Australian Association
for Infant Mental Health

Infants in Women's Refuges/Shelters

Purpose of AAIMH

The Australian Association for Infant Mental Health Ltd (AAIMH) is a not-for-profit organisation of professionals from a range of disciplines including health, education, and welfare, dedicated to the field of infant mental health. AAIMH's mission is to work for all infants and young children from pre birth to age three to ensure their social, emotional, and developmental needs are met through stable and nurturing relationships within their family, culture, and communities. This is achieved by supporting families, professionals, and communities to hold infants in mind, to honour the subjective experience of the infant and to assist parents/caregivers in building nurturing and strong relationships with their children, including enhancing their awareness of the causes and signs of mental, physical, and emotional stress in infants.

Purpose of position paper

The purpose of this position paper is to describe AAIMH's position on the vital importance of recognising and prioritising the social and emotional wellbeing of infants in Refuge/Shelters1 with their mothers/caregivers after fleeing family violence. The paper aims to serve as a guide for policy makers and staff working in domestic and family violence (DFV) services, family support services, non-government organisations (NGOs), the justice system, child protection services, and all those involved in decisions affecting the social and emotional wellbeing of infants in refuge/shelter. The focus of this paper is on infants up to the age of four, although much is relevant to children of all ages. AAIMH believes that the best interests and subjective experience of the infant should be the primary consideration for all decisions involving their care, safety, and welfare.

Definitions

There are two separate, though not mutually exclusive, meanings of the word 'refuge'. The word 'refuge' is used interchangeably with such words as '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 (i.e., a physical dwelling or entity) and is used today to mean both a place and/or a state of being, where safety is felt (Stevenson, 2010). These two strands of meaning point to refuge as either

[1] Refuge with a capital 'R' refers to a building or space which providers physical shelter, whereas refuge with a lowercase 'r' refers to the experience of feeling emotionally safe through relationship with others.

an 'entity' (a building or shelter) and/or a 'subjective experience' (feeling protected and safe from harm). The state of refuge will be delineated by the use of a lower case 'r', while the place of Refuge will be delineated by the use of a capital 'R'.

refuge (the feeling)

At the core of this position paper is an understanding of what makes an infant feel safe. This includes an understanding of what occurs specifically for the infant to provide them with 'refuge', in a place specifically created to offer shelter.

Every infant actively seeks out and/or maintains ready access to a familiar person, to feel secure and protected in case of a threat. This is something which Bowlby (1988) believed 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.

In ordinary circumstances when frightening things happen within the caregiving environment the carer steps in and protects and soothes the infant. This offers relational containment which settles and brings a physiological safety felt by the infant. The response does not have to be perfect, as seldom will the caregiver provide exactly what the infant needs exactly when they need it; nor is it useful for them to do so. Simply being 'good enough' provides the infant with a sense that when things feel upsetting or unsafe, the primary caregiver will step in and shield them from harm. To do this well enough and often enough allows the infant to feel as though the 'ordinary' primary caregiver(s) are reliable (Tronick, 2007; Winnicott, 1960).

Refuge (the place)

The concept of 'Refuge' as a place generally refers to a 'dwelling' or 'location' away from harm. It may provide physical distance from the cause of the harm, but the feeling of safety, experiences of comfort, and freedom from harm or distress is not simply a physical location but a psychological and visceral experience (Schore, 2003).

Women's Refuges are interchangeably known as half-way houses, havens, safe houses and shelters (Mizrahi & Davis, 2008). Refuges are considered one of the main 'crisis accommodation' options specifically for women and children who are leaving DFV and have nowhere else that is safe to go. Within Australia the terms Refuge or Shelter are mostly used. In 1974, Australia's first women's Refuge was established in Sydney (McFerran, 2007). Women who worked within the Refuge space argued that women fleeing DFV were in fact not homeless but rather "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.

Domestic and Family Violence

The term 'Domestic and Family Violence' (DFV), is commonly used within Australia to encompasses such terms as Intimate Partner Violence (IPV), Domestic Violence (DV) and Family Violence (FV). Within Australia, 'The Family Law Act' (Section 4AB) 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).

All genders can use violence and can be victims of familial violence. Reciprocal couple violence remains an unacknowledged issue within the family violence arena (Dutton, Saunders, Starzomski, & Bartholomew, 1994; Wangmann, 2011). It is generally accepted, however, that men perpetrate more severe physical violence and that women invariably are at greater risk of injury or death in violent heterosexual couple relationships. (Straus, Hamby, Boney-McCoy, & Sugarman, 1996; Straus & Michel-Smith, 2014). However, it is arguable to contend that the violence used by women is equivalent to that used by men, "as men's violence and women's violence differs in its contexts, its consequences, and its meanings" (Loseke & Kurz, 2005, p. 92). Violence within same sex couple relationships or where a partner is transgendered or identifies as non-binary has only recently garnered any significant attention (Rogers, 2021). Women in same sex relationships appear to experience DFV at "similar or somewhat higher rates than females in opposite-sex relationships" (Badenes-Ribera & Bonilla-Campos, 2021). Of the limited studies into DFV within trans and non-binary relationships, significant obstacles to accessing help from police, support services and Refuges exist, primarily due to entrenched homophobia and heterosexism (Guadalupe-Diaz & Jasinski, 2017). "Marginalised victims, including those who are culturally and linguistically diverse, LGBTIQ+, disabled, young, elderly, and Indigenous, encounter more barriers unaccounted for in their experiences of partner violence" (Workman, Kruger, & Dune, 2021, p. 547).

The infant experiencing DFV

The impacts of DFV and the subjective experience of the infant are under-researched and rarely acknowledged. Infants are often rendered invisible in our current approaches to thinking about and addressing DFV. Further still, there is a glaring absence of enquiry into the experience of the infant made homeless, along with their mother (or caregiver) when fleeing DFV (Bunston, Frederico, & Whiteside, 2021; Whitney & Basloe, 2019). This includes investigating or exploring the emotional and physical impacts of their direct exposure to DFV, the impacts on their still forming attachments and the additional often overwhelming implications of experiencing homelessness.

Australian Specialist Homelessness Services (SHS) data from 2020 – 2021 (AIHW, 2021) recorded 280 000 individuals and families seeking safe accommodation. Women were over-represented (77%) and family violence was cited as the predominant reason for seeking safe accommodation (79%). Aboriginal and Torres Strait Islander people (ATSI) were also over-represented (27%). Children under nine were the largest age group within this cohort, however infants (0-3), and young children up to five were not identified as a discrete developmental category. This is despite infancy being the most critical and rapid period of neuro-developmental growth across the lifespan (Zeanah, 2019). Little, if any specific data is collected on the number of infants identified as homeless, or who enter Refuge/Shelter with their mothers/carers to escape family violence.

Infants under five years of age are more likely to be present during, and, detrimentally impacted by exposure to DFV than any other age group in childhood, but least likely to receive any adequate service response or recognition (Easterbrooks, Katz, Kotake, Stelmach, & Chaudhuri, 2018; Lieberman, Chu, Van Horn, & Harris, 2011). Within Australian data, Aboriginal and Torres Strait Islander children are overrepresented in their exposure to and impacts of DFV and homelessness.

Attachment and early childhood development

"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). The infant develops within the context of their caregiving environment, forming a significant attachment to a specific caregiver/s which largely endures across time (Van Ryzin, Carlson, & Sroufe, 2011).

DFV reflects a 'disorder of an attachment' within a caregiving system according to Bowlby (1984). He believed violence, from male to female, or parent to child, tended to be transmitted across generations, and the excessive and distorted use of anger was used to prevent the threat of abandonment, maintain proximity or assert control over another. Bowlby (1984) was appalled that "family violence as a casual factor in psychiatry should have been so neglected by clinicians" (Bowlby, 1988, p. 9).

Conception

The circumstances surrounding an infant's conception has potential implications for their future mental health. This includes, for example, where infants are conceived through rape or coercion; a mother experiences increasing violence targeted at herself and the unborn foetus; a mother is prevented from seeking an abortion or feels trapped, or where the mother is accused of infidelity in relation to paternity. Such circumstances impact a mother's feelings and ideas about the baby growing inside of her. "Maternal representations" describe the process involved in how a mother comes to imagine what their baby is like, in character, temperament and personality, and is influenced by her own current circumstances and early experiences of being parented (Benoit, Zeanah, Parker, Nicholson, & Coolbear, 1997). Maternal representations are operationalised in the relationship through caregiving, and sensitivity of caregiving is crucial in the formation of attachment.

Sustained Exposure to DFV

Orr, Fisher, Preen, Glauert, and O'Donnell (2020) in their study of children born in Western Australia from 1987 to 2010, found that:

> *"Children exposed to FDV [family and domestic violence] are more likely to be hospitalised than non-exposed children. Children exposed to FDV in both the prenatal and early childhood period had a threefold increased odds of mental health hospitalisation. We found a significant increase in odds of pregnancy-related hospitalisation in FDV exposed children. When stratified by Aboriginal status, Aboriginal children had a higher proportion of hospitalisations than non-Aboriginal children"* (p.1).

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. Where their mother has experienced both past trauma and chronic homelessness, a child is less likely to enjoy a positive parent-child relationship (Perlman, Cowan, Gewirtz, Haskett, & Stokes, 2012).

Trauma

Early implicit memories, particularly those created through trauma, are believed to remain operating throughout our lives, acting as the foundation upon, and intimately linked with later developing explicit memories and a sense of self (Van der Kolk, 2014). The right brain, responsible for the emotional, non-verbal self is dominant in the first 24 months of life and is highly vulnerable to cumulative, traumatic events "which are imprinted into the neurobiological structures that are maturing during the brain growth spurt of the first two years of life, and therefore have far-reaching effects" (Schore, 2001, p. 208). Poor emotional development in the preverbal period impacts later developing, left hemisphere language, cognition and social capabilities (Schore, 2016; Van der Kolk, 2014). Teicher, Samson, Polcari, and McGreenery (2006) in their research into the various effects of childhood maltreatment found that the "combined exposure to verbal abuse and witnessing of DV was associated with extraordinarily large adverse effects, particularly on dissociation" (p. 997), an outcome which has profound implications for future interpersonal relationships, skill acquisition and learning.

Fathers

In the context of DFV, fathers, for better or for worse, remain significant attachment figures in the hearts and minds of many infants. The family violence sector, and Refuges have, in general, and perhaps understandably, poorly managed the complexity involved in respecting the complex attachments these infants have with their parent who uses violence. Refuges routinely neither invited (non-abusive) men (as staff) into the Women's Refuge space, nor entertain the idea of fathers being talked about as important and loved members of the families who enter Women's Refuges (Bunston, 2016). Very few (post violence) fathering programs exist in Australia or overseas for men who have used violence (Chung et al., 2020; Labarre, Bourassa, Holden, Turcotte, & Letourneau, 2016).

Whilst men are rarely employed in Women's Refuge's, and some Refuges still refuse older adolescent boys' entry into a Refuge altogether. Jones and Bunston (2012) argue that in therapeutic work with infants and young children that "some experiences, some of which may have been shared with the father, may have been loving and beneficial. It is incumbent, therefore, on infant–parent clinicians to think about love, when violence has felt to be so destructive" (p.229). This is equally relevant to work within Refuges. This is not an invitation to invite men who use violence into the Refuge space, rather recognition that infants and children will have complex attachments to both parents (whether heterosexual, same sex, non-binary or transgendered). It is incumbent on the part of Refuge staff to enable a space for that complexity for the infant and child, to be held, respected, and spoken about without judgement.

The Infant in Refuge

Children, four years and under, make up the highest group of children entering Refuge with their mothers (AIHW, 2012a; Shinn, 2010). Most of these children enter Refuge with their mothers to escape family violence (AIHW, 2012a, 2012b). Apart from this we know little else. Given that Women's Refuge's emerged some 40 years ago, this gap in our knowledge is astounding. Research undertaken by Bunston (2016) in eight shelters across three countries explored how infants found the experience of finding a sense of refuge within the walls of a Refuge. Her research found that:

1.The infant was not understood to have their own, separate experiences, resulting in them often being lost from view within the Refuge setting.

2. The mother, herself often traumatised, was expected to care alone for her infant, rather than the Refuge.

3. Only when the infant is in obvious distress do they receive attention, and usually from specialist workers outside of the Refuge.

4. It is often too painful for the adults in Refuge to see, or think, about the infant's trauma and distress.

5. The infant's father is either not spoken about, or with criticism, leaving the infant unable to make sense of this important person and their relationship with him.

6. The infant was often the reason the mothers sought Refuge, and why they were hopeful of building a different future.

For more information go to https://perspectives.waimh.org/2018/11/09/how-refuge-provides-refuge-to-infants-exploring-how-refuge-is-provided-to-infants-entering-crisis-accommodation-with-their-mothers-after-fleeing-family-violence-1/

A model of "infant led' Refuge/Shelter

The caregiving environment is, for the infant and child, their first and most formative experience of how safe Refuge/Shelter feels, why it is so important, and how and in whom to find and make use of finding refuge to replenish and grow. Refuge for the adult may or may not replenish and/or grow. Replicating and recognising satisfactory and/or healthy refuge is learnt in early childhood. Accessing refuge through destructive or damaging relationships or substances is more concerned with seeking refuge in what feels familiar rather than what heals. An infant and child led model of Refuge/Shelter is defined as all aspects of the Refuge experience combined to create healing. This is done so in a manner which recognises the foundational imperatives of what makes the infant and child feel safe and what makes mother (or any women/caregiver) feel safe. This approach recognises that the emerging subjectivity and neural development of the infant and child happens in the context of their primary and environmental relationships. It is therefore imperative to actively see, hear and hold the experience of the infant/young child in mind, to fan the hope that the newest member of the family holds for the mother/carer, and which includes the infant and young child in all aspects of Refuge/Shelter care. The infant/child's mother is integral to this now, and for most, the rest of their lives. The mother, herself potentially in recovery from years of relational trauma, needs relational recovery which holds her and her infant/children in mind now to inform her relationship with her child as a template for the rest of their lives together.

AAIMH's position on Infants in Refuge

1. AAIMH emphasises the critical importance of the early years (particularly conception to four years of age). Early experiences shape the architecture of the developing brain, establishing either a sturdy or fragile foundation for future development.
2. Infants exposed to DFV, and relational trauma are at significant risk of poor physical and mental health outcomes. DFV is the leading cause of children's homelessness in Australia.
3. Infancy is the most rapid developmental period in life. Infants experiencing DFV do not have the time to wait while their mother's recover from what is often significant and cumulative abuse. It is essential that the infant's needs are recognised and responded to in their own right.
4. Primary prevention of DFV is vital. Broader social and community views on gender roles, stereotyping and violence-supporting attitudes are associated with perpetration of DFV. Primary

prevention school-based programs focused on addressing these issues and equipping young people with the skills to form healthy and respectful relationships show promise. These need to be expanded with ongoing research.

5. A coordinated and collaborative response from child protection, family law, infant mental health and the DFV sector is required to improve outcomes for vulnerable infants.
6. Most women enter Refuge/Shelter with the motivation to ensure their infant's safety. Refuges are in a unique position to respond to the infant 'in their own right', while helping to heal and grow the infant-mother relationship.
7. The infant is often lost from view within DFV services, especially Refuges. Infants are seen as an extension of their mother, and it is expected that the infant's needs will be met by meeting the needs of the mother. Traumatised mothers are expected to be provide refuge for their infants and manage the emotional needs of their infant. However, it is often too painful for adults to see and reflect on the infant's trauma.
8. Refuge for an infant is not a building, but a relationship. The infant with an attuned responsive and sensitive caregiver has the opportunity to heal after experiencing DFV. An 'infant led' model of practice in the context of Refuge has the potential to revolutionise the DFV sector and improve maternal and infant outcomes. An 'infant led' approach places the infant and young children's relationships at the centre, using the mother-infant relationship to facilitate recovery for both the infant and mother.
9. The role of fathers needs to be incorporated into support work in the Refuge setting. The complex and sometimes conflicting relationship infants and young children may have with the male figures in their lives needs to be acknowledged and addressed. Without this, the infant has little or no means of how to make sense of how these figures feature in their lives, and therefore their early life and emerging sense of self.
10. Services and organisations within the DFV sector need to be adequately funded and resourced. This includes being staffed with infant mental health professionals who can work therapeutically with the mother and infant, focusing on relationship building opportunities with the infant and between the infant and mother.
11. Staff working in the DFV sector (especially Refuges) require ongoing professional development and support, including access to regular reflective supervision. These practitioners need to have the opportunity to regularly meet with a sensitive, trained supervisor (and ideally also trained in or familiar with infant mental health) to become aware of and reflect on how this work affects them on both a professional and personal level. Without this awareness, they may react to the stress and the strong feelings that this work may activate in them and may be less able to build and maintain safe, effective, and healthy working relationships with these infants and families.
12. AAIMH recognises the limited data available both internationally and in Australia on the experiences of infants in Refuge/Shelter. AAIMH advocates for increased attention and funding for research focusing on these infants and young children; reporting on the outcomes of such interventions and how to the develop, in the long term, infant-led approaches which harness the hope and healing opportunities that comes with mother/carers leaving violent relationship more often for their infant/child's safety that for their own.

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