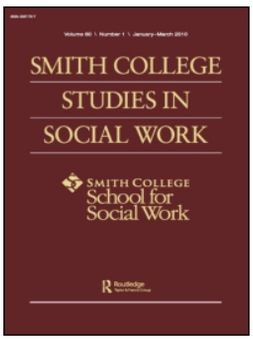

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Early Relational Health: Infants' Experiences Living with Their Incarcerated Mothers

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ABSTRACT

Little is known about the experiences and inner worlds of infants who live with their parents in prison-based residential programs. Infant observation and qualitative methods were used to study the experiences of seventeen infants living with their incarcerated mothers in a women's correctional facility. Glimpses into their inner worlds provide insights into factors that hearten and hinder early relational health. Practitioners and parents can use a relational health approach to recognize and cultivate budding capacities in infant-parent relationships. The researcher discusses the usefulness and relevance of infants' accounts for communities of practice and research.

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Infant observation; infants of incarcerated mothers; relational health; residential parenting program

Many infants in the United States have incarcerated parents (Pattillo, Weiman, & Western, 2004; Rebecca Project, 2010; Villanueva, 2009) and are at risk for poor social outcomes, partially as a result of disrupted attachment relationships (Cassidy, Poehlmann, & Shaver, 2010; Kjellstrand & Eddy, 2011; Lange, 2008; Myerson, Otteson, & Ryba, 2010). Although rigorous studies are few, parent–child relationship-focused interventions conducted in jails, as part of prison-based residential parenting programs, and during community-based alternative sentencing programs appear to positively affect parenting, attachments and infant and child behavior (Baradon, Fonagy, Bland, Lenard, & Sleed, 2008; Byrne, Goshin, & Joestl, 2010; Cassidy et al., 2010, 2010; Condon, Carver, Crawley, Freeman, & Van Cleave, 2010; Eddy et al., 2008; Fearn & Parker, 2004; Goshin & Byrne, 2009; Sleed, Baradon, & Fonagy, 2013). As more such programs are developed and tested, a body of research is accruing that provides insight into life stressors and felt experiences of incarcerated parents that can be used to help shape content and process, at least in regard to parents (Berry & Eigenberg, 2003; Borelli, Goshin, Joestl, Clark, & Byrne, 2010; Borja, Nurius, & Eddy, 2015; Fritz & Whitecare, 2016; Harris, 2014; Kjellstrand & Eddy, 2011; Whaley, Moe, Eddy, & Dougherty, 2008). Little is known about the experiences and inner worlds of infants and young children of incarcerated parents (Condon Weisenburg, 2011).

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What can infants communicate to us about their experiences? Quite a bit, it turns out. Attachment theory is the frame of reference for this study. Researchers working within that frame have pioneered the use of techniques to help in understanding infants' experiences. In the 1940s, John Bowlby and Esther Bick developed a clinical technique called infant observation. It has long been used to hone clinicians' understanding of the situated meanings of infant behaviors, infants' inner worlds, and the psychodynamics of infant–parent relationships (Bick, 1964/1987; Waddell, 2013). Work by scholars, practitioners, and researchers that is particularly relevant to the work conducted in this study include descriptions of attachment behavior (Ainsworth, Blehar, Waters, & Wall, 1978; Cassidy, 1999; Powell, Cooper, Hoffman, & Marvin, 2013; Spieker, Nelson, & Condon, 2011), how attachment relationships develop (Brazelton & Cramer, 1990; Cassidy, 1999; Crittenden, 2008; Karen, 1994; Stern, 1985, 1990, 1995, 2002), parents' states of mind (Crittenden & Landini, 2011; Powell, Cooper, Hoffman, & Marvin, 2007; Shlafer & Poehlman, 2010; Shlafer, Raby, Laler, Hesemeyer, & Roisman, 2015; Stern, 1995), factors that influence relationship development (Belsky, 1999; Berlin, Ziv, Amaya-Jackson, & Greenberg, 2005; Crittenden & Claussen, 2000; Fraiberg, Adelson, & Shapiro, 1975; Howes, 1999; McHale, 2007; Sameroff, McDonough, & Rosenblum, 2004; Shlafer, Raby, Laler, Hesemeyer, & Roisman, 2015), the inner worlds of infants (Lieberman, 1993), infants' attachment models (Johnson, Dweck, & Chen, 2007), infant mental health (Zeanah, 2009), and infant mental health interventions (Cicchetti, Rogosch, & Toth, 2006; Katz, Lederman, & Osofsky, 2011; Lieberman & Amaya-Jackson, 2005; Lombardi & Bogle, 2004; Makariev & Shaver, 2010; Osofsky, 2004). Collectively, this body of work influences policy as well as practice (Jones Harden, 2007) and the development of new research paradigms and tools. A relational health paradigm that has proved useful in describing trends in infant–parent interactions over time (Condon, Willis, & Eddy, 2016) also proved useful in understanding the relationship experiences of infants in the RPP.

Early relational health is a function of overarching emotional tone and mutual competencies that can be observed during interactions between an infant or toddler and a parent or caregiver. The fundamental concept is mutuality, meaning relational health is not the sum of individuals' skill sets. Relational health is a categorical description of a relationship between a young child and adult. When relational health is robust the following mutual capacities develop during the first 1000 days of life: engagement; enjoyment; responsiveness; attention; pacing; initiation; imitation; cooperation; mutual ability to recognize the other person's affect, develop a shared goal, and respond to challenges; and mutual engagement in pretend play, complex communication and language, and mutual ability to build bridges between ideas (Condon et al., 2016). In relationships with positive overarching emotional tone, the parent and child develop and practice mutual capacities that sustain and strengthen their

connection with one another almost effortlessly. Positive overarching emotion does not mean there are never missteps, ruptures, and upsets, only that a sense of warm connection predominates, and that ruptures can be readily repaired. Over time, these dyads develop and sustain secure, mutually heartening relationships. When overarching emotion in interactions is less than positive or negative, efforts to connect are constricted or stymied. Negative overarching emotion does not mean there is never laughter, only that missteps, ruptures, and upsets occur frequently, and are not easily repaired. In relationships with less than positive or negative overarching emotional tone, one or the other person may demonstrate skills but mutual capacities are weak or absent. These dyads are at risk for sustained relationship difficulties.

This study focuses on the early experiences, inner worlds, and relational health of seventeen infants living with their incarcerated mothers in a women's correctional facility. The term "inner world" pertains to the desires, ideas, expectations, and preferences that infants conveyed through emotional expressions, shifts in attention, and a wide range of behaviors during interactions with their mothers and environment. The infants and mothers lived together in a special unit known as the Residential Parenting Program (RPP). Monday through Friday, infants also participated in an on-site Early Head Start (EHS) intervention program. Through observations and interviews that occurred over a period of 2 years, thick descriptions of infants' experiences and interactions in different contexts with their mothers and other people provided glimpses into infants' relationship experiences and inner worlds. A researcher (and the author of this report) who is a social welfare scholar, early childhood special educator, and infant mental health practitioner conducted all observations and interviews. This report focuses on two key issues: variability in early relational health for mothers and infants living in the RPP and factors that impacted infants' experiences and the development of infant–mother relationships.

Method

Qualitative methods were used to gather and analyze content from infant observations, participant observations, and interviews with infants' mothers and other caregivers. Protections for participants were reviewed and monitored by the Internal Review Board of the University of Washington.

Sources of information

Participants

Seventeen mothers and their infants participated in infant observations. Mothers were diverse in terms of race, language, ethnicity, religion, age, sexual orientation, health, social class, and culture. Ages of mothers ranged from 18 to 42 years. Ages of infants ranged from newborn to 29 months, and

41% of infants were firstborn children. At the time of this study, 34% of the infants had disabilities, Individual Family Service Plans, physical or occupational therapy, and early childhood special education services. In terms of race, 5% of infants were African American, 12% were Native American, 18% were Latino/a, 24% were mixed race, and 41% were White. Most mothers spoke English with their infants (82%). A minority (29%) had high school diplomas or GEDs at the time of their incarceration. Like most incarcerated women in the United States, these mothers struggled with addictions, posttraumatic stress, and the stress associated with life in prison (Borja et al., 2015; Fritz & Whitecare, 2016; Harris, 2014). Chemical dependency was a factor in the health of 88% of the mothers. Many mothers struggled with mental health problems: 29% had dual diagnoses, including mood disorders, and 41% had severe trauma histories and posttraumatic stress disorder.

Context

The women's correctional facility within which this study was conducted is unusual in that, despite generally operating at 117% of capacity, it offers an RPP for eligible offenders who will be released within 30 months of the birth of their infant (Condon Weisenburg, 2011; Fearn & Parker, 2004; Kopec, 2010; Quillen, 2011). A collaborative partnership between the correctional facility and a local EHS program conceived and sustains the RPP. The partnership began in 1999. The RPP allows certain pregnant offenders to return to the corrections center with their infants after delivery in a community hospital. Before acceptance into the RPP and the birth of their children, offenders must meet several criteria including (a) serving a sentence of 30 months or less; (b) completing a satisfactory essay and written application; (c) a records review that shows no outstanding warrants, no major infractions since entering the institution, no open children's protective services cases, and no convictions for violent crimes, crimes against children, or arson; (d) satisfactory in-person individual interviews with corrections counselors; and (e) an in-person interview with a panel of corrections and EHS staff.

Infants remain in their mothers' care in the RPP until their mothers' release. The RPP is segregated from the general population in the minimum security section of the corrections facility. Each mother and infant lives in an individual room. Up to 20 dyads can be enrolled in the RPP at a time. Notably, the 20 rooms that are dedicated to 20 RPP dyads are actually capable of housing 80 offenders. From the age of 6 weeks, infants are also in the care of experienced EHS infant and toddler educators in a high-quality, on-site child development center. EHS educators provide relationship-focused therapeutic care for children on Monday through Friday while their mothers are in school or at work. They also provide individual "home" visits in mothers and infants' RPP rooms, parenting classes, referrals, and other support.

The RPP aims to reduce recidivism and improve the outlook for children affected by maternal incarceration by enhancing the quality of mother–infant relationships, parenting knowledge and skills, and children's development during the first 2 years of life. Despite the many positive aspects of the RPP, prison life is stressful and particular expectations within the RPP may make it even more stressful. There are higher expectations for offenders in the RPP than there are for offenders in the general population. The risk of expulsion from the RPP constantly overshadows mothers and infants. Sometimes an offender in the RPP is demoted for rule infractions before she and her child complete the program. In this case, mother and child are immediately separated, the mother is moved to a higher-level custody unit, and the child is sent to live with someone outside the prison. Infants and mothers cannot return to the RPP after expulsion. Despite many stressors, most mothers complete the program with their children, and after release most have not returned to prison (Fearn & Parker, 2004; Kopec, 2010).

Data collection

The researcher used ethnographic and observational techniques (Atkinson & Hammersley, 1994; Emerson, Fretz, & Shaw, 2007) to generate "thick" descriptions of infants' experiences; circumstances in which infants in an RPP develop relationships with their mothers and other caregivers; and situated meanings of infants' behaviors (Sandelowski, 2000). Specifically, participant observation, interviews (Mishler, 1986) and a reflective technique called infant observation (Waddell, 2013) were used to gather redundant content about infants' experiences and the context within which they develop relationships with their mothers and other caregivers. Data were collected over a nearly 2-year period of weekly visits (year 1) and twice-a-month visits (year 2). Altogether, 1390 hours of participant observation, infant observations, and interviews generated 1300 pages of field notes and transcriptions.

Infant observation

Seventeen infants were observed with their mothers from birth or early infancy until the mothers were released from prison. Each observation lasted 45 minutes to 1 hour. Videotapes of observations were not allowed. To understand the situated meanings of infants' behaviors, the researcher also observed infants with other caregivers besides their mothers, for example EHS educators, incarcerated caregivers, and other RPP mothers. Each infant and mother were observed in six specific contexts: (a) first moments after birth in the hospital or the mother's return to the RPP with her newborn; (b) routine transitions, separations, and reunions; (c) intimate moments such as bathing, changing, feeding, being settled to sleep, or greeted when waking; (d) parent–child play; (e) socializing with other adults and infants; and (f) the

morning of release from custody. The researcher wrote a detailed description of each observation on the day it was made (Waddell, 2013). Additional notes were made about (a) nuances in infant behaviors and indicators of degrees of attunement and synchrony in relationships; (b) infants' interests and needs; (c) adults' interests and needs; (d) the goodness of fit between infants' and mothers' needs and interests; (e) who the infant tried to engage; (6) who tried to engage the infant and for what purpose; (g) moments of engagement, responsiveness, shifts in attention, imitation, circles of communication, attachment strategies, and moments of delight, pleasure, flat affect, displeasure, distress, and extreme distress; (h) shifts in infants' emotions when they were in the presence of different people; (i) infants' temperaments; (j) mothers' temperaments; (k) the goodness of fit between infants' and mothers' temperaments and their temperament challenges; and (l) how mothers and infants managed transitions and coped with challenges. Sometimes observations were interrupted by prison-wide events like population count, staff shift changes, restricted movement, mail call, or summons to officers' stations. Depending on infants' and mothers' states after an interruption, the observation was either resumed or rescheduled.

Interviews

After each observation, mothers, other caregivers and/or EHS educators were asked questions about their experiences and their perceptions of the infant's behaviors during the observation. Examples of questions include (a) *I know my being here, watching your baby with you, is bound to change things for you and your baby. I wonder what parts of the experience that you and your baby had with one another today were typical, and what parts felt really different for you;* (b) *I saw you* (three- to five-word description of the mother's action at a particular moment in the interaction with her infant). *How did you know to do that?* (c) *What was going on for you when* (brief reference to the moment). *What do you think might have been going on for your baby at that moment?* (d) *What did you enjoy most?* (e) *What do you think your baby enjoyed most?* Responses to questions helped the researcher understand the significance of particular moments, events, activities, and interactions for mothers, and juxtapose and check their perspectives with hers. Most interviews lasted 45 minutes, with length depending mostly on the co-occurrence of aforementioned prison-wide events. Interviews were audiotaped and transcribed. Interviewees were invited to review their transcripts. All chose to do so, and few had edits. All the mothers asked to talk with the researcher about insights that came to them during the transcript review process.

Analyses

Empirical phenomenological techniques were used to analyze data in a multistep process: (a) studying first-order constructs and bracketing

hypotheses; (b) constructing second order constructs; (c) checking for unintended effects; and (d) relating results to practice, policy and future research (Aspers, 2009).

Process

Structured methods of analysis were used to counterbalance relatively unstructured methods of data collection. The researcher began studying first-order constructs by rereading content and generating codes, infant by infant. Content was compared and categorized according to context, participants, events, and types of experiences, behaviors, themes in adult narratives, and themes in infants' accounts. The researcher studied (a) how infants and adults used gaze, movements, facial expressions, touch, voice, and proximity/distance to engage and disengage with one another, rises and falls in energy between them, and the rhythm of their actions and utterances; (b) initiations, responses, circles of communication, moments when adults and infants imitated one another, elaborated on their own actions or utterances, and added to the other's actions or utterances; (c) situated moments of cooperation, missteps, ruptures, and repairs; (d) how infants engaged and disengaged with different adults, and shifts in emotions and attention when a third person entered the interaction or the context changed. Second-order constructs focused on (a) the situated meanings of infants' and mothers' behaviors, activities, identities, roles, and relationships; (b) the focus and significance of infants' and adults' communicative attempts and behaviors; (c) indicators of their emotional and social experiences; (d) moments in which mothers showed awareness of their own and their child's inner worlds (reflective capacity); and (e) high-stress moments during which it was very difficult for mothers to be anything but self-centered, reactive, self-protective, or dismissive of their children's experiences. Patterns in infants' experiences were organized along continuums: (a) frequency of being held in a beloved's mind; (b) safety, comfort, and relaxation in mother's presence, or not; (c) present, inconsistent, or absent circles of security (Powell et al., 2013); (d) frequency of intrusive, distressing experiences with mothers and other adults, being shown off or being handed to a relative stranger, versus being protected and transferred from the arms of one familiar, safe adult to the arms of another familiar, safe adult; and (e) frequency of moments of serenity, confusion, fear, anger, or despair. The process of toggling between content grouped by codes and coded content (Sandelowski & Barroso, 2003) led to understanding of the phenomenon of living with mother in an RPP.

Unintended effects

The researcher's presence, interest, activities, and questions combined with her nonjudgmental and reflective stance had unintended effects on participants, the

research process, and context. For example, incarcerated mothers, other offenders, officers, counselors, and educators who watched the researcher watch infants and heard her wonder with adults about infants' experiences were curious. Several asked, "What is the baby saying now?" or "What do you think she's thinking or feeling?" and moved to the researcher's side as if trying to see the infant's behavior or experience from a new perspective. Many said they had never thought about babies having thoughts, ideas, or perspectives. The presence of a civilian researcher, interested in infants' and adults' perspectives, who positioned incarcerated mothers as experts and valuable informants precipitated shifts in discourses and practices (Condon Weisenburg, 2011). It also created tension. Corrections administrators and long-term (non-RPP) inmates repeatedly asked the researcher, "Why not just tell them (or us) what to do?"

Bias and trustworthiness

Given her training and experience, the researcher was predisposed to see and think about a variety of issues in ways that influenced her impressions and interpretations. These include dynamics of rank and status, marginalization and oppression; infants' welfare; developmental differences; secure, insecure, and disorganized attachment strategies; evidence of trauma, resilience, chemical dependency, and mental health and illness; and differences in executive functioning and reflective capacities among participants. Further, at the beginning of her work, the researcher was naive about prison environments and routines; corrections systems; the dynamics of life in a women's prison; competing discourses within a prison containing an RPP unit; and meanings associated with her position as a civilian researcher in a prison (Byrne, 2005; Harris, 2014; Tewksbury & Dabney, 2009). Thus, at times it was difficult for the researcher to maintain a reflective stance. Attempts were made to moderate researcher bias through (a) monthly reflective supervision; (b) using a diverse participant–stakeholder advisory board as the hub for discussion about content and process; (c) building an audit trail to cross-check data and document steps in the analytic process; (d) data triangulation; and (e) soliciting participants' help in making meaning of observations and narratives and judging the plausibility of conclusions. Reflexivity, sustained attention to relationships with participants, social context, and evidence of unintended consequences of research contribute to the trustworthiness (validity) of results (Creswell, 2003; Stige, Malterud, & Midtgarden, 2009).

Results

Overall well-being

The general context of the RPP was positive and remained that way throughout the course of the study. Infants lived, slept, and played in safe, pleasant indoor and outdoor spaces specially designed for infants, toddlers, and

mothers. A dedicated pediatrician visited the infants and mothers in the RPP monthly and saw infants and mothers in a community clinic as needed between times. All received therapeutic childcare through EHS. Every mother and infant had an EHS educator who held them in mind, supported and coached mothers in understanding, caring for, and relating with their infants. EHS educators, corrections officers, and counselors monitored infants' well-being daily. Infants had active and engaging day-to-day lives and appeared to be cared for well.

Relational health

Every infant in this study remained in the RPP until at least 8 months of age and was clearly attached to at least one adult who served as a secure base and safe haven in daily life (Powell et al., 2013), meaning all infants had at least one relationship that heartened their development and internal model of attachment. Over half of the infants had consistently heartening relationships with two or more adults. Nearly 25% of infants only demonstrated secure attachment and positive relational health with an EHS educator or incarcerated caregiver who would not remain in their lives after their mothers' release from custody. In terms of infant–mother relational health, 12% of mothers and infants showed clear signs of positive relational health by 6 months of age. Over the course of time in the program, 47% of infants had mothers who became increasingly able to be emotionally present, calm, reassuring, and positively connected with them during daily routines. These mothers and infants became increasingly interested in one another's ideas, communication, and feelings. They invited responses from one another with nearly equal frequency and dominance as if they were accustomed to receiving positive responses to their attempts at engagement. These infants delighted in their mothers and felt their mothers delight in them. They tended to be calm, well-regulated infants. In contrast, 30% of infants had persistent unpredictable, less-satisfying relationships with their mothers and frequent experiences of dysregulation in their mothers' presence. In these cases, mutual interest waned and shifted to relationships with other people, and ambivalence or avoidance developed. At time of release, 18% of mothers and infants had robust positive relational health, 41% had positive relational health, and 41% remained at risk for relational health problems. The most meaningful, relevant, and differentiating aspect between infants' experiences was the extent to which their mothers were able to relate with them in authentic, healthy, and sustainable ways. Links were discovered between infants' and mothers' relational health, individual characteristics, and factors in the social environment that heartened, stalled, or thwarted infants' abilities to develop and sustain relationships.

Multiple caregivers

Attachment relationships for infants in the RPP develop in the context of multiple caregivers (Howes, 1999). The RPP is made up of a group of people who, despite having some characteristics in common, are thrown together by circumstance into close proximity and expected to function as a wholesome community. For some, but not all, participants, the RPP feels like a family. A family systems perspective is useful and relevant for considering what occurs over the course of mother–infant involvement in the program. The researcher saw shifts in relational health and dyadic functioning when the makeup of the cohort of RPP mothers and infants shifted as some were released and others were born. Thus, infants' experiences of "family" varied. Some RPP cohorts maintained a generally serene, predictable environment for infants and created a sense of community for mothers and children. Other cohorts were prone to drama, loud verbal altercations, unpredictability, and instability in adult relationships, resulting in greater irritability, neediness, and reactivity among their infants and high risk of disrupted infant–mother relationships secondary to demotions for infractions.

Reflective capacity

Mothers' responses to interview questions after infant observations revealed variations in their reflective capacities and mental states that corroborated indicators of positive and less-than-positive relational health. For example, mothers who struggled to identify and talk about their own feelings also struggled to remain sufficiently emotionally present to recognize and respond contingently to their infants' cues. Mothers who were able to respond to EHS educators' coaching and prompts to reflect on their infants' and their own experiences during play or childcare routines were more likely to enjoy interacting with their infants and sustain cycles of reciprocal responding that are essential for robust relational health. Some mothers were preoccupied or experienced diffuse distress or flashbacks to trauma during childcare routines like nursing or bottle-feeding, bathing, settling to sleep, and separations. These mothers tended to get angry with or avoid their infants, get other RPP mothers or caregivers to care for their infants, and (when their infants were calm and satisfied) ask them, "Do you love me?"

Two case studies

Contrasts in relational health are presented in Table 1. One is an example of positive-to-robust relational health; the other is an example of less than positive-to-worrisome relational health. "Penny" and "Tommy" are not the infants' real names. Both mothers were personable, single parents who had

Table 1. Variations in Relational Health.

	Penny (at 6 months)	**Tommy** (at 18 months)
Overarching emotion in interactions	**Positive** to **clearly positive**	**Less than positive** to **negative**
	Smiles on both faces; pleasant expressions; gentle touches; snuggling; relaxed postures; frequent eye contact; positive tones of voice and words. Penny is readily soothed. She reaches for mother and mother often leans towards her. Clear sense of safety in relationship.	Frequent flat facial expressions, frowns or grimaces on both faces. Mutual avoidance. Tommy is wary and stays out of mother's arms' reach. Mother scolds; teases; uses sarcasm and rough touch; attributes negative intents to Tommy's actions, expressions. Clear sense mother is not a secure base/ safe haven.
Mutual capacities during interactions	**Always observed**: Mutual engagement, enjoyment, responsiveness, pacing, attention, initiation **Sometimes observed**: Mutual imitation	**Sometimes observed**: Mutual engagement, responsiveness, attention, initiation, shared goal, complex communication **Rarely or never observed**: Mutual enjoyment, pacing, imitation, cooperation, recognition of other's affect, coping with a challenge, shared pretend play
	Penny's mother is emotionally present, supporting, touching and responding to infant's expressions, interests, vocalizations, and movements. There are moments of fussiness with quick recovery to calm, positive emotional experience. Penny and her mother respond to each other with changes in affect, attention and energy. They often delight in one another and reach for each other. They pay more attention to each other than to objects. Penny explores; notices her mother's attention; and builds on her support and energy. Her mother often imitates her vocalizations, and Penny repeats in a back and forth volley.	There are moments of eye contact, smiles and connection but generally separateness. Tommy and his mother react to one another. She ignores; questions or demands. He responds inconsistently to his mother's commands, invitations or guidance. Circles of communication do not last long. They can play in parallel but not interactively. Tommy sometimes initiates interests, but his mother responds inconsistently. They are often out of synch, and pay more attention to objects than each other. Tommy often watches his mother from a distance. His mother is often preoccupied. There are frequent snubs. Transitions are difficult for both.
Relational health (RH) summary	Infant–mother RH: **Positive** to **robust**	Toddler–mother RH: **High risk** for problems
	Infant–EHS educator RH: **Positive**	Toddler–EHS educator RH: **Positive**
	Infant–RPP caregiver RH: **Positive**	Toddler–RPP caregiver RH: **At risk** for problems
	Infant–grandmother RH: **Positive**	No relationships outside the RPP before release

high school diplomas or GEDs before incarceration. Both were incarcerated for nonviolent felony offenses. Both were active participants in the EHS program, earned college credits, and completed vocational training during incarceration.

Variability in relational health

An infant's mother, EHS educator. and incarcerated caregiver are the most constant people during an infant's daily life in the RPP. Other adults may be involved as well, but sporadically. For example, 41% of the infants had periodic opportunities to interact with grandparents, aunts, and siblings in a community room in the facility on visitation days and outside the facility on weekend excursions. Few had weekly or monthly visits that would enable relationships to truly develop. Some had no visitors. While she and her mother lived in the RPP, Penny had the opportunity to developing a heartening relationship with another person (her grandmother) who continued to be in her life on a daily basis after she and her mother were released. Tommy did not have a similar opportunity. By the time Penny was 11 months old, she was clearly using her mother as a secure base and safe haven (Powell et al., 2013). Penny and her mother behaved as if they felt safe, comfortable, and relaxed in each other's presence. There was clear mutual enjoyment. When Penny's mother came to pick her up from care, she smiled and approached Penny with open arms. Penny smiled in return or showed off, then crawled directly to her mother's arms. Adults smiled and commented on how happy Penny was to see her mommy. Penny's and her mother's interest in and affection for one another continued for the duration of their time in the RPP. At 11 months of age, Tommy could crawl faster than he could walk. When he saw his mother enter a room to pick him up, he immediately dropped to his knees; crawled quickly and silently to a far point in the room, and then turned, sat, and solemnly watched his mother from a distance for 3 minutes or longer. His mother greeted adults and sought their attention instead of his attention. Adults' attention invariably shifted from Tommy to his mother. Tommy's mother often snubbed him by glancing toward him then warmly greeting other children and offering them toys, hugs, and attention. On the rare occasions that she approached him, Tommy determinedly evaded his mother, crawled to the arms or legs of another caregiver, or got busy playing elsewhere. Time and again, adults either did not notice Tommy's behavior or interpreted Tommy's avoidance as independence, "flirting," reluctance to leave "school," or being a "typical" active boy. Adults seemed unable to see the reunification ritual from Tommy's perspective or its significance for his future well-being. Both dyads were considered successes at the time of their release from custody for the following reasons. Both mothers completed college and training

during their time in the program, meaning they had good employment prospects after release. Both had infraction-free records. Both left with healthy, typically developing, personable children. Six years after release, Penny, her mother, and their relationship are thriving. They are well connected to a network of positive formal and informal supports. Within a month of release, Tommy had begun experiencing a series of traumatic events and periods of abandonment and neglect. Less than 1 year after release, Tommy's mother was reincarcerated and he entered the child welfare system. Predictors of incarcerated parents' "success" after release do not necessarily align with predictors of infants' well-being.

Discussion

The purpose of this study was to document infants' early experiences and situated behaviors while living with their incarcerated mothers in an RPP, to understand their inner worlds and relational health. Despite a general context that remained positive throughout the course of the study, results showed variability in infants' experiences and relational health. Infant, mother, and larger systemic contributions to variability will be discussed categorically.

Infants' contributions

Infants' contributions to variability in their experiences and relational health were constitutional and maturational, namely the influence of health status at a given time on their energy, sense of ease in their bodies, and ability to breathe comfortably, sleep, eat, eliminate, move, and experience increasingly longer periods of calm alertness, pleasure, and regulation. These factors and temperament influenced infants' capacity for engagement, attention, enjoyment, and responsiveness to their mothers, other caregivers, and environment. The infants in this study were generally healthy. With one exception, none required special handling or sensitivity. Fortunately, in that case, the mother felt a strong bond with her infant, was emotionally present, enjoyed her infant, was exceptionally responsive to EHS educators' coaching, and steadily grew adept and confident in mothering her infant.

Mothers' contributions

Mothers' contributions to variability in infants' experiences and relational health are organized into five categories, namely the RPP mother's (a) health, (b) mindfulness, (c) relationship with her infant, (d) relationships with others, and (e) anticipation of a supporting matrix after release. Definitive examples of themes are presented in Table 2.

Table 2. Maternal Factors that Contributed to Infant–Mother Relational Health in the RPP.

Mother's health
Mother's physical and mental health and general well-being
The presence or absence of postnatal depression
Ongoing access to mental health care including timely prescription refills during incarceration
Sturdiness of recovery from chemical dependency, and awareness of triggers for relapse
Progress in transcending past traumas
Mother's mindfulness
Capacity for honesty, self-awareness, self-compassion, perspective taking, and impulse control
Ability to tune into her own needs, experiences in her body, emotions and thought patterns
Ability to self-regulate and help her infant be regulated during moments of stress
How mother reorganizes her identity during her time in the RPP
Mother's relationship with her infant
How predictably, accurately and sensitively mother interprets and responds her infant's cues
Ability to be emotionally present and to comfort her crying, fussy or irritable infant
Ability to think about her infant's temperament, experiences, feelings, and perspective
Continuity of access to a person with a positive internal model of infant–mother relationships who can support interactions when mother and infant struggle to relate with one another
Ways in which mother moves through space and social circles in the prison with her infant
How mother transfers her infant into the arms of another person and whether the other person is someone with whom her infant has a wholesome relationship
Extent to which mother intentionally protects her infant from exposure to interactions between offenders, or offenders and officers, that might be confusing or distressing for an infant
Mother's relationships with others
How mother relates to adults when her infant is and is not present, and to her infant when other adults and children are and are not present
Ability to respond to, relate and cooperate with other RPP mothers, other offenders, officers, counselors, and educators (as opposed to reacting, opposing, bargaining, or avoiding)
Motivation and ability to safeguard her relationship with her infant by not acting out, intentionally breaking rules or otherwise jeopardizing their time and place in the RPP
Reactions to shifts in status, rank, social dynamics, and rules in the RPP
Reactions when other mothers and infants come and go from the RPP
Mother's anticipation of a supporting matrix post-release
Anticipation of safety, security, and community support after release
Opportunities and ability to start building healthy relationships with people who will support the tough internal work and lifestyle changes that will be necessary to sustain sobriety, mental health, balance, and infant–mother relational health after release

Mothers' mental health affects infants' mental health and relational health. Sadly, the mental health system in the facility was overburdened during the time of this study, in part due to crowding in the prison. Priority access to mental health clinicians was understandably directed toward severe, acute cases that adversely affect custody unit functioning and offenders' and officers' safety. Consequently, when the system was particularly overburdened, there were lapses of 2 weeks or longer between refills for offenders' prescriptions. When RPP mothers with mood disorders experienced lapses in medication regimens, they were at risk for demotion and expulsion from the RPP, secondary to severe emotional dysregulation, ups and downs in mania, and depression. Their infants were confused and distressed. During these periods, infants' well-being depended on others' willingness and ability to calm them and care for them. It took time and effort to repair ruptures that

happened in these infant–mother relationships. Some were able to repair ruptures in 5 or 6 weeks, which is nonetheless a significant length of time in an infant's life. Others needed more time and extra support from EHS educators. Infants' life experiences are inextricably tied to their relationship experiences (Bowlby, 1988; Stern, 1985), meaning infants understand adults' behavior as a reflection of themselves. In the early months of life, infants do not differentiate adults' actions from how those actions make them feel. Over time, their experiences during interactions with their parents become a blueprint or inner working model for their developing sense of self, and set the stage for later relationship patterns (Cicchetti et al., 2006; Fraiberg et al., 1975; Lieberman & Amaya-Jackson, 2005; Osofsky, 2004). Consistent access to mental health care for parents and infants is needed when intermittent mental illness, chemical dependency relapse, hidden traumas or intergenerational patterns of difficulties in early relationships are a concern. This was the case for nearly nine of every ten infant-mother dyads in this study. A heartening factor in RPP infants' experiences may be their mothers' reasons for hope for their futures and their ability to envision better relationships with their children than they had with their parents. Mothers in this study who anticipated safety, security, and community support for lifestyle changes they began during their time in the RPP had more positive outlooks in general; they were more likely to be self-compassionate; to talk about fears, plans and resources; to enjoy their infants; and to help their infants form healthy attachments with people who would remain in their lives after release.

Caregivers' contributions

EHS educators and some incarcerated caregivers were able to serve as secure bases and safe havens for infants (Powell et al., 2013). This was an important relational health safety net for all the infants, particularly when infants and mothers struggled to relate with one another. For at least 8 months, every infant in this study had recurring opportunities to develop a positive sense of self, trust, emotional capacities, and skills they could use to generalize a positive model for relationships to future relationships. Some people question the merit of allowing infants to live with incarcerated mothers (Unity, 2001). In this study, every infant had positive to robust relational health with at least one adult. Neurodevelopmentally speaking, positive early parent– or caregiver–child relationships directly affect brain development and serve as a protective factor in future development and relationships.

System-level contributions

System-level contributions to infants' early experiences and relational health included (a) the corrections system's commitment to sustaining a high-

quality RPP; (b) the presence of on-site therapeutic care for infants in a high-quality EHS child development center; (c) ongoing collaboration between EHS and corrections personnel even when systems were under stress; (d) collaboration between corrections counselors, EHS educators and a community-based statewide organization of volunteers who helped many (but not all) of the mothers prepare for release in practical ways and generally made a commitment to remain connected with infants and mothers during their transition back to their local communities; and (e) corrections and EHS system's willingness to collaborate in an intense, qualitative, participatory study of the experiences and relational health of infants in their care. As findings emerged, corrections officers and other stakeholders imagined, advocated for, and enacted systems change, for example, revising internal RPP protocols and procedures and launching a statewide alternative sentencing program for mothers and fathers (Aguiar & Leavell, 2017).

Limitations

This study has several limitations. Data included thick descriptions of infant–mother interactions that included indications of relational health, but the researcher did not specifically collect relational health assessment data through standardized means. This study did not include following infants, mothers, and their relationships after release. Despite a desire to do so, the researcher was not able to videotape infant–mother interactions, watch them with mothers, and collect data about mother's reflections while watching their interactions. The researcher did not gather data across mothers about their inner working models of attachment, reflective capacities, physical, mental and relational health histories, and current status. Collectively, these additional data would provide some insight into the relationship models infants might develop. The incarcerated mothers of infants in this study feared and talked about the ever-present danger of making mistakes, receiving infractions, having to leave the RPP, and losing their children. These and other anxieties affected their mental states, ruminations, daydreams and nightmares, conversations, responses during interviews, and behavior. Prudence is needed in generalizing findings to other settings and populations.

Conclusion

This study adds consideration of relational health constructs to the literature on children of incarcerated parents. Variability in infants' experiences and relational health in an RPP has implications for social work practice, policy, and research. Systems could maximize relational health benefits to infants and toddlers who live with incarcerated parents by implementing collaborative cross-agency programs with aims that include positive early relational health,

participation in EHS or other infant–parent programs, and making prerelease planning for continued stability and positive relational health after release a priority. Crafting a supportive postrelease matrix for RPP infants and mothers means (a) making sure that there will be a smooth, immediate transfer to a EHS program, pediatrician, and a mental health care provider and (b) identifying a family member, friend, or community volunteer who demonstrates capacity for positive relational health with the infant before release and makes a commitment to remaining in the infant's life post-release. For different reasons, despite the quality of the programs, indicators of relational health for infants in this study were not apparent to the pediatrician, RPP counselors, and EHS educators who worked with them. If routine relational health assessments were a part of EHS services, parents, EHS educators, and RPP counselors would have opportunities to see strengths, vulnerabilities and change over time, and use the information to help them work with community providers in planning for release. Early indicators of relational health can be readily observed *in vivo* and in brief video clips by nonresearchers. Practitioners can learn to watch and discuss observations with parents and use parents' reflections to guide strengths-based, relational health-focused interventions (Condon et al., 2016). Weekly or biweekly consultation with an infant and early childhood mental health consultant would be a protective measure for children because (a) consultation would support counselors, officers, educators, parents, and other stakeholders in thinking about different levels of influence in difficult situations, interpersonal dynamics, and children's well-being; (b) help parents make choices that promote and protect their children's physical, mental, and relational health; (c) help stakeholders implement child- and relational health-centered decision-making; and (d) give stakeholders an indicator of the success of their efforts to promote stability for children and families affected by parental incarceration. Johnston and Brinamen (2006) describe a consultation model that could be adapted for use in prison- and community-based settings that aim to promote relational health and enduring benefits for infants, young children, and parents.

Jones Harden (2007) described infants' experiences in the child welfare system and suggested action steps to enhance their well-being. Her work mobilized and helped focus the efforts of advocates to change an overburdened and struggling system of care. This study is a step toward a similar treatise on behalf of infants whose lives are linked with corrections systems. Better understanding is needed of (a) the early experiences and relational health of infants and toddlers who remain in the care of their incarcerated parents; (b) associations between discourses in settings where infants and incarcerated parents receive services, parents' states of mind, and infants' and parents' relational health; (c) parallel processes of change and relational health outcomes in programs that do and do not embed infant and early childhood mental health consultation and reflective practices in their operations; and (d) longitudinal studies of the relational health of infants of incarcerated parents. The capacity of

infants' accounts to facilitate change in practices, policies, and systems will depend on the usefulness and relevance of findings of future phenomenological and mixed-methods studies to various communities of practice, particularly for the most vulnerable and marginalized populations of infants and parents.

Notes on contributor

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