How Portuguese families in early intervention benefice from video hometraining/video interaction guidance (VHT/VIG) approach

Fátima Feliciano\textsuperscript{a}, Paula Santos\textsuperscript{b}, Carlos Silva\textsuperscript{b}, Sandra Agra\textsuperscript{b}

\textsuperscript{a}Superior Institute of Intercultural and Transdisciplinary Studies, Piaget Institute
\textsuperscript{b}Department of Education and Research Centre in Didactics and Technology in Training for Trainers
University of Aveiro, 3810-193 Aveiro, Portugal

Abstract

This study aims to analyse the use of the Video Home Training/Video Interaction Guidance Method (VHT/VIG) in the development of relational competences by Early Intervention (EI) professionals and the families of at risk children they’re supporting. The variables identified within the families are depressive symptoms, family strengths and family needs. The data here presented compare results obtained in 2011 and 2012. The differences found are not statistically significant, with regards to family needs; we can however find differences in depression symptoms and in ‘pride’ factor of family strengths, when comparing the results found in the intervention group to the ones in the comparison group.

© 2014 Published by C-crcs. Peer-review under responsibility of the Editor of the Volume.

Keywords: Early Intervention; video hometraining; family strengths/needs; depression symptoms

1. Introduction
The project Promoting Relational Competences in Early Intervention through the Video Home training/Video Interaction Guidance Method (VHT/VIG) is being developed in Portugal, within

Open Access licence:
Aveiro district Early Intervention Local Teams (EILT) (the intervention group, with regular plus additional specific supervision and training in VHT/VIG method), and in the districts of Portalegre and Coimbra EILT (the comparison groups: one with regular supervision, the other without supervision). The project includes a dynamic of recording interactions on video - between children and their families, between EI professionals and the families they are supporting, and between EI professionals, either in local teams or supervision meetings - subsequently reviewed and analysed with the purpose of giving feedback to the elements of the dyad. These procedures are supervised by a specialist in VHT/VIG – the VIGer. The aim is to promote the development of relational competences in the dyads present in EI: family–child; EI professional–family; EI professional–EI professional; EI supervisor–EI professional. Assuming that through video feedback interventions addressing the dyad promote the consciousness of relational competences, the development of basic communication and positive reinforcement for professionals, parents and children, thus facilitating intervention in the natural context, with focus on interaction competences, as referred by authors such as Mesman et al., 2007, Zeijl et al., 2006 (both cited in Zeanah, Berlin & Boris, 2011), Kennedy (2009) and Feliciano (2002), the VHT/VIG method presents a path of excellence for the development of competences in EI.

2. Problem Statement
Families of at risk children face relational challenges that may affect their functioning, with consequences on strengths, needs and depression levels. Reinforcing interaction competences in parent-child dyad potentially increases the resiliency to deal with risk difficulties. VHT/VIG supports and optimizes change processes aimed by families. The first evaluation made in UK using VHT/VIG approach was carried out by Simpson, Forsyth and Kennedy (1995), who measured improvement in interactions in five families. The quantitative data obtained from initial and final videotapes were triangulated with qualitative data obtained through interviews to the families. The results showed that all the parents became more attuned to their children’s initiatives, flexible and competent (Kennedy & Sked, 2008). Research shows that depressed parents, preoccupied with feelings from their past, interact less with their babies (Music, 2011, cited in Celebi, 2012) and have more difficulty to interpret baby’s behaviour (Underdown, 2013), affecting baby’s emotional, cognitive and even neurophysiological development within the first year of life (Gerhardt, 2004, cited in Celebi 2012). The importance of infants receiving early sensitive care as a foundation for optimal development is largely registered (Shore, 1997; Siegel, 1999).

3. Research Questions
Do the families under VHT/VIG in EI/Aveiro present better results in depressive symptoms and ability to identify needs and strengths, than the families in EI/Coimbra and Portalegre?

4. Purpose of the Study
This study aims to identify differences between families receiving EI under VHT/VIG method (Aveiro’s district), and families who aren’t being approached with this method, although being supported by EI structures (Coimbra and Portalegre districts). The variables under analysis are depressive symptoms and the ability to identify family strengths and needs.
5. Research Methods
A field experimental study research has been conducted, involving an intervention group (Aveiro EI) and two comparison groups without intervention (Coimbra and Portalegre EI structures). The project develops over three years, comprehending three periods of data collection: T0 (2011), T1 (2012) and T2 (2013). The variables and dimensions identified as measures in the families are assessed through the use of The Center for Epidemiologic Studies Depression Scale (CES-D) (Gonçalves & Fagulha, 2003), the Family Strengths Test (FST) (Canavarro et al., 1993) and the Family Needs Survey (FNS) (Bailey & Simeonsson, 1990). The FST is composed by two factors, ‘pride’ and ‘accord’ within the family; an higher score in the questionnaire corresponds to better family resources. The FNS is composed by 32 items, grouped in six subscales: need for information, need for social and family support, financial needs, need for explain to others, need of providing care for children and need for community services; higher values mean that more needs are perceived.

6. Findings
The data generated within the families in T0 (2011) and T1 (2012) were treated and analysed with SPSS (version 20). Regarding the CES-D, the average score decreased between 2011 and 2012, in the intervention group/Aveiro and in Coimbra, but increased in Portalegre (cf. table 1). The average value for Family Strengths increased in Aveiro and Coimbra, but decreased in Portalegre, between 2011 and 2012 (cf. table 1). For FNS, the total average score decreased in Aveiro but increased in Coimbra and Portalegre (cf. table 1).

<table>
<thead>
<tr>
<th>Aveiro</th>
<th>Fam. Strengths</th>
<th>FNS</th>
<th>Coimbra</th>
<th>Fam. Strengths</th>
<th>FNS</th>
<th>Portalegre</th>
<th>Fam. Strengths</th>
<th>FNS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CES-D</td>
<td>Mean=17.32</td>
<td>Mean=41.78</td>
<td>Mean=51.91</td>
<td>Mean=39.81</td>
<td>Mean=58.62</td>
<td>Mean=41.95</td>
<td>Mean=41.75</td>
<td>Mean=57.35</td>
</tr>
<tr>
<td></td>
<td>(n= 50)</td>
<td>(n= 51)</td>
<td>(n=46)</td>
<td>(n=26)</td>
<td>(n=26)</td>
<td>(n=96)</td>
<td>(n=97)</td>
<td>(n=72)</td>
</tr>
<tr>
<td>CES-D</td>
<td>Mean=15.18</td>
<td>Mean=42.37</td>
<td>Mean=47.34</td>
<td>Mean=40.00</td>
<td>Mean=59.30</td>
<td>Mean=41.85</td>
<td>Mean=41.85</td>
<td>Mean=58.73</td>
</tr>
<tr>
<td></td>
<td>(n= 51)</td>
<td>(n= 51)</td>
<td>(n=47)</td>
<td>(n=27)</td>
<td>(n=27)</td>
<td>(n=101)</td>
<td>(n=101)</td>
<td>(n=95)</td>
</tr>
</tbody>
</table>

When comparing 2011 and 2012 data across a multivariate ANOVA, we find that, although there are no statistically significant differences in family needs presented by the families, we can however find statistically significant differences between Aveiro and Portalegre in depression symptoms ($F_{2,157}=3.094; p=0.048$) and ‘pride’ factor of family strengths ($F_{2,157}=7.132; p=0.001$). According to Zeanah, Berlin & Boris (2011), depressed parents interact less with their babies, affecting their emotional, cognitive and neurophysiological development;
thereby, a reduction in depression symptoms suggests benefits to families when EI’s professionals are trained and supervised under VHT/VIG; an increase in family ‘pride’ suggests these families felt more competent in the way they deal with the difficulties related to their children’s condition, which fits to Kennedy and Sked (2008) findings.

Conclusions

These findings lead us to question the impact of uncontrolled variables in the study, namely, the prior training of professionals, which may present important differences between the groups participating in the study. Nevertheless, we can point VHT/VIG as a method that can be used to improve parents’ emotional wellbeing, with benefits to the wellbeing of the whole family.

References


