How does video interaction guidance contribute to infant and parental mental health and well-being?

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Abstract

This article describes the contribution of video interaction guidance (VIG) to the development of infant and parental and VIG practitioners' mental health and well-being. The theoretical core of VIG was depicted in terms of concepts such as intersubjectivity, attunement and mediated learning. The way the VIG principles alongside the underpinning values and beliefs promote a process of attunement between parent and infant, the VIG practitioner and parent, and the VIG practitioner and supervisor is described. This article also describes some of the evidence about the effectiveness of video feedback techniques more generally and the way in which the underpinning theory of change enables VIG to target key ports of entry in terms of areas that have been highlighted by numerous epidemiological studies as being important in terms of supporting or derailing infant attachment security. A case study is used to demonstrate the way in which VIG can be integrated within broader therapeutic approaches such as parent–infant psychotherapy to support the interaction of parents who have been deeply traumatised in childhood. It also demonstrates how the parallel process of practitioner 'attunement' to mother is key to the mother's recovery and her new ability to form attuned relationships herself with her children and other adults.

Theoretical core of VIG

The concept of inter-related connectedness and intersubjectivity is at the heart of video interaction guidance (VIG). Intersubjectivity is the sharing of subjective states between two individuals (Scheff, Phillips, & Kincaid, 2006), and intersubjective abilities and motives are now

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recognised to be domain-general adaptations that cross-cut domain-specific motivational systems, including attachment, caregiving and sexuality (Cortina & Liotti, 2010). The achievement of attuned intersubjectivity or interaction with caregivers has been shown to be key for all aspects of children's social, emotional, behavioural and cognitive functioning (see below for further detail).

The core theoretical principles for VIG were derived from the observations of Colwyn Trevarthen, a psychologist and psychobiologist, using ethological methods. He observed the way in which the tiniest infants are active in developing cooperative activities with their parents. His observations of these successful interactions between infants and their primary caregivers demonstrated the way in which the mother's responsiveness to her baby's initiatives supported and developed 'intersubjectivity' (shared understanding) (Trevarthen & Aitken, 2001), which he regarded as the basis of all effective communication, interaction and learning.

This work was built on by the theories of Jerome Bruner (1995; mediated learning) and Barbara Rogoff (2002; learning through apprenticeship), who proposed that children learn by interacting with a more-experienced other who gently and skilfully 'scaffolds' the child's learning experiences so that they are able to learn without being overwhelmed by things that are not yet within their grasp. The term 'zone of proximal development' refers to the importance of working within the child's current range of abilities and is an important concept in VIG because the parent is encouraged to understand their infant's 'zone', while the VIG practitioner gradually explores the parent's zone, and in turn, the VIG supervisor scaffolds their interactions to maximise progress according to the VIG trainee's zone. In Figure 1, the 'Attuned interactions' is a shorthand for the VIG principles of attuned interactions and guidance (Figure 2), which encompasses the theories of intersubjectivity and mediated learning.
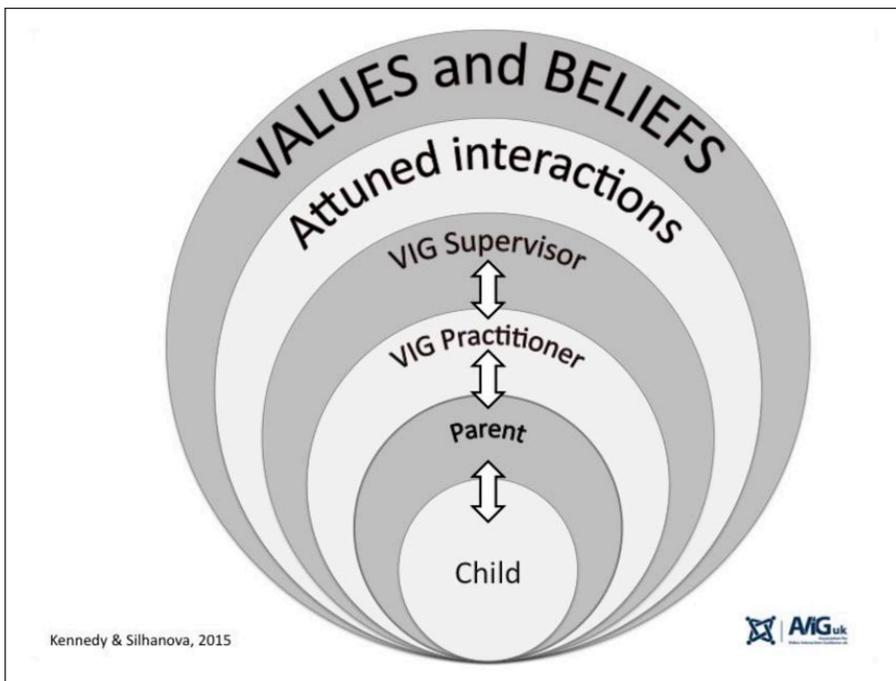
**Figure 1.** Embedded attunement in the VIG process.
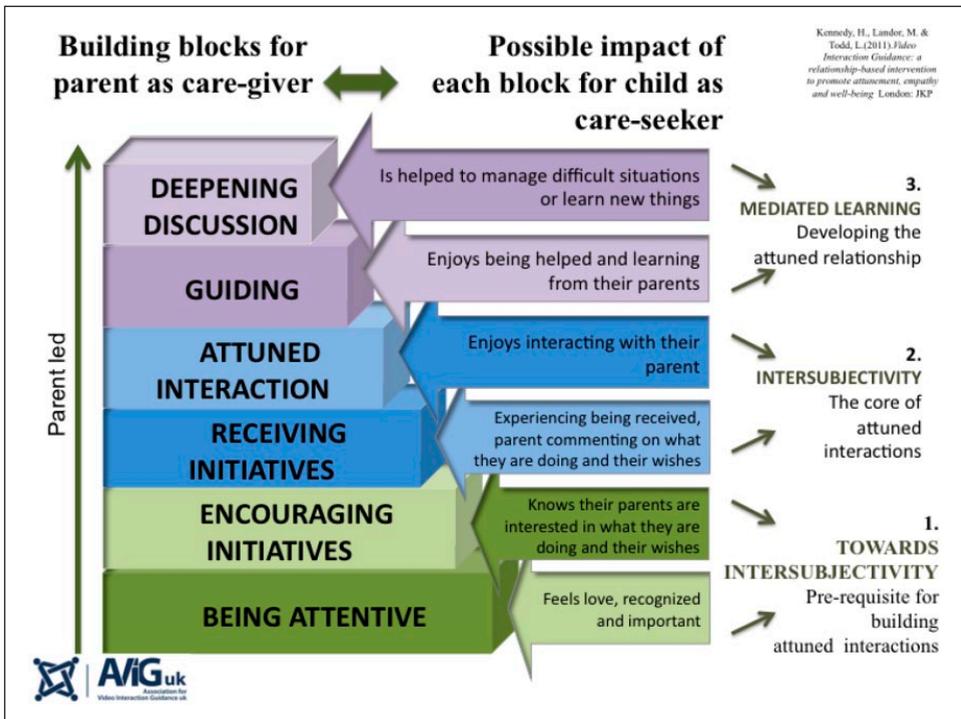
Figure 2. The building blocks of VIG.

These principles inform the core values and beliefs underpinning VIG and emphasise above all that it is a compassionate approach in which hope is maintained and trust is formed through building respectful attuned relationships. VIG practitioners demonstrate these principles, from the first meeting, through their own attuned interaction with their clients. They convey that change, even in adverse situations, is always a possibility and that the key to supporting change is an affirmation and appreciation of strengths alongside an empathetic regard for what people are already managing in difficult circumstances.

VIG in practice

VIG starts engaging parents in a possible change process by helping them form questions about how to improve their relationship with their infant. A filming session is carefully set up to capture the best possible interactions achievable at that time. The VIG practitioner then takes 5–10 minutes of video of the parent interacting with their child. The aim is to capture moments of 'better than usual' interaction on video by prompting or encouraging if necessary. The VIG practitioner then edits the video, selecting a few very short clips of successful interaction that link to the parent's goals for change. These are very likely to be exceptions to the usual pattern and exemplify various principles of attuned contact (Figure 2), especially parent's reception of their child's initiatives. For example, a mother of 3-month-old twins wanted to feel more confident and to recognise that she was understanding their needs. It was easy for the VIG practitioner to find video clips that showed attuned principles and thereby address the parent's goal.
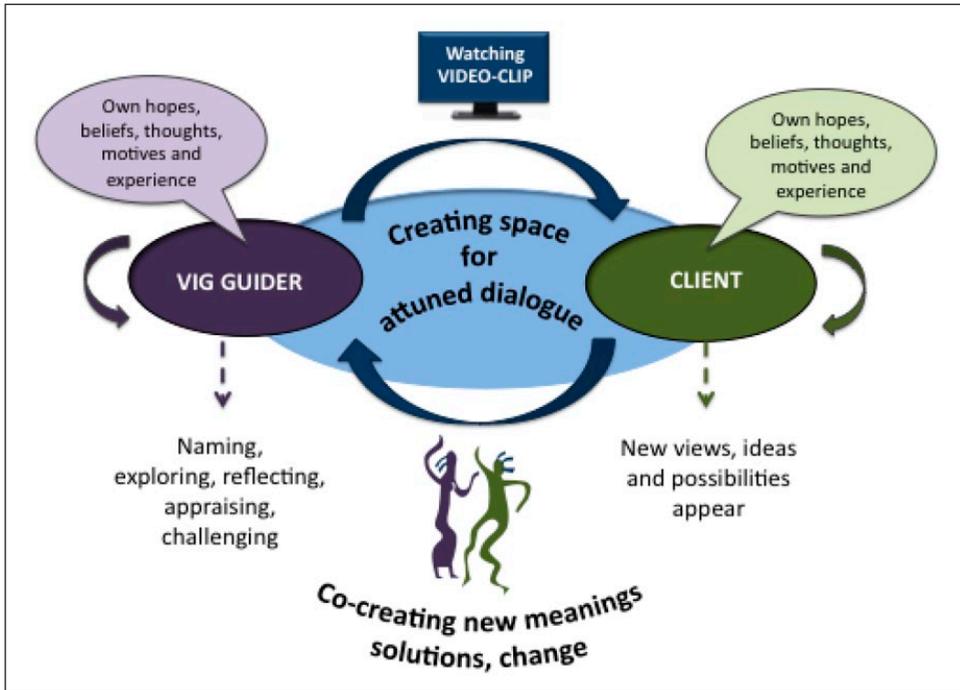
Figure 3. The VIG shared review.

In the shared review session (Figure 3) that follows, the parent and VIG practitioner study the selected micro-moments very carefully, working out together what the parent is doing that helps to build an attuned relationship with her child and thereby moving her towards her own goal. Through seeing their own attuned responses to their children, parents can start to observe and then to understand how important these experiences are for their children.

The VIG practitioner films the shared review of themselves with the parent and then discusses the micro-moments captured on film of their own moments of attuned interaction with their client in Supervision. Through this reflective supervision, VIG practitioners become increasingly skilled at engaging clients in, and then guiding them through, the change process. Figure 3 illustrates the systemic nature of VIG in which space created for attuned dialogue is key to the co-creation of new ideas and narratives.

Skilful use of the principles of attunement enables the guider to activate the parents in their own learning process, first describing what they see themselves and their children doing and then exploring their thoughts, feelings and their child's developmental needs. Guiders facilitate parents to lead their own 'learning journey' by identifying their own strengths and setting new goals at each reflective session. At the same time, they are experiencing an attuned interaction with the VIG practitioner who follows their initiatives and values their expertise as a parent.

Training in VIG

There are now over 1500 VIG practitioners or trainee practitioners working in the United Kingdom. They represent a wide range of helping professions, including social work, health, education and the third sector, and work across the age range from pre-birth to young adults and

with clients who have a wide range of educational levels (i.e. from basic school leaving qualifications to postdoctoral).

The training and supervision process of VIG mirrors the core attuned principles and beliefs, in which the supervisor scaffolds each trainee's learning, building on their unique strengths. VIG skills are developed through an intense supervision process over 18 months. The whole process of training is learner-led, mirroring the process with the families, in which the VIG practitioner places the parent(s) in the driving seat of their own change. The Association of Video Interaction Guidance UK (AVIGuk) regulates the standards of the quality of VIG training and practice in the United Kingdom and in the affiliated countries (Italy, Greece, Malta, Australia, Mexico, Ecuador and Argentina) that have chosen to follow the UK training standards.[1]

The quality of the delivery of VIG is maintained by the supervision process, and the training and continuing professional development of both supervisors and trainees is one of AVIGuk's top priorities. There are very few trainees who do not manage to complete the whole VIG training, reflecting the way in which the ongoing learning through supervision enables trainees to continually improve their practice. Below is a quotation from a 'reflective piece' written by a VIG practitioner about the process of client change at the end of her training. She was using VIG in a service with families experiencing mental health difficulties and child protection concerns:

> I think the experience of VIG has been hugely beneficial for my parents with infants as they have been able to recognize what they are doing well and start making changes which I feel would not have been achievable without VIG. One case, the Social Worker commented on how significantly more attuned the client was with her child outside of the VIG sessions. In another case a colleague was called to observe a family I had undertaken VIG with and she emailed me to comment on how much the contact had improved particularly the mother's attunement to her child.

This same practitioner also reflected on her own change:

> When I started on my VIG journey I felt apprehensive about being videoed and what I would think of myself as I have never had the opportunity to reflect on my own practice in this way. To be honest in the beginning I was quite critical of myself when I watched the video clips back such as seeing what clothes I was wearing, how my voice sounded, the faces I pulled when speaking. However, over time I have become far more comfortable seeing myself on video and have been able to move past thinking about what I looked like. This enabled me to really start looking at and identifying moments that I was pleased with within the shared reviews. I think in the early days I was more able to identify working points and have been 'hard on myself' as I wanted to be able to see myself being able to put into practice learning about applying the attuned principles. I have grown in confidence and am now comfortably able to watch my shared reviews and see moments where I have been attuned to my client and where I am pleased with how the shared reviews have gone. I think that during this process, as I have been able to see myself doing things well, it has definitely increased my confidence not only within my VIG work but when working with all my casework.

> I have also found myself adapting the attuned principles at home with my daughter and have recognized that she is far more able to respond to me when I have afforded her some attention particularly when I get home from work. I have also been able to name her frustrations for her especially when I have had to say 'no' to her. I think that having the experience of being received and listened to in an attuned way during supervision has helped me to empathize with how my clients feel. I can see a difference in how people engage with me when I am attuned to them. It makes me feel proud and happy to be able to communicate in a far more attuned way then I did before and think it has definitely contributed in my engagement with clients in my job.

Initially I often felt that I talked too much during shared reviews. I recognize now that I felt uncomfortable with silence and often tried to fill the gap. Having chosen clips where I have seen myself pausing and then seeing the client offer something else to the conversation has been important as I have realized that people need time to process and then if afforded some space can add something that otherwise could have been missed. I have thought about how I feel if someone is constantly talking to me and I think I would like to add something but when there is no pause, I don't get to say anything and sometimes forget and that point is missed/gone altogether.

During this journey I realize how effective it has been for me to see moments when I have been attuned or have done something well and I know that this has been encouraging for me to do more of that. I get excited when I see myself for example naming someone's pain as for me this was something I did find difficult to do. I remember worrying that I may make the situation worse in some way or that may be I was not qualified to hold someone's fragile mental health if they became distressed by seeing something in the clips I had shown. Supervision really helped me to talk this through via the clips to see that by actually naming someone's pain was a relief for them to feel validated and listened to. I have also experienced this within my own supervision when I have felt a bit overwhelmed and my supervisor was able to name that for me.

Does VIG make a difference?

VIG is now recommended as an evidence-based intervention in the United Kingdom through the National Institute for Clinical Excellence (NICE) guidelines: Children's Attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care (NICE, 2015); Social and Emotional Well-being – Early Years (NICE, 2012). The All Party Parliamentary Group for Conception to Age 2 (2015) and Public Health England (2015) have recommended VIG and other video feedback interventions as evidence-based methods of working with parents and children. This reflects the rapidly developing body of research demonstrating the effectiveness of video feedback techniques.

A meta-analysis of 29 studies showed that video feedback produced statistically significant improvement in parenting sensitivity (effect size: 0.49), parenting behaviour and attitudes (effect size: 0.37) and child development (effect size: 0.33) for children aged 0–8 years (Fukkink, 2008). Many of these studies involved 'high-risk' dyads (e.g. low socio-economic status (SES): 63%; parent clinical problems: 17%; and child clinical problems: 52%). Furthermore, a subgroup of studies that examined the effects of VIG using video home training (VHT) interventions) found even larger improvements (e.g. parental behaviour: 0.76; parenting skills: 0.56; and child development: 0.42), although it should be noted that these were mostly pre to post studies rather than randomised controlled trials (RCTs).

Similarly, Bakermans-Kranenburg, Van IJzendoorn and Juffer's (2003) meta-analysis of 51 attachment-focused interventions showed that interventions using video feedback were more effective than those without (effect size: 0.44) and that short interventions focused only on sensitivity were the most effective (effect size: 0.47).

Recent studies that have specifically focused on the effectiveness of video feedback with infants have found evidence of improved sensitivity in parents of premature babies (Barlow, Sembi, & Underdown, 2016; Cassibba, Castoro, Costantino, Sette, & Van IJzendoorn, 2015; Hoffenkamp et al., 2015), improved sensitivity and attachment in parents with low sensitivity (Kalinauskiene et al., 2009), fathers (Lawrence, Davies, & Ramchandani, 2013), postnatal eating disorder (Woolley, Hertzman, & Stein, 2008), infant–parent interaction problems (Høivik et al., 2015), depressed mothers (van Doesum, Riksen-Walraven, Hosman, & Hoefnagels, 2008), mothers with insecure attachment representations (Cassibba et al., 2015) and adopted infants (Stams, Juffer, Van IJzendoorn, & Hoksbergen, 2001).

Why does VIG work?

Effective interventions are typically underpinned by a theory of change, which links intervention components with the programme outcomes being sought and explains both how and why change can be achieved. Theories of change typically involve a logic model that defines the mechanisms by which change can be achieved. Before we examine the potential mechanisms by which VIG might be effective, it is necessary to describe in more detail what some of the epidemiological evidence tells us about what babies need from their primary caregivers to enable them to achieve key developmental milestones in terms of their socio-emotional development.

The early caregiving environment

The primary goal of VIG, as was suggested at the beginning of this article, is to support parents to achieve attuned interaction with their baby or child. A large body of evidence supports this goal, which shows that attunement between parent and child is key to their long-term development. For example, mid-range interaction has been found to be an important predictor of children's attachment security (Beebe et al., 2010), proto-conversational turn-taking is key to the early language and conversational skills of toddlers and young children (Carpenter, Nagell, Tomasello, Butterworth, & Moore, 1998; Markus, Mundy, Morales, Delgado, & Yale, 2000) and non-coercive cycles of interaction are key to children's later behavioural adjustment (Patterson, DeBarsyshe, & Ramsey, 1989).

In terms of infancy, one of the key developmental outcomes is a secure attachment to a primary caregiver, and research shows that such attachment confers a range of short- and long-term outcomes for infants across key developmental domains, including emotional and behavioural adjustment and learning (Sroufe, 2005), with insecure and disorganised attachment being associated with a range of poorer outcomes, including later psychopathology (Green & Goldwyn, 2002; Van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999), externalising disorders (i.e. conduct and behaviour problems; Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010) and personality disorder (Steele & Siever, 2010).

Although early evidence found that parental sensitivity was key to enabling the type of parent–infant attunement or interaction that would promote a secure attachment (De Wolff & Van IJzendoorn, 1997), this research also showed that such sensitivity explained only a limited amount of the variance (around a third) and that other explanatory factors needed to be identified. This led to a large body of developmental research, some of which identified the importance of repeated cycles between parent and infant of synchrony, rupture and repair (summarised in Gratier et al., 2015; Tronick, 2007) in addition to the way in which such cycles depend on the parent's ability to regulate their own emotional state in addition to the interaction with the child (Beebe et al., 2010). For example, parents who were preoccupied with regulating their own emotional state because they were depressed were found to engage in lower levels of tracking of the infant and were as a consequence also more likely to be insecurely attached. Parents who were preoccupied or overly anxious about the interaction were found to engage in higher levels of tracking (e.g. chase and dodge interactions) in which the infant was also more likely to be insecurely attached. These findings confirmed earlier research, which showed that a range of parental mental health problems were associated with poorer sensitivity and/or interaction, including depression (Murray & Cooper, 1997), borderline personality disorder (BPD; Laulik, Chou, Browne, & Allam, 2013) and schizophrenia (Wan, Penketh, Salmon, & Abel, 2008; Wan et al., 2007; Wan, Warren, Salmon, & Abel, 2008).

Research also began to focus on the impact of the parent's cognitive mind on the interaction, and in particular the parent's capacity for reflective functioning, which refers to a parents' capacity

to treat their infant as an intentional being and to understand their behaviours in terms of the child's feelings, beliefs and intentions (Fonagy, Gergely, Jurist, & Target, 2002). Recent research has found, for example, that reflective function (RF) was strongly associated with positive maternal parenting behaviours, such as flexibility and responsiveness, and use of the mother as a secure base on the part of the infant, while low RF has been found to be associated with emotionally unresponsive maternal behaviours such as withdrawal, hostility and intrusiveness (Grienenberger, Kelly, & Slade, 2005; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). 'Mind-mindedness', which refers to the parent's ability to read or understand the child's mind (Meins, Fernyhough, Fradley, & Tuckey, 2001), has also been found to be correlated with behavioural sensitivity and interactive synchrony (Meins et al., 2001) and to be a better predictor of attachment security at 1 year than maternal sensitivity (Lundy, 2003; Meins et al., 2001).

Other factors that have been found to be important in terms of the infant's attachment security are the mother's representations both of her own attachment status and of her baby. For example, one of the key predictors of whether an infant is securely attached is the parent's attachment status (Van IJzendoorn, 1995) as measured by tools such as the Adult Attachment Interview, which assesses caregiver states of mind with regard to their own attachment, with around 75% concordance for secure and insecure attachment patterns. The complexity of this intergenerational transmission of attachment is, however, indicated by recent research (Shah, Fonagy, & Strathearn, 2010), which found that while secure mothers had secure babies, there was an inversion of insecure patterns of attachment for insecure mothers such that Type A mothers (i.e. Avoidant) often had infants with a Type C pattern (i.e. Anxious-Ambivalent), and vice versa. Brain imaging studies using functional magnetic resonance imaging (fMRI) activation have shown that mothers who are securely attached show greater activation of brain reward regions when they view images of their own baby's face (both happy and sad) than mothers who are insecure (Type A) (Strathearn, Fonagy, Amico, & Montague, 2009), suggesting that the mother's own attachment experiences in childhood play a role in shaping reward and affiliation neural circuits in the brain, which may then influence the mother's ability for attuned responses to her own infant's cues (Strathearn et al., 2009).

Maternal representations of the baby as measured by tools such as the Working Model of Child (WMC) are also predictive of both parenting practices and infant attachment security when measured in both pregnancy (Barlow et al., in press) and the postnatal period (Vreeswijke, Mass, & van Bakel, 2012). For example, studies have found an association between such maternal representations in the postnatal period and mother–infant interaction in term and preterm infants (Korja et al., 2010), parenting behaviours (Schechter et al., 2008; Sokolowski, Hans, Bernstein, & Cox, 2007), and infant attachment security (Benoit, Parker, & Zeanah, 1997; Zeanah, Benoit, Hirshberg, Barton, & Regan, 1994).

In summary, research suggests that one of the key developmental outcomes for infants (e.g. attachment security) is promoted by sensitive and attuned interactions that occur within the mid-range (i.e. in terms of not being too passive or too intrusive) and that parental reflective functioning or mind-mindedness also promote type of flexible parenting behaviours that are associated with attachment security. Parental representations related to the parent's own attachment or regarding the infant also appear to affect infant attachment security as a result of their impact on parenting behaviours. Therefore, these represent potentially important targets or 'ports of entry' for VIG.

Ports of entry

Stern (1995) originally developed the term 'ports of entry' to depict the major and minor aspects of the parent–infant/child system that are targeted by the therapist in order to bring about change. The term has more recently been defined as 'the road that leads to the theoretical target of the
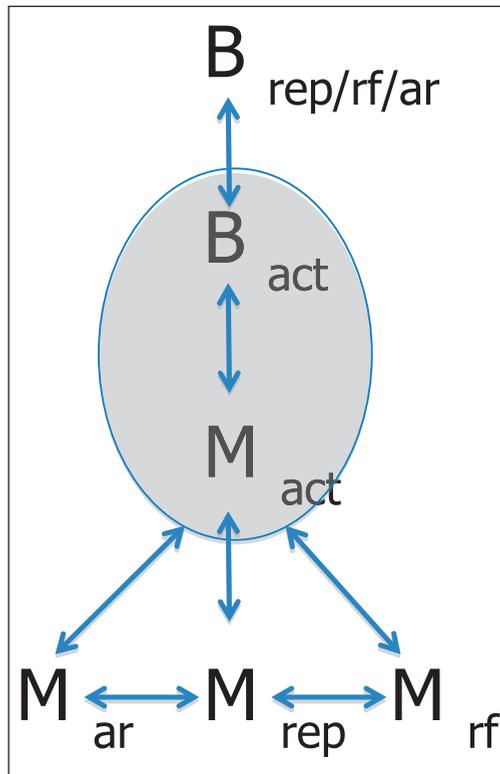
Figure 4. The caregiver–infant system.

intervention' (Lieberman & Van Horn, 2008) in recognition that this can involve a wide range of aspects of this system.

The caregiver–infant system comprises a number of components or ports of entry as is depicted in Figures 4 and 5. The baby (B) engages in his or her actions (act) with the caregiver, and these are informed by their as yet not fully developed representations (rep), reflective functioning (rf) and their affect regulation (ar). Similarly, for the caregiver (M), the actions are primary in terms of the relationship with the baby, but these are informed by their representations (rep), reflective functioning (rf) and affect regulation (ar) here represented as discrete domains because they are fully developed in the adult.

Different dyadic interventions target different aspects of this system. For example, infant massage focuses explicitly on the caregiver and baby actions using massage to promote more sensitive and attuned interactions. In terms of VIG, there is an additional component to the system, in the form of the guider. The earlier part of this article described the way in which the attuned interaction that is being sought between parent and infant is paralleled in terms of the relationship being developed between the VIG guider and parent and also by the relationship between the VIG supervisor and guider. Figure 2 shows the potential that VIG has to change a number of different aspects of the system as a result of the way in which this particular intervention directly involves the guider's (G) actions (act) and their own representations (rep).

VIG therefore provides two key mechanisms by which change can be brought about as a result of (a) their interactions with the guider and (b) the use of these interactions to explore the parent in
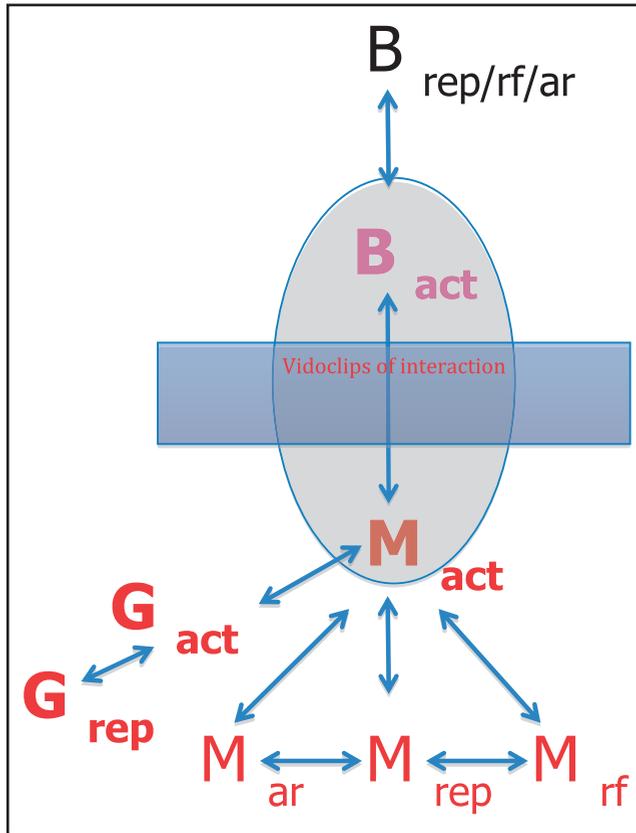
Figure 5. Ports of entry.

interaction with the infant using the video feedback. First, the attuned and mentalising stance of the guider enables the caregiver to experience first-hand attuned interactions with an adult who is able to think about the adult's internal states and the way in which these might be informing their interactions with the baby. These attuned, mentalising interactions have the potential to improve a number of aspects of the caregivers' functioning, including their reflective functioning and their representations regarding their own attachment.

Second, the opportunity to view themselves in interaction with their baby and to observe positive responses from the infant, in addition to the guider using the video to prompt the parent to think about what the baby might be feeling, can bring about a range of meta-cognitive changes resulting from the discrepancy between their own beliefs and about their ability to parent and what they can see on the video, in addition to an increase in feelings of empowerment and self-efficacy and their ability for reflective functioning.

Case study

The final section of this article describes a case study, which shows how VIG can be successfully integrated into parent–infant psychotherapy with a mother with severe postnatal depression with borderline personality traits and a background of severe sexual abuse. She was also being treated

by a consultant perinatal psychiatrist alongside the VIG therapy as part of a perinatal parent–infant psychotherapy service. At the beginning of therapy she said, 'I don't feel anything for my baby and I am thinking of having him adopted'. At the end of eight cycles of VIG, she said emotionally, 'the bonding and interaction between me and Luke is better than I could have ever dreamed of'.

VIG involves communication in action or 'learning by doing' and as such enables a therapist to cut through the different theoretical approaches and focus more on practice. It also takes a social constructionist approach, which emphasises how the therapy is co-constructed in a collaborative way between the client and the therapist (Burr, 1995). In the case of Julia, who was very fearful of therapy and whose history of abuse left her with a sense of things being done to her, the therapeutic stance required sensitively co-creating the therapeutic process with her, which had a powerful and immediate positive effect. In social constructionist systemic terminology, this is called 'relational reflexivity' whereby the therapist goes one step further than being mindful of what is going on in the therapy and shares this with the client as they go along (Burnham, 2005). Burnham (2005) writes, 'relational reflexivity is the intention, desire, processes and practices through which therapists and clients explicitly engage one another in coordinating their resources so as to create a relationship with therapeutic potential'. During VIG supervision, this process unfolded not only between the client and therapist but also between therapist and supervisor; the process of negotiating and co-constructing goals and aims in supervision paralleled the way in which the therapist began working with Julia in a process of 'mutual influence'.

Case

Julia (fictional name) is a 35-year-old British woman. At the time of referral, she had two older boys aged 6 and 7 and was married to a supportive husband. She said that she was worried that she did not like her new baby son, Luke (fictional name), and showed no eye contact or interest in him despite being able to hold him well. She also showed little affection for him and he presented as irritable and restless throughout the first session. She said she had a history of suicide attempts and during the early postnatal period with her other two children had self-harmed. With this new baby, she had had thoughts of walking in front of a car. In the first session, she was able to disclose that she had been sexually abused by her mother from the age of 7 until middle adolescence. This was the first time she had disclosed this despite many therapeutic sessions attended during her childhood to the present day. She was surprised to find that she was able to share this in the first session, and it frightened her to the point where she feared she would not come back. However, these fears were 'contained' and she continued to undertake the work.

She said that the impact of the abuse on her relationship with her baby was that she struggled to breast feed, touch him and be affectionate. She 'projected' her past experiences with her mother onto her relationship with her baby and felt that the baby's hands reminded her of her mother's. She was considering having him adopted and did not feel she wanted him or loved him. These feelings were understood to be a way of avoiding or getting rid of these feelings, and VIG in the context of psychotherapeutic work was required to 'contain' this. She felt happy to begin the work by focusing on the difficulty she had with bonding with Luke.

Cycle 1: the first video

During the first (planning the VIG) and second (taking the first video) sessions, two things were already clear. First, that Julia would need an extended therapeutic relationship to enable her form an alliance based on trust, and this would be a slow process given her history. Second, that she found speaking difficult, especially about her baby, and initial attempts got locked into cycles of

negative attributions towards her baby. Her projections seemed very fixed, and thus, it was decided that VIG would be the best method to give her the chance to shift her internal narrative. At the beginning of Session 2, the therapist asked her about how difficult she found the first session and the intrusive thoughts she was having about the abuse. Together they wondered how to proceed, and through this collaborative VIG approach, she felt able to talk about the impact the abuse had on her attachment to Luke. In talking about the impact it had on her mothering, they were able to 'co-construct some goals with her that she would like to work on'. The VIG then moves from goals to form 'helping questions' that will encourage her to find clear ways that she can support her goals (e.g. ' What can I do to enjoy being with my baby more?'). The joint setting of 'helping questions' is an important step on the VIG journey.

The first core element of VIG is empowerment as defined in terms of the 'theories of change that emphasizes respect, empowerment and collaboration with families' (Kennedy et al., 2011, p. 58). In VIG terms, responding to Julia's *initiative* involved listening to her difficulty with speaking and to be *attentive* to this. This is one of the basic principles of attuned interactions and guidance in VIG along with the second principle of '*giving time and space to the other*'. Both of these are vital at the beginning of the therapeutic relationship, as well as helping a parent reconnect with their baby. The emotional 'derailment' between two people and the consequences that follow have their starting point here, and hence, the therapeutic process needs to start here.

Julia decided herself that working on her relationship with the baby would feel safer than directly addressing the abuse at this stage, and she very much liked the idea of videoing the interaction because there was less emphasis on speaking about their relationship, which inevitably brought up painful memories of the abuse. It was also agreed that talking about the abuse was part of the work and that it was not being excluded or avoided but that therapist and patient could decide together when it felt right to talk about it. The VIG process began with the therapist initially taking her feelings and thoughts about her baby and translating them into helping questions. She wanted to work on being affectionate, loving and enjoying being with him, which at this point she found impossible. Having agreed on this, the first 5 minutes of videoing of her interaction with her baby were undertaken. It was a difficult 5 minutes for both therapist and patient; it was difficult for Julia to sustain interaction with her baby when she felt it was hopeless and when she felt awkward and unnatural doing the video, while the therapist felt awkward and sometimes hopeless as her VIG trainee guider. However, the therapist was able to 'contain' these feelings and maintain the therapeutic alliance, and Session 2 ended here with an agreement to meet again the following week at the same time, the therapist having shown and discussed the video with his VIG supervisor. Being transparent about this process of sharing the video is linked to the VIG principle of empowerment as well as building trust. In fact, Julia thrived on the idea of the supervisor seeing the video, and at times, the therapist talked about his supervisor in the session, wondering aloud to Julia, what she might think and say. This valuing of the supervision possibly reflected the fact that Julia needed and liked the idea of people with whom she felt safe 'witnessing' her new narrative. It has been suggested that therapy can be structured like a 'definitional ceremony' and that ' these ceremonies are rituals that acknowledge and regrade people's lives, in contrast to rituals . . . that degrade people's lives' (White, 2007, p. 165). By providing affirmation, these ceremonies provide a 'context for rich story development' (White, 2007). Similarly, in VIG, the supervision process lends itself to developing a strong alternative narrative to Julia's own experience of motherhood, which was about trauma, abuse, fear and failure.

Cycle 1: the first shared review

The first review is a pivotal part of the VIG process, and therefore, it is important to choose the clips from the first film carefully. It is essential to make sure that the clips do not show 'failed

moments', which can reinforce the dominant narrative rather than enabling the client to find a new one. In systemic practice, this is called the 'unique outcome', where we ask for an exception to the child's 'bad' behaviour, however, momentarily (Morgan, 2000, p. 57). With video, it requires editing precision to show only attuned moments in order to evoke this narrative effect. In this case, a clip was selected where the baby was turned away from Julia, and as a result of her talking to him and moving back to a 45° angle (i.e. at a dialogue distance) and giving him plenty of space, he turned towards her smiling. The clip lasted about 5 seconds, but it was enough to find this visual 'unique outcome'. It was an exception to her general pattern of trying very hard to make contact, leaving little space for the baby and again and again the baby rejecting her advances.

The therapist introduced the video clips by saying, 'I just wanted to show you this really nice clip of how we (i.e. therapist and VIG supervisor) felt that you managed to get Luke to engage with you'. She looked very uncertain, but as soon as she saw the moment of contact, her tone changed and she said, 'Oh, yea. He turns back, yes, oh yea'. He responds, 'just stopping that for a second we thought that was a beautiful moment between you and I am just wondering what you can see that you did to bring that about'. She pauses and then tentatively says, '*I* think I started talking to him, didn't I . . . I touched him, I think I touched him here (on his chin), . . . Yea'. The therapist adds, 'I think you are both smiling'. She looks carefully, and once she has seen the smiles she agrees and the therapist adds, 'do you see how immediate his response is?' Her look of emerging pride helped in the decision to explain the importance of the space she was giving him. Together the therapist and client looked at this space again, and she could see what he had seen. The therapist continued by saying, 'we noticed that the very best moments were when you created this lovely space, to me he seems to be a little boy with a very strong sense of self'. She liked this idea, and so we had created through the exploration of this first clip the idea of respecting 'space between herself and the baby'. This became an important theme for both client and therapist throughout the VIG intervention.

Therapist reflections

In this case, the VIG process was embedded within a wider psychotherapeutic approach, in which as a result of childhood abuse, the therapist needed to be able to conduct the VIG work and at the same time 'contain' other client fears, including the frightening abuse that was starting to be uncovered and disturbing projections or ghosts in the nursery that were emerging, such as the mother seeing the baby's hands as similar to her abuser, and the projections onto the therapist, in order to avoid the therapeutic relationship running the risk of avoiding the repetition of past failed relationships. There were, as such, a number of times when the therapist had to interrupt the VIG work to address these or when abuse issues arose naturally, and Julia needed the time and space to talk about these. At one point in the treatment, when Julia needed the additional help of the home treatment team, there was a risk of the professional system 'splitting', and effective liaison with other professionals, particularly the consultant psychiatrist, was a key part of 'holding' Julia (Diaz Bonino & Ball, 2013).

In Cycle 3, most of the video showed Julia tickling Luke in an attempt to get his attention. This interaction was parent led, and it was not succeeding. Julia looked at the therapist and said, 'I don't really know what else to do really?' and stopped tickling him. Instead she sat back and waited, watching Luke and giving him space. At this moment, in the video, Luke began to make eye contact with her and made efforts to engage with her. This clip was chosen from the moment Julia stopped tickling him and just sat back and became attentive to him. The shared review that that followed using this clip demonstrates using all three methods of doing parent–infant psychotherapy at once: using video, working with mother's projections and countertransferences and working directly with the baby.

The sequence of events is as follows: The therapist sat back to ask Julia what she saw, waiting patiently for her to describe this. It was a struggle at first, and he unconsciously had the urge to do exactly what Julia was doing in the video, in terms of being very active and trying to get her to respond. She continued to say, 'I don't really know, I don't know' and shrugged her shoulders. Luke was irritable, and it felt that we were at an impasse. Working directly with the infant at this point, the therapist picked Luke up and sat beside him himself, talking to Luke directly. This put Julia at ease, and she became more reflective, the tension between her and Luke subsiding. Julia was then able to see and say that 'when I stop tickling him he talks to me. He liked the **touch** of my voice'. She began to notice that Luke was interacting with her even though she was not trying to do anything. She said, 'I think that's why it's helping. That he actually wants to interact with me . . . this may sound crazy butts like a green light to be normal . . . its ok to play with him, to sing to him . . . he likes it'.

Cycle 7

Julia had developed, as one of her goals, being physically intimate with her baby, as well feeling safe. Indirectly, she was able to make the distinction in her mind between tenderness and abuse. Her capacity to give her baby space to interact and wait for his initiatives grew in synchrony with the therapist's capacity as a trainee guider to relax and be more natural with her. This parallel process was most clearly seen in Cycle 7 shared review when the therapist could be seen on video sitting back, relaxing and listening to Julia describing herself sitting back and giving space to Luke on the video. There were striking moments where as she was speaking about relaxing more with her baby, therapist and client were relaxing more with each other, and the eye contact and other attuned behaviours increased between them. The therapeutic relationship now paralleled how she was with baby. Supervision was vital in highlighting these dynamics because supervisor and therapist were able to observe these developments as part of their shared reviews. At the same time that Julia was finding herself as a mother, her therapist was also finding himself as a VIG trainee and becoming liberated by being more natural, more relaxed and enjoying the process more.

Julia continues to improve and reports that 'I am now doing this (giving them space and responding to them) with my other children and friends'. She is widening her ability for attunement beyond her relationship with her baby. This is an intrinsic part of VIG and extends its effectiveness beyond the original triad involved in the VIG work. In the same way, as a trainee guider, there is a process of continual professional growth through the wider VIG community that facilitates continual change and development.

Conclusion

VIG is effective because the intervention focuses clearly on rekindling or developing what is known to be optimal conditions for humans to thrive. Infants thrive when they have loving attention from at least one adult who has the capacity to focus on their needs. Parents and infants thrive when they are able to enjoy getting to know each other, to read each other's signals and to develop together. Parents thrive when they can connect easily and enjoy working respectfully together with a professional for a better future. Professionals thrive when they see their strengths and how they make attuned connections with a parent.

Furthermore, VIG training builds strong attuned relationships between members of teams while training them in a cost-effective intervention that is satisfying and enjoyable to deliver. Systematic research on the many observations and reports of improvement of well-being and mental health of the professionals delivering VIG is indicated.

Declaration of Conflicting Interests

Funding

Note

1. Details of these can be found on the website www.videointeractionguidance.net.

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