IMPrint
Newsletter of the Infant Mental Health Promotion Project (IMP)
REPRINT
Volume 28, Fall 2000

RIGHT FROM THE START: AN ATTACHMENT-BASED COURSE FOR PARENTS

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Using attachment theory as a framework, we developed an 8-week parent-training course, *Right from the Start*, to enhance caregiver skills in reading infant cues and responding sensitively (Niccols et al. 2000). In developing the course, we also used current wisdom about parent training, adult education, and large group processes. This course was developed in the Infant-Parent Program in Hamilton and originally was offered to parents of infants with, or at risk of, developmental delay due to biological/ medical, and/or psychosocial risk. Since then, we have opened registration to any parent of an infant under 2 years of age. The primary goal of *Right from the Start* is to improve parent-child interaction in order to foster infant attachment security. We also anticipated that group participation and networking opportunities would have a positive impact on parent functioning.

Structure

Right from the Start involves eight 2-hour sessions offered weekly, in either the evening or morning. Sessions are held at a convenient central location with free parking. The course is free. We offer help with transportation (bus tickets), and we provide free onsite childcare. These features are important to minimize barriers to accessibility and maximize participation.

Content

Group sessions focus on parenting skills that promote infant attachment security, i.e., perceiving, interpreting, and responding sensitively to infant signals (see insert on pages 4-5 for a description of the content).

Format

Right from the Start uses the Coping Modeling Problem Solving approach (Cunningham et al. 1995). In this active learning model, parents watch videotaped segments illustrating common parent-child interaction challenges and then discuss the video segments in small groups of 4-6 parents. Each group is asked to identify the parenting error and its short- and long-term consequences ("What mistakes did you notice on the videotape segment?" "How does it make baby feel right now?" "How will it make baby feel over time?"). Then they are asked to suggest solutions and identify the advantages of the solutions ("What advice would you give to the parent in the video?" "What are the possible benefits of the advice you suggested?" "What would happen if that advice was used over time?"). Subgroup leaders (parents) report back to the large group and then professional leaders facilitate large group discussions.

We expected that this approach, in which participants formulate and publicly state their own solutions to parenting challenges, would a) improve parents' understanding of their impact on their infant, b) enhance parental attitude change and commitment, and c) increase parents' feelings of personal competence and control. Parents are given opportunities to practice their newly acquired skills through homework assignments. For example, at the end of Session 4, parents are asked to observe their child during the coming week and note a) some of their child's particular "I don't like it" cues, b) what the cues communicate to the parent, and c) how the child reacted when they practiced sensitive responding to the cues. Then, during Session 5, parents discuss their homework and receive peer support for their efforts.

Who Attends?

Typically, 15 to 30 parents attend *Right from the Start*. The larger the group, the more smoothly the course runs (i.e., with less reliance on professional leaders and better use of the model's intended process). Groups have been quite mixed in terms of parent age, socioeconomic/cultural status, and psychiatric and cognitive functioning, and in terms of the child's special needs. Parents are typically quite supportive and helpful to each other. Higher functioning parents provide role models for others, while reinforcing their own positive parenting skills.

Leaders

Right from the Start leaders are infant development specialists (i.e., trained and experienced staff from the Infant-Parent Program) with educational backgrounds in one or more fields, such as psychology, early childhood education, and social work. They also have training in parent education and experience in home visiting for families of infants with a variety of disabilities and those living in high-risk environments.

Why Focus on Parent-Child Attachment?

The parent-infant relationship is the focus of many early intervention programs because the development of infant attachment security is a primary issue in infancy (van IJzendoorn et al. 1995). It has been argued that secure infant attachment increases the probability of future mental health (Bowlby 1969).

Research has documented the positive association between secure attachment and curiosity, persistence, compliance, cognitive development and social skills (e.g., Matas et al. 1978). Insecure attachment has been related to later behaviour disorders (e.g., Lewis et al. 1984). Thus, secure attachment is considered a protective factor and insecure attachment is considered a risk factor.

Attachment and Parental Sensitivity. Attachment security arises from caregiving that involves sensitive responding to infant cues and signals. Bowlby (1969) emphasized the impact of the primary caregiver's sensitivity in perceiving, interpreting, and responding to the child's needs, and Ainsworth's detailed observations provided empirical support for this notion (Ainsworth et al. 1978). Meta-analyses of studies predicting infant attachment security from maternal sensitivity have confirmed that caregivers rated as sensitive are significantly more likely to have securely attached infants than caregivers rated as less sensitive (Atkinson et al. in press, De Wolff & van IJzendoorn 1997).

Studies of infants of depressed mothers and parents affected by other mental health problems, infants of adolescent mothers, and infants with developmental, sensory, or medical needs suggest that these infants may be at elevated risk for insecure attachment (e.g., Atkinson et al. 1999, Rodning et al. 1989). Parents of these infants may have difficulty responding sensitively due to their own emotional distress, their children's difficult temperament, cognitive limitations, and/or dampened responsiveness (e.g., Atkinson et al. 1999), and the interaction of these factors. Observational studies of parents and their at-risk infants reveal parent-child interactions that are characterized by infants being difficult to read (e.g., Field 1980) and parents being directive (e.g., Marfo 1991), neither of which may bode well for the attachment relationship. Interventions aimed at increasing caregivers' sensitivity (i.e., attention and responsiveness) to the cues and signals of their infants may promote attachment security, which may then have implications for future development across a variety of domains.

Attachment-based Intervention. Van IJzendoorn and his colleagues (1995) found that the most effective attachment-based interventions were short-term behavioural approaches rather than longer-term, intensive psychotherapeutic approaches. Their meta-analysis included studies involving a variety of at-risk samples.

RIGHT FROM THE START SESSION CONTENT

SESSION 1: Attachment Security: "What is it & why is it important?"

The introductory session focuses on the importance of infant attachment security and the relevance of sensitive, responsive parent-child interaction to fostering attachment. Participants view a short video clip and are asked to discuss the value and importance of providing positive attention to the child, mutually rewarding interactions, and infant attachment security, as well as the potential benefits of participating in the course.

SESSION 2: Parent-child Interaction: "How do you show me you love me?"

Parents answer the question, "How do you and your baby become 'attached'?" and are introduced to the idea that infant attachment security arises out of parent-child interaction that is sensitive, responsive, and mutually enjoyable. Video problem solving and practice exercises provide parents with beginning-level opportunities to consider how babies communicate without words, interpret the meaning of different types of infant behaviour, and to formulate strategies for sensitive response to infant cues.

SESSION 3: Child and Parent Personality: "I am unique and so are you."

The third session focuses on the role of temperament, how this concept applies to infants and their parents, the match or mismatch of temperamental styles of infants and their parents, the potential impact on parent-child interaction, and short- and long-term implications. This session's exercises are designed to introduce parents to the idea that each child has unique characteristics (i.e., reactions to events and people) that impact on their relationship with their parent, who also has unique characteristics. Parents are asked to identify characteristics in themselves and their infant that make parenting challenging, to proactively plan strategies to improve the interaction, to practice these strategies in home situations and to evaluate the results.

SESSION 4: Disengage Cues: "I don't like what you're doing right now."

Parents learn skills in observing and responding to their infants' disengage ("I don't like it") cues. Video problem solving and practice exercises provide parents with opportunities to identify potential cues in infant behaviour indicating when they "need some space" or do not like something about the current interaction. Parents develop skills in attending to these cues and sensitively responding to them (i.e., when and how to "back off" and reduce coercive exchanges).

McCollum & Hemmeter (1997) reviewed 10 studies of parent-child interaction intervention with parents of children with disabilities. Most studies provided evidence of improvement in parents' skills in perceiving, interpreting, and responding contingently to their children's cues. None of the interventions reviewed used a group format.

Why Use a Group Format?

Despite its potential for effective and cost-efficient parent education and support, group-based parent training is infrequently used in attachment interventions and/or infant development programs. Clinical trials of parent group training with parents of children with behaviour problems have shown improvements in child management skills, parenting stress and confidence, and children's behaviour (e.g., Cunningham et al. 1995). Clinical trials of parent training with parents of children with developmental delay have shown that it is effective in improving child self-care skills and behaviour (e.g., Hornby & Singh 1983). What is unknown is if a group-based approach to parent training enhances infant attachment security.

Group-based interventions take advantage of three mechanisms that are missing in individual interventions. First is the opportunity for social networking with other parents. Social support is an important contributor to family and child outcomes, and social isolation can adversely influence parenting (e.g., Dunst et al. 1997). Group approaches may be particularly well suited for parents of at-risk infants because they have specific experiences (e.g., high-level caregiving demands, child-rearing challenges, unpleasant social and extended family reactions, and feelings of guilt, anger, anxiety and depression) that may be common. Having contact with parents who are facing similar difficulties can provide emotional support, encouragement, practical assistance and potentially useful information (Seligman 1993). Furthermore, such parents may receive these benefits with a degree of social comfort that may not be possible with an individual therapist.

The second mechanism that is missing in individual interventions is the therapeutic impact of group processes. Individual interventions do not take advantage of group dynamics such as the power of group self-regulation (e.g., intolerance of extreme deviance, motivation for conformity) and the potential for

SESSION 5: Engage/Approach Cues: "I like what you're doing right now." "I need you."

Parents learn how to observe and respond to approach/engage ("I like what you're doing"/"I need you") cues, especially as they relate to comforting an infant in distress. Video problem solving and practice exercises provide parents with opportunities to identify infant cues that indicate when they want to be attended to or approached, or when they like something about the current interaction. Parents are also given opportunities to formulate, rehearse, and apply strategies for sensitive responding to these signals. Parents are encouraged to practice reading and responding to their own child's unique signals at home during everyday caregiving routines, during play, and when their child is in distress. Parents are also encouraged to identify factors that interfere with their ability to respond to their infant in a sensitive manner.

SESSION 6: Following Your Child's Lead: "This is what I'm interested in right now."

Parents learn how to follow their baby's lead in play, why it is important (the message of interest it conveys to the child), the impact on the relationship, when to use this approach to interaction, and how it differs from directive or disciplinary interactions. Video and problem solving exercises provide parents with opportunities to identify potential cues that indicate when an infant is alert and communicating "This is what I'm interested in right now." Parents develop skills in letting the child set the agenda for play, how to watch, wait, and listen;, and how to show interest by encouraging face-to-face interaction, imitating the child's actions and sounds, interpreting and commenting on their actions and play, and taking turns (all strategies that help parents connect with their children and "share the moment" in a natural way).

SESSION 7: Building a Healthy Relationship: "I like being with you."

The seventh session targets ways to build a healthy relationship with an infant. Parents identify strategies to encourage interaction that would help foster parent-child attachment, as well as infant communication and play skills, and the impact of a healthy parent-child relationship on the child, the parent, and the family.

SESSION 8: Wrap Up

In the final session, the concepts and skills necessary for sensitive, responsive parent-child interaction and fostering infant attachment security are reviewed. Parents are encouraged to share their thoughts and feelings about the group process and to give feedback on their experience. Each parent receives a "diploma" (and some cake)!

modeling effective "family" (group) functioning. Family functioning also may be improved if parents generalize what they have learned to relations with other family members. The third mechanism is parental empowerment. Individual interventions run the risk of disempowering parents (Dunst, Trivette & Deal 1994), whereas groups offer opportunities for parents to build confidence, for example, through the altruistic act of helping others (Seligman 1993).

Additional advantages of group approaches include access and cost. High-risk parents (e.g., economically disadvantaged, socially isolated, depressed) are least likely to enroll in or complete traditional individual treatment programs, whereas community-based groups may reduce psychological and logistic barriers to access. Cunningham and his colleagues (1995) found that their community parent education program was accessed more readily than individual clinic-based services by parents with low educational levels and poor family functioning. Further, individual treatment can be at least 250% more expensive than community group-based interventions (Cunningham et al. 1995).

Why Use a Facilitative Group Model?

Many group programs involve lectures and reading materials. This type of didactic approach may increase knowledge but not sustained behavioural changes. Parents may achieve a less than optimal understanding of the complex principles involved in parent-child relationships if the consequences of both positive and negative approaches to parent-child interaction are not adequately explored (Cunningham et al. 1993). Finally, didactic approaches produce little attitude change and commitment or feelings of personal competence and control (Meichenbaum & Turk 1987).

Coping modeling represents an alternative to more didactic approaches to parent training. Rather than demonstrating correct skills, coping modeling allows parents to confront difficulties, make errors, but eventually arrive at an appropriate solution (Masters et al. 1987). Coping modeling has proven more effective than didactic parent training in the management of anxiety disorders (e.g., Kazdin 1974). The Coping Modeling Problem Solving approach (Cunningham et al. 1995) addresses some of the drawbacks of traditional parent training by involving active learning of effective parenting strategies. Participants identify common parenting errors depicted by videotaped models, discuss their consequences, suggest alternatives, and formulate supporting rationales by identifying the advantages of the alternative approaches. Clinical trials conducted at the Chedoke Child and Family Centre have shown that this community-based approach is more effective in terms of availability, utilization cost and outcome than clinic-based individual training for parents of children with disruptive behaviour disorders (Cunningham et al. 1995). Although coping modeling approaches have been applied to parent training for behaviour management (Cunningham et al. 1995), social skills training (e.g., Kendall & Braswell 1985), and child anxiety disorder programs (Kendall et al. 1991), the approach has not been used in attachment-focused parent training previously. A group-based approach to train parents in attachment-promoting skills takes advantage of the benefits of this model in terms of its effectiveness as a method of parent education, and as a means of providing peer support and opportunities for social networking and parental empowerment.

Does *Right from the Start* Work?

Pilot Study and Client Satisfaction. A small pilot study (Niccols & Mohamed in press) was conducted to evaluate intervention efficacy as determined from a comparison of 12 intervention group parents and 5 waiting list controls on several parent-report measures. On standardized measures, intervention group parents reported significantly lower levels of dysfunctional parent-child interaction, parental distress and depression after the course than at pre-test. Control parents reported a trend toward higher levels of depression at post-test than at pre-test. Client satisfaction data showed that the course was highly valued: 100% of the parents said that they would recommend it to others, 92% thought the content was relevant, 88% found the quality of the group-based service good or excellent, and many were satisfied with the logistics of the course (number of sessions, frequency, duration, timing). Effectiveness also was highly rated: More than 90% of the parents reported better interactions with their babies and other children in their families, having become better at problem solving and more confident in reading their babies' cues, and having increased their knowledge about early development, at-risk infants, their own babies and community resources. Many reported having made new friends, enjoying their babies more, and feeling less stressed after participating in the group, and they chose less intense follow-up services than they had initially requested.

The Next Step in Evaluation. The pilot study involved a relatively small sample, an opportunistic wait-list control group, and parent-report measures only. The next step in this research is a randomized clinical trial using observational measures of maternal sensitivity and infant attachment security to compare *Right from the Start* to home visiting. This study has been funded by the Ontario Mental Health Foundation and is currently in progress.

Future Directions for *Right from the Start*

We plan to continue our efforts to integrate *Right from the Start* into an efficient, effective service delivery model in our community. We have developed a manual for leaders (Niccols et al. 2000) and would like to train potential *Right from the Start* leaders from other agencies in Hamilton and elsewhere in order to improve outcomes for infants.

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