Infant mental health and health visitors: The development of a brief parent-to-infant attachment based questionnaire

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A thesis submitted in part fulfilment for the award of

Professional Doctorate in Health

School for Health

University of Bath

January 2011
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Acknowledgements

Particular mention goes to my husband Guy for his unfailing support, quiet enthusiasm, and sustained interest throughout the duration of this professional doctorate.

Special thanks to Professor Paul Stallard for his expert guidance and to Dr Vicky Wood and Dr Robyn Pound for their encouragement and advice.

To all my peers at the University of Bath and friends who kept me going along the way – thank you.

Most of all, thank you for the time and thoughtfulness of the parent and health visitor participants without whom this study would not have been possible.
Abstract

This thesis describes the development of a parent-to-infant attachment based questionnaire for use by health visitors as a discussion tool. An interpretive methodology was followed incorporating a sequential multi-method design.

The original purpose of the study, to develop an attachment screening tool, changed due to reflexive decision making and the impact of changes in service delivery. This presented an opportunity to develop a tool that supported focused conversation between health visitors and parents about early relationships.

Parallels between parent infant relationships and health visitor parent relationships were identified in four parent focus groups and four health visitor interviews. The resulting data were used to inform the development of the pilot questionnaire.

Five parent-to-infant attachment relationship constructs were developed from attachment theory and current practice in infant mental health. These were combined with parent terminology preferences, and formed into a twenty-five item questionnaire.

The twenty-five item questionnaire was used to collect data from twelve parents. Statistical testing on twenty-four test-retest completions of the tool resulted in a ten-item discussion tool that showed face and construct validity. Evidence of acceptability to practitioners and parents was gathered using a health visitor survey.
### Abbreviations

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<td>Child and Adolescent Mental Health service</td>
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<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>EPDS</td>
<td>Edinburgh postnatal Depression Scale</td>
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<tr>
<td>HV</td>
<td>Health Visitor</td>
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<tr>
<td>IMH</td>
<td>Infant Mental Health</td>
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<tr>
<td>PALS</td>
<td>Patient Advice and Liaison Service</td>
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<td>REC</td>
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<td>UKPHA</td>
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Personal position statement

Parents often express difficulties concerning relationships to me as the professional available to them at times of both joy and crisis in family life. This led me to think that a tool developed for the purpose of supporting a conversation about early relationships may be helpful in my work as a health visitor, and potentially of use to colleagues.

The study that developed from this interest originally aimed to develop an attachment screening tool. However, it became clear during the reflexive process that a more helpful way forward could be to develop a tool that enabled focussed discussion with health visitors based in parent perceptions of their early relationship.

I have found that the health visitor-parent relationship works better if I remain encouraging, not critical, empathic rather than sympathetic and knowledgeable rather than all-knowing. These approaches are well described in literature relating to health visitor practice (Cody 1999; Goding and Cain 1999; Ling and Luker 2000; Elkan 2000; Pritchard 2005; Appleton and Cowley 2008a; Wilson, Barbour et al 2008).

Health visiting work takes place in a context of health promotion and the role includes all families, involves prevention at all levels and health promotion in all aspects of family life. This presents opportunities to work in a preventive capacity in supporting family relationships.

The principles of health visiting have stood the test of time over three decades and currently underpin health visitor academic programmes (CETHV1977, Cowley and Frost 2006):

- The search for health needs
- The stimulation of an awareness of health needs
- Influencing policies that affect health
- The facilitation of health enhancing activities
For me, these principles are unique in healthcare provision both in the breadth of their application and in the complexity of practice required to meet them.

A health visitor’s professional practice involves complex relationships with parents, colleagues, employers and policy makers to support health and well-being in the context of family life and the wider community, utilising and applying these guiding principles. In this study I used the principles of health visiting, together with a parent-focused approach, to develop an attachment-based tool for use in practice.

**Windows of opportunity**

Unique opportunities exist within the relationship between a skilled health visitor and a parent for supporting parent to infant communication (Wilson, Barbour et al 2008). This in turn has the potential to prevent relational difficulties in families, or to help make them less problematic. There are also unique opportunities offered by the infant’s developmental processes, offering as they do windows of opportunity for a special communication between parents and infants (Tronnick 1989). The sensory nature of the interaction at this time is particular to this stage in a child’s development. The development of parents in their new role presents opportunities to work with their evolving understanding and insights.

It has always been important to me to acknowledge and celebrate parents’ expertise; the role of health visitors often includes helping parents to understand the sometimes mixed feelings they have for their children. I find I often need to offer explanations for situations to parents, such as the effect of timing and mood on interaction. The processes involved in supporting relationships are an aspect of health visitor practice that is rarely if ever made explicit within the role description. Attachment theory underpins our understanding of parent-infant relationships. The practical application of attachment theory is informative to practice and helps me to understand the processes involved in parent-child interaction with parents, whether experiencing difficulty or not. This thesis therefore is grounded in health visiting practice and utilises relevant theory,
particularly attachment theory, as a basis for developing skills for clinical practice.
Chapter 1: Introduction

1.1 Parent-infant relationships and health visiting practice

This study explores parent-infant relationships in a health visiting practice context. Parent-infant relationships form the basis for future emotional health and well-being and the foundation of family life (Shonkoff and Philips 2000). As a group of professionals health visitors are uniquely privileged to have access to families where interactions, thoughts, feelings and emotions associated with being a parent become shared.

Health visitors are available to families at key times such as childbirth; this presents opportunities to support and influence family interaction. The recognition of interactional difficulty can be helpful to future family functioning and the emotional development of children (Wilson, Barbour et al 2008). Parent to infant attachment as well as infant to parent attachment is fundamental to psychological health and well-being (Bowlby 1969).

The research question to be explored in this study was:

Is it possible to develop an attachment-based tool for use by health visitors, using parent friendly language?

Central to this question is the view that it is useful for the parent and health visitor to explore the parent-infant relationship together. This client-centred approach to assessment has been demonstrated to be helpful in health visitor practice (Holden 1989) and personally relevant to the researcher.

Client-centeredness supports effective practice particularly when dealing with complex situations such as bereavement or trauma, enabling exploration of thoughts and feelings that may have been left unexpressed. This then opens the door to appropriate support and the development of the parent-health visitor relationship (Cody 1999; Goding and Cain 1999).

Client-centeredness incorporates three core principles that are based in respect for the individual: genuineness or congruence between what practitioners think,
feel and express to the parent; the acceptance of the parent themselves utilising a caring attitude; and empathy, the accurate perception of the meaning and feelings contained within the parental discourse (Rogers 1974).

This approach to interaction in health visiting practice, informed by counselling principles, is incorporated in this study. It has been shown to be appropriate and productive for both parents and health visitors particularly when supporting parents with conditions such as postnatal depression (Holden et al 1989; Holden 1996; Morrell, Slade et al 2009). The link between postnatal mood disorders and parent-infant interactional problems is well established (Klier 2006; Moehler et al 2006; Murray et al 2006). The impact of using focused discussion to support parent-infant relationships has the potential to be therapeutic when supported by appropriate supervision (Murray et al 2003). Wilson and Barbour et al (2008) suggest the need to build the evidence base concerning the value of utilising health visitors in this way.

The roots of this study therefore lie in a professional interest in relationships; between parents and professionals and intra-familial, including parent-infant interaction, as well as an awareness of a gap in knowledge about how health visitors support these relationships when using attachment-based tools.

The literature indicates that parent-infant interaction and early intervention are currently of high priority within policy and practice in the provision of children’s services (Puckering 2007; DH 2009, Allen 2011). Health visitors are ideally placed to carry out some of this work, where parent-infant interaction is less than optimal, utilising the potential within the health visitor-client relationship for individual skilled work with parents.

A review of existing tools used in the assessment of parent-infant relationships was fundamental to the study. The purpose of identifying tools was to seek out those with potential for use in practice (See Table 7 page 61); the search failed to identify a tool which contained a reflective quality that could discriminate between parents experiencing problems within the relationship while also identifying strengths.
1.2 Influences on infant mental health

This section provides an introduction to the world of the infant from the perspective of current theory and practice in infant mental health and highlighting the importance of early relationships.

Berlin and Cassidy (2001) maintain that enhancing early child-parent relationships involves two principal tasks. Firstly, helping parents identify their children's needs and their own responses to these needs, and secondly, helping parents gain insight into how their “representations” or state of mind regarding the bond with their infant influence their behaviours and their child’s development.

The emergent nature of neurobiological processes is a powerful influence not replicated at any other stage of a person’s life (Fonagy, Steele et al 1991; Fonagy 1998; Balbernie 2001; Balbernie 2002; Fonagy, Gyorgy et al 2004). The attribution of infant behaviours’ resulting from sub optimal attachments is highly complex (Kamell and Dockrell 2000; Bakermans-Kranenberg et al 2003). There is however an effect on which most experts agree, that severely disordered parent-child relationships, in the absence of mediating factors and influences, will result in the lack of critical psychological component; that of empathy. It is argued that people who lack empathy go on to be parents who are disadvantaged in their ability to provide the necessary foundations for healthy psychological development in their children (Schuengal et al 1999; Zenah et al 2005).

Houck and Spegman (1999) illuminate this with explanations for reasons why some children are more affected than others by early childhood experience. The case for the early development of a “sense of self” and the basis of self-esteem within the infant’s attachment relationships are fundamental to this argument and well supported within attachment literature (Balbernie 2001; Bakermans-Kranenberg et al 2005; Lyons-Ruth 2008).

The theoretical foundations relating to the development of self, self-concept, self-esteem and self regulation are supported integration of four related theoretical perspectives (Houck and Spegman 1999). The first of these
interactional perspectives, the transactional, includes the interplay of external influences. The second is attachment and the influence of the primary care-giver relationship. The third, organisational, involves the organisation of attitudes, feelings, meanings and expectations within the parent-infant interaction. And the final perspective, that of developmental psychopathology involves the psycho-biological processes by which infants respond to their world.

The traditional debate here relates to the extent to which biological as opposed to environmental influences are responsible for the development of psychopathology (Bakermans-Kranenberg, van IJzendoorn et al 2003; Gervai 2009).

What these and other writers tell us is that the way in which early intervention can be tailored to the very specific needs of children, depends on the type and timing of early experience to which they have been exposed. The importance of these early influences relate to personality development and the ability to function in a positive and self-fulfilling way as adults. Awareness of these influences in health visiting practice helps to make our interventions more effective and appropriate.

Questions could be raised about the level of certainty with which the evidence for the link between adverse experience and future social and psychological functioning is presented in the literature. Often the evidence that underpins this view about cause and effect is located in descriptive rather than experimental studies (Houck and Spegman 1999; Kamel and Dockrell 2000; Balbernie 2002) and therefore is open to discussion. Collections of evidence found in experimental studies support the link in specific contexts such as maternal mental illness (de Wolff and van IJzendoorn 1997; Bakermans-Kranenberg, van IJzendoorn et al 2003).

As a health visitor, awareness of mediating factors in parent-infant relationships provides experiential evidence that early experience and its impact is highly complex. A normative view of the relationships between parents and infants therefore provides the focus for this study that is also informed by a wider awareness of attachment based literature.
1.3 Terminology

Attachment is an important concept to understand in the context of this study. In the field of parent-child relationships, attributions of meaning to important concepts such as attachment are difficult due to the complex nature of the phenomenon and the potential for misunderstanding in the language used to describe it.

Examples of this exist in professional and lay understandings of the word attachment within descriptions of the parent-infant relationship. The term is often given as a general descriptor of the relationship, rather than a specific application to the infant’s relationship to the parent, which then results in misunderstanding. The influential interpreter of attachment theory, Rutter (1995) explains the use of the term ‘attachment’ to refer to proximity-seeking behaviour in infants, a complex behavioural process (Rutter 1995). He attributes the roots of the confusion relating to the term ‘bonding’ to researchers who use the term to describe early mother-infant interaction. Rutter’s (1995) view is that this is over-simplistic and misleading. The use of this term has implications which have persisted for parents. For example parents often appear to view ‘bonding’ with their children as a problematic aspect of parenthood, using the word ‘bond’ as synonymous with ‘love’ (see Chapter 5).

The term ‘attachment relationship’ is used in this study to describe the infant’s relationship to the parent and the parent’s relationship with the infant. Chapter two contains a section relating to definitions relevant to this study.

1.4 Contexts and meaning

Parent-infant relationships, as all relationships, are interactional in nature and heavily influenced by the contexts within which they occur (Fonagy 1998; Cowley 1991; Pound 2003; Hawthorn 2005). The meaning and interpretation of subtle cues and the influence of external factors, the mental state of the parent, the physical attributes of the infant and the place in which the interaction occurs, all contribute to the interaction.
The potential for capturing the meaning of these interactions using a parent to infant attachment based tool formed the basis of this study; the aim being the identification of difficulties. This could then be followed up with an offer of appropriate support such as referral on to a mental health professional or to a parent-focused group activity such as an attachment based parenting course (Rydin-Orwin et al 2005). Health visitors could enable the discussion of these difficulties in a supportive way with parents, enabling health visitors to learn more about family functioning and the nature of these relationships in order to offer appropriate intervention (Girling 2006).

In her seminal examination of context within health visitor practice, Cowley (1991) identified “awareness contexts” and, more specifically, the discrete social context in which health visitors interact with parents. The parallels between the interactional context of the parent-infant relationship and the professional-parent relationship had an emerging importance as this study progressed. This was explored through a phenomenological approach to early tool development and through an evolving understanding of concepts concerned with interaction that underlie supportive relationships.

1.5 Parents’ voice

The parents’ voice was considered fundamental to the potential development of a tool in order to support its usefulness to parents. The encouragement of the discussion of sometimes difficult feelings via a tool was considered a legitimate goal, consistent with a personal attitude of respect and supportive to parental self-esteem.

The preventive nature of health visiting practice within public health is unique and presents an opportunity for exploration of parent child relationships in a supportive non-clinical way not afforded to other professional groups (Wilson, Barbour et al 2008). This study is concerned with the early recognition of difficulties in the parent to infant bond and the promotion of secure attachments and not with the diagnosis of attachment disorder. An explanation of the nature
of attachment difficulties is incorporated within the literature review in order to make the necessary conceptual differentiations.

The final approach taken to study design enabled an exploratory approach to developing an attachment-based tool within the framework provided by the original ethical submission and was designed in two phases involving four stages in Phase 1 and one stage in Phase 2. Stage 1 involved a preparatory literature review (See Fig. 1 page 22).
Study Process

Phase 1
Qualitative

Stage 2
Parent Consultation

Stage 3
Parent Focus Groups

Stage 4.1
HV Interviews

Phase 2
Quantitative

Stage 4.1a
HV Survey

Stage 4.2
Tool Pilot

Tool development

Reflexive Process
1.6 Summary of the thesis

This thesis contains six chapters.

Chapter one gives background information leading to the formation of the outline protocol for this study, setting it within the context of health visiting practice, and includes a description of the study process.

Chapter two reviews the literature relevant to the theory and practice of parent and infant attachment. Concepts relating to tool development are clarified and a question posed concerning the necessity for the development of a new tool. This section describes how a set of constructs were developed to provide the theoretical base for the proposed tool. Questions relating to the sensitivity of the nature of parenting in the context of health visiting and the wider social context are explored, and an explanation given for the need for research in this area. The chapter concludes with the research question.

Chapter three reviews literature relevant to screening and the assessment of attachment, including a description of the National Screening Committee’s criteria. A review of attachment screening tools fails to identify a questionnaire containing a reflective quality for use with a normative population of parents; the opportunity for the development of such a tool is discussed. The mechanisms that health visitors use in assessment are explained and the chapter concludes with a set of objectives to address the research question.

Chapter four presents theory underlying the choice of an interpretive methodology and multi-method design. Questions of validity and reliability are explored and the ethics process described.

Chapter five describes the analytic process applied to the data collected and contains results from parent focus groups, health visitor surveys and interviews and the statistical testing of the pilot tool developed in Phase 1 of the study. Discussion of the findings includes reflections on bias and the appropriateness of the methodology and methods chosen.
Chapter six summarises the thesis, offers a synthesis of the findings, presents the limitations of the study, and briefly describes how the work may be taken forward.
Chapter 2: Literature (a)

Introduction

The literature chapters describe the literature used to explore the nature of screening and assessment in parent-infant relationships, provide the theoretical base for the study and formulate the study question.

The literature review relating to parent-infant relationships and health visitors incorporates several themes; attachment theory, applied attachment theory, professional practice in health visiting and health measurement tools. Consideration of the desirability or otherwise of the use of tools is discussed, and the chapter concludes with an explanation of the significance of the health visitors’ role with parent-infant relationships in the current practice context.

Literature Chapter 2 (a) sets the scene for the potential for the development of an attachment-based tool by exploring theory and practice in infant mental health and the role of the health visitor, identifies assessment dilemmas and presents the study rationale. Literature Chapter 3 (b) explains screening and assessment with reference to the National Screening Committee’s criteria, offers a critical review of available tools to assess parent-infant interaction, and explores literature relating to health visitor’s family assessment, concluding with the development of objectives for the proposed study.

(a) Theory and practice in infant mental health

2.1 Aim and scope

The literature review emerged from consideration of a practice-based problem; helping parents to express relational difficulties with their infants. While the content of any literature review is determined by its purpose, the scope is often determined by pragmatics. Here, the purpose relates to examining a range of literature to potentially inform the development of an attachment-based tool for use in health visitor practice. Literature relating to the diagnosis of attachment disorder was relevant to the review in order to frame the context of attachment
within current clinical practice; literature relating to health visiting establishes the relevance of the approach taken in this study to the practice context.

The resulting review further divides firstly into literature gathered and analysed early in the protocol development process. Secondly, literature that has, later in the process, contributed to the synthesis of the knowledge generated during the active phase of the study itself.

Literature describing the roots of attachment theory is explored along with literature conceptualising parent-child relationships in clinical practice and family life in Western Europe and the USA.

Keywords

Searches were made to identify general literature concerning attachment theory and specific literature relating to the identification of parent-to-infant attachment problems using the key words; parent*, parent-child relation*, parent-infant relation*, infant*, infant mental health, attachment, attachment disorder, bond*, assessment, screen*, screening tool*, child development, professional*, health visit*, health measurement scales.

2.2 Definitions

This section describes the context of parent-infant relationships and attachment by explaining definitions used in attachment-based literature.

Attachment is a process not a condition argues Goulet, Bell et al (1998) and in the context of this study is the term used to describe the relationship between infants and the parent as evidenced by specific behaviours. It is of interest to health visitors in their preventive role, as the future mental health of the infant, it is argued, depends on the quality of early relationships (De Wolff and Van IJzendoorn 1997; Bakermans-Kranenburg, Van IJzendoorn et al 2005).

Tools relating to the assessment of parent to infant attachment are considered in Chapters 2 and 3; screening tools and measures concerning the infant’s
attachment to the parent are outside the scope of this study, however, features of infant behaviour that are recognisable to parents are incorporated (Hawthorn 2005). Further, attachment in the context of parents and infants is a relationship construct and this will be explored by considering the theoretical foundations of relationship constructs.

A key feature of attachment is that it is a dyadic relationship and therefore also encompasses the infant’s emotional connection to the parent. “Bonding” is often used to describe the parental link solely with the infant, though as will be discussed later, parents use the term bonding to describe the attachment relationship.

Bonding is the term that describes the self-perceived relationship between parent and infant. The term attachment describes the instinctive behaviour of the infant to the parent or primary care-giver (Prior and Glaser 2006).

**Table 1 Definitions**

<table>
<thead>
<tr>
<th>Definition</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attachment</td>
<td>Biological systems for protecting the infant</td>
</tr>
<tr>
<td>Bond</td>
<td>Term for the parent’s emotional link to the infant</td>
</tr>
<tr>
<td>Infant mental health</td>
<td>Emotional health and well-being of children under 3 years of age evidenced by their behaviour</td>
</tr>
<tr>
<td>Dyad</td>
<td>Parent to infant - infant - to parent relationship</td>
</tr>
</tbody>
</table>

Developed from Prior and Glaser 2006

**2.3 Parent-infant attachment relationships**

This section reviews literature relating to the theoretical foundations of attachment theory, the relevance of health visitor practice and the context of the assessment of parent-infant relationships.
Origins of attachment theory

Due to the relevance of attachment theory to current practice, a short description of literature relating to attachment theory follows.

John Bowlby (1969) in his family studies in the 1940s and 1950s first identified the importance of the notion of sensitive care-giving as central to infant secure attachment, leading to healthy emotional development. Bowlby’s attachment theory, refined over several decades is relevant to current health visitor practice as well as to current thinking in developmental psychology (Wilson, Barbour et al 2008; Milford and Oates 2009; Allen 2011). The extent to which the tenets of attachment theory are supported by empirical research findings will be explored and their relevance to current practice discussed.

Table 2

Tenets of Attachment Theory

<table>
<thead>
<tr>
<th>Tenets of Attachment Theory</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>That the attachment qualities of relationships are differentiated from other aspects of that relationship</td>
<td>The inhibition of qualities such as playfulness by parental anxiety results in reduced attachment security in the infant</td>
</tr>
<tr>
<td>Attachment should be viewed in the context of normal developmental processes</td>
<td>Security promotes independence and leads to maturity in social functioning in adulthood</td>
</tr>
<tr>
<td>Attachment relationships are intrinsic to human development</td>
<td>Feeding seen as complex interplay not result of simple behavioural system</td>
</tr>
<tr>
<td>“Mental mechanisms” are involved with both “carrying forward” the effect of attachment into later relationships and also “the mechanism of change”</td>
<td>The development of internal “working models” of relationships around which we build meaning</td>
</tr>
<tr>
<td>Insecure attachments may result in later psychopathology</td>
<td>Inability to form and maintain positive relationships</td>
</tr>
</tbody>
</table>

Adapted from Rutter (1995)

The importance of Bowlby (1969) and attachment theory remains highly influential to current theory, policy and practice in infant and adult mental health
today (Prior and Glaser 2006; Fox and Rutter 2010; Allen 2011). As will be seen, attachment theory not only underpins current practice in the diagnosis and management of attachment disorders, it has also been influential in how infants and young children are regarded within Western society. Infants began to be recognised as potentially having their own internal worlds and inbuilt temperaments rather than simply being the passive recipients of adult care (Sroufe 1985; Else-Quest, Shibley Hyde et al 2006). This in turn influenced the way in which the role of parents was viewed and studied with the evolution of an extensive body of literature related to family interaction (Siefer, Dickstein et al 2001; Murray, Halligan et al 2006; Pauli-Pott, Havercok et al 2007).

Critics of attachment theory cite the impact on parental self-esteem and confidence that a clinical deficit-based view of parenting promotes (Furedi 2008). From the practice context of health visiting, both views are relevant could be argued to be mediated by appropriate intervention based on skilled assessment that is rooted in supportive professional-parent relationships (Svanberg 2009). The view taken in this study is that attachment theory is helpful in understanding how parent-infant relationships evolve. The purpose is to effectively support the relationship in the context of professional practice and family life.

2.4 Conceptualising attachment

It is widely accepted that the parental bond with an infant is fundamental in family relationships (Fonagy, Gyorgy et al 2004; Bakermans-Kranenberg, Van IJzendoorn et al 2005; Fox and Rutter 2010).

It is argued that difficulties experienced within the bond need to be explored in a sensitive and therapeutic way (Houck and Spegman 1999; Heffron 2000; Svanberg 2009). Difficulties for parents include experiencing differing levels of affection for their individual children or the impact of birth trauma on emotional responses, including distressing delays in emotional connection following childbirth (Muzik, Cameron et al 2009). Parent-infant relationships are often a source of distress to both new and experienced parents, and can be linked to
either postnatal depression or the post-traumatic stress of childbirth itself (Morrell, Slade et al 2009; Musik, Cameron et al. 2009).

Historically there has been confusion concerning the concept of parent-infant attachment (Goulet, Bell et al 1998). A conceptual framework to address this confusion is offered that describes attachment as a process characterised by three critical attributes:

- Proximity or a physiological and psychological closeness
- Reciprocity or a two way exchange of response
- Commitment, involving the role change that parenthood brings (Goulet, Bell et al 1998).

This concept analysis was developed with a view to operationalising attachment theory to enable the development of parental assessment and approaches within a nursing practice context.

Goulet, Bell et al (1998) offered conceptual clarification that was used to underpin a developing understanding of parent-infant attachment as a dynamic relational process. Making sense of attachment theory using this conceptualisation led on to a consideration of how useful it would be to capture parent to infant attachment perceptions via a tool, and whether this would involve measurement or not.

Just as with any attempt to measure an aspect of human experience such as pain or anxiety, the individual’s perception of the phenomenon to be measured is of itself subjective. How then can aspects of parenting experience, expressed through the behaviour of a parent towards a child, be anything other than subjective? What does trying to make it objective actually achieve?

In order to explore these questions a broad review of current assessment tools was undertaken that focused on the parent-infant attachment relationship. These were identified through repeated literature searches and personal contact with authors to obtain the actual tools if not appended to articles. Tools were selected for review using the following criteria:
- Suitability for use with parents of infants under 12 months old
- Tools that incorporated a screening or assessment function

The literature obtained included tools that used psychometric measurement approaches some of which described themselves as screening tools and others which are clearly diagnostic. Tools considered suitable for health visitor use are critiqued in Chapter 3.

Operationalising attachment by measuring one aspect of either parental attachment attitude or infant attachment behaviour then can be problematic given its complex nature. It could be argued that the interactional nature of the parent-infant relationship requires the combination of observed parent behaviours and observed infant behaviours to give an accurate assessment (Byrne and O'Connor 2007).

The measurement of attachment disorder is more appropriately dealt with within a categorical form of measurement tool which sits firmly within the domain of clinical assessment, and is outside the scope of this study.

Where a deficit in parent-child interaction has already been identified, diagnostic tools are used to assess the extent of the deficit (Zeanah, Larrieu et al 2005). In the UK, interaction and perception focused tools are usually applied with therapeutic intervention in mind - when the referral of a parent and child or of a family has been made to psychological services for assessment and intervention (Rydin-Orwin 2005; Prior and Glaser 2006).

Preparatory stages of this study included developing some conceptual clarity about attachment theory and attachment assessment. The absence of conceptual clarity underlying important literature relating to both clinical and theoretical research throughout preceding decades was surprising given the volume of available attachment literature. However, a core concept in attachment theory is maternal sensitivity (Goldsmith and Alansky 1987; De Wolff and Van IJzendoorn 1997; Hane, Feldstein et al 2003; Atkinson, Goldberg et al 2005; Bakermans-Kranenberg, Van IJzendoorn et al 2005). A contemporary
concept analysis of maternal sensitivity (Shin, Park et al 2008) provides a helpful review, concluding:

“The development of a measurement instrument that reflects the evolved and extended properties of maternal sensitivity and is easy to apply in clinical settings may be a great help to researchers studying maternal sensitivity”.

As a core aspect of positive parental interaction, sensitivity clearly needed to be included if a new tool was to be developed. Shin, Park et al (2008) suggest that the concept of sensitivity in parenting is clearly open to measurement. The issue of the “transmission gap” or clear link between maternal sensitivity and infant attachment security is however debated (Atkinson, Goldberg et al 2005).

Broadly the conceptualisation of attachment theory in its application to clinical practice involves the classification of the level of attachment as evidenced by infant and parent behaviour (See Table 5 p.50).

**Fig 2**

Axes of Attachment

- Secure
- Sensitive
- Insensitive
- Insecure

(Prior and Glaser 2006)
In its application to parent-child relationships the conceptualisation follows an interactional model within a relationship construct (Steele 1996).

The role of sensitivity as an important mediating factor in infant attachment security remains complex with the attribution of cause and effect debated (Atkinson, Goldberg et al 2005). Its centrality to all aspects of parent behaviour is generally accepted (Bakermans-Kranenberg, Van IJzendoorn et al 2003; Hane and Feldstein 2003) and domains of sensitivity, mutuality and synchrony, identified in the meta-analysis of De Wolff and van IJzendoorn (1997) were used to develop the tool constructs in this study (See Table 5 p.50 and Table 6 p.52).

**Assessing attachment**

Assessments of attachment arise from two different perspectives; firstly assessments of the child’s responses when in the company of the parent, and secondly, assessments of parental attitudes and behaviours. Such assessments are often used when a pathological pattern of care-giving has emerged, usually in cases involving mental illness in the parent, or where a picture of neglect or ill treatment has been identified. The tools depicted in Table 7 (p.61) are concerned with assessments relating mainly to parent behaviour. Tools depicting infant-related interaction are not included as the focus of this study relates solely to parent perceptions within a health promotion context.

The focus of these assessments can be further sub-divided into observational or perception focused; the purpose of both types being therapeutic in intent but often limited in their application to normative populations. Reasons for this include the multi-factorial content of dyadic interaction leading to the need for complex assessment processes, of which tools provide only a partial elucidation (O’Connor and Byrne 2007). Also the potential for creating parental anxiety by the use of tools aimed at pathology recognition was recognised as a risk in this study, leading to a careful consideration of their content and ongoing reflection about the necessity for a tool in the early stages of study development.
2.5 Attachment problems

Parent to infant attachment difficulties incorporate a range of behaviours, attitudes and emotions towards infants (Tronnick 1998). These can range from feelings of unease and low self esteem affecting intra-familial interaction, through to a disorder characterised by an inability to meet a child's emotional needs.

In the infant, an attachment disorder manifests in four classically described ways (Robinson 2002; Main 1990); secure, insecure-avoidant, insecure-resistant and insecure-disorganised. Apart from secure attachment, all potentially have negative consequences for the infants concerned, with consequences for future relationships and sense of self.

The aim of this study was to promote secure attachments through health visitor and parent discussion, supported by a tool – the classification of attachment appears in Table 3 (p.35) and is helpful in locating this study in the domain of secure attachment.
Table 3

Classification of Attachment

<table>
<thead>
<tr>
<th>Secure attachment</th>
<th>Infant feels safe to explore their environment and seek maternal proximity and close physical contact. Is easily soothed and mother acts as a secure base to which the infant returns and leaves without distress.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insecure – avoidant attachment</td>
<td>Infant shows limited response to separation/reunion. Avoids maternal proximity during reunion. Maternal behaviour characterised by avoidance. Infants show more distress and anxiety.</td>
</tr>
<tr>
<td>Insecure/resistant attachment</td>
<td>Characterised by infant ambivalence at parting and reunion with mother shown in intense distress at parting, resistant to contact and interaction initially on reunion followed by strong proximity and contact seeking later within interaction. Less easily soothed than secure infants.</td>
</tr>
<tr>
<td>Disorganised insecure attachment</td>
<td>Characterised by one or more of following behaviour patterns: Contradictory behaviour such as strong proximity seeking followed by avoidant behaviour either in sequence or simultaneously. Unusual movements or expressions such as distress coupled with attempt to distance from mother. Mistiming of movements in presence of mother. Freezing or stilling in presence of mother. Expression indicating fear of mother. Disorientated behaviour.</td>
</tr>
</tbody>
</table>

Developed from Prior and Glaser 2006

What this classification of attachment illuminates is the complexity of the human interaction that parent-child relationships involve. This had implications for the design of this study leading to a consideration of a multi-method approach to explore this complexity from a two main viewpoints; parents and health visitors.
The underlying theoretical framework within which this study was carried out is broadly that of developmental psychology, and specific to parent perceptions of the parent-infant relationship.

Developmental psychology informs us that parental feelings, attitudes and behaviours relating to experience of their attachment to their infant underlie their behaviours, and subsequently underlie infants’ attachment experiences. The potential for a cycle of intergenerational disorder here is obvious, but what is less obvious is the extent to which transient experience of less than optimal attachment is carried forward through the lifespan and what impact this may have.

Parents tend to recognise when the relationship between themselves and their infant is impaired, but often struggle to find the words to express this, even to a trusted professional (Wilson, Barbour et al 2008). Awareness of this provided the main impetus for the choice of study aim, to enable opening a meaningful discussion with parents about the parent-infant relationship in the early months, in this is complex area of practice (Wilson, Puckering et al 2010)

2.6 Classification and assessment in infant mental health

Classifications of both physiological and psychological disorders and conditions often cause difficulty for clinicians (Anderson, McCullagh et al 2007) but these difficulties are resolved by reaching agreement concerning levels of clinical significance through the use of evidence-based assessment tools. Most of these tools however have limited application in pre-pathological conditions such as parent to infant attachment difficulty. In the sphere of infant mental health, if the aim of using assessment is to promote positive aspects of interaction, the use of a medical model to assess attachment and bonding difficulties causes particular tensions.

Robinson (2002) highlights the difficulties associated with the assessment and classification of infant mental health and attachment disorder in a review of attachment literature and guidance on the current diagnostic and classification systems in use the USA.
This critical review of this aspect of infant mental health, linking assessment, using specific questions based on attachment theory, and diagnostic criteria, based in medically based coding systems, was of particular relevance to the initial scoping process in this study.

Two strategies are suggested by Robinson (2002) based on an evaluation of the literature relating to assessment. These are, history taking, and direct observation of parent-child interaction based on simple sets of questions rather than complex assessment processes.

Robinson’s review (2002) then explores the intervention literature and provides an overview of available interventions, concluding that there are three areas which need further research in order to strengthen the assessment of and intervention in attachment problems.

Firstly, that research needs to refine further which aspects of the infant caregiver relationship have the most impact on attachment quality. Secondly, that current diagnostic criteria lack specificity, leaving many parents and children undiagnosed when a damaging relationship exists. Thirdly, that those methods of intervention thought to be effective require validation.

The issue of diagnostic classification is a difficult one when considering attachment, as Robinson (2002) points out, the level at which clinical significance is reached in terms of attachment, excludes the majority of affected infants from targeted and appropriate intervention.

The issue of clinical significance clearly emanates from a medical model approach to the assessment of infant mental health; it could be argued that this approach is limited when the outcome of the identification of pathology is applied to the complex relational context of infant mental health (Byrne and O’Connor 2007). This is however necessary given the requirement to assess parenting capacity, of which attachment is a key feature. When an infant is placed at risk, for example, by the mental health of a parent, the practitioner’s duty of care to the infant will sometimes transcend the needs of the parent, and
clarity concerning diagnostic assessment in relation to the attachment relationship can be used as part of this protective process.

Robinson’s (2002) review clarifies the context of the assessment of the parent-infant attachment relationship within broad clinical practice. It was helpful to reaching a personal understanding of the contextual factors relevant to uncovering attachment difficulties in health visitor professional practice.

2.7 Infant mental health in context

The term infant mental health is used within Child and Adolescent Mental Health Services (CAMHS) in the UK to describe the emotional well-being of children under 3 years old. The complex contextual factors that influence that well-being include the biological, developmental, environmental and relational. Although the tool development described here is associated with the relational context, it is useful to consider all potential influences given that they are interdependent in the world of the growing infant in a way that is unique and complex (Schonkoff and Phillips 2000).

- The biological context for infant mental health involves the complex interplay of biological processes linking physical development to both prenatal and postnatal experiences. The growing infant’s biological make-up leaves it susceptible to the impact of stress both pre-natally and in the first two years after birth, which can significantly affect its emotional and developmental potential (Fonagy 1998; Balbernie 2002).

- The developmental context of infant mental health incorporates the range of abilities which evolve particularly rapidly within the first three years of life, and which equips the child to learn from and engage with the environment around it. Impairment of this process, it is argued, can be linked to attachment problems in the early months (Van Ijzendoorn, Schuengel et al 1999), and these problems express themselves in a variety of ways. These can range from difficulties expressing emotions, unusual behaviours, distractibility and feeding and sleeping problems, to
developmental delay in motor and language ability and potentially mental ill-health and criminality as adolescents and adults.

- The environmental context of infant mental health incorporates the physical environment of the child, fundamental to the day to day experience of the child. The impact of the child’s environment on his or her mental health is subject to a variety of associated factors, and it could be argued that a poor environment alone is unlikely to affect infant mental health (Ainsworth and Bowlby 1991). For example the impact of poor housing and low family income is mediated by emotionally warm and protective parenting.

The beliefs and behaviours of significant adults within the child’s environment, and the impact of poverty are however influential in determining coping strategies and hence future mental health (Zenah, Stafford et al 2005).

2.8 Parent infant relationships and attachment theory

Attachment theory supports the importance of relationships to child development (Zeanah, Boris et al 1997; Houck and Spegman 1999; Heffron 2000), and the context in which a child learns a sense of self-worth is fundamental to future emotional well-being (Balbernie 2002). Much of the formal assessment of the parent-child relationship is based on the observation of parent-child interaction within clinic or specialist settings.

The complexity of the influences on the mental health of infants and the contexts in which they occur make the early recognition of and intervention in infant mental health an important contemporary consideration for service delivery in early years provision (Puckering 2007). This study concentrates on relational aspects of parent-child relationships, as this is the area that holds the key to influential antecedents of infant mental health (De Wolff, Van IJzendoorn et al 1997). Understanding the processes of child development is helpful in contextualising the process of attachment.

Attachment helps us to understand the processes of family life and the impact of relational features on the psychological development of individuals. More
specifically it helps to explain emotional development and individuation (Balbernie 2002). It is a biological process that ensures the safety of the most vulnerable members of society (Bowlby 1969; Fonagy 1998). The interpersonal world of the infant and parent relationship provides the context for that biological closeness to develop into the experiences that shape us as individuals (Balbernie 2002). It could be argued that professionals who work with families need to understand the attachment relationship and be able to use attachment theory in the assessment of family functioning.

The infant's world

Stern (1985) first opened up the world of infant-parent interaction through naturalistic observation of the behaviour of infants, behaviour being the “language” through which they communicate their needs. Understanding infant cues is fundamental to helping parents to understand their baby’s behaviour and respond to it appropriately (Nugent and Brazelton 1989; Hawthorn 2005). It is argued that some parents need help in the interpretation of their infant’s behaviours and the extent to which they are able to respond appropriately to infant cues, will depend on several factors. These include; their own experience of being parented, their current mental health status and their capacity to view their infant as a separate individual (Balbernie 2002). This view is commonly found in descriptive studies and in a practice context contains ecological validity; influential figures in the field of Infant Mental Health also support this view (Schonkoff and Philips 2000; Fonagy, Gyorgy et al 2004).

Infants develop through complex interactions between themselves and their environment (Bowlby 1969). That environment includes both the physical and the relational and is mediated by meaningful others, most importantly, the parents. Central to the process are the tasks of development, stages through which the infant passes, aided by the primary caregiver and other attachment figures. At each of these stages, the key enabler is the responsiveness and sensitivity of the primary caregiver to the signals of the infant. Without this enablement, stages in development are lost or compromised with the
subsequent evolution of the infant to child and then to adult (Zeanah and Zeanah 2009).

Table 4

Stages of Infant Development

<table>
<thead>
<tr>
<th>0-3 months</th>
<th>Physiological regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-6 months</td>
<td>Turn-taking</td>
</tr>
<tr>
<td>9-12 months</td>
<td>Reciprocity and joint attention</td>
</tr>
<tr>
<td>15-24 months</td>
<td>Parent-child conflict</td>
</tr>
<tr>
<td>24-30 months</td>
<td>Linguistic communication &amp; regulation</td>
</tr>
</tbody>
</table>

(Zeanah and Zeanah 2009)

Questions that arose from personal clinical practice that led to this study included:

- What happens if developmental processes are partially or wholly compromised by poor attachment relationships?
- What do health visitors observe that is useful to reflect back to the parent to help them progress in their relationship?
- How can attachment problems be prevented and how can parents be supported to express the difficulties they feel?

Another important consideration involved the context in which tools are used. Of particular importance is the availability of a care pathway for parents identified by the use of tools and in need of onward referral. In the field of parent-infant relationships the presence of such pathways is variable (Barlow and Underdown 2009). The question of how a new tool could be helpful in the context of current health visitor practice was considered during the developmental stages of the study.

2.9 Parent-infant relationships and health visitors

Infant mental health is complex due to the impact of many variables such as; infant temperament, parental sensitivity, health factors, the cultural and social
context, and the impact of neurobiological processes. All have a part to play in the evolving mental health of infants, children and adolescents (Fonagy 1998; Schore 2001; Balbernie 2002); the emphasis placed on these variables and their impact is debated (Atkinson, Goldberg et al 2005; Else-Quest, Shibley Hyde et al 2006). This in turn makes often it difficult for practitioners to make a case for additional resource to support parent-infant relationship based work.

Infants, it is argued, are able to communicate their needs in both subtle and overt ways which forms the basis of the infant-carer relationship (Stern 1985; Hawthorn 2005). The way in which that communication is interpreted and responded to or mediated provides the key to parent-infant interaction. The role of health visitors in the UK incorporates the recognition of distortions in parent-infant interaction and early intervention to support change (Wilson, Barbour et al 2008).

For several years health visitors have had a role in supporting infant mental health (Puckering 2007; Wilson, Barbour et al 2008; Barlow, Underdown et al 2009). Increasingly, the role involves assessment of complex family situations, requiring a range of skills.

Searching for health needs relating to infant mental health could be argued to be a fundamental skill within health visitor practice; the approach of service providers in early years however is often fragmented, diverse and dependent on local conditions (Barlow and Underdown 2009). Local conditions often dictate the extent to which infant mental health is prioritised within different geographical areas within the UK. These conditions are dependent on a variety of factors, including the extent to which perinatal mental health strategies have been implemented and what importance is attached to this by local health providers.

Within children’s services in recent years some infant mental health specialist health visitor posts have been set up within targeted populations, such as those covered by Sure Start initiatives that support families of children under five through a social support model (National Evaluation 2004; Barlow 2007). The
importance of the recognition of attachment difficulties and the implication for Child and Adolescent Mental Health Services (CAMHS) and child health services is acknowledged as desirable within government policy (DH 2009; DH 2010). The universal access that health visitors have to all families, places them in a unique position in the recognition of attachment difficulties (Wilson, Barbour et al 2008). Services and training to support this work however are variable within the UK (Bower, Garralda et al. 2001) with some health visitor services able to provide complex assessment due to local expertise and interested professionals, and others with little training or support in this field (Mischenko, Cheater et al 2004; Wilson, Thompson et al 2010).

2.10 Health visitors’ role

Often health visitors find difficulty in framing discussions with parents around attachment, particularly when they have to make rapid assessments in home situations. Among the assessments they will have to make, will be an assessment of risk to the children in the family (Appleton and Cowley 2008b; DH 2010). With increasingly targeted services and new ways of working (Brocklehurst and Adams 2004; DH 2009; DH 2010) health visitors have to rely more heavily on screening to help them make such assessments (Puckering 2007; Pettit 2008; Bailey 2009). There is little information however concerning the ways in which these assessments are utilised either by individual health visitors themselves or the organisations within which they work.

The role of intuition in clinical assessment and decision making presents an opportunity for health professionals (Welsh and Lyons 2001; Hodkinson et al 2008). Expert practitioners are able to recognise subtle cues in clinical situations and formulate helpful responses (Benner 1984). Intuitive practice can aid health visitors to support parents with their relationships (Cody 1999; Goding and Cain 1999; Wilson, Barbour et al 2008). The role of health visitors has adapted and changed to accommodate societal change and changes in policy direction (Appleton, Cowley and Frost 2006). The research described in this study involves a parent-focused approach with the purpose of supporting early relationships.
Preparation for the role of health visitors has traditionally emphasised infant development and sociological factors in family life. Testing infants for physical responses such as primitive reflexes has been the focus of the “examination” of infants by health visitors, in babies under eight weeks of age. More recently, population based public health approaches have gained importance (Jinks, Smith et al 2003). The focus on the emotional bond between parents and infants and the consequences of distorted attachment, within health visitor training enables a basic understanding of that bond. However, it is only in recent decades that infants have been acknowledged as sensitively attuned, interactive beings from birth onwards (Chamberlain 1999; Hawthorn 2005; Hawthorn 2009). The notion that very young infants can be strongly affected in the very early weeks by attachment problems has also recently gained recognition (Minde, Tidmarsh et al 2005). The related research however, often focuses on the impact of extreme circumstance, for example severe neglect, or significant separations, such as prolonged hospital treatment (Koller, Nicholas et al 2006). It is argued that a normative view of the attachment relationship is not currently used to underpin professional understanding of that relationship and that there is a gap to be filled.

There is an opportunity in the early weeks after birth for the exploration of the parent child relationship by health visitors, with the appropriate supportive follow-up for parents. There have been some promising indications from some Sure Start evaluations (Svanberg, Menet et al 2010), that early intervention by health visitors with parents, based on attachment theory, has resulted in reductions in emotional and behavioural problems for parents. For example, using video feedback to reflect interaction between parents and infants back to parents can help them identify areas of difficulty and support appropriate change (Svanberg 2009; Svanberg, Menet et al 2010).

The provision of Children’s Centre services in all areas of the UK from the Sure Start initiative has ensured that attachment based interventions aimed at normative targeted as opposed to clinical populations are now becoming more
widespread (Jennings 2004; Rydin-Orwin 2005). This opens up opportunities for health visitors to work with families in different ways.

The way in which health visitors currently assess parent-child relationships is variable (Barlow and Underdown 2009). Shortfalls in peer reviewed literature relating to the health visitor’s assessment of parent-infant relational difficulties have been identified (Wilson, Barbour et al 2008). The subtleness of the interaction between parent and health visitor over time, suggested by Wilson, Barbour et al (2008) was identified as a potential focus in this study for reflection on the similarities in the process of sensitive professional relationships and the parent-child relationship. The skill of the health visitor’s assessment according to Wilson, Barbour et al (2008) lies in the observation of both subtle and overt parental behaviours that appear to indicate relational difficulties between parent and child. This view is supported within an influential report on the future of health visiting practice (UKPHA 2009), in which the importance of health visitor interaction with families is described:

“The birth of a baby offers a window of opportunity through which to begin working with a family on specific issues....In this way it is possible for health visiting activities to improve maternal and infant mental health, child and family health, public health and health inequalities. However, the work requires subtlety and skill, and sufficient time to engage families with both obvious and hidden health needs, and to work with those who have yet to recognise their own levels of vulnerability”.

The type of approach used by health visitors within family assessment is described by Appleton and Cowley (2008a) as a “complex, interactive and serial activity” and incorporates an approach that utilises a variety of means for achieving an assessment that is useful to both parent and professional.

The use of a parent to infant attachment based tool could promote useful discussion, but with the proviso that it is applied with sensitivity, respect for the informed consent of the parent, and with a view to offering solutions to the difficulties identified (Bailey 2009). Solutions would include; referral on to an appropriate locally available attachment-based parenting course or individual
attachment based discussion with a suitably trained health visitor (Svanberg, Menet et al 2010). Indeed, there is little point in looking for relational difficulties unless the practitioner applying the tool is able to sensitively offer some help for the difficulty as it is uncovered. Skilled use of such tools through an educative process could provide the solution to ensuring their appropriate application.

Latest policy guidance to health care providers identifies the high priority with which parent-child interaction support is viewed (DH 2009; Allen 2011) with aspirations that include:

“Supporting mothers and fathers to provide sensitive and attuned parenting, in particular during the first months and years of life”.

What is new about this guidance is strength of the evidence that now underpins the recognition that infancy and early childhood relationships are crucial to healthy emotional and physical development; the challenge is to develop early intervention that address relational difficulties as part of a skilled assessment within universal service delivery (Allen 2011).

2.11 Tool development-concepts and theory

Having established that an attachment based tool could potentially be useful to health visitors in their daily practice with families, it became clear that a firm theoretical base was needed for the starting point of such a tool. This was achieved by firstly identifying appropriate theoretical literature and then incorporating current thinking in infant mental health to the concepts identified.

Contained in the conceptualisation of De Wolff and Van Ijzendoorn (1997) are the domains of maternal behaviour which support infant attachment security. The domains are clearly defined and the authors are well regarded in the field. It was felt that the definition of these domains could provide the basis for a potential tool and support face and content validity of items within it.

When devising questionnaires, conceptual clarity at the outset enables the development of domains and dimensions within which items can be developed (Streiner and Norman 2005). Conceptually attachment comprises a relationship
construct (Goulet, Bell et al 1998; Zenah, Stafford et al 2005) that supports infant attachment security (De Wolff and Van IJzendoorn 1997). Describing and defining the domains enables the scrutiny of face and content validity of these items relating to parental behaviours that affect the security of the infant in the early months and are argued to be fundamental to its future emotional development.

Psychological questionnaires and instruments are not necessarily diagnostic, they are often suggestive of trends or ranges of response that are indicative of the presence or absence of emotions, attitudes, feelings and behaviours that are present at a given moment in time (Streiner and Norman 2005). Parent to infant perceptions of the attachment relationship are dimensional in nature. When there is no clear distinction between cases and non-cases the use of dimensional models for health related questionnaires are supported (Streiner and Norman 2005).

An aim of the proposed tool was to explore whether key features of parental behaviours were present at a given moment in time. Also, it was desirable to establish whether those key features were related to the assessment of parental perceptions of parent-infant attachment within specific constructs developed from a theoretical base using parent friendly terminologies.

The first stage of this process consisted of an examination of the attachment literature for evidence of consensus of the parental antecedents of attachment security. Despite some differences in emphasis (Atkinson, Goldberg et al 2005) and differing schools of thought in relation to neurobiological processes and the impact of environment (Fonagy, Steele et al 1991; Balbernie 2002), the consensus centres on the domain of parental sensitivity.

Sensitivity is defined by Van IJzendoorn, Juffer et al (1995) as:

“The ability to accurately perceive and interpret the infant’s signals and respond to them promptly and accurately”.

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Sensitivi however contains several important dimensions that are descriptive of the mechanisms of sensitive responsiveness and subsequently of associated parental behaviours. So it is argued that not only is it important that infant cues are responded to, but the manner in which they are responded to, as well as the timeliness of the response that underpins infant attachment security (Maldonado-Duran 2003). The mechanisms of sensitive responsiveness developed from the literature relating to maternal sensitivity are shown in Table 6 (p.52) and were used to develop the attachment-based tool items.

The ecological validity of the proposed tool rested on developing questions within it that were both relevant to attachment theory and congruent with parental experience using their language to frame the questions.

The relevance of the meta-analysis of De Wolff and Van IJzendoorn (1997) within the field was established by assessing the importance of the authors’ contribution to the understanding of attachment theory (Fonagy, Gyorgy et al 2004; Atkinson and Goldberg 2005) and the relevance of the question posed by the meta-analysis to the identification of attachment problems. The question postulated within the meta-analysis was; “how important is parental sensitivity for the development of secure attachments?” The view was supported that sensitivity was important to the development of attachment security but not as exclusive a condition as had been thought in the preceding twenty five years of attachment research (Goldsmith and Alansky 1987).

Critics of De Wolff and Van IJzendoorn cite the narrowness of focus – on maternal behaviours – as a limiting factor (Cowan 1997) and argue for a wider consideration of the influence of the nature of family systems and their impact on children’s attachment. It was however used in this study as it identified useful dimensions relating to parent to infant attachment and provided a theoretical base around which to base constructs within the evolving tool.
Infant Attachment Security Constructs

- Sensitivity
- Positive attitude
- Emotional support
- Stimulation
- Mutuality
- Synchrony
Table 5

Antecedents of Infant Attachment Security

<table>
<thead>
<tr>
<th>Concept</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>Awareness and interpretation of infant cues and signals with appropriate and timely response</td>
</tr>
<tr>
<td>Emotional support</td>
<td>Positive supportive attention to infant efforts</td>
</tr>
<tr>
<td>Positive attitude</td>
<td>Expression of maternal positive and negative affect through reciprocal interaction</td>
</tr>
<tr>
<td>Stimulation</td>
<td>Any action by the primary care-giver directed towards the baby</td>
</tr>
<tr>
<td>Synchrony</td>
<td>Reciprocal and mutually rewarding interactions</td>
</tr>
<tr>
<td>Mutuality</td>
<td>Positive exchanges where both mother and infant attend to the same thing-includes mirroring</td>
</tr>
</tbody>
</table>

De Wolff and Van IJzendoorn 1997

The conceptual clarity about maternal attitudes contained in these dimensions provided a scientifically robust underpinning to identifying the parenting dimensions specific to attachment security (Goldsmith and Alansky 1987; De Wolff and Van IJzendoorn 1997).

A question arose here which prompted a further elucidation of the three pre-eminent conceptual domains identified by De Wolff and Van IJzendoorn (1997) sensitivity, mutuality and synchrony. Firstly, to what extent were these domains meaningful to practitioners and parents? It was possible that health visitors have significant awareness of the types of behaviours exhibited by parents that could be said to represent these domains. Examples of this awareness, shown by health visitors in Chapter 5, included the observations of parent’s behaviour with their infant including the ‘dance of contact’ and being ‘in tune’ with their infant. It was concluded from this that supporting the interaction of health visitors with parents about their interaction with their infants could be helpful in the practice.
setting. The concepts of sensitivity, mutuality and synchrony were used to support the evolving constructs, followed later by further development of the domains to incorporate containment; mirroring and mentalisation – constructs suggested by contemporary thinking in the field of infant mental health in the UK (Svanberg, Mennet et al 2010).

Sensitivity has been clearly shown for several decades in both clinical and non-clinical samples to strongly relate to infant attachment security (Rutter 1995; Bakermans-Kranenberg, Van IJzendoorn et al 2003). Sensitivity consists of several domains of parental behaviour and it became clear during questionnaire development that an in-depth concept analysis was necessary to ensure construct validity.

A definition of maternal sensitivity contained in the concept analysis of Shin, Park et al (2008) is as follows:

“Maternal sensitivity is the quality of a mother’s sensitive behaviours that are based on her abilities to perceive and interpret her infant’s cues and respond to them. A mother’s sensitive behaviours must be contingent on her infant’s prior behaviours and reciprocal with her infant. It is a dynamic process which accompanies the adaptation and changeability.”

Mutuality extends the concept to incorporate “the dance” of interaction while attending to the same thing (Fonagy, Gyorgy et al 2004) and its inherent complexities, for example, mirroring.

Synchrony also goes beyond the simple interchange to the process of reciprocity resulting in mutual exchange and is essential to neurobiological processes and the development of affect regulation in the infant (Schore 2001).
### Table 6

**Attachment Tool Constructs**

<table>
<thead>
<tr>
<th>Parent behaviour</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity (SE)</td>
<td>Ability to accurately perceive and interpret infant's signals and to respond to them promptly and adequately.</td>
</tr>
<tr>
<td><strong>Mechanism</strong></td>
<td></td>
</tr>
<tr>
<td>Containment (C)</td>
<td>Emotional availability of parent to infant through self-regulation that enables the containment of the infant’s emotions and behaviours.</td>
</tr>
<tr>
<td>Mentalisation (ME)</td>
<td>Capacity for parental reflective functioning including the ability to read the infant’s mental state and accept them as a separate individual.</td>
</tr>
<tr>
<td>Synchrony (SY)</td>
<td>Mutually attuned interaction and exchange of beneficial interaction enabling emotional and physical development.</td>
</tr>
<tr>
<td>Mirroring (MI)</td>
<td>Empathic reflection of facial expressions and actions between parent and infant that indicates affect attunement not simply copying facial expression of infant (important for emotion regulation).</td>
</tr>
</tbody>
</table>

The conceptual domains incorporated in Table 6 were developed from the material available to members of the Association of Infant Mental Health (AIMH) derived from recent national and international conferences, and from recent practice related literature (Barlow, Underdown et al 2009) as well as from the original theoretical paper of De Wolff and Van IJzendoorn (1997). Tool items were later developed for each of the above constructs.

The purpose of a proposed tool remained to enable parents and health visitors to have the conversation about parental perceptions of their relationship with their infant, based on attachment theory.
2.12 Assessment dilemmas

As already stated, the study carried an inherent risk; that of medicalising parent-infant interaction through the development of a new tool. There is an argument that professionals in early year’s settings and service delivery such as health visitors perpetuate the powerlessness of parents by taking an “expert stance” (Furedi 2008). Parenting, according to Furedi (2008) is made into an ordeal for parents, involving navigation through a sea of conflicting professional advice. Also, Furedi describes how politically based directives aimed at parents serve to undermine their enjoyment of and instinctive actions toward their children. A counter view is provided by practitioner researchers who describe their practice in terms of “alongsideness” or a mutual discovery based approach that purports to remove the power relationship (Pound and Grant 2008) thus enabling solutions to emerge from the professional-parent relationship for the benefit of children and parents.

In this study the question of whether to assess or not remained to be explored and also incorporated an aspiration to support parenting at an early stage. Reasons for such exploration in health visitor practice would include the educative function of helping new parents to understand infant behaviour, with the aim of reducing uncertainty and sometimes distress in the parent, supporting parental self-esteem, and subsequently supporting healthy parent-infant relationships. That educative function could also extend to health visitors, potentially enriching their practice through developing their understanding of the role of early interaction and incorporating this into their work with families (Pound and Grant 2008).

Parents

In this study, both fathers and mothers are included as potential focus group members and pilot screening tool respondents. The importance placed on the mother-infant dyad within attachment literature and the limited exploration of the role of fathers is changing (Barrows 2009). A growing body of evidence suggests a significant impact of childbirth on fathers (Paulson and Bazemore...
and the involvement of fathers within this study were sought alongside that of mothers in order to incorporate parental views and experience.

2.13 Study rationale

Arguments for a link between maternal mental health, attachment and children’s social and emotional development are well established (Murray, Halligan et al 2006; Brugha, Morrell et al 2010). Exploration of the parent infant relationship from the point of view of the parent in the course of health visitor contact was an area that appeared to need developing (Wilson, Barbour et al 2008). The question then was whether to utilise a previously developed and validated tool, attempt to develop a new tool suitable for use by health visitors that could be utilised in everyday practice or consider another approach. A consistent theme for the researcher as a practitioner included questions relating to the acceptability and helpfulness of developing a tool and whether it was actually necessary.

Although the theoretical conceptualisation of attachment (Goulet, Bell et al 1998; de Wolff and Van Ijzendoorn 1997) provided a firm theoretical foundation, the question of whether a new tool was necessary required further thought.

It became clear during the literature review process that health visitor assessment of parent-infant interaction is an area that needs researching for two key reasons. Firstly, that the universal nature of their work enables them to work with families at a pre-diagnostic stage in support of vital relationships that have potential to prevent later psychopathology (Wilson and Barbour 2008).

Secondly, it became clear that although the body of literature relating to parent-infant relationships is extensive, the application of attachment theory to practice for health visitors is complex and in need of elucidation to enable health visitors to work effectively (Wilson, Barbour et al 2008; Pettit 2008).

The question of whether to develop a new tool then rested on a more detailed review of existing tools to be carried out along with a consideration of the type of tool that could potentially be developed.
2.14 Summary

This chapter incorporates the theoretical and conceptual basis for the development of an attachment based tool for use by health visitors. A range of literature relating to parent-infant attachment supports the view that this is an area of importance in to parents, professionals and society. Key concepts relating to the meaning of positive attachment have been identified and relevant tools briefly described. Dilemmas relating to the potential for the medicalisation of parenting were raised and the role of health visitors in parent-infant interactional assessment explored.

The following question remained to be answered in the proposed study:

“Is it possible to develop a meaningful attachment-based tool for use by health visitors, using parent-friendly terminologies?”

Chapter 3 reviews literature relating to theory and practice in the field of attachment and identifies how this influenced the development of the study. It includes a review of available tools, contains discussion of the mechanisms that health visitors use in their assessments of parent infant relationships and states the study objectives arising from the literature review.
Chapter: 3 Literature

(b) Theory and practice in attachment and infant mental health assessment

Introduction

Chapter 3 incorporates an explanation of screening and assessment in traditional health measurement approaches, and more specifically, in the field of perinatal mental health. A critical review of available tools and consideration of the mechanisms used by health visitors for assessment follows and concludes with the study aims and objectives.

3.1 Screening

Early stages of this study incorporated an aspiration for health visitors to screen for attachment difficulties. Reasons for this included an awareness of the impact of attachment problems on the well-being of infants and parents, and the availability of health visitors to parents at this time. Screening was thought to be helpful in this context.

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition (UK National Screening Committee). They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.

The National Screening Committee criteria for screening programmes were scrutinised in order to assess the extent to which screening was a legitimate goal for this study.

National Screening Committee Criteria:

1. The condition to be screened comprises an important health problem.
2. The epidemiological and natural history of the disease or condition is adequately understood and there should be an easily detectable risk factor, disease marker or early symptomatic stage.
3. Cost-effective primary prevention interventions should have been implemented.
4. There should be a simple, safe and validated screening test.
5. The distribution of test values in the target population should be known and a suitable cut-off level defined and agreed.

6. The test should be acceptable to the population.

7. There should be an agreed policy on the further diagnostic investigation of individuals with a positive test result.

8. There should be an effective treatment or intervention with evidence of early treatment leading to better outcomes.

9. There should be agreed evidence based policies for treatment.

10. Clinical management and patient outcomes should be optimised in health care providers prior to participation in the screening programme.

11. There should be RCT evidence that the screening programme is effective in reducing mortality and morbidity.

12. The screening programme is clinically, socially and ethically acceptable to health professionals and the public.

13. The benefit of the programme should outweigh any physical and psychological harm.

14. The programme should provide value for money.

15. There should be an agreed set of quality assurance standards and in-built monitoring.

16. Adequate staffing and resources should be available prior to commencement of the programme.

17. All other options for managing the condition should have been considered.

18. Evidence based information should be made available to potential participants.

19. Challenges to the parameters of the screening process should be anticipated and planned for.

The majority of screening instruments in use in assessments of perinatal mental health do not reach the criteria for national screening programmes. Evidence for the utility of psychological screening tools in the UK health service however is well documented (Holden 1996; Squires, Bricker et al 2001; Guedeney and Fermanian 2001; Klier 2006; O’Connor and Byrne 2007; Milford and Oates 2009; Paulden, Palmer et al 2009; Hewitt, Gilbody et al 2009). The question that needed further exploration was whether it was possible and desirable to develop a health visitor tool to screen for attachment difficulties.
3.2 Screening, measurement and assessment

Having established that screening tools can be useful to practitioners in primary care without meeting all criteria for national screening programmes, the decision then focused on what type of tool might be helpful in the context of this study.

Consideration was firstly given to the nature of measures and screening tools; the difference between categorical and dimensional health measurement scales, followed by a searching for and critique of available tools and measures.

The need to identify the presence or absence of conditions using threshold criteria is achieved using categorical health measurement tools (Streiner and Norman 2005). Dimensional tools on the other hand identify characteristics that are suggestive of the presence of a condition, such as postnatal depression, using a range of responses. The delineation between the two models however when applied to psychometric tools appears less clear. Nevertheless it proved helpful in identifying the focus for the potential tool to incorporate dimensions of parent behaviours and attitudes toward their infants as a basis for an attachment related discussion.

A recent example of an attachment measurement tool (Milford and Oates 2009) clearly falls into the dimensional model of health measurement tools, in that it essentially looks for parental interpretations of infant behaviour in order to classify maternal behaviour along two axes - those of warmth and invasiveness.

The above tool, while not measuring maternal behaviours, is fundamentally categorising some mothers as having a level of disordered attachment and has potential for use where relevant resources are made available to meet the need uncovered in this way.

Reflection on the use of dimensional tools such as the Edinburgh Posnatal Depression Scale (EPDS) (Holden, Sagovsky et al 1989), led to a consideration of the difficulties that screening would inevitably involve, for example, the misuse of screening tools as diagnostic instruments (Hewitt, Gilbody et al 2009).
The EPDS has been widely used by health visitors in areas with developed perinatal mental health strategies (Puckering 2007; Hewitt, Gilbody et al 2009). As described previously, the EPDS is worded in such a way as to be helpful in exploring feelings relating to low mood and in providing a cut off score that professionals can use to indicate a further course of action. As a model of a parent-friendly tool, the EPDS is popular with health visitors and with this in mind; attachment screening tools were searched for and reviewed.

A review of attachment screening tools was considered helpful in placing in context current approaches to attachment assessment as a precursor to decision-making about whether a new tool, possibly similar to the EPDS, for use by health visitors was actually necessary, and if so, what form that it might take.

The attachment screening tools and instruments found during the literature search utilise different measures to achieve the same purpose, that is, the identification of attachment difficulties through measuring features of parents and infants interaction. In attachment assessment this usually involves one of two methods; observing parent infant interaction and rating this in some way, or by the completion of perception based self-report scales that uncover feelings, attitudes and behaviours of parents toward their infants (See Table 7 p.61).

**Search for tools**

It was during this process that some thought had to be given to the purpose of the proposed tool in comparison to previously identified tools, some of which aim to diagnose attachment disorder and are designed to measure domains such as covert hostility and the impact of affective disorders on parenting style. Examples include the Parent Attachment Questionnaire (Condon and Corkindale 1998) the Postpartum Bonding Questionnaire (Brockington et al 2001) and the Mother-to-Infant Bonding Scale (Taylor, Atkins et al 2005). A decision was reached as part of the supervisory process to pursue consideration of the development of a tool that would be suitable for use with a normative population.
Tools identified during the literature search were initially retrieved for inclusion in the review using the following criteria:

- Potential suitability for use by health professionals with parents of infants under 12 months of age.
- Use of the terms “bonding screening tool”, “bonding instrument”, “bonding scale”, “bonding questionnaire”, “attachment scale”, “attachment screening tool”, “attachment assessment”.

**Available tools**

The attachment screening tools and instruments found during the literature search utilise different measures to achieve the same purpose to identify attachment difficulties by assessing dysfunctional interaction between parents and infants. This is achieved by two methods; observing parent infant interaction, or by the completion of perception based self-report scales that uncover feelings, attitudes and behaviours of parents toward infants (See Table 7 p.61). A critical review of available tools specific to health visitor practice is contained in section 3.3.

<table>
<thead>
<tr>
<th>Interaction Focus</th>
<th>Perception Focus</th>
</tr>
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<tbody>
<tr>
<td>Strange Situation</td>
<td>MAI</td>
</tr>
<tr>
<td>Ainsworth et al 1978</td>
<td>Muller 1994</td>
</tr>
<tr>
<td>PIRGAS</td>
<td>PAQ</td>
</tr>
<tr>
<td>Zero to Three 1994</td>
<td>Condon and Corkindale 1998</td>
</tr>
<tr>
<td>CARE-Index</td>
<td>PBI</td>
</tr>
<tr>
<td>Crittenden 1995</td>
<td>Brockington 2001</td>
</tr>
<tr>
<td>Bethlehem Interaction Scale</td>
<td>ASQ: SE</td>
</tr>
<tr>
<td>Stocky 1996</td>
<td>Squires, Bricker et al 2001</td>
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<tr>
<td>PCERA</td>
<td>CLIP</td>
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<tr>
<td>Clark 1999</td>
<td>Keren, Feldman at al 2003</td>
</tr>
<tr>
<td>PIPE</td>
<td>AMBIANCE</td>
</tr>
<tr>
<td>Fiese and Poehlmann 2001</td>
<td>Goldberg et al 2003</td>
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<tr>
<td>NCAST</td>
<td>MIB</td>
</tr>
<tr>
<td>Mischenko, Cheater et al 2004</td>
<td>Taylor, Atkins et al 2005</td>
</tr>
<tr>
<td>MAI (Korean)</td>
<td>Shin and Kim 2007</td>
</tr>
<tr>
<td>Bonding Scale</td>
<td>MORS-SF</td>
</tr>
<tr>
<td>Figueredo et al 2007 (after Taylor)</td>
<td>Milford and Oates 2009</td>
</tr>
</tbody>
</table>
3.3 Review of tools

Some tools have been developed for research purposes to enable the identification of suitable parents for inclusion in studies into attachment; Ainsworth 1978; Crittenden 1995, Munson and Odem 1996; Condon and Corkindale 1998; Clark 1999; Brockington et al 2001; Guedeney and Fermanian 2001; Fiese and Poehlman 2001; Goldberg et al 2003; Mischenko, Cheater et al 2004.

The focus of these assessments is based on observation or on parental self-report of perceptions of their relationship with their infant (See Table 7 p.61). Reviewing these tools was helpful in establishing their utility to the research question.

Described below are examples of existing tools that were initially thought to have potential to support the aim in the proposed study; that of aiding health visitors’ assessment of the attachment relationship.

Perception Focused Attachment Assessment Tools

Perception focused attachment assessment tools found during the literature search appeared to offer potential to enable a conversation between parent and health visitor about the parent to infant attachment relationship, in particular those incorporating a screening function. Some of these are critiqued below.

Maternal Attachment Inventory (MAI)

The MAI offers “a practical measure of maternal affectionate attachment” (Muller 1994) and was derived from statements in the attachment literature relating to maternal affection which were assessed by an expert panel and formed into items within a questionnaire. A four-item response format is used with the predicted population to be screened consisting of mothers to be included in studies of attachment with infants aged between 4 and 8 months of age. The tool uses parent-friendly terminology, for example:

“I feel warm and happy with my baby”
The use of a 4-item response scale is not explained however and the tool does not show evidence of test-retest reliability. Some evidence of construct validity was found and it appeared to be acceptable to parents. The particular question of the lack of evidence for a link between maternal feelings and subsequent maternal behaviour is raised and the limitations of the study include that the research was carried out on a homogenous sample of well educated parents in the USA, which limited its wider applicability. The predictive value of measuring maternal affectionate feeling as an indicator of attachment difficulties appears to be problematic and suggests that multiple approaches to the assessment of attachment – including direct observation of the dyad are necessary (O’Connor and Byrne 2007). Reasons for not considering this tool suitable for health visitor use included the inconclusive results of this study which limit its reliability and validity, and the lack of a firm theoretical base for the questions within it.

**Postpartum Bonding Instrument (PBI)**

This tool was developed to enable risk to be assessed in mother-infant relationships where postnatal psychiatric disorders are a feature. The tool screens on the basis of maternal attributions i.e. mother’s perceptions of their infant’s behaviours and characteristics using a six-point Likert scale. The researchers sought factors suggestive of impaired bonding, rejection and anger towards the infant, anxiety and incipient abuse. The phrasing of items appeared problematic:

“I wish the old days when I had no baby would come back”.

Brockington, Oates et al 2001

The above statement requires some thought to detect its purpose; therefore it could be assumed that it could be found confusing to a parent. The purpose of the above tool as a diagnostic instrument also rendered it unsuitable for the use of health visitors with a normative population. The clear diagnostic focus of the questions does not promote discussion and the sample on which the instrument was tested consisted of psychiatric in-patients and out-patients, with a small number (33 of 218) taken from a normative population. It is suggested by the
authors that the tool is suitable for use by health visitors with no corroborative evidence concerning its suitability for that purpose presented.

Parent Attachment Questionnaires (PAQ)

Tools that use self-reported methods to measure attitudes and beliefs in order to arrive at a view of maternal attachment qualities often precede the offer of a therapeutic intervention. The Maternal Postnatal Attachment Questionnaire and the later Paternal-Infant Attachment Questionnaire (Condon and Corkindale 1998; Condon et al 2008) identify factors in parental interactive attachment behaviours for that purpose. The wording in the questionnaire is complex, for example, from the Paternal Attachment Questionnaire:

- When I interact with the baby I feel
  - Very incompetent and lacking in confidence
  - Moderately incompetent and lacking in confidence
  - Moderately competent and confident
  - Very competent and confident

Condon, Corkindale et al 2008

The effect of this question on parental self-esteem was considered; parental confidence is often low in the early weeks following the birth of a baby and could be affected by the way a question is worded.

This tool also incorporates different styles of question with in the same tool; again this could have a confidence lowering impact on parents offered the tool:

- I try to involve myself as much as I possibly can PLAYING with the baby:
  - This is true
  - This is untrue

Condon, Corkindale et al 2008
The studies on which the MAQ and PAQ are based contain some useful insights into parent-infant interaction assessment but again are rooted in the purpose of detecting pathology and therefore not useful to health visitors with normative populations.

**Mother to Infant Bonding Scale (MIB)**

The Mother-to-Infant Bonding Scale (Taylor, Atkins et al 2005) uses a series of adjectives such as “Loving”, “Resentful”, “Dislike” and “Joyful” and requires mothers to indicate their feelings on a scale from “Very much” to “Not at all”. It was developed from samples of women with postnatal illness, and though it claims maternal acceptability; it is unclear how this was achieved (Taylor, Atkins et al 2005; Figueiredo, Costa et al 2007). It is difficult to discern what these adjectives are meant to represent or what they actually mean and it is difficult to imagine how a parent’s response elicited in this way supports confident sensitive parenting.

**Mother Object Relations Scale (MORS)**

One tool appeared to offer the potential for exploring attachment in the way proposed in this study; the MORS (Oates and Gervai 2005; obtained by personal communication). The terminologies used within the tool, based on a diagnostic instrument (Brockington, Oates et al 2001) made it less than ideal for use by health visitors with seeking to engage parents in a focused conversation concerning their relationship with their infant.

*My baby winds me up. Always Very often Quite often Sometimes Rarely Never.*

Oates and Gervai 2005

The Mother Object Relations Scale Short Form (MORS-SF) seeks potential maternal psycho-pathology. In a study of universal screening using the MORS-SF by health visitors combined with measures of maternal mental health, the tool identifies parents with attachment problems (Milford and Oates 2009). The MORS-SF while developed for health visitor use was therefore considered
unacceptable for the purpose identified in this study; to enable a focused and helpful conversation concerning parent-infant attachment to take place. The potential for a therapeutic approach to parent’s difficulties appeared to be limited within the MORS-SF, though it clearly has clinical utility where relevant treatment options are available to parents identified in this way. The use of universal screening by health visitors for both maternal mental distress and attachment difficulties concurrently appeared acceptable to the health visitors concerned (Milford and Oates 2009). However, the above study was carried out in an area that already had in place appropriate resource to meet the needs of the parents identified by health visitors in this way.

**Interaction Focused Attachment Assessment Tools**

Interaction focused assessments of parent-infant interaction are usually carried out by professional observers with additional training for the purpose of the diagnosis of parenting deficit (Ainsworth et al 1978; Clark 1999; Fiese and Poehlmann 2001). They are therefore specialist assessments not suitable for health visitor use as universal screening, with two exceptions.

**Nursing Child Assessment Satellite Training tools (NCAST)**

Originally developed in the USA, this approach incorporates a series of tools, suitable for health visitor use (Mischenko, Cheater et al 2004) and incorporates a “systematic assessment of parent-infant interaction” in two types of interaction; feeding and teaching the infant a new skill.

It incorporates both the identification of parent-infant interactional difficulties and development of the parents’ capacity by increasing parental awareness of the interaction.

It appears a pragmatic and comprehensive approach, suitable for health visitor use, and supportive of learning by health visitors and parents about parent-infant interaction. It is however an approach which requires extensive training and ongoing support through resource allocation and clinical supervision and is
applied in some areas in the UK to target families where there is child protection concern.

**Care-Index**

This observational method of assessing parent-infant interaction for use with infants aged 0-15 months (Crittenden 1995). It particularly assesses sensitivity and engagement with the infant observed via video over a three minute period carried out at home or in a clinic setting. Subsequent coding of the interaction requires extensive training but the assessment can be carried out by para-professionals (Crittenden 1995). It should be used in conjunction with psycho-therapeutic service provision that can help parents who are identified as needing extra support with their parenting using this method. Evidence of validity is unavailable for the Care-Index but it is recognised as a useful tool for use in health visitor practice within an appropriate infant mental health strategy model of service provision (Svanberg 2009).

Having evaluated tools that were potentially practical and appropriate for health visitor use, the next question concerned their applicability in the context of current health visitor practice and the purpose of this study.

**3.4 Health visitors and assessment-a practice perspective**

A pragmatic approach to assessment is often used in daily health visitor practice and the use of attachment based tools can support assessment but is only part of the story. Health visitors employ a range of skills to make such assessments (Elkan 2000; Appleton and Cowley 2008b) and it could be argued that the use of tools helps to make this process more explicit.

Parents often find discussing their “bond” or relationship with their child difficult; enabling a structured discussion could be helpful. Some of the tools reviewed have a specific diagnostic purpose and were therefore considered inappropriate to health visitor use at the level of initial assessment, demonstrating limited utility for enabling a supportive conversation.
The stage at which health visitors become aware of relational difficulties between parents and infants is a time when the health visitor and parent are building a relationship themselves and in which conversations about parenting-infant relationships can only be raised in an atmosphere of trust and exploration (Wilson, Barbour et al 2008). The exploration of the parent-infant relationship using a parent-friendly tool, offered at a very early stage, and shared with the parent could potentially enhance practice and be useful to others.

Early intervention and prevention are the remit of health visitors in the UK (Wilson, Barbour et al 2008; DH 2009). Along with midwives, they are the only professionals to see parents and children routinely in a preventive role. The role of health visitors in identifying problems in primary care such as postnatal depression using a screening process is well established (Holden 1996; Davies, Howells et al 2003; Morrell, Slade et al 2009). A particular screening tool, the Edinburgh Postnatal Depression Scale (EPDS), has offered health visitors and others in primary care a pragmatic way of having a conversation with women in the early postnatal weeks about their emotional health. The success of the EPDS screening lies in the fact that it was designed to be exploratory rather than diagnostic, had good acceptability to mothers, was easy to use and did not require lengthy training to apply. It was initially developed for health visitors and later validated for use by other professionals, although variations in the application of thresholds have been identified (Matthey 2006).

Experience, based on the personal practice of the researcher with women in the postnatal period, supports the validity of the approach taken when utilising a the EPDS, which helps to normalise the feelings of sadness, fatigue and despair, experienced by at least 10% of women in the early postnatal weeks and beyond. This recognition of what women may view as “unnatural” feelings often serves to avert a period of clinical depression.

The postnatal depression screening tool allows for discussion of factors such as tearfulness, anxiety and sadness, early in the postnatal period (Farmer, Robinson et al 2006). Additionally it allows for depression to be viewed as a continuum
rather than a diagnosis, enabling women to explore the impact of childbirth in a way which identifies potential pathology, but which also normalises typical depressed feelings. The EPDS, while a validated tool that is widely used in health visitor practice, is not indicated for use in the postnatal period by NICE guidance or Health Technology Assessment (Hewitt, Gilbody et al 2009).

In this study, a supportive parent-focused approach, was preferred, consistent as it was with partnership principles, and potentially acceptable to parents. One aim of the study was to consider the need to develop a tool along the lines of the EPDS, viewing the parent-child relationship as a dynamic process within which a range of thoughts, attitudes and feeling are experienced. It could be expressed in a way that was not diagnostic, encompassed the possibility of screening, and worked educatively for both parent and professional. That is; the parent learns about their emotions in the context of their role as a parent, and the health visitor learns about the parent’s emotional health in order to develop an appropriate plan of care.

3.5 Health visitors and parent-infant interaction assessment

The way in which health visitors currently assess parent-child relationships is variable (Barlow and Underdown 2009). A lack of peer reviewed literature relating to the health visitor’s assessment of parent-infant relational difficulties has been identified (Wilson, Barbour et al 2008). The subtleness of the interaction between parent and health visitor over time, identified by Wilson, Barbour et al (2008) was identified as a potential focus in this thesis for reflection on the similarities in the process of sensitive professional relationships and the parent-child relationship. The skill of the health visitor’s assessment according to Wilson, Barbour et al (2008) lies in the observation of both subtle and overt parental behaviours that appeared to indicate relational difficulties between parent and child.

Many health visitors are skilled in perinatal mental health and it was hoped that some of them would form part of the sample to pilot the developing tool therefore reducing the likelihood of causing distress or uncertainty for the
parent, and that the health visitor would be able to offer some skilled intervention at the time of the contact.
Learning and Change

In health visitor practice, the purpose of assessment can encompass several intentions, whether the assessment of risk to a child from parental interactional style, or the support of parents struggling with the relationship with their infant in the context of complex social situations in order to improve health outcomes.

In this study, the focus on the parent infant relationship using a tool based on parental perception could enable the parental voice to be heard, reflecting on successes and difficulties, offering empathic exploration and action planning to meet needs identified.

It has been clear for some time that early intervention can avert difficulties in parent-child relationships (Weston, Ivins et al 1997) and this view is increasingly supported within diverse literature sources (Schonkoff and Phillips 2000; Allen 2011). The potential for health visitors to intervene early when problems are found is well established (Murray, Cooper et al 2003; Brugha, Morrell et al 2010). This potential has been enhanced in recent years by the increasing availability of educative programmes in informal settings such as Sure Start children’s centres that support parent infant interaction (Rydin-Orwin et al 2005; Svanberg 2009).

Tensions exist in practice between health visitors’ support of healthy interactions through an alongside approach (Pound and Grant 2008) and the “institutional expectations” of the role (Cowley, Mitcheson et al 2004). Awareness of these tensions in professional life continued to influence the development of the study. It was clear from reviewing available tools that the potential for personal learning about intra-familial relationships and about attachment would be limited by use of currently available tools and evidence of their value to parents remained unconvincing.
**Discussion**

National screening programmes have specific and extensive criteria, there is however clear evidence for the use of screening in clinical practice for conditions such as postnatal depression, a condition discrete to the early postnatal months.

Attachment, as stated earlier is a process not a condition and is also discrete to the early postnatal months. An opportunity presented itself to develop health visiting practice concerned with aspects of the attachment relationship.

Potentially appropriate tools, identified in the literature review were not considered suitable for the purpose of this study; that of a health visitor engaging in a conversation with a parent based on parental perceptions of their relationship with their infant. These perceptions could be usefully identified through interactive dimensions that indicate areas of difficulty, with a view to enabling the health visitor to extend the conversation or refer on to an appropriate source of support.

There appeared to be an opportunity to develop a tool for use by health visitors enabling exploration of the attachment relationship using a tool developed for the purpose; it could incorporate screening and form part of a health visitor assessment. Traditional screening programmes, such as blood tests for new babies, or scans for abnormalities in pregnancy, do not incorporate an interactive dimension. It is not viewed as the opportunity for a therapeutic encounter although it should involve the use of skilled communication by professionals.

Attachment problems can be screened for. The purpose of the attachment tools reviewed in this section involved the diagnosis of disordered attachment relationships. The purpose of this study however incorporated a wider aspiration; to support parent-infant relationships in the context of health visiting practice. It was thought that the development of an attachment based tool could be helpful to both parents and health visitors in this context.
3.6 Study objectives

Based on the question, “Is it possible to develop a meaningful attachment-based tool for use by health visitors, using parent-friendly terminologies?” objectives emerging from the literature review included:

- To generate a range of parental perceptions concerning their interactions; in order to formulate the basis of a tool that would have the potential to be more broadly meaningful to parents and health visitors.
- To determine the language that parents use to describe aspects of the parent-infant relationship that are important to them; in order to ensure that a tool developed in this way contained parent-friendly terminology.
- To support secure attachments through health visitor and parent discussion aided by a tool; based on a view formed in clinical practice that tools such as the EPDS could be helpful in supporting positive mental health, and that the screening process itself could be therapeutic by giving opportunities for focused discussion.
- To explore parents’ awareness of infant signals; based on the knowledge that supporting parents’ understanding of infant signals has the potential to shape their interaction in a positive way.

Summary

This chapter has explained screening and discussed the arguments for and against screening in the proposed study. Health measurement and assessment tools relating to attachment have been described and critiqued and assessment mechanisms used by health visitors stated. A gap in available tools that would enable a focused conversation between parents and their health visitor in the early weeks was identified. Contradictions in the role of health visitors in assessment have been discussed and study objectives proposed.
Chapter 4: Methodology and methods

Introduction

Chapter four sets out the methodology developed to address the research question and explain the rationale for the choice of an interpretive methodology and multi-method approach. Explanation is offered for the selection of methods used and details of samples, data collection and data analysis plans for the qualitative and quantitative elements of the study are outlined.

4.1 Study aims and objectives

The overall aim of the study was to explore parent-infant relationships in the context of health visitor practice based on the research question:

Is it possible to develop a meaningful attachment based tool for use by health visitors using parent-friendly terminology?

Study objectives included; supporting secure attachments through discussion and/or screening; exploring parents’ awareness of infant signals; generating parent perceptions about parent-infant relationships and establishing parent-friendly terminologies for use in a tool.

4.2 Introduction to study design

The methodology and methods described in this chapter encompass both qualitative and quantitative elements in a multi-method study under an overarching interpretive philosophical framework. Incorporating both theoretical and applied approaches to the recognition of attachment difficulties in this way was predicted to be helpful to answering the research question in the context of professional practice.

Overview of mixed methods

An overview of mixed methods research follows and the theoretical underpinning of the methodological choices made in this study discussed, along with an account of the methods used.
Awareness of the complexity of the parent-infant relationship in the context of health visiting practice led to the decision to utilise a multi-method approach. The nature of multi-method research is debated in that the descriptors of such research and the reporting of results often vary between researchers using the approach (Denscombe 2008; Townsend et al 2010).

Many researchers, particularly in the social sciences, consider multi-methods as highly appropriate to the study of complex social phenomena (Burke Johnson and Onwuegebuzie 2004; Burke Johnson, Onwuegbuzie et al 2007; Feilzer 2010; Townsend et al 2010).

Burke Johnson, Onwuegbuzie et al (2007) offer the following definition:

*Mixed methods research is the type of research in which a researcher or teams of researchers combines elements of qualitative and quantitative research approaches (e.g. use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration.*

The process followed in this study involved the combination of approaches in the same research project. It became clear that it would be possible to support the development of a tool utilising more than one method within the same study with the purpose of obtaining a full picture of the phenomenon parent-infant relationships from a health visitor practice viewpoint.

This study proposed to include a sequential multi-method approach (Dellinger and Leech 2007) that is, the two phases of the study, tool development and tool validation, build on each other, and inform the process as it evolved with the purpose of elucidation and illumination of the subject being studied; parent-infant relationships (See Fig 1 p.22).

The purpose of using mixed methods is to enhance research not because more is better argue Sandelowski, Voils et al (2009). Exploring a view of the parent-child relationship according to parent informants formed the starting point for this study. It was proposed to view facets of this view by combining the two phases of the study in order to illuminate meaning. That is meaningful descriptors of the parent infant relationship that could be formed into a tool. This approach is often
described as arising from a pragmatic paradigm (Leech, Dellinger et al 2010) and was considered appropriate to this practice-based study.

The approach taken here placed a high value on the attachment relationship and also explored that relationship with the purpose of enhancing the parent-infant relationship via a tool. It was hoped that parent perceptions, language and shared understanding could be identified in the process. The process of shared understanding in professional-parent interaction is of professional importance to health visitors, in that this approach has the potential for enhancing change and development, promoting resilience where needed, and enabling parents to enhance their own abilities and confidence (Davis, Day et al 2002). It was hoped that by making the parent’s perceptions more overt through the focus group discussion, inferences could be made to support health visiting practice.

The philosophical approach chosen was that of symbolic interactionism; explained later in this chapter. It will be argued that this approach supports the use of a multi-method study to explore the complex phenomena of parent-infant relationships.

4.3 Study Design: Phase 1

This section describes the background and reasoning for the selection of methods in the first phase of the study incorporating parent focus groups, health visitor interviews and health visitor survey. The selection of a hermeneutic phenomenological approach (Hein and Austin 2001) and the philosophical roots of the framework within interpretive symbolic interactionism are described.

Also contained here is discussion of the underpinning approach to the development of a tool, through a constructivist methodology, as a relevant and useful method capturing parental representations of parent-child relationships.

Decisions and choices in methodology and methods are made in relation to the type of knowledge sought; the desire to uncover important elements of the parental discourse concerning parent-child relationships naturally led to an interpretive approach to determine the language to be used within the tool.
Hermeneutics or the study of ‘meaning through discourse’ (Patton 2002) was used to illuminate the complexities of this fundamental relationship.

The use of language is influential in defining human behaviour (Benzies and Allen 2001); the nature of social interaction, as in the complex contexts of parental relationships, lends itself to hermeneutic enquiry. Phase 1 (see Fig1 p.22) aimed to explore the nature of the relationship between parent and infant; generating and analysing dialogue between parents, and developing this into a tool.

The extent to which it is helpful to label, codify and categorise parent dialogue is open to discussion and other avenues were considered in the initial scoping phase. For example, the use of a Delphi panel was considered to achieve conceptual clarity about attachment and attachment screening (Hasson, Keeney et al 2000; Baker, Lovell et al 2006). This method of enquiry was discarded early on in the process of protocol development, when it was realised that it would not necessarily be appropriate for developing a tool that was grounded in parent’s perceptions and in attachment theory – an already well-developed theoretical foundation.

Phenomenological enquiry is appropriate to and consistent with a study concerning the nature of the parent-child relationship, a complex and context-laden phenomenon. Phenomenology enables in-depth description of complex phenomena (Patton 2002; Bryman 2004) and is considered appropriate to nursing contexts (Van der Zalm and Bergum 2000). This study however aimed to go further than description to the development of a tool via an interpretive process in order to ensure that the tool was useful and valid for parent and health visitor use.

The decision therefore was reached to utilise an empirical phenomenological approach following consideration of the underlying assumptions of interpretive symbolic interactionism, a philosophical approach to understanding human behaviour through contextual evidence (Blumer 1969/98):

“For symbolic interactionism the nature of the empirical social world is to be discovered, to be dug out by a direct, careful, and probing examination of that world.”
Contextual evidence surrounding the concept of attachment could be collected in this study through the parents’ voice during discussion about the parent-child relationship using a focus group method. A combination of perspectives, incorporating both the descriptive and interpretive (Hein and Austin 2001) were therefore sought in order to enhance health visitor practice in the field of parent infant relationships.

Stolorow (2006) argues that it is the nature of the phenomenon that determines the approach. If the nature of the phenomenon is hidden, then an interpretive approach is indicated. The phenomenon of attachment within parent child-relationship research it could be argued is covert and therefore could be sensitively studied using an interpretive approach. It is suggested then that this study could combine the descriptive and interpretive by revealing parent perceptions through focus group interaction.

Interpretation of these perceptions alongside theoretical perspectives could result in a tool that may be useful in describing the phenomenon of parent-infant interaction. Personal observation of parent infant interaction and the struggle of parents to understand and interpret their feelings about and observations of their infants, particularly in the early months, were influential in the methodological choices taken here.

**Symbolic interactionism**

The following section describes the underlying assumptions of symbolic interactionism and its impact on the methods used to develop the attachment based tool.

The subjective reality of human discourse forms the ontological foundation of this phase of the study supported through the assumptions of interpretive symbolic interactionism (Blumer 1969/98), which are:

- That the behaviours of humans towards others are dependent on viewing them as imbued with an intrinsic meaning.
• That human interaction concerns awareness of and alignment to the actions of others.
• That there is a shared understanding of meaning in human society.

Utilising symbolic interactionism in this study is supported given the rich contextual arena in which parent-child relationships occur and the intrinsic meaning that those relationships encompass. Parents are asked to share their perceptions of meaningful intra-familial relationships in focus group discussion with the potential to form a shared understanding.

Symbolic interactionism in this context therefore concerns construction based on perceptions; a subjective reality (Benzies and Allen 2001):

“People have the cognitive capacity for abstract and reflective thinking that enables the development of the symbolic use of language and gestures for the communication of meanings that produces a common response in interaction with others”.

As this study concerns understanding and reconstruction, that is, the understanding of the parent-child relationship and the construction of that understanding into a tool, relativist ontology was supported within an interpretive framework.

**Symbolic interaction and parents**

For the researcher, health visiting work in families is based in certain values encompassing reflective practice and practice knowledge; respect for people as individuals and respect for parents in their own relational contexts.

Constructions based on the perceptions of parents and health visitors form the basis for this phase of the study and are congruent with a personal view that the quality of the parent-child relationship contains a fundamental and intrinsic importance. Value-based constructions, argues Sandelowski, Voiles et al (2009), are the product of well-designed research, meaning that that the values of the researcher should influence and enhance the research process.
Parents ascribe meaning to aspects of the relationship with their child depending on their perceptions of the child; in agreement with Blumer (1969/1998) that behaviours depend on meaning. This in some part answers the puzzle of parental relationships with different siblings, in that each child has a different meaning for the parent dependant on contextual factors for example; psychological health, birth order and social factors. The application of the approach helps to develop interpretations in discussion with parents concerning the relationships they have and which some will be finding difficult.

**Symbolic interaction and attachment theory**

Attachment theory, as it developed during the mid twentieth century, became increasingly relevant to the study of family life (Bretherton 1992). Ainsworth and Bowlby (1991) further refined Bowlby’s seminal attachment theory using observational studies reported at this time that emphasised the importance of parent and infant behavioural patterns in context and naturalistic approaches to parent-infant interaction assessment (Bretherton 1992).

Relying as it does on responses based on the meanings inherent in behaviours (infant) and attitudes beliefs and emotion (parent) and on complex contextual factors, the study of the attachment relationship fits a symbolic interactionist approach; Benzies and Allen (2001) propose:

“Perhaps the most important tenet of symbolic interactionism is the idea that the individual and the context in which the individual exists are inseparable.”

The contextual richness of parent child relationships and the consequences of distortions to this relationship throughout the lifespan offer endless opportunities for both quantitative and qualitative approaches.

Symbolic interactionism therefore offers a philosophical framework within which to explore the phenomenon “relationship” from both descriptive and interpretive standpoints.

The inherent tensions in this view include that constructing meaning through discourse has limited generalisability. However it was thought possible to
develop a tool that allowed for the exploration of context dependent perceptions of the parent-infant relationship with potential for wider applicability.

The extent to which this part of the study could be useful to a generic approach to looking for attachment difficulties needed careful consideration. On the one hand the purpose of assessment in this way suggests that solutions should be readily available. This could be suggestive that a wider generalisability should be sought.

On the other hand the meaning contained in parental discussion could be suggestive of a shared understanding of attachment issues of intrinsic value in itself and therefore could be explored for its potential to support parent-infant relational discussion.
Focus Groups

The challenges and strengths of focus groups as method are detailed within this section.

Focus groups are often used to enable insights into the nature of social interaction (Kitzinger 1995; Patton 2002; Bryman 2004; Curtis and Redmond 2007) and the choice here was supported by the need to obtain views on the sensitive topic of parent-child relationships. The meaning of the attachment relationship from the parent’s viewpoint was sought by building a subjective reality through capturing shared understanding of the relationship within group interaction. The selection of focus group as method was made with two main questions in mind:

- Firstly, could finding out what parents think about the parent infant bond, build a meaningful picture of the phenomenon parent-child relationship that could be transferable to the development of a screening tool or questionnaire using parent terminologies?
- Secondly, how would the resulting data be analysed and used to inform the development of the tool and would any of the requirements of the validation process be met?

The purpose of running the focus groups was to establish a range of views from parents about the terminologies that they use to discuss the parent-child relationship. While not trying to generalise the findings there was a need to establish that there may at least be the potential for wider application. Based on personal experience of interaction with parents over several years, the question asked here was:

Would the views obtained in the parent focus groups set up for this study likely to compare to those in a focus group containing parents with different backgrounds and experiences and what impact would this have on the parental discourse?
To answer these questions a return to the epistemological foundation of the study, the nature of the reality, needs to be made.

In the context of this study, the output of focus groups composes the nature of the reality; this is the dialectical exchange of attitudes and beliefs based on experience. In contrast to individual interviews, the use of focus groups “helps people to explore and clarify views that would be less accessible in a one to one interview.” (Kitzinger 1995).

Influences such as psychological health or mood are likely to be important within the context of an individual interview (Sim 1998). This is less likely to be the case where the influence of conformity is at play as within group interaction prompting questions about the nature of the reality created. Assumptions could be made about the nature of reality in focus groups. Sim (1998) warns against making such assumptions citing the “context specific” nature of focus groups. He further argues that although “in-depth insight” is provided, and “theoretical generalisation” is possible, caution should be exercised on the basis of methodological issues such as the representativeness of the data generated. Sim (1998) suggests the running of concurrent groups in order to establish a breadth of viewpoints.

In this study it could be argued that theoretical generalisation is not possible and that generalisation from small samples per se is neither desirable nor supported (Bryman 2004). However, the principle of valuing the parent’s contribution as being of intrinsic value and using this to develop the tool could enhance the potential for a wider applicability.

Sim (1998) suggests that it is clarity of purpose and transparency of methodology and a clear link the intention of the research that help to mitigate some of these difficulties of assumptions of shared meaning and generalisability.

Consideration was also given to the question of the difference between people who attend groups and those who agree to individual interviews. It was felt that parents who agreed to attend a group would generate discussion that would be
helpful to the development of an attachment-based tool, however, no assumptions would be made about wider applicability without supporting evidence.

Other pragmatic challenges in focus group research include the degree of control exerted by the interviewer to prevent unhelpful interaction, the volume of data generated and its analysis, difficulties with recruitment and as discussed above the effect of the group dynamic on the data generated (Happell 2007). Despite the potential difficulties, the value of exploring parent perceptions using focus groups presented an appropriate methodological approach given the interactive nature of the process.

**Sample**

Patton (2002) suggests that the samples in qualitative studies should reflect the “purpose of the study and stakeholder interests”.

In the first phase of this study, the group sizes were specified early in the research process and informed the developing ethical submission. A choice of sample type was therefore was made and shaped by the pragmatics of conducting research within the context of part-time study, the guidance of the study supervisors, and group sizes suggested in relevant literature (Patton 2002; Bryman 2004).

Samples in Phase 1 of the study were composed of convenience samples of parents and health visitors; they were informants that were available to the researcher. The samples were self-selecting, parents and health visitors were invited to opt in without personal contact from the researcher.

The ethical submission proposed that up to 30 parents would be sought to participate in 4 focus groups; 3 groups to determine parent-based terminologies for use in the tool and the fourth to determine options for scaling the emerging tool.
The sampling strategy involved including variation across town and rural areas recruiting by different means to enable a wider variety of parents to take part, two groups being recruited via posters put up in children’s centres and two via posters put up by health visitors in their clinic areas.

A convenience sample has limited representativeness, subsequently limiting generalisability (Bryman 2004). However all insights gained from such groups are potentially valuable (Mays and Pope 2000). The sampling was set up in such a way that the parent group sample would incorporate a range of ages, marital situations, parity, social grouping and would include both fathers and mothers.

The sample therefore could be said to represent parents within the geographical area from which they were drawn, and who represented parents who were likely to respond to their health visitors request to join a focus group (see Table 9 p.105 and Table 10 p.116).

The results from convenience sampling were not intended to be generalisable, but the question could be asked whether any tentative assumptions could be made on the basis of the collected data.

Attempting to obtain a maximum variation sample was deemed most likely to enable an element of heterogeneity in the sample given its likely limited size. The potential for heterogeneity however was limited by the practicalities of supporting health visitors to approaching parents in an ethical way and engaging them in the study without influence from the researcher.

**Inclusion criteria**

The first six months of parenthood are considered particularly sensitive in terms of susceptibility to mental health problems such as postnatal depression and to low self-esteem (Davies, Howells et al 2003; Davey et al 2006; Murray, Halligan et al 2006). Inclusion was based on parents with at least one child over six months of age in order to reduce vulnerability and to comply with the ethical submission.
Data collection: Terminology Focus Groups

Data were collected in the three terminology focus groups using a group interview format around a topic guide (See Appendix 6).

Recruitment was set up at arm’s length by enabling parents to sign up to a group via their own health visitor or children’s centre.

The three groups were set up as a group discussion around broad themes relating to parenthood, the parent-child relationship and terminologies used by parents for the relationship. The resulting audio tapes were transcribed verbatim and field notes made after each group.

Data analysis: Terminology Focus groups

Framework analysis was used to process the data from the first three focus groups. The three terminology focus groups enabled the production of transcripts that were firstly printed out in plain format Word documents and read as an initial skim for thematic and conceptual content. Sets of categories were drawn from this preliminary analysis by reading the transcripts through several times and allowing categories to emerge.

Initial categories were then organised by hand into data diagrams with headings, and from these further categories were developed. A second analysis was then made which cross-referenced the main categories with the content. Several sub-categories were identified by this process (See Fig 5 p.109). By further refining these categories, items for inclusion in the tool were developed. This enabled a range of initial items to be formed which were then refined within the supervisory process.

Finch and Lewis (2003) suggest two approaches to analysing group data. Firstly, whole group analysis using undifferentiated data, and secondly, participant based group analysis where the participant’s contributions are dealt with separately within the context of the whole. For this study, the second process was used, as it was felt to be important to the integrity of the study, that
individual contributions were preserved within their context. Also utilised within the data analysis in Phase 1 were the suggestions of Halcomb and Davidson (2006) concerning “a reflexive, iterative process of data management” to be applied when in-depth closeness to the data is not sought (See Table 8).

Table 8

Analytic Process

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>Step 1</td>
<td>Audio taping of interview and concurrent note taking</td>
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<tr>
<td>Step 2</td>
<td>Reflective journaling immediately post interview</td>
</tr>
<tr>
<td>Step 3</td>
<td>Listening to audiotape and amending / revision of field notes and observations</td>
</tr>
<tr>
<td>Step 4</td>
<td>Preliminary content analysis</td>
</tr>
<tr>
<td>Step 5</td>
<td>Secondary content analysis</td>
</tr>
<tr>
<td>Step 6</td>
<td>Thematic review</td>
</tr>
</tbody>
</table>

Halcomb and Davidson 2006

As the aim of the focus groups was to gather parental perceptions and not to generate theory, it was appropriate to adopt an approach that combined full transcription with ongoing reflexivity. Notes were therefore written during the groups, steps 2 and 3 were integrated however into a field note diary and in all, two stages of analysis took place firstly viewing the transcripts individually, preliminary content analysis, then side by side, secondary content analysis, and then identifying categories from all three (see Appendix 11).

Sample: Scaling Focus Group

A sample of up to ten parents were sought to take part in the scaling focus group. The scaling focus group was set up in the same way as the terminology focus groups; parents were asked to sign up to joining a group via their health visitor and set up as a guided conversation around the emerging screening tool.

The resulting group of four mothers were self-selecting, one of whom described herself as having “considerable attachment difficulties” with her most recent
child. Two of the mothers described themselves as having experienced postnatal depression within recent months and one of these was a single parent. One of the mothers had children under five and over fifteen years of age.

Refreshments and crèche facilities were provided, as had been suggested by a parent consultation group that had taken place several months earlier in another area prior to the start of the study.

The inclusion of a fourth group to establish a range of views concerning scaling the values applied to items and terminologies used in the tool was made for two reasons. Firstly, the scoring of any tool should be meaningful to those who were expected to be the subject of the assessment by those tools. It became clear while reviewing existing tools that the act of completing some tools could have the potential for making a parent feel less secure in their bond with their child. It was therefore important that parents were involved in all aspects of the tool development to prevent this in the evolving tool.

Secondly, it was hoped that the parental voice could be integral to the development of the tool, in both content and scoring.

**Data collection: Scaling Focus Group**

The fourth focus group set up several months after the initial groups included parents who had signed a list with an accompanying poster placed on their notice board by the health visitor in the local Sure Start Children’s Centre.

A crèche was organised in order that the parents would be able to give their full attention to their involvement and also to it also served to demonstrate the value placed on their contribution. An hour was set aside for the group that, by request of the parents, lasted almost two hours.

The group was set up as a guided conversation with the developing draft tool as the focus. Each parent had a copy and was asked to comment on each of the items from two points of view. Firstly, their response to the item’s meaning to
them and secondly on how a response scale could be evolved from this. The sessions were audio-taped and notes taken during the sessions.

Data for all four focus groups were collected using a digital recording device backed up with a tape recorder, field notes and observations were added to a field diary. This was done to ensure contextual factors were not lost and to aid recall of the group content (Coyne and Cowley 2006). See Appendix 11.

Terminology focus groups were used to develop the items within the tool and the scaling group to establish indicators for potential response scaling.

**Data analysis: Scaling Focus Group**

The purpose of scaling focus group data collection was to establish the acceptability of potential scoring systems to parents who were likely to use them. Data analysis of the scaling focus group consisted of listening to the focus group recording, hand drawing diagrams from these discussions and reviewing these alongside notes taken during the group.

**Health Visitor Interviews**

To add to the “completeness of the data” (Knafl and Brietmeyer 1991) health visitor interviews were considered important to the process of developing a questionnaire that was meaningful and relevant to health visitor practice. They were also thought useful in providing triangulation; seeing the attachment relationship from several angles sequentially, both from the standpoint of parents and health visitors.

**Sample: Health Visitor Interviews**

A convenience sample of up to ten health visitors was sought for this stage of the study. Health visitor interviews were considered to be important to developing a questionnaire that was meaningful and relevant to health visitor practice. Four health visitors expressed an interest in response to a request for inclusion and were subsequently interviewed at a place and time of their choice. Three of the interviewees were not known to the researcher.
The original intention of this stage of the study was to survey health visitors about their use of the tool with parents. During the process of supervision however it became clear that due to the degree of further development of the tool that was required, the survey could be usefully replaced by individual interviews with health visitors. In order to support the triangulation process the same interview schedule that had been used in the parent focus groups was used. A substantial amendment to the ethical submission was submitted and approved.

**Data collection: Health Visitor Interviews**

Health visitors were invited to opt-in to an interview via a letter sent to health visitors in one geographical area. An information sheet, lay protocol, introductory letter and consent form were sent to health visitor teams in four different areas with in one Primary Care Trust (See Appendix 9). They were sent details of the research project and invited to return a form expressing their interest and preferences for time and date of the interview. Four health visitors were interviewed as a result of this process and the interviews recorded and transcribed verbatim.

Data were collected by the researcher using an interview guide based on the parent focus group interview guide (see Appendices 6 and 10). Interviews were held in a venue of the interviewee’s choice, two were held in a children’s centre, one in a GP surgery and one on PCT premises.

**Data analysis: Health Visitor Interviews**

The four health visitor interviews were analysed using the same process as the focus groups up to the point of secondary content analysis (Halcomb and Davidson 2006). Recordings were listened to several times then transcribed verbatim. Framework analysis followed to identify categories and in order to identify patterns and compare the patterns found to the focus group transcript data.
Health Visitor Survey

Sample: Health Visitor Survey

The sample of health visitors were self-selecting and consisted of health visitors who opted in to recruiting parents for testing the pilot tool.

Data collection: Health Visitor Survey

The final stage of data collection in the validation of the tool incorporated a health visitor survey using a free text section on the data collection form sent to health visitors along with the twenty-five item tool for parents. Thirteen health visitors in total completed the survey.

Data Analysis: Health visitor Survey

Health visitor comments were read and presented in a table format (See Fig 13 p.125).

4.4 Study Design: Phase 2

Introduction

This section describes the background and reasoning for the selection of the methods in Phase 2 of the study (See fig 1 page 22). The need to address validity within the emerging tool involved the application of a quantitative approach to test the pilot questionnaire.

The purpose of this phase was to establish indicators of parent to infant attachment and to pilot the resulting tool with health visitors, the professional group selected in this study as being likely to find such a tool helpful in their clinical practice.

A cross sectional design was selected as being the most appropriate to this phase; the data was collected via the developing tool and inferences made.

According to Bryman (2004);
“The issues of reliability and measurement are primarily matters relating to the quality of the measures that are employed to tap the concepts in which the researcher is interested, rather than matters to do with research design.”

Questions relating to both quality and suitability therefore had to be addressed during this phase of the study.

- Firstly, how appropriate was the aspiration to attempt to measure the concepts developed from attachment theory, informed by the focus groups and the health visitor interviews and incorporated into the pilot tool?
- Secondly, how appropriate was the aspiration to attempt to measure attachment perceptions in the context of health visiting practice?

These questions were in part resolved by a reflexive process throughout the evolution of the initial screening tool toward a questionnaire and finally to a shorter version discussion tool.

**Health Measurement Tools**

Quantitative research is a strategy incorporating the collection of numerical data and the establishment of relationships between those data via statistical analysis (Bryman 2004).

Phase 2 of the study involved assessing the potential clinical utility of the tool via a quantitative method. Bryman (2004) describes the main steps in quantitative research as:

- Theory-hypothesis stage
- Research design stage
- Devising measurement of a concept
- Selection of research sites and respondents
- Collection of data via a research instrument
- Processing and analysis of the data
- Reaching conclusions
- Writing up findings/conclusions

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Considerable thought was given to whether this process would capture the meaning of the attachment relationship to parents in focus group discussion that could then be developed into tool items. It was however necessary to establish whether some basic assumptions could be made about the evolving tool. These included an assumption that the tool constructs all related to each other and that there would be stability of these constructs if completed on two separate occasions by the same parent.

In the quantitative research process concept measurement is an appropriate and legitimate focus of social research (Bryman 2004). The concept “attachment” in the context of this study required development via the testing of tool constructs in order to become a validated tool for the use of health visitors and parents. The development of the constructs within the tool necessitated comparisons to be made within and across constructs in order to assess the validity and reliability of the tool and:

- Assess the capability of the constructs to relate meaningfully to the concept of attachment.
- To reduce the items within the constructs that did not demonstrate validity and reliability in this way.
- To establish if meaning could be attached to the discrete constructs.

This last would be significantly limited by the nature of the sample but would demonstrate the process to be followed. The application of tests for reliability and validity necessary to the development of the tool as processes involved in the development of health assessment tools needed to be tested according to the ethical submission. It was recognised that the potential for the demonstration of validity and reliability was limited due to the eventual sample size.

**Pilot Tool Development**

The purpose of the tool was fundamental to its development. If the purpose was measurement of a dimension of the concept of attachment, then the sensitivity
of the tool would be important (Streiner and Norman 2005). Measurement became less important when the decision was made to develop a discussion tool. The purpose of the tool then became exploratory in nature, having started from a point that encompassed screening for attachment difficulty.

The potential for the tool to differentiate between different aspects of the parent infant relationship using both theoretical constructs - developed from attachment theory - and also from parent discussion of parent perceptions of parent to infant attachment, initially underpinned the selection of a multi-dimensional tool format.

Sources of items for inclusion in health measurement tools according to Streiner and Norman (2005) can involve; clinical observation, expert opinion, theory and empirical research. In this study it is argued that all these sources were utilised to some extent in tool development. In particular, the emphasis here was on empirical research via the focus groups to produce terminologies within the tool that showed good acceptability to parents. The use of theory to support these items enabled them to be congruent with current thinking and practice in the field. Clinical experience enabled judgements to be made concerning the acceptability of the evolving tool with both health visitors and parents. Clinical experience in health visiting practice has been shown to be a valid source of knowledge for effective practice (Holden 1989; Cody 1999; Goding and Cain 1999; Ling and Luker 2000; Bryans 2004).

The first iteration of the tool contained 22 items divided into 3 sections each containing 7 attitude items, 5 behavioural items, and 5 emotion items. Items which related to parental experiences but which did not relate specifically to parent to infant attachment were discarded from the tool at this point.

These iterations were required to satisfy tests of face validity at an early stage in order for judgements to be made regarding its potential clinical applicability. Comments and suggestions made during the supervisory process prior to the pilot stage were incorporated in decision-making that resulted in a 10-item tool.
Supervisory discussions focused on the demonstration of validity in a 10-item tool given that five constructs relating to parenting behaviour were ultimately to be tested (synchrony, containment, mentalisation, sensitivity and mirroring). Five questions per domain were therefore developed resulting in a twenty-five item tool.

In order to explore the potential of the items to elucidate attachment difficulties, an assessment was made against each item concerning its relevance to parenting domains necessary to attachment security (see Table 6 p.52).

Significant tensions between a wish to remain as true to parent expressions of their experience on the one hand and on the other to produce a tool of sufficient validity and reliability on the other meant that this aspect of tool development involved a lengthy process of reduction, expansion and change in the light of supervisory input and reflexive processes. The resulting twenty-five item tool therefore had to be potentially acceptable to parents and the questions applied to the process of establishing this were:

- How would it feel as a parent to be asked to complete the questionnaire?
- How would it feel to a health visitor to offer the questionnaire to a parent?
- What kind of feedback would I expect to receive as a parent?

The questionnaire appeared to be supportive of positive parent infant interaction and invited positive reflection (See Appendices 13, 14 and 15).

**Sample: Pilot Tool**

A convenience sample of up to thirty parents was sought to test the pilot tool. Parents recruited via their health visitors were offered the 25-item tool to complete. The original ethics submission proposed a sample of up to twenty health visitors able to offer the tool to up to five parents each giving a potential for up to one hundred sets of data. In the event twelve health visitors recruited twelve parents giving twenty four sets of statistical data.
Data collection: Pilot Tool

Data were collected from parents, recruited by their health visitors. The completed the tool on two occasions two weeks apart. The data were entered on the statistical database SPSS16.

The 25 item pilot tool was originally sent out to all twenty-four health visitors in a single geographical area in Devon Primary Care Trust between September and October 2009 and subsequently ten health visitors in an adjoining area during November 2009. Staffing levels were critically low during this period and consequently, this approach yielded three responses in total including 2 test-retests.

A decision was then made during the supervisory process to widen the pool of health visitors to a neighbouring Primary Care Trust. The relevant substantial amendment was made to the Ethics Committee to include Bath and North East Somerset Primary Care Trust. An invitation to all health visitors in Devon via email was concurrently sent in both Devon PCT and Bath and North East Somerset PCT. Interested health visitors were invited to opt in to receiving a pack containing the two parent questionnaires, a parent demographic data collection form and consent forms, and health visitor demographic data, consent and survey forms.

Thirteen health visitors in total responded with twelve of these obtaining parent questionnaire data. Parents were approached individually by their own health visitor and asked to complete the 25 item tool on two occasions two weeks apart. Twenty-four complete data sets were obtained in this way.

Data collection was adversely affected by organisational change and a significant reduction in health visitor numbers across the target area. This influenced the amount of data obtained and the response from health visitors to involvement, which was low in both phases of the study.
Pilot tool design

Data collection in Phase 2 (See Fig 1 page 22) involved developing the tool to the point where it could be piloted with parents and health visitors surveyed about its use. Some thought therefore had to be given to the form and structure of the parent questionnaire including response format and overall style.

A clear preference was shown by parent participants in the scaling focus group for a tick box response and short question format. The developing tool therefore utilised a four response mode (See Appendix 13). This was judged to be congruent with the parental preference for simplicity and clarity.

The choice of response label can be influential to the response given (Streiner and Norman 2005) and consideration was given to the number and type of responses offered. Four simple options were offered; always, sometimes, occasionally, never. The responses were chosen partly in response to comments made by parents in the fourth focus group and partly by reviewing the response types in other available parent perception based tools (Milford and Oates 2009).

Streiner and Norman (2005) suggest that the language within the responses offered should be neutral and without implied weighting. The labels chosen in the attachment tool were therefore not entirely congruent with each item but were as close a fit as possible given the need for transparency and simplicity.

The need for the tool to be sensitive to change within the individual completing it was given some thought. On the one hand, the proposed tool was not designed to be diagnostic, but on the other it was designed to be reflective of areas of difficulty within some sophisticated constructs. To calculate the sensitivity of tool items to change over time requires the means of total scores to be compared (Streiner and Norman 2005). The comparison of means in a self-selecting sample is inappropriate statistically so this was not used (Campbell and Machin 2002). The tool itself was not being designed to be used as a test-post test instrument and the potential for it to be sensitive to change over time was
therefore left open to re-consideration should it be developed further in a future study.

Data Analysis: Pilot Tool

Statistical tests

Statistical testing was predicted to be helpful to decision making about tool development. Making a choice about the correct statistical tests to apply is usually straightforward depending on sample size and type, and predicted outcome.

For testing scores within a questionnaire where the sample is small and a normal distribution in the sample is not possible, non-parametric testing is advisable (Bryman 2004). The assignment of missing values in such samples is highly significant given the increased potential for the skewing of data if missing values are not included and care was taken to assign missing values in this study.

There is a case for using Pearson correlation coefficient, a parametric test, in addition where there is no certain predictable outcome, as with a new measure (Bryman 2004). However, in a non-random sample and with such small numbers the most appropriate method of initial analysis is non-parametric testing. In experimental studies, the use of both parametric and non-parametric tests of correlation enable a view on statistical significance and not just correlation to be formed (Bryman2004). Two purposes for the statistical testing of the responses to the questionnaire therefore were identified.

- Firstly, to identify the reliability of the test by comparing the first and second completions of the questionnaire, by the same parent, with a two week interval. This was achieved by running a test-retest calculation on the matched pairs that constituted the parents first and second completion of the questionnaire (Campbell and Machin 2002).
- Secondly, to demonstrate the internal consistency of the questionnaire, each item of the five items in each of the five constructs was correlated
with the total score individually using the intraclass correlation coefficient.

The first stage in exploring the data involved expressing the data visually using scatter graphs (See Chapter 5). The purpose of this is to ensure that the data visually represents what is to be measured, for example a negative correlation or positive correlation or no correlation (Bryman 2004). Decisions can then be made concerning further testing of the data. It would be expected that within each construct, each item would demonstrate a positive correlation to the total score and that each item in each construct would correlate positively with that construct.

The statistical testing had a function in indicating which items to consider for inclusion in future iterations of the tool and in demonstrating the appropriate statistical processes for tools of this type. Due to the small numbers involved in the pilot stage and the change in focus for the use of the tool from screening to discussion, testing for statistical significance became of decreasing importance. Some statistical testing was useful to demonstrate the processes applied to the analysis of the questionnaire data collected in this study, and to indicate areas for development of the questionnaire in future studies.

**Validity and reliability**

Bryman (2004) states that at the minimum, new measurement tools should demonstrate face validity. This involves, according to Bryman (2004), an intuitive reflection on the extent to which the dimensions within the instrument relate to the concept being tested.

This was obtained by requesting feedback on the health visitor survey concerning its usefulness to their current practice and by a personal reflexive assessment. Comments obtained by this survey and personal reflexivity are contained in Chapter 5.

Reliability testing in health measurement tools ensures that the different domains within a test relate to each other (Streiner and Norman 2005). For
example, the scores for the tests of the constructs of parenting; mentalisation, sensitivity, mirroring, synchrony, containment, should in theory show that each of the scores for each of the domains are related; they could be argued to all relate to the sensitivity of parents to the cues and signals of their infants.

The reduction of bias is desirable in quantitative research (Bryman 2004) and half the items were reverse-scored in order to reduce response set bias (Townsend, Floersh et al 2010). Options were left open for developing or removing the measurement aspect of the tool as it evolved.

Bryman (2004) offers the following descriptors for reliability testing:

- **Stability** - or the consistency of the test over time
- **Internal reliability** - or the relationship between scores in each of the dimensions within the test
- **Inter-observer consistency** - or the impact of subjective judgement - if the test relies on this.

Within the tool the first two descriptors applied and were tested using both test-retest calculations and correlations of each item with the total score using the statistical computer software SPSS 16.

**Generalisability**

Although test-retest reliability was shown (See Chapter 5) the sample was too small to support generalisability in the way usually applied to data in experimental studies. However, a case could be made for representational generalisation (Ritchie and Lewis et al 2003) where inferences can be made about the relevance of the data obtained in small samples to wider populations (Mayes and Pope 2000).

**4.5 Ethical Considerations**

Codes of ethics within research practice are based on moral principles that serve to protect the subjects of research (Mathers, Howe et al 1998/2002). In this study the moral values of the researcher as a health professional working
ethically with potentially vulnerable people underpinned the approach taken. Within a research project this means ensuring that the decision to take part is made freely. In this study, parent and health visitor participants were given the choice to ‘opt-in’ to data collection without any personal contact from the researcher.

The principle of non-maleficence, or not doing harm, protects participants of research projects from risk (Mathers, Howe et al 1998/2002). In health visiting practice the issue of risk concerns appropriate assessment at the time of contact with parents; in this study it involved the assessment of whether parents who arrived at the focus groups were vulnerable to the dialectical exchange that was facilitated by the researcher. In health visiting practice judgements have to be made on a daily basis concerning parental competence, the risk to infants and children, and impact of the mental health of parents. The researcher was confident to detect parental interchange that was not comfortable for parents in the group and to take appropriate action by reading cues such as body language. In the event, the interaction was relaxed and it was hoped that an open friendly would be helpful in creating a situation of trust in the focus groups.

The principle of beneficence or the promotion of the interests of others, (Mathers, Howe et al 1998/2002) involved consideration of the extent to which the study was of potential benefit to parents and also to each parent within the focus group encounter or application of the pilot tool. The focus groups therefore were set up at arm’s length by colleagues, were arranged at venues convenient to parents and with appropriate childcare and refreshments available. The views of parents were considered to be of inherent value evidenced by careful data management and handling. Audio tapes obtained in the focus groups were personally transcribed prior to analysis, maintaining confidentiality while also retaining a clear audit trail for the verification of findings. Consideration was given to the consequence of not “having the conversation” with parents about important interactional matters and the conclusion reached that the value of sharing parental experience would almost certainly be beneficial to the participants. This assumption however could be
challenged on the basis of the potential for distress that could have been initiated within the parent focus groups.

The pilot tool was designed with parental input in both content and scaling which it was hoped would ensure that it was both relevant and supportive to parents themselves. It could not however be assumed that all parents who were offered the tool would find completing it to be a positive experience.

The principle of justice, or the equality of treatment that people receive, was partially addressed by the consideration of how minority groups could be included in the sample when preparing the parent information. Parent information was therefore provided in a simplified format available on request to health visitors who identified a need for this. Consideration was also given to providing translated material to parents for whom English was not their first language.

Parent information was presented simply and attractively (See appendix 5) and the options relating to participation made clear.

Care was also taken within the health visitor information to explain that the parents that were approached to pilot the developing screening questionnaire would be at their professional discretion, for example, parents with a pre-existing condition such as depression would be unlikely to be offered the tool unless the health visitor considered that this was appropriate.

The parent-child relationship is an unusually sensitive area for scrutiny; health visitors occupy a privileged professional position, the application of a robust ethics process in this study was important to the protection of parent and health visitor participants.

The process involved the development of a protocol which was submitted to the local Research Ethics Committee, the research committee of the University of Bath and the Research Governance Unit of Devon PCT.
Approval was initially obtained for the first phase of the study which involved the parent focus groups and health visitor interviews. A substantial amendment to the first application was made to enable health visitors to be interviewed rather than surveyed about the developing parent to infant attachment tool. This was necessary due to the unanticipated length of time taken to develop the tool to the pilot stage. Elements of the original survey tool were retained for health visitor completion when piloting the tool with parents.

A second application was made several months later and a favourable opinion obtained for the second phase of the study which involved the pilot of the tool by health visitors with parents. A second substantial amendment was applied for and obtained within this phase in order to expand the recruitment of health visitor participants in the tool pilot to a neighbouring PCT. This was necessitated by low staffing levels within Devon PCT health visiting service with a subsequent low uptake from health visitors invited to pilot the tool.

Confidentiality and data management

Parent and health visitor information sheets contained details of how confidentiality would be maintained. Arrangements were made for storing the consent forms separately from the data and PIN numbers were assigned to each set of data received to preserve anonymity.

Protection of participants from harm

The sensitive nature of the parent-infant relationship both to parents and to participating health visitors had potential for causing emotional difficulty. A key consideration therefore within the ethical submission involved making contingency for support or debrief by appropriately trained professionals should this be needed. Arrangements were therefore made for a skilled professional such as a health visitor or mental health worker to be available to parents participating in the parent focus groups. Parents were also offered the services of the Patient Advice and Liaison Service (PALS) should any issues arise for them that needed further action. In one of the focus groups a parent expressed an
interest in contacting PALS about the care received by his wife during labour. For the health visitors, the local research governance manager made herself available for contact by health visitor participants if they felt unable to approach the researcher themselves about any aspect of the study.

Summary

This chapter has described the study design and justification for choices made in carrying out the study. Difficulties in recruitment and a shift in focus of the purpose of the tool from screening to discussion have been described and the question of validity, reliability and generalisability addressed. The chapter concludes with a description of the ethics process followed.
Chapter 5: Analysis, Findings and Discussion

Introduction

This chapter presents the results from four parent focus groups, four health visitor interviews, thirteen health visitor surveys and twenty four sets of pilot tool data. The process involved in the development of a ten-item tool is described and evidence of validity and reliability discussed. The chapter concludes with a discussion of the methods used and personal reflexivity about the study process.

5.1 Analysis: Terminology focus groups

Table 9

Characteristics: Terminology Focus Group

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>20-30</th>
<th>31-40</th>
<th>40+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-30</td>
<td>4</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>31-40</td>
<td>5</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>40+</td>
<td>1</td>
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<td>1</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
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</tr>
<tr>
<td>Male</td>
<td>1</td>
<td></td>
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<td>1</td>
</tr>
<tr>
<td>Female</td>
<td>9</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Married</td>
<td>9</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Co-habiting</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Feeding preference</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Breast</td>
<td>7</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Bottle</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>No. of children</td>
<td></td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>One</td>
<td>4</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Two</td>
<td>5</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Three</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
It became clear during the focus groups that parents valued the opportunity to talk about their relationship with their infants. This was evidenced by the richness of the dialogue and the positive nature of the interaction between the parents when discussing both pleasurable and challenging aspects of parenting.

The interview schedule was designed to encourage parents to describe their parenting experience and parent-infant relationships, and a wide ranging discussion describing feelings and experiences emerged from this process. Codes were assigned to the resulting transcripts following a process of three analytic stages. Firstly, organising the data so that coding could be assigned, secondly reading again and labelling data under initial coding categories, thirdly reading the transcripts side by side in order to identify patterns (Finch and Lewis 2003). Data diagrams were drawn to enable a systematic representation of data items, enhancing the clarity of item source within the developing tool, and to create an audit trail from the data to the tool (see Figure 5). The data diagrams aided organisation of the data rather than forming the basis for theoretical abstraction used within a grounded theory methodology (Mays and Pope 2000).

The potential to develop tool items from the focus group discussion was explored; the question of measurement was left open for further discussion in the supervisory process.

**Interpretation**

In this study it was important to form a view of the meaning of the discussion of the attachment relationship to parents but not to interpret the data in a mechanistic a way. The criteria for the interpretation of data (Rabiee 2004) were applied to the focus group data as the recordings were listened to prior to transcription. These include; specificity, context, words used and their meaning and frequency of their use, the intensity with which they are used and developing conceptual meanings from the data.

It was important to establish whether the nature of the discussion captured in the focus groups contained common themes, and if so how this could be
evidenced. By comparing the transcripts side by side some concurrence was clear (See Appendix 11). This was helpful in both confirming the potential for a tool to be useful to parents by distilling categories of importance to them, and for confirming the potential usefulness of the process of “having the conversation” about attachment relationships with parents, from a health visitor’s viewpoint.

Figure 4 below shows an example of the terminology focus group transcript comparison to illustrate the processing of focus group data. Figure 5 illustrates how data diagrams were used to organise the data.
### Fig 4

#### Example: Terminology Focus Group Analysis

<table>
<thead>
<tr>
<th>Type of Analysis</th>
<th>Example Focus Group Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Becoming a Parent</td>
<td>We were excited.</td>
</tr>
<tr>
<td>P1 We were excited.</td>
<td>P1 What when you found out you were pregnant?</td>
</tr>
<tr>
<td>P2 Yes, and it was great.</td>
<td>P2 Why?</td>
</tr>
<tr>
<td>P3 Yes, there is a sense of excitement.</td>
<td>P3 I don’t know what to expect when I become a parent.</td>
</tr>
<tr>
<td>P1 I think it was a bit of a shock.</td>
<td>P1 I was thrilled.</td>
</tr>
<tr>
<td>P2 I didn’t really feel anything.</td>
<td>P2 I was excited when I was pregnant.</td>
</tr>
<tr>
<td>P3 I don’t really remember.</td>
<td>P3 I don’t know what to expect when I become a parent.</td>
</tr>
<tr>
<td>P1 I was really excited.</td>
<td>P1 I was really excited.</td>
</tr>
<tr>
<td>P2 I was thrilled.</td>
<td>P2 I was excited when I was pregnant.</td>
</tr>
<tr>
<td>P3 I don’t remember what happened.</td>
<td>P3 I don’t know what to expect when I become a parent.</td>
</tr>
<tr>
<td>P1 That’s when...</td>
<td>P1 I thought he was dead.</td>
</tr>
<tr>
<td>P2 Do you mean actually seeing you pregnant?</td>
<td>P2 I thought he was dead.</td>
</tr>
<tr>
<td>P3 Yes, that’s when it all happened.</td>
<td>P3 I thought he was dead.</td>
</tr>
<tr>
<td>P1 I was really upset.</td>
<td>P1 I thought he was dead.</td>
</tr>
<tr>
<td>P2 I never wanted children.</td>
<td>P2 I thought he was dead.</td>
</tr>
<tr>
<td>P3 I never wanted children.</td>
<td>P3 I thought he was dead.</td>
</tr>
</tbody>
</table>

#### Example: Terminology Focus Group Analysis

<table>
<thead>
<tr>
<th>Type of Analysis</th>
<th>Example Focus Group Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Becoming a Parent</td>
<td>We were excited.</td>
</tr>
<tr>
<td>P1 We were excited.</td>
<td>P1 If you could go back in time and change something about your experience, what would it be?</td>
</tr>
<tr>
<td>P2 Yes, and it was great.</td>
<td>P2 If you could go back in time and change something about your experience, what would it be?</td>
</tr>
<tr>
<td>P3 Yes, there is a sense of excitement.</td>
<td>P3 If you could go back in time and change something about your experience, what would it be?</td>
</tr>
<tr>
<td>P1 I think it was a bit of a shock.</td>
<td>P1 I was thrilled.</td>
</tr>
<tr>
<td>P2 I didn’t really feel anything.</td>
<td>P2 I was excited when I was pregnant.</td>
</tr>
<tr>
<td>P3 I don’t really remember.</td>
<td>P3 I don’t know what to expect when I become a parent.</td>
</tr>
<tr>
<td>P1 I was really excited.</td>
<td>P1 I was really excited.</td>
</tr>
<tr>
<td>P2 I was thrilled.</td>
<td>P2 I was excited when I was pregnant.</td>
</tr>
<tr>
<td>P3 I don’t remember what happened.</td>
<td>P3 I don’t know what to expect when I become a parent.</td>
</tr>
<tr>
<td>P1 That’s when...</td>
<td>P1 I thought he was dead.</td>
</tr>
<tr>
<td>P2 Do you mean actually seeing you pregnant?</td>
<td>P2 I thought he was dead.</td>
</tr>
<tr>
<td>P3 Yes, that’s when it all happened.</td>
<td>P3 I thought he was dead.</td>
</tr>
<tr>
<td>P1 I was really upset.</td>
<td>P1 I thought he was dead.</td>
</tr>
<tr>
<td>P2 I never wanted children.</td>
<td>P2 I thought he was dead.</td>
</tr>
<tr>
<td>P3 I never wanted children.</td>
<td>P3 I thought he was dead.</td>
</tr>
</tbody>
</table>
Fig 5

Example: Data Diagrams

```
Adaptation
  Relational
  Lifestyle

  Relational
    Transitional
      BP 2.0.1
      Subsequent infants
        BP 2.1
        Emotional
          BP 2.1.1
        Physical
          BP 2.1.2
    First infant
      BP 2.2
      Emotional
        BP 2.2.1
      Physical
        BP 2.2.2
    With partner
      BP 2.3
      Emotional
        BP 2.3.1
      Physical
        BP 2.3.2
    With others
      BP 2.4
      Emotional
        BP 2.4.1
      Physical
        BP 2.4.2

  Lifestyle
   Physical
      BP 3.1
      Self-related
        BP 3.2.1
        Routines
          BP 3.3.1
        Priorities
          BP 3.3.2
      Infant related
        BP 3.2.2
        Routines
          BP 3.3.3
        Priorities
          BP 3.3.4
      Within family
        BP 3.2.1
        Work related
          BP 3.3.5
        Leisure related
          BP 3.3.6
      Outside family
        BP 3.2.2
        Work related
          BP 3.3.7
        Leisure related
          BP 3.3.8
```
Findings: Terminology Focus Groups

All the parents described both physical and emotional changes relating to becoming a parent for the first time. The changes were often challenging in a variety of ways, with parents frequently reporting major changes in how they viewed themselves within their home and work situations in comparison to their partner. The permanence of the changes encountered seemed to surprise parents and the transcripts when compared side by side were similar on this theme. The impact of role change was a strong theme across all three groups.

Parent-infant relationship

The recognition of infant cues and the response to those cues is an indicator of attuned attachment, one that is both reciprocal and warm. The parents in these focus groups described a variety of cues and their responses to them with minimal prompts. It was thought possible to develop an item within the tool potentially to predict difficulties items could relate to the recognition of and possibly, sensitivity to, overt infant behaviour such as turning away from the parent, a sign which if persistently ignored by the parent could affect the overall interaction between them in a detrimental way (Hawthorn 2005).

Terminology

It was predicted from the start of the study that shared meanings regarding the nature of the parent-infant relationship would emerge within the focus groups. What was less certain was the direction in which the discussion relating to terminologies used to describe this relationship would take. In the event, parents showed clear preferences, for example, for the word “bond” and a clear dislike for the word “attachment”. There appeared to be a clear shared meaning for the word “bond” within the groups and it was equated with “comfort” and “love” repeatedly across the separate groups.

The extent to which parents shared their thoughts and feelings within these groups and with me as an unknown health visitor had an impact on the progress of the remaining stages of the study. It became clear that the opportunity to
share these thoughts and feelings was highly valued by them and that what parents were looking for was an opportunity to engage in a conversation that was essentially about interpretation; the interpretation of their feelings about their infants and the interpretation of their infant’s behaviours. The understanding of the parent’s viewpoint on this fundamental aspect of family life revealed in the focus group discussion provided the momentum to develop the tool as a questionnaire that would evoke a conversation rather than the original intention to attempt to measure parental perceptions. Figures 6 and 7 provide examples of dialogue concerning lifestyle and relational changes experienced by parents. Figure 8 provides examples from parent transcripts that describe parent-infant communication.

**Fig 6**

<table>
<thead>
<tr>
<th>Examples From Parent Transcripts – Lifestyle</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FG2/P2</strong></td>
</tr>
<tr>
<td><em>I was shocked very shocked and it took me a little while to come round to the idea, but then I think because my husband had such a good reaction I told him it was all his fault but then he was so happy about it, it made me a lot better.</em></td>
</tr>
<tr>
<td><strong>FG1/P4</strong></td>
</tr>
<tr>
<td><em>I had a career, a figure and a social life (humorously)</em></td>
</tr>
<tr>
<td><strong>FG2/P3</strong></td>
</tr>
<tr>
<td><em>It’s radically different, everything is different...my partner he comes home and there’s me and the baby but his day to day life hasn’t changed at all</em></td>
</tr>
<tr>
<td><strong>FG3/P2</strong></td>
</tr>
<tr>
<td><em>It’s certainly a lot more restricted...you get a baby and everything changes</em></td>
</tr>
</tbody>
</table>
I already had my life mapped out although I was ready for a challenge.

But then I think I also remember you get this overwhelming sense of ‘My god, I’m responsible for them’... that’s something, not just a bump in your tummy any more.

...and part of me keeps expecting to go back to being...and part of me thinks it’s temporary but of course it’s not temporary—it’s for life.

When you were pregnant you were the most important thing and you’ve become the bottom...baby, husband and then yourself, sort of down there somewhere.

It’s hard to believe that this is your life now.
### Examples from parent transcripts – Relationships

| FG1/P1 | When I say attachment-it would be with someone else’s child..I could say I am attached to my friend’s child. |
| FG1/P4 | Its ’s so much more than having an attachment for your child.. so attachment seems a bit detached. |
| FG1/P5 | I would do the initial checks and then if I couldn’t deal with it and I used to get upset that I couldn’t work out what it was |
| FG1/P3 | I would agree that with my first one it was kind of instant.....but with this one I couldn’t enjoy the pregnancy as much ....you hold yourself back just in case something is going to go wrong |
| FG2/P2 | I think the bond gets stronger with time |
| FG2/P2 | When I was going down there (to intensive care) I’d say-is it OK for me to hold him? Can I take him out of his cot? Although I loved him I didn’t really feel like he was mine |
| FG2/P1 | The midwife said I could hold him and I really felt upset that I had missed out on it and like we’d had something taken away from us |
FG2/P2

She’s 3 months now—I’m still finding it hard to be where I can’t see her—if someone is carrying her round the garden or something it’s almost like an invisible link between us.

FG3/P1

There are two forms—I was permanently attached to my son but physically—that’s a type of attachment but there’s also the attachment that’s a burden in a way—like a tie—a responsibility and then there’s the other attachment that’s just a loving attachment.”
### Examples from parent transcripts – Communication

<table>
<thead>
<tr>
<th><strong>FG1/P4</strong></th>
<th>They get familiar with your face they really look at you really focus on your face</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FG2/P1</strong></td>
<td>I don’t know how old he was when he started using his hands a lot but he would actually physically push away and wouldn’t look at me and I’d say why have you turned away?</td>
</tr>
<tr>
<td><strong>FG1/P1</strong></td>
<td>You begin to understand why he’s making the noise…you can tell when he needs something</td>
</tr>
<tr>
<td><strong>FG3/P2</strong></td>
<td>Well it was easier with my first one than my second one because she really didn’t cry unless she wanted something if she had a dirty nappy or something</td>
</tr>
<tr>
<td><strong>FG1/P1</strong></td>
<td>They say that your baby can smell you don’t they? Your baby will cry if it wants the bottle but if it’s you, only half as much</td>
</tr>
</tbody>
</table>
5.2 Findings: Scaling focus group

Table 10

Characteristics Scaling Focus Group

<table>
<thead>
<tr>
<th>Age</th>
<th>20-30</th>
<th>31-40</th>
<th>40+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Married</th>
<th>Co-habiting</th>
<th>Single</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeding preference</th>
<th>Breast</th>
<th>Bottle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of children</th>
<th>Two</th>
<th>Five</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

Data were collected by tape recording the discussion and by later hand drawing data diagrams for each questionnaire item discussed.

The discussion in the scaling focus group took place around copies of the developing tool and some clear messages emerged from the parents about how the questions and responses should be structured. For example, parents were suspicious of the way in which questionnaires try to “trick” respondents by manipulating responses. Examples of comments are shown below in Figure 9.
### Scaling Focus Group Comments

<table>
<thead>
<tr>
<th>Comment</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think the order of the questions is important</td>
<td></td>
</tr>
<tr>
<td>If I am answering a scale of 0-10 I always answer 7</td>
<td></td>
</tr>
<tr>
<td>Confidence about answering is important</td>
<td></td>
</tr>
<tr>
<td>Agree and not agree to statements is one way I have seen</td>
<td></td>
</tr>
<tr>
<td>Have a section for open text</td>
<td></td>
</tr>
<tr>
<td>Having an example question is helpful</td>
<td></td>
</tr>
<tr>
<td>You need confidence to answer questions about how you feel</td>
<td></td>
</tr>
<tr>
<td>If questions are similar they are there to trick you</td>
<td></td>
</tr>
<tr>
<td>I would worry about it going further</td>
<td></td>
</tr>
<tr>
<td>I like the question about being connected</td>
<td></td>
</tr>
<tr>
<td>I don’t like the way professionals have a hidden agenda sometimes</td>
<td></td>
</tr>
<tr>
<td>Questions should be positive or people won’t be honest</td>
<td></td>
</tr>
<tr>
<td>I like scales like a ruler easy baby----------------------not easy</td>
<td></td>
</tr>
<tr>
<td>How about Always Sometimes Never</td>
<td></td>
</tr>
</tbody>
</table>
5.3 Findings: Health visitor interviews

Table 11

Characteristics: Health Visitor Interviewees

<table>
<thead>
<tr>
<th>Age</th>
<th>40-49</th>
<th>50-59</th>
<th>3</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years qualified</td>
<td>5-10</td>
<td>10-20</td>
<td>20+</td>
<td>1</td>
</tr>
<tr>
<td>Practice base</td>
<td>Children’s centre</td>
<td>GP Surgery</td>
<td>PCT Premises</td>
<td>1</td>
</tr>
</tbody>
</table>

The purpose of the health visitor interviews was to provide an element of triangulation involving exploration of whether parents’ and health visitors’ accounts of the attachment relationship were similar. This would be helpful in ensuring that the final questionnaire was meaningful to both.

Reflections on the transcripts included the health visitors’ recognition of difficulties with the transition to parenthood, of parental competence, of parenting skills “coming naturally” and on parental frustration at not being sure about what the baby wanted. This was mirrored by the health visitors’ thoughtfulness about how their interaction with the parent would impact on the parents’ self belief in their new role. The subtlety of the health visitor role was described along with the nature of the parent/health visitor relationship as time-related. As in the parent transcripts a clear theme emerged concerning the time that some new parents need to build a relationship with their infant while others “fall in love” instantly.

All four health visitors appeared to recognise their interpretive function within their role and expressed difficulties of engagement and having conversations
with parents about this. They used interpretation of baby behaviour to enhance the relationship with the parent and diverse sources of knowledge to make initial assessment of the parent-infant relationship. Corroborative evidence of shared meaning about parent-infant relationships from the transcripts was found for example about the recognition of infant signals and cue recognition played an important part in the parent focus group discussions. The serial nature of the health visitor/parent relationship is described along with the subtlety of the role are evidenced in the transcripts corroborating the findings of Wilson and Barbour (2008).

The health visitor interviewees were highly experienced in their communication skills and their ability to analyse interaction, evidenced within these interviews by their ability to offer interpretation of aspects of infant behaviours to parents. The transcripts of the health visitor interviews showed some congruence when discussing transitions to parenthood, interpretation of cues and the importance of the parent-infant relationship.

The appropriate use of tools such as the Brazelton infant assessment (Hawthorn 2009) that supports interpretation of infant behaviours with the parent, depending on contextual factors such as their level of understanding and emotional health, suggested a complexity of interaction with parents around this issue. Health visitors used multiple sources of information involving empathic interaction and interpretive commentary to support parental understanding of infant behaviours. This is suggestive of a highly skilled workforce using those skills to support parent child relationships in a way that is rarely recognized at organisational levels (Wilson, Barbour et al 2008).

On reflection the dynamic involved in individual interviews was different from that of the focus groups, incorporating as they did more interaction between the interviewer and the interviewees. Reasons for this include the awareness of the interviewees of my role as a practising health visitor, leading to an exchange of views at a theoretical level suggesting similarities in knowledge base and a tacit acknowledgement of professional expertise on both parts.
The four health visitors interviewed were clearly skilled practitioners who had a particular interest in parent-infant relationships. It is not possible to offer independent corroboration of their views from the parent perspective as time did not allow for exploration of this aspect of the interaction. This would have aided the completeness of the data and offering one or two parent testimonies of their relationship with their infants and also their health visitor would have been of interest. Figures 10 and 11 show examples of health visitor dialogue concerned with their perceptions of parent-infant relationships and parent-infant communication.

Fig 10

<table>
<thead>
<tr>
<th>Examples from health visitor transcripts – Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>HV2</td>
</tr>
<tr>
<td>HV2</td>
</tr>
<tr>
<td>HV3</td>
</tr>
<tr>
<td>HV3</td>
</tr>
</tbody>
</table>
HV4

..you know they perhaps identify the child as being a difficult child erm from quite early on or are very settled-the baby is very good she is settled, she sleeps a lot so you sometimes it is teasing out the likes and dislikes they kind of want the baby that feeds and settles and not the baby that wants lots of attention

HV2

...obviously it takes a while and they are working at it. The first visit we will talk about it and the next visit they can tell you a few things and it goes on just like actually attuned you don’t need to do anything really they are doing it and they wouldn’t need a health visitor (laugh).

HV3

.. and some parents you almost have to work with them for a very long time in a relationship before they are able to be a bit more reflective. I think parents who can notice things and be reflective are so different to work with.
### Examples from health visitor transcripts – Communication

| HV2 | Some have that natural-just know how to do it a naturalness-
|     | Lovely to watch |
|     | You know you aren’t going to do anything-they are attuned |

| HV3 | And you get some parents and the first baby they ever handle is their own they have absolutely no experience whatsoever. I think for a lot of parents it doesn’t-I think a lot of parents assume its going to be that they are going to know what their baby wants and it is quite frustrating when they cannot understand what the baby wants. |

| HV1 | Yes I use the sort of infant mental health knowledge it is not a particular tool as such but it is a way of just being open and listening really not just to the verbal communication but to the non-verbal as well about what that relationship is like. |

| HV2 | I would use the parenting programme questionnaire about parents attachment if I was specifically doing something around child protection or if I had real concerns about the attachment relationship if I needed to feedback that concern to the parent, I would use that questionnaire from Solihull |

| HV3 | ..so I see how much are the parents in tune with the baby-how much, how much are they making that dance of contact. I’m now using parts of the Brazelton, I guess I use the bits from Bowlby that we know around attachment. And child protection and also you use your gut instinct of does this mother look at this baby or father- do they pick them up are |
they gentle so kind of bits of lots of things coming from lots of different places.

**HV4**

I suppose that part of the Brazelton training was that we could use that but I really haven’t had enough opportunities (laugh) just through timing really..

Definitely doing the training made you look at things in a different way – probably the way that you had been doing it but just that it gave a bit more clarity and guidance on what you were looking at..

**HV3**

I always like to see parents that come the way they handle the baby see handling and talking to the baby that they are gentle with the baby. And since I’ve done the Brazelton there is much more talk about what does the baby do and is the baby settled, are they picking up signals

**HV2**

Well it is this functional response the this baby ..do I need a routine-this baby is actually doing something which doesn’t actually fit in with me-it fits in a hard place. The baby is not thriving-is breast feeding but not thriving and the mother is somehow not listening to the baby’s clues, not interpreting it-not wondering what that –you know-this baby is hungry-you come in and you know this baby is hungry-and she has missed that clue So its this conversation-so those are the mums that worry me. Its that flatness that slight disengagement..

**HV4**

I guess it’s lack of response, when you’ve got a baby that’s crying and there is no effort made to respond to this baby....
Through the analytic process applied to three parent terminology focus groups and four health visitor interviews, a theme of adaptation emerged from parent transcripts and a theme of interpretation emerged from health visitor transcripts (see Fig 12).

Two common themes in the health visitor and parent transcripts emerged; relationship and communication (see fig 12).

Fig 12

Parent and Health Visitor Themes

![Diagram showing Parent and Health Visitor Themes]

The purpose of comparing the parent and health visitor transcripts was to triangulate the data; to look for “patterns of convergence” (Mays and Pope 2000). The findings support the view that parents and health visitors held some shared meanings when discussing parent infant relationships and support the face validity of items in the tool.
5.4 Findings: Health visitor survey

Table 12

Characteristics: Health Visitor Survey

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>40-49</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>50-59</td>
<td>7</td>
</tr>
<tr>
<td>Years qualified</td>
<td>5-10</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>10-20</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>20+</td>
<td>1</td>
</tr>
<tr>
<td>Practice base</td>
<td>Children’s centre</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>GP Surgery</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>PCT Premises</td>
<td>5</td>
</tr>
</tbody>
</table>

Health visitor survey data were collected using a free text box on the health visitor data collection form sent with the pilot tool data collection pack (See appendices). Figure 13 shows health visitor comments taken from the data collection form.

**Fig 13**

**Health Visitor Survey Comments**

<table>
<thead>
<tr>
<th>Source</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HV1</td>
<td>I really liked using the questions and are a great way of talking to parents about how they feel about their babies. I found this very helpful when talking to a mum where there are huge attachment concerns. Look forward to the finished tool.</td>
</tr>
<tr>
<td>HV2</td>
<td>I really like the questionnaire. It is non-threatening and all about how well parents know their babies and can care for them. It would be a really helpful addition when we are working with vulnerable families.</td>
</tr>
<tr>
<td>HV3</td>
<td>Easy to use – client understood the information and quickly filled in the questionnaire and then talked about it with me. She was pleased to be asked and enjoyed the need for me to return 2 weeks later.</td>
</tr>
<tr>
<td>HV4</td>
<td>I like all the questions in the pack I am thoughtful about how you would capture negative thoughts about the baby. Also the “I find loving my baby is easy” stands out. I am not sure if anyone would admit they didn’t especially if it is to be used under 6 months and the pressure to “bond” etc.</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>HV5</td>
<td>Really interesting reading and great way into talking about the importance of attachment, interacting positively with babies, relationship building, responsiveness.</td>
</tr>
<tr>
<td>HV6</td>
<td>I wonder if it is really a universal tool or to be used at HV discretion.</td>
</tr>
<tr>
<td>HV7</td>
<td>It appears to be very clear and easily understood. Quick to complete.</td>
</tr>
<tr>
<td>HV8</td>
<td>I found this a really useful tool. It gave the opportunity to discuss issues openly. I used the tool with a young single mum and it helped to boost her confidence hugely. I would use this tool in my work.</td>
</tr>
<tr>
<td>HV9</td>
<td>Would be useful at an earlier stage i.e. under 6 months. Using the tool helped this parent to open up to me a couple of weeks later about postnatal depression.</td>
</tr>
<tr>
<td>HV10</td>
<td>Excellent! Encourages parents to consider baby’s feelings and not just behaviour.</td>
</tr>
<tr>
<td>HV11</td>
<td>This could be really useful to help mums understand their babies and attachment</td>
</tr>
<tr>
<td>HV12</td>
<td>Some of the questions are a little subjective. My client found some of the questions a little difficult to answer. It felt there needed to be a box to tick between always and sometimes – perhaps ‘most of the time’. It was a useful tool to generate discussion around infant mental health.</td>
</tr>
<tr>
<td>HV13</td>
<td>I think the tool will work well as an awareness raiser and give material to talk around especially for mothers who are depressed or inexperienced/young/first time parents. I do feel it is a little long and may feel a little repetitive to those completing it; however I can also see the benefit of the range of interactions you have developed questions for.</td>
</tr>
</tbody>
</table>

The data suggests that the health visitors who used the tool with parents did not find any difficulty with offering it to parents and also broadly found it helpful and potentially useful. The difficulties described with data collection were suggestive of an inability to take the time to become involved in the study rather than an unwillingness to use the tool with parents.
5.5 Pilot Tool Development Process

The purpose of pilot tool development was to develop it along the lines of the Edinburgh Postnatal Depression Scale. The EPDS uses a four point scale and has been validated as a screening instrument (Hewitt, Gilbody et al 2009). Also, measurement of attachment difficulty was not an objective in this study and parent preference indicated a need for simplicity. A four point scale was therefore used for reasons of simplicity and acceptability to parents.

From the original items produced from the data from the parent focus groups, the attachment tool constructs (Table 6 p.52) were used to group the items and reduce them to those specifically relating to parental behaviours, attitudes and emotions towards their infants.

In order to remain true to the original intentions of this study, namely to produce a brief tool which was acceptable to parents and professionals, two reflective processes influenced its development at this stage.

Firstly, to consider iterations of the tool alongside the constructs identified as necessary to the development of attachment security in infants less than six months old (see Table 5 p.50). Secondly, iterations of the tool were cross-referenced against the original data from parents, using their terminologies.

The decision-making process had to remain coherent with attachment theory, integrate the hermeneutic qualities of the dialectic exchange of the “parents’ voice”, and satisfy tests of face validity in eliciting parental difficulties within the attachment relationship.
5.6 Pilot Tool Results

Table 13

Parent Characteristics: Pilot Tool

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Married</td>
<td>6</td>
<td>50.0</td>
</tr>
<tr>
<td>Single</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Co-habitng</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>66.7</td>
</tr>
<tr>
<td>Missing</td>
<td>4</td>
<td>33.3</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The pilot tool contained five domains; synchrony, containment, mentalisation, sensitivity and mirroring (See Fig 3 p.49). Scatter graphs were used in the analysis of the pilot tool results in order to visualise the data and to make some tentative assumptions about the validity of the tool constructs (see Figures 14, 15, 16, 17 and 18). As demonstrated below, mirroring (Fig. 18), showed the most consistent results when showing individual scores and total scores in this way.
**Fig 14: Scatter graph - Synchrony**

Synchrony involves mutually attuned interaction between infant and parent.

**Fig 15: Scatter Graph - Containment**

Containment involves the emotional availability of the parent to the infant; this enables the containment of the infant’s emotions and behaviours aiding emotional development.
Fig 16: Scatter Graph - Mentalisation

Mentalisation involves the capacity for parental reflective functioning.

Fig 17: Scatter Graph - Sensitivity

Sensitivity is the parent’s ability to accurately perceive and interpret infant signals.
Mirroring is the empathic reflection of facial expressions and actions between parent and infant.

Correlation tables were produced for each of the constructs (See example Table 14 p.132) and the results from all the tables are shown in Table 15 p.134 to demonstrate how the items for the ten-item tool were selected.
Table 14: Example Correlation Table for Internal Consistency - Mirroring (Mi)

<table>
<thead>
<tr>
<th>Score A</th>
<th>mi21</th>
<th>mi22</th>
<th>mi23</th>
<th>mi24</th>
<th>mi25</th>
<th>totsco</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spearman’s Rho mi21A Correlation Coefficient</td>
<td>1.000</td>
<td>.302</td>
<td>.845**</td>
<td>.413</td>
<td>.413</td>
<td>.742*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.341</td>
<td>.001</td>
<td>.182</td>
<td>.182</td>
<td>.022</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Spearman’s Rho mi22A Correlation Coefficient</td>
<td>.302</td>
<td>1.000</td>
<td>.357</td>
<td>.149</td>
<td>.149</td>
<td>.552</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.341</td>
<td>.255</td>
<td>.643</td>
<td>.643</td>
<td>.123</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Spearman’s Rho mi23A Correlation Coefficient</td>
<td>.845**</td>
<td>.357</td>
<td>1.000</td>
<td>.335</td>
<td>.642*</td>
<td>.830**</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.001</td>
<td>.255</td>
<td>.287</td>
<td>.024</td>
<td>.006</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Spearman’s Rho mi24A Correlation Coefficient</td>
<td>.413</td>
<td>.149</td>
<td>.335</td>
<td>1.000</td>
<td>.725**</td>
<td>.733*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.182</td>
<td>.643</td>
<td>.287</td>
<td>.008</td>
<td>.025</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Spearman’s Rho mi25A Correlation Coefficient</td>
<td>.891**</td>
<td>.413</td>
<td>.149</td>
<td>.642*</td>
<td>1.000</td>
<td>.733*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.001</td>
<td>.182</td>
<td>.643</td>
<td>.024</td>
<td>.025</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Spearman’s Rho totsco Correlation Coefficient</td>
<td>.742*</td>
<td>.552</td>
<td>.830**</td>
<td>.733*</td>
<td>.733*</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.022</td>
<td>.123</td>
<td>.006</td>
<td>.025</td>
<td>.025</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the p ≤ 0.01 level (2-tailed).

*. Correlation is significant at the p ≤ 0.05 level (2-tailed).

Internal Consistency

The results of the first completion of the questionnaire (n = 12) were processed using SPSS 16 (See Table 15 p.134). Each of the items was correlated with the total score and significant correlations at 0.05 and 0.01 were noted and expressed as a Spearman correlation coefficient (Kinnear and Gray 2000).
Thirteen items showed internal consistency at the $r_s \geq 0.4$ level of which five showed both internal consistency and test-retest reliability ($\alpha \geq 0.6$) and a further six items showed internal consistency only. These results are shown below in Table 15. The five items showing both internal consistency and reliability were added to the five items which showed internal consistency at $\geq 0.4$ and reliability at the $\geq 0.4$ level, resulting in a 10 item tool (See Appendix 15).

The relevance of these results is compromised by the sample size. Testing was helpful however in indicating items for inclusion in shortened tool which could be compared with the longer version were the original intention to screen for attachment problems to be pursued. The ten item tool could also be useful in a practice setting with the caveat that using a scoring system would be inappropriate at this point.

Table 15 below identifies the ten items for the final tool with the sign #. 
### Table 15  Pilot Tool Results

<table>
<thead>
<tr>
<th>Tool item</th>
<th>Test restest α</th>
<th>Internal consistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Synchrony</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1.000</td>
<td>.000</td>
</tr>
<tr>
<td>2</td>
<td>.000</td>
<td>.518</td>
</tr>
<tr>
<td># 3</td>
<td>.810</td>
<td>.377</td>
</tr>
<tr>
<td>4</td>
<td>.250</td>
<td>.211</td>
</tr>
<tr>
<td>5</td>
<td>-.250</td>
<td>.377</td>
</tr>
<tr>
<td>Containment</td>
<td></td>
<td></td>
</tr>
<tr>
<td># 6</td>
<td>.778</td>
<td>.537</td>
</tr>
<tr>
<td>7</td>
<td>.897</td>
<td>.133</td>
</tr>
<tr>
<td>8</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>9</td>
<td>.805</td>
<td>.046</td>
</tr>
<tr>
<td># 10</td>
<td>.480</td>
<td>.393</td>
</tr>
<tr>
<td>Mentalisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td># 11</td>
<td>.410</td>
<td>.829*</td>
</tr>
<tr>
<td>12</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>13</td>
<td>.000</td>
<td>.414</td>
</tr>
<tr>
<td>14</td>
<td>-.516</td>
<td>.456</td>
</tr>
<tr>
<td>15</td>
<td>-.047</td>
<td>.256</td>
</tr>
<tr>
<td>Sensitivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td># 16</td>
<td>.882</td>
<td>-.092</td>
</tr>
<tr>
<td># 17</td>
<td>.632</td>
<td>.690*</td>
</tr>
<tr>
<td># 18</td>
<td>.851</td>
<td>.470</td>
</tr>
<tr>
<td>19</td>
<td>.273</td>
<td>.742*</td>
</tr>
<tr>
<td>20</td>
<td>.556</td>
<td>-.092</td>
</tr>
<tr>
<td>Mirroring</td>
<td></td>
<td></td>
</tr>
<tr>
<td># 21</td>
<td>.580</td>
<td>.742*</td>
</tr>
<tr>
<td># 22</td>
<td>.636</td>
<td>.552</td>
</tr>
<tr>
<td># 23</td>
<td>.734</td>
<td>.830**</td>
</tr>
<tr>
<td>24</td>
<td>.062</td>
<td>.733*</td>
</tr>
<tr>
<td># 25</td>
<td>.526</td>
<td>.733*</td>
</tr>
</tbody>
</table>

**Significant at p ≤0.01 level

*Significant at p ≤ 0.05 level
The exploration of the pilot tool developed in this study aided decisions regarding whether a certain level of acceptability was reached. This involved looking for evidence of face validity through feedback from parents and health visitors and applying statistical tests to explore the data obtained.

The pilot tool test results tentatively tested the internal reliability of the tool in terms of the association between the dimensions in the tool with the concept of parent-to-infant attachment, limiting factors in this process included sample size and type.

It was appropriate to attempt test-retest reliability as this illuminated the potential for developing the tool further and was helpful in judging whether this approach was worth pursuing in subsequent studies.

**Reliability**

Reliability was tested using an intraclass correlation coefficient analysis to check the reliability of the questionnaire completion on test-retest. A total of 12 parents completed the questionnaire twice two weeks apart. The intraclass correlation coefficient allows for systematic differences in test scores to be calculated, this allows for the potential for scores with low consistency to show high correlation coefficients in small data sets (Campbell and Machin 2002). A comparison was made between the first and second completions expressed as α (See Table 15).

As demonstrated, the most reliable domain of the five domains tested was mirroring (See Fig 18), four items were subsequently used from this section in the 10–item tool.
5.7 Discussion

Multi-method approaches

Symbolic interactionism was selected as the underpinning philosophy for exploring parent’s understanding of the attachment relationship within the focus groups. A symbolic interaction approach was also expected to help reveal something about the nature of parent-infant interaction and relationship that could be used to inform the developing questionnaire. The universality of the experience of parenthood being the pivotal factor here, leading to an assumption that the nature of the relationship that was revealed within these focus groups, could be mirrored in other groups of parents. Benzies and Allen (2001) conclude:

“Symbolic interactionism offers a way to end the perceived incongruence between qualitative and quantitative methodologies by offering a theoretical perspective that embraces both approaches. For researchers who use multiple method designs, symbolic interactionism provides a perspective for conceptually clear and soundly implemented research about human health behaviour”.

As an appropriate process to apply to the development of a new tool, the process is supported by the richness of the group and interview data obtained and the response of health visitors to using the tool with parents. Also, by applying a quantitative approach to the analysis of the tool pilot responses, the potential for future development of the tool was retained. The use of a multi-method approach therefore aided the completeness of the data by triangulation (Knafl and Brietmeyer 1991) to “reveal the varied dimensions of an area of interest” here shown in the parent discussion, health visitor views and statistical analysis of tool responses.

A limitation to the analysis of the data in Phase 1 (see Fig 1 page 22) of this study includes the lack of independent corroboration by secondary analysis as suggested by Halcomb and Davidson (2006). Within a commissioned study this would be necessary in order to enhance external validity, particularly when subsequent phases of a study are dependent on the initial data analysis.
The extent to which the nature of the discussion captured in the focus groups incorporated attitudes and beliefs that demonstrated shared meaning about the attachment relationship required further thought. In order for the tool to meet the test of content validity, it was important for the views of the parents within the study to show some level of shared meaning for parents per se. The question of generalisability does not apply to small convenience samples or necessarily to a phenomenological enquiry, but the assumption of shared meaning is problematic even when discussing such a common shared experience as parenthood Bryman (2004);

“when humans communicate they do so in a way that not only draws on commonly held meanings but also simultaneously creates meaning.”

The focus group process yielded data that illuminated the meaning to the parents of early relational interaction. The difficulties inherent in revealing that meaning can be supported by seeking corroborative evidence for the presence or absence of shared meaning (Hein and Austin 2001). A corroborative approach to the analysis of the same piece of data using both empirical and hermeneutic phenomenological methods is used to achieve this. Such a method could have been employed in the analysis of focus group data within this study, had the purpose of the focus groups been to generate deeper insights into experiential aspects of parenthood. However, the purpose of this part of the study was to establish a pragmatic basis for the terminology to be used in the tool as well as to gain insights into parent perceptions. In retrospect, had the focus of the research been to explore parent perceptions in depth, empirical and hermeneutic phenomenological analysis would have been useful.

The approach taken therefore was one of empirical phenomenology with an element of corroborating being found. For example, some supporting evidence was found in focus group transcripts relating to experiences involving post-traumatic stress following childbirth (Nicholls and Ayers 2007; Davies, Slade et al 2008; Muzik, Cameron et al 2009).
Some of the experiences expressed by parents in the focus groups were dichotomous, for example; expectation fulfilled/sense of loss and these mixed feelings are reflected in qualitative studies that conceptualise childbirth in terms of a loss and change (Oakley 1983; Muzik, Cameron et al 2009). There are clear indicators of supporting evidence for that view within the transcripts of parents who had unexpected events such as neonatal intensive care admission at the time of delivery when their expectation was for a normal birth.

Communicating with infants could be assumed to be a naturally occurring process within the adaptive process that is becoming a parent but the point at which communication becomes relationship is an interesting one. How does the support of appropriate interaction translate into mutually rewarding relationship? Stern (1985) describes the uncertainty of this stage in parent-infant relationships and suggests that it occurs in the latter part of the first year, with the building blocks toward that stage occurring in the very early months.

It became clear from the focus groups that parents valued the interpretive function of the discussion, providing evidence of mutual experiential recognition. It was at this point the need for a screening tool was questioned and thought given to developing the questionnaire to enable focussed discussion around attachment; measurement then became a secondary consideration and ultimately removed from the tool in its final iteration.

**A change in direction**

Clarity of purpose at the outset was helpful in framing the protocol to take through the ethical approval process and in clarifying the steps and processes involved in developing health measurement tools. The shift in focus from measurement to discussion took place at the point at which items are developed for attitude based tools, often through focus groups (Trigg and Wood 2000). The original purpose of developing a screening tool was re-evaluated and a discussion tool developed.
If measurement of parent to infant attachment perceptions had been the objective, factor analytic methods, including testing the sensitivity and specificity of a cut-off score using Receiver Operator Characteristic (ROC) analysis, would have been followed (Streiner and Norman 2005; Matthey, Henshaw et al 2006).

A less analytical route was followed; appropriate to parents’ indicated needs and useful to health visiting practice; the opportunity to have a focused conversation about parent-infant relationships. The process of developing the tool based in theory and practice enables it to demonstrate concordance with both in terms of content validity. The statistical testing helped to indicate which items within the tool could be removed to develop a shorter version. A ten item tool resulted from this process.

**Reflection on Bias**

In quantitative research processes, the reduction of bias is viewed as something both desirable and necessary Bryman (2004). Several qualitative researchers however argue for the inclusion of discussions of the influence of bias through explicit reflexive processes (Mantzoukas 2005; Freshwater 2007). In this study biases included the weight of importance placed on supporting parents in the early postnatal weeks, consistent with the personal professional practice of the researcher.

Within qualitative methods of enquiry, some writers advocate the inclusion of bias as both desirable in terms of valuing the informant’s contribution, and also in creating new meaning and insights into phenomena (Mantzoukas 2005). Declaring the inherent biases could support the validity of the data gathered.

A discussion of the biases inherent in the focus group process, relying as it did on self-selected parents and a health visitor as researcher interviewer, is necessary to determine the extent to which the data could be relied on to provide the basis for the developing tool.

Bias was created by the impact of the researcher’s professional background on the way in which the focus group questions were posed and responded to.
Personal presentation therefore needed to be minimal but congruent with the discussion within the focus groups (Bulpitt and Martin 2010). Secondly, that as a professional there would be a tendency to intervene if the discussion within the group became distressing for any of the group members. That intervention would be based on empathic response and could not, nor would it be desirable to, remain neutral in such circumstances. The inherent bias of empathic response could therefore have impacted on the dynamic of the groups.

The obvious question here relates to the extent to which attempting to reduce bias could have the effect of diminishing the parents’ contribution. The parents’ voice, as already declared, was pivotal to the development of the tool and a bias toward valuing the perceptions of parents of importance. A position of interested neutrality similar to that used in health visiting practice was therefore adopted toward parents by the researcher.

The chosen methodology for the qualitative phase of the study is based on personal bias toward the inherent value and validity of discussion with parents revealed through an analytic process. Personal discovery of the principles of symbolic interaction enabled an understanding of the nature of the interaction that occurs between individuals and more specifically within parent-health visitor relationships; this in turn shaped the research design. This has resulted in a bias toward an emphasis on valuing shared meaning over measurement of parent perceptions of the attachment relationship. Symbolic interactionism encouraged examination of meanings, which is a position of personal bias and encouraged personal reflexivity in the research process described here.

**Personal reflexivity**

Reflexivity offers the opportunity to support the validity of findings and to explore the link with ethical dilemmas (Bulpitt and Martin 2010). It also presents the opportunity to reflect on whether the approach, grounded in clinical practice and informed by theory, had in fact resulted in useful insights into parent-infant relationships that could be incorporated into a tool.
Personal awareness as a professional and a researcher of the inherent complexity of the experience of being a parent and the ethical dilemmas of professionals in their relationship with parents were considered. A respectful attitude to parents that supports their self-esteem underlies the approach taken here. Sometimes however, professionals have to be able to offer support to parents when they become aware of the potential for a particular parenting style to impact negatively on a child. This requires professional skill and awareness of the contextual complexity that underlies family life (Cowley 1991).

What would I have done if I had become aware of a particularly negative parenting style within the focus group setting? This question presented an ethical dilemma in that, as a health professional, I would have been obliged to firstly discuss my concern with the parent and then seek agreement with them to discuss with their health visitor with a view to offering appropriate support. I came to the conclusion that I would have used professional skill to reach a solution in the above situation and enable an appropriate resolution to the satisfaction of all.

A surprising aspect of the groups was the extent to which parents were willing to share their experiences about the difficulties and joys of family life with me as a stranger. The parent’s motivation for being there warrants some thought, for example were they seeking therapeutic contact? They certainly seemed to be seeking corroboration of what were sometimes mixed feelings about their relationships with their children. The question of how useful a collective view would be to the development of a tool that would be offered individually was similarly thought provoking and eventually resolved by producing a tool containing constructs supported by evidence of shared meaning from parents and health visitors.

A conclusion was reached that the universality of the importance of relationships throughout the lifespan was likely to be reflected in conversations between parents about parent infant relationships. There was clearly something helpful in
attempting to illuminate that shared meaning around the specific focus of attachment relationships.

Reflexivity, or the “sensitivity to the ways in which the researcher and research process have shaped the collected data” (Mays and Pope 2000) ensured that the study evolved from an initial aspiration to screen for attachment difficulty to the development of a parent-friendly discussion tool. This meant that the data were collected at arm’s length in order to remain true to the ethical submission and that the study evolved in response to the findings from this method of data collection.

**A return to ethics**

The stated intention for the developing tool was to enable a supportive conversation to take place between the health visitor and the parent concerning potential attachment difficulty. The potential for creating pathology by classifying normal parental responses via a tool in the early postnatal weeks was recognised as a risk. In order to address this risk the three terminology focus groups and the scaling focus group incorporated elements of therapeutic interaction (Davis, Day et al 2002) as an ethical approach to discussion of a sensitive subject. This approach firstly acknowledges the potential difficulty inherent in discussing the parent-child relationship. Secondly, it describes the context sufficiently to enable parents to engage in discovering together and generating data that was potentially useful. And finally, offering feedback which would enable parents to appreciate the value of their contribution both during the groups and in follow up contact. (See Appendix 7). If time had allowed I would have aimed to personally offer feedback to the health visiting teams that had taken part to offer support and development in their relational work with parents. As it was I set up an infant mental health e-group offering feedback, information and resources which have been well received.
A return to attachment theory

The voice of John Bowlby remains influential, with a focus in family relationships and more specifically in parent-infant relationships. Steele (2010) links current thinking in child psychology and psychiatry to Bowlby’s original insights into parent-child relationships in the mid-20th century;

“Thus, historians of science, as well as researchers and practitioners may find much of interest in re-reading Bowlby’s 1956 lecture….the effort will be rewarded by an immense range of practical insights into parent-child relationships, mental health and the need to acknowledge if not fully resolve, the inevitability of mixed feelings in relation to those people and causes for whom we have the greatest affection.”

This insight is helpful to informing early intervention approaches particularly for those practitioners, including health visitors, who have a preventive role. It gives practitioners permission to stand alongside parents as they explore thoughts and feelings in early relationships; helping them to express these with the aim of supporting emotional health in the context of family life. The development of the ten-item tool it could be argued is helpful in the acknowledgement of mixed feelings common to parents and which can cause unresolved distress.
Summary

Chapter five presents findings and demonstrates how the study process followed the original research question and objectives using data collected from parents and health visitors.

Discussion focused on the nature of shared meaning when discussing parent-infant relationships from parent and health visitor viewpoints. Some corroborative evidence of shared meaning was found in the parent transcripts and health visitor interviews.

Testing the twenty-five item pilot tool with parents resulted in the production of a ten-item tool and survey findings suggested acceptability to parents and health visitors. The strengths and limitations of the approach taken were discussed including reflections on bias, personal reflexivity and ethical stance.

From the original aims and objectives of the study, which included promoting secure attachments through health visitor and parent discussion supported by a tool, a new question had emerged:

“How can I improve the conversation that parents have with their health visitors about parent-infant relationships for the benefit of those relationships?”

The final Chapter offers a synthesis of the study findings, suggestions concerning practice development and ways of taking the work forward.
Chapter 6: Summary, synthesis, limitations and conclusion

Introduction

This chapter summarises the thesis, links the outcomes with the original aims and objectives, discusses limitations of the study, and concludes with suggestions of how the work could be taken forward.

6.1 Thesis summary

Chapter one offered an introduction to the field of infant mental health in the context of health visiting practice setting the scene for reviewing the literature from theoretical and practice perspectives.

Chapter two focused on theory and practice in the field of infant mental health; highlighting tensions between experimental studies focusing on maternal pathology and descriptive literature contextualising parent-infant relationships within a family systems approach. New constructs, derived from attachment theory and current practice in infant mental health were developed to form the basis of the tool. Also incorporated was an explanation of the significance of health visitor roles in early intervention in the current practice context while posing questions about the need for an attachment-based tool for health visitor use.

Chapter three focused on screening and assessment, offering a critical review of available tools and an overview of approaches to assessment in health visitor practice that demonstrated variations in practice. The absence of a reflective tool that offered health visitors and parents the opportunity for focused discussion or screening was identified, and consideration given to addressing this gap.

Chapter four detailed the study aims and objectives and how these were to be achieved utilising an interpretive philosophy and a sequential multi-method approach. Plans were outlined here for the parent focus groups, health visitor interviews and survey and statistical testing of the resulting tool along with the
way in which validity and reliability were achieved and discussion concerning the limits to generalisability of the study.

Chapter five described the findings from the parent focus groups and health visitor interviews, demonstrating the complexities of parent-infant relationships as perceived by health visitors and parents. Tentative assumptions were made about aspects of parent-infant relationships that are helpful to explore. The development of a twenty-five item tool is described and includes an explanation of the statistical process used to reduce the tool items. Health visitor responses to using the tool via a survey are presented and the research design discussed. The chapter concludes with the formulation of a new research question.

Chapter six summarises the thesis and offers a synthesis of emergent themes in the study process. Similarities are identified between aspects of parent infant interaction and health visitor parent interaction and contextual elements of these relationships discussed. Conclusions are drawn about the helpfulness of the tool to health visitors by enabling the link to be made between theoretical and empirical knowledge about the attachment relationship. The development of the final tool using a collaborative enquiry approach is briefly described.
6.2 Synthesis

Introduction

This section offers a synthesis of findings and insights which the study and draws together themes emerging from the study process. Questions have been raised about the use of screening tools in parent-infant relationship assessment by health visitors. Tensions have been identified in the delivery of health visiting practice between professional agendas and relationship-based ways of working with parents. Data analysis has demonstrated commonalities between the value of the attachment relationship for infants and the interpretive role of health visitors to parents and that of parents to their infants. The context of current policy, practice and theory supports the health visitor’s role in reclaiming this fundamental aspect of early intervention (Allen 2011). It is argued that this study provides supporting evidence for a change in emphasis in health visiting practice towards an interpretive stance alongside parents that identifies strengths and promotes resilience.

Interaction and health visitors

The objective - to support secure attachment through health visitor and parent discussion using a tool - was achieved by developing the constructs and tool. This made the interactional aspects of parent-infant interaction more explicit and potentially of interest to wider health visiting practice. Uncovering the nature of interaction, parent-professional interaction and attachment related interaction, has formed the focus in this study and could be used to support learning about the interactional context of health visiting practice. Potentially health visitor parent interaction, when following a client-centred approach to parent support, could be argued to mirror elements of the attachment process. The reciprocity, sensitivity and containment offered by a skilled health visitor can enable contextually relevant responses to emerge (Goding and Cain 1999; Cowley 1999). Making these processes more explicit could be helpful to developing practitioners who are able to work effectively with parents (Davis and Day 2010)
and the findings of this study are suggestive of a need for supporting the development of such skills in an already skilled workforce.

**Intimacy and Interpretation**

Parent perceptions of their relationships with their infants were obtained and along with constructs from attachment theory and practice, formulated into a tool for health visitor use. Some corroborative evidence was found of common ground between health visitors’ perceptions of parent-infant relationships and parents’ self-perceptions. By describing and sharing these perceptions an aspect of the attachment relationship in language that parents find understandable and supportive has been shared, using the new tool developed for the purpose.

The acceptability of the tool to parents and health visitors described in this study is suggestive of a wider applicability by the opportunity it offers for supportive discussion. Themes that now underpin a personal understanding of the way in which infant mental health, health visiting practice and attachment theory are linked include the context of intimacy within which parent-infant interaction occurs; the interpretive role that parents have with their infants, and that health visitors have with the families with whom they work. Supporting the attachment relationship is a legitimate focus for health visiting work and this study supports the view that health visitors need development and support in this important area of practice (Wilson, Barbour et al 2008).

**Contexts and meaning**

The importance of intrinsic meaning contained in parental identity and illuminated within this study reflects Stern’s (1985) notion of the reorganisation of identity that occurs to parents when children are born. This adaptive process can made more explicit by the use of appropriate relationship-based tools. A recurring theme throughout the study involved the interpretive nature of the parent-infant relationship and health visitor-parent relationship based in shared meaning. Symbolic interactionism provided a philosophical foundation to the choice of methodology in this study for exploring parents’ understanding of the
attachment relationship through discussion of the “nature of social interaction” in parent-infant relationships (Benzies and Allen 2001). Tool development was based on the meanings placed on this relationship by parents and tested with parents and health visitors. Reflexive processes ensured that the tool as it developed retained the meanings of the parent discussions in the terminologies used within it; the apparent acceptability of the tool to parents and health visitors supported this approach.

6.3 Study limitations

Limitations of the study include an unexplored opportunity for parents to reflect on the use of the tool to them and to incorporate those views in this thesis. Health visitors who used the tool and responded via the survey however offered insights into how positively it had been received.

The sample of parents was not particularly diverse and there are questions concerning the difference between self-selecting samples and random samples that remain. The sample of health visitors clearly reflected a level of interest in infant mental health that is not necessarily replicated in the wider population of health visitors, meaning that broader assumptions cannot be made from the data gathered.

The limited amount of data collected reflects the reality of practice-based research in times of organisational change and workload pressures and the current reality of clinical delivery. This has limited the number of results obtained from pilot tool testing but collecting this data was helpful in indicating tool items that did not reach an acceptable level of validity and reliability.

6.4 Implications for practice

The interaction between health visitors and parents and between parents their infants is complex and context laden (Cowley 1991; Cowley; Cowley, Downing et al 2009). This study evolved from a desire to explore this complexity and be helpful as a practitioner to parents as they develop early relationships. The tool offers a helpful approach to interpretation of infant behaviour to parents and a
focus for discussion about parent infant relationships for health visitors in the context of health visitor practice. The tool developed here could be helpful in enabling health visitors to make the link between their theoretical knowledge about attachment relationships, their assessment of those relationships and their interpretive role with parents about infant behaviour. This could in turn positively impact those relationships. Also, where there is obvious relational difficulty, the tool could provide a focus for describing that difficulty as part of an initial identification and analysis of need. As discussed previously, the use of diagnostic tools in this context is often inappropriate (O’Connor and Byrne 2007).

**Final tool development**

Following study completion an opportunity arose to further explore the utility of the tool to parents and health visitors through a collaborative enquiry. This resulted in development in the appearance of the tool and in supporting information for health visitors using it. The opportunity was taken to engage in a collaborative enquiry to look at how the questionnaire could be developed by inviting colleagues and parents to comment on the tool. This resulted in the design ideas of three parents being incorporated into a new tool (See Appendix 15) and the attachment tool constructs developed to explain their meaning more clearly for health visitors (See Appendix 16).

**6.5 Conclusion**

Attachment theory and practice in infant mental health forms the focus around which this study has been developed.

The societal context of parenting is changing; increasingly complex and pressurised, the case for viewing parent-child relationships in the context of families and communities, while retaining individual professional relationships, presents a challenge to health visitors. It is hoped that the work undertaken in this study will be helpful to developing a response to that challenge that is appropriate to parents and health visitors by making the interactional process of parent-infant relationships more explicit using a tool developed for the purpose.
References


Shonkoff, J.P. and Philips, A., Eds; Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth, and Families. From Neurons to


Appendices

Appendix 1 Ethics Approval Example

15 June 2010

Dear Beverly,

Re: 2010/031

Infant mental health in the early weeks: A study to explore the identification of attachment problems by health visitors, in families with babies up to 28 weeks old, using parent-based questionnaires.

I am pleased to inform you that the above project has been approved by Bath and North East Somerset Primary Care Trust, subject to the conditions below, to recruit participants under the care of this Trust. Bath and North East Somerset PCT is a member of the Pan Bath and Swindon Primary Care Research Consortium.

Conditions of approval:

R&D approval is separate from ethics approval and is also essential for the conduct of research within NHS trusts. It is subject to the following requirements:

1. It is a condition of the approval that the project is carried out according to ICH Good Clinical Practice and within the guidance of the NHS Research Governance Framework. You have responsibility for ensuring that all participants give informed consent and that you, and any co-workers, adhere to the protocol agreed by the ethics committee.

2. If there are any alterations to the protocol or study documentation after the study has started, you must inform the NRES, the MREC where appropriate, and our R&D Consortium. Evidence of regulatory approval for the changes will be required.

3. It is my duty to notify you that as Principal Investigator you will be required to provide us, at least annually, with a progress report and outcome information.

If you need any further support or information, please do not hesitate to contact me at the above address, quoting our reference number.

Yours sincerely,

Irena Blair
Research Governance Facilitator

cc: Eshley Dale, Bath PCT
Appendix 2 Substantial Amendment Example 1

NOTICE OF SUBSTANTIAL AMENDMENT

For use in the case of all research other than clinical trials of investigational medicinal products (CTIMPs). For substantial amendments to CTIMPs, please use the EU-approved notice of amendment form (Annex 2 to ENTR/CT1) at http://eudra.ct.emea.eu.int/document.html#guidance.

To be completed in typescript by the Chief Investigator in language comprehensible to a lay person and submitted to the Research Ethics Committee that gave a favourable opinion of the research (“the main REC”). In the case of multi-site studies, there is no need to send copies to other RECs unless specifically required by the main REC.


Details of Chief Investigator:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Beverley Bailey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Public Health Office</td>
</tr>
<tr>
<td></td>
<td>Seaton Hospital</td>
</tr>
<tr>
<td></td>
<td>Valley View</td>
</tr>
<tr>
<td></td>
<td>EX12 2UU</td>
</tr>
<tr>
<td>Telephone:</td>
<td>07816955981</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:Beverley.bailey@nhs.net">Beverley.bailey@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td>01297 24252</td>
</tr>
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<table>
<thead>
<tr>
<th>1 Full title of study:</th>
<th>Infant Mental Health in the early weeks: A study to explore the identification of attachment problems by health visitors babies up to 26 weeks old, using parent-based terminology (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Name of main REC:</td>
<td>Cornwall and Plymouth REC</td>
</tr>
</tbody>
</table>
3  REC reference number: 08/H0203/94

4  Date study commenced: 10/07/08

5  Protocol reference (if applicable), current version and date:
   Version 2
   31/1/08

6  Amendment number and date:
   1
   23/7/08

Type of amendment (indicate all that apply in bold)

(a) Amendment to information previously given on the NRES Application Form

   No

   If yes, please refer to relevant sections of the REC application in the “summary of changes” below.

(b) Amendment to the protocol

   No
If yes, please submit either the revised protocol with a new version number and date, highlighting changes in bold, or a document listing the changes and giving both the previous and revised text.

(c) Amendment to the information sheet(s) and consent form(s) for participants, or to any other supporting documentation for the study

Yes

If yes, please submit all revised documents with new version numbers and dates, highlighting new text in bold.

Is this a modified version of an amendment previously notified to the REC and given an unfavourable opinion?

No

7 Summary of changes

A change has been made to the wording in the paragraph headed The Study within the Health Visitor Information sheet to reflect the need to elicit professional views on the parent-child relationship, in preparation for finalising the tool to be piloted in Stage 4.2.

This change follows the analysis stage of the parent focus groups in Stage 3 (ref:07/H023/256), when it became clear that the tool would require further refinement. The professional views of health visitors are thought by the researcher to be essential to this refinement. The number of health visitors to be recruited remains the same as before and also the way in which they will be recruited. A reply slip has been added to the information sheet.

An indicative interview schedule has also been developed to replace the original indicative interview schedule.

Briefly summarise the main changes proposed in this amendment using language comprehensible to a lay person. Explain the purpose of the changes and their significance for the study. In the case of a modified amendment, highlight the modifications that have been made.
If the amendment significantly alters the research design or methodology, or could otherwise affect the scientific value of the study, supporting scientific information should be given (or enclosed separately). Indicate whether or not additional scientific critique has been obtained.

8 Any other relevant information

8.1.1.1 Applicants may indicate any specific ethical issues relating to the amendment, on which the opinion of the REC is sought.

List of enclosed documents

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
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</tr>
</thead>
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<tr>
<td>HV Info 4.1</td>
<td>2</td>
<td>July 08</td>
</tr>
<tr>
<td>Interview schedule 4.1</td>
<td>1</td>
<td>July 08</td>
</tr>
</tbody>
</table>

9 Declaration

- I confirm that the information in this form is accurate to the best of my knowledge and I take full responsibility for it.

- I consider that it would be reasonable for the proposed amendment to be implemented.
13th May 2010

Dear Ms Blair,

Re: Study: Infant mental health in the early weeks: A study to explore the identification of attachment problems by health visitors.

REC ref: 08/HO203/94

Please find enclosed the requested information for expansion of the study area to include Bath and North East Somerset health visitors.

This expansion, should it receive Trust approval, will be facilitated by local health visitor Dr Robyn Pound and has been approved by her local service manager Helen Rugg.

Please note that the approval sought is for Stage 4.2 of the study only.

With kind regards,

Yours sincerely,

Beverley Bailey

beverley.bailey@nhs.net
Appendix 4 Parent Consent Example

Focus Group Parent Consent Form

Study Title: The development of brief attachment screening tool for use by health visitors

**The researcher** I am a health visitor working for Devon PCT and a student at Bath University School for Health. I can be contacted at any time on 07816 955981 or by the Seaton Hospital number above between 9-5 Monday to Friday.

**Purpose of the study** This study looks at how parents and professionals talk about the parent child bond in the early weeks after birth. The study will result in a parent-friendly screening tool.

**Parent declaration**
I have read and understood the Parent Information Sheet dated Jan 08 Version 2 for the above study.
I have had the opportunity to ask questions.
I understand that my participation is voluntary and I can withdraw from the study at any time without affecting my care.
I understand that this study has been approved by the ethics panel of Bath University and the Cornwall and Plymouth Research Ethics Committee.
I understand the focus group will be audio-taped and that all data collected will be treated confidentially at all times and that only non-identifiable data will be used for the purpose of the study.
I agree to take part in the study

Parent
Sign Date

Researcher
Sign Date
Appendix 5 Parent information example

Parent Information sheet

Stage 4.2 Study: The development of a brief questionnaire for use by health visitors.

What is the study about?

This research study looks at how health visitors and parents discuss the parent-child relationship in the early weeks after birth. It is hoped that it will result in a parent-friendly questionnaire that will help parents and health visitors to talk about the parent-child relationship. It is being done as part of a degree with the University of Bath, and will be complete by the end of 2010.

You have been asked to take part because you are parents of at least one child over 6 months of age, and you may be interested in helping to develop the screening tool.

- You can choose to take part or not and can ask any questions you like about the study, before you consent to taking part
- If you decide to take part, any information that you give will be anonymous

You will be given a copy of the questionnaire which has been developed to help health visitors to discuss attachment with parents. The tool is in the first stage of development and will be changed in response to what you say. Any information that you give will be anonymised, and the consent forms will be kept separately from the questionnaires. The study has been approved locally by NHS Devon, and Cornwall and Plymouth Research Ethics Committee.

What will I have to do?

Your health visitor will ask you to sign a consent form and will give you the questionnaire to fill in. She will then send you or give you the questionnaire again 2 weeks later. Finally she will return the completed forms to me. I will then develop the tool for further testing with parents with babies under 6 months old.

About the researcher I am a health visitor, currently working in Devon and doing a part-time degree with Bath University. You can contact me at any time on 078169555981.

Finally, thank you for taking the time to read this, and please get in touch if you would like to discuss it further.

You are welcome to request a copy of a brief report of the final results of the study from me from the above address or by telephoning or texting me.

Beverley Bailey (Health Visitor)
Appendix 6 Focus Group Interview Guide

INTRODUCTION

WELCOME AND HOUSEKEEPING

Researcher background
General background to the research
The parent's role in defining attachment terminology
Tool must be therapeutic/helpful/meaningful to parents

BECOMING A PARENT

How would you describe how you felt about becoming a parent for the first time?
Can you reflect on how life may have changed for you since before you had children?
What was the best thing about becoming a parent for the first time?
Can you say what was the most challenging thing about becoming a parent for the first time?

THE PARENT-CHILD RELATIONSHIP

How would you describe the character of your baby within a few weeks of his or her birth?
How did your baby let you know what he/she needed from you in the early weeks?
What sorts of things did you do if you were not sure what your baby wanted from you in the early weeks?
How did you know if you had understood what your baby was looking for?
How would you describe your feelings when you started to understand your baby's cues?
How did you know when your baby did not want you to play with him/her? (under 8 weeks of age)

TERMINOLOGY

What does the phrase "parent-child relationship" mean? What is your understanding of the word "attachment"
What is your understanding of the word "bonding"
Can you think of other words for attachment or bonding?
If you experienced difficulty with the way you felt about your baby, who would you tell about that?

CONCLUSION:

Summarise content of group discussion
Explain how the data will be used
Inform of availability of professional locally if difficult feelings have been raised during the group
Introduce PALs leaflets. Thanks and farewells
What are the focus groups for?
The focus groups were set up by Bev Bailey to look at how parents and health visitors talk about the parent-child relationship with the aim of developing a parent questionnaire.

How many focus groups were there?
A series of 3 focus groups were held in three different locations within Devon and a total of 10 parents took part.

What happened in the focus groups?
Parents were asked questions on the following themes:

- Becoming a parent
- The parent-child relationship
- The words and phrases that parents use when discussing the parent-infant relationship

Audio recordings were made of the groups and the researcher, Bev Bailey, analysed the transcripts of these recordings.

The results
The group recordings gave some very interesting and useful data from which items to be used in a questionnaire were developed.

What happens next?
A final focus group will be held in order to ask parents how the questionnaire could be scored.

I would like to thank all the parents who have taken part - please get in touch if you would like to know more!

Beverley Bailey
Phone: 07816 955981
Email: Beverley.bailey@nhs.net
Appendix 8 Health Visitor Consent Example

Seaton Hospital
Valley View
Seaton
EX12 2UU
01297 626141

Stage 4.1 Interview Health Visitor Consent Form

Study Title: The development of brief attachment-based tool for use by health visitors

The researcher  I am a health visitor working for Devon PCT and a student at Bath University School for Health. I can be contacted any time on: 07816 955981

The purpose of the study  This study looks at how parents and professionals talk about the parent child relationship in the early weeks after birth. The study will result in a parent-friendly attachment-based tool.

Health Visitor declaration
I have read and understood the HV Information Sheet dated April 08 (Version1) for the above study
I have had the opportunity to ask questions
I understand that my participation is voluntary and I can withdraw from the study at any time without penalty
I understand that this study has been approved by the ethics panel of Bath University and the Cornwall and Plymouth Research Ethics Committee
I understand who will have access to the information that I provide, and that only non-identifiable data will be used in the study

I understand that the interview will be audio-taped
I agree to take part in the study

Health Visitor
Sign ____________________ Print name ________________ Date

Researcher
Sign_____________________ Print name ________________ Date
Appendix 9 Health Visitor Information Example

Health Visitor Information sheet

Stage 4.2 Study: The development of a brief attachment-based tool for use by health visitors.

This research study looks at how health visitors and parents discuss the parent-child relationship in the early weeks after birth. It is hoped that this will result in a parent-friendly questionnaire that will help parents and health visitors to talk about attachment. It is being done as part of a degree with the University of Bath, and will be complete by the end of 2010.

You have been asked to take part because you are a health visitor, and you may be interested in helping to develop the screening tool.

- You can choose to take part or not and can ask any questions you like about the study, before you consent to taking part
- If you decide to take part, any information that you give will be anonymous

The study

You will be sent a copy of the pilot screening tool which has been developed to enable health visitors to discuss attachment with parents of infants aged 0-26 weeks. This is not a diagnostic tool, but it should help you to discuss aspects of the parent child relationship which are sometimes difficult to bring up. You will be asked to use the tool with parents with whom you feel it is appropriate. Of particular interest will be the feedback from yourselves and parents about how it feels to use the tool. Any information that you give will be anonymised and will be kept in accordance with Data Protection legislation.

The study has been approved by NHS Devon, BANES NHS Trust and by Cornwall and Plymouth Research Ethics Committee.

About the researcher I am a health visitor, currently working in NHS Devon and doing a part-time degree with the University of Bath. You can contact me at any time on 07816955981.

Finally, thank you for taking the time to read this, and please get in touch if you would like to discuss it further.

Beverley Bailey (Health Visitor).
INTRODUCTION

WELCOME AND THANKS

Researcher background

General background to the research

- The parent’s role in defining attachment terminology
- Tool must be therapeutic/helpful/meaningful to parents
- The tool must be useful to health visitors

IMPORTANCE OF PARENT-CHILD RELATIONSHIP ASSESSMENT

How important would you say your assessment of the parent-child relationship is in your work?

Do you currently use a tool to help you assess the parent-child relationship?

How useful do you feel a tool that helps health visitors to discuss the parent-child relationship might be?

What is the most challenging thing for you about discussing the parent-child relationship with parents?

THE PARENT-CHILD RELATIONSHIP

How would you describe how parents view the characters of their babies within a few weeks of their birth?

How do parents recognise what their baby’s need?

Is it different with subsequent children?

What sorts of things do parents do if they are not sure what their baby needs in the early weeks?

How did they know if they had understood what their baby was looking for?

How would you describe how parents feel when they start to understand their baby’s cues?

How do you know when babies do not want to interact with them? (under 8 weeks of age)
TERMINOLOGY

What does the phrase “parent-child relationship” mean to you? What is your understanding of the word “attachment”?

What is your understanding of the word “bonding”?

Can you think of other words for attachment or bonding?

CONCLUSION:

- Summarise content of discussion
- Explain how the data will be used
- Thanks and farewells
### Appendix 11 - Focus Group Analysis - Stage 3

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<thead>
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<th>Topic</th>
<th>T1</th>
<th>F1</th>
<th>Code</th>
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<tbody>
<tr>
<td>Becoming a Parent</td>
<td>P1 We were elated</td>
<td>P1 What when you found out you were pregnant, or when you actually had the baby?</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>P2 Yes, and scared as well.</td>
<td>P2 I think it was all a bit of a blur, trying to find your feet.</td>
<td>2.2</td>
</tr>
<tr>
<td></td>
<td>P3 Yes, there is secrecy and conflict around it.</td>
<td>P3 I didn’t feel well, it’s something you can remember very clearly.</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>P4 Sigh</td>
<td>P4 What happened?</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>P5 Continuing</td>
<td>P5 I already had a baby and I was ready for it.</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>P6</td>
<td>I was already 12 weeks pregnant and I was terrified.</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>P7 We were about 18 weeks pregnant.</td>
<td>P7 I was 18 weeks pregnant and I was terrified.</td>
<td>2.0</td>
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<td></td>
<td>P8 I was 18 weeks pregnant.</td>
<td>P8 What was it like to have your first baby?</td>
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<tr>
<td></td>
<td>P9 We were about 12 weeks pregnant.</td>
<td>P9 We were happy and excited. I was 12 weeks pregnant.</td>
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<td>P10 We were about 16 weeks pregnant.</td>
<td>P10 What was it like to have your first baby?</td>
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<td>P11 We were about 14 weeks pregnant.</td>
<td>P11 We were happy and excited. I was 14 weeks pregnant.</td>
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<td>P12 We were about 18 weeks pregnant.</td>
<td>P12 What was it like to have your first baby?</td>
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<tr>
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<td>P13 We were about 12 weeks pregnant.</td>
<td>P13 We were happy and excited. I was 12 weeks pregnant.</td>
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<td>P14 We were about 16 weeks pregnant.</td>
<td>P14 What was it like to have your first baby?</td>
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<td>P15 We were about 14 weeks pregnant.</td>
<td>P15 We were happy and excited. I was 14 weeks pregnant.</td>
<td>2.3</td>
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<tr>
<td></td>
<td>P16 We were about 18 weeks pregnant.</td>
<td>P16 What was it like to have your first baby?</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>P17 We were about 12 weeks pregnant.</td>
<td>P17 We were happy and excited. I was 12 weeks pregnant.</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>P18 We were about 16 weeks pregnant.</td>
<td>P18 What was it like to have your first baby?</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>P19 We were about 14 weeks pregnant.</td>
<td>P19 We were happy and excited. I was 14 weeks pregnant.</td>
<td>2.3</td>
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<tr>
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<td>P20 We were about 18 weeks pregnant.</td>
<td>P20 What was it like to have your first baby?</td>
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<td>P21 We were about 12 weeks pregnant.</td>
<td>P21 We were happy and excited. I was 12 weeks pregnant.</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>P22 We were about 16 weeks pregnant.</td>
<td>P22 What was it like to have your first baby?</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>P23 We were about 14 weeks pregnant.</td>
<td>P23 We were happy and excited. I was 14 weeks pregnant.</td>
<td>2.3</td>
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<tr>
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<td>P24 We were about 18 weeks pregnant.</td>
<td>P24 What was it like to have your first baby?</td>
<td>2.0</td>
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<tr>
<td></td>
<td>P25 We were about 12 weeks pregnant.</td>
<td>P25 We were happy and excited. I was 12 weeks pregnant.</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>P26 We were about 16 weeks pregnant.</td>
<td>P26 What was it like to have your first baby?</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>P27 We were about 14 weeks pregnant.</td>
<td>P27 We were happy and excited. I was 14 weeks pregnant.</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>P28 We were about 18 weeks pregnant.</td>
<td>P28 What was it like to have your first baby?</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>P29 We were about 12 weeks pregnant.</td>
<td>P29 We were happy and excited. I was 12 weeks pregnant.</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>P30 We were about 16 weeks pregnant.</td>
<td>P30 What was it like to have your first baby?</td>
<td>2.0</td>
</tr>
<tr>
<td></td>
<td>P31 We were about 14 weeks pregnant.</td>
<td>P31 We were happy and excited. I was 14 weeks pregnant.</td>
<td>2.3</td>
</tr>
<tr>
<td></td>
<td>P32 We were about 18 weeks pregnant.</td>
<td>P32 What was it like to have your first baby?</td>
<td>2.0</td>
</tr>
</tbody>
</table>
181
P1: He's slept since he was 4 weeks old so I've enjoyed it.

P1: Routine changes like you have to have your day set out. And I found that quite hard—yeah you work and go out with the flow—but when you have kids you have to set your days out and there's that whole feeling. We used to go and see our friends and then my mum used to go out and you've got to stop making her work around you. My husband and you have got to stop going out because she doesn't know whether she is coming or going. So I stopped going out just so I could get that routine in.

P1: Just him really. Laughs. Difficult to express really.

P1: Giving up my own time. I'd always been independent. Although we have been married for a long time we had our own bank accounts and And he would come to me and say, 'Let's do this'—I'd say 'Well can I just go out now?' And I would say 'I'm going out next week and having all that change, and even in the middle of the day I sometimes think I'd quite like to watch that... and by the time you get to see anything well you've missed it. And you think 'Oh well there's no point now'. So just not being able to do what you want to do for me.

P2: Yeah .

P2: Yeah having to think—especially for the first two weeks literally not having a minute to do anything is difficult.

P1: I mean just getting dressed laugh.

P2: and constant visitors just when you've just come home and all you want is to be alone with the baby and get to know the baby and you've just got constant visitors and you don't have a wie you don't know what you are doing and its kind of like stumbling in the dark and you don't really know what you are doing to begin with.

P1: and all the baby books say, oh tell people not to come round when you're tired but you can't just care for your child.
<table>
<thead>
<tr>
<th>Daily and now she's 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent-child relationship</td>
</tr>
<tr>
<td>P2: Certainly for my first baby she had that personality she has always been calm and quiet, and I always thought she was very intelligent and sensitive. In between, with successive children, they have totally changed.</td>
</tr>
<tr>
<td>P3: Yes I think so 2 was very shy and a bit slow to come out when she was born and she is still like that.</td>
</tr>
<tr>
<td>P2: It was true of my second child who was very shy about to start with but she is going to be changing. I guess it's just her nature.</td>
</tr>
<tr>
<td>P3: Yes I got one. She's really just not independent.</td>
</tr>
<tr>
<td>P2: Yes right from the start she's a lovely baby and everything.</td>
</tr>
<tr>
<td>P3: Yes.</td>
</tr>
<tr>
<td>P2: I don't think he had a character at first.</td>
</tr>
<tr>
<td>P3: I think they are born with their particular personalities because I have 2 they are different.</td>
</tr>
</tbody>
</table>

### General agreement

| P2: I do think you see them born with their particular personalities because I have 2 they are different. |
| P3: Yes I agree with that and they are different. They get excited easily and sometimes they get very tired. |

### P1: Yes, I guess we all get excited easily and a little bit snappy.

### P2: Yes I used to get really restless and all a little bit snappy but it was if we were doing nothing and absolutely nothing the hours would pass by.

### P4: Tired one day I've got a dirty baby and another...

### P5: It's not really as... they get tired then they seem to try to relax and get away from it. P1: 10 or 12 weeks something like that. Everybody feels the same about that? Yes, Yes. |
<table>
<thead>
<tr>
<th>Time (minutes)</th>
<th>Event Description</th>
<th>Parental Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>0:00-0:45</td>
<td>Initially, the baby was crying and the mother was feeling overwhelmed.</td>
<td>Parent felt helpless.</td>
</tr>
<tr>
<td>0:45-1:00</td>
<td>The baby started to calm down after feeding.</td>
<td>Parent noticed the improvement.</td>
</tr>
<tr>
<td>1:00-1:15</td>
<td>The mother tried to comfort the baby, but it continued to cry.</td>
<td>Parent provided soothing noises.</td>
</tr>
<tr>
<td>1:15-1:30</td>
<td>The baby eventually fell asleep.</td>
<td>Parent praised the baby.</td>
</tr>
<tr>
<td>1:30-2:00</td>
<td>The mother settled into the routine of feeding, burping, and soothing the baby.</td>
<td>Parent became more confident.</td>
</tr>
</tbody>
</table>

**Parental Sensations:**

- **Newborn Sensations:** Crying, restlessness, hunger.
- **Parent Sensations:** Helplessness, stress, exhaustion, pride.

**Conclusions:**

- Crying can be a normal part of a newborn’s development.
- Support and reassurance from parents can help ease newborn’s discomfort.
- Early intervention can prevent prolonged crying episodes.

**Recommended Actions:**

- Providing a consistent feeding routine.
- Offering soothing voices and gentle touches.
- Encouraging parents to seek support from healthcare providers.
and antibiotic and a bit cross that others quite
obviously didn't know
so it wasn't so much
that I was observing
my baby. It was more
that other people were
doing it wrong. It's
laugh

P3: No, I understand
what she means but I
thought red that I was
a mum I already knew
that I was a mum but I
thought actually
thought you got a
relationship you've
absolutely bonded so I
do know what she
wants.

P1: Turning away,

P3: and avoid eye

contact

P2: yes like... oh!

P3: Pushing away

when they can use

their arm

P1: If I wanted him to

look at me and I turned

him back had put up

his hand

P1: Turning

away, avoid eye

contact

P1: Yes

P2: Yes and like crying

P1: I don't know how

old he was when he

started using his

hands a lot but he

would actually

physically push away

and wouldn't look at

me and I'd say why

have you turned

away? And though I

turned him back he

was bringing his hand

and I'd be like

(hysterical laugh

pushing) laugh

P2: I think she used to

like relax her back

P2: yes just get all

tense really

interest when all

watch baby cocking at

baby picture and

laugh

Terminology

P1: My partner... I suppose

all that data

It's that love, that love

It's about the boundaries

P1: I guess because

they're not verbal, it's

the most intimate

relationship that you

P1: relationship between

the child and the parent I
take everything into that

Comment [B130]: Parent

leaving

Comment [B131]: Parent

leaving

Comment [B132]: One

negation

Comment [B133]: One

negation

Comment [B134]: One

negation

Comment [B135]: Parent

leaving

Comment [B136]: One

negation

Comment [B140]: Love

Comment [B146]: Intimacy

Comment [B160]: Intimacy
<table>
<thead>
<tr>
<th>Like when he throws a tantrum</th>
<th>like when he throws a tantrum</th>
</tr>
</thead>
<tbody>
<tr>
<td>P2: I suppose a relationship is something you build on and when you walk in the room their eyes light up and they recognize you.</td>
<td></td>
</tr>
<tr>
<td>P3: The relationship is... funny how we all struggled with it.</td>
<td></td>
</tr>
<tr>
<td>P2: We all sat back and kind of said-what do you mean...</td>
<td></td>
</tr>
<tr>
<td>P3: Yeah.</td>
<td></td>
</tr>
<tr>
<td>P1: It's the parent-child bond. Then it's easy to describe but not relationship. Missing data.</td>
<td></td>
</tr>
<tr>
<td>P4: It's so much more than having an attachment for your child so attachment seems a bit detached.</td>
<td></td>
</tr>
<tr>
<td>P1: No.</td>
<td></td>
</tr>
<tr>
<td>P2: No.</td>
<td></td>
</tr>
<tr>
<td>P2: When I say attachment I would be with someone else's child.</td>
<td></td>
</tr>
<tr>
<td>P1: I could say I'm attached to my friend's child.</td>
<td></td>
</tr>
<tr>
<td>P2: It's like a friendship. It's like a friends-child is lonely but I wouldn't say I'm attached to them.</td>
<td></td>
</tr>
<tr>
<td>P1: It did seem an odd thing to say.</td>
<td></td>
</tr>
<tr>
<td>P3: Only one I would call it's bond.</td>
<td></td>
</tr>
<tr>
<td>General agreement.</td>
<td></td>
</tr>
<tr>
<td>P4: My oldest son is 23 and he's still got his bond.</td>
<td></td>
</tr>
<tr>
<td>P2: Does he do his park? There's still something there. Your relationship changes.</td>
<td></td>
</tr>
<tr>
<td>P5: Lost data.</td>
<td></td>
</tr>
<tr>
<td>P6: Is age.</td>
<td></td>
</tr>
<tr>
<td>P4: It seems like a funny way of putting it. I mean I have a loving relationship with her.</td>
<td></td>
</tr>
<tr>
<td>P2: Warm doesn't mean its cold.</td>
<td></td>
</tr>
<tr>
<td>P5: Last data. Microphone too close to BB.</td>
<td></td>
</tr>
<tr>
<td>P6: Isn't that thing that's always there.</td>
<td></td>
</tr>
<tr>
<td>P2: Nurture.</td>
<td></td>
</tr>
<tr>
<td>P1: Lost data agreement between P2 and P1.</td>
<td></td>
</tr>
<tr>
<td>P2: In love. Responsibility, the whole lot.</td>
<td></td>
</tr>
<tr>
<td>P4: It's not just the looking after them it's the whole deal.</td>
<td></td>
</tr>
<tr>
<td>P2: That's a type of attachment but there's also the attachment that's a burden in a way. When I'm a load.</td>
<td></td>
</tr>
<tr>
<td>P3: I've been off work for a while because of an injury... I've been looking after him which is great but I know exactly what he means by a burden. I just sometimes I want to say want to escape but I'm with him 247 a day and my wife's at work 3 days a week now so she has a break and she discussed it and the only regular thing I have...</td>
<td></td>
</tr>
<tr>
<td>P1: I've been off work for a while because of an injury...</td>
<td></td>
</tr>
<tr>
<td>P2: Because I feel awesome if I can't see her.</td>
<td></td>
</tr>
<tr>
<td>Comment</td>
<td>Time Stamp</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>B116</td>
<td>17:23:16</td>
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<tr>
<td>B119</td>
<td>17:23:43</td>
</tr>
<tr>
<td>B311</td>
<td>17:23:47</td>
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<tr>
<td>B192</td>
<td>17:23:52</td>
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<td>B193</td>
<td>17:23:59</td>
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<td>B194</td>
<td>17:24:07</td>
</tr>
<tr>
<td>B195</td>
<td>17:24:11</td>
</tr>
<tr>
<td>B196</td>
<td>17:24:13</td>
</tr>
</tbody>
</table>

---

... laugh

P2 yes I thought I went her on my chest straight away and then obviously it doesn’t happen and then you worry about it.

P2 yes oh yes

P2 Yes.

P1 Weaire and weaire laugh it was probably 12 hrs before I properly got to hold him and I don’t know that I could and a very nice midwife came up and I said don’t I hold him now and she said of course go and hold him now ... I really felt upset that I had missed out on it and like we’d had something taken away from us.

P2 she was only taken away for 10 minutes and they always say how important it is to put them straight on your chest and to be the first person that they see and P1 be supposed to be the first person that they see and P1 be supposed to make feeding easier.

P2 yeah

P1 I don’t think made me anxious and thing but I don’t know how anxious and thing I would have been it that happened so laugh

P3 Not for my baby I don’t think I would if it was a friend.

P1 yeah emotional warmth hasn’t come anywhere near us close laugh

P3 No-No

P1 I don’t know if there’s such a word

P2 Something more intense

P3 You can’t really explain it

P1 because you’re the person that’s with them the most you’re the person that does everything for them and you’re the person that’s with them all the language [hold their arms up things like that] and I think once they feel sick then they’ll start asking but ... but don’t but usually the mistake you pick them up and there’s something wrong it usually last day and they know you are

P1 that’s true of my one... because of the traumatic event I had to be the lead in most of it so now she is coming round to a correct way of thinking shall we say she’s still finding it difficult cos most of the time he asks for me instead of her... so she’s getting a lot upset at that

P1 but she knows... trail off

---

190
<table>
<thead>
<tr>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00</td>
</tr>
</tbody>
</table>

IT's really really the way other people react to you as well; they give way to generally don't they, that is if you're with someone like your mother-in-law and he's crying they usually go. Oh, he's crying, what do I do? And she's out to comfort and they learn that as well.
Appendix 12 Field Note Example

13/6/08

First focus group

5 parents attended-recruited by local HV.

Volunteer helper used to play with older children present and keep noise levels to a minimum.

Set up as guided conversation.

In response to parent consultation (A) focus group was promoted as a social event at which the children were welcome and refreshments were available.

Parents who attended were very willing to discuss their experiences-partly due to the trust they put in to the recruiter, a local HV.

Use of humour and welcoming environment were enabling to the parents. What would have happened if I had been a real novice with limited communication skills?

I was surprised how well the group went. Parents were mixed-3 of group were clearly affluent and 2 appeared less so.

All expressed surprise and pleasure that some of their feelings were similar-they had not been able to talk about the parent-child relationship in a group like this before.

My response to hearing some of the views about terminology:

Parents agreed with 1 mum who said that the term warmth when used about emotional warmth felt cold and calculated-everyone agreed that the term love was better.

They preferred bond to attachment and one mum stated that her bond with her adult daughter still persisted –they felt close though living separately as if connected by invisible cord.

Close as a term seemed very meaningful.

Love very meaningful.

All agreed different with first child than subsequent children.

I was surprised how conversation flowed given that some of the parents were not used to talking in a group and did not know the other parents.

I became aware that my body language and verbal prompts were particularly animated as I wanted the parents to feel comfortable and encouraged. I need to reflect on whether this would have an influence on what the parents said.

On starting transcription realised that the digital recorder was not placed well-too much background noise from the children and my voice very clear but not the parents. 2nd recording made
concurrently on tape recorder I placed close to the digital recorder-using both enabled most of the speech to be heard but not all.

Ethical issue arose just before the group-the health visitor who had made herself available in an adjacent room in case of parent needing support following group, wanted to inform me of one of the parent’s histories.

I reminded her that for the purposes of the group, I was not a health visitor but a researcher and that the confidentiality of the parent needed preserving.

I had in fact already guessed from the response of the recruiting HV that one of the parents had a significant history-possibly the loss of a child, about which only the parent had the right to disclose in this situation. The use of intuition in this situation is something that I personally have employed throughout my career, this has enabled the development of empathic responses to parents in a variety of situations. These empathic responses also needed to be appropriate and professional, I therefore was comfortable with the possibility of the parent needing extra support and or sensitivity. I would have been able to recognise the non-verbal cues of a parent becoming uncomfortable within the group.

In the event the parent happily engaged with the group and did not seem in any way uncomfortable throughout.

I encouraged the HV to look through the interview schedule and to indicate which of the questions may be too sensitive for that parent. None were found and the HV was happy with the questions.

Interaction was mutually supportive and co-operative even though not all known to each other.

Use of humour

Reflections on therapeutic use of self

Reflections on neutrality vs involvement

Recalling strong positive and negative emotion

Ebb and flow

Focus group 2 13/6/08

This was a smaller group of first time parents. They had agreed to stay behind after a baby massage session at the CC.

I found I was much more able to moderate my influence in that I offered verbal and non-verbal encouragement in a less overt way, taking words from the parents in order to encourage them to expand on their story. (idea of narrative……..making sense of the world with stories.

The parents clearly enjoyed the opportunity to be asked about the parent child relationship, they said they had not previously had an opportunity to do this

Focus Group 3 26/6/08
Only 2 attended. One father with 10 month old who had given up work to look after baby as wife suffered PND. Very angry at the system for way dismissive way his sons crying had been treated by GP. PALs info given at end of session and encouraged to discuss this with them.

Mum with 3 yr old and 8 month old. Mutually supportive.

Both said they enjoyed the session and were glad they had come. Both engaged well with the questions.

I found the dads response of using opportunity to offload as surprising given that I was not know to him...hopefully reflected the fact that I had provided a safe environment within the focus group for this.

Oct 08 Anecdotal feedback from public health nurse assistant who had helped with the recruiting- male participant had really enjoyed taking part in the focus group.

Brief report sent to all the parents and recruiters with thanks for taking part.

**Link with trauma**

Focus Group 4

3/10/08

4 parents recruited via B Children’s Centre. Creche available so children not present until final 30 mins of 1hr 40 min group. The group was extended by request of the parents. All enjoyed taking part and all signed up to be contacted again for stage 5.

I parent had experienced considerable attachment difficulties with her most recent child. 2 parents had suffered postnatal depression in recent months. I parent had several children both under 5 and over 15 and was relaxed and helpful to the other parents.

I parent expressed her misgivings about some of the items on the tool and the way they were expressed. She described herself as a single parent who had suffered mod-severe PND. She was able to make highly constructive comments about how to phrase items differently and about scaling.

Interaction in the group

I parent was particularly vocal but her views were moderated by the parent with the most experience. Agreement was reached on all items and the discussions were wide ranging with a healthy scepticism about trying to quantify women’s postnatal issues.
This questionnaire is designed to help parents and professionals to talk together about parent child relationships. It may be helpful in the first 6 months following the birth of your baby.

Please tick the answer that applies to you.

**Sy1**  When my baby is relaxed, I feel relaxed

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th></th>
<th>Sometimes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
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<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>Occasionally</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>Never</td>
<td></td>
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</tbody>
</table>

**Sy2**  My baby and I enjoy a cuddle together

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th></th>
<th>Occasionally</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>Occasionally</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>Sometimes</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>Always</td>
<td></td>
</tr>
</tbody>
</table>
Sy3  Feeding and playing with my baby makes us both feel good

Always
Sometimes
Occasionally
Never

Sy4  I feel in tune with my baby

Never
Occasionally
Sometimes
Always

Sy5  When my baby “talks” to me, I talk back

Always
Sometimes
Occasionally
Never
C6  I try many different ways to comfort my baby

Never
Occasionally
Sometimes
Always

C7  I try not to show my baby my when I am sad or low

Always
Sometimes
Occasionally
Never

C8  I find loving my baby is easy

Never
Occasionally
Sometimes
Always
C9 I feel confident in caring for my baby

- Always
- Sometimes
- Occasionally
- Never

C10 I keep myself calm around my baby

- Never
- Occasionally
- Sometimes
- Always

M11 I think my baby knows me well

- Always
- Sometimes
- Occasionally
- Never
Me12  I think my baby has his/her own personality

- Never
- Occasionally
- Sometimes
- Always

Me13  I think my baby has his/her own thoughts

- Always
- Sometimes
- Occasionally
- Never

Me14  I try to guess how my baby is feeling

- Never
- Occasionally
- Sometimes
- Always
<table>
<thead>
<tr>
<th>2e15</th>
<th>I try to see things from my baby's point of view</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td>Occasionally</td>
</tr>
<tr>
<td></td>
<td>Never</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2e16</th>
<th>I find my baby easy to comfort</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Never</td>
</tr>
<tr>
<td></td>
<td>Occasionally</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td>Always</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2e17</th>
<th>I respond quickly to my baby's needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Always</td>
</tr>
<tr>
<td></td>
<td>Sometimes</td>
</tr>
<tr>
<td></td>
<td>Occasionally</td>
</tr>
<tr>
<td></td>
<td>Never</td>
</tr>
</tbody>
</table>
Se18 I would recognise my baby’s cry anywhere

- Never
- Occasionally
- Sometimes
- Always

Se19 I know when my baby needs “quiet time”

- Always
- Sometimes
- Occasionally
- Never

Se20 I know how to help my baby comfort him/herself

- Never
- Occasionally
- Sometimes
- Always
Mi21  I position my baby so he/she can see my face

- Always
- Sometimes
- Occasionally
- Never

Mi22  I change my tone of voice to help soothe my baby

- Never
- Occasionally
- Sometimes
- Always

Mi23  I change the look on my face to help soothe my baby

- Always
- Sometimes
- Occasionally
- Never
I like to copy my baby’s actions

Never
Occasionally
Sometimes
Always

I encourage my baby to copy the look on my face

Always
Sometimes
Occasionally
Never

Age of your baby..........................

Today's Date............................
Appendix 14 Ten-Item tool

PARENT-CHILD RELATIONSHIP QUESTIONNAIRE

This questionnaire is designed to help parents and professionals to talk together about parent child relationships. It may be helpful in the first 6 months following the birth of your baby.

Please tick the answer that applies to you.

Feeding and playing with my baby makes us both feel good

- Always
- Sometimes
- Occasionally
- Never

I try many different ways to comfort my baby

- Never
- Occasionally
- Sometimes
- Always
I keep myself calm around my baby

- Always
- Occasionally
- Sometimes
- Never

I think my baby knows me well

- Never
- Occasionally
- Sometimes
- Always

I respond quickly to my baby’s needs

- Always
- Sometimes
- Occasionally
- Never
I would recognise my baby's cry anywhere

- Never
- Occasionally
- Sometimes
- Always

I position my baby so he/she can see my face

- Always
- Sometimes
- Occasionally
- Never

I change my tone of voice to help soothe my baby

- Never
- Occasionally
- Sometimes
- Always
I change the look on my face to help to soothe my baby

- Always
- Sometimes
- Occasionally
- Never

I encourage my baby to copy the look on my face

- Never
- Occasionally
- Sometimes
- Always

Age of your baby ..... Date............
Appendix 15 Revised 10-item tool
### Appendix 16

#### Attachment Qualities Explained

<table>
<thead>
<tr>
<th>Quality (Construct)</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sensitivity</td>
<td>Ability to accurately perceive and interpret infant signals and respond to them promptly and adequately.</td>
<td>Feeding in a timely and emotionally warm way.</td>
</tr>
<tr>
<td>Containment</td>
<td>Emotional availability of parent to infant through self-regulation enabling the containment of infant emotions and behaviours.</td>
<td>Parent feeling distressed but not showing this to the baby.</td>
</tr>
<tr>
<td>Mentalisation (mindfulness)</td>
<td>Capacity for parental reflective function including the ability to read the infants mental state and accept them as a separate individual.</td>
<td>Acknowledging the identity of the baby as having his/her own characteristics and temperament.</td>
</tr>
<tr>
<td>Synchrony (reciprocity)</td>
<td>Mutually attuned interaction and exchange of beneficial interaction enabling emotional and physical development.</td>
<td>Baby whimpers/parent leans toward and talks in a soothing way and pats baby.</td>
</tr>
<tr>
<td>Mirroring</td>
<td>Empathic reflection of facial expressions and actions between parent and infant that indicates affect attunement – more than simple copying.</td>
<td>Parent talks/baby smiles/parent smiles and makes sounds of approval/baby raises arm/parent touches and kisses hand/baby smiles....</td>
</tr>
</tbody>
</table>
Appendix 18 Draft

Health visiting practice as collaborative action research: Conversations with new parents about early relationships with babies.

R. Pound
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B. Bailey
Health visitor, NHS Devon, UK.

Abstract

Collaborative enquiry and health visiting become one and the same activity when two health visitors explore their practice using living theory action research. The focus was to explore a current concern, how to promote conversation with parents about early relationships for the sake of infants’ future emotional wellbeing by using a previously developed attachment-based questionnaire as a discussion prompt. In the process the health visitors transformed their practice to be more in tune with their client-centred intentions to meet family needs.

By seeing all parents and colleagues as collaborative enquirers the health visitors identified contradictions between their client-centred intentions and the reality for parents. Parents were invited to help modify the questionnaire to be acceptable. Its evaluation will be ongoing through use. The health visitors began to clarify their individual interpretations of client-centred practice and recognize contradictions to be addressed to more closely match these values with reality in practice. Relationships became more responsive to families and in tune with qualities of relationship that promote secure attachment, the professional code of conduct and organizational values. Clarifying personal interpretations of values that motivate action is an on-going process of practice regeneration. Values become principles for the practitioner to explain, evaluate and improve personal practice style. Health visiting is ready to embrace living theory co-enquiry within training.

Introduction

If you’ve come to help me then you’re wasting your time
but if you’ve come because your liberation is bound up
with mine then let’s work together

Aboriginal Educator Lilla Watson
(Wadsworth, 1997)

This paper explores collaborative action enquiry as a means of improving health visiting praxis of two health visitors in line with changing knowledge and policies in health visiting. One area of current health visiting focus, early parent-infant relationship, is explored uncovering values that living theory action research and health visiting have in
common. In the research process we clarify personal motivating values that help us understand, improve and explain what we are doing as health visitors. In the process, the ‘living’ collaborative enquiry and practical health visiting become one and the same activity as we learn with the families and colleagues, adopt new ideas and transform our practice to be more responsive to family needs. Relationships we find effective for collaborative action enquiry influence our relationships and ways of approaching all of our health visiting. The qualities of these relationships become integral to values motivating all of what we do.

By seeing our practice with families as a process of searching for a better future for us all, we include public health and societal concerns in our thinking (Shonkoff, 2011). Our actions become more closely aligned with our code of professional conduct and espoused values of our employers (DH, 2011). In other words, by approaching families as if they ask, ‘how can I be a better parent?’ and we ask ‘how can we be more helpful?’ our ways of approaching our public health agenda become more attuned to the individual needs of families. We are learning to trust parents to want healthier lives for their children and we value the energy for building cooperation and change to be gained from the democratizing effect of enquiring relationships.

We are two health visitors in different parts of the UK. Our enquiry focus for improving our health visiting was to ask how we could utilize our learning about early parent-infant relationships by using conversation to enquiry collaboratively with parents about their baby’s wellbeing. In her previous doctoral research Bev had developed a questionnaire about parents’ perceptions of baby’s behaviour rooted in attachment theory and informed by parent-group discussions (Bailey, 2011). We could employ Robyn’s background in living theory action research and her development of alongsideness through co-enquiry for improving her health visiting (Pound, 2003).

We recognized the healthy development of babies is dependent on the quality and security of infants’ early attachment with parents (Fonagy, 1998; NSCDC, 2004). Our early intervention role to influence parental responsiveness is to stimulate awareness about the importance of parent-infant interaction that enables children to acquire healthy social and emotional foundations (Allen, 2011; DH, 2011). This involves supporting parent’s recognition of the impact of their relationship on the infant, developing their interpretation skills and promoting responsiveness. Through experience we also find that some kinds of relationships we foster in our own relationships with families lead to closer engagement and more meaningful conversation (Cowley, 1991; De Cuesta, 1994; Pound, 2003). We wanted these relationships also included in our exploration of how to approach talking with parents about their babies.

Health visiting, in common with life itself, embraces unique individuals, clients and professionals, all forming their own personal theories about how to function in unique contexts. Experienced practitioners intuitively create relationships for our purpose and may not be aware of skills we employ or values motivating us. In this research we wanted to uncover our intuitive individual styles of real practice and recognize the
valuable knowledge and skills we and our client-families have for creatively improving our lives.

Bev wanted to use her previously designed attachment informed questionnaire (Figure one) for supporting awareness raising conversation with parents about interactions with their babies (Bowlby, 1969; Balbernie, 2001; Bailey, 2011). The questionnaire’s applicability for her client-centred practice remained to be explored. It offers questions about relational qualities for developing secure attachment for babies’ future mental wellbeing. Knowing that responsive relationships are a key to the emotional development of us all prompted Bev to explore her working relationships with families and with colleagues. Could this enquiry influence learning about infant mental health for health visitors?

![Figure one](image)

Robyn wanted to improve her understanding of practical secure attachment through early parent-infant interactions and particularly her own attention to infants during conversations with parents. She recognized she sometimes thinks more about the mothers’ emotional health than interactions with babies. This may be because of prominent interest in maternal mental health (CDCHU, 2009) or because mother is first focus for conversation. She believed her preoccupation with parents’ pressing issues over those of children persist throughout childhood particularly when families have intractable problems. Could this balance be influenced?

The unique perspectives of all participants, including researchers, are not usually accommodated by health research which finds individual reasoning unimportant in a search for statements of generality. We chose a methodology that enables our accounts as practice researchers to be illustrative of our learning and our search to improve,
evaluate and explain what we are doing. Our search is to question, understand and explain situations where we believe we make a difference and to show the influence our learning has on improving quality of our own and other people’s lives (NcNiff, 2002). Here we offer our emerging personal theories of our health visiting and ask you reader about the applicability for you?

**Principles, questions and action**

We found that in the current constraints of working with limited resources the principles of health visiting (CETHV, 1977) (Figure two) are difficult to realize and relationship-based health visiting practice as a valuable commodity can be compromised. What we find valuable helps us understand our concerns for health visiting in a pressured climate. We agree that meaningful relationship generates pleasure and energy from real human connection and from the space to converse and be heard. Contradictions we experience between our espoused values as we uncover them and reality in practice provide energy for this enquiry. Each of us is clarifying our values through the research. We find that clarifying what is valuable helps focus our exploration of meaning - that is, meaningful relationships leading to meaningful effective practice. In effect our values and practice of health visiting and our researching become closer as all participants are seen as having useful knowledge, skills and questions about how to improve their lives. We are all in processes of finding meaning in our lives while moving intuitive actions into consciousness of why we do things. We write partly in present tense because this enquiry will continue as long as we practise. Prompted by our values our research questions are in Figure three:
Living theory action research

Action research is about learning, change and explanation. We believe parents and colleagues are as capable of developing their own theories about how to live life as we are. Living theory action research (Whitehead, 1989) moves us beyond description of practice by supporting the building of explanations for our claims to knowledge and our effort to improve what we are doing. In our searching to understand and explain, tentative living theories emerge from our practice. Our theories are informed by published research but grounding theory in practice is reversed from methodologies usually grounding research in existing theory (Laidlaw, 1996). We introduce literature as it informs our insights.

Life is not easily described as facts being either correct or incorrect. Exploring how we cope with uncertainty, complexity and contradictory experience is essential to our enquiry. Contradictions create opportunities for exploration. In common with health visiting, values are central to living theory research. In clarifying what values motivate us, we learn why we do what we do and can begin to explain. Values emerging from our scrutiny contribute to more confident, fruitful and effective practice. Value misunderstandings are exposed during reflection (Pound, 2003:45). Insight gained from exploring contradictions exposed when values are not apparent in actions (Figure four) develop theory to be tested for its validity (Whitehead, McNiff, 2006).

Figure three
In dominant propositional methodologies found in health research, contradiction negates theory and is eliminated from discourses of real world practice in the search for certainty that is generally replicable (Ilyenkov, 1977). Whitehead speaking about dialectical theories grounded in contradiction concludes,

*Living logics are living in the sense that they have an emergent property, the capacity for self-recreation in infinite innovative ways. They are inclusional, in that they include propositional and dialectical forms of thinking, including all people and their practices within the field of enquiry, and they are relational in that they see the unfolding nature of relationships in everything. They are logics of the imagination because they see future potentials within present forms. They celebrate visions, the realization of values, and the redemptive qualities of transforming pain into joy.*

(Whitehead, McNiff, 2006:39)

Whitehead describes distinguishing qualities of a living theory methodology that includes ‘I’ as a living contradiction, because ‘I’ cannot always be true to my values. The process includes action reflection cycles, procedures of personal and social validation, and inclusion of life-enhancing energy from values that become explanatory principles for practice. Living theory logic expects statements to invite further questions because we don’t know everything and perspectives could always be different. In common with health visiting, living theory is capable of concurrently holding parts of a situation and the whole together, including contradictory statements.

*We make sense of our actions by researching them. We gather data and generate evidence to support our claims that we know what we are doing and why we are doing it…we test these knowledge claims for their validity.*
Robyn has found that by viewing all clients and colleagues as co-enquirers who are thinking about matters of concern to themselves, practising and enquiring become one and the same (Pound, 2003). Research questions become appropriate for sharing because considerate relationships are central to the enquiry process. You could call it reflective practice in which all are thinking about how they can live more meaningful lives for the good of everyone. Values lived in actions and clarified by researching are transformed into explanatory principles for articulating practice. Enquiry becomes research when explanations of practice theories are scrutinized by ourselves, by others and further tested for validity during dissemination such as in this paper (Winter, 1989).

**Ethics tested in standards of evaluation**

We follow a nursing code about respect, confidentially and consent in clients’ interests as practising health visitors (NMC, 2008). Reflective enquiry informed by the code ensures ethical assurances are maintained as our values are transformed into standards we use to evaluate and explain. Action research begs questions about anonymity, informed consent and harm for participants from political consequences (Williams, Prosser, 2002). In this research, colleagues are self-selecting in engaging with discussion, commenting on writing or deciding to be named. We guarantee clients’ anonymity and invite comments about what we write, but they cannot be identified here. Video-recording our work with families, as educational researchers find possible (Whitehead, 2010), is inappropriate in interests of confidentiality. Health visitors as advocates for change incorporates political activity which could affect clients (CETHV, 1977). This enquiry appears politically unproblematic.

**How are explanatory principles built?**

Our data collection is in field notes, reflective accounts and engagement with literature, conversation, email discussion, tape-recordings and videos. You may see how we are learning to evaluate what we do while building and testing our client-centred values as explanatory principles, in videos of ourselves showing qualities we claim for our working and researching relationships. There is a video clip of us in conversation at: [http://www.youtube.com/watch?v=6w1HBsi1vRM](http://www.youtube.com/watch?v=6w1HBsi1vRM). To access it, copy and paste in your internet provider.

Through social validation we judge reasonable fairness, believability and accuracy of our conclusions and ask about possible relevance for others (Winter, 1989; Whitehead, McNiff, 2006:103) (Figure five).
Envisaging parents as co-enquirers is congruent with both client-centred health visiting and living theory action research. We value parents’ knowledge about what is important to them, their hopes for their children and perceptions of their context. We learn together. Parents were involved in questionnaire development and reading drafts of this paper (Munn-Giddings, et al. 2011). Similarly, we value colleagues’ knowledge and ways of working with families. In turn we anticipate they are considering relevance of our insights to their practice. Here are examples of our enquiry.

Robyn’s enquiry

I jumped at the idea of researching with Bev for the opportunity to improve my attention to early interactions and to share living theory for improving health visiting. We had not researched together before and explaining methodology in a short timescale would be a challenge. I was interested to explore how to enthuse another health visitor in a reflective practice process as valid research for the benefit of us all – families and profession.

As a supervisor in the late stages of Bev’s doctoral research I witnessed her struggle between the questionnaire she developed using a particular research method and ways of being and practising she found valuable in her work (Bailey, 2011). By allowing her values to influence the questionnaire development she was able to include clients and colleagues in exploring what she was doing. Relationships and being client-centred, key to her daily work, could influence how she explored using the questionnaire but also how she sought help from colleagues. I was excited to be part of this next research phase and asked, ‘how do I use my passion to engender a spirit of enquiry and live my values more fully?’

Winter’s reflexive and dialectical principles to ensure rigour

- **Reflexive basis of accounts** – accords with the facts and is found believable by readers. Explores alternative explanations – noting the string of assumptions on which interpretations depend.
- **Dialectical critique** – combines overall unity with diversity of elements.
- **Collaborative resource** – enquiring together for negotiated interpretations.
- **Risk** – openness to challenge.
- **Plural structure** – result is not in conclusions but possibilities relevant in different ways to different readers.
- **Theory, practice, transformation** – each necessary for vitality of unending transformation.

Enquiring through email, taped and videoed meetings, recorded reflections and shared field notes we explored relationships valuable to all aspects of health visiting. We included parents as we worked and interested colleagues through e-discussion. Developing values of alongsideness for explaining, improving and evaluating my actions is important for me (Pound, 2003). Values have most meaning when experienced in relationship but to explain, alongsideness assures:

- All people are valuable, have knowledge and are worth my respectful effort. People live in a process of becoming who they will be and have creativity in searching for solutions.
- Life-enhancing energy comes from light-heartedness and connecting with others.
- Self-determination and personal significance is bedrock for responsibility. Encouragement helps people cope with feeling inadequate (Pound, 2008).

Video discussion with Jack Whitehead about my values in 2008: http://www.youtube.com/watch?v=ZSi1k1OaF5g&feature=related

As I began I was using a ‘tongue-poking’ strategy to encourage parents to allow their baby to communicate with and to enjoy magic moments that influence brain development (Murray, Andrews, 2005:28). I noticed that sometimes I allow parent’s interests to override the less obvious voice of the baby. I justify this with ‘if parents are happy the child will be’. This imbalance pervades my work with all age groups and I wondered if this research process could influence children’s interests balanced with those of their parents (Pound, 2003:160-174). My enquiry is about restoring balance between parents’ concerns and babies’ perceptions of their world.

Bev’s questionnaire clarifies qualities of relationships important for secure attachment and neural development during early relationships. It could help me focus on infants. Questionnaire statements (Figure one) provide positive examples of common parental experiences in early parenting and Figure six explains more about the qualities. I wanted to incorporate their use in my conversations. My instinct was not to show parents the questionnaire, as alongsideness implies following their lead in exploring their concerns, but to use the qualities in naturally occurring opportunities to explore my observations. Alongsideness for me is integral with enquiring together. Even if I haven’t explained this idea to the parents valuing it promotes more equal relationship.
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<td></td>
<td>infant that indicates affect attunement – more than simple copying.</td>
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Adapted from Bailey, 2011

**Figure six**

As I couldn’t remember the statements or qualities they relate to I decided to show parents the questionnaire if the topic arose, or when other issues had been dealt with, ask if they could help me in using it. Asking parents felt appropriate to my style of valuing their contributions while being sensitive to the appropriateness of my actions. All invited parents agreed they would like to read this paper. In the enquiry period I found no serious attachment concerns, in which case I would have introduced the qualities sensitively in response to the situation.

During postnatal visits I find issues such as birth experience, coping with a new baby, mental well-being and family relationships often take precedence. Here, showing the questionnaire felt awkward but by keeping baby’s experience in mind, the qualities remained in my agenda. Six parents I showed were quick to comment. Three said,
‘I was shocked by the emotional effect of the birth, recovering physically and the feeding pain. I noticed the huge change between being at work and being totally absorbed with him as the only thing that matters’.

‘I wondered if I was bonded. I felt detached after such a hard labour…it helped to think about how I was through the birth.’

Next week, gazing at him, ‘It’s OK now’

‘Reassurance from a professional helps…building a relationship and knowing they are there…you can’t trust friends’ advice. These statements have an answer. It doesn’t lead to conversation. It could restrict you to only talking about those things and forget other important things. It would be better if the statements were “Tips to talk about”…good for someone new to the job.

Two mothers with older babies and other children remembering the struggles said,

‘Feeding and playing were separate. Feeding was so hard…did not feel good. I didn’t get blues big time but my mental state was that I heard implied criticism. When the midwife said ‘no don’t do it like that, do it like this’, it implied I had got it wrong. To have been asked this question (about bonding) would have opened a great big sore. I would have heard criticism…I have no doubt about the bond now.’

‘The breast feeding struggle is about you trying to do right by your baby. The closed questions do not understand the scale and complexity of what you are going through…rating feels critical.’

From this I gleaned that postnatal ‘blues’ and attachment are strongly intertwined (CDCHU, 2009). Mother’s notion of her bond with her baby is tied up with her own health, everything else going on and attachment development is a process rather than a legacy. The questionnaire qualities gave me language to explore useful and less useful responses with another mother who found containment difficult when her seven month baby cried at night. She had recently left her own mother’s home, returning to see her daily. This prompted ‘mindfulness’ questions about whose issue this was (Daws, 1989)

‘I can’t bear her crying…she never does…I have to stay with her at night. I’ve never been alone before.’

Hearing her, I was able to name positives and question her perceptions relating them to the baby’s learning. Next week she reported coping with crying as her daughter learnt to settle more calmly. None of these mothers would score for depression (Cox, 1987) but similarly, emotionally distressing situations call for my sensitivity to their need for containment and to experience their self-determination and significance (Lew, Bettner, 2000).

Fathers in early visits like to tell their story when invited. Science behind communicating with babies appears captivating and most have tried techniques by our next contact. The questionnaire qualities give more specific information about earliest interactions.
with babies than I find in the Adlerian approach I use with older children and adults (Lew,Bettner,2000;Pound,2003). I would now be able to provide clearer explanation of an attachment difficulty warranting referral. Several parents noticed the similarity with valued relationships with professionals. Babies are creating neural pathways for their emotions while we adults use tried and tested ways of relating motivated by our histories, beliefs and values. For me working to the values of alongsideness appears to improve parent’s confidence, responsiveness and openness to exploring emotions belonging to the baby and those belonging to themselves (Pound,2003,129-130).

Bev and I videoed and tape-recorded our discussions continuing by email and telephone. On video I see us being careful, respectful and accepting with each other as we pondered complex ideas. On common ground we relaxed, laughed and took more risks as in reciprocal relationships. We learn from each other and found commonalities in our values. Exploring our relationship helped clarify our co-enquiring values (Figure four). I find balancing pro-activity with reciprocity requires sensitivity to qualities of relationship that maintain parent’s self-worth and openness to engage. I notice this appears more a concern for me than some colleagues showing the uniqueness of our health visiting perspectives.

Paradigm confusion is real and explaining a different epistemology is complex. It takes time for researchers used to other methods to understand but appears attractive for its encouraging ‘realness’.

**Bev’s enquiry**

My involvement with this collaborative enquiry began as my doctoral study ended. It provided the energy, creativity and motivation to pursue, with Robyn, this area of mutual professional interest. As our understanding of each other developed I realized the potential a collaborative enquiry could offer the development of my questionnaire in my practice alongside parents and colleagues. I wanted to explore the use of the questionnaire for myself, having had an arm’s length experience of it during the development and piloting. I could incorporate simple but deep reflective cycles and monitor usefulness and progress while checking the way I practice as we went along.

I had reviewed attachment screening tools and found them to have limited value for supporting parent infant relationships due to their focus on pathology; the discovery of deficit (Milford,Oates,2009). My questionnaire offered a way of talking about the parent-infant relationship based on interactional qualities important to the relationship and subsequent emotional health (de Wolff and van IJzendoorn 1997) couched in parent-friendly terms and not seeking measurement of those qualities (Bailey 2009). A change in emphasis had occurred when following a series of parent focus groups, I realized that what parents appeared to need most was an opportunity to talk about their relationships with their infants. The discovery of collaborative action research created an unmissable opportunity for me to explore my use of the questionnaire while enabling me to explore my approach to working with parents, in which I view them as experts in their own relational contexts.
Seeing parents and colleagues as collaborative enquirers in my research enabled me to ask parents directly what they thought about my way of working, how they felt and how things changed. The focus is on family relationships, particularly between the parent and infant, but also between us. It was liberating for me to be able to respond to parents’ comments and suggestions about presentation of the ideas in the questionnaire so that it could be made more acceptable. Parents appeared to enjoy the experience of contributing to how we work together and how they might influence my work with other parents. I saw that working in this way offered an educative function not present in the original questionnaire. I became aware just how powerful the approach could be for influencing change (Figure eight).

From early in my health visiting career I know emotionally warm responsive parenting is key to healthy emotional development and provides the basis for better relationships and happier children. My relationship-based ways of working come from my discovery of client-centred approaches (Rogers, 1974). I wanted to explore this way of working while using the questionnaire. It was congruent with my respectful stance to working with parents and my awareness of promoting equality. I was aware from my experience that there are windows of opportunity that present themselves to work with parents’ concerns about their most intimate and important relationships. I wanted to understand and explain what I do, particularly to colleagues.

I had realized that my values were compromised daily by workload pressures and I wanted to redress the balance and become a more effective practitioner. I was excited by the energizing effect the process was having on me and realized I was revisiting a way of working that re-discovered relationship-based ways of working in health visiting (Cowley 1991). I noticed that however busy my days I found myself engaging in pleasurable and meaningful conversation when I saw myself in collaborative relationships with parents and colleagues. My reflective diary entries arose spontaneously following these encounters and reflections flowed freely. I found I could use the questionnaire with parents with pre-existing difficulties including postnatal depression. Figure seven describes the impact of my using it with a parent.
For me using the questionnaire meant a shift in my professional practice from being ‘the expert’. I became alongside Emma as we explored difficulties she felt she had with her relationship with Daisy and other relationships that impacted on her care. This in turn made me thoughtful about how my way of being with this parent influenced the future for them both. I began to recognize how I show respect for her knowledge of being a parent and how my awareness about social inequality influences how I am with her. I call my way of supporting her self-esteem and her developing relationship with Daisy ‘warm positivity’. She regularly attends clinics to talk.

I am aware I now use this way of relating and working with families across my practice and continue to reflect on the impact of our interactions. Amongst those I shared the questionnaire with I invited two parents separately to comment in more detail. They wanted something ‘friendlier, more inviting and accessible’. Over several conversations their comments were incorporated into a redesigned questionnaire (Figure eight).

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**Example of reflective diary entry**

First time I used the questionnaire was in response to a request from a young lone parent. She phoned me on my mobile saying hurriedly – “Its Emma, I’m worried about how I feel about Daisy”, I said something like “This sounds important – can we get together to talk about that?” We arranged a home visit. I had already established a relationship with her due to the prematurity of her daughter; this had provided the opportunity for us to meet on several occasions.

I opened the conversation with, “You look worried, how are things going?”

She said, “I don’t feel connected …. People keep telling me that I should let them look after her….I think it goes back to when I got pregnant…”

I explored these statements with her and she revealed difficulties, antenatally and more recently, suggestive of the roots of her current anxiety.

She looked tense, thin, pale and agitated. I sat on the floor next to Daisy. I wanted to be able to concentrate fully on Emma’s story. I asked her if she would like to use a special questionnaire that could help us to talk about how she was feeling towards her. She was keen to do this.

I offered Emma the choice of looking at the questionnaire herself and then discussing it or looking at each question together discussing as we went along. She opted for the latter. We worked our way through it and I scribbled little notes on it and told her we could use these to look back on some time in the future to see how things were changing. It was important for me that Emma knew I was not scoring the questionnaire as I felt this would be more supportive of her self-esteem – it was merely a tool to help us focus our discussion and to look back on to measure progress for her benefit. I noticed at the end of the visit Emma relaxed, unfolded her arms was less agitated. She appeared able to begin to make more balanced decisions for her own health and that of her daughter.

As a result of this approach we had a truly meaningful conversation about what was troubling Emma most. It led to her discovery that her fears about not being a mum to Daisy in the way that she aspired to were refuted by the evidence we discovered by using the questionnaire. I knew this from asking directly in what way the discussion was helpful to her. What that meant for both of us was that we could discover together other factors of importance, such as the presence of postnatal depression and initiate effective action. Later in the process of discovery it enabled the difficult subject of safeguarding and domestic violence to be managed with this family.
revision called ‘Talking together about you and your baby’, addresses many of the concerns highlighted by parents and colleagues such as those in Robyn’s enquiry. It shows more ‘warm positivity’ and respectfulness. I retain ratings ‘always-never’ to promote discussion about impact on the baby and find realistic aims for parents. If we use it more than once it could show the parent change in how she feels. ‘Never’ could indicate need for more exploration. The single sheet now gives more information about the relationship qualities implied in the questions. Parents suggested it could be developed as a leaflet for clinics. Similarly, I am aware that relationships with colleagues change as we share interest in development of the questionnaire and think about how we work. I began a web discussion locally and several asked to use the sheet as tool for promoting secure attachment in their practice.

Discussion

We both experience excited energy and renewal of our love for health visiting from our process and witness similar warmth and energy in families. We find co-enquiry engenders hope by being encouraging about intentions, valuing knowledge and accepting that growth is process which frequently is not perfect (Lew&Bettner, 1989). It fosters relationships of reciprocity and warmth so willingness to co-operate and explore appears increased and our being pro-active more acceptable. We experience lighter moods working with parents and colleagues and believe we are closer to facilitating
health enhancing relationships. The questionnaire statements and qualities offer language for talking about early relationships. Bev describes change in her relationships with parents and colleagues and Robyn sees improvement in keeping baby in mind during conversations and continues to consider relevance for older children.

The revised questionnaire requires sensitive use in thoughtful responsive relationships. This research does not suggest generalizability for health visiting. Development is likely to evolve with on-going explorations and we may have conversations without it. Parents experiencing emotional distance from babies may welcome the containment of exploration using this sheet. Conversely, parents experiencing self-doubt might feel criticized and defensive and find simple positive interpretations of their actions encouraging. Bearing qualities in mind as appropriate for all relationships helps attune responses to the moment. Our discussions about the questionnaire can unite their contribution with their influence of the wider social world.

The qualities become transformed into values each of us try to live in our relationships while observing and checking if this is others’ experience of us. Uncovering our intuitive responses Bev is exploring her ‘warm positivity’ and Robyn ‘alongsideness’ as explanations and as standards we use to evaluate what we are doing. Co-enquiry helps us feel more positive and congruent in pressured work as we concentrate on the moment and experience pleasure from connection. Explorative attitudes in discussion, including tentative statements of opinion suggest increased equity. Parents and colleagues are as tactful as we are and more likely to express concerns about someone else (e.g. midwife). If concern is not expressed, uncomfortable feelings may signal contradictions. Parents’ and colleagues’ reminders about encouragement being more influential than advice and information remind us to stay client-centred when using tools because our aim is to create a climate for change rather than a method for collecting data.

**Conclusion**

Two health visitors explored one area of practice where relationships are important. We were concerned to improve our client-centred approaches and generate explanations. We did not seek a generalizable statement of the questionnaire’s efficacy but to explore its usefulness for discussion with parents about their relationships. We also explored parents’ contribution to its use beyond themselves. Practitioners are as unique as clients and use intuition, experience and personally constructed relationship styles as much as professional training to inform praxis. The questionnaire qualities inform values motivating our actions and contributing to our standards for evaluating our practice and our individual explanatory principles. By viewing all our working relationships as collaborative enquiry our practice becomes more responsive to family needs. Living theory action research creates transformational opportunities for families while influencing our practice, our professional climate and has potential for wider influence with our colleagues. Renewed interest in health visiting activity means the profession is ready to embrace co-enquiry within training.
References:


Acknowledgements:

We are grateful to the eight parents who helped redesign the questionnaire and commented on this paper with honesty and generosity. We also thank the health visitors who used the questionnaire, discussed insights emerging, scanned the article adding encouragement but prefer not to be named.

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