Strong Beginnings: Promoting Resiliency Through Secure Parent-Infant Relationships

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As the facilitator leads the five young moms and their 6-month-old babies through a series of games, Susan holds her baby, Brian, at arm's length with his back to her, avoiding all opportunities for eye contact or cuddling. Susan begins to toss Brian roughly in the air, bringing a startled look and then a cry. The facilitator, speaking through the baby, says: "Hey Mom, I need to slow down and have a hug." Silently, Susan turns Brian toward her, but Brian places stiff arms between himself and his mother and screams a piercing cry.

Early relationships lay the foundation for a child's later development. A secure attachment in the 1st year of life helps the child develop working models of others as caring and responsive, and of the self as worthy of being loved and capable of getting positive response.

This article describes Project STEEP—Steps Toward Effective, Enjoyable Parenting. The program is designed to promote healthy parent-infant relations and help prevent social and emotional problems among children born to first-time mothers who are at risk for parenting problems. The sources of this risk are poverty, youth, lack of education, social isolation, and stressful life circumstances.

In this paper we describe a high-risk family involved with the program, review the importance of establishing a secure parent-child attachment, review the prevention strategies used in STEEP, summarize the effectiveness of the program, and draw implications for policies and programs.

The Challenge

Intervening with high-risk mothers and babies is a significant challenge. Susan, the mother described earlier, was neglected as an infant. She moved through a series of 10 foster homes during her childhood. Now a 21-year-old single mother, she is struggling to overcome her own history in order to care for Brian. It is not an easy task for Susan, or for those who work with her and her son.

Unlike many high-risk mothers, Susan got regular medical care during pregnancy and was careful about diet and chemical use. Brian was born a robust, alert baby. However, meeting the needs of a young infant is overwhelming for Susan. Brian is already lagging in motor and social development, which is not surprising given his mother's emotional unavailability and insensitivity. He is also beginning to resist his mother's attempts to hold him. This could push Susan further away.

Brian is on a track that will likely lead to learning problems, poor social and emotional functioning, and probably costly interventions later in life. Furthermore, the

interaction patterns between Susan and Brian are likely to reinforce her low self-esteem and her conviction that she will fail at everything she attempts.

There will be no quick fixes for Susan and Brian. However, being involved in Project STEEP during these crucial early months of their life together has the potential to begin a change for the better.

Why Intervene? Attachment Theory

The STEEP program is based largely on findings from the Mother-Child Interaction Project, a 14-year study at the University of Minnesota. The project helps define what promotes healthy outcomes in the face of poverty and the stressful life circumstances that often accompany it.

Mother-infant attachment in the first year of life is a powerful predictor of the child's future social development. For example, the Mother-Child Project showed that the quality of attachment at 12 months can predict preschool teacher ratings, behavior problems, and quality of relationships with peers (e.g., Erickson, Egeland, & Sroufe, 1985). Attachment also relates to social competency in a summer day camp setting when children are 10 and 11 years old (Sroufe & Jacobvitz, 1989; Urban, Carlson, Egeland, & Sroufe, 1991). Although not an inoculation against later problems, secure attachments in infancy lay the foundation for healthy development.

Although all children are powerfully inclined to become attached, many children do not receive care that encourages secure attachment. These children are described as being anxiously attached. Researchers estimate that at least 20% of all children are anxiously attached. Tragically, among families encumbered by poverty, highly stressful life circumstances, and lack of support, nearly half of the children develop anxious attachments.

The quality of the mother-infant attachment at 12 months can predict preschool teacher ratings, behavior problems, and quality of relationships with peers.

Depending on the particular pattern of care they received in infancy, children who are anxiously attached are likely either to be overdependent on teachers for help and attention or to behave in ways that keep others at a distance. They lack confidence, self-esteem, and motivation to learn. They have difficulty forming friendships and often are socially withdrawn. Many of these children tend to be disobedient and aggressive. Their behavior makes them vulnerable to becoming either a victim or victimizer. And, as their behavior drives others away, this reinforces their negative models of self and others.

Several reports also suggest that the quality of care received as a child influences how a parent responds to and rears his or her own child. Early history is not destiny, however. Mothers who were maltreated as children but were not abusive toward their own children usually had a positive additional relationship with an adult as a child or a significant positive relationship in their adult life (Egeland, acobvitz, & Sroufe, 1988).

Furthermore, researchers have identified what beliefs, attitudes, and behaviors in the parents are important to developing a secure attachment (e.g., Egeland & Farber, 1984). For example, research shows that caregiver sensitivity to the

child's cues and signals is the major factor. Children learn to trust the caregiver will meet their needs and, equally important, to trust their own ability to solicit care.

Attachment theory and supporting research form the framework for the STEEP program.

Strategies for Promoting Optimal Child Development

A second foundation for the STEEP program is strategies that have proven effective in supporting and empowering families and promoting optimal child development. STEEP follows a model that combines support, education, and what Selma Fraiberg has called "therapy in the kitchen" (Fraiberg, Adelson, & Shapiro, 1974).

Research shows that although no one can change the parent's history, what is most important is how a parent thinks now about that history. Therapeutic interactions aim to help the mother

- face her own developmental history,
- examine how it affects her parenting,
- express the pain associated with her past and present circumstances,
- look at current choices and actions and decide what to repeat and not repeat from her own childhood, and
- consider how she can move forward to a more empowered way of living.

The literature of intervention also helped us determine such things as the timing of enrollment in the program, incentives for participation, and logistics of service delivery. For example, the birth of the first child is a time of dramatic change, and usually anxiety, which in our experience encourages receptivity to intervention. This is a special window of opportunity to affect the prospective mother's view of herself, her child, and their relationship. Recruiting these women during pregnancy also means the mother does not yet feel she has "failed" at parenting in any way.

The STEEP Program: Steps Toward Effective, Enjoyable Parenting

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Project STEEP, a 4-year randomized evaluation of the effectiveness of the STEEP program, served 74 first-time pregnant women, with the first recruited in 1987, and compared them over time with a control group of 80 families. All were below the poverty level, which was the primary risk factor, and were recruited through Minneapolis area obstetrics clinics. All were at least 17 years old, and the average age was just over 20. The average education was 10.9 years. Forty percent were black, 92% were unmarried, and 88% were unemployed at intake

to the obstetrics clinic. Many had a history of being abused or neglected, and many were currently in abusive relationships. An additional 80 women were recruited and assigned to a control group for evaluating the program's effectiveness.

During the participants' second trimester of pregnancy, the program began both home visits and group sessions, which continued until the baby was a year old. Prenatal visits focused on the mother's feelings about pregnancy and preparation for parenting. Our previous research indicated that mothers most at risk are those who feel totally positive or totally negative about becoming a parent, rather than experiencing a more realistic ambivalence (Brunnquell, Crichton, & Egeland, 1981). This is also a critical time for the family life facilitator to build a relationship with the participant.

Sensitive, contingent response to infant cues is the major factor leading to a secure attachment.

Home visits continued every other week until the child's first birthday and were tailored to the unique needs, strengths, and interests of each family. Also, about the time the babies were born, approximately eight mothers with similar due dates were brought together for 3-hour group sessions that continued biweekly through the year. To build trust and ensure continuity, the staff person who conducted the home visits also led the group.

Using demonstration, discussion, and participatory activities, the facilitator

- taught child care skills,
- provided basic information about infant development,
- helped the mothers learn to understand and respond to their infant's cues and signals, and
- guided mothers in recognizing their own infant's special characteristics and needs.

The interactions were videotaped. Guided viewing of those tapes helped promote the mother's perspective taking and sensitivity. Again, previous research highlighted the importance of sensitive, contingent response to infant cues. This sensitivity is the major factor leading to a secure attachment.

"Mom talk" time and a free meal followed the baby-centered time. The mothers were encouraged to build supportive relationships with each other and to talk about their own emotional issues in relationships, personal growth, education and work, and general life management. The goal was to help empower the mothers to deal effectively with other aspects of their lives and to use existing community resources. The program promoted increasing responsibility for group activities by the participants to decrease their dependence on the facilitator and encourage initiative and cooperation within the group.

Therapy and Learning New Models

Home visits between group sessions focused on psychological therapy as well as more general life management and social support. The staff person explored with the mother how her own developmental history and current life events were influencing the way she interacted with her child. Other family members or friends were encouraged to participate in the home visits to the extent the mother wished.

For many parents, the demands of caring for a new baby may trigger their own feelings of sadness, loss, and anger because they have never really felt cared for. In our experience, some parents will (if given permission and acceptance from the facilitator and/or other group members) acknowledge some resentment, really a kind of jealousy or rivalry with the baby. Bringing such emotions into conscious awareness can be the first step toward letting them go so they don't interfere with the parent's ability to respond to the baby.

Accessing these feelings can help a parent see things from the baby's perspective. One technique is "talking for" the baby, using a small voice to put the baby's cues into words. Another very effective strategy is writing letters to the parents from the baby. One letter from an 8-month-old who always wanted mom in sight said, "You are the most important thing in my life right now. . . . I'd crawl for miles on my hands and knees just to see your face. . . . Sometimes even just hearing your voice is enough to make me feel okay."

STEEP staff often videotaped parents and babies in a variety of play, feeding, and child care situations at home and in the group sessions. They then watched the tape with the parents, using comments and questions to encourage them to discover what the baby was experiencing and communicating. They might say, for example, "Look at that expression on his face. I wonder what he was feeling then." Or perhaps they would comment, "You knew just what she needed there. How did you know?"

Nearly all the young mothers had a history of abuse or neglect, and their working models of others and self reflected this. It was through experience with a predictable, sensitive facilitator that many of the young mothers began to modify those working models.

Some mothers said this was their first experience with someone who "hung in there" with them.

There are several ways the STEEP program tried to help the mothers experience a new way of being in a relationship. First and most basic was to be consistent and predictable with the mother. This is easy to say, but sometimes hard to do. For STEEP staff it meant promising no more than they could deliver and always showing up when they said they would. This was true even if the mother herself had failed appointments or was not ready when the van arrived to take her to the group session.

As a policy, STEEP staff kept going back for a mother, assuming she would keep her commitment to the program unless she specifically said she did not want to participate. Some mothers said this was their first experience with someone who

"hung in there" with them, and some even admitted later that they tested their facilitator early on to see what she would do.

Personnel: The Critical Variable

Developing a caring, trusting relationship between the facilitator and participant is at the heart of the STEEP program. It takes skill to build such a relationship and deliver the complex services the mothers need. Facilitators must have well-developed problem-solving skills and a degree of psychological sophistication and therapeutic savvy. In Project STEEP the directors hired facilitators who had no professional license of any type, but had at least a bachelor's degree in education or the social sciences plus hands-on experience with young children—usually their own.

Evaluation

A rigorous evaluation of the STEEP program, funded by the National Institutes of Mental Health, showed a positive impact overall. Researchers administered a variety of assessments during pregnancy and when the babies were 12, 19, and 24 months old.

Mothers who participated fully in STEEP had more appropriate play materials in their homes; were more responsive; and scored higher on quality, organization, and stimulation in the home environment than mothers in the control group and those who participated only to a limited extent. The STEEP mothers had a better understanding of their child and their relationship with their child.

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It was disappointing to find no significant differences on the quality of mother-infant attachment at 13 months. However, by 19 months mothers and infants were moving toward more secure relationships, while relationships in the control group were moving in the opposite direction.

On measures of social support, mothers in the treatment group reported significantly more support than those in the control group. Mothers in the treatment group also showed higher scores on community life skills, indicating they were better able to manage their household and child-care responsibilities. In addition, the treatment group was significantly less depressed than the controls.

A major goal of STEEP was to help mothers become more sensitive to babies' signals. The program did appear to help the mothers buffer their interactions with their children from the effects of stress and depression. In the control group the researchers found a strong connection between stress, depression, and the mother's sensitivity. However, for mothers in the intervention group, sensitivity was not linked to depression and stress. Mothers in the STEEP group seemed to have learned to more effectively separate the effects of life stress on themselves from their interactions with their children.

Moreover, within 2 years of the birth of their first child, mothers in the treatment group had significantly fewer repeat pregnancies than mothers in the control group (Egeland & Erickson, 1993b).

Based on the research findings and clinical observations during implementation of the program, the developers of STEEP concluded that the program would be more effective if it continued through the child's 2nd year or longer. And, in fact, subsequent implementations of the program have lasted for at least 2 years.

Parents must have emotional support for themselves to be able to care for their children sensitively and consistently.

Many mothers lived in chaotic, disruptive, and, for some, violent home situations. These stressors needed to be dealt with before STEEP staff could focus on the parenting and personal goals of the program (see Egeland & Erickson, 1993a). Also, many mothers had psychological problems that interfered with focusing on the actual intervention (see Egeland, Erickson, Butcher, & Ben-Porath, 1991).

Policy and Program Implications

Our children are the hope of the future, but they are in trouble. Over 14.3% live in poverty; 2.7 million are neglected or abused; more and more are dropping out of school and out of life.

When we look for ways to make a difference for our children, research points to a relationship with a caring, supportive adult as being the most critical factor. It is best when that begins in the first months of life because a child's early relationship with a caregiver becomes a prototype for later interactions and relationships. Society must support children's opportunities to develop strong, secure attachments.

Several critical factors that help parents and children develop a secure attachment are identified by research. These sound relatively simple, but are often *not* basic to our programs and policies.

- To have the physical and emotional energy to meet their children's needs, parents must have their own needs met for housing, food, clothing, transportation, and health care.
- Parents must have emotional support for themselves to be able to care for their children sensitively and consistently.
- Parents need basic child development knowledge. Understanding certain key child behaviors, such as separation anxiety or negativism, lets them be more realistic in what they expect from their child and "see the world through the eyes of the child." Knowledge, understanding, and perspective taking are fundamental to the sensitive care needed for secure attachment.
- Parents need to deal with their own childhood history: facing its pain, acknowledging its influence, recognizing the option of making new choices, and mustering the resources to help them live up to those choices.

There are no quick, easy answers, but we must consider how we can ensure that children have the best possible chance to develop a secure attachment with at least one caring, supportive adult. Across all studies of vulnerability and resilience, such a relationship is the single most important factor accounting for good outcomes for children in the face of high-risk circumstances. A few actions that can help accomplish this goal include the following:

- Supporting natural neighborhood caregivers like churches and youth centers.
- Providing additional support for new parents (home visits, parenting classes, training service providers to identify and address the psychological issues that can undermine a parent's best intentions).
- Offering family life and child development education in middle and high school and assessing its effectiveness.
- Supporting workplace policies sympathetic to family and attachment issues.
- Establishing ways to identify early which families have potential attachment problems and offer extra support and intervention.
- Incorporating knowledge of attachment more effectively into adoption, foster care, and child custody decisions.
- Providing long-term mentorship programs through schools to let more children form meaningful relationships with caring adults.
- Assessing how policies and practices in child-care facilities help or hinder attachments.
- Disseminating the relatively unknown research on adult-child attachment to educators, health care professionals, human service providers, policymakers, the judicial system, and the general public.
- Investigating effective ways to prevent and/or treat attachment problems, linking the results to ongoing practice and program development and determining what additional research is needed.

Understanding child-adult attachment must become a lens through which we consider all decisions that touch the lives of children. This is not a political issue; it is a universal human issue.

Attachment with at least one caring, supportive adult is the single most important factor accounting for good outcomes for high-risk children.

Despite ongoing depression and limited capacity for insight, Susan participated regularly in the STEEP program, making slow progress in learning basic aregiving skills. Brian's father, who was involved in the home visits, actually gained much from the program and was the more emotionally invested parent. STEEP staff helped the family secure good quality child care for Brian while mom and dad were at school or work, and that outside care and stimulation was important to Brian's well-being. It will continue to be a long and challenging journey for this

family, but hopefully their positive experience with this program will make it easier for them to continue to seek and use the support they need.

The STEEP program currently operates at St. David's School for Child Development and Family Services in Minnetonka, Minnesota; Community-University Health Care Center in Minneapolis; and Health Start in St. Paul. A program is just getting started at Marybridge Hospital in Tacoma, Washington. STEEP strategies are also formally incorporated into the home-visiting work of public health nurses in Ramsey, Dakota, and Scott counties in Minnesota.

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