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CHAPTER 5

Steps Toward Effective, Enjoyable Parenting

Lessons from 30 Years of Implementation, Adaptation, and Evaluation

GERHARD J. SUESS, MARTHA FARRELL ERICKSON, BYRON EGELAND, HERMANN SCHEUERER-ENGLISCH, and HANS-PETER HARTMANN

Lucy (not her real name) was pregnant with a baby fathered by an occasional customer at the bar where she worked. After going out with the man a few times, Lucy realized he was disturbed and violent, so she wanted no further involvement with him, even though he was the father of her baby. She proclaimed that she and her baby would do fine on their own. Lucy reported having distant relationships with her parents, who lived in a neighboring state. She described in a flat, unemotional tone repeated childhood episodes of physical and sexual abuse by her father and chronic rejection by her mother. She dismissed her childhood experience by saying brusquely, "That was then, this is now." Within hours after giving birth to a healthy baby girl, Lucy began talking about how her tiny daughter would need to "learn to be tough," so she didn't want to coddle her too much.

Although every family is unique, the multiple issues Lucy and her baby face are not unusual: poverty; lack of marketable job skills to help parent and child move out of poverty; a weak support system (i.e., either isolation or a social network that is not supportive of health, well-being and positive parenting approaches); parent's dismissive state of mind about past relationships, as well as about baby's needs for comfort and security as the foundation for real strength rather than "toughness." It is these issues that the STEEP™ Program (Steps Toward Effective, Enjoyable Parenting) was developed to address through an individualized, relationship-based model of service grounded in attachment theory and research, and guided

by longitudinal findings on the risk and protective factors that shape the quality of parent–infant attachment and other aspects of positive parenting, including parents' healthy life choices throughout the child's growing-up years (Sroufe, Egeland, Carlson, & Collins, 2005).

Martha Farrell Erickson and Byron Egeland developed STEEP in 1986, at the University of Minnesota and, with funding from the National Institute of Mental Health (NIMH), implemented the program for the first time as part of a randomized controlled study of the program's effectiveness (Egeland & Erickson, 1993). The focus and overall program design of STEEP was guided by findings from the ongoing Minnesota Longitudinal Study of Risk and Adaptation, particularly the factors shown to predict parental sensitivity and responsiveness, secure parent–infant attachment, and positive parent–child interactions at later stages of childhood. Thus, the program aimed to promote (1) parental knowledge and understanding of infant and child development, with an emphasis on understanding the developmental meaning and significance of key behaviors such as separation anxiety or toddler negativism; (2) parental perspective taking with regard to child behavior, the ability to "see through the eyes of the child"; (3) sensitivity and responsiveness to infant cues and signals; (4) parental recognition of how past relationships, particularly childhood experiences, influence the way parents interpret and respond to their child; (5) life choices that are in the best interest of the child (e.g., relationship decisions, educational pursuits, financial management, health-related behaviors); and (6) support networks that encourage healthy, responsible behavior and positive parenting (Erickson, Korfmacher, & Egeland, 1992; Egeland & Erickson, 2004). Consultation with experienced frontline workers in public health, obstetrics, pediatrics, and social services informed practical components of the STEEP program, including strategies and timing for optimal engagement of participants, effective approaches and incentives for group participation, and logistical issues related to schedules, transportation, communication, and equipment needs.

We describe in this chapter the original STEEP program and the longitudinal research that informed it, original outcome findings from an evaluation of a 1-year version of the program, and highlights of dissemination, implementation, and adaptation of STEEP in various locations and contexts in the United States and Canada. We then provide an account of STEEP practice, research, and training in Germany that dates from 2005, concluding with a discussion of lessons learned from the collective body of more than 30 years of STEEP work.

STEEP Program Description

STEEP (Erickson, Egeland, Simon, & Rose, 2002) was designed from the beginning to be a relationship-based program, guided by research findings that resilience and positive shifts in the course of an individual's development often come about through experience with a caring, responsive person who offers a new way of being in relationship (Sroufe et al., 2005). In other words, relationships change relationships. Thus, the STEEP facilitator who will be working with the family is, whenever possible, the person who first approaches the expectant mother (ideally during the second trimester of pregnancy) to offer her the opportunity to participate in

the voluntary program, to describe what the program involves, and to answer any questions the woman has. The general approach is to explain to the potential participant that STEEP is a way for first-time moms to get the support and information they need for themselves and their babies as they embark on what often is the greatest joy and the greatest challenge a person faces—parenthood.

Recruitment usually is done through obstetric clinics, with nurses identifying women who meet eligibility criteria and asking their permission for a STEEP facilitator to talk with them about the program. (Note that as mentioned in later sections of this chapter, there have been necessary variations in recruitment strategies when STEEP has been implemented in different settings and with special populations.)

Home Visits

Biweekly home visits begin as soon as a woman is enrolled in STEEP and continue throughout the program (until the child's first birthday in the original NIMH-funded study, but until the child's second birthday in most subsequent implementations of the program). Home visits typically are 1–2 hours in length and are individualized to address the unique strengths and needs of each family, always with a focus on how the baby is growing and learning, how the parent–child relationship is developing, and how the health, well-being and life circumstances of the parents are (or are not) supporting good parent–child relationships and optimal child development.

There is great value in meeting with the family in the home environment; however, a home visit also may include going outside for a walk with parent and child or visiting a coffee shop or park in the neighborhood, which are especially healthy options when a mother is depressed and/or isolated. Walking side by side sometimes makes it easier for parents to let down their defenses and talk more candidly about their feelings and experiences, gradually building a relationship of trust with their facilitator. Although the mother is the point of entry into the family's participation in STEEP and is a primary focus of the program, fathers or father figures and other adults in the household also are engaged in home visiting when possible. For example, fathers often participate in the Seeing Is Believing® video strategy, described below.

Seeing Is Believing

A core strategy for working with parents during home visits is Seeing Is Believing, a part of the STEEP program from its conceptualization in 1985–1986, but later formalized and trademarked as a strategy that has been integrated into many different home-visiting and parent education program models, with training and support from STEEP trainers (Erickson, 2005). Seeing Is Believing involves video-recording a few minutes of parent–infant interaction (e.g., routine child care tasks such as feeding, dressing, or bathing; interactive floor-play with age-appropriate toys; or a favorite activity suggested by the parent). Then, the STEEP facilitator views the video with the parent, using primarily open-ended questions to help the parent discover how the baby is feeling, how the baby uses cues and signals to tell the parent what he or she needs or wants, and how the parent's responses to baby's cues are

teaching the baby what to expect and how to count on the parent. Questions might move from a very broad "What did you notice in this video?" to more specific questions, such as "What do you think your baby was telling you here?" or "What did your baby seem to enjoy most during this activity?"

Sometimes the baby becomes fussy or signals in other ways that this is not what he or she wants to do right now—or perhaps a parent tries too hard to direct the baby's play rather than follow the baby's lead. Then it can be effective to say, "Let's try something different. How about playing 'follow the leader' and letting your baby take the lead. I'll record for just a couple of minutes and we can see how that works." This captures the spirit of shared discovery that is central to the Seeing Is Believing strategy and the STEEP program as a whole.

Ideally, the STEEP facilitator reviews the video with the parent(s) right after recording. However, sometimes the baby's need or a parent's schedule makes that difficult or impossible. In these situations, the facilitator may choose to wait and review the video with the parent during the next home visit. Sometimes the video review process may take only 5 or 10 minutes. But often, what happens between parent and child on video may trigger a deeper discussion of emotionally sensitive issues that require more time. Because Seeing Is Believing is not a scripted curriculum, but a tool for helping parents reflect on their baby's needs and their own strengths and challenges in meeting those needs, STEEP facilitators follow the lead of both baby and parent in the video review process, using it as effectively as possible to help the parent learn and grow.

One of the most important reasons for using Seeing Is Believing during all or most home visits is that it is a very concrete way of keeping the baby—and the parent-infant relationship—front and center. So many other life events and crises (e.g., family conflicts, financial problems, difficulties with job or school) can become the focus of a home visit, just as those challenges can interfere with a parent's emotional availability and responsiveness to the baby's needs. So, no matter what else is going on in the household, using Seeing Is Believing is a very practical and literal way to answer the question, "What about the baby?" Viewing the video together affords an opportunity to explore with the parent(s) how they are managing to stay attuned to their baby even in the midst of challenges and difficult life events they are facing. (As described in a later section of this chapter, one of the positive findings of our initial STEEP evaluation was that participation in the program appeared to serve as a buffer between stressful life events and parental sensitivity [Egeland & Erickson, 2004].)

Mother–Infant Groups

STEEP facilitators recruit participants to form groups of eight to 10 families with due dates within a few weeks of each other. Initially after enrollment (during pregnancy), the facilitator gets to know each participating woman and her family through home visits. During that time, the facilitator sends brief informal newsletters to the participants, including helpful information about labor and delivery, preparing for the arrival of the baby, and ways to stay comfortable during the final days of pregnancy and after childbirth. These newsletters, which may be sent by mail or e-mail, depending on families' preferences and access to technology, also are a way

to begin to establish a sense of group belonging even before the participants meet each other. With permission of the individual moms, the facilitator includes in the newsletter a bit of information about each mom—her favorite activities, baby names she's considering, good deals she found on baby equipment, or her plans to return to school or work after her maternity leave.

Then, when some or all of the babies have arrived, the facilitator convenes the first mother–infant group session, with groups continuing to meet biweekly throughout the program. Each session begins with mother–infant interaction time, with activities structured around the developmental issues that are common for babies of the ages in the group. Structure is flexible to allow facilitators to capitalize on teachable moments in their observations of what the babies are doing.

Following interaction time, moms and babies share a healthy meal together—an enjoyable time of relationship building and also a situation rich with teachable moments. After the meal, mothers go with their facilitator into another room for "mom-talk" time while their babies are cared for and engaged in age-appropriate activities by STEEP early childhood staff. The STEEP facilitator's guide (Erickson et al., 2002; Erickson & Egeland, 2006) includes many possible activities to use both for mother–infant interaction time and for "mom-talk" time. But, in general, "mom-talk" is a time for mutual support and discussion of the mothers' own issues, including balancing baby's needs and adult needs, building or maintaining healthy relationships with partners and others, pursuing educational and work goals, and reflecting on how past relationship experiences shape the way mothers understand and respond to their children's needs. There are "aha moments" when mothers discover common feelings and experiences. And, because the same facilitator who

TABLE 5.1. Activities and Principles of STEEP Program

Activities

- Home visits
  - Prenatal: biweekly
  - 0–2: biweekly
- Seeing Is Believing: monthly or more
- Mother–infant group: biweekly
- Family nights: occasional (two to three per year)

Principles

- Relationship-based—change happens within a relationship of respect, authenticity, shared discovery, and problem solving
- Reflective—through reflection, knowledge is more easily integrated and applied, and life choices are viewed through a new lens
- Strengths-focused—each child and parent has strengths on which to build; leading with strengths eases the way to facing challenges
- Individualized—each person's history, experience, and life circumstances are unique and need to be addressed as such
- Ecological—the community, culture, and larger society of each family need to be taken into account, with a focus on both opportunity and challenge

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is leading the group will be visiting each mother in the next week or so, there are opportunities for personal follow-up and integration of group themes into the individualized work with each parent and child.

Family Nights

To more fully engage fathers of babies, grandparents, and other significant adults in the families of participants, the STEEP program also offers occasional family nights (typically two or three times a year), with each mother deciding whom she would like to invite. These are celebratory events that may be held indoors or outdoors, with a casual meal or refreshments, craft activities or games, or perhaps at a place for taking family photos and providing an opportunity for extended family members to view parent–child videos made during home visits. This can be a good time to give each family a book to read with baby, a CD of songs you have sung with moms and babies during group sessions, or simple tip sheets on parenting, such as how to make bedtime go smoothly, or helpful ways to handle separation anxiety.

Summary of Findings from Initial Research

We have described elsewhere the findings from the original implementation and evaluation of STEEP (Erickson et al., 1992; Egeland & Erickson, 1995, 2004). We summarize those early findings very briefly here, which allows us to focus more on recent findings (particularly from the ongoing research on STEEP in Germany) and on the practical lessons and lingering questions from the many applications and adaptations of STEEP. The initial implementation and evaluation was conducted on 154 low-income, English-speaking women age 17 years and older (range = 17–25, mean = 20.4) who were pregnant with their first child, had no more than a high school education (less in many cases), and were not known to have a diagnosis of a major mental health disorder or cognitive disability. Although marital status was not a selection criterion, 92% of participants were unmarried at the time of enrollment. As more information about the participants emerged during the implementation and evaluation of the program, it became clear that these young women had many other risk factors in their lives, most notably, a very high incidence of abuse and neglect in childhood, abuse by romantic partners, and significant symptoms of depression and other mental health problems (Egeland, Erickson, Butcher, & Ben-Porath, 1991).

The original study evaluated only a 1-year version of the STEEP program, and that evaluation was conducted on the first implementation of the program, without an opportunity to run a pilot intervention before launching the randomized study. Nonetheless, the study showed positive results of the program in promoting protective factors and reducing risks among participants. But results with regard to quality of parent–infant attachment, particularly at 1 year, were disappointing and complicated (Egeland & Erickson, 1995).

Compared to families in the control group (n = 80), mother–infant pairs participating in the STEEP program (n = 74) were no more likely to be classified as having a secure attachment at infant age 1, when the intervention ended. In fact,

infants in the intervention group exhibited more disorganized attachment behavior than the controls in the 1-year end-of-treatment assessments. However, in a second assessment of attachment at 19 months of age (7 months posttreatment), that no longer was the case, and there was a substantial drop in the percentage of control pairs (from 67 to 48%) who were classified as securely attached, which was not true of mothers and children in the intervention group.

In various other ways, intervention families were doing better than control families at the end of the intervention when their babies were 1 year old. Intervention mothers demonstrated better knowledge and understanding of child development. They had more appropriately organized home environments and were more responsive to their babies' needs during in-home assessments. Intervention mothers used better life management skills in their daily lives and more active coping strategies at times of duress. They also reported fewer depressive symptoms than did mothers in the control group. Intervention mothers also were less likely to have another baby within 2 years after the birth of their first child. Interestingly, while high levels of life stress were associated with maternal insensitivity in the control group, that was not true within the intervention group. Thus, it appeared that participating in the STEEP intervention had a buffering effect that allowed mothers in the intervention group to provide to their infants sensitive care even when facing difficult life circumstances.

Both positive and negative findings from the original implementation and evaluation have shaped the way the program—and the training and ongoing support and supervision of staff—have been refined and improved over the years. In a later section of this chapter, we discuss both challenges and successes of those 30 years of STEEP work and implications for practice and future research.

Examples of Subsequent Applications and Adaptations

Soon after the initial STEEP implementation and evaluation study summarized above, several agencies began working with the developers of STEEP to apply or adapt the program in different contexts with specific high-risk populations. What follows are brief descriptions of a small sample of those efforts.

St. David's Center for Child and Family Development

A large, multiservice agency with a focus on early childhood education, mental health and family support services, St. David's Center for Child and Family Development (SDC), in Minnetonka, Minnesota, implemented the full STEEP program, serving families identified by clinics as high risk for child abuse, from pregnancy until children were 3 years old. Families then were encouraged to use other services provided by the agency, including early childhood education for their children, and many did. Internal evaluations showed high participant satisfaction and good progress on measures of parental knowledge, understanding, and parenting behavior.

Adaptations for Substance-Abusing Families

With state funding aimed at substance-abusing families, two medical clinics, Community University Health Care Center (CUHCC) in Minneapolis and Healthstart in St. Paul, implemented the STEEP program with mothers who tested positive for drugs during pregnancy. The dynamics of building relationships with these mothers were especially challenging because of defensiveness and anger that they had been "caught." Many of the participants in the CUHCC program were Native Americans and, despite the many challenges they faced, they responded well to an effort to incorporate traditions and symbols from their native culture into the program, choosing to call their program "Circle of Women." For many, their babies became the motivators in their attempt to become alcohol- and drug-free.

Baby's Space Partnership

Building on the success of "Circle of Women"—and responding to the influx of many young mothers into the workforce due to welfare reform in the 1990s—Amos Deinard, Medical Director of CUHCC, and psychologist Terrie Rose developed the Baby's Space model, which integrated STEEP services and therapeutic child care for high-risk infants and toddlers. With funding from the Irving B. Harris Foundation, the University of Minnesota's Irving B. Harris Center (now merged with the Center for Early Education and Development) expanded the Baby's Space model to multiple urban child care centers in Minneapolis.

Parenting Partnership at Mary Bridge Children's Hospital

At Mary Bridge Children's Hospital in Tacoma, Washington, the STEEP model is used to serve families of premature, medically fragile babies who have spent time in the neonatal intensive care unit (NICU). Babies are at risk for developmental delays, and about 45% face long-term medical issues. On intake questionnaires, all parents in the program endorse having a childhood history of abuse. Families also experience many psychosocial stressors, including poverty, social isolation, and unstable housing, and more than 40% of mothers report domestic violence in their current relationships.

Toward Better Beginnings, Allina Health

Several urban obstetric clinics in Minneapolis and St. Paul implemented a brief (3–4 months) nurse home-visiting program that used STEEP principles and the Seeing Is Believing video strategy with high-risk mothers. Since the program was so brief, to maximize its impact, they also trained clinic staff members to deliver consistent messages about the importance of parental sensitivity and attachment. Compared to a control group of similarly high-risk mothers who gave birth before the program was launched, intervention mothers demonstrated better knowledge of child development and were observed to be more responsive to their infants and to provide more appropriate play materials (Guthrie, Gaziano, & Gaziano, 2009).

STEEP Principles and Strategies in Public Health Nursing

Working with health departments in several states and counties or provinces across the United States and Canada, STEEP developers and approved trainers have provided training and ongoing reflective consultation to public health nurses in how to integrate STEEP principles and the Seeing Is Believing video approach into their home-based work with high-risk mothers and babies. Nurses and administrators indicate that Seeing is Believing helps them focus more carefully on parent–child interaction, helps parents interpret and respond appropriately to infant cues, and provides a useful framework for exploring issues that sometimes hinder parental sensitivity. Also, as in other STEEP programs, mothers and fathers have responded enthusiastically to the use of video. For example, in Ontario, Canada, the Niagara Region Public Health began using Seeing Is Believing in their nurse home-visiting program in 2000. Based on monitoring of nearly 300 participating families from 2010 through 2016, the agency reports that parents say they learn, "when my baby needs me; how to get my baby talking; and how to talk and play differently" (Biscaro & Hicks, 2017, pp. 5–6).

STEEP in Germany

In Germany, prior to 2000, interventions to help young mothers like Lucy, the mother described in the case opening this chapter, were scarce. Generally, support was available for children age 3 or older, but not for infants and parents. However, conferences for researchers and practitioners were beginning to spread knowledge about attachment theory and raise awareness of the importance of early intervention (e.g., Papousek, Schieche, & Wurmser, 2004, 2007; Suess & Pfeifer, 1999; Suess, Scheuerer-Englisch, & Pfeifer, 2001;Scheuerer-Englisch, Suess, & Pfeifer, 2003; Brisch, Grossmann, Grossmann, & Köhler, 2002).

It was at one of those conferences in Munich, in July 2000 (see Brisch et al., 2002), that Martha Erickson, Byron Egeland, and Gerhard Suess met and began to build a collaboration to implement and evaluate the STEEP model with high-risk parents and infants in Germany. From 2001 on, annual workshops with Martha Erickson were carried out in Hamburg for interested professionals, with the aim of bringing STEEP to Germany and designing an evaluation study to test the program's effectiveness empirically with German families. In 2005, with a first grant from the German Ministry of Education and Research (BMBF), the German evaluation project began at the Hamburg University of Applied Sciences and soon extended to other cities.[1] At that time, important cases of fatal child abuse led

[1]Initially this expansion began in cooperation with an evaluation project at the University of Applied Sciences in Potsdam (Christiane Ludwig-Koerner). Later STEEP was extended to Frankfurt and Offenburg with additional partners (e.g., Ruediger Kissgen, M. Frumentia Maier, Gabi Mankau) and grants from BHF-Bank-Foundation, National Center for Early Prevention (NZFH), the Thomas Gottschalk Foundation, and the Rotary-Club Offenburg-Ortenau, important milestones in importing STEEP. Most of all, the successful expansion relied on the dedicated STEEP facilitators and competent, committed research assistants, Uta Bohlen and Agnes Mali, and H. Theresita Hettich and M. Frumentia Maier, who contributed enormously to the growth of the German STEEP Project.

to the establishment of the National Center of Early Intervention (NZFH; 2009), which significantly advanced the proliferation of early intervention programs in Germany and the evaluation of STEEP (Renner & Heimeshoff, 2011; Cierpka & Evers, 2015).

Questions and Challenges Confronting the German STEEP Project

The introduction of STEEP in Germany raised the frequently asked question of whether an American program could be effective in Germany. Cultural differences raised skepticism among researchers, who questioned whether the worries and troubles of mothers like Lucy, who exist in both countries, are comparable in Germany and the United States. Would it be feasible and appropriate to formulate comparable intervention goals for these German mothers, and would STEEP provide the path toward those goals? Initially, we asked practitioners. We introduced STEEP facilitators from Minneapolis to German social workers in Hamburg. These personal meetings, which usually included viewing and discussing video recordings together, are deeply rooted in the tradition of attachment theory and research. However, this is not the only reason we emphasized reciprocal visits and personal encounters as part of the transatlantic exchange and the implementation of STEEP. Relationship-based programs such as STEEP are best passed on in personal encounters, with careful reflection on the experience of the babies, the parents, and the service providers—all considered within the broader social and cultural context in which the families live. Last, but not least, this personal approach highly values the experience of the STEEP facilitators in Minnesota, who have accumulated their knowledge over many years of practical involvement in the program. So, building on case examples and video recordings of mother–child pairs from Minnesota and Hamburg, we brought STEEP to Germany. In these meetings, practitioners soon agreed that clienteles in the two countries were comparable, an observation that was confirmed in the later transatlantic exchange.

Evaluation of the adaptability of STEEP in Germany also can be based on the developmental mechanisms on which the program focuses (e.g., parental sensitivity and the significance of the different attachment models in childhood and adulthood, as well as their effects throughout life). These were similar on both sides of the Atlantic, as the attachment research team of Klaus and Karin Grossmann first showed within the German culture (Grossmann, Grossmann, Spangler, Suess, & Unzner, 1985; Suess, Grossmann, & Sroufe, 1992; Grossmann, Grossmann, & Kindler, 2005; Grossmann, Grossmann, Fremmer-Bombik, Kindler, Scheuerer-Englisch, & Zimmermann, 2002). Attachment is a universality (see van IJzendoorn, & Kroonenberg, 1988; De Wolff & van IJzendoorn, 1997) and is suitable worldwide as a basis for intervention and parent programs, as studies by Bakermans-Kranenburg, van IJzendoorn, and Juffer (2003, 2008) have shown.

Another challenge facing the German STEEP project was that practitioners were skeptical about our demand to test the effectiveness of STEEP empirically—an issue not unique to Germany, as we learned during the transatlantic exchange. Practice-oriented research and the translation of the findings from attachment research in a practical context create arcs of tension, which need to be addressed carefully (Cicchetti & Hinshaw, 2002; Coie, Miller-Johnson, & Bagwell, 2000). John

Bowlby (1988) summarized common differences in thinking and interests between scientists and practitioners: "As practitioners we deal in complexity; as scientists we strive to simplify. As practitioners we use theory as a guide; as scientists we challenge that same theory. As practitioners we accept restricted modes of enquiry; as scientists we enlist every method we can" (p. 43). However, this does not mean that practitioners are merely optimists and scientists are hopeless skeptics. Scientists possess enormous faith, according to Bowlby, "faith that in the long run the best route to reliable knowledge is the application of scientific method" (p. 42), something practitioners often doubt.

Attachment theory and research are advantageous, though, in helping practitioners move through their skepticism and uneasiness with empirical evaluation of their work. This is because attachment theory was developed by a practitioner (Bowlby) to improve practice, and in many aspects integrates clinical understanding and empirical testing approaches. Especially the ethological approach that underlies attachment theory (Hinde, 1976; Grossmann, 1988) encourages an understanding through theory-guided observation, which is similar to clinical case understanding, and is the core of STEEP training and practice. As practitioners have become more experienced in theory-guided observation, they generally have become more comfortable and accepting of the value of empirical evaluation of the program.

STEEP Training in Germany

Leaders of the German STEEP project worked closely with their U.S. colleagues to develop a systematic training for STEEP facilitators that was suited to the culture and practices of Germany and its mental health and social services systems. The development of the training program was greatly advanced by the translation, adaptation, and publication in Germany of the *STEEP Facilitators' Guide* (Erickson et al., 2002). That volume includes specific home-visit and group activities and strategies, as well as a practice-friendly summary of the attachment theory and research that frames the STEEP program.

We selected STEEP trainers who had extensive practical experience as mental health professionals and also were scientist-practitioners who had conducted attachment research. We expected that people with that combination of experience would best be able to address the arcs of tension in carrying out both the STEEP intervention and the necessary research procedures, as mentioned before.

The training was structured in 10 two-day modules, beginning with an introduction of the basic principles of attachment theory and the most important results from longitudinal studies of attachment, particularly those at the University of Minnesota in the United States and the University of Regensburg, Germany. Trainees gain insights into the different attachment models in infants and toddlers (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Solomon, 1990), attachment models in adulthood (Steele & Steele, 2008), the mechanisms responsible for continuities and changes in the lifespan, as well as an understanding of the role of early experiences in shaping lifelong relational attitudes and behavior (Sroufe et al., 2005; Grossmann, Grossmann, & Waters, 2005).

Our goal is to provide STEEP facilitators with as deep an understanding of attachment theory as possible, including attachment-based reflections about their

own biographies (elaborated later in this chapter). In an individualized program such as STEEP, decisions often present themselves in new shapes and forms, and are not predetermined. But solid theory informs and guides thoughtful decisions across the many individual situations.

Another core focus area within attachment theory and research is Ainsworth's sensitivity concept and its application. In group supervision, which is integrated throughout the initial STEEP training and also in four all-day follow-up sessions, trainees rate video recordings of mother–child pairs on the Ainsworth Sensitivity Scale (*www.psychology.sunysb.edu/attachment/measures/measures_index.html*), achieving reliability in assessing maternal sensitivity. Longitudinal studies of the effects of sensitivity are used to provide an empirically based description of the guiding principle of "good enough parenting" (Grossmann et al., 1985; De Wolff & van IJzendoorn, 1997). Especially during video work, there is a danger of trying to optimize the mother's interaction with her child beyond what is necessary, which may produce undesired effects in high-risk parents. For instance, a level of sensitivity that is "too high" may not be sustainable over the day, the week, and so forth, and may put pressure on the attachment figures. In this way, STEEP mothers who are at risk of trying to be the perfect parent may resign themselves more readily, or, when they experience failure, may withdraw from what they perceive to be the source of this feeling of failure. It is for these reasons that the concept of "good enough" parenting is emphasized in the work with high-risk parents; meanwhile, research on long-term effects of sensitivity allows discussion of "good enough parenting," with the assistance of video clips.

During training and also during follow-up reflective supervision, the STEEP trainees have repeatedly described the quality of the observed interaction; we pay attention to participants' use Ainsworth's terminology from the sensitivity scale in order to encourage an internationally available professional language. So far, the focus on sensitivity has proven to be valuable, as longitudinal studies have repeatedly shown effects of the sensitivity scores on the life course, whether at age 14 or age 32, whether within the parent–child relationship or in new relationships, peer friendships or romantic relationships (Raby, Roisman, Fraley, & Simpson, 2015; Beijersbergen, Juffer, Bakermans-Kranenburg, & van IJzendoorn 2012; Grossmann et al., 2002, 2005).

The intervention focus on "sensitivity" also has proven to be effective, as studies on attachment-based intervention focusing on sensitivity have shown (for a summary, see Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2014). However, interventions regularly show how sensitive parenting is hindered at different times and in different everyday situations. Parents may not react to their children's signals out of fear of spoiling their child, and may profit from information and knowledge that is provided by a psychoeducational approach. Other parents may not even be aware of their insensitivity and may even believe that they are extremely sensitive. The more insensitivity is linked to long-existing and deep-rooted automatic processes, the less a purely behavioral intervention to promote attachment security is sufficient. Hence, trainees learn to encourage parents to reflect critically on their day-to-day behavior toward the child. And they learn to help parents address the various factors that support or hinder them from providing sufficiently sensitive care.

To that last point, interventions can be framed within five different levels:

1. Level of parent–infant interaction.
2. Level of representation.
3. Level of "therapeutic" relationship, including practical help and problem solving.
4. Level of providing information and building knowledge.
5. Level of support (both providing support directly and also helping parents build or strengthen their natural support system).

Cutting across all five levels of intervention is the importance of enjoyment (the second E in STEEP), both in the relationship between the STEEP facilitator and the parents and the relationship between the parent and the child. STEEP developer Erickson has spent a great deal of time with STEEP trainers and facilitators in Germany and often has felt compelled to remind us to keep the second E in STEEP.

When parents do not find joy in the interaction with their child, sensitivity will not be long-lasting, especially for highly burdened young mothers. The Minnesota Longitudinal Study on Risk and Adaptation (Sroufe et al., 2005) observed that a change of attachment status from secure to insecure during the second year of life occurred more often in mothers who were less able to enjoy their time with their child. This was shown by video analyses of their interactions during the first year of life. Sroufe et al. took from these findings that Ainsworth's sensitivity scale tends to measure the technical part and the attainment of attachment security, while the joy in the interaction with the child measures emotional and motivational aspects that ensure sensitivity is sustained.

Interactions between a STEEP facilitator and parent often cut across all five levels of intervention, also embracing the concept of enjoyment. For example, when a facilitator observes during a video intervention that the mother has ignored her baby's cries (Level 1), she can can ask gently about the mother's own childhood memories about how caregivers responded to her cries (Level 2), while reflecting sensitivity toward the mother's desire to figure out the best way to deal with her baby's crying (Level 3). The facilitator also can share information about the importance of sensitivity and responsiveness to help the baby build the security that is the foundation of healthy child development (Level 4). And she can offer emotional support that acknowledges how exhausting it can be to care for a crying baby, encouraging the mother to reach out for help and support from other friends and family members (Level 5). And, of course, the facilitator can make sure to focus the mom's attention on those times (and video images) in which she and her baby share a feel-good moment in a smile or a cuddle or a laugh.

In addition to teaching STEEP trainees the theory and research on attachment patterns and the important role of parental sensitivity as a pathway to attachment security, we also address directly the trainees' attachment representations or states of mind and self-reflective functioning. At the start of training, we use the Adult Attachment Projective Picture System (George & West, 2012)[2] to assess

[2]Recently we switched to administering the Adult Attachment Interview (AAI; Main, Hesse, & Goldwyn, 2002; for use of the AAI in clinical settings, see Steele & Steele, 2008).

and then discuss attachment representations with each trainee. In a subsequent module focused on the inner self of the facilitators, we explore the special dynamic that arises from the encounter of different attachment models and examine both the beneficial and potentially negative effects on intervention outcomes. After initial concerns that working with the trainees' own attachment models may be too intimate and personal, we have learned that this part of the training is viewed by participants and trainers as one of the most important components of training. It lays the foundation for the ongoing self-reflection that is central to follow-up supervision and to STEEP work in general. (We say more about the self-reflection of workers in our discussion of the German research results that follow.)

Finally, as noted in the original STEEP research in Minnesota and as we also have found in Germany, mothers in the program often have a history of significant trauma, which they have not resolved, and they often present with symptoms of mental illness. Consequently, we also integrated general mental health competency into our training to prepare STEEP facilitators to recognize and address symptoms of mental illness, trauma, and potential threats to the child's welfare. The intent was not to train facilitators to do therapy but to prepare them to respond appropriately, to stay within the limits of their professional competence and support program participants in accessing psychological or psychiatric evaluation and treatment when needed.

Evaluation of STEEP in Germany

In three cities across Germany—Hamburg in the north, Frankfurt in the center, and Offenburg in the Black Forest in the south—STEEP was implemented by cooperating organizations whose employees successfully completed STEEP training (see Table 5.2), and the intervention was evaluated within a quasi-experimental design. A randomized controlled group design was not possible due to a lack of acceptance in practice. This acceptance was important to us because effective, careful implementation of both the intervention and the evaluation research rests on full acceptance and cooperation, a factor sometimes disregarded by researchers when they study interventions in the field. Thus, our study used a control group of mothers recruited when their babies were 12 months of age from welfare agencies other than those conducting STEEP interventions. Using different agencies prevented spillover effects of STEEP principles and strategies. Our data demonstrated that the 112 mothers who were recruited for the STEEP group across the three cities presented with significantly elevated risk levels compared to the 29 mothers in the control group.

Control-group mothers received treatment as usual within the German Child Welfare System (GCWS) and no STEEP intervention. Since youth services in Germany are of reasonably good quality nationwide, this was a good first test of STEEP in Germany. A better outcome in the intervention group would more readily be explained as a specific intervention effect than if the control group had received no support. As the study spanned 2 years, we ensured that differential attrition would not lead to biased interpretations of differences (for more information, see Suess, Bohlen, Carlson, Spangler, & Frumentia Maier, 2016; Suess, Bohlen, Mali, & Frumentia Maier, 2010).

At infant age one, 3.1 times more mother–child pairs of the STEEP group showed organized (71.8%) secure mother–child attachment in Ainsworth's Strange

TABLE 5.2. STEEP and Seeing Is Believing Training

I. Theoretical and research foundations of STEEP and Seeing Is Believing
   A. Attachment theory and research as a framework for relationship-based work with infants and families (including findings from the Minnesota Longitudinal Study of Risk and Adaptation, the concept of resilience, and the translational approach of STEEP).
   B. Patterns of attachment: antecedents and developmental consequences
   C. Parental sensitivity (Ainsworth Sensitivity Construct) and underlying factors
      1. Realistic expectations of parenthood
      2. Knowledge and understanding of child development
      3. Support for parents
      4. Guided look at history ("state of mind" about remembered attachment)

II. Seeing Is Believing: Using video recording to support and enhance parental sensitivity
   A. Presenting the idea
   B. Recording videos respectfully and effectively
   C. Viewing the video with parents. Using video and open-ended questioning to enhance parental understanding of infant behavior and development and sensitivity to baby's cues and needs
   D. Seeing Is Believing as a springboard for addressing broader issues
   E. Opportunities to practice the Seeing Is Believing approach

III. Prenatal visits: Expectations, preparation, and relationship building
   A. Recruiting participants
   B. Getting to know the family
   C. Gathering critical information: assets and challenges
   D. Preparing physically and emotionally for parenthood

IV. The group component of STEEP
   A. Engaging the group
   B. Establishing trust, ground rules, and confidentiality
   C. Format and activities
   D. Stages of group development

V. Digging deep: Integrating group and home visits to build family strengths and confront challenges
   A. Relationship as a vehicle for change
      1. How parent's relationship history and attachment state of mind shape their interactions with facilitator
      2. How facilitator's relationship history and attachment state of mind shape their interactions with families[a]
   B. Challenging parental state of mind
   C. Support and stress: An ecological approach
   D. Keeping the parent–child relationship center-stage

VI. Confronting issues of trauma, abuse (both domestic violence and child maltreatment), and mental health problems

VII. Opportunities to practice (practice dilemmas for discussion and role play)

[a]STEEP training in Germany has expanded this part of the training to administering the AAI to assess the attachment background and state of mind of trainees. Trainers then work individually with trainees to consider the results of the assessment and reflect on how relationship history and state of mind influence the trainee's perceptions and interactions, both professionally and personally.

Situation, which was significantly higher than in the GCWS control group. With 45.5% secure attachments, the GCWS control group demonstrates a result that is respectable for high-risk groups—especially in Germany, where there is a traditionally high percentage of insecure attachments (Grossmann et al., 1985; Rauh, 2000)—and highlights the significantly better results of the intervention group as a STEEP effect, which had to stand the test against an average quality youth service. A trend toward a positive effect was measured again after completion of the intervention, at age 24 months, this time using Waters's Attachment *Q*-Sort (AQS), which demonstrated a trend toward higher attachment security in the STEEP group. There also were significant differences between the intervention and control groups with respect to attachment disorganization/disorientation when infants were 12 and 24 months of age, using Main and Solomon's dimensional 9-point rating scale, with higher *D* scores for the GCWS control group. The same was true only for the 24-month-old infants when using the categorical *D* coding (Main & Solomon, 1990). Consider that STEEP was not evaluated under laboratory conditions, but in a real-world intervention practice setting. The STEEP intervention had to stand the test against a well-cared for GCWS control group, which had lower initial risk levels. Unfortunately, we were not able to recruit more participants for the control group. As a result, the sample size of the control group ($n = 29$) made it more difficult to consistently reach statistically significant results.

In addition to the attachment measures, we also compared the two groups (STEEP and GCWS control) with regard to parental stress (Parental Stress Index [PSI]), childrearing attitudes (Adult–Adolescent Parenting Inventory [AAPI]), and depression (Edinburgh Postnatal Depression Scale [EPDS]) after 1 year and at the end of the intervention study. In line with the higher risk levels at the start of the study, the mothers in the STEEP group still showed significantly higher stress levels compared to the GCWS control group after 1 year of intervention. However, these differences had disappeared at the 2-year assessment. Regarding the depression measures, there were no significant differences at either time. However, mothers in both groups showed a high risk of depression (EPDS), which indicates substantial strain on these parents. Based on the AAPI (Bavolek, 1989) scale for parental childrearing scores, we compared both groups on the extent to which mothers fell within the clinical risk range. While there was no group difference at age 12 months, STEEP intervention mothers received significantly lower scores on AAPI risk score at age 24 months. Post hoc tests reveal significantly superior scores of the STEEP intervention group on two out of five subscales: They demonstrated significantly more empathy (AAPI-S2) and they value their children more for expressing their views and making good decisions (AAPO-S5). All these differences were in the predicted direction and can be interpreted coherently (for more information, see Suess et al., 2016).

Earlier, we reported that we assessed the attachment background of the participating social workers, using the Adult Attachment Projective (AAP; George & West, 2012), as part of our STEEP training. Based on Bowlby's (1988) conviction about the effects of attachment background on the effectiveness of attachment-based intervention, we reexamined the effectiveness of the STEEP intervention of the STEEP facilitators, who were involved at one of the three study sites mentioned earlier, in relation to their attachment background (Suess et al., 2015). In order to

minimize errors, we coded the AAP of the STEEP facilitators twice independently, and in case of a disagreement, the AAP was coded a third time and the mode was used. Professionals with insecure and secure attachment backgrounds did not differ in the effectiveness of their STEEP intervention (i.e., both had similar numbers of parent–child pairs with secure attachment in their STEEP groups). However, when we observed professionals who presented with an unresolved attachment status (i.e., had not sufficiently processed a trauma or separation) and compared them to the rest of the professionals, significantly fewer parent–child pairs of the unresolved professionals showed a secure attachment quality at age 12 months (Suess et al., 2015). This effect of the professionals' unresolved status was not found at 24 months. Although this result is not very strong, we are convinced of the impact of the professional's own attachment status in attachment-based intervention. Our conviction is founded in our experiences in supervision and training settings, as well as evidence from other research (Dozier, Cue, & Barnett, 1994; Stovall-McClough, & Dozier, 2004; Dozier, Albus, Fisher, & Sepulveda, 2002; Schuengel, Kef, Damen, & Worm, 2012). The issue warrants further study with larger sample sizes.

In studies with a larger sample size, which are more tightly controlled, the effect of match between intervention providers' and mothers' different internal working models and the effects of different combinations of deactivating and hyperactivating attachment strategies could be examined more closely in relation to the intervention process. There are indicators suggesting that taking into account "differential susceptibility" and different phases of the intervention process could lead to a more complex transactional model in this area (Mallinckrodt, 2010; Velderman, Bakermans-Kranenburg, Juffer, & van IJzendoorn, 2006).

Further Developments in Germany: STEEP-Based Counseling

The experiences from more than 10 years of implementing STEEP as a training and intervention program within the German youth welfare system have led us to believe that limiting its scope to the first 2 years of a child's life is not sufficient in face of the broad demands of the practical work. Hence, youth service and health professionals who work with families and children beyond age 2 or 3 now participate in STEEP training seminars and are eager to utilize attachment knowledge successfully in their work.

Currently, we are developing additional, specific training modules addressing STEEP-based counseling beyond the second year of the child's life. This work is facilitated by instruments that focus on the attachment representation of the child, such as the Attachment Story-Completion Task for preschoolers (Bretherton, Ridgeway & Cassidy,1990) and the Late Childhood Attachment Interview (LCAI; Zimmermann & Scheuerer-Englisch, 2001), as well as applying an attachment framework to observations of family interaction, and to observations of how children approach and engage peers, teachers and other important adults. How children perform on social perception tasks with respect to pictorial stimuli of conflicts, as well as their attributional style with respect to intentions, are important cornerstones of extending STEEP to the preschool years (Suess et al., 1992; Suess & Sroufe, 2005) and beyond.

Throughout the preschool years, the focus of the intervention is to strengthen secure base use and support within important relationships. Significant questions include the following: Does the child communicate his or her worries? Does he or she seek comfort and support from adults when stressed? Can parents identify how the child feels, and is the child confident that the parents can effectively support him or her (Zimmermann, 1999; Scheuerer-Englisch, 2012).

We also have begun to apply STEEP-based strategies and approaches in inpatient and outpatient treatment of mothers with peripartum depression, with severe personality disorders combined with traumatic experiences, and even with psychotic mothers and their infants. This, of course, is challenging but very worthwhile work if it helps to bring about an early shift from the emergence of disorganized attachment patterns toward organized relationship patterns (Hartmann, 2012).

Lessons Learned from 30 Years of Implementing STEEP

With more than 30 years of implementing STEEP in the United States and more than 10 years in Germany—and with many opportunities for sharing ideas and reflections through our ongoing transatlantic exchange—we have gained insights, drawn cautious conclusions, and grappled with ongoing questions related to future practice and research. First, we have seen repeatedly that, for parents, the greatest challenge lies in the space between what they know and what they do. It is relatively easy to help parents build knowledge, but support (or the lack thereof) for shifts in parental states of mind are more difficult to achieve yet important to promote given the powerful influences of these states of mind on how parents apply what they know on a daily basis (Verhage et al., 2016). So a core challenge in this kind of work is finding ways to motivate parents to become mindful, to observe themselves and their children, and to develop the courage to question old patterns and try new ways of behaving—in other words, to apply the knowledge they have gained. Creating an atmosphere open to mistakes is fundamental. This is most likely to happen when parents feel secure with us rather than feeling devalued, exposed, criticized, or meeting with impatience. And it is most likely to develop when, as professionals, we step off the pedestal and allow parents to see us as vulnerable, imperfect people who also sometimes struggle to apply what we know on a daily basis. This self-revelation runs counter to what many of us learned in our own professional training, but we are convinced that this approach enhances the effectiveness of preventive intervention with high-risk parents and children.

That leads directly to the related issue, or principle, that relationships change relationships. Doing relationship-based work is a new approach for many experienced professionals who are used to working from an expert model (e.g., traditional education or health services). Knowledge alone is not enough for a facilitator to be able to provide the secure base that enables a client to explore new ways of being. Rather, the professional's own reflective capacity is often the engine of change. An intervention without continuous self-reflection on the part of the professional may lead to a standstill for the client, resulting in repetition of old, dysfunctional patterns, resignation, emotional withdrawal, or even dropping out of the program.

Secure facilitators provide support and encouragement to families and also are able to let go when necessary. They can serve as models of self-reflection.

As we have learned through both research and practice, parents' and workers' states of mind intersect in important ways. In an ideal scenario, the professional would bring a secure or "earned secure" state of mind that can complement and gently challenge insecure models or states of mind in parents and in parent–child relationships. But this very often is not the case, with many professionals having insecure or unresolved states of mind. The pulls and draws of inner working models (of both worker and client) create a sometimes invisible but powerful scaffold or framework for the processes of intervention. As we described earlier in this chapter, these forces need to be addressed in training and ongoing reflective supervision, an essential component of a responsible STEEP practice, so that the STEEP facilitator does not become a pawn of these forces and does not lose perspective during the intervention. Here, it is necessary to sensitively challenge trainees or supervisees at certain points, especially when they present with an insecure or unresolved attachment background.

We have never considered excluding candidates from training because of an insecure attachment background, although colleagues have raised the question; however, we challenge and support trainees to do what Erickson and Egeland have called "looking back, moving forward" in order to reflect on and understand their own attachment background and how their history shapes the way they perceive and respond to clients, especially during times of duress. This process of self-reflection parallels the "looking back, moving forward" in which facilitators are expected to engage STEEP parents. We have seen that authentic self-reflection of workers who are supported by sensitive, reflective trainers, and supervisors can bring about change in a worker's state of mind and, in turn, increase the likelihood of that same change process for parents served by the worker.

Without that self-reflection, workers may mirror and inadvertently reinforce a client's ineffective patterns. For example, when a facilitator presents with a dismissive state of mind and interacts with dismissive clients, intervention may remain superficial and be oriented toward enforcing the child's strict adherence to parental rules and limits, interpreting the behavior of the child as inappropriate rather than as a signal. This prevents the parents from developing a clear understanding of attachment needs and motives, and reinforces their dismissal of the child's emotional needs.

A similar process occurs when a facilitator shows a preoccupied—or even more, an unresolved—state of mind regarding his or her own attachment history and is confronted with a similar model in a client. The result may be overreaction on the part of the professional (e.g., a premature emotionally triggered recommendation that the child be removed from the home), overidentification with the aggrieved mother (agreeing without question that the violent partner/father must have his rights terminated), loss of professional boundaries (e.g., lending a client money in a moment of apparent financial crisis), or other enabling actions (jumping in to solve a problem for a parent rather than helping the parent strategize about solutions).

The implementation and evaluation of STEEP in Germany has included a more systematic approach than earlier studies in addressing the attachment representations of the professionals working in the program, and the results have been

encouraging. As described elsewhere, the German study has shown that insecure states of mind of professionals can improve through reflective supervision (Suess et al., 2015). These findings affirm our philosophy not to consider excluding facilitators with insecure attachment models, but to aim for an accepting attitude that nevertheless strives for change. We have observed that professionals with an "earned secure" status often develop a particularly deep understanding of insecure attachment processes, enhancing their ability to join with a client to discover new ways of being in relationship and understanding attachment needs in oneself and one's children.

Within the STEEP trainings and service programs in Germany, we continue to dig more deeply into the intersection of different attachment models or states of mind. For example, we are just beginning to empirically map the dyadic processes during the encounter with different attachment models and examine these processes in terms of their effects on the intervention process and also group processes (both among mothers in the STEEP groups and among STEEP facilitators working together). In a training context, we continue to experience the different deactivating and hyperactivating forces, both constructive and obstructive. Our aim in training and in ongoing supervision is to increase awareness and sensitivity regarding these forces and, using attachment theory, create a language that allows us to exchange thoughts about them and shape them in a positive way. Through the interplay of practice and research, perhaps in the future we will find not only developmentally meaningful dimensions and mechanisms but also better ways to help children and parents. This interaction of clinical understanding and empirical science is the very legacy of Bowlby and Ainsworth, as well as the now retiring first generation of attachment researchers.

While there has been a deepening of emphasis on the level of representation throughout the years of implementing and adapting STEEP, we still consider the focus on the here and now as an invaluable part of STEEP. The here-and-now behavioral component of STEEP is especially apparent in the Seeing Is Believing video strategy. Babies need good-enough parenting right now and may not be able to wait for parents to change their state of mind. Knowing this, the support of the parents through STEEP always includes concrete, routine-oriented, practical intervention strategies rooted in a strong learning alliance between the STEEP facilitator and parents. As partners in discovery, parents and their STEEP facilitator not only focus on the child's development but also look toward the future of the parents and other family members. We are convinced that building positive parenting behaviors (e.g., reading a baby's cues, responding sensitively and appropriately) and then seeing oneself on video using those behaviors can bring about change in a parent's self-view. We are not yet sure exactly how that relates to eventual changes in a parent's state of mind, but we believe it does. And we believe that the competence and confidence parents develop in interacting with their baby become a foundation for building other skills and making healthy choices for the well-being of their families and themselves.

We would be remiss if we did not include in our discussion of lessons learned the importance of the second E in STEEP: Enjoyable! Working with high-risk parents and infants is serious and difficult. But just as good parent–child relationships involve a great deal of joy and playfulness, so should the work with families—another

important example of parallel process. In a beautiful video made by STEEP facilitators in Hamburg, one of the STEEP groups (moms and toddlers) took a very special weekend trip to "Kalifornien" (not the one in the United States, but a beach in Northern Germany), where they stayed overnight in small cabins and spent a great deal of time romping and playing outdoors together. When we bring active, exuberant play and exploration into our work with families, parents learn firsthand about the importance of play to their children's learning. They hear the delight in their children's laughter and experience the joy of laughing with them. And, for too many moms, they begin learning to play for the first time themselves. It doesn't need to be a trip to California; 10 minutes of dancing to one's favorite music or splashing in buckets of water outside on a hot day work just fine.

Honoring the second E also includes building some fun and playful activities into Momtalk time during STEEP group sessions, just for moms—a lesson in the value of self-care and replenishment in the midst of all the demanding tasks of parenthood. Continuing the theme of parallel process, STEEP workers also deserve some breaks and fun along the way; by caring for each other and themselves, they are more able to care for the families they serve. But it is up to STEEP facilitators and supervisors to be sure that enjoyment is not squeezed out by the many grave and difficult issues they face in their work.

So, what is most important in this work with challenged families? Or phrased another way, what is the most valuable thing a STEEP facilitator brings to families in the program? It is oneself, one's eyes, feelings, thoughts, and honest reflections on one's own experience. The interpersonal encounters and the supportive sharing of observations and insights are cornerstones of the work, so the STEEP facilitator brings his or her whole self to that relationship. When mothers in the program begin to understand that no one's life is perfect, that sometimes we all are tired, sad, or frustrated, and that we all do things we know are not good, then growth and learning can happen. The challenges, sadness, and missteps are all part of the human journey or what the Greek Alexis Zorba in the classic movie called "the full catastrophe" (Kabat-Zinn, 2013). There is great joy and satisfaction for a parent who makes gains in navigating that challenging human journey. And there is great joy and satisfaction for the thoughtful, dedicated worker who has the privilege of supporting the parent in making those gains.

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