I'll take you under my wing: Positive parenting in foster care

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Chapter 3

Using Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD) in different types of families and in childcare settings

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ABSTRACT

Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD) is based on insights from attachment theory and social-learning theory. Since the development of VIPP-SD the effectiveness of this early intervention program has been demonstrated in several populations, with significant effects on sensitive parenting and positive child outcomes. In this intervention model description we elaborate on how VIPP-SD has been used in different types of families and in childcare settings with children aged zero to six. Populations with child-related challenges (e.g., Autism Spectrum Disorder), parent-related challenges (e.g., insecure attachment representations), or families in special situations (e.g., minority families) may benefit from specific parenting support and empowerment. Additionally, the family-focused VIPP-SD program can be used – with some adaptations – in group childcare settings. As an illustration of recent work we describe a slightly adapted version of VIPP-SD in foster families. Vignettes of the intervention process illustrate how the VIPP-SD program has been implemented and received in foster care.

INTRODUCTION

Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD; Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2008) is based on insights from attachment theory (Bowlby, 1982) and social-learning theory, particularly coercion theory (Patterson, 1982). VIPP-SD is an early intervention aimed at increasing caregiver sensitivity and improving adequate discipline strategies in order to encourage positive caregiver-child interaction, and to prevent or reduce challenging behaviors in children aged zero to six years. To reach this goal, this home-based program with video feedback works on: (1) increasing the observational skills of caregivers; (2) increasing caregivers' knowledge about the upbringing and development of young children; (3) increasing the capacity of caregivers to empathize with their children, and (4) making caregiving behavior more effective by using sensitive responsiveness and sensitive discipline. The method of video feedback is used: filming caregiver–child interactions and at a later time reviewing the videotape with the caregiver.

In this intervention model description we elaborate on how VIPP-SD has been used in different types of families and in childcare settings with children aged zero to six. Parents with young children may struggle with a great variety of challenges and may benefit from support and empowerment. Here we distinguish between parent-related challenges and child-related challenges. Parents may face difficulties resulting from the parent's own adverse childhood experiences (e.g., insecure attachment representations), difficulties in the parent's psychological wellbeing (e.g., eating disorder), and socio-economic and financial difficulties. Child-related challenges refer to the characteristics of children with special needs, requiring specific care from their parents (e.g., adopted and foster children, children with externalizing behaviors, children with Autism Spectrum Disorder). Such populations with parent-related or child-related difficulties, as well as families in special situations (e.g., ethnic minority families), may face various challenges and benefit from specific parenting support. Additionally, the family-focused VIPP-SD program requires some changes in a setting for group childcare.

We describe how the VIPP-SD program has been adapted for some specific populations and how these adapted programs differ from the original VIPP-SD program in terms of aims, content, and procedures. As an illustration of recent work we also describe a slightly adapted version of VIPP-SD in foster families. Vignettes of the intervention process illustrate how the VIPP-SD program has been implemented and received in foster care and in group childcare settings.

DEVELOPMENT OF VIPP-SD

Over the last 30 years the VIPP-SD program was developed and fine-tuned by Femmie Juffer, Marian Bakermans-Kranenburg, and Marinus van IJzendoorn. Together with colleagues they developed and rigorously tested several variants of VIPP-SD to make the program work in supporting parents in a variety of families, either as an adjunct or stand-alone intervention. The original VIPP program was aimed at increasing parental sensitivity in families with infants (see Table 1 for the sensitivity themes). Initially applied in families with an adopted infant (Juffer, 1993; Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2005) and in families with mothers rated as insecure on the Adult Attachment Interview (AAI, George, Kaplan, & Main, 1985; Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 1998), the program was extended to older children, ranging from one to six years of age, to specific parenting issues of sensitive limit setting to the "terrible twos and threes" (Van Zeijl et al., 2006), and to childcare settings (Groeneveld, Vermeer, Van IJzendoorn, & Linting, 2011; Werner, Vermeer, Linting, & Van IJzendoorn, 2017). Its theoretical basis – attachment theory – was broadened with insights from social learning theory of coercive cycles, resulting in the VIPP-SD program (Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2018; Juffer et al., 2008; for a case study see Juffer & Bakermans-Kranenburg, 2018).

Table 1. *Themes in the VIPP-SD program.*

Session	Sensitive Parenting[a]	Sensitive Discipline
1	Exploration versus attachment behavior	Inductive discipline and distraction
2	'Speaking for the child'	Positive reinforcement
3	Sensitivity chain	Sensitive time-out
4	Sharing emotions	Empathy for the child
5	Booster session	Booster session
6	Booster session	Booster session

[a] The VIPP program does not include the four sensitive discipline themes

Families with a child that shows externalizing behaviors frequently experience difficulties in parent-child interactions (Smith, Dishion, Moore, Shaw, & Wilson, 2013). These children have, for example, difficulties in following rules (i.e., complying with parental requests) and when they grow up they may display antisocial behaviors such as aggression and vandalism (Thompson et al., 2011). To support parents of children with externalizing behaviors VIPP-SD includes themes that address sensitive discipline strategies. Thus, VIPP-SD not only aims to increase parental sensitivity, but also to enhance the use of sensitive discipline strategies in order to diminish externalizing behaviors of the child and to increase empathy for the child (Juffer et al., 2008; Mesman et al., 2008).

To become a VIPP-SD intervener, professionals have to successfully complete the basic VIPP-SD training and supervision process in which they conduct a first VIPP-SD case under supervision of a qualified VIPP-SD supervisor or trainer, after which they receive certification and registration in the VIPP Training and Research Centre's database (Leiden University, 2018; Tavistock and Portman NHS Foundation Trust, 2019a, 2019b). Completion of the whole training process (4-day basic VIPP-SD training and supervision) will approximately take six months. A broad range of professionals can become a VIPP-SD intervener, e.g., (child) psychologists, therapists, social workers, and mental health professionals. So far, professionals from more than 15 countries have been trained and certified in VIPP-SD (Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2017b). Families preferably receive VIPP-SD from a professional who has experience in supporting families with similar parenting challenges. In the United Kingdom, for example, adoption professionals are specifically trained to support adoptive families that are eligible for receiving VIPP-SD (Tavistock and Portman NHS Foundation Trust, 2019c).

VIPP-SD interveners use a standardized manual (Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2015) and work with the primary caregiver (usually the mother) and the target child during six home visits, using video feedback. The first four home visits focus on a specific theme regarding sensitive parenting (e.g., children's exploration and attachment behavior) and sensitive discipline (e.g., reinforcement of positive child behavior), the last two visits are booster sessions in which all themes are repeated (see Table 1). During the booster sessions, the partner of the parent is invited to join the session. At the beginning of each home visit, the intervener films the interaction between parent and child during everyday situations for 10 to 30 minutes. Examples of such situations are playing or reading together, and a mealtime. After filming, the recorded interactions of the previous home visit are discussed and the intervener gives personalized video-feedback to the parent with an emphasis on positive moments and sensitive discipline. The intervener prepares the video-feedback during the interval between two home visits: the first four sessions are biweekly and between sessions four and five, and five and six, there is an interval of about three to four weeks. In two studies the majority of the participating mothers evaluated the video-feedback intervention method as valuable and useful (Klein Velderman, Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2008; Stolk et al., 2008).

The effectiveness of VIPP-SD has been demonstrated in several populations through 12 randomized controlled trials in different countries (total N = 1,116), with substantial effects on sensitive parenting (Cohen's d = 0.47) and positive child outcomes (Cohen's d = 0.37) (see for details Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2017a, 2017b). Families voluntarily participated in the effectiveness studies. In some studies families were screened based on parent-related challenges (e.g., insensitive parenting, see Kalinauskiene et al., 2009) or child-related challenges (e.g., high risk of developing an Autism Spectrum Disorder, see Green et al., 2013, 2015) before inclusion. Observations of sensitive parenting were coded with the

Ainsworth scale for sensitivity (Ainsworth, Bell, & Stayton, 1974; range of interrater reliability between coders: 0.72 to 0.86, see Kalinauskiene et al., 2009) or the Emotional Availability Scales (EA scales, Biringen, 2008; range of interrated reliability between coders: 0.72 to 0.95, see Negrão, Pereira, Soares, & Mesman, 2014). Attachment security was observed with the Strange Situation Procedure (Ainsworth, Blehar, Waters, & Wall, 1978) and child behavior problems were measured with the Child Behavior Checklist (CBCL, Achenbach & Rescorla, 2000; internal consistency of three broadband Externalizing Problems scales between 0.66 and 0.89, see Van Zeijl et al., 2006). An overview of populations and adaptations of VIPP-SD is presented in Table 2. The VIPP-SD program and its adaptations can support and help families with parent-related or child-related challenges as a short-term home-based intervention on its own, but also in combination with other interventions/programs in a broader treatment trajectory. VIPP-SD is successfully implemented and offered to families in clinical practice (e.g., Tavistock and Portman NHS Foundation Trust, 2019c).

Recently, some new adaptations to the VIPP-SD program were made. Lawrence, Davies, and Ramchandani (2013) conducted a pilot study (n = 5) in the United Kingdom to examine whether VIPP-SD can be used to enhance sensitivity of fathers. Overall, the fathers participating in this study were positive about the intervention. Based on these promising first results, the effectiveness of VIPP-SD is currently being investigated in a larger sample of fathers.

At Leiden University and VU University Amsterdam, the Netherlands, VIPP-SD is currently being adapted for use in families with older children (six years and older). Furthermore, at Leiden University, the Netherlands, in collaboration with the University of Québec at Montréal, Canada, VIPP-SD is examined as a diagnostic tool in the decision-making process of out-of-home placements in child protective services. At Leiden University, VIPP-SD is also used in a study supporting parents in responsive feeding practices during their infants' transition from fluid to solid foods (Van der Veek & Mesman, 2014). In Italy, an adapted VIPP-SD program for late-adopted children has shown positive results on parent and child outcomes (Barone, Barone, Dellagiulia, & Lionetti, 2018; Barone, Ozturk, & Lionetti, 2018). Lastly, VIPP-SD has been adapted for parents of children with a visual impairment at the VU University Amsterdam, the Netherlands (Sterkenburg, Platje, Overbeek, Kef, & Schuengel, 2017).

To summarize, after the development VIPP-SD and several adaptations to meet the needs of different populations, researchers are examining whether VIPP-SD can help even more caregivers to increase their sensitivity and adequate discipline strategies and thus prevent or decrease insecure attachment relationships and struggles with child characteristics, such as externalizing behaviors. For clinical and practical implementation purposes it is important to describe the components of the (adapted) VIPP-SD programs used in several research studies and to continue examining VIPP-SD adaptations in the future.

USING THE VIPP-SD PROGRAM IN DIFFERENT TYPES OF FAMILIES

SUPPORTING FAMILIES WITH PARENT-RELATED CHALLENGES

When parent-related challenges are present that might influence (sensitive) parenting, it is important that these families can be supported and empowered with the VIPP-SD program. We describe how VIPP-SD has been used in studies including mothers rated as insecure or insensitive, parents with eating disorders, maltreating parents, parents with intellectual disabilities, families in economically deprived contexts, and Turkish minority mothers.

Mothers with Low Sensitivity or an Insecure Attachment Representation

Parental sensitivity contributes to children's attachment security because sensitive parents are able to observe, interpret, and react adequately to their child's signals (Ainsworth et al., 1978; Bakermans-Kranenburg et al., 2003). The original VIPP program without adaptations was used to support mothers of 6-months-old infants with low sensitive responsiveness (i.e., below a cutoff of 5) according to Ainsworth's sensitivity rating scale (Ainsworth et al., 1974; Kalinauskiene et al., 2009, see Table 2). The VIPP program focusses solely on sensitivity (see Table 1 for the four themes), which made this program suitable to use with these mothers.

Parents with insecure attachment representations might unconsciously repeat the negative parenting skills of their parents with their own children (Cassibba, Castoro, Costantino, Sette, & Van IJzendoorn, 2015; Van IJzendoorn, 1995). Despite the importance of parents' feelings and thoughts about their own attachment experiences for the development of attachment relationships with their children, few interventions have aimed to support parents with insecure mental attachment representations (Bakermans-Kranenburg, Van IJzendoorn, & Juffer, 2003). Negative representations may be changed by letting the parents recall, re-experience and reflect on their childhood attachment experiences (Bakermans-Kranenburg et al., 2008; Fraiberg, Adelson, & Shapiro, 1975; Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2008). The original VIPP program was adapted to support this group of parents.

VIPP-R. VIPP-R (VIPP with a Representational approach, see Table 2) focusses on the representation of the mother's attachment experiences in her own childhood, and the association between these experiences and the development of the relationship with her child (Bakermans-Kranenburg et al., 2008; Cassibba et al., 2015). The intervention consists of four home visits in which the VIPP sensitivity themes are discussed (see Table 1), with additional discussions about the mother's own attachment experiences. The intervener has a supportive role and does not criticize when listening to the mother's childhood memories, thoughts and feelings.

Table 2. Overview of (adapted) VIPP/VIPP-SD programs.

Population	VIPP[1]/VIPP-SD or adapted VIPP[1]/ VIPP-SD	Additional material / treatment
Families with parent-related challenges		
Mothers with low sensitivity	VIPP[1]	
Mothers with an insecure attachment representation	Video-feedback Intervention to promote Positive Parenting with additional Representational discussions (VIPP-R)	Discussions about parent's own attachment representations
Mothers with eating disorders	VIPP[1]	Watch, Wait and Wonder Touchpoints Individualized photo-album with written information Self-help manual based on CBT[2]
Maltreating parents	VIPP[1]	Discussions about child development, emotion regulation, discipline, and family ecology
Parents with intellectual disabilities	Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline for parents with Learning Disabilities (VIPP-LD)	Personal scrapbook with screenshots and feedback or quotes
Families in economically deprived contexts	VIPP-SD	Booklet with messages and tips
Turkish minority mothers	Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline for Turkish Minority families (VIPP-TM)	

	Adapted or extra film episodes compared to VIPP	Adapted or extra themes compared to VIPP	Structural adaptations
		Additional themes: 1. Separations: past and present 1. Parenting: past and present 3. Defining adult relationships 4. Child of my parents, parent of my child	
	Additional episodes: Five extra mealtimes	Additional theme: 1. Conflicts (during mealtimes)	
	Specific rules for parents during videotaped situations (e.g., "Only react when child asks you to")		Video-feedback given immediately after filming
		Sensitivity and sensitive discipline themes repeated during several home visits Real life situation used for sensitive discipline strategies Sensitive time-out excluded Corrective feedback first given during 4th feedback session (instead of 3rd home visit)	Separate film visits (max. 10 minutes) and feedback visits Only care professionals as interveners with supervision from experienced behavior counselor
	Home visit 1: Play with tea set instead of reading a book together Home visit 3: Fantasy play instead of singing songs Home visit 4: Play with clay instead of play with hand puppets		Only female interveners from same ethnic group

Table 2. Continued.

Population	VIPP[1]/VIPP-SD or adapted VIPP[1]/ VIPP-SD	Additional material / treatment
Families with child-related challenges		
Children with externalizing behaviors	Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD)	Booklet with messages and tips
Children with an Autism Spectrum Disorder	Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline for Children with Autism (VIPP-AUTI)	
	VIPP within the British Autism Study of Infant Siblings (iBASIS-VIPP)	
Adopted and foster children	Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline for Foster Care/ Adoption (VIPP-FC/A)	Booklet with messages and tips Booklet with physical contact games
Childcare settings		
Home-based childcare	Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline for Child Care (VIPP-CC)	Booklet with messages and tips
Center-based childcare	VIPP-CC for center-based childcare	Booklet with messages and tips

[1] VIPP does not include the four sensitive discipline themes, [2] CBT = Cognitive Behavioral Therapy

	Adapted or extra film episodes compared to VIPP	Adapted or extra themes compared to VIPP	Structural adaptations
	Additional episodes (for discipline themes): "Do not touch"-task and "Clean-up"-task	Additional discipline themes: 1. Induction and distraction 2. Positive reinforcement 3. Sensitive time-out 4. Empathy	
		Additional themes: 1. Mastery motivation and play 2. Joint attention 3. Daily problems and routine 4. Emotions and (stereotypical) behavior	
			Up to six booster sessions (instead of two) 30 minute exercise for daily practice of parents in between home visits
	Additional episodes: Play with physical contact (e.g., Itsy Bitsy Spider)	Additional themes: 1. Disrupted/subtle signals 2. Positive physical contact	
	Toys suitable for a group of children (two to six children present)	"Speaking for the children" in addition to "Speaking for the child"	Interveners shortly leave the home after videotaping No second caregiver invited for booster sessions
	Toys suitable for a group of children (four children present) Adapted "Do not touch"-task instead of "Clean-up"-task	"Speaking for the children" in addition to "Speaking for the child"	Interveners shortly leave the center after videotaping No second caregiver invited for booster sessions Laptop used to watch videotapes instead of TV and DVD player

Four representational themes are discussed during the home visits, each focusing on past and current situations. First, separations that the mother has experienced as a child and separations from her own child in the present are reviewed. Parenting experiences as a child and as a parent are discussed during the second session. The process of forming adult relationships with one's parents are discussed during the third home visit. Furthermore, the mother is asked about what she expects of the relationship with her own child in the future. Lastly, the mother is invited to think about her childhood experiences which she also wants her own child to experience. This theme is also known as "child of my parents, parent of my child" (Juffer et al., 2008, p. 20).

Mothers with Eating Disorders

Eating disorders may influence parenting quality, including the quality of the mother-infant interaction. Woolley, Hertzmann, and Stein (2008) found that mothers with eating disorders show more intrusiveness and are less sensitive during mealtime compared to mothers without eating problems. Mealtimes are often characterized by negative maternal emotions, i.e. mothers with eating disorders express themselves in a negative way toward the child by, for example, using commands instead of suggestions. The children, in turn, show more negative affect during mealtime and have lower weights. VIPP was used to support the quality of mother-infant interaction and to reduce or prevent conflict during mealtime by encouraging maternal sensitivity and maternal understanding of the developmental skills and needs of their child (Stein et al., 2006; Woolley et al., 2008).

VIPP for mothers with an eating disorder. Following the VIPP protocol, the intervener focuses on positive behaviors of mother and child, and on moments of positive interactions between mother and child (Stein et al., 2006; Woolley et al., 2008). The intervener not only uses "speaking for the child" (Carter, Osofsky, & Hann, 1991), but also information from Watch, Wait and Wonder (Muir, 1992) and Touchpoints (Brazelton, 1994) to provide subtitles for the child's reactions and expressions (see Table 2). Mothers gradually will acknowledge and accept that while their child is learning new (eating) skills and becomes more independent, they will probably be messy (Woolley et al., 2008).

The researchers illustrated child behavior and development during the first 12 months in an individualized album using photographs and additional written information, to combine with the video-feedback intervention (Woolley et al., 2008). The album focused especially on mealtimes, by highlighting the normal development of early exploratory behavior of the infant (e.g., looking and reaching), experiences with new tastes and food textures (with stills from the videotapes), precursors of self-feeding (e.g., when the child plays with food), and of conflicts that occur regularly during mealtimes (e.g., the messiness). In addition, because the mothers' eating disorder also (partly) influences the way she interacts with her child, a self-help manual based on cognitive behavior therapy (CBT) was used to provide extra help for the mothers to work on their eating habits (Woolley et al., 2008).

Maltreating Parents

Maltreating parents are often less able to openly communicate, to have a reciprocal interaction with their children, and to deal with conflicts than other parents. Children of maltreating parents have an increased risk of developing an insecure or disorganized attachment relationship with their parents (Cyr, Euser, Bakermans-Kranenburg, & Van IJzendoorn, 2010). A program using principles similar to VIPP and other interventions (e.g., the Attachment and Biobehavioral Catch-up of Dozier et al. (2006)) was used to increase attachment security of the children by enhancing parental sensitivity (Moss et al., 2014).

Intervention for maltreating parents using principles similar to VIPP. At the beginning of each session, the parent and intervener discuss a theme related to child development, emotion regulation, discipline, and family ecology (see Table 2). After this, a play situation is videotaped for 10 to 15 minutes (Moss et al., 2011, 2014). The intervener chooses an activity that is suitable for the child's age and that addresses the child's needs. The intervener usually provides feedback on the videotaped episode immediately after filming. Because this can be quite challenging, the videotape may first be reviewed with a supervisor before video feedback is given to the parent (Moss et al., 2014). The home visit ends with a summary of the progress the parent has made so far and the intervener encourages the parent to continue with playing similar games with the child (Moss et al., 2011, 2014).

Parents with Intellectual Disabilities

Children of parents with intellectual disabilities are at higher risk of being neglected or abused and of having a developmental delay. These parents are more often under supervision of child protection services and they often find parenting stressful (Hodes, Meppelder, Schuengel, & Kef, 2014). However, existing interventions aimed at enhancing parenting skills may not work, because these families experience challenges with acquiring new knowledge and skills (Feldman, 1994). Video-feedback Intervention to promote Positive Parenting for parents with Learning Difficulties (VIPP-LD) was developed to enhance sensitivity and sensitive discipline strategies in parents with intellectual disabilities (Hodes et al., 2014; Hodes, Meppelder, de Moor, Kef, & Schuengel, 2017, 2018).

VIPP-LD. Several adaptations were made to the VIPP-SD program to make the intervention suitable for parents with intellectual disabilities (Hodes et al., 2014; see Table 2). The home visits were divided in film visits and separate feedback visits. Both types of visits preferably take place in the same week. The total duration of the video-taped episodes was limited to 10 minutes and fewer tasks were performed, because the parents may find it hard to concentrate for long periods and they may find a large number of different tasks overwhelming. "Speaking for the child" is used all the time to give the parents as much practice as possible to learn how to interpret their child's behavior, and the sensitivity and discipline themes are repeated in several home visits.

Each parent also gets a personal scrapbook to provide them with a visual reminder of the feedback visits. The intervener puts screenshots from the video fragments in the scrapbook and writes down the feedback or a quote of the parent that corresponds with the theme. General information about the themes is also written in the scrapbook in such a way that the parent can understand and use this information in the time between home visits.

Families in Economically Deprived Contexts

Parents living in poverty encounter significant challenges in providing a safe and stable caregiving environment for their child. The Family Stress Model (Conger et al., 1992, 1993) states that the economic struggles experienced by low-income families have negative effects on the emotions, behaviors, and relationships of parents, which in turn can lead to adverse parenting. Low quality of parenting subsequently may result in adverse child outcomes (Conger & Donnellan, 2007; Mesman, Van IJzendoorn, & Bakermans-Kranenburg, 2012).

Low-income families often receive material help, such as subsidies or social housing, but help with parenting is rarely provided (Negrão et al., 2014). To support families in an economically deprived context on a social-emotional level, VIPP-SD was implemented to enhance positive parenting and family functioning, and to decrease challenging behaviors of children (Negrão et al., 2014; Pereira, Negrão, Soares, & Mesman, 2014)

At the end of the VIPP-SD intervention, all families received a booklet in which the topics discussed during the home visits were summarized to enable the parents to reread the messages and tips given during the sessions whenever they needed to (Negrão et al., 2014; Pereira et al., 2014; see Table 2).

Turkish Minority Mothers

In several studies, ethnic minority parents have been found to be on average less sensitive and challenging behaviors are more common among their children (Barnett, Shanahan, Deng, Haskett, & Cox, 2010; Mesman et al., 2012; Propper, Willoughby, Halpern, Carbone, & Cox, 2007). Turkish minority families are the largest group of non-Western immigrants in the Netherlands (Centraal Bureau voor de Statistiek [CBS], 2015), and have also been found to show lower levels of sensitive parenting compared to Dutch parents (Yaman, Mesman, Van IJzendoorn, Bakermans-Kranenburg, & Linting, 2010). In addition, Dutch mothers showed more authoritative behavior (i.e., positive feedback, induction, and understanding) than Turkish minority mothers. To enhance maternal sensitivity and the use of sensitive discipline strategies among Turkish minority mothers in the Netherlands, VIPP-SD for Turkish Minority families (VIPP-TM) was developed (Yagmur, Mesman, Malda, Bakermans-Kranenburg, & Ekmekci, 2014).

VIPP-TM. Some adaptations to the original VIPP-SD program were made, based on the experience and knowledge of a focus group of Turkish experts and mothers (all second-generation immigrants), to make the video-intervention acceptable for Turkish minority mothers (Yagmur et al., 2014; see Table 2). Only female interveners should conduct VIPP-TM and they should use the language (Dutch, Turkish or a combination of both) the mothers use. Furthermore, some situations that are filmed during the original intervention, such as reading a children's book together or singing a song together, would not occur during the daily life of Turkish families. During the first home visit, reading together was therefore replaced by mother and child playing together with a children's tea set and singing of a song during the third session was replaced by fantasy play.

SUPPORTING FAMILIES WITH CHILD-RELATED CHALLENGES

Specific challenging behaviors of children – for example, stereotypic behavior of children with autism – require special attention and parenting qualities from their parents. Several features of the VIPP-SD program try to provide optimal help and empowerment for the parents of these children. We describe how VIPP-SD has been used in studies including children with Autism Spectrum Disorder, and adopted and foster children.

Children with an Autism Spectrum Disorder

Several studies suggest that parenting children with Autism Spectrum Disorders (ASD) can be particularly difficult, because the children's symptoms make observing and interpreting the child's (attachment) signals challenging (Green et al., 2013, 2015; Rutgers et al., 2007). In a study that examined their self-perceived health, parents of children with ASD reported more stress, which resulted in higher rates of depression and anxiety compared to parents of typically developing children and children with mental retardation (Benjak, Vuletic Mavrinac, & Pavic Simetin, 2009). To support these parents, two VIPP programs have been developed for families with infants or a child with (a high risk of) ASD (see Table 2). Video-feedback Intervention to promote Positive Parenting for Children with Autism (VIPP-AUTI; Poslawsky et al., 2014) was implemented in Dutch families with 1- to 6-year-old children with an ASD diagnosis. In the British Autism Study of Infant Siblings (iBASIS-VIPP) a preventive video-feedback intervention program was used for infants at high risk of ASD (Green et al., 2013, 2015). This program is based on VIPP with up to six (instead of two) booster sessions and with an extra exercise of 30 minutes every day-practice for parents between sessions.

VIPP-AUTI. VIPP-AUTI consists of five sessions with the first four sessions each addressing the original VIPP-SD sensitivity and discipline themes and an additional autism theme, and one booster session (see Table 2).

Children with ASD often show limited play behavior and have difficulties with joint attention (i.e. the ability to share visual attention towards an object with someone else; Naber et al., 2007). Also, it is important to verbalize the nonverbal reactions and expressions of the child, i.e. with "speaking for the child", because children with ASD rarely use nonverbal cues or these cues are difficult to read for the parents (Poslawsky et al., 2014). Furthermore, parents often face non-compliant behavior of their child (e.g., Couturier et al., 2005). Sensitive discipline themes of VIPP-SD are used during the third session to teach parents how they could manage non-compliant child behavior (Poslawsky et al., 2014). Children with ASD often show stereotypical behavior, which are discussed during the fourth home visit.

Adopted and Foster Children

A meta-analysis of 17 adoption studies and 11 foster care studies showed that both adopted and foster children were more often insecurely attached than children who lived with their birth families (Van den Dries, Juffer, Van IJzendoorn, & Bakermans-Kranenburg, 2009). The prevalence of disorganized attachment was twice as high among adopted and foster children, 31% and 36% respectively, in comparison with children living with their birth parents (15%). To help these children to feel (more) secure in their new homes, two video-feedback interventions to support sensitive parenting in adoptive and foster families were developed.

Adoptive families. Adoptive parents often face a lot of uncertainty about the early life experiences of their adopted child who usually lived in adverse circumstances before placement, experiencing neglect, abuse, and malnutrition (Juffer et al., 2011; Rutter & the English and Romanian Adoptees (ERA) Study Team, 1998). Although the overall catch-up of adopted children is impressive, they do show some delay in several domains of development (e.g., elevated rates of disorganized attachment and mental health referrals; Juffer & Van IJzendoorn, 2005; Van IJzendoorn & Juffer, 2006).

To help adoptive parents of adopted infants to provide a secure home environment for their adopted children, a brief video-feedback intervention was developed (Juffer, 1993; Juffer et al., 2005). This intervention was a first version of the VIPP program and consisted of three home-based video-feedback sessions. During the video-feedback sessions the intervener focused on sensitive parenting using "speaking for the child" (Carter et al., 1991) and positive reinforcement to enhance maternal sensitive behavior towards the child.

Foster families. Like children adopted at older ages, foster children often have histories of adversity before the placement in their foster family. These experiences may be reflected in difficulties trusting adults and developing secure attachment relationships (Dozier et al., 2009; Gabler et al., 2014), which, in turn, can result in (the persistence of) challenging behaviors. VIPP-SD for foster care and adoption (VIPP-FC/A) aims to support foster parents (and adoptive parents of older-placed adopted children) in creating a secure home environment.

VIPP-FC. VIPP-FC uses VIPP-SD themes plus some additional themes addressing specific behaviors often seen in foster children (see Table 2). Some signals of foster children are subtle or even completely absent. For example, foster children may not cry when they have hurt themselves because they are not used to being comforted in these situations. Sometimes foster children look briefly at the foster parents when they are distressed, but other foster children do not show any signals at all. By making foster parents aware of these small or absent signals and teach them how to nevertheless respond, they show their foster children that they can be relied on in times of need. Foster children may gradually adapt their expectations and start to feel secure in the presence of their foster parents.

An important basis for comforting children and sharing their emotions, is sensitive physical contact. Foster children often have had hardly any or mainly negative experiences with physical contact, due to a history of abuse and neglect. As a consequence, they may not actively seek physical contact or respond defensively when their foster parents want to touch them to soothe them. Positive physical contact appears to enhance parental sensitivity not only in parents and their birth children (Gordon, Zagoory-Sharon, Leckman, & Feldman, 2010a) but also in parents and their genetically unrelated children (Bick & Dozier, 2010). By sensitively promoting positive physical contact, children may gradually feel more secure in physical interactions with their foster parents. In addition to sharing emotions and providing comfort to children, physical contact may also reduce stress in both children and adults. Foster children often experienced a (chronically) stressful period before placement and foster parents often face challenges in taking care of children with difficult behaviors. Stress can dysregulate the hypothalamic–pituitary–adrenocortical (HPA) axis which results in increased levels of the HPA axis' end product cortisol. Increased cortisol levels are subsequently related to less parental sensitivity (Feldman, Weller, Zagoory-Sharon, & Levine, 2007). Sensitive physical contact can decrease cortisol levels in both children and adults (Field, 2010) and serves as a buffer against stress (Feldman, Singer, & Zagoory, 2010).

In VIPP-FC, the VIPP-SD program is extended with a theme addressing the observation and interpretation of disrupted or subtle signals of attachment behavior displayed by foster children. This theme is introduced in the first home visit and repeated during all following sessions. The intervener also focuses on enhancing adequate stress regulation through sensitive physical contact between foster parent and child. For example, foster parent and

child are videotaped in several games with physical contact, such as *Row row row your boat* or *Itsy bitsy spider*, during each home visit. During the video-feedback the intervener verbalizes the child's possible reluctance or avoidance of physical contact (with "speaking for the child"), and points to (subtle) moments of positive, shared physical contact.

At Leiden University we are investigating the effectiveness of VIPP-FC in a randomized controlled trial (for a study protocol see Schoemaker et al., 2018), after a pilot study including three foster families had been conducted. During the first home visits, all foster parents participating in this pilot study noted that they were worrying about the child's attachment and difficult behavior. They showed great enthusiasm towards the VIPP-SD and VIPP-FC themes. Vignettes 1 and 2 describe two families of the pilot study. Both families volunteered to participate in the pilot study. They completed all six sessions, each lasting approximately 90 minutes. Following the standardized manual, the VIPP-SD themes (e.g., exploration vs. attachment behavior; Juffer et al., 2015) and additional VIPP-FC themes (e.g., subtle or missing behavioral signals) were discussed and video feedback was provided by the intervener during the sessions. The two foster children in the vignettes showed behaviors often seen in foster children, i.e., controlling behavior and avoiding physical contact, respectively.

Vignette 1: VIPP-FC – A foster child with controlling behavior. Being the daughter of substance abusing parents, 4-year-old Amy was addicted to cocaine when she was born and she was severely neglected during the first years of life.

During the videotaped episodes at the start of the intervention, Amy showed externalizing behaviors and signs of controlling behavior, possibly as a result of insecure disorganized attachment. She showed non-compliant (e.g., actively resisted cleaning up when requested) and aggressive behavior, and she gave commands to her foster mother (e.g., pointing with her finger she fiercely commanded her foster mother to "Sit!" on the couch). When she was building a tower, Amy looked puzzled when she came to a point where she did not know how to proceed. She did however not ask or even look at her foster mother for help. Her foster mother offered her help by showing Amy the next building block, but Amy pushed the block away. The intervener discussed with the foster mother that this controlling behavior was probably a result of Amy's adverse early life experiences and how she could deal with it (i.e., setting clear boundaries and showing Amy that she is there to help if needed). After the intervention, Amy behaved quite differently: when the foster mother told her to clean up the toys, she was cooperative and compliant and completed the task together with her foster mother in a relaxed atmosphere.

Vignette 2: VIPP-FC – A foster child avoiding physical contact. Three-year-old Anita and her teenage mother moved into a foster family's home together when Anita was a few months

old. However, this did not work out well, and after two more placements Anita is now living with another foster family and her mother is visiting her every two weeks.

During the physical contact games (most of them unknown to Anita), she avoided having physical contact with her foster mother. She tried to escape to playing with toys instead, and created more distance between herself and her foster mother. When playing a game in which Anita was invited to run into her mother's arms, she again fiercely refused. The intervener noticed in the previous sessions that Anita did like to cuddle, however, and suggested that the foster mother calls Anita with the word she always used to start cuddling. As soon as the foster mother invited her with this familiar, 'magic' word, Anita ran into her foster mother's arms to cuddle and they continued with a warm and positive physical contact game.

USING VIPP-SD IN CHILDCARE SETTINGS

Parents often rely on childcare settings where professionals take care of their children while they are at work. As in families, one of the essential goals of childcare is to provide children with a secure base, and caregiver sensitivity is considered a key component in providing such a secure base. Therefore, the VIPP-SD approach was adapted to Child Care settings (VIPP-CC), and, as a first step, its effectiveness was empirically tested in home-based childcare. Home-based childcare is more personalized and reflects the children's home more than center-based childcare (Groeneveld et al., 2011). As a second step, VIPP-CC was adjusted for center-based childcare, with larger groups of children and at least two caregivers present on a group. Key component in this group-based intervention is the professional caregiver's sensitivity and discipline while interacting with a *group* of children (Werner et al., 2017).

VIPP-CC for home-based childcare. To implement VIPP-SD in home-based childcare, some adaptations were made (Groeneveld et al., 2011; see Table 2). The intervener uses "speaking for the children" in addition to "speaking for the child" to provide subtitles for the whole group of children during the video-feedback, with a focus on the different developmental levels of the pertinent children. Further, because the play material of the VIPP-SD program was not always suitable for use in a group setting, some toys were replaced. For example, a large storybook was used for group book reading.

VIPP-CC for center-based childcare. VIPP-CC for center-based childcare (Werner et al., 2017) is based on VIPP-CC for home-based childcare as described above (see Table 2). A laptop was used to review the videotapes with the caregiver, because often no TV screens and/or DVD players are available at the childcare centers.

DISCUSSION

The VIPP-SD program provides an illustration of how an attachment-based intervention enriched with components from social learning theory, in particular Patterson's (1982) theory of coercive cycles, can be implemented in a wide range of populations, with some adaptations for specific groups of children or parents. The changes to the original VIPP-SD program in the various study populations are relatively small, and the essential elements and structure of the original protocol have been maintained in all cases. From this perspective we may be optimistic about implementing the original or a slightly adapted version of the VIPP-SD program in new populations and settings.

We described how the intervention model of VIPP-SD can be used in different types of families, taking into account their specific characteristics. For example, adoptive and foster parents become parents through self-selection, and they usually go through a screening and training process. However, they may need extra support and empowerment to parent their adopted or foster children who often show developmental delays and challenging behaviors. Other parents may struggle with specific child characteristics, such as externalizing behaviors or autism. If parents experience difficulties themselves, they may also have a need for extra help with parenting. Their difficulties may range from personal challenges such as eating disorders to more environmental factors, for example financial struggles. To date, children spend a substantial amount of time in home-based or center-based childcare settings. Caregivers working at these settings become important attachment figures for these children, and thus, VIPP-SD adapted for group settings can be seen as an important building stone to improve the rearing environment of children. It should be noticed that all versions of the VIPP-SD program can be used as a component in a broader, more intensive or longer treatment. A combination of VIPP-SD with another treatment (e.g., CBT or a self-help manual for eating disorders; Woolley et al., 2008) can be relevant for specific populations or settings.

The various versions have some consequences for the VIPP-SD training. The basic VIPP-SD training, which consists of four training days and (after successfully completing the course) conducting a first case of VIPP-SD under supervision, is sufficient for a wide range of families (Leiden University, 2018; Tavistock and Portman NHS Foundation Trust, 2019b). During the 4-day training course, professionals practice with video feedback in a group and during role play with other professionals using the standardized manual (Juffer et al., 2015). Some extra training is needed for VIPP-AUTI, VIPP-FC/A, and VIPP-CC. During these extra training hours the specific adaptations are discussed, for example the theme of "speaking for the children" in VIPP-CC (Vermeer, Groeneveld, Werner, Linting, & Van IJzendoorn, 2015). In sum, professionals working with families or with caregivers in out-of-home childcare can be successfully trained to implement the VIPP-SD program, and depending on the target group some specific requirements should be taken into account.

Conclusion

Awaiting the results from the studies that currently examine the effectiveness of the VIPP-SD program for fathers, families with older children, and other populations (see section Development of VIPP-SD), the existing body of evidence convincingly shows that the VIPP-SD program has positive effects on parenting and child outcomes in various types of families (Juffer et al., 2017a, 2017b). Moreover, the successful use with Turkish minority mothers in the Netherlands points to opportunities for using VIPP-SD with other cultural groups in other (non-Western) countries.

To use VIPP-SD in foster care two specific foster care themes (i.e., subtle/missing attachment behaviors and importance of sensitive physical contact) were added to the original intervention program resulting in VIPP-FC. Vignettes 1 and 2 illustrated how VIPP-FC positively changed the behaviors of two foster children that showed controlling behavior or avoided physical contact, respectively. These behavioral changes and the experiences of the foster families participating in the VIPP-FC pilot study are promising for the results of our ongoing research study regarding the effectiveness of VIPP-FC.

VIPP-SD with minor adaptations (i.e., “speaking for the children” and some toy replacements) was also studied in home-based and center-based childcare settings (VIPP-CC). Vignettes 3 and 4 illustrated the positive evaluations of VIPP-CC in home-based childcare and how VIPP-CC can improve caregiver behavior in center-based childcare. The adaptation to childcare settings may provide clues for improving group childcare in which the quality of care is highly disadvantageous for young children, for instance in institutionalized care and orphanages.

In conclusion, the VIPP-SD program has been implemented successfully in various populations who could benefit from parenting support. The flexibility of this intervention model may be based on the use of personalized video-feedback in which the parents or caregivers in interactions with their children constitute the starting point. Each parent or caregiver is his or her own yardstick with unique expertise about their own children. This approach is not one size fits all as each parent or caregiver looks into the mirror of his or her own unique interactions with the child, with unique potentials for reflection on improvement in the direction of more sensitivity and sensitive discipline. Therefore, there seems to be room for application of the VIPP-SD program in other, as of yet unserved populations.

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