

Video Interaction Guidance (VIG) in the Perinatal Period

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“Watching the footage back: that was just, I mean, that was huge for me (...) actually being able to see myself, like, almost step out of myself and see myself, and see my interaction – it really helps me understand and digest what was happening.”

“It helped me to be more calm with my baby when I am mentally not well. It helped me to be calm with her.”

Quotes from parents who took part in a one year pilot program where Video Interaction Guidance (VIG) was provided by health visitors and family support workers to parents and infants under one where there were concerns around bonding (1). For those who have not come across it yet, VIG is an evidence-based intervention which seeks to support participants to develop more meaningful and rewarding connections with important others in their lives, through the shared detailed analysis of video clips of ‘better than usual’ real life interactions.

It has been around since the early 90s and has been used with families with a wide range of difficulties and from across the life span (2). It is recommended in two NICE Guidelines (3,4), and also listed as a recommended intervention in the First 1001 Days All Parliamentary Party Group report: Building Great Britons, February 2015 (5). VIG has an established UK training and accreditation programme through AVIGuk (www.videointeractionguidance.net) which includes ongoing video-reflective supervision and rigorous accreditation criteria.

At this point I should declare an interest as I approach the end of my VIG practitioner training, joining a small but growing group of psychiatrists (perinatal and child and adolescent), and a much wider group of professionals from other disciplines, who are using VIG in a wide variety of settings in the perinatal and infant mental health arena. These include: mother and baby units, community perinatal mental health teams, joint local authority and NHS teams working with parents whose babies are in care proceedings including parents with substance misuse/dual diagnoses, parents with premature babies, NHS and third sector infant mental health teams, third sector projects working with parents where there is domestic violence and post adoption support teams.

There are many other effective video feedback interventions based on the same aims of enhancing parental sensitivity while helping parents guide their children’s development and behaviour (6,7). However, in this article, I will focus on VIG, as the technique I am most familiar with, and because I think the collaborative, flexible and self-reflective nature of the technique and training provide a good ‘fit’ with the complex and emotionally charged reality of perinatal mental illness, from the ‘mild’ to the ‘severe’ ends of the spectrum.

Begin at the beginning

The growing interest and expansion of VIG in the perinatal and infant mental health field is fitting given that VIG has its origins in the work of Professor

Colwyn Trevarthen, a psychologist and psychobiologist (8). His observations of how parents and babies follow each other, the rhythm, the tone and the 'pauses' that help communication work, inspired Harry Biemans, a Dutch Child Psychologist, to develop the 'Principles for Attuned Interactions and Guidance' (see Fig. 1). From these, VIG as we know it today was further developed by Hilary Kennedy and others in Dundee (2).

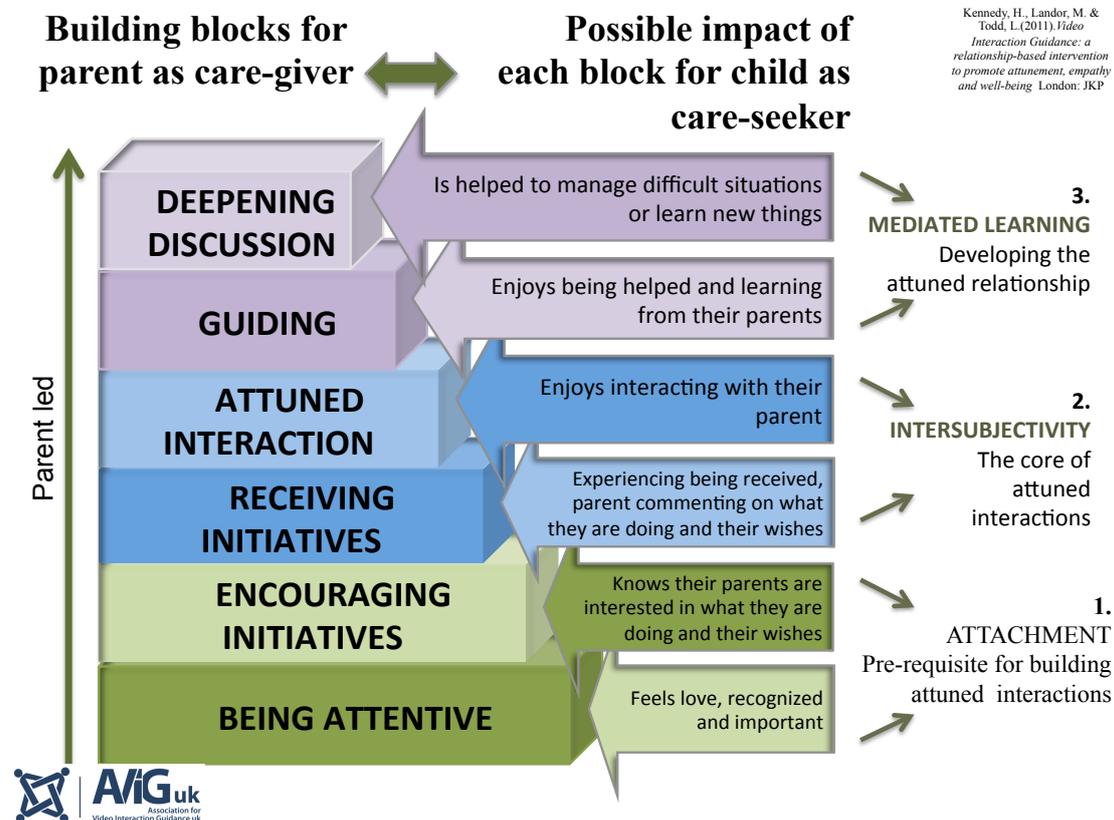


Figure 1. Principles of Attuned Interactions and Guidance - The building blocks of VIG

These principles are not only the 'building blocks' of the emerging relationship between the parent and the baby, but also underpin the growing relationship between the VIG practitioner and the parent, and the relationship between the VIG trainee and supervisor, something I will return to later.

In addition to promoting parental sensitivity, which has been shown to be an important mediator between parental mental illness and adverse outcomes for the child (9,10), perinatal VIG seeks to support and enhance other related concepts which have been shown to be important to the healthy emotional and cognitive development of the baby (10,11). These include: parental 'reflective function', that is a curiosity about the meaning and intention of their baby's signals and a capacity to view their baby as separate from themselves (12); a parent's ability to recognize their baby's need for a break ('rupture') and then gently re-attune to their new emotional state (repair) as described by Tronick (13); 'mid-range contingency' referring to parent-baby interactions that are neither too withdrawn (parent preoccupied with their own thoughts and

feelings) nor too vigilant and intrusive (parent overly preoccupied with the baby)(14); and 'mind-mindedness', the capacity of parents to accurately read their children's cues and put them into words related to thoughts and feelings (15).

Outline of the VIG method

VIG begins by exploring with parents what it is *they* are concerned about in their relationship with their baby. This may differ from what professionals are concerned about and these concerns will be borne in mind, but it is important to begin with what is important to the parents and support them to form these concerns into 'helping questions' or goals, e.g. ("To have a better bond with my baby").

A brief (10-15 mins) filming session of the parent-baby dyad is then set up in such a way as to capture the best possible interactions available at that time, e.g. gently encouraging a parent to hold their baby at the optimum distance for interaction. From this film, 3-4 short clips and/or stills will be edited of successful interactions linked with the parent's helping question, and particularly looking for moments or short sequences where the parent has left space for and then received an 'initiative' from their baby (a look, gesture or vocalization) in a sensitive, attuned way. These clips and stills are then 'microanalysed' together with the parent in a 'shared review', watching and re-watching them, sometimes with the sound off and in slow motion, to enhance the joint discovery of what it was that the parent was doing that led to the successful interaction. If the baby is on the parent's lap during the shared review, often watching themselves in a loving moment with their baby can naturally prompt a further attuned moment between parent and baby which the VIG practitioner can notice and gently reinforce.

The VIG practitioner follows the parent's pace, allowing space for them to voice thoughts and ideas triggered by the clips, receiving these ideas and building upon them, while keeping the focus of the conversation in the 'here and now' and on the helping questions by a careful return to the video. From moment to moment they will judge when to bring in information, e.g. prompting parents to identify which of the principles of attuned interaction (Fig. 1) they were demonstrating in the clip. The aim is for parents to be 'in the driving seat' in shared reviews and to become active agents in their own change. At the end of each shared review, the practitioner will 'check in' to see if the helping questions are being adequately addressed and whether they need to be modified.

A VIG 'cycle' comprises a filming and a shared review and the average length of a VIG intervention is 3-4 cycles, though there is a recognition that with parents with a history of childhood trauma and abuse who are dealing with other complex problems (e.g. substance misuse, domestic violence) more cycles may be required. Throughout the intervention but particularly towards the end, the focus of the shared review will include reflecting upon how positive changes in their interactions with their baby might lead on to changes in other areas of their parent's life e.g. their relationship with their other children, their partner, their community. We know that parental mental health problems do not exist in a

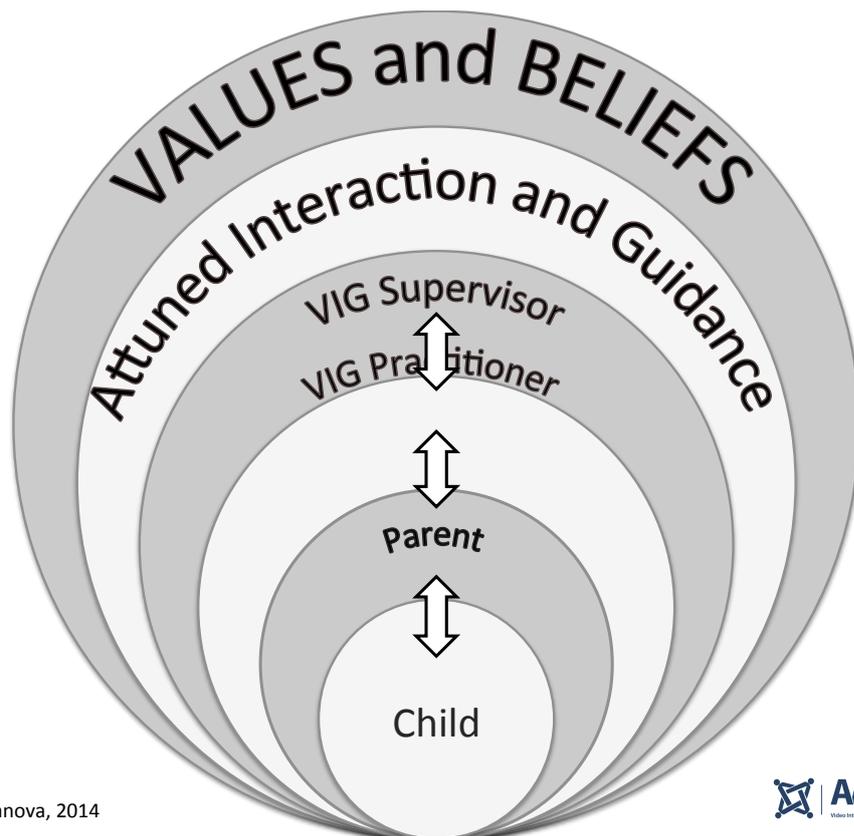
vacuum, with socioeconomic status and inter-parental conflict being important mediating factors on parenting and parent-child relationships (9,16,17). Therefore this inclusion of 'context' in the VIG intervention is important and an integral part of the ending is the VIG practitioner supporting the parent to plan 'next steps' in achieving positive change in other areas of their life.

There is a growing recognition of the existence and impact of prenatal and postnatal mental depression in fathers and interest in the relationship between maternal and paternal perinatal depression (18,19,20,21). Research into other paternal mental health disorders and their impact in the perinatal period has been largely lacking, though the available literature suggests that different disorders have a unique effect on the father's parenting, relationship with their child and the emotional outcomes for children (22). VIG has been used with fathers in a wide range of settings including the perinatal period. Indeed an RCT assessing the VIG as an intervention for parents of premature babies suggested that it might be particularly beneficial for fathers in terms of parental bonding (23).

An additional possibility is offering VIG to both parents as part of the same intervention, with separate cycles initially, starting with the parent who is struggling most in their interactions with the baby, then progressing to a shared review with both parents, where each parent can appreciate the strengths of the other in the shared clips. This approach could also work well for single parent families where another adult such as a grandparent provides significant support in caring for the baby.

VIG Training, Supervision and Continuing Professional Development

The VIG training process is essentially learning VIG with real families under close supervision, with the trainee 'in the driving seat' and an active participant in their own learning. The trainee films their shared reviews and brings this film, along with their proposed edited clips from the parent-baby filming to supervision. The VIG supervisor, drawing on the principles from Fig. 1, scaffolds each trainee's learning, building on their unique strengths as they microanalyse together clips of successful moments of attunement between the trainee and the parent. Thus, the VIG practitioner through experiencing attuned interaction with their supervisor is better able to attune sensitively to the parent, which, in turn, supports the parent's capacity to attune to their baby (Fig. 2). In cases where the severity and risk associated with perinatal mental illness is high, VIG supervision can play an important role in supporting the clinician as outlined in a case study where VIG was used alongside other treatments for a mother with a history of childhood abuse and attempted suicide and self harm in the early post natal period (10).



Kennedy & Silhanova, 2014



Figure 2 Embedded Attunement in the VIG process

The VIG training process has recently been streamlined so that accredited practitioner level could be completed in a year, with a mid point review and final accreditation day where trainees present edited clips of their work and a structured self assessment of their skills to an external supervisor. Those who wish can then apply to more advanced level training and then accredited supervisor training. The latter involves taking on supervisory cases with support from experienced VIG supervisors and so teams embarking on VIG training can eventually become self-sustaining.

VIG practitioners at any stage in training are encouraged and supported to participate in regular multidisciplinary ‘intervision’ events where VIG work is presented and reflected upon in a supportive group setting. ‘Building Babies Minds’ is one such regular event in London for those working in perinatal and infant mental health settings. Recent presentations have included innovative work including antenatal VIG (24), VIG in groups (25), and VIG using an interpreter. There is also an online forum available through the VIG website allowing sharing of ideas and resources. The intensity of the supervision and ongoing CPD has facilitated those without a formal clinical training to take up VIG training, as a voluntary parent mentor organization in Essex have done recently (<https://www.parents1st.org.uk/once-in-a-lifetime-videos-vig>).

Conclusion

VIG is an effective, flexible, strengthsbased intervention which can be used across the spectrum of perinatal mental disorder with both mothers and fathers

to support their growing relationship with their baby. Building a strong, empowering therapeutic alliance with parents is a key component of VIG and this task is supported by the reflective supervision integral to the training and practice of VIG.

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