Overview and Early History

Training in the Michigan Model of Infant Mental Health Home Visiting

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

zero TO THRIVE

Acknowledgements

This training was informed by the foundational work of Selma Fraiberg, Betty Tableman and other pioneering clinicians in the field of infant mental health. A summary of the history and notable contributors to this model can be found at: Tableman, B., & Ludtke, M. (2020). Introduction to the special section: The development of infant mental health home visiting in Michigan state government. Infant mental health journal, 41(2), 163–165. https://doi.org/10.1002/imhj.21855 .

This training was created and developed by Katherine Rosenblum, PhD, ABPP, IMH-E®, Julie Ribaudo PhD, LMSW, IMH-E®, Karen Smith LMSW, IMH-E®, and Maria Muzik MD, MSc, with later contributions from June Hall, LMSW, IECMH-E®. **This training is the core curriculum for the evidence-based Michigan Model of Infant Mental Health Home Visiting (IMH-HV).**

Acknowledgements

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Trainer's Intentions

- Explain the foundational values of the training
- Review the framework of the training
- Explain the roles and expectations for trainers and trainees
- Consider the lens through which the founders of IMH saw the world

Orientation to Infant Mental Health - Home Visiting Learning Collaborative

IMH-HV Learning Collaborative Values

As believers in relationship-based practice, we acknowledge supremacy in all its forms (e.g., race, age, class, ability, body size, sexual orientation, gender identity, religion) and its influence on therapeutic relationships.

During the next 12 months, we will hold in mind the ways our unique identities can become barriers to or opportunities for connection, within relationships with families served and in reflective supervision relationships.

This may be uncomfortable work, and in the spirit of “good enough” we invite you to co-create a “good enough”- braver and safer- space as we enter a deep dive of the IMH-HV practice.

This statement is our intention to purposefully integrate IMH-HV work with the value of dismantling supremacy in this training, in work with families, in reflective supervision, and into future work.

Mom and Baby?

We recognize a variety of people may care for an infant - biological parents, foster parents, adoptive parents, guardianships. During the training, we will use the labels caregiver, father, mother, biological parent, foster parent, grandparent, guardian, etc., including those who identify as non-binary/queer when discussing the dyad.

History of IMH-HV Training in Michigan

- Public Act 291 of 2012 (PA 291) - Michigan's Home Visiting Act limited expenditures throughout the state budget to only support evidence-based, or promising programs advancing to evidence-based, home visitation programs.

- MDHHS consulted with the University of Michigan (Principal Investigators (PI): Rosenblum, Muzik) regarding the feasibility, cost and timeframe of an evaluation to meet the requirements

History of IMH-HV Training in Michigan

- A Leadership Team convened and worked to identify funding, sites for the evaluation, and plan for sustainability of IMH HV (eventually to meet rigorous standards for national/federal evidence-based recognition and to develop a standardized training for providers)

- A research advisory board with representatives from many academic institutions, the Michigan Collaboration for Infant Mental Health Research, convened to design, implement and analyze data from evaluations

Evaluation Outcomes of Families

- *To meet state requirements (PA 291):* Two quasi-experimental studies (Study 1, Study 2) evaluated IMH HV as delivered in community mental health settings across southeast Michigan

- *To ensure ongoing fidelity to the IMH HV model:* A standardized training curriculum was developed and piloted

- *To meet national/federal requirements:* A rigorous university-based randomized controlled trial (RCT) evaluated IMH HV as delivered by providers trained in the standardized curriculum

Training Development

- Developers at UM created, field-tested, and refined a curriculum for training providers in IMH-HV as an Evidence-based Practice
- Content incorporated key strategies identified from evaluations
- A Training of Trainers model was implemented to develop a cadre of qualified IMH-HV trainers

Training Development Cont.

- Focus Groups with providers and parents further informed curriculum refinement with a focus on cultural responsivity and therapeutic alliance
  - We will be weaving in the themes from the FG
  - A limitation of the FG was the limited diversity of provider participants. Primarily white and Black providers, though did have a limited number of Hispanic providers.

Focus Group – Findings From Parents

- The Importance of Working Relationships
  - **Building Rapport**
  - **Trust**
  - **Consistency**
- Home Visitor Interpersonal Skills and Traits
  - **Open Communication**
  - **“Showing Up”**

Focus Group – Findings From Parents

- Preparedness for the Work
  - **Practicing Non-Judgment**
  - **Recognizing Skills**
- Team Building
  - **Eliminating Barriers to Care**
  - **Building a Bridge**
  - **Co-Creating a Conduit**

Focus Group – Findings From Providers

- Themes heard from providers
  - **Earning Trust**
  - **Continual Self-Work**
  - **An Openness to Learn**
  - **Boundaries**

What is Your Investment in Learning?

- Trainings can be a place where you go because it is a part of your job requirements
- Training can be an investment in your career
- The energy that we bring to each of these frames of mind makes a difference in how we approach learning

Investment in Babies and Families

When you come prepared to immerse yourself in learning, it will positively impact the babies and families you serve.

- Parallel process
  - Trainers hold in mind your needs and that of the families and babies that are served
  - Clinicians actively engage in learning on training days and coaching calls to improve their understanding and skills
  - Clinicians provide services to families and children that support their growth
  - Families and babies benefit

The more energy you invest into a pursuit, the more valuable it becomes

If you want to be successful, invest in yourself to get the knowledge you need to find your unique factor. When you find it and focus on it and persevere, your success will blossom.

- Sydney Madwed

Let the beauty of what you love be what you do.

-Rumi

Learning Collaborative Expectations

- Clinicians and supervisors must have Master's level education in social work, psychology or related fields and meet any relevant state licensing requirements and currently work with infants, toddlers, birth through 2 years of age at intake, and their parent(s)/ caregiver(s).
- It is strongly recommended that clinicians and supervisors are endorsed as an Infant Mental Health Specialist Michigan Association for Infant Mental Health endorsement .
- Clinicians and their supervisor are not currently taking part in another evidence-based training/Learning Collaborative.
- A 12-month commitment for coaching calls from clinicians and their supervisor.

Learning Collaborative Expectation

Attendees are responsible to complete...

- Pre-Training Homework
- Learning Gathering 1
- Learning Gathering 2
- Pre-Coaching call homework
- Coaching Calls
- Learning Gathering 3

Learning Collaborative Expectation

CLINICIANS

- Attend all 3 Learning Gatherings
- Attend a minimum of 80% of coaching calls.
- Come prepared for trainings and coaching calls.
- Provide assessment and implement the model with a minimum of 3 infants/toddlers and their caregiver(s)
- Video record, and review video with each family, once every 3 months during services
- Participation in bi-weekly individual or group Reflective Supervision.

Learning Collaborative Expectation

SUPERVISORS

- Attend all 3 Learning Gathering.
- Attend a minimum of 80% of coaching calls.
- Attend a minimum of 80% of supervisor calls.
- Come prepared for trainings and coaching calls.
- Provide assessment and implement the model with a minimum of 2 infant/toddler and their parent(s)/caregiver(s)
- Video record, and review video with each family, once every 3 months during services
- Review clinician videotapes with the clinician
- Provide regular clinical supervision during and after the learning collaborative.
- Participation in bi-weekly individual or group Reflective Supervision.

Learning Collaborative Expectation

IMPLEMENTATION COORDINATORS

- Attend Learning Gathering 1
- Support team's implementation of the IMH-HV model
- Attend Quarterly Implementation Coordinator Calls
- Facilitate solving problems that may arise in your agency

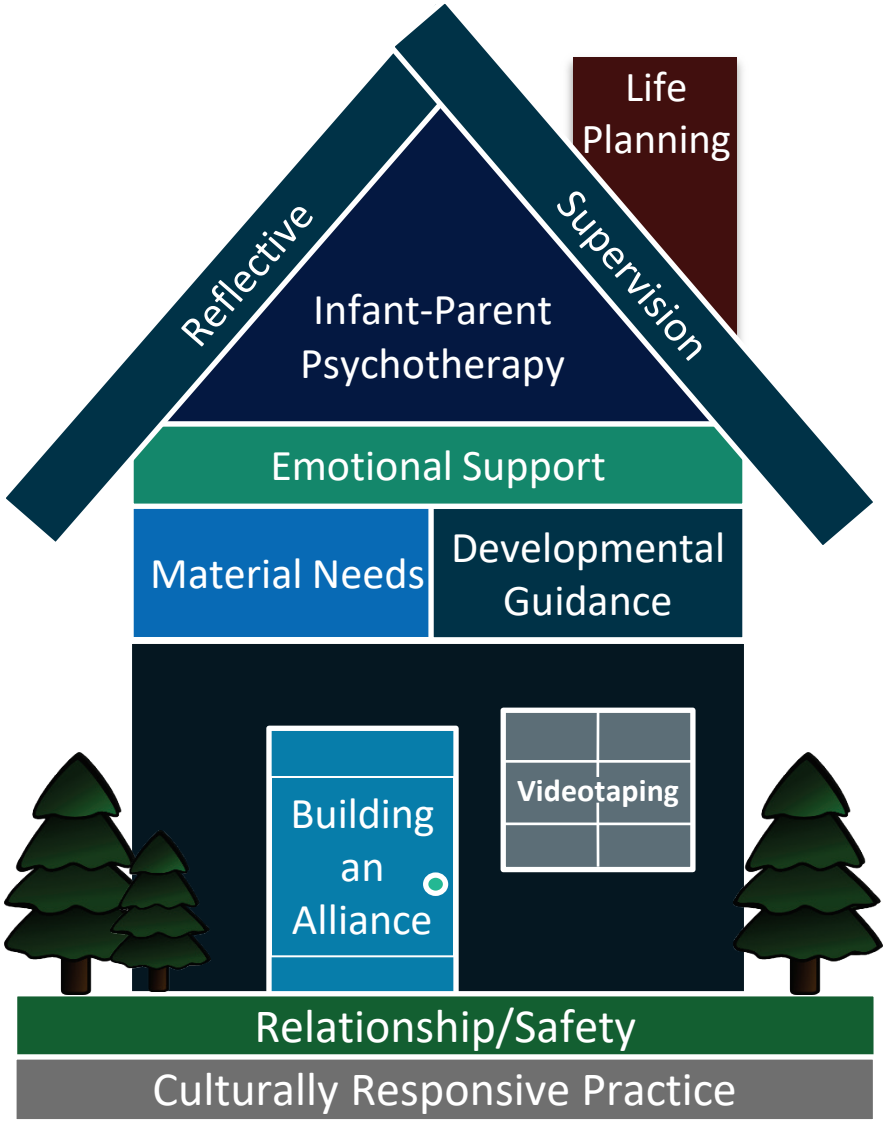
Learning Collaborative Expectation

TRAINERS

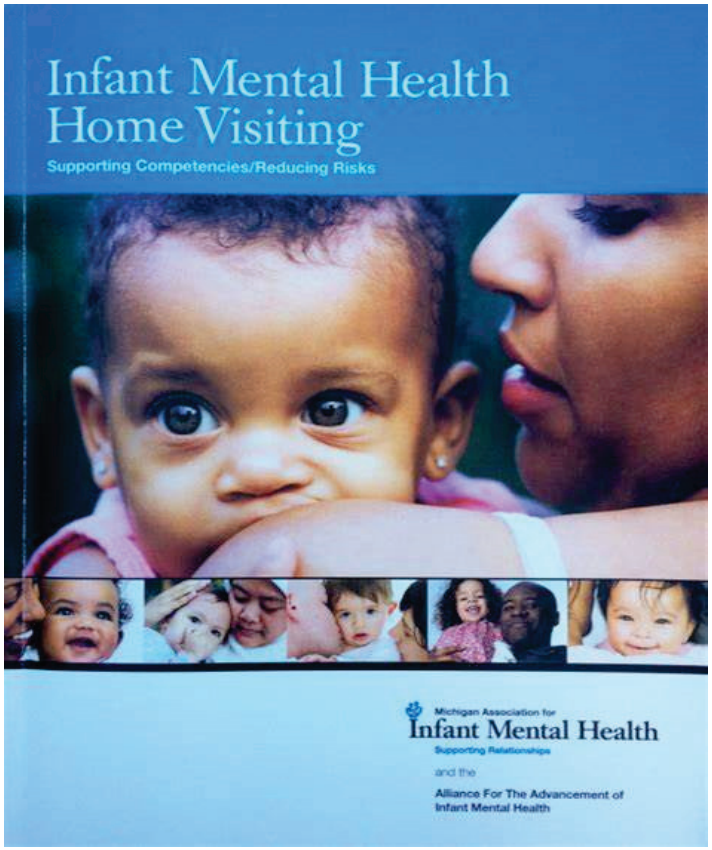
- Prepare for and provide the for all 3 Learning Gatherings
- Facilitate coaching calls
- Facilitate supervisor calls

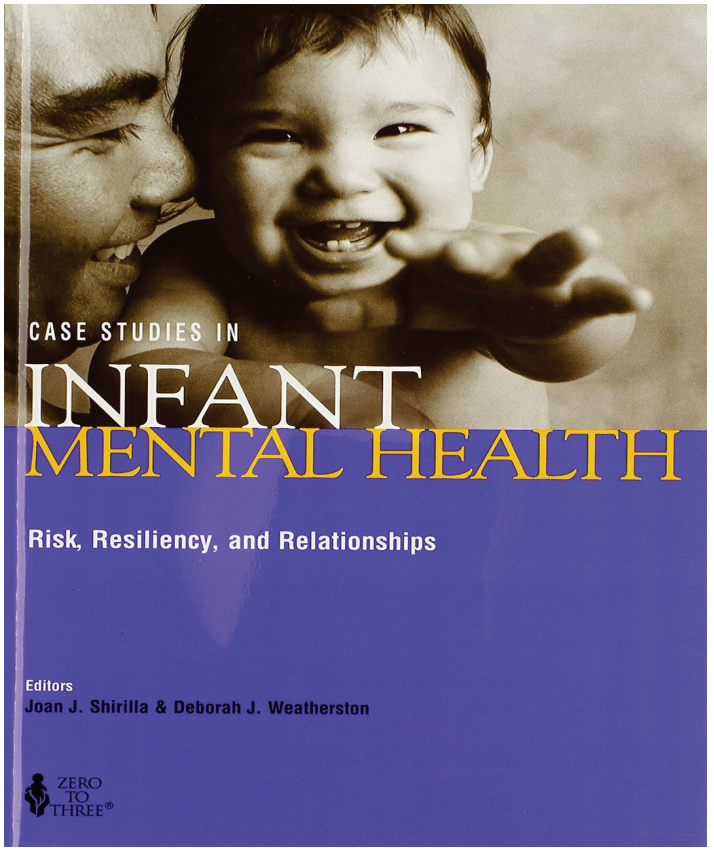
Infant Mental Health Home Visiting Components

- Culturally Responsive Practice
- Building an Alliance
- Material Needs
- Developmental Guidance
- Emotional Support
- Infant-Parent Psychotherapy
- Life Course Planning
- Reflective Supervision
- Videotaping



Training Schedule	
Learning Gathering 1 **Day 1**	• Module 1: Overview and History • Module 2: Cultural Genogram • Module 3: Pre-work Group Debrief
Day 2	• Module 4: IMH Skills • Module 5: Therapeutic Alliance
Day 3	• Module 6: IPP
Learning Gathering 2 **Day 4**	• Module 7: Culture & Diversity In-Depth • Module 8: Observation In-Depth
Day 5	• Module 9: IMH-HV Video Review How-To • Module 10: Case Studies LG2
Learning Gathering 2 **Day 6**	• Module 11: Reflective Supervision and IPP • Module 12: Termination
Day 7	• Module 13: Case Studies LG3





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History of IMH Theory

Sigmund Freud

- Born Sigismund Schlomo Freud in 1856 in Austria (in town now part of Czech Republic), married and had six children, Jewish (Ashkenazi), Secular, Neurologist/Physician, Intellectual non-conformist, founder of psychoanalysis
- Advanced the concept of “unconscious” motivations, inner ”conflicts” and ”defense mechanisms”
- 1933 Nazi party took control, his books were banned and burned; lived in Vienna during the 1938 Anschluss, daughter Anna was arrested and interrogated by Gestapo, and he agreed to have the International Psychoanalytic Association help him, and several family members, flee to England
- All four of his sisters died in concentration camps despite his attempts to get them out of Austria; he died in London in 1939

Anna Freud

- 1895-1982
- Sixth and youngest child of Sigmund and Martha Freud.
- Moved from Austria to London with her father after being arrested and questioned by the Gestapo
- Jewish heritage. Her mother was the granddaughter of the Chief Rabbi
- First a grade-school teacher, then became a psychoanalyst
- Interested in “developmental lines” – to stress the continuous and cumulative nature of child development, with emphasis on interactions between maturational and environmental determinants of development
- Her life partner was Dorothy Burlingham
- Lived with her father until his death

Melanie Klein

- 1882-1960, Jewish, Moved from Vienna to Berlin in 1921.
- Father was a doctor but she was not able to attend medical school due to a downturn in family fortunes.
- Was married, had 3 children, struggled with depression (“nerves”), was separated from her husband. Oldest son died at 27.
- Lead developer of object relations theory– a departure from traditional psychoanalysis (Rival of Anna Freud’s)
- Advanced notion that the relationship with the mother was based on more than feeding/food (traditional oral stage theory) and instead that the attachment with the baby was just as important
- Studied her own children, and was one of the first to base theories on observations of young children. Among first to use psychoanalysis with young children including through play.

John Bowlby

- 1907-1990
- British psychoanalyst who departed from psychoanalytic norms by advancing a theory rooted in ethology that posited that there is an innate, universal, evolutionarily adaptive human attachment behavioral system, hard-wired and present at birth
- Father was a surgeon, fourth of six children,
- Primarily raised by nannies he had a nanny from birth to age four and was devastated when she left
- He saw his mother one hour a day
- Sent to boarding school at age seven
- Married and had four children

Mary Ainsworth

- 1913-1999
- Canadian/American
- Parents educated
- Middle class
- Oldest of three daughters
- Close to father, not to mother
- PhD in psychology
- Divorced
- No children
- Primarily an attachment researcher and not an infant-parent psychotherapist

Selma Fraiberg

- 1918-1981
- American
- Jewish
- Family had a poultry business
- Middle class
- MSW and studied psychoanalysis
- Married and adopted one child, stayed at home with daughter
- Wrote important books including the classic text that established the field of IMH, "Case Studies in Infant Mental Health" and the more popular press book "The Magic Years"

Reflection Questions

What commonalities did you notice amongst the founders?

What differences did you notice?

The Foundational Lens of IMH Theory

- White
- Middle or upper class
- Educated
- European/Canadian/American
- Able bodied
- Healthy
- Patriarchal societies
- Jewish or Christian
- Individualistic
- Cisgender

The Thread of Loss Through Their Lives

- Religious and cultural identities were stripped away in the holocaust
- Deaths of family members
- Individual and social trauma
- Divorce or permanent separation
- Relationships not acknowledged by society as valid
- Rifts with family members

History is vibrant,
Broadening, and ongoing

Alicia Lieberman

Jeree Pawl

Barbara Stroud

Charles Zeanah

Amittia Parker

Susan McDonough

Marva Lewis

Arietta Slade

Daniel Stern

Nadia Bruschweiler Stern

Daniel Gaztambide

Some contributors to IMH-HV & IPP over recent decades

Infant Parent Psychotherapy (IPP) Beginnings

From its inception, Infant-Parent Psychotherapy was a prevention model. There was an understanding that there were intergenerational factors at play that could compromise the infant-parent interaction.

IMH-HV Families

- Infants and young children who qualify for Medicaid
- Many ethnic and racial backgrounds
- Caregivers have varying levels of education
- Biological parent most likely lives in or on the edge of poverty
- If with guardian/foster parent, economics vary
- Varying levels of physical and cognitive abilities
- Exposed to poverty, homelessness, substance use, interpersonal violence, etc.
- Many have histories of loss or trauma
- Higher levels of parental physical health problems
- Varying levels of social support
- Many spiritual traditions that do not include a Judeo-Christian framework
- Caregivers from a range of gender and sexual orientations

Cultural Limitations of IPP

- Underlying theory is rooted in Western, Euro normative lens, which focused on pathology and wasn't necessarily strengths based.
- Tends to be rooted in individualism vs. collectivism.
- Has not incorporated indigenous knowledge.
- Tends to focus on individual and family level trauma without fully acknowledging the role of historical trauma, oppression, and systemic racism and oppression
- Has an underlying assumption that it is culturally appropriate to talk about family interactions/trauma (i.e., skeletons in the closet).

Cultural Strengths of IPP

- Maintains a focus on helping the family tell us about who they are - focuses on coming to know each family without making assumptions
- Designed to have the family lead in telling us their story...doesn't assume the therapist has the answers
- Used internationally in non-Western societies, so it has some cultural adaptability

Review

- Values
- Training as an investment in your career success
- Framework of the IMH-HV Cohort
- Roles of participants
- The historical cultural lens of IMH