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**Qualitative research into mothers' experiences of receiving early intervention for  
their children's difficulties**

by

**Helena Willson-Maunders BSc (Hons)**

A thesis submitted in partial fulfilment of the requirements for the degree of  
Doctor of Clinical Psychology

Coventry University, School of Health and Social Sciences  
and University of Warwick, Department of Psychology

July 2005

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## Acknowledgements

Thank you to Dr. Hazel Douglas (my clinical supervisor) who gave me all the clinical knowledge and containment I needed to write this thesis. Also grateful thanks to Dr. David Giles (my academic supervisor) for his patience with advising me on the seemingly endless drafts. Thank you also to Charlotte Webb, Julie Hobbs, and Karen Bateson who were kind enough to give me comments on the final drafts.

I would also like to thank the mothers who generously gave their time to participate in my research. I appreciated the openness with which they shared their experiences.

Sincere thanks also go to my research cohort: Lisa Summerhill, Vicki Lloyd and Lucy Knight, who are women of many skills, in research, in cooking, and in friendship.

My parents also deserve much credit for all the support they have given me over the years. They have taught me to believe in myself, and to trust that somehow it will all work out in the end.

Finally, special thanks go to my husband, Marc, for all the practical and emotional support he has given me. Marc, it must have felt like you have come last throughout all of this. I would like you to know that you are not last in my life. You are first. Always.



## Declaration

This thesis was carried out under the supervision of Dr. David Giles and Dr. Hazel Douglas. The study ideas and designs arose from collaboration with my supervisors. I carried out all the interviews.

Dr. David Giles advised on qualitative methodology, and checked drafts of all the chapters. Dr. Hazel Douglas provided access to participants, advice regarding the Solihull Approach (an early intervention programme), and checked drafts of the chapters. Charlotte Webb, Julie Hobbs, Stephen Joseph, and Karen Bateson gave comments on the final drafts of the literature review (chapter one), main research paper (chapter two), and brief research paper (chapter three).

Dr. Hazel Douglas checked the validity of the analysis for the study reported in chapter three. Vicki Lloyd, Lucy Knight, and Lisa Summerhill carried out validity checks for the main research paper (chapter two). Apart from these collaborations, this thesis is my own work.

The literature review (chapter one) is prepared for submission to the “Infant Mental Health Journal”. The main research paper (chapter two) is prepared for submission to the journal “Early Development and Parenting”. The brief research paper (chapter three) is prepared for submission to the journal “Early Development and Care” (see Appendix A for instructions to authors).

Authorship of any publications from this thesis will be shared with my supervisors. This thesis has not been submitted for a degree to any other university.

## Summary

Previous research has shown that negative experiences, such as abuse and neglect, early in infants' lives can have a long-term detrimental impact on their mental health and development. A number of early intervention programmes and initiatives have recently been implemented by the government in order to try to prevent such problems.

The first chapter of this thesis provides a review of the findings of current research into early intervention programmes, in terms of the reported benefits to infant mental health. The review identifies four areas of impact: social development, behaviour, cognitive development and the parent-child relationship. There is critical consideration of the research in each area, and direction suggested for programme designers and future researchers.

The second chapter reports a research study using interpretative phenomenological analysis to explore mothers' experiences of their relationships with community health professionals who were providing early intervention for their children's difficulties. The study provides a unique insight into mothers' perceptions of the process of seeking help and aspects of the therapeutic relationship that they consider important.

The third chapter details a research study using a deductive qualitative methodology to analyse mothers' reports of health visitors' use of psychological theories underpinning an early intervention programme (the Solihull Approach). The findings reveal variations in the reporting of the different theories. Possible reasons for these variations are discussed. Ideas considered are relevant to professionals who provide inter-disciplinary training, and to future researchers studying clients' experiences of psychological approaches.

The fourth chapter is a reflective paper that discusses further methodological issues, the process of conducting the thesis, and the resulting changes to the main researcher's professional practice.



## Chapter 1: Literature Review

In what areas of infant mental health are early intervention programmes effective?

Word count: 5387

(excluding tables and references)

## **1.1 Abstract**

Negative experiences in infancy have been linked to changes in brain development that can predispose children to mental health problems. Early intervention has been prioritised by the government as an attempt to prevent problems later in life. This paper critically reviews current research in order to answer the question, “in what areas of infant mental health are early intervention programmes effective?” Research has identified changes to infants’ social development, behaviour, cognitive development and the parent-child relationship following early intervention programmes. There is a paucity of research on changes to the parent-child relationship. There is also a need for more rigorously designed studies and for more research into factors that mediate the effects of early intervention. The current research does, however, provide some guidance for those responsible for designing and implementing early intervention programmes.

## **1.2 Introduction**

Research has shown that negative experiences in infancy can have a latent detrimental impact on children's mental health. Schore (2001) reviewed evidence to show that attachment disorders in infancy can be linked to behavioural problems later in life. Glaser (2000) reviewed studies that showed a correlation between early childhood abuse and neglect, and cognitive, social and emotional difficulties in later childhood and adulthood.

In the United Kingdom the government has supported the concept of intervening early in order to prevent mental health problems later. Sure Start is a nationwide early intervention initiative launched by the government in 1998 that aims to improve the health and emotional development of young children in disadvantaged areas. In addition the National Service Framework for Children was published in 2004 (Department of Health, 2004). The first standard prioritises "promoting health and well-being, identifying needs and intervening early" (Department of Health, 2004; p.6).

With this recent emphasis on early intervention, there is a need to evaluate programme outcomes. On a financial level it is important for co-ordinators to provide evidence to support programme efficacy in order to justify costs. Many research studies have been commissioned as a response to this need. For example, the government has invited both national and local evaluations of Sure Start programmes and this has resulted in a number of publications (e.g. Ford, Evans, & McDougall, 2003; Wiseman & Wakeman, 2004).

Early intervention programmes have been shown to be effective in terms of parental and child outcomes. Brooks-Gunn, Berlin, and Fuligni (2000) reviewed the impact of early intervention programmes on parents, and divided their findings into the impact on maternal education and employment, on maternal mental and physical health, on parent-child relationship, on use of child-related services, on parenting knowledge, attitudes and quality of home environment, and on indicators of child maltreatment.

All of the studies reviewed by Brooks-Gunn et al. (2000) that measured the impact of early intervention on maternal education and employment showed a positive change. The majority of reviewed studies that analysed the impact on maternal mental and physical health showed positive results including decreases in depression and anxiety, although a number of studies failed to find any change. One study highlighted a negative treatment outcome in the area of physical health; mothers who participated in an early intervention programme had higher blood pressure than those who did not.

The majority of studies in Brooks-Gunn et al.'s (2000) review that assessed the quality of parent-child relationships found positive outcomes following the programmes including less use of physical punishment and more sensitive responses to their children. A small number found no change to the parent-child relationships. Studies that measured the usage of child related services found that there were increases in the use of clinics for check-ups and immunisations, and decreases in the use of accident and emergency services. Following early intervention the majority of studies reviewed showed improvements were made to the quality of the home environment, although changes to parental knowledge of child development and attitudes to childrearing were less likely.



Farran (1990; 2000) reviewed infant outcomes following early intervention programmes, for studies published between 1977 and 1997. Farran (2000) reported that outcomes research into early intervention programmes did not change substantially over this time. Farran (1990; 2000) highlighted methodological problems with research across both decades, including lack of random assignment to groups, lack of control groups and high attrition rates amongst low-income, single and minority ethnic parents. Whilst there have been some recent reviews concentrating on specific populations, such as children on the autism spectrum (eg Horner, Carr, Strain, Todd and Reed, 2002), there has not been a recent review of the literature on early intervention programmes for all populations of children. The authors of the current paper therefore aim to focus their attention on the most recent research, and answer the question, “in what areas of infant mental health are early intervention programmes effective?”

### **1.3 Methodology for literature search**

The term “early intervention” was entered into PsychInfo (internet search engine). Limits were set on age (birth to one month, infancy, neonatal, preschool age, two to twenty three months and two to five years old), language (English) and publication year (2002-2004). The search yielded two hundred and forty one records.

Published studies were selected if they discussed infant mental health outcomes following an early intervention programme with a psychological component. Studies were only included if they discussed infant mental health outcomes. Studies were excluded if they discussed maternal mental health without reference to infant mental health. In addition, only outcomes directly related to the work of clinical psychologists were included. For example, language production and complexity was not included



because this area is considered to be more relevant to the work of speech and language therapists rather than clinical psychologists. For details of the exclusion criteria see table 1.1. From the original two hundred and forty one studies, twenty-eight were selected for inclusion in this review.

Table 1.1: Exclusion criteria for selection of studies

<b>Exclusion criteria</b>
<ul style="list-style-type: none"><li>• Production and complexity of language</li><li>• Individual play</li><li>• Academic achievement</li><li>• Motor development</li><li>• Hearing</li><li>• Sight</li><li>• Weight</li></ul>

#### **1.4 Results of literature search**

All of the programmes studied involved infants considered to be “at risk” for mental health problems, and early intervention aimed to address the specific difficulties faced by the population treated. The majority of programmes involved children with social communication disorders, children from disadvantaged neighbourhoods or low birth weight preterm babies. There was a tendency to report interventions that included psycho-education for the parents. Measures of infant mental health were mainly taken using a standardised clinician, teacher or parent-rated inventory in addition to (or instead of) conducting observations of child behaviour and interactions. The twenty-eight studies and their early intervention programmes, measures and procedures and results applicable to infant mental health have been summarised in Table 1.2 (key follows table). Changes to infant mental health were demonstrated in the areas of social development, behaviour, cognitive development and the parent-child relationship. Following the table, these four areas are each discussed in terms of general findings and mediating factors identified in the relevant research studies.

Table 1.2: Summary of studies (page 1 of 3)

Reference	Early intervention programme	Sample size & age range	Measures & procedure	Results
Aparicio & Balana (2003)	Social stimulation of Down's syndrome infants.	20 children assigned to one of two INT's: parents either receiving written instructions or observing clinician.	The Brunet-Lezine First Childhood Scale repeated during INT.	↑ SD.
Blair (2002)	Cognitive stimulation for LBW infants & problem solving for parents.	945 children entered study at birth & assigned to INT or CON.	ICQ & CBCL completed repeated during INT.	↑ CB & ↑ CD.
Blair, Peters & Lawrence (2003)	Same as Blair (2002).	Same as Blair (2002).	ICQ, CBCL & SBIS completed & interactions video-taped during INT.	↑ CB. No change in CD.
Brisch et al. (2003)	Parent group, individual psychotherapy for parents, sensitivity training & home visits for parents of LBW preterm infants.	87 children assigned at birth to INT or CON.	ASSP & neurological exam completed at FUP.	↑ PCR.
Carpenter & Nangle (2002)	Group psycho-education about aggression for at risk children (e.g. low SES).	8 aggressive preschoolers assigned to INT, 11 non-aggressive preschoolers assigned to CON.	OBS & Social Skills Rating System completed pre & post-INT & FUP.	↑ SD & ↑ CB.
Chandler et al. (2002)	Individual psycho-education & support for parents of children with ASD.	4 children aged 22 to 33 months assigned to INT.	Preverbal Communication Checklist and Pragmatics Profile & interviews repeated pre, during INT & FUP.	↑ SD.
Claussen et al. (2004)	Group or individual activities to teach children social/emotional, language, cognitive, motor & self-help skills.	130 children at assigned birth to centre-based, or home based programme, or CON (primary care).	BSID, CBCL & Adaptive Social Behavior Inventory repeated during INT.	No change in SD. ↑ CB & ↑ CD.
Craig-Unkefer & Kaiser (2003)	Group based play activities for children at risk for delays in social communication.	6 children aged 37 to 47 months, assigned to INT.	CB videoed & coded pre & during INT.	↑ SD.
Elliot et al. (2002)	Pre-reading skills group for children of low SES & group / individual behaviour management programme for parents.	330 children, average age of 57 months, assigned to reading programme, or parents attending behaviour management group, or both INTs or no INT.	Preschool Behaviour Questionnaire completed at pre, INT & Rutter Child Behaviour Questionnaire completed at FUP.	↑ CB after one programme, ↓ after another.
Garfinkle & Schwartz (2002)	Children with ASD / developmental delays instructed to copy leader in groups.	4 children aged 43 to 65 months completed INT.	OBS conducted pre INT, during INT & FUPs.	Variable ↑ in SD. ↑ CB.



**Table 1.2: Summary of studies (page 2 of 3)**

<b>Reference</b>	<b>Early intervention programme</b>	<b>Sample size &amp; age range</b>	<b>Measures &amp; procedure</b>	<b>Results</b>
Hancock, Kaiser, & Delaney (2002)	Parents of children with language delays & CB problems taught behaviour management & responsiveness.	5 children aged 38 to 46 months completed INT.	CBCL & Social Skills Rating System completed pre & post INT. CB recorded during INT, & FUP.	↑ CB.
Hill, Brooks-Gunn, & Waldfogel (2003)	Parents of LBW preterm infants received individual information on parenting & child development.	1082 children assigned at birth to INT or CON.	SBIS, WWPSI & WISC completed during INT & FUPs.	↑ CD.
Johnston, Nelson et al. (2003)	Children with ASD & cognitive delays taught to join playgroups.	3 children aged 53 to 61 months completed INT.	CB repeatedly recorded during & post-INT.	↑ SD & ↑ CB.
Johnston, McDonnell et al. (2003)	Children with disabilities given individual guidance on communication.	3 children aged 39 to 54 months completed INT.	The Ecobehavioral System for Complex Assessment of Preschool Environments completed pre-INT, repeatedly during INT & FUP.	↑ SD & ↑ CD. ↑ in some areas of CB, ↓ in others.
Kaminski et al. (2002)	Classroom based programme for at risk children (e.g. low SES), teaching social competence, self-regulation, & language skills. Parent education included for some.	74 children, aged 48 months at start of study, in INT or CON classrooms.	CBCL, Eyberg Child Behavior Inventory, Social Competence Scale & ADHD Rating Scale repeated during INT & PCR observed.	Variable ↑ in SD & CB.
Kurtz et al. (2003)	Individual INT's for self-harming children.	24 children, avg age 33 months, completed INT.	CB recorded during INT.	↑ CB.
Lawrence & Blair (2003)	Same as Hill, Brooks-Gunn, & Waldfogel (2003).	985 children assigned to INT or FUP group at birth.	BSID, SBIS, WPPSI & WISC repeated during INT & FUPs.	Initial ↑ in CD.
Lee (2003)	Same as Hill, Brooks-Gunn, & Waldfogel (2003).	606 children assigned at 40 weeks to INT or FUP group.	Revised Version of Health & Daily Living Form & CBCL completed during INT.	↑ CB.
Mahoney & Perales (2003)	Individual programmes teaching responsiveness to parents of children with ASD.	20 children assigned to INT (80% under 36 months, 20% between 48 & 60 months).	PCR videoed & coded, & Infant Toddler Social Emotional Assessment & Temperament & Atypical Behaviour Scale completed pre & post-INT.	↑ SD.
Morrison et al. (2002)	Individual activity schedules for children with ASD.	4 children with ASD assigned to INT (aged 42 to 70 months) & 8 preschoolers assigned to CON.	CB video-taped pre-INT & repeatedly during INT.	↑ CB.

Table 1.2: Summary of studies (page 3 of 3)

Reference	Early intervention programme	Sample size & age range	Measures & procedure	Results
Muhadmedrahimov et al. (2004)	Improved consistency of caregivers for orphanage children.	8 children aged 12 to 20 months completed INT.	ASSP conducted repeatedly post-INT.	↑ CB.
Murray et al. (2003)	Individual therapy for mothers with post-natal depression.	177 infants entered programme at birth. Mothers assigned to primary care, non-directive counselling, CBT or psychodynamic therapy.	Checklist of management of CB & PCR, Behavioural Screening Questionnaire, ASSP, Rutter A2 Scale, Pre-school Behaviour Checklist & McCarthy Scales of Children's Abilities completed & PCR videoed post INT.	↑ CB & ↑ PCR. No change in CD.
Robertson et al. (2003)	Children with developmental delay taught joint play in dyads.	2 children aged 43 & 57 months completed INT. 4 children with no delays formed comparison group.	CB recorded pre & during INT, & FUP.	↑ SD & ↑ CB.
Salt et al. (2002)	Therapy teaching children with ASD social & developmental skills.	14 children assigned to INT group, 6 waiting list children formed CON.	BSID, VABS & Early Social Communication Scale completed pre & post-INT.	↑ SD & ↑ CB.
Stahmer & Ingersoll (2004)	Group psycho-education, & speech & occupational therapy for children with ASD & their families.	20 children avg age 28 months assigned to INT.	BSID, VABS, the GARS & checklist of social behaviours completed pre & during INT.	↑ SD & ↑ CD.
Toth et al. (2002)	Psychotherapy/psycho-education for parents of maltreated children.	87 children, avg age 48 months, assigned to psychotherapy group, psycho-educational group or standard service group. 35 non-maltreated children formed CON.	Story stems from the MMSB & ASCT, Bickham & Fiese's global relationship expectation scale completed pre & post-INT.	↑ PCR.
White, Agnew, & Verduyn (2002)	Parenting group (CBT approach), & individual sessions.	56 parents attended programme.	CBCL, Eyberg Child Behaviour Inventory and Preschool Behaviour Checklist completed pre & post INT & FUPs.	↑ CB.
Woods et al. (2004)	Individualised strategies for parents of children with social communication delays.	4 children aged 15 to 31 months received INT.	Assessment, Evaluation & Programming System for infants & toddlers completed repeatedly pre-INT, INT & FUP.	↑ SD.



Key for table 1.2

ASD	Autism spectrum disorder
LBW	Low birth weight
SES	Socio-economic status
OBS	Observation
WPPSI	Weschler Preschool and Primary Scale of Intelligence
WISC	Weschler Intelligence Scale for Children
BSID	Bayley Scales of Infant Development
CBCL	Child Behaviour Checklist
ICQ	Infants Characteristics Questionnaire
SBIS	Stanford-Binet Intelligence Scale
VABS	Vineland Adaptive Behaviour Scales
ASSP	Ainsworth Strange Situation Procedure
INT	Intervention
FUP	Follow-up
CON	Control
CBT	Cognitive Behavioural Therapy
↑	Improved
↓	Declined
SD	Social development
CD	Child development
CB	Child behaviour
PCR	Parent-child relationship

### 1.4.1 Social development

#### **General findings**

Eleven of the original twenty-eight studies demonstrated improvements to infants' social development following participation in early intervention programmes. Two more studies showed positive changes at some times and in some areas of social development, and a lack of change at others. One study showed a lack of change in this area. No studies showed negative change.

Of the studies that showed positive change, overall infants became more sociable after intervention (e.g. Salt et al., 2002). Infants from disadvantaged neighbourhoods who were at risk for delays in social communication showed improved communication with adults (Craig-Unkefer & Kaiser, 2003). It is possible, however, that the results from Craig-Unkefer and Kaiser's (2003) study cannot be generalised to children with certain other mental or physical health problems, such as children with learning disabilities or sensory difficulties, since these children were excluded from the sample.

Early intervention has proved successful for helping some children on the autism spectrum become more attentive and demonstrate greater affect when interacting with their mothers (Mahoney & Pearles, 2003), however, it can often prove more difficult to engage these children with their peers as opposed to a familiar adult. Despite this, early intervention has helped these children become less avoidant of other children (Stahmer, & Ingersoll, 2004) and even become more likely to ask to join in others' play (Johnston, McDonnell, Nelson, & Magnavito, 2003). Children with non-specified social developmental delay will also stand closer to peers and are more responsive to other

children's initiations (Robertson, Green, Alper, Schloss, & Kohler, 2003). Over time these children have been shown to learn to imitate their peers' behaviour and become more involved in reciprocal interactions (Robertson et al., 2003).

The ability to self-regulate emotions is an important skill for young children to learn in order to integrate into society. It is a skill that children with autism spectrum disorder often find difficult to master. Mahoney and Perales' (2003) study showed that children with autism were more able to control their own emotions, following an early intervention programme involving weekly sessions over eight to fourteen months, teaching the parents to be more responsive during interactions with their children. Stahmer and Ingersoll (2004) measured the severity of children's autism and found that between pre and post intervention these children began to exhibit fewer stereotypical autistic behaviours. There was, however, no control group included in this study, and therefore it is not possible to conclude that the changes in the children's behaviour were attributable to the intervention rather than to normal maturation.

Even brief intervention has been shown to be effective at increasing pro-social behaviour. A group of aggressive children was given a short oral instruction about the consequences of anger and alternative ways of responding, and this resulted in significant improvements in teacher-rated pro-social behaviour (Carpenter & Nangle, 2002).

Of the two studies that showed variable change, one study (Garfinkle & Schwartz, 2002) showed more significant increases in one area of social development compared with another. Although children showed an increase in peer imitation, social interaction remained relatively low. The other study showed a change according to the length of



intervention; children's social competence did not improve after the first year of intervention, but it did change after the second year (Kaminski, Stormshak, Good, & Goodman, 2002). It is possible that social competence is a more complex area of development that takes a longer time to influence.

Claussen, Scott, Mundy, and Katz (2004) showed that there was no advantage of early intervention over standard primary care on measures of pro-social behaviour. Different studies did, however, select different control groups, with some comparing the difference between children receiving an early intervention programme to children receiving standard primary care, and others to children receiving no intervention. Very few studies included an "early intervention" group, a "standard care" group and a "no intervention" group, making it difficult to precisely define the unique benefits of some early intervention programmes.

### **Mediating factors**

Child and maternal characteristics have been identified that are more likely to result in greater social development following intervention. Changes in maternal responsiveness have been associated with changes in the child's social interaction (Mahoney & Perales, 2003). A mother who becomes more responsive to her child's needs is likely to encourage a proportionate amount of change in her child's social abilities, particularly in his or her emotional self-regulation (Mahoney & Perales, 2003). Unfortunately sampling in Mahoney and Perales' (2003) study was biased towards white middle class mothers, making it difficult to know if their conclusions apply to other populations.

The way in which therapeutic information is presented to parents during interventions has also been linked to level of change in children's social development. In Aparicio and Balana's (2003) study, parents were assigned to two groups: one group observed the clinician carrying out the intervention with their child and the other group was just given written information. Children whose parents had observed the intervention scored significantly higher on measures of social development than those whose parents had just received written information.

## **Summary**

It therefore appears that early intervention can be beneficial in improving infants' social development both with adults and peers. Some of its effects may, however, be mediated by other variables. If the mother becomes more responsive, or the child is very vulnerable, or the parents observe the intervention, then the child appears more likely to improve on measures of social development. In addition some areas of social development may require a longer intervention in order to result in change, whereas others may show an improvement after a relatively brief intervention.

### 1.4.2 Child behaviour

#### **General findings**

Ten of the original twenty-eight studies evidenced improvements to child behaviour. Two studies showed that some areas of child behaviour were more influenced at certain times during the intervention rather than at others. Two studies showed some negative outcomes of intervention.



A number of studies have shown a decrease in externalising and internalising problem behaviours following early intervention (Hancock, Kaiser, & Delaney, 2002; Johnston, Nelson, Evans, & Palazolo, 2003; Murray, Cooper, Wilson, & Romaniuk, 2003). Early intervention programmes have been shown to reduce anxiety in children who have been pre-natally exposed to cocaine (Claussen et al. 2004), and in children from disadvantaged neighbourhoods (Elliot, Prior, Merrigan, & Ballinger, 2002). Claussen et al.'s (2004) study also showed that children became less withdrawn and demonstrated less somatization. These children also had fewer sleep problems. In terms of externalising problems, children have been shown to become less aggressive and destructive following intervention (Claussen et al., 2004).

The conclusions of Elliot et al.'s (2002) and Claussen et al.'s (2004) studies may, however, have been biased since neither of them randomly assigned their participants to the different groups. In Elliot et al.'s (2002) study, participation in one of the intervention groups was voluntary and the control group was not matched to account for the lack of random assignment. In Claussen et al.'s (2004) study participants were randomly assigned to the two intervention groups and then those infants that were referred to the service in later years (and hence were younger) were assigned to the control group. It is therefore possible that the results of this study were biased by differences in the groups at the outset.

Kurtz et al. (2003) carried out functional analyses for children's self-harming and problem behaviours, and developed an individual intervention programme for each child. This process enabled the sources of reinforcement for self-harm and problem

behaviours to be identified, and the behaviours themselves to be reduced in the majority of children.

In addition to decreasing internalising and externalising problems, early intervention has been shown to increase desirable behaviours and affect. Children have shown greater levels of engagement following intervention (Garfinkle & Schwartz, 2002; Robertson et al., 2003). In an intervention designed to create a family-like environment in an orphanage, children demonstrated greater levels of positive emotions when their identified care-giver was in the same room (Muhamedrahimov, Palmov, Nikiforova, Groark, & McCall, 2004). Unfortunately there were only a small number of participants in this study (n=8) and therefore no statistical analysis was carried out on the data, and as a consequence it is not possible to know whether or not this change is significant. A large scale study is however planned. Preliminary results of the study in progress show promising results in terms of infant attachments to care-givers. For example intervention children were more likely to return to their care-giver after contact with strangers.

One study showed that an early intervention programme took two years to cause a change in emotional development. It was found that children showed significant improvements on measures of self-regulation after two years' intervention focussed on literacy and child behaviour rather than after only one year (Kaminski et al., 2002). Emotional self-regulation is possibly quite a complex skill to master and therefore a longer intervention may be needed to cause significant change.

In terms of negative changes following early intervention, Johnston, McDonnell et al. (2003) showed a small decrease in self-care by one participant. Elliot et al. (2002) found

that children who just received a literacy programme with no psychological component became more aggressive and hyperactive following intervention compared with those who received psychological input as well. Although it is beyond the scope of this literature review to address non-psychological early interventions, Elliot et al.'s (2002) results would suggest that certain programmes might increase child behaviour problems. Future researchers might consider reviewing this possibility.

### **Mediating factors**

Blair (2002) identified child characteristics that were more likely to result in successful behavioural outcomes following early intervention. The programme studied by Blair (2002) was designed for low birth weight preterm infants and taught caregivers parenting skills as well as including educational stimulation for the infants. Specifically those children who had a negative disposition at twelve months old (measured by high frequency of crying and overall rating of difficulty) had fewer behavioural problems at three years old following intervention. These children tended to benefit most from intervention, showing the largest reduction in behaviour problems. In addition the intervention was shown to be more effective with increasing number of sessions. The intervention was, however, less effective at reducing externalising behaviours at three years old if children had displayed higher levels of angry behaviour at twelve months old. Therefore there appear to be certain early characteristics that may be predictive of later intervention outcome.

Maternal characteristics were also identified that were more likely to result in successful outcome for the infant following an early intervention programme. Children of mothers who used the most avoidant coping skills tended to show the most significant reduction



in behaviour problems (Lee, 2003). It was postulated that mothers who were depressed tended to use avoidant coping skills. Lee (2003) suggested that the early intervention programme taught these mothers more adaptive coping skills resulting in reduced maternal depression, and that in turn had a positive impact on child behaviour. Alternatively if these mothers had learnt to stop avoiding their children's difficulties they may have naturally begun to manage them better.

In addition results have shown that early intervention can teach mothers to use more guidance as opposed to using directive strategies when their children are non-compliant (Blair, Peters, & Lawrence, 2003). There was an interaction effect between intervention and use of guidance strategies during non-compliance: children of mothers who learnt to use guidance strategies during the intervention showed a greater reduction in behaviour problems than mothers in the control group who did not learn guidance strategies.

Unfortunately attrition and incomplete data biased the samples in all these studies, with up to a third of the original participants failing to complete the studies (Blair, 2002; Blair et al., 2003; Lee, 2003). Those who left the studies or did not complete measures correctly tended to be white (Blair, 2002; Blair et al., 2003), teenage mothers, with lower income and less education (Lee, 2003). This makes it difficult to generalise the results to other populations.

## **Summary**

These outcomes studies can be summarised, with due caution, as evidence to indicate that early intervention programmes can reduce internalising and externalising behaviours, and that they can also increase positive behaviours and affect. Individual results may, however, be influenced by the infant's disposition and behavioural problems, and maternal coping and behaviour management style, and by programme length.

### 1.4.3 Cognitive development

#### **General findings**

Five of the original twenty-eight studies showed increased cognitive skills following early intervention. Two studies (Blair et al., 2003; Murray et al., 2003) measured changes to infant cognitive development following early intervention, but failed to show any changes in this area. One study (Lawrence & Blair, 2003) showed an initial benefit of intervention on children's intellectual quotients (IQs) but following its completion these children were comparable with children who had only received monitoring appointments.

The majority of studies used control groups to show that children who attended the intervention programmes scored higher on general measures of cognition than children who did not attend (e.g. Claussen et al., 2004). Stahmer and Ingersoll (2004) did not include a control group. Instead Stahmer and Ingersoll (2004) measured the children's nonverbal mental age at intake and calculated the expected trajectory for their cognitive



development if they had not received intervention. The children showed an increase in their nonverbal cognitive development above their expected trajectory. By then comparing the children's pre and post scores with a trajectory for typically developing children, it was shown that the children evidenced an increase in developmental progress over the duration of the intervention. Lawrence and Blair (2003) however showed that the gains in cognitive development were short-lived. Lawrence and Blair's (2003) experimental group of infants accelerated on measures of IQ during the three years of intervention compared with a control group, but after the intervention terminated the control group showed an accelerated rate of intellectual development, and by eight years old the two groups had similar IQs.

### **Mediating factors**

It appears that very vulnerable infants might benefit the most from early intervention programmes in terms of mental development. Blair (2002) showed that those preterm infants who exhibited greater negative disposition at twelve months old were most likely to benefit from early intervention. These children had higher scores on measures of intellectual development following intervention than preterm babies who did not have such a fragile status.

In addition programme characteristics appear to influence how much a child will benefit from intervention. Those children who received the intervention in a centre showed greater change on measures of mental development than those who received it at home (Claussen et al., 2004). The difference between the two groups was attributed to the level of programme intensity; children who attended the centre received more hours of input than the children who received home visits (Claussen et al., 2004).

Hill, Brooks-Gunn, and Waldfogel's (2003) findings support the conclusion, that attendance and vulnerability can influence outcomes. Hill et al.'s (2003) analysis showed that if the low-attenders (particularly the lowest birth weight preterm babies) had instead attended more days, their outcome would have been significantly better.

## **Summary**

In summary, early intervention has been shown to increase children's cognitive development although in some cases its impact may be limited to the intervention period. More vulnerable children appear to benefit most from intervention programmes. It is possible that the amount of input also affects the degree of cognitive development, with more input being more beneficial.

### 1.4.4 Parent-child relationship

#### **General findings**

Only three of the original twenty-eight studies measured any change to the parent-child relationship following early intervention. All of these studies found positive change in this area.

Different psychological approaches have been shown to affect the degree to which changes in the parent-child relationships occur. Murray et al. (2003) compared maternal reported incidents of relationship problems with their children. Mothers were assigned to receive cognitive behaviour therapy, psychodynamic counselling or non-directive counselling. All three therapies were shown to be effective at reducing maternal

reported incidents of moderate or marked relationship problems with their children. By comparison, mothers who did not receive any therapy were much more likely to report that any relationship difficulties were left unresolved.

For maltreated children, psychotherapy addressing internal representations of attachment relationships resulted in the most significant decrease in maladaptive representations of their mothers (Toth, Maughan, Manly, Spagnola, & Cicchetti, 2002). These children became less likely to represent their mothers as punitive, rejecting, controlling or inconsistent. The children in the psychotherapy group also had a stronger tendency to report that the relationship became more predictable and trustworthy over time. If the child's mother received psycho-education and parenting skills training instead, there was a marginally significant decline in maladaptive representations of their mother, although there was no change in negative self-representations. Children in the psychotherapy group reported the greatest increase in positive self-representations over time and became less likely to represent themselves as being aggressive, shameful or false.

Brisch, Bechinger, Betzler, and Heinemann (2003) studied a programme for low birth weight preterm infants and found that neurological impairment significantly corresponded with insecure attachment for the infants who did not attend the programme, but not for those who did attend. This finding implies that the intervention protected neurologically impaired infants from attachment problems. It therefore appears that early intervention could be particularly beneficial for these vulnerable infants in terms of improving their quality of attachment.

## Summary

From the limited number of studies in this area it is only possible to conclude that some psychological approaches, including psychotherapy, may improve maternal and child representations of their relationship. In addition early intervention may be a protective factor against attachment problems for some vulnerable infants.



## **1.5 Conclusion**

Current research provides evidence that early intervention programmes can have a beneficial effect on infant social and cognitive development, behaviour, and parent-child relationships. Methodological problems such as exclusion criteria and attrition, and lack of control groups have unfortunately limited the conclusions that can be drawn from some of the results.

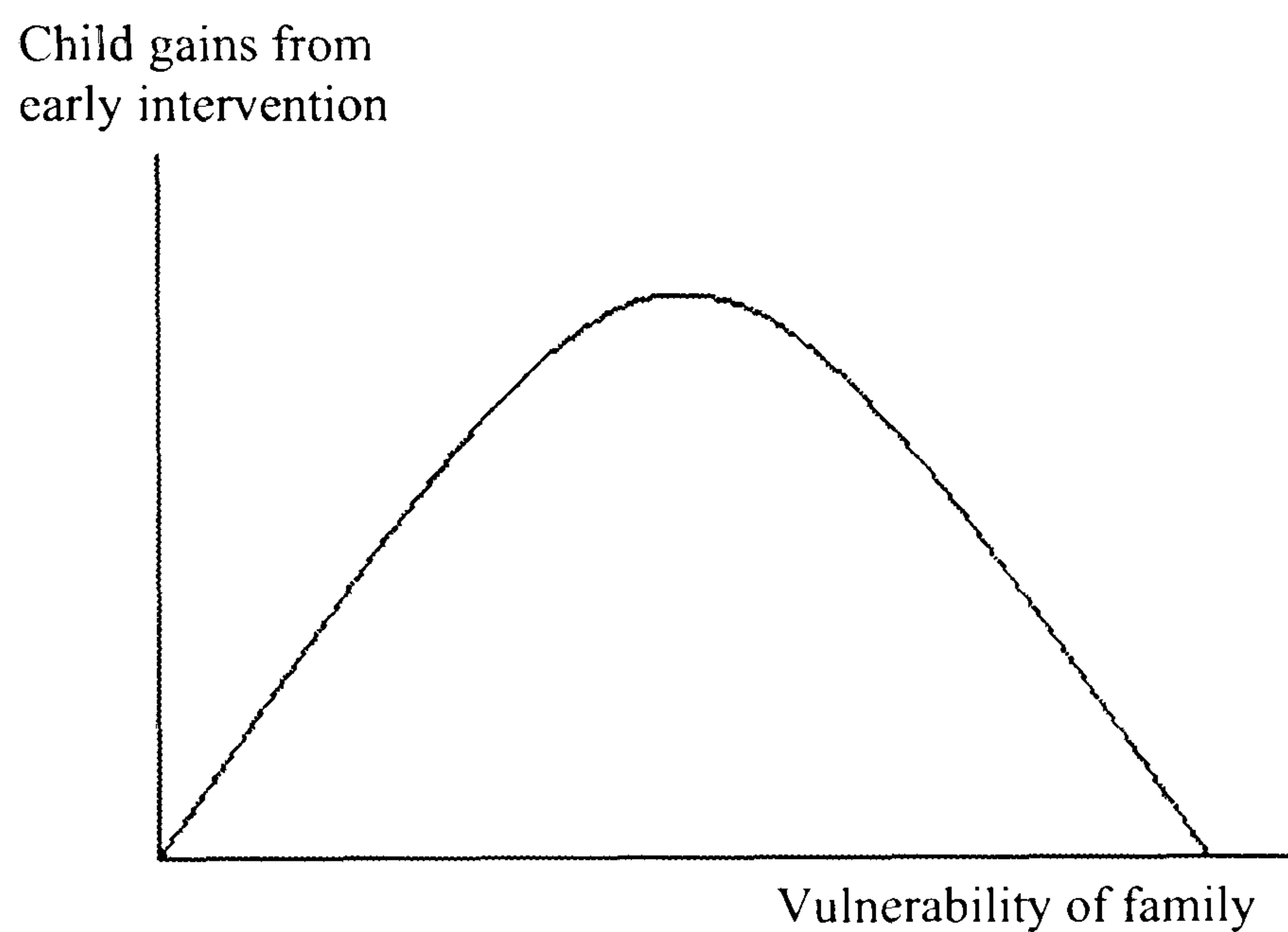
### **Attrition and exclusion**

Attrition and exclusion particularly have meant that the most vulnerable families, such as children of teenage mothers or children with learning disabilities, have been left out of studies into early intervention programme efficacy (e.g. Blair, 2002; Lee, 2003; Craig-Unkefer & Kaiser, 2003). For example, low birth weight preterm infants whose mothers were depressed showed larger improvements after early intervention than those whose mothers were not depressed (Lee, 2003), but since this conclusion did not include the most vulnerable families such as low birth weight preterm infants with depressed teenage mothers, it is possible that there is a limit to the level of difficulties that a family can experience before they do not have the resources to make use of early intervention. Dawson-McClure, Sandler, Wolchik, and Millsap (2004) found a similar phenomenon in the context of interventions for children of divorced parents, showing that children with a higher risk index (numbers of environmental stressors experienced) were less able to benefit from intervention programmes. They suggested that children with a moderately high risk index may benefit most from interventions, because they are in need of help and have the capacity to utilise the skills. It is therefore proposed that a curvilinear relationship also exists between benefit from early intervention and the



family's vulnerability in terms of risk factors. This is illustrated in figure 1.1. With increasing vulnerability children achieve increasing gains from early intervention until a certain point at which the family no longer have the resources to make use of new strategies.

Figure 1.1: Graph to show hypothetical relationship between family vulnerability and the child's gains from early intervention



Very vulnerable families may not even have the resources to be able to attend early intervention services. Frequently in research and in clinical work there are a number of marginalised people who are difficult to engage. Earlier reviews have highlighted similar difficulties retaining vulnerable participants in research studies (Farran, 2000). Community services like Sure Start provide early intervention in disadvantaged areas, and are one way of engaging these people in programmes, where they can also potentially be recruited into studies.

## **Discrepancies between areas of infant mental health studied**

More of the reviewed studies discussed the impact of early intervention on social development (n=14), child behaviour (n=18), and cognitive development (n=8) as opposed to the impact on the parent-child relationship (n=3). Researchers may have been more likely to study social and cognitive development, and child behaviour, because these are often areas of concern for the populations that have been selected for early intervention programmes. For example children on the autism spectrum typically have problems with social communication (Wing, 1981), low birth weight preterm infants are more likely to have delayed cognitive development (Vicari, Carlesimo, Casadei, & Allemand, 2004) and children from disadvantaged neighbourhoods are more likely to experience behaviour problems (Blor, Najman, Andersen, O'Callaghan, Williams, & Beeriness, 1997).

The smaller number of studies in the area of parent-child relationships may alternatively (or additionally) reflect that there are fewer ways to measure the quality of this bond. Cassidy and Shaver (1999) reviewed attachment measures and concluded that the least reliable assessment tools were available for children aged twenty one to forty eight months old. Cassidy and Shaver (1999) reported that this is because children of this age are not developmentally mature enough in the areas of behaviour and language, making it difficult to reliably record attachment either by observational or representational measures. Future research into early intervention should focus on developing tools and investigating outcomes in this important area of infant mental health.

## **Influencing outcomes**

Change in infant mental health may occur as a response to new strategies and approaches acquired by parents involved in early intervention programmes. The infant brain is malleable to neurological change, in response to both negative and positive early life experiences, and therefore these experiences can have a long-term impact on child development (Glaser, 2000). Mothers' increasing responsiveness and use of guidance strategies, and decreasing use of avoidant coping strategies have been shown to be important influencing factors on the benefit that a child receives from early intervention (Blair et al., 2003; Lee, 2003; Mahoney & Perales, 2003). Children whose mothers change their behaviour following the programmes benefit more in terms of mental health gains. These limited numbers of studies confirm previous ones showing that the quality of the parent-child relationship can have an important influence on infant mental health (Carlson, 1998; Schore, 2001). The current studies also imply that early intervention programmes should emphasise approaches and techniques that improve the quality of this relationship in order to achieve a greater degree of change in infant mental health.

Programme design also appears to be an important predictor of infant mental health outcomes, and certain findings should be taken into account by developers. More intensive input seems to increase the chances of a successful outcome following early intervention (Blair, 2002; Claussen et al., 2004). In addition, giving parents the opportunity to observe a clinician working with their child is more beneficial to child outcomes than just giving parents written information about how to carry out the intervention (Aparicio & Balana, 2003). Toth et al.'s (2002) findings on the specific benefits of psychotherapy on infant mental health imply that different therapeutic



approaches may be responsible for different changes in the infant. This kind of research needs to be replicated with other psychological approaches, so that the benefits of each approach can be identified and programmes designed to maximise change in the most relevant area of mental health to the participants. For example if an early intervention programme was being created for abused children who have been identified as having low self-worth and being withdrawn, the intervention might incorporate approaches that have been proven to be beneficial for raising the self-esteem of abused children and alleviating depression. The aims of the intervention should, however, be considered in conjunction with the length of the intervention. Certain psychological problems may need longer input (Kaminski et al. 2002).

Although programme creators have influence over the design and content of the programme, some intrinsic child and maternal characteristics may independently influence the outcomes of programmes. For example babies who cried frequently and were difficult to settle have been shown to benefit more from early intervention programmes in terms of reduced behavioural problems (Blair, 2002). It may therefore be better to assess relevant characteristics in all referred children and offer places to those most likely to benefit from intervention. Children who do not meet the criteria could be referred for other work such as individual therapy or family therapy depending on their needs.

In summary, current research provides some evidence to support the hypothesis that early intervention can be effective for increasing social development, reducing behavioural problems and improving cognitive development. There is much less research, however, conducted on changes to parent-child relationships and future work needs to concentrate on this area. There is also a need to conduct more rigorous research



studies into early intervention generally so that conclusions can be stated less tentatively.

Some research has been conducted into programme design, and maternal and child characteristics, to identify variables that influence infant mental health outcomes. Although the results of these studies can provide some guidance for programme creators, there is still a paucity of specific information on mediating factors. It is important not only to understand in what areas early intervention is effective but also to discover which children are most likely to benefit. With enough evidence it should become possible to design programmes and select participants in order to maximise infant mental health outcomes following early intervention.

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Chapter 2: Main research paper

Mothers' experiences of relationships with community health professionals in their  
children's preschool years

Word count: 4851

(excluding tables, references and raw data)

## 2.1 Abstract

There has been limited previous research into mothers' experiences of their relationships with community health professionals. In this study nine mothers who had received early intervention from their health visitors for their children's difficulties were interviewed. In addition to discussing their health visitors' work, mothers also discussed the input they had received from a number of other community health professionals including clinical psychologists. Transcripts were analysed using interpretative phenomenological analysis and four super-ordinate themes emerged. These were: mother's faith in herself, mother's trust in the relationship with the health professional, health professional's appreciation of the mother's perspective, and perception of the outcome following health professional's input. The research findings provide a unique contribution to current literature on the ideal of a "good mother", mothers' perceptions of coping and their need for help, professional empathy and reliability, and mothers' beliefs about professionals' expertise in the realm of parenting. Clinical implications are discussed and direction is suggested for future research.

## 2.2 Introduction

Early motherhood is often regarded as a time of great psychological change, as women learn the skills and responsibilities associated with caring for vulnerable young infants. Mothers often seek advice and support in adapting to the changes associated with their new role. Levitt *et al.* (1986) found that an average mother of young children is supported by around thirteen people. The mother's partner is usually her primary source of support, then her own mother and one or two other family members or close friends.

Mothers often have to manage difficulties with their infants, such as delayed toilet training or sleeping problems. In 2004, the Office of National Statistics reported that around seven per cent of three year olds showed moderate to severe behaviour problems, and a further fifteen per cent showed mild difficulties (Maughan *et al.*, 2004). Previous experience with children has been shown to impact on mothers' perceptions of success with managing their infants (Deutsch *et al.*, 1988). Practical and emotional support from partners can also be psychologically beneficial to mothers. Priel and Besser (2002) reported that social support could positively influence mothers' perceptions of their infants. In addition perceived infant difficulty has been shown to negatively correlate with mothers' sense of well-being (Levitt *et al.*, 1986) and perceived self-efficacy (Porter and Hsu, 2003).

Professional support has been shown to be beneficial to both mothers and their babies. Heinicke *et al.* (1999) showed that mothers who received weekly support from a health professional, and who attended a group for mothers and infants, perceived that they received more support from other individuals such as partners and family, than did mothers who received no intervention. In addition in the Strange Situation Procedure

(Ainsworth *et al.*, 1978), professionally supported mothers were shown to be more responsive to their infants and in turn their infants were shown to be more securely attached (Heinicke *et al.*, 1999). The intervention appeared to give mothers the opportunity to problem-solve any difficulties concerning their partner and family, thus improving relationships with these people. This possibly allowed mothers to be more emotionally available for their children, and in turn, this improved emotional consistency may have resulted in the children becoming more securely attached.

Taggart *et al.* (1998) found, however, that mothers sometimes feared professionals because they had the power to have children taken into care. Volunteer “therapists” who were mothers themselves were perceived to induce a sense of equality in their relationship with clients (Hiatt *et al.*, 1997; Taggart *et al.*, 1998; Paris and Dubus, 2005). Mothers have reportedly appreciated input from women who can genuinely empathise with their experiences (Hiatt *et al.*, 1997), finding that it has a normalising effect (Taggart *et al.*, 1998). The validation of the mothers’ experiences can then empower them into the action of caring for their babies (Paris and Dubus, 2005). Good supervision was, however, needed for the volunteers in order to identify and deal with the tendency for transference and counter-transference to occur (Hiatt *et al.*, 1997).

Whilst there have been a number of qualitative studies conducted on mothers’ relationships with volunteer “therapists” (Hiatt *et al.*, 1997; Taggart *et al.*, 1998; Paris and Dubus, 2005), the main researcher could only find one qualitative study on mothers’ relationships with paid health professionals (Lupton and Fenwick, 2001). Lupton and Fenwick’s (2001) study investigated the experience of motherhood in the context of special care baby units. Mothers in this study initially attempted to conform to the nurses’ definition of a “good mother”, by following the nurses’ routines, avoiding



challenging the nurses' opinions and controlling their own anger. Other studies have found alternative definitions of a "good mother", that appear to vary cross-culturally (Welles-Nystrom *et al.*, 1994; Kobrynowicz and Biernat, 1997).

The current study aims to explore mothers' experiences of their relationships with community health professionals in their children's preschool years. The study also aims to contribute to health professionals' understanding of current clinical practice in this area, and to provide direction for future research. Interpretative phenomenological analysis (IPA) was chosen as the methodology for this research because it allows researchers to explore the themes in participants' dialogues in order to provide an insight into their experiences (Smith *et al.*, 1999). In addition IPA permits patterns within the data to be analysed, and tensions and connections between themes to be explored. IPA also allows the themes to be linked to psychological literature, in order to explore their implications both clinically and in terms of future research.

## **2.3 Method**

### **2.3.1 Participants**

Nine mothers were recruited through the National Health Service (NHS) Trust's database (anonymised for confidentiality). The database comprised of mothers who had received early intervention for their preschoolers' difficulties from their health visitors between 1<sup>st</sup> April 2003 and 31<sup>st</sup> March 2004. Since there were a large number of entries on the database, every third mother was selected to receive an information pack about the research (see Appendix B). This process was closely supervised by the clinical supervisor (Dr Hazel Douglas) who works for the NHS Trust.

Forty-two information packs and consent forms were sent out. Ten mothers returned consent forms (see Appendix C) to indicate that they would like to participate in the research. Interviews were arranged with all ten participants, although one mother later declined to participate. The demographic details for these nine participants are summarised in table 2.1 (key on page following table). Mothers' and children's names have been changed to maintain confidentiality. The mean age of participants was 31 years 10 months old (age range = 26 years 2 months old to 44 years 7 months old). All participants were regarded to be middle class.

Table 2.1: Participants' demographic details

<b>Mother's code name</b>	<b>Children's code names &amp; ages at time of interview (years: months)</b>	<b>Children's problems</b>	<b>Community health professionals involved</b>
Zoe	Chloe (3:7) *William (1:4)	T, J, F & S.	MW, HV, & D.
Amy	* Ben (1:11) Becky (0:1)	F & S.	MW, HV, & D.
Kathy	Kerry (9:5) *Simon (2:8)	T, J, S & B.	MW, & HV.
Caroline	Peter (7:8) Nick (3:10) *Lucy (2:1)	F, S, PH & At.	MW, & HV.
Lesley	*Tom (3:10)	F, S, B, PH & At.	MW, HV, & D.
Ellen	Emma (15:3) *Tony (3:4) Sue (1:7)	T, J, F, S, B, PH, At & DD.	HV & CP.
Bethany	*Chris (3:4)	T, F, S, B & PH.	MW, HV, D, & O.
Tamsin	Judith (10:10) *Mark (4:10)	S, B, So, & E.	HV, D, & CP.
Janet	Steven (9:6) *Nathan (5:8)	T, F, PH, DD & Sp.	HV, D, & O.

\* = child identified on database.

### Key for table 2.1

<b>Children's problems:</b>	<b>Community health professionals involved:</b>
T=Toileting	MW=Midwife
J=Jealousy	HV=Health visitor
F=Feeding	D=Medical doctor
S=Sleeping	CP=Clinical psychologist
B=Behaviour	O=Other health professional
PH=Physical health	
At=Attachment	
Sp=Specch	
So=Social	
E=Emotional	
DD=Developmental difficulties	

### 2.3.2 Procedure

#### **Ethics**

Ethical approval was obtained from the Local Research Ethics Committee (see Appendix D) and from Coventry University Ethics Committee (see Appendix E).

#### **Data collection**

The information packs containing details about the study were sent out to the mothers selected from the database. If the mothers required more information before deciding whether or not to take part, they were invited to contact the researcher. None of the mothers requested further information before making their decision. Mothers who wished to take part were asked to return a consent form. The researcher then contacted those mothers who had returned forms to arrange an interview at the mother's home.



At the beginning of the interview the boundaries of confidentiality were explained to the mother and she was given a copy of her consent form. A semi-structured interview was then carried out and recorded onto audiotape (see Appendix F for copy of the interview schedule). The questions in the interview schedule focussed on mothers' experiences of their health visitors' approach. The schedule was intended as a starting point from which to explore mothers' general experiences of early intervention for their children's difficulties. Smith and Osborn (2003) (p. 57) stated that this style of interviewing allows the respondent to be "perceived as the experiential expert on the subject". The interviews lasted between thirty-five minutes and two hours. At the end of the interview the mother was given information sheets containing details of organisations she could contact if she needed any help concerning issues raised (see Appendix G).

### **Pilot study**

Two participants were interviewed and the audio-tapes were transcribed in order to check whether or not the interview schedule needed to be changed. It was decided that the transcripts contained sufficient detail about mothers' experiences of early intervention for their children's difficulties. The original interview schedule was therefore retained, and the two transcripts were included in the data set.

### 2.3.3 Data analysis

The remaining seven interviews were conducted and transcribed (a sample of transcript is shown in Appendix H), and then all the transcripts were analysed using interpretative phenomenological analysis (IPA) (Smith *et al.*, 1999). The stages for this idiographic approach are shown in table 2.2.

Table 2.2: Stages in an idiographic approach to interpretative phenomenological analysis

(Smith et al, 1999)

<b>Stages</b>	<b>Description of process</b>
Stage 1: Looking for themes in the 1 <sup>st</sup> case	The 1 <sup>st</sup> transcript is read a number of times and initial notes about anything significant are written in the left margin. The process is then repeated, writing themes in the right margin that capture the essential quality of the participant's words.
Stage 2: Looking for connections	The emerging themes are then written out separately, so that it is possible to work out which themes naturally cluster together. Some clusters may become super-ordinate themes. The process is iterative: each stage involves checking back to the data to ensure that there is a close connection between the analysis and the participant's words.
Stage 3: Creating a table of themes	A table of themes with references is created for the 1 <sup>st</sup> transcript.
Stage 4: Continuing the analysis with other cases	The table of themes from the 1 <sup>st</sup> transcript is used to analyse the 2 <sup>nd</sup> transcript. New themes are also recorded, and previous transcripts are analysed for incidents. This process is continued until all transcripts have been analysed.
Stage 5: Creating a master list of themes for the group	A final master list of themes is created by selecting themes based on their prevalence and richness within the data, as well as how much they elucidate the other emergent themes.
Stage 6: Writing up	The analysis continues during the write up. The results section presents the master list of themes and uses quotes from participants to explain each one. The discussion section links the themes to the literature in order to understand their possible implications in a psychological context.

### **Researcher's position**

Interpretative Phenomenological Analysis acknowledges that the researcher's position is an essential factor in the research process, and that "access (to the participants' worlds both) depends on, and is complicated by, the researcher's own conceptions" (Smith and Osborn, 2003; p. 51). The main researcher understands that two particular aspects of her will have affected how the interviews progressed and how the transcripts were interpreted. These two aspects were: herself as a trainee clinical psychologist and herself as a woman in her late twenties.

With respect to the first position, mothers will probably have regarded the researcher as being closely linked to the National Health Service. It is possible that some women may have withheld some of their feelings about health professionals because of perceived negative repercussions on their health care, despite the researcher's assurances to the contrary. In addition the researcher's background in clinical psychology will have influenced the way that the data was analysed. It is accepted that the resulting interpretation is from a psychological perspective and that researchers from other disciplines may have interpreted the same data differently.

As a woman in her late twenties, it is possible that the participants construed the researcher either as being a mother or as being childless, and this may have impacted on how the mothers explained their experiences. The researcher did not tell the participants that she is childless, although during the research process she did reflect on how being childless affected her interpretation of the transcripts. It is possible to allow too much empathy to bias the interpretation. Conversely too little empathy may distance the researcher from the meaning of participants' accounts (Quinn Patton, 2002). The researcher acknowledged that whilst her own position prevented her from becoming too close to the women's worlds to maintain a distinction between their stories and her own, she had to work harder to ensure that she understood their perspective.



## **Validity**

IPA acknowledges that the researcher's own world-view has an impact on data analysis (Smith et al., 2003). Other researchers are invited to check the audit trail in order to ensure that they can follow the main researcher's process (Conroy, 2003). Three colleagues, independent of the research study, but experienced in IPA, checked the main researcher's stages of analysis for the first transcript, from creating the emergent (sub-ordinate) themes to forming the super-ordinate themes. The independent researchers agreed that they could follow the audit trail.



## 2.4 Results

The analysis of the nine transcripts produced a master list of ten sub-ordinate themes clustered under four super-ordinate themes. All the themes, the number of participants who discussed each theme and the total frequency of references are summarised in table 2.3.

Table 2.3: Master list of super-ordinate and sub-ordinate themes

<b>Super-ordinate theme</b>	<b>Sub-ordinate theme</b>	<b>No. of participants discussing theme</b>	<b>Total frequency of theme</b>
<b>1) Mother's faith in herself</b>	Perception of self as a "good mother"	7 out of 9	42
	Perceived child difficulty	9 out of 9	35
	Perception of ability to cope	9 out of 9	49
<b>2) Mother's trust in relationship with health professional</b>	Professional's reliability	8 out of 9	43
	Belief in professional's expertise	9 out of 9	55
<b>3) Health professional's appreciation of the mother's perspective</b>	Understanding beliefs about being a "good mother"	7 out of 9	23
	Understanding mother's perception of child difficulty	7 out of 9	19
<b>4) Perception of the outcome following health professional's input</b>	Perceived improvement	7 out of 9	21
	Perceived lack of change	6 out of 9	16
	Perceived negative impact	2 out of 9	8

### Super-ordinate theme 1: Faith in self

The women in this study often appeared to work hard to achieve their own ideal of a “good mother”. Mothers also frequently commented on their perceptions of the severity and impact of their children’s difficulties. There was sometimes a tension between the woman’s image of a “good mother”, and how difficult she perceived her child: high expectations and a difficult child often resulted in frustration. Mothers also often discussed their perceptions of their ability to cope with their children’s problems. In some cases the tension between the image of a “good mother” and perceived child difficulty influenced the mother’s perception of coping. Sometimes if the tension between the mother’s expectations and the child’s difficulties was too great, the mother regarded herself as not able to cope. Mothers often stated that this belief in their ability to cope with their children’s problems influenced whether or not they sought help from health professionals.

### Sub-ordinate theme 1: Perception of self as a “good mother”

Seven participants appeared to have an idea of how a “good mother” should behave and how close they were to that ideal, even if they were perhaps not explicitly aware of this construct. This image of a “good mother” was usually of a woman who not only completely understood her children’s needs but who also put those needs ahead of her own.

Amy was able to verbalise these ideas:

“I’m the kind of person that, especially with children, it’s my job to get it right... you see too many kids out in their push-chairs screaming their heads off because they’re so tired and their mum’s not recognising the signals... and I just didn’t want him to be... like that, I wanted to provide everything for him”

(Amy, 2: 634-643).

### Sub-ordinate theme 2: Perceived child difficulty

All nine mothers described how stressful they perceived their children’s problems to be, with respect to their perceived severity and their impact on themselves and the rest of the family.

Zoe commented on the impact that her son’s sleeping problems had on her relationship with her daughter:

“William would start crying...he wasn’t a very good sleeper so he’d wake up, and he wouldn’t give us that much time...then I just sort of got frustrated”

(Zoe, 1: 209-218).

### Sub-ordinate theme 3: Perception of ability to cope

All nine participants tended to make judgments about how capable they felt to deal with their children’s problems, often based on how difficult they perceived their children to be, and how far they were from their own ideal of a “good mother”. Mothers who felt that they were not capable of coping with their child’s problems often approached health professionals for help:

“ The reason I went down...(to the clinic was because)...there was a lot of shouting at Tom... and we were smacking him... and I wanted it to stop... I just felt like as a family... we were under that much pressure... we were just spiralling out of control”

(Lesley, 5:73-82).

### **Super-ordinate theme 2: Mother’s trust in relationship with health professional**

All the mothers received input from health professionals, and the majority said that they preferred professionals who were reliable, for example in terms of informing them about future appointments and planning for endings. In addition mothers often made an implicit or explicit judgement about health professionals’ expertise, for example seeking reassurance if they trusted professionals, or seeking second opinions if they doubted them.

#### **Sub-ordinate theme 4: Professional’s reliability**

Eight mothers often said that they needed professionals to offer reliable support, particularly with their first child. Many mothers stated that they had more confidence with subsequent children and therefore they had less need for professional involvement, although this was not always the case.

Kathy said that she believed her health visitors had made an incorrect assumption about her need for support:

“If you have a second child they think...you’re a dab hand at it and don’t sort of take so much notice of you...(or) come out as stringently as they did like the



first time round...I thought they could have come out a bit more...just really to sort of reassure me about things”

(Kathy, 3: 434-437).

#### Sub-ordinate theme 5: Belief in professional's expertise

All nine mothers expressed their beliefs about professionals' level of expertise. In some circumstances mothers expressed their need for validation or reassurance from professionals, implying that they regarded professionals' opinions to be superior to their own:

“It makes you feel better that a professional is saying, “yes try that” ... a new baby to me was a new baby, they deal with them every single day for their careers”

(Amy, 2: 157-161).

At other times mothers verbalised their disagreements with health professionals' advice, doubting their expertise. Mothers often appeared to be more likely to doubt health professionals' expertise if it conflicted with their own ideas. They would occasionally seek a second opinion to support their own ideas.

Caroline said that she was advised by one health professional not to lie in bed to breast-feed as she was doing, so she sought the advice of a second professional who told her:

“Carry on doing what you're doing...just disregard what he's saying...go with what you want to do”

(Caroline, 4: 455-460).

### Super-ordinate theme 3: Health professional's appreciation of the mother's perspective

Mothers reflected on the importance of health professionals understanding their beliefs and perceptions. In particular mothers seemed to find the most successful relationships were those in which the professional appeared to be aware of and responsive to their beliefs about being a “good mother”, as well as being able to appreciate their perceptions of their children's problems. Perceived social similarity with the professional in terms of age, gender, social class or the shared experience of being a parent, appeared to impact on mothers' opinions of the professional's ability to empathise.

#### Sub-ordinate theme 6: Understanding mother's beliefs about being a “good mother”

Seven participants spoke of their need to find support from someone who understood their beliefs about being a “good mother”. Sometimes health professionals did attempt to explore and challenge mothers' beliefs. At other times professionals did not appear to identify these beliefs and would make suggestions that conflicted with them, which the mother often found difficult to implement.

Bethany said that she felt that others perceived her negatively because of her son's tantrums:

“I want him not to have temper tantrums so that people (won't)...stare at me and...think... I'm a bad mother”

(Bethany, 7: 276-279).

Bethany added, however, that health professionals' advice to ignore her son's tantrums was difficult to carry out:

"I feel so self-conscious that I sometimes come home crying... because... there's people staring at me thinking.... why aren't I controlling him?... I've been told by the health visitors how to behave with him... and that's what I'm doing even though... it's difficult"

(Bethany, 7:257-274).

#### Sub-ordinate theme 7: Understanding mother's perception of child difficulty

Seven of the mothers stated that it was also important that health professionals appreciated their perceptions of their children's problems, in particular by acknowledging the level of severity and the impact on their families.

Lesley said that she appreciated one health professional visiting her at home because it gave the professional an insight into the problems that Lesley was experiencing:

"It really worked well that she could come...and sit with me in the house...she could see...what was going on at home"

(Lesley, 5:781-786).

Mothers often attributed professionals' ability to empathise to a shared characteristic, such as age, gender, social class or the experience of motherhood:

"She just basically sat and listened and sort of empathised with me, and tried to make me laugh. She was...really good because I think she's...a similar sort of age to me"

(Zoe, 1: 108-111).

## Super-ordinate theme 4: Perception of the outcome following health professional's input

Mothers frequently reflected on the outcome of their work with health professionals, indicating whether or not it had had a positive impact on their children's problems. In addition mothers discussed the personal impact of any emotional support given. A successful outcome was often perceived to be linked to a trustworthy relationship with the health professional (super-ordinate theme 2) where the mother felt her perspective was acknowledged (super-ordinate theme 3).

### Sub-ordinate theme 8: Perceived improvement

Seven mothers reflected back on the process of seeking help and acknowledged those professionals that they perceived had improved their children's problems. Mothers often linked a good outcome to trustworthy relationships with health professionals or to professionals' understanding of their perspective.

Ellen said that she appreciated the input from one health professional who understood that she did not want to leave her baby to cry (the controlled crying technique) and gave her alternative advice to help with sleep problems:

“She was just teaching me how to read her better... rather than people like, ‘put you in a room and leave you to cry and I’ll walk away’... because I couldn’t do that”

(Ellen, 6: 593-603).



### Sub-ordinate theme 9: Perceived lack of change

Six mothers perceived that health professional involvement had not resulted in any real change within the family system. There were a number of reasons for this including health professionals and mothers having different ideas about the causes of the children's problems.

Janet had different ideas to one professional about the causes of Janet's son's toileting problems. Janet believed her son's toileting was delayed, and she just needed to be patient with him. The health professional, however, had tried to motivate him with rewards. Janet felt that the health professional's input had little impact because her formulation was incorrect:

“I think all she did was refer us to the (toileting) clinic, oh, she may have mentioned star charts... (but) he wasn't interested...He just clicked himself when he got to school”

(Janet, 9: 125-134).

### Sub-ordinate theme 10: Perceived negative impact

In two cases, health professional input had a perceived negative impact, usually because the professional had reportedly failed to appreciate the mother's perspective.

Caroline said that one professional did not appear to appreciate her lack of experience with children, and how difficult she found it to carry out advice as well as look after her child:

“”Still having difficulties settling Peter, but not yet managed to get baby swing”... She...didn’t sort of understand that this was my first baby and...I hadn’t got any cousins...or sisters that had had babies”

(Caroline, 4: 1292-1317).

## 2.5 Discussion

Interpretative phenomenological analysis was carried on the data in order to explore mothers' experiences of relationships with community health professionals. Mothers discussed their relationships with health professionals, preferring them to be understanding and reliable. Mothers often made an implicit or explicit judgement about an individual professional's expertise, and based on this judgement they either chose to place trust in that individual or to seek a second opinion. Mothers' perceptions of health professionals' understanding, reliability and expertise impacted on their perceptions of outcomes of professionals' involvement.

In addition to discussing their relationships with the health professionals, mothers discussed the process that they went through prior to seeking help. The participants considered whether or not they were coping sufficiently well on their own, by appraising both their perception of how close they were to their image of a "good mother", and how difficult they perceived their children. Previous research has shown that infant difficulty can predict a significant proportion of the variance in maternal perceptions of coping (Porter and Hsu, 2003). The current research suggests that an interaction between child difficulty and perceived distance from ideal of a "good mother" may be an even more significant predictor of maternal perceptions of coping.

In considering their need for help, participants often discussed their concept of a "good mother" and whether or not they were close to achieving that ideal. These participants seemed to have a different definition of the "good mother" than previous researchers have found (Lupton and Fenwick, 2001; Welles-Nystrom *et al.*, 1994; Kobryniewicz and Biernat, 1997). Many of the participants in the current study appeared to have quite a

high ideal of a “good mother” as being someone who completely understands her child’s needs, and who puts those needs ahead of her own. By contrast Welles-Nystrom *et al.* (1994) found definitions that appeared to be more lenient: in Sweden a “good mother” was defined as a woman who acknowledged other aspects of her life as well, and in Italy there was no apparent judgement made about mothers. All mothers were perceived to be good. The results of the current study would appear to add to previous researchers’ findings that the definition of a “good mother” varies cross-culturally. With the exception of the current study, there has been little research into English participants’ definitions of a “good mother”.

England is a relatively multi-cultural society, and it is possible that there may also be variations in the definitions of a “good mother” between different minority ethnic groups throughout the country. The racial homogeneity of the participants in the current sample (eight women were Caucasian and one was Asian) limits the generalisability of these results to populations of women from other racial backgrounds. Similarly the lack of diversity within the sample in terms of social background and ages of participants (all were middle class women between twenty six and forty five years old) limits the applicability to other populations, such as women from lower socio-economic groups or teenage mothers. There is a need for more research exploring the cultural, social, and socio-economic variations of the definition of a “good mother”.

The “good mother” ideals that participants in the current study held sometimes appeared to be a source of distress, particularly when their children had more severe problems. Participants occasionally commented that they appreciated professional advice that helped with their children’s problems but did not conflict with their own beliefs about being a “good mother”. Clinically it appears to be important that health professionals



explore any beliefs that clients hold about being a “good mother”. If clients have high expectations that are causing distress it may be advantageous to prioritise raising awareness of these beliefs before suggesting techniques to manage child behaviour. Clinical psychologists and other health professionals trained in cognitive behavioural therapy may be in a unique position to gently challenge ideals that are causing mothers distress, and to potentially replace an unrealistic concept of a “good mother” with a more achievable one.

Participants also frequently commented that they appreciated professionals who understood their perceptions about their children’s difficulties, particularly in terms of understanding the severity and impact of their children’s problems. Previous research showed that mothers valued support from volunteer “therapists” who were parents themselves, perceiving that these “therapists” could genuinely empathise with the mothers’ experiences (Hiatt *et al.*, 1997). The current study is relatively unique because it explored the relationship between paid health professionals, who were not necessarily parents themselves, and their clients. Some of the participants did state that they appreciated receiving support from health professionals who disclosed that they were parents themselves. There were, however, other factors that affected mothers’ perceptions of professional empathy, including similarity of age, gender or social class. The results of the current study would suggest that mothers define empathy in terms of social similarity, which includes, but is not limited to the shared experience of parenthood.

Previous research has shown that mothers’ perceptions of the reliability of social support affects their ability to self-regulate their own distress (Priel and Besser, 2002). Participants in the current research emphasised the importance of professionals being

reliable, in terms of maintaining consistent contact. These findings would suggest that reliability is an important constituent of both formal and informal supportive relationships during motherhood.

Deutsch *et al.* (1988) showed that the more previous experience mothers had with infants, the more successful they perceived they were with managing subsequent infants. The results of Deutsch *et al.*'s (1988) study would imply that mothers with more children might perceive that they are more successful parents, and may consequently have less need for professional help. The results of the current study, however, indicated that whilst this may be an accurate assumption for some mothers, others might still require reliable support with all their children. Whilst quantitative research may be able to elucidate the average mother's requirements for support, professionals still need to be responsive to clients' needs on an individual basis.

Mothers' beliefs about professionals' expertise in the realm of parenting also appeared to affect their responses to the work carried out. If mothers regarded professionals to be experts at parenting they appeared more likely to accept the advice given. Doubting professionals' expertise sometimes led to rejection of advice and negative recollections of the relationship with the professional. Some participants stated that they regarded professionals to be the experts with respect to some aspects of parenting, whereas in other areas participants regarded themselves to be the experts. Clinically, in some circumstances it might be beneficial for professionals and mothers to discuss their ideas about expertise with respect to parenting issues, and to share their knowledge in the interests of the children.

## **2.6 Conclusion**

This study provides an insight into mothers' experiences of their relationships with health professionals in the community setting. Participants raised the concept of the "good mother" and the difficulty of trying to achieve this ideal when their children have problems. Participants frequently discussed the importance of health professionals recognising and taking into account their beliefs about being a "good mother" when offering support. An empathic understanding of their experiences of their children's problems, and reliability were also important. In addition participants held beliefs about professionals' expertise, and these beliefs sometimes appeared to affect mothers' responses to professional input. It is important for health professionals to be aware of these issues when working with mothers of young children. Future research should concentrate on qualitative approaches to understanding mothers' experiences of the therapeutic relationship, since analysis of clients' perceptions can make a valuable contribution to improving clinical practice.



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Chapter 3: Brief research paper

Containment, reciprocity and behaviour management in mothers' dialogues about health  
visitors' use of the Solihull Approach (an early intervention programme)

Word count: 2946

(excluding tables, references and raw data)

### **3.1 Abstract**

Previous studies have shown that health visitors are able to effectively apply brief early intervention programmes, such as the Solihull Approach. The current research study analysed six mothers' reports of their health visitors' use of the Solihull Approach. A deductive qualitative methodology was used in order to understand how mothers perceived that their health visitors were using the psychological theories that underpin the Approach. Mothers' reports of health visitors' use of the theories was variable. This is likely to have reflected a combination of mothers' difficulty verbalising psychological processes, mothers' and health visitors' familiarity with different theories, and health visitors' ability to apply techniques. The findings highlight the importance for clinical psychologists to remain aware of the skills and needs of professionals from other disciplines when providing training. In addition it appears important that future researchers are conscious of the potential difficulty participants may have with reflecting on psychological processes.



### **3.2 Introduction**

Clinical psychologists in Child and Adolescent Mental Health Services often fulfil other roles beyond direct intervention work with children and their families. For example, clinical psychologists may provide consultation and training to tier one professionals, such as health visitors, in order to disseminate psychological skills and knowledge. A number of research studies have been carried out to evaluate the effectiveness of psychological intervention programmes that have been taught to health visitors. Positive changes have been found in health visitors' clinical skills (Elliott *et al.*, 2001; Hewitt *et al.*, 1989), and to the mental health outcomes for the families who receive the interventions (Davis & Spurr, 1998; Elliott *et al.*, 2001).

The Solihull Approach is an example of an early intervention underpinned by psychological theory, which can be utilised by health visitors (Douglas, 2001). The Solihull Approach is a brief psychological intervention for families with preschool children with sleeping, feeding, toileting or behavioural problems (Douglas, 2001). Previous research has found that the training can have a positive impact on health visitors' skills and on the outcomes for the families with whom the health visitors work (Douglas & Ginty, 2001; Douglas & Brennan, 2004; Whitehead & Douglas, 2005).

Qualitative research in other areas has shown that analysis of clients' experiences of therapy can provide valuable guidance for clinical practice and future research. For example, Messari and Hallam's (2003) qualitative research into clients' experiences of cognitive-behavioural therapy highlighted the value of particular therapeutic components, and gave an insight into clients' understanding of techniques. It was anticipated that qualitative research into mothers' experiences of the Solihull Approach

might provide similar insight and guidance. The current research aimed to analyse mothers' reflections on their health visitors' use of the three theories that underpin the Solihull Approach. These three theories are "containment" from psychoanalysis (Bion, 1990), "reciprocity" from child development (Brazelton *et al.*, 1974) and "behaviour management" from behaviourism (Skinner, 1938).

The skill of containment (Bion, 1990) is to recognise and reflect on projection (Freud, 1926) and projective identification (Klein, 1990) in sessions with clients, in order to help them to better manage their difficult emotions. Containment involves professionals being conscious of their own emotional responses to clients, and considering how that might reflect the clients' feelings. The Solihull Approach states that the process of calmly sharing these reflections can help to restore the client's capacity to think. The Approach also explains that parents can provide containment for their children, by understanding and acknowledging their children's emotions in a calm, reflective manner (Douglas, 2001).

Reciprocity describes the synchronicity that can occur between a parent and infant during their interactions (Brazelton *et al.*, 1974). The Solihull Approach defines reciprocity as, "the process whereby the parent is sensitive to the needs and feelings of the child and the child responds to the parents in a two-way flow of communication" (Douglas, 2001, p.29). The Solihull Approach teaches professionals to provide feedback when there is a lack of reciprocity in the parent-child relationship, in order to encourage parents to be "in tune" with their children. Reciprocity is the basis of interactions within all relationships, for example it is found in the "rhythm between people alternately speaking and listening" (Douglas, 2001; p.36). The Solihull Approach emphasises that a reciprocal relationship is also necessary between the professional and parent; the

professional needs to recognise when to be active and when to be passive within a session.

The Solihull Approach contains techniques and resources based on a number of behavioural theories. For example, Skinner's (1938) theory of operant conditioning showed that behaviour could be reinforced by the consequences following it. The Solihull Approach contains resources, such as star charts, that can be used to positively reinforce desirable behaviour.

The Solihull Approach is based on the premise that it is first necessary for professionals to contain parents' emotions and to encourage reciprocity in their interactions with their children, before offering behaviour management advice (Douglas, 2001). Thus the professional sets an appropriate context for teaching behaviour management techniques, in which the parent is able to be receptive to the advice, and is in synchrony with their child.

The current research aimed to analyse mothers' dialogues about sessions where health visitors had used the Solihull Approach. The study aimed to identify instances of containment, reciprocity and behaviour management in the dialogues, in order to understand how mothers perceived health visitors to be using these theories. It was anticipated that the findings would provide guidance for clinical work and recommendations for future research. A deductive qualitative methodology adapted from Yardley and Beech (1998) was used to analyse the data, because it allows the researcher to identify and explore instances of predefined categories, and to relate the findings to psychological literature.



### **3.3 Method**

#### **3.3.1 Participants**

Nine mothers were recruited through the National Health Service (NHS) Trust's database (anonymised for confidentiality). The database comprised those mothers who had received at least one session of Solihull Approach intervention, for their preschoolers' sleeping, feeding, toileting or behavioural difficulties, from their health visitors, between 1<sup>st</sup> April 2003 and 31<sup>st</sup> March 2004. The Solihull Approach is a brief intervention and one session is often sufficient to improve children's difficulties. Every third mother was selected to receive an information pack about the research (see Appendix B). This process was closely supervised by the clinical supervisor (Dr. Hazel Douglas) who works for the NHS Trust.

Forty-two information packs and consent forms were sent out. Ten mothers returned consent forms (see Appendix C) to indicate that they would like to participate in the research. Interviews were arranged with all ten participants, although one mother later declined to participate. Two participants' interviews (participants two and four) were excluded because it was not clear when these mothers were referring to health visitors who used the Solihull Approach. A further interview was excluded (participant eight) because the mother did not discuss aspects of her health visitor's care that were relevant to the Solihull Approach. The demographic details for the remaining six participants are summarised in table 3.1. Mothers' and children's names have been changed for confidentiality. The mean age of participants was 36 years 10 months old (age range = 32 years 1 month old to 44 years 7 months old). All participants were regarded to be middle class. Every mother had a different health visitor.



Table 3.1: Participants' demographic details

Participant number	Mother's code name	Code name & age (years: months at time of interview) of identified child	No. of Solihull Approach sessions with health visitor
P1	Zoe	William (1:4)	8
P3	Kathy	Simon (2:8)	1
P5	Lesley	Tom (3:10)	18
P6	Ellen	Tony (3:4)	2
P7	Bethany	Chris (3:4)	1
P9	Janet	Nathan (5:8)	2

### 3.3.2 Procedure

#### **Ethics**

Ethical approval was obtained from the Local Research Ethics Committee (see Appendix D) and from Coventry University Ethics Committee (see Appendix E).

#### **Data collection**

The information packs about the study were sent out to the selected mothers. Mothers who required more information before deciding whether to take part were invited to contact the researcher, although none did request further information. Mothers who wanted to take part were asked to return a consent form. The researcher then contacted those mothers who had returned forms to arrange an interview at the mother's home.

At the start of the interview the boundaries of confidentiality were explained and the participant was given a copy of her consent form. A semi-structured interview was then

conducted and recorded onto audiotape (see Appendix F for interview schedule). It was anticipated that mothers would not be familiar with psychological terminology. Therefore mothers were asked about areas relating to containment, reciprocity and behaviour management, such as changes in feelings, or changes in relationships with their children, and any strategies they had been given. At the end mothers were given contact details of organisations they could approach if they needed further help (see Appendix G).

### 3.3.3 Data analysis

The interviews were transcribed (a sample of transcript is shown in Appendix H), and then analysed using a deductive qualitative methodology adapted from Yardley and Beech (1998). The stages for this methodology are outlined in table 3.2.

Table 3.2: Stages in deductive qualitative methodology

<b>Stages</b>	<b>Description of process</b>
Stage 1: Developing & applying coding rules	Definitions of containment, reciprocity & behaviour management were taken from the Solihull Approach manual (see Appendix I) & applied to sections of transcripts where participants discussed input from health visitors who had used the Approach.
Stage 2: Creating tables of sub-categories	Text segments were copied to below each of the three categories, & clustered under sub-headings that summarised the content of those segments. A non-exclusive coding system was adopted.
Stage 3: Constructing master charts	A chart was created for each participant detailing the problems discussed, the three categories (containment, reciprocity & behaviour management) & the relevant text segments with their sub-headings. This allowed the researcher to observe the patterns of statements both within & between transcripts.
Stage 4: Interpretation	The findings were interpreted with reference to the Solihull Approach manual & other relevant psychological literature.

## **Researchers' positions**

Oskowitz and Meulenberg-Buskens (1997) stated that it is important for the qualitative researcher to reflect on their own ideas about the research topic since "questions they choose to ask and answers they choose to hear, could reflect their own opinions, attitudes and beliefs" (p. 85). It was valuable for the main researcher to reflect on the researchers' interests in the Solihull Approach, in order to try to address any bias. Dr Hazel Douglas (clinical supervisor) is the author of the Solihull Approach, Dr David Giles (academic supervisor) has no connections with the Approach beyond this research, and Helena Willson-Maunders (main researcher) has been trained in the Approach. During the research process the main researcher tried to maintain an unbiased position in relation to the data analysis.

## **Validity**

The main researcher applied the definitions of containment, reciprocity and behaviour management to the relevant sections of one transcript. The clinical supervisor, Dr. Hazel Douglas checked the coding of the data in order to ensure that the definitions were being correctly applied. Although inter-rater reliability was not measured formally, there appeared to be a high degree of agreement about the coding of the data. The main researcher therefore continued to apply the definitions to the remaining transcripts.

### **3.4 Results**

The analysis identified instances of containment, reciprocity and behaviour management advice in mothers' dialogues about their health visitors' use of the Solihull Approach. Under each of the three categories, text segments were clustered together, and then a sub-heading was given to each cluster. Containment had two sub-headings: "health visitor reportedly containing the mother's emotions" and "health visitor reportedly teaching the mother how to contain her child's emotions". Reciprocity had only one sub-heading: "health visitor perceived to encourage reciprocity between mother and child". Behaviour management had four sub-headings: "health visitor reported to teach mother to reward child's desirable behaviour", "health visitor reported to teach mother to ignore child's undesirable behaviour", "health visitor reported to teach mother a technique based on exposure and extinction" and "health visitor reported to give other behavioural advice". A summary of all the categories and sub-headings relating to all the participants can be found in table 3.3 (key on page following table). Descriptions of all the findings follow the table and key.



Table 3.3: Summary of findings

Sub-headings		Categories									
		Containment			Reciprocity	Behaviour management				Other behavioural advice	
Transcript number	Problem	Containing mother	Teaching mother to contain child	Encouraging reciprocity between mother & child	Teaching mother to reward desirable behaviour	Teaching mother to ignore undesirable behaviour	Teaching mother exposure & extinction technique	Other behavioural advice			
T1	S	X	✓	✓	--	--	✓	--			
T3	S	--	--	--	--	--	✓	--			
T5	S	--	--	--	--	--	--	✓			
	B	--	✓	✓	--	✓	--	--			
T6	S	--	--	--	--	--	--	✓			
T7	B	--	--	--	✓	✓	--	--			
T9	T	--	--	--	✓	--	--	--			
	F	--	--	--	--	--	--	--			

**Key for table 3.3**

<b>Problems treated using the Solihull Approach:</b>	<b>Health visitor's reported use of containment, reciprocity and behaviour management advice:</b>
S = Sleeping B = Behaviour problems T = Toileting F = Feeding	✓ = mother reporting health visitor's use of containment, reciprocity or behaviour management advice ✗ = mother reporting overwhelming feeling, but not reporting containment by health visitor -- = not discussed

**Summary of findings**

**3.4.1 Containment**

**Health visitor reportedly containing the mother's emotions**

In one case the participant reportedly had overwhelming feelings but said that her health visitor had not addressed these feelings with her.

Zoe said that her health visitor had given her behaviour management advice to deal with her son's sleeping problems, but had not addressed Zoe's anxieties about the problems:

(Zoe) "I was panicking about going back to work and getting enough sleep"

(Researcher) "Did she talk to you about the feelings...or was it just the technique?"

(Zoe) "Just really the technique"

(Zoe, 1: 701-702; 948-953).

### **Health visitor reportedly teaching mother how to contain her child**

Two of the participants reported that their health visitors encouraged the mothers to contain their children's emotions.

Lesley's health visitor taught her to recognise the distress that her child was trying to communicate when he "misbehaved", and encouraged her to address this with him:

"She'd say... "Tell him ... you understand he's upset ...but he mustn't throw things over the fence"

(Lesley, 5: 131-138).

### 3.4.2 Reciprocity

#### **Health visitor perceived to encourage reciprocity between mother and child**

Two of the participants reported that their health visitors had encouraged reciprocity between themselves and their children.

Zoe said that the health visitor had taught her to use containment and reciprocity in the process of carrying out a technique based on exposure and extinction:

"She said, "When he wakes up...stroke his head, let him (know) that you're there. Try and calm him down. Don't pick him up at all...He knows that you're there, and you know that he gets reassured so you keep going back"

(Zoe, 1: 760-771)

### 3.4.3 Behaviour management

#### **Health visitor reported to teach mother to reward child's desirable behaviour**

Two mothers discussed behaviour management advice given by their health visitors that recommended that they positively reinforce their children's "good" behaviour.

Bethany stated that her health visitor had encouraged her to reward her son when his tantrums ceased:

"He knows that...if he doesn't stop crying I'm not going to pick him up...He's rewarded with being cuddled and picked up...so that's helped a lot"

(Bethany, 7: 197-202).

#### **Health visitor reported to teach mother to ignore child's undesirable behaviour**

Two mothers recalled their health visitors' advice not to react to their children's "bad" behaviour.

Lesley recalled her health visitor advising her to ignore her son's tantrums:

"So (name of health visitor) just said, "...the next time he does it, just bring him in", and I did that and it...stopped. I mean...he'd have tantrums but I'd just leave him"

(Lesley, 5: 122-129).



## **Health visitor reported to teach mother a technique based on exposure and extinction**

Two mothers stated that their health visitors had given them a behavioural technique based on exposure and extinction (“controlled crying”) to help with their children’s sleeping problems.

Kathy said that she had found the “controlled crying” technique to be useful:

“ She suggested this controlled crying...technique which...I did...and it worked”

(Kathy: 3:57-60).

## **Health visitor reported to give other behavioural advice**

Two mothers commented that their health visitors had given them more general behavioural advice in order to deal with their children’s difficulties.

Ellen said she was reluctant to try a technique based on exposure and extinction for her son’s sleeping problems, so her health visitor had given her alternative behavioural advice:

“There was no way I could do controlled crying ... but we just went through a process of eliminating things. We tried...sitting in the room with him...and he was better at that...We just slowly done it...through what worked with him really, and then slowly he got used to being in his own bed”

(Ellen, 6: 41-58).

### **3.5 Discussion**

A deductive qualitative methodology adapted from Yardley and Beech (1998) was used in order to identify how mothers discussed their health visitors' use of containment, reciprocity and behaviour management. The Solihull Approach emphasises the importance of giving behaviour management advice after the mother's emotions have been contained, and there is reciprocity between mother and child (Douglas, 2001). Although two of the mothers did describe examples of health visitors encouraging containment and reciprocity between themselves and their children, positive containment of mothers' emotions was not discussed by any of the participants. All participants did, however, discuss health visitors' use of child behaviour management advice.

Two participants noted that their health visitors taught them to contain their children's emotions, but none of them discussed containment of their own emotions by their health visitors. There were a number of possible reasons for this. Participants may not have been able to recall instances when their health visitors had contained their feelings, because the process of containment might have occurred at an unconscious level, and they might not have been able to verbalise what had happened. Alternatively it is possible that some health visitors might have found it difficult to use the technique of containment, possibly because they had difficulty understanding the concept or knowing how to apply the skill. Even if health visitors were able to use containment, if they were overwhelmed by difficulties of their own they might not have had the capacity to contain their clients' feelings.

The research identified a lack of examples of containment in mothers' dialogues. It was, however, difficult to know whether or not health visitors were using techniques such as containment, because the study solely focussed on mothers' experiences of sessions. Research into health visitors' reports of their use of skills in sessions might provide insight into whether health visitors perceive they are using containment. Triangulation of these accounts with mothers' reports of the same sessions might additionally reveal whether mothers are able to reflect on any psychological techniques that health visitors report they are using.

Two participants gave examples of health visitors encouraging reciprocity in the mother-child relationship, consistent with Solihull Approach training. It is notable, however, that despite the Solihull Approach also emphasising the importance of reciprocity within the therapeutic relationship, none of the mothers discussed this, and hence no sub-heading relating to this was introduced into the analysis. Reciprocity in this context is concerned with the two-way flow of communication within sessions. It concerns such aspects as the professional knowing when to be active and when to be passive. It might have been difficult for mothers to discuss whether or not reciprocity occurred, because doing so would have involved reflecting on the abstract concept of the synchronicity within sessions. Mothers instead appeared to focus on the more tangible aspects of therapy such as the advice that was given, possibly because it was easier to process and recall.

All the mothers discussed health visitors' use of behavioural advice. It is possible that this was a reflection of a combination of the mothers' and health visitors' familiarity with behavioural techniques. The Solihull Approach manual comments that parents naturally shape their children's behaviour through a process of positive reinforcement



and punishment, by rewarding children for “good behaviour” and punishing “bad” behaviour (Douglas, 2001). Mothers may have already been familiar with the foundations of behavioural techniques, even if they were not conversant with the psychological terminology.

In addition health visitors may have been familiar with behavioural approaches prior to the Solihull Approach training, since generic health-visiting courses frequently incorporate child behaviour management teaching. Previous research concerning other supplementary training programmes supports this possibility, with health visitors perceiving themselves to be reasonably proficient in behaviour management techniques prior to receiving additional behaviour management training (Hewitt *et al.*, 1989). Despite health visitors potentially already being skilled in behaviour management, the Solihull Approach training appeared to be useful for expanding on health visitors’ knowledge in this area, since they reportedly made use of the behaviour management resources and techniques from the Solihull Approach manual.

In conclusion, the current research found that reported use of the psychological theories underpinning the Solihull Approach was variable. This possibly reflected a combination of differences in mothers’ and health visitors’ familiarity with the theories, mothers’ difficulty verbalising certain processes, and health visitors’ ability to utilise certain techniques. The results suggest that clinical psychologists need to be aware of the skills and needs of other professionals when providing inter-disciplinary training. In addition researchers need to be aware of the potential difficulty clients may have reflecting on psychological processes, even if meanings are interpreted using qualitative approaches.



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Chapter 4: Reflective paper  
Reflections on the research process

Word count: 2609  
(excluding references)

## **4.1 Introduction**

Three papers are presented in my doctoral thesis in clinical psychology. My literature review considered in what areas of infant mental health early intervention programmes are effective. My main research study explored mothers' experiences of their relationships with community health professionals during their children's early years. My brief research study explored how mothers perceived that health visitors were using the psychological theories underpinning an early intervention programme. My reflective paper now considers the process of conducting and writing the thesis, and what this experience has taught me.

## **4.2 Selecting a question for my literature review**

My research journey began with the desire to learn more about early intervention. I have a number of family members and friends who have had mental health problems following childbirth, and therefore I understand how important it is for mothers and their children to get appropriate support. It appears that I am part of a growing number of mental health professionals who also hold the belief that it is important to work with children as early as possible in order to try to prevent problems later in life. After initially looking at the research on early intervention, it seemed there were a number of recent reviews of studies on early intervention programmes for specific populations of young children, but no recent overview of the general early intervention literature. Therefore I decided I would focus on this area for my literature review.



### 4.3 Carrying out the literature review

Whilst I started out my literature review answering the question, “in what areas of infant mental health are early intervention programmes effective?” my findings led me into a broader critique of the studies into effective early intervention programmes. The review addressed gaps in the current literature, ideas for future research and guidance for programme developers. The interpretative phenomenological analysis (IPA) study seemed to involve a similar process of starting out with a particular question in mind, but ending up somewhere different, although no less interesting, by allowing the data to guide me.

### 4.4 Selecting questions and methodologies for my main and brief research papers

I was keen to hear the experiences of mothers who had received early intervention for their children’s difficulties, and I was made aware of a clinical psychologist, Dr Hazel Douglas, who was interested in similar qualitative research. Dr Hazel Douglas is the author of the Solihull Approach (Douglas, 2001). Dr Hazel Douglas and I decided to collaborate on research addressing the experiences of mothers who had received the Solihull Approach. With the help of Dr David Giles (academic supervisor) we designed two research studies using the same participants. The brief research paper used a deductive qualitative approach to the data analysis, and the main research paper used an inductive qualitative approach.

Quinn Patton (2002) stated that, “*inductive analysis* involves *discovering* patterns, themes, and categories in one’s data. Findings emerge out of the data, through the analyst’s interactions with the data, in contrast to *deductive* analysis where the data are

analyzed according to an existing framework” (p.453). The Solihull Approach is a theoretical framework, and therefore it could be applied to mothers’ dialogues in order to understand how they perceived health visitors to be using the theories. It was hoped that the results would reveal the saliency of the different theories for the mothers, and provide useful clinical guidance for the professionals involved with the Solihull Approach and similar early intervention programmes.

The inductive qualitative approach (IPA) used for the main paper was anticipated to reveal themes not considered by the brief paper analysis, such as the wider experiences of mothers whose children needed early intervention. Since the main and brief research papers used the same participants, this had potential benefits and limitations for the different stages of the research process, which are discussed in the relevant sections below.

#### **4.5 Recruiting and interviewing participants for my main and brief research papers**

Once I had selected my methodologies and had been through ethics, I was ready to begin the process of recruiting and interviewing participants. At the outset of the recruitment process I had mixed feelings about how successful I would be in gaining enough participants. Whilst I anticipated difficulties, imagining that there would be very few mothers of young children with the time and energy to commit to an interview, this worry was offset by the knowledge that I had to recruit only one set of participants. In the end, I was pleased by the high response rate (24%), and reflected on the possible reasons for participants’ interest in the study. Through the analytic process I found that many of the participants had experienced difficulties with at least one community health

professional. Some participants explicitly discussed their difficulties, whilst others' only became apparent through interpretation of the transcripts. I reflected that participants might have been motivated by the wording in the information sheet that stated, "the study will help us to continue to improve the Solihull Approach" (see appendix B), implying that participants could potentially influence future service provision. Whilst participants also discussed positive experiences with community health professionals, it is possible that the negative experiences were the motivating force behind people's initial responses. Participants' apparent motivation to share their experiences in order to improve services has instilled in me the motivation to disseminate the research through publications and at professional development meetings.

The sample's demographics revealed that there were populations of women who were under-represented, such as minority ethnic groups. It is possible that since information sheets were in the English language, some women from minority ethnic groups would have been unable to participate. In my literature review I commented that due to attrition and exclusion, vulnerable families were often left out of studies into early intervention. It appears important that researchers critically regard their own recruitment methods in order to try to counter-act this potential bias. I will certainly carefully consider the way I recruit participants in future studies now that I am more aware of this.

After I had recruited enough participants I began to conduct the interviews. During the interview process I found there was a conflict between obtaining the data for the IPA study, and obtaining the data for the deductive qualitative analysis study. The objectives of the former involved allowing the participants the opportunity to talk more freely about their experiences, whereas the objectives of the latter involved following up any



areas relating to the theories underpinning health visitors' use of the Solihull Approach. The interview schedule was therefore designed with the needs of the brief research paper in mind, however, these questions needed to be embedded in the context of a much broader discussion of mothers' experiences of early intervention due to the requirements of the main research paper. It was difficult to balance the needs of these two studies within one interview, and possibly it would have been easier to have a separate group of participants for each study.

After the interviews were conducted, the transcripts were transcribed and analysed in two ways: first using IPA, and then using a deductive qualitative analysis approach.

#### **4.6 Conducting the analysis and write up for the main research paper**

IPA acknowledges the "double hermeneutic" involved in the qualitative research process (Smith & Osborn, 2003). Participants place meaning on their experiences, and the researcher then places further meaning through the process of interpretation. In the methodology of my main paper, I briefly discussed how aspects of myself influenced the way that I interviewed participants and interpreted the data. In particular I considered how being a trainee clinical psychologist and a woman in my late twenties affected the research process. With respect to the latter position I commented that being childless might have made it difficult for me to empathise with participants.

I would further add that the fact that I am female also impacted on participants' discourses and on my interpretation of the data. I found myself privy to information that might not have been so openly disclosed to a male researcher, such as discussions about breast-feeding and lack of support from husbands. In addition, I tended to find myself



erring towards a feminist perspective on the data. For example the sub-ordinate theme “perception of self as a good mother” emerged from the data. Discussions about being a “good mother” are also replete in feminist literature. It is conceivable that a male researcher would have interpreted this the data differently, and perhaps would not have had a theme concerning images of the “good mother”.

During the research process, I was part of a small group of fellow researchers who met to validate each other’s audit trail. Although the other researchers agreed that they could follow how my sub-ordinate and super-ordinate themes had emerged from my data, they were often keen to add their own opinions about how they viewed the meanings of the participants’ words. Sometimes opinions were quite divergent. This highlighted to me the impact that different life experiences can have on data analysis in qualitative research.

During the process of analysing two of the participants’ transcripts I became conscious of dialogues that I was unaware of whilst I was interviewing these two women. When I directly asked about these women’s current experiences of their difficulties, they told me that everything had resolved, but later they contradicted themselves, discussing the same problems but implying that they were ongoing and unchanged. Whilst I was interviewing these women I found myself following up the answers they gave about how well they were doing, rather than exploring the difficulties that still existed in their lives. The underlying dialogues in these women’s interviews were only revealed when I carried out the analysis, and it made me appreciate how easy it could be to fail to explore the underlying discourses in sessions with clients. I wondered if other clinicians had also missed these women’s need for help. I reflected that it might be valuable for

me to tape, transcribe and analyse part of one of my clinical sessions in the future, in order to better understand and address any similar processes.

I began the research with the intention of exploring mothers' experiences of early intervention for their children's difficulties. Through the process of analysis, however, it was revealed that mothers were discussing what had led to them seek help, and their subsequent relationships with the health professionals. I allowed the participants' experiences to guide me, and only began to use psychological theories to understand their dialogues later in the analysis. Although connections and tensions were found between some themes, there was not a sense of flow between all the themes.

Smith, Jarman and Osborn (1999) outlined two approaches to IPA, one in which an account of the super-ordinate and sub-ordinate themes is the end stage of the process, and one which concludes with an exploration and theorising of shared experiences. My analysis had the former outcome. Perhaps if I had used a model such as Lazarus and Folkman's (1984) theory of coping early on in the analysis, then the findings would have been guided more towards process rather than an account of themes. The experience has made me interested in the influence that psychological literature can have on data analysis. It appears that the precedence that psychological theories are given in the analytic process may have an effect on the outcome, and I will attempt to be aware of this in any future qualitative research.

#### **4.7 Conducting the analysis and write up for the brief research paper**

Six of the nine transcripts were re-analysed for the brief research paper. I chose to first carry out the data analysis for the main research paper and then carry out the analysis

for the brief research paper. It was anticipated that searching for emergent themes for the main research paper first would mean that the inductive analysis would not be biased by the pre-defined categories of data identified by the brief research paper analysis. Despite this precaution, I was still concerned that the results of the analyses for the main and brief research papers would be similar. I was surprised, however, at how different the results for both papers were, and it made me appreciate that it is possible to see the same data in an entirely different way, depending on how they are interpreted.

Using the same participants meant that the generalisability of both studies' results was limited by the sample's demographics, including its relative ethnic homogeneity (eight women were Caucasian and one was Asian). It is feasible mothers from other cultural backgrounds would have interpreted health visitors' use of the Solihull Approach differently, and that they would have had different experiences of their relationships with community health professionals. Employing two different samples potentially would have introduced more variation into the studies, and allowed for some speculation about the potential overall implications of the research for other groups, such as minority ethnic populations.

Whilst the brief paper analysis provided valuable insight into mothers' capacity to reflect on processes like containment and behaviour management, the focus on mothers' experiences limited the conclusions that could be drawn about health visitors' application of the Solihull Approach. In retrospect it might have been more appropriate to interview health visitors about their uses of the Solihull Approach, in conjunction with interviewing mothers about their experiences of the same sessions in order to triangulate the data, and strengthen the implications that could be drawn from the data.



## **4.8 Conclusion**

Immersing myself in the data, and trying to understand the essence of people's words has been simultaneously frustrating and rewarding. I have recently become interested in Buddhist philosophy, and in some ways I liken the effect that my changing spiritual beliefs has had on my view of the world, to the effect that learning about qualitative research has had on my view of people's dialogues. I have begun to appreciate another dimension to the world of which I was previously unaware. Quinn Patton (2002) quoted one of the participant's from his research study when describing the nature of qualitative research, "doing this project the way I'm doing it allows me to touch things that otherwise I would never touch" (p. 47). This research has given me an appreciation of the depth that there can be within people's dialogues. I was interested that Smith (2004) used a section of one his participants' transcripts to demonstrate how IPA can be conducted on a number of different levels. The analysis that I carried out has helped me to be aware that there are often a number of different ways that clients' words can be interpreted, and that my chosen interpretation may be influenced my own world-view.

In addition this research has changed my view on qualitative approaches. I began the process with a tendency towards positivist research. I believe that this was because I used quantitative methodology in my undergraduate research. My thesis also began by focussing on positivist approaches. The literature review was the first paper to be written and it included only quantitative research, because it focussed on effective early intervention programmes. Conducting my own research studies taught me that qualitative approaches can also provide valuable information for clinical practice. In the future I would be interested to review the contribution that other qualitative researchers'



studies have made to our understanding of early intervention. I would also feel more confident about conducting further qualitative research studies of my own.

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# Appendices

**Appendix A Instructions to authors:**

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# **Appendix A**

## **Instructions to authors**

### **Infant Mental Health Journal**

(Literature Review)



## **Infant Mental Health Journal**

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**For Authors**

### **Instructions to Authors**

The Infant Mental Health Journal (IMHJ) is the official publication of the World Association for Infant Mental Health (WAIMH) and is copyrighted by the Michigan Association for Infant Mental Health.

### **Information for Contributors**

Reflecting the interdisciplinary nature of the field and the international focus of the Journal and WAIMH, the IMHJ publishes research articles, literature reviews, program descriptions/evaluations, clinical studies, and book reviews on infant social–emotional development, caregiver–infant interactions, and contextual and cultural influences on infant and family development. These contributions focus on assessment, evaluation, and/or treatment. There is particular interest in those conditions that place infants and or families at risk for less than optimal development. The Journal is organized into three sections: Research and Intervention Studies, Clinical Perspectives, and Book Reviews. The first section on Research and Intervention Studies involves peer reviews based on more traditional research journal models. However, the Clinical Perspectives section allows for more diversity both in types of submissions and through the review process. This increased flexibility provides the opportunity to expand both the interdisciplinary and international scope of the Journal. The Book Review Editor screens books that are received by the Journal and requests a review from an appropriate person. The book reviews are then reviewed by the Book Review Editor and the Journal Editor. The Journal welcomes a broad perspective and scope of inquiry into infant mental health issues and has an interdisciplinary and international group of consulting editors and reviewers who participate in the peer review process. In addition to regular submissions to the Journal, the intent is to publish two special issues or sections each year that may be guest edited and which provide an in-depth exploration through a series of papers of an issue that may be of particular interest to the readers of the Journal. Please submit requests for special issues directly to the Editor.

MANUSCRIPTS (an original and three copies) should be submitted to the Editor typed, with double spacing throughout, and ample margins. Each copy of the paper should include a cover sheet with the following information: Title of manuscript, name of author(s), and affiliation of author(s). The title should appear on the abstract and on the first page of text. Information about the identity of the author(s) contained in footnotes should appear on the title page only. The title page is not included when the manuscript is sent out for review. Blind reviewing is used. A cover letter to the Editor should accompany the paper; it should request a review and indicate that the manuscript has not been published previously or submitted elsewhere.

An abstract of approximately 150–200 words must be included. Tables and figures must be sufficiently clear so that they can be photographed directly. (Black and white glossy prints are acceptable.) Letter quality or near-letter quality print must be used for computer-prepared manuscripts.

A final version of your accepted manuscript should be submitted on diskette as well as hard copy, using the guidelines for Diskette Submission Instructions.

Style must conform to that described by the American Psychological Association *Publication Manual*, Fifth Edition, 2001 revision (American Psychological Association, 750 First Street, N.E., Washington, D.C. 20002-4242). Authors are responsible for final preparation of manuscripts to conform to the APA style.

Manuscripts are assigned for peer review by the Editor or Associate Editor(s) and are reviewed by members of the Editorial Board and invited reviewers with special knowledge of the topic addressed in the manuscript. The Editor retains the right to reject articles that do not conform to conventional clinical or scientific ethical standards. Normally, the review process is completed in 3 months. Nearly all manuscripts accepted for publication require some degree of revision. There is no charge for publication of papers in the *Infant Mental Health Journal*. The publisher may levy additional charges for changes in proofs other than correction of printer's errors. Proofs will be sent to the corresponding author and must be read carefully because final responsibility for accuracy rests with the author(s). Author(s) must return corrected proofs to the publisher in a timely manner. If the publisher does not receive corrected proofs from the author(s), publication will still proceed as scheduled.

Additional questions with regard to style and submission of manuscripts should be directed to the Editor: Joy D. Osofsky, Ph.D., Division of Child Psychiatry, Louisiana State University Health Sciences Center, 1542 Tulane Avenue, New Orleans, Louisiana 70112-2822. Telephone (504) 568-3997; fax (504) 568-6246.

### **Disk Submission Instructions**

**Please return your final, revised manuscript on disk as well as hard copy.  
The hard copy must match the disk.**

The Journal strongly encourages authors to deliver the final, revised version of their accepted manuscripts (text, tables, and, if possible, illustrations) on disk. Given the near-universal use of computer word-processing for manuscript preparation, we anticipate that providing a disk will be convenient for you, and it carries the added advantages of maintaining the integrity of your keystrokes and expediting typesetting. Please return the disk submission slip below with your manuscript and labeled disk(s).



## **Guidelines for Electronic Submission**

### *Text*

**Storage medium.** 3-1/2" high-density disk in IBM MS-DOS, Windows, or Macintosh format.

**Software and format.** Microsoft Word 6.0 is preferred, although manuscripts prepared with any other microcomputer word processor are acceptable. Refrain from complex formatting; the Publisher will style your manuscript according to the Journal design specifications. Do not use desktop publishing software such as Aldus PageMaker or Quark XPress. If you prepared your manuscript with one of these programs, export the text to a word processing format. Please make sure your word processing program's "fast save" feature is turned off. Please do not deliver files that contain hidden text: for example, do not use your word processor's automated features to create footnotes or reference lists.

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**Labels.** Label all disks with your name, the file name, and the word processing program and version used.

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**Instructions to authors**  
**Early Development and Parenting**

(Main research paper)



**For Authors**

**Instructions to Authors**

**Initial Manuscript Submission.** Submit **four** copies of the manuscript (including copies of tables and illustrations) to: Brian Hopkins, Department of Psychology, Fylde College, Lancaster University, Bailrigg, Lancaster, LA1 4YH, U.K. Papers should normally be 3000 - 5000 words in length.

Authors **must** also supply:

- an electronic copy of the final version (see section below),
- a Copyright Transfer Agreement with original signature - without this, we are unable to accept the submission, and
- permission letters - it is the author's responsibility to obtain written permission to reproduce (in all media, including electronic) material which has appeared in another publication.

Submission of a manuscript will be held to imply that it contains original unpublished work and is not being submitted for publication elsewhere at the same time. Submitted material will not be returned to the author, unless specifically requested.

**Electronic submission.** The electronic copy of the final, revised manuscript must be sent to the Editor **together with** the paper copy. Disks should be PC or Mac formatted; write on the disk the software package used, the name of the author and the name of the journal. We are able to use most word processing packages, but prefer Word or WordPerfect and TeX or one of its derivatives.

Illustrations must be submitted in electronic format where possible. Save each figure as a separate file, in **TIFF** or **EPS** format preferably, and include the source file. Write on the disk the software package used to create them; we favour dedicated illustration packages over tools such as Excel or Powerpoint.

**Manuscript style.** The language of the journal is English. All submissions including book reviews must have a title, be printed on one side of the paper, be double-line spaced and have a margin of 3cm all round. Illustrations and tables must be printed on separate sheets, and not be incorporated into the text.

- The **title page** must list the full title, a short title of up to 70 characters and names and affiliations of all authors. Give the full address, including email, telephone and fax, of the author who is to check the proofs.
- Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)**.
- Supply an **abstract** of up to 200 words for all articles [except book reviews]. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work.
- Include up to six **keywords** that describe your paper for indexing purposes.

**Reference style.** References should be quoted in the text as name and year within brackets and listed at the end of the paper alphabetically. Where reference is made to more than one work by the same author published in the same year, identify each citation in the text as follows: (Collins, 1998a), (Collins, 1998b). Where three or more authors are listed in the reference list, please cite in the text as (Collins *et al.*, 1998)

All references must be complete and accurate. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

Butterworth G, Jarrett N. 1982. Piaget's stage 4 error: Background to the problem. *British Journal of Psychology* **73** 175-185

Fogel A. 1981. The ontogeny of gestural communication: The first six months. In R. Stark (Ed.), *Language behaviour in infancy and early childhood* (pp.17-44) New York: Elsevier

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**Instructions for authors**  
**Early Child Development and Care**

(Brief research paper)



# Early Child Development and Care

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## Instructions for Authors:

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**Length:** The maximum preferred length is 15-20 pages.

**Language:** Papers are published only in English, but the editors welcome suggestions of non-English papers that have been, or are about to be, published in another language elsewhere.

**Abstract:** Each paper requires an abstract of 100-150 words summarizing the significant coverage and findings.

**Key words:** Each abstract should be accompanied by up to six key words, which between them should characterize the paper. These will be used for indexing and data retrieval purposes.

## FIGURES

All figures should be numbered with consecutive Arabic numbers, have descriptive captions, and be mentioned in the text. An approximate position for each figure should be indicated in the margin.

**Preparation:** Figures submitted must be of a high enough standard for direct reproduction. Line drawings should be prepared in black (india) ink on white art paper or tracing paper, with all lettering and symbols included. Alternatively good sharp photoprints ("glossies") are acceptable. Photographs intended for halftone reproduction must be good glossy original prints of maximum contrast. Each figure should be clearly labelled with the author's name and figure number. Redrawing or retouching of unusable figures will be charged to authors.

**Captions:** A list of figure captions should be typed on a separate sheet and included with the manuscript.

**References** should be indicated in the typescript by giving the author's name, with the year of publication in parentheses. If several papers by the same author and from the same year are cited, a, b, c, etc. should be put after the year of publication. The references should be listed in full, including pages, at the end of the paper in the following standard form:

*For books:*

Norton, P. & Wiberg, K. (1998) *Teaching with technology* (Orlando, FL, Harcourt Brace).

*For articles:*

Loughran, J. & Corrigan, D. (1995) Teaching portfolios: a strategy for developing learning and teaching in preservice education, *Teaching and Teacher Education*, 11(6), 565-577.

*For chapters within books:*

Marzano, R. J. (1994) Commentary on literacy portfolios: windows on potential, in: S. H. Valencia, E. H. Hiebert & P. P. E. Afflerbach (Eds) *Authentic reading assessment: practices and possibilities* (Newark, NJ, International Reading Association), 41-56.

*For online documents:*

Standler, R. (2000) *Plagiarism in colleges in the USA*. Available online at: [www.rbs2.com/plag.htm](http://www.rbs2.com/plag.htm) (accessed 6 August 2004).

Titles of journals and names of publishers, etc. should **not** be abbreviated. Acronyms for the names of organisations, examinations, etc. should be preceded by the title in full.

If you have any further questions about the style for this journal, please submit your questions using the Style Queries form.

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### **PRICE CHARGES**

There are no page charges to individuals or institutions.

# **Appendix B**

## **Information pack for participants**

(Main and brief research papers)

**Programme Director**  
**Doctorate Course in Clinical Psychology**  
Dr Delia Cushway  
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)  
**School of Health and Social Sciences**  
Coventry University  
Priory Street, Coventry, CV1 5FB  
Telephone: 024 7688 8326  
Fax: 024 7688 8390



COVENTRY  
UNIVERSITY

To

Your name

Date

2<sup>nd</sup> July 2004

Dear .....

I am doing a study on the approach your health visitor has been using to help you with your child's difficulties (it is known by health visitors as the Solihull Approach). I am interested in what you think of this approach. I have enclosed an information sheet which should answer any questions you have about the study. If you have any other questions please leave a message for me on (024) 76888328. **If you are interested in taking part please return the consent form in the prepaid envelope attached.**

Thank you.

Yours sincerely,

Helena Maunders

(Trainee Clinical Psychologist)



**Programme Director**  
**Doctorate Course in Clinical Psychology**  
Dr Delia Lushway  
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)  
**School of Health and Social Sciences**  
Coventry University  
Priory Street, Coventry CV1 5FB  
Telephone: 024 7688 8328  
Fax: 024 7688 8300



Our ref:

Your ref:

Date:

## CLIENT INFORMATION SHEET

1) A study about mothers' experiences of the Solihull Approach

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please feel free to contact me if there is anything that is not clear or if you would like more information (contact details can be found in paragraph 12). Take time to decide whether or not you wish to take part. Thank you for reading this.

2) What is the purpose of the study?

The purpose of the study is to find out what mothers have found to be helpful and unhelpful about the Solihull Approach (the Solihull Approach is used by health visitors to help with a number of difficulties including children's sleeping, feeding and behaviour). The study will help us to continue to improve the Solihull Approach.

The study will be carried out and written up between March 2004 and May 2005.

3) Why have I been chosen?

All mothers who have recently received input from health visitors using the Solihull Approach will be sent this information asking if they would like to participate in the study. There will be up to 14 mothers in total involved in the study.

4) Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you should complete the consent form attached and send it in the prepaid envelope. Please retain this information sheet for future reference. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision not to take part will not affect the standard of care you receive.

5) What will happen to me if I take part?

If you decide to take part please write your telephone number on the consent form. I will then call you to arrange to visit you at home. I will ask you questions about your experiences of the Solihull Approach. The "interview" will take about an hour and will be recorded on audio-tape so that I can write it up later.

6) What are the possible disadvantages of taking part?

It is unlikely that the study will cause you any distress, however, I will give you a list of contact telephone numbers in case you do need to talk to someone about your feelings afterwards.

7) What are the possible benefits of taking part?

Sometimes people find that talking to someone makes them feel better about things.

8) Complaints

If you have any complaints about the way this study is being carried out please contact Hazel Douglas (Consultant Clinical Psychologist at <anonymised> ) on <anonymised>.

9) Will my taking part in this study be kept confidential?

If you decide to take part your personal details (such as your name and address) will be kept confidential.

10) What will happen to the results of the research study?

The study will be written up for the thesis part of my doctorate in Clinical Psychology. It may also be written up for publication in professional journals and presented at professional seminars. Your personal details will not be reported in the thesis, seminars or journals. I will write to you in summer 2005 to let you know the results of the study and also where I will publish the results.

11) Who has reviewed the study?

The study has been reviewed by Coventry University and by <anonymised> Ethics Committee.

12) Contact for further information

If you have any questions please leave a message with Cath Ashton (course administrator, clinical psychology department, Coventry University) on tel. (024) 76888328 and I will get back to you as soon as possible (please leave your name, telephone number and the best time of day to contact you).

If you would like to take part please complete the consent form (attached) and send it to: Helena Maunders, Clinical Psychology Doctorate, School of Health and Social Sciences, Coventry University, Priory Street, Coventry CV1 5FB (prepaid envelope

enclosed). This information sheet is yours to keep. I will bring a copy of your consent form when I meet you.

Thank you.

Signed: Helena Maunders.....  
(Helena Maunders, Trainee Clinical Psychologist)

Date: 2/7/04.....



# **Appendix C**

## **Letter of consent**

(Main and brief research papers)

**Programme Director**  
**Doctorate Course in Clinical Psychology**  
 Dr Delia Custwray  
 BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)  
**School of Health and Social Sciences**  
 Coventry University  
 Priory Street Coventry CV1 5FB  
 Telephone 024 7688 8328  
 Fax 024 7688 8300



**CONSENT FORM**

- 1) I confirm that I have read and understood the information sheet and I am aware I can contact the researcher with any questions I have.
  
- 2) I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, without my medical care or legal rights being affected.
  
- 3) I agree to take part in the above study and I would like you to contact me to arrange an interview.

\*The best telephone number to contact me on is .....  
 (please include area code)

\*The best times to contact me are: .....

\*Signed .....

\*Name (please print) .....

\*Date .....

\*Please complete, and return to Helena Maunders, Clinical Psychology Doctorate, School of Health and Social Sciences, Coventry University, Priory Street, Coventry CV1 5FB.

## **Appendix D**

### **Local Research Ethics Committee approval**

(Main and brief research papers)

<anonymised> Ethics Committee

<anonymised>

<anonymised>

<anonymised>

1 June 2004

Ms H Maunders  
Clinical Psychology Doctorate  
Health & Social Sciences  
Coventry University  
Priory Street  
Coventry  
CV1 5FB

Dear Ms Maunders,

**REC Reference: P14/04**

**Mothers' experiences of the Solihull Approach: Qualitative research into mother's experiences of an early intervention approach for their children's sleeping, feeding and behavioural difficulties.**

Thank you for your letter of 20 April 2004, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Committee held on 25 May 2004. A list of the members who were present at the meeting is attached.

#### **Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised

The favourable opinion applies to the following research site:

Site: <anonymised> Primary Care Trust  
Principal Investigator: Ms H Maunders

#### **Conditions of approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

#### **Approved documents**

The final list of documents reviewed and approved by the Committee is as follows:

- Form B – revised version dated 20.4.04
- Interview schedule - revised
- Dear participant letter – revised
- Client information sheet - revised
- Consent form
- Your letter dated 20 April 2004



As discussed by<anonymised>with you, the only comment made by the Committee was that on the Dear Parent letter the 2<sup>nd</sup> sentence states 'I am interested in what you think of your health visitor's approach.' As the previous sentence refers to the Solihull Approach it might be better worded 'I am interested in what you think of this approach.' If you decided to make this amendment I would be grateful if you could send a revised copy of the letter for our files.

**Management approval**

The study may not commence until final management approval has been confirmed by the organisation hosting the research.

**Notification of other bodies**

We shall notify the host organisation that the study has a favourable ethical opinion.

**Statement of compliance (from 1 May 2004)**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

<b>REC reference number: P14/04</b>	<b>Please quote this number on all correspondence</b>
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Yours sincerely

<anonymised>

Chairman

*Enclosures Standard approval conditions*

*List of names and professions of members who were present at the meeting*

# **Appendix E**

## **Coventry University Ethics Committee approval**

(Main and brief research papers)

COVENTRY UNIVERSITY - SCHOOL OF HEALTH AND SOCIAL SCIENCES

STUDENT SUBMISSION TO SCHOOL RESEARCH ETHICS COMMITTEE

1. Student's name: HELENA MAUNDERS Course: CLINICAL PSYCHOLOGY  
(BLOCK CAPITALS)

3. Title of project: MOTHERS' EXPERIENCES OF THE SOLIHULL APPROACH QUALITATIVE RESEARCH INTO MOTHERS' EXPERIENCES OF AN EARLY INTERVENTION APPROACH FOR THEIR CHILDREN

4. Summary of the project in jargon-free language and in not more than 120 words: SLEEPING, FEEDING &

Sample: 12-14 WOMEN (MOTHER) TO BE RECRUITED. HEALTH VISITORS MUST HAVE <sup>BEHAVIOURAL</sup> <sup>DIFFICULTIES</sup> WITH THEM USING THE SOLIHULL APPROACH HOMES IN SOLIHULL.

Research site: WITH THEM USING THE SOLIHULL APPROACH HOMES IN SOLIHULL.

Design (eg experimental): MAIN PAPER: INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

Methods of data collection: BRIEF PAPER: QUALITATIVE CONTENT ANALYSIS

- ALL WOMEN WHO HAVE RECENTLY RECEIVED INPUT FROM A HEALTH VISITOR USING THE SOLIHULL APPROACH WILL BE SENT A LETTER & INFORMATION PACK INVITING THEM TO TAKE PART IN THE STUDY
- THOSE WOMEN WHO WOULD LIKE TO BE INVOLVED CAN RETURN THE CONSENT FORM IN THE PREPAID ENVELOPE
- THE RESEARCHER WILL CONTACT THOSE WOMEN WHO HAVE RETURNED FORMS & ARRANGE TO VISIT THEM AT HOME TO CONDUCT A SEMI-STRUCTURED INTERVIEW.

Access arrangements (if applicable): VIA <ANONYMISED> NHJ TRUST'S CLIENT DATABASE

- |  |   |  |
|--|---|--|
| 5. Will the project involve patients(clients) and/or patient(client) data?   | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/>            |
| 6. Will any invasive procedures be employed in the research?   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| 7. Is there a risk of physical discomfort to those taking part?  | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| 8. Is there a risk of psychological distress to those taking part?   | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| 9. Will specific individuals or institutions (other than the University) be identifiable through data published or otherwise made available? | Yes <input type="checkbox"/>            | No <input checked="" type="checkbox"/> |
| 10. Is it intended to seek informed consent from each participant (or from his or her parent or guardian)?                                   | Yes <input checked="" type="checkbox"/> | No <input type="checkbox"/>            |

Student's signature: Helena Maunders

Supervisor's signature: David Gale

Date: 14/6/04

**FOR COMMITTEE USE:**

- |   |                                     |   |                          |
|---|-------------------------------------|---|--------------------------|
| Immediate approval                          | <input checked="" type="checkbox"/> | Referral to full School Committee                               | <input type="checkbox"/> |
| Referral to local Hospital Ethics Committee | <input type="checkbox"/>            | Decision pending receipt of further information (specify below) | <input type="checkbox"/> |

Committee Member's signature: [Signature]

Date: 14/6/04

# **Appendix F**

## **Interview schedule**

(Main and brief research papers)



## Interview schedule

The interview will be semi-structured and therefore questions below are intended as guidelines only. The order and style of questions may change, some questions may be omitted and some added in order to elicit as much information as possible from each participant. Rapport will be established with the participant before the interview commences.

### 1) Experiences of the Solihull Approach:

- i) What kinds of difficulties do you have with your child? (Prompt: sleeping, feeding, toileting, behavioural)
- ii) What do you think of your health visitor's approach to helping you with your child's difficulties? What have you found helpful? What have you found not helpful?

### 2) Managing problem behaviours:

- i) Have these difficulties changed in any way? If so, how?
- ii) If so, what do you think might have caused the change?  
(Prompt: mother's or father's management of behaviour, child's maturity, other)

### 3) Relationship with child:

- i) **How do you view your relationship with (child's name)?**
- ii) Do you feel the relationship has changed over time? If so how?
- iii) What do you feel is responsible for the change?

### 4) Mother's feelings:

- i) What feelings do you have about being a mum?
- ii) Have your feelings changed? If so, how?
- iii) What do you think is responsible for the change?

5) Additional information:

- i) Is there anything else you would like to add about your health visitor's approach?
- ii) Is there anything else you feel I should be aware of?  
(Prompt: relevant changes in personal circumstances)

# **Appendix G**

## **Further support sheets for participants**

(Main and brief research papers)

**Programme Director**  
**Doctorate Course in Clinical Psychology**  
Dr Delia Cushman  
BA (Hons) MSc PhD AFBPS CPsychol (Clin Foren)  
**School of Health and Social Sciences**  
Coventry University  
Priory Street, Coventry, CV 5EB  
Telephone 024 7688 6328  
Fax 024 7688 8000



**COVENTRY  
UNIVERSITY**

Our ref:

Your ref:

Date:

Research into mothers' experiences of the Solihull Approach

Thank you very much for your participation in this research project. I hope you have enjoyed taking part. Very occasionally people find that talking about their experiences makes them feel that they need more support. In the first instance you can approach your health visitor or GP. They can help you to access services at clinics like <anonymised>.

I have also enclosed an information sheet about Parentline Plus. They run a number of services aimed at supporting parents, including a free helpline (tel. 0808 800 2222). There is more information on their website ([www.parentlineplus.org.uk](http://www.parentlineplus.org.uk)).

If you have any questions about the research please do not hesitate to contact me at Coventry University on tel. (024) 76888328. I will write to you during summer 2005 to provide you with feedback about the research.

With best wishes

Helena Maunders



## **How can Parentline Plus help?**

Parentline Plus runs a number of services designed to support parents and their families.

### **Free helpline**

Free helpline: 0808 800 2222

Our helpline is a free, confidential 24 hour service for anyone looking after a child - parent, stepparent, grandparent, stepgrandparent, or foster carer.

The helpline is staffed by trained volunteers who have experience of being parents. For many who call the helpline it may be the first time they have spoken to someone about their concerns, and these are wide ranging – from a new baby, bullying, truancy, drugs, and teenage pregnancy to managing divorce or separation, and introducing new partners to their children.

Free textphone helpline: 0800 783 6783

Our free textphone helpline is open 9am-5pm, Monday-Friday.

This service is for parents and carers with speech and/or hearing impairments and runs like the helpline by providing help and information on a range of parenting concerns, from having a new baby, to children being bullied, to maintaining contact with children after divorce and separation.

## **Courses for Parents**

These courses are for anyone involved in caring for a child. They provide skills and personal development training to anyone in a parenting role to help them to improve their relationships with their children and others. For more information on courses available go to [Courses for parents](#).

## **Publications**

Parentline Plus produces a range of leaflets containing ideas and tips to help parents improve relationships within their families. [Publications](#)

## **Training**

Parentline Plus offers a range of training courses for professionals working with families, including training around the impact of divorce, separation and challenges of stepfamily life. [Training](#)

## **Expanding support services**

Parentline Plus works with health, education, social services and voluntary sector organisations to develop and improve services for children and families. Go to [Professionals](#) for more information.

Parentline Plus is the operating name of FamilyLives.

FamilyLives is a company limited by guarantee.

Registered company number: 3817762.

Registered charity number: 1077722

Registered in England and Wales

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# **Appendix H**

## **Sample of transcript seven**

(Main and brief research papers)

255 R it sounds quite difficult when you're out in town with  
256 him, when there's other people watching and things  
257 M it is, I feel so self-conscious that I sometimes come  
258 home crying  
259 R mm  
260 M thinking, "I'm not going to go again with him"  
261 because I can't get anything done, number one and number two,  
262 it does cause a lot of problems. there's people staring at me  
263 thinking, "what's going on?" you  
264 know, he's kicking and screaming and why aren't I controlling  
265 him  
266 R uh-huh  
267 M and so on but they don't understand that I can't keep giving in to  
268 him  
269 R mm  
270 M if I do, he'll just get worse and I've been told by the  
271 health visitors how to behave with him  
272 R uh-huh  
273 M and that's what I'm doing. even though you know,  
274 umm, it's difficult  
275 R yes  
276 M because I want him to stop crying and I want him not  
277 to have to temper tantrums so that people will look at  
278 me and stare at me and, you know, think "Oh, I'm a bad mother"  
279 or whatever....



# **Appendix I**

## **Definitions of containment, reciprocity, and behaviour management**

(Brief research paper)

**All of the following definitions are taken from: Douglas, H. (2001) The Solihull Approach Resource Pack. Cambridge: Jill Rogers Associates Ltd.**

### Containment

“Containment describes the process of helping parents to manage their own anxiety and emotions, for example, of anger or guilt, so that they do not feel overwhelmed by these feelings and therefore have the capacity to start to think about the situation.” (p. 23)

“The key to containment is listening in a particular way. What do parents make you feel as you listen? This is an important source of information. Do they make you feel helpless, hopeless, angry? This is a clue to how the parents feel, but it is also part of the process of containment, in that now you have some experience of the feelings of these parents, without, hopefully, being overwhelmed by it. You are more likely to be able now to use it as information to think about the current situation together with the parents, thereby using yourself as the mediator to bring the feelings into a thinking mode.” (pp. 88-89)

“Children have intense emotions and experiences ... Ideally, the parent helps the child process those experiences, rather than allowing the child to feel too overwhelmed or frightened by the experience to learn from it.” (p. 23)

### Reciprocity

“Reciprocity describes the process whereby the parent is sensitive to the needs and feelings of the child and the child responds to the parents, in a two-way flow of communication.” (p. 29)

“With regard to reciprocity, the health and care professional can observe how the parent is with the child and how the child is with the parent and give them feedback.” (p. 38)

“Reciprocity is not just something to be observed between the child and the parent. Reciprocity also exists in the relationship between the mother and health care professional.” (p. 90)

“As you listen to the mother, you may become aware of the reciprocity developing in the relationship between you, the rhythm of social communication as you find a ‘natural’ space in which to comment or ask a question. On the other hand, you may have the experience of not being able to get a word in edgeways, or the feeling of a stilted and strained interaction. This will give you clues about the parent as well as letting you know when the interaction changes to a more reciprocal one, when it is more likely that you have developed a working relationship.” (pp. 90–91)

## Behaviour Management

“Behaviour management is part of the process whereby parents teach their child self-control, thus enabling the child to participate in society. The parents work together to place reasonable boundaries on the child’s behaviour. They encourage the child with attention and other rewards. Gradually, the child becomes able to internalise both the restraints and the satisfactions for himself.” (p. 37)

“Parents use reinforcement for desired behaviour. They praise and give attention when a child behaves in ways that please them. They punish undesirable behaviour, perhaps with an immediate and strong ‘No’. They shape a child’s behaviour, helping the child slowly develop new skills, chaining or linking together actions towards, for example, the final skill of getting dressed. They try to be consistent. They have clear rules and expectations of behaviour. They act as role models, demonstrating the behaviour they want the child to emulate.

Health and care professionals can help families by observing if this process has gone astray and by making relevant suggestions when the parents are in a good enough state to put them into practice. This may be sufficient, or sometimes techniques such as the disappearing chair routine may need to be explained. This technique is based on systematic desensitisation from behaviour theory. Controlled crying is based on exposure and extinction. Star charts are based on reinforcement.” (p. 40)