INTRODUCTION

As a family nurse (FN), you engage in observations of caregiver-child interactions every time you meet with your client and her child during a home visit. You notice how your client is feeling as well as the new developmental milestones her child is accomplishing. You may notice that your client seems tired, or that her child has learned to roll over. You might notice that your client seems frustrated with her child or she is beaming because her child can smile and she wants to share this with you.

Although you are already observing important aspects of caregiver-child interactions, the Dyadic Assessment of Naturalistic Caregiver-child Experiences (DANCE) will help to organise your observations and your thinking about caregiver-child interactions in ways that will help you identify both strengths within the caregiver-child relationship as well as areas for growth for your clients’ caregiving behaviours.

The DANCE STEPS (Strategies To Enhance Parenting Skills) then utilise findings from DANCE observations to provide parenting pathways that guide interventions in the maternal role domain of the programme. They help you identify the most appropriate FNP programme materials to reinforce areas of strength and support areas for growth for client’s caregiving behaviours. The FNP DANCE STEPS serve to build caregiver’s reflective capacity, knowledge, and skill around caregiving interactions.

KEY CHARACTERISTICS OF THE DANCE

Successful promotion of competent caregiving requires that nurses have feasible, clinically useful, and valid tools to assess qualities of caregiver-child interactions so that such information can be used to target intervention.

Through extensive review of the literature on caregiver-child interactions, existing caregiver-child interaction measures, reviews of papers and reports from the original Nurse-Family Partnership (NFP) trials to identify the parenting dimensions that the programme is targeted at addressing, expert input, and guidance from the project’s Advisory Committee (composed of NFP nurses, supervisors, and NFP state and national nurse consultants), and colleagues in the UK implementing the FNP, the DANCE was created to:

- Focus on core FNP caregiving competencies and behaviours,
- Guide developmentally appropriate observation of caregiving behaviours,
- Capitalise on the unique opportunity that FNs have to view the caregiver-child relationship in natural settings over the course of a family’s participation in the programme, and
- Provide FNs with information and resources that will readily support their work with families around the promotion of competent caregiving.
The DANCE has been developed to be a valid and reliable tool, be feasible to use in the context of home visitation, and be clinically useful for nurses working with families to support caregiving. Reliability and validity testing with over 100 families observed using the DANCE assessment at child age 6, 12, and 21 months demonstrates that the DANCE is a reliable tool that predicts children’s outcomes across a range of developmental domains (language development, cognitive development, academic achievement, executive functioning, and emotional and behavioural regulation) through child age 9.

What is the clinical value of using a reliable measure?

The term "reliability" refers to the degree to which the DANCE measures a given attribute consistently across observers. For example, if the DANCE behaviours are reliable, two family nurses observing a caregiver and child interacting together at the same point in time should score the interaction very similarly.

Reliability of the DANCE assessment holds great value clinically. For nurses, a reliable DANCE instrument ensures that when a nurse completes a DANCE observation s/he will have accurate information to help guide his/her work with the client. A reliable assessment tool allows the nurse to provide the most appropriate support for the client given where the client is at. This support can help the client move along the parenting continuum. A tool (or user) that does not evidence reliable assessment may result in differences in that assessment by users influenced by his/her own experience, beliefs, interpretations, and biases. This type of assessment can result in a misperception of the client’s strengths and areas for growth and the possibility of not supporting the client in the most appropriate and effective manner. Additionally, a reliable DANCE tool allows the nurse to complete the DANCE assessment at different points in time and have confidence that changes in caregiving behaviour are more likely to be true differences and not an artifact of scoring. Finally, a reliable assessment tool holds significant clinical value to the larger team of practitioners. A reliable tool ensures that nurses and supervisors discussing DANCE behaviours hold a common understanding of what a specific behaviour and score for that behaviour represent. This type of common understanding allows nurses and supervisors to support each other during supervision, case discussions, visit planning, and covering caseloads when a nurse is out of the office.

What is the clinical value of using a valid measure?

The term “validity” refers to the degree to which the DANCE measures a set of constructs and that these constructs relate to healthy outcomes for caregivers and their children. Clinically, this means that the DANCE measures aspects of caregiving that are related to the outcomes the programme is targeted at impacting (e.g., children’s language development, positive peer relationships, pro-social behaviour, academic achievement). Therefore, as a DANCE user you can have some assurance that the information from the DANCE will help you to target aspects of caregiving that are likely to have a positive impact on children’s growth and development.
What does the DANCE provide to users?

The DANCE is a strengths-based assessment tool that has been developed to help nurses identify areas of strengths and areas for growth in their clients’ caregiving behaviours. The DANCE provides users with a rigorously developed tool and education model designed to enhance nurses’ delivery of the FNP programme. The DANCE: 1) deepens nurses’ understanding of dyadic interaction; 2) serves as a framework to guide intervention in the maternal role domain of the programme; and 3) offers opportunities for ongoing assessment over the course of the programme to determine how the caregiver is developing his/her caregiving skills and supporting developmental shifts in the child. The DANCE was developed in consultation with NFP/FNP family nurses, supervisors, educators, and nurse consultants in the US and UK to ensure that the tool meets the needs of family nurses and is feasible to use in the context of home visitation.

DANCE THEORETICAL OVERVIEW

One of the most important processes that shape the lives of very young children is the interaction they have with their primary caregivers. Over the past 30 years, hundreds of studies have substantiated the relationship between qualities of early parenting behaviours and children’s emotional development (Spinrad et al, 2004; Kochanska, Aksan, & Carlson, 2005; Little & Carter, 2005), cognitive development (Feldman, Greenbaum, Yirmiya, & Mayes, 1996), social development (Brown, Donelan-McCall, & Dunn, 1996; Dunn et al, 1991; Kochanska et al, 2005), and the development of aggression, conduct disorder, antisocial behaviour, and depression/anxiety in children (Kaufman, 1991; Warren et al, 1997). Evidence in support of the relationship between early parental care and child outcomes has made a significant contribution to our understanding of adaptive (and maladaptive) child development.

The promotion of caregivers’ competence in providing care that is sensitive, responsive, and supports developmental growth is at the core of the FNP model. The DANCE has been developed to help nurses identify areas of strengths and areas for growth in caregiver’s behaviours to enhance competent caregiving. As described in Figure 1, the dance between a caregiver and child is comprised of a combination of steps: Step 1) children come into the world with physiological and psychological needs; Step 2) children have the ability to communicate these needs through signals or cues; Step 3) caregivers learn to read the signals or cues; Step 4) caregivers learn to respond to their children’s signals or cues in ways that meet their children’s needs; and Step 5) children respond to their caregivers' responses. When all five steps are regularly performed, a graceful dance between the caregiver and child is achieved. When there are repeated missteps, the dance is awkward and disruptive.
It is important to note that the dance between the caregiver and child is not based on any individual step but how all the steps combine across interactions to create synchrony in the relationship. Despite the developmental significance of dancing in synchrony, caregivers and children are not perfect and are expected to misstep. According to Tronick (1989), about 30 percent of the time exchanges between mothers and their babies are perfectly “in sync” with one another. The remaining 70 percent of the time, interaction errors occur. However, Tronick believes that warm, sensitive caregivers become especially skilled at repairing these errors and returning to a synchronous state, or in our terms a graceful dance.

The DANCE has been developed to help nurses work with caregivers to enhance the quality and maintenance of positive caregiver-child interactions. When caregiver-child interactions are positive and synchronous, caregivers spend more time with their children. They develop a sense that they are effective caregivers and discover that when they support their children’s growth and development, their children respond positively. Children who experience positive caregiver-child interactions will engage more with their caregivers, will reinforce caregivers’ behaviours, and will develop a sense of trust in their relationships with their caregivers and others.

THE DIMENSIONS OF THE DANCE

The DANCE consists of a set of parenting behaviours that were selected after an extensive review of the literature and deep consideration of the model. After developing a list of over 50 candidate behaviours, caregiving behaviours were chosen based on the following criteria:

1. The behaviour is likely to be observed during routine home visits,

2. The behaviour is amenable to change through the FNP programme,
3. The behaviour is reflective of a dyad’s communication and interaction styles, and

4. The behaviour supports children’s healthy development.

In total, 18 caregiving behaviours have been selected for inclusion in the DANCE. The 18 behaviours have been grouped into four caregiving dimensions: Emotional Quality, Sensitivity and Responsivity, Support of Behavioural and Emotional Regulation, and Promotion of Developmental Growth.

The boxes in Figure 2 provide an overview of how the DANCE can be incorporated into the FNP programme model; specifically, how the DANCE can be used to help FNs work with families to promote responsive and competent caregiving and in turn positive outcomes for child health and development. Family nurses have the opportunity to work with families using the information obtained from the DANCE to influence the pathways illustrated in Figure 2. The FNP programme has been developed to help FNs work with families around the promotion of competent caregiving with the goal of reducing child maltreatment and injuries and fostering children’s cognitive development and emotional and behavioural regulation. Such impacts on children’s growth and development have lasting effects on their later functioning, including prosocial behaviour, positive peer relationships, academic achievement, and executive functioning (e.g., sustained attention, decision-making, impulsivity). The unshaded boxes represent the pathways through which the DANCE can be used to help FNs promote competent caregiving. The shaded boxes represent the two other primary goals of the FNP programme, 1) improving pregnancy outcomes (through improved prenatal health behaviours) and 2) improving economic self-sufficiency. These goals are included in this model because all three FNP goals are inter-related.
The DANCE dimensions are embedded in the “Responsive and Competent Caregiving” box on the far left of Figure 2. Within this box we see a bidirectional (two-way) arrow between child characteristics (shaded) and DANCE dimensions indicating that a child’s characteristics influences his or her caregiver’s behaviours, and the caregiver’s behaviours influence the characteristics of the child. For example, children who are characterised by greater reactivity may have caregivers who become more disregulated in response to their children’s distress. Alternatively, caregivers whose responses are characterised by inconsistency to their children’s distress may have children who become increasing reactive to their environments.

Moving from the “Caregiving” box on the far left to the middle “Attachment” box we see a unidirectional (one-way) arrow indicating the relationship between caregivers’ behaviours...
(classified into one of four dimensions) and the quality of children’s attachment relationships. Caregivers who read their children’s cues accurately provide care that is sensitive and responsive to their children’s needs, support their children’s emotional states by helping their children to regulate their affect during distress, share positive affect with their children during interactions, demonstrate reflective functioning, and foster a sense of safety and security in their children. According to Bowlby (1988), children organise their experiences with their primary caregivers in the form of working models, which consist of inner representations of the attachment figure(s), the self, and the environment. Children with secure attachment classifications develop an internal working model that the world is predictable and reliable and that they can trust and rely on their caregiver.

To the right of the “Attachment” box we see an arrow leading to children’s neurodevelopment outcomes including emotional and behaviour regulation and cognitive, language, and social cognitive competence (understanding others’ thoughts, feelings, and beliefs). Theoretically, children whose primary caregivers are sensitive, responsive, affectively supportive, and understand their children’s thoughts, beliefs, emotions, and perspectives as separate from their own, have children who develop internal working models that the world is a safe place to explore, that their primary caregiver will be available if needed, and that they are valued and loved. The development of emotion regulation has been related consistently to sensitive caregiving and attachment security (Bell & Ainsworth, 1972; Braungart-Rieker et al, 1998; Bridges & Grolnick, 1995; Cassidy, 1994; Fish, Stifter, & Belskey, 1991). It is hypothesised that within the context of a secure relationship with a primary caregiver, children learn how to experience and regulate their emotional and behavioural responses. Children who develop an internal working model of the world as safe and believe that their primary caregiver will be available when needed are more likely to explore their world and gain experiences that foster cognitive growth and development.

We also see a single directional arrow that directly links DANCE caregiving dimensions to children’s neurodevelopment. This arrow represents both the theoretical and empirical relationship that exist independent of children’s attachment relationships between caregiving behaviour and children’s emotional and behaviour regulation and cognitive and social-cognitive competence. For example, several researchers have found that aspects of families’ conversations about emotions, beliefs, and intentions are predictive of children’s emotion regulation and social cognitive competencies, even if you take into account the children’s attachment classification.

Similarly, children who develop secure attachment relationships with their primary caregiver are less likely to experience high levels of anxiety when exploring their environments. High levels of anxiety can interfere both on a neurologic and experiential level to inhibit exploration that fosters cognitive development. Although attachment may mediate the relationship between parenting behaviour and cognitive outcomes, there are direct influences of caregivers’ behaviour on children’s cognitive development. For example, research has indicated that parent’s deliberate action to develop child language is a significant predictor of language acquisition; availability of age appropriate toys and books and opportunities to explore the environment in a developmentally appropriate, supportive manner are predictive of children’s language development and school readiness. Therefore, Figure 2 represents how parenting behaviours
and child characteristics, through their bi-directional effects on each other, serve to foster attachment relationships that in turn predict children’s emotional, behavioural, cognitive, language, and social cognitive competence.

The final arrow in Figure 2 represents the relationship between children’s emotional, behavioural, cognitive, language, and social-cognitive competencies and a range of child and adolescent outcomes. The capacity to regulate emotion is believed to play a major role in the development of children’s social competence, peer relationships, and problem behaviours. Positive associations have been reported between children's ability to understand others' emotions and positive peer relationships, and children’s early language abilities are predictive of their school adjustments and academic achievement.

The ways in which the FNP programme influences the life course of clients and their children are many. One of the most important aspects presented in Figure 2 is that there are specific parenting behaviours (competencies) that predict children’s healthy development. The DANCE helps you to observe these behaviours and support your work with families around strengthening these behaviours to improve the development and life course of children.

Following is a review of each of the DANCE dimensions and an in-depth discussion of how the behaviours in each dimension support the relationship between the caregiver and child, as well as the child’s development.

Although each of the behaviours in the DANCE have been listed in a single dimension, it is important to note that many of the behaviours are not mutually exclusive of other behaviours and often are aspects of other caregiving dimensions. For example, Response to Distress is a behaviour that Supports Behavioural and Emotional Regulation but also is indicative of Sensitive and Responsive caregiving and the Emotional Quality of the relationship. Each behaviour has been assigned to a dimension where there was the greatest conceptual connection to other behaviours; however, all caregiver behaviours help to support the interactive dance that supports children’s optimal development.

**Emotional Quality**

The Emotional Quality dimension is comprised of five caregiver behaviours including Expressed Positive Affect, Caregivers’ Affect Complements Child’s Affect, Verbal Quality, Response to Distress, and Negative Comments About the Child to Others. The behaviours in the Emotional Quality dimension are predominately observed through the caregivers’ affect or the verbal, facial, and behavioural (posture, eye contact) displays caregivers use to express their feelings and emotions.

The emotional quality of the dyad is critical for development of a trusting, secure relationship (Kochanska, 1998), for the development of children’s emotional and behavioural regulation (Eisenburg, Spinrad, & Eggum, 2010), and development of emotional understanding (Dunn and Brown, 1992). According to Kochanska (1998), when mothers respond to infants’ cues and dyads share more pleasant emotions and experiences together, the development of the infant’s attachment security is supported. Similarly, Isabella and Belsky (1991) have described the term
interactional synchrony as a sensitively tuned “emotional dance” in which the caregiver responds to the infant’s signals in a well-timed, appropriate fashion and, in addition, both partners match emotional states, especially the positive ones. Interactional synchrony distinguishes children with regard to their attachment classification. These studies suggest that it is the combination of responsiveness and affective quality that supports the development of attachment security.

During the first two years of life children are rapidly learning how to be social partners with their caregivers. Caregivers play a significant role in this learning by supporting their children’s development of emotional and behavioural understanding and regulation. According to Dodge (1989), emotional self-regulation refers to the strategies we use to adjust our emotional state to a comfortable level of intensity so we can accomplish our goals. Behaviour regulation can be thought of as the strategies we use to express our thoughts, feelings, beliefs, wants, desires, and states in ways that are acceptable to our society and facilitate goal attainment. As caregivers help infants regulate their emotional states, they also provide lessons on the social rules around expressions of emotions and behaviours. Parents support this learning in three ways: modeling affective responses that are predominately positive, helping children regulate their emotional and behavioural responses, and talking about emotional states (Eisenberg, Spinrad, and Eggum, 2010). Maternal interactions characterised by warmth (or positivity), sensitivity, and supportive responses with emotional coaching during distress are related to the development of children’s emotion regulation and effortful control (Eisenberg et al, 2005; Gaertner et al, 2008; Lengua, 2008; Spinrad et al, 2007).

Additionally, caregivers’ responses to children’s emotional disregulation (particularly negative disregulation) provide children with valuable information about expressions of emotion, strategies for regulating negative arousal, and social expectations for the display of negative emotions. Caregivers who are able to support their children’s distress by responding in a supportive manner are more likely to have children who demonstrate higher levels of emotional understanding and behavioural regulation as preschoolers than caregivers who do not support their children’s distress (Denham & Couchoud, 1991; Spinrad et al, 2004). The caregiver-child relationship offers the first opportunity for children to learn the rules and expectations for emotional expression and effortful control and it is the starting point for developing strategies for managing their emotions and behaviours.

Sensitivity and Responsivity

The Sensitivity and Responsivity dimension contains six behaviours including: Positioning, Visual Engagement, Negative Touch, Pacing, Non-Intrusiveness, and Responsiveness. Caregiving sensitivity has been defined as the ability to accurately perceive the child’s signals and to respond to these signals in prompt and adequate ways (Ainsworth et al, 1978). Sensitive and responsive parenting during infancy is associated with the development of trust and a secure attachment (e.g., Ainsworth, Bell, & Stanton, 1971; Bowlby, 1988). Caregivers who are sensitive and responsive to their children’s needs foster a sense of security and safety in their children. This sense of security and safety allows children to explore their world and learn from their experiences.
The development of emotion regulation has been related consistently to sensitive caregiving and attachment security (Bell & Ainsworth, 1972; Braungart-Rieker et al, 1998; Bridges & Grønlick, 1995; Cassidy, 1994; Fish, Stifter, & Belskey, 1991). Sensitive responsive caregiving is caregiving that involves mothers’ responsivity to their infants’ cues and emotional reactions. This has been linked with lower negativity and more regulatory behaviour (Kochanska et al., 2000; Spinrad et al., 2007). Furthermore, individual differences in maternal sensitivity and responsiveness have been associated with differential outcomes in children’s self-esteem (Cassidy, 1988), peer interactions (Jacobson & Wille, 1986; Rydell, Bohlin, & Thorell, 2005) and dependency (Sroufe, Fox, & Pancake, 1983). Caregivers who accurately read their babies’ cues, empathise with their infants, and respond sensitively to their babies’ signals are less likely to abuse or neglect their children and are more likely to read their children’s developmental competencies accurately, leading to fewer unintentional injuries (Peterson & Gable, 1998) and more sensitive parenting.

Support for Behavioural and Emotional Regulation

The capacity to regulate emotion and behaviour is believed to play a major role in the development of children’s social competence (Cassidy et al., 1992; Eisenberg & Fabes, 1992; Saarni, Mumme, & Campos, 1998) and problem behaviours (Eisenberg et al., 2001). Therefore, observing the role caregivers play in supporting their children’s behavioural and emotional regulation is an important aspect of competent caregiving. The Support for Behavioural and Emotional Regulation dimension captures this aspect of caregiving through the observation of two behaviours: Limit Setting and Completes Interactions. Maternal limit setting has been related to higher effortful control in children (Lengua et al., 2007) and caregivers who complete interactions with their children create predictability and routines for their children and foster security and trust. Completing interactions also enhances children’s ability to transition from one activity or experience to the next with less disruptive behaviours.

Promotion of Developmental Growth

Vygotsky (1978) believed that developmental phenomena such as voluntary attention, memory, and problem solving have their origins in social interactions. Through joint activities with more mature and experienced partners, children master activities and learn the social rules of their society. Caregivers who provide support for their children’s development through their use of language, scaffolding, and supportive environments have children who demonstrate more sophisticated problem solving abilities, superior language scores, higher scores on measures of executive functioning, and better academic achievement (Bradley, 1999; Evans & Kantrowitz, 2002; Feldman et al., 1996; Tamis-LeMonda et al., 2005; Tamis-LeMonda et al., 2004). Executive functioning involves cognitive processes such as planning, working memory, attention, problem solving, verbal reasoning, inhibition, multi-tasking, initiation and monitoring of actions and are essential to successfully handling novel situations.

Additionally, children enjoy listening to caregivers and will orient themselves toward their caregiver when they hear their caregivers’ voice. Children’s marked interest in speech (including orienting toward the caregiver) encourages parents to engage with and talk to their children, fostering more opportunities for interaction. The Promotion of Developmental Growth
domain captures five behaviours related to caregivers support for children’s developmental growth including: Supports Exploration, Scaffolding, Verbal Connectedness, Praise, and Negative Verbal Content.

In the most basic sense, caregiver’s behaviours serve to either support or inhibit children’s interactions with their caregivers and their subsequent development. At its best, the interaction is coordinated and has the grace of a dance in which each partner’s movements influence the other, helping both dance partners grow and flourish. It is important to keep in mind that both the caregiver and the child are actively contributing to how the dance unfolds.

**EMOTION AND AFFECT IN CAREGIVER-CHILD INTERACTIONS**

As human beings, emotional communications underlie all of our social encounters, including those between caregivers and children. In fact, the emotional relationship between parents and their children lays the foundation for infants to learn healthy emotional communication, a necessary skill for engaging in the social world. Through their emotional communications caregivers provide opportunities for infants to see and learn about emotions, express emotions in healthful ways, and learn to talk about and discuss their emotions. As infants grow older, they use emotional cues from their caregivers to help guide their exploration and to learn which behaviours and actions are valued and which are not. Because the emotional relationship between caregivers and infants is so critical for healthy development, the DANCE includes several behaviours that represent the emotional aspects of the relationship and therefore the observer will observe the affect of both the child and caregiver. Before using the DANCE it is important to understand the DANCE definition of emotions and how emotions can be seen and heard through affect displays (or affect).

**What are Emotions?**

Emotions are states of consciousness in which feelings are experienced as responses to stimuli. We can think about emotions along two continuums: 1) pleasure - displeasure and 2) low intensity – high intensity (Bullock and Russell, 1986). Pleasure is the state or feeling of being happy or gratified and creates a positive feeling (positive emotions) that one is motivated to recreate in the future. Displeasure is a state of being dissatisfied or annoyed and is an experience that creates negative feelings (negative emotions) that one is motivated to avoid in the future. The intensity of an emotion describes the arousal level of the emotion, the degree of pleasure or displeasure.

**What is an Affect Display (Affect)?**

The expression of emotion is known as an affect display or affect. Affect can be observed by others and is expressed or displayed by facial expressions, body language, and tone of voice. As displayed in Figure 3 below, we can conceptualise affect displays considering both pleasure and intensity. Surprise is an example of an emotion that is considered to be high intensity pleasure whereas interest is considered to be low intensity pleasure. Flatness is an example of an emotion that is considered to be low intensity displeasure, whereas anger is considered to be high
intensity displeasure. When using the DANCE to observe caregiver-child interactions, the family nurse will observe the affect of both the child and caregiver.

**Figure 3: Intensity and Pleasure of Various Affect Displays**

![Diagram showing intensity and pleasure of various affect displays with high and low intensity categories and examples of positive and negative affect]

**How Can I See and Hear Affect?**

Affect can be observed by examining facial expressions, body language, and tone of voice. Through facial expressions we can recognise positive affect through wide, bright eyes; raised brow; and an up-turned mouth. These characteristics are evident in a joyful smile but also are present when we think about contentment or interest (albeit at a lower intensity including focused-eye contact, slightly up-turned mouth). Negative affect is characterised by such facial expressions as a furrowed brow, down-turned mouth, narrowed or dropping eyes. Affect can also be seen in one’s body language including posture (sitting up and leaning toward someone as signs of positive affect versus slouching and leaning away as signs of negative affect), arm movements (slow and fluid movements for positive affect versus quick and sudden movements for negative affect). In addition to seeing affect displays, you can hear affect through one’s tone of voice. Tone of voice includes the pitch, volume, speed/rhythm, and emphasis of communication. Positive tone is often reflected in tone characterised by variable pitch, lower volume, relaxed variable, but predictable rhythm. Negative tone is often reflected in tone that is loud, tense, monotone, harsh, not rhythmic, and very high or very low pitch. Table 2 presents characteristics of facial expressions, body language, and tone of voice for positive and negative affect displays. Understanding these characteristics and looking for them at various levels of intensity will help aid your DANCE observations of many of the behaviours that involve the emotional quality of the relationship.

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### Table 2: Positive & Negative Characteristics of Facial Expressions, Body Language, and Tone.

<table>
<thead>
<tr>
<th>Affect</th>
<th>Facial Expression</th>
<th>Body Language (including gestures)</th>
<th>Tone of Voice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pleasure</strong></td>
<td>• Wide, bright eyes</td>
<td>• Slow, fluid movements</td>
<td>• Soft, but easily heard volume</td>
</tr>
<tr>
<td>* (Positive)</td>
<td>• Open eyelids: the upper lid is raised and the lower lid is drawn down</td>
<td>• Open body and arms</td>
<td>• Warm, welcoming</td>
</tr>
<tr>
<td></td>
<td>• Eyebrows that are raised so they become curved and high.</td>
<td>• Relaxed muscles</td>
<td>• Variable tone, sing-song</td>
</tr>
<tr>
<td></td>
<td>• Horizontal wrinkles across the forehead.</td>
<td>• Attentive posture</td>
<td>• Relaxed tone</td>
</tr>
<tr>
<td></td>
<td>• Upturned mouth, often into a smile or with laughter</td>
<td></td>
<td>• Moderate pitch</td>
</tr>
<tr>
<td></td>
<td>• Dropped jaw so that the lips and teeth are parted, with no tension around the mouth.</td>
<td></td>
<td>• Variable, but predictable rhythm</td>
</tr>
<tr>
<td><strong>Displeasure</strong></td>
<td>• Furrowed brow</td>
<td>• Abrupt, quick movements</td>
<td>• Loud</td>
</tr>
<tr>
<td>* (negative)</td>
<td>• Down-turned mouth, pursed lips</td>
<td>• Tense muscles</td>
<td>• Tense</td>
</tr>
<tr>
<td></td>
<td>• Narrowed-eyes, down-turned lids, lost focus, poor eye contact</td>
<td>• Yawning</td>
<td>• Flat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Tilted head, slouched posture, oriented away from others</td>
<td>• Lacking in energy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Very high or very low pitch</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Monotone, non-rhythmic</td>
</tr>
</tbody>
</table>

### What if I See One Thing and Hear Another?

While affect displays are typically consistent across the various display modalities (facial expressions, gestures, tone) there are occasions when you may see conflicting information. One might see a caregiver whose facial display presents low intensity, negative affect (e.g., flat) but has a low-intensity, positive tone of voice (e.g., interest). Determining the caregiver’s emotional state can be challenging when mixed affect is displayed. For the DANCE, we consider any display of positive affect (facial, tone of voice, gestures) to be an indication of positive affect. Therefore, if a caregiver provides a mix of positive and negative affect displays concurrently, their affect should be coded as positive.
PREPARING TO USE THE DANCE

The DANCE has been developed to be completed based on naturalistic observations that occur during routine home visits.

Naturalistic Observations

Naturalistic observation is a method of observation that involves observing caregivers and children interacting together in settings familiar to the dyad (Connors & Glenn, 1996; Pett et al, 1992). The nurse is able to carefully observe the relationship between the caregiver and child in the setting where the caregiver and child most often interact (Gardner, 2000). This method gives nurses important insight into the relationship experiences that each individual child has with their mother or other caregivers. This observation approach is invaluable for planning interventions and evaluating outcomes that are specific to each dyad’s strengths and areas for growth. As mentioned previously, this observation approach is part of nursing assessment and involves collecting and organising data (Timby, 2009).

There are many approaches to observing caregivers and their children that vary in terms of the presence of an observer, type of task observed, and location of interaction. Often observations of caregivers and their children are conducted in the context of standardised, brief interactions designed to illicit the variability and quality of naturally occurring behaviours (Gardner, 2000; Pett et al, 1992). Reviews of the few studies that have examined the presence of an observer, type of observation task, and location of observation found that the presence of an observer does not necessarily affect the generalizability of the observations to behaviour in the home; however, observations in structured tasks or in laboratory/clinic settings do not necessarily represent the types of interactions that are naturally occurring in the home (Gardner, 2000).

Naturalistic observation has the advantage of imposing little burden on the dyad. The caregiver and child have little interference and the natural flow of behaviours is allowed to occur (Gardner, 2000). The FNP visit schedule is an advantage for family nurses’ ability to engage in naturalistic observation, and creates regular and frequent opportunities to view dyads. This provides information on patterns of behaviours and allows progress towards enhanced caregiving as determined by the observation.

Although naturalistic observations have many advantages in the context of interventions, they also create challenges that warrant caution. In naturalistic observations, caregivers and children may be affected by the presence of the observer, known as observer reactivity (Connors & Glenn, 1996). The presence of the observer may cause the caregiver or child’s behaviour to be altered. Individuals who know they are being observed may alter their behaviour to try to gain approval from the nurse, but reactivity tends to diminish after the first 10 minutes of the observation period. A benefit to using naturalistic observation for completing the DANCE is that clients are already accustomed to having a nurse present in their home given the nature of the FNP programme. An additional concern of naturalistic observation is that certain behaviours may not be observed during the defined observation period. Observational parameters for using the DANCE, which will be discussed later in this section of the DANCE manual, have been
structured to minimise this concern. One final concern for using naturalistic observation is that it can be a time consuming endeavor. However, the DANCE has been structured so that it can be completed within the normal context of a home visit and does not require longer observation or more frequent observation periods than the FNP home visit schedule.

Utilising the DANCE in nursing practice requires that the family nurse plan to observe, and subsequently record, caregiver-child interactions that occur during a home visit. Family nurses already have experience observing dyads during PIPE and caregiving interactions and later documenting their observations on their clinical records. Becoming familiar with using the DANCE during home visits will require some practice to be able to conduct a home visit, observe the specific DANCE behaviours, and complete the DANCE coding sheet immediately after the visit, but these activities build upon observation and documentation skills nurses’ regularly use in practice.

Preparing to Observe

As individuals prepare to use the DANCE in practice, there are several activities that can help increase observation skills. Individuals can reflect on how they currently observe dyads and what has been learned through observation. Furthermore, one may want to consider what has facilitated or hindered observation in the past or in certain context. In addition to reflecting on observation approaches, being well prepared for the visit enhances the ability to observe dyadic interaction. The ability to fully engage in observation may be reduced if the client or child is ill, if distractions or disruptions occur during the visit, or if the observer is experiencing her own stressors. Consider which of these factors can be controlled and what can be done to structure the home visit and environment for focusing attention and maximising observation. Specific observation parameters for the DANCE will be addressed in the next section. These parameters provide further considerations for ensuring observation opportunities can be maximised.

It is important to be aware of any biases one may carry into an observation. Therefore, observers are encouraged to reflect on thoughts and feelings about individual clients and their children, and caregiving behaviours that may influence observation. Are there certain behaviours that may influence observations of a caregiver or child? For example, if a caregiver uses a form of discipline that does not align with the observer’s approach to discipline, will this cause an observer to bias coding of the caregiver-child interaction? Recognising and acknowledging personal judgments and biases, and talking with colleagues and supervisors about one’s reflections, will increase the likelihood of remaining objective as possible when completing the DANCE.

Objective Observation

An essential tenet of naturalistic observation is that the observer should remain neutral, and not influence a change in the environment beyond the inevitable change that accompanies the presence of an observer. The nurse role is to observe the DANCE behaviours in the home without attempting to influence or control the caregiver-child interactions. Remaining neutral also requires the family nurse to remain as objective as possible. This is sometimes challenging given the fact that the family nurse and client are engaged in a relationship with each other.
Additionally, FNs are trained to work with clients in a strengths-based model. A focus on identifying client strengths may create a tendency for the nurse to want to “up-code” clients on the DANCE. Being mindful of this natural inclination will enhance one’s objective observation skills, and better support the promotion of positive caregiver-child relationships by capturing a true picture of where the dyad is at on any given day, and identifying next steps for building stronger parenting competencies.

The most realistic and useful assessments of the dyad will be completed when the family nurse can observe the dyad with “Fresh Eyes.” Developing curiosity and enthusiasm to view the dyad as if it were for the first time allows the family nurse to see exactly what is happening between the caregiver and child at this exact moment in time. The DANCE is created from a strengths-based perspective recognizing that all caregivers have areas of strength and areas for growth. Objective observation provides information about where this dyad is currently at and facilitates planning follow-up interventions that will be the most relevant and helpful to the dyad.

**Documentation of Objective Observation**

Part of objective observation using the DANCE is to document, objectively, what you observe. Using the DANCE behaviours and observational parameters as your framework for viewing the dyadic interaction, your documentation should include the following:

- Examples of when you see the behaviour occurring (based on the DANCE definition and developmental consideration),
- Examples of when you did not see the behaviour occurring (based on the DANCE definition and developmental consideration), and
- Wording to indicate the frequency, duration, and intensity of the behaviour you are observing
  - Frequency: rarely, few, on occasion, infrequently, frequently, often, usually, consistently, constantly, once, twice, many
  - Duration: brief, short, fleeting, quick, prolonged, 10 seconds (any indicator of time), extended, lengthy, extensive
  - Intensity: Sudden, abrupt, forceful, slow, gentle.

A DANCE coding sheet has been developed to support your observation and documentation for each DANCE behaviour. This documentation will support your learning of the tool during training and when using the tool in practice.

**OBSERVATION AND CODING GUIDELINES FOR THE DANCE**

**Using the DANCE During a Home Visit**

The DANCE has been designed to support observation of caregiving behaviours and child characteristics that occur when caregivers and children are engaged in everyday activities in
environments that are familiar to them. Therefore, when completing the DANCE in the context of a home visit, the visit must meet certain requirements. The requirements include:

- Child Available for Interaction: The child must be present, awake, and available to interact with the caregiver for at least half the visit.
- Caregiver is Active Caregiver: The caregiver is acting as the caregiver during the interaction period. For example, the grandmother or father of the child is not taking primary care of the child during the observation period.
- Familiar Location: The visit should take place where the caregiver and child are currently living (preferred) or in a familiar location.
- Routine Visit: Neither caregiver or child should be experiencing any unusual acute social or medical issues. If the client experiences chronic social or medical issues, then dealing with these issues during the visit does not disqualify the visit for DANCE coding.
- Caregiving Activity: A caregiving activity, lasting at least 5 minutes, must occur during the visit (e.g., nappy changing, feeding, play, reading, putting the child to sleep, holding or cuddling, PIPE demonstration).

If any of these conditions cannot be met, then DANCE coding should be conducted during a future visit.

If there is more than one child present in the home (e.g. multiples), code only one child per observation period. Also, if there are multiple caregivers present (e.g. mother, father, grandparent, etc.) code only one caregiver per observation period.

*In order to ensure accuracy in use of the DANCE, it is an expectation that the DANCE coding sheet be completed immediately following the visit.* Home visits should be scheduled with this consideration in mind.

**Guiding Principles for Scoring the DANCE**

1) The DANCE has been developed as a strengths-based tool that will help nurses identify caregiver strengths and areas for growth.

2) The DANCE has been developed to be clinically useful and feasible to use in the context of a home visit. Most behaviours are scored as a proportion of time that they occur and a few are based on the frequency of occurrence. These proportions and frequencies are categorised to support translation to the DANCE STEPS as follows:

   a. Area of Strength – The behaviour “Usually” occurred (75-100% of the observation period). These behaviours can be reinforced and are skills to support the caregiver through difficult times or child development transitions. These behaviours may also offer an entry point to other behaviours that may be areas for enhancement or growth.
b. Area for Enhancement – The behaviour occurred “At times” (between 25 – 74% of the observation period). These are behaviours that the caregiver demonstrates occasionally but may need support to consistently demonstrate, or may need guidance to understand the context in which the caregiver does and does not exhibit the behaviour.

c. Area for Growth – The behaviour occurred “Rarely” (0-24% of the observation period). These are behaviours that are infrequently observed and these can be behaviours to strengthen.

3) The DANCE was developed with the understanding that caregivers are not perfect. Even the most sensitive caregiver can miss a cue, tune out for a moment or two, or respond (on occasion) in an intrusive manner. The DANCE examines the caregiver’s behaviours over the course of a home visit and looks for caregiving behaviours that represent “good enough” caregiving (e.g., for the behaviour to be considered an Area of Strength, it needs to be present at least 75% of the time).

4) Most behaviours are rated on how the caregiver responds to or reacts to the child and not on the success of a response. A mother may respond in a very sensitive and responsive way to her child’s distress but may not successfully calm the child.

5) The actions (or inactions) that caregivers and children engage in during the course of an interaction do not necessarily influence a single DANCE behaviour or characteristic. Rather, a behaviour may influence a score across several behaviours. For example, a caregiver who uses a very directive communication style to guide her child’s exploration may influence the rating of Verbal Quality, Responsiveness, Limit Setting, Verbal Connectedness, and Supports Exploration behaviours.

**The DANCE Scales and Operational Definitions**

The DANCE scales and operational definitions are organised by dimension, as indicated previously. For each DANCE behaviour, an operational definition has been developed to provide the following information:

**Scale:** The scale label, definition, and behavioural anchors for coding the behaviour.

**Theoretical Importance:** A brief paragraph or two on the theoretical and empirical support for the behaviour or characteristic. The theoretical importance of each behaviour has been structured based on how the behaviour supports two aspects of children’s development:

i. Enhancing the quality and maintenance of positive caregiver child interactions, and

ii. Supporting children’s physical, cognitive, social, and emotional development.
Definition: The scale definition of the behaviour or characteristics (this definition may be more detailed than the definition presented in the scale).

Terms to define: Specific terms used in the definition of the measure or rating categories that are defined to ensure a common understanding by all raters.

Observational Parameters: Instructions on when and how the behaviour or characteristic should be measured. Clients assume dual roles during home visits, that of a client and that of a caregiver. In the client role, focus is on interaction with the home visitor and the visit content. However, the caregiver role is the client’s primary role, even within the context of a home visit. It is expected that the caregiver attend to the child as needed. The client-nurse relationship requires multitasking between competing roles, and represents a proxy for how the client manages competing responsibilities in her daily life. DANCE coding is completed during the parts of the visit that the client is in the caregiver role. Most behaviours are coded while the caregiver and child are interacting with each other, while a subset are coded during the time the child is present, but not necessarily interacting with the caregiver. The standard statements for these observational parameters are:

P = Item is to be rated for the portion of the home visit that the child is present, but not necessarily interacting with the caregiver. The caregiver is serving as the primary caregiver to the child during this time.

CA = Item is to be rated for the portion of the home visit (at least 5 and not longer than 8 minutes) that the caregiver and child are engaged in a caregiving activity. This can include a PIPE demonstration, nappy changing, feeding, playing, putting the child to sleep, holding or cuddling, etc. Play can include playing with toys, reading, singing, nursery rhymes, playing hand clapping games, etc. The activity can come about spontaneously but the family nurse must consciously decide that this is the caregiving activity that will be observed for DANCE purposes.

D = Item is to be rated only for those periods of interaction where the child exhibits distress.

Developmental/Child Considerations: Information on how the demonstration of the parenting behaviour or child characteristic may differ as a function of children’s developmental stage or child characteristics.

Exceptions/Qualifiers for Ratings: Instructions on exceptions to rating guidelines or qualifiers for ratings.

Examples: This section includes written examples that serve to illustrate each behaviour, including examples that highlight good and poor caregiving behaviours across developmental time points.
Arc of Learning in DANCE Education

Based on feedback from family nurses, the DANCE training is a very intensive and rewarding experience. Learning a tool that is reliable, valid, and clinically meaningful and captures so many critical aspects of caregiving takes dedication and persistence. The DANCE Education model is designed to support development of knowledge and skill to successfully integrate the DANCE into nursing practice. The DANCE Education model consists of three components as outlined in the table below.

<table>
<thead>
<tr>
<th>DANCE Preparation</th>
<th>DANCE Fundamentals</th>
<th>DANCE Integration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 4 hours</td>
<td>• 24 hours (3 days)</td>
<td>• 6 months</td>
</tr>
<tr>
<td>• Individual and team-based</td>
<td>• Face-to-face training</td>
<td>• Individual and team-based</td>
</tr>
<tr>
<td>• Designed to prepare new DANCE users for DANCE Fundamentals</td>
<td>• Designed to support learning and implementation of the DANCE, develop DANCE observation and documentation skills, and support translation of DANCE observations into intervention strategies (DANCE STEPS)</td>
<td>• Designed to support mastery of the DANCE and integration into practice</td>
</tr>
</tbody>
</table>

DANCE Preparation consists of individual and team-based learning activities completed up to 8 weeks before DANCE Fundamentals. Keys to Caregiving and DANCE Preparation are prerequisites for attending DANCE Fundamentals. DANCE Fundamentals is an interactive face-to-face programme with a fast-paced agenda designed to support learning and implementation of the DANCE tool as well as introduce the translation of DANCE observations into intervention strategies during home visits using the DANCE STEPS. The knowledge and skills gained during DANCE Fundamentals lay the foundation for using the DANCE in practice and creates a deeper understanding of caregiver-child interactions. However, DANCE Fundamentals is just a beginning for learning to incorporate this new dyadic observation and intervention framework into practice. DANCE Integration is a six month period following DANCE Fundamentals consisting of team and individual based learning activities to support nurses to incorporate the DANCE and DANCE STEPS into practice. The recommended DANCE Integration activities support mastery of the DANCE and fulsome integration into practice. Nurses who have previously learned the DANCE recommend utilizing the tool as soon as possible after DANCE Fundamentals and as often as possible in practice. This enables nurses to feel comfortable and confident using the tool with clients who have a wide range of parenting styles and skills.

Strategies to support learning and adoption of DANCE into practice are woven throughout the entire DANCE Education programme. General concepts and theories are introduced during DANCE Preparation and later built upon during DANCE Fundamentals and Integration. During DANCE Fundamentals, behaviours are introduced one dimension at a time, with the goal to practice observing using all 18 behaviours at the end of the 3 day training. There are frequent
opportunities for discussion and questions while learning the details of the DANCE behaviours along with many practice opportunities for using the tool to observe caregiver-child interactions. Regular breaks, along with learning activities and demonstrations are dispersed throughout the training days to break the information learned into small, manageable chunks. DANCE Integration activities support review of the behaviours along with practice opportunities to begin to utilise the observation tool during home visits. A DANCE Trainer or Nurse Consultant will offer support to supervisors and sites for six months following the completion of DANCE Fundamentals.

**Videos Clips for DANCE Training**

The video clips we will be using throughout the training were obtained from several sources. Most of the video clips shown during the training were selected to highlight very specific behaviours. These specific clips are not meant to represent a caregiver’s overall caregiving qualities, but specific instances within the interaction when DANCE behaviours are present or absent at each measurement level. Practice coding tapes are longer in duration and are intended to represent the strengths and areas for growth of a caregiver.

**Denver Trial Videos**

Selected families from the Denver trial of the NFP graciously agreed to have their videos used for education of professionals working with at-risk families. The videos were obtained as part of the research component of the trial and therefore contain structured interactions in the home and lab settings. Most of the video clips are excerpts from a free play interaction in which mothers were provided with a standardised set of toys and asked to play with their child as they normally would at home. Mothers were encouraged to have themselves and their children facing the camera at all times. The videos from the Denver trial include observations of children at 6, 12, 15, 21, and 24 months of age. This range of ages gives DANCE trainees the opportunity to see how behaviours of the child and caregiver might look differently overtime.

**Dr. P.O. Svanberg Videos**

We are thankful to Dr. Svanberg and the families he has worked with for sharing their videos of caregiver-child interactions. The families in Dr. Svanberg’s sample are predominately younger than 6 months of age, a nice complement to the videos that reflect interactions with older children from the Denver trial. Most of the interactions were obtained in the families’ homes and the mothers were asked to interact with their children in a typical manner.

**Other Videos**

Clients from Colorado NFP sites agreed to have their FNs videotape them interacting with their children during routine home visits. In addition, some video has been collected from non-FNP families who have also agreed to have their interactions recorded for use in the DANCE video training library. Excerpts from these videotaped interactions have been created to use as exemplars of specific behaviours and as practice coding interactions. We are grateful to all of these families for letting us into their homes and sharing these interactions with us. Videos from...
the World Wide Web have periodically been used when our video sample did not provide examples needed to illustrate some DANCE behaviours.

Selection of Example Clips for each DANCE Behaviour

During the DANCE training, trainees will view video examples (1-5 examples for each DANCE behaviour) that help to define the behaviour(s) they will observe. These video examples were selected by consensus agreement between two of the DANCE developers/trainers and were endorsed by three additional members of the DANCE development team. Only those clips with consensus support and endorsement are presented as training examples.

Scoring of Video Clips for Practice Coding and Proficiency

During the DANCE training, trainees will have several opportunities to practice using the DANCE based on their observations of videotaped interactions (practice coding). After viewing and coding the practice videotaped interactions, the DANCE trainers will review and discuss the “gold-standard” codes for each behaviour. To obtain “gold-standard” codes each video-taped interaction was coded, independently, by four DANCE coders. The four coders met to review and discuss discrepancies and to reconcile differences using consensus agreement.

Obtaining DANCE Proficiency

DANCE proficiency ensures that learners are prepared to use the tool in practice. One of the learning objectives of DANCE education is to establish proficiency in using the DANCE in observations of caregiver/child interactions. DANCE proficiency is determined by comparing trainee codes to the gold-standard codes. Percentages within 15% of the Gold Standard (or exact frequencies) are considered accurate. For dyadic observation, there is a level of acceptable variability across observers that does not impact the validity of the tool. For the DANCE, given the scale 0-100, a range of 15% around the gold standard is considered to fall within the range of acceptable validity.

Following completion of DANCE Fundamentals, copies of trainees’ coding sheets are submitted to the Prevention Research Center (PRC) for calculation of trainee proficiency. Proficiency results are provided to learners 2-3 weeks following completion of DANCE Fundamentals. Nurses who are determined to be proficient are encouraged to immediately begin using the DANCE in FNP practice. Nurses who are not proficient following the completion of DANCE Fundamentals will be provided with specific behaviours that could benefit from review, will be offered support from a DANCE trainer, and will have up to 3 months to further demonstrate proficiency.
### Emotional Quality Dimension

<table>
<thead>
<tr>
<th>Caregiver Behaviour</th>
<th>Area for Growth</th>
<th>Area for Enhancement</th>
<th>Area of Strength</th>
<th>Not Observable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CA</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Expressed Positive Affect</strong></td>
<td>Rarely (0-24%)</td>
<td>Sometimes (25-74%)</td>
<td>Usually (75-100%)</td>
<td></td>
</tr>
<tr>
<td>Caregiver Behaviour</td>
<td>Observable display (facial expression, verbal tone, body language, and gestures) that reflects low to high intensity pleasure.</td>
<td>At times, caregivers express positive affect. Experienced affect is:</td>
<td>CG usually expresses positive affect.</td>
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<td></td>
<td></td>
<td>o Angry</td>
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<td></td>
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<td>o Sad</td>
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<td>o Flat</td>
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<td></td>
<td></td>
<td>o Irritable/agitated</td>
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<td></td>
<td></td>
<td>o Bored</td>
<td></td>
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<tr>
<td><strong>Caregiver’s Affect Complements Child’s Affect</strong></td>
<td>Sometimes (25-74%)</td>
<td>Usually (75-100%)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>CG’s affect usually complements child’s affect.</td>
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<thead>
<tr>
<th>Caregiver Behaviour</th>
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<th>Area for Enhancement</th>
<th>Area of Strength</th>
<th>Not Observable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CA</strong></td>
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</tr>
<tr>
<td><strong>Verbal Quality</strong></td>
<td></td>
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<tr>
<td>Caregiver’s verbal communication to child is kind, respectful, cheerful.</td>
<td></td>
<td></td>
<td>No verbal communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CG’s verbal communication to child is usually kind, respectful, cheerful.</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>CG’s verbal communication to child is kind, respectful, cheerful.</td>
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<tr>
<td><strong>Response to Distress</strong></td>
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</tr>
<tr>
<td>Caregiver regulates her affect in response to child’s distress in a complementary manner.</td>
<td></td>
<td></td>
<td>No distress observed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CG usually responds to child’s distress in a complementary manner.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CG usually responds to child’s distress in a complementary manner.</td>
<td></td>
</tr>
<tr>
<td><strong>Negative Comments About the Child to Others</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver’s negative comments about the child to others.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>CG never makes negative comments about the child to others.</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CG makes 1-2 negative comments about the child to others.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>CG makes 3 or more negative comments about the child to others.</td>
<td></td>
</tr>
</tbody>
</table>

**P= when child is present**  **CA= when CG and child are engaged in a caregiving activity**  **D=when distress occurs**
**Sensitivity and Responsivity Dimension**

<table>
<thead>
<tr>
<th>Caregiver Behaviour</th>
<th>Area for Growth Rarely (0-24%)</th>
<th>Area for Enhancement Sometimes (25-74%)</th>
<th>Area of Strength Usually (75-100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>P</strong> Positioning</td>
<td>CG is infrequently positioned to read child’s communications.</td>
<td>At times CG is positioned to read child’s communications.</td>
<td>CG is usually positioned to read child’s communications.</td>
</tr>
<tr>
<td>CA Visual Engagement</td>
<td>Infrequently, CG’s visual attention is directed toward the child or a shared focus of interest.</td>
<td>At times, CG’s visual attention is directed toward the child or a shared focus of interest.</td>
<td>CG’s visual attention is usually directed toward the child or a shared focus of interest.</td>
</tr>
<tr>
<td>CA Pacing</td>
<td>CG’s pace infrequently complements child’s behaviour, activity level, and needs.</td>
<td>At times CG’s pace complements child’s behaviour, activity level, and needs.</td>
<td>CG’s pace usually complements child’s behaviour, activity level, and needs.</td>
</tr>
<tr>
<td><strong>P</strong> Negative Touch</td>
<td>CG’s touch of the child is rough 3 or more times.</td>
<td>CG’s touch of the child is rough 1-2 times.</td>
<td>CG’s touch of the child is never rough.</td>
</tr>
<tr>
<td>CA Non-Intrusiveness</td>
<td>CG usually intrudes upon child’s activity, emotional, or physical space.</td>
<td>At times CG intrudes upon child’s activity, emotional, or physical space.</td>
<td>CG infrequently intrudes upon child’s activity, emotional, or physical space.</td>
</tr>
<tr>
<td><strong>P</strong> Responsiveness</td>
<td>CG’s responses to child’s state, affect, communication infrequently supports child’s needs.</td>
<td>CG’s responses to child’s state, affect, communication at times supports child’s needs.</td>
<td>CG’s responses to child’s state, affect, communication usually supports child’s needs.</td>
</tr>
</tbody>
</table>

**Notes:**
- **P** = when child is present
- **CA** = when CG and child are engaged in a caregiving activity
- **D** = when distress occurs
## Support of Behavioural and Emotional Regulation Dimension

<table>
<thead>
<tr>
<th>Area of Strength (75-100%)</th>
<th>Area for Enhancement (25-74%)</th>
<th>Area for Growth (0-24%)</th>
<th>Not Observable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caregiver Behaviour</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P Limit Setting</td>
<td>P Complete Interactions</td>
<td>P Completes Interactions</td>
<td></td>
</tr>
<tr>
<td>Caregiver establishes and maintains limits for the child.</td>
<td>Caregiver provides safety of the child.</td>
<td>Caregiver provides closure to interactions.</td>
<td>Caregiver provides interactions with child.</td>
</tr>
<tr>
<td>CG usually establishes and maintains limits for the child.</td>
<td>CG infrequently establishes and maintains limits for the child.</td>
<td>CG infrequently establishes and maintains limits for the child.</td>
<td>No opportunity to observe limit setting.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area of Strength (75-100%)</th>
<th>Area for Enhancement (25-74%)</th>
<th>Area for Growth (0-24%)</th>
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<tbody>
<tr>
<td><strong>Caregiver Behaviour</strong></td>
<td></td>
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</tr>
<tr>
<td>P Limit Setting</td>
<td>P Complete Interactions</td>
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<td></td>
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<tr>
<td>Caregiver establishes and maintains limits for the child.</td>
<td>Caregiver provides safety of the child.</td>
<td>Caregiver provides closure to interactions.</td>
<td>Caregiver provides interactions with child.</td>
</tr>
<tr>
<td>CG usually establishes and maintains limits for the child.</td>
<td>CG infrequently establishes and maintains limits for the child.</td>
<td>CG infrequently establishes and maintains limits for the child.</td>
<td>No opportunity to observe limit setting.</td>
</tr>
</tbody>
</table>

**Legend:**
- P = when child is present
- CA = when CG and child are engaged in a caregiving activity
- D = when distress occurs

### Table Examples

- **Limit Setting**
  - Caregiver establishes and maintains limits for the child.
  - CG usually establishes and maintains limits for the child.
  - CG infrequently establishes and maintains limits for the child.
  - No opportunity to observe limit setting.

- **Complete Interactions**
  - Caregiver provides safety of the child.
  - CG usually provides closure to interactions.
  - CG infrequently provides interactions with child.
  - No opportunity to observe limit setting.
### Promotion of Developmental Growth Dimension

<table>
<thead>
<tr>
<th>Caregiver Behaviour</th>
<th>Area for Growth</th>
<th>Area for Enhancement</th>
<th>Area of Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>P Supports Exploration</td>
<td>Infrequently CG facilitates exploration that meets the child’s needs.</td>
<td>At times CG facilitates exploration that meets the child’s needs.</td>
<td>CG usually facilitates exploration that meets the child’s needs.</td>
</tr>
<tr>
<td>CA Scaffolding</td>
<td>CG never attempts to provide support to promote success beyond what the child is able to do on his or her own.</td>
<td>CG attempts to provide support to promote success beyond what the child is able to do on his or her own 1-2 times.</td>
<td>CG attempts to provide support to promote success beyond what the child is able to do on his or her own 3 or more times.</td>
</tr>
<tr>
<td>CA Verbal Connectedness</td>
<td>Infrequently, CG’s verbal communication creates a connection that facilitates interaction.</td>
<td>At times CG’s verbal communication creates a connection that facilitates interaction.</td>
<td>CG’s verbal communication usually creates a connection that facilitates interaction.</td>
</tr>
<tr>
<td>CA Praise</td>
<td>CG never genuinely compliments or encourages the child.</td>
<td>CG genuinely compliments or encourages the child 1-2 times.</td>
<td>CG genuinely compliments or encourages the child 3 or more times.</td>
</tr>
<tr>
<td>P Negative Verbal Content</td>
<td>CG uses negative verbal content with the child 3 or more times.</td>
<td>CG uses negative verbal content with the child 1-2 times.</td>
<td>CG never uses negative verbal content with the child.</td>
</tr>
</tbody>
</table>

P= when child is present  
CA= when CG and child are engaged in a caregiving activity  
D= when distress occurs