The Signal

SUPPORTING SECURITY:
A Parent Group Intervention to Foster Secure Attachment Between Parents and Infants

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INTRODUCTION

Supporting Security is a 12-session intervention for groups of parents, designed to promote healthier, more secure attachment relationships between parents and infants. . Feeling secure about your primary attachments when you are a baby is associated with having a better life in many ways. Supporting Security teaches parents how important it is for babies and toddlers to feel secure, helps parents recognize when babies and toddlers are not feeling secure and helps them find ways to improve interactions so that their children feel more secure. In developing Supporting Security we focused on research findings associated with insecure attachment. These are found more often in at-risk parent-infant dyads but are not uncommon in the general population. Thus Supporting Security can be helpful to higher risk families as well as those in the general population.

Contents

In order to make Supporting Security available to many families we organized it so that we could train leaders such as nurses, family home visitors, etc to lead groups of parents with young babies. We wanted to make it acceptable/accessible to parents from many different cultures and communities. Thus we have leaders who are already in their communities and can help us adapt the intervention so that it is compatible with community traditions and values as well as with the findings of Attachment Theory. Supporting Security is adapted to each new community when we carry out the training. We learn from the new leaders as much as they learn from us.

The group sessions are highly structured so that leaders with little experience are able to learn how to run these sessions easily; training takes from three to five days plus supervision over the course of one to two sets of group sessions. The supervision can be done by teleconference so that our reach is extended widely. Each group is run by two leaders who provide support to each other as well as being more attentive to the members of the group.

THEORY AND TECHNIQUES IN SUPPORTING SECURITY

Attachment Theory

Supporting Security addresses a number of factors that have been associated with insecure attachment.

Insecure attachment has been associated with:
- insensitive responses from caregivers (i.e. responses that do not recognize a baby's signals of feeling insecure and do not quickly and effectively reduce feelings of insecurity (Ainsworth, et al , 1978).
- disorganized attachment (Main and Solomon, 1986, 1990) and that in turn has been associated with parental behaviours that frighten or confuse babies (Lyons-Ruth et al 1999).

Therapies Integrated into Supporting Security

The immediate goal of the intervention is to teach parents to recognize infants' "cries for help" more quickly and accurately, and to respond effectively. Several schools of therapy were considered and influenced the shape of this intervention.

1. Psychoanalysis and Psychodynamic Psychotherapy

Attachment theory arose out of psychoanalytic theory (Bowlby, 1969-1980) and has been developed within the field of developmental and clinical psychology. Infant observation has been the fundamental instrument for advances in our understanding of child development. In Supporting Security we teach parents how to observe and give them practice in observing their babies.

Fonagy and Target (1997) described reflective functioning and its association with attachment theory. Reflective functioning is the capacity

to envision mental states in oneself and others; to reflect on what one is thinking, feeling, etc. and what another person might have in her/his mind. Better reflective functioning in parents is associated with secure attachment status in infants. A parent who can reflect on her infant's behaviour, intentions, feelings and wishes is more likely to read his communications accurately. Thus she will more effectively identify the baby's expressions of insecurity. Parents who can reflect on their own reactions are more likely to be able to contain the frustrations (and other negative feelings) that are inevitable when rearing children. These parents are also more able to overcome the difficulties and traumas they may have endured themselves as infants and young children. All of these characteristics enable parents to help their babies feel more secure.

To support the development of reflective functioning, we encourage parents to consider points of view that differ from their own (coming from other parents or group leaders and most importantly, from their own infants). Parents are encouraged to wonder about the behaviours, intentions and communications in their own infants. They are encouraged to reconsider conclusions they have drawn from previous experiences. As parents wonder about or reflect on their impressions and responses, they are likely to become more accurately sensitive and contingently responsive to their infants. Note that this is much more than an intellectual or purely cognitive change. If a parent accurately perceives her infant's need for reassurance, she will be emotionally motivated to respond to increase the baby's feeling of security. This is part of the biological root of attachment theory that Bowlby described.

It is also important for group leaders to be able to reflect on their experiences and those of the others in the group. This enables leaders to respond supportively to each other and to the group members as well as to the babies. Leaders must be able to consider and reflect on the experiences of all the others in the group. This is particularly relevant when a group member is challenging the group or one of the group leaders. There may be times when a baby's behaviour interferes with the group's

activity or the goals a leader has for the group. There may be times when a parent's responses to a baby are less than ideal or cause concern. Leaders must be able to consider and reflect on the experiences and intentions of the baby, the parent, the other members of the group and the other leader as they respond. For example consider a crying baby whose mother seems to be irritated with the baby as he does not settle down. The group cannot focus on its activity. The leader must provide leadership to the group. This includes demonstrating awareness of the baby's distress and of the mother's distress. It is likely that the mother wants to settle her baby and is becoming anxious about disrupting the group. She may feel ashamed, feel like a failure, that she cannot settle her baby more quickly. She may begin to see the baby as her enemy, someone who is making her look bad. As the mother becomes more stressed, the baby is likely to feel more insecure. The leader must empathize with the mother, the baby and the group in order to find a solution that advances the understanding and experience of security for all. Sometimes reassuring the mother that she can take her time relieves her stress enough to let her soothe her baby. Sometimes accompanying her outside the group to settle the baby may be needed. Other solutions may be suggested or thought of by the leaders or other members of the group. Any solution must include helping mother soothe the baby – this is a priority. At the same time the leader, or her partner, can discuss the attachment perspective of what is going on.

2. Parent Training

The structure of group sessions for Supporting Security has been informed by the approach used in Parent Training interventions. Parent Training approaches are used when children and youth present with problems of aggressive behaviours. Widespread empirical support for Parent Training interventions has been found, with medium to large effect sizes, generalization to home and community settings, maintenance of improvement, and high levels of consumer satisfaction (Chambless & Ollendick, 2002; Kazdin & Weisz, 1998; Weersing & Weisz, 2002). Group sessions include opportunities for learning and practicing both in the group setting and at home.

These characteristics are also part of Supporting Security, although there is more emphasis on self awareness and on relational systems in the latter. In Supporting Security we focus on insecurity rather than aggression and we are dealing with parents of much younger children. Our purpose is to improve parental sensitivity to infants' signals and communications about insecurity and to enable parents to respond in ways that are likely to increase infants' feeling secure. Thus we create opportunities for parents to observe their babies together and we encourage them to do the same at home.

3. Psychoeducation

Psychoeducation is a large part of Supporting Security. We teach parents about attachment theory and about infant and child development with the understanding that an educated parent is more likely to recognize, understand and respond to a child's distress accurately.

4. Group therapy

Meta-analyses of treatment outcome research provide considerable evidence that group therapy benefits children, adolescents and adults (for an extensive review see, Bednar & Kaul, 1994; Kazdin, 2000; Weisz, Weiss, Han, Granger, & Morton, 1995). Yalom (1995) devised an inventory of 11 curative factors that contribute to the power of group therapy's in effecting change. Among these factors are universality, imparting of information, imitative behaviour, and group cohesiveness, characteristics built into Supporting Security.

Supporting Security is designed for groups of parent and can include both individual parents and couples. It is desirable for both parents to attend whenever possible. Individuals such as grandmothers, close friends, etc. who provide support to a parent can accompany that parent to group sessions. The degree to which a parent can feel supported in the group by the presence of these supportive individuals must be balanced against changes in group membership, which tend to cause uncertainty and distraction in the group as a whole. We encourage anyone who attends, to attend regularly.

Leaders seek to make the group a supportive, interesting and enjoyable experience for parents. We want parents to feel secure within the group. That feeling of security will help them be reflective and help them learn. For some parents, this may be an unusual experience – they may feel threatened in their lives more often than they feel secure. The feeling of security may act as a motivator, encouraging them to attend group meetings. The group should function to maximize peer support and create an environment in which different and perhaps even opposite points of view can be voiced within an emotionally positive and tolerant atmosphere. There is also evidence that when mothers have supportive relationships with other mothers their babies are more likely to feel secure (Huth-Bocks et al, 2004).

Unlike group interventions that evoke abreactive responses (venting) and thus intense feelings, the purpose of this intervention is to provide support for members, convey information and create opportunities to reflect. Thus leaders work to minimize intense affect in the members. This also reduces challenges to group organization and cohesion for inexperienced leaders.

5. Problem Solving Therapy

Providing parents with strategies and solutions to problems is likely to help parents reduce their anxiety and stress not only when their babies are distressed, but at other times in the day too. There is evidence that when parents feel more stressed on a day-to-day basis, their babies feel more insecure (Easterbrooks and Graham, 1999). We think this could happen in two ways. Parents who are stressed are more likely to evoke insecurity in their infants; i.e. these parents are more likely to manifest FR behaviours (Lyons-Ruth, 1999). They are also likely to have difficulty being sensitive to their babies' signals and responding effectively.

Nezu & Nezu (2001) describe a problem-solving model for depression that highlights the moderating nature of problem solving ability. Problem Solving Therapy (PST) involves training individuals in five major processes: problem orientation, problem definition and formulation, generation of alternatives, decision making, and solution implementation

and verification.

In Supporting Security we help parents use a problem solving framework to address a number of day-to-day challenges they may face. We encourage them to think together and individually, in the group meetings and later when doing their homework, about the sorts of problems they are confronted with when taking care of young babies. We help them rehearse ways of dealing with those problems. Our expectation is that they will become able to apply the technique when faced with real problems away from the group meetings.

6. Mindfulness training

Mindfulness-based interventions have been found to be associated with better outcomes in a number of different disorders: anxiety disorders, depression, borderline personality disorder, pain-associated disorders, etc. (Baer, 2003). Mindfulness is described as paying attention to the present experience in a non-judgemental way on a moment-to-moment basis (Baer, 2003; Kabat-Zinn, 1994). We have included this practice as a way of helping caregivers learn to pay attention to and recognize their babies' signals as well as their own internal reactions. These are components of reflective functioning and of sensitive responsiveness. Mindfulness is also associated with stress relief (Kabat-Zinn, 1992). We expect it to support reflective functioning and to reduce stress, to complement and facilitate the problem-solving formula referred to above.

GROUP SESSIONS

Each session lasts two hours and includes a regular schedule of checking in, discussing homework assignments, teaching, a group activity in which members practice what has been the subject of the teaching and finally home work is assigned for the next week which is once again an opportunity to practice the teaching. Teaching topics include attachment theory, infant emotional and cognitive development, infants' perceptions in relationships, parental self-regulation, problem solving, parental anxiety, depression and anger, violence in the family and the neighbourhood,

and choosing alternative caregivers. The focus of all topics is repeatedly brought back to its relevance to attachment and feelings of security.

Leaders contact each group member once between each group session.

OUTCOMES AND PLANS

We have conducted three feasibility studies, two in a challenged neighbourhood in Toronto and one on an isolated aboriginal reserve in northern Ontario. These demonstrated:
1. we were able to train leaders to run groups adherent to the manual.
2. leaders could engage and retain mothers with babies up to one year of age in the course of 12 sessions
3. participants benefited from the intervention in the directions we predicted although numbers were too small for statistical significance.

We have trained leaders in five northern Ontario aboriginal communities and are conducting a randomized control outcome study.

Groups have been running in five separate sites for several years in Israel, where the concept of this intervention first arose, thanks to Ravit Nisan who translated the original manual into Hebrew.

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Les défis du lien: an attachment assessment kit

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In March 2009, the Centre jeunesse de Montréal-Institut universitaire (CJM-IU), launched a kit entitled Les défis du lien[2]. The kit provides an initiation, in French, to two assessment tools related to parent-child attachment: the Q-sort by Pederson (Pederson, Moran, & Bento, 1999) for maternal behaviour and that by Waters [3] and Deane (1985) for attachment behaviour.

BETTER UNDERSTANDING FOR BETTER INTERVENTION

The CJM-IU is one of Canada's largest public child-protection agency. Its mandate is to provide services aimed at supporting parents in meeting their parental responsibilities and developing their parental capacities. Moreover, as a university institute, it also pursues a teaching and research mandate. The CJM-IU strives to acquire a better understanding of the causes underlying the problems afflicting maltreated children, to remedy these problems and, insofar as possible, to prevent them (Young, 2008).

Over the past decades, attachment theory (Bowlby , 1988, 1980, 1973-1969, 1982-1969) has allowed gaining a firmer grasp of the very disorganized reactions of children that had seemed inexplicable until then (Bakermans-Kraneburg, Van Ijzendoorn, & Juffer, 2005). It has also allowed comprehending just how much time matters in the life of a child (Coster, Wolfs & Courtois, 2007; Paquette, 2004) and just how important it is to act rapidly (Gouvernement du Quebec, 2009). Today, we know to what extent instability in the life of very young children can affect their development (Chamberlain, Price, Reid, Landsverk, Fisher, & Stoolmiller 2006; Allen, & Vostanis, 2005; Cicchetti & Toth, 1995). We have understood also that various factors can affect parenting capacities (Cicchetti & Valentino, 2006).

Notwithstanding these advances, there are still numerous challenges associated with child victimization to be met. The stability of life projects continues to be cause for concern (Paquette, Labrecque, & Gaudet, 2005), mobilizing families and assisting change in a context of authority is not easy, decision-making in a socio-judicial context is a complex affair, and the issues surrounding placement remain unresolved. This is why it is important to bring to bear all means capable of enhancing the impact of interventions by making the most of existing knowledge.

However, experience has shown that, despite the progress achieved in terms of knowledge development and despite the fact that best practices are sometimes known and recognized, the capacity of practice settings to integrate innovations in their day-to-day activities remains limited. According to recent studies, only a slim proportion of practitioners, all disciplines considered, including medicine--which is quite troubling—apply best practices with their clientele (US Department of Health and Human Services, 1999). According to McGlynn, Asch, Adams, Keesey, Hicks, DeCristofaro, & Kerr (2003) :

« [...] Americans receive about half of recommended medical care processes. Although, this point estimate of the size of the quality problem may continue to be debated, the gap between what we know works and what is actually done is substantial enough to warrant attention. » p. 2643

Chaffin & Friedrich (2004) make a similar observation :

« [...] most field services provided to abused children and their families are not based on any clear evidence that the services actually work. It is common for models to be widespread despite fairly strong evidence that they do not work well, at least as currently implemented [...] » p. 1098

How can we explain this state of affairs? Multiple factors are no doubt at play. Part of the answer rests on the fact that good practices must first get to those likely to apply them. As it happens, the circulation of information remains a considerable challenge despite the advance of information technologies. Although information is certainly more accessible, sorting through the phenomenal amount disseminated requires time, keenness and know-how—three elements not always in abundant supply.

Furthermore, even when good practices catch the attention of potential users, they are not always exportable or applicable as is. They often need to be reworked and adapted to the specificities of the practice context before being implemented. They must be examined, experimented, tested, and remodelled. In addition, any such adaptation must preserve the integrity of the good

practices. This transformation effort, too, requires time, keenness and know-how. It necessitates an even greater investment than the previous challenge in that it often calls for the setting whence the knowledge derives—often but not exclusively universities—to join forces with the practice setting in order for the endeavour to bear fruit. In sum, gaining access to knowledge regarding best practices is not easy for interveners operating on the front lines on a daily basis. According to Torrey, Finnerty, Evans, & Wyzik:

« Implementing a new practice in a routine mental health care setting entails promoting change in the behaviour of groups of mental health providers. Theorists suggest that behaviour changes when intention to change is combined with the necessary skill and the absence of environmental constraint » p. 884

The idea of producing this kit to render information on these two card-sort measures accessible initially arose in response to a need on the part of CJM-IU personnel for greater knowledge access. The transfer of knowledge concerning these instruments constitutes a constant challenge on account of personnel mobility and retirements.

Other bodies, too, have expressed a marked interest in these card-sort measures. Our establishment is solicited on a regular basis by interveners operating in the areas of prevention and protection, as well as by students in Quebec or abroad engaged in study or research projects who are seeking out information on these tools. As it turns out, while information is relatively easily accessible in English [4], the same is not true in French. Furthermore, the literature contains accounts of their application for research purposes above all (Tarabulsy, Provost, Moss, Bernier, Maranda, Larose, Larose & Tessier, 2005; van Ijzendoorn, Vereijken, Bakermans-Kranenburg, & Risksen-Walraven , 2004; Pederson, Gleason, Moran, & Bento, 1998; Pederson, Moran, 1996; Posada, Waters, Crowel, & Lay, K.-L., 1995), whereas our experience has taught

us that these instruments are of great clinical value and utility. The idea of creating a kit sprang out of this need.

IMPORTANCE OF CONTEXTUALIZING TOOLS: ATTACHMENT THEORY

However, the desire to transmit scientific knowledge to users operating in practice settings raises a major challenge, namely, that of preserving its essence while rendering it user friendly. Indeed, it is hard to simplify something complex without losing something in the process.

As it happens, the two card-sort instruments are founded on attachment theory. This is why different experts--professors, clinicians, child psychiatrists, psychologists, and managers—bear witness in the kit regarding the clinical challenges associated with childhood attachment and the contribution of the card-sort measures to intervention. The aim of these testimonials is to promote the proper use of these instruments, bearing in mind both their potential and their limitations.

POTENTIAL, LIMITATIONS AND RISKS

According to Larin (2007) [5], the biggest advantage afforded by these card-sort measures is to provide, on the basis of the reflection carried out and the consensus reached by experts, a synthesis of what needs to be observed in the parent-child attachment tie. The scientific rigour exercised by the research teams that developed these assessment instruments allows clinicians and researchers to benefit from knowledge without the pain of conducting a literature review or of actually carrying out research.

The use of these card-sort instruments affords many benefits, including the possibility of validating clinical intuition, as all observers use the same 90 items to reach decisions regarding

the quality of what transpires in course of their observations. This provides observers with common reference points for analyzing what goes on in a dyad. These are concrete instruments that incite the observer to focus on the observation and that offer a solid analytical framework. As a result, observation is elevated to a higher degree of refinement that translates into a more acute clinical judgement. The use of these instruments sharpens the ability of observers to discern the behaviours that favour or undermine the establishment of secure attachment.

The card-sort method has the advantage of preventing the halo effect [6] thanks to the constraint it imposes on the observer to describe what he finds most significant in the parental behaviour. It is also of particular interest due to its focus on the attachment behaviours of children and on parental sensitivity to them. This method provides precise anchors that allow drawing a picture of the tie at a given point in time. Moreover, from a longitudinal perspective, it affords the opportunity to verify potential changes over time.

The two card-sort instruments are useful also in establishing a common language regarding the concepts of parental sensitivity and attachment. This fosters complementarity and coherence across the various services offered as part of an intervention. Finally, these instruments allow generating precise objectives with a child's parents or other attachment figures by focusing on certain specific behaviours that, as we know, are amenable to change through therapeutic work.

Though use of the card-sort instrument presents numerous advantages, a caveat is in order regarding their limitations. First, it is important to keep in mind that the information obtained by way of these tools remains

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4   Everett Waters offers the Attachment Q-set, the Pederson and Moran Maternal Sensitivity Q-set, as well as numerous interesting articles related to attachment, online free of charge.

5   Psychologist Stéphanie Larin of the CSSS sud de Lanaudière, from an interview recorded in October 2007 for the purpose of the kit.

6   The halo effect refers to a cognitive bias that affects one's perception of others, whereby a given trait deemed positive in a person tends to render other traits positive as well, without necessarily having any actual knowledge of these other traits. The inverse is true for negative traits. Accordingly, Clifford (1975) demonstrated that persons were judged to be more intelligent than others solely on the basis of their physical attractiveness. The halo effect was first brought to light by social psychologist Edward Thorndike in 1920.

incomplete. The issues surrounding the parent-child relationship are of such complexity that they necessarily go beyond what can possibly be determined via a mere card-sort instrument. As underscored by St-André (2007)[7], while the use of these instruments fosters better communication among professionals and allows sketching a profile, **it does not allow formulating a diagnosis**.

To make proper use of these instruments, observers must be trained. Moreover, this must occur together with others for the sake of good inter-rater reliability. Using a card-sort instrument also requires a minimum amount of rigour when observing. Observers must take the time not only to watch properly but also to reflect upon the behaviours noted when sorting the cards. Furthermore, the results obtained through a card-sort instrument carry, like all standardized measures, a margin of error. In addition, according to Parent (2007) [8], the present state of the research on these tools does not allow defining cut-off points between normal and clinical populations. Further studies are required in order to establish these thresholds. Finally, according to Moss (2007),[9] the Q-sort for attachment behaviour does not allow classification by style (A, B, C, D). If it becomes necessary to identify the attachment type of high-risk children, such as those with disorganized attachment, observers will need to be trained in decoding these styles.

DEVELOPING A KIT TO MAKE THE MOST OF EXISTING KNOWLEDGE

Developing a kit such as Les défis du lien is both stimulating and demanding. It constitutes a rigorous and structured process that requires the collaboration of multiple experts, administrators and frontline clinicians.

It is an experience that calls upon clinicians to become familiar with an assessment approach that places technology at the service of content. It is also a process that requires a certain technological know-how. Finally, a commitment from the organisation is required so that a sense of ownership develops within the practice milieu. As so accurately remarked the group of Torrey in 2003 : « To improve the availability of services that have been shown to work, leaders must lead ».

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[7] Child Psychiatrist Martin St-André of the Centre hospitalier universitaire Ste-Justine de Montréal From an interview recorded in October 2007 for the purpose of the kit

[8] Professor Sophie Parent of the Université de Montréal, from an interview recorded in October 2007 for the purpose of the kit

[9] Professor Ellen Moss of the Université du Québec à Montréal, from an interview recorded in October 2007 for the purpose of the kit.

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Seasonal Greetings to all WAIMH members!

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EDITOR'S PERSPECTIVE

Is culture really taken into consideration in our tools for assessment and intervention?

When we implemented Wittenberg's Supporting Security Group program in our Infant Mental Health Unit, located in the Tel-Aviv area (Israel) and we started with training community health nurses and social workers, we asked one of the Israeli Arabic nurses what is the word for "Attachment" in Arabic…and she could not find any. Same happened with the Ethiopian social worker…My team and I were quite puzzled, and we thought these health workers don't know about the concept of attachment because the professional literature in infant mental health has not been translated into Arabic nor into Amharic…The thought that attachment may not be relevant to their specific cultures (although they are part of the Israeli society) did not come through our "Western mind", despite the bulk of papers that have been written on culture and infant mental health, the most recent being the IMHJ issue on Development of Infants and Toddlers in Ethnoracial Families (Fitzerald et al, 2009).

We had to realize that in fact, Ethiopian as well as Arabic infants tend to grow up within enlarged families, while all the grownups around them are caregivers, as opposed to the native Israeli Jewish infants who are raised in nuclear families.

Tronick's (2007) recent publication draws new attention to a long standing issue in infant research, namely, the extent to which culture influences early development, and it broadens the conversation on culture, neurobiological and behavior organization, mental representations, and social-emotional regulatory processes that influence self-other relationships during the earliest years of life.

"Culture tailors the phylogenetically based aspects of caregiver investment strategies to the locally specific, relatively stable, social and physical features of the environment. Most importantly, culture helps define those features of the child's behavior and communication that require attention and response, as well as the culturally appropriate form of the response" (Tronick, 2007, p. 99).

Specifically relating to attachment behaviors across cultures, the Efe people (in the Ituri rainforest in Congo) have adopted a strategy that mitigates against risk of infant's survival, as well as against loss of parents, in the form of multiple nursing and caregiving. This practice enhances the infant's ability to form trusting relationships with a variety of individuals, and probably impacts on the infant's and adult caregivers' brain. The Efe infant will show attachment behaviors to any individual in the group when distressed, as opposed to the Wwestern infant who is expected to turn only to their immediate caregiver. Another example is the Peruvian manta pouch, developed by the high-altitude living Quechua people: it is a tight wrapping system that provides a hospitable and portable microenvironment for the infant, warmer, more humid, lower in oxygen and higher in carbon dioxide. The higher level of CO_2 enables the infant to sleep more, thus spending less energetics demands that can be used for growth and maintenance. On the other hand, the manta pouch restrains all the infant's movements and keeps a low level of stimulation (baby's face is covered by a blanket) and of social interchange. Instead of "diagnosing" this parental behavior as under stimulating and under involved, one should remember the specific context of the Quechua people: at the age of 6-7 years, children are expected to care the herd, a high-responsibility task that requires high degrees of vigilance, low curiosity and exploratory behavior, and an ability to tolerate a lack of social interchange…a totally different context from the 6 years old Western child's… A last example is about the Gusii culture in Kenya: display of intense affects is to be avoided, as a potentially disruptive force. The face-to-face situation may call up strong feelings, therefore needs to be particularly regulated. A typical adult-adult interaction often occurs with completely averted eye gaze (which, in our Western culture, is seen as a violation of mutual trust and arouses suspicion of malintent or insincerity). Greeting behavior is also strictly governed by rules. The analysis of face-to-face interactions (Tronick, 2007), has shown that Gusii mother-infant relationships are characterized by avoidance of eye-to-eye contact, restraint in playful interactions, rare affectionate and social behaviors toward the baby (who is perceived not capable of communicative intent other than hunger or distress), and almost no talking to infants, nor response to infant's vocalizations (again because lack of giving interactive meaning to it), but only to cries (It is silly to talk to a baby" a Gusii mother said). Enhancing social development or cognitive growth are not part of the mother's culture-specific parental goals, and Gusii children are much less attention-seeking than infants from other cultures.

In sum, while we assess parent-infant interactions, we must know what is the profile of the best fitted individual to the specific cultural group they belong to: the interactions of mother and infant can be seen as uniquely suited to the cultural goals and expectations. Overlooking it may lead to false diagnoses and irrelevant interventions.

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