

Mother-Infant Intervention Programme for the Khayelitsha Treatment Trial

Antenatal Visit 1

Agenda for this visit:

- i. Introductions to the intervention.
- ii. Contracting for: the structure of the visits.
- iii. Contracting for: time and setting of the visits.
- iv. Contracting for: confidentiality.
- v. Discussion and input: the mother's current pregnancy.
- vi. Ending off and arrangements for the next visit.

Building trust

The main purpose of the first antenatal visit is to start to build a trusting relationship with the mother so that she feels that **you are absolutely on her side, understand her point of view, and are supportive of her**. For that reason try to arrange time alone with the mother during this visit. This might require some negotiating, as the mother probably did not know when you would be visiting her for the first time. It is important to be accepting of the mother, whatever you may feel about her or her circumstances. **Make it very clear that you are not there as an authority figure who checks up on mothers and evaluates them.**

NB

You need to adopt a counselling attitude of listening and reflecting her feelings. Stay with her and follow her lead throughout the visit and only once you feel you have established a trusting relationship do you begin, gradually and with sensitivity, to introduce your own agenda for the session. This applies to all future visits.

AGENDA:

i. Introductions

Introduce yourself to the mother and explain who you are in relation to the study.

Tell her a little about yourself. (For example, that you are a mother, how many children you have and their ages, that you have a special interest in the support of new parents and their infants and that you understand that adjustment to parenthood is not always easy. You should say that you live in the community, but it is best, at this stage, not to give out your address.)

Explain that you are visiting pregnant women in the community at their homes antenatally and for the first 6 months after the birth of the baby.

Explain how you came to know about her.

Explain that **your role will be to support her and that your focus will be on her and her experience with her baby. You will be helping her to learn about her baby.** For example you will be demonstrating her baby's individual qualities and interactive capacities which enable her baby to communicate with her and the rest of the outside world, to make sure his/her needs are met as they should be.

Explain that the programme is designed to help a mother have the best possible experience with her baby.

Explain that parenting is challenging for most parents, but that there are various factors that make it even more difficult for a mother to form an attachment to her baby ("bond" with her baby) and care for her baby. These include:

- Her pregnancy is unwanted or unplanned and she may have considered having an abortion.
- She has had stressful events in her life in the past year, for example, retrenchment, loss of home, loss of someone close.
- She has experienced a lack of emotional and financial support from her partner.
- She has been involved in incidents of domestic violence.
- She has experienced abuse in the past, for example, physical, emotional, sexual, rape.
- She has experienced a lack of support and practical help from family and friends.
- She has a poor, unsupportive relationship with her own mother.
- She experienced a miscarriage, stillbirth or the death of a child.
- She has had a serious depressive episode in the past.
- She is a teenage mother.
- She is a single-parent.

Suggest to the mother that perhaps one or some of these might be relevant to her. (She may start to open up to you or she may just nod in agreement or she may just stare back at you. Do not put her under pressure to open up.)

Explain that when a mother has had any of these experiences, she needs a lot of support and our home visits can provide her with some support.

ii. Contracting for : the structure of the intervention

You should explain what your involvement with her over the following months will be. This includes:

- There will be 2 **visits before the birth** (including this one).
- Each visit will last **an hour**.
- **Fourteen further visits will follow postnatally** until her infant is 6 months of age. For the first two months the visits will be weekly, then for the next two months the visits will be every second week, and for the last 2 months the visits will be monthly.

iii. Contracting for: time and setting of the visits

Try to **set up a time** in the week when it would best suit both you and the mother to visit.

Arrange with the mother that when you visit, you and she will have private space where you would both feel free to talk without being interrupted by the radio or family, friends or neighbours. **This is very important.**

iv. Contracting for: confidentiality

It is very important that you explain to the mother how you will be working within a team, under supervision, and that **anything discussed with her will be kept confidential within the team.**

v. Discussion and input: Mother's current pregnancy

a. Ask the mother to tell you about her pregnancy:

Explore how she has been feeling physically and emotionally and whether she has experienced any problems in this time that are of concern to her.

b. Explore whether this pregnancy has been planned and the feelings related to this:

The very young mothers are unlikely to admit that they planned their pregnancy. Where mothers still feel unsure about the pregnancy, just allow them to speak about it. Don't try to reassure or convince them either way. It is their feelings we are concerned with.

c. If the baby, planned or unplanned, is now much wanted:

If the mother is an adolescent herself she might be dealing with very angry and disappointed parents. She may feel as though she is not allowed or can't be seen to show interest in her pregnancy, and might value an opportunity to talk about and validate her own feelings of disappointment, guilt, anticipation and excitement.

Some questions you could ask the mother:

- Does she have particular thoughts and feelings about her baby?

- Does she have any impressions about the baby so far (e.g. Is the fetus active? Does he or she react to particular external events or the mood of the mother? Can the mother sense some kind of routine in this activity? etc.).
- Does she (or anyone else) have a preference about the sex of the baby?
- Explore any concerns or fears that the mother may express. (e.g. particular fears in relation to whether the baby will survive, might be imperfect/handicapped, have positive or negative personality characteristic, etc....?)

d. Explore whether the mother has experienced any previous pregnancies, births, miscarriages, abortions, stillbirths or deaths of children or any other close family members.

Encourage the mother to talk and express her feelings about such experiences, as she will be close to these feelings in this pregnancy.

vi. Ending off and arrangements for the next visit

- Arrangements must be made for the next visit.
- The mother should be asked if she would like you to meet her partner (or any other important figure in her life who might be involved with the care of the baby).

It is vital to provide private time for the mother to speak about issues she would **not** address in front of other family members, including her partner. But we also want to support the relationship between the baby and his/her father, as well as the relationship between the mother and other people who are part of her support structure.

- Make an arrangement with the mother to get a message to you should the baby arrive sooner than expected. Many mothers are unclear about their dates. You might want to give the mother a phone number where someone could call to let you know.

Antenatal Visit 2

Agenda for this visit:

- i. Tuning in to mother.
- ii. Discussion: mother's support structures.
- iii. Discussion and input: the labour and birth.
- iv. Discussion: employment.
- v. Discussion: the mother's partner / the baby's father.
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

On this visit you may meet the woman's partner and / or other family members.

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise.**

Be aware that sometimes a mother who has been very open with you during the first session, might be much quieter during this session, perhaps fearing that she has revealed too much about herself, too soon.

2. When you feel that the mother has had sufficient time to express her **concerns**, gradually and with sensitivity, introduce your own agenda for the session.

ii. Discussion: mother's support structures

The fact that the visit is being conducted in the home allows you to enquire more easily about the housing situation and the household, including the availability of support. Try to cover the following questions -

- Whether she and the father of her baby are still together and if so: What his feelings are about this pregnancy. Does she feel cared for and supported emotionally and financially by him?
- Is her own mother present? How did she respond to the pregnancy? Is she supportive?

- Is her mother-in-law present? Is she supportive? What are her feelings about this pregnancy?
- Does mother have friends? Are they supportive?

iii. Discussion and input: the labour and birth

This visit will focus to a large extent on the mother's feelings about the birth and on how she will manage, and the mother's experience of previous pregnancies and births.

iv. Discussion : employment

Try to find out about work issues. For example, are there pressures to go back to work? Have arrangements been thought about? If the mother is unemployed and she has no other financial support, ask about her **plans to support herself** once her baby is born.

v. Discussion : the mother's partner / the baby's father

If the partner is seen, a number of points should be kept in mind. The main aim should be to encourage a mutually supportive relationship between the two partners. If the couple are in harmony, you should reinforce the partner's support and emphasise the value of his contribution for both the mother and the child.

If the partner communicates his own vulnerability and anxiety, this can also be used to strengthen the link between the couple, in that it can be noted that this is a very big emotional event for both of them. The father may find it useful to have you acknowledge his feeling that everyone is focusing on the mother, but that he too may need attention. Thus, you should convey the feeling that both partners receive consideration and that diverse points of view can be heard, despite the primary focus being on the mother at this stage.

You should be aware of potential competition between the woman and her partner and the possibility that one or both of them may wish to create a situation where each individual is concerned to have you see them as the "good" partner, and the other as the "bad" one. In such situations, it will be important to find a way of supporting both partners, reflecting back the perspective of each, but doing so in a way that does not ally you with one individual. **It is especially important that the mother's feeling that you understand and sympathise with her is preserved.**

vi. Ending off and arrangements for the next visit

- Arrangements must be made for the next visit.
- Make an arrangement again with the mother to get a message to you should the baby arrive sooner than expected.

Postnatal visit 1 - Day 3

Agenda for this visit:

- i. Tuning in to mother.
- ii. Discussion and input: the birth.
- iii. Discussion and input: the blues.
- iv. Discussion: concerns for the baby.
- v. Note and comment on: infant social responsiveness.
- vi. Note and comment on: infant behaviour.
- vii. Wider concerns.
- viii. Ending off and arrangements for the next visit.

AGENDA:

This visit, to be held as near as possible to the third day after the birth, will focus to a large extent on the mothers' detailed account of the birth and any joys and disappointments should be shared.

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

ii. Discussion and input: the Birth

Invite the mother to tell you her story of her experience of labour and birth in her own words. **Listen and reflect** on any concerns that the mother may raise.

Once she has told her story gently explore some of the areas she might not have covered. Encourage her to talk about:

- How she felt she was cared for.
- How she felt she managed the process of labour and birth.
- Did she want and was she allowed a birth attendant to accompany her.
- What were her feelings and thoughts as she saw her baby for the first time.
- What would have improved the experience for her.

iii. Discussion and input: the blues

You should enquire whether the mother has found she feels fragile and weepy, (has she had “the blues”)? ***If so, be as supportive as possible and*** focus on any anger or sadness she may be feeling. You should point out that these feelings are common, experienced by nearly all women, and that they will usually quickly settle down. It should be acknowledged that having the baby provokes strong feelings; and any particular issues that came up to the surface should be aired. If the blues continues for more than a few days, be aware that the mother may be postnatally depressed.

iv. Discussion: concerns for the Baby

The mother may have had anxieties and concerns about the baby in pregnancy. These should have been shared with you in the antenatal sessions. The fact of the baby’s presence gives an opportunity to return to these concerns and, in particular, to focus on relevant aspects of the infant’s behaviour and functioning. For example, the mother may have concerns about the baby’s being damaged by the birth. Listen carefully to the mother and if you are equally concerned about an aspect of the infant identified by the mother, refer her back to the MOU for the problem to be assessed.

v. Note and comment on: Infant Social Responsiveness

The full Behavioural and Interactive Assessment of the Baby will not be done until postnatal session 2 at 6-10 days. However, if the infant’s behaviour gives any opportunity to comment on the infant’s responsiveness to, say, the mother’s voice, face or smell, you should exploit this by specifically pointing it out.

vi. Note and comment on Infant Behaviour

You could use the opportunity to talk about the infant’s behavioural state. If you suspect that this may be an irritable/sensitive infant, it may be appropriate for you to say a little about individual differences in babies, and to introduce the idea that some infants are more sensitive than others, and that these babies need more support to help them regulate their state. The aim should

be to prevent any belief that, if the infant shows behaviour which the mother finds problematic, this is somehow the mother's fault.

The mother might highlight aspects of the baby's behaviour which concern her. For example, a mother might be anxious that her baby does not sleep at night. These concerns need to be discussed and placed in the context of normal infant capacities and development.

vii. Wider concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

viii. Ending off and preparations for the next visit

The mother should be reminded that, at the next visit, you will be carrying out the Behavioural and Interactive Assessment of the Baby. You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present.

Postnatal visit 2 - Day 6- 10

Agenda for this visit:

- i. Tuning in to mother
- ii. The Behavioural and Interactive Assessment of the Baby
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise.**
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

At all times be aware and ready to recognize, point out and praise any positive, sensitive, responsive, loving, attuned, observant, emotionally expressive communication and interaction between the mother/caregiver and the child.

iii. The Behavioural and Interactive Assessment of the Baby (BAIB)¹

The main agenda of this visit will be you and the mother (and father and the potential caregiver, if they are present) **thinking together about the baby as a person.**

a. The role of the PICC when demonstrating the Behavioural and Interactive Assessment of the Baby:

- You will have to judge whether the mother is accepting of your undressing and assessing the baby before the umbilical cord has dropped off. Some mothers have strong feelings about this and you might have to wait until the cord is off before going ahead with this assessment.
- The assessment should be administered in a way that actively, and in a supportive manner, involves the mother (and other caregivers, if they are present).
- It is important to be aware that **your interactions with the baby during the assessment will be a model for the mother.** You therefore need to be especially sensitive to cues from the baby. Very importantly, you should demonstrate a pace of talking that is not so fast that it cuts across the baby's initiatives, nor so slow that you lose the baby's attention.
- You should give a careful explanation of what the various components of the assessment reveal about the baby.
- You should point out to the mother that a particularly effective way of entraining baby in face-to-face engagement is to monitor the baby's own expressions and gestures and then respond, either through imitation or affirming the baby's initiative. This serves to give the baby immediate feedback about his/her own behaviour.
- You should be alert for any opportunities to facilitate sensitive communication between the mother and her baby, pointing out to the mother, her baby's responses to her. *

Summary of the Behavioural and Interactive Assessment of the Baby (BAIB)

1. 6 infant behavioural states
2. Ability to shut out intrusive light and sound while asleep.
3. Uncovering and undressing and placing in supine.
4. Ventral suspension.
5. Crawling.
6. Defensive movements (cloth over face).
7. Crying and consolability.
8. Cuddliness.
9. Social interactive package.
10. Imitation, responsiveness and reciprocity.
11. Intrusiveness.
12. Rooting and sucking

*Such sensitivity to the baby, and the early active involvement of the baby in this two-way process of communication, in which his attention is maintained on a focus for prolonged periods, has been found to be highly predictive of the baby's later cognitive development.

¹ This assessment is derived, in part, from the Brazelton Neonatal Behavioral Assessment Scale, *Clinics in Developmental Medicine*, No. 137, T.B. Brazelton and J.K.Nugent, 1995, and from *The Social Baby*, L.Murray & L.Andrews, 2000.

- With regard to social interaction, remember to inform, and possibly show the mother that, within the first five days, her baby will turn towards her smell rather than another woman's smell. Similarly, he/she will quickly come to prefer the sound of her voice to that of any other person. He/she will also look more to her face than to the face of another woman. These behaviours are probably biologically programmed to help the mother feel that her baby is connecting with her and to foster or encourage a sense of a special relationship between them. This, of course, is just what the baby needs for optimum (best) psychological development.
- Also with regard to social interaction, remember to inform the mother that within the first few weeks (usually by around four to six weeks) babies show an intense interest in becoming engaged in prolonged (drawn out) interpersonal communication.

If the mother gives the baby good head support and places her face at the optimal distance for the baby's vision (about 22cms), the baby will watch intently and, if the mother is responsive, can be drawn into a "conversation".

Babies of this age will use their mouth and tongue actively, with wide, open, shaping, or protrusions of the tongue over or into the lips (so-called 'pre-speech').

If the mother can be helped to see that this behaviour is not random, but a purposeful effort at communication, they can join in with the baby and together experience a two-way dialogue (referred to as 'proto conversations'). This is typically intensely satisfying for mothers, giving them the feeling that they are really in contact with their baby.

- You should give a running commentary to the baby of what is happening between you and him/her. Watch the baby's response to your commentary. For example, you might say to the baby "You really like talking these days" and then watch the response. This will help the mother to see which strategies elicit and sustain the baby's engagement. Once you have demonstrated this, explain to the mother what you and she have just learned about the baby, and how she could implement this.

If you were insensitive and caused the baby to be avoidant, draw the mother's attention to it and explain to her what has just happened. For example, you might say "Did you just notice that? When I laughed suddenly he turned away from me. I think I overloaded him and came in too forcefully".

- At this stage, do not point out weaknesses such as the baby being low in tone and floppy, or some delay in the baby's response to situations. Keep your concerns in mind and monitor development with time. If you continue to feel concerned about an aspect of the baby's development it is likely that the mother has noticed it too. Affirm her observation and if you are sufficiently concerned and judge it to be necessary, refer her to the

appropriate service. If you are concerned, but the mother is not either aware or concerned, bring your concerns gently to her attention and then refer.

- Once you have completed the assessment, you should give a review of how any difficulties which emerged in the assessment might be displayed during ordinary family care giving (e.g. when changing a nappy, undressing for a bath, putting the baby down to sleep). Also help the mother; father or potential caregiver who is present, think about managing these difficulties.

b. Helping mothers who experience difficulties in engagement:

There are four groups of mothers who need special help engaging with their babies.

1. Mothers who are severely depressed, emotionally flat and unresponsive

Some mothers, especially those who are severely depressed, are emotionally flat and unresponsive. Their babies will typically try to draw them into engagement, fail, and then withdraw. These mothers need to be helped to engage with their babies. A number of strategies can be used.

First, the mother will need to be encouraged to talk to and play with her baby.

Second, the assessment must be used to draw the mother's attention to her baby's individual characteristics and social capacities. It is especially important that you highlight instances of the mother behaving sensitively towards her baby, as well as instances of the baby responding to the mother.

Finally, 'modelling' (that is, your demonstrating sensitive engagement) should be used to give the mother an idea of what sort of adult behaviour her baby finds engaging.

2. Mothers who overload their babies and are not sensitive

Another form of difficulty is where a mother overloads her baby by a constant stream of talk, without any sensitivity to the baby's own perspective.

Since the baby is overwhelmed by the bombardment of stimulation, to protect himself, he may withdraw or become distressed and, consequently, will not engage properly.

These mothers can be helped by slowing the mother down. They should be advised that the baby is having difficulty keeping up with them; and that it would be useful to see how the baby responds to the mother's remaining quiet and only responding to an initiative of the baby. By encouraging the mother to imitate the baby's communicative gestures and commenting upon them, she will be drawn into a meaningful engagement with her baby.

3. Mothers of babies whose motor control is rather poor

A mother who has a baby who has poor motor control (is either, jerky, tremulous (unsteady or shaky), tense or flat and sluggish) need help to achieve satisfying face-to-face engagements.

For example, the latter group of babies may need additional head support to help them keep eye-to-eye contact.

Those who are jerky and tense may find it distressing to be in a situation that babies with better motor control find optimal for social contacts (such as lying supine during a nappy change). These babies are also likely to benefit from a supportive holding environment in order to be able to be fully interpersonally engaged.

The assessment can inform you about the characteristics of the individual infant and the most effective strategies for facilitating a good state; and this information should be used to promote the best possible experience of face-to-face engagement for mother and baby.

4. Mothers who have babies who are irritable and sensitive

Mothers of babies who are irritable / sensitive, and who therefore have difficulty in regulating their state in relation to environmental stimulation, need particular help.

These babies tend to startle at slight events, becoming rapidly disorganized and finding it hard to return to a stable calm state.

In order to achieve and sustain such a baby's positive involvement in face-to-face interactions, the mother should be made particularly aware of the role her responses can play in helping to support the regulation of the baby's state.

Stimulation that is pitched strongly, which may not disturb other babies, will in the case of one who is sensitive, be likely to contribute to the baby's state becoming disorganized.

Mothers of such babies should also be made aware that it will be helpful to pay attention to the context of their interactions. Thus, laying the baby in supine undressed may mean that the baby's spontaneous gross movements are more likely to destabilise a state of calm alert. Providing a more physically supportive environment, where the baby is held, for example, on her lap, may help the baby feel contained.

iv. Discussion and input: sleeping

New parents often have two main concerns about their baby's sleep:

1. They want to help their baby develop a clear distinction between night and day with prolonged sleep during the night.
2. They will want to establish procedures for settling their baby off to sleep in a manner that is peaceful for the baby and that does not place enormous demands on them (by, for example, spending prolonged periods rocking a pram, or walking up and down with the baby in their arms).

The way in which you can help the mother is:

a. Listening

Listen to her, allowing her share her concerns and challenges regarding her baby's sleeping.

Try to understand the expectations the mother has in terms of sleep, both for herself and the baby. Be aware that she may or may not be realistic about what she expects from her baby.

You should bear this in mind when thinking through strategies with the mother.

b. Giving her information about sleeping behaviour in young babies

- During the first few days after birth babies typically spend considerable amounts of time in an awake, alert state, more time in fact than they will do for the next three weeks.

These periods of alertness, cycling with sleep states, give the parents frequent opportunities to engage in direct personal contact with the baby, and to observe how the baby's state and behaviour change in relation to the environment. (it provides an opportunity for them to get to know their baby).

- In the beginning the sleep cycle of the baby and that of his parents are quite disparate or dissimilar. (e.g the baby can be wide awake during the night, a time during which his parents usually are asleep).

Gradually, their sleep cycles become synchronised (happen more or less at the same time) through the parent responding in a way that helps the baby to make the transition to sleep. Also, quite naturally, through the course of ordinary life, exchanges take place that help the baby adapt to his parents rhythms and day-night cycles. For example, having the baby sleep in a crib next to his parent's bed (or in his parent's bed) gives him and his parents repeated opportunities through the night to sense each other's rhythms through changes in breathing and state.

There is some evidence that the first ten days may be an optimal time for establishing the initial co-ordination between the baby and the caretaking environment. Babies who have had care that is unresponsive in the first ten days are more difficult to manage in the subsequent two weeks than babies whose care has been responsive from the start.

- All babies wake frequently during the night. Most babies wake every 45 to 90 minutes throughout the night. Some wake up into a very light sleep or drowsy state but do not wake fully, and if they do wake up, they are able to go back to sleep on their own. Others, however, wake up, but are unable to make the transition back to sleep on their own and need external support, such as being rocked.

c. Helping her to understand her baby's behaviour patterns and rhythms and way of making the transition to sleep

Each baby comes with his own unique rhythms of activity and quiescence (calm) and manner of moving between the six different infant behavioural states.

With regard to particular advice, the best approach to achieving both the aims of settling to sleep and establishing a day-night cycle is founded upon a close observation of the unique behaviour patterns of each baby, and in particular an understanding of the individual baby's capacity to regulate his state, including how the baby uses his environment (personal or physical).

The Behavioural and Interactive Assessment of the Baby will give you and the mother the opportunity to observe how smoothly the baby is able to shift from each of these states to the other, and how much, and what kind of environmental support the baby may need.

Helping the mother to see the distinct states the baby experiences and what her baby needs to regulate his state will help her manage her baby's sleep in a way sympathetic to his own nature. This is to everybody's benefit because the *research evidence shows that where infant care fits in with a baby's own rhythms and is responsive to that baby's behaviour, babies are generally less distressed, and day -night differences in sleep patterns are established earlier than in those whose care is managed less responsively.

Some babies have the capacity to move smoothly from one state to the next without a great deal of support. Others find transitions from awake to sleep states hard to manage themselves and need much more direct help.

d. Encouraging her to read her baby's cues for moving to a sleep state

Ideally, parents should become aware, from observations of the baby over the first few days, of the very first signs that their baby is becoming tired. These might be, for example, the baby's becoming avoidant or unavailable, moving to state 3 or becoming drowsy; or it could be shown in fussy or irritable behaviour.

Again, based on observation of the individual baby, it may then be possible for the parents actively to arrange the environment to support the baby's transition to a sleep state as soon as the baby shows a sign that he is tiring.

The effectiveness of a particular intervention is maximal when it occurs at a point where the baby is shifting from one phase in his rhythm to the next. For a particular intervention to become a cue for the baby to use in the future to help him make a transition to sleep, it should be used repeatedly by the parent at a particular phase in the baby's state cycle (For example, when the mother

* The best text, which is the most accurate in relation to the research evidence, is 'Sleep: the secret of Problem free Nights' by Beatrice Hollyer and Lucy Smith. It is endorsed by the Health Visitor's Association.

observes that her baby is tired she then lays him in his cot. She has learnt that he falls asleep easier when the radio is playing softly in the background. She lays him in his cot and puts the radio on softly when she notices that he is tired. This then becomes the baby's cues for sleep).

e. Helping her to devise interventions that are based on her baby's unique behaviour pattern and rhythms, that help him to make the transition into sleep

Babies vary widely in what will help them make the shift to sleep state. A range of strategies is listed below, from those for babies who find it relatively easy to settle to those for babies who experience real problems. In highlighting these strategies, consideration has been given to the fact that most parents will want to find a method of settling their infant that will not involve their having to be directly physically involved with the infant until he is asleep (as, for example, in patting the baby on his back, or rocking or feeding him to sleep).

- **Visual stimulus**

Some babies may need relatively little direct support and may be calmed by, say, engaging visually with the environment. If the mother has noticed this she may subsequently, as soon as she notices the first sign that the baby is getting tired, try putting her baby in his crib under a mobile with distinct visual contrasts and edges (placed 22cms above his head if on his back), or arranging similar patterns on the inside of the crib if placed on his side.

- **Auditory stimulus (e.g lullabies)**

Another, similarly easily settled baby, may be able to use an auditory stimulus, a tape of lullabies for example, or the noise of a vacuum cleaner (!) to make the transition to a sleep state.

- **Active stimulation (e.g touch, sucking)**

Other babies prefer rather more active stimulation through touch to help them go to sleep, perhaps sucking on something. It is easy for mothers of such babies, and particularly those who are breast feeding, to misread these babies' cues and imagine that the baby is actually hungry. The mother in this situation may well offer the breast; and, indeed, the baby might suck, become less distressed, and fall asleep. The potential problem with establishing this pattern is that the baby will become adjusted to it, and might subsequently always need to suckle on the breast in order to be able to move to a sleep state. Some families may not find this problematic, but mothers should be aware that this might not be a pattern she would like to establish. In such cases it is advisable to help the mother check first whether the baby is genuinely hungry. This can be done by seeing if the baby will root and suck strongly on a finger, and by noting the quality of the cry. If, of course, the baby is genuinely hungry he should be fed. However, it is possible that such a baby's behaviour does not specifically indicate hunger so much as a need for oral comfort. Some babies who find sucking helpful are comforted by sucking on their own fist. Some might be able to achieve this by themselves. Others might only be able to find

their fist if they are wrapped so that their fist is in position near their mouth. If the baby cannot achieve this kind of self-control, and sucking seems to be an important way in which this particular baby regulates his state and calms himself to sleep, then the mother might wish to consider using a dummy for this purpose.

- **Direct physical support (e.g swaddling)**
Other babies may require more direct physical support to make the transition to sleep. Such babies may have rather poor motor control, and startle themselves easily out of a drowsy state into an alert one. In these cases, firm swaddling in a thin cotton sheet may be helpful to contain the baby's movements, and generally calm and soothe them. Some babies might require substantial ventral contact or physical support. It is obviously important if advising on swaddling to explain the issues of overheating.
- **Intensive support (e.g rocking whilst walking around)**
In spite of trying out the strategies outlined above, some babies who become rapidly very disorganised and distressed when needing to sleep may need even more intensive support to become calm and sleep. These babies are usually highly sensitive to slight environmental changes and place great demands on parents. Parents may be helped considerably by having an understanding of the baby's difficulty in regulating their state themselves, and in this way the parents may be able to tolerate giving the kind of support such babies require much more willingly. The baby might, for example, need input from several modalities to contain them: for example, ventral contact and movement, such as in actively rocking the baby.
- **Reducing stimulation**
Alternatively, there are babies who also become disorganised and distressed when needing to sleep, but who require a reduction in stimulation. Trying to intervene actively with such babies may make them even more agitated, and it may be observed that these babies will calm better if all stimulation is cut right down.

Whichever strategy is used to help the baby move into a sleep state, he may find it helpful to have next to him a cloth or cover that has been in contact with his mother and which therefore carries her smell.

v. Discussion and input: crying and consolability

a. Understanding crying

Crying is normal for babies. All babies cry. It is a clear form of communicating needs and is essential for survival. A baby does not cry because s/he is "naughty" but because of one of the following reasons:

- Hunger
- Tiredness
- Over-stimulation

- Discomfort caused by a dirty nappy; digestive disturbances such as cramps, bloating, reflux; indigestion, constipation, diarrhoea, over-feeding, medical conditions, allergies, being too hot or too cold.
- Feeling lonely- the need to be touched, soothed and spoken to

Babies differ in how much they cry. Some babies cry for an hour altogether in a whole day whilst other babies cry for a couple hours unceasingly.

Research has shown that there can be quite a big difference in how much a baby cries and how much the mother expects her baby to cry. There can also be quite a big difference in how much the baby is **actually crying** and **how much the baby seems to be crying**. For example, a baby may be crying for 1 hour altogether in a day but it might seem to the mother that the baby has been crying the whole day.

Crying evokes powerful emotions. It can evoke joy (e.g when the mother hears her baby crying for the first time). It can also evoke anger; frustration; rage; disappointment, etc.

How a mother copes with crying and how much crying it takes to push her to the point of desperation, also differs from one mother to the next.

All mothers want to settle their babies as quickly as possible.

b. Strategies for consoling a crying baby

The principles that apply to the management of the transition to sleep apply similarly to baby crying. That is, there should be careful observation of the individual baby's behaviour in order to build up a picture of the circumstances that both provoke and relieve crying. Strategies found to be effective for settling the baby to sleep are also likely to be relevant to relieving crying. However, whereas parents may often want to avoid getting in to a pattern of having to intervene directly with the infant through the transition to sleep, this will almost certainly not be an issue with consoling the infant. The following strategies, therefore, while using the same understanding of the infant's use of different stimulation for regulating their state, involve direct personal intervention by the parents. **They progress from minimum to maximum direct intervention.**

CRYING AND CONSOLABILITY

Minimum Intervention



1. Using voice alone.
2. Presenting face and voice.
3. Assisting with use of hand to mouth, or dummy.
4. Placing a steady hand on the baby's front.
5. Placing hand on baby's front and holding one or both arms.
6. Picking up and holding.

Maximum intervention	7. Swaddling, holding and rocking. 8. Dummy or finger to suck, and swaddling, holding and rocking.
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It is important for the mother to be aware that, as with sleep strategies, some infants may become more distressed with additional stimulation. In such cases, as for sleep, the infant may be better calmed by being left in a quiet semi-dark environment, checking of course to make sure that the baby is all right.

Decisions about the best strategy to try will be most effective when based on detailed observation of the individual baby's responses. There are no universal rules, other than that the mother must be guided by the unique patterns of behaviour of her baby.

vi. Wider concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vii. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

Postnatal visit 3 - Day 17 - 21

Agenda for this visit:

- i. Tuning in to mother
- ii. Completion of Behavioural and Interactive Assessment of the Baby
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

ii. Completion of the Behavioural Interactive Assessment of the Infant

While you will not on this occasion formally perform the Behavioural Interactive Assessment of the Baby, you might want to complete certain items of the assessment that could not be completed in the previous session.

iii Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes.

v. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

Remember to arrange for the next visit to be at bath time so that you can demonstrate baby massage for the mother.

You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present.

Postnatal visit 4 – 4 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. Discussion and input: sleeping
- iii. Discussion and input: crying and consolability
- iv. Wider concerns
- v. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

ii. Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iii. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.

Refer to the Postnatal visit 2 notes.

iv. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy

should be aired again, and strategies to help make most effective use of resources discussed.

v. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

The mother should be reminded that at the next visit you will be carrying out the Behavioural Interactive Assessment of the Baby again.

You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present.

Postnatal visit 5 – 5 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. The Behavioural and Interactive Assessment of the Baby
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

On this visit the Behavioural and Interactive Assessment of the Baby will be repeated. As arranged during the previous visit, you should include mother's partner, co-habiting grandparent or older children in this visit.

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

ii. Behavioural and Interactive Assessment of the Baby

This assessment should be repeated in full.

The baby's development over the weeks can be seen and should be highlighted. In the light of these changes, you should review with the mother strategies for care giving.

Give special attention to the social interaction items. Emphasise any social responsiveness shown to the mother.

iii. Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.

Refer to the Postnatal visit 2 notes.

v. Discussion: Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

- Arrangements must be made for the next visit.

Postnatal visit 6 – 6 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. The Behavioural and Interactive Assessment of the Baby – only the social interactive package and imitation, responsiveness and reciprocity
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise**.
2. When you feel that the mother has had sufficient time to express all her **concerns**, gradually and with sensitivity, introduce the other issues on your own agenda for the session.

ii. Behavioural and Interactive Assessment of the Baby – items 9 and 10 only

On this visit items 9 (social interactive package) and 10 (imitation, responsiveness and reciprocity) of the Behavioural and Interactive Assessment of the Baby will be repeated.

As the visits progress, the emphasis needs to focus more and more on the social interactive items of the assessment – the imitation, sensitive responsiveness on the part of the mother or father towards the baby, reciprocal games and other conversations or communications, and thinking and reflecting on how you understand the baby's behaviour.

You will need to model face-to-face interactions in the form of reciprocal and sensitive exchanges with the baby and look for opportunities to comment on the mother's and father's sensitive and reciprocal face-to-face interactions with the baby when they occur.

You may also need to help the mother to position the baby to facilitate engagement during feeding and at other times.

iii. Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.

Refer to the Postnatal visit 2 notes.

v. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

Remember to arrange for the next visit to be at bath time so that you can demonstrate baby massage for the mother.

You should discuss with her whether her partner, or older children, or any other important figure in her life who might be involved with the care of the baby, could be present.

Postnatal visit 7 – 7 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. The Behavioural Interactive Assessment of the Baby
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise** as a result of the issues raised in the previous visit.
2. When you feel that the mother has had sufficient time to express her concerns, **gradually and with sensitivity, introduce your own agenda for the session.**

At all times be aware and ready to recognize, point out and praise any positive, sensitive, responsive, loving, attuned, observant, emotionally expressive communication and interaction between the mother/caregiver and the child.

ii. The Behavioral Interactive Assessment of the Baby

Repeat aspects of the Behavioral Interactive Assessment of the Baby, especially those highlighting infant social responsiveness.

iii. Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.

Refer to the Postnatal visit 2 notes.

v. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

- Arrangements must be made for the next visit.

Postnatal visit 8 – 8 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. The Behavioural and Interactive Assessment of the Baby
- iii. Discussion and input: sleeping
- iv. Discussion and input: crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise** as a result of the issues raised in the previous visit.
2. When you feel that the mother has had sufficient time to express her concerns, **gradually and with sensitivity, introduce your own agenda for the session.**

ii. The Behavioural and Interactive Assessment of the Baby

Run through the full assessment for the last time. Ask the mother to tell you about all the changes she has seen and pointing out how much development you have noticed.

iii. Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it. Refer to the Postnatal visit 2 notes.

v. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

Remind the mother or caregiver that as from next week your visits will only be every second week and then once a month from the fourth month. Explore and allow her to express her feelings about this change of routine.

Postnatal visit 9 – 9 weeks

Agenda for this visit:

- i. Tuning in to mother
- ii. Encouraging social interaction between mother / caregiver and baby
- iii. Discussion and input: sleeping
- iv. Discussion and input : crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

AGENDA:

i. Tuning in to mother

1. Enquire in an open-ended way how the mother has been since last seen and **listen and reflect on any concerns that the mother may raise** as a result of the issues raised in the previous visit.
2. When you feel that the mother has had sufficient time to express her concerns, **gradually and with sensitivity, introduce your own agenda for the session.**

ii. Encouraging social Interactions between mother and baby

The focus of the visits now shifts substantially to encouraging social interactions between the mother or caregiver and the baby.

Take advantage of the infant's pre-speech developing at this time and his or her fascination with mother's face and eyes. You will model face-to-face interactions and sensitive reciprocal exchanges in the form of verbal and non-verbal conversations with the baby. Comment to the baby about what is going on around her or him and reflecting on how baby might be experiencing this.

Try to find an opportunity to see the mother interact face-to-face with the baby. Help the mother to position the baby to facilitate social engagement.

iii. Discussion and input: sleeping

Discuss the baby's sleeping.

Refer to the Postnatal visit 2 notes on sleeping.

iv. Discussion and input: crying / consolability

Discuss the baby's crying and how the mother is managing with it.

Refer to the Postnatal visit 2 notes.

v. Wider Concerns

You should be alert to the mother's general circumstances and, in particular, to the kind of support she has available. Issues that were raised in pregnancy should be aired again, and strategies to help make most effective use of resources discussed.

vi. Ending off and preparations for the next visit

Arrangements must be made for the next visit.

Remind the mother or caregiver that as from next week your visits will only be every second week. Explore and allow her to express her feelings about this change of routine.

Agenda for P10 – 15 visits:

- i. Tuning in to mother
- ii. Encouraging social interaction between mother / caregiver and baby
- iii. Discussion and input: sleeping
- iv. Discussion and input : crying and consolability
- v. Wider concerns
- vi. Ending off and arrangements for the next visit.

Postnatal visits 10 – 15

Postnatal visit 10 –11 weeks
Postnatal visit 11 – 13 weeks
Postnatal visit 12 – 15 weeks
Postnatal visit 13 – 17 weeks / 4 months
Postnatal visit 14 – 21 weeks / 5 months
Postnatal visit 15 – 25 weeks / 6 months

Additional input:

Postnatal 12 visit:

Remind the mother that after your P13 visit you will be visiting her on a monthly basis. Explore and allow her to express any feelings regarding this change.

Postnatal 13 visit:

Discuss changes in the baby's social responsiveness with the increase in maturity. Remind the mother that you only have two more visits before this programme comes to an end. The baby's eyesight has developed and the baby can now see better at a distance. This will mean his interest will shift away from just playing face-to-face, to events and objects further away. The mother's understanding this shift and noticing the baby's new interests, will allow her to respond sensitively in new ways: following the infant's interest, starting to play simple body games, such as, 'peek-a-boo' and 'round and round the garden'.

Postnatal 14 visit:

Remind the mother at the beginning of this session that you only have one visit left before this programme comes to an end. Now the baby will be able to reach out and grab things nearby; again if the mother follows the baby's cues, she can use this new development to have different social experiences with her baby that will hold the baby's interest and give enjoyment.

Despite the best preparation there will be mothers who will have very strong feelings of abandonment and sadness about this ending. You need to be aware of this even though this may not be conscious in the mother or

expressed openly to you. Remind the mother that as part of the study there will be further assessments of her and her baby and this will provide her with further opportunities to express any concerns she may have.

Postnatal 15 visit:

You will need to say goodbye to the mother and her baby and the others with whom you have worked in the household. It might be helpful to review, with the mother, what this has meant to her and what she feels she has learnt through the process.