

EARLY PARENTING SUPPORT: APPLICATION OF AN INTERVENTION
PROGRAM TO ENHANCE MATERNAL SENSITIVITY IN TURKEY

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ABSTRACT

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The present study aimed to adapt, apply and test the effectiveness of the Video-Feedback Intervention to Promote Positive Parenting-Sensitive Discipline (VIPP-SD) in the Turkish context. The sample consisted of 56 mothers from relatively underdeveloped regions of Ankara and Istanbul having infants between 10 and 33 months old. The sample was randomly divided into two groups and four thematic sessions were conducted among 38 intervention mothers. In each session, mother and child were videotaped during daily interactions and video feedback was provided to the mother on sensitive parenting. In the control group, 18 mothers did not receive any intervention but four telephone calls from the intervener. Maternal sensitivity was assessed through video-recorded mother-child interactions, and independent raters coded these interactions using the Maternal Behavior Q-sort and Ainsworth Maternal Sensitivity Scale. In addition, maternal attitudes toward sensitivity and sensitive discipline were assessed through self-reports. The results revealed that observed sensitivity of intervention mothers had improved in comparison to control mothers. In addition, intervention mothers had more positive attitude toward sensitivity than control mothers. These findings provide support for the effectiveness of the VIPP-SD program on promoting sensitivity among low-SES mothers in a collectivistic culture. In this sense, it extends previous research among middle-to-high SES mothers in individualistic cultures, and shed light on the applicability and

effectiveness of the video-feedback intervention in different cultural and socio-economical contexts. The present study also serves as a resource for researchers and practitioners who plan to develop and implement early support or intervention programs in Turkey.

Keywords: Early intervention, maternal sensitivity, positive parenting, video-feedback

ÖZ

ERKEN DÖNEM EBEVEYNLİK DESTEĞİ: ANNE DUYARLIĞINI ARTTIRMAYA YÖNELİK MÜDAHALE PROGRAMININ TÜRKİYE UYGULAMASI

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Bu çalışmanın amacı, bakım veren kişinin duyarlılığını artıran bağlanma temelli bir müdahale programının Türkiye kültürüne uyarlanması, uygulanması ve etkisinin görgül olarak test edilmesidir. Çalışmaya, Ankara ve İstanbul'un görece düşük gelir ve eğitim düzeyine sahip 10-33 ay arasında çocukları olan 56 aile katılmıştır. Örneklem, müdahale ve kontrol grupları olmak üzere seçkisiz olarak iki gruba ayrılmış, müdahale grubundaki 38 anne ile dört temalı görüşme yapılmıştır. Görüşmelerde annelere, daha önceden anne-çocuk etkileşimlerinin kaydedildiği videolar üzerinden anne duyarlılığı konularında bireysel geribildirimler verilmiştir. Kontrol grubundaki 18 anneyle ise çocuklarının gelişimleri ile ilgili dört telefon görüşmesi yapılmıştır. Anne duyarlılığı videoya çekilmiş anne-çocuk etkileşimleri ile ölçülmüş; bağımsız kodlayıcılar tarafından Anne Davranışları Sınıflandırma Seti ve Ainsworth Anne Duyarlık Ölçeği ile değerlendirilmiştir. Annelerin duyarlı davranış ve disipline yönelik tutumları da öz bildirim ölçekleri ile ölçülmüştür. Çalışmanın sonucunda müdahale annelerinin kontrol annelerine göre gözlemlenen duyarlı davranışlarında anlamlı düzeyde artış gözlenmiştir. Bunun yanısıra, müdahale annelerinin kontrol annelerine oranla müdahale sonrasında duyarlı davranışa yönelik daha yüksek düzeyde olumlu tutum bildirdikleri bulunmuştur. Bu bulgular VIPP-SD

programının toplulukçu bir kltrde yařayan dřk sosyoekonomik dzeye sahip annelerin duyarlıđını artırmada etkili olduđunu gstermektedir. Bu alıřmada bireyci kltrde yařayan orta ve yksek sosyoekonomik dzeye sahip annelerle yapılmıř alıřmaları bir adım ileriye tařıyacak, video-geribildirimine dayanan mdahale programının farklı kltrel ve sosyoekonomik bađlamalarda uygulanabilirliđi ve etkinliđine iliřkin bulgular elde edilmiřtir. Ayrıca bu alıřma Trkiye'de erken dnem destek veya mdahale programı geliřtirmeyi ve uygulamayı planlayan arařtırmacı ve uygulayıcılara iřlevsel bir kaynak sunmaktadır.

Anahtar Kelimeler: Mdahale programı, anne duyarlıđı, olumlu ebeveynlik, video-geribildirimi

To my dear family

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CHAPTER 1

INTRODUCTION

1.1. Motivation for the Study

Early years of life are considered to be the most critical period for optimal child development. In particular, early caregiving environment is of crucial importance for brain development almost eighty percent of which is completed in the first three years of life (Allen, 2011). This period of fast neuropsychological growth gives caregivers the opportunity to provide children with social and emotional capabilities. In particular, early interventions that support caregivers in early years contribute to the development and promotion of child's social capabilities such as getting along with other children, interacting cooperatively with adults and responding to others' emotions, and emotional capabilities such as building secure attachment, recognizing and empathizing with others' emotions as well as regulating their own emotions and behaviors (Allen, 2011).

These capabilities help children attain healthy socio-emotional development, which in turn promotes educational and occupational attainments, and successful parenthood in later years (see Allen, 2011; Kagitcibasi, 2007; Sandler, Schoenfelder, Wolchick, & Mackinnon, 2011 for a review). For instance, research in Western Countries have shown that early intervention and support programs that promote children's social and emotional capabilities reduce their problem behaviors, school dropout and criminal activities, and thus reduce economical burden on the state and make long-term savings in public expenditure. Besides, early interventions are more effective, economic and easier to apply than late interventions. Therefore, the development of early intervention programs holds key for healthy individuals and societies (Allen, 2011; Kagitcibasi, 2007; Sandler et al., 2011).

Given the significance of early interventions, a great number of researchers and practitioners have developed early intervention and support programs that

promote positive parenting and optimal child development (i.e. Juffer, Van IJzendoorn, & Bakermans-Kranenburg, 2008d; Sandler et al., 2011; Watson, White, Taplin, & Huntsman, 2005). In general, early intervention programs vary in terms of their goal and focus. For instance, community-based early enrichment programs (i.e. Early Head Start) focus broadly on improving disadvantaged child's individual and environmental resources (Administration for Children and Families [ACF], 1999), while attachment-based early interventions (i.e. Video-Feedback Intervention to Promote Positive Parenting [VIPP], Juffer, 1993; Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2008c) focus solely on improving the quality of caregiver-child relationship.

1.2. The Scope and Purpose of the Study

Accordingly, the present study aimed to adapt, apply, and test the effectiveness of the VIPP program in the Turkish context. The VIPP program was developed based on attachment theory (Ainsworth, Blehar, Waters & Wall, 1978; Bowlby, 1958; 1969/1982) with the goal of enhancing maternal sensitivity and promoting child attachment security. The vast majority of research have provided support for the effectiveness of the VIPP program in Western cultures. To my knowledge, however, there are limited attempts in non-Western cultures (i.e., Yagmur, Mesman, Malda, Bakermans-Kranenburg, & Ekmekci, 2014). This study, therefore, would be the first VIPP study among families in Turkey, which have mainly a collectivistic and relational culture (Kağıtçıbaşı, 2007). Besides, to my knowledge, there is only one VIPP study which selected its target sample from families with low socioeconomic background (i.e. Negrao, Pereira, Soares, & Mesman, 2014). However, there is a great need for information and support from professionals to enhance parenting skills in disadvantaged contexts. The current study, therefore, aimed to address this gap by selecting the target sample from low-SES Turkish families. Hence, the findings of this study would provide support for the applicability and effectiveness of the video-feedback interventions in different cultural and socio-economical contexts.

Before giving detailed information about the VIPP programs and their effectiveness, it would be helpful to explain the main tenets of attachment theory and attachment-based early interventions for a better understanding of the program efficacy. Therefore, the introduction section first explains attachment theory and reviews effectiveness of attachment-based early interventions. Second, it introduces the VIPP programs and reviews effectiveness of these programs. Third, it explains culturally-sensitive intervention program and hypotheses of this study. Next, the method section explains the methodology and the result section presents the findings of the main and supplementary analyses of the present study. Finally, the discussion section discusses these findings in relation with the extant literature and provides implications for future research.

1.3. Attachment Theory and Attachment-Based Early Interventions

1.3.1. Theoretical Background

The attachment bond is of critical importance to the child's functioning. Separation from the caregiver, especially in the early years of life, leads to deficits in the infant's regulation of physiological and behavioral systems, which in turn may extend into later years (Hofer, 2006). Bowlby's work (1958) on attachment theory emerged from a need to understand the mechanisms underlying the strong affectional bond between infant and caregiver. When Bowlby was first formulating his theory, there were several explanations (i.e. drive-reduction and classical conditioning) for the development of this bond (Cassidy, 2008). For instance, it was proposed that infant is passively dependent on mother for food, and associates the pleasure achieved through the satisfaction of the hunger drive with the mother's presence, which in turn leads to the generation of the affectional bond. However, Lorenz's (1935) study on infant geese and Harlow's study (1958) on infant rhesus monkeys showed that infants might also be attached to caregivers who did not provide food but rather close bodily contact and comfort (cited in Cassidy, 2008).

After having searched several fields for new explanation, Bowlby formulated his theory on evolutionary mechanisms. In general, he proposed that the biological

function of attachment behavior is seeking protection from danger by maintaining proximity to attachment figure (Bowlby, 1958, 1969/1982). Since human infants are unable to defend themselves from predators and other dangers, they are more likely to survive when they stay close to their mothers. Therefore, attachment behaviors have a survival advantage for the infant by providing proximity to and contact with the mother. For instance, signaling behaviors such as 'smiling, vocalizing and crying' and active behaviors such as 'moving toward the caregiver and clinging' serve to bring infant and mother into proximity with each other (Bowlby, 1958; Cassidy, 2008).

Attachment behaviors are mainly organized into an attachment behavioral system (Bowlby, 1969/1982, Cassidy, 2008). This system provides flexible adjustment to the infant when there are environmental changes. It operates in a 'goal-corrected manner' that is, the infant's goal is to maintain the desired distance from the mother and when this goal is exceeded, the system becomes activated for proximity-seeking usually in times of real or perceived stressors either within the infant (i.e. illness, fatigue, pain or hunger) or in the environment (i.e. loud noise, presence of a stranger or absence of the attachment figure). The system is however terminated when sufficient proximity or comfortable setting with the mother ('the goal') is achieved. In other terms, infants are biologically predisposed to use the attachment figure as '*a safe haven*' for receiving protection and comfort in times of threat (Ainsworth et al., 1978; Bowlby, 1969/1982).

There is a complex interplay between attachment and caregiving behavioral systems (Bowlby, 1969/1982; George & Solomon, 2008). In general, parents are biologically-predisposed to provide protection, care and comfort for infants. Caregiving behaviors such as retrieval, calling, reaching, grasping, following and soothing are reciprocal to infants' attachment behaviors. The physical features of a new born baby ('baby-ness') also evoke caregiving behaviors. This system is activated by the caregiver's perceived internal cues such as "presence of hormones, cultural beliefs, state of the caregiver (i.e. tiredness), activation of other behavioral systems" and external cues such as "environment (i.e. presence of stranger), state of the infant (i.e. illness) and behavior of the infant (i.e. attachment behavior)"(Cassidy, 2008, p. 11). When caregiving system is activated, the infant does not need to

activate the attachment system. However, when caregiving system is not activated, the infant is more likely to activate the attachment system to achieve proximity with the mother. Thus, caregiving system may be considered as complementary to attachment system (see Bretherton, 1992; George & Solomon, 2008).

Attachment system is in a dynamic equilibrium with exploratory system through which the infant learns about the environment (Bowlby, 1969/1982; Cassidy, 2008). When the infant feels distressed, attachment system is activated and the infant is less likely to explore the environment. However, when attachment system is terminated through achieving proximity with the mother, the infant feels more comfortable and exploration is more likely. In other terms, infants use the attachment figure as '*a secure base*' from which to explore the environment (Ainsworth et al., 1978; Bowlby, 1969/1982). The extent to which attachment figure provides a secure base for exploration in the early years is highly crucial for the development of autonomy and competence in later years (Sümer, 2012).

1.3.2. Individual Differences in Attachment Security

Based on mother-child observations in the early 1950s in Uganda and in the early 1960s in Baltimore, Mary S. Ainsworth and her colleagues proposed that there are individual differences in the quality of attachment relationship (Ainsworth et al., 1978). That is, nearly all children (even those who are mistreated) are attached (*'Universality Hypothesis'*; Van IJzerendoorn & Sagi, 2008) but they vary in their quality of attachment security. Building on Bowlby's formulations, they created a controlled laboratory environment namely "Strange Situation Procedure (SSP)" to empirically assess the quality of attachment patterns (Ainsworth & Bell, 1970). In this procedure, 12-18 months old infants are confronted with several mildly stressful conditions: an unfamiliar room with toys, an unfamiliar adult interacting with the child, and two brief separations from the mother followed by a reunion. The aim is to activate infant attachment behavioral system and observe the balance between attachment needs and exploration behavior in the presence of caregiver and/or stranger (Ainsworth & Bell, 1970).

On the basis of infant's behavioral response to parent in brief separation and reunion episodes, the quality of attachment relationship is classified into two categories: 'secure' and 'insecure' (*insecure-avoidant* and *insecure-resistant or ambivalent*) attachment relationships (Ainsworth et al., 1978). In *secure attachment (B)*, infant uses the mother as a secure base for exploration, shows little distress at separation, seeks proximity with the mother even greet her with smile at reunion. Research have provided convincing evidence that majority of the infants are securely attached across cultures ("*Normativity Hypothesis*", Van IJzerendoorn & Sagi, 2008).

In *insecure-avoidant attachment (A)*, infant shows little visible distress at separation, ignores, avoids and turn away from the mother at reunion. In other terms, they do not show attachment needs and mostly seem to be involved in exploratory behavior. In *insecure-resistant or insecure-ambivalent attachment (C)*, infant does not use the mother as a secure base for exploration, shows quiet distress upon separation, seeks proximity or contact at reunion but also shows anger and can not be easily calmed by the mother.

In the following years, Main and his colleagues (Main, Kaplan, & Cassidy, 1985) identified a new pattern as *insecure-disorganized attachment (D)*, in which infant shows bizarre and inconsistent behaviors such as seeking contact but also displaying sudden freezing or expression of fear towards mother at reunion. An unresolved loss or trauma experienced by the mother may lead to frightening behaviors towards the child, and may prevent her from accurately perceiving child's signals. Therefore, children of these mothers show disorganized attachment (Main et al., 1985).

1.3.3. Antecedents of Individual Differences in Attachment Security

Ainsworth's and her colleagues' mother-child observations have shown that individual differences in the quality of attachment security is related to the extent to which the mother is available and appropriately responsive to the child's needs (Ainsworth et al., 1978; Ainsworth, Bell, & Stayton, 1974). That is, mothers of securely attached children were highly sensitive and appropriately responsive to their

children's signals of distress. However, mothers of insecure-ambivalent children were inconsistent and unreliable in responding to their children's signals of distress, and mothers of insecure-avoidant children were consistently unresponsive, unavailable or rejecting to child's expressions of distress and negative emotions.

Indeed, the quality of attachment security is mainly governed by the child's expectations for the availability and responsiveness of the mother. In Bowlby's terms, these expectations are incorporated into *internal working models* (or *mental representations*) of the self, the attachment figure and the relationship that reflect attachment-related interaction patterns (Bretherton, 1992; Bretherton & Munholland, 2008). In general, repeated interactions patterns with attachment figure are stored in memory as mental representations or scripts such as "*When I feel bad, Mum helps me feel better*", "*When I need help, Mum is usually there for me*" (Bretherton & Munholland, 2008, p.112). These representations help children anticipate the attachment figure's likely behaviors to signs of distress or contact and guide their beliefs, expectations and behaviors in later relationships (Weinfeld, Shoufe, Egeland, & Carlson, 2008).

What type of mental (working) model children construct over the course of repeated interactions with the attachment figure determines the quality of the attachment security in the early years (Bretherton, 1992; Bretherton & Munholland, 2008). For instance, when children construct their mental representations of the mother as emotionally available and responsive when needed (positive representation of others), and feel themselves valued and competent (positive representation of self), they are more likely to develop secure attachment. In contrast, when children have negative representations for the mother as inconsistently available or consistently rejecting and ignoring, and feel themselves devalued and incompetent, they are more likely to develop insecure attachment. It is important to note that even though these models persist over time, they can be revised when they no longer make adequate predictions (Bretherton & Munholland, 2008). For new attachment relationships in later years, new representation may develop or already existing representations may be integrated.

1.3.4. Developmental Consequences of Individual Differences in Attachment Security

Attachment styles and the underlying mental models are highly crucial for social and personality development. It is widely argued that exploration behavior is promoted in secure attachment relationships. That is, securely attached children are confident in their mothers' sensitive and responsive availability in a threatening environment, therefore they rely on their mothers in times of distress, achieve self-confidence and mastery of their environments (Ainsworth et al., 1978; Weinfeld et al., 2008). In contrast, insecure relationships may compromise exploration behavior. Insecurely attached children are anxious about their mothers' inconsistent availability or unavailability, thus they can not achieve self-confidence and mastery of their environments. Accordingly, longitudinal studies have shown that securely attached children develop more self-reliance (autonomy), ego-resilience, efficacy, empathy, and are more socially competent as compared to insecurely attached children from infancy to adulthood (see Sroufe, 2005; Weinfeld et al., 2008 for a review).

In addition to mental representations, the quality of attachment security may have an impact on child functioning through brain development, emotional self-regulation, behavioral regulation and behavioral synchrony (Weinfeld et al., 2008). For instance, through repeated interactions with attachment figure, infants learn how to regulate their emotions and how to behave in a relationship, which in turn influence their self-regulatory abilities and social skills (*'Competence Hypothesis'*; Van IJzerendoorn & Sagi, 2008). Considerable research have shown that secure attachments during early childhood predict optimal emotional and social development including better emotion regulatory skills, close and satisfying relationships with their parents and peers, positive self-concept and desirable personality qualities (See Thompson, 2008 for a review). For instance, a recent meta-analytic study with 80 independent samples has yielded that secure attachment is associated with social competence with peers regardless of child's age (Groh et al., 2014). In contrast, insecurely attached children are at risk for social and emotional problems, even child psychopathology. At this point, it is important to consider the impact of early attachment security on later functioning in the context of subsequent

developmental influences. Even though early history of maternal care initiate developmental pathways, later quality of care and other environmental circumstances might also contribute to the prediction of later functioning (Sroufe, 2005; Weinfeld et al., 2008). In other terms, child's functioning can be revised by the changes in the caregiving environment.

1.3.5. Maternal Sensitivity and Attachment Security

Given the impact of the quality of caregiving environment on child's adjustment and relationship functioning, it is of crucial importance to promote positive caregiving. In particular, maternal sensitivity is proposed as the primary antecedent of attachment security (De Wolff & Van IJzendoorn, 1997). Ainsworth and her colleagues (1978) defined and measured sensitivity in four main dimensions. The first dimension '*sensitivity-insensitivity*' refers to the mothers' ability to perceive and interpret child's signals accurately, and respond to these signals adequately and promptly (Ainsworth et al., 1974, p.127). This dimension consists of four essential components. These are mother's (1) awareness of the child's signals and availability, (2) accurate interpretation of the signals which requires awareness, freedom from distortion and empathy (3) appropriate and (4) prompt response to child's signals. The second dimension '*acceptance-rejection*' refers to the mothers' positive affect and warmth toward the child. The third dimension '*cooperation-interference*' refers to the mothers' respect and support for the child's autonomy. The last dimension '*accessibility-ignorance/neglect*' refers to the mothers' being physical and psychological accessible to the child. These four dimensions are strongly correlated (above .80), indicating the difficulty of separating each dimension (Ainsworth et al., 1974; 1978).

Considerable research has provided evidence for the relationship between maternal sensitivity and attachment security in Western (De Wolff & Van IJzendoorn, 1997; Bakermans-Kranenburg, Van IJzendoorn, & Juffer, 2003) and non-Western cultures (Van IJzendoorn & Sagi, 2008) including African (i.e. Uganda, Kenya), Chinese, Japanese, Israel (i.e. Kibbutz), Indonesian cultures. Even though Rothbaum and his colleagues (Rothbaum, Weisz, Pott, Miyake, & Morelli,

2000) have questioned the universality of *Sensitivity hypothesis* (Van IJzendoorn & Sagi, 2008) due to culture specific manifestations of sensitive caregiving, the meta-analytic findings using Maternal Behavior Q-Sort (Pederson et al., 1990; Pederson & Moran, 1995), Attachment Q-sort (Waters, 1995), Ainsworth's Sensitivity scale (Ainsworth et al., 1974), and Strange Situation procedure (Ainsworth & Bell, 1970) have shown that sensitive caregiving is moderately associated (overall $r = .39$) with attachment security in the U. S. ($r = .20$), Canada ($r = .53$) and Europe ($r = .48$) (See Van IJzendoorn, Vereijken, Bakermans-Kranenburg & Riksen-Walraven, 2004 for a review). Furthermore, empirical studies have confirmed sensitivity-security link across a wide range of cultural contexts such as Columbia (Posada et al., 1999, 2002, Posada, Carbonell, Alzate, & Plata, 2004), Chile (Valenzuela, 1997), Japan (Vereijken, Riksen-Walraven, & Kondo-Ikemura, 1997) and Turkey (Sümer et al., 2008).

Given this substantial body of evidence supporting the universality of sensitivity-security link, early intervention efforts have been directed to enhance maternal sensitivity to promote child attachment security. These programs are of crucial importance in two aspects. First, they provide an opportunity to examine whether experimental manipulation of maternal sensitivity leads to changes in child attachment security. In this sense, they increase our knowledge of factors that are causally related to children's development, thus provide *theoretical* contribution to attachment literature (Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2005a). Second, early interventions meet the needs of at-risk children or parents, thus provide *practical* contribution to the well-being of families and societies. In the next section, attachment-based early interventions are reviewed in relation to their effects on enhancing maternal sensitivity and promoting child attachment security.

1.3.6. Attachment-Based Early Intervention Programs

For the last few decades, researchers and practitioners have shown great interest in the development, implementation and evaluation of attachment-based intervention programs (Juffer et al., 2008d). These interventions are guided by attachment theory, and aim at promoting infant attachment security by trying to

improve maternal sensitivity and/or maternal mental representations of attachment. It is of crucial importance to promote maternal security since it might lead to insensitive parenting and insecure child attachment via intergenerational transmission of attachment (Van IJzendoorn, 1995). That is, mothers' mental representations regarding their own attachment relationships are transmitted to their children through sensitive behaviors and influence the quality of the child's attachment. Even though mothers' sensitive behaviors may not explain all the processes in this transmission ('*transmission gap*', Van IJzendoorn, 1995), two approaches that focus on mothers' sensitive behaviors and attachment representations are adopted to promote child attachment security in early interventions (Van IJzendoorn, Juffer, & Duyvesteyn, 1995). In behavioral approach, the aim is to enhance mothers' sensitive behaviors through videotaped mother-child interactions, personal video feedbacks and written materials (i.e. booklet) on sensitive parenting. On the other hand, in representational approach, the aim is to enhance mothers' secure attachment representations through discussions about their own childhood attachment relationships.

Several reviews and meta-analyses have documented how effective these early intervention programs are and which features of these programs contribute to positive outcomes. In general, the effectiveness of attachment-based interventions varies depending on its focus, time of starting, number of sessions and sample characteristics (Bakermans-Kranenburg, Van IJzendoorn, & Juffer, 2003, 2005; Juffer et al., 2008d; Van IJzendoorn et al., 1995). For instance, a meta-analysis conducted by Van IJzendoorn et al. (1995) on 11 intervention studies on sensitivity and 12 intervention studies on attachment showed that: 1) interventions were more effective in enhancing maternal sensitivity ($d = 0.58$) than attachment security ($d = 0.17$), 2) short-term interventions that focus directly on enhancing maternal sensitivity (behavioral approach) were more effective ($d = 0.48$) than long-term interventions ($d = 0.00$) that focus on changing mothers' mental representations of early attachment experiences (representational approach).

Despite including small number of interventions, Van IJzendoorn et al.'s (1995) review was important for showing greater impact of short-term interventions with behavioral focus. This finding was also confirmed by Bakermans-Kranenburg et

al.'s (2003) review on 70 studies (88 interventions). The researchers suggested that: (1) interventions were more effective in enhancing maternal sensitivity ($d = 0.33$) than attachment security ($d = 0.20$); (2) interventions with a clear behavioral focus (sensitivity) were more effective ($d = .45$) than interventions with broader focus (sensitivity, representation and support combined) ($d = .27$); (3) short-term interventions that include fewer than 5 sessions ($d = .42$) were as effective as interventions with 5 to 16 sessions ($d = .38$). In addition, they were more effective ('less is more') than long-term interventions with more than 16 sessions ($d = .21$); (4) interventions starting after the first six months of the infant's life ($d = .44$) were more effective than interventions starting prenatally ($d = .32$) or within the first six months ($d = .28$); (5) interventions with video-feedback ($d = .44$) were more effective than interventions without video feedback ($d = .31$); and finally, (6) interventions with clinically-referred sampled were more effective ($d = .46$) than interventions with other groups ($d = .31$).

The findings were also in line with Doughty's (2005) comprehensive report on effectiveness of early interventions, and Bakermans-Kranenburg et al.'s (2005) systematic review on 15 preventive interventions that included infant disorganized attachment as an outcome measure. The researchers reported that: (1) interventions that focus on sensitivity only were more effective ($d = .26$) than interventions that focus on support and representation ($d = -.08$); (2) interventions starting after six months of the infant's life ($d = .23$) were more effective than those starting prenatally or before six months of the infant's life ($d = -.13$); and (3) interventions with children at risk ($d = .29$) were more effective than interventions with at-risk parents ($d = -.10$) in preventing or reducing attachment disorganization (Bakermans-Kranenburg et al., 2005).

Taken together, attachment-based interventions vary in focus, time of starting, number of sessions, and sample characteristics. These characteristics appear to distinguish more effective interventions from less effective ones. Aforementioned reviews and meta-analyses suggest that first, interventions are more effective in enhancing maternal sensitivity than promoting attachment security. Given that promoting positive parenting is the proximal goal of most interventions, it is easier to enhance maternal sensitivity than to promote child attachment security. In addition,

they may be a sleeper effect of enhanced maternal sensitivity on child attachment security. That is, the effect of maternal sensitivity on attachment security might not be immediately apparent but be detected several months or years after the intervention. Second, short-term interventions with a clear-behavioral focus are more successful than long-term interventions with nonbehavioral focus. The long-term interventions might fail to succeed due to higher rates of attrition, which in turn lead to differential effects for experimental and control groups (Van IJzendoorn et al., 1995). In addition, long-term interventions might take too much time and energy, be less standardized and more overburden for interveners (Bakermans-Kranenburg, Van IJzendoorn, Mesman, Alink, & Juffer, 2008). These adverse consequences points out why interventions with a moderate number of sessions are more effective ('less is more') in previous research. Besides, mothers' preoccupation with their own attachment biographies in long-term interventions with representation focus might increase their defensiveness in associating past representations to actual parenting behaviors, and prevent them acknowledge the need to change these behaviors. Since changing mental representations requires more time than changing sensitive behaviors (Van IJzendoorn et al., 1995), it seems promising and cost-effective to implement short-term intervention with a clear-behavioral focus. Third, interventions are more effective when they are applied after the infant's age of six months than earlier. It is argued that mothers experience great difficulty in meeting with demands of intervention while trying to adapt to new family situations and caregiving immediately after birth; however, they gain more from interventions in later periods (Bakermans-Kranenburg et al., 2005). In light of such findings, the current study aimed to apply a short-term behavioral focused attachment-based intervention, namely the VIPP, to enhance sensitive behaviors among Turkish mothers. The next section explains this newly developed and empirically tested intervention, and discusses its effectiveness in the extant literature.

1.4. Video-Feedback Intervention to Promote Positive Parenting

1.4.1. Outline of the VIPP Programs

The VIPP program was first developed to enhance maternal sensitivity and attachment security among Dutch families with adopted children (Juffer, 1993; Juffer, Hoksbergen, Riksen-Walraven, & Kohnstamm, 1997). In three home sessions, *in vivo* video feedback was used to reinforce mothers' sensitive and responsive behaviors through videotyped mother-child interactions. In later years, the program was further developed and elaborated at the Leiden Centre for Child and Family Studies (Netherlands), and adapted for different cultures, settings and families. At present, there are three modules of the VIPP programs: VIPP, VIPP-SD and VIPP-R (Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2008b; 2008c).

The first module, the standard VIPP, is a behaviorally-focused intervention program which aims to promote maternal sensitivity and positive mother-child interactions in four home sessions (Juffer et al., 2008b, 2008c). In this program, mothers are expected to develop parenting behaviors sensitive to their children's needs with the opportunity to observe their behaviors in videotyped interactions. Later, this program was extended to sensitive discipline and named as the VIPP-Sensitive Discipline (VIPP-SD). This second module is a behaviorally-focused intervention program which aims to promote maternal sensitivity and sensitive discipline behaviors especially among mothers with children suffering from oppositional and externalizing behavior problems or children at-risk for the development of these problems (Juffer et al., 2008b; 2008c; Mesman et al., 2008). In this program, mothers are expected to learn how to use effective discipline strategies in a sensitive way and develop empathy during four thematic sessions and two booster sessions.

The last module, VIPP combined with a representational component (VIPP-R), is a representation-focused intervention program which aims to promote a secure mental representation of attachment through representational discussions on past and present attachment relationships. In particular, this program is applied among mothers with insecure representations of attachment, and they are expected to

develop new patterns of parenting behaviors sensitive to their children's needs with the opportunity to reevaluate their own childhood experiences and explore the link between early experiences and current relationships with their own children during four thematic sessions (Juffer et al., 2008b; 2008c).

Despite their distinction, there are some methodological similarities among three modules. For instance, in all modules, mothers and children are videotaped at home during daily interactions (i.e. playing together, reading book, mealtime), and personal video feedback is provided to stimulate mothers' sensitive interactive skills. A modest number (usually four to six) of sessions are implemented by female interveners with a master's or doctoral degree in psychology or child and family studies. In all modules, it is crucial to build a positive and supportive relationship with the mother, give the mother the role of an expert on her own child and focus on positive mother-child interactions. Furthermore, all interventions are standardized through a general protocol but individualized to each mother-child dyad based on the guidelines and intervention themes (Juffer et al., 2008b; 2008c).

Among three modules, the VIPP-SD was adopted in the current study. Because research have shown that it is not only effective in promoting sensitive behaviors and discipline strategies of mothers, but also effective in decreasing externalizing problems of toddlers and preschoolers (Mesman et al, 2008). Due to its wide application and straight focus on sensitive discipline, the VIPP-SD is more broadly implemented across cultures as compared to other VIPP programs. The next section explains the detailed protocol of this program with a description of the content, methods and themes.

1.4.2. Video-Feedback Intervention to Promote Positive Parenting-Sensitive Discipline

The VIPP-SD program mainly targets families with children having externalizing problems. In general, externalizing problem refers to display of harmful behaviors that are against social rules and expectations (Mesman et al, 2008, p. 172). In a broader term, it includes display of aggressive behaviors (i.e. hitting), oppositional behaviors (i.e. disobedience), delinquency (i.e. vandalism) and

overactive behaviors (i.e. inability to concentrate). Studies have shown that the early onset of externalizing problems increases the risk for future antisocial problems (see Mesman et al, 2008 for a review). Therefore, prevention of externalizing problems in early years is of special interest to researchers.

Based on Bowlby's Attachment Theory (1969/1982) and Patterson's Coercion Theory (1982), several researchers have pointed out the influence of early negative parent-child interactions on the development of child externalizing problems (see Mesman et al, 2008 for a review). First, they have proposed that insensitive and unresponsive parenting may lead to development of negative internal working model, which in turn increases anger and mistrust in child's social interactions. Second, child may adopt highly negative behaviors to get attention of an insensitive parent. Third, insensitive parenting may lead to deficits in early socialization process especially in terms of empathy and internalization of norms, which in turn results in child's noncompliance to parental rules. Finally, parental use of coercive discipline strategies may contribute to the development of child externalizing problems (see Mesman et al, 2008 for a review).

In his coercive theory, Patterson (1982) emphasizes the role of reinforcement (positive and negative) processes in explaining the development of antisocial behaviors through coercive discipline interchanges between parent and child (Mesman et al., 2008; Van Zeijl et al., 2006). According to this theory, when child's aversive behaviors to parental request is negatively reinforced, the child will display difficult behaviors in future interactions. However, when child's compliant behaviors is positively reinforced, the child will display prosocial behaviors. The following case illustrates the contingency of the child's behavior on the reaction of the parent.

'A mother tells her child to clean-up his/her toys and the child shows coercive behavior (i.e. whining), then the mother uses coercive discipline (i.e. yelling and repeating the same request); however the child shows more coercive behaviors (i.e. screaming and hitting); and finally the mother withdraws her request' (Mesman et al., 2008, p.175).

This case illustrates an ineffective strategy since it negatively reinforces child's coercive and noncompliant behavior. In future interactions, it is more likely that coercive discipline interchanges between mother and child be repeated. That is,

the child will display coercive behaviors (since it was effective in previous interaction), and the mother will need to use more severe coercive discipline strategies to achieve compliance. In line with this reasoning, if the mother fails to praise her child when he/she cleans up his/her toys, it would be an ineffective strategy as well since it doesn't positively reinforce his/her compliant behavior (Mesman et al, 2008; Van Zeijl et al., 2006).

As indicated in this example, ineffective and coercive parental discipline in conflict situations may lead to the development of externalizing problems. In this regard, prevention efforts may be most effective if early interventions target coercive discipline behaviors in addition to maternal insensitivity (Mesman et al., 2008; Van Zeijl et al., 2006). Accordingly, the VIPP-SD was developed to decrease children's externalizing problems and prevent the development of antisocial behaviors in later years through enhancing maternal sensitivity and effective discipline behaviors, which is lacking in attachment-based interventions.

Similar to the standard VIPP program, the VIPP-SD is a behaviorally-focused intervention program since it focuses on mother's behaviors. In this program, mothers are expected to learn how to use effective discipline strategies in a sensitive way and develop empathy while struggling with difficult and challenging child behaviors such as noncompliance and oppositional behaviors. In this way, it provides mothers alternative strategies for coercive discipline during potentially difficult situations (i.e. forbidden toys, clean up, etc.) which emerge after the first year. Basically, the intervention program consists of four thematic sessions where sensitive behaviors and effective discipline strategies are reinforced. In addition, it has two (extra) booster sessions where all sensitivity and discipline themes are reviewed (Mesman et al., 2008).

1.4.3. Intervention Methods of the VIPP-SD

1.4.3.1. Video-Recordings

At the beginning of each session, mother-child interactions (i.e. playing together, reading book, mealtime) are videotaped for 10-20 minutes to be used for

the next session (Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2008a, 2008b). During video-recordings, the intervenor plays a nonintrusive role, meaning that she avoids any behavior that interferes with a natural mother-child interaction such as giving comments, attracting child's attention, or intervening when child's distressed. It is also important that mothers react to their children the way they normally do since they usually feel awkward when they are videotaped for the first time. In order to prevent unnatural behaviors, the intervenor puts the mother at ease before videotaping by explaining that it is very normal, and most parents gets used to it in a short time (Juffer et al., 2008a, 2008b).

1.4.3.2. Video-Feedback

Following recording of the mother-child interactions, personal video-feedback is given. That is, the intervenor watches and review the previous video-recordings together with the mother (Juffer et al., 2008a, 2008b). The aim of watching and reviewing interactions together is to: (1) provide an opportunity to the mother to develop better observational skills and empathy for her child by watching his/her signals and expressions, and (2) reinforce her sensitive behaviors by showing that she was capable of acting this way. In this sense, the video-feedback addresses both components of Ainsworth et al.'s (1978) concept of sensitivity: (1) accurately perceiving and interpreting child signals (sensitivity), (2) adequately and promptly responding to them (responsiveness). In addition, the mother does not need to identify with the specific model of parent-child dyad on the videotape. Instead, she becomes her own role model, which might have more influence on her behaviors (Juffer et al., 2008a, 2008b).

Personal video-feedback is provided to the mother by commenting and reviewing the selected fragments of the video-recordings (Juffer et al., 2008b). The feedback is prepared by the intervenor in the period between two intervention sessions. She reviews video-recordings, prepares personal feedback by selecting specific fragments (of the child's behaviors or mother's reactions to the child) that needs to be emphasized and writesdown scripts of comments in relation to the information in the guidelines of the intervention protocol. Even though the structure

and content of every session are the same, the feedback is adjusted to the theme of specific session (Juffer et al., 2008b).

1.4.3.3. Written Materials

At the end of intervention, the intervenor provides mother with a booklet which informs about child development, sensitive responding in daily situations and key issues discussed in all sessions including the tips and exercises (Juffer et al., 2008a; 2008b). For instance, the topics in the booklet are about playing together, telling the child not to do something (non-coercive discipline strategies), teaching the child to obey (non-coercive discipline strategies), giving compliments, extremely difficult behaviors (sensitive time-out) and maintaining good atmosphere (showing understanding to the child). The booklet enables mothers remember the useful information about sensitive parenting after the intervention. Besides, the intervenor notes her impression of the session, the mother's reaction to the comments and/or any strange situations occurring in each session into a semistructured logbook. It helps her remember what they had discussed in the previous session and what needs to be emphasized in the next session. Furthermore, the logbook enables her to follow the changes and improvement in mother's profile (Juffer et al., 2008a; 2008b).

1.4.4. Intervention Themes of the VIPP-SD

The VIPP-SD includes four sessions each of which is implemented around specific themes with respect to sensitivity and discipline (see Table 1). The sensitivity themes are developed based on Bowlby's attachment theory (1969/1982). The sensitivity theme of the first session is "*exploration versus attachment behavior*" which focuses on raising mothers' awareness on the difference between child's exploratory and contact-seeking behaviors. The sensitivity theme of the second session is "*speaking for the child*" which encourages mother's accurate perception of the child's reactions and facial expressions. The sensitivity theme of the third session is "*sensitivity chain (child signal → parental sensitive response → positive reaction of the child)*" which addresses mother's accurate perception as well as prompt and

adequate responding to the child's signal. Lastly, the sensitivity theme of the fourth session is "*sharing emotions*" which deals with mother's affective attunement to the child's positive and negative emotions (Juffer et al., 2008a;2008b).

The discipline themes are developed based on Patterson's coercion theory (1982). The discipline themes of the first session are "*inductive discipline*" and "*distraction*" which promotes mother's non-coercive responses to child's difficult behaviors. The discipline theme of the second session is "*positive reinforcement*" which is used to encourage mother's praising the child's positive behaviors and ignoring negative attention-seeking behaviors. The discipline theme of the third session is "*sensitive time-out*" which serves to enhance mother's ability to cope with the child's temper tantrums. Lastly, the discipline theme of the fourth session is "*showing empathy for the child*" which increases mother's understanding of the child's thoughts and feelings (Juffer et al., 2008a; 2008b).

Overall, the VIPP-SD consists of six intervention sessions which can be grouped into three phases according to their focus (Mesman et al., 2008). In sessions 1 and 2 (the first phase), the focus is on observing child behaviors (i.e. through '*speaking for the child*') and building a positive relationship with the mother. In sessions 3 and 4 (the second phase), the focus is on encouraging mother's sensitive and responsive behaviors (i.e. through '*sensitivity chain*' and '*corrective messages*'). In sessions 5 and 6 (the third phase), the focus is on repeating all sensitivity and discipline themes of the first four sessions (Mesman et al., 2008).

1.4.4.1. The First Thematic Session

As stated previously, the sensitivity theme of the first session is "*exploration versus attachment behavior*". The aim of this theme is to show to mother the difference between child's contact-seeking and exploratory behaviors (Juffer et al., 2008a; 2008b). In order to reinforce mother's reactions to child's (subtle) signals of seeking contact, the intervenor uses the video of '*playing together*'. She selects fragments of positive and successful interaction moments such as child's eye contact or cheerful interaction with the mother or child's getting closer to the mother. Then, she stills the videotape and makes explanations about child attachment needs. In

addition, she emphasizes the importance of playing together. By watching these positive interaction moments, the mother views herself as a successful mother who fulfills child's attachment needs, which in turn reinforces her sensitive behaviors. In this way, the mother becomes her '*own role model*' (Juffer et al., 2008b). In order to encourage mother's behavior of not interrupting the child's play and respecting his/her exploration, the intervenor uses the video of '*playing alone*'. She selects fragments of child's playing behavior, then stills the videotape and makes explanations about child exploration needs.

In this session, the intervenor emphasizes the differences between moments when the mother is 'in the picture' (child is seeking-contact) and when she is not 'in the picture' (child is exploring and discovering) (Juffer et al., 2008a; 2008b). It is important that mother understands differential responsiveness is required for two different types of child behavior that is, contact-seeking requires mother's comfort, care or (even playful) interaction while exploration requires mother's nonintrusive but supporting attitude (Wooley, Hertzmann, & Stein, 2008). For instance, she should meet child attachment needs adequately and promptly when the child is seeking contact (ex; providing comforting while crying); however, she should not interfere child exploratory behaviors but facilitate and support when the child is exploring (ex; watching, verbalizing or praising while playing). Exploration is highly crucial because children learn a lot by manipulating toys. If the mother interferes with children's exploratory behaviors, it would hinder their learning and developing autonomy and competence (Juffer et al., 2008a; 2008b).

The discipline themes of the first session are "*inductive discipline*" and "*distraction*". The aim of the former theme is to encourage mother's use of induction (Mesman et al., 2008). This strategy enables the child understand why he/she should (not) do something and thus, internalize the rule. In addition, the child can develop empathy for the others since he/she learns the consequences of this behavior for other people. The aim of the latter theme is to encourage mother's distracting child's attention from forbidden objects/situations to others that are allowed. The active distraction enables the child focus on another object/situation and thus, forget what is forbidden. In this sense, induction and distraction are non-coercive discipline tactics that can be used as opposed to power assertion and punishment during conflict

situations. In order to reinforce mother's use of induction and distraction, '*don't touch*' video is used where the child is not allowed to touch any attractive toys for a few minutes (See 'Procedure' for details). During this video section, the intervenor selects the fragments where the mother makes an explanation or distracts the child; then, stills the videotape and points out these strategies. In this way, the mother observes that she can do it and how this strategy works. Thus, the desired behavior is reinforced (Mesman et al., 2008).

1.4.4.2. The Second Thematic Session

The sensitivity theme of the second session is "*speaking for the child*". The aim of this theme (or technique) is to show the perspective of the child and thus, promote mother's accurate perception of the child's (subtle) signals (Juffer et al., 2008a; 2008b). For this purpose, the intervenor uses the videos of '*playing alone*', '*playing together*', '*clearing up*', and '*reading book*'. She shows fragments of mother-child interaction moments. Then, she stills the videotape and verbalizes child's facial expressions and nonverbal cues (i.e. "*It is nice for X to know that you are here*" or "*X feels so good when you support him*", Juffer et al., 2008a). In other terms, she provides 'subtitles' for the child's behaviors, feelings or expressions. Sometimes the intervenor repeats the video-section again to point out the behavior or feeling just mentioned and asks the mother to provide subtitles for her child. This promotes mother's observational skills and empathy for her child, and enables her feel like an expert on her child (Juffer et al., 2008a; 2008b). Starting from the first session, this technique is used to give feedback to the mother on sensitivity and sensitive discipline in the following sessions.

The discipline theme of the second session is "*positive reinforcement*". The aim of this theme is to encourage mother to compliment the child's positive behavior (Juffer et al., 2008a; 2008b). In order to reinforce mother's praising, "*clearing up*" video is used where mother and child are asked to clean up the toys for a few minutes (See 'Procedures' for details). She selects fragments of the mother praising the child for clearing up, then stills the videotape and makes explanations about giving compliment. The mother is also asked to count the number of times she compliments

and double this number in the following days (Juffer et al., 2008a). In addition to giving compliments for the child's positive behaviors, the intervenor encourages the mother to ignore the child's negative attention seeking behaviors and use other non-coercive discipline techniques in conflicting situations such as (1) announcing the coming change beforehand, (2) giving an active role to the child in the change, (3) developing understanding (empathy) for the child, (4) giving alternative to the child and (5) postponing (Juffer et al., 2008a).

1.4.4.3. The Third Thematic Session

The sensitivity theme of the third session is “*sensitivity chain*”. The aim is to promote mother's accurate perception, adequate and prompt responding to the child's (subtle) signals (Juffer et al., 2008a; 2008b). Beginning from this session, the focus is on mother behaviors. For this purpose, the intervenor uses the ‘*mealtime*’ video and shows fragments of mother's responding sensitively to child's positive or negative signals during eating lunch or snack. Then, she stills the videotape and verbalizes each three components of the sensitivity chain: *child signal* → *parental sensitive response* → *positive reaction of the child*.

Child signal refers to any child behavior such as crying, talking, pointing, smiling combined with looking at the mother (Juffer et al., 2008a). Sensitive reaction of the mother refers to mother's appropriate and prompt reaction to child signal such as comforting the child when (s)he is crying or answering the child when s(he) is talking. Finally, reaction of the child refers to all child behaviors following the sensitive reaction of the mother such as smiling, talking, or stopping crying combined with looking at the mother. It is important that the intervenor explains each link of the entire chain to the mother so that she understands the relevance of her response and appreciation of her child. In this way, the mother feel competent in responding sensitively to her child's signals and understand how important she is for the child's well-being (Juffer et al., 2008a).

Beginning from the third session, the intervenor gives some remarks about mother's negative behaviors (Juffer et al., 2008a). For instance, when the mother follows the child's lead at the first scene but not at the later scenes, the intervenor

may give a corrective message (“*Here you could also have followed the child’s lead as you did before*”) by pointing the desired behavior (“*Look, here you are doing it really well!*”). This helps the mother improve her negative behaviors and feel competent by observing her own positive behaviors. It is important that the intervenor gives corrective messages after the first quarter of the video, and ends the session with a positive message such as compliment (Juffer et al., 2008a).

The discipline theme of the third session is “*sensitive time-out*”, which aims at enhancing mother’s coping with the child’s temper tantrums (Juffer et al., 2008b; Mesman et al., 2008). For this purpose, the ‘*mealtime*’ video can be used to explain how to calm down the child when he/she is having temper tantrum during lunch or snack. In general, when a child is so angry that he/she does not hear the mother, sensitive time-out can be used as an effective technique to help the child calm down. In this technique, the mother puts the child in another room for a while. After this brief apart, she praises the child’s efforts and empathizes with the child. In this way, time-out is ended with a positive atmosphere. For this technique to be effective, the mother and child should know that it is not a punishment for the child rather a way of de-escalating the situation (Juffer et al., 2008a; Mesman et al., 2008).

1.4.4.4. The Fourth Thematic Session

The sensitivity theme of the fourth session is “*sharing emotions*”. The aim of this theme is to promote mother’s affective attunement to the child’s positive and negative emotions (Juffer et al., 2008a; 2008b). For this purpose, ‘*singing*’ video is used (See ‘*Procedure*’ for details). The intervenor shows fragments of playful mother-child interactions. Then, she stills the videotape and verbalizes child’s feelings using ‘*speaking for the child*’ technique. In addition, she makes explanation about how important sharing of feelings and bodily contact is for the child. The previously mentioned themes and methods are also used in this session. For instance, when the child reacts to the mother while playing alone in ‘*child invites*’ video (See ‘*Procedure*’ for details), the intervenor stills the videotape and emphasizes child’s contact-seeking behaviors and how important she is for her child, using ‘*speaking for*

the child' technique. In addition, the intervenor emphasizes mother's sensitive response to the child using 'sensitivity chain' technique (Juffer et al., 2008a).

The discipline theme of the fourth session is "*showing empathy for the child*", which aims at promoting mother's understanding of the child's thoughts and feelings when there are rules (Mesman et al., 2008). In order to explain empathy and all other discipline themes previously mentioned, 'task' video is used where the mother and child are building a tower (See 'Procedure' for details). Building a tower may be difficult for small children, thus they may get frustrated if they can not succeed. When the child experiences difficult moments, it is important to let the child know that his/her mother understands how difficult it is for him/her. Therefore, during the video of "the task", the intervenor stills the video and verbalizes child's feelings using 'speaking for the child' technique (i.e. "*That is really difficult, isn't it?*") or emphasizes the development of empathy for the child (i.e. "*I understand that you don't like to...*") (Juffer et al., 2008a). In this way, the child feels himself/herself as being understood and learns to show empathy for others, which in turn may promote prosocial development (Mesman et al., 2008).

1.4.4.5. Booster Sessions

In the last two sessions, all previous themes and methods of sensitivity and sensitive discipline (i.e. sensitivity chain, induction, etc.) are reviewed once more. For this purpose, '*playing together*' (Session 5), '*reading book*' (Session 5), '*task*' (Session 6), and '*clearing up*' (Session 6) videos are used. In general, both the mother and intervenor feel more comfortable and the mother becomes more open to suggestions in booster sessions as they have formed an intimate relationship in previous sessions (Mesman et al., 2008).

Fathers are also invited to participate in these session salong with the mothers as their presence might strengthen the intervention effects (Bakermans-Kranenburg et al., 2003). First, explaining all the previous themes to the father enables the mother remember what they have discussed with the intervenor (Mesman et al., 2008). Second, they might support mothers to implement the newly acquired skills. Finally, both parents might have an opportunity to evaluate their behaviors, and actively

implement sensitive behaviors. On the other side, the presence of father in the intervention might be intrusive especially when he is critical and unsupportive of the mother. For instance, the presence of the father might prevent the mother from openly expressing their emotions. Therefore, it is important that fathers attend the sessions upon mother's request (Mesman et al., 2008).

Table 1

Sensitivity and Sensitive Discipline Themes of the VIPP-SD

Session	Sensitivity	Sensitive Discipline
1	Exploration versus Attachment *	Inductive Discipline and Distraction
2	Speaking for the Child *	Positive Reinforcement
3	Sensitivity Chain **	Sensitive Time-out
4	Sharing Emotions **	Empathy for the Child
5 & 6	Review of all themes and methods	Review of all themes and methods

Note: * refers to the first and ** refers to the second component of Ainsworth et al.'s (1978) concept of sensitivity (Juffer, Bakermans-Kranenberug, & Van IJzendoorn, 2014)

1.4.5. Research on Effectiveness of VIPP Interventions

A considerable amount of research have provided convincing evidence for the beneficial effects of the VIPP programs on promoting maternal sensitivity, child attachment security and adjustment (see Table 2 for details). In specific, the VIPP programs were implemented on various samples including nonclinical groups (i.e. adoptive mothers, Juffer, Bakermans-Kranenburg, & Van IJzendoorn, 2005b), at-risk groups (i.e. insecure mothers, Klein Velderman, Bakermans-Kranenburg, Juffer, Van

IJzendoorn, Mangelsdorf et al., 2006), clinical groups (i.e. mothers of children with externalizing behavior problems, Van Zeijl et al., 2006) and other groups (i.e. professional caregivers, Groeneveld, Vermeer, Van IJzendoorn, & Linting, 2011). In these intervention studies, researchers have specifically examined whether the VIPP interventions were effective in promoting positive mother and child outcomes. More importantly, they have asked the question of *'what works best for whom'* in order to better understand differential intervention effects. It is of crucial importance since it contributes to the development of more effective interventions and their applications among specific target groups. The next section provides research on the VIPP interventions and discusses their effectiveness on mother and child outcomes through addressing this question.

1.4.5.1. VIPP Interventions in Nonclinical Groups

The VIPP program was first implemented with three home sessions among Dutch adoptive families to enhance maternal sensitivity with the goal of promoting secure infant-parent attachment relationship and infant exploratory competence (Juffer et al., 1997). The previous research have shown that adopted children usually experience deprivation and insensitive caregiving environment in institutions, thus they are less well-adjusted and show more disorganized attachment as compared to nonadopted children (see Juffer, Van IJzendoorn, & Bakermans-Kranenburg, 2008e for a review). Therefore, early intervention efforts have in particular targeted adoptive families.

In one of the earliest applications of the VIPP, Juffer et al. (1997) conducted early interventions on 90 adoptive families without biological children. Mothers of six months old adopted infants were randomly assigned either to control group or intervention groups. In one of the intervention groups, the mothers were provided with a personal book namely *"The first year of life"* providing information about sensitive parenting using vignettes and pictures, information about the influence of maternal sensitivity on child development, and suggestions on how to apply sensitive behaviors in daily situations (i.e. holding and comforting the infant, playful interactions). In the other intervention group, the mothers were provided with three

home-based sessions of video-feedback during six months on how to accurately observe child's signals, how to respond sensitivity to child's attachment needs and how to encourage child's exploratory behaviors in addition to personal book. In the control group, however, the mothers did not receive any intervention but a booklet on adoption issues.

The interventions were carried out between six and nine months. To test the effects of interventions, maternal sensitivity and infant competence were assessed at 6 month (pretest) and at 12 month (posttest) in the home using free-play situations (Ainsworth et al., 1974) and exploration episodes, and infant attachment was assessed at 12 and 18 months in the laboratory using the Strange Situation Procedure (Ainsworth et al., 1978). The results showed that the intervention of three video-feedback sessions combined with personal book led to increases in mothers' cooperative behaviors, attachment security and exploratory competence. That is, these mothers showed more respect for their children's autonomy and avoidance of interruption and direct control of their behaviors as compared to control group mothers. In addition, their children were more securely attached than control group children, and became as competent in exploration as control group children after the intervention. However, the intervention providing the personal book alone was not as effective as the intervention combined with three home visits, indicating the influence of video-feedback in promoting mothers' observational skills and sensitive responding (Juffer et al., 1997).

In later years, Juffer and her colleagues (Juffer et al., 2005b) combined samples of two related intervention studies, and examined the effectiveness of video-feedback combined with the personal book among 130 mothers of six month-old adopted infants who are at risk for developing disorganized attachment. The sample consisted of (1) 90 adoptive families without biological children, (2) 40 adoptive families with biological children. In the first (larger) subsample, there were two intervention groups, one of which was provided with personal book only. In the second (smaller) subsample, there was only one intervention group receiving video-feedback with a personal book. In both subsamples, there was a control control receiving a booklet on adoption issues.

When these two subsamples combined into one sample, the results showed higher levels of maternal sensitivity among mothers, and lower rates of disorganized attachment among their 12 month-old infants in the intervention group receiving both video-feedback and personal book as compared to control group. In addition, there were fewer number of infants classified as disorganized in this intervention group compared to control group. Unlike previous findings (Juffer et al., 1997), infants in the intervention group provided only with the personal book showed lower continuous disorganization scores, but not lower rates of disorganized attachment classifications than infants in the control group. It indicates that the personal book alone was effective but not sufficient to affect the number of disorganized children (Juffer et al., 2005b).

The long-term effects of the VIPP intervention were also examined in middle childhood (Stams, Juffer, Van IJzendoorn, & Hoksbergen, 2001). The researchers conducted two follow-up studies. One of these studies was conducted among 35 mixed families (adoptive families with biological children) and the other was among 112 all-adoptive families (adoptive families without biological children). The results of the follow-up study revealed supporting evidence for the positive long-term effects of the intervention on child personality development and internalizing problem behaviors when children were 7 years old. Among mixed-families, implementing three video-feedback sessions with a personal book was effective on ego-resiliency (responding flexibly to changing demands) and optimal ego-control (adequate control of impulses and emotions) among girls, and on internalizing problem behaviors among both genders. However, among all-adoptive families, the positive effects of intervention in early childhood (Juffer et al., 1997) were not enduring in middle childhood. It can be argued that the different child-rearing context in all-adoptive families might impact long-term effects of the intervention (Stams et al., 2001).

It is worth to note that even though the results did not reveal any significant long-term effects of intervention on maternal sensitivity, positive child outcomes might occur as a result of positive parenting (Stams et al., 2001). That is, intervention mothers' higher scores in respect for child's autonomy at 12 months might be reflected upon their child's competence and personality development in later years.

Even though long-term effects of the intervention could only be seen among families with biological and adopted children, the findings suggest that it seems promising to implement short-term intervention among families with adopted children since it is associated with optimal child development and adjustment in early and middle childhood.

With early intervention, development of attachment disorganization might also be prevented. It has been shown that disorganized attachment in early years predicts cognitive development and optimal ego-control negatively when it is combined with difficult temperament in middle childhood (Stams, Juffer, & Van IJzendoorn, 2002). However, maternal sensitivity and attachment security in early years predict social and cognitive development positively in later years. Thus, early intervention efforts to enhance maternal sensitivity and promote attachment security is of crucial importance especially among families with adopted children who are at-risk for developing disorganized attachment.

1.4.5.2. VIPP Interventions in at-Risk Groups

Early interventions have been widely implemented in at-risk groups such as insensitive or insecurely attached mothers. For instance, Kalinauskiene and her colleagues (2009) implemented the standard VIPP program (with an addition of one booster session) among low sensitive (scoring below the midpoint of 5 on Ainsworth sensitivity scale), nonclinical Lithuanian mothers. It was revealed that the intervention improved mothers' sensitivity even after controlling for mother characteristics (age, education, depression, self-efficacy and daily hassles) and child characteristics (gender, positive and negative affect). However, the intervention was not effective in promoting child attachment security (Kalinauskiene et al., 2009).

Besides, researchers have implemented VIPP interventions among children of mothers with insecure representation of attachment. Since past research have shown that mothers' insecure attachment negatively influence their sensitive behaviors and thus, their children's socioemotional development (see Klein Velderman Bakermans-Kranenburg, Juffer, Van IJzendoorn, Mangelsdorf et al., 2006 for a review). In the study by Klein Velderman and her colleagues (2006b), the standard VIPP and the

VIPP-R programs were implemented among insecurely attached mothers. The results revealed that the VIPP intervention during infancy (7th to 10th month of age) was effective in protecting children from developing externalizing problem behaviors at preschool age (40th month of age). Researchers in particular showed that there were fewer number of children in the VIPP intervention group scoring in the clinical range for externalizing and total behavior problems as compared to control group (Klein Velderman, Bakermans-Kranenburg, Juffer, Van IJzendoorn, Mangelsdorf et al., 2006).

In addition, maternal sensitivity scores in the VIPP intervention group was higher than that of control group at 11 and 13 months (Klein Velderman, Bakermans-Kranenburg, Juffer, Van IJzendoorn, Mangelsdorf et al., 2006). However, maternal sensitivity did not mediate the effect of intervention on behavior problems. There were also no significant group differences on child attachment security and internalizing behavior problems. Interestingly, the VIPP-R, the representation part of the intervention, was not effective in decreasing the number of children scoring in the clinical range for externalizing and total behavior problems. The lack of positive outcomes of the VIPP-R might indicate increased focus on attachment discussions and a need for more concentration on sensitive behaviors (Klein Velderman et al., 2006b).

The type of maternal insecurity may also moderate the differential effectiveness of VIPP interventions on mother outcomes (Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 1998). For instance, Bakermans-Kranenburg and her colleagues (1998) compared the effectiveness of the standard VIPP (behavioral approach) and the VIPP-R (representational approach) among mothers with insecure-dismissing or insecure-preoccupied mental representations of attachment. Insecure-dismissing mothers (low in attachment anxiety and high in avoidance), in general, idealize their parents or minimize the importance of their early childhood attachment relationships. Insecure-preoccupied mothers (low in avoidance and high in attachment anxiety), on the other hand, are usually preoccupied with their past or have a continuing anger towards attachment figures or experiences. These two groups of insecurely attached mothers were randomly assigned into three groups in

this study: The standard VIPP intervention group, the VIPP-R intervention group or a control group (Bakermans-Kranenburg et al., 1998).

As expected, mothers in two intervention groups were more sensitive than mothers in control group (Bakermans-Kranenburg et al., 1998). Similarly, in Klein Velderman Bakermans-Kranenburg, Juffer and Van IJzendoorn's study (2006), posttest sensitivity scores of the mothers in the two intervention groups were higher than that of control mothers after controlling pretest sensitivity scores. However, there were no group differences in terms of promoting infant attachment security, indicating the difficulty of changing attachment security than maternal sensitivity (Bakermans-Kranenburg et al., 1998; Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn 2006; Klein Velderman, Bakermans-Kranenburg, Juffer, Van IJzendoorn, Mangelsdorf et al., 2006).

When the type of maternal insecurity was taken into account, Bakermans-Kranenburg et al. (1998) have revealed differential effectiveness of two interventions on maternal sensitivity. That is, the standard VIPP was more effective for insecure-dismissing mothers, while the VIPP-R was more effective for insecure-preoccupied mothers. Even though this interaction was not significant, the finding of this study indicates that interventions with behavioral and representational approaches might address different needs of these mothers. For instance, preoccupied mothers are in general more engaged with reflections upon early childhood experiences, and attachment discussions in the VIPP-R was effective for these mothers. In contrast, dismissing mothers are in general more likely to devalue early experiences for their current lives and therefore, attachment discussions in the VIPP-R was not as effective as it was for preoccupied mothers (Bakermans-Kranenburg et al., 1998). Overall, the type of maternal insecurity might moderate differential effectiveness of VIPP interventions on promoting maternal sensitivity.

In addition to mother characteristics, identification of child characteristics which put them at-risk and influence the effectiveness of intervention is of strong interest. Considerable research have conducted based on Belsky's (1997) *differential susceptibility hypothesis*, stating that some children are more susceptible to positive effects of supportive rearing environments ('for better') and negative effects of unsupportive rearing environments ('for worse') due to temperamental negativity or

genetic vulnerability (Belsky, Bakermans-Kranenburg, & Van IJzendoorn, 2007). For instance, a group of researchers have investigated gene-environment (G x E) interaction in order to test whether children are differentially susceptible to intervention effects depending on their genetic differences. In particular, they investigated whether intervention effect interacted with the dopamine receptor DRD4 gene (Bakermans-Kranenburg, Van IJzendoorn, Mesman et al., 2008; Bakermans-Kranenburg, Van IJzendoorn, Piljman, Mesman, & Juffer, 2008).

In general, the dopamine receptor gene (DRD4) is characterized by less efficient reuptake of dopamine neurotransmitter, which plays role in attentional, motivational and reward mechanisms, and is associated with impulsive behaviors, substance use and ADHD in children (see Bakermans-Kranenburg & Van IJzendoorn, 2007; Bakermans-Kranenburg, Van IJzendoorn, Mesman et al., 2008; Bakermans-Kranenburg, Van IJzendoorn, Piljman et al., 2008 for a review). Past research have shown that only among children with DRD4 gene, maternal insensitivity was positively associated with child externalizing behaviors (Bakermans-Kranenburg & Van IJzendoorn, 2006), and maternal unresolved loss or trauma was positively associated with child disorganized attachment (see Van IJzendoorn & Bakermans-Kranenburg, 2006; Bakermans-Kranenburg & Van IJzendoorn, 2007 for a review). The research indicates the importance of maternal behaviors in the development of temperamentally or genetically vulnerable children.

Accordingly, in order to test whether children are differentially susceptible to intervention effects depending on their genetic differences, researchers implemented the VIPP-SD among mothers having 1-to 3-year-old children with high levels of externalizing problems (Bakermans-Kranenburg, Van IJzendoorn, Mesman et al., 2008; Bakermans-Kranenburg, Van IJzendoorn, Piljman et al., 2008). They asked parents to collect their children's saliva samples three times at home in order to assess their daily basal cortisol levels. Since past research have shown that basal cortisol is positively associated with externalizing behaviors (see Bakermans-Kranenburg, Van IJzendoorn, Mesman et al., 2008; Bakermans-Kranenburg, Van IJzendoorn, Piljman et al., 2008 for a review). The posttest results showed that children with DRD4 gene gained most from the intervention ('for better'). That is, compared to the control children, intervention children with DRD4 7 repeat allele

showed lower levels of basal cortisol (Bakermans-Kranenburg, Van IJzendoorn, Mesman et al., 2008) and lower levels of externalizing behaviors (i.e. oppositional behaviors) at follow-up (Bakermans-Kranenburg, Van IJzendoorn, Piljman et al., 2008).

The positive effect of intervention on externalizing behavior is most in particular when mothers of children with DSD4 7 repeat allele showed increased use of sensitive discipline strategies (Bakermans-Kranenburg, Van IJzendoorn, Piljman et al., 2008). At this point, it can be argued that the VIPP-SD addresses needs of children who are genetically less sensitive to environmental stimuli by actions such as such as rewarding the nature of parents' interactions through reinforcing children's awareness of the connection between their own actions and parents' responses (Bakermans-Kranenburg, Van IJzendoorn, Piljman et al., 2008). Overall, these studies indicate the differential susceptibility of children with DRD4 gene to environmentally induced changes in positive parenting. Furthermore, they provide sufficient evidence for gene-environment (G x E) interaction on child development.

Numerous studies have also revealed differential effectiveness of intervention for children with different temperamental characteristics and their mothers (Cassidy, Woodhouse, Sherman, Stupica, & Lejuez, 2011; Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2006). In one of these studies, Klein Velderman and his colleagues (2006) investigated the differential effectiveness of the VIPP and the VIPP-R programs for children with high versus low emotional reactivity. Infants scoring at or above the 80th percentile on temperament scale were considered as highly reactive infants and are easily distressed and show more negative emotions. Infants scoring below this cutoff level were considered as less reactive infants. The results showed that highly reactive infants in intervention and control groups did not differ in their posttest attachment security scores. However, highly reactive infants in intervention group were more susceptible to changes in maternal sensitivity than less reactive infants. That is, attachment security scores of highly reactive infants (but not less reactive infants) in intervention group were correlated with changes in their mothers' pretest and posttest sensitivity scores. Thus, the level of infant's temperamental reactivity moderated the effect of changes in

maternal sensitivity on infant attachment security (Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2006).

Furthermore, mothers of highly reactive infants profited more from the intervention than mothers of less reactive children (Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2006). That is, mothers with highly reactive infants in intervention group were more sensitive at posttest than those mothers in control group. However, mothers with less reactive infants in intervention group and control groups did not differ in their posttest sensitivity scores. It indicates greater susceptibility of mothers having children with high emotional reactivity to the influence of intervention. This effect might be explained by their possible reactions to the positive changes in their children's behavior after the intervention or by their genetic vulnerability to higher emotional reactivity just like their children (Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2006).

Even though Van Zeijl et al. (2006) and Kalinauskiene et al. (2009) could not replicate the findings of previous studies (i.e. Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn 2006) on differential effectiveness of the VIPP intervention for children with different temperamental characteristics, considerable research on early interventions have provided support for Belsky's hypothesis (Blair, 2002; Cassidy et al., 2011; Van den Boom, 1994). That is, highly reactive infants in intervention group (but not in control group) were more securely attached than less reactive infants in the same group (Cassidy et al., 2011). Furthermore, highly reactive infants of intervention mothers scored higher in sociability, self-soothing, cognitively sophisticated exploratory behaviors, and attachment security (Van den Boom, 1994). These infants also scored lower on externalizing and internalizing behaviors (Blair, 2002). It is also important to note that the mothers of irritable infants receiving an intervention showed more sensitive behaviors, which plays a crucial role in these positive outcomes (Van den Boom, 1994).

In general, this and all other findings provide support for the claim that "supportive rearing environment influences vulnerable children for better rather than for worse" (Belsky et al., 2007, p.301). Given the beneficial effects of supportive environment for vulnerable infants, it seems promising and cost-effective to

implement short-term early interventions among families with highly reactive infants. These infants and their mothers may be important targets that profit from these interventions. Accordingly, this study addressed the question of whether vulnerable infants, those with high emotional reactivity, and their mothers profit more from early intervention that promote positive parenting.

The current study also aimed to address mostly low-SES Turkish families where children are at-risk for insecure attachment. Considerable research shows that parents who experience economic difficulties are more likely to show insensitive parenting (Emmen, Malda, Mesman, Ekmekçi, & Van IJzendoorn, 2012; Zevalkink & Riksen-Walraven, 2001) and their children are at greater risk for developing insecure attachment (Mesman, Van IJzendoorn, & Bakermans-Kranenburg, 2012). In particular, economic constraints lead to parenting stress, which in turn negatively influence parenting beliefs about sensitivity and parents' sensitive behaviors (Emmen et al., 2012). Furthermore, low educated parents show less sensitive behaviors (Richman, Miller, & LeVine, 1992; Valenzuela, 1997; Zevalkink & Riksen-Walraven, 2001; Yaman, Mesman, Van IJzendoorn, Bakermans-Kranenburg, & Linting, 2010) and their children are less securely attached to their mothers (Sümer & Kağıtçıbaşı, 2010). Earlier studies also supports weaker relation among maternal sensitivity and attachment security among low-SES families (De Wolff & Van IJzendoorn, 1997; Posada et al., 1999).

All these findings indicate the need for early intervention among mothers from low education and socioeconomic background. However, the majority of the VIPP interventions have been implemented among mothers from middle-to-high socioeconomic backgrounds. To my knowledge, there is only one intervention that targets families from disadvantaged contexts (i.e. Negrao et al., 2014). In this study, researchers implemented the VIPP-SD among Portugues families living in poverty (Negrao et al., 2014). At the end of six video-feedback sessions, intervention group showed more improvement in positive parenting (maternal nonintrusiveness), positive child behavior (responsiveness and involvement) and family relational functioning (cohesion) compared to control group. The findings suggest the VIPP-SD is effective for families who live in poverty and struggle with multiple stress factors in terms of enhancing positive parent-child interactions (Negrao et al., 2014).

1.4.5.3. VIPP Interventions in Clinical Groups

As stated previously, the VIPP-SD was specifically designed to prevent or reduce child behavior problems and thus, widely implemented in clinical groups such as children who are suffering from externalizing problems, or those who are at-risk for the development of antisocial problems in later childhood and adolescence (Mesman et al., 2008). In one of the intervention studies, researchers implemented the VIPP-SD among mothers of 1-3 year old children with externalizing problems (those scoring above the 75th percentile on the CBCL) to enhance their sensitive discipline behaviors (Van Zeijl et al., 2006). The results showed that the program was effective in enhancing maternal attitudes toward sensitivity and sensitive discipline and use of positive discipline strategies. However, it was not effective on enhancing observed maternal sensitivity and decreasing negative discipline strategies. These findings indicate that the intervention has partially addressed the specific needs of mothers having children with high externalizing problems such as how to adopt adequate discipline strategies in conflict situations (Van Zeijl et al., 2006).

Similarly, Yagmur and her colleagues (2014) implemented the VIPP-SD among second-generation Turkish minority families living in the Netherlands. The aim was to enhance maternal sensitivity and sensitive discipline among Turkish mothers with children having externalizing problems (those scoring above the 75th percentile on the CBCL). Researchers also aimed to examine the effectiveness of the VIPP intervention on an ethnic immigrant (Turkish) culture. For this purpose, they made culturally-sensitive adaptations to the original VIPP-SD program (the VIPP-TM; see Methods section for detail). In order to examine the effectiveness of this program, researchers observed maternal sensitivity through unstructured free-play strategies through two discipline tasks ('don't touch' and 'clean-up'). They coded observed sensitivity and nonintrusiveness using the Emotional Availability Scale (EAS, Biringen, 2008) and observed discipline through an adapted version of a discipline rating scale (Verscheueren, Dossche, Marcoen, Mahieu, & Bakermans-Kranenburg, 2006).

Similar to findings in Western cultures, they found significant intervention effects of the VIPP-TM (the VIPP-SD adapted for Turkish minorities) on maternal sensitivity and nonintrusiveness. In particular, intervention mothers showed more appropriate responding to the child's needs and signals, and less intrusion through following the child's lead and waiting without interrupting his/her activity than control mothers (Yagmur et al., 2014). However, the intervention was not effective in improving maternal sensitive discipline. It indicates that it might take more time to change discipline strategies, especially in a cultural context where authoritarian parenting (i.e. obedience) was more valued (Yagmur et al., 2014). Extending aforementioned research in majority Western samples, this study provides support for the effectiveness of the video-feedback approach on maternal sensitivity in a non-Western sample. Being the first implementation of the VIPP-SD among Turkish families, this study also reveals applicability of this intervention in a non-Western cultural context and thus, provides important directions for the current study (Yagmur et al., 2014).

Mothers' sensitive behaviors and the quality of mother-child interaction are also influenced when the child has a chronic illness (see Cassibba et al., 2008 for a review). The child's chronic illness such as heart problems, dermatitis or preterm birth may make parents overly concerned for their child's health, and they may become tired, stressed and depressed from taking care of a sick child. In addition to these conditions, mothers who have to cope with their children's health problems may experience difficulties, distortions and restrictions in their interactions with the child. For instance, they may experience physical contact with a child having dermatitis as unpleasant or avoid it due to vulnerability of the child's skin (see Cassibba et al., 2008 for a review). Besides, a preterm child may avoid external stimuli and mothers may not interpret child's less clear signals to communicate. As a result, child's illness may interfere with mothers' ability to perceive and react adequately to the child's signals, and the construction of a secure attachment relationship (Cassibba et al., 2008).

With the purpose of promoting maternal sensitivity and child attachment security, a group of researchers have implemented the VIPP-R intervention among Italian families with preterm children and children suffering from atopic dermatitis

(Cassibba et al., 2008). These children are specifically at risk for developing insecure attachment. Thus, researchers have implemented a video-feedback intervention with attachment representation discussions. As expected, they revealed higher levels of attachment insecurity in clinical children than healthy children. Interestingly, the effect of the intervention was not dependent on the clinical status of the children, but dependent on (in)security of the mother's attachment representations. That is, children of insecure mothers receiving intervention were more securely attached than those of insecure mothers not receiving an intervention regardless of the clinical status. However, this effect was not significant for children of secure mothers receiving intervention (Cassibba et al., 2008).

In addition, insecure mothers benefited from the intervention in terms of enhancing their sensitivity in line with the previous findings (Bakermans-Kranenburg, et al., 1998; Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2006; Klein Velderman, Bakermans-Kranenburg, Juffer, Van IJzendoorn, Mangelsdorf et al., 2006). However, the intervention was not effective for securely attached mothers and their children, indicating that the VIPP-R addresses the specific needs of insecurely attached mothers and their children regardless of their clinical status. At behavioral level, it increases these mothers' capacity to accurately perceive and interpret the child's signals. At representational level, it enables mothers' to restructure their disappointing attachment experiences, which in turn fosters their positive interactions with the child (Cassibba et al., 2008).

A modified VIPP intervention was also implemented by researchers to diminish mealtime conflict among mothers with eating disorders and their children (Stein et al., 2006). Mothers with eating psychopathology usually experience mealtime conflict with their child, which is reflected through child's distress, noncompliance, and repeated food refusal, or mother's concern about messiness and refusal for child's self-feeding attempts (Stein et al., 2006; Woolley et al., 2008). In general, these mothers' preoccupying thoughts and behaviors about (avoidance of) food, body shape and weight interfere with daily functioning, in particular, their sensitive behaviors. The previous findings have shown that mothers with eating disorders were less facilitative, more verbally controlling (i.e. use of commands rather than suggestion) and more intrusive than control mothers (see Woolley et al.,

2008 for a review). During feeding, these negative behaviors reduce child's motivation, self-confidence for self-feed as well as sense of agency and exploratory behavior. Even though psychotherapy is effective in improving mothers' psychopathology, it is not sufficient to promote positive parenting (see Woley et al., 2008 for a review). Therefore, researchers implemented a modified VIPP intervention among British mothers diagnosed with an eating disorder to promote positive mother-child interactions (Stein et al., 2006).

The pilot study including four video-feedback sessions on mealtime and play interactions was conducted among 10 mothers of 4-to 6 months old infants, mostly with bulimic type of eating disorders (Woolley et al., 2008). As a result, researchers yielded better maternal facilitation, less intrusion, and less verbal negativity toward children, and accordingly less mealtime conflict. Later, this program was extended to a final treatment program including 13 home-visits, with seven video-feedback sessions, a guided cognitive behavioral self-help (CBT) and an individualized album (photos of infant during mealtimes). According to researchers, it was of crucial importance to address mother's eating disorder cognitions and behaviors since they interfere with their parenting process (Woolley et al., 2008). Therefore, a guided cognitive-behavioral self-help was directed to reduce mothers' concerns about body shape and weight, use of laxatives, vomiting, and increase their personal control over eating (Stein et al., 2006).

The results showed that mothers receiving this treatment showed more facilitation, more appropriate nonverbal responses and less inappropriate verbal responses to child's cues than control mothers receiving supportive counselling (Stein et al., 2006). Accordingly, there was less mealtime conflict and greater child autonomy in treatment group than control group. The video-feedback intervention was effective in facilitating mother's recognition of child's cues and needs, and diminishing mealtime conflicts. Consistent with the findings of Cassibba et al. (2008), the VIPP intervention program is well-suited for clinical mothers who need support for sensitive parenting, and for their children who are at risk for developing insecure attachment. Similarly, a group of researchers examined whether the video-feedback intervention has benefits for parents with intellectual disabilities and implemented the VIPP-LD program, a modified version of the VIPP-SD program for

parents with learning difficulties (Hodes, Meppelder, Schuengel, & Kef, 2014). In particular, several adaptations were conducted due to these parents' limitations in cognitive processes and differences in social information processes such as more repetition of information, use of visual materials, etc. At the end of seven home-sessions with 36 parents experiencing ID, 17 home visitors evaluated the intervention process using the semistructured logbooks. According to home visitors, intervention parents showed an increase in easiness to work, openness and become more influential, while showed no change in cooperation. In addition, these parents showed decreased levels of parenting stress at posttest and followup. The results indicate positive working alliance between parents and home visitors, which in turn may have an impact on parent-child relationship through decreasing their stress (Hodes et al., 2014).

Another modified version of the VIPP program (VIPP-AUTI) was implemented among 40 families having children diagnosed with Autistic Spectrum Disorder (Poslawsky et al., 2014). In general, the quality of parent-child interaction is lower among families with autistic children due to child's deficits in reciprocal interactions. Thus, the VIPP-AUTI was designed to enhance parental sensitivity to the child's autistic characteristics. A group of professionals who were trained on sensitivity themes (i.e. *'Speaking for the Child'*) and autism themes (i.e. *'Mastery motivation and play'*) of the program conducted five home sessions (including a booster session) with intervention families. In these sessions, they tried to promote joint attention, parent's communication and encouragement of child's play as well as recognition and interpretation of the child's (subtle) signals and emotions. As a result, parents receiving intervention showed more respect for their child's autonomy and exploration, and reported more competence in childrearing than control parents (Poslawsky et al., 2014). It suggests that the VIPP-AUTI as a short-term attachment-based intervention with limited burden is well-suited for families with autistic children since it clearly addresses the needs of these families.

1.4.5.4. VIPP Interventions in Group-Care Setting

Even though considerable number of researchers have mainly focused on mother-child relationship and the VIPP program was originally developed to enhance maternal sensitivity, a group of researchers have applied the video-feedback intervention among professional caregivers (Groeneveld et al., 2011; Elicker, Georgescu, & Bartsch, 2008). As Bowlby stated, a child might form an attachment bond to any person who provided care for a significant amount of time (1973, cited in Elicker et al., 2008). Accordingly, research have shown that the quality of the child's attachment to a nonparental childcare provider is associated with child's socioemotional and cognitive development (see Elicker et al., 2008 for a review). Given this fact, improving the quality of caregiving in center-based and home-based childcare contexts is of great importance.

In a pilot study, Elicker and his colleagues (2008) applied a focused staff training intervention program with video-feedback sessions to increase sensitivity and responsiveness among four professional center-based caregivers from the Early Head Start Program. Caregivers received Tuning In intervention with four video-feedback sessions (i.e. VIPP and VIPP-R), structured activities (i.e. Blindfold activity, Relationship History Activity, Individual Temperament Checklist etc.) and a handout explaining sensitivity and responsiveness. The results of the pilot study showed more positive interaction and less intrusion among three of four caregivers. It indicates positive effects of the video-feedback intervention on caregiver sensitivity in the context of group childcare (Elicker et al., 2008).

In another study, Groeneveld and her colleagues (2011) applied the video-feedback intervention in home-based childcare context, in which a caregiver is taking care of a maximum of six children under the age of four in her own house. Similar to center-based childcare, home-based childcare is a widely seen type of caregiving in the Netherlands (Groeneveld et al. 2011). In order to implement the video-feedback intervention in this group-care setting, researchers (Groeneveld et al., 2011) did minor modifications to the VIPP-SD program and named it as the video-feedback intervention to promote positive parenting- child care (the VIPP-CC). The adaptations considering the procedure and materials were as follows:(1) The

intervenor first recorded interaction moments and left the home. After caregiver put children into bed for sleep, she returned back to home for video-feedback, (2) The method of ‘speaking for the child’ was directed to more than one child, (3) Different toys were used for group setting. Besides, the interveners were trained not only for the original VIPP-SD but also for this newly adapted version of the program (Groeneveld et al., 2011).

Similar to previous findings (Elicker et al., 2008), the intervention improved caregivers’ global child care quality (Groeneveld et al., 2011). That is, caregivers receiving intervention provided more stimulating and supportive environment to the child, which in turn promotes their social and cognitive development (see Groeneveld et al., 2011 for a review). Even though there was no group difference in caregiver sensitivity, intervention caregivers had more positive attitude toward sensitive caregiving and limit setting than control caregivers (Groeneveld et al., 2011). It might be argued that it is easier to change attitudes toward sensitive behavior than sensitive behavior itself (Groeneveld et al., 2011). In other terms, changing behaviors may require more time or more intervention sessions than changing attitudes especially for professional caregivers who take care of multiple children and need to divide attention across these children at a time. The intervention studies on nonparental caregiving settings indicate that the VIPP intervention which was developed originally for families might also be applied for caregivers in a childcare setting (Elicker et al., 2008; Groeneveld et al., 2011).

1.4.5.5. Family Circumstances and Intervention Processes

Even though there is considerable research investigating differential effectiveness of the VIPP interventions on various samples, only a limited number of studies have addressed which family circumstances and intervention processes lead to more intervention effects (Groeneveld et al., 2011; Stolk et al., 2008a; 2008b; Van Zeijl et al., 2006). In one study, adverse family circumstances or risk factors (i.e. higher levels of daily hassles and marital discord) were examined as possible moderators on the effect of intervention on child adjustment (Van Zeijl et al., 2006).

Children of intervention mothers experiencing higher levels of marital discord or higher levels of daily hassles showed less overactive problem behaviors.

In a related vein, the influence of multiple (cumulative) family risk factors (i.e. marital discord, lack of social support, daily hassles, physical health problems, low maternal educational level, and maternal psychopathology) and parity (being first-time mothers or 'primiparas' versus having more than one child, or 'multiparas') were examined in relation to intervention outcomes (Stolk et al, 2008b). The results did not reveal any cumulative effects of family risk factors but separate effects of risk factors on intervention outcomes. That is, similar to the results of the previous study (Van Zeijl et al., 2006), intervention was more effective in decreasing overactive and oppositional problem behaviors of children whose mothers were experiencing higher levels of marital discord, daily hassles or dissatisfaction with support (Stolk et al, 2008b). It indicates that families experiencing risk factors had more gains from the intervention.

In addition, researchers found differential effectiveness of intervention for first-time mothers and experienced mothers (Stolk et al, 2008b). That is, first-time mothers ('primiparas') in intervention showed more sensitive discipline strategies as compared to first-time mothers in control group. However, this effect was not found among mothers having more than one child ('multiparas'). Interestingly, multiparas in control group showed an increase in sensitive behaviors as compared to multiparas in intervention group who showed constant level of sensitivity (Stolk et al, 2008b).

Risk factors also interacted with parity in the effect of the intervention on child externalizing behaviors (Stolk et al, 2008b). That is, children of primiparas experiencing high levels of dissatisfaction with social support showed less overactive and oppositional behaviors, while children of multiparas experiencing high daily hassles showed less overactive behaviors. It can be argued that first-time mothers have probably not yet developed specific parenting beliefs and practices and lack experience. Therefore, they may be more open to supporting tips and advices from the intervenor, and the intervention may be more supportive for these mothers (Stolk et al, 2008b).

On the other hand, experienced mothers may already have developed specific parenting behaviors based on earlier experiences and thus, they may develop higher

expectations from the intervenor and it might be more difficult to change their rigid parenting behaviors than to develop new ones (Stolk et al, 2008b). In addition, daily hassles due to taking care of more children might intervene their parenting practices, and intervention may be beneficial for these mothers to remind them how to interact positively with their children. This might explain differential effectiveness of the intervention among first-time mothers and mothers having more than one child (Stolk et al, 2008b).

Overall, the intervention was most effective in the context of stressful family circumstances such as high levels of daily hassles, marital conflict or mothers' dissatisfaction with social support. Thus, families living in adverse circumstances or having risk-factors (in other terms, families who need greatest need) may be important targets that profit from early interventions and it seems promising and cost-effective to implement short-term interventions among these families. Accordingly, the present study addresses this issue and examines whether families at-risk profit more from early intervention that promote positive parenting.

Besides, researchers implementing the VIPP-SD examined which intervention processes lead to more intervention effects (Stolk et al., 2008a). In specific, they examined alliance between mother and intervenor, mother's active implementation of skills and father involvement in booster sessions as process characteristics. Alliance, the quality of the relationship between mother and intervenor, was measured through closed-ended questions from logbooks where intervenor notes her impression of the session (i.e. '*Did the mother show an open attitude during the intervention?*' or '*How pleasant was the contact with the mother?*'). Mother's active implementation of the skills was measured through closed-ended questions whether they have practiced the tips or advices, discussed the intervention with others or read booklet. Interestingly, they found that only alliance was related to changes in maternal sensitivity in terms of supportive presence. That is, more positive alliance results in higher levels of mother's positive regard and emotional support to the child (Stolk et al., 2008a).

In addition, majority of the intervention mothers and caregivers were satisfied with the program (Groeneveld et al., 2011; Stolk et al., 2008a). That is, they reported the duration of intervention as appropriate (94% of the mothers), number of home

sessions as sufficient (78% of the mothers and 79% of the caregivers). Furthermore, they evaluated the recording of interactions as pleasant (85% of the mothers and 58% of the caregivers), watching and discussing these interactions as instructive (82% of the mothers). Finally, they evaluated the booklet as very clear, interesting and instructive (86%, 69% and 64% of the mothers respectively) (Groeneveld et al., 2011; Stolk et al., 2008a). When caregivers were asked whether the intervention was beneficial, they indicated that the intervention was not beneficial to their own children (50% of the caregivers); but beneficial to children in child care (75% of the caregiver), to themselves (83% of the caregivers) and to child care setting (87.5% of the caregivers) (Groeneveld et al., 2011). Research on process evaluation are of crucial importance since they enlighten process moderators that can explain program outcomes and thus provide valuable information on how to improve early interventions and facilitate their effectiveness.

Table 2. Summary of the Sample Characteristics, Design and Results of VIPP Interventions

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
VIPP& VIPP-R Bakermans-Kranenburg, M. J., Juffer, F. & Van IJzendoorn, M. H. (1998)	<i>Sample size:</i> 30 families (10 families in each group) <i>Inclusion criteria:</i> Mothers with insecure attachment representations with their 4-month first-born infants	Randomized control trial, Intervention groups: Four home visits a) Video-feedback with a personal book (VIPP) b) Video-feedback with additional discussions and a personal book (VIPP-R) Control group,	Observed maternal sensitivity Observed child attachment security, Maternal attachment representation	1) Compared to control mothers, intervention mothers showed more sensitivity to their children at 13 months. 2) Insecure dismissing mothers gained more from the VIPP, while insecure preoccupied mothers gained more from the VIPP-R in terms of maternal sensitivity 3) There was no significant group differences on attachment security
VIPP-SD Bakermans-Kranenburg, M. J., Van IJzendoorn, M. H., Mesman, J., Alink, L. R. A. & Juffer, F. (2008)	<i>Sample size:</i> 130 families (66 intervention families, 64 control families) <i>Inclusion criteria:</i> Mothers with 1 to 3-years old children having externalizing problems	Randomized control trial, Intervention group: Six home-visits Control group: Six phone calls	Child temperament, Externalizing problems, DRD4 genotyping, Salivary cortisol,	1) Compared to control children, intervention children only with the dopamine receptor D4 (DRD4) showed lower levels of daily basal cortisol level

Table 2 (Continued)

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
48 VIPP-SD Bakermans-Kranenburg, M. J., Van IJzendoorn, M. H., Piljman, F. T. A., Mesman, J. & Juffer, F. (2008)	<i>Sample size:</i> 157 families (74 intervention families, 83 control families) <i>Inclusion criteria:</i> Mothers with 1 to 3-years old children having externalizing problems	Randomized control trial, Intervention group: Six home-visits Control group: Six phone calls	Observed maternal discipline, Externalizing problems, DRD4 genotyping,	1) Compared to control children, intervention children only with the dopamine receptor D4 (DRD4) showed lower levels of externalizing problems (i.e. oppositional behavior) at follow-up, particularly when their mothers showed increased sensitive discipline strategies
A modified VIPP: For center-based caregivers Elicker, Georgescu, & Bartsch, E. (2008)	<i>Sample size:</i> 4 professional center-based caregivers <i>Inclusion criteria:</i> Caregivers from the Early Head Start Program	Intervention group: Tuning In intervention with four video-feedback sessions (i.e. VIPP and VIPP-R), structured activities and a handout explaining sensitivity and responsiveness.	Positive interaction Intrusion	1) The intervention was effective in increasing positive interaction and decreasing intrusion among three caregivers

Table 2 (Continued)

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
VIPP-CC: VIPP-SD with child care Groeneveld, M. , G., Vermeer, H. J., Van IJendoorn, M. H. & Linting, M. (2011)	<i>Sample size:</i> 48 professional caregivers (24 intervention caregivers, 24 control caregivers) <i>Inclusion criteria:</i> Caregivers who take care of at least two children	Randomized control trial, Intervention group: Six home-visits Control group: Six phone calls	Global child care quality, Observed sensitivity, Attitudes toward sensitive caregiving and limit setting, Evaluation of the intervention	1) Compared to control caregivers, intervention caregivers showed improvement in global child care quality 2) Caregiver sensitivity did not differ between intervention and control groups. 3) Intervention caregivers had more positive attitude toward sensitive caregiving and limit setting than control caregivers
VIPP Juffer, F., Hoksbergen, R. A. C.Riksen- Walraven, J. M. A. & Kohnstamm, G. A. (1997)	<i>Sample size:</i> 90 adoptive families without biological children (30 families in each group) <i>Inclusion criteria:</i> Mothers with children adopted before 6 months	Randomized control trial, Intervention groups: a) A personal book b) Three home-based sessions of video- feedback combined with a personal book Control group: A booklet on adoption	Observed maternal sensitivity, Observed child attachment security, Observed exploratory competence	1) Compared to control mothers, intervention mothers receiving video- feedback and personal book showed more sensitivity 2) Compared to control children, intervention children receiving video- feedback and personal book showed more attachment security and exploratory competence 3) The intervention mothers provided with a personal book did not show any increase in sensitivity

Table 2 (Continued)

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
VIPP with one booster session Kalinauskiene, L., Cekuoliene, D., Van IJzendoorn, M. H., Bakermans-Kranenburg, M. J., Juffer, F. & Kusakovskaja, I. (2009)	<i>Sample size:</i> 54 families (26 intervention families, 28 control families) <i>Inclusion criteria:</i> Low sensitive, nonclinical Lithuanian mothers	Randomized control trial, Intervention group: Four home-visits plus one additional booster session Control group: Five phone calls	Observed maternal sensitivity, Observed attachment security, Child temperament, Mothers' daily stress, depression and efficacy	1) Compared to control mothers, intervention mothers showed more sensitivity to their children 2) Attachment security did not differ among intervention and control children. 3) Maternal sensitivity and child attachment security did not differ between groups of children with high and low emotional reactivity
VIPP & VIPP-R Klein Velderman, M., Bakermans-Kranenburg, M. J., Juffer, F., & Van IJzendoorn, M. H. (2006)	<i>Sample size:</i> 81 families (28 VIPP families, 26 VIPP-R families, 27 control families) <i>Inclusion criteria:</i> First-time mothers with insecure attachment	Randomized control trial, Intervention groups: Four home-visits a) Video-feedback with written material (VIPP) b) Video-feedback with written material and additional discussions, (VIPP-R) Control group	Observed sensitivity Observed attachment security, Child temperament, Behavioral problems Maternal attachment representation	1) Compared to control mothers, intervention mothers were more sensitive at posttest after controlling pretest sensitivity scores. 2) There was no significant group differences on child attachment security 3) Interventions were more effective among highly reactive infants and their mothers

Table 2 (Continued)

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
VIPP & VIPP-R Klein Velderman, M., Bakermans-Kranenburg, M. J., Juffer, F., Van IJzendoorn, M. H., Mangelsdorf, S. C. & Zevalking, J. (2006)	<i>Sample size:</i> 81 families (28 VIPP families, 26 VIPP-R families, 27 control families) <i>Inclusion criteria:</i> First-time mothers with insecure attachment representations	Randomized control trial, Intervention groups: Four home-visits a) Video-feedback with written material (VIPP) b) Video-feedback with written material and additional discussions, (VIPP-R) Control group:	Observed maternal sensitivity Observed child attachment security, Child temperament, Behavioral problems Maternal attachment representation	1) Compared to control group, there were fewer number of children in the VIPP intervention group scoring in the clinical range for Externalizing and Total behavior problems 2)Compared to control group, maternal sensitivity scores in the VIPP intervention group was higher at 11 and 13 months. 3)There was no significant group differences on child attachment security 4)There was no significant group differences on internalizing behavior problems 5) Maternal sensitivity did not mediate the effect of intervention on behavior problems.

Table 2 (Continued)

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
VIPP-SD Negrao, M., Pereira, M., Soares, I. & Mesman, J. (2014)	<i>Sample size:</i> 43 (22 intervention families, 21 control families) <i>Inclusion criteria:</i> Poor Portugues families with their 1-to 4-year-old children having at least one risk factor	Randomized control trial, Intervention group: Six home-visits Control group: Six phone calls	Observed maternal sensitivity, Observed positive child behaviors, Quality of family relations	1) Compared to control group, intervention group showed more improvement in positive parenting (maternal nonintrusiveness), positive child behavior (responsiveness and involvement) and family relational functioning (cohesion).
VIPP-AUTI: VIPP for Families with Autism Poslawsky, I. E., Naber, F. B. A., Bakermans- Kranenburg, M. J., De Jonge, M. V., Van Engeland, H. & Van IJzendoorn, M. H. (2014)	<i>Sample size:</i> 78 (40 intervention families, 38 control families) <i>Inclusion criteria:</i> Families with children having symptoms of ASD	Randomized control trial, Intervention group: Five home-visits Control group	Observed maternal sensitivity Parental feelings of competence Parental satisfaction with the program	1) Compared to control mothers, intervention mothers showed more respect to child's autonomy and exploratory behaviors 2) Compared to control mothers, intervention mothers showed more competence in childrearing

Table 2 (Continued)

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
VIPP Stams, G. J. M., Juffer, F., Van IJzendoorn, M. H., & Hoksbergen, R. A. C. (2001)	<i>Sample size:</i> 35 adoptive families with biological children (17 intervention, 18 control families); 112 adoptive families without biological children (28 families receiving video feedback and personal book, 27 families provided with personal book, 28 control families, 29 families in post-test only group) <i>Inclusion criteria:</i> Mothers with children in previous studies	Randomized control trial, Intervention groups: a) A personal book only (in larger subsample) b) Three home-based sessions of video-feedback combined with a personal book (both in smaller and larger subsamples) Control group: A booklet on adoption issues	Observed maternal sensitivity, Personality development (ego- resiliency and ego- control), Social development, Behavioral problems	1) <i>In the small sample of mixed families:</i> Compared to control children, children of intervention mothers receiving video-feedback with a personal book showed more ego-resiliency and optimal ego- control (among girls) and fewer internalizing problem behaviors (among girls and boys) 2) <i>In the large sample of all- adoptive families:</i> Intervention was not effective on maternal sensitivity, attachment security and exploratory competence in middle childhood

Table 2 (Continued)

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
A modified VIPP: VIPP with information album and CBT	<i>Sample size:</i> The pilot study: 10 families The final program: 77 (38 intervention families, 39 control families)	<i>The pilot study:</i> Four home-visits <i>The final treatment program:</i> Treatment group: A total of 13 home-visits, including seven video-feedback sessions, a guided cognitive behavioral self-help (CBT), an individualized album (photos of infant during mealtimes). Control group: Supportive counselling and CBT	Observed level of mealtime conflict between parent and infant, Observed measures of mother-child interaction: Maternal facilitation, number of verbal and nonverbal responses to infant's cues, and maternal intrusiveness Observed infant autonomy, Maternal eating disorder psychopathology, Infant weight	<i>The Pilot Study:</i> 1) Intervention mothers yielded better maternal facilitation, less intrusion, and less verbal negativity toward children 2) There was less mealtime conflict <i>The final program:</i> 1) Compared to control mothers, mothers receiving treatment showed more facilitation, more appropriate nonverbal responses and fewer inappropriate verbal responses to child's cues 2) Compared to control group, there was less mealtime conflict and greater child autonomy in treatment group 3) There were no group differences in maternal psychopathology and infant weight

Table 2 (Continued)

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
VIPP-SD Stolk, M. N., Mesman, J., Van Zeijl, J., Alink, L. R. A., Bakermans- Kranenburg, M. J., Van IJzendoorn, M. H., Juffer, F., & Koot, H. M. (2008a)	<i>Sample size:</i> 237 families (120 intervention families, 117 control families) <i>Inclusion criteria:</i> Mothers with 1 to 3- years old children having externalizing problems	Randomized control trial, Intervention group: Six home-visits Control group: Six phone calls	Observed maternal sensitivity, Observed maternal discipline, Child temperament Cumulative risk variables: marital discord, lack of social support, daily hassles, physical health problems, low maternal educational level, and maternal psychopathology Parity, Externalizing problems	1) Cumulative family risk factors did not affect intervention outcomes 2) Intervention was more effective in decreasing child overactive and oppositional problem behaviors in families with higher levels of marital discord, daily hassles or dissatisfaction with social support 3) Intervention primiparas showed more sensitive discipline as compared to control primiparas 4) Control multiparas showed an increase in sensitive behaviors as compared to intervention multiparas 5) Children of intervention primiparas experiencing high levels of dissatisfaction with social support showed less overactive and oppositional behaviors 6) Children of intervention multiparas experiencing high daily hassles showed less overactive behaviors

Table 2 (Continued)

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
VIPP-SD Stolk, M. N., Mesman, J., Van Zeijl, J., Alink, L. R. A., Bakermans- Kranenburg, M. J., Van IJzendoorn, M. H., Juffer, F., & Koot, H. M. (2008b)	<i>Sample size:</i> 237 families (120 intervention families, 117 control families) (Only intervention families were examined in this study) <i>Inclusion criteria:</i> Mothers with 1 to 3- years old children having externalizing problems (scoring above the 75 th percentile on the CBCL- Externalizing Behaviors)	Randomized control trial, Intervention group: Six home-visits Control group: Six phone calls	Observed maternal sensitivity, Observed maternal discipline, The alliance between mother and intervener, Maternal active implementation of skills, Father involvement, Maternal satisfaction with program	1) Alliance was related to changes in maternal sensitivity in terms of supportive presence 2) Mother's active implementation of the skills and father involvement was not related to intervention outcomes 3) Majority of the mothers were satisfied with the program: <ul style="list-style-type: none"> ▪ 94% of the mothers reported the duration of intervention as appropriate and 78% of the mothers reported number of home sessions as sufficient ▪ 85% of the mothers evaluated the recording of mother-child interactions as pleasant ▪ 82% of the mother evaluated watching and discussing mother- child interactions as instructive ▪ Majority of the mothers evaluated the booklet as very clear, interesting and instructive (86%, 69%, 64%)

Table 2 (Continued)

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
VIPP-SD Van Zeijl, J., Mesman, J., Van IJzendoorn, M.H., Bakermans- Kranenburg, M.J., Juffer, F., Stolk, M.N. et al. (2006)	<i>Sample size:</i> 237 families (120 intervention families, 117 control families) <i>Inclusion criteria:</i> Mothers with 1 to 3- years old children having externalizing problems	Randomized control trial, Intervention group: Six home-visits Control group: Six phone calls	Attitudes toward maternal sensitivity and sensitive discipline, Observed maternal sensitivity and discipline, Externalizing problems, Child temperament, Marital discord, Daily hassles	1) Compared to control mothers, intervention mothers had more favorable attitudes toward sensitivity and sensitive discipline 2) Intervention mothers showed more increase in positive discipline over time. 3) The intervention was not effective on enhancing observed maternal sensitivity and decreasing negative discipline strategies 4) The intervention was effective in decreasing child overactive behaviors especially in families with more marital discord and families with more daily hassles

Table 2 (Continued)

<i>Intervention</i>	<i>Sample Characteristics</i>	<i>Design and Method</i>	<i>Variables</i>	<i>Results</i>
VIPP-TM: VIPP-SD for Turkish minorities Yagmur, S., Mesman, J., Malda, M., Bakermans-Kranenburg, M. J. & Ekmekci, H. (2014)	<i>Sample size:</i> 76 Turkish minority families living in the Netherlands (36 intervention families, 40 control families) <i>Inclusion criteria:</i> Turkish minority mothers living in Netherlands with 18 months- 3- years old children having externalizing problems	Randomized control trial, Intervention group: Six home-visits Control group: Six phone calls	Observed maternal sensitivity Observed maternal nonintrusiveness Observed maternal discipline, Externalizing problems	1) Compared to control mothers, intervention mothers showed more sensitivity 2) Compared to control mothers, intervention mothers showed less intrusion 3) There were no significant group differences on sensitive discipline

Note. VIPP: Video-Feedback Intervention to Promote Positive Parenting; VIPP-SD: Video-Feedback Intervention to Promote Positive Parenting- Sensitive Discipline; VIPP-R: Video-Feedback Intervention to Promote Positive Parenting-Representation

1.5. Implementing Culturally-Sensitive Intervention Program in the Turkish Context

The vast majority of attachment-based interventions have been designed and implemented in Western cultures (see Juffer et al., 2008d; Sandler et al., 2011; Watson et al., 2011 for a review). This led to bias in intervention programs in favor of more individualistic Western norms and values (Rothbaum et al., 2000). However, it is essential that interventions are tailored for individuals of different cultures in the way that they reflect culturally dominant norms and values. Given that the major purpose of this study is to adapt and implement the VIPP-SD program in Turkish context, it is necessary to consider '*culturally-sensitive*' or '*culturally-relevant*' adaptations. Before moving onto explain culturally-sensitive adaptations in detail, it will be useful to explain how childrearing practices differ in non-Western collectivistic cultures such as Turkey from Western individualistic cultures which constitute the majority of the world. This will ease understanding of adaptation of intervention themes and identification of factors that influence the effectiveness of the intervention programs across cultures.

In general, all infants develop attachment to their caregivers. However, there are cultural variations in specific attachment behaviors and caregiver sensitivity (Rothbaum et al., 2000; Rothbaum, Nagaoka, & Ponte, 2006; Rothbaum, Rosen, Ujiie & Uchida, 2002). According to Rothbaum and his colleagues (2000; 2002), biological and evolutionary basis of attachment theory has led attachment researchers to underestimate the role of larger societal and cultural context on attachment and take a universalist view instead. As illustrated by these authors, there are cultural differences in antecedents (i.e. caregiver sensitivity), consequences (i.e. competence) and nature of attachment (i.e. secure base). For instance, mothers in non-Western cultures (i.e. Japan) prefer to rely on situational cues that reflect child's needs and demands. They identify possible stressful situations and take proactive measures to minimize child's distress before receiving direct signals. However, these behaviors are more likely to be considered as overinvolvement and intrusion, and thus foster insecure (ambivalent) attachment in Western contexts. Because mothers in Western

cultures (i.e. U.S.) prefer to anticipate direct signals from the child before responding (Rothbaum et al., 2000; 2002; 2006).

Furthermore, maternal emotional involvement and affective sharing, prolonged physical contact, emotion-oriented, nonverbal and indirect communication, and distracting child's attention to social objects are considered as sensitive behaviors leading to attachment security in non-Western cultures as compared to contingency of maternal behaviors to infant's signals, distal eye contact, information-oriented, verbal and direct communication, and distracting child's attention to physical objects in Western cultures (Richman et al., 1992; Rothbaum et al., 2000; 2002; 2006; Völker, Keller, Lohaus, Cappenberg, & Chasiotis, 1999; Yovsi, Kartner, Keller, & Lohaus, 2009).

Even though all these behaviors indicate sensitivity and responsiveness of the mother to child's need (Posada et al., 1999; 2002), there are basic differences in the way that sensitivity is behaviorally expressed in each context. These differences in maternal sensitivity mainly reflect culture specific socialization goals and thus, they are adaptive in that particular context. For instance, sensitive behaviors are directed to foster exploration, independence and autonomy in individualistic cultures, while they are directed to foster emotional closeness, interdependence and mutuality between parent and child in collectivistic cultures (Rothbaum et al., 2000; 2002; 2006). Accordingly, intervention attempts to promote mothers' observation and perception of *situational nonverbal cues* reflecting child's needs and demands, and attempts to promote their ability to react to these indirect signals appropriately and promptly may be more successful at enhancing child attachment security in mainly collectivistic cultures such as Turkey.

In addition to cultural differences in behavioral expressions of sensitivity, other parenting practices may also reflect norms and values that are relevant and adaptive in that particular context. For instance, children may attribute different meaning and intention to parental control in different cultural contexts. Parental control, in general, has negative implications in individualistic cultures (Barber, 1996). However, it may be perceived as parental involvement and attention in collectivistic cultures (Chao, 1994; Kağıtçıbaşı, 2005; 2007). For instance, an empirical study conducted among Turkish school children showed that controlling

behaviors such as (over)protection and guilt induction are positively associated with perceived parental warmth and not associated with attachment insecurity (Sümer & Kağıtçıbaşı, 2010). As noted by authors, parental control may indicate parental involvement and warmth, thus may be functional and predict attachment security in this cultural context.

Kağıtçıbaşı's Psychological/Emotional Interdependence Model (2005; 2007) provides an explanation for the differences in the implications of parental control in the Turkish cultural context. According to Kağıtçıbaşı (2005; 2007), the changes in traditional family system from being an agricultural, rural society into an urban, industrial one have led children of urban, middle-class Turkish families to become increasingly autonomous in the material domain while remaining interdependent in the emotional domain. In other terms, autonomy and emotional closeness started to be more emphasized in childrearing among modern Turkish families. Accordingly, parental control became functional and adaptive to ensure child's emotional closeness in the family. Given that close knit family ties are strongly emphasized in the Turkish culture (Kağıtçıbaşı, 2005, 2007), it can be argued that intervention attempts that promote both individualistic values such as autonomy, and collectivistic values such as relatedness would be more successful in this cultural context. In addition, addressing these two basic human needs would promote healthy children and families (Kağıtçıbaşı, 2005; Imamoğlu, 1998).

Early parental support in encouragement of child autonomy is of crucial importance in particular for traditional Turkish families. Because child's compliance to societal norms and respect to others are still emphasized by low-class parents living in rural areas (Kağıtçıbaşı, 1984; Nacak, Yagmurlu, Durgel, & Van de Vijver, 2011; Sunar, 2002). Therefore, early interventions that support mother's encouragement of child autonomy may contribute to optimal child development in these contexts. However, to my knowledge, there are limited attempts that integrate cultural norms and values into early intervention programs. In one of these attempts, Kağıtçıbaşı and her colleagues (Kağıtçıbaşı, Sunar, & Bekman, 2001) implemented a culturally-sensitive intervention program to support the development of '*autonomous-related self*' among children of low-SES Turkish mothers (The Turkish Early Enrichment Program). In this program, mother trainings were directed at

emphasizing close-knit family ties, relatedness, autonomy and ways of supporting '*autonomous-related self*'. At the end of the training, low-SES mothers who emphasized *obedience* in childrearing in the beginning appeared to value *autonomy* and *emotional-closeness* (Kagitcibasi et al., 2001). Most importantly, these gains sustained over time. The findings indicate that culturally-sensitive adaptations were effective in enhancing the cultural trend emphasizing a synthesis of autonomy and relatedness values.

Based on aforementioned research, it can be argued that more emphasis needs to be given to promote Turkish mothers' support and encouragement to child's autonomy, use of non-punitive moderate control while maintaining an affectionate and emotionally close relationship with their children in early intervention attempts. Indeed, the sensitivity and discipline themes and methods of the VIPP-SD program addresses most of these needs. First, they provide an opportunity to mothers to develop better observational skills and empathy for her child by watching his/her signals and expressions (Juffer et al., 2008b). In particular, "*speaking for the child*" technique is effective for mothers to accurately understand child's nonverbal signals and reactions. Thus, they can better understand their children's *situational nonverbal cues*, which is considered as caregiver sensitivity in collectivistic cultures (Rothbaum et al., 2000; 2002; 2006).

Second, the VIPP themes and methods provide an opportunity to mothers to learn how to respond adequately and promptly to child's nonverbal signals. In particular, "*sensitivity-chain: child signal → parental sensitive response → positive reaction of the child*" method helps the mother feel competent in responding sensitively to her child's nonverbal signals and understand how important she is for the child's well-being (Juffer et al., 2008a; 2008b). Showing the desired behavior on the video and giving positive comments reinforce mothers' sensitive behaviors.

Third, the VIPP themes and methods provide an opportunity to the mother to understand the difference between child's exploratory and contact-seeking behaviors (Juffer et al. 2008a; 2008b). In particular, "*speaking for the child*" technique is effective for mothers to differentiate between child's attachment and exploration needs, and learn how to respond accordingly. That is, she should provide comfort when the child is seeking contact, and facilitate and support but not interfere when

the child is exploring. In this way, mother's encouragement of child's exploration is reinforced, which in turn promotes the development of autonomy and competence (Juffer et al., 2008a; 2008b).

Fourth, the VIPP themes and methods provide an opportunity to the mother to learn how to use effective discipline strategies in a sensitive way (Juffer et al., 2008a; 2008b). In particular, positive discipline themes including “*induction, distraction, positive reinforcement, and sensitive time-out*” help to promote mothers' use of non-coercive discipline strategies when children show difficult behaviors. Finally, they enhance mothers' ability to develop understanding of the child's thoughts and feelings. In particular, the discipline theme of “*empathy*” is effective in promoting their understanding of the child's feelings when there are rules. In this way, the child feels himself/herself as being understood and learns to show empathy for others, which in turn promotes prosocial development (Mesman et al., 2008). Furthermore, the sensitivity theme of “*sharing emotions*” is effective in promoting mother's affective attunement to the child's positive and negative emotions (Juffer et al., 2008b). In this way, mother's emotional involvement and affective sharing with the child are reinforced, which are considered as sensitive behaviors in collectivistic cultures (i.e. Völker et al., 1999).

1.6. Hypotheses of the Present Study

As stated previously, the major purpose of this study was to adapt, apply, and test the effectiveness of the VIPP-SD program in the Turkish context, using a completely randomized design. In accordance with this purpose, it was expected that the intervention would promote mothers' sensitive behaviors. That is, posttest sensitivity scores of mothers in the intervention group would be higher than their pretest sensitivity scores. However, pretest and posttest sensitivity scores would not be different for mothers in the control group. Another purpose of this study was to examine differential effectiveness of the intervention on maternal sensitivity. Accordingly, it addressed the question of ‘*what work best for whom?*’ and examined child temperament and maternal psychological symptoms as potential influencers on the efficacy of the VIPP-SD program.

Given that the vast majority of the VIPP programs are implemented in West, this study would be the first VIPP study among families in Turkey, a collectivistic and relational culture. In the past, several intervention efforts have been spent among Turkish families living in Turkey (TEEP; Kağıtçıbaşı et al., 2001) and second-generation Turkish minority families living in the Netherlands (VIPP-TM; Yagmur et al., 2014). However, to my knowledge, this study would be the first attachment-based intervention study in Turkey. Accordingly, the findings of this study would contribute to the further development and implementation of early interventions and its related literature in Turkey. In addition, the current study would provide support for the applicability and effectiveness of the video-feedback intervention in non-Western cultures.

CHAPTER 2

METHOD

2.1. Participants

In the current study, the sample consisted of 56 Turkish mothers ($N_{\text{ank}} = 38$, $N_{\text{ist}} = 18$) having infants between 10-33 months old and living in relatively underdeveloped regions of Ankara and Istanbul. Considerable research shows that early interventions are effective among families with 6 months or older infants, and among families from lower socioeconomic status and educational backgrounds (Juffer et al., 2008d). In addition, the VIPP-SD is widely implemented among mothers with 1- to 4- year old children since discipline practices become more useful for children older than one year. In line with this reasoning, the study sample was mostly chosen among families from lower socioeconomic status and educational background and those having children around one year or older.

The participants were first selected using convenience sampling. Eligible families were recruited from (1) records of several municipalities and family health centers located in low SES suburbs of Ankara and Istanbul, (2) social media, in particular, facebook accounts namely 'My child and I' and 'Baby Caregiving', (3) acquaintances of İstanbul Kemerburgaz university students, (4) acquaintances of project assistants. Then, they were contacted by phone and informed about the study by the intervener. Some mothers refused to participate because their husbands felt uncomfortable with video-recordings or they were busy. If they agreed to participate, they were enrolled to the participant list. After enrollment, the families were randomly assigned to the intervention and control groups. The rest of the participants were selected using snowball sampling since they were neighbours or relatives of the already participating families and eager to participate in the study. The sample consisted of 38 mother-child dyads in the intervention group and 18 mother-child dyads in the control group. Among all participants, one intervention mother dropped

out from the study after the pretest session and one intervention mother after the first intervention session.

Table 3 shows the demographic characteristics of the sample. Children's age ranged from 10 to 33 months with an average of 20.5 months ($SD = 7.2$, range = 23) at pretest session; and ranged from 12 to 37 months with an average of 23.1 months ($SD = 6.9$, range = 25) at posttest. The mother's age ranged from 20 to 42 with an average of 29.9 years ($SD = 5.04$) at pretest. Among children, 30 (53.6 %) were girls, 27 (48.2 %) were firstborns, and 28 (50 %) had no sibling. The vast majority of children were living with two parents (94.6 %) and the mother was the primary caregiver (57.1 %).

As shown in Table 3, 12.5 % of the mothers and 16.1 % of the fathers graduated from four years of university, 8.9 % of the mothers and 5.4 % of the fathers graduated from two years of university, 48.2 % of the mothers and 42.9 % of the fathers graduated from high school, 19.6 % of the mothers and the fathers graduated from secondary school, and 7.1 % of the mothers and 12.5 % of the fathers graduated from primary school. Considering family income, 25 % of the participants had monthly family income lower than 1000 TL, 23.2 % had 1000 to 1500 TL, 17.9 % had 1500 to 2000 TL, 10.7 % had 2000 to 3000 TL, and 19.6 % had more than 3000 TL. With respect to occupation, 75 % of the mothers were housewives while 10.7 % of them were full-time employed, 5.4 % were half-time employed and 3.6 % were unemployed.

Considering child and family wellbeing, 2 (3.6 %) children had a chronic health-related problem, 2 (3.6 %) children used medicine regularly, 46 (82.1 %) children went to a hospital, 6 (10.7 %) children stayed in the hospital for the last 12 months, 2 (3.6 %) children underwent a medical operation and 14 (25 %) children underwent a medical treatment in the last 12 months. Eleven (19.6 %) mothers experienced the loss of a close family member in the last year, and 7 (12.5 %) mothers had a family member experiencing a chronic illness which required to stay in the hospital for at least 2 months.

Table 3

Demographic Characteristics of the Sample

	<i>Intervention</i> (<i>N</i> = 38)	<i>Control</i> (<i>N</i> = 18)	<i>Total</i> (<i>N</i> = 56)
<i>Gender</i>			
Girl	24 (63.2%)	6 (33.3%)	30 (53.6%)
Boy	14 (36.8%)	12 (66.7%)	26 (46.4%)
<i>Number of siblings</i>			
No sibling	19 (50%)	9 (50%)	28 (50%)
One sibling	17 (44.7%)	6 (33.3%)	23 (41.1%)
Two sibling	1 (2.6%)	2 (11.1%)	3 (5.4%)
<i>Child's birth order</i>			
First-born	18 (47.4%)	9 (50%)	27 (48.2%)
Second-born	18 (47.4%)	7 (38.9%)	25 (44.6%)
Third-born	1 (2.6%)	1 (5.6%)	2 (3.6%)
<i>Caregiver person</i>			
Mother	25 (65.8%)	7 (38.9%)	32 (57.1%)
Other	12 (31.6%)	10 (55.6%)	22 (39.3%)
<i>Mother's Education</i>			
University (four years)	5 (13.2%)	2 (11.1%)	7 (12.5%)

Table 3 (Continued)

	<i>Intervention</i> (<i>N</i> = 38)	<i>Control</i> (<i>N</i> = 18)	<i>Total</i> (<i>N</i> = 56)
University (two years)	4 (10.5%)	1 (5.6%)	5 (8.9%)
High school	18 (47.4%)	9 (50%)	27 (48.2%)
Secondary school	7 (18.4 %)	4 (22.2%)	11 (19.6%)
Primary school	3 (7.9 %)	1 (5.6%)	4 (7.1%)
<i>Father's</i>			
<i>Education</i>			
University (four years)	4 (10.5%)	5 (27.8%)	9 (16.1%)
University (two years)	3 (7.9%)	0 (0%)	3 (5.4%)
High school	19 (50%)	5 (27.8%)	24 (42.9%)
Secondary school	5 (13.2%)	6 (33.3%)	11 (19.6%)
Primary school	6 (15.8%)	1 (5.6%)	7 (12.5%)
<i>Mother's</i>			
<i>occupation</i>			
Housewife	31 (81.6%)	11 (61.1%)	42 (75%)
Full-time employer	2 (5.3%)	4 (22.2%)	6 (10.7%)
Part-time employer	2 (5.3%)	1 (5.6%)	3 (5.4%)
Unemployed	1 (2.6%)	1 (5.6%)	2 (3.6%)
<i>Income</i>			
0-1000 TL	11 (28.9%)	3 (16.7%)	14 (25%)

Table 3 (Continued)

	<i>Intervention</i>		<i>Control</i>		<i>Total</i>	
	<i>(N = 38)</i>		<i>(N = 18)</i>		<i>(N = 56)</i>	
1000-1500 TL	10 (26.3%)		3 (16.7%)		13 (23.2%)	
1500-2000 TL	6 (15.8%)		4 (22.2%)		10 (17.9%)	
2000- 3000TL	5 (13.2%)		1 (5.6%)		6 (10.7%)	
3000 -4000TL	3 (7.9%)		2 (11.1%)		5 (8.9%)	
4000- 5000TL	0 (0%)		4 (22.2%)		4 (7.1%)	
Above 5000TL	2 (5.3%)		0 (0%)		2 (3.6%)	
<i>Child's health status</i>	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
Chronic health-related problem	1 (2.6%)	36(94.7%)	1 (5.6%)	16 (88.9%)	2 (3.6%)	52 (92.9%)
Regular use of medicine	1 (2.6%)	36 (94.7%)	1 (5.6%)	16 (88.9%)	2 (3.6%)	52 (92.9%)
Went to a hospital in the last 12 months	31(81.6%)	6 (15.8%)	15 (83.3%)	2 (11.1%)	46 (82.1%)	8(14.3%)
Stayed in the hospital for the last 12 months	3 (7.9%)	34 (89.5%)	3 (16.7%)	14 (77.8%)	6 (10.7%)	48(85.7%)
Underwent a medical operation in the last 12 months	1 (2.6%)	36 (94.7%)	1 (5.6%)	16 (88.9%)	2 (3.6%)	52 (92.9%)
Underwent a medical treatment in the last 12 months	8(21.1%)	29 (76.3%)	6 (33.3%)	11 (61.1%)	14 (25%)	40 (71.4%)
Loss of a close family member in the last year	8(21.1%)	28 (73.7%)	3 (16.7%)	14 (77.8%)	11 (19.6%)	42 (75%)
Family member staying at hospital for at least 2 months	3 (7.9 %)	34 (89.5%)	4 (22.2%)	13 (72.2%)	7 (12.5%)	47 (83.9%)

2.2. Measures and Procedure

The current study was part of a research project financially supported by the Scientific and Technological Research Council of Turkey (TUBİTAK; Project no: 113K542). The project aimed to adapt the VIPP-SD program for the Turkish mothers, and test its effectiveness on various child and family outcomes. The current study, in particular, examined the effectiveness of the intervention on enhancing mothers' sensitive behaviors. For this purpose, maternal sensitivity was assessed via observational and self-report measures at pretest and posttest. Maternal sensitive behaviors were observed during 10 min of mother-child free-play (the Ainsworth Maternal Sensitivity scale; Ainsworth et al., 1974) and during one hour of mother-child interactions (the MBQS; Pederson et al., 1990; Pederson & Moran, 1995). In addition, mothers reported their attitudes toward sensitivity and sensitive discipline (the MATSD; Bakermans-Kranenburg & Van IJzendoorn, 2003). In addition, child's age, gender and temperament, mother's age, education, and psychological symptoms, family income and parenting stress were measured.

2.2.1. Video-Feedback Intervention to Promote Positive Parenting-Sensitive Discipline

2.2.1.1. Training of the Intervenors

The intervention was delivered by seven female intervenors who completed the VIPP-SD training and online supervisions by an expert from Leiden University. Six intervenors were psychology graduates in developmental, social or clinical psychology, and had enough experience in observing mother-child dyads from past developmental research. One intervenor was an associate professor with at least ten years of experience as clinical psychologist.

Before intervening, all intervenors received a 4-day training in Ankara by an expert from Leiden University. In this training, they were informed about attachment theory, sensitive parenting and the VIPP-SD program (protocols, themes, etc.). They were given home assignments on specific mother-child interaction videos. They also

participated in role playing where they had an opportunity to act as an intervener, give feedback to the mother, and receive feedback from the trainer through videotaped mother-child interactions. Following this training, all interveners completed four-thematic sessions with one mother-child dyad not included in the sample (*'pilot study'*; explained below in detail). During this first application, the interveners received three online supervisions from the same trainer. Those who completed all supervisions received the certificate of '*VIPP-SD intervener*' and became eligible to conduct intervention

2.2.1.2. The First Phase: Pilot Study and Cultural Adaptation of the VIPP-SD

The current study includes two phases. In the first phase, a pilot study was conducted for: (1) the supervision of the interveners, (2) the adaptation of the program for the Turkish mothers. In pilot study, each intervener completed four thematic sessions with a mother-child dyad not included in the sample. For each supervision meeting, they prepared video-feedback script on one of the mother-child interaction videos (i.e. '*playing alone or together*', '*reading book*', etc.), and then sent this script together with the video to the trainer. At each scheduled Skype meeting that lasts around one hour, they received individualized feedback upon their scripts from the trainer. In addition, they received feedback upon video of themselves giving feedback to the mother.

Pilot study was also conducted for adaptation of the program for the Turkish sample. In past intervention conducted among second-generation Turkish minorities in the Netherlands, several adaptations considering the protocols were made on the original VIPP-SD program (Yagmur et al., 2014). For instance, researchers changed certain toys and materials since they thought they would be unsuitable for Turkish minority families: (1) '*reading book*' was replaced by '*playing together with a tea set*'; (2) '*singing*' activity was replaced by '*fantasy play*', (3) '*playing together with hand puppet*' was replaced by '*playing together with clay*' (Yagmur et al., 2014). In the pilot phase of the current study, '*singing*' activity did not work since children either did not know or want to sing in the presence of a stranger. This was not

appropriate to the sensitivity theme of the session ('sharing of emotions'). Therefore, the '*singing*' activity was replaced by '*playing together with a tea set*', which induces more sharing of emotions between mother and child. However, there was no need for further adaptation since mothers and children in the sample were familiar with hand puppets and reading books. Thus, only one adaptation was integrated into the program.

2.2.1.3. The Second Phase: Implementation of the VIPP-SD

In the second phase, a total of six home sessions including four thematic sessions, a pretest and a posttest session were conducted with intervention mothers. Each session lasted approximately for 2- 2,5 hours and took place in every two or three weeks. The relatively long duration of each session was due to a social ritual in Turkey, which requires a visitor to engage in social conversation and accept the treat (i.e. snacks) prepared by the host. Otherwise, it would be considered rude and impair the relationship between intervener and mother. In order to increase willingness and continuation to the sessions, mothers were given money for each session they participate and a booklet on sensitive parenting. In addition, children were given a tiny feathered duckling and a reading book as a gift. General procedures of each session are described in detail below.

In pretest session (Home Visit 0), the mother was informed about video-feedback intervention program and signed informed consent form. Three activities ('*playing alone*', '*playing together*' and '*don't touch*') were videotyped for the first feedback session (Home visit 1). In '*playing alone*' activity, the mother was asked to give her child a pop-up toy and let him/her play for three minutes. In '*playing together*' activity, she was given two or three types of toys and asked to play with her child for five minutes in the way she normally would. In '*don't touch*' activity, the mother was given a bag full of attractive toys and asked to take the contents out of bag, and not allow her child to touch or play with these toys or any other toys for two minutes. She was also told that the child could play with forbidden toys for a little while after video-recording.

The pretest assessment was taken after recordings of three activities. First, mother-child free play was videotaped for 10 minutes to assess maternal sensitivity (using the Ainsworth's sensitivity scale). Later, mother-child interaction was videotyped for approximately one hour to assess the quality of maternal behaviors (using the MBQS). Before video-recording, the mother was asked to interact with her child as she would normally do in daily life even when the child cries or protests. In the first half of this recording, the intervener recorded mother-child interactions such as playing with toys, eating lunch or snack. In addition, she recorded specific instances such as when the mother leaves the room and the child stays with the camera person (similar to Strange Situation). In the second half of this recording, she was asked to complete a questionnaire on various domains of child development, parental attitudes toward sensitivity and sensitive discipline, parental stress and marital relations as a part of a large research project. If the child did not let his/her mothers fill the questionnaire or attempt to draw on it, the mother was let to complete it afterwards. The same procedures except recordings of activities for video-feedback were replicated for posttest session.

The first thematic session (Home Visit 1) took place after the pretest session. In this session, four activities (*'playing alone'*, *'playing together'*, *'clean up'*, *'reading book'*) were videotyped for the next feedback session (Home visit 2). The same procedures were applied for *'playing alone'* and *'playing together'* activities except the duration (four minutes) and toys used in the activities. In *'clearing up'* activity, the mother was asked to clear up the toys together with her child for two minutes. Finally, in *'reading book'* activity, she was given two books suitable for child's age and asked to read them together with her child for six minutes. She was also told that she could read more than once if they want. Following video-recordings, personal feedback on maternal sensitivity and discipline was provided on previously videotaped mother-child interactions (*'playing alone'*, *'playing together'* and *'don't touch'*). At the end of this session, the intervener informed the mother that the next video-recording would be at mealtime and they arranged the timing of the next visit accordingly.

The second thematic session (Home Visit 2) took place two or three weeks after the first thematic session. In this session, *'mealtime'* was videotyped for the

next feedback session (Home visit 3). The intervener recorded the mealtime from the beginning (i.e. preparation of the table) to the end. In general, the duration of mealtime was approximately 15-20 minutes. Following video-recording, personal video-feedback on maternal sensitivity and discipline was provided on previously videotaped mother-child interactions (*'playing alone'*, *'playing together'*, *'clearing up'*, *'reading book'*).

The third thematic session (Home Visit 3) took place two or three weeks after the second thematic session. In this session, three activities (*'child invites'*, *'singing/playing together'*, *'task'*) were videotaped for the next feedback session (Home visit 4). In *'child invites'* activity, the child was let to play alone, and the mother was told only to react briefly when child invites her (i.e. looks at or says something to her). In other words, the rule for the mother was not to show any initiative until the child asks for during four minutes. In *'singing'* activity, the mother was asked to sing with her child for three minutes. When they couldn't remember any song, the intervener gave examples of favorable child songs. In this activity, it was important to record joyful interaction moments of mother and child, especially for the theme of the next session (*'sharing of emotions'*). When the mother or child did not want to do it, similar to past intervention (Yagmur et al., 2014), this activity was replaced with another activity, where the mother and child were playing together with a tea set. In the last activity *'task'*, the mother was asked to build a tower with her child for five minutes, and help him/her in her own way as it might be difficult for a child of this age.

Following video-recordings, personal video-feedback on maternal sensitivity and discipline was provided on previously videotaped mother-child interaction (*'mealtime'*). Before coming to the session, the intervener arranged the duration of the mealtime video to 15-20 minutes, remaining the beginning and the end parts of mealtime, so that it wouldn't be too long for the feedback. Finally, the intervener informed the mother that the next session would be the last thematic session and therefore, there wouldn't be any video-recording.

The fourth thematic session (Home Visit 4) took place two or three weeks after the third thematic session. In this session, the intervener did not record any activity since this was the last thematic session. Therefore, merely personal video-

feedback on maternal sensitivity and discipline was provided on previously videotaped mother-child interactions ('*child invites*', '*singing/playing together*', '*task*'). In addition, a booklet on sensitive parenting and small gifts (a tiny feathered duckling and a reading book) were given at the end of this session. Finally, the intervener informed the mother about the posttest session which would be in two or three weeks.

The posttest session (Home Visit 5) took place two or three weeks after the last thematic session. Similar to the procedure in the pretest assessment, mother-child free play was videotaped for 10 minutes to assess maternal sensitivity (using the Ainsworth's sensitivity scale). Later, mother-child interaction was videotaped for approximately one hour to assess the quality of maternal behaviors (using the MBQS). In the first half of this recording, the intervener recorded mother-child interactions such as playing with toys, eating lunch or snack. In the second half of this recording, she was asked to complete the same questionnaire given in the pretest session as a part of large project (except measures on child temperament, mothers' clinical symptoms and adult attachment).

Mothers in the control group did not receive any intervention. However, they received four telephone calls from the intervener parallel to intervention sessions. In these telephone calls lasting 5-10 minutes, the mothers were encouraged to talk extensively about the development of the child (i.e. eating, sleeping, motor movements, etc.) and the intervener did not give any information or advice to the mothers on child development or problem behaviors. In pretest session, the intervener did not record any activity for feedback but recorded 10 minutes of free play and one-hour of mother-child interaction to assess maternal sensitivity. The same procedures were also replicated for the posttest session (within two months after the pretest session). Mothers in the control group also completed the same questionnaires given to intervention mothers in pretest and posttest sessions and received small gifts for their children. At the end of posttest session, control mothers were provided with brief information on sensitive parenting, non-coercive discipline strategies and the booklet in order to make them gain from the intervention. The purpose was to minimize the ethical concerns of not giving support to the control group.

2.2.2. Maternal Sensitivity and Sensitive Discipline

2.2.2.1. Ainsworth Maternal Sensitivity Scale

Mothers' sensitive behaviors was measured during 10 min of mother-child free-play at pretest and posttest sessions. Mothers were provided with the same collection of toys and instructed to play with their children as they would normally do. Independent coders rated maternal behaviors through videotaped mother-child interactions using Ainsworth's descriptions of sensitive and insensitive behaviors on a 9 point scale (1 = *highly insensitive*, 3 = *insensitive*, 5 = *somewhat sensitive*, 7 = *sensitive*, 9 = *highly sensitive*). Based on Ainsworth's definition of sensitivity, a mother was considered as highly sensitive if she could perceive and interpret the child's need and signals accurately, and respond to them promptly and appropriately (Ainsworth et al., 1974). Whereas a mothers was considered as highly insensitive if she couldn't perceive and respond to majority of the child's need and signals, or responded to the child's intense or prolonged signals inappropriately and incompletely. The descriptions of (in) sensitive mother were translated into Turkish for this study. Interrater reliability was obtained from multiple codings of 20 % of the interaction videos. The average intraclass correlations for interrater reliability were .80 ($p < .001$) for all codings, .81 ($p < .001$) for the pretest codings and .73 ($p < .01$) for the posttest codings.

2.2.2.2. Maternal Behavior Q-Sort

The quality of maternal behaviors was measured during approximately one hour of mother-child daily interactions such as playing together, eating lunch or snack, etc at pretest and posttest sessions. Independent coders rated the quality of maternal behaviors using Maternal Behavior Q-Sort (the MBQS) developed by Pederson and his colleagues (1990; Pederson & Moran, 1995). In this measure, there are 90 items developed based on Ainsworth's definition of caregiver sensitivity (Ainsworth et al., 1974). These items describe many aspects of maternal behaviors such as child care (i.e. "*Provides age-appropriate toys*"), maternal affect (i.e. "*Seems*

to resent baby's bids for attention and signals of distress"), attentiveness (i.e. *"Arranges her location so that she can perceive baby's signals"*), interaction style (i.e. *"Points to and identifies interesting things in baby's environment"*), and communication skills (i.e. *"Response so delayed that baby can not connect mother's response to the action that initiated it"*) (Pederson et al., 1990, pp.1976-1977).

In particular, independent coders placed 90 item cards in one of the three piles ("characteristic of the mother", "neither characteristic nor uncharacteristic", "uncharacteristic of the mother"). Then, they further placed three piles into nine piles of 10 card each (1 = "most uncharacteristic of the mother", 9 = "most characteristic of the mother"). Following sorting, discrepant items by three or more points were discussed and revised by coders, and a final sensitivity score for each mother was generated by averaging two codings. A global sensitive score for each mother was calculated by correlating the final sensitivity score by a criterion sensitivity score (an aggregate score of 10 judges) that describes a prototypical sensitive (ideal) mother (Pederson et al., 1990). Higher correlation indicated mother's higher sensitivity to the child or mother's being closer to a prototypical sensitive (ideal) mother.

Previous research have provided strong evidence for the validity of the MBQS in assessing child attachment security. For instance, mother's sensitivity scores rated via the 90 items of the MBQS is related to attachment security scores in the AQS ($r = .32$) in the Turkish sample (Sümer, Sayıl, & Kazak-Berument, in press) and the Colombian samples ($r = .42-.55$) (see Posada, 2013 for a review). Furthermore, mother's sensitivity scores rated through the 25 item video coding version of the MBQS is related to attachment security scores in the Strange Situation ($r = .65$; Pederson, Bailey, Tarabulsky, Bento, & Moran, 2014) and in the AQS ($r = .34$; Tarabulsky et al., 2009) in two Canadian samples. Sümer and his colleagues (2008) adapted the MBQS among 110 Turkish mother-child dyads and developed a computer program (METU Q-sort) for this q-sorting technique. In this study, METU Q-SOFT program was used for sorting, interrater reliability analysis, and generation of a global sensitivity score. Past study in the Turkish sample (Sümer et al., in press) yielded the intraclass correlation for interrater reliability as .85 (range = .62 –.95). In the current study, interrater reliability was obtained from multiple codings of 20 % of

the interaction videos. The average intraclass correlation for interrater reliability was .85 (range = .74 to .93).

2.2.2.3. Maternal Attitudes toward Sensitivity and Sensitive Discipline

Mothers reported their attitudes toward sensitive parenting and discipline on a 18-item scale developed by Bakermans-Kranenburg and Van IJzendoorn (2003) at pretest and posttest sessions. This scale consists of two subscales. Maternal Attitudes toward Sensitivity subscale has 9 items (MATS; i.e. "*I believe that I should praise my child at least once a day*") and Maternal Attitudes toward Sensitive Discipline subscale has 9 items (MATD; i.e. "*If a child continues to be disobedient, punishment is the only thing that works*", reversed). Mothers indicated the degree to which they agree with each statements on a 1 (*strongly disagree*) to 6 (*strongly agree*) point scale. The composite scores for each subscale and for the total scale were computed by averaging item scores after rescaling reverse items. Higher score indicated mother's positive attitudes toward sensitivity and sensitive discipline. The items were translated into Turkish for this study. Past research yielded low internal reliability coefficients for Sensitivity subscale (.54), Sensitive Discipline subscale (.58) and for Total scale (.64) (Groeneveld et al., 2011; Van Zeijl, et al., 2006). Similarly, in the current study, the alpha coefficients were .56 (pretest) and .55 (posttest) for Sensitivity subscale, .76 (pretest) and .72 (posttest) for Sensitive Discipline subscale, and .43 (pretest) and .66 (posttest) for Total scale.

Confirmatory factor analysis was performed using the LISREL 8.51 program to evaluate goodness of fit of the factor structure of the scale. The covariance matrix was used as input and maximum likelihood estimation was employed in the analyses. For each factor of 9 items, three parcels were created by averaging scores of three random items in that particular factor. In Sensitivity factor, parcel 1 consists of items 10, 13 and 17, parcel 2 consists of items 1, 12 and 15, and parcel 3 consists of items 11, 14 and 18. In Sensitive Discipline factor, parcel 4 consists of items 2, 5 and 8, parcel 5 consists of items 3, 6, and 9, and parcel 6 consists of items 4, 7 and 16. As a first step, a confirmatory model in which all six parcels clustering under a single

latent variable was tested to examine the possibility of common method variance. It was expected that the single-factor model would yield a poor fit to the data. As expected, the single-factor model yielded a poor fit to the data [$\chi^2(9) = 30.6, p < .001, \chi^2/df = 3.4, GFI = 0.84, CFI = 0.70, NNFI = 0.50$ and $RMSEA = 0.21$]. Next, the proposed model with three parcels for each factor was tested. The proposed model revealed an adequate fit to data [$\chi^2(8) = 18.3, p < .05, \chi^2/df = 2.28, GFI = 0.90, CFI = 0.86, NNFI = 0.74$ and $RMSEA = 0.15$]. As shown in Figure 1 with standardized coefficients, all of the parcels loaded significantly on the appropriate factor (ranging from .28 to .86).

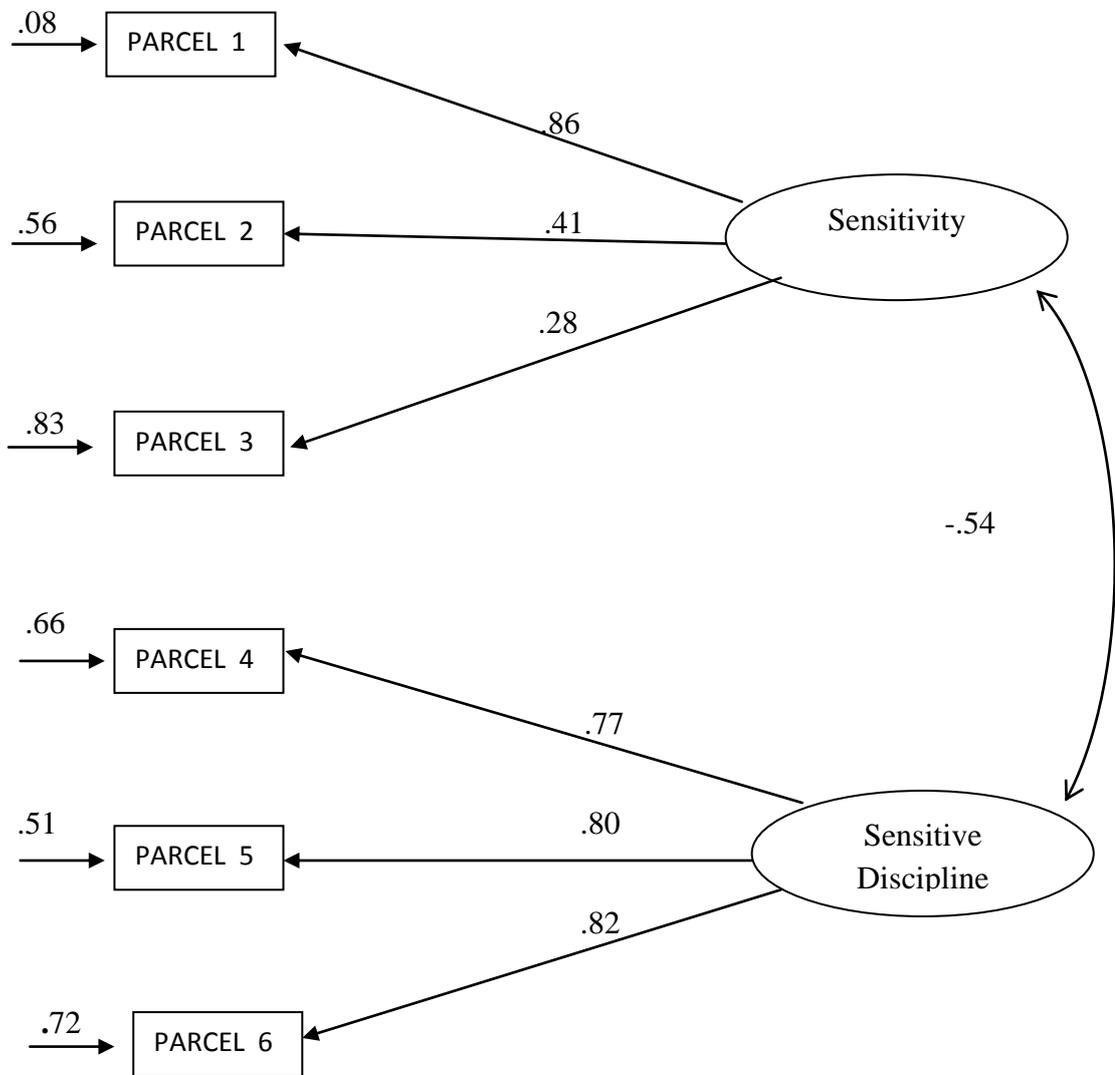


Figure 1

CFA Model of Maternal Attitudes toward Sensitivity and Sensitive Discipline Scale (MATSD)

2.2.2.4. Child Temperament

Child temperament was measured by EAS Temperament Survey for Children developed by Buss and Plomin (1984). The scale consists of 20 items that measures three dimensions of temperament: Emotionality, Activity and Sociability. The emotionality subscale assesses the intensity of child's emotional arousal (i.e. "*My child cries easily*"). The activity subscale assesses the level of child's motor activity (i.e. "*My child can not sit still long*"). The sociability subscale assesses the child's tendency to approach others (i.e. "*My child tends to be shy*"). Mothers indicated how frequent their children show these behaviors on a 1 (*never*) to 4 (*always*) point scale. The composite scores for each subscale were computed by averaging item scores after rescoring reverse items. Higher score indicated children's higher emotionality, activity and sociability levels. Sümer and his colleagues (2008) adapted EAS in the Turkish sample and yielded adequate internal reliability coefficients for Emotionality (.78 and .69), Activity (.65) and Sociability (.71 and .61) subscales in two different samples. In this study, the EAS Temperament Survey for Children was used only at pretest and yielded the alpha coefficients as .71 for Emotionality, .33 for Activity and .57 for Sociability subscales.

2.2.2.5. Parenting Stress

Mothers' experience of difficulty and sense of competence in the role of parent was measured by 26 items of the 36-item Parenting Stress Index-Short Form (PSI-SF) developed by Abidin (1995) at pretest and posttest sessions. The scale measures five dimensions of parenting stress: The Quality of Marital Relationship, Social Isolation, Feelings of Incompetence, Life Restrictions due to Parenting Role, Dysfunction in Attachment. Mothers indicated the degree to which they agree with item (i.e. "*I feel trapped by my responsibilities as a parent*") on a 1 (*strongly disagree*) to 6 (*strongly agree*) point scale. The composite score for parenting stress was computed by averaging item scores after rescoring reverse items. Higher score indicated higher stress experienced by mothers. In the current study, the alpha

coefficients of the PSI-SF were .89 for the pretest and .91 for the posttest assessment.

2.2.2.6. Maternal Psychological Symptoms

Mothers' current patterns of psychological symptoms were measured by 27 items of the Symptom Inventory developed by Derogatis (SCL-90, 1992). The Symptom Inventory was originally developed with 90 items. Researchers, then, revised and validated its short form of 53 items across cultures (Derogatis & Lazarus, 1994). The short-symptom inventory was adapted into Turkish by Şahin, Batıgün and Uğurtaş (2002) with five dimensions: Anxiety, Depression, Negative Self, Somatization and Anger/Aggression. Mothers indicated how much they experience each symptom in the past 7 days on a 1 (*never*) to 5 (*always*) point scale. The composite score for psychological symptom was computed by averaging item scores. Higher score indicated higher levels of psychological symptoms. In the current study, the scale yielded high alpha coefficient (.92).

CHAPTER 3

RESULTS

3.1. Overview

The results of the study are presented in three parts. In the first part, descriptive statistics of the study variables and bivariate correlations among these variables are documented. In the second part, the main hypotheses of the study are tested. In the third part, supplementary analyses are reported.

3.2. Preliminary Analyses

Prior to the substantive analyses, the data were screened for normality and outliers. There were two outliers in the pretest MBQS scores and they were replaced with the next highest value in that particular variable. For other study variables, none of the skewness and kurtosis values exceeded the absolute value of 2 indicating that distributions were generally normal and no outliers were identified. Data were also screened for missing values. There were 5 missing values in the pretest and posttest MBQS scores, 4 missing values in the posttest Ainsworth sensitivity scores, 2 missing values in the pretest and 3 missing values in the posttest MATS, MATD and MATSD scores, 4 missing values in the pretest and 3 missing values in the posttest parenting stress scores, 2 missing values in child emotionality scores and 3 missing values in SCL scores. Missing values were substituted with the median by nearby points belonging to that particular experimental group.

3.3. Descriptive Statistics

Independent samples t-test analyses were conducted to investigate differences between intervention and control groups in terms of demographic variables and outcome measures at pretest and posttest. The goal was to examine whether random assignment successfully prevents initial group differences and whether intervention was effective on outcome measures. As shown in Table 4, there was a significant group difference on child's gender, $t(54) = 2.14, p < .05$. That is, there were more girls in experimental group ($N_{\text{girl}} = 24, N_{\text{boys}} = 14$) as compared to control group ($N_{\text{girl}} = 6, N_{\text{boys}} = 12$). Due to this difference at baseline, gender was included as covariate in the further analyses. In addition, there was a significant group difference on parenting stress at pretest, $t(54) = 2.11, p < .05$. That is, mothers' stress level was higher in the control group ($M = 3.34, SD = .82$) as compared to intervention group ($M = 2.93, SD = .60$). Besides, there was a marginal difference in child's emotionality between groups, $t(54) = 1.94, p = .06$. That is, child's emotionality was higher in the control group ($M = 2.46, SD = .52$) as compared to the intervention group ($M = 2.20, SD = .46$). There were no other significant group differences in any of the pretest measures.

Considering posttest measures, two groups were significantly different in the MATSD scores, $t(54) = -2.26, p < .05$ and parenting stress $t(54) = 2.43, p < .05$. That is, intervention mothers ($M = 4.40, SD = .54$) had more favorable attitudes toward sensitivity and sensitive discipline as compared to control mothers ($M = 4.05, SD = .51$). In addition, intervention mothers ($M = 2.94, SD = .67$) showed less stress as compared to control mothers ($M = 3.44, SD = .81$). Besides, there was a marginal difference in the MATS scores between groups, $t(54) = -1.95, p = .06$. That is, intervention mothers ($M = 4.76, SD = .67$) had more favorable attitudes toward sensitivity as compared to control mothers ($M = 4.38, SD = .65$). Besides, even though they were nonsignificant, intervention mothers ($M_{\text{int}} = 4.04, M_{\text{cnt.}} = 3.72$) had more favorable attitudes toward sensitive discipline, had higher sensitivity scores measured via the MBQS ($M_{\text{int}} = .68, M_{\text{cnt.}} = .63$) and measured via the Ainsworth sensitivity scale ($M_{\text{int}} = 6.76, M_{\text{cnt.}} = 6.59$) as compared to control mothers (see Table 4). These posttest differences indicate that the intervention mothers showed

improvement in sensitivity and sensitive discipline. In order to examine whether there is any difference between groups in terms of improvement from pretest to posttest, further repeated measures analysis of variance were conducted.

Table 4

Group Comparisons for Demographic Variables and Outcome Measures

	Measure	Intervention					Control					Significance		Reliability	
		M	SD	Min	Max	Range	M	SD	Min	Max	Range	t	df	α	
	1. Child Gender											2.14*	54		
	2. Maternal Education											-.27	52		
§	3. Maternal Age ¹	29.64	4.73	20	41	21	30.50	5.80	22	42	20	.56	51		
	4. Child Age ²	19.80	7.40	10	33	23	22.11	6.70	10	30	20	1.11	53		
	5. EAS	2.20	.46	1.14	3	1.86	2.46	.51	1.71	3.57	1.86	1.94 ⁺	54	.71	
	6. SCL	1.77	.50	1	3.04	2.04	1.94	.54	1.07	3.11	2.04	1.19	54	.92	
	<i>Pretest Measures</i>														
	7. MBQS Sensitivity	.65	.16	.16	.81	.65	.66	.16	.16	.85	.69	.19	54		
	8. Ainsworth Sensitivity	6	1.41	3.5	8.5	5	6.49	.94	5	8	3	1.34	54		

Table 4 (Continued)

Measure	Intervention					Control					Significance		Reliability	
	M	SD	Min	Max	Range	M	SD	Min	Max	Range	t	df	α	
9. MATS	4.29	.66	3	5.78	2.78	4.37	.76	3	5.67	2.67	.39	54	.56	
10. MATD	3.88	.97	1.78	5.89	4.11	3.45	.77	2	4.89	2.89	-1.66	54	.76	
11. MATSD	4.09	.50	2.89	5.11	2.22	3.91	.47	2.88	4.67	1.79	-1.28	54	.43	
12. PSI-SF	2.93	.60	1.77	4.50	2.73	3.34	.82	1.85	4.92	3.08	2.11*	54	.89	
<i>Posttest Measures</i>														
13. MBQS Sensitivity	.68	.17	.21	.89	.68	.63	.16	.20	.84	.64	-1.06	54		
14. Ainsworth Sensitivity	6.76	1.15	3.5	9	5.5	6.59	.65	5	8	3	-.56	54		
15. MATS	4.76	.67	2.44	6.00	3.56	4.38	.65	2.78	5.44	2.67	-1.95 ⁺	54	.55	
16. MATD	4.04	.83	1.67	5.78	4.11	3.72	.82	1.44	5.11	3.67	-1.37	54	.72	
17. MATSD	4.40	.54	2.78	5.56	2.78	4.05	.51	3.17	4.94	1.78	-2.26*	54	.66	
18. PSI-SF	2.94	.67	1.38	4.65	3.27	3.44	.81	1.88	4.77	2.89	2.43*	54	.91	

Note. MBQS = Maternal Behavior Q-sort; MATSD = Maternal Attitudes toward Sensitivity and Discipline Scale; MATS = Sensitivity Subscale; MATD = Discipline Subscale; EAS: Emotionality Subscale, PSI-SF: Parenting Stress Index; SCL = Symptom Check List; ⁺ $p < .10$; * $p < .05$; $N_{\text{int.}} = 38$, $N_{\text{cnt.}} = 18$; ¹ Maternal age is in years; ² Child age is in months

3.4. Correlational Analyses

Bivariate correlations among demographic variables and outcomes measures were computed. As shown in Table 5, child's age was significantly correlated with the pretest MBQS scores ($r = .37, p < .05$) and the pretest Ainsworth sensitivity scores ($r = .49, p < .01$) in the intervention group, but not in the control group ($r = -.15, r = -.08, ns$ respectively). As child's age increases, maternal sensitivity scores at pretest also increase in the intervention group. Child emotionality was significantly correlated with maternal psychological symptoms ($r = .34, p < .05$), the pretest MATS scores ($r = .33, p < .05$) and posttest parenting stress ($r = .35, p < .05$) in the intervention group, but not in the control group ($r = .04, ns; r = -.12, r = .18, ns$ respectively). Besides, maternal psychological symptoms were significantly correlated with parenting stress at pretest ($r = .38, p < .05$) and posttest ($r = .54, p < .01$) in the intervention group, but not in the control group ($r = .18; r = .36, ns$ respectively). Finally, maternal education was significantly correlated with the posttest MATD scores ($r = .70, p < .01$) and the posttest MATSD scores ($r = .60, p < .05$) in the control group, but not in the intervention group ($r = .13; r = .00, ns$ respectively).

Table 5 also demonstrates bivariate correlations among study variables. In the intervention group, the pretest MBQS scores were significantly correlated with the posttest MBQS scores ($r = .42, p < .01$), and the pretest ($r = .50, p < .01$) and the posttest ($r = .34, p < .05$) Ainsworth sensitivity scores. However, in the control group, pretest the MBQS scores were significantly correlated with only the pretest Ainsworth sensitivity scores ($r = .60, p < .01$). The pretest Ainsworth sensitivity scores were also significantly correlated with the pretest MATD scores ($r = .33, p < .05$), the pretest MATSD scores ($r = .35, p < .05$), the posttest the MBQScores ($r = .47, p < .01$) and the posttest Ainsworth sensitivity scores ($r = .66, p < .001$) in the intervention group. However, they were significantly correlated only with the pretest MATS scores ($r = .51, p < .05$), the pretest ($r = .50, p < .05$) and the posttest MATSD scores ($r = .50, p < .05$) and the posttest Ainsworth sensitivity scores ($r = .54, p < .05$) in the control group.

In addition, the pretest MATS scores were significantly correlated with the pretest MATSD scores in both groups ($r_{int.} = .40, p < .05$; $r_{cnt.} = .60, p < .01$); however they were correlated with the posttest MATS scores ($r = .62, p < .01$) and the posttest MATSD scores ($r = .51, p < .05$) only in the control group. Similarly, the pretest MATD scores were significantly correlated with the pretest MATSD scores in both groups ($r_{int.} = .76, p < .001$; $r_{cnt.} = .62, p < .01$); however it was correlated with the posttest MATD scores ($r = .57, p < .001$) and the posttest MATSD scores ($r = .51, p < .01$) only in the intervention group. The pretest MATSD scores were significantly correlated with the posttest MATD scores ($r_{int} = .42, p < .01$; $r_{cnt.} = .47, p < .05$) and the posttest MATSD scores ($r_{int} = .50, p < .01$; $r_{cnt.} = .69, p < .01$) in both groups. However, they were correlated with the pretest Ainsworth sensitivity scores ($r = .50, p < .05$), the pretest ($r = .60, p < .01$) and the posttest MATS scores ($r = .49, p < .05$), the pretest MATD scores ($r = .62, p < .01$) in the control group. Pretest and posttest parenting stress scores were significantly correlated in two groups ($r_{int} = .60, p < .001$; $r_{con} = .76, p < .001$).

The posttest MBQS scores were significantly correlated with the posttest Ainsworth sensitivity scores ($r = .56, p < .001$) in the intervention group, and the posttest MATS scores ($r = .49, p < .05$) in the control group. The posttest Ainsworth sensitivity were significantly correlated with the posttest MATSD scores ($r = .34, p < .05$) in the intervention group. The posttest MATS scores were significantly correlated with the posttest MATSD scores ($r_{int} = .64, p < .001$; $r_{cnt.} = .60, p < .01$) in both groups. Similarly, the posttest MATD scores were significantly correlated with the posttest MATSD scores ($r_{int} = .79, p < .001$; $r_{cnt.} = .77, p < .001$) in both groups.

Table 5

Bivariate Correlations among Demographic Variables and Outcome Measures in Intervention and Control Groups

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. Child Gender	-	.08	-.48	-.22	-.42	.13	-.09	-.11	-	-.17	-.14	-.24	-.11	-.01	-.44	.15	-.16	-.31
2. Mother Education	-.12	-	.26	-.52*	.06	-.23	.05	.14	.32	.15	.39	-.13	.33	.10	.06	.70**	.60*	-.16
3. Mother Age	-.11	.09	-	.22	-.11	-.49	-.16	.07	.36	.12	.35	.25	.50*	.19	.34	-.07	.12	.38
4. Child Age	.04	-.14	-.10	-	-.32	-.19	-.15	-.08	-	.33	.05	.05	-.28	.04	.05	-.19	-.12	.00
5. EAS	-.11	.00	-.05	.08	-	.04	.04	-.05	-	-.24	-.29	.27	-.01	-.08	.16	-.35	-.18	.18
6. SCL	.19	.16	.01	.11	.34*	-	.17	-.22	-	-.25	-.23	.18	-.41	-.44	-.11	-.02	-.08	.36
<i>Pretest Measures</i>																		
7. MBQS Sensitivity	.04	.04	.16	.37*	.25	.30	-	.60**	.11	.05	.13	.05	-.09	.11	-.10	.15	.06	-.03
8. Ains. Sensitivity	-.07	.08	.27	.49**	.14	.22	.50**	-	.51*	.11	.50*	.19	.28	.54*	.45	.26	.50*	-.19

Table 5 (Continued)

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
9. MATS	- .08	-.20	.16	.05	.33*	.08	.17	.05	-	-.26	.60**	.45	.32	.23	.62* *	.14	.51*	.27
10. MATD	- .01	.21	-.14	.06	-.10	.09	-.02	.33*	.29	-	.62* *	-.37	-.24	.18	-.01	.43	.34	- .47*
11. MATSD	- .06	.05	-.02	.10	.12	.15	.10	.35*	.40*	.76***	-	.06	.06	.34	.49*	.47*	.69**	-.17
12. PSI-SF	.12	.25	.08	-.31	.09	.38*	-.01	-.11	.10	.02	.09	-	.36	.36	.47*	-.42	-.03	.76***
<i>Posttest Measures</i>																		
13. MBQS Sensitivity	- .02	.06	-.06	.22	-.06	.02	.42* *	.47* *	.21	.16	.29	-.11	-	.30	.49*	-.02	.29	.18
14. Ains. Sensitivity	.05	.15	.14	.18	.06	.23	.34*	.66**	-.00	.31	.30	.10	.56**	-	.07	.06	.09	.07
15. MATS	.25	-.16	-.31	.01	-.10	.12	-.14	.13	.25	.11	.28	.05	.28	.32	-	-.04	.60**	.16

16

Table 5 (Continued)

Variables	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
16. MATD	-	.13	-.05	-.10	.12	.11	.05	.18	-.19	.57 ***	.42*	-.13	.11	.19	.04	-	.77 **	-.44
	.03																*	
17. MATSD	.13	.00	-.22	-.69	.04	.16	-.05	.22	.01	.51 **	.50 **	-.07	.26	.34*	.64 ***	.79 ***	-	-.25
18. PSI-SF	.36 *	.23	.06	-.06	.35*	.54 ***	.15	.06	.26	-.17	.02	.60 ***	-.12	.11	-.03	-	-	-
																.34*	.27	

29

Note. Correlations within the intervention group are displayed below the diagonal and correlations within the control group are displayed above the diagonal. MBQS = Maternal Behavior Q-sort; MATSD = Maternal Attitudes toward Sensitivity and Discipline Scale; MATS = Sensitivity Subscale; MATD = Discipline Subscale; SCL = Symptom Check List; EAS: Emotionality Subscale; PSI-SF: Parenting Stress Index; * $p < .05$; ** $p < .01$; *** $p < .001$; $N_{int.} = 38$, $N_{cnt.} = 18$.

3.5. Hypothesis Testing: Intervention Effects on Maternal Sensitivity

The major purpose of the study was to test the effectiveness of the intervention program on maternal sensitivity. Accordingly, it was expected that the intervention would promote mothers' sensitive behaviors. That is, (1) posttest sensitivity scores would be higher than pretest sensitivity scores for intervention mothers, (2) pretest and posttest sensitivity scores would not be different for control mothers. To assess intervention effects on the observed (the MBQS and the Ainsworth sensitivity scale) and self-reported measures (the MATSD) of maternal sensitivity, separate GLM Repeated Measures analyses were performed. For all these analyses, a 2 X 2 Mixed Factorial ANOVA was conducted with 'experimental group' (intervention vs control) as between-subjects factor, and 'time' (pretest vs posttest) as within-subjects factor. Some of the analyses were conducted with child's gender as covariate because of gender differences between intervention and control group on certain variables. Table 6 shows intervention effects for all outcome measures.

First, the effect of the intervention was examined on the MBQS sensitivity scores. The main effect for time [$F(1,54) = 0, p = .99, \text{partial } \eta^2 = .00$], group [$F(1,54) = .32, p = .57, \text{partial } \eta^2 = .00$] and time X group interaction [$F(1,54) = 1.10, p = .30, \text{partial } \eta^2 = .02$] were not statistically significant. Further analyses were conducted with child's gender, maternal education and location as covariates, the results again showed nonsignificant interactions between time and group on the MBQS scores. Even when only mothers of primary, secondary and high school graduates were selected, time X group interaction was found to be nonsignificant. Besides, paired samples t-test analysis was conducted to compare pretest and posttest sensitivity scores in the intervention and control groups separately. Even though it was nonsignificant, the paired-samples t-test showed an increase in maternal sensitivity from pretest to posttest in the intervention group [paired $t(37) = -1, p = .31$], but not in the control group [paired $t(17) = .54, p = .60$]. That is, mothers in the intervention group had higher sensitivity scores in the posttest assessment ($M = .68, SD = .17$) compared to the pretest assessment ($M = .65, SD = .16$). Whereas, mothers in the control group had lower sensitivity scores in the posttest assessment ($M = .63, SD = .16$) compared to the pretest assessment ($M = .66, SD = .16$).

Second, the effect of the intervention was examined on the Ainsworth sensitivity scores. The main effect for time [$F(1,54) = 9, p < .01, \text{partial } \eta^2 = .14$] and interaction effect for time X group [$F(1,54) = 5.20, p < .05, \text{partial } \eta^2 = .09$] were statistically significant. However, the main effect for group [$F(1,54) = .3, p = .59, \text{partial } \eta^2 = .00$] was not significant. Even when gender was controlled, time X group interaction effect remained significant, $F(1,53) = 6, p < .05, \text{partial } \eta^2 = .10$]. As shown in Figure 2, the posttest sensitivity scores ($M = 6.76, SD = 1.15$) of intervention mothers were higher than pretest sensitivity scores ($M = 6.00, SD = 1.40$). However, the posttest sensitivity scores ($M = 6.59, SD = .65$) of control mothers were not that much higher than pretest sensitivity scores ($M = 6.49, SD = .94$). The results showed that mothers in intervention group showed significant increase in sensitive behaviors, whereas mothers in control group did not show such increase. Thus, the intervention was effective in increasing maternal sensitive behaviors measured via the Ainsworth sensitivity scale.

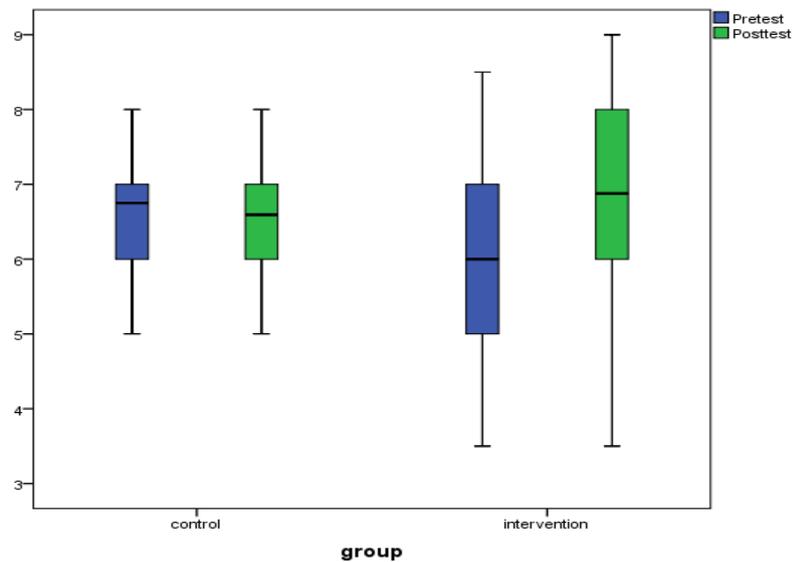


Figure 2
Intervention Effect on Maternal Sensitivity Measured via the Ainsworth Sensitivity Scale

Third, the effect of the intervention was examined on Maternal Attitudes toward Sensitivity (MATS) scores. The main effect for time was significant, [$F(1,54) = 4.86, p < .05, \text{partial } \eta^2 = .08$], however, the main effect for group was not significant [$F(1,54) = 0.83, p = .37, \text{partial } \eta^2 = .02$]. In addition, time X group interaction effect was significant, $F(1,54) = 4.23, p < .05, \text{partial } \eta^2 = .07$. Even when gender was controlled, time X group interaction effect was still significant, $F(1,53) = 4.53, p < .05, \text{partial } \eta^2 = .08$. As shown in Figure 3, the posttest sensitivity scores ($M = 4.75, SD = .67$) of intervention mothers were higher than pretest sensitivity scores ($M = 4.29, SD = .66$). However, the pretest ($M = 4.37, SD = .76$) and posttest ($M = 4.38, SD = .65$) sensitivity scores of control mothers did not differ. The results showed that mothers in intervention group showed significant increase in their attitudes toward sensitive behaviors, whereas mothers in control group did not show such increase.

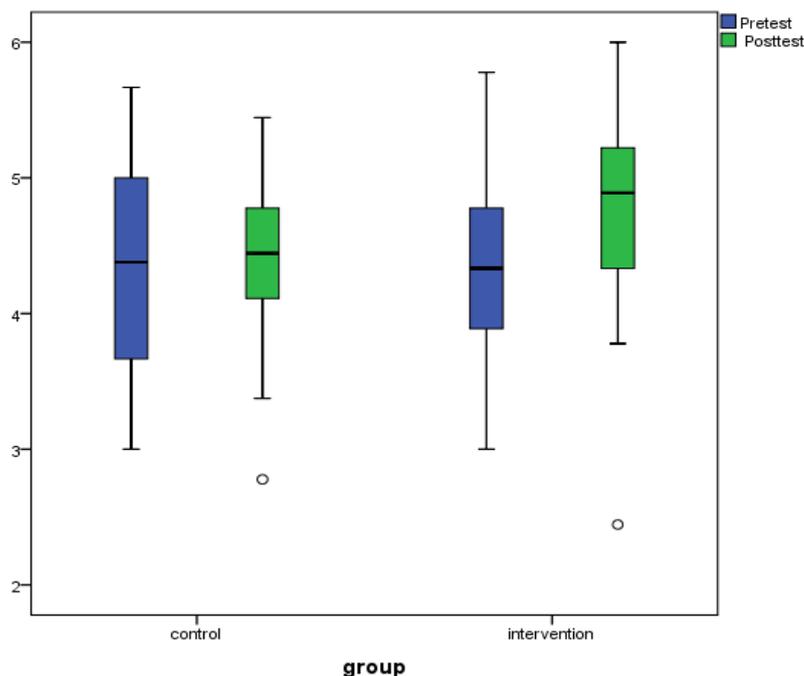


Figure 3

Intervention Effect on Maternal Sensitivity Measured via the MATS Scale

Fourth, the effect of the intervention was examined on Maternal Attitudes toward Sensitive Discipline (MATD) scores. The main effect for time [$F(1,54) = 3.09, p = .08, \text{partial } \eta^2 = .05$], group [$F(1,54) = 3.03, p = .09, \text{partial } \eta^2 = .05$] and interaction effect for time X group [$F(1,54) = .20, p = .65, \text{partial } \eta^2 = .00$] were not statistically significant. Finally, the effect of the intervention was examined on Maternal Attitudes toward Sensitivity and Sensitive Discipline (MATSD) scores. The main effect for time [$F(1,54) = 10.32, p < .01, \text{partial } \eta^2 = .16$] and group [$F(1,54) = 4.14, p < .05, \text{partial } \eta^2 = .07$] were significant, but time X group interaction effect [$F(1,54) = 1.42, p = .24, \text{partial } \eta^2 = .03$] was not statistically significant. However, further analysis showed significant increase in maternal sensitivity and sensitive discipline from pretest to posttest in the intervention group [paired $t(37) = -3.60, p = .001$], but not in the control group [paired $t(17) = -1.50, p = .14$]. That is, mothers in the intervention group had significantly higher sensitivity and sensitive discipline scores in the posttest assessment ($M = 4.40, SD = .54$) compared to the pretest assessment ($M = 4.09, SD = .50$). However, pretest ($M = 3.91, SD = .47$) and posttest ($M = 4.05, SD = .51$) sensitivity and sensitive discipline scores of mothers in the control group did not differ.

Table 6

Intervention Effects for Outcome Measures

Measure	Pretest		Posttest		Intervention Effects	
	Intervention M (SD)	Control M (SD)	Intervention M (SD)	Control M (SD)	time * group	Effect size η^2
MBQS Sensitivity	.65 (.16)	.66 (.16)	.68 (.17)	.63 (.16)	$F(1, 54) = 1.10$.02
Responsiveness	7.10 (.51)	7.08 (.54)	6.91 (.64)	6.96 (.64)	$F(1, 54) = .08$.00
Restrictiveness	3.95 (1.44)	3.19 (.97)	3.29 (.92)	3.32 (1.00)	$F(1, 54) = 3.73^+$.07
Ainsworth Sensitivity	6 (1.40)	6.49 (.94)	6.76 (1.15)	6.59 (.65)	$F(1,54) = 5.20^*$.09
MATS	4.29 (.66)	4.37 (.76)	4.75 (.67)	4.38 (.65)	$F(1, 54) = 4.23^*$.07
MATD	3.88 (.97)	3.45 (.77)	4.04 (.83)	3.72 (.82)	$F(1, 54) = .20$.00
MATSD	4.09 (.50)	3.91 (.47)	4.40 (.54)	4.05 (.51)	$F(1, 54) = 1.42$.03
PSI-SF	2.93 (.60)	3.34 (.82)	2.94 (.67)	3.44 (.81)	$F(1, 54) = .29$.01

Note. MBQS = Maternal Behavior Q-sort; MATSD = Maternal Attitudes toward Sensitivity and Discipline Scale; MATS = Sensitivity Subscale; MATD = Discipline Subscale; PSI-SF: Parenting Stress Index; ⁺ $p < .10$; * $p < .05$; $N_{\text{int.}} = 38$, $N_{\text{cnt.}} = 18$.

3.6. Supplementary Analyses

The effectiveness of the intervention on sub-domains of the MBQS were also examined to better understand a potential effect on specific dimensions which may have some cultural implication. For this purpose, two factors that were obtained via factor analysis by Sümer et al. (2008) were formed using various MBQS items. The first factor ‘responsiveness’ was formed by averaging scores of 15 items that assess mother’s accurate interpretation and prompt response to child’s needs (i.e. “*Notices when baby is distressed*”). The second factor ‘restrictiveness’ was formed by averaging scores of 10 items that assess mother’s restrictive behaviours (i.e. “*Provides baby with little opportunity to contribute to the interaction*”). A 2 X 2 Mixed Factorial ANOVA was conducted with ‘experimental group’ (intervention vs control) as between-subjects factor, and ‘time’ (pretest vs posttest) as within-subjects factor.

As shown in Table 6, the main effect for time [$F(1,54) = 1.91, p = .17$, partial $\eta^2 = .03$], group [$F(1,54) = .01, p = .92$, partial $\eta^2 = .00$] and time X group interaction [$F(1,54) = .08, p = .77$, partial $\eta^2 = .00$] were not statistically significant on responsiveness factor. Further analysis with child’s gender as covariate again revealed nonsignificant interaction between time and group on maternal responsiveness. Considering restrictiveness factor, the main effect for time [$F(1,54) = 1.67, p = .20$, partial $\eta^2 = .03$] and group [$F(1,54) = 2.10, p = .15$, partial $\eta^2 = .04$] were not statistically significant. However, time X group interaction was marginally significant, [$F(1,54) = 3.73, p = .06$, partial $\eta^2 = .07$]. Even when gender was controlled, time X group interaction effect was significant, $F(1,53) = 5.19, p < .05$, partial $\eta^2 = .09$.

That is, the posttest restrictiveness scores ($M = 3.29, SD = .92$) of intervention mothers were lower than the pretest restrictiveness scores ($M = 3.95, SD = 1.44$). However, the posttest restrictiveness scores ($M = 3.32, SD = 1.00$) of control mothers were not significantly different than the pretest restrictiveness scores ($M = 3.19, SD = .97$). The results showed that mothers in intervention group showed a significant decrease in restrictive behaviors, whereas mothers in control group showed no

difference. Thus, the intervention was effective in decreasing maternal restrictive behaviors measured via the MBQS.

In addition to the main hypothesis, the study examined the differential effectiveness of the intervention. First supplementary analysis was conducted to test the moderating effect of child emotionality on intervention effectiveness for maternal sensitivity. In particular, it was examined whether there is any difference in sensitive behaviors for mothers of children with high versus low emotionality. For this purpose, two groups of children were formed based on their emotionality scores in the EAS Temperament Survey. The higher emotionality group ($N = 28$) consisted of children scoring above the median whereas the lower emotionality group ($N = 28$) consisted of children scoring below the median. A 2 X 2 X 2 Mixed Factorial ANOVA was performed with experimental condition (intervention vs control) and child emotionality (higher vs lower) as between-subjects factors, and time (pretest vs posttest) as within-subjects factor.

Considering main effects, time was significant on the Ainsworth sensitivity scores [$F(1,52) = 8.29, p < .01, \text{partial } \eta^2 = .14$] and the MATSD scores [$F(1,52) = 9.21, p < .01, \text{partial } \eta^2 = .15$]. Considering two-way interaction effects, time X group interaction effect was significant on the Ainsworth sensitivity scores [$F(1,52) = 4.90, p < .05, \text{partial } \eta^2 = .09$] and the MATS scores [$F(1,52) = 4.95, p < .05, \text{partial } \eta^2 = .09$]. Considering three-way interaction effect, time X group X emotionality interaction was not significant on any of the measures of maternal sensitivity. These results indicated that child's emotionality did not moderate the effect of the intervention on maternal sensitivity. Besides, when child emotionality was taken as covariate, the time X group interaction was significant only on the Ainsworth sensitivity scores, [$F(1,53) = 4.09, p < .05, \text{partial } \eta^2 = .07$].

Second supplementary analysis was conducted to test the moderating effect of maternal psychological symptoms on intervention effectiveness for sensitivity. In particular, it was examined whether there is any difference in sensitive behaviors for mothers showing high, moderate or low levels of psychological symptoms. For this purpose, mothers were divided into three groups based on their SCL scores. First group ('high level of symptoms') consisted of mothers scoring one SD above the mean ($N = 8$). The second group ('low level of symptoms') consisted of mothers

scoring one SD below the mean ($N = 10$). Third group ('moderate level of symptoms') consisted of mothers scoring in between ($N = 38$). A 2 X 3 X 2 Mixed Factorial ANOVA was performed with experimental condition (intervention vs control) and mothers' level of symptoms (high, moderate, low) as between-subjects factors, and time (pretest vs posttest) as within-subjects factor. Considering main effects, time was significant on the MATS scores [$F(1,50) = 5.30, p < .05$, partial $\eta^2 = .10$] and the MATSD scores [$F(1,50) = 10.4, p < .01$, partial $\eta^2 = .17$]. Considering two-way interaction effects, time X group interaction effect was significant on the Ainsworth sensitivity scores [$F(1,50) = 9, p < .01$, partial $\eta^2 = .15$]. However, none of the three-way interactions was significant on any measure of maternal sensitivity. These results indicated that mother's level of psychological symptoms did not moderate the effect of the intervention on sensitive behaviors. Besides, when mothers' psychological symptoms was taken as covariate, the time X group interaction was significant only on the Ainsworth sensitivity scores, [$F(1,53) = 4.72, p < .05$, partial $\eta^2 = .08$] and the MATS scores, $F(1,53) = 4.00, p = .05$, partial $\eta^2 = .07$.

Third supplementary analysis was conducted to test the effectiveness of intervention on parenting stress. A 2 X 2 Mixed Factorial ANOVA was conducted with 'experimental group' (intervention vs control) as between-subjects factor, and 'time' (pretest vs posttest) as within-subjects factor. The main effect for group was significant, $F(1,54) = 6.19, p < .05$, partial $\eta^2 = .10$. That is, parenting stress in the intervention group ($M = 2.94$) was significantly lower than parenting stress in the control group ($M = 3.39$). However, the main effect for time [$F(1,54) = .50, p = .48$, partial $\eta^2 = .01$] and interaction effect for time X group [$F(1,54) = .29, p = .59$, partial $\eta^2 = .01$] were not statistically significant. These results indicated that the intervention was not effective on parenting stress.

Finally, gender difference was examined on outcome measures across two groups. In the intervention group, gender difference was significant only on posttest parenting stress, $t(36) = -2.32, p < .05$. That is, intervention mothers having son had higher stress scores ($M = 3.26$) at posttest as compared to intervention mothers having daughter ($M = 2.76$). In the control group, however, gender difference was marginally significant on the posttest MATS scores, $t(16) = 1.96, p < .10$ and child

emotionality scores, $t(16) = 1.87, p < .10$. That is, control mothers having daughter had higher self-reported sensitivity scores ($M = 4.78$) at posttest as compared to control mothers having son ($M = 4.19$). In addition, girls ($M = 2.76$) had higher level of emotionality than boys ($M = 2.32$) in the control group.

3.7. Summary of Findings

To test whether intervention resulted in changes in the observed and self-reported maternal sensitivity, repeated measures ANOVAs were conducted. As a result of these analyses, maternal sensitivity observed via the Ainsworth sensitivity scale improved in the intervention group in comparison to control group. The same trend was also observed in the MBQS scores. That is, maternal sensitivity observed via the MBQS improved from pretest to posttest assessments in the intervention group but not in the control group. With respect to dimensions of maternal behaviors, restrictiveness observed via the MBQS decreased in the intervention group in comparison to control group. However, responsiveness observed via the MBQS did not increase as a result of intervention. Considering self-reported measures, mothers in the intervention group showed more positive attitudes toward sensitivity than mothers in comparison to control group. However, they didn't show more positive attitude toward sensitive discipline and less stress in comparison to control group. Finally, child emotionality and mother psychological symptoms did not moderate the effect of intervention on maternal sensitivity and sensitive discipline.

CHAPTER 4

DISCUSSION

4.1. Overview

The quality of the relationship between infant and caregiver in the early years of life is considered to be the most critical element for optimal child development. According to attachment theory, infants are biologically predisposed to use the caregiver as ‘a safe haven’ for receiving protection and comfort in times of threat and as ‘a secure base’ from which to explore the environment (Ainsworth et al., 1978; Bowlby, 1969/1982). More specifically, caregiver sensitivity, which refers to interpreting a child’s signals accurately and responding to them appropriately and promptly (Ainsworth et al., 1978), is an important determinant of child attachment security (De Wolff & Van IJzendoorn, 1997). Given this substantial body of evidence, researchers and practitioners have shown great interest in the development, implementation and evaluation of early support and intervention programs to improve maternal sensitivity and promote child attachment security (Juffer et al., 2008d; Sandler et al., 2011; Watson et al., 2005).

Accordingly, the current study aimed to adapt, apply, and test the effectiveness of a short-term attachment-based intervention program with the goal of enhancing maternal sensitivity in the Turkish context. Specifically, it explored the effectiveness of the VIPP-SD program on observed and self-reported maternal sensitivity among Turkish mothers, using a completely randomized design. It also examined differential effectiveness of the intervention on maternal sensitivity. In this section, the findings related to the original hypotheses and supplementary analyses are discussed with respect to the extant literature and cultural context. Furthermore, the strengths, limitations and implications of the study are discussed in order to

provide important direction for researchers and practitioners who plan to develop, implement and evaluate early intervention programs to promote positive parenting.

4.2. Findings From the Study Hypothesis

Overall, the findings supported the main hypotheses of the study. First, it was expected that the intervention would promote mothers' observed sensitive behaviors. Even though the interaction effect on the MBQS sensitivity scores was not statistically significant, further separate analyses for two groups indicated a trend for improvement in sensitive behaviors from pretest to posttest in the intervention group. That is, observed posttest sensitivity scores measured via the MBQS in the intervention group was higher than observed pretest sensitivity scores. However, in the control group, posttest sensitivity scores were lower than pretest sensitivity scores. The lack of significant interaction on the MBQS scores might be due to relatively higher maternal sensitivity scores at pretest ($M_{int.} = .65$, $M_{cnt.} = .66$) in this community sample. The higher scores might lead to ceiling effect, decrease variance and hinder the effectiveness of the intervention. The future studies on high-risk samples such as families with lower education or from the disadvantaged communities or families with children having externalizing problem behaviors may provide better explanation for the interaction effects on the MBQS scores.

In a related vein, the results showed that observed posttest sensitivity scores measured via the Ainsworth sensitivity scale in the intervention group was higher than observed pretest sensitivity scores; however, there wasn't that much of increase in observed sensitivity from pretest to posttest in the control group. It indicates that the intervention was effective in promoting maternal sensitivity. These findings are in line with a great body of research that reveal the effectiveness of the VIPP program on maternal sensitivity assessed via the Ainsworth sensitivity scale (i.e. Bakermans-Kranenburg et al., 1998; Juffer et al., 1997; 2005; Kalinauskiene et al., 2009; Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2006) or Emotional Availability scale (Yagmur et al., 2014).

Second, it was expected that the intervention would promote mothers' attitudes toward sensitivity and sensitive discipline. The results showed that

intervention mothers have more favorable attitudes toward sensitive behaviors at posttest assessment than pretest assessment. However, control mothers did not show any difference in their attitudes toward sensitive behaviors at pretest and posttest assessments. In a related vein, the results showed that intervention mothers, but not control mothers, have more favorable attitudes toward sensitive behaviors and discipline at posttest assessment than pretest assessment. It indicates that the intervention was effective in promoting sensitivity not only in terms of maternal behaviors, but also in terms of maternal attitudes. This finding diverges from Van Zeijl et al. (2006)'s study which revealed more positive maternal attitudes toward sensitive behaviors and discipline, but not an improvement in sensitive behaviors in the intervention group. The discrepancy between improvement in maternal attitudes and behaviors in the previous study might stem from the specific needs of that sample which consists of children with high externalizing problems. As the authors suggested, these parents might focus more on use of discipline strategies in conflict situations than use of sensitive practices in nonconflict situations since they experience difficulty with their children's problem behaviors (Van Zeijl et al., 2006).

However, the results of this study also showed that the intervention was not effective in promoting mothers' attitudes toward sensitive discipline. That is, intervention and control group did not differ in terms of maternal attitudes toward sensitive discipline. This finding contradicts with Van Zeijl et al.'s (2006) study which revealed more favorable attitudes toward sensitive discipline and an increase in use of positive discipline strategies among intervention mothers with children having externalizing problems. This can be explained by that particular group in Van Zeijl et al.'s (2006) study since these mothers might be more motivated to reduce the problems they experience with their children. On the other hand, the findings of the present study are in line with Yağmur et al.'s (2014) study which revealed significant improvement in observed maternal sensitivity and nonintrusiveness; but not in observed discipline among second-generation Turkish immigrant mothers living in the Netherlands and their children having externalizing problems.

Several explanations can be put forward for the lack of significant improvement in sensitive, non-coercive discipline. As stated by the authors (Yağmur et al, 2014), the short-time period of six months between pretest and posttest

assessments, which was 12 months in Van Zeijl et al.'s study, might not be sufficient for mothers to practice their sensitivity skills in more stressful discipline context. In the current study, the time between pretest and posttest was even shorter, on average two months, than the previous studies. In addition, four thematic sessions without two booster sessions might not be sufficient for mothers to change their attitudes toward sensitive discipline. Future studies which provide mothers sufficient time to practice their newly learned sensitivity skills into discipline contexts and assess its effectiveness at follow up, and studies that use observational measure of discipline in addition to self-report measure may provide better explanation for the effectiveness of the program on mothers' attitudes and use of positive, non-coercive discipline strategies.

Besides, the authors argued that the lack of significant improvement in sensitive, non-coercive discipline could stem from cultural differences in attitudes toward discipline strategies (Yağmur et al., 2014). In particular, they proposed that it might take more time to change discipline strategies in collectivistic cultures, where authoritarian parenting (i.e. obedience) was more valued. Thus, the intervention aiming at enhancing autonomy-supporting discipline might not be effective in this cultural context. However, with the changes in traditional family system from being an agricultural, rural society into an urban, industrial one, modern, urban, middle-class Turkish families started to emphasize autonomy and relatedness in childrearing (Kağıtçıbaşı, 2005; 2007). Accordingly, to ensure child's emotional closeness in the family, parental control became functional and adaptive. Thus, it can be argued that autonomy-supportive discipline strategies fit the modern Turkish family system (Yağmur et al., 2014). However, child's compliance to societal norms and respect to others are still emphasized by low-class parents living in rural areas (Kağıtçıbaşı, 1984; Nacak et al., 2011; Sunar, 2002). Thus, the VIPP-SD might not be effective in promoting mothers' attitudes toward sensitive discipline in the current sample which includes families with low socioeconomic background. Future intervention research that assess parental beliefs and values on childrearing may uncover the mechanisms underlying the effectiveness of the program on maternal discipline.

The results of this randomized control trial, overall, provide support for the effectiveness of the VIPP-SD in increasing sensitivity among mothers. This

significant improvement on maternal sensitivity was expected given the fact that the proximal goal of this program is to promote sensitive parenting. First of all, the sensitivity themes address two components of Ainsworth et al.'s (1978) concept of sensitivity: (1) accurately perceiving and interpreting child signals (sensitivity), (2) adequately and promptly responding to them (responsiveness). For instance, “*speaking for the child*” method shows to mother the perspective of the child and thus, promotes her accurate perception of the child's (subtle) signals, and “*sensitivity-chain: child signal → parental sensitive response → positive reaction of the child*” promotes mother's adequate and prompt responding to these signals (Juffer et al., 2008a; 2008b). Second, the medium of video and the use of video-feedback provide an opportunity for the mother to develop better observational skills and empathy for her child by watching his/her signals and expressions as well as to reinforce and encourage responsive behaviors by showing her positive interactions. In this way, she becomes her own role model (Juffer et al., 2008a; 2008b). Hence, it is not surprising that the video-feedback method to promote maternal sensitivity was successful in the current study.

More importantly, similar to Yağmur et al. (2014)'s study, the results of the current study hold promise for the applicability and effectiveness of the video-feedback approach in a non-Western collectivistic culture. In this sense, it extends previous research in Western individualistic cultures. The validity of the program across cultures can be mainly explained by the characteristics of the VIPP program which fit the collectivistic cultural context. As stated previously, Rothbaum and his colleagues (2000; 2002; 2006) propose that there are cultural variations in specific attachment behaviors and caregiver sensitivity. In particular, mothers in collectivistic cultures prefer to rely on (*subtle*) *situational nonverbal cues* that reflect child's needs and demands rather than anticipating direct signals from the child before responding. Because these behaviors are more adaptive in that particular cultural context.

Accordingly, the VIPP attempt was successful at promoting mothers' observation and perception of *situational nonverbal cues* reflecting child's needs and demands in the Turkish cultural context. For instance, some intervention mothers stated that they didn't realize their pace was faster than their child's pace, and he/she needed more time to explore the new toy until they saw him/her in the video looking

at the toy enthusiastically. As indicated in this statement, the use of video-recordings and giving personal feedback on child's nonverbal cues contribute to the mothers' accurate perception of child's exploration need, which is of crucial importance for optimal child development. In a related vein, the VIPP attempt was successful at promoting mothers' appropriate and prompt responding to the child's *situational nonverbal cues*. For instance, some intervention mothers stated that they didn't realize their child was happier in the play when they followed his/her lead rather than their own until they saw his/her smile in the video. These statements, overall, exemplify the effectiveness of the video-feedback approach in promoting mothers' accurate perception and appropriate responding to their child's (subtle) *situational nonverbal cues*, which is preferred in this collectivistic cultural context. Accordingly, researchers and practitioners may give more emphasis on child's nonverbal (rather than verbal) cues in future intervention attempts.

In particular, the results provided support for the beneficial effect of the program among Turkish mothers with relatively lower education and socioeconomic status. In past research, the VIPP program has been found to be effective among nonclinical, at-risk or clinical families such as adoptive mothers (i.e. Juffer et al., 1997; 2005b), insecure mothers (i.e. Bakermans-Kranenburg et al., 1998; Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2006; Klein Velderman, Bakermans-Kranenburg, Juffer, Van IJzendoorn, Mangelsdorf et al., 2006), insensitive mothers (i.e. Kalinauskiene et al., 2009), mothers with eating disorders (i.e. Stein et al., 2006), mothers with learning difficulties (i.e. Hodes et al., 2014), mothers with temperamentally (i.e. Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2006) and genetically vulnerable children (i.e. Bakermans-Kranenburg, Van IJzendoorn, Mesman et al., 2008; Bakermans-Kranenburg, Van IJzendoorn, Piljman et al., 2008), mothers with children having externalizing behavior problems (i.e. Van Zeijl et al., 2006; Yağmur et al., 2014), chronic illness (i.e. Cassibba et al., 2008) and autism (i.e. Poslawsky et al., 2014), as well as among professional caregivers (i.e. Elicker et al., 2008; Groeneveld et al., 2011). A few studies have also demonstrated that the program was effective among families experiencing higher levels of daily hassles, marital discord and/or dissatisfaction with social support (i.e. Stolk et al., 2008; Van Zeijl et al., 2006) and

families living in poverty (i.e. Negrao et al., 2014). The current study with a sample from relatively lower socioeconomic status adds to this body of literature by showing that the VIPP program contributes to strengthening the families' resilience to the impact of adverse socioeconomic circumstances. In this sense, the study serves as a resource for researchers and practitioners who plan to develop and implement early support or intervention programs among families in need of support.

At this point, it is important to note the powerful aspects of the VIPP-SD program that contribute the most to its efficacy (Bakermans-Kranenburg, Van IJzendoorn, Mesman et al., 2008; Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2006). First, this program is a behaviorally-focused intervention program which makes its purpose (promoting sensitive behaviors) well-defined. Second, its brief duration, with four to six 1,5 hour sessions, limits the intervention burden and prevents high attrition. Systematic reviews and meta-analyses have also provided more evidence for the effectiveness of short-term interventions ('less is more') with a clear-behavioral focus compared to long-term interventions with a nonbehavioral focus (Bakermans-Kranenburg et al., 2003, 2005; Van IJzendoorn et al., 1995). Third, use of video-recordings helps mothers to observe the child's signals and the impact of their behaviors on the child. Thus, the mother becomes her own role model. Fourth, implementing the program after the second half of the child's first year rather than immediately after birth makes mothers more open to suggestions for change. Because mothers need great assistance when they realize that they can not solve caregiving problems alone (Klein Velderman, Bakermans-Kranenburg, Juffer, Van IJzendoorn, Mangelsdorf et al., 2006). Last, standard protocols, detailed manuals and relatively modest training enable new interveners to easily learn and implement this program. Furthermore, the modification of the program enables researchers and practitioners to successfully address the needs of special groups such as autistic children (i.e. VIPP-AUTI; Poslawsky et al., 2014), preterm children and children with chronic illness (Cassibba et al., 2008), mothers with learning difficulties (i.e. VIPP-LD; Hodes et al., 2014), and professional caregivers (i.e. VIPP-CC; Groeneveld et al., 2011). The individualized aspect of the video-feedback method acknowledges the characteristics of the target group. Given

these powerful characteristics of the VIPP program, it is not surprising that the program was effective in enhancing mothers' sensitive behaviors.

4.3. Findings From the Supplementary Analyses

The current study also examined the effectiveness of intervention on several sub-domains of maternal behaviours. Even though the interaction effect on the MBQS sensitivity scores was not statistically significant, the intervention was effective for decreasing mothers' restrictive behaviors assessed via the MBQS items such as interference with child's exploration, opposing child's wishes, use of verbal prohibitions, etc. Accordingly, some interventions mothers in the current study stated that they realized they were following their own agenda and interfering with their child's exploration. Persistent restrictiveness of children is not uncommon in Turkish culture. Consistent with previous study (Yağmur et al., 2014), this finding implies that mothers having the intervention becomes more sensitive to child's autonomy and less restrictive compared to the control group. Given that one of the goals of this program is to increase mother's awareness of and support for child exploration needs, it is expected that the intervention reduces mothers' restrictiveness. However, the intervention was not effective for enhancing mothers' responsive behaviors assessed via the MBQS items. As previously stated, the lack of significant interaction might be due to relatively higher responsiveness scores at pretest ($M_{int.} = 7.10$, $M_{cnt.} = 7.08$) in this community sample. The future studies on high-risk samples such as families with lower socioeconomic status or families with children having externalizing problem behaviors may provide better explanation for the interaction effects on maternal responsiveness.

In addition to the main hypothesis, the study examined the differential effectiveness of the intervention. First, it was examined whether child emotionality would moderate intervention effectiveness for maternal sensitivity. Based on Belsky's (1997) differential susceptibility hypothesis, it can be argued that highly emotional children would benefit more from the intervention. However, the findings did not provide support for this argument. The results showed that there is no difference in maternal sensitive behaviors for children with high or low levels of

emotionality. Converging with studies of Kalinauskiene et al. (2009) and Van Zeijl et al. (2006), and diverging with study of Klein Velderman, Bakermans-Kranenburg, Juffer and Van IJzendoorn (2006), children with high emotionality versus low emotionality did not differ in their gains from the intervention. The relatively small sample size and higher emotionality scores of control children ($M = 2.46$, $SD = .52$) as compared to intervention children ($M = 2.20$, $SD = .46$) might have contributed to this nonsignificant effect.

Second, it was examined whether maternal psychological symptoms would moderate intervention effectiveness for sensitivity. The past VIPP studies have shown the greater effects of intervention on child externalizing behaviors among mothers experiencing higher levels of daily hassles, marital discord and/or dissatisfaction with social support (i.e. Stolk et al., 2008; Van Zeijl et al., 2006). However, the findings of the current study did not provide support for stronger effect of the intervention among mothers in need of psychological support. The lack of significant interaction effect might be due to relatively small ratio of number of mothers with high levels of psychological symptoms. Besides, unlike previous VIPP interventions that target only mothers with eating disorders (Stein et al., 2006) or mothers with intellectual disabilities (Hodes et al., 2014), the present study did not target only mothers with high levels of psychological symptoms. Thus, additional research needs to be conducted to shed light on the effectiveness of the video-feedback intervention among mothers in need of psychological support.

Third, it was examined whether intervention would influence parenting stress. In contrast with past study (Hodes et al., 2014) showing decreased levels of parenting stress among intervention mothers at posttest and followup, the intervention was not effective in reducing mothers' stress level. Several explanations can be put forward for this finding. First, the intervention mainly focuses on promoting mothers' sensitive-behaviors and thus, it might require more time to decrease their stress levels. Second, the relatively higher stress scores of control mothers ($M = 3.34$) than intervention mothers ($M = 2.93$) at pretest might lead to a ceiling effect, which hinders effectiveness of the intervention. Future follow up studies may provide better understanding of the intervention effectiveness on parenting stress and other familial outcomes such as relationship satisfaction or family conflict.

4.4. Strengths and Limitations

One strength of this study was the use of a randomized control trial. The participants were randomly assigned into two groups and experimental manipulation was applied to the intervention group. Unlike correlational studies, it offers an opportunity to infer causal relationships. Another strength of this study was the use of multiple methods (standardized observational measures and self-reports) and independent raters. Maternal sensitivity was assessed via two observational (i.e. Ainsworth Sensitivity scale, MBQS) and one self-report measure (i.e. Maternal Attitudes toward Sensitivity and Sensitive Discipline Questionnaire) at pretest and posttest. To my knowledge, this is the first VIPP study that uses the MBQS for codings of video-recorded one-hour mother-child interactions. This measure contributes to strengthen the validity of the assessment by providing information on a broad range of maternal behaviors. In this sense, it is a strength of this study. Besides, observational data were coded by independent raters who are unaware of the condition of the participant (intervention or control) and the type of assessment (pretest or posttest). Thus, reliance on independent raters and multiple measures of maternal sensitivity minimize shared method and rater variance. Finally, in addition to intervention mothers, control mothers were provided with information on sensitive parenting, which minimizes ethical concerns of not giving support to these families.

Study also had limitations. First, the sample size was relatively small and the distribution of the participants across experimental and control conditions was not equal in number. It is due to several reasons: (1) Some participants were not eligible for the study because of exclusion criteria, (2) Some participants refused to participate because their husbands felt uncomfortable with video-recordings or they were too busy, and (3) Some participants dropped out from the study at the beginning stages after either the pretest or the first thematic session because of similar reasons. A larger sample might have resulted in larger power to detect moderate intervention effects on sensitive discipline and parental stress. In addition, a larger sample might have resulted in better understanding on whether some mothers (i.e. mothers with

high psychological symptoms) and children (i.e. children with high emotionality) would benefit more from the intervention than others.

Second, even though it was aimed to recruit the sample among mothers with low education and socioeconomic status, there were mothers of high school graduates (48.2 %) and mothers of two- and four- years of university graduates (8.9 % and 12.5 %, respectively) in the final sample. In addition, this study did not specifically target mothers with children having externalizing problems. As a result, the sample of the current study did not consist of highly disadvantaged families, which in turn might restrict the intervention effects on maternal sensitivity and sensitive discipline. Future studies on highly disadvantaged groups (i.e. families with lower education or from the disadvantaged communities or families with children having externalizing problem behaviors) may reveal greater intervention effects on mother and child outcomes. Third, there were seven interveners who implemented the program in the current study. The great number of interveners might have increased the within-group error variance, and potentially limited obtaining significant effects or decreased the effect size.

Fourth, unlike previous research (i.e. Bakermans-Kranenburg et al., 1998; Bakermans-Kranenburg, Van IJzendoorn, Piljman et al., 2008; Juffer et al., 1997; 2005; Kalinauskiene et al., 2009; Klein Velderman, Bakermans-Kranenburg, Juffer, & Van IJzendoorn, 2006; Klein Velderman, Bakermans-Kranenburg, Juffer, Van IJzendoorn, Mangelsdorf et al., 2006; Stolk et al., 2008b; Van Zeijl et al., 2006), this study did not examine the effectiveness of the VIPP-SD program on child outcomes. Even though the main focus of this program is to promote maternal sensitivity, it was developed to promote child attachment security (in particular, the VIPP) or to decrease child externalizing behaviors (in particular, the VIPP-SD) and prevent the development of antisocial behaviors in later years (Mesman et al., 2008). Thus, the findings of this study are limited in the way that it reveals change in maternal behaviors but not in child behaviors. However, an increase in maternal sensitivity may bring about accompanying increase in positive child outcomes. Therefore, a broad range of child behaviors in the areas of emotional and social development needs to be investigated as well. Last, the short-time period after the last thematic session in the current study might not be sufficient to bring about enduring effects of

the intervention. Further follow up studies need to be conducted to establish the long-standing effects of the intervention on mother and child outcomes.

4.5. Broader Implications and Future Directions

Important implications and several directions can be formulated for future research. The current study is the first VIPP study among families living in Turkey, which have mainly a collectivistic and relational culture (Kağıtçıbaşı, 2007). In the past, several intervention efforts have been spent among Turkish families living in Turkey (TEEP; Kağıtçıbaşı et al., 2001) and second-generation Turkish minority families living in the Netherlands (VIPP-TM; Yagmur et al., 2014). However, this study is the first attachment-based intervention study in Turkey. To my knowledge, it is also one of the few VIPP studies (i.e. Negrao et al., 2014) which selected its target sample from families with relatively lower socioeconomic background. In this way, it provides support for the applicability and effectiveness of the video-feedback intervention not only in a non-Western collectivistic cultural context but also in an economically disadvantaged context. Given that the vast majority of the VIPP interventions are implemented in Western individualistic samples with middle-to-high socioeconomic backgrounds, it seems promising to implement this program among families from diverse cultural and economical backgrounds. Dissemination of program across cultures will help systematically improve positive parenting among mothers and contribute to healthy emotional development of children.

At this point, it is important to note some characteristics of the Turkish culture (i.e. conservative, showing off, etc.) which interfere with the implementation of this program. First, some mothers refused to participate in the study because their husbands did not accept the video-recordings. This situation might have resulted in a restricted sample. In addition, some mothers felt uncomfortable with the video-recordings and thus, they either showed overinvolvement with the child or avoided from interaction due to being observed by a professional. These types of unnatural and sometimes artificial or superficial mother-child interactions might have influenced the comments given by the intervener and interfered with the objective of the program. Accordingly, researchers

and practitioners who plan to implement early intervention in the Turkish cultural context may try various strategies such as talking with the mother and comforting her or doing sample video-recordings beforehand in order to minimize the influence of recording on mother-child interactions.

In addition to providing cultural implications and directions for researchers, this study contributes to the related literature in terms of application of the program. That is, the majority of VIPP-SD interventions were conducted with two extra booster sessions in which all the sensitivity and discipline themes are reviewed. However, in the current study, the intervention was conducted with only four thematic sessions in order to limit the intervention burden and prevent dropout of the participants. As a result, like previous research, mothers showed improvement in their sensitive behaviors. It indicates that the program can still be effective when it is short-term ("less is more", Bakermans-Kranenburg et al., 2003).

In a related vein, fathers were not asked to participate in the current study since there was no booster session. As stated previously, paternal participation might either strengthen the intervention effects through supporting mothers to implement the newly acquired skills or weaken through being intrusive and preventing the mother from openly expressing their emotions (Bakermans-Kranenburg et al., 2003; Mesman et al., 2008). Researchers also demonstrated a low rate of paternal participation among low-SES families, indicating fathers' avoidance of childrearing responsibilities (Negrao et al., 2014). Future research may address this gap and try to overcome difficulties in participation of fathers among low-SES, high risk families.

Finally, in the current study, only one adaptation was integrated into the already existing program. This adaptation pertained to replacing the '*singing*' activity with '*playing together with a tea set*' activity. Since children either did not know or want to sing in the presence of a stranger, '*singing*' activity was replayed with another activity that brings out more enjoyment between mother and child and provides more opportunity for comment in the next video-feedback. However, unlike previous study among Turkish minorities (Yagmur et al., 2014), there was no need for further adaptation since mothers and children in the sample were familiar with hand puppets and reading books. Compared to developing a new program, adapting an already existing program has more benefits in terms of application and

accumulation of knowledge (Poortinga, 2013). In future studies, researchers and practitioners may take advantage of this approach.

In conclusion, the present study suggests that the VIPP program is an effective early intervention program for improving the quality of parent-child interactions. The findings of this study provide important insights and contribute to a better understanding and improvement of theoretical processes that are central in optimal child development. That is, maternal sensitivity which is of critical importance for child attachment security (De Wolff & Van IJzendoorn, 1997) can be improved through early support and intervention programs. Given that secure attachment predicts better emotion regulatory skills, close and satisfying relationships with parents and peers, positive self-concept and desirable personality qualities (see Thompson, 2008 for a review), it can be argued that improvement in maternal sensitivity induced by interventions would contribute to child's emotional and social development. Secure attachment and healthy emotional development are the most critical social capital for an optimal psychosocial development and the well-being of individual as well as for the society. Given this fact, it is imperative to adopt and apply an early intervention program to promote positive parenting especially among families with children at risk for developing insecure attachment, maladjustment and even psychopathology.

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APPENDICES

Appendix A Informed Consent Form for Intervention Group

Gönüllü Katılım Formu ve Anne Onay Mektubu

Sevgili Anneler,

Orta Doğu Teknik Üniversitesi Psikoloji Bölümü'nde olarak TÜBİTAK destekli "Çocuğum ve Ben" başlıklı araştırma projesini yürütmekteyiz. Araştırmamızın amacı, "12-30" aylık çocuğu olan annelerin anababalık davranışlarını artırarak, çocuklarının olumlu sosyal ve duygusal gelişimini desteklemektir.

Araştırmamıza katılmayı kabul ederseniz, birkaç ay boyunca toplamda sizi yedi kez ziyaret edeceğiz. Bu ziyaretlerde çocuğunuzla geçirdiğiniz kısa zamanı videoya kaydedeceğiz ve sonraki görüşmelerde bu görüntüleri sizlerle paylaşacağız. Bu paylaşımlardan sizlere anababalık davranışları hakkında ayrıntılı bilgi vereceğiz. Ayrıca sizden bazı anketleri doldurmanız isteyeceğiz.

Anketlere verdiğiniz cevaplar ve alınan video kayıtları tamamen gizli tutulacak ve sadece bilimsel araştırmalar amacıyla kullanılacaktır. Bu formu imzalarsanız bile siz de çocuğunuz da çalışmadan istediğiniz zaman ayrılma hakkına sahipsiniz. Araştırma sonuçlarının özeti tarafımızdan size ulaştırılacaktır.

Anketleri doldurarak bize sağlayacağınız bilgiler ve bu araştırmadan elde edilecek sonuçlar, ülkemizde çocukların sosyal ve duygusal gelişimini etkileyen faktörlerin saptanmasına önemli bir katkıda bulunacaktır. Araştırmayla ilgili sorularınızı aşağıdaki e-posta adresini veya telefon numarasını kullanarak bize yöneltebilirsiniz.

Saygılarımızla,



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Bu araştırmaya tamamen gönüllü olarak katılıyorum ve çocuğum'nın da katılımcı olmasına izin veriyorum. Çalışmayı istediğim zaman yarıda kesip bırakabileceğimi biliyorum ve verdiğim bilgilerin bilimsel amaçlı olarak kullanılmasını kabul ediyorum.

Anne Adı-Soyadı.....

İmza

Appendix B Informed Consent Form for Control Group

Gönüllü Katılım Formu ve Anne Onay Mektubu

Sevgili Anneler,

Orta Doğu Teknik Üniversitesi Psikoloji Bölümü'nde olarak TÜBİTAK destekli "*Çocuğum ve Ben*" başlıklı araştırma projesini yürütmekteyiz. Araştırmamızın amacı, "12-30" aylık çocuğu olan annelerin anababalık davranışlarını artırarak, çocuklarının olumlu sosyal ve duygusal gelişimini desteklemektir.

Araştırmamıza katılmayı kabul ederseniz, birkaç ay boyunca toplamda sizi üç kez ziyaret edeceğiz. Bu ziyaretlerde çocuğunuzla geçirdiğiniz zamanı videoya kaydedeceğiz. Ayrıca sizden bazı anketleri doldurmanızı isteyeceğiz. Bunun yanı sıra, belli aralıklarla yapılacak telefon görüşmelerinde size çocuğunuzun gelişimiyle ilgili bazı sorular soracağız. Araştırma sonunda ise size anababalık davranışları hakkında ayrıntılı bilgiler vereceğiz.

Anketlere verdiğiniz cevaplar ve alınan video kayıtları tamamen gizli tutulacak ve sadece bilimsel araştırmalar amacıyla kullanılacaktır. Bu formu imzalarsanız bile siz ve çocuğunuz istediğiniz zaman çalışmadan ayrılma hakkına sahipsiniz. Araştırma sonuçlarının özeti tarafımızdan size ulaştırılacaktır.

Anketleri doldurarak bize sağlayacağınız bilgiler ve bu araştırmadan elde edilecek sonuçlar, ülkemizde çocukların sosyal ve duygusal gelişimini etkileyen faktörlerin saptanmasına önemli bir katkıda bulunacaktır. Araştırmayla ilgili sorularınızı aşağıdaki e-posta adresini veya telefon numarasını kullanarak bize yöneltebilirsiniz.

Saygılarımızla,



Prof. Dr. Nebi Sümer

Proje Yürütücüsü

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Bu araştırmaya tamamen gönüllü olarak katılıyorum ve çocuğum'nın da katılımcı olmasına izin veriyorum. Çalışmayı istediğim zaman yarıda kesip bırakabileceğimi biliyorum ve verdiğim bilgilerin bilimsel amaçlı olarak kullanılmasını kabul ediyorum.

Anne Adı-Soyadı.....

İmza

Appendix C Demographic Information Form

Sayın Anne,

Projemiz kapsamında yaptığımız gözlemlere çocuğunuzla birlikte katıldığınız için teşekkür ederiz. Son olarak sizden bazı soruları cevaplandırmanızı istiyoruz. Cevaplandıracağınız sorulardan oluşan anket ektedir. Lütfen her soru grubunun başındaki açıklamaları dikkatlice okuyun ve değerlendirmelerinizi buna göre yapın. Soruları cevaplarken acele etmeyin. Rahatsız edilmeyeceğiniz bir zaman seçin. Hiçbir sorunun doğru ya da yanlış cevabı yoktur, önemli olan sizin ne hissettiğiniz ve ne düşündüğünüzdür. Bu nedenle lütfen değerlendirmelerinizi gerçek duygu ve düşüncelerinizi yansıtacak şekilde yapın. Cevaplarınız kesinlikle gizli tutulacak ve bu anketten elde edilen bilgiler yalnızca araştırma amacına yönelik olarak kullanılacaktır.

Araştırma sonuçlarının sağlıklı olması ve çocukların sosyal ve duygusal gelişimini etkileyen faktörlerin saptanması için önemli olan sizin cevaplarınızdır. Bu yüzden, lütfen anketi doldururken sorular hakkında eşinizle ya da başka birileriyle görüş alışverişinde bulunmayın ve soruları eşinizden ya da başkalarından etkilenmeden yalnız başınıza cevaplandırın. Araştırmayla ilgili sorularınızı aşağıdaki e-posta adresini veya telefon numarasını kullanarak bize yöneltebilirsiniz. Katılımınız için tekrar teşekkür ederiz.

Saygılarımızla,



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1. Çocuğunuzun nesi oluyorsunuz?

- Öz anne
- Koruyucu anne
- Evlat edinen anne
- Üvey anne
- Diğer (lütfen belirtiniz)

2. Kaç yaşındasınız?

3. Çocuğunuzun doğum tarihi (gün/ay/yıl)?

4. Çocuğunuzun kaç kardesi var? (büyük ya da küçük)

- Hiç
- Bir
- İki
- Üç veya daha fazla

5. Çocuğunuz doğum sırasına göre kaçınıcı?

- İlk (en büyüğü)
- İkinci
- Üçüncü
- Dördüncü veya daha fazla

6. Ailenizde çocuklarınız dışında sizinle yaşayan başkaları var mı?

- Hayır
- Evet (lütfen belirtiniz)

7a. Çocuğunuza sizden başka bakan oluyor mu?

- Evet
- Hayır (soru 8'ye geçiniz)

b. Çocuğunuza sizden başka kim bakıyor? (birden fazla cevap mümkün)

- Kreş
- Babası
- Aileden biri (lütfen belirtiniz)
- Evde çocuk bakıcısı
- Bakıcı kendi evinde bakıyor
- Komşular
- Diğer (lütfen belirtiniz)

c. Haftada toplam kaç saat bakıyorlar?

- 5 saatten az
- 5-10 saat arası
- 10-20 saat arası
- 20 saatten fazla

8. Tamamladığınız eğitim düzeyinizi işaretleyiniz.

- Okuma yazma bilmiyorum
- İlkokul
- Ortaokul
- Lise
- Yüksek okul (2 yıllık)
- Üniversite (4 yıllık) ve üzeri

9. Eşinizin tamamladığı eğitim düzeyini işaretleyiniz.

- Okuma yazma bilmiyor
- İlkokul
- Ortaokul
- Lise
- Yüksekokul (2 yıllık)
- Üniversite (4 yıllık) ve üzeri

10a. Aile durumunuzu sizin, eşinizin ve çocuğunuzun durumunu en iyi yansıtacak şekilde işaretleyiniz.

- Evli ve anne-baba birlikte
- Evli ve anne baba ayrı yaşıyor
- Boşanmış ve çocuk anne ile yaşıyor
- Boşanmış ve çocuk babayla yaşıyor
- Boşanmış ve çocuk akraba ile yaşıyor
- Diğer (Lütfen belirtiniz).....

b. Evliyseniz:

Ne kadar süredir evlisiniz? yıl ay
Bu kaçncı evliliğiniz?

11. Size en uygun seçeneği isaretleyiniz.

- Ev hanımıyım
- İşsizim
- Emekliyim
- Tam-zamanlı çalışıyorum
- Yarım-zamanlı çalışıyorum
- Varsa, mesleğiniz.....

12. Eve giren aylık gelir miktarını işaretleyiniz.

- (1) 0- 1000 TL
- (2) 1000 -1500 TL
- (3) 1500 -2000 TL
- (4) 2000 - 3000 TL
- (5) 3000 - 4000 TL
- (6) 4000 - 5000TL
- (7) 5000 ve üzeri

13. Çocuğunuzun fiziksel sağlık durumu nasıl?

	Evet	Hayır
Sürekli/kronik bir hastalığı var mı?	<input type="radio"/>	<input type="radio"/>
Düzenli olarak ilaç kullanıyor mu?	<input type="radio"/>	<input type="radio"/>
Geçtiğimiz 12 ay içerisinde hastaneye gitti mi?	<input type="radio"/>	<input type="radio"/>
Geçtiğimiz 12 ay içerisinde hastanede yatılı kaldı mı?	<input type="radio"/>	<input type="radio"/>
Geçtiğimiz 12 ay içerisinde ameliyat oldu mu?	<input type="radio"/>	<input type="radio"/>
Geçtiğimiz 12 ay içerisinde tıbbi tedavi gördü mü (ameliyat için değil)	<input type="radio"/>	<input type="radio"/>
Bedensel engelli	<input type="radio"/>	<input type="radio"/>

14. Şu an sizin ve ailenizin sağlık durumu nasıl?

(Lütfen her sütun için tek bir seçenek işaretleyiniz)

	Çocuğunuz	Siz	Babası ya da baba yerine geçen kişi
Çok iyi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
İyi	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Orta derece	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kötü	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Çok kötü	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

15. Geçen yıl içinde:

- a. Yakınlarınızdan hayatını kaybeden oldu mu? Evet Hayır
Yakınlığı
- b. Eşinizin yakınlarından hayatını kaybeden oldu mu? Evet Hayır
Yakınlığı
- c. Aile üyelerinden birinin uzun süreli (2 aydan fazla) tedavi ya da hastane bakım gerektiren ciddi bir sağlık sorunu oldu mu? Evet Hayır
Yakınlığı Sorun neydi?

16. Genel olarak yaşamınızdan ne kadar memnunsunuz?

1-----	2-----	3-----	4-----	5-----	6-----
Hiç memnun değilim	Memnun değilim	Biraz memnun değilim	Biraz memnunum	Memnunum	Çok memnunum

**Appendix D Maternal Attitudes toward Sensitivity and Sensitive
Discipline Scale**

Aşağıda ÇOCUK YETİŞTİRMEYE YÖNELİK TUTUMLARLA ilgili cümleler verilmiştir. Lütfen her bir ifadeye ne oranda katıldığınızı 6 aralıklı cetvel üzerinde ilgili rakamı yuvarlak içine alarak belirtiniz.	Kesinlikle Katılmıyorum	Katılmıyorum	Pek Katılmıyorum	Biraz Katılıyorum	Katılıyorum	Kesinlikle Katılıyorum
1. Çocuğunuzla oyun oynamak onun zor veya yaramaz davranışlarını önlemeye yardımcı olur.	1	2	3	4	5	6
2. Bir çocuk doğuştan kolay ya da zor bir çocuktur. Anababanın bunu değiştirmek için yapabileceği pek birşey yoktur.	1	2	3	4	5	6
3. Çocuklar anababaları onlarla oynasın diye mızızlanmamalıdır.	1	2	3	4	5	6
4. Çocuğunuza birşeyi yasakladığınızda sakın kalmak zorundasınız.	1	2	3	4	5	6
5. Çocuğuma günde en az bir kez övmek güzel söz söylemek gerektiğine inanıyorum.	1	2	3	4	5	6

Appendix E EAS Temperament Survey for Children

<p>Aşağıda çocukların gösterdiği bazı davranışlar sıralanmıştır. SİZİNLE BİRLİKTE ÇALIŞMAYA KATILAN ÇOCUĞUNUZUN gösterdiği davranışları dikkate alarak her bir maddeyi değerlendiriniz ve 1 ile 4 arasındaki uygun bir rakamı gösterilen davranışın sıklığına göre işaretleyiniz. Şayet belirtilen davranış çocuğunuzun hiç göstermediği bir davranışsa, duruma göre 1 ya da 2'yi; çok sık gösterdiği bir davranışsa, duruma göre 4 ya da 3'ü işaretleyiniz.</p> <p>ÇOCUĞUM....</p>	Hiçbir zaman	Bazen	Sık sık	Her zaman
1. Utangaçtır.	1	2	3	4
2. İnsanlarla bir arada olmayı sever.	1	2	3	4
3. Sakin, sessiz oyunları aktif ve hareketli oyunlara tercih eder.	1	2	3	4
4. Yalnızken tek başına, ayrı kalmış hisseder.	1	2	3	4
5. Keyfi kaçtığında şiddetli tepki gösterir.	1	2	3	4

Appendix F Parenting Stress Index-Short-Form

Aşağıda ÇOCUĞUNUZU BÜYÜTÜRKEN KARŞILAŞABİLECEĞİNİZ ZORLUKLAR hakkında cümleler verilmiştir. Lütfen her bir ifadenin duygu ve düşüncelerinizi ne oranda yansıttığını karşılardaki 6 aralıklı cetvel üzerinde ilgili rakamı yuvarlak içine alarak belirtiniz.	Kesinlikle Katılmıyorum	Katılmıyorum	Pek Katılmıyorum	Biraz Katılıyorum	Katılıyorum	Kesinlikle Katılıyorum
1. Çocuk büyütürken bu kadar sorunla karşılaşmayı beklemiyordum.	1	2	3	4	5	6
2. Çocuklarıma bir şeyi yapmasını veya yapmamasını sağlamak konusunda çoğu zaman başarılı olduğumu düşünüyorum.	1	2	3	4	5	6
3. Çocuklarıma bakma konusunda kendimi becerikli ve yetkin hissediyorum.	1	2	3	4	5	6
4. Çocuklarım olduğumdan beri sevdiğim şeyleri hemen hemen hiç yapamadığımı hissediyorum.	1	2	3	4	5	6
5. Çocuklarımin ihtiyaçlarının, hayatımı kontrol ettiğini sıklıkla hissediyorum.	1	2	3	4	5	6

Appendix G Short-Symptom Inventory

	Hiçbir zaman	Nadiren	Bazen	Sık sık	Her zaman
<p>Asağıda insanların ara sıra yaşadıkları ve hissettikleri bazı belirtilerin ve yakınmaların bir listesi verilmiştir. Listedeki her maddeyi lütfen dikkatle okuyunuz. Daha sonra o belirtinin SİZDE BUGÜN DAHİL SON BİR HAFTADIR NE KADAR VAROLDUĞUNU 5 aralıklı cetvel üzerinde ilgili rakamı yuvarlak içine alarak belirtiniz.</p> <p>Bu belirtiler son bir haftadır <u>sizde ne kadar var?</u></p>					
1. İçinizde bir sinirlilik ve titreme hali	1	2	3	4	5
2. Bir başka insana hiç yakınlık duymamak	1	2	3	4	5
3. Dehşet ve panik nöbetleri	1	2	3	4	5
4. Yerinde duramayacak kadar tedirgin hissetmek	1	2	3	4	5
5. Kendini değersiz görmek/ değersizlik duyguları	1	2	3	4	5

Appendix H Ainsworth Maternal Sensitivity Scale

Duyarlık – Duyarsızlık Ölçeği

9. Yüksek derecede duyarlı. Bu anne bebeğinin sinyallerine mükemmel şekilde uyum sağlamış, uygun ve çabuk şekilde yanıtıyor. Durumu bebeğin bakış açısından görebiliyor; bebeğin sinyalleri ve ilettikleri ile ilgili algısı kendi ihtiyaçları ve savunma mekanizmaları tarafından çarpıtılmıyor. Bebeğin sinyal ve iletilerini becerikli şekilde “okuyabiliyor”, en ufak, üstü kapalı ve hafif işaretlerinin bile anlamını biliyor. Mutlak şekilde olmasa da hemen her zaman bebeğin istediğini belirttiği şeyi veriyor, Bebeğin isteklerine uymanın doğru olmadığını düşündüğünde – (örneğin, bebek çok heyecanlı veya buyurgan olduğunda veya zararlı birşey istediğinde) usturuşlu şekilde isteğini algıladığını belli edip kabul edilebilir bir alternatif sunuyor. Bebeği ile olan etkileşimi “dört başı mamur”, etkileşim rahat şekilde hem kendisi hem de bebek tatmin olacak şekilde tamamlanıyor. Son olarak, yanıt ve tepkileri zamanlama olarak bebeğin sinyalleriyle bağdaşıyor, uyumlu.

5. Tutarsız duyarlı. Bu anne zaman zaman çok duyarlı olabilmekle beraber, bazı zamanlarda ise bebeğin iletişimine duyarlı değil. Annenin tutarsız duyarlılığı birkaç nedenden kaynaklanabilir ama sonuç itibariyle bebeği ile olan duyarlı ilişkisinde boşluklar var. Bazı zamanlarda veya bebeğin davranışlarının belli yönlerine duyarlı, diğerlerine ise değil. Bebekle ilgili farkındalığı kesik kesik. Bazen oldukça düşkün, bazen vurdumduymaz. Veya bebekle ilgili algısı çoğu önemli konuda doğruyken belli açılardan çarpık. Yanıtları çoğu zaman ve çoğu durumda çabuk ve uygun olmakla beraber, belli zaman ve durumlarda uygunsuz veya gecikmeli. Ancak, genel olarak bakıldığında duyarsız olduğundan daha sıklıkla duyarlı. Çarpıcı olan ise, belli durumlarda bu kadar duyarlı olabilen bir annenin diğer durumlarda böylesine duyarsız olabilmesi.

1. Yüksek derecede duyarsız. Aşırı duyarsız anne neredeyse açıktan kendi istekleri, ruh hali ve aktivitelerine odaklanıyor. Öyle ki, annenin iletişim müdahaleleri ve iletişimi başlatması çoğunlukla kendi içindeki sinyallere göre öngörülüyor ve şekilleniyor. Bunlar bebeğin sinyalleri ile örtüşüyor olsa bile aslında bu durum tesadüften başka bir şey değil. Bu annenin bebeğin sinyallerine asla cevap vermediği anlamına gelmiyor; eğer bebeğin sinyalleri yeterince kuvvetli, yeterince uzatılmış ve

yeterince tekrarlanmışsa, anne bir süre cevap verebiliyor. Cevap vermedeki gecikme zaten tekbaşına duyarsızlık. Bunun ötesinde, sıklıkla annenin kendi istekleri ve aktiviteleri ile bebeğin sinyalleri arasında bir uyumsuzluk var. Rutin olarak ve büyük oranda kendi sinyallerine odaklanmış olan anne, bebeğin davranışlarının anlamını önemsemiyor ya da çarpıtıyor. Bu nedenle de, anne bebeğin sinyallerine cevap verdiğinde, bu cevap uygun olmayan türde ya da bölük pörçük ve tamamlanmamış biçimde.

Appendix I Maternal Behavior Q-Sort Items

1. Etkileşime katkıda bulunması için B'ye pek fırsat tanımaz.
2. Ziyaret süresince B'nin ne yaptığını yakından izler.
3. A'nın tepkileri tutarsızdır, kestirilemez.
Düşük: Tutarlı olarak aynı şekilde tepki verir.
4. Ziyaretçilerle ilgilenirken B'nin ne yaptığının farkında olmaz.
5. B ile yakın etkileşim sırasında acemice ve tedirgin davranışlar gösterir.
6. B'nin ziyaretçilerle etkileşime girmesini destekler.
7. Dolaştırırken veya duruşunu düzeltirken B'ye cansız bir nesneymiş gibi davranır.
8. Odadan ayrılırken B'ye gittiğini belli eder veya açıklama yapar.
9. Olumlu işaretleri (sesler çıkarma, gülcükler, uzanmalar gibi) gözardı eder.
10. Doğrudan B'ye konuşur.
11. B'ye bir nesnenin veya aktivitenin adını veya anlamını öğretiyormuş gibi kelimeleri dikkatle ve yavaşça tekrarlar.
12. Uyku saatleri B'nin o anki ihtiyacından ziyade A'nın düzenine göre belirlenir.
13. B'yi oyalamak için kardeşlerini veya televizyonu kullanır.
14. Ziyaretçiyle konuşmak veya başka bir şey yapmak için B'yle etkileşimini pat diye keser.
15. Çevreyi tek başına keşfetmesi için B'yi teşvik eder.
16. B'yi yatıştırmak için yakın fiziksel temas kullanır.
17. Ziyaret boyunca B ile konuşur, sesler çıkarır.
18. B ile sosyal/etkileşimsel oyunlar oynar.
19. B'nin istekleri A'yı strese sokar.
20. B kendisiyle işbirliği yapmadığı zaman rahatsız olur.
21. B'ye olumlu duygularını kendiliğinden (spontan olarak) gösterir.
22. Yakınında olduğunda B'nin hareketlerini fiziksel olarak kısıtlar.
23. B ile etkileşimi sırasında uzak, ilgisiz.
24. A'nın gösterdiği duygu, B'nin gösterdiği duygu ile uyumsuzdur, örtüşmez (örn., B stresliyken A güler).
25. B ile etkileşimleri tamamlanmadan sona erer.
26. B tatmin olmadan fiziksel teması keser.
27. B'nin arzularına bilfiil karşı çıkar.
28. B ile etkileşimlerinde çatışma hakimdir.
29. A'nın müdahaleleri B'yi tatmin eder.
30. B ile etkileşim sırasında cezalandırıcı veya karşılık vericidir.

Appendix J Semistructured Logbook

Her ev görüşmesinden sonra bu formu doldurunuz. Görüşmeyi gerçekleştirdiğiniz gün, aşağıdaki soruların yanıtlandığından emin olunuz.

Çocuğun ismi:
Görüşme tarihi:

Görüşme no:
Uygulayıcı adı:

Genel

1. Görüşmeyi kısaca betimleyiniz

2. Değişmek istediğiniz farklı ya da olağan dışı herhangi bir şey var mı?

3. Bu anneyle çalışmak hoşunuza gitti mi?

- | | |
|--------------------------|------------------|
| <input type="checkbox"/> | Çok hoşuma gitti |
| <input type="checkbox"/> | Fena değildi |
| <input type="checkbox"/> | Kayıtsızım |
| <input type="checkbox"/> | Pek hoşlanmadım |
| <input type="checkbox"/> | Hiç hoşlanmadım |

4. Bu annenin kolay etkilenebilen bir anne olduğunu düşünüyor musunuz?

- | | |
|--------------------------|--------------------------------|
| <input type="checkbox"/> | Onu etkilemek çok kolay. |
| <input type="checkbox"/> | Onu etkilemek oldukça kolay, |
| <input type="checkbox"/> | Onu etkilemek biraz kolay. |
| <input type="checkbox"/> | Onu etkilemek pek kolay değil. |
| <input type="checkbox"/> | Onu etkilemek hiç kolay değil. |

Video-Geri Bildirimi

5. Video kayıtlarını izlerken annenin tepkisi nasıldı?

6. Anne kendi davranışları ya da çocuğunun davranışları konusunda herhangi bir yorum yaptı mı (olumlu ya da olumsuz)?

7. Annenin bugünkü video müdahalesine tepkisi nasıldı?

8. Konuşma sırasında annenin tutumu nasıldı?

1	2	3	4	5
<i>Sıkılğan</i>				<i>İşbirlikçi</i>
<i>Çekingen</i>				

1	2	3	4	5
<i>Kapalı</i>				<i>Açık</i>

9. (Geçerli ise) Anne video müdahalesinin önceki görüşmelerine kendi inisiyatifiyle atıfta bulundu mu?

10. (Geçerli ise) Annenin önceki video müdahalelerinden bir şeyler öğrendiği ve/veya verilen ipuçları ve tavsiyeleri çocuğuyla iletişimde kullandığı izlenimini edindiniz mi?

11. Anne-çocuk iletişimi konusundaki izleniminizi belirtiniz:

12. Video müdahalesinin yönergelerini ve nihai hedefini dikkate aldığınızda (annenin profili), profile dair hangi maddeler üzerinde çalışacaksınız (1-14)

Appendix K Turkish Summary

Giriş

Bağlanma Kuramı ve Anne Duyarlığı

Çocuğun ebeveynleriyle, özellikle annesiyle kurduğu bağlanma ilişkisi onun bebeklikten başlayarak tüm yaşamı boyunca duygusal ve sosyal gelişimini etkiler. Bowlby (1969/1982) bağlanma kuramında kişinin erken yaşlarda onu büyütenlerle kurduğu ilişkinin kalitesinin ileriki yaşantısında, özellikle kişiler arası ilişkilerindeki, duyu ve davranışlarını biçimlendirdiğini öne sürmüştür. Bowlby'ye göre bağlanma, kişinin kendisi için önemli gördüğü bir başkasına (bağlanma figürü) karşı geliştirdiği güçlü duygusal bağıdır. Bu duygusal bağ bir bağlanma sistemi içerisinde işlevselleşerek çocuğun annesini yakınında tutmasına ve bu yolla annenin sağladığı bakım, ilgi ve korumadan maksimum düzeyde yararlanmasına olanak sağlar. Çocuk, erken yaştaki bu en yakın ilişkisinde bağlanma kişinin tepkileri temelinde zihinsel modeller (içsel çalışan modeller) geliştirir ve bu modeller onun sonraki yıllardaki ilişkilerini yönlendiren bir rehber görevi görür (Bretherton, 1992; Bowlby, 1969/1982; Cassidy, 2008).

Bağlanma kuramı temelinde Ainsworth ve arkadaşları (1978), “Yabancı Ortam” adını verdikleri gözleme dayalı bir yöntem kullanarak anne-çocuk ilişkisinde bağlanma davranışını sistematik olarak gözlemlemiş, çocukların bağlanma stillerini güvenli, kaygılı/kararsız, kaçınan ve görece daha seyrek gözlenen yönelim bozukluğu güvensiz bağlanma stilleri olarak nitelendirmiştir (Ainsworth, Blehar, Waters ve Wall, 1978). Batı ülkelerinde yapılan çok sayıdaki meta analiz çalışması (örn., de Wolff ve Van IJzendoorn, 1997; Van IJzendoorn, Vereijken, Bakermans-Kranenburg ve Rikensen-Walraven, 2004) ve Türkiye’de TÜBİTAK Projesi kapsamında yürütülen bir çalışma (Sümer ve ark., 2008) anne duyarlığının çocuklarda güvenli bağlanmayı yordayan öncelikli ebeveyn özelliği olduğunu göstermiştir.

Ainsworth ve arkadaşları (1978) anne duyarlılığını birbiriyle ilişkili dört boyutta tanımlamış ve ölçmüştür. *Duyarlı – duyarlı olmayan* anne davranışı boyutu, annenin bebeğinin örtük mesajlarını ve verdiği sinyalleri algılaması ve doğru yorumlaması, buna dayanarak bebeğin duygusal ve fiziksel ihtiyaçlarına zamanında ve uygun tepki vermesi olarak tanımlanmaktadır. *Kabule karşı reddetme* boyutu, annenin ne kadar kabul edici ya da olumsuz beklentileri nedeniyle reddedici bir yaklaşım içinde olduğu ve nasıl bir atmosferde ebeveynlik yaptığını yansıtmaktadır. *İşbirliğine karşı müdahale* boyutu, annenin bebeğin bireysel özelliklerine ve isteklerine saygı göstererek bakım davranışlarını düzenleyebilme becerisini göstermektedir. *Ulaşılabilirliğe karşı ihmalkârlık* boyutu ise annenin fiziksel ve psikolojik olarak ne derece ulaşılabilir durumda olduğunu ifade etmektedir. Anne duyarlılığının güvenli bağlanmanın gelişimi ve duygu düzenleme becerisinin kazanılmasında önemli rol oynadığını ortaya koyan bulgular (örn., de Wolff ve Van IJzendoorn, 1997), erken dönem ebeveyn destek programlarının geliştirilmesinin ne kadar önem arz ettiğini doğrular niteliktedir.

Bu önerme temelinde araştırmacılar bakım veren kişinin duyarlılığını artırarak çocukların optimum sosyal ve duygusal gelişimlerini destekleyen erken dönem müdahale programları geliştirmiştir (örn; Juffer, Van IJzendoorn ve Bakermans-Kranenburg, 2008d; Sandler, Schoenfelder, Wolchick ve Mackinnon, 2011; Watson, White, Taplin ve Huntsman, 2005). Yapılan meta analiz çalışmaları bağlanma-temelli geliştirilen bu programların, çocuğun güvenli bağlanmasına kıyasla anne duyarlılığını artırmada daha etkili olduğunu; kısa vadeli ve davranışsal düzeyde müdahale amaçlayan programların uzun vadeli ve yoğun içerikli görüşmeler ve tartışmalardan oluşan programlara göre daha etkili olduğunu; bebekler altı ayı doldurduktan sonra başlayan müdahale programlarının bebek doğmadan önce veya doğduktan sonra ilk aylarda başlayan müdahale programlarına göre daha etkili olduğunu ve video-geribildirimine dayalı müdahale programlarının bu yöntemin kullanılmadığı programlara göre daha etkili olduğunu göstermiştir (Bakermans-Kranenburg, Van IJzendoorn ve Juffer, 2003; 2005; Van IJzendoorn, Juffer ve Duyvesteyn, 1995). Tüm bu bulgular ışığında bu çalışmada anne duyarlılığını artırmaya yarayan kısa ve davranış odaklı video-geribildirimine dayalı müdahale

programını Türkiye kültürüne uyarlamak, uygulamak ve etkisini görgül olarak test etmek amaçlanmıştır.

Olumlu Ebeveyn Davranışlarını Arttırmaya Yönelik Video-Geribildirimli Müdahale Programı -Duyarlı Disiplin (VIPP-SD)

Bağlanma kuramı temelinde Juffer ve ark. (1993; Juffer, Bakermans-Kranenburg ve Van IJzendoorn, 2008b) tarafından geliştirilen bu program bireysel geribildirimler vererek annenin duyarlı davranışlarını arttırmayı amaçlamaktadır. *VIPP-Standard* program ilk olarak çocuklarını evlat edinen anneler için duyarlık temalı üç ev görüşmesi şeklinde geliştirilmiştir (Juffer, 1993). Ardından Leiden Üniversitesi Çocuk ve Aile Çalışmaları Merkezi'nde yapılan çalışmalar sonucunda temalı dört görüşmeye dönüştürülmüştür. Daha sonraki yıllarda bu program, güvensiz bağlanan annelerin zihinsel temsillerini değiştirmek (*'VIPP- Zihinsel Temsil'*) ve çocukların dışavurum problemlerini azaltmak (*'VIPP-Duyarlı Disiplin'*) amacıyla farklı temalar da eklenerek yaygın bir şekilde uygulanmıştır (Juffer ve ark., 2008b). Bu çalışmada annelerin hem duyarlı davranışlarını hem de zorlayıcı olmayan ve duyarlı disiplin uygulamalarını artırmak amacıyla *VIPP-Duyarlı Disiplin* programı uyarlanmıştır.

Bu program, kısa süreli ve detaylı olarak yapılandırılmış dört temalı ev görüşmesi ve iki ekstra görüşmeden oluşmaktadır (Juffer, Bakermans-Kranenburg ve Van IJzendoorn, 2008a; 2008b). Görüşme sırasında annelerden çocuklarıyla günlük faaliyetlerini her zaman olduğu gibi yürütmeleri istenmekte (oyun, yemek yeme vb.) ve anne-çocuk arasındaki tüm etkileşimler video kaydına alınmaktadır. Araştırmacı etkinliklere katılmamakta, görüşme bittikten sonra video kaydını baştan sonra yalnız izlemekte ve bir sonraki görüşmede anne ile tartışmak/görüşmek üzere görüşmenin temasına ve program protokolüne uygun yorumlar hazırlamaktadır. Video kayıtları sonrasında ise araştırmacı anneye çocuğun davranışları ve kendisinin tepkileri üzerinden bireysel geribildirimler vermektedir. Geribildirim yoluyla annenin gözlem yapma ve empati kurma becerisini artırması ve duyarlı davranışlarını pekiştirmesi sağlanmaktadır. Bu anlamda verilen geribildirimler Ainsworth ve arkadaşlarının (1978) duyarlı ebeveynlik tanımına karşılık gelmektedir. Bunun yanı sıra anneye

duyarlı ebeveynlik davranışları konusunda bilgilendirici kitapçık ve eğitici ödevler verilmektedir. Ayrıca araştırmacı her görüşme sonrasında o görüşmeyle ilgili izlenimlerini ve annenin yorumlarını not etmektedir (Juffer ve ark., 2008a; 2008b).

Görüşmelerde işlenen duyarlık temaları sırasıyla şu şekildedir (Juffer ve ark., 2008a; 2008b); (1) ‘Çocuğun keşif davranışları ile bağlanma davranışları arasındaki denge’: Bu temada amaçlanan anneye çocuğun keşif ve bağlanma davranışları arasındaki farklılıkları göstermektir. (2) ‘Çocuk için konuşmak’: Bu temanın amacı annenin çocuktan gelen sinyalleri doğru bir şekilde algılamasını sağlamaktır. (3) ‘Duyarlık zinciri: çocuğun işareti -> annenin karşılığı -> çocuğun tepkisi’: Bu temada anneye çocuktan gelen sinyallere doğru, hızlı ve yerinde cevap vermesinin önemi ve sonuçları hakkında farkındalık oluşturulması hedeflenmektedir. (4) ‘Duyguların paylaşımı’: Bu son temanın hedefi anneye çocuğun duygularına doğru bir şekilde karşılık verebilmeyi öğretmektir. Görüşmelerde ele alınan ilk iki tema çocuğun davranışı, son iki tema ise annenin çocuğa karşı davranışı odaklıdır. Disiplin temaları ise sırasıyla şu şekildedir; (1) ‘Açıklama yapma ve dikkat dağıtma’: Bu temalarla amaçlanan anneye çocuğun zor davranışlarıyla duyarlı yöntemler kullanarak başa çıkabilmeyi öğretmektir. (2) ‘Olumlu pekiştirme’: Bu temada annenin çocuğun olumlu davranışlarını överek çocuğu cesaretlendirmesi hedeflenmektedir. (3) ‘Duyarlı mola zamanı’: Bu temada amaçlanan anneye çocuğun öfke nöbetiyle başa çıkabilmesini öğretmektir. (4) ‘Empati kurma’: Bu son temanın hedefi ise anneye çocuğun duygu ve düşüncesini anlayabilmeyi öğretmektir (Juffer ve ark., 2008a; 2008b).

Geçmiş çalışmalar, bu programın anne duyarlılığı ve güvenli bağlanma üzerindeki olumlu etkisini görgül bulgularla desteklemektedir. Programın olumlu etkisi; güvensiz bağlanan annelerde (Bakermans-Kranenburg, Juffer ve Van IJzendoorn, 1998; Klein-Velderman, Bakermans-Kranenburg, Juffer ve Van IJzendoorn, 2006; Klein-Velderman, Bakermans-Kranenburg, Juffer, Van IJzendoorn, Mangelsdorf ve Zevalkink, 2006), duyarsız annelerde (Kalinauskiene ve ark., 2009), yeme bozukluğu olan annelerde (Stein ve ark., 2006), öğrenme güçlüğü çeken annelerde (Hodes, Meppelder, Schuengel ve Kef, 2014), evlat edinmiş annelerde (Juffer, Hoksbergen, Riksen-Walraven ve Kohnstamm, 1997; Juffer, Bakermans-Kranenburg ve Van IJzendoorn, 2005), dışavurum problemleri olan

çocukların annelerinde (Van Zeijl ve ark., 2006; Yağmur, Mesman, Malda, Bakermans-Kranenburg ve Ekmekçi, 2014), otistik çocukları olan annelerde (Poslawsky ve ark., 2014) ve prematüre ve kronik rahatsızlığı olan çocukların annelerinde (Cassibba ve ark., 2008) ve düşük sosyoekonomik düzeydeki ailelerde (Negrao, Pereira, Soares ve Mesman, 2014) gösterilmiştir. Annelerin yanı sıra programın olumlu etkisi evde ve merkezde bakımveren kişilerde de görülmüştür (Elicker, Georgescu ve Bartsch, 2008; Groeneveld, Vermeer, Van IJzendoorn ve Linting 2011).

Son yıllarda yapılan araştırmalar, video-geribildirime dayanan bu programın her çocuğu aynı şekilde etkilemediği, mizaç ve genetik özelliklerine göre etkisinin farklılık gösterdiğini ortaya koymaktadır. Ayırıcı yatkınlık hipotezine göre (Belsky, Bakermans-Kranenburg ve Van IJzendoorn, 2007) genetik olarak örselenmeye daha yatkın olan çocuklar, hem olumsuz hem de destekleyici ebeveynliğin etkisine daha açıktır. Bu hipotezi destekler nitelikte, araştırma bulguları DRD4 genetik alelleri taşıyan ya da duygusal bakımdan kırılabilir mizaca sahip olan çocuklarda bu programın olumlu etkisinin daha fazla olduğunu göstermiştir (Bakermans-Kranenburg, Van IJzendoorn, Mesman, Alink ve Juffer, 2008; Bakermans-Kranenburg, Van IJzendoorn, Piljman, Mesman ve Juffer, 2008; Klein Velderman, Bakermans-Kranenburg, Juffer ve Van IJzendoorn, 2006). Kısacası, bu program hem risk altında olan çocuklu ailelere bir destek hem de sorunlu (örn. dışavurum problemleri) ya da mizaç ve genetik özellikleri bakımından hassas çocuğu olan ebeveynler için bir müdahale programı olarak da uygulanabilmektedir.

Türkiye Kültürüne Duyarlı Müdahale Programı Uygulaması

Bu çalışmada amaçlanan Batı kültüründe etkisi pek çok çalışma ile desteklenmiş bir programı Türkiye kültürüne uyarlamaktır. Bu doğrultuda ülkemizde uyarlanacak olan bir programın kültüre özgü ebeveyn davranışları esas alınarak tasarlanması, uygulanması ve etkisinin test edilmesi gerekmektedir. Rothbaum ve arkadaşları duyarlı ebeveynlik davranışlarının içerik ve gösterim şekli bakımından Doğu ve Batı ülkelerinde farklılaştığı öne sürmüştür (Rothbaum, Nagaoka ve Ponte, 2006; Rothbaum, Rosen, Ujiie ve Uchida, 2002; Rothbaum, Weisz, Pott, Miyake ve Morelli, 2000). Örneğin, Doğu ülkelerinde (örn. Japonya) duyarlı annelerin en temel

özelliđi çocukların örtük ve sözel olmayan işaret ve ihtiyaçlarını anlaması iken, Batı ülkelerinde (örn, Amerika) bu özellik, annelerin tepki vermeden önce çocuktan gelecek işaret ve sinyalleri beklemesidir.

Bunun yanı sıra, toplulukçu kültürlerde güvenli bağlanma ile ilişkili duyarlı ebeveynlik davranışları duygu paylaşımı, uzun süren fiziksel temas ve sözel olmayan duygu-odaklı iletişim içeren ve çocuđun dikkatini sosyal nesnelere yönlendirmeye dayanan davranışlar iken, bireyci kültürlerde bunlar, çocuktan gelen sinyallere yönelik, göz teması ve sözel bilgi-odaklı iletişim içeren ve çocuđun dikkatini fiziksel nesnelere yönlendirmeye dayanan davranışlardır (Richman, Miller ve LeVine, 1992; Rothbaum ve ark., 2000; 2006; Völker, Keller, Lohaus, Cappenberg ve Chasiotis, 1999). Dolayısıyla annelerin çocuđun örtük, sözel olmayan işaretlerini doğru okuma ve bunlara uygun tepki verme becerisini ve duygu paylaşımını destekleyen programların Türkiye ve benzeri toplulukçu ya da ilişkisel kültürlerde güvenli bağlanmayı artırmada daha etkili olacağı önesürülebilir.

Diđer yandan, Kađıtçıbaşı'nın (2005; 2007) "psikolojik/duygusal bađlılık modelinde" belirttiđi gibi kentleşme ile deđişen yaşam tarzı ile birlikte Türk toplumunda özellikle gelişmiş kentsel kesimde yaşayan anne babalar için çocuklarının özerk ve aynı zamanda ailesine duygusal anlamda yakın ve bađlı bir birey olarak yetişmesi önem kazanmıştır. Ayrıca Türkiye ve benzeri toplulukçu ya da ilişkisel kültürlerde çocuklar anne baba kontrolünü bireyci toplumlarda olduđu gibi olumsuz deđil; düzenleyici, açıklayıcı, sevgi ve şefkat içeren olumlu bir ebeveyn davranışı olarak algılamaktadır (Kađıtçıbaşı, 2005; 2007). Geleneksel kültürün devam ettiđi kırsal kesimlerde ise halen itaatkâr çocuk yetiştirmeye önem verilmesi özellikle bu bölgelerde özerkliđin desteklenmesi gerektiđine işaret eder. Buradan yola çıkarak sosyokültürel ortama uygun olarak çocuđun özerkliđini destekleyen, düzenleyici ve açıklayıcı kontrol içeren, yakınlık, sevgi ve duygusal bađlılığa önem veren girişimlerin daha etkili olacağı önesürülebilir.

Bu anlamda VIPP-SD programı kullanılan temalar ve yöntemler ile Türkiye bağlamına uygun özellikler taşımaktadır. Örneđin, 'Çocuk için konuşmak' yöntemi ve 'Duyarlık zinciri' teması annelerin bu bağlamda duyarlı ebeveynlik davranışı olarak görülen, çocuktan gelen örtük ve sözel olmayan sinyalleri doğru bir şekilde algılama ve bunlara uygun tepki verme becerisini destekler niteliktedir. Buna

ilaveten, annelerin çocuğun keşif davranışları ile bağlanma davranışları arasındaki denge kurmasını sağlayarak onların özerkliğini desteklemeye yardımcı olur. Ayrıca bu program annelerin çocukların zor davranışlarıyla başa çıkmada duyarlı ve etkili disiplin yöntemleri kullanmalarını, duygu paylaşımlarını ve empati kurmalarını sağlayarak bu bağlama özgü duyarlı ebeveynlik davranışlarını desteklemektedir.

Amaç ve Hipotezler

Bu çalışmanın amacı, olumlu ebeveyn davranışlarını artırmaya yönelik olarak geliştirilen bireysel video-geribildirim dayalı müdahale programının (VIPP-SD) Türkiye kültürüne uyarlanması, uygulanması ve etkisinin test edilmesidir. Bu doğrultuda uygulanacak olan programın anne duyarlılığını artırması beklenmektedir. Diğer bir ifadeyle, müdahale grubundaki annelerin sontest ölçümlerinde gözlemlenen duyarlı davranışlarının öntest ölçümlerine göre anlamlı düzeyde artması; kontrol grubundaki annelerin ise öntest ve sontest ölçümlerinde bir fark olmaması beklenmektedir. Bunun yanısıra programın anne duyarlılığı üzerindeki etkisinin değişkenliğini incelemek amaçlanmıştır. Bu çalışma, Türk göçmenleriyle yapılan uygulama (Yağmur ve ark., 2014) dışında, Türkiye gibi toplulukçu ya da ilişkisel bir kültürde yapılan bağlanma temelli ilk müdahale uygulamasıdır. Bu anlamda erken dönem programların farklı kültürel bağlamlarda da uygulanabilirliği ve etkinliğini göstermesi açısından önemlidir.

Yöntem

Katılımcılar

Çalışmaya Ankara ve İstanbul'un görece düşük gelir ve eğitim düzeyine sahip çocukları 10-33 ay (Ort = 20.5) arasında olan 56 aile ($N_{ank} = 38$, $N_{ist} = 18$) katılmıştır. Kriterleri sağlayan ailelere çeşitli yöntemlerle ulaşılmıştır. Bu yöntemler: (1) Ankara ve İstanbul'un düşük sosyoekonomik bölgelerinde yer alan belediyeler, muhtarlıklar ve aile sağlık merkezleri, (2) 'Çocuğum ve Ben' ve 'Bebek Bakımı' gibi sosyal medya hesapları, (3) İstanbul Kemerburgaz üniversitesi öğrencilerinin

tanıdıkları ve (4) proje asistanlarının tanıdıklarıdır. Çalışmaya katılmak isteyen anneler, müdahale ve kontrol grupları olmak üzere seçkisiz olarak iki gruba ayrılmıştır. Örneklemin geri kalanı ise kartopu yöntemi ile seçilmiştir. Annelerden biri öntest görüşmesi sonrasında, diğer ise birinci temalı görüşme sonrasında çalışmadan ayrılmıştır.

Çalışmaya katılan annelerin yaşları 20 ila 42 arasında (Ort. = 29.9), çocukların yaşları ise öntestte 10 ila 33 ay arasında (Ort. = 20.5), sontestte ise 12 ila 37 ay arasında (Ort. = 23.1) değişmektedir. Çocukların 30'u kız, 27'si ilk çocuk ve 28'i tek çocuktur. Çocukların çoğu anne babasıyla beraber yaşamaktadır (%94.6) ve annesi tarafından bakılmaktadır (%57.1). Annelerin çoğu ise lise mezunu (%48.2) ve ev hanımıdır (%75). Ailelerin gelir düzeyi çoğunlukla 0-1000 TL (%25) ve 1000-1500 TL (%23.2) aralığında değişmektedir.

İşlem ve Veri Toplama Araçları

Bu çalışma, video-geribildirimine dayanan müdahale programının anne ve çocuk değişkenleri üzerindeki etkisini incelemeyi amaçlayan geniş kapsamlı ve TÜBİTAK destekli (Proje no: 113K542) araştırma projesinin bir parçasıdır. Müdahale grubundaki 38 anne ile dört temalı görüşme yapılmıştır. Kontrol grubundaki 18 anneye ise müdahale programı uygulamalarına paralel olarak çocuklarının gelişimleri ile ilgili dört telefon görüşmesi yapılmıştır. Anne duyarlılığı öntest ve sontest görüşmelerinde videoya çekilmiş anne-çocuk etkileşimleri ile gözleme dayalı olarak ölçülmüş; bağımsız kodlayıcılar tarafından Anne Davranışları Sınıflandırma Seti (ADSS) ve Ainsworth Anne Duyarlık Ölçeği ile değerlendirilmiştir. Annelerin duyarlı davranış ve disipline yönelik tutumları ise öntest ve sontest görüşmelerinde anne bildirimine dayalı ölçümle değerlendirilmiştir. Bunun yanı sıra, çocuğun mizacı, annenin psikolojik semptomları ve ebeveyn stresi gibi değişkenler de ölçülmüştür.

Olumlu Ebeveyn Davranışlarını Arttırmaya Yönelik Video-Geribildirimli Müdahale Programı -Duyarlı Disiplin (VIPP-SD):

Uygulayıcıların Eğitimi. Müdahale uygulamaları gelişim, sosyal ve klinik psikoloji alanlarında eğitimlerine devam eden, anne-çocuk gözlemleri konusunda deneyimli altı psikoloji öğrencisi ve bir uzman klinik psikolog tarafından gerçekleştirilmiştir. Müdahale öncesinde araştırmacılar Leiden Üniversitesi'nden gelen uzman Dr. Claudia Werner'dan VIPP-SD müdahale programı uygulaması konusunda dört gün boyunca eğitim almışlardır. Bu eğitim sonrasında her bir uygulayıcının bir anne-çocuk çifti ile dört temalı görüşme yapması ve uzmandan geribildirim alması ile pilot çalışma tamamlanmıştır. Bunu tamamlayan araştırmacılara VIPP-SD Uygulayıcı Sertifikası verilmiştir.

Birinci Aşama: Pilot Çalışma ve Programın Kültürel Uyarlaması. Birinci aşamayı oluşturan pilot çalışmada amaçlanan; (1) uygulayıcıların eğitim almaları, (2) programın Türkiye kültürüne uyarlanmasıdır. Pilot çalışma ile uygulama sırasında ortaya çıkabilecek sorunlar tartışılarak belirlenmiştir. Örneğin, 'şarkı söyleme' etkinliği Türk ailelerinde çok yaygın olmadığından, daha önceki uyarlamalar esas alınarak (Yağmur ve ark., 2014) bu etkinlik anne ve çocuğun duygusal paylaşımını ortaya çıkarabilecek 'çay setiyle oynama' etkinliği ile değiştirilmiştir.

İkinci Aşama: Müdahale Uygulaması. İkinci aşamada ise müdahale anneleriyle dört temalı görüşme, öntest ve sontest görüşmeleri yapılmıştır. Ev görüşmeleri iki-üç hafta arayla ve yaklaşık iki-iki buçuk saat süreyle gerçekleştirilmiştir. Görüşmeler süresince annelere katılımlarından ötürü para, duyarlı ebeveynlik konusunda bilgilendirici kitapçık, çocuklara ise hediye kitap ve oyuncak verilmiştir. Öntest görüşmesinde anneler ilk olarak çalışma hakkında bilgilendirilmiş ve ardından birinci temalı görüşme için anne-çocuk etkileşimlerini içeren kısa süreli video çekimleri ('tek başına oynama', 'beraber oynama', 'dokunmama') yapılmıştır. Öntest ölçümleri için anne ve çocuğun serbest oyunları yaklaşık 10 dakika süreyle, günlük yaşantıları ise yaklaşık bir saat süreyle videoya kaydedilmiştir. Bunun yanısıra anneden geniş kapsamlı bir anket doldurması istenmiştir. Birinci temalı görüşmede ilk olarak ikinci temalı görüşme için anne-çocuk etkileşimlerini içeren kısa süreli video çekimleri ('tek başına oynama', 'beraber oynama', 'oyuncakları toplama',

'kitap okuma') yapılmış ve ardından ilk görüşmede kaydedilen etkileşim videoları üzerinden anneye geri-bildirim verilmiştir. İkinci temalı görüşmede ilkin üçüncü temalı görüşme için yemek yeme videosu çekilmiş ve ardından birinci görüşmede kaydedilen etkileşim videoları üzerinden anneye geri-bildirim verilmiştir.

Benzer şekilde üçüncü temalı görüşmede ilkin dördüncü temalı görüşme için anne-çocuk etkileşimlerini içeren kısa süreli video çekimleri ('çocuğun daveti', 'şarkı söyleme/beraber oynama', 'görev') yapılmış ve ardından ikinci görüşmede kaydedilen video üzerinden anneye geri-bildirim verilmiştir. Dördüncü temalı görüşmede ise video çekimi yapılmamış, sadece üçüncü görüşmede kaydedilen etkileşim videoları üzerinden anneye geri-bildirim verilmiştir. Sontest görüşmesinde ise ilk görüşmede olduğu gibi anne ve çocuğun serbest oyunları yaklaşık 10 dakika süreyle, günlük yaşantıları ise yaklaşık bir saat süreyle videoya kaydedilmiştir. Bunun yanı sıra anneden geniş kapsamlı bir anket doldurması istenmiştir. Kontrol grubundaki annelerle temalı görüşme yapılmamış, sadece müdahale uygulamalarına paralel dört telefon görüşmesi, öntest ve sontest görüşmeleri yapılmıştır. Bu telefon görüşmelerinde annelere çocuğunun gelişimi ile ilgili sorular sormuş, herhangi bir bilgilendirme yapılmamıştır. Görüşmeler tamamlanınca ise annelere bir oturumluk duyarlık eğitimi ve müdahale grubuna verilen para, bilgilendirici kitapçık ve hediyeler verilmiştir.

Ainsworth Anne Duyarlık Ölçeği (ADÖ)

Anne duyarlığını ölçmek amacıyla Ainsworth ve arkadaşları (1974) tarafından geliştirilmiş gözleme dayalı bir ölçümdür. Bu ölçümde anne ve çocuğun serbest oyunları yaklaşık 10 dakika süreyle videoya kaydedilir ve anne davranışları 9 aralıklı ölçek (1 = *yüksek derecede duyarsız*, 3 = *duyarsız*, 5 = *tutarsız duyarlı*, 7 = *duyarlı*, 9 = *yüksek derecede duyarlı*) üzerinden değerlendirilir. Duyarlı-duyarsız anne davranışları bu çalışma kapsamında Türkçe'ye çevrilmiştir. Videoların %20'si iki gözlemci tarafından kodlanmıştır. Sınıf içi korelasyon ortalamaları tüm kodlamalar için .80, öntest kodlamaları için .81 ve sontest kodlamaları için .73'tür.

Anne Davranışları Sınıflandırma Seti (ADSS)

Anne duyarlığını davranışsal boyutta ölçmek amacıyla Pederson ve ark. (1990; Pederson ve Moran, 1995) tarafından geliştirilmiş, Sümer ve ark. (2008) tarafından Türkçe'ye uyarlanmış gözleme dayalı bir ölçümdür. Bu ölçümde anne-çocuk etkileşimleri (örn. yemek yeme, beraber oyun oynama) yaklaşık bir saat süreyle videoya kaydedilir. Kodlayıcılar bu videoları izleyerek ilgi-bakım davranışlarını tanımlayan 90 maddeyi ilk olarak üç gruba (“annenin en sık yaptığı”, “annenin orta sıklıkta yaptığı” ve “annenin hiç yapmadığı”), ardından dokuz gruba ayırır (1 = annenin hiç yapmadığı davranışlar, 9 = annenin en sık yaptığı davranışlar). Daha sonra belirtilen ölçütlerle karşılaştırılarak annenin “duyarlık” puanı elde edilir. Videoların %20’si iki gözlemci tarafından kodlanmıştır. Gözlemciler arası güvenilirliğin ortalaması .85'tir (Ranj = .74-.93).

Duyarlık ve Duyarlı Disipline Yönelik Anne Tutumları Ölçeği (DDYTÖ)

Annenin duyarlı davranışa ve disipline yönelik tutumlarını ölçmek amacıyla Bakermans-Kranenburg ve Van IJzendoorn (2003) tarafından geliştirilmiş 18 maddelik bir ölçektir. İki altölçekten oluşmaktadır. Bunlar, 9'ar maddelik Duyarlı Davranışa Yönelik Anne Tutumları altölçeği (DYT; örn. “Çocuğuma günde en az bir kez övmek güzel söz söylemek gerektiğine inanıyorum”) ve Duyarlı Disipline Yönelik Anne Tutumları altölçeğidir (DDYT; örn. “Eğer bir çocuk hiç söz dinlemezse cezadan başka bir şey işe yaramaz”, ters madde). Tüm maddeler bu çalışma kapsamında Türkçe'ye çevrilmiş ve 6 aralıklı ölçek (1 =kesinlikle katılmıyorum, 6= kesinlikle katılıyorum) üzerinden değerlendirilmiştir. Yüksek skorlar annelerin duyarlılığa ve duyarlı disiplin davranışlarına yönelik olumlu tutuma sahip olduğunu gösterir. İç tutarlık katsayıları DYT altölçeği için .56 (öntest) ve .55 (sontest), DDYT altölçeği için .76 (öntest) ve .72 (sontest) ve DDYTÖ için .43 (öntest) ve .66 (sontest) 'dır. Ölçeğin yapısını incelemek amacı ile yapılan doğrulayıcı faktör analizi sonucunda model uyumluğunun istatistiki olarak kabul edilebilir

düzyeyde olduđu görülmüştür [$\chi^2(8) = 18.3, p < .05, \chi^2/df = 2.28, GFI = 0.90, CFI = 0.86, NNFI = 0.74$ ve $RMSEA = 0.15$].

Çocuk Mizaç Ölçeđi (ÇMÖ)

Çocuđun mizacını ölçmek amacıyla Buss ve Plomin (1984) tarafından geliştirilmiş, Sümer ve ark. (2008) tarafından Türkçe'ye uyarlanmış 20 maddelik bir ölçektir. Üç altölçekten oluşmaktadır. Bunlar, Duygusallık (örn., “*Kolayca ağlar*”), Hareketlilik (örn., “*Yerinde duramaz.*”) ve Sosyallik (örn., “*Tanımadığı insanlara ısınması zaman alır*”) altölçekleridir. Tüm maddeler 4 aralıklı ölçek (1=*hiçbir zaman*, 4=*her zaman*) üzerinden değerlendirilmiştir. Yüksek skorlar çocukların yüksek düzeyde duygusallık, hareketlilik ve sosyallığe sahip olduğunu gösterir. İç tutarlık katsayıları Duygusallık altölçeđi için .71, Hareketlilik altölçeđi için .33 ve Sosyallik altölçeđi için .57' dir.

Ebeveynlik Stres Ölçeđi (ESÖ)

Annenin ebeveynlik deneyimine ilişkin yaşadığı zorluk ve bu zorluklara karşı yetkinlik hislerini ölçmek amacıyla Abidin (1995) tarafından geliştirilmiş 36 maddelik bir ölçektir. Bu ölçeđin 26 maddesi (örn., “*Anne olmak düşündüğümde daha zormuş*”) 6 aralıklı ölçek (1=*kesinlikle katılmıyorum*, 5=*kesinlikle katılıyorum*) üzerinden değerlendirilmiştir. Yüksek skorlar annelerin yüksek düzeyde ebeveynlik stresi yaşadığını gösterir. Ölçeđin iç tutarlık katsayıları .89 (öntest) ve .91(sontest) 'dir.

Kısa Semptom Envanteri (KSE)

Annenin psikolojik belirtilerini tespit etmek amacıyla Derogatis (1992) tarafından geliştirilen, Şahin, Batıgün ve Uđurtaş tarafından (2002) Türkçe'ye uyarlanan 27 maddelik bir ölçektir. Anneler her bir maddenin kendilerinde son bir haftada ne kadar var olduğunu 5'li ölçek (1=*hiçbir zaman*, 5=*her zaman*) üzerinden

değerlendirmiştir. Yüksek skorlar annelerin yüksek düzeyde psikolojik belirtiye sahip olduğunu gösterir. Ölçeğin iç tutarlık katsayısı .92'dir.

Bulgular

Betimsel İstatistikler

Öntest ve sontest ölçümlerinde gruplar arası benzerlik ve farklılıkları betimlemek amacıyla bağımsız örneklem t-testi (independent samples t-test) analizi yapılmıştır. Bu analiz sonucunda çocuğun cinsiyetinde gruplar arası anlamlı fark ortaya çıkmıştır, $t(54) = 2.14, p < .05$. Buna göre müdahale grubunda ($N_{\text{kız}} = 24, N_{\text{erkek}} = 14$) kontrol grubuna kıyasla ($N_{\text{kız}} = 6, N_{\text{erkek}} = 12$) daha fazla kız çocuğu yer almaktadır. Bu nedenle çocuğun cinsiyeti varyans analizlerine kontrol değişkeni olarak eklenmiştir. Buna ilaveten ebeveynlik stresinin öntest ölçümünde gruplar arası anlamlı fark ortaya çıkmıştır, $t(54) = 2.11, p < .05$. Buna göre, kontrol annelerinin stres düzeyinin ($Ort. = 3.34$) müdahale annelerine ($Ort. = 2.93$) göre daha yüksek olduğu bulunmuştur. Ayrıca duygusallık değişkeninde de sınırda anlamlı fark ortaya çıkmıştır, $t(54) = 1.94, p = .06$. Buna göre, kontrol grubundaki çocukların ($Ort. = 2.46$) müdahale grubundakilere ($Ort. = 2.20$) göre daha fazla duygusallık gösterdiği bulunmuştur.

Sontest ölçümlerine bakıldığında, iki grup DDYTÖ [$t(54) = -2.26, p < .05$] ve ebeveynlik stresi [$t(54) = 2.43, p < .05$] ölçümlerinde anlamlı düzeyde farklılaşmıştır. Buna göre, müdahale anneleri kontrol annelerine göre müdahale sonrasında duyarlı davranış ve disipline yönelik daha yüksek düzeyde olumlu tutum ($Ort._{\text{müd}} = 4.40, Ort._{\text{knt}} = 4.05$) ve daha az düzeyde stres ($Ort._{\text{müd}} = 2.94; Ort._{\text{knt}} = 3.44$) bildirmiştir. Buna ilaveten DYT ölçümünde sınırda anlamlı fark ortaya çıkmıştır, $t(54) = -1.95, p = .06$. Buna göre müdahale anneleri ($Ort. = 4.76$) kontrol annelerine ($Ort. = 4.38$) göre, duyarlı davranışa yönelik daha yüksek düzeyde olumlu tutum bildirmiştir.

Hipotez Testi: Müdahalenin Anne Duyarlığına Etkisi

Daha önceden de belirtildiği gibi uygulanacak olan müdahale programının anne duyarlığını artırması beklenmektedir. Bu doğrultuda müdahalenin gözlemlenen (örn., ADSS ve ADÖ) ve rapor edilen (örn., DDYTÖ) anne duyarlığı üzerindeki etkisini test etmek amacıyla Tekrarlı Ölçümler için Varyans Analizleri (Repeated Measures ANOVA) yapılmıştır. Bu analizlerde 2 X 2 Karışık Faktöriyel Varyans Analizi (Mixed-Factorial ANOVA) uygulanmış; deneysel grup (müdahale ve kontrol) gruplar-arası faktör, zaman (öntest ve sontest) ise gruplar-içi faktör olarak ele alınmıştır.

Gözleme dayanan anne duyarlığı ölçümlerine bakıldığında, zaman*grup etkileşiminin ADSS skorları üzerinde anlamlı bir etkisi bulunamamıştır, [$F(1,54) = 1.10, p = .30, \eta^2 = .02$]. Çocuğun cinsiyeti, anne eğitimi ve uygulama yeri kontrol edildiğinde bile iki yönlü etkileşimin anlamlı olmadığı gözlenmiştir. Diğer taraftan, müdahalenin ADÖ skorları üzerindeki etkisine bakıldığında, zaman*grup etkileşimi anlamlı bulunmuştur, [$F(1,54) = 5.20, p < .05, \eta^2 = .09$]. Çocuğun cinsiyeti kontrol edildiğinde bile iki yönlü etkileşimin anlamlı olduğu gözlenmiştir, $F(1,53) = 6, p < .05, \eta^2 = .10$. Buna göre, müdahale annelerinin sontestte gözlemlenen duyarlık skorları ($Ort. = 6.76$) öntestte gözlemlenen duyarlık skorlarına göre ($Ort. = 6.00$) daha yüksekken, kontrol annelerinin sontestte ($Ort. = 6.59$) ve öntestte ($Ort. = 6.49$) gözlemlenen duyarlık skorları çok farklılık göstermemiştir. Bu sonuç müdahalenin ADÖ ile gözlemlenen duyarlı davranışları artırmada etkili olduğunu göstermektedir.

Anne bildirisine dayanan ölçüme bakıldığında, zaman*grup etkileşiminin DYT skorları üzerinde anlamlı etkisi bulunmuştur, $F(1,54) = 4.23, p < .05, \eta^2 = .07$. Çocuğun cinsiyeti kontrol edildiğinde bile iki yönlü etkileşimin anlamlı olduğu gözlenmiştir, $F(1,53) = 4.53, p < .05, \eta^2 = .08$. Buna göre, müdahale annelerinin sontestte bildirdikleri duyarlı davranışa yönelik tutumları ($Ort. = 4.75$) öntestte bildirilen tutumlara göre ($Ort. = 4.29$) daha yüksek düzeyde olumlu iken, kontrol annelerinin öntestte ($Ort. = 4.37$) ve sontestte ($Ort. = 4.38$) bildirdikleri tutumlar farklılaşmamıştır. Bu sonuç müdahalenin annelerin duyarlı davranışa yönelik tutumlarını olumlu yönde etkilediğini göstermektedir.

Diğer taraftan, zaman*grup etkileşiminin DDYT skorları [$F(1,54) = .20, p = .65, \eta^2 = .00$] ve DDYTÖ skorları [$F(1,54) = 1.42, p = .24, \eta^2 = .03$] üzerinde anlamlı etkisi bulunamamıştır. Ancak eşleştirilmiş iki grup t-testi (paired-samples t-test) analizi yapıldığında, müdahale grubundaki annelerin öntestten sontestte duyarlı davranışa ve disipline yönelik tutumlarında olumlu yönde bir artış gözlemlenirken [$t(37) = -3.60, p = .001$], kontrol grubunda böyle bir artış gözlemlenmemiştir [$t(17) = -1.50, p = .14$]. Buna göre, müdahale annelerinin sontestte bildirdikleri duyarlı davranışa ve disipline yönelik tutumları ($Ort. = 4.40$) öntestte bildirilen tutumlara göre ($Ort. = 4.09$) daha yüksek düzeyde olumlu iken, kontrol annelerinin öntestte ($Ort. = 3.91$) ve sontestte ($Ort. = 4.05$) bildirdikleri tutumlar farklılaşmamıştır.

Tamamlayıcı Analizler

Müdahalenin ADSS maddeleriyle oluşturulan iki altboyut (örn., anne duyarlılığı ve sınırlama davranışı) üzerindeki etkisine bakabilmek için 2 X 2 Karışık Faktöriyel Varyans Analizi uygulanmış; deneysel grup (müdahale ve kontrol) gruplar-arası faktör, zaman (öntest ve sontest) ise gruplar-içi faktör olarak ele alınmıştır. Bu analiz sonucunda zaman*grup etkileşiminin anne duyarlılığı üzerindeki etkisinin anlamsız [$F(1,54) = .08, p = .77, \eta^2 = .00$], sınırlama davranışı üzerindeki etkisinin ise anlamlı olduğu bulunmuştur [$F(1,54) = 3.73, p = .06, \eta^2 = .07$]. Bu sonuç müdahalenin annelerin sınırlayıcı davranışlarını azaltmada etkili olduğunu göstermektedir.

Temel hipotezlerin yanı sıra bu çalışmanın diğer bir amacı uygulanacak olan müdahale programının anne duyarlılığı üzerindeki etkisinin değişkenliğini incelemektir. İlk olarak çocuğun duygusallık düzeyinin müdahalenin etkisi üzerindeki rolünü incelemek amacıyla 2 X 2 X 2 Karışık Faktöriyel Varyans Analizi uygulanmış; deneysel grup (müdahale ve kontrol) ve duygusallık (düşük ve yüksek) gruplar-arası faktörler, zaman (öntest ve sontest) ise gruplar-içi faktör olarak ele alınmıştır. Bu analiz sonucunda zaman*duygusallık düzeyi*grup etkileşiminin gözlemlenen ve rapor edilen anne duyarlılığı üzerinde anlamlı bir etkisi bulunamamıştır. Çocuğun duygusallığı kontrol edildiğinde ise zaman*grup

etkileşiminin sadece ADÖ skorları üzerinde anlamlı olduğu görülmüştür, [$F(1,53) = 4.09, p < .05, \eta^2 = .07$].

Benzer şekilde, annenin psikolojik belirtilerinin müdahalenin etkisi üzerindeki rolünü incelemek amacıyla 2 X 3 X 2 Karışık Faktöriyel Varyans Analizi uygulanmış; deneysel grup (müdahale ve kontrol) ve psikolojik belirti düzeyi (düşük, orta ve yüksek) gruplar-arası faktörler, zaman (öntest ve sontest) ise gruplar-içi faktör olarak ele alınmıştır. Bu analiz sonucunda zaman*psikolojik belirti düzeyi *grup etkileşiminin gözlemlenen ve rapor edilen anne duyarlılığı üzerinde anlamlı bir etkisi bulunmamıştır. Annenin psikolojik belirtileri kontrol edildiğinde ise zaman*grup etkileşiminin ADÖ skorları [$F(1,53) = 4.72, p < .05, \eta^2 = .08$] ve DYT skorları [$F(1,53) = 4.00, p = .05, \eta^2 = .07$] üzerinde anlamlı olduğu görülmüştür.

Ayrıca müdahalenin ebeveynlik stresi üzerinde etkisini incelemek amacıyla 2 X 2 Karışık Faktöriyel Varyans Analizi uygulanmış; deneysel grup (müdahale ve kontrol) gruplar-arası faktör, zaman (öntest ve sontest) ise gruplar-içi faktör olarak ele alınmıştır. Ancak zaman*grup etkileşiminin ebeveynlik stresi üzerinde anlamlı etkisi bulunmamıştır, [$F(1,54) = .29, p = .59, \eta^2 = .01$]. Bu sonuçlar çocuğun duygusallık düzeyinin ve annenin psikolojik durumunun müdahalenin etkisini değiştirmediyiğini ve müdahalenin ebeveynlik stresini azaltmada etkili olmadığını göstermektedir. Son olarak cinsiyet farklarına bakıldığında, müdahale grubunda erkek çocuğu olan annelerin ($Ort. = 3.26$) kız çocuğu olan annelere göre ($Ort. = 2.76$) sontest ölçümünde daha fazla stres rapor ettikleri görülmüştür, $t(36) = -2.32, p < .05$. Kontrol grubunda ise kız çocuğu olan annelerin ($Ort. = 4.78$) erkek çocuğu olan annelere ($Ort. = 4.19$) göre sontestte duyarlı davranışa yönelik daha yüksek düzeyde olumlu tutum bildirdikleri görülmüştür, $t(16) = 1.96, p < .10$. Bunun yanı sıra kontrol grubundaki kızların ($Ort. = 2.76$) erkeklere göre ($Ort. = 2.32$) daha yüksek fazla duygusallık gösterdiği gözlemlenmiştir, $t(16) = 1.87, p < .10$.

Tartışma

Mevcut çalışmanın sonuçları video-geribildirime dayanan müdahale programının gözlemlenen (örn., ADÖ) ve rapor edilen (örn., DYT) anne duyarlılığını artırmada etkili olduğunu göstermiştir. Bu anlamda uygulanan program anne

duyarlılığını hem davranış hem de tutum düzeyinde olumlu yönde etkilemiştir. Bu etki, programın duyarlı davranış odaklı bir program olma özelliğinden dolayı beklendik yöndedir. Örneğin, ‘Çocuk için konuşmak’ yöntemi ve ‘Duyarlık zinciri’ teması, duyarlı ebeveynlik tanımıyla örtüşerek (Ainsworth ve ark., 1978), annenin çocuktan gelen örtük ve sözel olmayan sinyalleri doğru bir şekilde algılamasını ve bu sinyallere doğru, hızlı ve yerinde cevap vermesini sağlamaktadır. Buna ilaveten video kaydı ve geribildirim yöntemleri annenin gözlem yapma ve empati kurma becerisini artırmakta ve duyarlı davranışların pekiştirmesini sağlamaktadır.

Müdahalenin ADSS ile ölçülen anne duyarlılığı üzerinde etkisinin gözlenememesi az riskli gruptan gelen annelerin en baştan yüksek düzeyde duyarlılığa sahip olmasıyla ilişkilendirilebilir. Bu anlamda müdahalenin davranış sorunları olan çocuklu aileler üzerinde daha etkili olması beklenmektedir. Bunun yanı sıra müdahalenin annelerin duyarlı disipline yönelik tutumları üzerinde etkisinin gözlenememesi iki şekilde yorumlanabilir. Bunlardan biri, öntest ve sontest arasındaki sürenin annenin yeni öğrendiği disiplin stratejilerini uygulaması için yeterli bir süre olmayışıdır (Yağmur ve ark., 2014). Diğeri ise otoriter ebeveynlik stiline yaygın görüldüğü toplulukçu kültürlerde özerkliği destekleyen disiplin uygulamalarının artırılmasının uzun zaman almasıdır (Yağmur ve ark., 2014). Bu anlamda annelere uygulamalar için daha fazla zaman tanıyan ve disiplini gözleme dayalı ölçen çalışmalar (örn., Van Zeijl ve ark., 2006) müdahalenin duyarlı disiplin üzerindeki etkisini daha açık bir şekilde ortaya koyabilir.

Mevcut çalışmadan elde edilen bulgular bu programın Türkiye ve benzeri toplulukçu ya da ilişkisel kültürlerde ve düşük sosyoekonomik bağlamlarda da uygulanabilirliğini ve etkinliğini göstermesi açısından önem arz eder. Kullanılan yöntem ve temaların (örn., ‘Çocuk için konuşmak’, ‘Duyarlık zinciri’) programın kültürel geçerliğini artıran temel etmenler olduğu söylenebilir. Programa katılan annelerin bir kısmı bu program sayesinde çocuklarının (örtük) sinyallerini daha iyi fark ettiklerini ve bunlara uygun cevap verebildiklerini belirtmişlerdir. Örneğin, anneler bu program sayesinde çocuklarının keşif için daha fazla zamana ihtiyaç duyduklarını ancak onlara bu zamanı tanımadıklarını belirtmişlerdir. Bu anlamda program Türkiye bağlamında duyarlı ebeveynlik olarak tanımlanabilecek davranışları destekler niteliktedir.

Müdahalenin etkinliğinden söz ederken programın bu etkiyi artıran diğer özelliklerine de değinmek gerekir (Bakermans-Kranenburg, Van IJzendoorn, Mesman ve ark., 2008; Klein-Velderman, Bakermans-Kranenburg, Juffer ve Van IJzendoorn, 2006). Örneğin, VIPP programının davranış odaklı bir program olması amacının (duyarlı davranışı artırmak) daha net olmasını sağlamaktadır. Kısa süreli bir program olması (4-6 temalı görüşme) programın yükünü ve annelerin programdan ayrılma ihtimalini azaltmaktadır. Video geribildirim annelerin çocuklarının sinyallerini ve kendi davranışlarının etkisini gözleme becerisini artırmaktadır. Çocuk altı ayı geçtikten sonra müdahalenin başlaması annelerin değişime daha açık olmasını sağlamaktadır. Programın standart prosedürü ve detaylı elkitabı uygulamanın kolayca öğrenilmesine yardımcı olmaktadır. Son olarak, programın uyarlanabilmesi farklı gruplara (örn., otistik çocuklar) uygulanabilmesini sağlamaktadır.

Bu araştırma bazı kısıtlılıklar içermektedir. Bunlardan ilki örneklem sayısının görece düşük olmasıdır. Daha geniş bir örneklemle yapılacak çalışmaların müdahalenin etki gücünü artırması beklenmektedir. Özellikle çocuğun duygusallığı ve annenin psikolojik durumu gibi değişkenlerin müdahale üzerindeki etkileri geniş bir örneklemde daha iyi gözlemlenebilir. Bunun yanı sıra örneklemin tamamıyla düşük eğitim ve sosyoekonomik düzeye sahip ailelerden seçilmesi planlanmışken, bu gerçekleştirilememiştir. Daha yüksek riskli gruplarda yapılacak çalışmalar müdahalenin etkisini daha fazla ortaya koyabilir. Bir diğer sınırlılık ise müdahalenin çocuğun güvenli bağlanmasını artırmada ya da davranış problemlerini azaltmadaki etkisinin incelenmemesidir. Gelecek çalışmalara anne değişkenlerinin yanı sıra çocuk değişkenlerinin de eklenmesi önerilmektedir. Son olarak, izleme ölçümü yapılmaması müdahalenin uzun süreli etkisinin gözlenmesini engellemektedir. Özellikle ebeveynlik stresini azaltmada müdahalenin uzun süreli etkisi izleme ölçümleri ile gözlemlenebilir.

Kısıtlılıklarının yanı sıra mevcut çalışmanın güçlü yanları bulunmaktadır. Bunlardan ilki deneysel desen ile neden-sonuç ilişkisinin ortaya koyulabilmesidir. Diğerleri, anne duyarlılığının hem gözleme dayanan (örn., ADSS, ADÖ) hem de öz-bildirim yöntemi (örn, DDYTÖ) ile ölçülmüş olması ve bağımsız kodlayıcılar tarafından kodlanmasıdır. Bu da “ortak yöntem varyansını” azaltan bir durumdur.

Son olarak, kontrol annelerine bir oturumluk duyarlık eğitimi verilmesi tüm katılımcıların faydalanmasını sağlamıştır. Mevcut çalışma Türkiye’de uygulanan bağlanma-temelli ilk müdahale çalışması olma özelliği ile yazına önemli bir katkıda bulunmaktadır. Video-geribildirimine dayanan müdahale programının farklı kültürel ve sosyoekonomik bağlamlarda da uygulanabilirliği ve etkinliğini göstererek erken dönem destek veya müdahale programı geliştirmeyi ve uygulamayı planlayan araştırmacı ve uygulayıcılara işlevsel bir kaynak sunmaktadır. Gelecekte başta dezavantajlı kesimler olmak üzere tüm sosyal kesimlerinde bu programın sistematik olarak yaygınlaştırılması, annelerin olumlu ebeveynlik davranışları geliştirmesi ve bunun sonucunda çocukların optimal psikolojik gelişim göstermesi bakımından topluma önemli katkı sağlayacaktır.

Appendix L CURRICULUM VITAE

PERSONAL INFORMATION

Surname, Name: Metin Orta, İrem
Nationality: Turkish (TC)
Date and Place of Birth: 4 October 1984, Adana
Marital Status: Married
Phone: +90 312 586 8646
email: metinirem@hotmail.com

EDUCATION

Degree	Institution	Year of Graduation
MS	Koç University, Developmental Psychology	2010
BS	Middle East Technical University, Psychology	2007
High School	Samsun Anadolu High School	2002

WORK EXPERIENCE

Year	Place	Enrollment
2012 -Present	Atılım University, Department of Psychology	Instructor
2011- 2012	Atılım University, Department of Psychology	Assistant
2007-2010	Koç University, Department of Psychology	Assistant

FOREIGN LANGUAGES

Advanced English, Elementary Spanish, Basic German

PUBLICATIONS

Uysal, A., Akbaş, G., Helvacı, E. & Metin, I. (2014). Validation and correlates of the vicarious embarrassment scale. *Personality and Individual Differences*, 60, 48-53.

- Metin Orta, I., Corapci, F., Yagmurlu, B., & Aksan, N. (2013). Mediation role of effortful control and emotion dysregulation in the link between maternal responsiveness and Turkish preschoolers' social competency and externalizing symptoms. *Infant and Child Development, 22*, 5, 459-479.
- Metin, I. (2013). Impact of cross-group romantic relationships on intergroup prejudice. *Social Behavior and Personality: An International Journal, 41*(1), 1-6.
- Metin, I. (2011). Self and well-being. *International Journal of Business and Social Science, 2*(18), 302-305.
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- Metin Camgöz, S., Özkan Tektaş O., & Metin, I. (2008). Academic attributional style, self-efficacy and gender: A cross-cultural comparison. *Social Behaviour and Personality: An International Journal, 1* (36), 97-114.

AWARDS AND SCHOLARSHIPS

The Scientific and Technological Research Council of Turkey (TÜBİTAK), National Scholarship Programme for Ph.D. Students

The Scientific and Technological Research Council of Turkey (TÜBİTAK), National Scholarship Programme for M.A. Students

Scholarship of the Erasmus Program

HOBBIES

Swimming, Travelling

Appendix M TEZ FOTOKOPİSİ İZİN FORMU

ENSTİTÜ

Fen Bilimleri Enstitüsü	<input type="checkbox"/>
Sosyal Bilimler Enstitüsü	<input checked="" type="checkbox"/>
Uygulamalı Matematik Enstitüsü	<input type="checkbox"/>
Enformatik Enstitüsü	<input type="checkbox"/>
Deniz Bilimleri Enstitüsü	<input type="checkbox"/>

YAZARIN

Soyadı : METİN ORTA

Adı : İREM

Bölümü : PSİKOLOJİ

TEZİN ADI (İngilizce) : Early Parenting Support: Application of an Intervention Program to Enhance Maternal Sensitivity in Turkey

TEZİN TÜRÜ : Yüksek Lisans Doktora

1. Tezimin tamamından kaynak gösterilmek şartıyla fotokopi alınabilir.
2. Tezimin içindekiler sayfası, özet, indeks sayfalarından ve/veya bir bölümünden kaynak gösterilmek şartıyla fotokopi alınabilir.
3. Tezimden bir (1) yıl süreyle fotokopi alınamaz.

TEZİN KÜTÜPHANEYE TESLİM TARİHİ: