Journal of Early Intervention

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Journal of Early Intervention 2000; 23; 133
DOI: 10.1177/105381510002300207

The online version of this article can be found at:
http://jei.sagepub.com/cgi/content/abstract/23/2/133

Published by:
SAGE Publications
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On behalf of:

Division for Early Childhood of the Council for Exceptional Children

Journal of Early Intervention, 2000
Vol. 23, No. 2, 133–143

Parent Training in Groups: Pilot Study with Parents of Infants with Developmental Delay

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This paper describes an innovative 8-week parent-child interaction skills training group for parents of infants with developmental delay. We developed the "Skill Building Group" within an attachment theory framework. Parents actively learned skills in sensitive responding to infant cues through small and large group discussion of video segments of common parenting challenges, homework assignments, and peer support. We conducted a pilot study comparing 12 participants and 5 controls on several self-report pre-test/post-test measures. Results for the intervention group indicated decreases in dysfunctional parent-child interaction, parental distress, sadness/depression, and follow-up service utilization, and high levels of consumer satisfaction. For the comparison group, pre-post differences were not significant.

Infant development programs provide service for families of infants with developmental delay, or who are at risk of developmental delay, due to established deficits (e.g., genetic conditions), biological factors (e.g., extreme prematurity), or environmental factors (e.g., poverty, parenting concerns). Currently, the standard intervention involves home visiting and a family-centered approach incorporating parent support and education. This paper describes an innovative service for parents of infants under 2 years of age with, or at risk of, developmental delay. Using attachment theory as a framework, we developed an 8-week parent-training group ("The Skill Building Group") to enhance caregiver skills in reading infant cues and responding sensitively. The primary goal of the Skill Building Group is to improve parent-child interaction in order to foster infant attachment security. We also anticipated a positive impact of group participation and networking opportunities on parent functioning. Results of a small pilot study are reported in this paper.

The Importance of Infant Attachment Security

The parent-infant relationship is an important focus of many early intervention programs because the development of infant attachment security is a primary issue in infancy (van IJzendoorn, Juffer, & Duyvesteyn, 1995). Attachment is defined as the affectional bond between infants and their primary caregiver (Ainsworth, Blehar, Waters, & Wall, 1978). It has been argued that secure infant attachment increases the probability of future mental health (Bowlby, 1969). Research studies have provided empirical validation of the theoretical importance of attachment throughout life by documenting the positive influence of secure attachment on curiosity, enthusiasm, persistence, compliance, mastery motivation, cognitive development, social skills, and peer interaction (e.g., Arend, Gove, & Sroufe, 1979; Estrada, Arsenio, Hess, & Holloway, 1987; Waters, Wippman, & Sroufe, 1979). Insecure attachment has been related to later internalizing and externalizing behavior disorders (e.g., Lewis, Feiring, McGuffog, & Jaskir, 1984). Thus, secure attachment is considered a protective factor and insecure attachment is considered a risk factor (e.g., Bretherton, 1985).

Attachment and Parental Sensitivity

The cornerstone of attachment theory has been that infant attachment security arises

from a caregiving history 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). More recently, meta-analyses of studies of the prediction of infant attachment security from maternal sensitivity have confirmed that caregivers rated as sensitive are more likely to have secure infants than caregivers rated as less sensitive (e.g., Atkinson et al., in press; De Wolff & van IJzendoorn, 1997). When sensitivity is assessed with the best available measures, the effect size for the prediction of infant attachment security is consistently large (Atkinson et al.).

Studies of 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; Plunkett, Meisels, Stiefel, Pasick, & Roloff, 1986). To explain the difficulties encountered by parents and these children in the development of the attachment relationship, various hypotheses have been suggested including child characteristics that may make interaction difficult (including cognitive limitations and dampened socioemotional responsiveness; e.g., Atkinson et al.; Blacher & Meyers, 1983; Serafica & Cicchetti, 1976), parental factors that may hamper sensitivity (including affective distress; e.g., Emde & Brown, 1978), and the interaction of these factors. Observational studies of parents and their infants with disabilities reveal parent-child interaction that is characterized by infants being difficult to read (e.g., Field, 1980) and parents being insensitively directive (e.g., Hanzlik & Stevenson, 1986; Mahoney, Fors, & Wood, 1990), neither of which may bode well for the attachment relationship. Very few studies have examined the relationship between caregiver sensitivity and infant attachment security in dyads with infants with developmental delay, but the existing research suggests that the risk of insecure attachment for these children may be related to caregiver responsiveness (Lederberg & Mobley, 1990; Wasserman, Lennon, Allen, & Shilansky, 1987). In a longitudinal study of children with Down syndrome, Atkinson and his colleagues found that maternal coping style and affective distress interact to influence maternal sensitivity (Atkinson et al., 1995), and that maternal sensitivity and child cognitive level interact to predict attachment security (Atkinson et al. 1999). Taken together, these findings suggest that interventions aimed at increasing a caregiver's sensitivity in perceiving, interpreting, and responding to the cues and signals of their infants with developmental delay may promote attachment security, which may then have implications for future development across a variety of domains.

Attachment-based Interventions

In a meta-analysis of 16 clinical trials of attachment-based interventions and their effects on maternal sensitivity and infant security, van IJzendoorn and his colleagues (1995) found that the most effective were short-term behavioral approaches rather than longer-term, intensive psychotherapeutic approaches. The meta-analysis included studies involving a variety of at-risk samples, but none involved parents of infants with developmental delay. McCollum and 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 contingently responding to their children's cues, but many did not investigate the generalization of positive impact beyond interaction skills (e.g., parental confidence, distress). None of these interventions used a group format, and effect sizes were typically small (van IJzendoorn et al.; McCollum & Hemmeter).

Individual- versus Group-based Interventions

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. Traditionally, parent training has been used with parents of children

with behavior problems, and clinical trials have shown improvements in child management skills (Barkley, Guevremont, Anastopoulos, & Fletcher, 1992), parenting stress and confidence (Pisterman et al., 1992), and child behavior (Cunningham, Bremner, & Boyle, 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 behavior (e.g., Hornby & Singh, 1983; Koegel, Koegel, Kellegrew, & Mullen, 1996). What is unknown is if a group-based approach to parent training could be used to enhance attachment security in infants with developmental delay.

Group-based interventions may take advantage of three potentially powerful mechanisms that could be 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 for high-risk infants (Crnic & Stormshak, 1997; Dunst, Trivette, & Jodry, 1997) and social isolation can adversely influence parenting (Dumas, 1986). Group approaches may be particularly well suited for parents of high-risk infants because they have unique experiences (i.e., high-level caregiving demands, child-rearing challenges, unpleasant social and extended family reactions, and feelings of guilt, anger, and depression) that they may share with group members (Seligman, 1993). Furthermore, these parents may receive empathy, acceptance, support, and practical suggestions for strategies that have worked for other parents with a degree of social comfort that may not be possible with an individual therapist (Seligman).

The second mechanism missing in individual interventions is therapeutic 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, group participants' motivation for conformity). Third is parental empowerment. Individual interventions run the risk of disempowering parents (Dunst, Trivette, & Deal, 1994), whereas groups offer opportunities for parents' to build confidence 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 (Kazdin, Mazurik, & Bass, 1993), whereas community-based groups may reduce psychological and logistic barriers to access. For example, Cunningham and his colleagues (1995) found that their community parent education program was accessed more readily than individual clinic-based services by high risk parents (e.g., those 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.; Niccols, McFadden, & Parker, 1996), thereby potentially restricting its availability.

Facilitative Group-based Intervention: The Coping Modeling Problem Solving Approach

Parent training may improve skills, but many programs involve lectures and reading materials. This type of didactic approach may (a) increase knowledge but result in behavior changes that are not sustained (Gardner, 1972), (b) produce high levels of participant noncompliance thereby paradoxically increasing resistance to learning new skills (Patterson & Forgatch, 1985), (c) result in parents achieving less than optimal understanding of the complex principles involved in parent-child relationships due to the lack of exploration of the consequences of both positive and negative approaches to parent-child interaction (Cunningham, Davis, Bremner, Dunn, & Rzasa, 1993), and (d) produce little attitude change and commitment or feelings of personal competence and control (Meichenbaum & Turk, 1987).

Coping modeling (Masters, Burish, Hollon, & Rimm, 1987) represents an alternative to more didactic approaches to parent training. In contrast to traditional parent training in which correct skills are demonstrated, coping models confront difficulties, make errors, but eventually arrive at an appropriate solution (Masters et al.). Coping modeling has proven

more effective than didactic parent training in the management of anxiety disorders (e.g., Kazdin, 1974). A variant of coping modeling is the Coping Modeling Problem Solving approach, an active learning approach in which 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 (Cunningham et al., 1995). Clinical trials conducted on large group, community-based parent training using this approach have shown that it is more effective in terms of availability, utilization, cost, and outcome than clinic-based individual training for parents of children with disruptive behavior disorders (Cunningham et al.). Although coping modeling approaches have been applied to parent training for behavior management (Cunningham et al.), 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. A group-based approach to train parents in attachment-promoting skills could take advantage of the benefits of this model in terms of its potential effectiveness as a method of parent education, and as a means of providing peer support and opportunities for social networking and parental empowerment.

THE SKILL BUILDING GROUP

The Skill Building Group was developed in the Infant-Parent Program at Chedoke-McMaster Hospital to address the drawbacks of traditional parent training and group-based interventions noted earlier. The purpose of the Group is to train parents of infants at developmental risk to read and respond sensitively to their infants' cues (Niccols, Kitching, McFadden, Parker, & Harrison, 1997) using the Coping Modeling Problem Solving approach (cf. Cunningham et al., 1995). The content of group sessions focuses on parenting skills that promote infant attachment security (i.e., perceiving, interpreting, and responding sensitively to infant signals; see the Appendix for a description). The model used in the Skill Building Group allows participants to formulate and publicly state their own solutions to common parent-child interaction challenges illustrated in videotape segments. We expected this approach 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. Parent participants in the Skill Building Group are given opportunities to practice their newly acquired skills through structured 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 discussed their homework and received peer support for their efforts. For families of high-risk infants, having contact with parents who are facing similar difficulties can provide emotional support, encouragement, practical assistance, and potentially useful information (Seligman, 1993). Family functioning also may be improved if parents generalize what they have learned to relations with other family members, which occurred in previous parent-training programs (e.g., Eyberg & Robinson, 1982).

Skill Building Group leaders are infant development specialists whose role is to lead the sessions, facilitate group work, and consultant with the parents. Infant development specialists have educational backgrounds in one or more fields, such as psychology, early childhood education, and social work. Infant development specialists also have additional training in parent education and experience making home visits with families of infants with a variety of disabilities. The Skill Building Group meets for eight weekly 2-hour sessions, either in the evening or morning. To minimize barriers to accessibility and to maximize participation, sessions are held at a convenient, central location with free parking and onsite childcare.

THE PILOT STUDY

To begin evaluating the Skill Building Group, we conducted a small pilot study. The pilot study involved an evaluation of intervention efficacy as determined from a comparison of 12 intervention group parents and 5 waiting list controls on several parent-report measures. We hypothesized that Skill Building Group participants would (a) show decreases in dysfunctional parent-child interaction, parental distress, sadness or depression, and follow-up service utilization, and (b) increases in parenting confidence and effective family functioning.

METHOD

Subjects

Parents of infants referred to an infant development program who were on the waiting list for individual in-home intervention were invited to participate in the Skill Building Group. The comparison group consisted of parents who were further down the waiting list. Parents in both groups were asked to participate in a pilot study evaluating the new group-based service. Parents in the comparison group were eligible for another (later) offering of the Skill Building Group.

Over three offerings in 1996, 63 families were invited to attend the Skill Building Group. Although 44 (70%) agreed to participate in the group, only 22 (50%) actually attended. This attendance rate, however, is consistent with reports by other parent-training groups (e.g., Cunningham et al., 1995). Of the 22 parents who attended, 12 (55%) agreed to both participate in the evaluation and complete all pre-test and post-test measures. Five (42%) of the wait list comparison group parents completed all measures. Study participants, study dropouts, and non-attendees were not different in terms of parent education, socioeconomic status, marital status, family composition, or child age.

On average, pilot study participants were high school educated, married, and had other children in the family. As a group, however, these parents were quite mixed in terms of age (although no teenagers participated), socioeconomic and cultural status, and psychiatric and cognitive functioning. Pilot study participants attended an average of 7.5 of the 8 sessions. Their infants were an average of 1 year old, and one third to one half were described as difficult and receiving additional services from medical and developmental specialists. In terms of primary diagnosis, 7 (42%) of the infants had developmental delay of unknown etiology, 4 (24%) had cerebral palsy, 3 (18%) Down syndrome, 1 (6%) an acquired brain injury, 1 (6%) visual impairment, and 1 (6%) had prenatal drug exposure.

Measures and Procedures

Prior to and after the 8-week Skill Building Group, parents in both the intervention and comparison groups were asked to complete the following set of standardized questionnaire measures: (a) Parenting Stress Index Short Form (PSI-SF) Parent-Child Dysfunctional Interaction Scale (Abidin, 1990), (b) PSI-SF Parental Distress Scale, (c) Parenting Sense of Competence Scale (Gibaud-Wallston & Wandersman, 1978), (d) Centre for Epidemiological Studies Depression Scale (Devins & Orme, 1985, and (e) Family Assessment Device General Functioning Scale (Epstein, Baldwin, & Bishop, 1983). At the end of the Skills Building Group, parents in the intervention group also completed a consumer satisfaction questionnaire (Client Satisfaction Questionnaire; Niccols, 1996) and a follow-up service options menu. Parents choices for follow-up services ranged from non-active options (e.g., no further involvement with the infant development program or remaining on a mailing list to receive newsletters and flyers advertising parent workshops and social gatherings) to active service options (e. g., repeating the Skill Building Group, receiving consultation services, or having regularly-scheduled individual in-home intervention).

RESULTS & DISCUSSION

Pre- and Post-Test Findings

Pre-test levels of parental distress and parent-child dysfunction. Inspection of the pre-test mean scores for each of the five standardized

measures (i.e., those assessing parent-child dysfunctional interaction, parental distress, depression, parenting confidence, and family functioning) revealed that the intervention group means hovered near clinical cutoff scores, indicating some distress or dysfunction. Comparison group pre-test means were at or above clinical cutoff scores for most measures, indicating a relatively high level of distress or dysfunction. Group differences could be attributed to characteristics peculiar to the small sample available for the pilot study, especially the comparison group.

Overall, parents in both the intervention and comparison groups reported high levels of distress prior to the Skill Building Group. This is consistent with studies demonstrating that parents of children with developmental delay experience high levels of stress and feelings of guilt, sorrow, pity, and depression (e.g., Beckman, 1983; Emde & Brown, 1978). Parenting an infant with special needs can be practically and emotionally challenging and this can be stressful.

Pre-post comparisons. All pre-post differences were in the predicted direction for the intervention group (i.e., showing improvement after the Skill Building Group), with three of five t-test results reaching statistical significance (i.e., those assessing decreases in parent-child dysfunctional interaction, parental distress, and depression). The intervention group showed improvement in their scores which ranged from one fifth to two thirds of a standard deviation in size. The average standardized difference between the means (d) for the intervention group was .40, which is considered moderately strong (Cohen, 1988).

Parents in the comparison group reported an increase in depression or sadness over time that showed a trend toward statistical significance. No other comparisons approached statistical significance. Standardized effect sizes ranged from approximately three fifths of a standard deviation in the negative direction to approximately two fifths of a standard deviation in the positive direction. The average d for the comparison group was -.05.

Implications of pre-post analyses. The parents in the intervention group reported statistically significantly lower levels of parent-child dysfunctional interaction, parental distress, and depression after participating in the Skill Building Group. This was not true for the comparison group. In fact, the comparison group showed a trend towards increasing symptoms of depression over time.

These results are consistent with previous research on parent education and support group programs which have demonstrated lower levels of perceived stress and sadness or depression in parents after completion of the group program (Seligman, 1993). These findings are important in relation to attachment security because previous studies have demonstrated a relationship between the insecure attachment of infants and parenting stress and sadness (Jarvis & Creasey, 1991). In fact, the Skill Building Group addressed many of the significant parental predictors of infant attachment security (cf. Ainsworth et al., 1978; Atkinson et al., 1998; De Wolff & van IJzendoorn, 1997) either directly (i.e., caregiver sensitivity, social support) or indirectly (i.e., parental depression, parenting stress). Because infants with developmental difficulties are at heightened risk for insecure attachment (e.g., Atkinson et al., 1999; Plunkett et al., 1986) and insecure attachment in infancy has been associated with a higher risk of malfunctioning in the social, emotional, and cognitive domains (Bretherton, 1985), the statistically significantly lower levels of dysfunctional interaction and parental distress achieved by the intervention group at post-test may have positive long term developmental consequences for their infants at developmental risk. At least, it may be possible that attachment risk may decrease if the Skill Building Group prevents escalation in parental distress and/or parent-child dysfunctional interaction.

In their meta-analysis of individual attachment-based interventions, van IJzendoorn et al. (1995) found a combined effect size (d = .48) for short-term behavioral interventions similar to that reported here (d = .40). Although maternal sensitivity and attachment were not assessed directly, findings from this pilot study to some extent replicate studies

showing the effectiveness of individual attachment-based interventions (e.g., van IJzendoorn et al.) and extend the findings to a group-based intervention.

Client Satisfaction

In general, participants reported that they highly valued the Skill Building Group: 88–100% said that they would recommend it to others, found the content relevant, the quality good or excellent, and the logistics satisfactory (number of sessions, frequency, duration). Parent perceptions of the Skill Building Group with respect to the perceived helpfulness of the content, format, and processes were extremely positive. Effectiveness also was highly rated: More than 90% of the parents reported better interactions with their baby and other children in the family; having become better at problem solving and more confident in reading their baby's cues; and having increased their knowledge about early development, at-risk infants, their own baby, and community resources. Many (74–89%) reported having made new friends, enjoying their baby more, and feeling less stressed after participating in the Skill Building Group.

Follow-up Service Requests

Despite the fact that all intervention and comparison group parents were on the waiting list for individual in-home intervention prior to the Skill Building Group, the majority (75%) of parents who participated in the Skill Building Group subsequently chose consultation as their preferred follow-up service option. Consultation involves service initiated at the family's request around specific issues as identified by the family, and includes a limited number of home visits and unlimited telephone contact. This represents a lower level of service intensity than initially requested. Only 3 (25%) of the intervention group parents requested regularly scheduled individual in-home intervention following the Skill Building Group, which was noticeably different from the control group, all of whom continued to request regular in-home intervention (Fisher's exact probability $< .01$). Together with the client satisfaction results, these findings suggest that parents were satisfied with the group service and perhaps felt that they did not require as intense follow-up services upon completion of the Skill Building Group as initially requested. The implication of these results may be reduced costs to the social service system as the more intense and expensive follow-up services were not perceived by parents who attended the Skill Building Group as necessary to meet their needs. Incorporation of group services within early intervention service delivery models warrants further exploration and investigation, especially in these times of fiscal restraint.

LIMITATIONS AND FUTURE DIRECTIONS

This pilot study involved a cohort sample, an opportunistic wait-list control group, and parent-report inventory measures only. Resource limitations precluded follow-up to ensure return of inventories from a larger proportion of those surveyed. The study design and analyses were limited by the small and uneven group sample sizes. This pilot study should be viewed as exploratory and interpretation of findings made cautiously. In particular, we have no objective data demonstrating that the intervention enhances parent-child attachment. The next step in this program of research involves a randomized clinical trial using observational ratings of parent-child interaction and attachment security, as well as investigation into potential factors influencing adherence, and maintenance of gains at follow-up. Clinically, the intervention remains to be integrated into an efficient, effective, multidisciplinary service delivery model.

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This study was financially supported by the Infant-Parent Program, Chedoke Child and Family Centre, Hamilton Health Sciences Corporation and McMaster University. This paper was submitted in partial fulfillment of Shaheen Mohamed's B.Sc. degree in Biopsychology at McMaster University. Portions of this research were presented at the 1996 Zero to Three National Conference, Washington, DC. We are grateful to the staff of the Infant-Parent Program who contributed to the development of this new service, and to the parents who so generously gave of their time to participate in the pilot study evaluation. We thank Leslie Atkinson, Charles Cunningham, Joseph Ducharme, Linda Hancock, Kathleen Kitching, Mirek Lojkasek, and Helen Williamson for their helpful comments on earlier drafts of the manuscript.

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APPENDIX

SKILL BUILDING GROUP 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 behavior, and to formulate strategies for sensitive responding 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 behavior 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).

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 indicating 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 indicating when an infant is alert and indicating, "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, reviewing the concepts and skills necessary for sensitive, responsive parent-child interaction and fostering infant attachment security completes the Skill Building Group. Parents are encouraged to share their thoughts and feelings about the group process and to give feedback on their experience.