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Looking from the outside in: the use of video in attachment-based interventions

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Looking from the outside in: the use of video in attachment-based interventions

Miriam Steele^{a*}, Howard Steele^a, Jordan Bate^a, Hannah Knafo^a, Michael Kinsey^a, Karen Bonuck^b, Paul Meisner^c and Anne Murphy^d

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This paper provides an account of multiple potential benefits of using video in clinical interventions designed to promote change in parent–child attachment relationships. The power of video to provide a unique perspective on parents’ ways of thinking and feeling about their own behavior and that of their child will be discussed in terms of current attachment-based interventions using video either as the main component of the treatment or in addition to a more comprehensive treatment protocol. Interventions also range from those that use micro-analytic as compared to more global units of analyses, and there are potential bridges to be made with neuro-scientific research findings. In addition, this paper provides a clinical illustration of the utility of showing parents vignettes of video-filmed observations of parent–child interactions from the Group Attachment Based Intervention (GABI) for vulnerable families. Emphasis is placed on the motivational force arising from seeing (and hearing) oneself in interaction with one’s child on video, thus serving as a powerful catalyst for reflective functioning and updating one’s frame of reference for how to think, feel and behave with one’s child.

Keywords: video feedback; attachment-based interventions; parent–child relationship; Group Attachment Based Intervention; reflective functioning

Going back nearly half a century, clinicians understood the unique power of video film in illuminating and facilitating therapeutic processes. As Alger and Hogan (1967, p. 1) commented: “It may be no exaggeration to say that videotape recording represents a technological breakthrough with the kind of significance for psychiatry that the microscope has had for biology.” The use of video film is a powerful addition to our clinical toolbox that is increasingly being used across many attachment-based therapeutic modalities and parent groups (e.g., Beebe, 2003, 2005; Downing, 2005; Downing, Bürgin, Reck, & Ziegenhain, 2008; Dozier, Dozier, & Manni, 2002, 2006; Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2008; McDonough, 2000, 2004; Powell, Cooper, Hoffman, & Marvin, 2013; Schechter et al., 2012; Zelenko & Benham, 2000). It has particular relevance to parent–child intervention work, when the motivation to achieve change for the benefit of the child is great (Murphy, Ponterotto, Cancelli, & Chinitz, 2010). It can be the main component of a therapeutic modality, or an additional technique to enhance the delivery of a particular intervention. Attachment-based interventions, especially those with infants and young children, which incorporate the use of video are

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becoming plentiful and are accruing an evidence base. From the perspective of attachment theory and research, video-film integrated into clinical work seems a natural next step linking the documentation of careful observations of caregiver–infant interactions with the clinical roots of the theory (Bowlby, 1988). This paper comments on the clinical power video feedback brings to an attachment-based intervention, selectively reviewing existing intervention approaches with an attachment focus, before illustrating how video feedback is used in an ongoing randomized controlled trial testing the effectiveness of the Group Attachment Based Intervention (GABI), specifically designed for use with vulnerable parents and their young children.

Observation, attachment and video

Much has been written about the influences upon John Bowlby's thinking as he conceptualized attachment theory including ethology, control systems, psychoanalytic theory, and studies of bereavement. However, the role of carefully observing the impact of separation and reunion behaviors in mothers and children holds a special place. In Bowlby's trilogy *Attachment, Separation and Loss* (1969, 1973, 1980), he cites the work of Spitz (1945) who collected a total of 31,500 feet of film of abandoned children living in institutional settings or foundling homes as a way of understanding the high rates of infant mortality among institutionalized infants. One can trace the strands of influence on Bowlby's thinking in the powerful images that he collected with the help of John Robertson of infants separated from their mothers in the hospital. Years later, Mary Ainsworth would collect hundreds of hours of hand written observations and movie footage of mothers and infants in their homes, providing the impetus for developing the Strange Situation paradigm, the recognized gold standard measure of parent–child attachment relationships. Importantly, the 20-minute design of the observational paradigm was decided upon because that was the amount of time that would fit easily on one reel of 16mm film, the technology available at the time (Ainsworth & Marvin, 1995). The leap from using video for research to using it to enhance clinical intervention is gaining wider usage, in part perhaps because the collection and editing of video-film has become increasingly accessible and affordable.

The unique contribution of video to the goal of therapeutic change

There are a range of approaches for the ways in which video can be used in attachment-based interventions which fall into two major categories of treatment, what may be called global behavioral approaches to intervention and micro-analytic approaches.

The global behavioral approaches draw inspiration from the basic principles of attachment theory and research, i.e., promoting maternal sensitivity and helping parents strike the right balance between serving as a secure base from which the child can explore, and serving as a safe haven to which the distressed child can return (Ainsworth, Blehar, Waters, & Wall, 1978). A short series of sessions, with specific themes designated for each session, are the content of what we are here calling global behavioral approaches, supported by meta-analytic findings showing “less is more” (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003; Dozier et al., 2006).

In contrast, micro-analytic approaches draw inspiration broadly from psychodynamic theory, including attachment theory, and from lab-based observations of mother–infant interactions (e.g., Tronick & Weinberg, 1997). In micro-analytic approaches to treatment, numbers of sessions are not typically specified, and a variety of themes may arise in any

session but always with close attention being paid to modes of communicating and coordinating affect across a range of modalities, e.g., vocal rhythms, gaze, touch, etc. This paper will summarize three examples of each approach. Videos in both approaches always contain footage of parent and child interaction. Both approaches can be said to share the same characteristic of challenging the parent to view one's own behavior in association with the child's behavior, to understand the motivational roots of behavior, and to update one's thinking permitting new, more flexible ways of engagement in the parenting role. These can be linked to a capacity for reflective functioning – the ability to think about and put into words thoughts and feelings regarding their own childhood experiences and current state of mind regarding attachment relationships (Fonagy, Steele, Steele, Moran, & Higgit, 1991; Steele & Steele, 2008).

Parent's reflective functioning is a unique and powerful predictor of infant–parent attachment security (Fonagy et al., 1991; Slade, 2005). A parent's reflective functioning ability is linked to a wide range of adaptive social and emotional child outcomes in the pre-school, middle childhood and early adolescent years (Steele & Steele, 2008). Thus, using video to trigger the parent's capacity for reflective functioning is likely to provide immediate and long-term benefits for the child and the parent–child relationship.

Global behavioral approaches

The most extensive evidence base exists for Video-feedback Intervention to promote Positive Parenting (VIPP). VIPP is an interaction-focused attachment-based intervention aimed at promoting sensitivity and positive parent–child interactions that is conducted in four to eight home-based sessions with parents and children in the age range of 6 months to 5 years (Juffer et al., 2008). The mother and infant are videotaped during daily situations at their home (i.e., playing, bathing, mealtime) for 10–30 minutes. During the feedback session, the intervener and parent watch the video together, while pausing at certain moments, and repeating and discussing selected fragments (Juffer et al., 2008). Focus is primarily on positive interactions, showing the parent that she is able to act as a sensitive, competent parent, fulfilling her child's attachment and exploration needs. At times the intervener will use “stills”, where the tape is paused to emphasize these positive moments for the parent, and so consolidate a more positive representation of themselves in the role of parents. These are then brought to the parents' attention when negative interaction moments are introduced, and parents are encouraged to use their more positive behaviors seen elsewhere in the video in order to act more responsively and sensitively in the future. Consistent with its targeted aims, randomized controlled trials have shown that mothers whose attachment patterns were classified as insecure increased in maternal sensitivity following treatment with VIPP, compared to a control group (Bakermans-Kranenburg, Breddels-van Baardewijk, Juffer, Velderman, & van IJzendoorn, 2008). At follow-up, when children were approximately three years old, fewer children who received VIPP were in the clinical range on externalizing and total problems than children who were in the control group (Klein Velderman et al., 2006).

VIPP has been adapted for use in different populations, with VIPP-R (Representation) including the additional aim of promoting a secure mental representation of attachment and VIPP-SD (Sensitive Discipline) integrating attachment theory and coercion theory specifically targeting families challenged by children with externalizing problems (Van Zeijl et al., 2006). Other variations on VIPP have focused on families with premature babies and dermatitis (Cassiba et al., 2008), adoptive families (Juffer, van IJzendoorn, & Bakermans-Kranenburg, 2008), and families where the mother has a diagnosed eating

disorder (Wooley, Hertzman, & Stein, 2008); VIPP-CC (Child Care) is specifically for home-based childcare providers (Groeneveld, Vermeer, van IJzendoorn, & Linting, 2011).

Attachment and Biobehavioral Catch-Up (ABC) (Bernard et al., 2012; Dozier et al., 2002, 2006) utilizes feedback to parents “in the moment” where the clinician comments on the interaction as it is happening as well as using video collected of caregivers and their children in set tasks, which are then viewed by the caregivers as part of an intervention targeting attachment behaviors and physiological dysregulation. This manualized intervention, originally developed for children in foster care, consists of 10 sessions that include discussions regarding the child’s behaviors, the caregivers’ difficulties in nurturing their child, the importance of physical contact with the child, helping the child take charge of his or her environment, following the child’s lead, and attending to the child’s signals. In randomized controlled trials, foster children treated with ABC with their foster parents had lower cortisol levels than those in a control group, indicating some successful amelioration of physiological dysregulation, and children whose biological parents were considered at-risk for child maltreatment and received ABC showed lower rates of disorganized attachment and higher rates of secure attachment than a control group (Bernard et al., 2012). Results, however, have not yet demonstrated a significant decrease in children’s problematic behaviors as a result of the intervention, though this was an outcome studied by Dozier et al. (2006) in foster children. The use of video-feedback in this work and overall clinical stance to support attachment is decidedly non-judgmental, and particularly suited to containing any feelings of self-criticism participating parents may feel.

The Circle of Security Intervention (CoS), which has been applied in various formats, is directly informed by attachment theory and has been thoroughly described in a recent book (Powell et al., 2013). CoS uses video feedback in a group format where previously collected video footage of the parent and child in the Strange Situation is presented and reviewed (Marvin, Cooper, Hoffman, & Powell, 2002). The first videos are selected to highlight positive features of the relationship, with later videos including more challenging aspects that are presented with care and attention once a high level of group cohesion is established. Initial results comparing families who received the CoS intervention suggested a clinically significant shift from Disorganized to Organized child attachment patterns (Marvin et al., 2002), which was confirmed in a pre-intervention post-intervention study of CoS with 75 families with children age 11–58 months (Hoffman, Marvin, Cooper, & Powell, 2006). In a larger study, the first to report CoS results based on a randomly controlled trial design, Cassidy, Woodhouse, Sherman, Stupica, and Lejuez (2011) used a modified and shorter version of CoS, CoS-Home Visiting-4, which consisted of four home visits during the second half of the infants’ first year. The goal was to increase rates of infant–mother attachment security for 220 moderately and highly irritable infants recruited at birth from economically stressed families (Cassidy et al., 2011). Results found the intervention was efficacious for highly irritable infants, but was not as efficacious for moderately irritable infants (Cassidy et al., 2011). This study adds to the growing literature on differential susceptibility (Belsky, 2005) that has opened up fresh perspectives for understanding what treatment works for whom. The CoS protocol has been modified such that individualized videos are no longer used, making the intervention easier to deliver but the mechanisms of action could differ from the earlier reports of the intervention.

All of these approaches are infused with the main premises of attachment theory and research as outlined by Bowlby and Ainsworth and are focused on promoting behaviors associated with secure attachment. Examples of focusing on behavioral expressions of

attachment behavior could include the child's expressing signs of distress and the parent's sensitive response to such signals, or empathically responding to a child's display of affect, both positive and negative.

Micro-analytic observation of video material

Micro-analytic approaches to the use of video are guided by an interest in identifying specific aspects of behavior that contribute to patterns of interaction shaping relationships. Importantly the behaviors that are focused upon are ones highlighted by micro-analytic approaches to mother–infant interactions (Beebe et al., 2010; Cohn & Tronick, 1989; Fogel, Dedo, & McEwen, 1992). The theoretical and clinical underpinnings are also infused with psychodynamic approaches, including attachment theory. While the goals are similar to the global behavioral approaches mentioned above, i.e., enhancing parental sensitivity to children's cues and facilitating secure child–parent relationships, the units of behavior are smaller so that they include gaze, body orientation, and vocalizations, which can be seen as underlying features of behavior for more “global” constructs like maternal sensitivity. In order to capture these smaller units, the video footage is often slowed so as to provide the clinician and parent with an opportunity to carefully look at the interactions in ways that are not often visible to the human eye. Eliciting and retaining the parent's attention to identify constituent behaviors underpinning adaptive or maladaptive parenting is the goal of these interventions.

Foremost amongst those using microanalytic techniques in the service of parent–infant intervention are Mechthild and Hanus Papousek, Beatrice Beebe, and George Downing. Papousek et al. (2011) incorporated video into their therapeutic approach to infants with regulatory problems at the Munich Interdisciplinary Research Intervention Program for Fussy Babies (MIRIP). Data from the research program have been used to further understanding of disorders of behavioral and emotional regulation in the first years of life (Papousek, Schieche, & Wurmser, 2008), and underscore the need for treatments that center on regulatory dysfunction in the parent–child system (Papousek et al., 2011). Footage of parent and child are collected and a segment selected by the therapist showing positive and negative sequences is viewed with the parent, *often in a slowed down version*. The video segments in this method are very short (often no more than 10–15 seconds), and studied at a micro-analytic level. This approach is along the same lines as the micro-analytic research of Beatrice Beebe and colleagues (2010), which has demonstrated how detailed communication takes place in micro-seconds of interactions between mothers and their 4-month-olds and impressively predicts infant–mother attachment at one year (Beebe et al., 2010; see Beebe & Steele, 2013 for a summary of this work and its relevance to understanding attachment disorganization).

An approach inspired in part by the Papousek model, and also by Beebe's research, is George Downing's Video Intervention Therapy (VIT), which takes a multimodal approach incorporating psychodynamic and cognitive-behavioral elements (Downing, 2005; Downing et al., 2008). In VIT, many types of video footage of interactions can be used, including those collected either in a clinic or research setting, or by the family in their home (typically of the situations that are most concerning, e.g., meal time, or bath-time, or leaving for school time). The parent(s) then view their video with the therapist, who monitors and elicits the parent's reaction, always beginning by pointing out positive patterns. The therapist then shows and explores with the parent a more negative pattern and implements a behaviorally focused intervention, with a focus on consolidating the

therapeutic goals (Downing et al., 2008). VIT pays special attention to “micro-details” exemplified by a penchant for selecting no more than a few seconds of observation to look at in slow motion, and stills, in order to identify and probe for interactional patterns that reveal essential features of the more global parent–child relationship. At times, the emphasis is more upon how the parent might expand their reflective capacities; at other times, it is upon how to broaden one’s range of emotional expressions or otherwise effect some behavioral change in the self or others. VIT blends knowledge of micro-analytic research of mother–infant interactions (Beebe, 2005; Tronick & Weinberg, 1997) which emphasizes the detailed attention to emotion, with psychodynamic and attachment concerns of working with the parent’s childhood past. Another important strand is the influence from clinicians and researchers studying nuances revealed by careful observation of the body. Downing pays careful attention to non-verbal communication including body posture and movement as important information to source a more comprehensive understanding of the complexities inherent in a parent–child relationship (Downing, 2005).

Stimulating reflective functioning

What the more global and the micro-analytic approaches share is the potential to stimulate reflective functioning, by providing the opportunity for parents to explore and ultimately reveal deeper emotions and meanings that underlie parent and child behavior.

The interventions described vary in how directly they promote reflective functioning, with some more focused on observing the behavior which can be a more implicit link with a reflective capacity to those that explicitly ask the parent to think about what might have been going on in their mind, what might their child have been thinking. But regardless of the specific approach, showing a parent a segment of video footage of themselves in interaction with the parent as Beebe states operates as a “shock” to the unconscious (see Beebe, 2003). We might think of this as akin to the experience of the Adult Attachment Interview insofar as the AAI aims to “surprise the unconscious” (Main, Kaplan, & Cassidy, 1985). This similar aim, and the success with which video achieves it, is clear from the myriad of emotional responses parents experience when presented with images of themselves in interaction with their children. These emotional responses can include surprise, fear, embarrassment, pride, doubt, or shame. The sights, sounds and movements that make up the images of one’s self displayed on the screen showing the video vignette can appear to the subject as unsettling or perplexing as it reveals ways of being, hitherto unrecognized. This capacity of video to “shock” lies at the heart of why it is such a powerful tool. Beebe comments:

The specificity of microanalysis reveals the behavioral details of the interaction, which become a springboard for reflection, association and memories. The same sequence can be replayed, and the videotape can be viewed in slow motion, or even paused. The videotape is a concrete record that can be referred back to, rather than a memory which is always subject to distortion. The therapist and the parent together co-construct what they can see and represent, in a collaborative rather than didactic mode. The parent learns to observe both directions of the sequence of the interaction: how the parent affects the infant, and how the infant affects the parent. (2005, p. 61)

Thus, video feedback serves to activate powerful feelings, based on early attachment representations, in therapeutic sessions where the parent can be helped to become aware

of these thoughts and feelings that underlie their behavior with their children, thereby opening up new ways of being with their children.

Convergent evidence from neuroscience research

For anyone doubting the power of video-film to activate anxieties and provoke reflective functioning, recent neuroscientific inquiries provide supporting evidence. In trying to understand what happens to us when viewing ourselves, there are studies using functional Magnetic Resonance Imagery (fMRI), which may elucidate what is happening in our brains as we watch. For example, fMRI studies have shown differences when we view images of ourselves as compared to viewing images of others (Devue & Bredart, 2011; Keenan, Wheeler, Gallup, & Pascual-Leone, 2000; Platek et al., 2006; Sugiura et al., 2005; Uddin, Kaplan, Molnar-Szakacs, Zaidel, & Iacoboni, 2005). We also know that parents react differently to seeing images of their own children as compared to seeing photographic images of other children (Gobbini, Leibenluft, Santiago, & Haxby, 2004). In a study by Noriuchi, Kikuchi, and Senoo (2008), mothers watched video clips of their own infant and four unfamiliar infants in both a play and a separation situation, while being scanned by an fMRI machine. Mothers experienced greater activation in the caudate nucleus and right interior frontal gyrus (IFG), among other areas, while watching their own infant in the separation than in the play situation. The greater caudate nucleus activation is related to motor programming and initiating emotion-induced behavior and indicates a more complicated cognitive and motor processing that occurs when viewing one's own infant. The right IFG involves decoding emotions of facial expressions, critical to understanding what might be happening with the intense viewing of one's own child in a video context. Schechter et al. (2012) using fMRI techniques investigated brain activation effects of watching one's own child, as opposed to other children, in a study of 20 mothers of infants aged between 12 and 42 months, 11 of whom were diagnosed with post traumatic stress disorder (PTSD) and nine with no PTSD. Mothers watched play and separation sequences from their own and unfamiliar children and though both groups showed distinct patterns of brain activation in response to viewing children in separation versus play, PTSD mothers showed greater limbic and less frontocortical activity than the control mothers. PTSD mothers also reported feeling more stressed than the mothers without PTSD when watching own and unfamiliar children during separation. These studies seem to provide important convergent evidence as to why some parents engage more easily with reflective functioning (linked to frontocortical activity) when viewing a video of themselves with their children, and others show resistance presumably on account of hyper-activation of limbic areas of the brain or, in other words, heightened anxiety.

Three reasons why video might enhance therapeutic input

There is no research to date that has clearly investigated the added value of using video in a therapeutic intervention as compared to delivering the same intervention without using video. However, clinically, three reasons may be postulated as to why using video seems such a powerful catalyst for therapeutic change:

- (1) The viewing experience itself feels helpful in facilitating a therapeutic alliance in that the parent and therapist are watching and to some extent experiencing a sequence of interaction together, which is rather different from having the parent describe an interaction that occurred between themselves and their child, relying

on memory, from some previous point in time. Viewing and hearing the video can also strip away some of the many layers of defenses and distortions that can arise in parents' relaying of challenging incidents with their child as the video "tells it as it is" (Jones, 2006). Sensitivity to the parent's experience of the viewing is paramount as feelings of shame and embarrassment can easily arise.

- (2) Secondly, the experience of watching oneself in interaction with one's child demands reflection either implicitly or explicitly, thereby enhancing reflective functioning. It is hardly possible to be sitting and watching video interactions of oneself with your child, without being internally motivated to think about one's own thinking at the time, and about what might be going on for the child.
- (3) Thirdly, watching video footage in the context of an intervention demands a multi-modal experiencing of affect laden information including watching (visual), hearing (aural) and paying attention (cognition) to body movement (kinesthetic). When one verbalizes to the therapist (and oneself) one is translating sensations, beliefs and desires derived from these various modalities into words. This process of putting feelings into words has often been described as fundamental to the therapeutic enterprise (Edgumbe, 1984; Jones, 2006; Novick & Novick, 2002; Olesker, 2012). It is the combination of these elements that propels the power of video in intervention contexts.

With the power of video generally established as an adjunct to promoting changes in parent-child interaction, relationship patterns, and internal psychological processes, the paper turns now to a close look at a specific attachment based intervention, that includes video feedback, for the most difficult to reach parents, with complicated trauma histories (Murphy et al., 2014; Steele, Murphy, & Steele, 2010). The use of video evolved as an important component of the intervention. Hours of video footage of the clinical work were collected in order to develop the manual of treatment as we readied for conducting a randomly controlled trial demonstrating its efficacy. Some of this footage was then shown to the parents as a catalyst to positive change in the parent's attachment state of mind and the parent-child relationship. While informed by the micro-analytic approach, in terms of the clinicians' careful observation of the video, the approach is delivered in a more global format. As described above, our clinical experience with GABI has found that using video enhances the therapeutic alliance, facilitates a reflective stance in the parent, and consolidates clinical gains by focusing the parents' attention on specific attachment related behaviors that they are asked to translate into words, thereby helping to "metabolize" what are often difficult to process thoughts and feelings.

GABI: Group Attachment Based Intervention

Group Attachment Based Intervention (GABI) is a parent child therapeutic program that was developed in collaboration between the Center for Babies, Toddlers and Families at the Albert Einstein College of Medicine and the Center for Attachment Research at the New School for Social Research. GABI's effectiveness in improving parent-child attachment relationships in socially isolated parents with children birth to three is being tested in a pragmatic randomized clinical trial. To reach parents with histories of multiple adverse childhood experiences and ongoing exposure to poverty, domestic and neighborhood violence and risk of child maltreatment, GABI is an intensive 120-minute, three-times-weekly intervention with three treatment modalities: a joint parent-child session where several dyads meet in a large playroom with lead clinicians and psychology and social

work trainees, followed by a separation where a simultaneous parent group and child group occur, and ended with a most important reunion. Every segment of the intervention is filmed for training purposes, manual development and parent video feedback sessions.

Video feedback is conducted during the parent group, one day per week with two video feedback sessions per family during the first six months of treatment beginning after one month of treatment in order to allow for the therapeutic alliance to form and the parent to start consolidating reflections that have begun to develop in treatment. Each parent is shown a two-minute video of a neutral interaction between themselves and their children. The video is used to activate the attachment system and the primary purpose is to provide an additional tool to facilitate reflective functioning. Much like a projective test, the clinician is deliberately reticent allowing for silence and following the parent's lead rather than the clinician's agenda. Seeing oneself with one's child on video can be both compelling and jarring and the group "audience" seems to amplify this experience for the parent while also providing support and additional lens necessary to help the parent tolerate and explore the video. Video feedback in GABI is unique in that it is delivered in a group, where parents often express feelings generated when they observe another parent's video or how they "feel in the shoes" of either the parent or the child.

Case study: therapeutic video: "*The baby's not scared, right?*"¹

Background: Pam is the 23-year-old mother of 24-month-old Doug, referred to GABI after mother's hospitalization due to extended postnatal depression. In the course of treatment, Pam revealed significant domestic violence and initiated an order of protection against her son's father. Though initially gentle and at times hypervigilant in responding to the needs of other children in the group, Doug's symbolic play themes shifted from animals fighting to Daddy fighting, and to Daddy hurting Mommy and the baby crying. Pam, however, was emphatic that her son was sleeping when the violence occurred and unable to understand why her toddler was so aggressive. Visibly annoyed during the parent-child session, Pam questioned "*why he only plays this way in therapy.*"

Video clip

Doug is shown bringing a baby doll and bottle over to his mother, saying, "*the baby is hungry.*" After pretending to feed the baby, Pam stopped and her gaze turned down in a vacant stare, while Doug continues looking at the baby doll. He then turned back to her and said, "*the baby is scared.*" She replied as if pleading with her young son, "*the baby is scared? The baby is not scared, right?*"

Video feedback session

The clinician began by asking, "***what do you see?***" Focusing on herself, Pam commented, "*I don't know, I see myself spaced out, like now.*" Pam then described in great detail her ambivalence about following the court's order of protection and not allowing Doug's father to see him. The clinician refocused her attention back to her child in the video again and asking what Doug had said. Pam repeated his words, "*he said 'the baby is scared' and I told him 'no the baby is not scared.' He's always thinking about fighting and being scared.*" When asked what it would mean if the baby IS scared, Pam answered: "*I don't know, he's like trying to say (it's) himself. I'm trying for him not to see everything that is negative. I try to show him that everything is like ok.*" The clinician showing she

understands her wish offered, ***“I think as parents we want to protect our kids, right? And think they are not going to be scared, they are not going to see fighting, and they are not going to see things that will worry them. Well, what if they do? What can we do?”*** Pam tentatively replied, *“I don’t know, tell them that it is going to be ok”* but added rethinking her initial comment, *“I mean it is easy to give advice, but it’s hard to actually believe it.”* The clinician then suggested that perhaps it is also hard for Doug to believe that everything is going to be ok. Pam responded, *“yea, I have my whole family telling me that it is going to be ok, and like I can be ok one day and then like the other day I start thinking about the same situation.”* The clinician reflected, ***“It seems like Doug is trying to tell a story and make sense of it, with the fighting and all the boo boos and being scared. He’s trying to make sense of it and I think you are trying to make sense of it too.”*** Pam nodded and the clinician then asked, ***“And when you are scared, what do you want to hear from people who can protect you? Do you want them to say ‘don’t be scared’ or you want them to ask you what you are scared of?”***

When Pam answered, *“to ask what I am scared of,”* the clinician elaborated, ***“Because I wonder if we could do this again, and could say to Doug ‘Why is the baby scared?’”*** Offering further interpretation, the clinician commented, ***“It’s almost like he has a cut on his finger and we could go deeper into the cut and clean it up and bandage it, or we could pretend there is no cut. We can ask him, ‘what’s the baby scared of?’ to let him know, ‘it’s ok to tell us what it is, we are the grown ups, we are going to help you cope with this.’”*** Pam thoughtfully nodded and said this made sense. Parents sat quietly watching the session unfold, one mother commented, *“I did not see any of that but now that you point it out, I see. We always hope they don’t see or hear what is really going on when we fight.”*

Clinical interpretation

This video feedback session illustrates the demand on the clinician to balance the parent’s needs to be heard, with the child’s need to be heard by the parent. Observing the video made it difficult for Pam to avoid the content of Doug’s play, and its reflection of what she had hoped he did not see. And it is after having her own fears acknowledged and explored by the clinician that Pam is able to acknowledge the difficult realities that her child is facing and explore new ways to promote healing in both parent and child, and their relationship. Video film has helped Pam to know what she is not supposed to (or would prefer not to) know, and feel with her baby what she is not supposed to (or would prefer not to) feel (Bowlby, 1988).

Conclusion

Video-film as an adjunct to, if not the central focus of, attachment-based interventions facilitating positive change in parent–child relationships is becoming well established. Very likely the inclusion of video feedback in clinical work accelerates desired change processes. Clinicians using video as part of an intervention have little doubt about this. Yet, further research is needed to isolate the impact of video and the added value it provides to treatment protocols. It is no simple matter to begin working with video-film in an intervention; all the therapeutic modalities discussed in this paper provide training and certification to interested professionals. The relevance of training is underscored by consideration of the powerful effects of seeing oneself on film interacting with loved ones.

The effects of the experience of watching oneself on video-film, especially when watching oneself interacting with one's child, can be startling and evocative in ways that promote change. Multiple sensations, emotions, beliefs and representations are aroused, often in unsettling ways, very likely activating the attachment system. The value of receiving video feedback in a group has been underscored. Often group members, as peers, are able to validate each other's feelings and experiences in a genuine "down-to-earth" manner on account of their similar status in the group. Within the group, parents are able to communicate directly to other parents with powerful emotion, as they are closer to the experience than the therapist, while also being stretched to explore their own reactions by the therapist's gentle probes, so that the group as a whole is likely to benefit.

Of course, video as an adjunct to therapy has relevance, as has been indicated in the review section of this paper, to a range of therapeutic work including individual work with a therapist, as well as couple and family work. Attachment-based therapeutic work will no doubt come to increasingly rely on video given its accessibility and power to positively influence therapeutic change. All of the therapeutic models that include video that have been considered in this paper share the conviction that initially video should be used to highlight strengths and resources available to the parent and demonstrated in any film reviewed. This is vital as the "shock" to the unconscious, mentioned above, is one that can evoke shame or guilt reactions that can adversely affect the therapeutic relationship. It is much safer to start with benign or positive video fragments to show in the context of video feedback, and much good can be attained by restricting the material shown to film that can be used to shore up parental resources and help parents to see how much they are regarded by their children as attachment figures, bigger, stronger, and wiser. At the same time, all therapeutic approaches utilizing video that have been reviewed in this paper include room attending to challenging or negative interactions between parent and child, where change is sought and desired. But in all cases the framework for such video feedback must be a supportive and empowering one for the parent. This is vital as there is no greater wish in the life of a parent than the wish to thrive and excel in the job.

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Note

1. The therapist's speech is shown in *italics and bold*, the parent's speech is shown in *italics*.

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