchy of possible attachments' in seeking proximity to a 'preferred figure' (Holmes, 1993).

This was what was most compelling in Infant 5, and what set him apart from Infant 8. Infant 5 could discern at this early age just who she felt safe with and who she did not. Her behaviour with her mother was consistent with an ambivalent avoidant attachment, yet with the worker she felt safe enough to protest at her imminent departure and her distress was assuaged when the worker took her. The variation in this infant's behaviour may have been linked to what the Refuge environment itself offered. Where staff and others are consistently on site, infants are offered access to alternative caregivers. Infant 8 experienced a similarly sharp rebuke from his mother, as did Infant 5 from her mother, but Infant 5 determined it was safest not to protest in any way. Infant 5 was quite capable of protesting, as she demonstrated when offered an alternative yet familiar caregiving relationship in the form of a Refuge worker

Few alternative options

Generally, it would seem that the infant has few refuge options apart from their mother. As noted in the literature review, these infants and mothers may arrive in Refuge already struggling with issues that have left them feeling isolated (Anooshian, 2005; Gilroy, Maddoux, Symes, Fredland, & McFarlane, 2015; Tolan, Gorman-Smith, & Henry, 2006; Tolman & Rosen, 2001). However, as some mothers discuss later in Chapter Seven, they find that Refuge isolates them even further. This has potential implications for the infant. There were few times when workers were present for any great length of time during the observations. However, on the occasions when I did

observe different Refuge workers directly engaging with certain infants, the infants enjoyed this contact immensely.

Infant 5 clearly demonstrated feeling comfortable with a particular staff member and also feeling at ease with the other mothers present at the house meeting. Infant 2 was held by a worker when his mother was making herself a cup of coffee: *"She was talking to him and for the first time I noticed smiles and he made a shrieking sort of noise as he was interacting with the worker, watching her face with great interest*" (2nd Observation). In my observation with Infant 4 I noted that: *the little boy had approached the worker and there was a vinyl tile turned upside down on the floor, the contours of the glue leaving a pattern that he and the worker traced together with their fingers"*. The infants showed interest in me as well, and instigated approaches towards me on numerous occasions: "*Infant 1 was looking at me a lot more than she did last visit. She looked over to me sitting on a chair a number of times*" (2nd Observation, Infant 1). *" … He suddenly popped up and gave me this big grin and started to engage again and play with me and started popping up and down"* (1st Observation, Infant 4).*" … She came up to me a few times looking at me quite intently"* (1st Observation, Infant 6). *" …She gazed at me and returned my gaze and looked at me and I would just do a little smile and she would smile back"* (1st Observation, Infant 9).

A ready interest in engaging with others was demonstrated by most infants when they were given the opportunity. It appears that at such a critical time in their development, the more the infant could have lively, empathic, congruent and attuned relational experiences, the more they were open to asking for this. Conversely, the less they were given the less they asked for. This is particularly worrying given that the literature suggests that the mother-infant bond has already been adversely affected by the presence of violence during the pregnancy and/or early in the life of the infant (Lieberman, 2007; Malone et al., 2010; Schwerdtfeger & Goff, 2007). The infant is

already likely to have experienced considerable relational trauma, much of which may not dissipate simply because they have entered Refuge. The infant requires more than the cessation of violence. They need to be seen, engaged with and responded to, in their own right. The tendency to lose sight of the infant, sometimes by their mothers and often by the workers (as explored further in the following two chapters), appears to be a common occurrence

4. I (the infant) am lost from your (the mother's) view

This last key theme was the most prevalent of all the themes, and perhaps equates to an unintended or benign disregard for the experience of the infant. This involved instances where mothers did not seem to truly see their infant, nor have the emotional or psychological space to contemplate what they might be communicating. Cues from the infant were either misread or missed altogether, resulting in the infant becoming more agitated or giving up. This theme is significant not only because it was evident in so many of the observations but because it was so resoundingly reinforced within the interviews with the mothers as well as with the staff themselves. This was through the existence of a particular mindset which seemed to make the infant 'disappear' in various ways. What makes this theme different from the previously described nuances of how individual infants sought, found or failed to find refuge is that this theme pertains to a shared or collective narrative that appeared to operate in the Refuge setting. This narrative dismissed the subjectivity of the infant and diminished their needs.

In Refuge, as in all settings, there are multiple distractions which may pull attention away from the infant. This is neither uncommon nor necessarily problematic. Tronick (2007) argues that 'losing sight of the infant' is 'normal' as most mothers fail to match their infants' cues 70% of the time. It is the work undertaken in the remaining 30%, with the mother and infant attempting to find synchronicity, that is important for problem solving and 'meaning-making together' as "self-

regulation and interactive regulation are two sides of one regulatory process" (Tronick, 2007, p. 158). What places the Refuge setting apart from others, however, is the set of circumstances which bring the mother and infant to Refuge. These are not on an equal footing with what are considered 'normal' circumstances, just as Refuge is not a 'normal' setting. Being 'lost sight of', developmentally and emotionally, and at critically important times of need, exponentially increases the risk factors which will impede a healthy trajectory for these infants. It can be confidently assumed that the infant arrives at Refuge already affected to some degree. As a result, the pathway to recovery for these infants is particularly fraught if what they need and want from their environment is not seen nor provided.

In what would be considered 'everyday situations', the infant will look to their mothers for help in managing their emotional regulation. If there is a 'mismatch' between them – including not being seen – together they then endeavour to work it out and repair the dissonance (Tronick, 2007). This was seen with Infant 1. Her mother missed seeing what caused her frustration but this frustration was short-lived in any case, as they both soon reconnected to find an alternative solution (see p. 136). In general, however, the collaboration needed for repairing any dissonance was not often evident, with the majority of the mothers appearing, and understandably so, to be preoccupied with their own recovery as well as anxiety about their future. These mothers were not necessarily available caregivers, able to help co-regulate the overwhelmed and withdrawn infant. Nor did the environment of Refuge necessarily make available emotional support to assist with the co-regulation of the mother and infant as a dyad.

Indications of there being a mismatch between the infant and mother were evident on many occasions. These involved the infant making overtures for attention, wanting assistance with settling or having some need which failed to be met. The most extreme examples of these were

observed with Infant 7 when she was handed along the row of mothers at the house meeting (p.142) and in the case of Infant 2, frozen and unsmiling in his pram (p.141). Mismatches between the infants and their mothers were also evident in situations in which the infants became disengaged or needed to fend for themselves, as happened with Infant 8, who relied only on himself when stuck in his walker (p.159). Less dramatic examples were also evident, as with Infant 2 who was lying on the floor and enjoying his mother sitting beside him during the 2nd Observation:

> *He lay looking up at her, as she knelt in front of him, looking into her face … which he seemed to be enjoying. She said to him, "I'II get you some toys," but as she tried to move away he got grizzly so I offered to pick up some and toys and gave them to her … She held them in front of him and engaged him with that but not for very long. I think he didn't actually need that, he was just some enjoying having mum sitting in front of him.*

Infant 2 was simply content to have his mother close, but this was disrupted by his mother's need (and anxiety) to give him more than just herself on this, and other, occasions. Infant 6, after a lengthy wait, gave numerous signals of wanting to get out of her cot and of being hungry until she could tolerate this no longer (p.147). Infant 8 battled with his mother while she tried to feed him, and I could feel the brittleness in their relationship. She was *"being too vivacious and trying to distract him and a bit too playful with him to get him to eat and him not being playful and not wanting to eat".* This theme of mothers losing sight of their infants is further illustrated in two distinctive yet intriguing examples.

Disappearing completely from view

The first example involves Infant 3, who, at just three weeks of age was literally lost sight of when his mother left him alone with me on two separate occasions. This mother had met me only briefly; however in the first observation she 'disappeared' for a short time, moving to another

part of the unit without giving me or the infant warning. Not long after the second observation began she left the unit altogether, announcing as she left that she was "just popping out". She had, I assumed, gone to another unit at the back of the property. Twenty long minutes passed during which the baby, who had been sleeping, nearly woke up once, but I was able to settle him. I wasn't as successful the next time he began to show signs of stirring:

> *He was beginning to wake up and was making a couple of squawks like he was beginning to get ready to cry, so I made the judgement at that point to pick him up and I basically rocked him and held him walking around the room, which did seem to settle things … we did this for some time until I got to the point where my arms were actually getting quite tired, so I was beginning to think, What would I do? Should I put him back on the bed to adjust my arms or what should I do?"*

I sat down on the bed and continued to rock him, but it was now almost 30 minutes since his mother had left and he was becoming increasingly unsettled. I decided to find his mother, and made my way to the end unit.

> *She came out and she said, "Oh, I'm sorry," and that she was just having lunch with the other family. He had been crying on the way to the unit so I think she must have heard us coming, and then when she came out he stopped crying! Altogether! He was still in my arms but with the sun now coming out, he just went back to sleep. So I said that he had been crying and I was sorry to disturb her and she said he probably needed to be fed and she came back to the unit with me.*

I spent thirty anxious minutes alone with this 3 week-old infant. This mother spoke little English and, despite using an interpreter to explain the purpose of the research, she may have misunderstood my role. Or perhaps this 'disappearance' reflected something more. For me, the

experience of being left alone with the infant generated feelings of great uncertainty and anxiety. I was curious about what prompted me to apologise for bringing her infant to her. I was left with a powerful sense of how it felt to be responsible for an infant. My feelings of inadequacy, and sense of desperation for the mother to return and take over, perhaps paralleled what this very new mother yearned for: someone to take over. Might this be what equates to 'refuge for the mother'? Needing someone else to take over, safely, when she can't manage anymore? Perhaps it is not only the infant who is lost sight of. The worker who accompanied me to the unit for this first observation told me that she liked to leave new mothers and babies alone when they were resting. The next worker, on the second visit, did not accompany me to the unit as she had a cold and did not want the infant to catch this. The fact that this very new, first-time mother was being purposefully left alone by staff could suggest that in their effort to respect the mother/infant they were inadvertently neglecting them. In less isolated and more 'normal' circumstances, new mothers might expect to have partners, family and friends actively involved and supporting them in their early days of mothering, but new mothers in Refuge do not enjoy such support

Even when we are together, you don't see me

In contrast with the complete disappearance of Infant 3's mother, in this second example Infant 4's mother was physically, though not always psychologically, present for the entire session. The observation with Infant 4 and his mother moved between four different locations within the Refuge. A similar pattern occurred in each location. The first took place in the staff office. The Refuge was in the midst of some minor renovations and the space was particularly cluttered, with piles of equipment and boxes scattered around. Whilst the mother kept somewhat of an eye on her very mobile son, both she and the worker became distracted with discussing appointments and other business matters:

> *The infant was going back and forth between the couch and the music system, pressing buttons and trying to get things to work. Wires were hanging down, little electrical cords*

from the music system, and I wondered if they might end up coming down on top him but thankfully they didn't … at one point he managed to not only turn on the sound system but turn the volume on full blast … the noise gave him quite a fright and he took a few steps back, and Mum then got up and turned the record player (stereo) off at the power point … There were two pieces of long flat metal-like rods sitting along the very back of the couch, and he went to pick those up and I quickly moved them away from him because they were potentially quite dangerous. I moved them down further along the back of the couch and with my finger and face made a 'no' gesture. He seemed to know what I was communicating, and although he remained interested in where I had put these rods didn't pursue touching them. (1st Observation – Infant 4, 16 months old).

I felt a considerable sense of anxiety during this observation. Perhaps this is what an infant feels when not adequately seen or 'held in mind'. I reflected in my field notes later that "*there's a lot going on in here, I (the infant) am buzzing around like a busy bee working out where to go, and who to go to, to get some feedback*". I became preoccupied with the physical safety of this infant during this session. There were so many potential hazards in the room, and I worried that this space was not actually very safe for this infant. It was after some time of being tentatively curious about me that the infant in fact engaged with me regarding the issue of his safety:

He started to climb up on the back of the couch towards the window and grabbed onto a door handle of a door directly behind the couch. The door couldn't open but his body was splayed precariously across the arm of the couch as he grabbed at the handle, pulling it up and down. He was leaning so far out on the arm of the couch that I thought he might fall off it, so I started to hold my arm out towards him in case I needed to suddenly grab at him … he was almost playing with me, and moved towards me, and at one point with his hand stretched out towards me almost mimicking what I was doing … eventually he slid back down next to mum and laid down on his side, curled up with his head down, one hand to his

mouth, sucking his thumb, the rest of his hand splayed open and the other hand resting on his head, caressing his own hair like he was comforting himself ... (1st Observation).

Although there were three adults in the room, the infant seemed to be quickly lost sight of and he acted accordingly, entertaining himself and, upon tiring from his whirl of activity, comforting himself. He was in plain view, but not really seen or engaged with unless his behaviour demanded some kind of response. The mother was preoccupied with other urgent issues that had either led up to or resulted from her arrival Refuge. The capacity of this mother to be healthily 'preoccupied' with her infant was impeded. Winnicott (2002) describes this as "to almost lose themselves in an identification with the baby, so that they know (generically, if not specifically) what the baby needs just at this moment" (p.73). This does not mean that the mother loses her sense of self but rather is aware of the vulnerability of, and need to protect, her infant. The infant's period of dependency is considered quite lengthy (Leckman, Feldman, Swain, & Mayes, 2007). As a caregiver with much on her mind, this mother was distracted. So too, however, were the staff. The infant maintained a steady pace, asking for someone to notice him, but the interest shown him was cursory. The constant physical activity of this infant was perhaps a way of distracting himself from his sense of being lost. He worked hard to fill up the space and continued to invite his mother, but when this did not work he invited me to hold him more firmly, ensuring that he stayed foremost in my mind.

Conclusion

The infant observational material suggested that overall, most infants found safe refuge in their mother when they were either being held by her physically and/or in her mind. When these forms of caregiving were not made available to the infant, the infant appeared to accommodate the needs of their mother by ameliorating their behaviour in order to maintain some proximity with

her. In some instances, however, when the mother herself was overwhelmed, the infant had no choice but to shut down altogether. Two exceptions to 'shutting down' were noted. One infant found refuge in an alternative caregiver in preference to her mother, and another infant exhibited behaviours that indicated his attempts to manage his feeling states on his own. Both of these infants had been in Refuge considerably longer than the other infants involved in the study, and both were over eight months of age. All of the infants, apart from one, appeared to have little choice other than to rely on what their mothers could offer as there were few alternative caregiving opportunities available. It was not evident in any observation that what the infant was receiving from the mother, or the Refuge generally, was sufficient for the infant. There was a collective, unspoken mindset which appeared to contribute to mothers and workers losing sight of the infant beyond what were the particular relational patterns operating within each infant-dyad. The next chapter explores this collective mindset in greater depth, together with the mother's overall perspectives on how refuge is provided to infants in Refuge.

CHAPTER SIX (The Mother)

This chapter takes one step back from the infant observation data to explore the mother's understanding of their infant's experience, and how these findings coalesce with those emerging from the infant data. In essence, the mothers believed it was their responsibility, not that of the Refuge, to provide their infant with refuge. They considered themselves the primary caregiver, this being based on the assumption that leaving the infant's other significant caregiving figure, their father, had had no impact the infant. In these mothers' eyes their role as the primary caregiver left the Refuge with the job of supporting them, rather than their infant. Further to this, as their infant could not and did not have the ability to communicate, the mothers felt that there was little the Refuge could offer them in any case. Rather than their infant being lost from view, as indicated by the infant data, the mothers felt that it was in fact they, the mothers themselves, who were sometimes overlooked by the Refuge. Whilst there to provide for these mothers' needs, the Refuge did fail them at times by not always providing their infant with the level of safety they had expected from such an environment. This chapter draws predominantly on the interview data of the mothers; however, additional data from the infant observations, worker/key informant interviews and field notes are included to extend some of the themes being examined.

The four key themes and two sub-themes to emerge from the mothers' data were:

1. **She, the mother, gave her infant refuge, rather than the Refuge.**

   The infant is not missing their father because he was never really there.

2. **By supporting me (the mother), the Refuge supports my infant.**

   There is nothing the Refuge can offer my infant as my infant can't communicate.

3. **I (the mother) am 'lost sight of' by the Refuge.**

4. **In some ways the Refuge is 'unsafe' for the infant.**

The previous chapter established that the infant predominantly sought refuge from their mother, and in preference to any other person. This corresponded with what the mothers believed, ie. that the infant used them as their refuge, rather than the Refuge itself. In the mother's interview answers, there was little suggestion that what they believed they provided, as mothers, was not always 'good enough'. This assumption of the mothers of being 'good enough', however, did not always correspond with what the infant observation data revealed. Often it appeared that the infant had little choice other than to 'make do' with what they were given. In stark contrast, however, one mother suggested that it was the infant's father, rather than herself, with whom her daughter shared the strongest bond, and that she was distressed by his absence.

Just as these mothers considered themselves to be the refuge for their infants, they often also considered that what their infants needed was indistinguishable from what they, the mothers, needed. Most questions about what the infant needed were interpreted by the mother as 'what they (the mother) needed' and 'what they (the mother) wanted from' the Refuge. The infant was an extension of, rather than separate to, them. This notion of the mother and infant as one was reinforced by the Refuge workers, as will be elaborated on in the next chapter (Theme 1, p. 199). That the Refuge was really there to support them in their role as mothers was linked to a belief expressed by some mothers that the infant could not communicate, and therefore did not require anything other than material goods. This second sub-theme reinforced the idea that they (the mothers) were the entry point for any input from their children because infants cannot speak, so by deduction they have nothing to say. The third theme resonates strongly with the phenomenon that seemed very present in the observations of the infants, but was expressed by some of the mothers themselves – that they felt the Refuge had 'lost sight of' them Some mothers further expressed concern that the Refuge was, in fact, a less-than-safe place for their infant, which seems to contradict the purpose of Refuge, this being to enable women and children to find safety. This anxiety was also shared by some Refuge workers (p. 195).

1. She, the mother, gave her infant refuge, rather than the Refuge.

A number of similar threads ran throughout many of the mother's interviews. Fundamentally, these underlined the belief that the way in which the Refuge provided for their infant was through giving them, as their mother, practical support and a safe place in which to be with them. After that, as was encapsulated by Mother 1: *"a baby only needs her mother"*. Mother 1 had been through a number of Refuges herself growing up, and made it very clear that she considered her mother to have been an inadequate caregiver (see Chapter 5, p.156). However, she did not appear to see herself as similar to her own mother. When asked how the Refuge provided for her infant, she explained that she saw its role as emotionally peripheral to her infant, providing just *"the use of materialistic things like nappies etcetera. And being away from an unsafe area*" (Interview Transcript). Similar sentiments were echoed by other mothers. The key to the infant receiving refuge came "*down to us mums*" (Mother 2), as the infant is "*my responsibility*" (Mother 3), "*they just live with us, no stress, no panic, nothing*" (Mother 6), as "*his mind is on me*" (Mother 8).

I am all my infant needs

Overall, the infant was not considered to have needs beyond that of having access to their mother, and as long as the mother was okay the infant was perceived to be okay. Mother 8 commented: *"If he screams now, he screams now because he wants attention, not because he's emotionally distressed*" (Interview Transcript). She could not contemplate that her infant's screaming could possibly indicate that her infant found her, or their current situation, at all distressing. The concept that if the mother is fine, so too is the infant, is not an unreasonable proposition in itself. The suggestion that the mother does not need to be anything more than 'good enough' was first and famously asserted by Winnicott (1960). However, there were indicators that some of these mothers were actually struggling, and with more stresses than other mothers in the general population might face, particularly in recovering from a violent relationship (Appleyard & Osofsky, 2003). Implied was that the absence of intimate partner violence equals 'good enough'

parenting. As summed up by Mother 11: "*So when it comes to refuge, for her, my thing is that she is safe and that she is secure".*

Furthermore and perhaps most significantly, the observation data, as evidenced in the preceding chapter, suggested that the lack of violence currently experienced by being in Refuge had not necessarily removed all barriers to the capacity of these mothers to be appropriately available to their infants. Winnicott (1960) suggests that when the maternal care is 'not good enough', "the continuity of being is interrupted by reactions to the consequences of that failure" (p. 593). That is, some of the infants within this study appeared to be navigating how to manage a lack of continuity of care by adjusting their expectations and behaviours. This disruption to the 'continuity of being' interrupts capacities for exploration and development of the 'emerging self' of the infant as survival trumps flourishing (Stern, 2003). Inadvertently, this perhaps stifles the infant's subjectivity and encourages their identity to become merged with their mother's, as this is what keeps them close. This disruption to the 'continuity of being' may well be a component of the anxiety about oneself and the potential insecurity in being negatively perceived or seen as incompetent by others, and which Lieberman (2007) suggests operates within the inter-generational transmission of family violence. The background information provided by these mothers certainly suggested that the wounds of the past and the present were still alive and operating in the minds of many of these mothers (Fraiberg et al., 1975). That their infants now only need and/or want them ignores how much more is needed and wanted. This was indicated by Mother 6 when asked if her infant daughter was aware of her surroundings: *"She know that she is here with me, and that's it"* (Interview Transcript). Similarly Mother 8 announced: *"I'm not letting anyone take care of my child. I'm going to take care of my child myself"* (Interview Transcript). It also infers that the Refuge is, in some ways, superfluous to the subjectivity of the infant, as they are without subjectivity. This also carries a further implication – that the other contributor to the infant's creation was, and is now, irrelevant.

The infant is not missing their father because he was never really there

It was as though the fathers of these infants had completely vanished. They were obviously not present in the Refuge, nor receiving access. They were spoken of little, and when they were it was generally not complimentary and their connection to the infant had been diminished. For example, Mother 10 spoke only once of her partner and did not identify whether or not he was the infant's father. Her reason for entering Refuge, she explained, was simply that *"her partner was going off to get alcohol, and she wanted to have a break from this"* (Interview Transcript). Similarly, the workers and key informants appeared to neither speak of nor regard the fathers as worthy of mention. For the infants, it would seem that they had disappeared. If the concept of refuge for these infants was their 'mother' (in a violence-free environment), this also appeared to imply the absence of fathers and, more generally, men. Only Infant 5 and Infant 10 had access to their fathers – Infant 5 as he was not the perpetrator, and Infant 10 who, with his mother and siblings, were planning to return to the home in which the father was living, as there were no other options in their remote community (they had entered Refuge as a circuit breaker). Only one mother (Mother 3) was positive about the father and hoped that "*with having a baby it could help him try to change"*. This made Mother 3 either the exception or simply less guarded in her wish to reunite with her husband in a setting which actively discourages women from returning to the place of violence (Abrahams, 2010; Gordon et al., 2004; Horton & Johnson, 1993).

Out of sight, out of mind

Not only was the father physically absent in the lives of the mothers and infants studied, but any lingering psychological presence of the father was erased. Mother 2 immediately corrected a question I asked about her partner (the infant's father), replying firmly, *"Ex-partner!"* Some mothers minimised the significance of the relationship of the father in their infant's lives by suggesting that the infant would not miss him. This was "*because he is kind of working every day,*

9 AM till really late" (Mother 7). Another suggested, *"She was happy when he is going to work"* (Mother 6). Mother 9 felt that a relationship had never really existed, as "*he didn't really get to spend much time with her so there really wasn't much a bond at that point".*

The significance, harm and dangerous nature of the violence notwithstanding, it was difficult to ascertain any real sense of the father's presence in these infants' lives other than the fact of being noticeable through their absence. Mothers 2 and 10 barely mentioned their children's respective fathers, and Mother 1 described him more in terms of being her partner than as the father of their infant. It was only Mother 11 who volunteered the father's importance in their infant daughter's life. This, she felt, was verified by her infant's behaviour since entering the Refuge: "*I think the impact was huge on the baby, because her and her dad are very close … it's like she is looking and waiting for him to show up".* The dilemma for this mother was that the act of leaving to ensure the safety of herself and all of her children came at a profound cost to her infant: *"He threatened my life on many occasions, but more recently leading up to the time that we left … and I had no doubt that it would come to that at some point if I didn't get out*". Being safe was the choice this mother made over maintaining the special bond the infant had – and she alone, it would appear – had with her father, *"because everything she's ever known was seeing her dad, you know, assault her mum, so I don't know if that's become normal to her*" (Interview Transcript).

It was still early days for seven of the mothers, having only recently arrived in Refuge. However, overall, most of these mothers appeared to have little capacity to contemplate the psychological bond all children have, for better or for worse, real or imagined, with their biological fathers. The fathers' complete banishment is impossible. Mother 6, one of the three mothers who had been in Refuge for a lengthy period, sagely noted that she had noticed some mothers' hatred for their partners spilling over to their sons: *"I think it's about what happened before she came here to*

Refuge … if she have a son I think she hate him because he is man". When it came to her own daughter, however, she felt there would be no impact in growing up without her father, diminishing his relevance in her daughter's life or any possibility that she could miss him because "*she doesn't remember"* (Mother 6 Interview).

Men not allowed

The implication that all men were potentially harmful because of one violent man resonated throughout the interviews. Having a negative opinion of someone who is violent towards you is not unreasonable. Unfortunately, completely demonising the infant's father is as destructive as it would be to completely idealise him. Lieberman, Padrón, Van Horn, and Harris (2005) argue that finding and holding aspects of goodness amongst even the most destructive of caregiving behaviours provides important 'protective intergenerational influences': "We propose that the parallel identification of "beneficial cues" can hasten recovery from trauma by placing the traumatic cues within the larger perspective of nurturing and growth-promoting experiences" (p. 507). The mothers generally showed little idea of how to negotiate the absence of the father in their infants' lives. In denying or denigrating the father/infant relationship, the capacity to celebrate that which is good about the fathering relationship also celebrates something positive from the infant's sense of self as a product of that relationship. Jones & Bunston (2012) note that when working with infants impacted by family violence:

> there may be a pull towards thinking exclusively about repairing the infant's relationship with her mother and to expelling any thinking about the parental couple. However, we risk losing something of great significance when we restrict our work to the infant's relationship with her mother. The infant has a mother and a father, the sexual couple who created her; that coupling underpins her history (p.230).

A less recognised influence on the way in which the mothers think, or try not to think, about the fathers may be linked to how the fathers are viewed by the Refuge staff. An alternative way of interpreting Mother 2's insistence that her partner was now her ex-partner is that this was her attempt to prevent me from thinking that she had any lingering feelings for him, or worse still, plans to reunite with him. Particularly as Child Protection had given this mother an ultimatum that involved leaving her partner or losing her infant. The fear of having a child removed, or of being admonished for still having feelings for the partner who caused you harm, is liable to be strong within this setting. Similarly, Mother 11 believed that her infant was pining for her father (p.179). This mother recognised that despite the violence endured, her infant daughter had experienced something special in her relationship with her father. Her daughter could benefit from having this made sense of and tolerated. It would seem more likely, in the face of a situation which appears overwhelmingly negative for the rest of her family, that something positive this infant might receive from her father risks being eliminated.

2. By supporting me (the mother), the Refuge supports my infant.

As the mothers in general saw themselves as the Refuge for their infants, it was they who needed the primary support in the Refuge, over their infants. This idea centred on a belief that the Refuge could only really offer their infants support by supporting them, the mothers. This was in part because most mothers thought that their infant couldn't communicate (the sub-theme described next). As such, this translated into 'my infant is supported when I am supported'. This premise also corroborated the view that their infant was an extension of them. This theme offers a more nuanced insight into understanding the perspective of the mother's relationship with their infant, and how they view the infant's relationship with them. It elucidates further the thinking that underscores the first theme in this chapter: the mother as refuge. The support the mothers were

given, and the support they wanted, focused on their being kept safe, provided with material aid, not being separated from their infant and being emotionally attended to.

Finding a place safe from violence

Foremost for all of the mothers interviewed, Refuge meant being in a place safe from violence. This appeared to relate more to finding physical rather than emotional safety. Mother 10 explained refuge as *"offering a safe, clean space for her and her children".* Mother 11 expressed a similar sentiment: *"in every sense it's about security and safety for myself and the kids"*. Mother 6 simply commented, "*I am safe here".* It was implied that with the mother safe, so too were the infants. Refuge also provided more than just physical safety, as Mother 7 explained: "*Everybody here is very very welcome and very warm and the first time you came here, just you feel, the staff and everybody else that you belong here. You are no stranger, you think you belong here*". Other than a place safe from violence, what most readily came to mind for mothers in describing Refuge was the tangible support that was provided.

Being 'given things'

The experience, and for some the expectation, of being 'given things' was the other component identified in relation to their experience of Refuge. This ran through most interviews. When asked, "*What happens for a baby in the first week of coming in?*" Mother 1 replied, "*It was giving, like nappies and nappy rash cream and like cream if she had a rash on her neck, the use of the bath … and things like that".* Being 'given things' by the Refuge was certainly evident in the infant observations. In the observation of Infant 5, I wrote: "*When I walked into her room, there was stuff everywhere."* Mother 5 said that *"when the staff ask if they want things, some women will say no but I'm always like sure, sure, I'll have whatever's going"* (Interview Notes). Similarly, in the observation of Infant 3, "*there were lots of things … Bags of food and goodies and there were Christmas bags there which I assume had been probably given to the shelter staff at Christmas time",*

and in the observation of Infant 2, "*On the spare bed there were all these little piles of (donated) clothes laid out".*

One mother equated the giving of support as having access to nice surroundings. Mother 6 noted: "*We have playrooms or neighbours with children. It's fine for me and for her. We have a lot of garden, a large garden."* However, not being given things was also seen as an issue. Mother 9 expected more:

> *I think if there were really, proper baby toys rather than toddler toys because things like that does help, rather than coming into a property with nothing and then trying to have to entertain a baby, you know it's hard if you've not got anything.*

This statement at first glance appears to suggest that this giving is directly about the infant, but upon further scrutiny suggests that the giving of the toys, whilst no doubt of benefit to her infant, is more about helping her in her role as mother. Mother 10 was very happy with the support given by the Refuge, but felt that there *"could be more equipment suitable for babies, like a proper bath"*.

Keeping us together

The literature suggests that many mothers resist coming into Refuge for fear of having their children removed (Anooshian, 2005; Crawford et al., 2011; McCoy-Roth et al., 2012; McGee, 2000). Two mothers in this study expressed the opposite, noting that the Refuge was "*keeping us together. I didn't hear of anything, you know, any reason why we would be torn apart or anything like that*" (Mother 1). Mother 2 came into Refuge so that her infant would not be removed by Child Protection: "*I don't want to lose him, you know, I'm prepared to go anywhere".* It would seem that Mother 2 would not have chosen to come to Refuge to protect herself, and despite initial misgivings, when we met again a month after the first of three separate observations, this mother explained that it had actually turned out to be a very good thing for her and her baby and she was

"actually feeling sad about leaving the Refuge in some ways" (taken from the last (3rd) Infant Observation). Supporting the mothers in their wish to not be separated from the infant is important. Determining and, more crucially, assisting the mother to indeed be the best option for the infant is just as important. Simply coming to Refuge in order to keep their infant may not be enough. Seeing the infant as possessing their own subjectivity, and having their own needs and own rights, may be part of this.

Defining support

It is perhaps difficult to actually define how support is experienced and, further to this, spoken about by these mothers who appear to have had so little experience of it over their lifetime. It is much easier to identify that which is tangible. As the mothers expressed so poignantly in the previous chapter (Theme 2, pp. 154-157), it was that which they had *not* received from their caregivers that was easy to articulate: "*My mum left when I was three months … she didn't take us with her"* (Mother 8). "*[My] mother was too busy with alcohol to look after [me]"* (Mother 10). "*I did ask my mum to choose … unfortunately she chose him"* (Mother 9). "*She is a 'holiday nanna'…. really not that interested in the children but more interested in herself*" (Mother 5). Asking for, and expressing adequately, what you want emotionally is particularly complex for survivors of trauma as quite literally they are often unable to find words. "All trauma is preverbal … Trauma by nature drives us to the edge of comprehension, cutting us off from language based on common experience or an imaginable past" (Van der Kolk, 2014, p. 43).

This could in some way go towards explaining the perceived fusion between mother and infant. With so much already taken from these mothers, the infant, having come from them and being seen as remaining part of them, could not be taken from them. Mother 10 was unable to consider

what support the Refuge offered her infant other than the fact of being with her and away from violence. She felt that she could tell that her infant "*knows this is a different place …This is not home for him."* But she couldn't suggest how he might be supported in Refuge other than through Refuge supporting her. It was easier for her to describe how Refuge provided refuge to her older children – by letting them know that *"there is a big wide world out there"* and *"they learn to say thank you and good afternoon … it's nice here because we all have support*."

Feeling unsupported

Just as getting support for the mother supported the infant, the opposite also applied. Mother 1 felt that the Refuge offered her little in the way of emotional support: *"Yeah well emotionally I didn't really get that much … people never really came up and talked to me about anything that happened."* The consequence of not getting the emotional support she wanted impacted her infant as *"the more stress I have, the more stress the baby has"*. Mother No. 6 also referred to this indelible bond: *"Because they feel what mums feels. Yeah. If I was nervous, she's nervous. When I was crying, she's crying as well. (Long Pause). I think babies and mums have a connection for all life."* Having the mother (or parent) as the centre of the infant's world is entirely appropriate for the very young and dependent infant. However, as the infant develops, this lack of separateness poses some inhibitors to the infant's developing a sense of self, connected to but different from the mother. Where the infant experiences a secure attachment, they know their mother is available to them while also enabling themselves, the developing child, to successfully manage their own regulatory experiences and develop an openness to forming healthy relationships with others (Bowlby, 1988; Rifkin-Graboi et al., 2009; Salter-Ainsworth, 1991). The mothers did not conceive of the infant needing, or receiving, any relational support from the Refuge, nor that they may be able to benefit from such support in any way.

3. There is nothing the Refuge can offer my infant as my infant can't communicate

This sub-theme explores the belief that most of the mothers appeared to hold: my infant "*can't communicate and tell us how she is feeling"* (Mother 11). There is a purpose served by seeing the infant as unable to communicate, and therefore unable 'to know' what has happened to them. The mothers generally considered their infant as too young to know, remember or understand what was happening to them, and certainly unable to communicate this in any meaningful way. Mother 11 noted: *"I don't know what they could do for my baby"* (Interview Transcript). The Refuge might be able to offer something to "*the other kids that (are) older who can communicate if they're scared",* but there was little the Refuge could do for an infant, "*because they're babies, they can't tell us how they feel".* Mother 2 lamented directly to her son, *"If only I could read your mind"*. The notion that the infant may have their own reactions, trauma and feeling states and that they did in fact possess physiological memories of trauma (Van der Kolk, 2014) was largely foreign to the mothers. Even when a children's worker was allocated to an infant, the mother felt the best they could do was "*just stay and we chat, that's all because he's too young and there's nothing he can really do"* (Mother 8).

The belief commonly held by these mothers was that the infant requires no more than being with the mother as "*she is fine here, she is happy here … she know that she is here with me, and that's it*" (Mother 6). As such, everything reverts back to what the Refuge can offer the mother: "*There isn't really much I think that they'd be able to do other than maybe offer the support of like finding them a bit of crèche that you could put a baby in for a couple of hours to get a break"* (Mother 9). Finding her infant 'a bit of crèche' appeared to be about a break for the mother rather than for the infant. Mother 10 seemed to be alone in her capacity to suggest that her son actually did demonstrate his own subjective response to coming into Refuge (as was noted in Chapter Five, Theme 1, p.138). She described that he "*hears different voices, sees different things and smells different*

things. Sees him looking around … She knows her baby gets frightened as she can feel him jerking in her arms when he is scared." The shift in this infant's demeanour from initial clinginess to becoming a more relaxed infant who engaged proactively with his environment the following day suggested that this mother was well attuned to her infant's communications.

Is 'not knowing' better?

The very mothers who doubted their infant's ability to communicate their emotional states soon contradicted themselves. In one instance they would minimise or deny the infant's capacity to feel or remember experiences, as though unable to comprehend that this was possible, but then in the next instance provide evidence of how they did do this. Mother 6 said that there had been no impacts of the violence on her daughter, but then remarked, *"but she is just scared when someone is shouting".* Her daughter was 5 months old when she entered Refuge and was now 8 months old. That shouting might be a traumatic reminder is not at all surprising given what her daughter was exposed to prior to entering Refuge. Mother 11 stated: "*Oh, I don't know what they could do for baby, yeah, because she can't communicate and tell us how she is feeling*" but then explains:

> *To her it's just a drastic change, yeah … she is a lot more quieter, she is very quiet, she won't kick up a fuss easily, you know, like before, she sort of just looks around at night time. Me and the two older boys, we sort of swap (laugh) it's like shift-work, one of us will nurse her for so long and then just to get her, you know to sleep* (Interview Transcript).

Mother 8 said that her now 7 month-old son would not remember the violence that had occurred throughout the pregnancy and until he was six weeks old, when she had left his father. However, as she spoke she recalled her baby son's habit of covering his face with a muslin cloth (favourite

comforter), a habit which was not apparent at the hospital after giving birth but began soon after he came home:

> *"I don't know because when he was really young he just want to sleep, and when I take this away from him (the comforter) he wakes up. So he more is like hiding or something … I don't know why he does that but when I had him in the hospital he wasn't doing that, but when I got home because of all the yelling and stuff I think that's why"* (Interview Transcript).

Whether this contributed to the infant using his comforter as a place beneath which to hide, or whether this action was perhaps even due to the intensity of the mother and infant's current circumstances – isolated and alone in their transition house together (see Previous chapter, Theme 3, 159) – this mother began to consider that perhaps maybe '*all the yelling and stuff*' had impacted her son. "It is now clear that there are recall memory "systems" that are not language-based and that operate very early. Motor memory is one of them" (Stern, 2003, p. 91). Infants do remember, and their memory is physiological, preverbal and stored in the body (Schore, 2003b; Van der Kolk, 2014). Furthermore, it appears that all of the mothers in this study may too have suffered early childhood trauma. How this impacts on their ability to read their infant's traumatic responses, let alone their own, has considerable implications.

Memories of trauma

Traumatic memories held by the mothers themselves but held physiologically (implicit) rather than cognitively (explicit) are neither easily accessed nor processed (Schore, 2001; Schore, 2003a; Van der Kolk, 2014). It is possible that such memories and the subsequent developmental strategies used to defend themselves impinge on the mothers' ability to see or connect with the distress of their infants. To conceive of their infants as being able to experience or communicate

their own feelings, or for their infant to have any sort of recall regarding events which they may have found distressing, is perhaps something these women would prefer to not to know about.

The seminal work of Fraiberg et al. (1975) in their landmark paper "Ghosts in the Nursery" spoke of a small but highly traumatised group of mothers who themselves experienced early childhood mistreatment. The mothers defended themselves psychologically by blocking out their own pain, and consequently that of their infants. The infant's distress tapped into something within the mother and her own earliest implicit memories, and thus came to "represent the repetition of the past in the present" (p.389), negatively impacting the way in which they interacted with their infant. This may apply to the mothers in this study. Knowing, or believing, that their infant is experiencing real emotional pain ("*she is a lot more quieter, she is very quiet"* Mother 11) is risky. As noted by a participant in a Refuge worker's group interview:

> *"I don't think when they come in they understand that their children have suffered this as well ... when they do realise that, especially in the DV workshop, that is one of the things that is for them really upsetting. And especially if they're second generation, if they've been in this situation with their own parents, I think then it brings it all back"* (Staff Focus Group, London).

Not seeing the infant as separate from themselves, nor having the capacity to feel, experience or remember, offers a form of protection. This is a protection from being reminded and therefore emotionally overwhelmed by how their most significant relationships, as infants themselves and now as adults, failed them so spectacularly and, worse still, put them in peril. To think that they may have, or could still, expose their infants to such perils is perhaps to reach a place that feels much too treacherous to visit.

3. I (the mother) am 'lost sight of' by the Refuge

The inverse of receiving support from the Refuge was not receiving support or, worse, being forgotten about altogether. This parallels Theme 4 in the previous chapter (p.166) of the infant 'being lost from view'. Some, though not all, of the mothers appeared to feel that they were neither seen nor remembered by the Refuge staff themselves. In some respects, this goes to the very heart of this enquiry. More than the notion of 'by supporting me you support my infant' (Key Theme 2 above), this latter sentiment operates at a much more embryonic level – the desire for the mothers to be seen simply for themselves, not because this is part of the Refuge workers' job but because the mothers are people worthy of being thought about and seen. Whilst being lost sight of was not something expressed by every mother, it seemed to be an underlying insecurity which made them vulnerable to their environment and the kind of refuge being provided by the Refuge.

Mother 3, for example, exclaimed that the Refuge "*was my salvation in that I don't know where to go but now that I know there is some places like this so it's really good*". She was a non-resident in Australia on a Visitor's Visa, and being in Refuge appeared to bring her more clearly into view. She had met another Vietnamese mother also staying at the Refuge and had even been offered potential security in the form of assistance with her application for residency. Mother 7 similarly felt that the Refuge offered her much more than "*just a room … you are no stranger, you think you belong here".* She was a migrant, isolated from familial support, and now found herself in a Refuge where the majority of the residents were, like herself, migrants. Both of these mothers seemed to feel great relief and even 'community' despite only having recently arrived in the Refuge.

Being forgotten

Those mothers who felt 'lost from view' expressed feeling forgotten, ignored and abandoned. They were grateful for the accommodation but expected and wanted more emotional recognition,

involvement and for some, tangible assistance. Mother 1 felt that little effort had been made to ask her what she wanted, or to explain what options might be available in terms of secure housing, "*because they were quite blunt that that's not what they were there to help for".* Mother 9 was much more explicit, and repeatedly expressed feeling abandoned by the Refuge throughout the interview:

> *To me it's felt like they have basically put me in the property and left basically, not dumped me, but it feels like they dumped me and kind of forgotten until they need to meet their quota, if you know what I mean* (Interview Transcript).

These two mothers (1 and 9) had also only been in Refuge a short time, but offered starkly different responses to Mothers 3 and 7 as mentioned above.

Mother 8 and her infant had been in Refuge for six months. They were currently alone in the house as the other, single resident had recently moved out. The children's worker – "*she stays like about an hour*" – had not been to visit in over two weeks: "*Normally she comes every week, so I think she is busy or something*". This mother's own mother had left her, abandoning her to the care of her father and, when he remarried, her stepmother, whom she described as both cruel and violent. She seemed to be grieving her co-tenant's departure, feeling like once again she was being abandoned: "*He gets used to that one and they go as well. So not only affects him, it affects me as well. Because you just get used to someone and all of a sudden the person is out of your life".*

This mother felt clearly isolated, and seemingly forgotten about, in a transitional house. She did not have ready access to staff as occurred in the bigger Refuges. She seemed to feel the familiar tug of loss experienced when you allow yourself to begin to rely on someone only to discover that they will eventually abandon you. In this instance, it was a fellow resident. *"So she just found a house and she moved on*." *And we were left behind*, is what was possibly left unsaid. The Refuge,

by virtue of offering this kind of accommodation model, was also implicated. However, rather than acknowledging her feelings of abandonment the mother complained of how this impacted her infant in the first instance, before stating: "*you just get used to someone and all of a sudden the person is out of your life, so I just think it is too emotionally draining for both of us".* Her housemate had gone and the children's worker had not been to visit. She was not a priority, people had forgotten about her and she was lost from view.

Changes over time

As with all feelings, both of gratitude and of feeling forgotten, these could change over time and with circumstances. That is, some mothers felt initially grateful for being granted entry into Refuge but, as time passed, resentful that more was not done for or with them. Conversely, other mothers felt forced, and as such resentful about having to access Refuge. This changed over time, however, with the mothers coming to appreciate what Refuge offered. Mother 2, entering Refuge under duress from Child Protection, said in her interview during her first week:

> *I'm not too sure what the process is from here, being in Refuge and if they can't find me somewhere, what happens after that? After that six weeks am I on the streets with my baby? You know what I mean? What happens to me and my baby?*

A month later, in the third observation session with her infant, both infant and mother presented as much calmer and very settled. She had moved from a short stay Refuge to one which offered longer stay and had, until recently, enjoyed the company of another mother who had an infant of a similar age to hers:

> *She (the mother) seemed quite pleased to see me and asked me a number times how I was, how things had been going and I asked her how things were going and she explained that she was getting a housing commission house and was really excited about this … She had gone from initially considering this experience of the involvement of child protection as*

something that was very distressing, very negative, to now feeling like it had actually turned out to be a very good thing for her and her baby and was actually feeling sad about leaving the Refuge in some ways, even though she was excited to go to her home (3rd Observation-Infant 2).

The observations picked up changes in the emotional states of the infant and in the mother, these being influenced by what was happening at the time of the visit. Of those mothers and infants whom I visited at different stages, I was able to monitor the progress that was being made towards their building of a new life for themselves and their infants.

4. In some ways the Refuge is 'unsafe' for the infant.

Perhaps the most disconcerting aspect, for both the mothers and for myself as researcher, was the discovery that some aspects of the Refuge environment in fact provided the opposite of refuge. Recognition that the Refuges were not especially 'infant-friendly' environments, nor always psychologically safe, was expressed by some mothers, as well as workers. This was evident within a number of the infant observations. The environment itself appeared to pose risks to the infant's physical safety – through exposure to other children, exposure to other mothers and even the privileging of the Refuge rules over all else. One mother, Mother 5, went so far as to question the longer term psychological risks to her infant of having been born and spending her first 12 months of life in Refuge. Mother 11 was concerned that her infant was not able to crawl around: "*like the floors and stuff, and they're never clean all the time, there's so many kids, and basically spill things on the floor all the time … so she is not free in that sense … she is in the cot. Or I'm carrying her."* Other children posed possible risks to the infant: "*I'd like to be able to like, say, leave him here and go to the bathroom … There's nobody that can sort of um, you know, get tripped over, or accidentally hurt, so the kids are, they're so nice, it's just they're trying to play with him and that, and sometimes it can be a bit overwhelming* (Mother 2).

The lack of funding that Refuge receives prohibits the capacity to provide well-designed and furnished environments (Grossman et al., 2010; Theobald, 2014). What funding is available appears to be dispensed according to the needs of adults in the first instance, with much of what is provided to infants and children coming through donations. This seems to speak to the overall picture emerging in this study: of children, and particularly infants, not always being thought of or taken into account

Expecting but not finding safety

For some mothers, entry into Refuge was solely about the safety of their infant. Child Protection had threatened to remove Infant 2 should her mother not leave what they considered to be an unsafe environment. However, this mother and infant then went on to face other challenges:

> *I'd love to be able to put him down on his play rug on the floor … I'm not (clears throat) worried about what other people are doing, or feeling like that (clears throat) yeah, I'm just protective like all mums I guess (small laugh)… in a sense, feel like we've gone a little bit backwards, a little bit …* (Interview Transcript).

The most harrowing outcome seemed to occur for Mother 1 and her infant. After having sought Refuge for themselves, they were effectively exited from the Refuge a few days later for a perceived breach of security. This forced a temporary stay with Mother 1's own mother, who was an alcoholic and lived in a small caravan. "*I didn't really have anywhere to go. I didn't want to end up staying at my mum's."* This mother was reluctant to re-engage with any further crisis accommodation service after this, and felt unfairly treated by the Refuge. This left a three month-old infant without appropriate accommodation. I later wrote in my field notes:

> *"Has the infant got lost in all this? Despite Mother's great ability to parent, is being at her mother's a good idea (does the boyfriend also live there, go there, know where it is etc.) –*

should a notification to Child Protection have been made?? More help given to find alternative accommodation?"

That Refuge offered an inadequate environment for infants and toddlers was also raised by a number of Refuge workers. Key Informant 2 (Australia) felt that there were *"lots of toys here for the kids and they do art but something for mothers and babies as well was important".* A worker from the group interview (Australia) was clear that for the infant, "*Refuge isn't the best place"*. She worried about what the infants saw as a result of being in Refuge, particularly those who stayed for any length of time, as "*there's a lot of violence that women experience. So you'll have a family here and then you'll have a woman coming in that's been beaten, that's black and blue, broken body, you know".* Key Informant 2 (Scotland) raised the question of whether the Refuge workers themselves are even skilled enough to keep the very young infant safe:

I don't think with 12 months and under, in terms of development, unless you're someone who works in the [infant development] field and is very astute to notice the developmental signs I think you probably wouldn't pick things up. Unless a baby was unduly distressed or there were particular difficulties" (Interview Transcript).

Within the infant observations, some Refuge environments appeared wanting. The most obvious safety issues were apparent throughout the observation of Infant 4 (Chapter Five, Theme 4, p.170) in the crammed office space in which there seemed to be any number of opportunities for this infant to harm himself. Even in the family bedroom of Infant 4, I felt concern as he

tried to climb up the window which had wooden vertical bars it appeared, and he was trying to climb up the bars and by this time the girl was busy doing something else and mum was distracted by her so I moved over to the corner of the room because I was scared he was

going to get up to a certain level of the bars and then fall off" (1st Infant Observation – Infant 4, 16 months).

Four of the eight Refuges had extremely steep stairs up to a second level, and in the third and final observation of Infant 2 I worried how steep these were as "*we went upstairs and I opened the safety gates for mum, opened the door for her and she then placed him in his cot*". Such stairs were difficult to negotiate holding a baby whilst also opening safety doors and unlocking locked doors (to ensure privacy).

On the whole, being safe, and finding Refuge was experienced more as a physical manifestation than an emotional one for these mothers, and even more so for their infants. This perhaps fits, to some degree, with what the Refuge believes in relation to infants. Not unlike the mothers, as will be presented next, the idea that by supporting the mother you support the infant was shared by the staff and key informants interviewed for this research. Ironically, as this current theme shows, however, not everything is as it appears, and in some instances leaving an unsafe and violent home can lead to other less apparent but potential dangers. Being 'safe from violence' in the Refuge setting does not appear to always guarantee the infant's safety overall, nor perhaps even that of all mothers.

Conclusion

This chapter revealed how the mothers saw themselves as the Refuge for their infants, with the expectation that Refuge would support them in their mothering role. The notion of 'the mother as Refuge' was based on their belief that the mother could best meet the needs of her infant. This gave her priority over the infant's father, who was seen as both physically and psychologically redundant. Only needing their mothers meant that generally infants' needs were met by

supporting their mother's needs. Even in cases where the mothers acknowledged that their infants might have needs that were separate from their own, the mothers felt that the infants were essentially incapable of communicating these needs. Thus, there was little more that could be done for their infant. The deeper significance of seeing the infant as unable to communicate was that, by implication, they could neither experience nor recall trauma. To think otherwise may be too unbearable for their mothers, who have often experienced significant early-life trauma themselves. Just as Chapter Five revealed that infants were often 'lost sight of' by their mothers, so too did some mothers feel 'lost sight of', and forgotten by, the Refuge. While the mothers understood Refuge to be a place free of violence, some felt that the Refuge environment was not always very safe for the very young infant, a sentiment shared by some workers and which I also observed on occasion. One mother went so far as to worry about the long-term impact on her daughter of having been born, and initially raised, in Refuge. Another mother worried about 'where to next' when no longer allowed to stay in Refuge.

CHAPTER SEVEN (The Refuge)

The way in which Refuge provides refuge to infants has been considered from the perspective of the infant as inferred through the observation data, as well as from the viewpoint of the mothers themselves. This chapter turns its attention to what the Refuge itself considers to be 'refuge' for infants, and their role in its provision. This third tier of enquiry consists of those who make up Refuge, and appears to substantiate what was found in the first and second tier. This is that the Refuge does not provide refuge to the infant, but rather to the mother, who is then expected to provide this to their infant. That the mother may be neither willing, ready nor able to provide their infant with adequate refuge is not consciously taken into consideration by the Refuge, despite evidence to the contrary being offered in some interviews. It is only when serious difficulties for the infant become apparent that they are actively attended to, and this is generally through the accessing of outside expertise or, in extreme circumstances, through the involvement of child protection.

The explanation given by Refuge for their not prioritising to the infant in-house is that they lack the skills or funding to do so. There exists another possible reason for this reluctance on the part of Refuge staff to work with infants directly, and this is to protect themselves from the pain, distress and vulnerability involved in being fully present for, and actively engaging with, the traumatised infant. Excluded from the service provision of Refuge were men, who, as was evidenced in the mothers' interviews, were mentioned rarely and unfavourably.

The themes to emerge from the Refuge were:

1. **We are the refuge for the mother; the mother is the refuge for the infant.**

   The infant can afford to wait.

2. **Outside experts need to be called in for the obviously 'distressed infant'.**

   How we are resourced affects what we can do.

   Infants are too scary, too fragile and too easy to break.

3. **We are Refuge for women and children only.**

As was apparent in some of the interviews with the mothers, the idea that the infant would require or desire any direct input from the Refuge at all was perhaps one of the most telling revelations of the interview process. Similarly, the questions that were directly asked in relation to the infants' experience and potential needs, as separate from those of their mothers, appeared to give the workers pause for thought. The aim was to explore what they currently provide for infants, and what they imagine they might possibly provide.

1. We (the Refuge) are the refuge for the mother; the mother is the refuge for the infant.

There was no disagreement amongst the workers and key informants in relation to this point. The responsibility for the infant clearly lay with the mother. Practical and emotional support were directed towards the mother and these, in turn, were meant to empower her to care for her infant. This concept of 'mother as Refuge' is consistent with the mother's view and the mother was the person to whom the infant themselves, as was observed, turned in the majority of cases. Quite

literally, the Refuge provided the infant with little more than a building and sustenance, bedding and equipment to meet their basic needs. On the whole, the rest was up to the mother. This was an attitude consistently expressed throughout all the worker/key informant interviews. It is also another way in which 'losing sight of the infant' can be viewed as acceptable.

All seven work group and key informant interviews included statements such as: "*We provide more care and nurturing of the mother and support her to look after the baby*" (Key Informants, London). "*It's not directly with the infant but it's about concepts of what the mother is able to do in relation to the infant in their development*" (Key Informant 2, Scotland). "*Shelter is really here to cater for the women, children are more seen as an extension of the mothers*" (Key Informant 2, Australia). "Y*ou need to look after mum as well because if mum's not okay, then the baby won't be okay"* (Key Informant 1, Scotland). "*It's just get mum in and get her home and hosed – babies always just tagged along"* (Key Informant 1, Australia). *"Babies wouldn't be … the first consideration. Their safety is, but then … it's the mum"* (Worker Interview Group, Australia). "*We kind of prepare them to go out in the community again … to have that confidence to look after themselves and their kids as well. We give them the tools"* (Worker Interview Group, London).

The contradiction inherent in subscribing to the notion of 'mother as Refuge' was that somehow this highly traumatised, often inter-generationally disadvantaged group of mothers could themselves have recovered sufficiently to be available to their infants. Perhaps it was felt that innately, 'the mother within' could emerge, assisting in the mending of her own trauma, past and/or present, and thus be in 'good enough' working order for her infant. The idea that women instinctively possess maternal attributes is neither new nor uncommon (Featherstone, 2003). There appears to be a hope that this natural instinct for motherhood holds true for mothers in Refuge. As was stated by a worker from Australia, "e*verything should be done to keep that mother*

and child relationship – that bond – because we've seen how great a mum they are. Given the right opportunity, given the safe environment, they are doting, caring mums, and we know that".

When mother is not refuge

The appropriateness of the emphasis on 'the mother as refuge' was contradicted by the answers given by the Refuge workers and key informants themselves. This was not dissimilar to the way in which the mothers contradicted themselves in relation to their suggestion that 'infants can't communicate' (Chapter Six, Theme 3, p. 186). One worker suggested that many first-time mothers coming into Refuge struggle as *"she's got this tiny little baby that she hasn't got a clue what to do with, we've had a few that literally didn't know his head from his arse".* A worker from the Interview Group in London remarked: "*because the mums are preoccupied with what's going on for them, I think they do tend to forget and they are very quick to want to put them in the playroom."* Another worker in that same interview group noted, "*We've had babies that are so much happier to be with staff*." Similar hesitations with regard to some mothers' availability for their infant were echoed within the Australian Group Interview, with a worker suggesting, *"I don't think mums realise what their children see?"* Another worker in this interview group commented that *"if their mother is just going to continue having babies, the parents just chuck them away. You know, and just say you wanted him, you know. I keep telling you he's no good. She just keeps going back to him and then having more babies and more babies.*"

The interview process itself, and the focus on what the infants experienced in Refuge, appeared to create a space for reflection and allow a more nuanced narrative to emerge. This was not just in relation to the complex presentation of the mothers, but in the way in which they began to more clearly articulate that perhaps their infants' needs were more than simply practical. For example, it was made apparent that there were mothers who gave clear indications of not being

available for the needs of their infants, and infants who demonstrated that they did not expect such support from their mothers, so actively sought it from others:

> "*The fact is that they're not used to being given so much attention, so they crave it. So they'll come in and if you're working, if you really keep on working they will be disruptive, the children … You either get that or you get the opposite, the really overprotective (mothers), but you also get where the baby is craving that, you see, you blatantly see it. And (the mothers) meet all their everyday needs … but it's the emotional side."* This worker was quick to qualify this statement regarding the mother; however, "*because of what they've been through it's difficult for them to pick up at that baby stage"* (Workers Interview Group, London).

Refuge as refuge

As a more nuanced picture of the infant emerged, so too did a fuller picture of some workers experiencing times at which they related to the infant individually, and just tried *"to love them"* or *"cuddle them"*. Approaching the infant was appropriately tempered by "*the history you have with that client and the children … Or you can see a baby's not going to want to come to you. You can see that. Then you wouldn't even attempt it"* (Worker Interview Group, Australia). One Key Informant declared, "*I don't even like babies*" but spoke compellingly of the impact one particular infant had had on her: "*She was my favourite baby too. I actually got the chance for the first time in my whole life to watch a baby grow up into an almost, I don't know what – a toddler is probably that big or something."* This infant demanded a relationship with her and would *"start that little bit of a cry if I left her alone".* The Key Informant admitted, *"I felt privileged actually to be part of the baby starting to talk and focus and things and do stuff because she was so very little when she came here"* (Key Informant 1, Australia).

The 'unpacking' of what is refuge and who provides it yielded a richer, more complex picture than simply that of 'the mother as refuge'. In a remote community in which one of the Refuges was located, this picture involved how both the workers and the Refuge space itself came to be known as a safe place by certain children: "*I had four sisters. I think the oldest was 11, down to about four. And 1 o'clock in the morning, they were ringing the bell. They knew to come here"* (Worker Interview Group, Australia). One Key Informant found the question of 'how the infant experienced the Refuge' as revelatory: *"It's interesting because I've never really thought specifically about what you're saying. I think for me, I've always looked at the impact of Refuge on infants [as having] been via the impact of the Refuge on women"* (Key Informant 2, Scotland). She went on to recall a very poignant story of an older woman in the Refuge in which she had worked taking a younger mother under her wing, effectively teaching her how to mother her baby. These were the small exceptions to the narrative of "*by keeping mum safe, we'd keep baby safe"* (Worker Interview Group, Australia).

The infant can afford to wait

A more entrenched belief that appeared to operate for the Refuge was that the infant could afford to wait. This was again linked to the notion of mother and infant as one, but the person who came first was seen to be the mother as they *"just need their time, don't they?"* (Worker Interview Group, Australia). As already established, the infants tended not to actively approach others. When they did make overtures to others, it seems it had to be overt and unmistakable. "*The baby will go sometimes to the other women, it's these certain babies that will look at one woman, their eyes are wide open because they know they're going to get that (affection from her) as normal babies do"* (Worker Interview Group, London). What was less clear was what occurred for the infant who did not and could not ask for refuge when their mothers were unable to provide this. It was almost expected that mothers might have difficulties relating to their infants: "*that's purely because of the abuse that she's suffered. It is a detachment*" (Worker Interview Group, London). However the mothers and apparently separately from their infants, were considered to need

saving first, with the *"keyworker … looking after the practical and emotional needs of the mother, the woman"* (Key Informants, London).

It is assumed that the rapidly developing infant can afford to wait until his/her mother recovers sufficiently. The need to give mothers their time was asserted in both worker group interviews representing two different countries (as above in Australia), and: *"I think they need time don't they, where they've got lots going on and it's a lot for them to have to think about what the children need as well I think"* (Worker Focus Group, London). However, the current research is clear. Infants are compromised by exposure to violence and potentially traumatic caregiving experiences (Rifkin-Graboi et al., 2009; Schechter & Willheim, 2009; Schore, 2003a; Schwerdtfeger & Goff, 2007). Infancy is the most rapid growth period for neuro-physiological development, and the infant simply cannot afford to wait (Schechter & Willheim, 2009; Schore, 2001; Schore, 2005; Siegel, 2012; Van der Kolk, 2014). It was certainly acknowledged by staff throughout this study that infants are impacted by violence. *"So babies are mostly held all the time. So for them, they would then see first-hand the violence*" (Worker Interview Group, Australia). What is not acknowledged is what needs to happen next. Perhaps the workers, as do the mothers, take comfort in believing that the infant can't communicate, feel or remember, as this is a far less painful view to hold than the grim alternative.

The mother and infant arrive in Refuge to escape violence. They often arrive traumatised, and both may sometimes remain traumatised. Any existing difficulties within their mother/infant relationship arrive with them. Humphreys, Thiara, and Skamballis (2011) argue that 'domestic violence intervention needs to change to take account of the significant barriers that may have been created between mothers and their children by violence and abuse' (p.167). They contend that 'readiness for change' does not happen immediately. When the infant remains in an

overwhelmed and highly distressed state, and when the exposure to trauma is ongoing, 'these states organise neural systems resulting in traits' (Perry et al., 1995, p. 275). In the Worker Group Interview (Australia), mention was made of babies "*just crying and crying",* even with "*mum still holding them".* When asked what the staff do when this happens, the response was that they simply wait: "*Mostly, they do get settled … after mum's been really upset, she feels a little calmer here. Then the baby will feel a little bit calmer"* (Worker Interview Group, Australia).

Mostly, they do get settled

What occurs for the infant who does not settle is not explained, nor what this settling actually involves. When an infant is overcome by their own or their mother's distress, they may need to 'shut down', as this is the 'safest and only option' available to them' (Rifkin-Graboi et al., 2009). Is 'shutting down' by the infant interpreted as *"They do get settled"*? These same (Australian) workers were able to acknowledge that they worry about the infant's exposure to violence and "*Just thinking (about) what they've seen. How it will affect them when they grow up?"* What seemed harder for the staff to tolerate thinking about was the cost to the infant when their mother was unavailable to help the infant to regulate their emotional states given that she, the mother, struggled to effectively regulate her own. Recognising that the infant cannot afford to wait does not nullify the need to give mothers time to recover. However, nor should attending to the mother nullify the infant's need for timely and responsive caregiving. Furthermore, Refuges do not always offer the most conducive environments for 'recovery work' (Humphreys et al., 2011). The flipside of this lack of recognition of the infant's need for immediate assistance is the failure to see the infant in their own right.

They come as a package

The infant as an extension of mother, though not the reverse, presents as a core theme permeating this research. *"Just get the mum safe, get the mum safe, get the kids safe. The babies just come as a package"* (Key Informant 1, Australia). The assumption that the majority of mothers will need time and support to recover – "*we have to think that they've been abused, their trust has been damaged … you have to build the trust with them*" (Worker Interview Group, London) – is not also afforded the infant. *"It would only be if there were apparent issues with the baby that we would start to pay that particular attention"* (Key Informant 1, Scotland). The question, then, is what sort of attention the infant would receive and from whom. Key Informant 2 from Scotland was not "*aware of anywhere doing work with infants".* She went on to explain, "*That's one of the things our members are constantly saying to us – that they have an issue … there is very very little understanding and support available for children of 4, 3, 2, 1 and as they get younger there is less and less information and less knowledge".* This creates a barrier in itself. Just who possesses this '*understanding and support*'? The answer is not, apparently, to be found 'with-in' Refuge but 'with-out', and this means it is time to outsource this "*very specialist job"* (Key Informant 1, Australia).

2. Outside experts need to be called in for the obviously 'distressed infant'

When serious concerns for the infant were recognised, concerns which were beyond the mothers' capacity to address, the outsourcing of any serious work with the infant was the preferred response. Many staff did not see themselves as equipped to deal with what they considered such specialist work. While some work was done 'in-house' – *"We have parenting classes, we have one-to-one groups; we have peer support groups within the Refuge … it may be specialists' help that can be provided or social workers come in and make further investigations about the care of the child"* (Key Informants, London) – this was generally because staff were not trained in, or lacked the expertise required to provide, the skilled response necessary for these vulnerable and often distressed infants. Outside help would thus be needed. Some Refuges were fortunate enough to

be able to employ family support workers or even children's workers, but there might still be times when it was necessary to call in the 'experts'. Two Key Informants suggested simply 'calling in the midwives' as they "*come into our Refuge on a regular basis, so they would know that there was a baby of under one or a mother who was pregnant in the Refuge … bringing in external people, health visitors, midwives, [to attend to] the needs of [the babies]"* (Key Informants, London); and again, "*I think if the baby is distressed it would be an issue for the visiting health worker*" (Key Informant 2, Scotland).

Some Refuges had no-one else they could call in. They only had themselves and, because they saw working with the infant as such specialist work*, "the babies are an absolute afterthought … we're not taught or trained in anywhere that I know of to treat the baby as a separate entity that could be damaged in any way by what it's just been through"* (Key Informant 1, Australia). The strategy for this last Key Informant was to employ staff who were mothers themselves. She had met their children and "*that gives me confidence that these women know what they're doing, if they have to hold a baby while mum, with an injury, has to go and have a shower. I know that they'll be safe and I can leave that (baby) alone (with) them."* For those Refuges lucky enough to be able to employ family support workers, the role of these specialist staff appeared to support the 'woman as mother' over the children themselves. This coupling of mother and child together acknowledged the importance of the mother/child relationship, and the worker's role in 'a lot of strengthening of mother and baby relationships' (Worker Interview Group, London). However, this suggests once again that the mother is the only valid entry point for work, fusing the mother and child together as one.

Whilst some Refuges employed specific children's workers, their role was to work with children of all ages. When an infant is involved, a children's worker helps out, *"particularly with new mums*

with small babies and her in a state of chaos to try and to help mum establish routine for herself and for the child" (Key Informant 1, Scotland). This notion of helping mothers with their babies, as opposed to seeing and attending to the infant, appeared to be directly borne out by the experience of Mother 8, who suggested that the children's worker can do little other than chat to her as the infant is too young to be offered anything specific themselves (see Chapter Six, Theme 3, p. 186). This suggests that the worker tends to focus their attention and effort, when required, on the older, verbal children, and that there is little else they can do with infants other than support the mother to support the infant. This returns to seeing the 'mother as refuge'.

Outsourcing the needs of the infant

The idea of 'mother as refuge' implies no real need for infant-specific responses and, as such, an assumption that none really needed to be offered. The larger the Refuge, the more likely it was to provide some in-house mother/child support, and the larger Refuge considered themselves *"lucky to have the facilities"* (Worker Focus Group, London). Some Refuges appeared to have established links with community-based health nurses or services; however, these also appeared to be routine, universal services. Other Refuges did not have such links, nor were likely to develop them due to the limited availability of such services.

Overall, the consensus was that infants attract additional attention only when they are overtly 'in trouble'. The assistance that is accessed lies outside the Refuge. Beyond what might be routine visits to maternal child health services, this help is likely to be subject to whatever skills, time and professionals are available, unless there is some medical emergency or an urgent protective concern presents. Effectively, there were no designated workers for infants and no specific consideration given to the idea that workers in general needed to be particularly aware of, knowledgeable about, or involved in interacting with, the infants in their care.

Where child protection involvement was considered necessary, this sometimes resulted in the ultimate in 'outsourcing': the outsourcing of the infant themselves. Some Refuges, however, appeared to be proactive in involving child protection in the first place, both as a safeguard for infants/children and in an endeavour to prevent infants from being removed from their mother, as keeping them with her has:

> *been very successful actually … in maintaining the place, the baby staying with mother.* So, *because (child protection) social workers tend to see that as reducing risk and so do we usually, we've lost very few babies"* (Key Informants, London).

Staff at other Refuges felt that the removal of children (for Indigenous Australians in particular) was a 'fait accompli' when child protection became involved. "*It's like … One little mistake from the mum, gone straight away. Kids gone. She's left thinking what she done wrong?"* (Worker Interview Group, Australia). Within Australia there remains considerable angst associated with what has been termed 'The Stolen Generation' – the widespread removal of indigenous children from their family and community into what was largely institutionalised care which has cast a shadow over this country's history. Stolen Generation practices involved the forced, systematic removal of aboriginal children from the early 1900's until the late 1960's (HREOC, 1997; Read, 1981/2006; Schaffer, 2004). While not the subject of this thesis, it would be remiss not to acknowledge that anxiety remains, and was expressed by these workers, regarding the assumptions made about indigenous compared to non-indigenous mothers. This anxiety was perhaps also fuelled by their regular contact with Child Protective Services, *"who we have a lot to do with"* (Worker Interview Group, Australia). The statistics in Australia indicate that the number of indigenous children involved in child protection and foster care programs is disproportionately high (SCRGSP, 2014).

That there could perhaps be something more to offer mothers and infants was the ardent wish of these workers, who were located in a remote community.

3. How we are resourced affects what we can do

The reluctance to engage directly with the infant was quickly attributed to a lack of funding. Women's Refuges are not well-funded (Grossman et al., 2010; Theobald, 2014). Nor are infants and their needs identified as core business or funded as such. As one Key Informant (London) put it bluntly: "*Money equates to what one is worth … they're not thinking of the children … what they do is think adult*." In one interview I asked, *"How do babies fit with regards to funding and job descriptions?"* The answer was: "*They don't fit at all"* (Key Informant 1, Australia). A London-based Key Informant explained that they rely on the mercy of others – "*through getting trusts and foundations funding".* This was then used to employ workers to support the functioning of the family as a whole. Again, the belief operating here is that funding for Refuge is for the care of the mother, while it is her responsibility to care for the child. The irony in this thinking is that the numbers of children going into Refuge can often outstrip the number of women: *"0-3 was our highest category … I think, on average, each mother would have 1.8 children"* (Worker Interview Group, Australia). Nevertheless, as one key advocate (Scotland) explained, the Government was doing a lot of work to *"let people know that the impact in those early years and responding is crucial"*. She also noted: *"We all know the impact (of violence) on small babies in the very early years."* What was not forthcoming was additional funding for this work and, in fact, she felt that Refuge was likely to have monies redirected towards other ways of responding, with a *"big commitment to prevention".*

When I asked different workers/key informants to consider the question '*Should money be no problem?',* however, the respondents did struggle to actually identify or articulate just what they

might offer the infant: *"I don't know, just a hostel … I don't know. I don't know what it would be."* Responses often returned to what could be provided to the mother. The workers from the London Focus Group considered that mothers could benefit from "*funding for childcare for them to attend appointments"* or buying in the expertise of others such as *"a health visitor",* or aiding with better access to the *"children's centre".* The workers from the Australian Focus Group suggested better accommodation but floundered when asked what more could be done within the system, other than responding: "*Trying to keep families together. Support mothers who would do anything for the children, but are just stuck in a rut and can't get out of it. There's no escape from it"* (Worker Focus Group, Australia). The other Key Informant (2) from Australia did suggest employing another worker and "*would run mother bubs groups"* as well as *"have a baby health nurse employed"* on-site.

It was a novel idea for most workers to consider that infants were not only enormously impacted by family violence but by their mother's trauma and potentially compromised caregiving capacities. Further to this, that the infants might require not just immediate but ongoing attention. That this was something that could be thought of as being facilitated 'in house' by Refuge was even more startling. When I asked, 'What might it look like if Refuge did start to think about the mind of the baby and as separate subjects in themselves?' Key Informant 1(Australia) answered:

> *I can't even imagine what would happen if I'm understanding you correctly … Would it look different? Yes it would look different … I know it would be different to what we're doing because what I do know is that we're not catering for babies as individuals or as separate traumatised entities to what mother is. So yeah it would have to look a lot different".*

A further risk to the already meagre funding provided to Women's Refuges is seen to be the trend of competitive tendering, occurring in the crisis accommodation sector across many states and

countries, along with the push to keep women at home and to remove the perpetrator. At times this goes as far as closing women's Refuges altogether and handing these services over to generic providers. These changes are seen to be threatening the specialist nature of family violence work with women and their children:

> *The government push more towards keeping women in their own home and that basically because it's a cheap houses situation … but we know that if you've got a perpetrator that knows where you live, they can put as many bars on your windows as you like, you've got to walk out and it very rarely works for women who have real domestic violence"* (Worker Interview Group, London).

Further to the funding cuts and risks of closure that appear to be facing women's Refuges, in their own right the infant is not currently seen as critical enough, nor the work urgent enough developmentally, for the state to fund their care in Refuge appropriately or in addition to their mothers. This means that the odds are already stacked against them, and that any imperative for creating infant-specific cultures and services in Refuge is not acted upon and thus goes unrecognised.

Infants are too scary, too fragile, and too easy to break

The complex threads of this work and what might most successfully provide vulnerable infants, children and mothers safety from family violence involve issues that are vexed. Increased funding and access to resources such as accommodation and external experts would certainly assist with some of the pressures faced by this poorly financed crisis accommodation sector. But it does not appear that this alone would address what seems to be a deeper and often more confronting concern. This is the question of just why the infant so often disappears from view in the first place. Refuge work is emotionally confronting. The enormity of just how vulnerable these infants are is possibly easier to deal with when kept at a 'safe' distance. This means trying not to see, or think

about, the infants too much. To immerse yourself in that distress and really contemplate just what these infants have been through and are perhaps still going through may be just a little too much for these veterans of Refuge work.

Simply removing a woman from a violent situation was seen as possibly 'not enough' to offer the infant: "*But as I say, I just don't really know how babies work, how much they take in. They hear a loud bang, are they traumatised forever, you know cars backfire all the time. I don't really know enough about it"* (Key Informant 1, Australia). With further, brutal honesty she went on to say, "*I just don't want to be a part of it. I don't want to know about them. They're too scary. They're too fragile. They're too easy to break … I hate even the thought about how the little buggers are being affected at all".*

As the interviews progressed and more specific questions forced the interviewees to focus on thinking about the infants as individuals in their own right, the enormity of their vulnerability became distressingly apparent:

> "*It would be traumatic. It would be terrible. Because it would be just yelling and – there'd just be so much fear, I think. Afraid and crying. Then we have other babies who wouldn't even – who are used to it. They don't get upset when they see violence. They're just used to it. Because babies – they learn – they absorb everything … A lot of violence is at night time, so it would be even scarier, you know"* (Worker Interview Group, Australia).

This interview became more upsetting as it continued, and ended with me and the workers in tears. The workers spoke of the common practice of removing infants from mothers in their remote community and how devastating it then was for those mothers to return to Refuge, now, without their children. "*One of them used to say, 'I just keep thinking about my kids every time I*

come back here'. She doesn't sleep … Yeah, they can't – some of the mothers can't come back here because it's too hard" (Worker Interview Group, Australia).

The emotional costs of seeing the infant

The workers presented as extremely committed to the work of the Refuge. The Key Informants were equally passionate. Not seeing the infants, not feeling their pain, but trying to assist their mothers potentially felt more do-able for these interviewees than directly focusing on the infant. The observation of Infant 3, and my being left alone with that infant (Chapter Five, p. 169), gave me an enormous sense of anxiety and an understanding of how powerless one might feel when in a position of responsibility for another person's baby – particularly in a setting such as Refuge. The observation of Infant 2 captured my feelings of emotional depletion and incredible sadness: "*He was exhausted and he was looking at me intently and frowning. There was no friendly curious engagement, it was like, just frozen and I felt very teary, and feel teary now saying it. Just looking at his little face and thinking what a day this little baby has had"* (Chapter Five, p.140). During the observation of Infant 8 I wrote, "*At one point she became quite sharp with him and said 'enough', which gave me a bit of a fright when she said it so I imagine gave her baby a little bit of a fright*" (Chapter Five, p. 159). Later that day, I wrote in my field notes of this observation session: *"Great sadness, loss and loneliness seemed to permeate this interview and observation."* It was profoundly and emotionally touching to both observe the infants and speak with the mothers, and at times even quite distressing. The amount of time spent collecting this data, however, was nothing compared to the amount of time these workers spend with these infants and their mothers.

Taking the work home

Workers from this group spoke of trying not to take the worry of this work home with them, but acknowledged thinking *"'I hope they wake up with the baby' and that sort of stuff … I try not to, if*

you can help it". Trying not to see the infant in their mind suggests that it may be much more preferable to 'lose sight of the infant' as a survival mechanism in what is already a very tough job. Losing sight of the infant is not exclusive to Refuge. Specific to Refuge, however, is the likelihood of the infants being highly traumatised by the events leading to their mother's decision to flee a violent home, and the subsequent possibility of their mother's emotional unavailability as a result of her own unprocessed trauma. It would be a grave error in the presentation of this data to underestimate the emotional toll of this work and the self-protective mechanisms necessary for Refuge workers to use in order for them to be able to remain employed in this setting. "*It's something I don't go to because I just think that that's such a huge subject about babies and violence. I admit that I put it over there. It's hard enough doing what we're doing … and then trying to work with the women as well … let alone everybody else"* (Key Informant 1, Australia).

These infants are not lost sight of in this particular setting simply because they are small and voiceless, nor because of society's tendency in general to overlook the perspective of infants. It is much more complicated than this. It appears that their partial 'invisibility' to staff within Refuge is a way of coping with the emotional enormity of this work. Just as the infant is lost sight of, it would be easy to lose sight of these mothers and workers within the broader setting outside the Refuge context. How to attend to the risks associated with this 'disappearance' of the infants, as well as their mothers and, at a broader level, even the workers and Refuges tucked away from view within our society, will be an important subject of scrutiny in the concluding chapter of this thesis.

4. We are Refuge for women and children only

This last theme captures what appears to be a common practice in Refuge. This involves removing all traces of men once women and children step through the Refuge door. This then, presumably,

sets them immediately on the road to recovery. Refuge was created for women and children. Men are physically prohibited from entering, and recognition of any emotional attachments to men, especially if they are the perpetrator, appear to be discouraged. The Refuge workers in this study reinforced this emotional separation through an attitude which seemed to indicate that the father did not matter. The fathers were mentioned little or not at all in the worker and key informant interviews. It is perhaps pertinent to note that the women were not directly asked questions in relation to the fathers of their children. Only one Key Informant mentioned men; this was in relation to the fact that their Refuge was a member of an umbrella organisation of women's Refuges known as Scottish Women's Aid, and as such:

> *If you're affiliated, you subscribe to the feminist analysis of domestic abuse and you would have only female workers because of the women volunteering to support women. Some groups have male workers, but they can't be affiliated to Scottish Women's Aid* (Key Informant 1).

Whenever fathers or men were mentioned by workers, it was generally to emphasise how violent and intractable they were. Regarding the behaviour of the male partners of the women coming into Refuge, a worker commented, "*You think the partner would see that mother's just had a baby, or the baby's young. You'd think that would make a difference as to their behaviour. But it doesn't. It doesn't make a difference"* (Australia). Then again, later in the same interview, reference was made to the long and negative shadow cast by these fathers: "*You get kids come in and say 'Dad did this and Dad did that, and Dad said that'. You know? Because they see it"* (Worker Focus Group, Australia).

Perhaps fathers were mentioned so infrequently because it was felt that acknowledging the father was akin to condoning his violent behaviour. Furthermore, maybe Refuge staff felt that the use of violence by these men lost them the privilege of being called a 'father'. The research also possibly contributed to the disappearance of the fathers, by not including them more directly in the interview questions with the workers and key informants. Eradicating the fathers, as a result of the men's actions themselves or by the women and the services that support them, appears to offer short-term safety and relief. In the long term, this could be another area which, if left unresolved, contributes to the inter-generational transmission of family violence. The complete removal of the father, particularly psychologically, leaves an immature infant with no resources to help them process what it means to not have their father constructively in their lives, nor to make sense of why this is.

Conclusion

As had the mothers, the Refuge appeared to lose sight of the infant unless the infant was blatantly struggling. Outside assistance was then enlisted, as the workers considered themselves to have neither sufficient skills nor resources to attend to such matters. More than this, however, was the emotional cost for the Refuge workers of truly seeing the raw vulnerability and distress of the infant. Fathers, as the main perpetrators of the violence suffered by these women and infants, and men in general, were rarely mentioned unless to express disgust at their use of aggression. The major theme to emerge from the workers' and key informants' data affirmed much of what the mothers purported to believe: that it was their role, as mothers, to be the refuge for their infant. Additionally, just as the mothers contradicted their assessment of their infant's inability to communicate, the Refuge staff contradicted their assessment of the 'mother as refuge' and their capacity to offer the most appropriate or realistic source of refuge for the infants under their roof. Contradictions such as these seemed to ripple their way through all levels of the data.

The infant observation data provided information regarding the ways in which the infants responded to their mothers, and to the Refuge, which appeared at odds with both the mothers' and the Refuges' perceptions . This dissonance also extended to what the Refuge felt they offered the women, and how the women themselves perceived this. These areas of dissonance and areas of agreement are entirely appropriate for a study which is interested in inter-subjectivity and the creation of meaning between two or more separate and inter-connecting parts, namely the infants, the mothers and the workers/key informants who make up what is Refuge. This has ultimately yielded a richer and more profound description of the Refuge context and what it may, and does, offer the infant (Neisser, 2006).

It is now timely to reflect further on what meanings might be further extracted from these three tiers of data, how they intersect with the existing literature, and what 'theoretical constellations' might be formed to enhance not just how the infant is thought about, but whether the infant can be better supported within the Refuge setting.

PART FOUR

CHAPTER EIGHT

The infant in Refuge is not guaranteed of finding refuge, nor to experience a feeling of safety, even if they do find it. In fact, as would be consistent for any infant within any environment, infants are exceptionally vulnerable to the actions of adults and others in that environment. As Perry, 1997) argues, "The child and the adult reflect the world they are raised in" (p.124). How much refuge each infant finds depends, to a large degree, on who provides it, and how. In the Refuge setting the infant is neither the priority for service provision nor considered to have any urgent needs other than those which are noticeably associated with their physical, rather than emotional, wellbeing. This research began with six operational questions developed to answer the core question of "How does Refuge provide refuge to infants?" These questions will now be briefly revisited, and how they were answered will be addressed. This will then lead to a discussion of the key findings that emerged from this research and how these fit within, and in fact go beyond the existing literature.

The six questions of this research

Six sub-questions were developed at the very beginning of this research journey in order to guide the research process and ensure the integrity of what was being attempted. This was a study which was infant-led and endeavoured to capture the experience of the infant by honouring the subjective experience of the infant within the inter-subjective context of their caregiving environment. These questions were:

- **What is refuge for the infant?**
- **How are the needs of the infant met when entering Refuge?**

- **How are the infant/mother attended to in order to bring the infant into an emotionally regulated and healthy state?**
- **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 regarding the needs of infants entering the Refuge?**

Question one: What is experienced as refuge for the infant?

Answer: **Staying in proximity to their primary relationship figure, most often their mother, whatever measures this may involve**.

The data clearly demonstrated that Refuge for an infant is not a building but a relationship. They do not seek out a place – they seek out a person. To this end, the research suggested a delineation between the physical (being held in the arms of) and the emotional (being held in the mind of) for many of these infants, resulting in some infants settling for whatever they could get. The protection they largely sought, and the protection they were given, predominantly came from the one source: their mother. This was demonstrated through their interactions with one another. When the infant found refuge in that interaction, their behaviour and emotional state often aligned with what they anticipated their mothers needed from them so as not to risk severing that connection. Some infants were able to find a reciprocity in their relationships with the mother where they not only found refuge but safety, and a mutuality of co-regulation and meaning-making. These particular infants demonstrated that they could express their feeling states and that these were seen, and responded to, by their mother as they together discovered how best to manage these states. Two infants, however, found neither refuge nor safety in their relationship with their mother, with one exhibiting a level of 'pseudo-independence' suggestive of a greater reliance on himself than on his mother (Pretorius, 2004) whilst the other appeared

to have learnt to 'shut down' when with her mother. A third infant exhibited the changes of emotional states that can occur over time. This involved the extremity of entering a dissociative state in the first observation to a month later presenting as significantly more settled, albeit still exhibiting self-reliance.

Question two: How are the needs of the infant met when entering Refuge in order to make them feel safe?

Answer: **In her role as 'refuge for her infant', the mother is responsible for meeting the developmental needs of her infant while the Refuge supports her.**

Just as the mother is expected to provide refuge for the infant, so too are they expected to meet their infant's developmental needs. This is not without some support from the Refuge through key women's and family support workers or, as in the larger Refuge, through services such as parenting classes. The prevailing view was that the infant was seen as an extension of the mother. This was a view held not only by the staff, but by the mothers themselves. Therefore, the common expectation was that by meeting the needs of the mother, the needs of the infant were also assumed to be met. Direct practical support, shelter and equipment attended to the infant's physical necessities. However, the developmental needs of an infant are as intrinsically emotional as they are physical and nutritional.

Question three: How are the infant/mother attended to in order to bring the infant into an emotionally regulated and healthy state?

Answer: **The infant is attended to by the mother while the Refuge attends to the mother through providing her with shelter, food, clothing, goods and support when needed. The**

mother is expected to emotionally manage the infant. If she is unable to do this, expert help from outside the Refuge is called upon, or child protection involvement may be required.

Attention to the emotional states of the infant requires an awareness within the mother of her own emotional and mental state without impinging on that of the infant's own subjectivity and developing sense of self. This means being able to think about her infant as separate from herself. Fonagy et al. (2007) contends that "the awareness of the infant in turn reduces the frequency of behaviours that would undermine the infant's natural progression towards evolving its own sense of mental self through the dialectic of her interactions with the mother" (p.302). It is this inter-subjective process which provides security, over and above all else. The mother's ability to think about her own needs let alone those of her infant, appears to be severely compromised by the cascade of events leading up to their admission into Refuge. This is supported by research undertaken specifically with mothers who have family violence-related PTSD and who demonstrate limited capacity to read the emotional cues of their infant (Huth-Bocks, Levendosky, Theran, et al., 2004; Schechter et al., 2012). Should the Refuge itself not possess the capacity to reflect on the mind of the mother, and therefore her capacity to reflect on the mind of the infant, it may be that neither infant not mother is having their developmental needs met adequately in the context of recovery from violence and the transition to motherhood.

Question four: How does entry into Refuge impact on the infant/mother relationship?

Answer: **The removal of the violent ex-partner upon entering the protected space of Refuge serves to intensify the infant/mother relationship, magnifying the perceived responsibility of the mother for her infant.**

In some respects the entry into Refuge may in fact heighten fragile elements within the relationship the mother has with the infant, and perhaps in unanticipated ways. All of the mothers

in this study ultimately chose their infant over their partner, privileging the protection of their infant over their relationship with their violent partner. With the violence removed and the partner absent from the mix there was, particularly for the first-time mothers, somewhat of a void, which this relationship with her baby now had to fill. There was perhaps also an unanticipated sense of loss in some cases. Most of these mothers had been in relatively lengthy relationships before the birth of their infant. Given the complexity of intimate relationships, and taking into account the increased complexity when violence is thrown into the mix, some elements of these women's relationships may nevertheless have been positive and their absence felt upon separation from the partner. Should the mother or infant want to express any positive feelings regarding the father, this would perhaps be difficult in a culture within Refuge which appears to omit references to fathers and men in general. Thus, leaving a violent partner does not necessarily guarantee a better sense of wellbeing or quality of life for all women (Bell et al., 2007; Davies, 2008; Rhodes & McKenzie, 1999). The infant, too, can experience a sense of loss in relation to their father. In fact, the absence of the father and the way in which he is spoken about or not spoken about has implications, both positive and negative, for infant development and future relationships (Featherstone & Fraser, 2012; Jones & Bunston, 2012; Thiara & Humphreys, 2015).

The mothers' experience of the Refuge itself appeared to also impact how they felt about their relationship with their infant. Some mothers felt that coming into Refuge removed the distress they had previously felt when living with a violent partner. The less stressed they were, the better mother they could be. Again, this reinforced the notion of the baby as an extension of mother as 'the baby feels what I feel'. Their happiness would be automatically transferred to and shared by the infant. Where a mother was not satisfied with the Refuge, she could attribute difficulties her infant appeared to be having to the inadequacies of the Refuge, rather than to any struggles she may be finding in her mothering role. The infant themselves seemed to get lost in this process.

Question five: How does the infant experience safety ('refuge') in a Refuge environment?

Answer: **When being seen, thought about, acknowledged, enjoyed and responded to for who they were, 'in and of themselves', the infant appeared to experience a feeling of safety in their interactions to the extent that they were able to relax ('let go'). This included being able to respond in-kind, and enjoy being with their mother, and sometimes staff as well, within the Refuge environment.**

This question and answer is very important to this thesis as it heralds a vital distinction to emerge from an understanding of the difference between the 'experience of safety' and 'finding refuge'. Within the particular context we are exploring, that of a Refuge environment, the manifestation of 'experiencing safety' seemed to be when the infant could actually 'let go', confident in both feeling physically held and experiencing the safety that comes with being fully seen and enjoyed. 'Finding refuge', on the other hand, appeared to involve being in proximity to their mother or sometimes others, but did not necessarily result in them feeling safe. Being really 'seen', and thus feeling safe, appeared to involve being thought about and responded to in a manner consistent with helping them to manage their physiological states, and in a manner congruent with what they were communicating. This is different to being 'looked at', as Beebe et al. (2011) suggests – a situation which, for the anxious mother, can involve "vigilant visual monitoring, without empathic emotional response, [which] suggests that mothers may be 'looking through' the infants' faces, as if the infant is not 'seen' or 'experienced'" (p. 194).

Question Six: What knowledge do both staff and mothers have in relation to the needs of infants entering the Refuge?

Answer: **Cultural, community and familial beliefs, as well as inter-generational relationship patterns, inform mothers' knowledge about infants and even the knowledge of the staff, rather than looking to the infants themselves.**

Staff: On the surface, it would appear there was little difference in how staff viewed the needs of the infant who requires the protection of Refuge accommodation in order to escape violence, and the infant who does not require such protection. That is, there was no tangible perception that the infants themselves might be needing their own specific support to recover from the impacts of living with family violence. However, the practice of 'calling in the experts' effectively enabled staff to keep themselves distant from the infant, emotionally and psychologically. When staff did reveal any sort of emotional attachment they had formed with an infant, it was acknowledged almost surreptitiously, and quickly dismissed. The staff were either not actively engaged in providing any direct caregiving to the infant or minimised how much of this they did, as such involvement was not really in their job description. This responsibility was seen to belong, in the first instance, to the mother, and in the second to the outside experts.

Mother: The refuge workers' appeared to assume that through meeting the needs of the mothers; they were also meeting the needs of the infant. This assumption was not expressed through an inattention to the physical needs of the infant, but rather through the notion that the infant is not affected by the events that happen around them, even when there is evidence to the contrary. Should the infant be affected, they will not be likely to remember the events as they were too young and do not possess the capacity to talk about them. The mothers believe that Refuge for their infant occurs through them, and if they have their needs met they can, in turn, meet the needs of their infant. This implies that the 'mother knows best' what their infant needs.

Discussion

It is perhaps assumed by the mothers and workers alike that when leaving family violence and entering Refuge, the needs of the infant will be largely attended to and any trauma abated. This research reveals a different story, one which suggests that entry into Refuge simply marks the beginning of the infant's journey towards recovery. In fact, in situations in which the mother herself is so traumatised that she cannot realistically be there for her infant, the recovery may not commence at all. It needs to be clearly stated at the beginning of this discussion that this research does not set out to promote 'mother blaming' or 'Refuge blaming', as has been suggested by other research undertaken in relation to the Refuge system (Davies & Krane, 2006; Koyama, 2006). What this research does argue is that for a myriad of reasons, the infant in Refuge has been lost from view. This has been due to assumptions that infants neither possess a perspective that can be measured and acted upon – lacking as they do the communication skills of older children – nor need urgent attention. The infant is believed to be both unable to remember their own experiences or to express what they have experienced verbally or behaviourally.

Indeed, what this research has found is that there are a number of assumptions important to explore in light of the absence of literature particular to the infant in Refuge. Further to this, it is valuable to explore the ways in which these assumptions may influence future policy, practice and research regarding infants within the family violence and homelessness sector, and the significant implications for women's Refuges specifically. This discussion will explore the nature of these key assumptions and the ramifications of such assumptions for the infant, these being:

- The perspective of the adult should be given preference over that of the infant
- The infant is adequately attended to by virtue of leaving the place of violence
- The impact on the infant is neither significant nor lasting
- The infant finds refuge by being in a Refuge
- The infant can afford to wait while the work starts with the mother.

- Infants cannot speak, so there is little they can tell us

The following discussion will argue that adult-centric thinking, albeit not exclusive to Refuge (McIntosh, 2003; McIntosh, 2002; Thomson Salo & Campbell, 2007), nevertheless largely pervades this setting to the detriment of both the infant and the mother, as well as their future relationship. What knowledge is available regarding the infant, their development and the impacts of trauma is informed by the current flurry and dissemination of research into the brain (Cozolino, 2006; Perry & Szalavitz, 2006; Rifkin-Graboi, Borelli, & Enlow, 2009; Schechter & Willheim, 2009; Schore, 2005; Siegel, 2012; Teicher et al., 2004; Tronick, 2007; Van der Kolk, 2014). This knowledge appears, however, to only be held by Refuges in this study in a cursory and unintegrated manner. This is in part because they do not see it as their responsibility to understand or apply this knowledge to their practice. It also appears, to some extent, to be tied to a fear of feeling the full emotional force that comes with understanding exactly how infants are impacted by their experience of living in a Refuge situation.

The assumption that leaving the violence is simply enough for the infant is discussed, together with what might be the consequences of incorporating an infant-led perspective into the culture and practices within Refuge. How this research compares to the small amount of literature specific to the infant in the Refuge setting that is currently available will be reflected on throughout, as will be the new knowledge that this research brings. The discussion closes with a summation of these key findings and discussion points. Following this component of the discussion, the remainder of this section begins with an overview of the limitations of this research. This is followed by an examination of the implications of this research for policy, practice and future research before a final concluding overview of what has been learnt through the undertaking of this study into the ways in which Refuge provides refuge to infants.

The reluctance of Refuge workers to see the infant as having the same rights and needs as the mother may have its origin in the distorted perception that viewing the infant in this way takes them away from, or places them in competition with, their mothers (Davies & Krane, 2006; Krane & Davies, 2002, 2007). That is, viewing the infant to be as entitled as the mother is to receive support within the Refuge setting risks taking something away from the mother, rather than giving something to her. The mutuality of relating, something that the workers in this research felt the mothers needed from them to assist with their healing is as powerful to ignite as the relationship that exists between the infant and the mother.

Beyond the Refuges themselves, society generally operates from within an adult-centric framework when it comes to children, seeing the parent as entitled to determine what is best for them (Maillard, 2010, 2012). This extends to service delivery and research regarding traumatised infants and children (McIntosh, 2003; McIntosh, 2002; Thomson Salo & Campbell, 2007). Infants impacted by family violence need to be engaged with directly, "talked to rather than only being talked about or distracted with a toy" (Thomson Salo, 2007, p.183). This research supports the contention made by Glennen (2011) that the homelessness sector ascribes to infants a status of simply the 'accompanying child', in thinking and in practice. This way of seeing or, more accurately, not seeing the infant as separate from their mother removes the 'subjectivity of the infant' from the mind, and therefore from the actions of Refuge staff. This may be further exacerbated by the philosophy underlying the purpose of women's Refuges. In fighting to empower women, they have, to a large degree, inadvertently done so at the expense of the infant. Assisting mothers to take control and 'actively [encouraging] women to take and implement decisions affecting the lives of themselves and their children' (Pahl, 1979, p. 28) still operates in Refuge. Taking control does not always equate to creating healthy intimacy in relationships. This

is in addition to the idea that relating to the infant requires 'specialist' skills, an approach which reinforces an arm's length relationship.

Knowledge integration: The shift to 'medicalise' children, or, as captured by the Refuge staff in this study, to 'specialise' the infant, is increasingly driven by the vast neurobiological research now available in relation to the functioning of children as they develop (Papageorgiou & Ronald, 2013; Schechter et al., 2012; Shonkoff, 2010; Van der Kolk, 2014). Interest in the brain systems of the mother is also increasing in attention (Barrett & Fleming, 2011; Schechter et al., 2012). In the general community this has resulted in an expectation that "in the face of difficulties, mothers are to look for expert help'" (Clarke, 2015, p. 317). In the Refuge setting it appears to be the staff who are more likely to ask for outside help when anxious about an infant. This is despite staff being in a secondary position to the mother to offer infants a positive caregiving experience. To some degree, the mothers themselves were less likely than the staff to see when their infant was struggling, particularly emotionally. This perhaps reinforces research undertaken by McCoy-Roth et al (2012) suggesting that mothers who are homeless are reluctant to invite inspection of their caregiving capacities for fear of having their children removed.

The knowledge now available on infant development is considerable, increasingly sophisticated and intimidating on many levels. Refuge staff may have found that this new and complex knowledge justifies their need to put a distance between themselves and the infants'. Refuges are now considered a professional workplace setting (Koyama, 2006; Srinivasan & Davis, 1991; Wies, 2008) – however, infants are seldom formally recognised within the job descriptions of staff. While Refuges appear to have some idea that infants are particularly vulnerable, their prevailing belief is that infants who seem to be in particular trouble require specialist workers. This means that those with specialist knowledge, and not themselves, are viewed as being more valuable for

the infant. However, when workers were disclosing any emotional stories, feelings or interactions they had felt with different infants, it almost felt as though the workers were revealing something subversive.

Historically, women's Refuges provided advocacy, empowered women, and provided temporary housing, referrals and support in accessing resources and services (Pahl, 1979; Schechter, 1982; Women's Liberation Halfway House Collective, 1976). This was prior to what is now an established and widely accepted knowledge regarding the detrimental impacts of trauma. Giving women back their control over their own offspring was also considered fundamental (Pahl, 1979, 1985). These are priorities that the mothers in this study themselves identified, particularly in relation to the care of their infant and with regard to support and housing. These priorities in Refuge service provision still largely remain. However, the professionalisation of staff within this sector, and the shift to a greater dependency on government funding, sees a much greater emphasis now being placed on bureaucratic processes – and, some would argue, hierarchy – than on the 'collective action' approaches previously taken (Finley, 2010; Wies, 2008).

Aiding the infant's recovery from trauma, or prioritising the enhanced functioning of the mother-infant relationship was found, in this research, to not be the priority of the Refuges. Serendipitously, it may sometimes be a by-product. Precisely when the mother and infant departed Refuge was not determined by their level of wellbeing and their current condition, but rather by when alternative accommodation was found for them. While in some Refuges children were directly engaged with rather than the infants, this was sometimes, but not always, about giving the mother 'time-out' rather than 'time-in' with her child. The bind for Refuge staff may stem from an expectation by local Government, their key funding bodies, that they do more with children and possibly also infants, but without the benefit of additional training, resources and

support. Only the largest Refuge visited in the study and one other appeared able to employ specific workers with a child focus; however, this had been made possible with alternative and/or philanthropic monies they had attracted

Leaving a violent relationship is not enough

What stood out in this research was the range of variability in what the infants were offered emotionally, psychologically and physically, and the fact was that this was largely dependent on the mother alone. The role of Refuge in hiding away women escaping violence may have some impact on what the infant is offered relationally by their mother, however, the expectation exists in Refuge that the mother and infant will adequately manage their relationship, given adequate time and space, and that any direct support need only go to the mother rather than for the infant and mother. This research suggests, however, that for the infant to also receive refuge, support within the interchange of seeking and receiving safety within their relationship with their mother needs to be privileged. When this is unable to occur, or requires considerable time in which to occur, the Refuge can greatly assist the infant by stepping in to offer them the intersubjective and other experiences that the mother cannot. What the mothers could offer was significantly compromised by their experience of, and need to escape, past and current violent/threatening relationships. Entry into Refuge did not immediately assuage these difficulties, though it offered temporary accommodation free of violence, the promise of protection and some expectation of support.

Leaving these mothers essentially to themselves, whilst a respectful sentiment, effectively meant that some infants were also left to themselves, emotionally if not physically. Infancy is not a time of needing isolation. Infancy urgently requires mutuality of experience, companionship, playful discovery and sensitive care. Coming into Refuge did not guarantee the experience of safety for

the infant. The infant's experience of feeling safe in Refuge is not simply brought about by the provision of accommodation for the infant, though this may well (but is unlikely to) create a sufficient feeling of safety for the mother. In order for an infant to experience safety in Refuge, more than shelter is required. The infant needs ready access to available, consistent and attuned caregiving relationships.

Irrespective of how well a mother coming into Refuge appears to be managing, and particularly new mothers, these mothers need more, as do their infants. As (Bowlby, 1988) argues:

> Despite voices to the contrary, looking after babies and young children is no job for a single person … In most societies throughout the world these facts have been, and still are, taken for granted and the society organized accordingly. Paradoxically it has taken the world's richest societies to ignore these basic facts (p.2).

Also, paradoxically, the very research that pioneers such as Bowlby undertook to demonstrate the impacts of relational trauma on infant development may have led to a general increase in anxiety about relating to infants. This is because advances in technology and research into infant development have today become so sophisticated and complex that relating to infants is perhaps perceived to be less about what "feels right" than about not doing wrong. It is neither science nor specialists who create safety for infants. It is the infants' experience of relationships within their immediate environment that can create safety, just as relationships, or the lack thereof, can create risk.

Unrealistic expectations: What the mothers expected from themselves, as well as what was expected of them by the staff, was less than realistic given the enormity of not only what they had been through but also what their infant had been through. Leaving the violence was indeed a protective act. However, this step alone was not a failsafe measure against the transmission of

relational dynamics or the erasure of all traces of trauma. Nor did the cessation of violence address what appeared to be unrealistic expectations by the mothers of themselves, and now of their infants, in their quest to create a new future. Perhaps these are the sorts of expectations that contribute to the 'revolving door' use of Refuge, and/or the high incidence of returning to a violent partner as reported in the literature (Bell et al., 2007; Gondolf, 1988; Gordon et al., 2004; Spinney, 2012). This is because the trauma underlying the mother's reason for needing Refuge has not necessarily been identified or addressed. However, in remote areas the lack of alternatives features strongly in the repeated use of those Refuges included in this study. Just as mothers in general are expected to "devote themselves to their children's physical and mental health and overall well-being, and to seek and follow the advice of experts to do this" (Clarke, 2015, p. 310), the same is expected of them in this context. In the meantime, the infant gets what they can from whom they can and when they can. The Refuge leaves the mother to get on with the job of mothering and the infant is expected to 'make do'.

The notion of what constitutes 'safety' for an infant in a Refuge setting, as in any other setting, has an emotional dimension as well as a physical one. The physical layout, equipment, furniture and other residents within some of the Refuges themselves posed potential hazards for the infant. Lack of adequate funding certainly explained some of these issues, but not all. The infant was lost sight of emotionally by the workers and Refuge system, leaving them on occasion un-catered for, unaccounted for and unsafe. The homelessness sector is inadequately resourced, supported and trained. Women's Refuges do not fully cater for the variety of ages, cultures and needs of all those who come through their doors, but, unrealistically, are expected to do so.

Too painful to see

All the infants within this study had been exposed to violence, in utero and/or beyond. That the infants cannot speak about the violence does not mean it did not occur or was not experienced. What was too painful to talk about often appeared to be left unspoken between the staff, mothers and infants, and between the mothers and infants themselves. Violent actions and violent feelings were dealt with by expelling these emotions, eg. by believing that the infant would have no memory or be impacted in any way; by literally ignoring or shutting out any aspects of the infant that reminded the mother of the infant's father; or by mothers and staff removing any trace of the father all together. Another way of dealing with these emotions was to emotionally abandon the infant, just as some of these mothers felt they had been abandoned when young. The mother commanding their infant to stop protesting was yet another way. Irrespective of how such confronting feelings were managed by others, this left the infant alone and with enormously difficult emotional states to deal with. The still-developing and immature infant cannot developmentally deal with overwhelming emotional states alone (Rifkin-Graboi et al., 2009; Schechter & Willheim, 2009; Schore, 2001). As such, there are very few options left to them. These options are to find another caregiver who can make themselves available to them, to fight back, to manage alone, or to simply shut down. Even though in the aforementioned study there were accounts of worker practices which were inconsistent with the more 'hands off' approach the interviews and observations appeared to suggest, overall staff identified bringing in others (experts) to deal with the infant who was struggling. Conversely, when the difficulties of the mother could no longer be ignored, bringing in child protection was another way to manage the needs of the infant.

Perhaps, more than anything, it was the fragility and dependency of the infant and their need to come into a Refuge at all which evoked the most powerful feelings of helplessness in Refuge staff. They wanted to outsource these feelings to others. Notwithstanding the impact that the

'specialising' of infancy has had, remaining at a distance – by leaving the infant to the mother, or by calling in the experts – defended them from the enormity of feeling the infant's vulnerability. This may resonate with what some mothers feel when coming into Refuge. This is a sense of powerlessness in the face of what they feel their infant needs from them. By coming into Refuge, some mothers are perhaps outsourcing that feeling state to the Refuge, hoping that the Refuge can take over part of the infants care, only to find that the Refuge disappoints, just as at some level they perhaps feel they disappoint their infant.

The inability to recognise the infant as having experiences independent of the mother's experiences may be attributable to a sense of being unable to cope with any more emotional pain rather than to a lack of caring. The enormity of what these mothers have already been through may make the task of contemplating what these experiences might be like for their infants one which induces, in the mothers, feelings of emotional unsafeness or feelings that are just unbearable. If you believe your infant is not only unable to communicate but has nothing really to communicate, then their pain can be denied and, therefore, not felt. Despite the infant being the catalyst for coming into Refuge – in itself a protective behaviour – paradoxically, believing that their infant was unaffected by the violence could be seen as a self-protective measure. This, in my opinion, could be interpreted as a preferable way of defending themselves from considering the full implications of what entering Refuge might mean for their infant and their development.

Wired to connect: The ability of infants to be active protagonists in connecting with others, and demanding attention where they would elsewise have received none, speaks to the innate biological capacity infants possess to court engagement (Fishbane, 2007). This makes the recollections by the staff of where the infants initiated engagement with them not surprising, because the infant, whilst dependent, possesses subjectivity, and their own emotional responses

and self-agency. Infants are participants in relating to others and letting them know what they need (Morgan, 2007; Stern, 2003; Winnicott, 1960). Winnicott suggests that the ability of the infant to express what they need is reliant on their caregiving environment, in which they recognise and respond to the overtures of others:

> In infancy, however, good and bad things happen to the infant that are quite outside the infant's range. In fact infancy is the period in which the capacity for gathering external factors into the area of the infant's omnipotence is in process of formation. The ego support of the maternal care enables the infant to live and develop in spite of his being not yet able to control, or to feel responsible for, what is good and bad in the environment (p.585).

When the capacity to be seen in, of and for themselves was limited, the infant usually took what they could get from their mother or an alternative caregiving figure in order to retain some proximity with someone who was bigger than them, receptive to some level of engagement and might offer them security (Marvin, Cooper, Hoffman, & Powell, 2002; Salter-Ainsworth et al., 1978/2014). It was when more than this was offered – when they were seen by the mother or by an alternative carer who wanted to communicate with them and try to understand them that the infant was able to experience safety in the Refuge and, as such, to become curious about and explore their world.

Mothering in Refuge: Many of these mothers were first-time mothers. They came to the Refuge in traumatic circumstances and were often socially isolated. Mothers were seen by staff to have suffered enormous abuse and needing the opportunity to rebuild their lives and trust in the world. This included being given the chance to be the sort of mother they were not able to be when confronted with violence in their relationship. This resonates with what Peled and Dekel

(2010) found in their research with shelter staff in Israel. Staff made allowances for many mothers through what they called "excusable deficiencies" because "depicting the mothers as helpless victims themselves is the only socially acceptable prism through which 'bad mothering' may be excused" (p. 1234). However, the yardsticks applied to the mothers by these shelter staff was found to be informed by rather restrictive and idealised societal notions of mothering, creating the paradox of trying to 'empower' mothers whilst also keeping a vigilant eye on the welfare of the children. "The very existence of an empowering agent who initiates and controls the empowerment puts the person being empowered in an inferior, controlled position. It is as if the power source lies within the empowering person" (Peled & Dekel, 2010, p. 1233).

The inevitable challenge within any organisation, including Refuge, is the dilemma of the survival of the organisation at the expense of its members (Srinivasan & Davis, 1991). Notwithstanding the complexity of this monitoring gaze, there is an active endeavour in this sector to understand rather than to judge. This reflects a general shift away from 'mother blaming', in which mothers were once predominately apportioned the blame for whatever difficulties befell their children (Jackson & Mannix, 2004). The key informants and staff were keen to keep infant and mother together and expressed a sensitivity towards the complexity of the role of mothering, and in such circumstances as might result from living with family violence. This correlates with a shift in community perceptions of mothers which was found in a study undertaken by Clarke (2015). She argues that through the 'medicalising' of childhood, another layer of complexity is being recognised;

> Mothers are responsible for their children but they are not necessarily thought to be blameworthy. There is some mitigation of mother blame by the idea that mothers are vulnerable to the social, political and economic contexts that can lead to behavioural problems" (Clarke, 2015, p. 317).

However, this focus again rests with the mother, and any difficulties experienced by the infant reflect her struggles rather than those of the infant. This justifies the provision of resources and support first and foremost for the mother, a measure which effectively translates into meeting the infant's needs – needs which are believed to be "resolved when issues for the adult are addressed" (Glennen, 2011, p. 35).

Finding refuge in Refuge

When not feeling safe, the energies of most infants are fully directed towards the desire to manage their own emotional states, something they are ill-equipped to do at this very early age. Every infant in this research was susceptible to the vicissitudes of the environment in which they were living. What is intended to be different about this environment, the Refuge, is that its purpose is to provide refuge from harm (Theobald, 2014; Tutty, 1999; Wies, 2008). Harm is not always defined by violence. Many infants arrive battle-weary, having already undergone enormous tribulations. An already depleted infant can be unwittingly traumatised further by the Refuge environment itself, which rushes to meet the procedural demands of a 'workplace' while trying to create 'refuge'. Coupled with their mother's anxiety or distress, the infant may not necessarily find this strange and unfamiliar place reassuring. In attending to pressing practical concerns, the infant's emotional needs may be dismissed.

The relational fabric of what is 'refuge' in Refuge calls for a need to recognise the complexities and relational components of all aspects of Refuge work. This includes being available emotionally to the infant and their mother as to not be available risks compromising the subjectivity of all the players in this setting, the workers included. Krane and Davies (2007) argue that shelter practices render "everyday mothering" invisible, by scrutinising their behaviour towards their children from an idealised notion of mothering. This emphasis on the safety of the

child, the once 'forgotten' victim of family violence, has served to push the mother out of the focus and compromised the ability of workers to engage with mothers 'as subjects within their own right (Davies & Krane, 2006, p. 413).

This study argues the reverse. It is the infant who, as the only pre-verbal occupant in Refuge, risks being lost altogether. More than this, however, the powerful capacity of relationships is lost when pitting one against another. Inherent in the perspective offered in this study has been the assumption that the infant is so dependent on the mother that any consideration of what the infant brings to the relationship is dismissed, especially where both infant and mother are recovering from the experience of family violence (Letourneau et al., 2013). The infant's everyday emotional needs are ignored if they are left waiting in line behind the mother's needs. It is during this waiting time that the greatest risk occurs for the infant, unwittingly contributing as it does to the infant's decline rather than its recovery. Forcing the infant to "wait" for support also risks diminishing the benefits that may arise when infants and mothers are supported in growing together (Morgan, 2007).

Together we find what feels best: That a mother knows best was at odds with how these mothers' own childhood experiences unfolded. Many felt that their mothers had not adequately met their needs, either abandoning them emotionally or physically or through choosing their father or partner over them. In effect, in their experience of being parented, neither mother nor father knew best. The choice to come into Refuge was the most significant way in which they could meet the needs of their infant as they had removed them from harm's way, something their own parents had not done. There was little recognition of what their infant had been through and little notion that, as a family unit, they needed anything more than to move forward. Apart from the obvious need for appropriate accommodation, moving forward involved the provision of

equipment or accessing of material aid for themselves and their infant/children. It did not really seem to occur to mothers that the Refuge had anything to offer their infant other than practical assistance which would help them to attend to the task of parenting.

The place of Fathers: What are the implications for the infant when neither their mother nor staff speak highly of their father, if at all? That part of the infant's heritage is at risk of either being removed, along with the father's heritage, or of being remembered destructively should the infant in some way remind their mother of her ex-partner/father. Entering Refuge facilitated the capacity to expel the father from the life of the infant, and the partner from the life of the mother, at least for that time period. For some mothers coming into Refuge was, of course, a consequence of very real threats made by the father to expel them permanently – by killing them, their children or both. I make no suggestion whatsoever in this thesis that the level or effects of violence perpetrated should be mitigated simply because it was the infant's father who perpetrated it.

Not talking about the father does not, however, remove his presence altogether, nor give room for both mother and infant to make sense of this complex relational reality in their lives. As Abrahams (2010) noted: "Women could still feel love, as well as fear and hatred, towards their abuser" (p.24). Generally when fathers or men were spoken of it was in a negative manner, one which risked shutting down any chance for mothers to speak and make sense of their full experience of their relationship. Similarly, this 'no go' area risked setting up a space where the growing infant could make up their own fantasies about what their father was really like (Jones & Bunston, 2012). Together with the other, overwhelming circumstances the infants in this research were left to deal with, they had to make sense and meaning of their complex relationship with their father. This is too much for infants to manage on their own if there is hope that this will be done in a way which enhances, rather than damages, their burgeoning sense of identity.

Start at the very beginning

Refuges are in an ideal position to not only work with mothers and their infants, given the high numbers of both, but to consider the implications of recognising the inherent value that such early intervention work might provide. Furthermore, this occurs at a highly critical stage in the development of the infant and the forming of the relational bond between the infant and their mother. Rayna & Laevers (2011, p. 163) declared a revolutionary concept, this being that:

> we are now confirming and developing the image of the very young child as a rich and competent citizen … we must realize the enormous relevance of the insights coming from research on the under-3s … how much potential there is for a bottom-up movement where early years takes the lead (p.169).

'Viva la revolución!' This thesis supports taking a revolutionary shift in the way in which we view infants. This may be done by adopting practices and ideals which secure "the most sacred values and the highest principle" (Gawronski, 2002, p. 366), such as those which have driven major political revolutions without resorting to replacing one regimented knowledge base with another. The inter-subjective and relational nature of human existence requires that we not diminish the subjectivity of the infant, or their relationship with their mother or others involved in the infant's life. In the setting of Refuge this includes staff, siblings and mother, other mothers and their children, and, psychologically, even fathers.

In order to bring about much-needed change in how we think about and address the complexities of family violence and the subsequent need for Refuge, seeking the perspective of infants can only assist us. This involves recognising not just the contribution of the infants to their mothers' decision to enter Refuge but what life is like for infants once they are in Refuge. To date, infants

as “subjects” unto themselves remains one of the last frontiers of discovery, and particularly so in an environment such as Refuge. Refuge itself appears to also operate as a last frontier, staying as it does on the periphery of not only society but the human service sector and the family violence field itself. Why is the current knowledge and research now available regarding infants and their enormous capacities for active engagement in, and contribution to, relationships so poorly understood in the family violence sector particularly and in the community generally? It seems that the increase in research on and knowledge regarding infants has not been matched by advances in our understanding of how this might helpfully be applied to practice.

Learning from the past: It is some forty years since the first women’s Refuges were created. We do not appear to have come very far in our ability to conceptualise the place and experience of infants and children needing refuge when they enter crisis accommodation with their mothers after fleeing family violence. Written forty years ago, this very powerful quote from an unidentified Refuge worker could have been written today:

> *Women and their children … It is difficult to separate the two because when trying to help the women overcome their problems the children almost always come into it. Often in fact, they are the cause of it. Also, many of the children’s problems concern their mothers, in that the mother may be neglecting them or even blatantly mistreating them.*
>
> *However, I do feel that we are too concerned with the women and are not concerned enough with the kids. We idealistically say that we are trying to break down the nuclear family because it is an oppressive unit in our society and that children are individuals in their own right. Yet our treatment of the children puts lie to this whole idea.*
>
> *We still see the children as appendages of their mothers. How often do we say, “This is Jane-Mary’s daughter”, instead of simply saying “This is Jane”? We are forced to consult the mothers on any decision we make concerning the children because it is ultimately (they)*

> *who must take the responsibility. Because, despite our fancy notions of changing society, this is the reality with which we must work. Often to the women, the children are the only realm of power that they have, and so they often quite actively resent any intrusion into their domain. After all, they are 'the mother'. While I agree with the idea that children should not be the sole responsibility of their mother I cannot see how we can put this idea into practical action. How can we change a life time of conditioning in the space of a month? Is it even feasible to think of doing this?* (Women's Liberation Halfway House Collective, 1976, p. 123)

This remarkable quote speaks to the complexity of how children in Refuge were thought about, and treated, in 1976. The findings of this research, though specific to infants, suggest that these complexities continue to exist. The safety of infants was not the primary consideration in the creation of women's Refuges in the 1970s and this remains the case today. This is despite the fact that in today's Refuges the numbers of children often outstrip the numbers of women, with infants as the highest cohort (AIHW, 2012a, 2012b; Shinn, 2010; Webb et al., 2001; Women'sAid, 2014). Without compromising the infant's need to be held by a more powerful, kindly caregiver, it is time for change. Just as the women's movement revolutionised the way in which gender relations were viewed, it is timely to reconsider the position of infants in relation to all other family members. The penultimate question of the powerful quote given above is; "*How can we change a life time of conditioning in the space of a month?*" Perhaps an alternative question for further research could be: *"*How can we create a lifetime of change in mothers, Refuge workers and the family violence sector?" This research suggests such a change might occur by both seeing, and responding to the infant in their own right. To answer the final question of the unnamed Refuge worker – yes, it is indeed '"feasible to think of doing this". The service sector and the community in general can no longer afford to ask the infant to wait.

Infants are enormously and emotionally capable of giving, and are generative in their interactions. Their history of trauma is shorter than that of their mothers and they are more quickly able to respond to engagement and interventions (Rifkin-Graboi et al., 2009). The infants in this study helped their mothers to carry the hope of creating a different future. What the infant represented for the mothers seemed to be complex and raw. However, by more actively engaging with the infant the Refuge may serve to create opportunities for new ways in which the infant and mother can relate to one another. This is not by taking over the care of the infant but by being 'infant-inclusive'. In this way, opportunities to introduce new ways for the mother and infant in which to see themselves, and each other, within their relationship are captured. The Refuge actively seeing, thinking about and engaging with the infant may enable what Morgan (2007) calls 'a definitive statement' about:

> an intentional relating to the infant as a subject. … this active involvement of the infant, which really may be quite difficult and not only to initiate but to also sustain, can make a difference to the way we all think about the problem in hand (p.12).

The infants in this study had already made a difference. How to sustain this warrants further exploration. More often than not, they appeared to represent hope for a new future and an opportunity for their mothers to provide for them in a way in which their own parents were unable. The infant was the catalyst for coming into Refuge and, for most, the motivation to leave a relationship with a violent partner. This was consistent with other, recent studies which found that the motivating factor for mothers leaving was what was in 'the best interests' of their children (Rasool, 2015). This is in contrast to older studies which indicated that having children was a factor in having "difficulty leaving because of economic dependence and a lack of options for supporting themselves and their children" (Rhodes & McKenzie, 1999, p. 402). The relationship with the infant offered some level of repair and compensation for the violence experienced within

their 'other' most intimate relationship – that shared with their (ex) partner (Letourneau et al., 2013). What the infant represented for many of the mothers was the prospect of healing. The very experience of relating to their infant helped them to 'make good' and even offered a feeling of security not previously experienced. The early childhood experiences of the majority of the mothers suggests that a sense of emotional safety was not often available in their families. The presence of the infant in their lives appeared to possibly re-dress some of the disappointments and hurts from their pasts. It is not an appropriate expectation that an infant should fix the ills of their past, but capitalising on feelings of hope for their future together presents an amazing opportunity to build new relationship experiences.

Summary

This research has found that leaving a violent relationship and entering a Refuge does not guarantee that the traumatised infant and their mother will find refuge in Refuge. The provision of crisis accommodation may ameliorate the immediate physical threats to mother and infant but Refuge staff are often ill-equipped, or inadequately supported, to address the lingering and complex psychological impacts on both. Staff not seeing the infant as subjectively affected by the experience of the violence, and/or leaving the infant emotionally unattended to by their mother once in Refuge, can add to the emotional deterioration of the infant.

There is considerable existing knowledge, as referred to in Table 3, in relation to infants and the impacts of trauma associated with family violence and homelessness. Infancy is developmentally the most vulnerable of any of the ages within childhood. Infants are also the most likely to be present during violent incidences and are the highest cohort to accompany their mothers into Refuge, yet are the least likely to be seen or provided with services. What new knowledge this research adds is noted in Table 4 below.

Table 3. Existing Knowledge

WHAT IS ALREADY KNOWN
1. Infants are detrimentally and developmentally impacted by un-addressed trauma associated with family violence and homelessness.
2. Infants experience higher levels of trauma than older children yet are least represented in the literature and least likely to be provided with services in the community.
3. Infants make up the highest cohort of children entering women's Refuges with their mothers to escape family violence.
4. Infants are seen as 'accompanying' the mother and as they are non-verbal are responded to with practical aid.
5. Refuges were created foremost with the women in mind and children were seen to accompany them.

This includes the way in which the specialisation of infancy, and collusion with 'adult centric' practices, contributes to infants being lost from view, particularly those infants most at risk. In particular, the expectation that the mother alone will be the refuge for the infant is unrealistic in the face of the mother's own extensive past and present traumas. While such practices continue, we will do little to interrupt the inter-generational transmission of violence. Refuges are imperative for those mothers and their infants and children most at risk. They are an important, physically safe holding space which is enhanced by the relational opportunities offered when they are adequately staffed. There was evidence of some valuable but largely intermittent work undertaken with infants directly.

Table 4. New Knowledge

WHAT THIS RESEARCH ADDS
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 father is either not spoken of or spoken of with disdain, leaving the infant alone to make sense of this complex relationship. 6. 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.

The inhibitors to seeing the infant as capable of being engaged with directly and emotionally were connected with a belief that it was the role of the Refuge to support the mother while she supported the infant. Both mothers and Refuge staff minimised the impact of the family violence experienced by the infant. In part, this was because they could not conceive of the infant as having a memory or relatable response to what was happening to them. In part, perhaps, it was also to defend themselves from feeling the full extent of what the possession of such knowledge would mean, and how it might affect them. The significance of the father, and to some degree men in general, was also reduced and/or rendered unimportant. This had the potential to leave the immature infant with little means by which to make sense of where and how their father, and men generally, featured in their lives.

The rapidly developing infant cannot afford to wait while their mother recovers from what has been significant abuse, and, for most, accumulative abuse. Furthermore, the sooner the infant is responded to and their subjectivity and inter-subjectivity acknowledged, the sooner will come opportunities to capitalise on the relational hope the mother carries for her infant and herself. These mothers largely accessed Refuge in order to create a different future. Refuge is in a unique

position to start at the very beginning with these infants and mothers in working towards the realisation of this goal.

Limitations

A criticism that could be made in relation to this research is that the infant did not, and could not, use their own words to tell "their side of the story". The purpose of the 'infant-led' approach was to place the infant firmly at the centre of the research and to strive to capture their experience. As the infants were pre-verbal, this was dependent on my interpretation of their inter-subjective space and was achieved through what was seen and felt through my engagement with them. There was no pretext that this research was 'objective', as its purpose was to 'illuminate' rather than to 'measure' (Charmaz, 2014; Crotty, 1998; Denzin & Lincoln, 2003; Krefting, 1991; Medico & Santiago-Delefosse, 2014). To have sought to measure that which is subjective would have been contrary to what this research hoped to uncover and preserve: the 'phenomenon of interactions' (Silverman, 2013). It should also be recognised that the transcripts included in this thesis cannot do justice to the complexity of the stories associated with the mothers who came into the Refuge setting. Nor can this narrative adequately capture the depth of feeling associated with how very distressing this work can be for Refuge staff. However, what the methodology has been able to do is successfully capture the relational behaviours of the infants, and make meaning of these without the level of intrusion or inflexibility encountered in some of the more traditional methods used to undertake research with infants.

Another limitation is the brevity of contact with each infant, mother and Refuge. This research offers only a snapshot of a period of time and, as such, does not provide a sequential sense of the infants' experience to any large degree. The inclusion of Refuges, essentially across three very different locations – urban, regional and remote – as well as three different countries, offers valuable points for comparison. However, the numbers overall are small, and to extrapolate extensively from this under-researched area using this small cohort of participants would be a

mistake, and is not the intended purpose. A factor also unable to be explored in greater depth is whether more infants might have reached beyond their mothers to other adults for support, had there been more adult options available to them at the Refuge during the observations. My presence, as much as I endeavoured to not be intrusive, would still have impacted on the environment and may have discouraged staff from being as involved with the infants and mothers possibly as would normally occur – another case of 'leaving it to the expert', perhaps?

Furthermore, it should be acknowledged that to have provided a more nuanced 'inter-subjective' process would have required the perspective of siblings, as well as other mothers, women and children in the Refuge. However, this risked creating a potentially unwieldy amount of data and presented complicated ethical considerations (particularly those that might arise from the involvement of these other mothers, women and non-related children). The potential impact on the infant of all who reside in the Refuge, and the infant's impact on these people in turn, should not be underestimated. The lack of research regarding the infant in the setting of Refuge, even in the increasingly expansive arena of infant mental health, is indicative of the extent to which this environment in which so many infants are accommodated tends to be overlooked. This study offers a starting point for others to follow.

Finally, it may be considered a limitation not to have purposefully mined, in greater depth, the differing racial and cultural aspects operating within these different environments. This would have been an enormous task, given the diversity of cultures represented by both the cohort of mothers and the Refuge staff. This inclusion would have been interesting, albeit difficult to manage along with all of the other data considered, but it may not have particularly strengthened this thesis, as a need for adequate refuge is common to all infants across all cultures.

The infant sits at the bottom of the hierarchy within Refuge, just as women's Refuges sit at the bottom of the hierarchy within the family violence and homelessness sectors (Haldane, 2010; Srinivasan & Davis, 1991). That the infant is vulnerable to developmental harm in families in which there is violence is generally accepted by society today (Levendosky, Bogat, & Huth-Bocks, 2011; Levendosky et al., 2013; Lieberman & Van Horn, 2004; Miller, 2007; Schechter & Willheim, 2009; Van der Kolk, 2014). This does not translate, however, into specific funding or practice applications in Refuge or the community service sector generally.

Until infants are fully 'seen' in Refuge, ideally by their mother and the Refuge as well as by other mothers and even external support services, Refuge may never fully provide infants with the experience of feeling safe. The infant not being fully seen precludes them from the opportunity of 'letting go' and, as such, from the chance to feel safe enough to then engage in experiences necessary for healthy development, exploration and discovery. These are experiences which, at their most fundamental level, all infants are entitled to be supported in. The women's liberation movement created something which governments did not and would not see at first. This was a community led uprising that has now seen the scourge of violence against women made overt and recognised as something which is "front and centre in the public domain" (Arnold & Ake, 2013, p. 558). What might it take to recognise that infants are all too often present when family violence occurs? To recognise that infants require just as much help as, and with, their mother in order to recover, "since even the still vulnerable self, in the process of formation, can cope with serious traumata if it is embedded in a healthily supportive milieu" (Kohut & Wolf, 1978, p. 416).

Refuges also deserve the safety of adequate funding and recognition of their contribution. This study highlights the fact that Refuges need to be seen and held within the family violence and welfare sector as a legitimate and critical service which can provide enormously valuable

opportunities for repair to those most 'at risk' vulnerable infants and their mothers, who require the protection that Refuge offers. Understanding and attending to the needs of these infants should be central to the policies applied in Refuge, with training urgently prioritised. There would be few research projects undertaken in the human services, health and welfare sector that would not conclude with recommendations for both further research and increased funding to preventative services. But the challenge is so much greater than this. What is required is a major cultural shift in how we think about the youngest victims of family violence. This work is entirely relational, not procedural. No amount of money will ensure that those who work with the infant truly see the infant. This shift involves an internal recognition and thus an ability to provide infants with an empathic emotional response. We cannot keep making infants vanish, or simply "looking through' the infants' faces, as if the infant is not 'seen' or experienced" (Beebe et al., 2011, p. 194).

Working with infants who have been traumatised requires thoughtfulness and, at times, specialist involvement. However, this is not simply achieved through the further 'professionalisation' of Refuges or sucking dry all of the passion, commitment and energy that most workers in Refuge bring to this work. It would be a mistake to not honour that which has gone before, or to not respect the relational integrity that forms the basis of what created Refuge in the first place. To do this involves bringing in skills and service expertise which can not only support and strengthen the existing system of Refuges but which, in turn, leads to these very specialist services being educated about, and held accountable for, the incredibly important work that must be carried out with infants. Mental health services – 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 et al., 2008; Kemp et al., 1995; Tolman & Rosen, 2001; WHO, 2013).

It is no longer acceptable to say that family violence is not 'core' business for mental health, community health and maternal child health. 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, is a commitment 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).

This tailoring of interventions necessitates research into what works best in terms of supporting this particular infant and mother cohort. The tendency to transplant established interventions into vastly different settings is enormously attractive, as it appears to save time and money, but it does not always guarantee success (Bain, 2014). Throwing resources at the treatment end of adult work rather than injecting this into early intervention and prevention with infants and children can be a false economy. Humphreys et al. (2011) argue that:

> 'Readiness to change' has been used as a concept that is not only applicable to individual women and children, but is just as relevant to the relationship between women and their children, as well as workers and organisations (p. 181).

This work needs to begin early, and to cater to those families specific to Refuge. 'Readiness to change' requires the Refuge to think differently about what is 'refuge' for the infant.

Infant work is completely relational. It is relationships that have harmed the infant, and within an environment such as Refuge it is relationships that offer the best capacities for healing. A realignment of what are the most important priorities needs to occur. Concerns about buildings, material aid, legalities and pressing appointments are important. However most urgent for the

infant and most likely to have the greatest long-term and beneficial outcomes, is attendance to the immediacy of the infant's need for safe relationships. As Gaensbauer & Siegel (1995) argue: "The complex psychophysiological effects of trauma in the infancy period should be approached with the same diligence that has been applied with older children and adults" (p.304). Refuge for the infant needs to be less about the building and equipment and more about the people and relationships. This is as true for the mother as it is for the infant. Existing Refuge workers need to be encouraged to act as a community of carers for the infant and their mother, and be supported in becoming so. What might happen if the rich heritage of the women's movement extended its passion to include the rights of infants?

Implications for future research

Secret, *hidden*, *invisible*, *silence* and *shame* are some of the words commonly used in research to describe how family violence is experienced or responded to (Arnold & Ake, 2013; Humphreys, 2006; Krane & Davies, 2002, 2007). The more visible the dynamic of violence within intimate relationships becomes, the more it can be understood. The greater the knowledge regarding the experience of the infant, the greater the awareness that infants need to be attended to in and of themselves. In considering their experience important, their voice can be incorporated into the wider knowledge base that speaks to the impacts of family violence. The infant will then start to appear in the literature pertaining to family violence and will influence the way in which we think about Refuges. Future research may explore how the infant themselves impacts on Refuge, and stories that speak of how powerfully the infant impacts on the lives of their mothers, other women, other children and Refuge workers may come to light.

Gaining access to that which is so prevalent yet so hidden in our society is another matter altogether. Researchers need to engage with the family violence sector more creatively and be

prepared to go to where the infant is, rather than expecting the infant and mother to come to them. There needs to be more learning taken from, imparted to, and incorporated into the family violence sector. Frontline workers such as family violence support workers, police, maternal child health nurses, midwives, mental health professionals, early childhood educators, day-care staff, homelessness workers and child protection workers are likely to have considerable contact with infants impacted by family violence. Research can tap into the knowledge, experience and relationships that already exist between professionals and families where there is violence, in order to enable a richer picture of the infant's subjective experiences of this issue to emerge.

As some Refuges revealed, they face the risk of their current government contracting Refuge work out to the bigger, generic housing services in order to cut costs. This undermines the critical emphasis required to adequately provide protection and support to mothers escaping violence from their partners. Further still, the closure of women's Refuges would seem to invalidate the extensive evidence regarding the prevalence of largely male-to-female violence, not to mention representing a false economy of savings in an area proven to substantially cost societies around the world, both economically and socially (Mottram & Salter, 2015; WHO, 2014). This research would suggest that women's Refuges offer enormous potential for early intervention work. More research on the value of enhancing the relationship between infants and their mothers in Refuge is called for, research that requires considerably more attention than this thesis alone can provide. Furthermore, the use of infant-led methodological approaches and analysis such as those pioneered in this study may bring further clarity regarding the experience of the infant.

Conclusion

Commencing with the infant, multiple vantage points have been sought within this research to infer an understanding of the experience of the infant who enters Refuge. This research has drawn

on data collected from infant observation sessions – the least intrusive manner in which to come to know their world – together with interviews with mothers, Refuge staff and Key Informants. The research has remained purposefully 'infant-led' (Bunston, 2008a, 2008b; Paul & Thomson-Salo, 1997; Thomson-Salo, 2012), from the order of the data collection through to the analysis and subsequent layout of this thesis. This was done in order to honour the voice of the infant, and their inter-subjective experience, by using an approach which acknowledges the mutual meaning made through relating to another (Beebe & Lachmann, 1988; Beebe & Lachmann, 1998; Bürgin, 2011; Medico & Santiago-Delefosse, 2014; Stern, 2003; Trevarthen & Aitken, 2001; Tronick & Beeghly, 2011). This approach drew on a 'constructivist grounded theory method' (Charmaz, 2003, 2008; Charmaz, 2014) that also made my voice as researcher transparent. In order to gain entry into the hidden world of women's Refuge, I was required to take advantage of whatever opportunities presented themselves to me.

In seeking to understand the perspective of the infant within the Refuge context it became apparent that much gets in the way of seeing the infant and taking on their point of view. The less clear the view of the infant, the poorer the ability to see who or what provided them with refuge. There appeared to be distorted perceptions of the infant and what they wanted, and needed, from the mothers and the Refuge itself. This had the implication of denying the mother and staff the opportunity to engage together with the infant in a mutual discovery of meaning. This potentially robbed some infants of accessing the early relational opportunities which would enable them to feel that they were worthy of attention, and of the chance to have their feeling states tolerated as well as validated. In order to retain some level of connection with their mother, however tenuous this might be, many of the infant's forfeited exploration in order to retain proximity. Largely, this resulted in the infant adapting their behaviours and effectively sublimating their subjectivity to meet the needs of their caregiving environment. Distressingly, one infant, however, appeared to

resist retaining a connection, and instead found it safer to forfeit proximity to his mother altogether.

The adult-centric nature of society in general was evident within Refuge. This was despite the large numbers of infants residing in Refuge, together with the burgeoning research pointing to the imperative to intervene early with infants impacted by the trauma of family violence, dislocation and anxiety resulting from homelessness. Further, for the mothers themselves, the inter-generational transmission of trauma was keenly apparent, and compounded by recent experiences of violence within their intimate adult relationships. For the staff, keeping the infant at a distance protected them from needing to deal with even more emotional anguish in an already complex and confronting workplace. At the bottom of the pecking order lay the infant – the child who, for these mothers, was the reason for leaving a violent relationship and who was the 'hope bearer' for the future. Ironically the hope of 'what could be', as represented by their new baby, diverted many mothers from what actually was: a very real, unique and rapidly developing infant who needed to be thought about, attended to and seen for who they were, rather than as others wanted them to be. The capacity to truly 'see' and 'emotionally connect' with the very youngest infants affected by family violence may open up possibilities not yet fathomed in understanding how we might, as a society, address the destructive impacts of family violence.

APPENDICES

Appendix One

Infant Observation Consent Form

Mothers Consent Form

Workers Consent Form

Key Informant Consent Forms

Appendix Two

Example of Nuance Coding of an Infant Observation

Appendix Three

Final "Major', 'Stand-Alone' & Minor themes

Appendix Four

Examples of 'collapsing' themes into Theme One

Appendix one

Infant observation consent form

DEPARTMENT OF SOCIAL WORK AND SOCIAL POLICY

STUDY INTO "HOW REFUGE PROVIDES 'REFUGE' TO INFANTS: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing violence"

Mothers Consent Form – To Agree To My Infant Being Observed

I, _____ have read and understand the Information Statement about this research and the Consent Form that I am now signing. I have been able to ask any questions that I wanted to about this study and feel happy with the answers. I understand that myself and my infant will be observed during our time in this refuge on up to three occasions for no more than an hour each time.

I also understand that I will again be asked for my verbal permission before each of the observations of my infant can go ahead, and that these times will be arranged to suit me and my infant. I understand that if I change my mind now or at any time in the next five weeks I can withdraw completely from this study.

I agree that in giving my full consent to be involved in this study that my information and the information about my infant will be kept confidential. I agree that this information can be used in written reports, and used in training and conferences, published in journals and used for teaching purposes but that in no way will my confidential information be used in any way to identify myself or my infant.

Name of Mother (Block Letters) _____ Signature _____	Date _____
Researcher doing the study WENDY BUNSTON Signature _____	Date _____

DEPARTMENT OF SOCIAL WORK AND SOCIAL POLICY

STUDY INTO "HOW REFUGE PROVIDES 'REFUGE' TO INFANTS: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing violence"

Mothers Consent Form – To Agree To Being Interviewed

I, _____ have read and understand the Information Statement about this research and the Consent Form that I am now signing. I have been able to ask any questions that I wanted to about this study and feel happy with the answers. I understand that I will be interviewed to ask my opinion on how crisis accommodation services such as this refuge provides my infant with refuge, that is, with the feeling of being safe from harm.

I understand that I will be interviewed for up to 1 and a half hours and at a time that is suitable for me. I understand that I change my mind any time over the next five weeks and that I can withdraw completely from this study.

I agree that in giving my full consent to be involved in this study that my information will be kept confidential. I agree that this information can be used in written reports, and used in training and conferences, published in journals and used for teaching purposes but that in no way will my confidential information be used in any way to identify myself or my infant.

Consent for Interview to be Audio recorded

I also give consent for this interview to be audio recorded and understand that this audio recording will be kept secure and confidential. If I want the researcher to stop recording this interview I understand that I can ask this to happen immediately. TICK Yes ☐ or No ☐

Name of Mother (Block Letters) _____ Signature _____	 Date _____
Researcher doing the study WENDY BUNSTON Signature _____	Date _____

DEPARTMENT OF SOCIAL WORK AND SOCIAL POLICY

STUDY INTO "HOW REFUGE PROVIDES 'REFUGE' TO INFANTS: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing violence"

Worker's Consent Form – To Agree To Being Involved in a Focus Group

I, _____ have read and understand the Information Statement about this research and the Consent Form that I am now signing. I have been able to ask any questions that I wanted to about this study and feel happy with the answers. I understand that I will be interviewed as part of up to two focus groups with other workers in my organisation to ask my opinion on how crisis accommodation services such as this refuge provides infants with 'refuge', that is, with the feeling of being safe from harm.

I understand that the focus group will take up to 1 and a half hours and that the focus groups will be organised at a time that is suitable for the whole group. I understand that I can leave the focus group discussion at any time should I choose to and I am aware that my opinions are to be shared with others in the groups and that I will share only that which I am comfortable to share in the presence of others in the group. I also understand that by agreeing to be involved in a focus group all the information collected from this focus group will be kept confidential and de-identified.

I understand that in giving my full consent to be involved in this study that my information will be kept confidential. I agree that this information can be used in written reports, and used in training and conferences, published in journals and used for teaching purposes but understand that in no way will any of my confidential information be used in such a way as to be able to identify who I am.

Consent for Focus Group to be Audio recorded

I also give consent for this interview to be audio recorded and understand that this audio recording will be kept secure and confidential. If I want the researcher to stop recording this interview I understand that I can ask this to happen immediately. TICK Yes ☐ or No ☐

Name of Worker (Block Letters) _____ Signature _____	Date _____
Researcher doing the study WENDY BUNSTON Signature _____	Date _____

DEPARTMENT OF SOCIAL WORK AND SOCIAL POLICY

STUDY INTO "HOW REFUGE PROVIDES 'REFUGE' TO INFANTS: Exploring how 'refuge' is provided to infants entering crisis accommodation with their mothers after fleeing violence"

Key Informant Consent Form – To Agree To Being Involved in an interview

I, _____ have read and understand the Information Statement about this research and the Consent Form that I am now signing. I have been able to ask any questions that I wanted to about this study and feel happy with the answers. I understand that I will be interviewed as a key informant as I have specialised knowledge about how crisis accommodation services, and in particular that of the refuge, work. I can offer useful opinions about how refuge provides infants with 'refuge', that is, with the feeling of being safe from harm.

I understand that the interview will take up to 1 and a half hours and that the interview will be organised at a time that is suitable for me. I understand that I can cease the interview at any time should I choose to. I also understand that by agreeing to be involved in an interview all the information I provide from this interview will be kept confidential and will be de-identified. I also understand that I can withdraw from this study and have four weeks from the conclusion of this interview to withdraw my permission to be involved.

I understand that in giving my full consent to be involved in this study that my information will be kept confidential. I agree that this information can be used in written reports, and used in training and conferences, published in journals and used for teaching purposes but understand that in no way will any of my confidential information be used in such a way as to be able to identify who I am.

Consent for the interview to be Audio recorded

I also give consent for this interview to be audio recorded and understand that this audio recording will be kept secure and confidential. If I want the researcher to stop recording this interview I understand that I can ask this to happen immediately. TICK Yes ☐ or No ☐

Name of Key Informant (Block Letters)_____ Signature _____	Date _____
Researcher doing the study WENDY BUNSTON Signature _____	Date _____

Appendix two

Example of stage two coding taken from one infant's observations

INFANT	MOTHER	REFUGE	RESEARCHER
B2 I will settle when I am back being held by you I really want you I've had enough, this is all too much I give in as I have no other choice I have disappeared. No one can see me. I have to fend for myself. I don't know where I am. I need to keep alert to any danger I am frozen – I am terrified – where is my mother? I am on guard, I don't know what is going to happen I am not available - I cannot be reached – I am protecting myself I have to keep on my guard I can't hold on anymore- I am exhausted I have learnt to hold myself – stuck and still- I have no other choice	M2 M. I need to get out of here M. I really want out M. I will not hear your protests M. I need something that makes me feel back in control M. I know I am putting myself first but maybe it can be not so bad Mum is still in shock – feeling betrayed I was forced to choose between my son and his father This baby is my second chance at being a mother M. I don't know how to give my baby an ongoing sense of safety	R1 here – we have a lot to do Ref. Nice Communal Space or too much at first Getting back to business Ref. Not listening to the infant Ref. We can tend to your physical needs – that will make you and us feel better Ref. Baby forgotten Ref. We will support you Mum and try and help baby also Ref. How can I help? Refuge priorities exacerbated the disconnect between mother and infant Mother rather than infant focused.	Everything is frazzled, risks falling apart R. We are losing our way R. Where is the baby R. This feels painful to watch (the baby) R. I can feel this infant's anxiety quite intensely The infant was frozen looking at me- who are you? R. I feel weepy looking at this infant's pained face R. What can I do to make you feel safe, how can I show you that your mummy is here R. How can I make this lovely woman Available to her infant? R. I want to help you. How can I take away this pain

Appendix three

Final combined coding stage of all infants coded and re-coded

EMERGING THEMES FROM INFANT OBSERVATIONS

The Infant

I feel safe when I am being held by you (Mother), (Infant 1, 2, 3, 4, 6, 7, 9, 10)

I primarily use you as my refuge (Infant 1, 9, 10)

I primarily acquiesce to your needs (Infant 2, 3, 5, 6, 7, 8)

I use myself primarily to navigate my emotional world (Infant 2, 4, 5, 6, 7, 8)

I am interested in what is happening around me (Infant 1, 2 (over time), 5, 6, 9)

I am wary of others at times (Infant 2, 4, 6, 7, 8, 10, 11)

I am vulnerable to my environment and to you (mother)

I actively solicit my mother's attention (B1, 7, 9, 10)

We have developed a pattern of relating but I know something is different

I don't know who all these other people are (Infant 1, 2, 4, 6, 7, 10)

I use you as my reference point – I am expect others to behave towards me as you do (Infant 1, 9,

I am lost from your view (Mother) at times

Battle weary baby- multiple forced separations B2, B4, 8)

I am left to manage overwhelming emotions by myself (Infant, 2, 3, 4, 5, 7, 8)

I quickly learn my place (B2, 3, 4, 5, 6, 7, 8, 9)

I am left unprotected by you at times and need to protect myself

I will take what I can get (Infant 3, 4, 5)

I am not sure of how I am separate to you

Who do I belong to? (B5)

I have learnt to fight you (B4, 8 – both boys)

I feel very alone

Too many people are overwhelming (2, 4, 6, 7, 10)

I don't always feel happy, is that ok? (1, 3, 4(sister) 5, 6, 8, 9)

1. THE INFANT

- **I FEEL SAFE WHEN I AM BEING HELD by you (Mother)**
- **I PRIMARILY ACQUIESCE TO YOUR NEEDS**
- **I AM VULNERABLE TO MY ENVIRONMENT AND TO YOU (mother)**
- **We have developed a pattern of relating but I KNOW SOMETHING IS DIFFERENT**
- **I AM LOST FROM YOUR VIEW (Mother) at times**
- **They disappear (the busyness of Refuge) – avoidance**
- **BATTLE WEARY BABY- multiple forced separations**
- **I am not sure of HOW I AM SEPARATE TO YOU**
- **WHO DO I BELONG TO?**
- **I AM OVERWHELMED BY WHAT YOU WANT FROM ME**

2. SIBLINGS

- Don't turn to me, I am falling apart and cannot manage myself let alone you (sister of Infant 4)
- I am available to you, I help care for you (Infant 10)
- We will take what we can get

3. THE MOTHER

- ***I WANT A DIFFERENT FUTURE for my baby***
- ***I AM GRATEFUL/RELIEVED TO BE HERE,***
- ***I HAVE BEEN ABANDONED/ NEGLECTED by the Refuge***
- ***ANXIOUS ABOUT WHAT NEXT***
- ***THE FATHER – Infant's and their own (Mothers)***

4. THE WORKER & KEY INFORMANTS

- THE BUSINESS OF REFUGE
- HAVE TO MAKE DO WITH WHAT YOU HAVE

5. THE RESEARCHER

- SETTING
  - GOOD INTENSIONS – CREATING A 'NORMAL SPACE' – OR A DEPERSONALISED SETTING
  - REMOTE – CIRCUIT BREAKER
  - BOTH GIVES AND TAKES,
  - ***NO SPACE FOR INFANTS***
- SYSTEM
- REFLECTIONS ***(Resonances)***
  - ***MISSED OPPORTUNITIES***

TOO PAINFUL TO WATCH this infant's distress

Appendix four

Example of 'collapsing' all themes into theme One

1. I (the infant) come to you (the mother) for refuge and to feel safe

Emerging Themes from Infant Observations (Black Bold)
MAJOR THEMES Underlined

Corresponding Themes (Red & Black*) from the Mother's Interviews*
Corresponding Themes from Workers –infants/mothers/workers/refuge/system/managers

THE INFANT

I FEEL SAFE WHEN I AM BEING HELD by you (Mother), (Infant 1, 2, 3, 4, 6, 7, 9, 10) & Mother held by Infant *A baby only needs her mother – 1, She really only needs me - 9,* "I was empty so she is filling up where I was empty" (M7), Babies are kept safe by their mothers M10 ,I make him feel safe M2, He gets clingy initially but he trusts I am protecting him M10 , Baby doesn't need refuge. Need their mothers. Refuge is for the mother? M9 4. Best place for baby is with mother, **You work out what I need** (Infant 1, 2, 3, 10) 24. Mothers put babies' interest's first, **I primarily use you as my refuge (Infant 1, 9, 10) &** Infant as refuge for Mother, *She loves chatting to me, and I listen – 9, I try to protect him and the baby knows this – 10,* She has me back and I have her now as my priority in life – my goal and purpose in life (M7), **I love it when you delight in me** (Infant 1, 2, 3, 6, 7, 9, 10), Enjoys her baby and her children W – M 10, **I am interested in what is happening around me (Infant** 1, 2 (over time), 5, 6, 9), 8. The relationship we offer mothers is very important 8, **I actively solicit my mother's attention (B1, 7, 9, 10) I delight in my baby,** Having the baby makes me happy (M2), She has opened up something in me I didn't know I had before – M7, Anything to put a smile on her face M9, 10. Baby catalyst for coming into Refuge, *"Future research should explore if infants may themselves compensate in their interactions by being more sensitive and responsive to changes in their caregiving environment, providing clearer cues, and* ***driving overall improved*** *maternal–child interactions, as the findings of this study suggest" (Letourneau et al., 2013 p:582)*- 16. Refuge same for baby as mother, safe from violence (Ref to Letourneau et al., 2013), **I find refuge in my infant,** Baby Represents Hope M3, Baby as Saviour (M3, 7), The baby can change things- me, my husband, our life M3, She has me back and I have her now as my priority in life – my goal and purpose in life (M7), She will succeed where I did not – she will make me a better person (M7), **I delight in my baby.**

REFERENCES

Abrahams, H. (2010). *Rebuilding Lives after Domestic Violence : Understanding long-term outcomes*. London: Jessica Kingsley Publishers. Retrieved from http://latrobe.eblib.com.au/patron/FullRecord.aspx?p=677656

Abrahamson, M. (1983). *Social Research Methods*. Englewood Cliffs, N.J.: Prentice-Hall.

Adamo, S. M. G. (2008). Observing educational relations in their natural context. *Infant Observation, 11*(2), 131-146. doi:10.1080/13698030802242765

Adesina, O., Oyugbo, I., & Olubukola, A. (2011). Prevalence and pattern of violence in pregnancy in Ibadan, South-West Nigeria. *Journal of Obstetrics and Gynaecology, 31*(3), 232-236. doi:10.3109/01443615.2010.547954

Ahlfs-Dunn, S. M., & Huth-Bocks, A. C. (2014). Intimate partner violence and infant socioemotional development: The moderating effects of maternal trauma symptoms. *Infant Mental Health Journal, 35*(4), 322-335. doi:10.1002/imhj.21453

AIFS. (2010). *Child Deaths from Abuse and Neglect in Australia*. Australia: Australin Institute of Family Studies.

AIHW. (2012a). *A Picture of Australia's Children 2012* (1742493572). Canberra: AIHW. (Cat. no. PHE 167.).

AIHW. (2012b). *Specialist Homelessness Services Collection: First results, september quarter 2011.* (Cat.no. HOU 262.). AIHW. Canberra.

AIHW. (2013). *Child Protection Australia 2011- 2012* (Cat. no. CWS 43.). Canberra: AIHW.

Alasuutari, P. (2009). The rise and relevance of qualitative research. *International Journal of Social Research Methodology, 13*(2), 139-155. doi:10.1080/13645570902966056

Allaby, M. (2010). *A Dictionary of Ecology*. New York: Oxford University Press.

Ammaniti, M., & Gallese, V. (2014). *The Birth of Intersubjectivity: Psychodynamics, neurobiology, and the self*. USA: WW Norton & Company.

Anderson, K. M., Renner, L. M., & Danis, F. S. (2012). Recovery: Resilience and growth in the aftermath of domestic violence. *Violence Against Women, 18*(11), 1279-1299. doi:10.1177/1077801212470543

Anooshian, L. J. (2005). Violence and aggression in the lives of homeless children: A review. *Aggression and Violent Behavior, 10*(2), 129-152. doi:10.1016/j.avb.2003.10.004

Appleton, J. (1998). Nature as honorary art. *Environmental Values, 7*(3), 255-266. doi:10.3197/096327198129341564

Appleyard, K., & Osofsky, J. D. (2003). Parenting after trauma: Supporting parents and caregivers in the treatment of children impacted by violence. *Infant Mental Health Journal, 24*(2), 111-125.

Arnold, G., & Ake, J. (2013). Reframing the narrative of the battered women's movement. *Violence Against Women, 19*(5), 557-578. doi:10.1177/1077801213490508

Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H., Evans, M., . . . Blaustein, M. E. (2011). Treatment of complex trauma in young children: Developmental and cultural considerations in application of the arc intervention model. *Journal of Child & Adolescent Trauma, 4*(1), 34-51. doi:10.1080/19361521.2011.545046

Asling-Monemi, K., Pena, R., Ellsberg, M. C., & Persson, L. A. (2003). Violence against women increases the risk of infant and child mortality: a case–referent study in Nicaragua. *Bulletin of the World Health Organization, 81*(1), 10-18.

Baibazarova, E., van de Beek, C., Cohen-Kettenis, P. T., Buitelaar, J., Shelton, K. H., & van Goozen, S. H. M. (2013). Influence of prenatal maternal stress, maternal plasma cortisol and cortisol in the amniotic fluid on birth outcomes and child temperament at 3 months. *Psychoneuroendocrinology, 38*(6), 907-915.

Bain, K. (2014). "New beginnings" in South African shelters for the homeless: Piloting of a group psychotherapy intervention for high-risk mother–infant dyads. *Infant Mental Health Journal*, 1-12. doi:10.1002/imhj.21457

Baker, H. (2005). Involving children and young people in research on domestic violence and housing. *Journal of Social Welfare and Family Law, 27*(3-4), 281-297. doi:10.1080/09649060500386786

Bakermans-Kranenburg, M. J., van Ijzendoorn, M. H., Caspers, K., & Philibert, R. (2011). DRD4 genotype moderates the impact of parental problems on unresolved loss or trauma. *Attachment & Human Development, 13*(3), 253-269. doi:10.1080/14616734.2011.562415

Barca, R. (2013). [Personal Communications].

Barrett, J., & Fleming, A. S. (2011). Annual research review: All mothers are not created equal: Neural and psychobiological perspectives on mothering and the importance of individual differences. *Journal of Child Psychology and Psychiatry, 52*(4), 368-397. doi:10.1111/j.1469-7610.2010.02306.x

Barron, J. (2007). *Kidspeak: Giving children and young people a voice on domestic violence*. UK: Womens Aid.

Bartholomew, K., Henderson, A., & Dutton, D. (2001). Insecure attachment and abusive intimate relationships. In C. Clulow (Ed.), *Adult Attachment and Couple Psychotherapy* (pp. 43-61). London: Brunner-Routledge.

Bassuk, E. L., Buckner, J. C., Perloff, J. N., & Bassuk, S. S. (1998). Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. *American Journal of Psychiatry, 155*(11), 1561-1564.

Bassuk, E. L., & Rosenberg, L. (1988). Why does family homelessness occur? A case-control study. *American Journal of Public Health, 78*(7), 783-788.

Bassuk, E. L., & Weinreb, L. (1993). Homeless pregnant women: Two Generations at Risk. *American Journal of Orthopsychiatry, 63*(3), 348-357. doi:10.1037/h0085034

Bassuk, E. L., Weinreb, L. F., Buckner, J. C., Browne, A., Salomon, A., & Bassuk, S. S. (1996). The characteristics and needs of sheltered homeless and low-income housed mothers. *JAMA, 276*(8), 640-646.

Beebe, B. (2005). Mother-infant research informs mother-infant treatment. *Psychoanalytic Study of the Child, 60*, 7-46.

Beebe, B. (2006). Co-constructing mother–infant distress in face-to-face interactions: Contributions of microanalysis. *Infant Observation, 9*(2), 151-164. doi:10.1080/13698030600810409

Beebe, B., & Lachmann, F. (1988). The contribution of mother–infant mutual influence to the origins of self- and object representations. *Psychoanalytic Psychology, 5*(4), 305-337.

Beebe, B., & Lachmann, F. M. (1998). Co-constructing inner and relational processes: Self-and mutual regulation in infant research and adult treatment. *Psychoanalytic Psychology, 15*(4), 480-516.

Beebe, B., Steele, M., Jaffe, J., Buck, K. A., Chen, H., Cohen, P., . . . Feldstein, S. (2011). Maternal anxiety symptoms and mother–infant self- and interactive contingency. *Infant Mental Health Journal, 32*(2), 174-206. doi:10.1002/imhj.20274

Beijers, R., Risken-Walraven, M. J., & De Weerth, C. (2013). Cortisol regulation in 12-month-old human infants: Associations with the infants' early history of breastfeeding and co-sleeping. *Stress, 16*(3), 267-277. doi:10.3109/10253890.2012.742057

Bell, M., Goodman, L., & Dutton, M. (2007). The dynamics of staying and leaving: Implications for battered women's emotional well-being and experiences of violence at the end of a year. *Journal of Family Violence, 22*(6), 413-428. doi:10.1007/s10896-007-9096-9

Benoit, D., Coolbear, J., & Crawford, A. (2008). Abuse, neglect, and maltreatment of infants. In M. H. Marshall & B. B. Janette (Eds.), *Encyclopedia of Infant and Early Childhood Development* (pp. 1-11). San Diego: Academic Press. doi:10.1016/b978-012370877-9.00001-3

Bick, E. (1964). Notes on infant observation in psycho-analytic training. *The International Journal of Psycho-Analysis, 45*, 558-566.

Bick, E. (1986). Further Considerations on the Function of the Skin in Early Object Relations. *British Journal of Psychotherapy, 2*(4), 292-299. doi:10.1111/j.1752-0118.1986.tb01344.x

Bigby, C. (2015). Preparing manuscripts that report qualitative research: Avoiding common pitfalls and illegitimate questions. *Australian Social Work, 68*(3), 384-391. doi:10.1080/0312407X.2015.1035663

Bion, W. R. (1985). Container and contained. *Group Relations Reader, 2*, 127-133.

Biringen, Z. (2000). Emotional availability: Conceptualization and research findings. *American Journal of Orthopsychiatry, 70*(1), 104-114. doi:10.1037/h0087711

Blessing, D., & Block, K. (2009). Sewing on a shadow: acquiring dimensionality in a participant-observation. *Infant Observation, 12*(1), 21-28. doi:10.1080/13698030902731675

Bogat, G. A., DeJonghe, E., Levendosky, A. A., Davidson, W. S., & von Eye, A. (2006). Trauma symptoms among infants exposed to intimate partner violence. *Child Abuse & Neglect, 30*(2), 109-125.

Bogat, G. A., Garcia, A. M., & Levendosky, A. A. (2013). Assessment and psychotherapy with women experiencing intimate partner violence: Integrating research and practice. *Psychodynamic Psychiatry, 41*(2), 189-217. doi:http://dx.doi.org/101521pdps2013412189

Booth, S. (1999). Researching health and homelessness: Methodological challenges for researchers working with a vulnerable, hard to reach, transient population. *Australian Journal of Primary Health, 5*(3), 76-81. doi:http://dx.doi.org/10.1071/PY99037

Booth, T., & Booth, W. (1994). The use of depth interviewing with vulnerable subjects: Lessons from a research study of parents with learning difficulties. *Social Science & Medicine, 39*(3), 415-424. doi:http://dx.doi.org/10.1016/0277-9536(94)90139-2

Bosquet Enlow, M., Egeland, B., Blood, E. A., Wright, R. O., & Wright, R. J. (2012). Interpersonal trauma exposure and cognitive development in children to age 8 years: a longitudinal study. *Journal of Epidemiology and Community Health, 66*(11), 1005-1010. doi:10.1136/jech-2011-200727

Bowker, J. (2000). *The Concise Oxford Dictionary of World Religions*. New York: Oxford University Press

Bowlby, J. (1951). Maternal care and mental health. *Bulletin of the World Health Organization, 3*, 355-533.

Bowlby, J. (1952). *Maternal Care and Mental Health* (2nd ed. Vol. 2). Geneva: World Health Organization

Bowlby, J. (1969/1982). *Attachment and Loss: Attachment* (Vol. 1). New York: Basic Books.

Bowlby, J. (1988). *A Secure Base: Clinical applications of attachment theory*. London: Routledge.
Brandon, M., Belderson, P., Warren, C., Howe, D., Gardner, R., Dodsworth, J., & Black, J. (2008). *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn?: A biennial analysis of serious case reviews 2003-2005* (DCSF-RR023). UK: Department for Children, Schools & Families. Retrieved from http://dera.ioe.ac.uk/7190/1/dcsf-rr023.pdf
Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa
Breidenstine, A. S., Bailey, L. O., Zeanah, C. H., & Larrieu, J. A. (2011). Attachment and trauma in early childhood: A review. *Journal of Child & Adolescent Trauma, 4*(4), 274-290. doi:10.1080/19361521.2011.609155
Bretherton, I. (1991). The roots and growing points of attachment theory. In C. M. Parkes, J. Stevenson-Hinde & P. Marris (Eds.), *Attachment Across the Life Cycle* (pp. 9-32). London: Routledge.
Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology, 28*(5), 759-775.
Bretherton, I., & Salter-Ainsworth, M. D. (1974). Responses of one-year-olds to a stranger in a strange situation. In M. Lewis & L. A. Rosenblum (Eds.), *The Origin of Fear* (pp. 131-164). Oxford, England: Wiley-Interscience.
Brewers (1952/1977) *Dictionary of Phrase and Fables*. (Centenary Edition ed.). New York: Cassell.
Briggs-Gowan, M. J., & Carter, A. S. (2007). Applying the infant-toddler social & emotional assessment (itsea) and brief-itsea in early intervention. *Infant Mental Health Journal, 28*(6), 564-583. doi:10.1002/imhj.20154
Briggs, S. (1999). Links between infant observation and reflective social work practice. *Journal of Social Work Practice, 13*(2), 147-156. doi:10.1080/026505399103377
Brinamen, C. F., Taranta, A. N., & Johnston, K. (2012). Expanding early childhood mental health consultation to new venues: Serving infants and young children in domestic violence and homeless shelters. *Infant Mental Health Journal, 33*(3), 283-293. doi:10.1002/imhj.21338
Bromfield, L. M., Gillingham, P., & Higgins, D. J. (2007). Cumulative harm and chronic child maltreatment. *Developing Practice: The Child, Youth and Family Work Journal, 19*(Winter/Spring), 34-42.
Browning, W. R. F. (2009). *A Dictionary of the Bible* (2nd ed.). Great Britain: Oxford University Press.
Bryant, A. (2003). A constructive/ist response to Glaser. *Forum : Qualitative Social Research, 4*(1). http://nbn-resolving.de/urn:nbn:de:0114-fqs0301155.
Bryant, A., & Charmaz, K. (2007). Grounded theory research: methods and practices. In A. Bryant & K. Charmaz (Eds.), *The Sage Handbook of Grounded Theory* (pp. 1-28). London: Sage.
Brzuzy, S., & Lind, A. (2008). *Battleground : Women, Gender, and Sexuality*. USA: Greenwood Press.
Buchanan, F. (2011). *The Effects of Domestic Violence on the Relationship between Women and their Babies: Beyond attachment theory* (Flinders University, Unpublished).
Buchanan, F., Power, C., & Verity, F. (2013). Domestic violence and the place of fear in mother/baby relationships: "What was I afraid of ? Of making it worse". *Journal of Interpersonal Violence, 28*(9), 1817-1838. doi:10.1177/0886260512469108
Buckner, J. C. (2008). Understanding the impact of homelessness on children challenges and future research directions. *American Behavioral Scientist, 51*(6), 721-736.
Buckner, J. C., Bassuk, E. L., & Zima, B. T. (1993). Mental health issues affecting homeless women: Implications for intervention. *American Journal of Orthopsychiatry, 63*(3), 385-399.
Bunston, W. (2008a). Baby lead the way: Mental health groupwork for infants, children and mothers affected by family violence *Journal of Family Studies, 14*(2-1), 334-341.

Bunston, W. (2008b). Who's left holding the baby: Infant-led systems work in IPV. In J. Hamel (Ed.), *Intimate Partner Violence and Family Abuse* (pp. 155-172). New York: Springer Publishing Company.

Bunston, W. (2011). Let's start at the very beginning: The sound of infants, mental health, homelessness and you. *Parity, 24*(2), 37-39. http://search.informit.com.au/documentSummary;dn=908022936502962;res=IELFSC.

Bunston, W., & Glennen, K. (2008). 'BuBs' on board: Family violence and mother/infant work in women's shelters. *Parity, 21*(8), 27-31.

Bunston, W., & Glennen, K. (2015). Holding the baby costs nothing. *DVRCV Advocate, Spring/Summer*, 46-49.

Bunston, W., & Sketchley, R. (2012). *Refuge for Babies in Crisis*. Melbourne, Australia: RCH-IMHP. Retrieved from https://www.salvationarmy.org.au/Global/State%20pages/Tasmania/Safe%20from%20the%20start/Refuge_for_Babies_Manual%20small.pdf

Burgess, K. B., Marshall, P. J., Rubin, K. H., & Fox, N. A. (2003). Infant attachment and temperament as predictors of subsequent externalizing problems and cardiac physiology. *Journal of Child Psychology and Psychiatry, 44*(6), 819-831.

Bürgin, D. (2011). From outside to inside to outside: Comments on intrapsychic representations and interpersonal interactions. *Infant Mental Health Journal, 32*(1), 95-114. doi:10.1002/imhj.20285

Calkins, S. D., & Fox, N. A. (2002). Self-regulatory processes in early personality development: A multilevel approach to the study of childhood social withdrawal and aggression. *Development and Psychopathology, 14*(03), 477-498.

Carlson, J. A. (2010). Avoiding traps in member checking. *The Qualitative Report, 15*(5), 1102-1113.

Caron, N., Sobreira Lopes, R., Steibel, D., & Schneider Donelli, T. (2012). Writing as a challenge in the observer's journey through the Bick method of infant observation. *Infant Observation, 15*(3), 221-230. doi:10.1080/13698036.2012.726519

Caron, N. A., Sobreira Lopes, R., & Schneider Donelli, T. (2013). A place where verbalisation has no meaning. *Infant Observation, 16*(2), 170-182. doi:10.1080/13698036.2013.808511

Carpenter, L. L., Tyrka, A. R., Ross, N. S., Khoury, L., Anderson, G. M., & Price, L. H. (2009). Effect of childhood emotional abuse and age on cortisol responsivity in adulthood. *Biological Psychiatry, 66*(1), 69-75.

Cassidy, J., & Shaver, P. (1999). *Handbook of Attachment: Theory, research, and clinical applications*. USA: Guilford Press.

Chamberlain, C., & MacKenzie, D. (2008). *Counting the Homeless*. Canberra: Australian Bureau of Statistics.

Charmaz, K. (2003). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of Qualitative Inquiry* (Vol. 2, pp. 249-291). Thousand Oaks, California: Sage.

Charmaz, K. (2008). Grounded theory as an emergent method. In S. N. Hesse-Biber & P. Leavy (Eds.), *Handbook of Emergent Methods* (pp. 155-170). New York: The Guilford Press.

Charmaz, K. (2014). *Constructing Grounded Theory* (2nd ed.). London: Sage Publications Ltd.

Chhabra, S. (2007). Physical violence during pregnancy. *Journal of Obstetrics and Gynaecology, 27*(5), 460-463. doi:10.1080/01443610701406075

Cirulli, F., Berry, A., & Alleva, E. (2003). Early disruption of the mother–infant relationship: effects on brain plasticity and implications for psychopathology. *Neuroscience & Biobehavioral Reviews, 27*(1–2), 73-82.

Clark, C. L., St. John, N., Pasca, A. M., Hyde, S. A., Hornbeak, K., Abramova, M., . . . Penn, A. A. (2013). Neonatal CSF oxytocin levels are associated with parent report of infant soothability and sociability. *Psychoneuroendocrinology, 38*(7), 1208-1212.

Clarke, J. N. (2015). Advice to mothers about managing children's behaviours in Canada's premier woman's magazine: a comparison of 1945–1956 with 1990–2010. *Child & Family Social Work, 20*(3), 310-321. doi:10.1111/cfs.12079

Cohn, H. H., & Elon, M. (2007). City of refuge. In M. Berenbaum & F. Skolnik (Eds.), *Encyclopaedia Judaica* (2nd ed., Vol. 4*,* pp. 742-745). Detroit: Macmillan Reference USA.

Coker, A. L., Sanderson, M., & Dong, B. (2004). Partner violence during pregnancy and risk of adverse pregnancy outcomes. *Paediatric and Perinatal Epidemiology, 18*(4), 260-269. doi:10.1111/j.1365-3016.2004.00569.x

Coll, C. G., Buckner, J. C., Brooks, M. G., Weinreb, L. F., & Bassuk, E. L. (1998). The developmental status and adaptive behavior of homeless and low-income housed infants and toddlers. *American Journal of Public Health, 88*(9), 1371-1374.

Cowal, K., Shinn, M., Weitzman, B., Stojanovic, D., & Labay, L. (2002). Mother–child separations among homeless and housed families receiving public assistance in New York city. *American Journal of Community Psychology, 30*(5), 711-730. doi:10.1023/a:1016325332527

Cozolino, L. (2006). The social brain. *Psychotherapy in Australia, 12*(2), 12-16.

Cozolino, L. (2008). It's a jungle in there. *Psychotherapy Networker*(September/October).

Crawford, D. M., Trotter, E. C., Hartshorn, K. J. S., & Whitbeck, L. B. (2011). Pregnancy and mental health of young homeless women. *American Journal of Orthopsychiatry, 81*(2), 173-183. doi:10.1111/j.1939-0025.2011.01086.x

Crotty, M. (1998). *The Foundations of Social Research: Meaning and perspective in the research process*. Australia: Allen & Unwin.

Crowell, J. A., & Treboux, D. (2006). A review of adult attachment measures: Implications for theory and research. *Social Development, 4*(3), 294-327.

Cunningham, A. J., & Baker, L. L. (2007). *Little Eyes, Little Ears: How violence against a mother shapes children as they grow* (1895953324). Ontario, Canada: National Clearinghouse on Family Violence.

Curl, J. S. (2006). *A Dictionary of Architecture and Landscape Architecture*. Great Britain: Oxford University Press.

Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. J., & Van Ijzendoorn, M. H. (2010). Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. *Development and Psychopathology, 22*(01), 87-108.

Datler, W., Datler, M., Hover-Reisner, N., & Trunkenpolz, K. (2014). Observation according to the Tavistock model as a research tool: remarks on methodology, education and the training of researchers. *Infant Observation, 17*(3), 195-214. doi:10.1080/13698036.2014.977558

Davenhill, R., Balfour, A., Rustin, M., Blanchard, M., & Tress, K. (2003). Looking into later life: psychodynamic observation and old age. *Psychoanalytic Psychotherapy, 17*(3), 253-266. doi:10.1080/1474973032000114897

David, D. H., Gelberg, L., & Suchman, N. E. (2012). Implications of homelessness for parenting young children: A preliminary review from a developmental attachment perspective. *Infant Mental Health Journal, 33*(1), 1-9. doi:10.1002/imhj.20333

Davies, J. (2008). *When Battered Women Stay… advocacy beyond leaving*. USA: NRCDV. Retrieved from http://www.bcsdv.org/resources/BCS-Pub20.pdf

Davies, L., & Krane, J. (2006). Collaborate with caution: protecting children, helping mothers. *Critical Social Policy, 26*(2), 412-425. doi:10.1177/0261018306062592

Davis, E. P., Glynn, L. M., Waffarn, F., & Sandman, C. A. (2011). Prenatal maternal stress programs infant stress regulation. *Journal of Child Psychology and Psychiatry, 52*(2), 119-129.

De Wolff, M. S., Theunissen, M. H. C., Vogels, A. G. C., & Reijneveld, S. A. (2013). Three questionnaires to detect psychosocial problems in toddlers: A comparison of the BITSEA, ASQ:SE, and KIPPPI. *Academic Pediatrics, 13*(6), 587-592. doi:10.1016/j.acap.2013.07.007

Dearnley, K., & Hartland-Rowe, L. (2009). From baby to boardroom: The Tavistock–Bick method of infant observation and its application to organisations and in consultancy. A conference held at the Tavistock Centre, 17–18 October 2008. *Infant Observation, 12*(1), 117-119. doi:10.1080/13698030902764957

Denzin, N. K., & Lincoln, Y. S. (2003). The discipline and pratice of qualitative research. In D. Norman K & L. Yvonna S (Eds.), *Strategies of Qualitative Research* (2nd ed.*,* pp. 1-45). Thousand Oaks, California: SAGE Publications.

Denzin, N. K., & Lincoln, Y. S. (2013). The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Landscape of Qualitative Research* (4th ed.*,* pp. 1-42). USA: SAGE Publications.

DFHCSIA. (2008). *The Road Home: A national approach to reducing homelessness*. Australia: Homelessness Taskforce, Commonwealth of Australia.

Diem-Wille, G., Steinhardt, K., & Reiter, H. (2006). Joys and sorrows of teaching infant observation at university level – implementing psychoanalytic observation in teachers' further education programmes. *Infant Observation, 9*(3), 233-248. doi:10.1080/13698030601070656

Doom, J. R., Cicchetti, D., Rogosch, F. A., & Dackis, M. N. (2013). Child maltreatment and gender interactions as predictors of differential neuroendocrine profiles. *Psychoneuroendocrinology, 38*(8), 1442-1454.

Dosen, A. S., & Ostwald, M. J. (2013). Methodological characteristics of research testing prospect–refuge theory: a comparative analysis. *Architectural Science Review, 56*(3), 232-241. doi:10.1080/00038628.2013.809689

Drake, M. A. (1992). The nutritional status and dietary adequacy of single homeless women and their children in shelters. *Public Health Reports, 107*(3), 312-318.

Edalati, H., Krausz, M., & Schütz, C. G. (2015). Childhood maltreatment and revictimization in a homeless population. *Journal of Interpersonal Violence*. doi:10.1177/0886260515576972

Ehrensaft, M. K., Cohen, P., Brown, J., Smailes, E., Chen, H., & Johnson, J. G. (2003). Intergenerational transmission of partner violence: a 20-year prospective study. *Journal of Consulting and Clinical Psychology, 71*(4), 741-753.

Elfer, P. (2011). Psychoanalytic methods of observation as a research tool for exploring young children's nursery experience. *International Journal of Social Research Methodology, 15*(3), 225-238. doi:10.1080/13645579.2011.582295

Elzinga, B. M., Roelofs, K., Tollenaar, M. S., Bakvis, P., Van Pelt, J., & Spinhoven, P. (2008). Diminished cortisol responses to psychosocial stress associated with lifetime adverse events: a study among healthy young subjects. *Psychoneuroendocrinology, 33*(2), 227-237.

Eriksson, I., Cater, Å., Andershed, A.-K., & Andershed, H. (2011). What protects youths from externalising and internalising problems? A critical review of research findings and implications for practice. *Australian Journal of Guidance and Counselling, 21*(2), 113-125.

Fairbairn, W. R. D. (1952). *Psychoanalytic Studies of the Personality*. London: Tavistock Publications Ltd/Routledge & Kegan Paul Ltd.

Fantuzzo, J., Boruch, R., Beriama, A., Atkins, M., & Marcus, S. (1997). Domestic violence and children: Prevalence and risk in five major U.S. cities. *Journal of the American Academy of Child &*

Adolescent Psychiatry, 36(1), 116-122. doi:http://dx.doi.org/10.1097/00004583-199701000-00025

Family Court of Australia. (2013). *Family Violence Best Practice Principles*. Canberra, ACT: Commonwelath of Australia.

Featherstone, B. (2003). *Family Life and Family Support: A feminist analysis*. Great Britain: Palgrave Macmillan.

Featherstone, B., & Fraser, C. (2012). Working with fathers around domestic violence: contemporary debates. *Child Abuse Review, 21*(4), 255-263.

Ferraro, K. J. (1983). Negotiating trouble in a battered women's shelter. *Journal of Contemporary Ethnography, 12*(3), 287-306.

Finley, L. L. (2010). Where's the peace in this movement? A domestic violence advocate's reflections on the movement. *Contemporary Justice Review, 13*(1), 57-69. doi:10.1080/10282580903549219

Fishbane, M. D. (2007). Wired to connect: Neuroscience, relationships, and therapy. *Family Process, 46*(3), 395-412.

Fleming, S. (2004). The contribution of psychoanalytical observation in child protection assessments. *Journal of Social Work Practice, 18*(2), 223-238.

Flykt, M., Punamäki, R.-L., Belt, R., Biringen, Z., Salo, S., Posa, T., & Pajulo, M. (2012). Maternal representations and emotional availability among drug-abusing and nonusing mothers and their infants. *Infant Mental Health Journal, 33*(2), 123-138. doi:10.1002/imhj.21313

Fonagy, P. (2010). *Attachment theory and psychoanalysis*. New York: Other Press, LLC.

Fonagy, P., Gergely, G., & Target, M. (2007). The parent–infant dyad and the construction of the subjective self. *Journal of Child Psychology and Psychiatry, 48*(3-4), 288-328. doi:10.1111/j.1469-7610.2007.01727.x

Fonagy, P., Luyten, P., & Strathearn, L. (2011). Borderline personality disorder, mentalization, and the neurobiology of attachment. *Infant Mental Health Journal, 32*(1), 47-69. doi:10.1002/imhj.20283

Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C. (1991). The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment. *Infant Mental Health Journal, 12*(3), 201-218. doi:10.1002/1097-0355(199123)12:3<201::aid-imhj2280120307>3.0.co;2-7

Fonagy, P., & Target, M. (2007). The rooting of the mind in the body: New links between attachment theory and psychoanalytic thought. *Journal of the American Psychoanalytic Association, 55*(2), 411-456.

Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective-Functioning Manual, version 5.0, for application to adult attachment interviews*. London.

Fontaine, R. (2015). Abraham Ibn Daud. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Spring Edition ed.). Retrieved from http://plato.stanford.edu/archives/win2010/entries/abraham-daud/

Fox, N. A., & Card, J. A. (1999). Psychophysiological measures in the study of attachment. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 226-245). New York: Guilford Press.

Fraiberg, S. (1982). Pathological defenses in infancy. *Psychoanalytic Quarterly, 51*, 612-635.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the nursery. *Journal of the American Academy of Child Psychiatry, 14*(3), 387-421.

Frederico, M., Jackson, A., & Jones, S. (2006). *Child Death Group Analysis: Effective responses to chronic neglect*. Victoria, Australia: Office of the Child Safety Commissioner.

Freeman, J. (1973). The origins of the women's liberation movement. *American Journal of Sociology, 78*(4), 792-811. doi:10.2307/2776604

Gaensbauer, T. J., & Siegel, C. H. (1995). Therapeutic approaches to posttraumatic stress disorder in infants and toddlers. *Infant Mental Health Journal, 16*(4), 292-305. doi:10.1002/1097-0355(199524)16:4<292::AID-IMHJ2280160405>3.0.CO;2-3

Gartland, D., Hemphill, S. A., Hegarty, K., & Brown, S. J. (2011). Intimate partner violence during pregnancy and the first year postpartum in an Australian pregnancy cohort study. *Maternal and Child Health Journal, 15*(5), 570-578.

Gawronski, V. T. (2002). The revolution is dead. ¡viva la revolución!: The place of the Mexican revolution in the era of globalization. *Mexican Studies/Estudios Mexicanos, 18*(2), 363-397. doi:10.1525/msem.2002.18.2.363

Gayford, J. J. (1975). Wife battering: a preliminary survey of 100 cases. *British Medical Journal, 1*(5951), 194-197.

Gazmararian, J. A., Petersen, R., Spitz, A. M., Goodwin, M. M., Saltzman, L. E., & Marks, J. S. (2000). Violence and reproductive health: Current knowledge and future research directions. *Maternal and Child Health Journal, 4*(2), 79-84.

Gewirtz, A., Hart-Shegos, E., & Medhanie, A. (2008). Psychosocial status of homeless children and youth in family supportive housing. *American Behavioral Scientist, 51*(6), 810-823. doi:10.1177/0002764207311989

Gewirtz, A. H., DeGarmo, D. S., Plowman, E. J., August, G., & Realmuto, G. (2009). Parenting, parental mental health, and child functioning in families residing in supportive housing. *American Journal of Orthopsychiatry, 79*(3), 336-347. doi:10.1037/a0016732

Gilroy, H., Maddoux, J., Symes, L., Fredland, N., & McFarlane, J. (2015). Predictors and outcomes of community agency use in abused mothers. *Public Health Nursing, 32*(3), 201-211. doi:10.1111/phn.12136

Glaser, B. G. (2002). Constructivist grounded theory? *Forum : Qualitative Social Research, 3*(3), Art.12.

Glennen, K. (2011). The homeless infant. *Parity, 24*(2), 35-36.

Gondolf, E. W. (1988). The effect of batterer counseling on shelter outcome. *Journal of Interpersonal Violence, 3*(3), 275-289.

Gopnik, A., Glymour, C., Sobel, D. M., Schulz, L. E., Kushnir, T., & Danks, D. (2004). A theory of causal learning in children: causal maps and Bayes nets. *Psychological Review, 111*(1), 1-32.

Gordon, K. C., Burton, S., & Porter, L. (2004). Predicting the intentions of women in domestic violence shelters to return to partners: Does forgiveness play a role? *Journal of Family Psychology, 18*(2), 331-338.

Gorse, C., Johnston, D., & Pritchard, M. (2012). *A Dictionary of Construction, Surveying, and Civil Engineering*. Great Britain: Oxford University Press.

Graham-Bermann, S., Howell, K., Miller, L., Kwek, J., & Lilly, M. (2010). Traumatic events and maternal education as predictors of verbal ability for preschool children exposed to intimate partner violence (IPV). *Journal of Family Violence, 25*(4), 383-392. doi:10.1007/s10896-009-9299-3

Grossman, S. F., & Lundy, M. (2011). Characteristics of women who do and do not receive onsite shelter services from domestic violence programs. *Violence Against Women, 17*(8), 1024-1045. doi:10.1177/1077801211414169

Grossman, S. F., Lundy, M., George, C. C., & Crabtree-Nelson, S. (2010). Shelter and service receipt for victims of domestic violence in illinois. *Journal of Interpersonal Violence, 25*(11), 2077-2093. doi:10.1177/0886260509354505

Groves, B. M. (2002). *Children Who See Too Much: Lessons from the child witness to violence project*. Boston: Beacon Press.

Gunnar, M., & Quevedo, K. (2007). The neurobiology of stress and development. *Annual Review of Psychology, 58*, 145-173. doi:10.1146/annurev.psych.58.110405.085605

Gustafsson, H., Cox, M., & Blair, C. (2012). Maternal parenting as a mediator of the relationship between intimate partner violence and effortful control. *Journal of Family Psychology, 26*(1), 115-123. doi:10.1037/a0026283

Haldane, H. (2010). Everyday work with family violence: Voices from the frontline. *Te Awatea Review, 8*(1&2), 15-20.

Hall Gueldner, S., Britton, G. R., & Terwilliger, S. (2012). Giving voice to vulnerable populations. In M. d. Chesnay & B. A. Anderson (Eds.), *Caring for the Vunerable* (3rd ed., pp. 125-134). Burlington, MA: Jones & Barlett Learning.

Harding, H., & Helweg-Larsen, M. (2009). Perceived risk for future intimate partner violence among women in a domestic violence shelter. *Journal of Family Violence, 24*(2), 75-85.

Harris, J., & White, V. (2013). *Oxford Dictionary of Social Work and Social Care,* Great Britain: Oxford University Press.

Helfrich, C. A., Fujiura, G. T., & Rutkowski-Kmitta, V. (2008). Mental health disorders and functioning of women in domestic violence shelters. *Journal of Interpersonal Violence, 23*(4), 437-453. doi:10.1177/0886260507312942

Herman, J. (1992). *Trauma and Recovery*. USA: Basic Books.

Hesse, E., & Main, M. (2000). Disorganized infant, child, and adult attachment: Collapse in behavioral and attentional strategies. *Journal of the American Psychoanalytic Association, 48*(4), 1097-1127.

Hesse, E., & Main, M. (2006). Frightened, threatening, and dissociative parental behavior in low-risk samples: Description, discussion, and interpretations. *Development and Psychopathology, 18*(2), 309-343. doi:10.1017/S0954579406060172

Hingley-Jones, H. (2011). An exploration of the use of infant observation methods to research the identities of severely learning-disabled adolescents and to enhance relationship-based practice for professional social work. *Infant Observation, 14*(3), 317-333. doi:10.1080/13698036.2011.616305

Hoffman, K. T., Marvin, R. S., Cooper, G., & Powell, B. (2006). Changing toddlers' and preschoolers' attachment classifications: the circle of security intervention. *Journal of Consulting and Clinical Psychology, 74*(6), 1017-1026. doi:10.1037/0022-006X.74.6.1017

Hollway, W., & Jefferson, T. (2000). *Doing Qualitative Research Differently: free association, narrative and the interview method*. London: SAGE.

Holmes, J. (1993). *John Bowlby and Attachment Theory*. London: Routledge.

Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. *Child Abuse & Neglect, 32*(8), 797-810.

Hornby, A. S. (Ed.). (2010). *Oxford Advanced Learner's Dictionary* (8th ed.). Oxford, UK: Oxford University Press.

Horton, A. L., & Johnson, B. L. (1993). Profile and strategies of women who have ended abuse. *Families in Society, 74*(8), 481-492.

HREOC. (1997). *Bringing them home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families*. NSW: Human Rights and Equal Opportunity Commission.

Hughes, M., & Heycox, K. (2005). Promoting reflective practice with older people: Learning and teaching strategies. *Australian Social Work, 58*(4), 344-356. doi:10.1111/j.1447-0748.2005.00231.x

Huizink, A. C., Robles de Medina, P. G., Mulder, E. J. H., Visser, G. H. A., & Buitelaar, J. K. (2003). Stress during pregnancy is associated with developmental outcome in infancy. *Journal of Child Psychology and Psychiatry, 44*(6), 810-818.

Humphreys, C. (2006). *Domestic Violence and Child Abuse* (14). UK. Retrieved from http://hdl.handle.net/11343/34799

Humphreys, C., & Houghton, C. (2008). The research evidence on children and young people experiencing domestic abuse. In C. Humphreys, C. Houghton & J. Ellis (Eds.), *Better Outcomes for Children and Young People experiencing Domestic Abuse: Directions for good practice*. Edinburgh: The Scottish Government.

Humphreys, C., Thiara, R. K., & Skamballis, A. (2011). Readiness to change: Mother–child relationship and domestic violence intervention. *British Journal of Social Work, 41*(1), 166-184. doi:10.1093/bjsw/bcq046

Huntington, N., Buckner, J. C., & Bassuk, E. L. (2008). Adaptation in homeless children: An empirical examination using cluster analysis. *American Behavioral Scientist, 51*(6), 737-755. doi:10.1177/0002764207311985

Huth-Bocks, A. C., Levendosky, A. A., Bogat, G. A., & von Eye, A. (2004). The impact of maternal characteristics and contextual variables on infant–mother attachment. *Child Development, 75*(2), 480-496. doi:10.1111/j.1467-8624.2004.00688.x

Huth-Bocks, A. C., Levendosky, A. A., Theran, S. A., & Bogat, G. A. (2004). The impact of domestic violence on mothers' prenatal representations of their infants. *Infant Mental Health Journal, 25*(2), 79-98. doi:10.1002/imhj.10094

Huth-Bocks, A. C., Theran, S. A., Levendosky, A. A., & Bogat, G. A. (2011). A social-contextual understanding of concordance and discordance between maternal prenatal representations of the infant and infant–mother attachment. *Infant Mental Health Journal, 32*(4), 405-426. doi:10.1002/imhj.20304

Ingram, R. (2013). Locating emotional intelligence at the heart of social work practice. *British Journal of Social Work, 43*(5), 987-1004. doi:10.1093/bjsw/bcs029

Ingram, R. (2015). Exploring emotions within formal and informal forums: Messages from social work practitioners. *British Journal of Social Work, 45*(3), 896-913. doi:10.1093/bjsw/bct166

Insetta, E. R., Akers, A. Y., Miller, E., Yonas, M. A., Burke, J. G., Hintz, L., & Chang, J. C. (2015). Intimate partner violence victims as mothers: Their messages and strategies for communicating with children to break the cycle of violence. *Journal of Interpersonal Violence, 30*(4), 703-724. doi:10.1177/0886260514535264

Izaguirre, A., & Calvete, E. (2015). Children who are exposed to intimate partner violence: Interviewing mothers to understand its impact on children. *Child Abuse & Neglect, 48*, 58-67. doi:http://dx.doi.org/10.1016/j.chiabu.2015.05.002

Jackson, D., & Mannix, J. (2004). Giving voice to the burden of blame: A feminist study of mothers' experiences of mother blaming. *International Journal of Nursing Practice, 10*(4), 150-158. doi:10.1111/j.1440-172X.2004.00474.x

James, J., & Newbury, J. (2010). Infants, relational truama and homelessness. In T. Baradon (Ed.), *Relational Trauma in Infancy*. Great Britain: Routledge.

Janesic, V. J. (2003). The choreography of qualitiative research design. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of Qualitative Inquiry* (Vol. 2*,* pp. 46-79). Thousand Oaks, California: SAGE.

Jarvis, K. L., Gordon, E. E., & Novaco, R. W. (2005). Psychological distress of children and mothers in domestic violence emergency shelters. *Journal of Family Violence, 20*(6), 389-402.

Jasinski, J. L., Wesely, J. K., Wright, J. D., & Mustaine, E., E. (2010). *Hard Lives, Mean streets: Violence in the lives of homeless women*. USA: Northeastern University Press.

Jenney, A., Alaggia, R., Mazzuca, J., & Redmond, M. (2006). *Children and Women First? Voices from the front lines of domestic violence on the impact of child welfare reporting*. Canada. (March).

Johnson, K. (2013). Maternal-infant bonding: A review of literature. *International Journal of Childbirth Education, 28*(3), 17-22.

Johnston, K. (2005). Integrating and adapting infant mental health principles in the training of consultants to childcare *Infants and Young Children, 18*(4), 269-281.

Jones, S., & Bunston, W. (2012). The" original couple": Enabling mothers and infants to think about what destroys as well as engenders love, when there has been intimate partner violence. *Couple and Family Psychoanalysis, 2*(2), 215-232.

Jordan, B., & Sketchley, R. (2009). *A Stich in Time saves Nine*. Melbourne, Australia: V. Press. (30). Retrieved from http://www.aifs.gov.au/nch/pubs/issues/issues30/issues30.html

Jordan, J. (2011). Pragmatic arguments and belief in God. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Spring Edition ed.). Stanford, CA: Standford University. Retrieved from http://plato.stanford.edu/archives/spr2011/entries/pragmatic-belief-god/

Jouriles, E. N., Vu, N. L., McDonald, R., & Rosenfield, D. (2014). Children's appraisals of conflict, beliefs about aggression, and externalizing problems in families characterized by severe intimate partner violence. *Journal of Family Psychology, 28*(6), 915-924.

Jung, V., Short, R., Letourneau, N., & Andrews, D. (2007). Interventions with depressed mothers and their infants: Modifying interactive behaviours. *Journal of Affective Disorders, 98*(3), 199-205. doi:http://dx.doi.org/10.1016/j.jad.2006.07.014

Keeshin, B., Oxman, A., Schindler, S., & Campbell, K. (2015). A domestic violence shelter parent training program for mothers with young children. *Journal of Family Violence, 30*(4), 461-466. doi:10.1007/s10896-015-9698-6

Kemp, A., Green, B. L., Hovanitz, C., & Rawlings, E. I. (1995). Incidence and correlates of posttraumatic stress disorder in battered women: Shelter and community samples. *Journal of Interpersonal Violence, 10*(1), 43-55.

Kemp, A. H., & Guastella, A. J. (2011). The role of oxytocin in human affect: A novel hypothesis. *Current Directions in Psychological Science, 20*(4), 222-231. doi:10.1177/0963721411417547

Kestenberg, J. S. (1985). The flow of empathy and trust between mother and child. In E. J. Anthony & G. H. Pollack (Eds.), *Parental Influences in Health and Disease* (pp. 137-163). Boston, MA: Little Brown.

Kimura, T., Tanizawa, O., Kensaku, M., J, B. M., & Hiroto, O. (1992). Structure and expression of a human oxytocin receptor. *Nature, 356*(6369), 526-529.

Kohut, H., & Wolf, E. S. (1978). The disorders of the self and their treatment: An outline. *International Journal of Psychoanalysis, 59*(4), 413-425.

Kosfeld, M., Heinrichs, M., Zak, P. J., Fischbacher, U., & Fehr, E. (2005). Oxytocin increases trust in humans. *Nature, 435*(7042), 673-676.

Koyama, E. (2006). Disloyal to feminism: Abuse of survivors within the domestic violence shelter system. In A. Smith, B. E. Richie & J. Sudbury (Eds.), *Color of Violence: The INCITE! anthology* (pp. 208-222). Cambridge, Massachusetts: South End Press.

Krane, J., & Davies, L. (2002). Sisterhood is not enough: The invisibility of mothering in shelter practice with battered women. *Affilia, 17*(2), 167-190. doi:10.1177/088610990201700203

Krane, J., & Davies, L. (2007). Mothering under difficult circumstances: Challenges to working with battered women. *Affilia, 22*(1), 23-38. doi:10.1177/0886109906295758

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy, 45*(3), 214-222.

Laing, L. (2000). *Children, Young People and Domestic Violence. Issues paper 2*. Sydney: Australian Domestic & Family Violence Clearinghouse.

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology, 3*(2), 102-120. doi:10.1191/1478088706qp062oa

Lathrop, A. (1998). Pregnancy resulting from rape. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 27*(1), 25-31. doi:10.1111/j.1552-6909.1998.tb02587.x

Leckman, J. F., Feldman, R., Swain, J. E., & Mayes, L. C. (2007). Primary parental preoccupation: Revisited. In L. Mayes, P. Fonagy & M. Target (Eds.), *Developmental Science and Psychoanalysis: Integration and innovation* (pp. 89-115). Great Britain: Karnac Bookks.

Lehrner, A., & Allen, N. E. (2009). Still a movement after all these years?: current tensions in the domestic violence movement. *Violence Against Women, 15*(6), 656-677.

Letourneau, N., Morris, C. Y., Secco, L., Stewart, M., Hughes, J., & Critchley, K. (2013). Mothers and infants exposed to intimate partner violence compensate. *Violence and Victims, 28*(4), 571-586.

Letourneau, N., Tryphonopoulos, P., Giesbrecht, G., Dennis, C.-L., Bhogal, S., & Watson, B. (2015). Narrative and meta-analytic review of interventions aiming to improve maternal–child attachment security. *Infant Mental Health Journal, 36*(4), 366-387. doi:10.1002/imhj.21525

Levendosky, A. A., Bogat, A. G., & Huth-Bocks, A. C. (2011). The influence of domestic violence on the development of the attachment relationship between mother and young child. *Psychoanalytic Psychology, 28*(4), 512-527. doi:10.1037/a0024561

Levendosky, A. A., Bogat, G. A., Huth-Bocks, A. C., Rosenblum, K., & Von Eye, A. (2011). The effects of domestic violence on the stability of attachment from infancy to preschool. *Journal of Clinical Child & Adolescent Psychology, 40*(3), 398-410. doi:10.1080/15374416.2011.563460

Levendosky, A. A., Bogat, G. A., & Martinez-Torteya, C. (2013). PTSD symptoms in young children exposed to intimate partner violence. *Violence Against Women, 19*(2), 187-201.

Levendosky, A. A., Huth-Bocks, A. C., Semel, M. A., & Shapiro, D. L. (2002). Trauma symptoms in preschool-age children exposed to domestic violence. *Journal of Interpersonal Violence, 17*(2), 150-164. doi:10.1177/0886260502017002003

Levendosky, A. A., Leahy, K. L., Bogat, G. A., Davidson, W. S., & von Eye, A. (2006). Domestic violence, maternal parenting, maternal mental health, and infant externalizing behavior. *Journal of Family Psychology, 20*(4), 544-552.

Liamputtong, P. (2007). *Researching the Vulnerable*. London: SAGE Publications.

Liddle, M.-J. E., Bradley, B. S., & McGrath, A. (2015). Baby empathy: Infant distress and peer prosocial responses. *Infant Mental Health Journal, 36*(4), 446-458. doi:10.1002/imhj.21519

Lieberman, A. F. (2007). Ghosts and angels: Intergenerational patterns in the transmission and treatment of the traumatic sequelae of domestic violence. *Infant Mental Health Journal, 28*(4), 422-439.

Lieberman, A. F., Chu, A., Van Horn, P., & Harris, W. W. (2011). Trauma in early childhood: Empirical evidence and clinical implications. *Development and Psychopathology, 23*(2), 397-410. doi:10.1017/S0954579411000137

Lieberman, A. F., Padrón, E., Van Horn, P., & Harris, W. W. (2005). Angels in the nursery: The intergenerational transmission of benevolent parental influences. *Infant Mental Health Journal, 26*(6), 504-520.

Lieberman, A. F., & Van Horn, P. (2004). *Don't Hit My Mommy: A manual for child-parent psychotherapy with young witnesses of family violence* Washington, DC.: Zero To Three Press.

Lieberman, A. F., & Van Horn, P. (2008). *Psychotherapy with Infants and Young Children: Repairing the effects of stress and trauma on early attachment*. New York: Guilford Press.

Lieberman, A. F., & Van Horn, P. (2009). Child-parent psychotherapy. In J. Charles H. Zenah (Ed.), *Handbook of Infant Mental Health* (3rd ed., pp. 439-449). New York: The Guilford Press.

Lieberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(12), 1241-1248. doi:10.1097/01.chi.0000181047.59702.58

Lindsey, E. W. (1998). The impact of homelessness and shelter life on family relationships. *Family Relations, 47*(3), 243-252.

Longhofer, J., Floersch, J., & Hoy, J. (2013). *Qualitative Methods for Practice Research*. New York: Oxford University Press.

Luijk, M. P. C. M., Roisman, G. I., Haltigan, J. D., Tiemeier, H., Booth-LaForce, C., van Ijzendoorn, M. H., . . . Bakermans-Kranenburg, M. J. (2011). Dopaminergic, serotonergic, and oxytonergic candidate genes associated with infant attachment security and disorganization? In search of main and interaction effects. *Journal of Child Psychology and Psychiatry, 52*(12), 1295-1307. doi:10.1111/j.1469-7610.2011.02440.x

Lyon, E., Lane, S., & Menard, A. (2008). *Meeting Survivors' Needs: A multi-state study of domestic violence shelter experiences*. USA. (225025). Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/225025.pdf

Lyons-Ruth, K., & Block, D. (1996). The disturbed caregiving system: Relations among childhood trauma, maternal caregiving, and infant affect and attachment. *Infant Mental Health Journal, 17*(3), 257-275.

MacLean, P. D. (1990). *The Truine Brain in Evolution*. USA: Plenum Press.

Madigan, S., Atkinson, L., Laurin, K., & Benoit, D. (2013). Attachment and internalizing behavior in early childhood: A meta-analysis. *Developmental Psychology, 49*(4), 672-689.

Maillard, K. N. (2010). Rethinking children as property: The transitive family. *Cardozo Law Review, 32*(1), 101-141.

Maillard, K. N. (2012). *Rethinking Children as Property*. College of Law Faculty Scholarship, Paper 75. Retrieved from http://surface.syr.edu/lawpub/75

Main, M. (1991). Metacognitive knowledge, metacognitive monitoring, and singular (coherent) vs. multiple (incoherent) model of attachment. In C. M. Parkes, J. Stevenson-Hinde & P. Marris (Eds.), *Attachment Across the Life Cycle* (pp. 127-159). London: Routledge

Main, M. (1999). Attachment theory: Eighteen points with suggestions for future studies. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment: Theory, research, and clinical implications* (pp. 845-887). New York: Guildford Press.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth strange situation. In M. T. Greenberg, D. Cicchetti & E. M. Cummings (Eds.), *Attachment in the Preschool Years: Theory, research, and intervention* (Vol. 1, pp. 121-160). USA: The University of Chicago Press.

Maliphant, J. (2008). The triad in mind: An exploration of what is needed by the learning support assistant to facilitate integration of the child with special educational needs into mainstream education. *Infant Observation, 11*(2), 161-178. doi:10.1080/13698030802242872

Malone, J. C., Levendosky, A. A., Dayton, C. J., & Bogat, G. A. (2010). Understanding the "ghosts in the nursery" of pregnant women experiencing domestic violence: Prenatal maternal representations and histories of childhood maltreatment. *Infant Mental Health Journal, 31*(4), 432-454.

Marshall, M. N. (1996). Sampling for qualitative research. *Family Practice, 13*(6), 522-526.

Martin, S. L., Li, Y., Casanueva, C., Harris-Britt, A., Kupper, L. L., & Cloutier, S. (2006). Intimate partner violence and women's depression before and during pregnancy. *Violence Against Women, 12*(3), 221-239. doi:10.1177/1077801205285106

Martinez-Torteya, C., Bogat, G.A, Von Eye, A., & Levendosky, A. A. (2009). Resilience among children exposed to domestic violence: The role of risk and protective factors. *Child Development, 80*(2), 562-577.

Marvin, R., Cooper, G., Hoffman, K., & Powell, B. (2002). The cricle of security project: Attachment-based intervention with caregiver-pre-school child dyads. *Attachment & Human Development, 4*(1), 107-124.

Masten, A. S. (2011). Resilience in children threatened by extreme adversity: Frameworks for research, practice, and translational synergy. *Development and Psychopathology, 23*(2), 493-506. doi:10.1017/S0954579411000198

Mbilinyi, L., Edleson, J., Hagemeister, A., & Beeman, S. (2007). What happens to children when their mothers are battered? Results from a four city anonymous telephone survey. *Journal of Family Violence, 22*(5), 309-317. doi:10.1007/s10896-007-9087-x

Mc Dermott, B., & Cobham, V. (2012). *A Road Less Travelled: A guide to children, emotions and disasters*. Queensland, Australia: TFD Publishing.

McCoy-Roth, M., Mackintosh, B. B., & Murphey, D. (2012). When the bough breaks: The effects of homelessness on young children. *Child Trends, 3*(1), 1-11.

McFarlane, J., Campbell, J. C., Sharps, P., & Watson, K. (2002). Abuse during pregnancy and femicide: Urgent implications for women's health. *Obstetrics & Gynecology, 100*(1), 27-36.

McFarlane, J., Nava, A., Gilroy, H., Paulson, R., & Maddoux, J. (2012). Testing two global models to prevent violence against women and children: Methods and baseline data analysis of a seven-year prospective study. *Issues in Mental Health Nursing, 33*(12), 871-881. doi:10.3109/01612840.2012.731135

McFarlane, J., Parker, B., & Soeken, K. (1996). Physical abuse, smoking, and substance use during pregnancy: Prevalence, interrelationships, and effects on birth weight. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 25*(4), 313-320. doi:10.1111/j.1552-6909.1996.tb02577.x

McFerran, L. (2007). *Taking back the Castle: How Australia is making the home safer for women and children*. NSW: Australian Domestic & Family Violence Clearinghouse, UNSW.

McGee, C. (2000). *Childhood Experiences of Domestic Violence*. London: Jessica Kingsley Publishers.

McIntosh, J. (2003). Children living with domestic violence: Research foundations for early intervention. *Journal of Family Studies, 9*(2), 219-234. doi:10.5172/jfs.9.2.219

McIntosh, J. E. (2002). Thought in the face of violence: a child's need. *Child Abuse & Neglect, 26*(3), 229-241. doi:http://dx.doi.org/10.1016/S0145-2134(01)00321-0

McKenzie-Smith, S. (2009). Observational study of the elderly: an applied study utilizing Esther Bick's infant observation technique. *Infant Observation, 12*(1), 107-115. doi:10.1080/13698030902731766

Meaney, M. J. (2010). Epigenetics and the biological definition of gene × environment interactions. *Child Development, 81*(1), 41-79. doi:10.1111/j.1467-8624.2009.01381.x

Medico, D., & Santiago-Delefosse, M. (2014). From reflexivity to resonances: Accounting for interpretation phenomena in qualitative research. *Qualitative Research in Psychology, 11*(4), 350-364. doi:10.1080/14780887.2014.915367

Menezes-Cooper, T. (2013). Domestic violence and pregnancy: A literature review. *International Journal of Childbirth Education, 28*(3), 30-33.

Mertin, P., & Mohr, P. B. (2002). Incidence and correlates of posttrauma symptoms in children from backgrounds of domestic violence. *Violence and Victims, 17*(5), 555-567.

Meyer, S. (2012). Why women stay: A theoretical examination of rational choice and moral reasoning in the context of intimate partner violence. *Australian & New Zealand Journal of Criminology, 45*(2), 179-193. doi:10.1177/0004865812443677

The Oxford Essential Dictionary of the US Military. (2002). USA: Oxford University Press, Inc.

Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., . . . Silverman, J. G. (2010). Pregnancy coercion, intimate partner violence and unintended pregnancy. *Contraception, 81*(4), 316-322.

Miller, R. (2007). *Cumulative Harm: a conceptual overview*. Melbourne: Victorian Government Department of Human Services.

Mingo, M. V., & Easterbrooks, M. A. (2015). Patterns of emotional availability in mother–infant dyads: Associations with multiple levels of context. *Infant Mental Health Journal, 36*(5), 469-482. doi:10.1002/imhj.21529

Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (1990). *In-depth Interviewing: Researching people*. Melbourne, Australia: Longman Cheshire.

Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (2008). *In-depth Interviewing: Principles, techniques, analysis* (2nd ed.). Melbourne, Australia: Longman.

Mininni, G., Manuti, A., Scardigno, R., & Rubino, R. (2014). Old roots, new branches: The shoots of diatextual analysis. *Qualitative Research in Psychology, 11*(4), 384-399. doi:10.1080/14780887.2014.925996

Mizrahi, T., & Davis, L. (2008). *Encyclopedia of Social Work* (20th ed.). USA: Oxford University Press.

Monticelli, M. (2014). The experience of infant observation in difficult situations: Retaining the ability to observe. *Infant Observation, 17*(3), 179-194. doi:10.1080/13698036.2014.980638

Moore, L. W., & Miller, M. (1999). Initiating research with doubly vulnerable populations. *Journal of Advanced Nursing, 30*(5), 1034-1040.

Moore, T., McArthur, M., Noble-Carr, D., & Harcourt, D. (2015). *Taking Us Seriously: Children and young people talk about safety and institutional responses to their safety concerns*. Canberra: Royal Commission into Institutional Responses to Child Sexual Abuse.

Morgan, A. (2007). What am I trying to do when I see the infant with his or her parents. In F. Thomson Salo & C. Paul (Eds.), *The Baby as Subject* (2nd ed.). Melbourne: Stonnington Press.

Morris, A., Hegarty, K., & Humphreys, C. (2012). Ethical and safe: Research with children about domestic violence. *Research Ethics,* 8(2), 125-139.

Mottram, B., & Salter, M. (2015). "It's an ethical, moral and professional dilemma I think": Domestic violence workers' understandings of women's use of violence in relationships. *Affilia*, 1-15. doi:10.1177/0886109915574580

Mullender, A., Hague, G., Imam, U. F., Kelly, L., Malos, E., & Regan, L. (2002). *Children's Perspectives on Domestic Violence*. London: Sage.

Mundy, P., Fox, N., & Card, J. (2003). EEG coherence, joint attention and language development in the second year. *Developmental Science, 6*(1), 48-54.

Murgatroyd, C., & Spengler, D. (2011). Epigenetic programming of the HPA axis: Early life decides. *Stress, 14*(6), 581-589.

Murray, L. (1996). Winnicott: A research perspective. *Journal of Child Psychotherapy, 22*(3), 362-372. doi:10.1080/00754179608254507

Murray, S., & Powell, A. (2009). "What's the Problem?": Australian public policy constructions of domestic and family violence. *Violence Against Women, 15*(5), 532-552. doi:10.1177/1077801209331408

Neckoway, R., Brownlee, K., & Castellan, B. (2007). Is attachment theory consistent with aboriginal parenting realities? *First Peoples Child & Family Review, 3*(2), 65-74.

Neckoway, R., Brownlee, K., Jourdain, L. W., & Miller, L. (2003). Rethinking the role of attachment theory in child welfare practice with aboriginal people. *Canadian Social Work Review / Revue Canadienne de Service Social, 20*(1), 105-119.

Neisser, U. (2006). *The Perceived Self: Ecological and interpersonal sources of self knowledge* (Vol. 5). New York: Cambridge University Press.

Ng, A. V. (2009). Making sense of dementia using infant observation techniques: a psychoanalytic perspective on a neuropathological disease. *Infant Observation, 12*(1), 83-105. doi:10.1080/13698030902731741

Nicholson, J., Sweeney, E. M., & Geller, J. L. (1998). Focus on women: mothers with mental illness: I. The competing demands of parenting and living with mental illness. *Psychiatric Services, 49*(5), 635-642.

O'Dwyer, L. (2008). Translating observation into practice: how has infant observation helped a primary care mental health worker understand families' experiences of loss? *Infant Observation, 11*(1), 41-55. doi:10.1080/13698030801940591

O'Sullivan, L., & Ryan, V. (2009). Therapeutic limits from an attachment perspective. *Clinical Child Psychology & Psychiatry, 14*(2), 215-235. doi:10.1177/1359104508100886

Osofsky, J. D. (1995). Children who witness domestic violence: The invisible victims. *Social Policy Report, IX*(3), 1-19.

Osofsky, J. D. (1999). The impact of violence on children. *The Future of Children, 9*(3), 33-49.

Pahl, J. (1979). Refuges for battered women: Social provision or social movement? *Nonprofit and Voluntary Sector Quarterly, 8*(1-2), 25-35. doi:10.1177/089976407900800105

Pahl, J. (1985). Refuges for battered women: Ideology and action. *Feminist Review, 19*(1), 25-43.

Pajulo, M., Helenius, H., & Mayes, L. (2006). Prenatal views of baby and parenthood: Association with sociodemographic and pregnancy factors. *Infant Mental Health Journal, 27*(3), 229-250. doi:10.1002/imhj.20090

Papageorgiou, K. A., & Ronald, A. (2013). "He who sees things grow from the beginning will have the finest view of them" A systematic review of genetic studies on psychological traits in infancy. *Neuroscience & Biobehavioral Reviews, 37*(8), 1500-1517.

Papoušek, M. (2011). Resilience, strengths, and regulatory capacities: Hidden resources in developmental disorders of infant mental health. *Infant Mental Health Journal, 32*(1), 29-46. doi:10.1002/imhj.20282

Patton, S. (2003). *Pathways: How Women Leave Violent Men*. Tasmania: Department of Premier and Cabinet.

Paul, C., & Thomson-Salo, F. (1997). Infant-led innovations in a mother-baby therapy group. *Journal of Child Psychotherapy, 23*(2), 219-244. doi:10.1080/00754179708254543

Pedley, J. (2006). *Sanctuaries and the Sacred in the Ancient Greek World*. USA: Cambridge University Press.

Peled, E., & Dekel, R. (2010). Excusable deficiency: Staff perceptions of mothering at shelters for abused women. *Violence Against Women, 16*(11), 1224-1241. doi:10.1177/1077801210386775

Peled, E., & Gil, I. B. (2011). The mothering perceptions of women abused by their partner. *Violence Against Women, 17*(4), 457-479. doi:10.1177/1077801211404676

Perlman, S., Cowan, B., Gewirtz, A., Haskett, M., & Stokes, L. (2012). Promoting positive parenting in the context of homelessness. *American Journal of Orthopsychiatry, 82*(3), 402-412. doi:10.1111/j.1939-0025.2012.01158.x

Perry, B., Pollard, R., Blakley, T., Baker, W., & Vigilante, D. (1995). Childhood trauma, the neurobiology of adaptation, and "use-dependent" development of the brain: How "states" become "traits" *Infant Mental Health Journal 16*(4), 271-291.

Perry, B., & Szalavitz, M. (2006). *The Boy Who Was Raised As A Dog.* USA: Basic Books.

Perry, B. D. (1997). Incubated in terror: Neurodevelopmental factors in the 'cycle of violence.'. In Joy D Osofsky (Ed.), *Children in a Violent Society* (pp. 124-149). New York: The Guilford Press.

Perry, N. B., Mackler, J. S., Calkins, S. D., & Keane, S. P. (2013). A transactional analysis of the relation between maternal sensitivity and child vagal regulation. *Developmental Psychology,* 50(3), 783-793.

Pierson, J., & Thomas, M. (2010). *Dictionary of Social Work : The definitive A to Z of social work and social care* (1 ed.). Maidenhead: McGraw-Hill Education. Retrieved from http://latrobe.eblib.com.au/patron/FullRecord.aspx?p=650315

Pinheiro, P. S. (2006). *World Report on Violence against Children*. Switzerland: UN.

Pizzey, E. (1975). Chiswick Women's Aid— a refuge from violence. *The Journal of the Royal Society for the Promotion of Health, 95*(6), 297-298.

Porges, S. W. (1995). Orienting in a defensive world: Mammalian modifications of our evolutionary heritage. A polyvagal theory. *Psychophysiology, 32*(4), 301-318.

Porges, S. W. (2007). The polyvagal perspective. *Biological Pychology, 74*(2), 116-143.

Postmus, J. L. (2003). Valuable assistance or missed opportunities?: Shelters and the family violence option. *Violence Against Women, 9*(10), 1278-1288.

Pratchett, L. C., & Yehuda, R. (2011). Foundations of posttraumatic stress disorder: Does early life trauma lead to adult posttraumatic stress disorder? *Development and Psychopathology, 23*(2), 477-491. doi:doi:10.1017/S0954579411000186

Pretorius, I.-M. (2004). The skin as a means of communicating the difficulties of separation—individuation in toddlerhood. *Infant Observation, 7*(1), 68-88. doi:10.1080/13698030408401710

Psalms (1971 print version). The Living Bible. USA: Tyndale House Publishers.

Puckering, C., Connolly, B., Werner, C., Toms-Whittle, L., Thompson, L., Lennox, J., & Minnis, H. (2011). Rebuilding relationships: A pilot study of the effectiveness of the mellow parenting programme for children with reactive attachment disorder. *Clinical Child Psychology and Psychiatry, 16*(1), 73-87. doi:10.1177/1359104510365195

Puckering, C., Evans, J., Maddox, H., Mills, M., & Cox, A. D. (1996). Taking control: A single case study of mellow parenting. *Clinical Child Psychology and Psychiatry, 1*(4), 539-550. doi:10.1177/1359104596014006

Quinlivan, J. A., & Evans, S. (2005). Impact of domestic violence and drug abuse in pregnancy on maternal attachment and infant temperament in teenage mothers in the setting of best clinical practice. *Archives of Women's Mental Health, 8*(3), 191-199. doi:10.1007/s00737-005-0079-7

Quinlivan, J. A., & Evans, S. F. (2001). A prospective cohort study of the impact of domestic violence on young teenage pregnancy outcomes. *Journal of Pediatric and Adolescent Gynecology, 14*(1), 17-23.

Rabben, L. (2012). *Give Refuge to the Stranger : The past, present, and future of sanctuary*. Walnut Creek: Left Coast Press. Retrieved from http://latrobe.eblib.com.au/patron/FullRecord.aspx?p=688826

Raby, K. L., Cicchetti, D., Carlson, E. A., Cutuli, J. J., Englund, M. M., & Egeland, B. (2012). Genetic and caregiving-based contributions to infant attachment: Unique associations with distress reactivity and attachment security. *Psychological Science, 23*(9), 1016-1023. doi:10.1177/0956797612438265

Rasool, S. (2015). Help-seeking after domestic violence: The critical role of children. *Journal of Interpersonal Violence*, 1-26. doi:10.1177/0886260515569057

Rayna, S., & Laevers, F. (2011). Understanding children from 0 to 3 years of age and its implications for education. What's new on the babies' side? Origins and evolutions. *European Early Childhood Education Research Journal, 19*(2), 161-172. doi:10.1080/1350293X.2011.574404

Read, P. (1981/2006). *The Stolen Generations*. NSW: NSW Department of Aboriginal Affairs.

Reddy, V., & Trevarthen, C. (2004). What we learn about babies from engaging their emotions. *Zero to Three, 24*(3), 9-15.

Renner, L. M., & Slack, K. S. (2006). Intimate partner violence and child maltreatment: Understanding intra-and intergenerational connections. *Child Abuse & Neglect, 30*(6), 599-617.

Rhode, M. (2004). Infant observation as research: Cross-disciplinary links. *Journal of Social Work Practice, 18*(3), 283-298. doi:10.1080/0265053042000314384

Rhodes, N. R., & McKenzie, E. B. (1999). Why do battered women stay?: Three decades of research. *Aggression and Violent Behavior, 3*(4), 391-406.

Richardson, J., Coid, J., Petruckevitch, A., Chung, W. S., Moorey, S., & Feder, G. (2002). Identifying domestic violence: cross sectional study in primary care. *BMJ, 324*(7332), 274-280.

Riem, M. M. E., Bakermans-Kranenburg, M. J., van Ijzendoorn, M. H., Out, D., & Rombouts, S. A. R. B. (2012). Attachment in the brain: Adult attachment representations predict amygdala and behavioral responses to infant crying. *Attachment & Human Development, 14*(6), 533-551. doi:10.1080/14616734.2012.727252

Rifkin-Graboi, A., Borelli, J. L., & Enlow, M. B. (2009). Neurobiology of stress in infancy. In Charles H Zeneah. Jr (Ed.), *Handbook of Infant Mental Health* (3rd ed., pp. 59-79). New York: The Guilford Press.

Rigterink, T., Fainsilber Katz, L., & Hessler, D. M. (2010). Domestic violence and longitudinal associations with children's physiological regulation abilities. *Journal of Interpersonal Violence, 25*(9), 1669-1683. doi:10.1177/0886260509354589

Rog, D. J., & Buckner, J. C. (2007). *Homeless Families and Children.* Proceedings of the 'Toward Understanding Homelessness': The 2007 National Symposium, Washington.

Rosen, D., Seng, J. S., Tolman, R. M., & Mallinger, G. (2007). Intimate partner violence, depression, and posttraumatic stress disorder as additional predictors of low birth weight infants among low-income mothers. *Journal of Interpersonal Violence, 22*(10), 1305-1314. doi:10.1177/0886260507304551

Rothbaum, F., Rosen, K., Ujiie, T., & Uchida, N. (2002). Family systems theory, attachment theory, and culture. *Family Process, 41*(3), 328-350.

Ruesch, J., & Bateman, G. (1951). *The Social Matrix of Psychiatry* (1st ed.). USA: W. W. Norton & Company, Inc.

Rustin, M. (1997). What do we see in the nursery? Infant observation as 'laboratory work.'. *Infant Observation, 1*(1), 93-110. doi:10.1080/13698039708400828

Rustin, M. (2006). Infant observation research: What have we learned so far? *Infant observation, 9*(1), 35-52.

Rustin, M. (2009). Esther Bick's legacy of infant observation at the Tavistock—some reflections 60 years on. *Infant Observation, 12*(1), 29-41.

Sabina, C., & Tindale, R. S. (2008). Abuse characteristics and coping resources as predictors of problem-focused coping strategies among battered women. *Violence Against Women, 14*(4), 437-456.

Saldaña, J. (2009). *The Coding Manual for Qualitative Researchers*. London: SAGE.

Salomon, A., Bassuk, E., Browne, A., Bassuk, S. S., Dawson, R., & Huntington, N. (2004). *Secondary Data Analysis on the Etiology, Course, and Consequences of Intimate Partner Violence against Extremely Poor Women*. USA: US Department of Justice.

Salter-Ainsworth, M., Blehar, M., Waters, E., & Wall, S. (1978/2014). *Patterns of Attachment: A psychological study of the strange situation*. New York: Pyschology Press.

Salter-Ainsworth, M. D. (1969). Object relations, dependency, and attachment: A theoretical review of the infant-mother relationship. *Child Development, 40*(4), 969-1025.

Salter-Ainsworth, M. D. (1979). Infant-mother attachment. *American Psychologist, 34*(10), 932-937.

Salter-Ainsworth, M. D. (1991). Attachments and other affectional bonds across the life cycle. In C. M. Parkes, J. Stevenson-Hinde & P. Marris (Eds.), *Attachment Across the Life Cycle* (pp. 33-51). London: Routledge.

Salter-Ainsworth, M. D., Blehar, M. C., Waters, E., & Wall, S. (1978/2014). *Patterns of Attachment: A psychological study of the strange situation*. New York: Psychology Press. (Original work published Lawrence Erlbaum Associates, 1978)

Salter-Ainsworth, M. D., & Bowlby, J. (1991). An ethological approach to personality development. *American Psychologist, 46*(4), 333-341.

Salter-Ainsworth, M. D., & Eichberg, C. (1991). Effects on infant-mother attachment of mother's unresolved loss of an attachment figure, or other traumatic experience. In C. M. Parkes, J. Stevenson-Hinde & P. Marris (Eds.), *Attachment Across The Life Cycle* (Vol. 3*,* pp. 160-183). London: Routledge.

Samuelson, K. W., Krueger, C. E., & Wilson, C. (2012). Relationships between maternal emotion regulation, parenting, and children's executive functioning in families exposed to intimate partner violence. *Journal of Interpersonal Violence, 27*(17), 3532-3550. doi:10.1177/0886260512445385

Santana, M. C., Raj, A., Decker, M. R., La Marche, A., & Silverman, J. G. (2006). Masculine gender roles associated with increased sexual risk and intimate partner violence perpetration among young adult men. *Journal of Urban Health, 83*(4), 575-585. doi:10.1007/s11524-006-9061-6

Sarkar, N. N. (2008). The impact of intimate partner violence on women's reproductive health and pregnancy outcome. *Journal of Obstetrics and Gynaecology, 28*(3), 266-271. doi:10.1080/01443610802042415

Schabel, C. (2008). Francis of Marchia. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Winter Edition ed.). Retrieved from http://plato.stanford.edu/archives/win2008/entries/francis-marchia/

Schaffer, K. (2004). Narrative lives and human rights: Stolen generation narratives and the ethics of recognition. *Journal of the Association for the Study of Australian Literature, 3*, 5-26.

Schechter, D. S. (2004). Intergenerational communication of violent traumatic experience within and by the dyad the case of a mother and her toddler. *Journal of Infant, Child, and Adolescent Psychotherapy, 3*(2), 203-232. doi:10.1080/15289160309348462

Schechter, D. S., Moser, D. A., Wang, Z., Marsh, R., Hao, X., Duan, Y., . . . McCaw, J. (2012). An fMRI study of the brain responses of traumatized mothers to viewing their toddlers during separation and play. *Social Cognitive and Affective Neuroscience, 7*(8), 969-979.

Schechter, D. S., & Willheim, E. (2009). The effects of violent experiences on infants and young children. In C. H. Z. Jr (Ed.), *Handbook of Infant Mental Health* (pp. 197-213). New York: The Guilford Press.

Schechter, S. (1982). *Women and Male Violence: The visions and struggles of the battered women's movement*. Cambridge: South End Press.

Scheeringa, M. S., Zeanah, C. H., Myers, L., & Putnam, F. W. (2003). New findings on alternative criteria for PTSD in preschool children *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(5), 561-570.

Schmidt Neven, R. (2007). *Constructing Mental Health Problems: A critical inquiry into the views of professionals working with children, parents and families* (Victoria University).

Schore, A. (2001). The effects of early relational trauma on the right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1-2), 201-269.

Schore, A. N. (1996). The experience-dependent maturation of a regulatory system in the orbital prefrontal cortex and the origin of developmental psychopathology. *Development and Psychopathology, 8*(1), 59-87.

Schore, A. N. (2001). Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*(1-2), 7-66. doi:10.1002/1097-0355(200101/04)22:1<7::AID-IMHJ2>3.0.CO;2-N

Schore, A. N. (2003a). *Affect Dysregulation and Disorders of the Self*. New York: WW Norton & Company.

Schore, A. N. (2003b). *Affect Regulation & the Repair of the Self* (Vol. 2). New York: WW Norton & Company.

Schore, A. N. (2005). Back to basics attachment, affect regulation, and the developing right brain: linking developmental neuroscience to pediatrics. *Pediatrics in Review, 26*(6), 204-217.

Schore, J. R., & Schore, A. N. (2008). Modern attachment theory: The central role of affect regulation in development and treatment. *Clinical Social Work Journal, 36*(1), 9-20.

Schwerdtfeger, K. L., & Goff, B. S. N. (2007). Intergenerational transmission of trauma: Exploring mother–infant prenatal attachment. *Journal of Traumatic Stress, 20*(1), 39-51. doi:10.1002/jts.20179

Scottish-Women's-Aid. (2013). *Changing Lives: Women's Aid in Scotland*. Edinburgh: S. W. s. Aid.

SCRGSP (2014). *Overcoming Indigenous Disadvantage: Key indicators 2014*. Canberra: Productivity Commission.

Scribano, P., Stevens, J., & Kaizar, E. (2013). The effects of intimate partner violence before, during, and after pregnancy in nurse visited first time mothers. *Maternal and Child Health Journal, 17*(2), 307-318.

Senanayake, L. (2012). Domestic violence: an emerging concern in maternity care. *Sri Lanka Journal of Obstetrics and Gynaecology, 33*(4), 142-149.

Shapiro, L. (2013). Elisabeth, Princess of Bohemia. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Fall Edition). Retrieved from http://plato.stanford.edu/archives/fall2013/entries/elisabeth-bohemia/

Shatz, C. (1992). The developing brain. *Scientific American, 267*(3), 35-41.

Shinn, M. (2010). Homelessness, poverty, and social exclusion in the United States and Europe. *European Journal on Homelessness, 4*, 21-44.

Shinn, M., Schteingart, J. S., Williams, N. C., Carlin-Mathis, J., Bialo-Karagis, N., Becker-Klein, R., & Weitzman, B. C. (2008). Long-term associations of homelessness with children's well-being. *American Behavioral Scientist, 51*(6), 789-809. doi:10.1177/0002764207311988

Shonkoff, J. P. (2010). Building a new biodevelopmental framework to guide the future of early childhood policy. *Child Development, 81*(1), 357-367.

Shonkoff, J. P., & Phillips, D. A. (2000). *From Neurons to Neighborhoods: The science of early childhood development*. Washington, D.C: National Academy Press.

Shuttleworth, J. (2008). Creating religious experience in contemporary society. *Infant Observation, 11*(1), 17-24. doi:10.1080/13698030801936615

Siegel, D. J. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships,"mindsight," and neural integration. *Infant Mental Health Journal, 22*(1-2), 67-94.

Siegel, D. J. (2012). *Developing Mind: How relationships and the brain interact to shape who we are* (2nd ed.). New York: Guilford Press.

Silverman, D. (2013). *Doing Qualitative Research: A practical handbook* (4th ed.). London: SAGE.

Smolen, A. G. (2003). Children born into loss: Some developmental consequences of homelessness. *Journal for the Psychoanalysis of Culture and Society, 8*(2), 250-257.

Sokoloff, N. J. (2004). Domestic violence at the crossroads: Violence against poor women and women of color. *Women's Studies Quarterly, 32*(3/4), 139-147.

Sokoloff, N. J., & Dupont, I. (2005). Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities. *Violence Against Women, 11*(1), 38-64. doi:10.1177/1077801204271476

Solomon, E. P., & Heide, K. M. (2005). The biology of trauma: Implications for treatment. *Journal of Interpersonal Violence, 20*(1), 51-60. doi:10.1177/0886260504268119

Spangler, G., & Grossmann, K. E. (1993). Biobehavioral organization in securely and insecurely attached infants. *Child Development, 64*(5), 1439-1450.

Spietz, A., Johnson-Crowley, N., Sumner, G., & Barnard, K. (2008). *Keys to Caregiving Study Guide* (Revised Edition ed.). Seattle, Washington: NCAST-AVENUW Programs.

Spinney, A. (2012). *Reducing the Need for Women and Children to make Repeated use of Refuge and other Crisis Accommodation*. Melbourne: Swinburne Institute of Technology.

Spinney, A., & Blandy, S. (2011). *Homelessness Prevention for Women and Children who have experienced Domestic and Family Violence: Innovations in policy and practice*. Australia: AHURI.

Sprangers, M. A. G., Sloan, J. A., Veenhoven, R., Cleeland, C. S., Halyard, M. Y., Abertnethy, A. P., . . . Zwinderman, A. H. (2009). The establishment of the geneqol consortium to investigate the genetic disposition of patient-reported quality-of-life outcomes. *Twin Research and Human Genetics, 12*(03), 301-311. doi:doi:10.1375/twin.12.3.301

Srinivasan, M., & Davis, L. V. (1991). A shelter: An organization like any other? *Affilia, 6*(1), 38-57.

Sroufe, L. A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment & Human Development, 7*(4), 349-367. doi:http://dx.doi.org/10.1080/14616730500365928

Stern, D. N. (2003). *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology*. London: Karnac Books.

Stern, P. N., & Porr, C. (2011). *Essentials of Accessible Grounded Theory*. California: Left Coast Press.

Stevenson, A. (Ed.). (2010). *New Oxford American Dictionary* (3rd ed.). New York: Oxford University Press.

Strøm, A., Kvernbekk, T., & Fagermoen, M. S. (2011). Parity: (im) possible? Interplay of knowledge forms in patient education. *Nursing Inquiry, 18*(2), 94-101. doi:10.1111/j.1440-1800.2011.00517.x

Sullivan, C. M., Baptista, I., O'halloran, S., Okroj, L., Morton, S., & Stewart, C. S. (2008). Evaluating the effectiveness of women's refuges: A multi-country approach to model development. *International Journal of Comparative and Applied Criminal Justice, 32*(2), 291-308.

Swain, J. E., Lorberbaum, J. P., Kose, S., & Strathearn, L. (2007). Brain basis of early parent–infant interactions: psychology, physiology, and in vivo functional neuroimaging studies. *Journal of Child Psychology and Psychiatry, 48*(3-4), 262-287.

Swartz, J. R., Graham-Bermann, S. A., Mogg, K., Bradley, B. P., & Monk, C. S. (2011). Attention bias to emotional faces in young children exposed to intimate partner violence. *Journal of Child & Adolescent Trauma, 4*(2), 109-122. doi:10.1080/19361521.2011.573525

Szewczyk-Sokolowski, M., Bost, K. K., & Wainwright, A. B. (2005). Attachment, temperament, and preschool children's peer acceptance. *Social Development, 14*(3), 379-397.

Taft, A. J., Watson, L. F., & Lee, C. (2004). Violence against young Australian women and association with reproductive events: a cross-sectional analysis of a national population sample. *Australian and New Zealand Journal of Public Health, 28*(4), 324-329. doi:10.1111/j.1467-842X.2004.tb00438.x

Tailor, K., & Letourneau, N. (2012). Forgotten survivors of intimate-partner violence: The role of gender and mothering in infant development. *Infant Mental Health Journal, 33*(3), 294-306. doi:10.1002/imhj.21316

Talge, N. M., Neal, C., & Glover, V. (2007). Antenatal maternal stress and long-term effects on child neurodevelopment: how and why? *Journal of Child Psychology and Psychiatry,* 48(3-4), 245-261. doi:10.1111/j.1469-7610.2006.01714.x

Tay-Lim, J., & Lim, S. (2013). Privileging younger children's voices in research: Use of drawings and a co-construction process. *International Journal of Qualitative Methods, 12*(1), 65-83.

Teicher, M. H. (2002). Scars that won't heal. *Scientific American, 286*(3), 68-75.

Teicher, M. H., Andersen, S. L., Polcari, A., Anderson, C. M., Navalta, C. P., & Kim, D. M. (2003). The neurobiological consequences of early stress and childhood maltreatment. *Neuroscience & Biobehavioral Reviews, 27*(1–2), 33-44.

Teicher, M. H., Dumont, N. L., Ito, Y., Vaituzis, C., Giedd, J. N., & Andersen, S. L. (2004). Childhood neglect is associated with reduced corpus callosum area. *Biological Psychiatry, 56*(2), 80-85.

Theobald, J. (2009). Constructing a feminist issue: Domestic violence and the Victorian refuge movement. *Parity, 22*(10), 12-14.

Theobald, J. (2012). Collaboration, confrontation and compromise. *DVRCV Quarterly, Autumn*(1), 9-12.

Theobald, J. (2014). Women's Refuges and the State in Victoria, Australia: a campaign for secrecy of address. *Women's History Review, 23*(1), 60-81. doi:10.1080/09612025.2013.846116

Thiara, R. K., & Humphreys, C. (2015). Absent presence: the ongoing impact of men's violence on the mother–child relationship. *Child & Family Social Work*, 1-9. doi:10.1111/cfs.12210

Thompson, S., & Phillips, D. (2007). Reaching and engaging hard-to-reach populations with a high proportion of nonassociative members. *Qualitative Health Research, 17*(9), 1292-1303. doi:10.1177/1049732307307748

Thomson-Salo, F. (2012). Engaging with the baby as a person in their own right: Early intervention with parents and infants. *Psychoanalysis, 23*(1), 3-9.

Thomson-Salo, F., & Paul, C. (2001). Some principles of infant-parent psychotherapy: Ann Morgan's contribution, *The Signal, 9*(1-2), 14-19.

Thomson-Salo, F., Paul, C., Morgan, A., Jones, S., Jordan, B., Meehan, M., . . . Walker, A. (1999). 'Free to be playful': therapeutic work with infants. *Infant Observation, 3*(1), 47-62. http://dx.doi.org/10.1080/13698039908400854

Thomson Salo, F. (2007). Relating to the infant as subject in the context of family violence. In F. Thomson Salo & C. Paul (Eds.), *The Baby as Subject* (2nd ed.). Victoria, Australia: Stonnington Press.

Thomson Salo, F. (2010). Parenting an infant born of rape. In S. Tyano, M. Keren, H. Herrman & J. Cox (Eds.), *Parenthood and Mental Health: A bridge between infant and adult psychiatry* (pp. 289-299). UK: Wiley-Blackwell.

Thomson Salo, F., & Campbell, P. (2007). Some principles of infant-parent psychotherapy. In F. T. Salo & C. Paul (Eds.), *The Baby as Subject* (2nd ed*.,* pp. 247-259). Melbourne: Stonnington Press.

Tischler, V., Edwards, V., & Vostanis, P. (2009). Working therapeutically with mothers who experience the trauma of homelessness: An opportunity for growth. *Counselling & Psychotherapy Research, 9*(1), 42-46.

Tolan, P., Gorman-Smith, D., & Henry, D. (2006). Family violence. *Annual Review of Psychology, 57*(January), 557-583.

Tolhurst, E. (2012). Grounded theory method: Sociology's quest for exclusive items of inquiry. *Qualitative Social Research, 13*(3), Art. 26.

Tollenaar, M. S., Beijers, R., Jansen, J., Riksen-Walraven, J. M. A., & De Weerth, C. (2011). Maternal prenatal stress and cortisol reactivity to stressors in human infants. *Stress, 14*(1), 53-65. doi:doi:10.3109/10253890.2010.499485

Tollenaar, M. S., Beijers, R., Jansen, J., Riksen-Walraven, J. M. A., & de Weerth, C. (2012). Solitary sleeping in young infants is associated with heightened cortisol reactivity to a bathing session but not to a vaccination. *Psychoneuroendocrinology, 37*(2), 167-177. doi:http://dx.doi.org/10.1016/j.psyneuen.2011.03.017

Tolman, R. M., & Rosen, D. (2001). Domestic violence in the lives of women receiving welfare: mental health, substance dependence, and economic well-being. *Violence Against Women, 7*(2), 141-158. doi:10.1177/1077801201007002003

Trevarthen, C. (2001). Intrinsic motives for companionship in understanding their origin, development, and significance for infant mental health. *Infant Mental Health Journal, 22*(1-2), 95-131.

Trevarthen, C., & Aitken, K. J. (2001). Infant intersubjectivity: Research, theory, and clinical applications. *Journal of Child Psychology and Psychiatry, 42*(1), 3-48.

Tronick, E., & Beeghly, M. (2011). Infants' meaning-making and the development of mental health problems. *American Psychologist, 66*(2), 107-119.

Tronick, E. Z. (2001). Emotional connections and dyadic consciousness in infant-mother and patient-therapist interactions: Commentary on paper by Frank M. Lachmann. *Psychoanalytic Dialogues, 11*(2), 187-194. doi:10.1080/10481881109348606

Tronick, E. Z. (2007). *The Neurobehavioral and Social-emotional Development of Infants and Children*. U.S.A.: W. W. Norton & Company.

Trout, M. M. A. (2011). Presence and attunement in health care: A view from infancy research. *Creative Nursing, 17*(1), 16-21.

Trowell, J., & Miles, G. (2004). The contribution of observation training to professional development in social work. *Journal of Social Work Practice, 18*(1), 49-60. doi:10.1080/0265053032000183688

Turner, T. V. (2007). *Tu Kaha: Nga Mana Wahine Exploring the Role of Mana Wahine in the Development of Te Whare Rokiroki Maori Women's Refuge* (Victoria University of Wellington, Wellington).

Tutty, L. (1999). *Shelters for Abused Women in Canada: A celebration of the past, challenges for the future*. Ottawa, ON: H. C. Family Violence Prevention. (Project #H5227-7-K002).

Tryphonopoulos, P. D., Letourneau, N., & Ditommaso, E. (2014). Attachment and caregiver–infant interaction: A review of observational-assessment tools. *Infant Mental Health Journal*, 1-14. doi:10.1002/imhj.21461

UN. (1989). *Convention on the Rights of the Child*. Geneva: United Nations. (Document A/RES/44/25).

Urwin, C. (2011). Infant observation meets social science. *Infant Observation, 14*(3), 341-344. doi:10.1080/13698036.2011.616309

Van der Kolk, B. (2014). *The Body keeps the Score: Brain, mind, and body in the healing of trauma*. England: Penguin.

Van der Kolk, B. A. (2003). Posttraumatic stress disorder and the nature of trauma. In M. F. Solomon & D. J. Siegel (Eds.), *Healing Trauma: Attachment, mind, body and brain* (pp. 168-195). New York: W.W. Norton & Company.

Van der Kolk, B. A. (2005). Developmental trauma disorder. *Psychiatric Annals, 35*(5), 401-408.

Vaughn, M. G., Salas-Wright, C. P., Cooper-Sadlo, S., Maynard, B. R., & Larson, M. (2014). Are immigrants more likely than native-born Americans to perpetrate intimate partner violence? *Journal of Interpersonal Violence*, 1-7. doi:10.1177/0886260514549053

Vliegen, N. (2006). 'She doesn't want to look at me' Mother–infant observation as a bridge between clinical practice and research. *Infant Observation, 9*(3), 261-268. doi:10.1080/13698030601070623

Waddell, M. (2013). Infant observation in Britain: a Tavistock approach. *Infant Observation, 16*(1), 4-22. doi:10.1080/13698036.2013.765659

Walker, J. (2008). Communication and social work from an attachment perspective. *Journal of Social Work Practice, 22*(1), 5-13. doi:10.1080/02650530701872231

Walsh, A. (1997). *The Story of Ursula Frayne: A woman of mercy* (pp. 64). Victoria, Australia: John Garratt Publishing.

Waxman, L. D., & Reyes, L. M. (2007). *Hunger and Homelessness: A status report on hunger and homelessness in America's cities*. USA: A. A. Inc.

Weatherston, D., & Fitzgerald, H. E. (2010). Role of parenting in the development of the infants interpersonal abilities. In S. Tyano, M. Keren, H. Herrman & J. Cox (Eds.), *Parenthood and Mental Health* (pp. 181-191). UK: Wiley-Blackwell.

Webb, E., Shankleman, J., Evans, M. R., & Brooks, R. (2001). The health of children in refuges for women victims of domestic violence: cross sectional descriptive survey. *BMJ, 323*(7306), 210-213.

Weinreb, L. F., Buckner, J. C., Williams, V., & Nicholson, J. (2006). A Comparison of the Health and Mental Health Status of Homeless Mothers in Worcester, Mass: 1993 and 2003. *American Journal of Public Health, 96*(8), 1444-1448.

Wenzel, S. L., Leake, B. D., & Gelberg, L. (2001). Risk factors for major violence among homeless women. *Journal of Interpersonal Violence, 16*(8), 739-752. doi:10.1177/088626001016008001

Whittingham, K., & Douglas, P. (2014). Optimizing parent–infant sleep from birth to 6 months: A new paradigm. *Infant Mental Health Journal, 35*(6), 614-623.

WHO. (2013). *Global and Regional Estimates of Violence against Women*. Geneva, Switzerland: W. H. Organisation.

WHO. (2014). *Global Status Report on Violence Prevention 2014*. Luxembourg.

Widom, C. S. (1999). Posttraumatic stress disorder in abused and neglected children grown up. *American Journal of Psychiatry, 156*(8), 1223-1229.

Wies, J. R. (2008). Professionalizing human services: A case of domestic violence shelter advocates. *Human Organization, 67*(2), 221-233.

Wilson, K. (1992). The place of child observation in social work training. *Journal of Social Work Practice, 6*(1), 37-47. doi:10.1080/02650539208413485

Wilson, M., Baglioni, A. J., Jr., & Downing, D. (1989). Analyzing factors influencing readmission to a battered women's shelter. *Journal of Family Violence, 4*(3), 275-284.

Winnicott, D. (1960). The theory of the parent-infant relationship. *International Journal of Psychoanalysis, 41*, 585-595.

Winnicott, D. W. (1965). The maturational processes and the facilitating environment. *The International Psycho-Analytical Library, 64*, 1-276.

Winnicott, D. W. (1970). The mother-infant experience of mutuality. In E. A. James & T. Benedek (Eds.), *Parenthood: Its psychology and psychopathology* (pp. 245-256). Oxford: Little Brown.

Winnicott, D. W. (1971/2005). *Playing and Reality*. New York: Routledge Classics.

Winnicott, D. W. (2002). *Winnicott on the Child*. USA: Perseus Publishing.

Wolfe, D. A., Jaffe, P., Wilson, S. K., & Zak, L. (1985). Children of battered women: the relation of child behavior to family violence and maternal stress. *Journal of Consulting and Clinical Psychology, 53*(5), 657-665.

Women's-Liberation-Halfway-House-Collective. (1976). *HERSTORY of the Halfway House 1974-1976*. Melbourne: Sybylla Cooperative Press Ltd.

Women'sAid. (2014). *Women's Aid Annual Survey 2013*. UK: Women's Aid Federation of England.

Women'sAid. (2015). *Women's Aid Annual Survey 2014*. England: Women's Aid Federation of England.

Zabkiewicz, D. M., Patterson, M., & Wright, A. (2014). A cross-sectional examination of the mental health of homeless mothers: does the relationship between mothering and mental health vary by duration of homelessness? *BMJ Open, 4*(e006174), 1-8. doi:10.1136/bmjopen-2014-006174

Zago, C. (2008). Coming into being through being seen: an exploration of how experiences of psychoanalytic observations of infants and young children can enhance ways of 'seeing' young people in art therapy. *Infant Observation, 11*(3), 315-332. doi:10.1080/13698030802507613

Zeanah, C. H., Benoit, D., Hirshberg, L., Barton, M., & Regan, C. (1994). Mothers' representations of their infants are concordant with infant attachment classifications. *Developmental Issues in Psychiatry and Psychology, 1*, 1-14.

Zeanah, C. H., & Scheeringa, M. S. (1997). The experience and effects of violence in infancy. In J. D. Osofsky (Ed.), *Children in a Violent Society* (pp. 97-123). New York: Guilford.
Zeanah Jr, C. H. (2009). *Handbook of Infant Mental Health*. New York: Guilford Publication.