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## The intervention model for affective involvement and its effectiveness

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## Chapter 1

### **Introduction**

## 1.1 Background and aims of the thesis

Affective involvement, or the mutual sharing of emotions, helps people maintain consistent orientation to the social environment, and to elicit and maintain positive emotions and limit negative emotions (Feldman, 2003). Social awareness and emotion regulation are vital because they form the basis for communication and development (Trevarthen & Aitken, 2001). Mutual emotional exchanges between communication partners with a typical development arise spontaneously, predominantly supported by the senses of hearing and sight. Not being able to use these senses properly from birth or soon after birth (i.e., before language develops) places a heavy burden on the exchange of emotions and on the construction of social interaction and communication of people with congenital deafblindness. The inability to engage in shared attention through eye contact and speech hinders people from sharing dynamic emotional exchanges (Hart, 2010; Janssen & Rødbroe, 2007). It makes people with congenital deafblindness highly vulnerable to negative emotions and tensions because it is hard for them to understand what is happening around them and to exchange thoughts and feelings with their communication partners about their experiences.

Parents, professionals, and researchers agree that it is the communication partners' responsibility to establish a sense of well-being in people with congenital deafblindness (see, e.g., Rødbroe & Souriau, 1999). This can be achieved by building emotional communication relationships through the tactile modality (Chen & Downing, 2006; Janssen & Rødbroe, 2007; Miles & Riggio, 1999; Nafstad & Rødbroe, 1999). However, communication partners may find it difficult to foster affective involvement tactilely during meaningful exchanges (Hart, 2010).

The aim of the current thesis was to provide theory- and evidence-based guidelines for fostering affective involvement in practice. In this context, we assumed that it is complex for communication partners to evoke and preserve the flow of interaction while simultaneously focusing on the exchange of meaning with people with congenital deafblindness. Therefore, we investigate how affective involvement could be fostered during both interaction and communication. Building on Janssens's former work on fostering harmonious interactions (Janssen, Riksen-Walraven, & Van Dijk, 2003a, 2003b; see also Janssen, 2003), we developed a new, two-phased diagnostic intervention model for fostering affective involvement between persons with congenital deafblindness and their communication partners during daily practice. Phase I of the model focuses on fostering affective involvement during interaction, and phase II on fostering affective involvement during communication. Next, we examined whether the intervention model was applicable and effective in naturalistic settings. The intervention model was applied to nine persons with congenital deafblindness and their 34 communication partners during three empirical studies. The effectiveness of the model-based interventions was assessed using repeated and detailed observations of the interaction and communication between the participants with congenital deafblindness

and their communication partners. These observations focused on the following main research questions: (1) do interventions based on our intervention model increase dyadic affective involvement, and increase positive emotions and decrease negative emotions in persons with congenital deafblindness, (2) are these interventions effective during both interaction and communication, and 3) are they effective with different communication partners and in different settings, interactional situations, and organizations?

## **1.2 Thesis outline**

After the present introductory chapter (Chapter 1), this thesis continues with a theoretical study describing the background and development of the Intervention Model for Affective Involvement (IMAI; Chapter 2). The next three chapters address three consecutive empirical studies on the effects of interventions based on the IMAI (Chapter 3, 4, and 5).

Chapter 3 presents the first study in which the applicability of the IMAI was empirically tested in a pilot study. The effects of the IMAI-based intervention were examined in this first study by applying the IMAI to one adult with congenital deafblindness and his five communication partners in two different settings in an organization specialized in communication and auditory and/or visual disabilities. Chapter 4 presents the effects of an IMAI-based intervention in a second empirical study. The IMAI in this second study was applied to two children and two adults with congenital deafblindness and their 16 communication partners in three different settings in the same organization used in the first empirical study. Chapter 5 reports on the effectiveness of the IMAI in a third empirical study. The intervention in this final study was applied to four adults with congenital deafblindness and their 13 communication partners. The four participants have different backgrounds and receive care services from four different Dutch organizations with expertise on intellectual and/or visual disabilities.

The concluding chapter (Chapter 6) summarizes the four studies described in this thesis and presents the main conclusions. Chapter 6 concludes with a general discussion, including the most important limitations of the studies and implications for practice.

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