

**How Do Health Visitors Identify, Manage and Refer  
Infant Mental Health Problems?**

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**Doctorate in Clinical Psychology**

**By Lucy Carmel Murray**

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## **Declaration**

**I confirm that the literature review and research report  
contained within this thesis have not been submitted  
for any other degree, or to any other institution**

## Acknowledgements

*I would like to dedicate this thesis to my beautiful children*

*Ella and George*

I would like to thank the health visitors, who kindly agreed to participate in this study, for their openness and generosity in sharing thoughts and ideas about infant mental health.

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# **PAPER ONE**

## **Literature Review**

**How effective are Attachment theory-informed interventions  
for children under the age of five?**

## **How effective are Attachment theory-informed interventions for children under the age of five?**

**ABSTRACT:** A range of electronic databases and two journals were subjected to a detailed literature search, focusing on studies evaluating psychological interventions with children aged 0-5 years of age. Outcome studies, utilising experimental design, were included for critical review. The search strategy revealed predominantly attachment-informed intervention studies, prompting a review of this aspect of the literature. A total of twelve studies were identified for closer scrutiny: five with a preventative focus; four describing interventions with clinical populations and three detailing large-scale intervention programmes. This review found evidence that early interventions are effective in altering maternal sensitivity and insecure patterns of attachment. Moreover, interventions were effective in reducing the effects of post-natal depression on attachment security, reducing the incidence of placement breakdown in fostered and adopted children and preventing behaviour difficulties in school-age children. These findings indicate a burgeoning evidence base for attachment-based intervention models for the prevention or treatment of infant or child psychopathology.

**Key words:** infant, preschool, under-five, psychological, attachment, intervention, treatment.

*"I believe that infant mental health clinicians and researchers face a formidable task over the decade to come: to persuade society and its agents, the politicians and the administrators of mental health budgets to invest in the mental wellbeing of infants, to accept and internalise what we all believe to be a fundamental truth of our field, that the preservation of the mental health of infants is the key to the prevention of mental disorder throughout the lifespan."*

(Fonagy, 1998, p.126).



## **1. Introduction**

### **1.1 Outline of the review**

Treatment models utilised with <sup>1</sup>infants and children under the age of five have drawn on a broad spectrum of psychological theory including behaviour and psychoanalytic theory (Barnes, 2003). This paper seeks to examine the literature regarding treatments or interventions, informed or underpinned by Attachment theory (Bowlby, 1969). The field of early intervention is introduced, the evidence base for this approach is outlined and the aims and objectives for this review are delineated. The review adopts a systematic approach to reviewing research papers and inclusion and exclusion criteria for selected articles is carefully stipulated (See Appendix A for a summary of intervention studies included). Methodology utilised by the studies is critiqued and research implications are considered in light of relevant government policies. Finally, research questions relevant to a doctoral research project are identified. The targeted journal for this review is the *Infant Mental Health Journal* (see Appendix B).

## **2. Context for the review**

### **2.1 Early intervention in infant mental health**

Psychological interventions may be understood within the broader context of intervening early in the lives of children in order to reduce childhood mental health problems, referred to as psychopathology within this literature. Critical to early

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<sup>1</sup> This review is concerned with children under the age of five years. The term 'infant' refers to the 0-3 age group and 'pre-schooler' to 3-5 age group. Except where a particular age group is referred to within a study, the term infant and pre-schooler will be applied.

intervention is an understanding about factors which serve to protect children from mental health difficulties and factors which increase the risks (Svanberg, 1999). Early interventions draw on a wide range of theoretical models derived from psychological, ecological, sociological and educational perspectives (Barnes, 2003; see Appendix C for summary table).

Infant mental health (IMH) is a broad term encompassing theory, research and clinical practice related to the emotional wellbeing of very young children and their families (Zeanah & Zeanah, 2001). Although a wide range of models is applied to early intervention, Attachment Theory, put forward by John Bowlby (1969), is the dominant framework within this literature for understanding the needs of young babies and children (see Crittenden, 1995; Fonagy, 1998; Svanberg, 1999). For an overview of this theory, see Appendix D.

## **2.2 Evidence for early intervention**

The case for intervening early in the lives of children is supported by a growing evidence base. Studies have indicated 20 per cent of children and young people are affected by psychiatric impairment (Zahner, Jacobs, Freeman & Trainor, 1993) and such difficulties have been associated with poor outcomes later in life, such as depression, alcohol and drug misuse, psycho-social problems, delinquency and criminal behaviour (Barlow & Parsons, 2003). Literature pertaining to early brain development suggests there is a period when growth is very rapid (Shonkoff & Philips, 2001), during which the effects of maltreatment or other risk factors may have serious neurological as well as behavioural consequences (Cicchetti, Toth & Lynch, 1995). These findings imply a critical period in an infant's life when risk and protective factors have maximum impact. A crucial time-scale has similarly been

recognised by research exploring the effects of maternal depression (MD) on parent-infant interaction and subsequent development (Murray, 1992).

Another body of research evidence relates to “transfer of risk”. Parental characteristics or behaviours have been found to increase the probability that similar or related problems will occur in the next generation (Serbin & Karp, 2004). For example, longitudinal studies have demonstrated intergenerational consistency for harsh parenting (Simons, Beaman, Conger, & Chao, 1991) and child abuse (Egeland, Jacobvitz & Sroufe, 1988). Significantly for the field of early intervention, there is evidence intergenerational cycles can be broken with effective intervention (Phelps, Belsky, & Crnic, 1998). Thus, child mental ill-health is a significant problem, contributory negative patterns of parenting are at risk of being repeated and early timing may be crucial to achieving successful intervention.

Longitudinal studies have demonstrated attachment security mediates the risks of psychopathology in high-risk samples, such as single <sup>2</sup>mothers on low income (Egeland & Sroufe, 1981) and infants with depressed mothers (Lyons-Ruth, Zoll, Connell & Grunebaum, 1989). The breakdown or absence of any organised strategy employed by a child, to cope with environmental stresses, has been described as “disorganised” attachment (Main & Soloman, 1986). This category of insecure attachment in particular, has been closely associated with later problems (Shaw & Vondra, 1995). Although insecure attachment is not a measure of psychopathology, “it may set a trajectory that, along with other risk factors, increases the risk for either externalising or internalising psychopathology” (Greenberg, 1999, p. 477).

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<sup>2</sup> The terms ‘mother’ or ‘parent’ will be used unless otherwise specified within a particular study due to the frequency with which these terms are used within this literature.

Meta-analyses have demonstrated a causal link between maternal sensitivity and attachment security and have indicated early interventions are more effective for altering parental insensitivity than changing attachment insecurity (van Ijzendoorn, Juffer & Duyveteyn, 1995; Bakermans-Kranenburg, van Ijzendoorn & Juffer, 2003). Interventions have also been found effective in preventing disorganised attachment (Bakermans-Kranenburg, van Ijzendoorn & Juffer, 2005). Overall, short-term interventions after the age of six months, with a specific focus on improving sensitivity seemed to be most effective.

This body of research has paved the way for outcome studies focused on the treatment of attachment disorders or preventative interventions, aiming to increase attachment security as a strategy for buffering the impact of other risk factors, identified in psychopathology (Greenberg, 1999).

### **3. Literature review method**

#### **3.1 Aims and objectives**

In order to focus the search strategy, a key question was proposed: “How effective are psychological interventions for children under five?” To answer this question, the review aimed to identify outcome studies detailing treatment approaches with this age group.

### **3.2 Search terms**

The search terms selected were 'infant' OR 'toddler' OR 'preschool\*' OR 'under five' AND 'psycholog\*' OR 'mental health' OR 'behaviour' OR 'attachment' AND 'intervention' OR 'treatment' OR 'therapy'. In order to identify relevant studies, the terms were applied to journal abstract and a wide range of electronic databases; Psycinfo; Embase; Cinahl; Medline, Cochrane Library, ISA Web of Knowledge and ASSIA. Furthermore, two pertinent journals; Infant Mental Health Journal and Children & Society, pertinent to the area of interest, were hand searched.

### **3.3 Inclusion studies**

Preliminary literature searches in the field of early intervention identified two comprehensive review articles and a large-scale meta-analysis (Fonagy, 1998; Barnes, 2003; Bakermans-Kranenburg *et al.*, 2003). In order to focus on new studies, articles published prior to 2000 were not considered. Papers were selected according to the following criteria:

- POPULATION - Interventions or treatments targeting children under the age of five.
- INTERVENTION or TREATMENT model - A variety of treatment models were included in the review.
- METHODOLOGY - Experimental designs, including a control group or follow-up.
- SAMPLE SIZE - Studies with variable sample sizes were included.
- OUTCOMES - Studies were included with a wide range of outcome measures applied.

## **4. Results**

Thirty-one papers were identified for closer examination and exclusion criteria were applied to omit non-English language articles, dissertations, book chapters, and narrative reviews. This search strategy identified 14 fairly homogenous articles, united by the common theme of attachment theory and targeted age group. There is varied opinion about what constitutes an attachment intervention (See Eagle, 2006 for a review), but for current purposes, studies describing interventions as informed by Attachment Theory (Bowlby, 1969) have been included. Two papers were not attachment related and were specifically concerned with the prevention of early conduct problems or attention deficit hyperactivity disorder (e.g Shaw, Supplee, Arnds, Dishion & Gardner, 2006). Therefore, the remaining 12 articles were specifically reviewed here.

### **4.1 Preventative studies**

Five studies aimed to demonstrate treatment efficacy by comparing attachment classifications pre and post intervention. Participants in these studies included children at risk of insecure attachments; children from low socio-economic groups; recently-adopted infants; infant offspring of mothers with insecure attachment and premature infants from low socio-economic groups.

#### **4.1.1 Circle of security**

Hoffman, Cooper and Powell (2006) described the use of an American group treatment underpinned by attachment theory, known as the Circle of Security programme. The key elements were education in attachment theory and its

implication for parenting, the use of accessible language and visual aids to promote better understanding of complex issues and concepts, and an individualised intervention tailored to meet the needs of each child-carer dyad identified at initial assessment. The study participants were 65 infant or pre-schooler-caregiver dyads recruited from an early Headstart<sup>3</sup> programme. The findings concluded that the programme was a promising intervention for reducing the incidence of disorganised and insecure attachment in high-risk infants and pre-schoolers.

The particular strength of this programme was that while it used a standardised and systematic treatment protocol, there was sufficient flexibility to tailor the interventions to the needs of individual clients. It also maintained a therapeutic focus on three key elements which have been shown in the research to impact on child mental health: infant security, mother's representation and maternal sensitivity. The authors rightly highlighted the importance of offering interventions which will do no harm as an absolute basic tenant of any treatment modality being scrutinised for effectiveness and the study demonstrated 92 per cent stability in secure attachment (one participant who changed has a carer who returned to drug use following treatment). Lastly, the use of a "secure base/safe haven" concept reflected the true essence of Bowlby's original theories (Eagle, 2006).

The weakness of this study design was the absence of a control group and the reliance on test-post-test longitudinal methodology. This means it is more difficult to attribute changes in attachment classification to the intervention, since other factors

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<sup>3</sup> Headstart is the US equivalent of Sure Start. This is a British Government programme to deliver the best start for every child. It brings together early education, childcare, health and family support.

may have been responsible. Although the families within the programme were deemed to be “at risk” they had not been specifically identified as children with attachment difficulties. This raises questions about the transferability of the treatment to “referred” families. For example, how might it respond to non-compliance in referred dyads?

The recruitment of dyads with securely-attached infants or pre-schoolers raises questions about the treatment elements which are effective, for example what is the impact of peer modelling as a treatment effect? Furthermore, if the mix of needs within the intervention group played any role in outcome, this treatment element may not be transferable in an intervention for targeted and referred dyads. Finally, it is useful to comment on the applicability of the model to a UK setting. In order to draw firm conclusions, the study would need to be replicated for the UK population. Despite these reservations, the programme has considerable value as an example of early intervention with high-risk families where clients are not specifically identified.

#### **4.1.2 Video intervention to promote positive parenting**

A Dutch study by Klein Velderman, Bakermans-Kranwnburg, Juffer, Van Ijzendoorn, Mangelsdorf and Zevalkink (2006) tested the effects of two attachment-based interventions in infancy. Video intervention to promote positive parenting (VIPP) was a behavioural approach incorporating video feedback to enhance maternal sensitivity and promote positive parenting. The second intervention combined VIPP with a representational focus (VIPP-R). This additional component aimed to alter the mothers’ representation of attachment. The interventions had a preventative focus and targeted children at risk of developing insecure attachments. The adult attachment



interview (AAI) was used to select a participant sample of insecurely attached mothers (n=81). Participants were randomly assigned to VIPP, VIPP-R or a control group. A wide range of measures was applied at an initial assessment home visit (see Appendix B) and the mothers in the control group received no further treatment. The intervention groups were visited four times for 1 ½ - 3 hours each visit. All participants were reassessed at three subsequent intervals.

The participants were selected on the basis that insecure attachment on the AAI is associated with lower maternal sensitivity and child-attachment insecurity. In turn, these factors have been found to raise the risk of children experiencing behavioural difficulties (Klein Velderman *et al.* 2006).

The main study outcome measure was behavioural difficulties and the authors hypothesised the rate of preschool behaviour problems would be lower in the intervention groups than in the control group at follow-up. The authors proposed that intervention effect on child behavioural problems was mediated by intervention effects on parental sensitivity or child-parent attachment. Following intervention, eleven per cent of the VIPP intervention group were assessed as having clinical behavioural problems, which was in line with Dutch norms for behaviour problems - significantly less than the 35 and 42 per cent for externalising and total problems in the clinical range for the control group (exceeding Dutch norms). In conclusion, this study found an attachment-based video-feedback intervention in infancy was effective in preventing preschool clinical externalising and total behavioural problems, but not internalising problems. Contrary to the authors' expectations, there was no difference

between the VIPP-R and the control group, which conflicts with evidence that representation affects maternal sensitivity and in turn attachment security.

The authors suggested participants may have experienced less satisfaction with the representational part of the intervention or may have found the attachment discussions resulted in tensions which led to less favourable outcomes. It is also possible that, while brief interventions with a strong behavioural focus may be very effective, this timeframe may be insufficient for dealing with deeper psychological issues. It is possible that in the short term, increased awareness about the impact of mental representations on parenting could hinder the behavioural mechanism for positive change. These questions require further consideration, as they may have implications for wider therapeutic work.

Further perusal of this study suggested some methodological flaws. Changes noted in the VIPP group may not be attributable to any specific attachment intervention. The reported correlation between maternal satisfaction with support received and behavioural difficulties occurring at preschool age may be attributable to generic “support” experienced by the mothers. The authors also suggested experimental flaws in their reliance on self-report for the behavioural difficulties. However, the intervention design did enable the authors to test out theoretical assumptions and hypotheses regarding parenting and child behavioural difficulties. This has contributed to the evidence base for clinical practice in early intervention and moves the focus away from behaviour management strategies or discipline, which are more commonplace for interventions targeted later in the pre-school years. In early

infancy, parents may be more willing to accept social-emotional attunement of parent and child as the main focus for intervention.

VIPP attachment intervention protects infants from developing problematic behavioural problems at preschool, but the mechanism for this is unclear. It is possible that increased sensitivity in the short term resulted in overall improvement but could not be captured in the sensitivity measures administered at a later date. Improvements in a mother's ability to empathise or understand her child's perspective may have been sufficient to offset the risks posed by maternal insecurity as defined on the AAI.

#### **4.1.3 Preventative intervention in adoptive families**

A randomised intervention study by Juffer, Bakermans-Kranenburg and van Ijzendoorn (2005) evaluated the impact on reducing disorganised attachment of two attachment interventions seeking to promote sensitive responsiveness and infant security. It involved 130 families with six-month adopted infants being assigned to two treatment groups and a control group. The first involved a personalised book detailing sensitive parenting and the second included provision of the book and three sessions of infant-carer interaction video feedback. The outcome measures were maternal sensitive responsiveness observed in an eight-minute videoed free-play session, infant-mother attachment, observed through the strange situation (Ainsworth, 1978) and perceived child temperament. The study found the video-feedback treatment was effective in altering sensitive responsiveness but not the book only treatment. Unexpectedly, the video intervention was also effective in preventing disorganised attachment. 6.1 per cent of the video group classified as disorganised following intervention compared to 22.4 per cent of the control group. Regression

analysis revealed the video-feedback intervention appeared to have a distinct, significant influence on attachment disorganisation over and above the other predictors, including sensitive responsiveness. The authors suggest that the video-feedback enables parents to be coached in recognising their child's signals and receive reinforcement for sensitive responsiveness.

This was a detailed and thorough study, employing random control methodology. Care was taken to minimise assessment bias, and the participant sample was scrutinised for significant differences that could contribute to treatment effects. By way of criticism, these findings may have little significance for the wider population of adopted children, who are placed with families later than six months of age and have experienced maltreatment and multiple separations.

#### **4.1.4 Video-feedback intervention to promote positive parenting and sensitive discipline (VIPP-SD)**

On the basis of findings that maladaptive patterns of parent-child interaction are a component in externalising problems, Van Zeijl, Mesman, Van Ijzendoorn, Bakermans-Kranwnburg, Juffer, Stolk, and Koot, (2006) evaluated a preventative attachment-based intervention aimed at reducing externalising behaviour in a high-risk sample. The study rationale was based on there being a paucity of literature within the field of attachment indicating effective discipline approaches for parents. The authors proposed Coercion Theory, based on social learning perspective and focused on ineffective parental discipline, bridged this gap and informed the design of a new component to the previously researched VIPP programme. In addition, the study aimed to establish whether child temperament or age moderated intervention

effect. The findings indicated mothers who received the intervention had more favourable attitudes towards sensitivity and towards sensitive discipline afterwards, when compared with the control group and the effect was not found to be related to child temperament, sex, age, family characteristic or professional training of the therapist. The study also found a reduction in overactive behaviours in children from families with high levels of daily hassles and marital discord. The largest effects were found to be associated with families with greater need for support. Since the study did not establish a relationship between improved maternal attitudes to sensitivity, sensitive discipline, enhanced sensitive behaviours and overactive problem behaviours, the precise mechanism for the improvement is unclear and this requires further investigation

Justification for the study was made explicit and the hypotheses were clearly stated. The study recruited 246 children from a very large eligible population and homogenous participants were selected to eliminate bias. The sample was randomly assigned to either intervention or control group and treatment fidelity was supported by a treatment manual and regular supervision. Weaknesses of this study were the over-representation of middle class families and the extensive exclusion criteria, for example ethnic minority and single-parent families. Consequently, findings may generalise poorly to a clinical population, which is likely to be diverse.

#### **4.1.5 Family-based neonatal intensive care unit (NICU) interventions.**

Pre-term infants born to lower socio-economic mothers are at higher risk of poor developmental outcomes than those born to middle-class mothers (Browne & Talmi, 2006). Few studies have examined the impact of brief hospital interventions to

address this. Browne and Talmi (2006) describe findings from a randomised controlled trial (RCT), investigating the effects of guided interaction versus educational interventions with low-income mothers of pre-term infants. The outcome measures included physical health, parenting stress, assessment of characteristics unique to interaction during feeding and awareness of pre-term infant behaviour. The first intervention group received an interaction demonstration using a refined form of the Brazelton Neonatal Behaviour Assessment Scale (1973). The session was individually tailored to encourage parental participation. The second group received education only, in the form of slides, books and tapes. The control group participated in an informal discussion with no specific reference to behaviour or social interaction. At follow-up dyad interaction during feeding was videoed and independently scored.

The findings were consistent with other research cited in the article; hospital-based interventions with low socio-economic status mothers of pre-term infants improve their knowledge of infant behaviour, their interaction with the infant and levels of parental stress. However, the study found no discernible differences between the outcomes for the two intervention groups. Several points can be made in support of the evidence generated by this study. It was well designed and had clearly stated objectives. There are clinical implications in that the least costly option of providing educational materials alone was sufficient intervention to achieve a good outcome. However, on reflection, these findings cannot be generalised due to the nature of the population studied. Moreover, success could feasibly be explained by positive effects on the concurrent risk factors faced by this population, which may not be present for other samples. Also, engagement was an important discussion point in

this study and these findings do not deliver an understanding about its role alongside the “intervention” for generating good outcomes.

## **4.2 Intervention studies**

A second group of studies targeted clinical or referred populations. These four studies included children referred to mental health services, children whose mothers were depressed and children who were fostered or adopted.

### **4.2.1 Watch, wait and wonder programme**

Cohen, Lojkasek, Muir, Muir and Parker (2002) reported follow-up findings from an American study conducted to compare the outcomes of two mother-infant psychotherapies (Cicchetti, Toth & Rogosch, 1999). Sixty-seven 10 to 30-month-old infants and their mothers were recruited from a children’s mental health clinic with longstanding problems including difficulties with feeding, sleeping, behavioural regulation and parent report of attachment or relational difficulties. One participant group received the ‘Watch, wait and wonder’ programme (WWW), which placed the infant in the role of initiating play and activity. WWW works at the behavioural level, teaching the mother to follow her infant’s lead, and also at the representation level in the post-session discussions aimed at eliciting the mother’s thoughts and feelings about the session. The second group received a psychodynamic psychotherapeutic approach (PPT) (Frailberg, Adelson & Shapiro, 1987), which focused primarily on engaging the mother or the family. After five months, a reduction in the presenting symptoms and improvement in the mother-infant relationship occurred in both treatment groups. Mothers receiving WWW showed greater improvements in depression than the PPT group and reported a sense of competence in the parenting

role. There was also greater improvement in the WWW infants for cognitive development and emotional regulation and finally a greater shift in attachment security.

The follow-up study employed a range of measures (see Appendix B) to review treatment effects over time. Mothers in both groups reported further significant reductions in depression from post-treatment to follow-up. For the PPT group this decrease only occurred in the post-treatment to follow-up period. The findings showed mothers in the WWW group reported a greater increase in comfort in dealing with infant behaviour from post-treatment to follow-up, while the PPT group did not. However, the mothers' ratings of symptom severity and their own effectiveness in dealing with the problems improved further by follow-up in both groups. In conclusion, both these interventions were effective in achieving treatment goals but those dyads engaged in the WWW programme appeared to make progress in a shorter timeframe.

There are notable strengths within this study. Firstly, the authors made explicit their aims, hypotheses and purpose for investigation. Validity was enhanced by the report that dyads lost to follow-up comprised less than 10 per cent of the original participant sample and there were no differences in the background measures or pre-treatment scores between dyads who did not complete the follow-up and those who remained in the study. The infant-parent dyads were randomly assigned to the two treatment groups and the design appeared to minimise the opportunity for systematic bias. Consistency across the groups was noted with regards to infant age, family



income and maternal education. Finally, the number and breadth of outcome measures incorporated into the study afforded a thorough examination of treatment outcome.

There are some weaknesses worth noting. The authors acknowledged that in the absence of a control group, there is inconclusive evidence that the changes in outcome measures were attributable to the interventions. Since this study was undertaken within a clinical context, there were considerable ethical issues associated with adopting ideal methodology. In particular, the authors noted infants could not wait for treatment.

In conclusion, this study imparts practice-based evidence for the use of two treatment protocols responding to real clinical referrals. On this basis it is probable the positive outcomes could be replicated elsewhere, although as with several studies discussed here, replication within a UK setting would be necessary in order to ensure this.

#### **4.2.2 Toddler-parent psychotherapy**

The literature indicates that children whose mothers are depressed face an increased risk of developing psychopathology during childhood (Cicchetti & Toth, 1998; Murray, 1992). One possible contributory factor is the impact of MD on the attachment security of the child. Mothers with depression demonstrate less sensitivity as parents, show greater negativity and less positive affect in their interactions with their children. This is experienced by the child as physical and emotional unavailability and affects the security of the attachment they form with their parent (Murray, 1992). One explanation for this phenomenon is that the mother's own

internal attachment representations affect her sensitivity and responsiveness to her child's attachment signals (Toth, Rogosch, Manly & Cicchetti, 2006). Despite such evidence, there is limited research evaluating interventions aimed at supporting the relationship between mothers with depression and their children. Toth *et al.* (2006) attended to this discrepancy by investigating the effectiveness of Toddler-Parent Psychotherapy (TPP) (Cicchetti, Toth & Rogosch, 1999). TPP is informed by attachment theory and offers a preventative approach to fostering attachment security in the infant and pre-schooler offspring of mothers with MD.

The study participants were 130 mothers who had experienced a major depressive episode since the time of their child's birth and 68 non-depressed mothers recruited for comparison. The average age of the children was 20.34 months and the mothers ranged in age from 21 to 41. Low socio-economic status families were excluded to avoid co-occurring risk factors for MD. The depressed participants were randomly assigned to intervention and control groups and this process was double-blind to researchers involved in the study. Measures were applied at baseline and follow-up when the children were aged 30 months (see Appendix A).

The authors hypothesised the offspring of mothers with MD would show higher levels of insecure attachment at baseline than offspring of non-depressed mothers. Secondly, they hypothesised the provision of TPP would result in increased attachment security in the depressed intervention group and there would be no change in the depressed control group. TPP was not specifically tasked with reducing symptoms of depression.

The study found baseline differences in attachment classifications for the three groups, with 55.6 per cent of infants and pre-schoolers in the non-depressed control group classified as securely attached, compared with only 16.7 per cent of the depressed intervention group and 21.9 per cent of the depressed control group. Following intervention, the rate of change from insecure to secure attachment was significantly higher in the depressed intervention group (54 per cent) when compared with the depressed control group (7.4 per cent) and also in contrast with the comparison group (14.3 per cent). The difference in change between the two control groups was not significant. Another important finding was the stability of insecure attachment within the depressed control group (72 per cent). By examining the potential moderating role of mothers having a subsequent depressive episode on intervention outcomes, the authors found that recurring maternal depression did not undermine the effectiveness of this intervention. In conclusion, this study found insecure patterns of attachment are more common in the children of mothers with MD than in those of non-depressed mothers. Secondly, the intervention was successful in altering insecure attachments in children of depressed mothers, including the category of disorganised insecure attachment. These findings are consistent with research indicating treatment of MD is insufficient to improve parenting behaviour (Austin & Priest, 2005) and which suggest improved outcomes for children may be better achieved by prioritising parenting rather than mental health interventions. Finally, despite evidence of rigidity in attachment classifications in the case of depressed mothers (Toth et al., 2006), very early intervention appears effective in altering the attachment security.

This was a robust study with a strong experimental design. The authors checked for differential attrition by comparing the participants who completed the study with those lost to follow-up and found no significant differences between the groups for baseline MD scores or demographic characteristic. This suggests no evidence of selection bias in the retained sample. A high degree of rigour was applied to the conduct of this study, which strengthens the validity of the findings. For example, the authors strived for treatment fidelity and consistency, which was achieved through video-taping of sessions and close supervision of therapists.

#### **4.2.3 The keys to care giving**

Jung, Short, Letourneau, and Andrews (2007) described an evaluation of the Keys to caregiving (KTC) intervention, which aims to help parents understand and respond to infant behaviours in order to increase positive affective expression in the infant. This pilot study included 11 dyads with a mild to moderately-depressed mother. The intervention comprised five-weekly group sessions initiated when the infant was aged three months. Participants were trained in understanding and interpreting their infant's responses. Video recordings of dyad interaction, including a form of "still-face perturbation"<sup>4</sup> were coded as pre and post measures. Results demonstrated an increase in the infants' expressions of interest and of joy following intervention. Infants were found to be more able to anticipate their mother's responses and could signal their feelings more readily. Such skills form the basis of relationship and suggest a healthier developmental trajectory. This study is reported as a pilot so the small numbers and lack of control are understandable but do undermine the drawing of conclusions. The study reports an original participant group of 17, so 11

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<sup>4</sup> Still-face perturbation is a procedure for assessing infants' responses to low maternal affect.

participants represents a significant drop-out. Moreover, this study lacked follow-up, so there is no indication of positive change being sustained over time. The authors comment the study illustrates that interventions focusing on what parents do rather than how they feel show significant promise.

#### **4.2.4 Attachment and bio-behavioural catch-up programme**

Dozier, Peloso, Lindhiem, Gordon, Manni, Sepulveda, Ackerman, Bernier and Levine (2006) outlined preliminary data derived from testing an intervention targeted at foster carers. The model, developed by the authors, and known as attachment and bio-behavioural catch-up (ABC), consists of 10 videotaped therapy sessions offered to the carer and child within the family home. They focus on the carers' mental representations (or internal working models). The underlying premise for the intervention is that insecure internal working models are likely to trigger old anxieties and unresolved losses and traumas for the carer. These feelings inhibit their ability to offer sensitive and attuned care for the child. The carers are encouraged to reflect on their own attachment history using the therapist as a secure base. By working with the carer and the placed child, therapy can also focus on the child's disorganised attachment. This is manifested in the child holding a mental representation of carers as either hostile or helpless and their own controlling strategies employed to maintain this status quo. Therapy tasks are to help the child feel safe and trust their carers and to allow them to let go of their defensive behaviour so they can experience sensitive and attuned care. Furthermore, therapy aims to improve children's ability to regulate their own emotions effectively.

In the study, 60 children aged between 3.6 and 39.4 months at follow-up were randomly assigned to the experimental or control intervention (developmental intervention for families (DIF)). A third group of 104 normally developing infants aged between 20 and 60 months was included for comparison. In both conditions, the foster parents received 10 weekly training sessions and post-intervention measures were collected one month after completing the training. Outcome measures included the children's diurnal production of cortisol (a stress hormone), and parental report of children's problem behaviours. The results showed that children who received the ABC intervention had lower cortisol levels than children in the control intervention. Comparisons with the normally developing children showed differences between the control intervention group but not between the ABC intervention group and the normally developing group. Regarding behaviour outcomes, in the ABC group parents of toddlers reported fewer problems than parents of infants, indicating a treatment effect over time. This difference was not found in the control group. Other differences were noted but not found to be significant. The authors suggest that the brief intervention impacts more widely on parent-child interaction, accounting for the positive effect.

Strengths of this study include the RCT method employed and the stringent application of the model. Experienced professionals delivered the programme and all sessions were videotaped to ensure fidelity. In combination with the large effect size reported, these strengths indicate that early intervention with this population is effective and achievable in a brief timeframe.

### **4.3 Large-scale treatment approaches**

This final group of studies document large-scale treatment approaches which have been evaluated over an extended timeframe. They target children in foster care, and children at risk of abuse or neglect.

#### **4.3.1 Multi-dimensional treatment foster care for preschoolers**

In the past, therapeutic approaches have often focused on individual therapy for trauma rather than relationship issues and there appears to be a paucity of well-researched interventions for young children with attachment difficulties living with foster or adoptive families (Dozier, 2006; Howe, 2006).

Two variables have been found to be associated with children in foster care forming secure attachments: a younger age at the time of placement and being placed with carers who showed higher levels of autonomy on the AAI (Fisher & Kim, 2007). This has led to important questions about whether treatment interventions can successfully alter attachment classifications and bring wider benefits for children placed in foster care. A study by Fisher and Kim (2007) used randomised control trial methodology to evaluate a mode of treatment called Multi-dimensional treatment foster care for preschoolers (MTFC-P) (Fisher, Ellis & Hamberlain, 1999).

This is a specific intervention aimed at young children in foster care. Supporters of the programme claim it is effective in promoting secure attachments in foster care and some research has found it to be effective in reducing permanent placement failure rate and helping to offset the effects of multiple foster placement risk for permanent placement failure (Fisher *et al.* 2005).

MTFC-P adopts a team treatment approach: training foster carers and providing on-going consultation and support; providing children with individual skills training and a therapeutic playgroup and providing family therapy. The therapeutic elements involve the encouragement of pro-social behaviour; consistent, non-abusive limit-setting to address disruptive behaviour and close supervision of the child. In addition, the MTFC-P intervention employs a developmental framework in which the challenges of foster preschoolers are viewed from the perspective of delayed maturation.

The study outcome measure was whether intervention altered a participant's ability to seek out their caregiver when distressed which was indicative of secure behaviour, low resistance and avoidance measured using the parent attachment diary (PAD). This measure has been found to be consistent with classifications derived from the stranger situation test (Fisher & Kim, 2007). The authors also investigated whether age at initial placement was associated with differential effectiveness of the intervention on attachment outcomes. The study participants were 137 three to five-year-old foster preschoolers entering a new foster placement and they were divided into control and treatment groups. The recruitment period spanned three-and-a-half years and eligibility criteria dictated the placement was expected to last for three or more months. Participants were assessed at time one, again at three-month intervals over the subsequent 12 months and finally post intervention. The attachment classifications of the children were assessed using PAD and the data analysed using latent growth curve modelling (LGM) methodology. Findings indicated children who received the intervention tended to show more secure behaviour over time than the control group participants.



In critique of this study, it is worth noting that the initial analysis did not demonstrate significant differences between the two groups of children for security scores on the PAD. Using the LGM statistical method, a trend was identified but it is questionable whether sufficient change could be achieved over time to deem the intervention successful. Further longitudinal research would be beneficial. The study can also be criticised for a lack of clarity in stating its aims and objectives. Unfortunately, the authors were only able to conclude that positive changes in attachment related behaviours are possible within foster care. This is encouraging but does not inform the audience about the actual validity or efficacy of the treatment applied within the study. The authors did however look at the differences between participants who dropped out at baseline and found no significant differences regarding attachment, child age, gender or ethnicity. This measure suggests a degree of integrity.

In summary, although there seems to be evidence that foster placements may be strengthened by MTFC-P, the research to date is not conclusive in documenting the mechanism for this outcome. Of great interest is whether altering attachment classifications is key to stabilising placements or whether the additional support offered by this programme is the influencing factor. There are considerable methodological challenges in developing the evidence base for this population. Measurements of attachment security derived from the strange situation assessment (Ainsworth, 1978), are unreliable for children who may not relate to their carer as a primary carer. The PAD may be a useful tool in bridging this gap.

#### **4.3.2 Florida infant mental health pilot programme**

One million cases of child abuse and neglect are substantiated in the USA each year and this is not thought to represent the true scale of the problem (Osofsky, Kronenberg, Hammer, Lederman, Katz, Adams, & Hogan, 2007). Forty-five per cent of these cases concern children under the age of five. These statistics formed the basis of an intervention and treatment model for Florida's infant and young children mental health pilot project, described by Osofsky *et al.* (2007). The programme aimed to identify and treat families with children at risk of abuse and neglect.

During the three-year project, 129 child-caregiver dyads were referred on the basis of risk of or actual abuse/neglect of their child. Seventy-two dyads were non-compliant from the outset and a further 15 did not complete treatment. Pre and post outcome measures were gathered for a total of 50 dyads. The programme aimed to reduce abuse and neglect by providing 25 sessions of child-parent psychotherapy alongside intensive engagement work and support.

The treatment model was designed for children aged from 0-5, showing signs of mental health or behavioural problems. The main finding was that no further reports of abuse or neglect were made during the course of treatment up to follow-up. Following treatment, the health and development status of the children increased for 50% of the sample and caregiver depressive symptoms fell from 53 per cent to 32 per cent. Parent-child relationship functioning, based on observation and self reports, improved significantly in all domains for parents and children.

This sample represented a high-risk population where mental health and substance issues were prevalent and 59 per cent were ordered by court to participate.

Treatment compliance was not routinely expected. The study had clearly stated aims and objectives and analysis of non-compliance and drop-out showed that mothers who had completed high school were more likely to complete treatment. The study employed independent raters to score tapes of child-carer play using parent-child relationship scales and high levels of inter-rater agreement were reported. Again the evaluation process related to more than the therapeutic model employed, as there was a range of additional supportive mechanisms in place, such as case management and referral to other appropriate services. The engagement process, estimated to be 10 hours for every one hour of therapy, was felt to be key for success. Despite great efforts, only just over half of the referrals did not complete the programme. Combined with the lack of control, this limits the generalisability of the findings. However, this is a very complex population and RCT methodology may be unethical since at-risk infants cannot wait for treatment for the purpose of providing a control condition.

#### **4.3.3 Nurse-family partnership**

Olds (2006) summarised the findings of three random-controlled research trials investigating the effectiveness of a pre-natal and early childhood home visitation programme. This nurse-led intervention targeted first-time mothers identified as being at risk of poor health outcomes and drew on Ecological, Self-efficacy and Attachment Theories. It consisted of weekly visits during pregnancy and the early months of the infant's life, which reduced gradually to fortnightly and monthly visits before ending when the child reached the age of two.

The study demonstrated improvements in parental care of the child, indicated by fewer injuries and ingestions, improved developmental outcomes and enhanced

maternal life course. The effects were found to be most significant for families facing greater risks. The strength of this study was its documentation of a 27-year intervention programme, with sound theoretical underpinnings. For example, it aimed to modify specific risks such as child abuse and neglect injuries and compromised parental life-course. Furthermore, it adopted rigorous methodology including RCT, the application of wide-ranging outcome measures and it attended to treatment fidelity.

Success appeared to relate to the broad programme approach and it is hard to identify specific elements responsible for the outcome. Indeed, it is not possible to compare and contrast these findings with other studies detailing more discreet intervention models.

The trials were conducted in the USA, where the UK system of health visiting is not comparable. While UK health visitors do not routinely offer this level of intense homevisiting, there may be considerable overlap with the Sure Start initiatives located in high-risk communities (Sure Start, 2004). The US programme is due to be piloted in the UK and questions of transferability will be answered.

## **5. Summary**

The introduction observed that promoting secure attachments in infancy preschool years may have many benefits for child and adult mental health over time and this is particularly true for high-risk groups. This review considered a range of

attachment interventions, which seek to prevent insecure attachments from developing or promote secure attachments in the context of other risk factors.

The studies identified by the search strategy were largely attachment based, which supports the view that Attachment Theory offers an important framework for understanding the mental health needs of young children and provides a basis for early intervention.

This review found that time-limited behaviour-focused interventions for maternal sensitivity appear effective not only for improving maternal sensitivity but for strengthening children's attachment security. Moreover, insecure attachments, including disorganised attachments, may be altered but positive adjustments in maternal sensitivity do not necessarily translate into improvements in attachment security. The model components responsible for the change were not always clear. For example, many studies included a representational approach with good effect, while one notable example (VIPP-R) demonstrated poor outcomes when a representational element was added. The use of feedback was consistently found to be a valuable mechanism for altering maternal behaviour, most commonly through the use of video.

This review offered valuable insights regarding clinical problems. For example, treatment of maternal depression appears insufficient to improve parenting behaviour. Improved outcomes for children may be better achieved by prioritising parenting rather than mental health interventions. In fact, despite some evidence of rigidity in attachment classifications, the early timing of the intervention appears

crucial in achieving attachment security for these children. Similarly, early interventions appeared effective in stabilising placements for looked-after children, and reducing incidence of abuse and neglect in high-risk populations.

Barnes (2003) previously suggested interventions must be grounded within a multi-disciplinary approach in order to achieve a lasting effect for high-risk infants and their parents. Similarly, this review found successful outcomes appeared to be related, not just to the particular focus of the therapeutic model, but also to the support system in place to facilitate it, for example transport and time spent engaging families.

It is remarkable that many of these interventions demonstrated success within a clinical setting with clinical populations. This suggests replication may be achievable. However, it is also important to recognise that all of the studies featured were set outside the UK. Firm conclusions about the effectiveness of these programmes with a UK population would require further investigation.

## **6. Clinical implications**

A recent government publication pertinent to this review is the National Service Framework for Children, Young People and Maternity Services (NSF) (Department of Health, 2003). The framework recognises sensitive and responsive interaction between child and carer to be important for cognitive and emotional development. Significant to this review, it recommends that services should be directed towards high-risk families caring for babies in the first six months.

Despite government guidelines and the evidence base presented in this review, the mental health needs of infants and pre-schoolers are not routinely met by clinical psychologists and their CAMHS colleagues, due to services being overwhelmed by the demands of school age children (Young Minds, 2003). This age group is more likely served by health visitors, Sure Start workers and social workers who do not have specialist mental health knowledge. Clinical psychologists are well placed to offer consultation to such professionals regarding early identification and treatment of IMH difficulties. In addition, they may also be well placed to influence the directions of evidence-based services for this age group. This is particularly relevant in the case of vulnerable, high-risk or difficult to engage families who would be unlikely to attend clinic appointments. Lancaster (2004) commented that clinical psychologists are under-represented in this multi-disciplinary field, despite the role of psychological theory in IMH research and intervention. Their skills could be usefully applied to developing and testing theories, evaluating and refining methodologies and assessment instruments, carrying out outcome research, clinical interventions and providing consultation and training.

## **7. Future research**

For early intervention to be realised, not only do IMH issues need to be placed higher up the agenda - questions about identifying problems early need to be raised. Carter, Briggs-Gowan and Ornstein Davis (2004) comment on the considerable resistance to identifying problems early and suggest this is partly due to stigma surrounding mental health and the potential for parents to self-blame or lose confidence in their parenting abilities. Bricker, Schoen, Davis and Squires (2004)

suggest there are at least five barriers to the development of mental health screening programs: variability in young children's behaviour, paediatric gate-keeping; lack of family involvement; eligibility guidelines and a lack of accurate low-cost screening measures. Their study found that, with the right tools, parents were able to effectively screen for social-emotional or mental health problems. The inclusion of parents as first-level screeners requires further investigation.

Experimental research studies examining psychological interventions for under-fives need to be replicated with a UK sample. There is limited research focused on those parents who do not complete interventions offered to them or who cannot easily be engaged (Barnes, 2003). Difficult to engage families raise serious questions about generalising research findings. A better understanding of this group would inform clinical services and future research design.

The NSF seeks to ensure that “Staff working with children and young people are advised and supported in identifying possible mental health problems and making appropriate referrals” (DOH, 2004, p9). This recommendation triggers questions about how non-mental health professionals understand mental health problems in young children and what processes govern identification and referral processes. Health visitors are a front-line NHS profession working with this age group. Research seeking to understand how they identify, manage and refer IMH issues would inform future referral pathways for psychological interventions with this age group and may identify important training needs.



## **8. Current Empirical Study**

The empirical study reported within this thesis was conceived in order to respond to some of the research challenges outlined above. Specifically, the study aimed to generate a detailed understanding of how infant mental health difficulties are conceptualised by health visitors working with infants and pre-schoolers. Moreover, the study sought to examine health visitors' processes as they engaged in identification, management and referral of mental health difficulties located within this population.

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## Appendix A

### **Table of intervention studies reviewed**

Table of Intervention Studies Reviewed						
	Reference	Name of model	Participants	Brief description	Outcome measures	Study findings
1	Hoffman, K. T., Marvin, R. S., Cooper, G. & Powell, B. (2006) Changing toddlers and preschoolers' Attachment Classifications: The Circle of Security Intervention. <u>Journal of Consulting and Clinical Psychology</u> , 74 (6) 1017-1026	<b>Circle of security</b>	65 toddler or preschooler caregiver dyads identified as high risk.	<u>PREVENTATIVE intervention</u> 20-week group-based parent education and psychotherapy intervention using video aimed to alter insecure patterns of attachment.	Attachment security: Strange situation	Authors concluded that the circle of security intervention was a promising intervention for the reduction of disorganised and insecure attachment in high-risk toddlers and preschoolers.
2	Velderman, M., Bakermans-Kranenburg, M. J., Juffer, F., Van Ijzendoorn, M.H. Mangelsdorf, S.C. & Zevalkink, J. (2006) Effects of Attachment-Based Interventions on Maternal Sensitivity and Infant Attachment: Differential Susceptibility of Higher Reactive Infants. <u>Journal of Family Psychology</u> , 20(2) 266-274	<b>Video Intervention to promote positive parenting (VIPP)</b>  <b>Video Intervention to promote positive parenting with Representational focus (VIPP-R).</b>	81 insecurely-attached mothers and their infants.	<u>PREVENTATIVE intervention</u> VIPP is a behavioural approach, which incorporated video feedback to enhance mothers' sensitive responsiveness and promote positive parenting. VIPP-R combined VIPP with a representational focus. This additional component aimed to alter the mothers' representation of attachment.  <b>Experimental design with control</b> <u>PREVENTATIVE intervention</u>	Attachment Q-sort, Child behaviour checklist, sensitive responsiveness, strange situation, emotional availability scales, maternal health questionnaire, support and stress questionnaire and a baby diary.	Study found evidence for VIPP as effective for intervention in infancy to prevent preschool clinical externalising and total behaviour problems, but not internalising problems. The additional representation focus included in VIPP-R was found not to be effective.
3	Juffer, F., Bakermans-Kranenburg, M.J. & van Ijzendoorn, M., H. (2005) The Importance of Parenting in the Development of Disorganised Attachment: Evidence from a Preventive Intervention Study	<b>Programmes aimed at enhancing sensitive responsiveness.</b> Personalised information book	130 families with six-month-old adopted infants	<u>PREVENTATIVE intervention</u> Families were assigned to one of two treatments or a control group. The additional video-feedback involved three home-based sessions,	Infant- Carer attachment: Strange Situation, Maternal sensitive responsiveness observed in an 8-minute free-play session. Dutch temperament	The intervention with video feedback and the personal book resulted in enhanced maternal sensitive responsiveness and prevented disorganised attachment. The study supports the importance of parenting in the development of infant attachment

	in Adoptive Families. <u>Journal of Child Psychology and Psychiatry</u> 46(3) 263-274	intervention and book intervention and three home-based sessions of video feedback.		examining carer-infant interaction. <b>RCT methodology</b>	questionnaire, Disorganised attachment strange situation.	disorganisation.
<b>4</b>	Van Zeijl, J., Mesman, J., Van Ijzendoorn, M.H. Bakermans-Kranenburg, M. J., Juffer, F., Stolk, M.N. & Koot, H.,M. (2006) Attachment-Based Intervention for enhancing Sensitive Discipline in Mothers of 1-3- year old children at risk for externalising behaviour problems: A randomised Controlled Trial. <u>Journal of Consulting and Clinical Psychology</u> 74 (6), 994-1005	<b>Video-feedback Intervention to promote positive parenting and sensitive discipline (VIPP-SD).</b>	237 families with 1-3 year old children scoring relatively highly on measures for externalising behaviour.	<u>PREVENTATIVE intervention</u> VIPP-SD is based on attachment theory and coercion theory and consists of six 1.5 hour sessions aimed at discussing actual parent-child interactions in the family home <b>RCT methodology</b>	Daily hassles, marital discord, well being, difficult temperament, externalising problems, maternal attitudes towards sensitivity and sensitive discipline, maternal sensitivity, maternal discipline.	VIPP-SD was effective in improving maternal attitudes to sensitivity and sensitive discipline and in promoting sensitive discipline interactions
<b>5</b>	Browne, J.,V., Talmi, A. (2005) Family-based Intervention to Enhance Infant-Parent Relationships in the Neonatal Intensive Care Unit. <u>Journal of Paediatric Psychology</u> 30(8), 667-677	<b>Family-based interventions in the neonatal intensive care unit (NICU)</b>	84 high-risk mother-infant dyads	<u>PREVENTATIVE intervention</u> Participants were randomly assigned to two intervention and one control group <b>RCT methodology</b>	Nursing Child Assessment Feeding Scale, Parenting Stress Index, Knowledge of Pre-term infant behaviour scale.	In a high-risk sample, short-term hospital ICU interventions may enhance mother's sensitivity, contingency and stress.

6	Cohen, N.J., Lojkasek, M., Muir, E., Muir, R. & Parker, C. J. (2002) Six-month follow-up of two mother-infant psychotherapies: convergence of therapeutic outcomes. <u>Infant Mental Health Journal</u> 23(4)361-380	<b>Psychodynamic psychotherapeutic approach (PPT)</b> (Frailberg et al., 1986); <b>Watch, Wait and Wonder (WWW)</b> (Cohen et al., 1999).	67 10-30 month old infants and carers selected from a children's mental health clinic	<u>TREATMENT intervention</u> PPT and WWW interventions were compared. PPT was a conventional infant psychotherapy based on exploring maternal attachment representations and their impact on the parent relationship. WWW adopted a child-led approach incorporating a behavioural element.	Parenting stress index; competence sense of Maternal depression measured on Beck Depression Inventory, Bayley Scales, Chatoor mother/infant/toddler play scale; Attachment security: (strange situation)	Similar outcomes found for both models; reduction in the presenting symptoms and improvement in the mother-infant relationship. Both groups showed significant reduction in depression symptoms at follow-up. Outcomes included improvement in infant behaviour, parent- infant behaviour and parent feelings and wellbeing
7	Toth, S.L., Rogosch, F., A. & Cicchetti, D. (2006) The efficacy of Toddler-Parent Psychotherapy to reorganise attachment in the young offspring of mothers with major depressive disorder: A Randomised Preventative Trial. <u>Journal of Consulting and Clinical Psychology</u> 74 (6) 1006-1016	<b>Toddler Parent Psychotherapy (TPP)</b> Cicchetti, Toth & Rogosch, (1999)	Children of 130 mothers with major depressive disorder and Children of 68 non-depressed mothers as a control group. Mean age of infants 20.34 months	<u>TREATMENT intervention</u> Study investigated the effectiveness of TPP. TPP is an attachment theory-informed preventative approach to fostering attachment security in the toddler offspring of mothers with a major depressive disorder (MDD).	DIS-III-R (Robins et al., 1985) BDI (Beck et al., 1961) Strange Situation (Ainsworth et al. 1978)	Insecure patterns of attachment are more common in the children of mothers with MDD than in those of well mothers. The intervention was successful in altering insecure attachments in children of depressed mothers, including the category of disorganised insecure attachment. Improved outcomes for children may be better achieved by prioritising parenting rather than mental health interventions.
8	Jung, V., Short, R., Letourneau, N., & Andrews, D. (2007) Interventions with depressed mother and their infants: Modifying interactive behaviours. <u>Journal of Affective Disorders</u> 98, 199-205	<b>The Keys to Care giving</b>	11 dyads with a mild to moderately-depressed mother.	<u>TREATMENT intervention</u> Intervention pilot study comprised five-weekly group sessions initiated when the infant was aged three months.	A form of 'still-face perturbation' was videoed and coded.	Results showed increase in the infants' expressions of interest and of joy following intervention. Infants were found to be more able to anticipate their mothers' responses and could signal their feelings more readily.
9	Mary Dozier, Elizabeth Peloso, Oliver Lindhiem, M. Kathleen	<b>Attachment and Bio-behavioural</b>	60 adopted and fostered infants aged	<u>TREATMENT intervention</u>	Children's diurnal production of cortisol (a	Time limited intervention aimed foster carers is effective for enhancing foster

	Gordon, Melissa Manni, Sandra Sepulveda, John Ackerman, Annie Bernier, Seymour Levine (2006) Developing Evidence-Based Interventions for Foster Children: An Example of a Randomized Clinical Trial with Infants and Toddlers <u>Journal of Social Issues</u> 62 (4), 767–785.	<b>catch-up (ABC)</b> <b>Control</b> <b>intervention:</b> <b>Developmental Intervention for families (DEF)</b>	between 3.6 and 39.4 months at follow-up were allocated to a treatment or control group. 104 normally-developing infants aged 20-60 months were recruited for comparison.	ABC aims to help children develop regulatory capabilities. It comprises ten sessions aimed at child and carers. Carers helped to interpret their child's behaviour signals in order to offer more nurturing care. Carers are encouraged to reflect on their own feelings, which may impact on the relationship. The dyad is encouraged in activities, which will aid emotional regulation. <b>RCT methodology</b>	stress hormone), and parent report of children's problem behaviours.	children's regulatory capabilities.
<b>10</b>	Fisher, P.A. & Kim, H.K. (2007) Intervention Effects on Foster preschoolers Attachment Related Behaviours from a Randomised Trial. <u>Prevention Science</u> 8, 161-170	<b>Multidimensional Treatment Foster care for Preschoolers (MTFC-P)</b> Fisher Ellis & Chamberlain (1999)	137 3-5 year old foster preschoolers entering a new foster placement.	<u>LARGE-SCALE treatment approach</u> Investigated the impact on attachment security and placement permanency for treatment with fostered preschoolers <b>RCT methodology</b>	PAD	Authors were only able to conclude that positive changes in attachment related behaviours following MTFC-P intervention are possible within foster care.
<b>11</b>	Ososky, J., D., Kronenberg, M., Hayes Hammer, J., Lederman, C., Katz, L. Adams, S. & Hogan, S. The development and evaluation of the intervention model for the Florida infant mental health pilot program. <u>Infant Mental</u>	<b>Florida infant mental health pilot programme</b> <b>Child-Parent Psychotherapy.</b>	120 Families with children at risk for abuse and neglect ranging in age from one-52 months.	<u>LARGE SCALE treatment approach</u> Families were referred to the service, assessed and offered 25 sessions of treatment. A structural approach coincided with therapy, including intensive engagement work	Modified parent-child relationship assessment (Crowell & Fleishman, 1993); child development status: Ages and Stages Questionnaire; BDI, Parenting Stress Index	No further abuse or neglect reported during intervention and up to follow-up Significant improvements in the parent-child relationship functioning based on observation and self-reports. Study found that the program was



	Health Journal 28 (3), 259-280			and support. <b>Pre and post follow-up with no control group.</b>	Caregivers and Therapists Qualitative Impressions of Treatment	effective in all objectives, but findings were limited by the high drop-out and non-compliance of the original sample.
12	Olds, D.L. (2006) The nurse-family partnership: an evidence based preventative intervention <u>Infant Mental Health</u> 27(1) 5-25	<b>Nurse family partnership</b> Three RCT trials	A wide range of first-time mothers from different socio economic groups and ethnicities	<u>LARGE-SCALE treatment approach</u>  A 27- year early intervention approach to preventing poor childhood outcomes. <b>RCT methodology</b> <b>longitudinal methodology</b>	Child IQ, HOME inventory, Child abuse and injuries, parental life course, physical health	Program was successful in improving parental care of children reflected in fewer injuries and ingestions and better emotional language development. Maternal life course was improved, reflected in fewer pregnancies and greater workforce participation

## Appendix B

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## Appendix C

Summary of the theoretical models for early intervention outlined by Barnes (2003).

Model	Author	Comment
Parent-child bonding	Klaus and Keel (1976)	Extra mother-infant time post-birth to promote bonding.
Psychodynamic (brief) parent-infant psychotherapy	Frailberg (1980)	Direct work with mother and child aimed at modifying the maternal representation of herself and of her child. Therapists interpret what mothers project onto the child and the link between present and past conflicts. Therapy aims to enhance the dyad's reciprocity, communication and mutually-shared pleasure.
Infant-led psychotherapy	Lojkasek et al (1994), Muir (1992), Greenspan and Lieberman (1989)	Therapy involves setting aside time for the child's activity to be acknowledged by the mother in a similar way to a therapist working with an adult patient. Therapy aims to improve mutual sensitivity and responsiveness.
Attachment theory	Bowlby (1969)	Therapy aims to; <ul style="list-style-type: none"> <li>• Alter a maladaptive attachment relationship between parent and child by changing the internal working model of the relationship.</li> <li>• Increase mutual sensitivity and responsiveness.</li> <li>• Utilise the infant's capacity to play an active role in the relationship and his/her development.</li> <li>• Increase consistency so that the infant will develop in a more secure context .</li> </ul>
Developmental theory – infant capability	Brazelton, (1973)	Approach aims to improve partners' responsiveness by alerting them both to the interactive abilities of their newborn and to areas of relative weakness.
Pedagogical – parent as teacher	Wagner and Clayton (1999)	Also known as 'developmental guidance' and focuses on activities to enhance infant development and the mother-child relationship through sensitive interactions. Curriculum led activities aim to increase parents' knowledge of child development and their feelings of competence and confidence.
Interractional-relational guidance	Cramer et al (1990), McDonough (1993)	More individualised and flexible than developmental guidance, it aims to modify patterns by making mothers aware of their interactive styles, emphasising harmonious interactions over pathological ones.
Transactional Theory	Sameroff & Fiese (1990)	Interventions focus on ongoing dynamic transactions over time between parent and child using problem-solving strategies to cope with parental challenges.
Support/family self-sufficiency and empowerment	Lojkasek et al (1994)	Interventions rooted in social work and nursing. Based on premise that parents are better able to care for their children when they are themselves supported adequately. Mothers are assisted to access community resources such as housing, work or childcare to gain self-help e.g. counselling or social skills training.
Ecological theory	Belsky (1993), Bronfenbrenner(1979)	Child maltreatment and the resulting child difficulties are influenced not just by the individual but the family, the community and the culture in which the family is embedded. Intervention involves connecting women with formal and informal services and utilising home-visiting.

## **Appendix D**

### **Attachment Theory**

Attachment theory was first presented by John Bowlby (1969) and developed in collaboration with his colleague, Mary Ainsworth. Attachment is described by Bowlby as the special emotional bond developed between the infant and caregiver in the first years of life. He theorised that the attachment system has a strong evolutionary function in promoting human protection and survival by ensuring the infant remains in close contact with its caregiver. Bowlby described the secure base from which an infant could explore the world and to which it could return when threatened. Attachment theory also has a strong developmental premise as it recognises the need for human contact, reassurance and comfort in the face of illness, injury and threat as a normal response not only in infancy but also throughout the lifespan. In later life the secure attachment provides the knowledge the caregiver is potentially available at times of crisis (Carlson, Sampson & Scroufe, 2003).

An important premise of attachment theory is the assumption all infants with sufficient adult contact will develop an attachment regardless of treatment, but the strength of the attachment is dictated by the reliability and quality of the care given (Ainsworth, 1978). A secure attachment develops when the infant has confidence in the availability of the caregiver and the effectiveness of its own demands. Less confident relationships are the result of physically or emotionally unavailable or inconsistent care. Bowlby hypothesised the differences in quality of care (caregiver regulation) resulted in a variation in the quality of the attachment (dyadic regulation). He suggested these variations in turn influence the self-regulation of the infant

throughout childhood and into adulthood. Ainsworth (1978) began the process of testing these hypotheses and developed the well-known “strange situation” assessment to categorise attachment patterns into secure, anxiously avoidant and anxiously ambivalent. Attachment researchers agree that most infants utilise a range of strategies in order to cope with the stresses within their environment. Main (1990) describes the different categories of attachment as different adaptive responses to the environment. However, a fourth category appears to be a *breakdown or absence of an* organised strategy and has been described as a disorganised attachment (Main & Solomon, 1986). This pattern has been linked to frightening or confusing parental behaviour. (Lyons-Ruth, Bronfman & Parsons, 1999) and has been found to occur in 15 per cent of dyads in the normal population, increasing to 80% within high risk samples (Van Ijzendoorn & Sagi, 1999).

International studies support the universality of the theory (Bowlby, 1969) and many studies have provided evidence that parents from different cultures conceptualise attachment and security in similar ways (Van Ijzendoorn & Sagi, 1999). Moreover, findings that maternal sensitivity impacts on attachment security have also been replicated in cross-cultural studies (Tomlinson, Cooper & Murray, 2005). Many studies have replicated the work of Ainsworth and her findings that attachment security in the laboratory is related to caregiver sensitivity at home. Stability over time for these classifications has been identified to be as high as 82 per cent (Main & Cassidy, 1988) but children’s attachments have been found to alter with changes in the environment (Crittenden, 1995). Significantly, for the field of early intervention, Bowlby strongly believed attachment plays an important role in the development of mental health difficulties in later life and research on this question has gained momentum over the past decade.

## **PAPER 2**

### **RESEARCH REPORT**

**How Do Health Visitors Identify, Manage and Refer**

**Infant Mental Health Problems?**



## **Abstract**

### **Title: How Do Health Visitors Identify, Manage and Refer Infant Mental Health Problems?**

**Background:** There is substantial evidence supporting early intervention in the lives of children, to reduce mental disorder throughout the lifespan (Fonagy, 1998; Svanberg, 1999). Since child and adolescent mental health services are not routinely directed towards under-fives (Young Minds, 2003), health visitors, located in primary care services, are well placed to identify and manage infant mental health (IMH) problems. A detailed understanding of the processes governing these practices could usefully inform developments in service provision for under-fives and highlight areas of support or training that may be required.

**Method:** This study investigated health visitors' conceptualisations of IMH and sought to understand how they identified, managed and referred IMH problems in their caseload. Nine health visitors participated in the study and their views were explored using semi-structured interviews and grounded theory methodology.

**Results:** A theoretical account of participant conceptualisation of IMH was incorporated into a process model. This model offers a framework for understanding key activities in relation to IMH; promoting, identifying, intervening and referring. It also details contextual factors impacting on these processes. The most significant finding was that participants demonstrated expertise consistent with IMH programmes described in the literature, but did not always conceptualise their work in these terms.

**Conclusions:** The study discusses the possible role for health visitors in designated IMH work and the support and structures which may be needed to facilitate this. The implication of the findings for specialist mental health practitioners, such as clinical psychologists, is also considered.

**Key words:** Health visitors, infant mental health, qualitative, process model

# **Chapter 1**

## **1. Introduction**

### **1.1 Infant mental health**

Infant mental health (IMH) is a broad term encompassing theory, research and clinical practice related to the emotional wellbeing of very young children and their families (Zeanah & Zeanah, 2001). Knitzer (2001) defined the remit of IMH clinical practice. 'To improve the social and emotional wellbeing of young children and families by strengthening relationships with care-givers and promoting age appropriate social and emotional skills' (p9). Wetherston (2001) detailed five principle tasks embedded in IMH practice: emotional support; concrete assistance; developmental guidance; infant-parent psychotherapy and advocacy. Because the primary care-giving relationship is pivotal in IMH, relational perspectives continue to dominate current thinking about risk, psychopathology, assessment and intervention (Zeanah, 2000). From this perspective, problems do not reside solely in the mother or the child but occur in the relationship (Cohen, Lojkasek, Muir, Muir and Parker, 2002).

### **1.2 Background literature**

Justification for early intervention in IMH is well documented (Greenberg, 1999; Fonagy, 1998; Svanberg, 1999) and the evidence-base for preventative and treatment interventions for under-fives is growing (Murray, 2008). For early intervention to be realised, not only do IMH issues require prioritisation-questions about early identification also need to be raised.

Olds (2006) reported positive child and maternal health outcomes associated with an American-based intensive programme of nurse homevisiting during infant and preschool years. Pilot sites have been established since March 2007 to evaluate the model within a UK setting. In a recent review, Walker et al. (2008) concluded that a programme of intensive, tailored packages of homevisiting provided by specialist, trained and supported health visitors needs to be adopted more widely. Since the nurse-client relationship is the key to positive outcomes, the authors advocated a shift in nursing approach from a medical to a psycho-social model. Alternatively, health visitors could be supported by the provision of IMH-trained consultants. A further option, advocated by the authors, is the integration of a mental health-oriented theoretical framework, such as the Solihull Approach (Douglas, 2006), into day-to-day nursing practice.

### **1.3 Qualitative literature**

Although there is no specific literature exploring UK health visitor processes in relation to IMH, two grounded theory studies provide useful insights. Halpin (2007) explored the health visitor role with families where infants and pre-school children may have autistic spectrum disorder and participants perceived a role for themselves in early identification and family support. Sigel and Leiper (2004) examined General Practitioner (GP) views of their management and referral of psychological problems in adults. The process of *exploring psychological problems* was a dominant theme in assessment, referral and interface between GPs and mental health services. Referral occurred when GPs felt they had reached the limits of their capabilities to address a problem, and was affected by their views and expectations of mental health services.

A qualitative study by Summers, Funk, Twombly, Waddell and Squires (2007) investigated the elements of an effective IMH intervention from the perspective of those providing it. The study was particularly concerned with how a service provider's beliefs, views and conceptualisation of IMH affected their practice. The emotional experience of attachment work posed the greatest challenge to practitioners, but they found the practice of videotaping homevisits and regular consultation vital for skill development and helping them to place their expertise within a broader mental health framework.

#### **1.4 Research question**

This research study seeks to understand processes by which under-fives may be identified for early interventions. Since health visitors are in a front-line profession working with this age group, exploration of their views and experiences could further this aim. Moreover, given the scarcity of literature centred on how health visitors engage with IMH, this study aims to capture how they conceptualise, identify, manage and refer IMH problems in their caseload.

#### **1.5 Clinical implications**

This study aims to contribute to the literature by raising awareness about IMH work currently undertaken by health visitors. It is anticipated findings will build on literature relating to longer-term preventative strategies set out in the National Service Framework for Children, Young People and Maternity Services, (Department of Health, 2003).

Lancaster (2004) commented on the diversity of professionals contributing to the emerging field of IMH and the under-representation of clinical psychologists. She suggested they are unaware of important opportunities available to them, including developing theories, evaluating methodologies and assessment instruments, carrying out research, clinical interventions and providing consultation and training. This study acknowledges the contribution of clinical psychology and seeks to inform clinical practice in this emerging field by developing a clearer understanding of referral pathway for IMH problems and by informing professional consultation and training offered to early years professionals.

## **Chapter Two**

### **2. Method**

#### **2.1 Overview**

This chapter outlines the methodology utilised within this study. Consideration is given to the research question, epistemological stance and the rationale for choosing a qualitative approach, and more specifically employing Grounded Theory methodology. Research procedure is detailed, including recruitment, data collection and analysis. Finally, issues concerning quality are addressed.

#### **2.2 Forestructure and position**

Prior to commencing clinical training, I worked in an early years setting and acquired a strong interest in psychological interventions with young children and their families. I was particularly drawn to Attachment Theory, proposed by John Bowlby (1969), as it offers a framework for understanding how a child's emotional and psychological wellbeing can be fostered during childhood and beyond.

My initial research project aimed to explore the experiences of a group of vulnerable first-time mothers<sup>5</sup> engaged in an early intervention treatment approach. Although this was ultimately not possible due to practical challenges, I noted their health visitors had identified these mothers as vulnerable and referred for intervention. I contemplated what factors informed judgement and referral decision-making on the

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<sup>5</sup> The terms 'mother' and 'parent' will be used to depict 'primary-carer', since they were the terms most commonly used by participants, but the author acknowledges diversity in children's primary-carers may not be captured by these terms.

part of this professional group. As I became more focused on this research question, I acknowledged that in the absence of early interventions, health visitors may be identifying and managing IMH issues within their caseload. These ideas shaped my first steps towards writing a research proposal.

In this study, I adopted a ‘critical realist’ stance (see critical appraisal for a fuller exploration of my assumptions and beliefs in relation to the research question), which is informed by prior knowledge of this subject. This stance proposes that reality exists but can never be fully understood. Moreover, the natural laws governing this reality cannot be fully known.

### **2.3 Choosing Grounded Theory methodology**

In order to answer the question **‘how do health visitors identify, manage and refer infant mental health problems?’**, I needed to ascertain how this group conceptualise IMH problems within their caseload. Qualitative methodology was selected due to the paucity of literature about how potential participants understand the key concept. Qualitative methods are particularly well suited to capturing the perspectives and experiences of the people who are being studied, allow theory to be developed from fieldwork (Elliott, Fischer & Rennie, 1999) and have been commended when studying phenomena not previously researched (Turpin et al., 1997).

A Grounded Theory approach was selected for its emphasis on building a theory or model to explain particular phenomena (Strauss & Corbin, 1998); in this

case, how health visitors conceptualise, identify, manage and refer IMH problems. The laudable aim of generating new theory was felt to be an important outcome for this study. Firstly, it created possibilities for applying findings more widely within the health visiting profession and, secondly, it offered a framework for exploring resonance across different professional groups working within IMH. The Grounded Theory method proposed by Charmaz (2006) was selected for its applicability to the research question. It helps to develop substantive theory, which generates understanding about a specific area of inquiry, in this case IMH.

Finally, for expediency, this approach offered a clear structure and provided rigorous procedures for checking, refining and developing ideas and intuitions about the data (Charmaz, 2006). As such, this method is suited to the task of exploring a new field and the needs of an inexperienced researcher.

## **2.4 Participants**

### *2.4.1 Procedure*

Ethical approval was gained from the University of Leicester and Sheffield NHS Research Ethics Committee, (see appendix A) and research governance was granted by the relevant NHS trusts. Subsequently, I met with a health visitor, identified by my field supervisor, who had agreed to assist with the recruitment of other health visitors from the selected primary care trust. She spoke informally to colleagues about the research and provided an 'information sheet' (see Appendix B) and a 'consent to be approached' form (see Appendix C) to those who were interested. In addition, I discussed the study with a health visitor manager who also recruited and distributed paperwork on my behalf. Health visitors who signed and returned 'consent to be approached' forms were contacted directly by telephone to discuss their



involvement in the study and arrange a convenient time for an interview to take place. Nine health visitors agreed to participate in the study. They were derived from five different teams within the chosen area and their health visiting experience ranged from four to 36 years (see Table 1.). A principal clinical psychologist acted as field supervisor for the project and oversaw the recruitment process locally. All the interviews took place at the participants' work bases, with one exception. Interview seven was held in the participant's home.

Health visitor (identified by initial <sup>6</sup> )	A	B	C	D	E	F	G	H	K
Years working as a health visitor	17	25	20	28	7	4	Missing data	2	36

Table 1. Years of health visiting experience held by participants.

#### 2.4.2 Sampling

With respect to participant sampling, four participants were recruited on a pragmatic basis, because they returned their consent forms early on in the recruitment process. Three participants were recruited because of their particular interest in the subject of inquiry and specialist knowledge or experiences. Two participants were recruited on the basis that they worked in different parts of the city and could contribute to a broader understanding of health visitor views.

There were ethical constraints placed on the propensity for broader theoretical sampling (see critical appraisal for discussion), however 'Theoretical sampling' was evident in my exploration of the utility of the term 'infant mental health'. It emerged

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<sup>6</sup> Health visitor participants were assigned an initial in order to maintain their anonymity. The letters 'I' and 'J' were not selected, in order to avoid confusion with the interviewer.

as a theme early in data collection and I took this into consideration in subsequent interviews.

## **2.5 Data collection**

Charmaz (2006) recommended collating a brief list of open-ended questions in preparation for data collection. I employed a schedule (see appendix D) to guide the interview procedure and incorporated prompt questions, which could be drawn upon depending on the pace set by each participant. As the data collection progressed, I adopted a naturalistic conversational interview style, which helped participants to relax and generated rich data. As themes began to emerge within the data, I adjusted the emphasis within my schedule. This allowed me the freedom to explore prominent participant responses in more detail. For example, I explored the meaning of ‘infant mental health’ in more detail as I realised the term had different meanings for different people. Interviews were conducted, audio-recorded and transcribed verbatim, with the participants’ consent (see Appendix C).

## **2.6 Data analysis**

### *2.6.1 Epistemological stance of the researcher*

Grounded Theory offers a methodological procedure which may be applied by researchers with different epistemological stances (Charmaz, 2006). However, it is important for individual stances to be made explicit to ensure treatment of data by the researcher is transparent for the audience.

The critical realist stance was evident at each stage of the research. For example, in the development of the research question, ‘infant mental health’ was

assumed to exist and there was an expectation that health visitors would have a relationship with it. During data collection, there was a willingness to explore different conceptualisations of this concept and give consideration to how it could be deconstructed (see critical appraisal for a terminology discussion).

### *2.6.2 Coding data and raising terms to conceptual categories*

The initial stage of analysis was carried out after the first two interviews had been transcribed. Charmaz (2006), described the process of coding as ‘naming segments of data with a label that simultaneously categorises, summarises and automatically accounts for each piece of data’ (p43). She suggests this is the first step towards making analytical interpretations. During this phase, I adhered to the discipline of line-by-line coding, which enabled me to become ‘immersed’ in the data and minimised personal biases (Charmaz, 2003). Table 2 provides an example of line-by-line coding from the seventh interview.

<b>Extract from transcript: Participant G</b>	<b>Line-by-line codes</b>
<p>‘Err, I suppose for me when I think about a baby when it is first born, I think of it in terms of attachment and bonding, err, and how well a mother and baby is able to bond together and how that affects the way the child is parented from the beginning. And therefore how their mental health thrives and flourishes because of their relationship with their, their mother.’</p> <p>G:12-16</p>	<p>Conceptualising infant mental health as attachment and bonding in mother and baby.</p> <p>Perceiving a relationship between quality of bonding and quality of parenting.</p> <p>Perceiving a relationship between healthy relationship and mental wellbeing.</p>

Table 2. Example of line-by-line coding.

During the second phase of coding, dominant and frequently occurring codes were identified. This process was more directive, selective and conceptual in form than the initial coding (Glaser, 1978). It led to new lines of inquiry and helped generate tentative theoretical categories indicative of the line-by-line codes (Charmaz, 2006). These ‘focused’ codes were recorded on index cards and on Word documents. I recorded ideas, thoughts and questions arising from the process and used subsequent interviews to examine, verify or simply build complexity into the fledgling ‘categories’. Writing ‘memos’ (Charmaz, 2006) allowed me to ‘crystallise’ and ‘thicken’ emerging themes (see Fig.1 for a memo example).

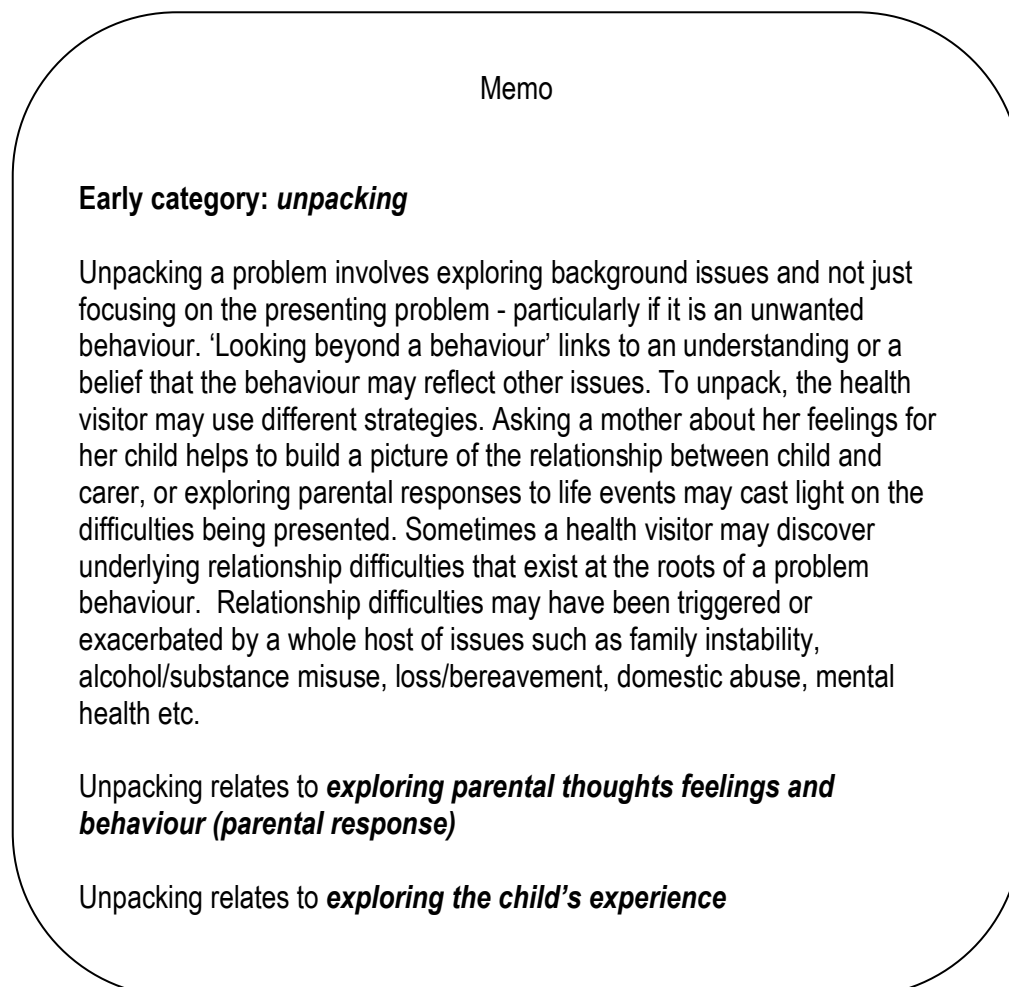


Fig. 1. Memo example

Interviews and analysis continued in parallel until the seventh interview (G). At this juncture, focused codes were reproduced on large flip chart paper using different colours to indicate different participants. A ‘story’ for each interview was scripted, (see Appendix E for an example) and the interviews were listened to again in their entirety. I used diagramming techniques (Charmaz, 2006) to represent categories and relationships between them. Thus, focused codes were selected and raised to a more abstract and theoretical level. These steps generated a preliminary model, which was adjusted in light of interviews eight and nine. This process constituted a form of respondent validation and helped to minimise errors within the analysis (Mays & Pope, 2000). Appendix F illustrates a change of emphasis within the analysis, which occurred in response to feedback provided by participant K. By this point ‘saturation’ was thought to have been achieved for the key theoretical categories (Strauss & Corbin, 1998; Charmaz, 2006).

## **2.7 Enhancing quality**

The desire to carry out high-calibre research prompted questions about what this actually entailed and how best it could be achieved. The utility of constructs such as reliability and validity, widely used to critique quantitative methods, have been challenged within the qualitative field, and alternative frameworks have been proposed (Merrick, 1999; Yardley, 2000; Elliott, Fischer & Rennie, 1999). In light of such debates, I employed a number of strategies to enhance quality in the research process and promote credible findings. The concepts of *trustworthiness*, *reflexivity* and *representation* (Merrick, 1999) offered guidance for this.

Firstly, I declared my research stance and made prior knowledge of the subject matter explicit. I completed a reflective diary throughout the research process, which provided an opportunity to express subjective opinions and increase my awareness about how my handling of data might be affected by race, gender, class, sexuality and my world-view.

Secondly, measures were taken to minimise interpretative bias. The ‘constant comparative method’ was employed (Glaser & Strauss, 1967) to help construct categories derived from the data rather than basing them on preconceived ideas or expectations. Comparisons were made at each stage of the analysis to highlight similarities and differences. Initially, this involved comparing statements and incidents within an interview and then, as the research progressed, statements and incidents were compared across different interviews. In the early stages of analysis, newly-formed categories were checked against subsequent data in order to establish consistency. This method facilitated the Grounded Theory process, allowing data to shape new lines of inquiry and test incipient themes.

Sections of data were coded by peers from a qualitative support group and also by the research supervisor. Similarly, the preliminary theoretical models were presented to research participants, peers and to the field supervisor for feedback.

## Chapter Three

### 3. Analysis.

This chapter will detail an analysis of the nine interview transcripts. It will introduce a model, which offers one understanding of how this group of health visitors identify, manage and refer IMH problems in their caseloads. One core category and twelve main categories were found to represent participants' conceptualisation of the IMH phenomenon, the processes governing their interaction with it and the range of contextual factors affecting this dynamic. For the sake of clarity, the analysis will be described in three layers under the core category (see figs.3,5, & 7 for summaries).

#### **Unravelling a story**

*'..Rather than solving the behaviour, it might be a sleep problem or an eating problem; it's about how you feel about that. How did it start? What were the issues around it? And nearly always it goes back to things like relationship.. And it's not usually just about the behaviour. It's nearly always about a whole host of other things that are going on in the background.'* G:69-74

#### **3.1 CORE CATEGORY: Unravelling a story.**

Enthusiasm and motivation to understand what was happening for children and their families was a theme permeating all of the interviews. Participants used metaphors such as 'unpacking', 'unravelling', 'unpicking', 'looking at different strands' and 'teasing out' to describe the process of gaining insights into young childrens' emotional lives. The unravelling was concerned with 'looking more deeply

at', or 'beneath the surface' of a presenting problem. It led to exploring the interaction between different elements of a child's life. The process of unravelling featured in participants' accounts of identifying, referring and intervening with IMH difficulties. Participant conceptualisation of IMH was crucial to the way they unravelled the story. Many participants conceptualised IMH quite broadly:

*'as the emotional wellbeing of a family and of a child and of a mother and of a mother- child relationship. I feel as though that is of course the crux of a child's emotional well-being, is the relationship that that child has with its mother'*

*K:161-164*

Other participants were more focused in their understanding of IMH, for example child behaviour. Often, ideas about 'good' mental health were useful when thinking about how difficulties may be identified and worked with.

*'IMH is very much about babies feeling safe and secure and happy and contented, knowing that their needs are going to be met' B:104-105*

### ***First Layer Analysis: Conceptualisation of IMH***

Data analysis revealed five main categories representing the first steps towards unravelling the story; how participants conceptualised IMH. These were

**Understanding the child experience, Exploring the parent response,**

**Understanding the context, Observing attachment and bonding and Maintaining**



**a child development focus.** Fig.2 shows three interlocking circles, which depict these categories, and the interaction between them.

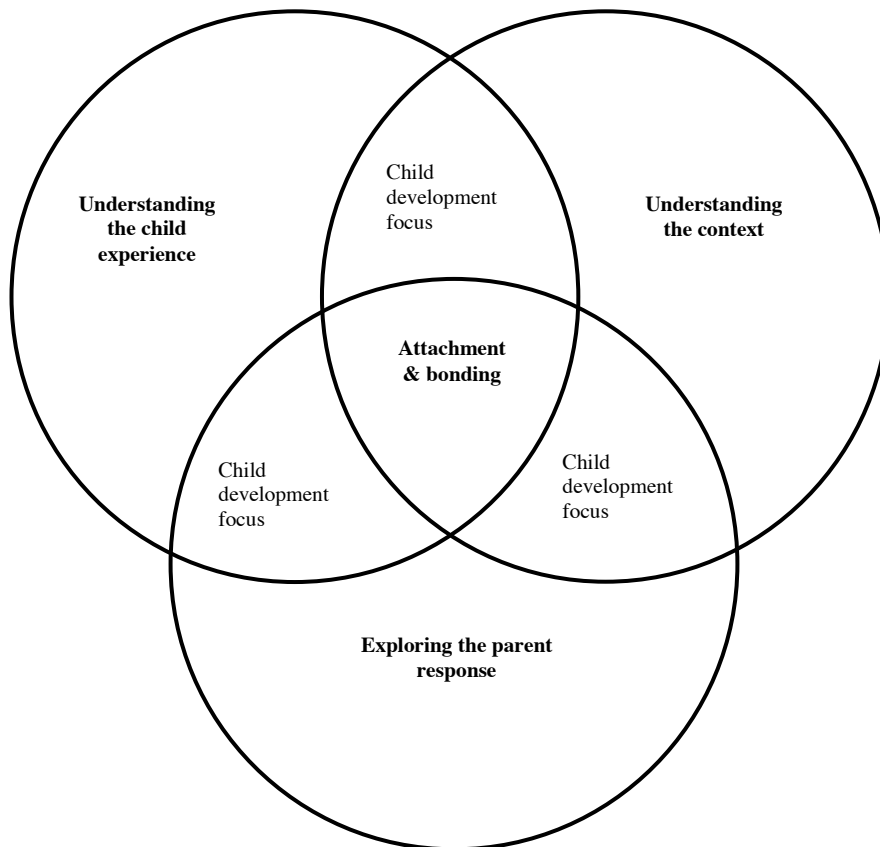


Fig. 2. Venn diagram representing participant conceptualisation of IMH.

### **3.2 MAIN CATEGORY ONE: Understanding the child's experience.**

This category represents a view of IMH as the infant's experience:

*'you know, just, just looking at the way.. how.. looking at what this baby is experiencing really. B:395-396*

Several participants' definitions of IMH difficulties were demarcated by problematic behaviour, demonstrated by observable 'behaviour problems' or negative affect.

*'..babies crying a lot, not sleeping well, not feeding terribly well and not responding to warmth. Not responding to their parents very well. That would make me think something wasn't quite... right' D:66-70*

This category contained two lower categories, illustrating how participants unravelled the child's experience; **Understanding the meaning of problematic behaviour** and **Understanding the child's emotional state.**

#### **Understanding the meaning of problematic behaviour.**

Efforts made by participants to attribute meaning to problematic child behaviour, they encountered formed a significant theme. Some participants understood IMH as symbolising extreme difficulties associated with sleep, feeding, toileting, social withdrawal or specific challenging behaviour (Quote-1)<sup>7</sup>. Participants

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<sup>7</sup> Additional supporting quotes will be numbered in brackets and listed in **Appendix H** for reference.

commented on the function and origin of these behaviours, for example as a vehicle for communication or a symptom of affect:

*‘But the behaviour is coming out, and almost as that child talking back to them to say this is how it’s affecting me, this is what I’m saying to you.’ F:405-407*

Participants pinpointed significant family life events, or circumstances as causal factors (Quote-2).

### **Understanding the child’s emotional state.**

Analysis of the transcripts revealed the child’s mood was key to unravelling the story:

*Whether it’s say hyper aroused and it’s causing chaos or is it a child that is very withdrawn and quiet? H:217-218*

Participants gained insights into a child’s emotional state, for example, through play (Quote-3) and observing facial cues (Quote-4).

### **3.3 MAIN CATEGORY TWO: Exploring parent response.**

This category represents the participant view of parent experience as a component of IMH. Participants continued to unravel the story by understanding how parents were thinking, feeling and behaving. Health visitors spoke about how parents’ past experiences affected present relationships. They reflected on the interface

between parental thoughts and feelings, a developing relationship with their child and the child's experience of being parented. Particularly in the case of babies, participants conceptualised the emotional wellbeing of child and parent as being inextricably linked:

*'you can't separate out can you; maternal well-being and the well-being of the child?'* C:313-314

Moreover, in their accounts, participants considered parental responses and their potential consequences for children's emotional development.

*'..her ill health [alcohol problems and depression] was such that she wasn't taking the baby out. How that affected the baby, to me I thought the baby seemed a bit flat and its speech wasn't developing at the right time.'* D:550-552

Three lower categories were identified; **Reflecting on mood, Reflecting on thoughts and feelings about the baby and Reflecting on parenting behaviour**

### **Reflecting on mood.**

Throughout the transcripts participants expressed concern about the consequences of poor maternal mental health for children's emotional development.

*' I think that does have such a big impact on the babies anyway but for the mums too. I think its just absolute hell for them to go through and there's so little available.'*  
E:340-342

### **Reflecting on thoughts and feelings about the baby.**

This embodies the idea that parental thoughts and feelings about a child impacted on a child's emotional wellbeing.

*'..the most painful one is when mother says well I never wanted the child anyway.. you know that is quite a hard one to deal with. Ones that were never wanted or the ones..or these children are getting on my nerves, that sort of thing. So it is a very negative approach from mother or father'D:180-185*

Participants considered how unhelpful attributions held by parents may play a role in IMH difficulties (Quote-5).

### **Reflecting on parenting behaviour.**

This category characterised the perceived role of parenting behaviour in IMH

*'..she was behaving in a certain way because of him[abusive partner] and the children were behaving in a certain way because of that..' H:557-558*

### **3.4 MAIN CATEGORY THREE : Understanding the impact of the child's context.**

This category conveys the idea that the child's context impacts on their emotional wellbeing and behaviour.

*'..there's substance misuse, there's housing and harassment issues that are all.. the parents are entangled in. ... That child is feeling quite unsettled and unstable in that environment and its obviously impacting on them in some way to affect their behaviours.'* F:392-394

Participants identified two key strands within this category. Firstly, an understanding of the role of environmental factors such as drug and alcohol use, domestic abuse, poor housing and family support in shaping parental and child experience:

*'I think if the mother is very isolated then I would be very much more worried..'* A:346-347

Secondly, participants considered the significance of parental life events in determining IMH. For example, the child experience, attachment and bonding and parental response were felt to be affected by events such as bereavements, separations, traumatic incidents and in some cases the timing of pregnancy itself.

*'The pregnancy just came at the absolute wrong time'* C:426-427

**E** talked compassionately about domestic abuse within her caseload and sought to understand how it was experienced by the infant (Quote-6).

### **3.5 MAIN CATEGORY FOUR: Observing attachment and bonding.**

This category depicts the infant-parent relationship as a pivotal element in participant conceptualisation of IMH.

*‘..when I think about a baby when it is first born, I think if it in terms of attachment and bonding err and how well a mother and baby is able to bond together and how that affects the way the child is parented from the beginning. And therefore how their mental health thrives and flourishes because of their relationship with their, their mother’ G:12-16*

While some participants spoke about the attachment as a key concept in IMH, others referred to it as a tangible measure or barometer for IMH and wellbeing. E described observing physical manifestations of distress in very young children. This involved looking for clues in baby’s facial and body movements in response to the care-giver.

*‘the eye contact and the way people relate to each other. And quite often you’ll get babies moving away, jerking away, not responding... Just the facial can give quite a lot of clues’ E:244-247*

### **3.6 MAIN CATEGORY FIVE : Maintaining a child development focus.**

This category represents participant perception that IMH was located within a broader concept of child development. Two themes emerged. Firstly, the idea that

physical development could not be contemplated in isolation. In fact, developmental markers were used to gauge IMH.

*‘yes that’s it, not a happy baby, or the parents come and see us and say ‘I’m at my wits end, my child won’t eat’.... You know, or if the child’s failing to thrive, you know with weights, it’s struggling with its weights..’ A:589-593*

Secondly, participants applied a developmental framework to consider the interaction between categories and ultimately the developmental impact on the child.

*‘So I’m always pushing this child into the middle, it’s their development and if mum’s got mental health problems, how is that affecting this child’s development. And try and keep that as a focus.’ G:610-612*

#### **Summary of categories 1-5**

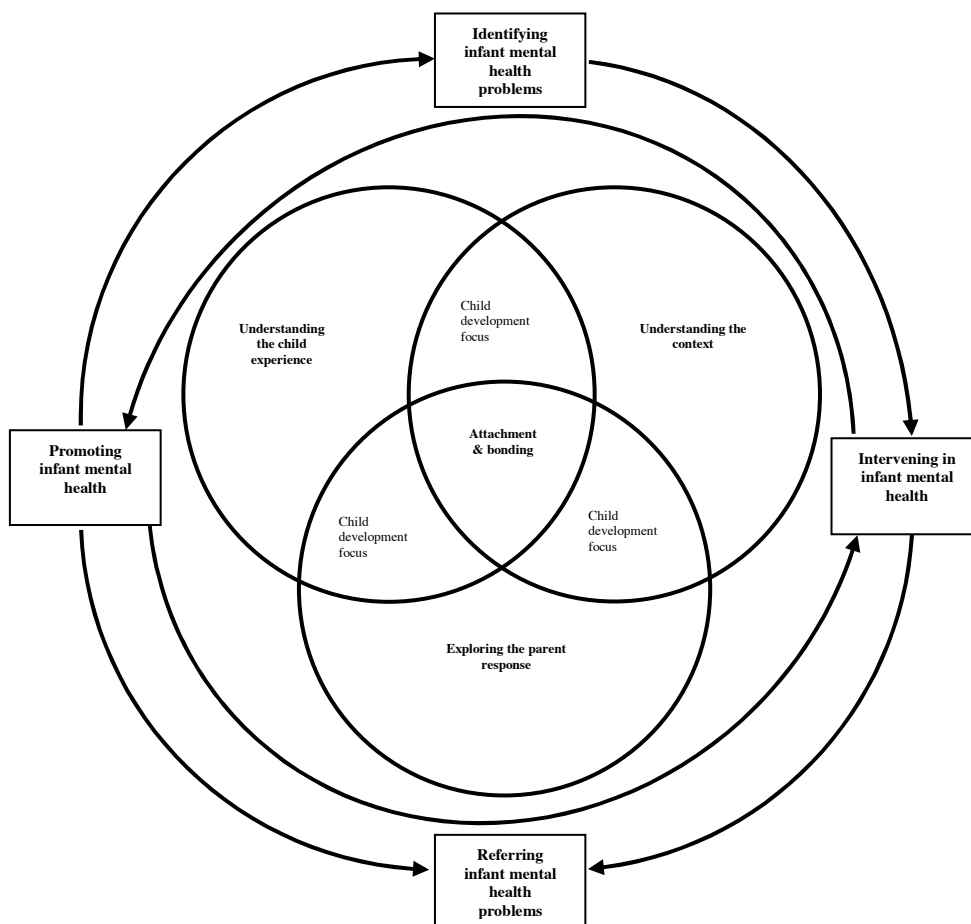
In summary, these five categories represent the health visitor participant group’s understanding of IMH. Analysis of the transcripts showed strong interplay between the five conceptual categories, represented by interlinking circles in fig.2. Participants commented on environmental factors such as family support, housing, and significant life events impacting on parent emotional well-being, early attachment and bonding and a child’s emotional development.

**Fig.3 Layer summary.**



## *Second layer analysis: Participant process*

The next group of categories were derived from participant accounts of their work in relation to IMH. Four categories emerged; **Promoting infant mental health, Identifying infant mental health problems, Intervening in infant mental health and Referring infant mental health problems.** Fig. 4. represents participant activity in relation to the earlier categories. The arrows depict relationship between the participant processes.



**Fig.4** Diagram representing participant activity in relation to IMH

### **3.7 MAIN CATEGORY SIX: Promoting infant mental health.**

Analysis of the data revealed a large part of health visitor practice centred on preventing IMH difficulties through health promotion activities. Participants felt it was important to make contact with mothers antenatally and offer good support in the first year of a baby's life.

*'it is very important to get in there antenatally because ..obviously those first few weeks and months. It's about parenting. It's about bonding'. K:117-119*

Health promotion occurred in relation to each of the first five categories. With respect to exploring parent response, **E** and **B** talked about the need to provide a space for new or expectant parents to think. They emphasised emotional preparation alongside practical preparation for parenthood (Quote-7).

The transcripts revealed efforts to promote and foster child-parent interaction and relationship.

*'Well, we always talk to them about promoting...attachment and bonding from an early age and sort of continue that. Even to asking whether they get kisses and cuddles and the rest of it. That is about, then the child will feel loved and that will be good for their emotional development as they get older.' F:175-179*

Participants outlined how they encouraged new parents to think about the emotional needs of their babies and supported them in meeting those needs.

*‘..right from the early days talk about the emotional wellbeing of the baby. And that’s..we talk a lot in our postnatal group, and I certainly talk a lot about how we respond to babies really from very, very early.’ K:183-185*

Finally, participants spoke about preventing child behaviour difficulties as a way of improving IMH (Quote-8).

### **3.8 MAIN CATEGORY SEVEN: Identifying infant mental health problems.**

This category comprises activities engaged in identifying IMH and forms an interface with the previous main categories. Participants identified difficulties by reflecting on the child’s experience of being parented.

*‘a mum um, sat with me for a while and then went and fetched the baby from another room.. that that sort of makes you wonder what the baby is experiencing’ B:358-360*

**K** felt that difficulties surfaced behaviourally by about fifteen to eighteen months of age:

*‘And often it is food refusal, even at that tender age, or... sleep and sometimes behaviour, you know head banging.’ K:210-211*

Even with very young babies, participants felt able to identify signs of negative affect.

*‘..you see that kind of like frozen appearance in a baby that can be quite sad, quite difficult and painful to see.’E:167-168*

Participants also identified IMH difficulties as they explored parental thought and feelings about their child. Participants were alerted to ‘warning signs’ such as negative parental attributions, and evidence of poor bonding.

*‘I do feel in those early days when you sort of talk to a mum and talk about ‘he’s a really naughty baby’ ..and already your hackles are raised and you’re ready for how that relationship is going to develop and how they see the child as something in those early days who is able to be naughty and able to do something not very nice to somebody. And it makes you aware that their relationship is slightly, ..off-kilter’*  
*G:57-64*

Identification occurred in relation to understanding the child’s context, for example during participant screening for social problems (Quote-9), and by observing the infant attachment and parental bonding processes directly.

*‘ Occasionally you will see a mum holding a baby, and rather than sort of cradling it in your arms and sort of looking down and kissing the top of his head and all those things that you’d expect, and stroking. They’ve got the baby and it’s facing away from them and they’re just talking to you and that baby is just there but they’re not. They don’t.. , they could be holding a dolly for all..’C:185-190*

### **3.9 MAIN CATEGORY EIGHT: Intervening in infant mental health.**

This category represents participant activities which sought to address identified problems. Interventions ranged from brief to in-depth and could be directed at all or any of the first five categories. Interventions aimed to alleviate some of the pressures metered by contextual factors, for example, **D** talked about steps taken to reduce a mother's experience of being isolated.

*'we tried to get her to go out, to bring him to toddler group' D:554*

Interventions were directed at the relationship; offering guidance about interaction and helping parents to understand an infant's early communication. More complex interventions focused on helping parents reflect on difficulties in their relationship with their child.

*'I'll sort of say 'look how your baby is looking at you!' 'just look how they are focusing on you' 'they are so in love with you' and try and sort of build that relationship with them by saying 'they just love being with you, don't they just love being with you ?'' G:312-315*

Interventions may have predominantly targeted parenting behaviour. **B** felt it was valid to support parents in increasing their own confidence. Participants talked about challenging negative attributions about an infant:

*‘So when I hear someone say that to me, with a baby, it might be three months old, six months old, it might be nine months old, what ever ‘oh he or she has got a temper’ then I never leave it. I always go back to that, have a discussion about that. You know ‘what do you mean by temper, what do you mean?’ K:200-204*

Interventions also converged on parental mental health and wellbeing.

*‘..that’s why I was really on the phone rollicking psychiatric services yesterday for a young dad of mine because of the impact him not being seen is having on the rest of the family and the mental health of a two year old’ K:140-142*

The use of behaviour modification techniques concentrated on child experience and parental behaviour (Quote-10) and participants maintained a child development focus, working with parents to evolve more realistic expectations of their child (Quote-11)

### **3.10 MAIN CATEGORY NINE: Referring infant mental health problems.**

Participants unravelled the IMH story through the process of referral. They gleaned fresh insights and clarified or validated their own perceptions via the knowledge and expertise of those they referred to. Referral decisions were motivated by an assortment of factors and were governed by varying expectations about referral outcome. Two lower categories emerged; **Making a referral decision** and **Anticipating a referral outcome.**

### **Making a referral decision.**

There was a plethora of reasons underpinning referral decisions but two key themes were identified. Participants described a process of seeking a second opinion based on the need for additional expertise with a problem. This was prompted by feeling ‘out of their depth’ (Quote-12), or a need for conclusions they had reached thus far to be validated.

*‘..You’re not one hundred per cent sure what is going on. You don’t know whether this is an emotional problem, behavioural problem, physical problem or a learning problem or whatever so it is very useful to get another pair of eyes onto it’ E:448-451*

Secondly, referral decisions were grouped around the task of securing resources for a child and family. This involved referral for a specific service, perceived to be beneficial for the family, such as baby massage, group work or individual support. Although referrals did include specialist mental health services, various referral destinations were described by participants (see Appendix G).

### **Anticipating a referral outcome.**

This category represents expectations held by participants when they engaged in the referral process. Only explicitly ‘mental health’ cases seemed to be referred to CAMHS (Quote-13) and participants talked about a need for flexible services, which would offer clients different opportunities to address their difficulties. E spoke about the ‘baby’s first year project’<sup>8</sup> meeting her expectations.

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<sup>8</sup> *Baby’s first year project is an attachment-based programme for first time mothers who have been identified as vulnerable.*

[the project] *'allows people to erm respond on different levels. Either on a one-to-one or a group or with a professional or with a peer . It allows a whole range of things that people can tap into to get their needs met'* E:302-305

Participants also wanted to be informed about the referral outcome (Quote-14)

#### **Summary of categories 6-9**

This layer of analysis explored the processes participants engaged in as they worked with IMH issues on their caseload. Participant activity was collated under four categories; preventing, identifying, intervening and referring. These activities were found to occur in relation to all aspects of IMH, as conceptualised by the participants, and this interaction was represented diagrammatically.

Fig.5. Layer summary



### ***Third Layer analysis: Contextual factors***

The final set of categories complete the model derived from the analysis (see fig. 6.). They denote contextual factors impacting on how participants thought about and worked with IMH. They are **Health visitors' use of self**, **Overcoming obstacles** and **Supportive mechanisms**. Arrows within the diagram represent the impact of contextual factors on the first two layers of the model.

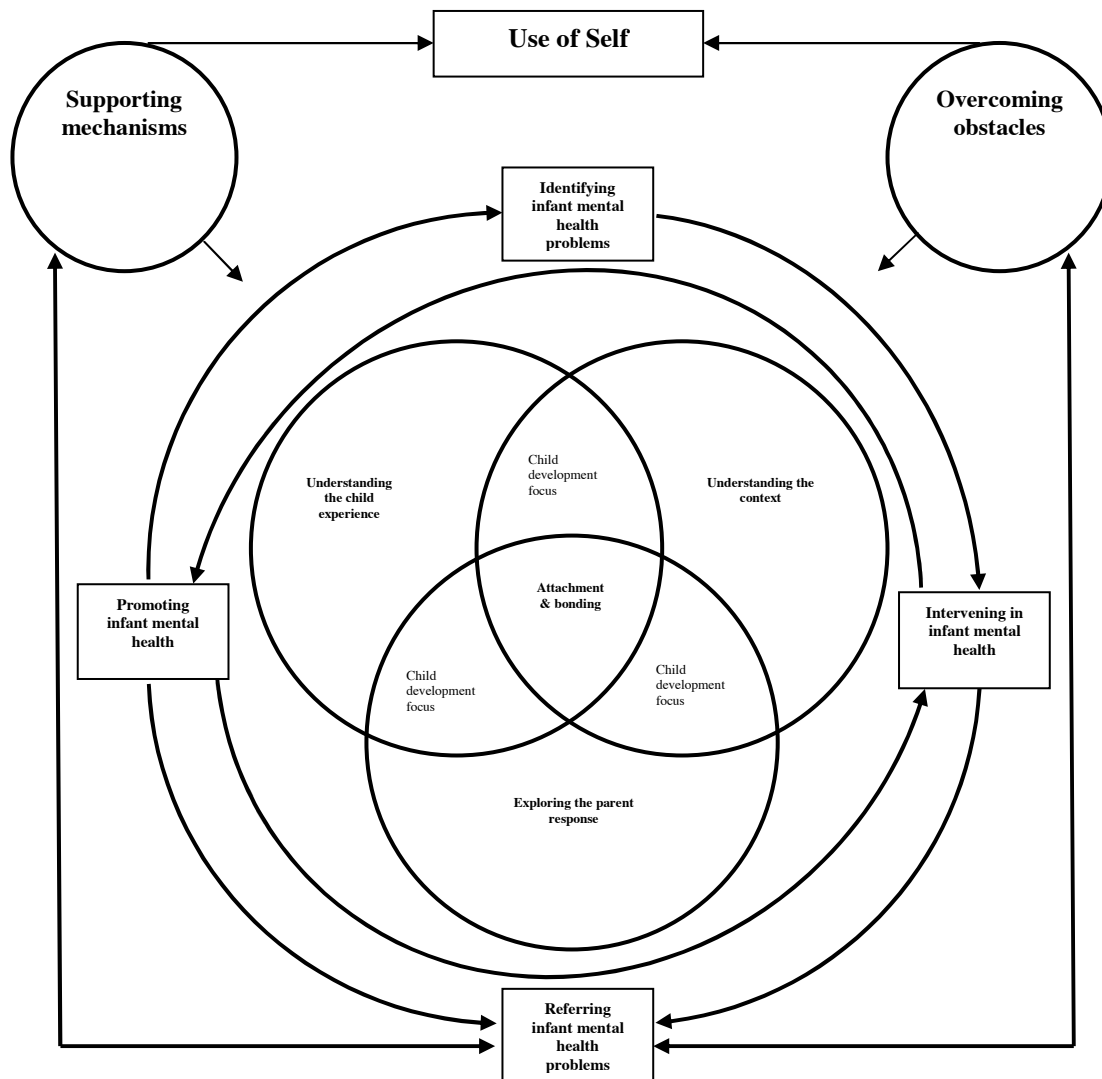
#### **3.11 MAIN CATEGORY TEN: Health visitor use of self.**

This category represents the personal contribution made by participants in their IMH work. Participant use of self was evident in their capacity for relationship with clients and in the diverse skills, experience and values they brought to the process of conceptualising and engaging with IMH. E felt strongly that this should be a cause for celebration:

*' I think we've got to celebrate and we've got to, to look at what our skills are. Because we are the profession that works with children under five. And we are the people who see more babies- we see all babies under a year... more than anybody else' E:272-277*

Four lower categories were generated; **Celebrating health visitor skills**, **Building relationship**, **Drawing on experience** and **Drawing on professional values**.

## Unravelling the story



**Fig.6. Model representing how participants identify, manage and refer infant mental health problems on their caseload**

### **Celebrating health visitor skills.**

The transcripts revealed a vast array of skills employed by this participant group as they attended to the IMH needs of their clients. A dominant theme was the use of observation in participants' encounters with families, either at home or in the clinic setting. Careful observation afforded insights into developing infant-parent relationships, provided clues about a parent's fragile state of mind or provided reassurance that many of the ingredients were in place for a child to thrive and flourish.

*'you know you are really very alert. I'm certainly very alert visually, mm when I visit families. I'm visually alert to what sort of relationship is developing between a mum and the baby' B:393-395*

Other skills celebrated within the transcripts were the effective use of gentle questioning and reflective conversations to elicit parental thoughts and feelings, goal setting (Quote-15), teaching (Quote-16) and the use of modelling techniques. Finally, the transcripts showed feedback was given to parents in order to improve confidence and reinforce positive parenting. (Quote-17)

### **Building relationship.**

This category represents the relationship participants strived to establish and maintain with their clients.

*'You've given them a lot of support, you've seen them often, they trust you, they have that relationship with you. They realise that you are experienced and that you care about them and they know that they can come to you.'* K:224-227

Relationship with families underpinned all IMH work, for example in ascertaining the origins of problem behaviours (Quote-18)

### **Drawing on experience.**

Analysis indicated participants' experiences shaped their view of IMH and their clinical practice. **G** described how personal events had shaped her conceptualisation of attachment and bonding. Similarly, participants drew on diverse professional experience gained prior to training as health visitors (Quote-19).

Participants recalled drawing on personal reactions experienced in response to families they worked with, for example, **E** described awareness of non-verbal communication and **F** reported having a 'gut feeling'.

*'The other thing that is spoken about in health visiting is this sort of gut feeling of that family...it's sort of almost like having a sort of sixth sense'* F:671-674

Experience informed all areas of IMH work. **F** thought her feelings about a child's context influenced how she balanced child protection risks. **G** described having her 'hackles raised' when a parent described her newborn baby as 'naughty'. These feelings alerted her, not only to relationship difficulties, but also to potential avenues for intervention.

### **Drawing on Professional values.**

This category characterises the way in which participant attitudes and actions regarding IMH were supported by professional values underpinned by personal philosophies. There were a number of different themes within this category.

Intervening early seemed to be a guiding principle and was underpinned by a view that helping families in the early years could offset difficulties later in childhood and adulthood. G felt that problem behaviour in infancy needed to be taken more seriously, since left to escalate it could cause lasting damage to family relationships and children's emotional wellbeing.

*'And we do lots of times hear parents saying things like you're stupid, you're horrible, you're stupid' And all those nasty messages sit with a child for a long time. So I think we do have to see it as very important. That we do manage behaviour, that we do pick it up as an issue and try and help families where possible.'* G:380-384

Other themes were working with strengths (Quote-20) and a desire to tailor an individual approach in order to respond to the unique journey of each family. Some participants recognised a shift in their practice in recent years, away from being prescriptive and didactic in their approach. Other participants felt they had always strived to offer an individualised service (Quote-21). Participants utilised various concepts to guide their decision-making. For example, notions of 'vulnerability' or 'normal development' appeared to inform the processes of identification, intervention, promotion and referral. (Quotes-22 & 23)

### **3.12 MAIN CATEGORY ELEVEN: Overcoming obstacles.**

This category pertains to the frustrations encountered by participants. In addition, it illuminates the nature of the challenges and the wide-ranging responses they provoked. Three lower categories were generated: **Responding to organisational change, Coping with inequity and Developing professional confidence in IMH.**

#### **Responding to organisational change.**

This category represents the unwelcome impact of reorganisation on IMH work. Although being part of a large health visiting team was valued, due to increased peer support, some participants feared fewer opportunities to build relationships with clients and lack of continuity in the service.

*'I'm really struggling with this massive caseload now, where you know, there's a number of us trying to health visit on this big locality. And I sometimes see parents outside with little children and I think well they're on my caseload and I haven't a clue who they are' B:44-47*

Another perceived consequence of reorganisation was increased workloads, loss of services previously provided by health visitors (Quote-24) and less time to attend to the more specialist elements of the role such as IMH work, due to competing priorities:

*‘..and sometimes the pressures of the rest of the work mean you haven’t got time..because this is specialist stuff isn’t it?’ D:234-235*

### **Coping with Inequity.**

This category symbolises concern felt by participants about inconsistencies in services provided by health visitors and wider agencies in relation to IMH. **C** felt strongly maternal depression was not being picked up and responded to consistently across the city.

*‘We use the Edinburgh postnatal <sup>9</sup>. Not all teams.. It’s very patchy the use of it across the city,’ C:251-252*

One group of participants were particularly appreciative of the specialist skills of a health visitor colleague trained in IMH, but believed this was not a resource other teams enjoyed (Quote-25). **K** was particularly passionate and protective about universal service provision as an effective measure in IMH. However, she also felt that there were not enough health visitors to meet local need adequately (Quote-26).

### **Managing the demands of IMH work.**

This category relates to professional confidence imperative in IMH work. Confidence was undermined by a fear of unravelling something unmanageable either due to scant expertise or lack of time. Participants experienced different levels of confidence. **A**, **C** and **D** reported some discomfort in exploring a parent’s feelings about their baby, while other participants felt very differently.

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<sup>9</sup> Edinburgh Post-natal Depression Scale is used routinely within health visiting practice to screen for post-natal depression.

*'I feel comfortable exploring that. I feel it's important to. I feel it's good to give people the opportunity to reflect on things and not just the practical issues'*

*E:319-320*

Despite these issues, participants were managing IMH cases and this impacted on the process of referral (Quote-27). Participants acknowledged the emotional impact of this aspect of their work:

*'..I've had one of them visits where I feel like I've been quite projected onto. Sometimes you don't even want to write your records, you've just got to sit with it for a bit. Have a cup of tea. Sometimes I might even write my record the next day'*

*H:412-415*

### **3.13 MAIN CATEGORY TWELVE: Supporting mechanisms.**

These categories pertain to contextual factors aiding participant's understanding of and work with IMH. Three lower categories emerged; **Training, research and knowledge, Supporting structures and tools** and **Supportive relationships**

#### **Training, research and knowledge.**

This category represents the positive impact of training and research on a participant's capacity to undertake IMH work. **B** felt that specialist training had



helped her move away from crude behaviour management towards exploration of parent experience and a quest to understand the meaning of problem behaviour. **G** described how training in the ‘Solihull approach’<sup>10</sup> had empowered her to practice as she had instinctively wanted to, attending more closely to attachment and bonding issues thereafter. Participants spoke about keeping abreast of research and new ways of thinking in order to be effective in their IMH work (Quote-28)

### **Supporting structures and tools.**

Participants felt supported in their work by structures, routines and tools pertinent to their role. For example, making the ‘core offer’, which insures at least minimum contact with all families, was viewed as vital for effective management of IMH difficulties.

*‘There are crucial points in that first year when a health visitor sees that family individually, that I think are absolutely crucial. And that is why the core offer is absolutely crucial’ K:230-232*

The capacity to offer flexible contact with families (duration and location) was viewed as supportive, as was the Health Assessment Record.<sup>11</sup> **D** felt it was inestimable in bridging continuity gaps and providing a thread of communication between colleagues (Quote-29). The routine use of the Edinburgh postnatal depression screening tool was thought to be invaluable, not only for gauging maternal

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<sup>10</sup> Solihull approach is a clinical psychology designed parenting intervention approach offered by health visitors

<sup>11</sup> The Health Assessment Record is the national system of recording Health visitor contact with families

mood but also for triggering in-depth conversations about parent experience (Quote-30).

### **Supportive relationships.**

Participants felt supported with IMH work by their professional networks. A outlined how she effectively managed a complex case in close collaboration with the GP.

*‘And I worked quite closely with the GP, the GP would see the mum as well’ A: 952*

This category also operates inversely and in the absence of supportive relationships, participants felt impeded. Participant accounts revealed a feeling of being left to get on with IMH issues, unsupported by specialist services.

*‘I get the impression that CAMHS<sup>12</sup> aren’t very interested in the under fives... it may be different elsewhere. ... and they perhaps see, oh it’s the health visitors should be dealing with those sorts of things’ C:507-514*

#### **Summary of categories 10-12**

The third layer of analysis revealed the contextual factors, which affected how participants understood and engaged with IMH problems in their caseloads. The categories use of self, supporting mechanisms and overcoming obstacles complete the full process model; unravelling a story.

Fig.7. Layer summary

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<sup>12</sup> Child and Adolescent Mental Health Service.

### **3.14. Analysis Summary.**

Analysis of the transcripts produced one core category ‘Unravelling the story’ and twelve main categories. The interaction between all the emergent themes was captured in a pictorial model, Fig 6. It illustrates how participant accounts converged to form a fluid understanding of IMH. This included the overlapping elements of the child’s experience, their wider context, the parent response), the parent-child relationship and the developmental framework applied by the health visitors. Furthermore, it shows how the participant’s core tasks of promoting, identifying, intervening and referring occurred in conjunction with the elements comprising IMH. Lastly, the model illustrates the range of factors impacting upon this dynamic, including the participants’ use of self supporting mechanism and overcoming obstacles. Arrows within the diagram represent the interdependency of the different layers of the model.

## **Chapter Four**

### **4. Discussion**

#### **4.1 Introduction**

This chapter will provide a thorough discussion of the model derived from data analysis. It aims to comment on weaknesses contained within the study and offer suggestions regarding new directions for research. Furthermore, a range of clinical implications indicated by these findings will be reviewed and a number of recommendations proposed. Finally, the chapter will summarise the most salient points.

#### **4.2 The core category: ‘unravelling the story’**

The core category of unravelling the story acts as a metaphor for participant interaction with IMH. The process of unravelling comprises a range of participant processes including exploring, unpacking, understanding and gaining new insights. This overarching theme provides a common thread between the different elements of the model and encapsulates participant engagement with the emotional and psychological lives of the children and families on their caseloads. To provide continuity with the previous chapter, each layer of the analysis will be discussed in relation to the wider literature.

##### ***4.2.1 First layer analysis: conceptualisation of IMH***

The first layer of analysis dealt with participants’ conceptualisations of IMH and provides the foundation for the process model. The five categories represented in

the Venn diagram are an amalgamation of the distinct and individual understanding of the term proffered by participants. As such, the model has evolved beyond the contribution of any one participant and represents a dynamic interaction between the child's experience, the parental response, the evolving relationship, the contextual factors and a developmental framework through which the other elements are filtered. The model indicates an understanding of IMH may be achieved through simultaneous consideration of its component parts. In essence, unilateral thinking about elements depicted by the Venn diagram does not provide sufficient depth of understanding about the IMH concept. For example, problematic child behaviour may only be considered in light of developmental knowledge, a broader environmental context and the security of the infant-parent relationship. Parental behaviour, thoughts and feelings must also be factored into the understanding. This conceptualisation may resonate beyond the participant group, for other health visitors and possibly allied professions.

Despite the term IMH holding common currency, there did not appear to be a shared meaning for study participants. Diversity of views about IMH may be due to a perceived ambiguity of the language (see critical appraisal for discussion of terminology), but it also mirrors variance in the conceptualisation of IMH found within the literature (Fraiberg, 1980; Onunku, 2005; Link Egger & Angold, 2006; Zeanah & Zeanah, 2001).

Significantly, the model integrates a number of different conceptualisations. For example, the emphasis on the child-parent relationship is consistent with a dominant conceptualisation of IMH derived from Attachment Theory (Bowlby,

1969). Bowlby suggested babies are hard wired to form attachments to primary carers and effective attachments enable them to become trusting, confident and able to regulate stress and distress. There is evidence secure attachments build resilience in children to overcome adversity and that insecure attachments are associated with poorer outcomes later in life (Svanberg, 1999). Equally, the model incorporates a conceptualisation more closely aligned to adult mental health constructs. Participants referred consistently to problematic and challenging behaviours, which were held by some participants to be synonymous with IMH problems. This view, represented under the category *understanding the child's experience*, is consistent with a drive to diagnose mental disorder in the pre-school age group (Link Egger & Angold, 2006).

The integration of different conceptualisations of IMH within the model acknowledges the unease participants felt in locating problems with individual infants when they felt inclined to consider the needs of the dyad and the wider system. This dilemma has been commented on within the literature. Lancaster (2004) offered a pragmatic solution and suggested that 'disorders' in the early years are best conceptualised as relationship disorders, which manifest as problems with eating, sleeping, irritability or attachment. As such, clinical work should promote or support nurturing relationships for infants. Although this stance offers a focus for intervention and resolves the issue of locating IMH difficulties with the child, it does place IMH conceptualisation within the confines of an attachment framework.

The integrated model brings together different ideas evident within the literature. It is not solely focused on the infant or pre-schooler; rather it embraces family wellbeing and the contextual factors which influence thoughts, feelings and the

behaviour of children and parents. In doing so it resonates with cognitive behavioural frameworks (Beck, 1991). It also reflects the holistic approach taken by participants and their ability to draw on a range of frameworks for understanding the difficulties they encountered. The notion of a secure and stable relationship (Fraiberg, 1980), is represented at the point where the three circles intersect, depicting how all these elements interact to determine the quality of the relationship and the infant or pre-schooler's subsequent emotional wellbeing.

Although the wider literature refers to a range of factors, which impede or enhance the development of secure bonds (for reviews see Greenberg, 1999; Svanberg, 1999), this model explicitly incorporates them into the conceptualisation of IMH. For example, the point of intersection in the model, between parental response and infant-parent relationship, is consistent with literature pertaining to maternal depression. There is evidence pregnancy is a time of adjustment and an opportunity to contemplate becoming a parent. After delivery, mothers learn about their child and develop maternal 'sensitivity', an awareness of the child's needs, and 'responsiveness', a capacity to respond to those needs. In the event of depression occurring, mothers are not always able to fulfil these tasks. Some find it hard to provide the emotional nurturing, protection and stimulation babies depend on. Even in the presence of basic care, emotional unavailability restricts parent-child interaction and may trigger negative patterns in parenting (Austin & Priest, 2005). Within the model, parental response, in this example depression, affects the relationship between parent and child and the child's experience of being parented. Furthermore, a range of contextual factors, represented by the third circle, may relate to the depression in its cause, maintenance or as a mediating factor in its impact on other elements of the

IMH representation. Specific examples given by participants included poor social support, marital conflict and poverty, factors which have been associated with maternal depression (Cooper & Murray, 1998).

More uniquely, the model communicates a broader notion of child development, which travels beyond the social-emotional and cognitive domains described in Fraiberg's model of IMH. The emphasis on physical development suggests physical as well as emotional clues, offering insight into the state of the emerging relationship and IMH.

Summers *et al.* (2007) commented 'infant mental health' terminology may be useful in research or commissioning arenas, but in the workplace it may evoke images of serious pathological and chronic conditions and undermine a broader conceptualisation. Zeanah (2001) suggested that reluctance by professionals to embrace IMH terminology might be due to their own discomfort with acknowledging the reality of mental health issues in very young children. Summers *et al.* (2007) also cautioned against adopting less comprehensive terms such as 'behaviour difficulties' or 'emotional difficulties', as they may fail to communicate the importance of ensuring children have a foundation of good IMH. The model generated by this study goes some way towards addressing these issues. It provides a coherent view of IMH which is fluid and able to alter in response to shifts within the component domains. This affords the model clinical utility; the categories provide a focus for assessment, intervention and referral of IMH difficulties.



#### ***4.2.2 Second Layer: participant process.***

The second layer of analysis centred on participant processes as they interfaced with IMH. A picture emerged of health visitor practice that was sedulously involved with IMH at various levels. From their earliest contact with families, participants were engaged in preventative measures, promoting IMH across the model domains. They identified difficulties and offered interventions as a matter of course and finally they made referrals to other agencies, triggered by the need for additional services or a second opinion. These findings reflect the holistic approach taken by participants and may be considered in the context of wider literature pertaining to health visiting practice, IMH practice and clinical decision-making.

Key tasks, roles and responsibilities have been ascribed to the health visiting profession. Health visitor practice consists of planned activities aimed at improving the physical, mental, social and emotional health and wellbeing of the population, preventing disease and reducing inequalities in health. (Council for the education and training of health visitors (CERHV), 1977). Despite such broad responsibilities, day-to-day practice focuses largely on the needs of under-fives. This is justified by swathes of evidence suggesting patterns of parenting and the early childhood environment are hugely significant for individual health outcomes later in life (Onunku, 2005; Svanberg 1998; Barnes 2003). Furthermore, they also relate to the broader objective of maintaining a healthy and functional society (CERHV, 1977), making the early years a legitimate remit for public health endeavour. Four key principles govern health visitor practice: the search for health needs; the stimulation of awareness of health needs; the influence on policies affecting health and the facilitation of an awareness of health needs (CERHV, 1977 p9). In contrast with other

public health professions, health visiting is particularly concerned with health and wellbeing rather than disease and illness. Participant practice represented by the model is wholly consistent with health visitor principles. For example, searching for (mental) health needs echoes the process of ‘identifying’.

The process of ‘intervening’ paralleled a range of IMH approaches described within the literature. Although participants did not view themselves as specialists, the processes they engaged in overlapped significantly with specialist intervention programmes, such as intensive and targeted home visiting (Olds, 2006). There was also common ground with the approach detailed by Fraiberg (1980). This focused on home-based observations of the young child in the context of the emerging relationship with their carer. It is possible that participants are not only undertaking IMH interventions, but also have considerable experience and arguable expertise in doing so. Even in the absence of formal ‘infant psychotherapy’ the interventions detailed in the transcripts used therapeutic measures, such as reflecting with parents on the parent-child relationship, offering containment and applying behavioural principles.

The decision to make a referral was associated with three key processes: seeking a second opinion or validation for ideas already held about a case; securing a service to meet a need and holding expectations about the referral outcome. Although there is scant literature reviewing health visitor referral practice, these findings are consistent with a recent study examining General Practitioner (GP) views of their management and referral of psychological problems in adults. *Exploring psychological problems* was a central activity and one which ‘pervaded all aspects

from assessment to referral to interactions between GPs and mental health services' (Sigel & Leiper, 2004, p8). Referral occurred when GPs felt they had reached the limits of their capabilities to address a problem, and was affected by their views and expectations of mental health services. Participants in the present study were also governed by expectations, for example, flexibility of services to meet their clients' needs and feedback about client outcomes. The GP process of reaching the limits of their capabilities also relates to the participant experience of 'offloading' which occurred when a second opinion was sought and participants no longer felt sole responsibility for a case. This signals a participant need for support and containment when they undertake complex IMH work, a phenomenon widely identified (Whitehead & Douglas, 2005), which may be addressed by clinical supervision and peer consultation.

Participants did not necessarily phrase their work in IMH terms, but their practice resembled IMH tasks described in the literature (Wetherston, 2001). Zeanah, Larrieu, Boris, and Nagle (2006) explored the experiences of nurses delivering the Nurse Family Partnership (NFP) programme and described a 'paradigm shift' occurring in nursing practice, which manifested in a more psychotherapeutic rather than 'medical' approach. Indeed, nurses estimated that 40%-75% of their time was taken up with mental health issues due to the complexity of the family problems they encountered. Although participants in the current study were not always aware of their IMH work, in common with the NFP study, it seems likely this work was taking up more and more of their time. They did not allude to a paradigm shift but this has been referred to within the health visiting literature (Cody, 1999). This therapeutic role seems to be under-recognised and possibly under-catered for in terms of the

support required. Participants were concerned about taking on new responsibilities, but it is likely they already hold them. The struggle to recognise mental health expertise may be symptomatic of tensions inherent within the health visitor role (Cuesta, 1993).

#### ***4.2.3 Third layer: contextual factors.***

The final layer of the model pertains to the contextual factors impacting on the participant's conceptualisation of IMH and their clinical practice.

This section of the model comprised three elements: participant use of self; overcoming obstacles and mechanism for support.

Use of self is a celebration of the participant's wide-ranging experience, derived from previous roles or non-professional life, their broad skill base including the capacity to form relationships with clients, and the professional values that underpinned their approach to IMH work. The model suggests participants used themselves as a resource in their IMH work to a large degree. For example, 'gut instinct' and personal values guided their conceptualisation of IMH and their clinical practice. These findings corroborate those of Kam and Midgley (2006), who found 'gut instinct' and past experiences were defining factors in clinical decision-making regarding identifying and referring child mental health problems.

The model showed that supportive mechanisms come in a variety of guises. They include supportive structures, research and knowledge, training and supportive relationships. An example of a supportive structure was the provision of 'core offer'.

This entailed a commitment of service to each newborn baby and family, alongside targeted provision, which included increased home visits to those families in greater need. International studies have demonstrated the efficacy of nurse home visiting programmes, such as the NFP (Olds, 2006) for preventing child abuse and increasing maternal and child health outcomes. This evidence emphasised the value of home visiting as an effective IMH intervention and corroborated with study findings that supportive structures, in this case making a minimum service commitment, serve as a catalyst for IMH practice.

The final element of the model, overcoming obstacles, provided insight into the barriers to effective IMH practice. Reduced service provision was a constant threat to IMH work as participants saw their numbers falling and their workload increasing. This experience is verified by official findings that health visitor numbers have fallen year on year since 1988 (Cowley, 2003). Participant perception that services provided by them and other agencies were inequitable was also a significant barrier to IMH practice. Lastly, the issue of professional confidence determined whether IMH work was undertaken. For example, for some participants identifying a problematic attachment was taboo. Although participants felt skilled to do so, they were fearful of opening a ‘can of worms’ they felt ill-equipped to deal with. Figure 8. provides a summary of the research findings.

### Summary

- The aim of this study was to explore how health visitors identify, manage and refer IMH problems within their caseload and Grounded Theory methodology guided the analysis beyond the confines of the original research question.
- This study has looked in detail at participant conceptualisation of IMH before considering the processes which capture the participant's responses to IMH problems. This revealed an important theme in 'promoting' IMH, which shifted the emphasis away from IMH problems. This task resonated strongly with the four principles of health visiting and the wider focus on public health.
- Questions were raised about how useful the IMH language is and how a lack of shared understanding may impede clinical practice. Finally, the key finding was that this group of participants engaged in IMH work, although they may not have used this terminology and received little recognition for the complexity of work they routinely undertook.

Fig. 8. Summary of research findings.

### 4.3 Critique of study design and methodology

The decision to employ the term 'infant mental health' during data collection (see critical review for rationale) may have narrowed the scope of the data.

Discussions were tapered by participant knowledge of the term and were not necessarily consistent with their understanding of concepts inferred by the term. The use of terminology such as 'emotional and psychological wellbeing' or 'attachment difficulties' may have yielded very different data. Although this has provoked a useful discussion about the utility of academic language within a clinical setting, it may have distracted from the original research focus.

A second weakness in this study is the complexity of the questions, given the imposed time and scope limitations of this thesis. Each of the areas investigated was worthy of individual attention, and there is a very real risk that in attempting to answer too many questions the analysis lacks sufficient depth.

A further factor, which may have influenced the outcome of this study, was the possibility that participant comments were focused largely on their experience of 'first-time' parents. It is possible that the experiences of such parents reflect a unique set of challenges for health visitors, untypical of their dealings with parents of subsequent children. More specific questioning may have clarified this point.

It could be argued this study did not apply the principles of theoretical sampling with sufficient rigour. Merkins (2004) called for a high degree of transparency when sampling in this way and suggested seeking out extreme cases, typical cases and critical cases is essential to ensure maximum variation in the sample. Efforts were made to collect data from a range of participants to ensure diversity in health visitors and the client groups they engaged with. Theoretical sampling was evident in interviews with participants who declared an interest in the topic and relative expertise. These views were contrasted with participants who felt under-confident and ill-informed about the topic area. Beyond this, there were significant limitations on theoretical sampling, due to time restrictions and ethical constraints (see critical appraisal). This problem has been recognised by Pope *et al.* (2006), who concur that the practical application of grounded theory within a clinical setting may be very difficult, as the flexibility required to sample theoretically may not be

amenable to the technical process governing the conduct of research. They have discussed the phenomenon of ‘modified grounded theory’, which describes the reality many researchers face as they use inductive and deductive methods.

#### **4.4 New directions for research**

- This study found that participants engaged in IMH work. This raised the question of whether these findings extend beyond the participants group and more widely within the health visiting profession. The focus of inquiry is no longer as simple as to how health visitors work with IMH problems but rather how open are they to conceptualising large parts of their work in these terms? Moreover, how comfortable are mental health specialists with the idea health visitors hold expertise in IMH?
- In addition to these questions, it would be helpful to establish whether it is the language of ‘mental health’ which is alienating rather than the constructs implied. Given that under-fives are unlikely to be diagnosed with ‘major mental health disorders’, this language may prove unhelpful for this population. The validity and clinical utility of alternative language could be usefully investigated. This could be undertaken by conducting qualitative research exploring the term with different professional groups engaged with under-fives.



- Real world decision-making was present in the participant use of self in relation to all aspects of IMH work. This finding implies a need for further investigation into the balance of influence on decision-making, between personal experience and contextual knowledge about a child and family and external guidelines or policies.

#### **4.5 Clinical implications**

There is a clear role for clinical psychology in supporting IMH work within the community, through provision of support, consultancy and training. With regard to health visitors, a commitment to meeting the emotional and mental health needs of young children and their families could be bolstered by such expertise.

The study findings raise the possibility that mental health expertise revealed here exists elsewhere within professional ranks. It is important to consider potential variation in training and expertise across different regions of the UK, and in relation to different employing organisations or regulating bodies. Despite these reservations, the findings still form a valuable starting point for understanding how health visitors beyond the participant group conceptualise and work with infant mental health problems.

Cody (1999) maintains that although good health visiting practice is based on strong relationships, facilitating therapeutic support, a recognised framework is necessary to ensure recognition and acceptance for this area of health visiting practice. Summers *et al.* (2006) cautioned that support for IMH practice must be

understood and sanctioned at an organisational level. Clinical psychologists have much to offer on both fronts. They could be validating current IMH practice, cascading skills and expertise and promoting a specialist infant mental health identity within the health visiting profession.

Although health visitors represent an established profession, with vast clinical experience and training, they face significant challenges within the current political climate. Reduced staffing levels have limited services and there has been a struggle to clarify the unique contribution of health visitors among other health service personnel. These findings suggest the profession can lay claim to significant expertise regarding the social-emotional wellbeing of infants and their parents. In common with all professionals, they have a responsibility to ensure the safety of children but they also have a vital role to play in identifying and intervening in IMH. This study has illustrated how well placed health visitors are for this task and indicated an important way forward for the profession.

The findings also suggested that IMH difficulties were detected and acted upon in the course of providing a universal service to families. Herein lies another dilemma facing modern health visiting. The growth of more specialist health visitors attending to the needs of ever more complex families may be valid in the short term, but if the future identification of vulnerable families is to be safeguarded, there is a need for ongoing universal provision. Based on the evidence of this study, the tasks are not incompatible, but do require appropriate funding and support. These findings provide evidence of a sufficient skill base to undertake IMH but overwhelming limitations include large caseloads and competing demands on time. There is a need

to challenge a feeling within the profession that IMH work is a burden, and instead celebrate the breadth of skill already being applied to it, and the potential for great strides in this area.

It is certainly true that systematic and strategic IMH work has yet to be implemented across the country in line with the National Service Framework for Children, Young People and Maternity Services guidance (Department of Health, 2003), despite a number of publications by interested parties (AIMH, 2007; Young Minds, 2003). There are many examples of good practice to learn from. The Solihull approach (Douglas, 2006) was developed by clinical psychology practitioners for practitioners, particularly health visitors, working with under-fives exhibiting sleep, feeding, toileting or behavioural difficulties. It integrated ideas from psychoanalytic traditions with behavioural and developmental frameworks and promoted the idea of intervening early. In Sunderland, the clinical psychologist Po Svanberg (2005) has been instrumental in establishing an IMH service offering assessment and targeted intervention by specially- trained health visitors supported by mental health specialists. The NFP programme has recently been piloted across ten UK sites and the hope is that American successes will be replicated here. A local service, 'Baby's first year project', was praised by some of the participants. This is based on an American model for early intervention in IMH, which is well researched and evidenced (Egeland, 2000).

These models represent a small selection of the evidence-based early interventions in IMH found within the literature. Their wider application could be greatly supported by the efforts of clinical psychology and health visiting professions.

It is important that the mental health needs of children under the age of five are given the attention they deserve. Moreover, health visitors have much to contribute to the task of interpreting the manifestations of mental health difficulties in very young children, offering interventions and making appropriate referrals.

The findings indicate that effective IMH work requires professionals to engage with the infant, the parent and a range of contextual factors affecting their capacities to form a healthy relationship. The literature supports the need for a multi-dimensional approach where psychological tasks occur within a supportive framework, which takes into account the social and mental health needs of the parents (Egeland, 2000; Barnes, 2003). This raises questions about where mental health provision for under-fives should come from. Is it a child domain or an adult mental health domain? The model suggests a greater emphasis on single service delivery for infant and parent mental health in order to maximise the benefits brought by psychological interventions aimed at increasing parental sensitivity and altering parent mental health.

There needs to be greater understanding and recognition regarding the impact of IMH work on practitioners. The emotional experience of attachment work has been found to pose the greatest challenge (Summers *et al.*, 2007), but it is also very difficult for practitioners to encourage client openness while managing their own emotions effectively (Zeanah *et al.*, 2006). IMH work needs to be well supported in order to be sustainable for practitioners. Clinical psychologists have an important supervisory role to play in this respect.

## **4.6 Conclusions**

This model provides a clear framework for IMH carried out by the participants. It provides an abstract representation for their understanding of IMH, the wide variety of tasks they undertake in relation to infant wellbeing, the sources of support available to them and the factors which obstruct them. Given that health visitors do not profess to be IMH specialists, this model could serve to validate this aspect of their work, provide a road map for building on work currently undertaken and further foster awareness about the mental health needs of very young children. The challenge therefore is raising the profile of current IMH practice, offering more effective support and reflecting on how best the skills, understanding and experiences represented within the participant group may be harnessed and targeted effectively. Finally, it is envisaged the process of dissemination of research findings will promote local dialogue and help with this endeavour.

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## **Appendix A**

- Ethical approval from the University of Leicester and Sheffield NHS Research Ethics Committee.
- Research Governance granted by Leicester Partnership NHS Trust.

**FW: PC\_ethics2006 - Lucy Murray**

De Lillo, Dr C. [cdl2@leicester.ac.uk]

**Sent:** 23 April 2008 13:16

**To:** lm120@leicester.ac.uk

---

Dear Lucy Murray,

Your project "How do Health visitors identify, manage and refer infant mental health difficulties in their caseload" has been approved by the Psychology Research Ethics Committee.

This e-mail is the official document of ethical approval and should be printed out and kept for your records or attached to the research report if required – this includes all undergraduate and postgraduate research.

We wish you every success with your study.

Carlo De Lillo  
Psychology Research Ethics Committee Chair

Dr. Carlo De Lillo  
University of Leicester  
School of Psychology  
Henry Wellcome Building  
Lancaster Road  
Leicester  
LE1 9HN  
Tel. +44-0116-229-7193  
Fax +44-0116-229 7196  
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Web-page: <http://www.le.ac.uk/pc/cdl2/>

Amelton

11.20

Research & Development Office  
Daisy Peaks Building  
Towers Hospital  
Gipsy Lane  
Leicester  
Tel: 0115-225-3743  
Fax: 0115-245-3091  
David.Clarks@leicpart.nhs.uk

DC/LCM

14 February 2007

Miss Lucy Murray  
C/o Dept. of Clinical Psychology  
University of Leicester  
104 Regent Road  
Leicester  
LE1 7LT

Dear Lucy

Re: Making a difference in the early years  
How do Health Visitors identify, manage and refer infant mental health  
problems: A qualitative study

Thank you for supplying outline details of your application for ethical approval for the above study. This study has been assigned the Trust reference CHAF0450, and you should use this on all correspondence with this office.

- Under the Research Governance Policy of the Trust, confirmation of appropriate ethical approval is a necessary prerequisite for obtaining Trust Management Approval.

I can also confirm that in principle, the Trust will undertake the role of research sponsor in respect of the above study and have enclosed a copy of the relevant page for your application. This is conditional on gaining a favourable ethical opinion and on receiving from you a complete set of documentation as supplied to the ethics committee.

This letter also serves as confirmation that as Principal Investigator you are covered by the terms of the Trust's research indemnity for the duration of the project.

Regards,

*D. Clarke*

Dr. Dave Clarke  
Associate Director (R&D)

Enc.



## National Research Ethics Service

### South Yorkshire Research Ethics Committee

G/o The Rotherham NHS Foundation Trust  
Ward B11 Corridor  
Moorgate Road  
Oxlewood  
Rotherham  
S60 2UD

Telephone: 01709 304177

Facsimile: 01709 307555

Email: [jean.brown@rothgen.nhs.uk](mailto:jean.brown@rothgen.nhs.uk)

30 April 2007

Ms Lucy Murray  
Trainee Clinical Psychologist  
University of Leicester  
104 Regent Road  
Leicester  
LE1 7LE

Dear Ms Murray

Full title of study: Making a difference in the early years. How do Health Visitors identify, manage and refer infant mental health problems: A qualitative study

REC reference number: 07/Q2306/1

I acknowledge receipt of your letter dated 26 April 2007 complying with the Committee's wishes set out in the favourable opinion letter dated 4 April 2007 and confirm that the final list of documents reviewed and approved by the Committee is as follows:

#### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Application	1	06 March 2007
Investigator CV	1	05 March 2007
Protocol	1	05 March 2007
Covering Letter		06 March 2007
Letter from Sponsor		14 February 2007
Peer Review		
Interview Schedules/Topic Guides	1	05 March 2007
Participant Information Sheet	2	21 April 2007
Supervisor's CV		05 March 2007
Consent to be Approached Form	1	05 March 2007
Briefing & Consent Form	1	05 March 2007
Flowchart	1	05 March 2007

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority  
The National Research Ethics Service (NRES) represents the NRES Directorate within  
the National Patient Safety Agency and Research Ethics Committees in England



You are free to go ahead with your project as soon as R & D approval has been obtained.

Yours sincerely

J Brown

of

Miss Jo Abbott  
Chair

Copy to:

Leicestershire Partnership NHS Trust, Research & Development  
Office, Daisy Peake Building, Towers Hospital, Gipsy Lane, Leicester,  
LE5 0TD.

R & D Manager, Sheffield Health & Social Research Consortium  
Research Office, Fulwood House, Old Fulwood Road, Sheffield,  
S10 3TH

*This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority  
The National Research Ethics Service (NRES) represents the NRES Directorate within  
The National Patient Safety Agency and Research Ethics Committees in England*

## **Appendix B**

### **Participant Information Sheet**

*To be printed on headed paper*

#### **Information Sheet**

##### **Part 1.**

##### **Title of Study**

How do health visitors identify, manage and refer infant mental health difficulties in their caseloads?

##### **Invitation**

I am inviting you to take part in a research study that I am undertaking as part of my training in Clinical Psychology. Before you decide to participate it is important for you to understand what it will involve. Please take time to read the following information carefully. If anything needs clarifying please ask. If you do decide to participate you will be free to change your mind at any time.

##### **Purpose of the Study**

This study seeks to understand how health visitors conceptualise infant mental health problems and investigate how they identify, treat and refer these difficulties in their caseload. It is hoped that the study's findings will raise awareness about infant mental health work currently undertaken by health visitors and highlight any support or training that may be required from specialist mental health professionals. Lastly, it is anticipated that the findings will build on literature relating to longer-term preventative strategies set out in the National Service Framework for Children, Young People and Maternity Services.

**Why have I been Chosen?**

This study aims to find out more about the views and beliefs of health visitors working with children under the age of five and their families. The study aims to speak to between eight and twelve health visitors on an individual basis.

**Do I have to take part?**

*No. It is entirely optional and deciding not to participate, or to withdraw from the study, will have no consequences for you.*

**What happens if I agree to take part?**

You will be asked to sign a form saying that you have agreed to take part. This is only to ensure that I have acted properly in asking you to take part. It is not a contract and you still have the right to change your mind at any time. I will then arrange to meet with you at a location of your convenience to do an informal interview to discuss your experiences of working young children and their families. The interview will not last longer than one hour but you will be free to end it sooner if you wish. Please note there are no right or wrong answers; it is your views that are important for this study. With your consent the interview will be tape recorded and typed up so that I can be accurate in representing your views.

**What are the possible disadvantages and risks I should know about before I take part?**

If you find that you feel upset in any way during the interview then I will stop and ask you whether or not you would like to take a break, or stop altogether. You will decide whether or not you want to continue with the interview. In such an event you would also be offered a follow-up meeting with Claire Pearson, clinical psychologist.

**What happens if something goes wrong?**

If you have a concern about any aspect of this study, you should ask to speak to the researcher - Lucy Murray, contactable on Tel. 01162231639 or the Field research supervisor, Dr Claire Pearson, contactable on Tel. 07765977671. If you

are not satisfied with this you can contact the Trust Complaints Advisor, Ms Sara Greasley on Tel. 0116 2463461.

**Will my taking part in this study be kept confidential?**

Yes. All information about your participation in this study will be kept confidential. These details are included in Part 2.

**Contact Details**

Lucy Murray, Trainee Clinical Psychologist, University of Leicester, 104 Regent Road, Leicester, LE1 7RH. Tel. 01162231639

**This completes Part 1 of the Information Sheet.**

**If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision**

**Part 2.**

**Will my taking part in this study be kept confidential?**

Utmost care will be taken in order to ensure your anonymity. Your taped and typed information and consent form will be kept in a locked cabinet. Any information that is entered onto a computer will be entered in such a way that your name will not be used or able to be linked with the information. The computer will also be password-protected meaning that only I will be able to access it. Your name and personal details will not be mentioned anywhere in the study in order to protect your identity.

The taped interview will be heard and transcribed only by myself. The audio-tape will be kept in a secure environment and destroyed after the study has been completed. The completion date is scheduled for September 2008.

**Will anyone else be told what I said in my interview if I take part?**

Information from your interview will **not** be discussed with anybody unless you specifically request me to do so. Once the interview is typed up I will require

some assistance with analysis from my supervisors at the University of Leicester, and a trainee peer supervision group I attend. It is important to note that your name and personal details will not be assigned to the transcript and so your interview will remain anonymous.

**The only circumstance when I would be required to inform someone else about something said in your interview would be if it led me to believe that you or another person was in danger. I would be duty-bound to take further action, but would discuss this openly with you before doing so.**

**What will happen to the results of the study?**

The results will be written up as a thesis, which will be submitted to the University of Leicester as part of their requirements to gain a Doctorate in Clinical Psychology. They may also be published in a relevant journal. You can request a summary of the results if you would like them once the study is completed.

**Who is organising and funding the research?**

The study is being organised by the University of Leicester and funded by Leicestershire Partnership NHS Trust.

**Who has reviewed the study?**

The study has been reviewed by staff at the University of Leicester and has been given a favourable ethical opinion for conduct in the NHS by the South Yorkshire Regional Ethics Committee.

If you wish to participate we can organise a time to meet and conduct an informal interview. You will be asked to sign two copies of the attached 'Briefing and Consent' form prior to the interview starting. I will keep one copy for my records but the second copy and this information sheet are for you to keep. You can change your mind and withdraw at any time.

Thank you for taking the time to read this information sheet and consider participating in this study.

## **APPENDIX C**

- Consent to be approached form
- Briefing and consent form

*(Form to be on University of Leicester headed paper)*

**Consent to be approached form**

I agree for Lucy Murray to contact me directly by telephone to discuss my participation in her research

Signed .....

Name.....

Contact details.....

.....

*(Form to be on University of Leicester headed paper)*

## **Briefing and Consent form.**

### **Title of Study**

**How do Health visitors identify, manage and refer infant mental health difficulties in their caseload.**

### **Consent**

1. I confirm that I have read and understand the information sheet (version no.2) for the above study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.

**yes/no**

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason

**yes/no**

3. I give permission for the any identifiable information in my transcript to be made anonymous.

**yes/no**

4. I would like a copy of my transcript and be to check that steps to maintain my anonymity are satisfactory to me

**yes/no**

5. I would like to receive a summary of the results of this study

**yes/no**

6. I give my consent to take part in this study

**yes/no**



-----  
Name of Participant                      Date                      Signature

-----  
Name of Researcher                      Date                      Signature

**Confidentiality and data protection**

Data will be kept in a locked cabinet in University of Leicester premises. Electronic data will be kept on a password-protected computer and will be coded so that it cannot be linked to your name. This project complies with the requirements of the Data Protection Act.

## **Appendix D**

### **Proposed Interview Schedule**

#### **Warm up questions**

- Work context  
E.g. Where do you work? Tell me about the community that you work into?
- Career path  
E.g. Could you tell me about your route into health visiting?

#### **Conceptualisation**

How do you understand the term ‘infant mental health difficulties’?

#### **Identification**

How do you identify infant mental health difficulties in your caseload?

Tell me about the process?

#### **Management**

How do you manage these difficulties?

Tell me about how you have worked with these difficulties?

What kinds of approaches have you found useful/effective?

What have you found difficult/frustrating?

What kind of support did you have to work with these cases? – What kind of support would you have found helpful?

#### **Referral**

How do you make the decision to refer families with these difficulties for specialised help?

Where have you referred? – CAMHS, Social work, Paediatric services, Child development services, etc

What factors may affect your decision to seek specialised child mental health services for a family?

Would anything make these process more effective/easier for you?

What is your view of these services, the referral process and possible outcomes?

### **Prompt Questions**

If the participant is struggling to answer any of the above questions, prompt questions will be used to clarify and enrich the data.

- Without sharing any identifying details, and by using pseudonyms, can you tell me about a particular case where you identified/ managed/ referred infant mental health difficulties.
- Can you tell me about the process?

### **End of interview Debrief**

- Check with participant that they are satisfied with the interview process
- Check if the participant has any questions
- Check if participant is in need of follow-up support

## Appendix E

### Story for interview seven

#### **Key themes**

Personal experience informs understanding of IMH

Passion/interest in IMH

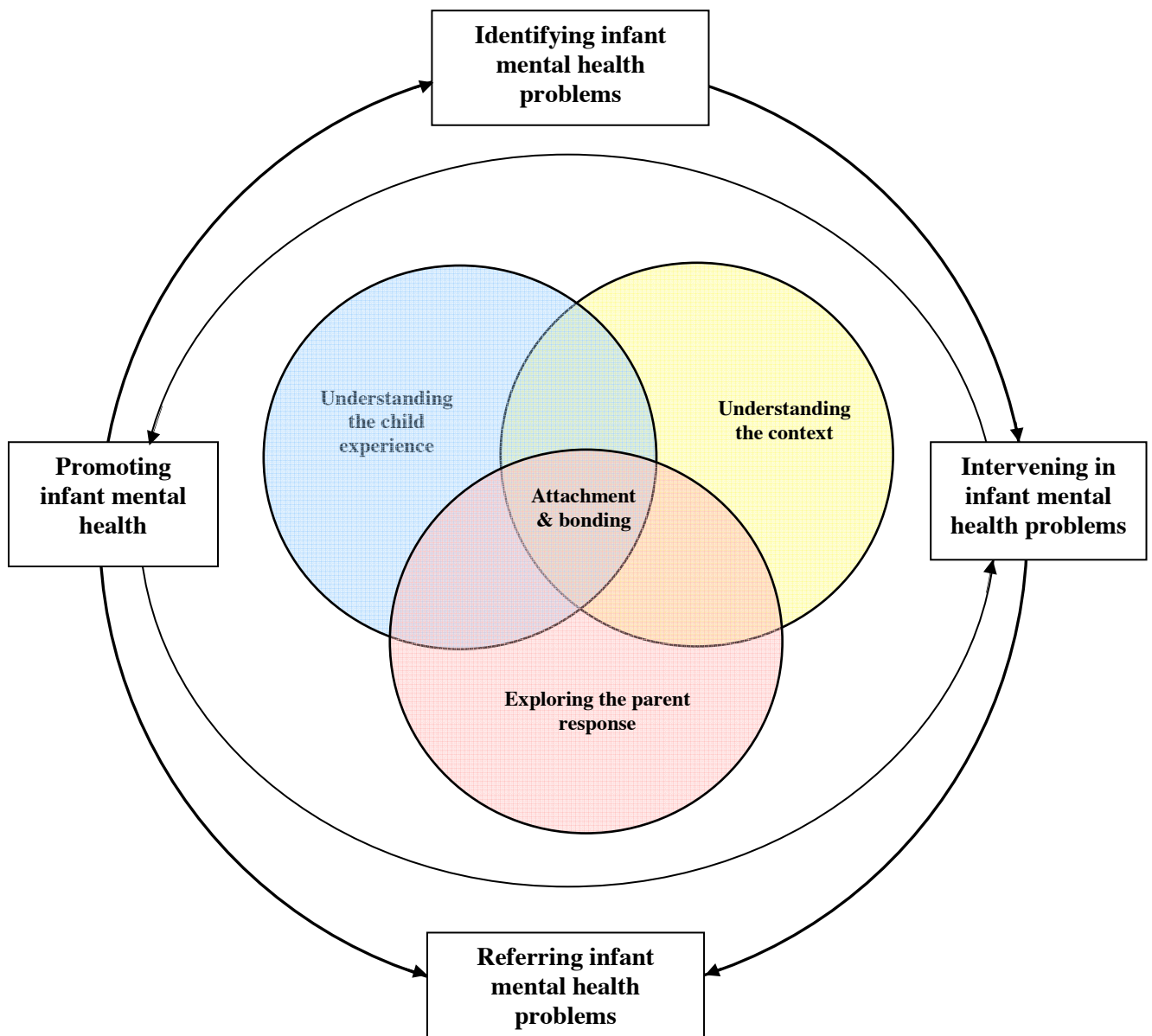
Valuing the Physical assessment

- **G was interested in raising awareness about IMH issues**
- **She had a very clear understanding of IMH: Attachment and bonding in the early days determine whether MH flourishes- because of the quality of the relationship**
- **This attachment has consequences for how a child feels about him/herself**
- **Understanding a problem: ‘unpacking’ a problem = Gaining a deeper understanding. Helping parents to do this may resolve problematic behaviour and improve mental health**
- **Moving away from a prescriptive, one-size-fits-all approach - Telling people what to do is NOT enough**
- **Taking preventative steps: communication and relationship building**
- **Not wanting to lose the physical focus: this is an important indicator of IMH for this age group.**

## Appendix F

### Example of the model evolving following the interview with K

The diagram below shows a section of the full model that was shared in the final interview with K. She felt that the emphasis on child development was not strong enough. This theme was not incorporated into the diagram at this juncture. I decided to raise it to a higher category and include it in the venn diagram representing how participants understood other elements of the three circles using a developmental framework. This decision resonated with several interviews. In particular, G felt it was important for health visitors to consider parental and contextual issues in terms of their consequences for child development. It also resonated strongly with the emphasis on physical development and how this was a possible barometer for emotional development.



## Appendix G

**Table to show referral destinations, triggers and health visitor process**

<b><i>Referral destination</i></b>	<b><i>Triggers</i></b>	<b><i>Health visitor process</i></b>	<b><i>Interviews</i></b>
<i>Community paediatricians</i>	<i>Queried underlying developmental delay or physical health difficulties</i>	Seeking a second opinion	A,F,E,G
<i>CAMHS</i>	<i>'Extreme' behaviour difficulties,</i>	Seeking a second opinion or Securing resources	J
<i>CAMHS triage clinic</i>	<i>'Extreme' behaviour difficulties,</i>	Seeking a second opinion'	E
<i>Social Services</i>	<i>Risk of or actual harm to child</i>	Securing resources or seeking a second opinion	F, G, K
<i>Another health visiting team</i>	<i>Maintaining continuity of care</i>	Securing resources	C, B
<i>Homestart</i>	<i>Isolation, poor parenting skills, parental low self esteem</i>	Securing resources	A,B,D
<i>Speech and language Therapy</i>	<i>Feeding difficulties</i>	Securing resources or seeking a second opinion	A
<i>Baby's first year project</i>	<i>Poor relationship with own mum, ambivalence about pregnancy, instability re housing</i>	Securing resources	B, E
<i>Sure Start (family support)</i>	<i>Isolation, poor parenting skills</i>	Securing resources	F,G,K,B
<i>GP</i>	<i>Depression/anxiety</i>	Seeking a second opinion	A, D,
<i>GP- Counsellor</i>	<i>Depression, personal trauma, bereavement</i>	Securing resources	A, D
<i>GP-CPN/CMHT</i>	<i>Major mental illness,</i>	Securing resources or seeking a second opinion	B, A,
<i>Specialist IMH health visitor</i>	<i>Enduring feeding, sleeping, toileting problems,</i>	Seeking a second opinion	A, B, C, D, E
<i>Baby massage</i>	<i>Isolated parents, dyads with attachment difficulties</i>	Securing resources	K, B, D
<i>Parenting support groups</i>	<i>First time parent</i>	Securing resources	K, D, B, E
<i>Health visitor sleep clinic</i>	<i>Enduring sleep problems</i>	Seeking a second opinion'	A
<i>Postnatal depression support group</i>	<i>Postnatal depression</i>	Securing resources	B, A, K, F

## **Appendix H**

Additional quotes supporting the analysis.

Category/ subcategory	Supporting Quote(s)
<p><b>Main Category:</b>  <b>Understanding the Child's experience</b></p> <p><i>Understanding the meaning of problematic behaviour</i></p> <p>Understanding the child's emotional state</p>	<p><b>Quote 1</b>  <i>'children that sort of smear their own faeces and children that act in ways that are not age appropriate... You know real sort of aggressive behaviours as well in terms of to themselves but also to others' F:56-60</i></p> <p><b>Quote2</b>  <i>'..a two year old that used to kick its mother and say 'fuck off you bitch' ... it was shocking-really shocking to see this two year old... Because that's all he'd heard his father say to his mother. He used to kick her black and blue. And he just used to say to her, you know 'fuck-off you bitch' And that's perfectly understandable why that that little boy was doing it' C:596-602</i></p> <p><b>Quote 3</b>  <i>'So this child was just so, you know unhappy. You could see it in the way he played and the way the mum responded to him' A:937-938</i></p> <p><b>Quote 4</b>  <i>'The kind of like frozen face; nothing going on there really. Which you do see from time to time' E:253-254</i>  <i>I've been quite surprised really at how babies' or young children's behaviours are described (laugh). And you know when you get a six, seven, eight-month-old baby being described as being naughty, it's quite upsetting really. B-19-21</i></p>



<p><b>Main category: Exploring parent response</b> Reflecting on thoughts and feelings about the baby</p>	<p><b>Quote 5</b> <i>I've been quite surprised really at how babies' or young children's behaviours are described (laugh). And you know when you get a six, seven, eight-month-old baby being described as being naughty, it's quite upsetting really. B:427-430</i></p>
<p><b>Main Category: Understanding the impact of the child's context</b></p>	<p><b>Quote 6</b> <i>'.. what it's like as a baby to experience emotional, physical erm, erm abuse going on between members of the family. And being in there and feeling very unsafe in there as well' E:177-179</i></p>
<p><b>Main Category: Promoting Infant Mental health</b></p>	<p><b>Quote 7</b> <i>'I think parents need information when they are really receptive, like they are antenatally. It's a good time to me to get them to think about what sort of parent they are likely to be' B:182-184</i></p> <p><b>Quote 8</b> <i>'I think once the behaviours start being displayed as difficult behaviours I think that's when their mental health is becoming an issue anyway so it's trying to prevent it before it does become an issue' F:186-188</i></p>

<b>Main Category: Identifying infant mental health problems</b>	<p><b>Quote 9</b>  <i>"then we do explore a little bit around whether there is any alcohol or substance misuse in the family...and also there is a question around err any issues to do with domestic abuse' B:282-288</i></p>
<b>Main Category: Intervening in Infant mental Health.</b>	<p><b>Quote 10</b>  <i>'So I do very simple behaviour modification, which I have to say, is very successful, and I've done it for many many years..'</i>  K:429-430</p>
<b>Main Category: Intervening in Infant mental Health.</b>	<p><b>Quote 11</b>  <i>'People's expectations of children are so high and they talk about how um dreadful the behaviour tantrums are and you try to sort of work with parents to get them to think about how um able this child is to um communicate um for the age that they are'</i>  B:439-442</p>

<p><b>Main Category: Referring Infant mental health problems</b></p> <p>Anticipating a referral outcome</p>	<p><b>Quote 12</b>  <i>'Yeah, or perhaps ones that I don't feel I've got the skills to deal with, yeah, that's what I do' H: 492</i></p> <p><b>Quote 13</b>  <i>'I suppose the only times I've ever referred to CAMHS or mental health services has been clear physical.. you know the child's pulling their hair out or.' H:1212-1213</i></p> <p><b>Quote 14</b>  <i>'so they would give some advice to the family, they could come back to the health visitor with what the findings were or some suggestions..' E:407-409</i></p>
<p><b>Main Category: Use of Self</b></p> <p>Celebrating health visitor skills</p> <p>Building relationship</p>	<p><b>Quote 15</b>  <i>'you might be able to get parents to think about what would they like and how would you manage to get them to sleep a little bit longer. And how do you think you might manage that. You know help them to think about what outcomes they want...' B:491-493</i></p> <p><b>Quote 16</b>  <i>'And just explain why it's good for babies and that research, that shows it helps with their brain development. And the more you talk to them ..' C:232-234</i></p> <p><b>Quote 17</b>  <i>'sometimes when you see women that just chatter away and I'll just make a comment 'oh it's really nice to see you talking to the baby, you know it's good for babies the way you're talking to your baby' C:235-237</i></p> <p><b>Quote 18</b>  <i>'Because of the relationships that we have with families we would always know it's not just innate in that child.' F:81-82</i></p>

Drawing on personal experience	<p><b>Quote 19</b>  <i>'My other two colleagues in this office came from being nursing sister and through mental health services, so you know there is a lot of experience there in life,' K:605-607</i></p>
Drawing on Professional values	<p><b>Quote 20</b>  <i>'So you have to be subtle in your approach. You have to start with something positive. You know 'he looks very well today. Oh the breast-feeding is going very well. Oh the weight gain is excellent....So, you know you build up on the positive things' D:237-241</i></p> <p><b>Quote 21</b>  <i>'discussion around sleep management varies depending on who the family are and who the child is..so you know adapting information, according to what the needs are' B:545-546</i></p> <p><b>Quote 22</b>  <i>'I think a lot of erm families that we work with come with behavioural problems in children but often are normal behaviours, that's age appropriate' F:48-50</i></p> <p><b>Quote 23</b>  <i>'You expect in the newborn period, err and certainly up till about three months, you expect babies to be unsettled and to cry a lot. But you, the norm is for them to be, by three months, to become more settled' C-5-17</i></p>
<b>Main Category:</b> <b>Overcoming obstacles</b> Responding to organisational change	<p><b>Quote 24</b>  <i>'There used to be one or two first parent groups around like in (names two areas of the city). The health visitors don't have time to do them now. So there is a lot of unmet need out there' D:278-281</i></p>

<p>Coping with Inequity</p>	<p><b>Quote 25</b>  <i>'It's not across the whole of the city. It's just very lucky that we work in the area where she works.'</i> C:506-507</p> <p><b>Quote 26</b>  <i>'whether you're a forty-five year old woman with her first child who's had a high flying job, having a first child, or whether you're somebody who has got six children and has had a miserable life, everybody should be offered core service.'</i> K:315-318</p> <p><b>Quote 27</b>  <i>'I don't think we refer a lot of children into...into anything to be honest. I think we do hold it. ..I think we do hold a lot of mental health....we probably don't realise that we are doing what we are doing. I think we don't realise we're dealing with a lot of child and adult mental health'</i> H:443-449</p>
<p>Managing the demands of IMH work.</p>	

<p><b>Main Category: Supporting mechanisms</b></p> <p>Training, research and knowledge</p> <p>Supporting structures and tools</p>	<p><b>Quote 28</b>            'because I have student health visitors I think. It keeps you fresh; it keeps you on the ball and up to date with research. You have to be at that level always but you've also got that wealth of experience' K:290-293</p> <p><b>Quote 29</b>  <i>'That is written down so when the next person picks it up, they can see that this person is a more motivated mother or...grandmother lives next door, or ..Very isolated, no friends, you know so if then someone picks this up they can say so you've no friends you know so that's how we get a picture of it. It's written down. So even thought you haven't visited previously you've got something to go on'</i> D:414-418</p> <p><b>Quote 30</b>  <i>'We've always used it and I do find it a useful tool to look at mother's mood....To give you an idea and to sort of talk about. You know, I keep a supply at clinic'</i> C:254-258</p>
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## **Paper Three**

### **Critical Appraisal**

## **1.Introduction**

In this chapter I aim to document my research journey and reflect on important decision points along the way. Moreover, I will consider the scale of the learning curve I have experienced, and provide illustrative examples. This appraisal is not exhaustive; rather it provides a summary of a research process within the context of clinical training.

## **2.Origins of the research**

### **2.1 Developing the research question**

The first step in my journey was writing a literature review in the area of ‘early intervention’ in my first year of clinical training. This was prompted by a long-standing interest in attachment theory and its implications for clinical psychology practice with under-fives. Prior to training, I was drawn to preventative work and valued the pre-school period in children’s lives as an opportunity to support families with the hope of averting complex family problems later in childhood.

I was inspired by some of the key writers in the field (Fonagy, 1998; Barnes, 2003, and Svanberg, 1999) and the body of evidence in support of early interventions. Subsequently, I contacted a local clinician involved with an attachment intervention, based on an American model I had reviewed. In collaboration with the project, I developed a research question relating to the experiences of first-time mothers who had engaged with the service.



At this juncture I experienced my first disappointment, when the study collapsed due to anticipated difficulties with recruitment. I faced the realities of researching the experiences of a 'hard to reach client group'. Although I was committed to learning more about this group of people, I had to reflect on the academic pressures upon me and became sensitive to how little control I felt I had over my planned fieldwork. I made the decision to restart my project and could not help feeling that the early departure probably saved a lot of misdirected energy.

In developing a new research question and writing a further proposal, I was keen to learn from my mistakes. I felt more in control of my current project and believed that recruitment of participants was within my reach. I also maintained a thread from my literature review, through my first proposal and on to my final proposal. I had discovered an evidence base indicating that early interventions were available and offered benefits to young children and their families. I believed it was a natural progression to think about how such children might be identified. I was aware that health visitors predominantly made referrals for the attachment project I had been involved with. This triggered my thinking about how this professional group engaged with the emotional and psychological needs of infants and young children.

### **3. Methodological considerations**

#### **3.1 Choosing Grounded Theory**

Justification for selecting qualitative methodology and grounded theory in particular is outlined in the method chapter, but there are a number of points I would like to reflect on. Although I am aware the research question dictates which method is

employed, and I feel confident I made good choices in this respect, I do acknowledge other influencing factors. For example, I carried out a very detailed large-scale quantitative service evaluation in my second year of training and was interested in gaining experience of a different methodology for my final project. Furthermore, I felt the struggles experienced by the ‘early adopters’ of qualitative methods on the clinical training course had prepared the way for my training cohort. I felt the climate was very supportive of qualitative approaches and there was knowledge of Grounded Theory within the clinical tutor group. I was eager to make use of the chance to learn about a new method within a supportive environment.

I opted to use Charmaz’s (2006) Grounded Theory because it offered a coherent method amenable to the novice researcher. Charmaz holds pragmatic views about her methods being used by researchers who do not necessarily share her social constructionist ideas. This again influenced my choice.

Finally, I was drawn to the ‘grounded’ nature of grounded theory. What sets grounded theory apart as distinct from other methods is the “inductive process of coding incidents in the data and identifying analytical categories as they ‘emerge’ from data (developing hypothesis from the ‘ground’ or research field upwards rather than defining them in advance)” (Pope, Ziebland & Mays, 2006. p70).

### **3.1. Developing an epistemological stance**

Prior to my research journey, I had considered constructionist ideas in relation to theology and my attempts to think about the ‘big questions’ in life. As I approached

my research questions, the subject matter felt very different to me. Reviewing the literature, I was drawn to the peer reviewed evidence supporting early intervention and the longitudinal studies suggesting links between insecure attachment patterns and childhood mental health outcomes.

As I reflected on my epistemological stance, I felt comfortable with a realist framework in relation to Infant mental health (IMH), because I work in a mental health profession and am engaged with the mental health problems experienced by clients.

Although I could agree with the idea that mental health may be conceptualised differently by different people, I found it hard to relate to it as an entirely constructed notion. The critical realist stance struck me as the middle position and enabled me to approach my interviews with some confidence that infant mental health existed as a phenomenon. It also allowed me the flexibility to seek to understand the variety of ways people may make sense of it and recognise these viewpoints generate greater insights into the phenomenon.

#### **4. Ensuring quality research**

Yardley (2000) outlined three principles for evaluating the quality of qualitative research: sensitivity to context; commitment, rigour, transparency and coherence; impact and importance. Merrick (1999) referred to notions of trustworthiness, reflexivity and representation as important for establishing quality within this branch of research. With these ideas in mind, I endeavoured to maintain

quality within my own research. I felt I was sensitive to the context of my study, both in terms of my clinical path towards researching this area and the academic preparation I had undertaken prior to commencing. I was aware my lack of familiarity with the research method could compromise my sensitivity to the data, but I was confident in the function of supervision. My own clinical interests guided my research area, so I was ever mindful that the research should have utility, and I plan to maintain my commitment to this area of research, taking it forward into my new career. I was careful to consider clinical implications in detail in order to enhance the validity of the research. I feel my own process of reflexivity has been addressed here in this chapter, aided by my research journal. I became acutely aware of my own capacity for bias and mindful of the effect this may have on the research process. This is particularly well illustrated by my own notions of IMH as I approached the interviews. I consciously let them go in order to understand the views of my participants, only revisiting them again when I reviewed the literature for my discussion.

#### **4.1 Transcribing**

I made the decision to transcribe my own interviews, which was a long and laborious task. This provided me with ample opportunity to familiarise myself with the data and helped me to develop my thinking at different stages. I think this was particularly beneficial for me as a novice researcher, as it eased me into the mechanics of coding and helped me form a strong relationship with my data. I also felt it demonstrated a degree of rigour and thoroughness in my approach.

## 4.2 Using a reflective diary

The reflective journal was an important learning tool and provided an outlet for me to explore my feelings and consider how they may impact on my fieldwork.

Extract 1. illustrates the anxiety I felt at the start of the interview process and the learning this prompted.

### **Extract 1: Journal entry prior to interview one.**

I felt nervous about the first interview, aware that even with background reading on theory and technique, the reality was that this was the first time I had conducted a research interview of this nature. I reflected on clinical interviews and the crossover skills required, but still this seemed different. I was interviewing allied professionals. I had worked previously with health visitors but might not be wholly familiar with the culture of the profession and possibly the language. Reading up on Charmaz, I reminded myself this unfamiliarity afforded me the capacity to be curious, possibly to have the freedom to ask the obvious. This may prove to be a valuable asset in my work...

Prior to each interview I conducted, I noted down any preconceived ideas that I held as I met my participant. At the close of each interview, again I took time to reflect on immediate thoughts and impressions that were brought about by the interaction. Extract 2 provides an example of how I had misheard my participant because I was so narrowly focused. The research journal helped me to think about this error and enabled me to see how my preconceived ideas could block new perspectives.

### **Extract 2: Journal entry following interview one**

'A' talked about referral to CMHT in situations where she was very concerned about a mother's capacity to bond... Is this because services are very skewed towards depression and the risk this poses for bonding attachment issues? This is good in one sense, but does it limit the assessment to include wider explanations for such difficulties? I wonder why a CMHT might be deemed a useful referral destination for such cases. For sure there is mental health expertise there but what about the child centred perspective. Interestingly she made a distinction between Adult mental health services and social services as adult/ child-centred. ... What about a mental health approach that is child centred? Is there such a thing? I was thinking she was talking about CAMHS. I was so preoccupied with my own expectations for the interview that I didn't hear .. I realised a little later what she was referring to and felt surprised.

I hadn't thought about adult services. I was very preoccupied with CAMHS and social services and I wasn't thinking about the expertise in adult services until the point when A talked about CMHT and whether they delivered on her expectations or not..

I continued to make journal entries during the transcription and analysis phases of my research. Although, I noted thoughts and ideas periodically as they came to me during my field- work, the structure outlined above underpinned my analysis and ensured it was 'grounded' in the data. It served as a quality control, allowing me greater insights into my own voice within the analytical process. Importantly, it enabled me to keep my assumptions and biases in check and brought a degree of transparency to my analysis.

### **4.3 The use of supervision**

During the course of my research I received supervision from three individuals- two academics and one clinician in the field. I found their differing views and experiences motivating and encouraging throughout the research process.

Supervision was a great mechanism for testing out emerging theory, fledgling models and tentative attempts to link research findings with the wider literature. I

experienced supervision as collaborative and valued the insights of my collaborators. I remember feeling anxious at the prospect of sharing my thoughts and ideas. Were my theories up to scratch? Did my model make the grade? This element of pressure helped me to stay on task during difficult times and hopefully steered me towards a good outcome.

#### **4.4 Peer supervision**

Peer supervision bolstered my application to the research tasks in many ways. A qualitative support group provided an opportunity to explore methodology, dilemmas, questions and progress on a month-by-month basis. Within this forum my transcripts were subjected to peer review. Discussing the codes for sections of data reassured me I was on track and also provided an important quality control for my analysis. The experience led me to think about the parallel between diversity of views expressed by the participant group and the plethora of views expressed by my peers as they grappled with the transcripts. I recall feeling overwhelmed by the enormity of the task before me, perceiving myself as tiny in relation to the vast data I had collated, and the multitude of interpretations available to me. The peer support I garnered during my research journey was very valuable. This helped me to think about issues such as clarity of language and clinical relevance.

### **5. Decision points, critical moments and important considerations**

#### **5.1 Theoretical sampling**

Theoretical sampling is an important element of grounded theory and allows the researcher freedom to collect data in response to leads and ideas revealed by

earlier analysis until the point of saturation, when no further categories may be identified. For example, one participant had undertaken additional training in the area of IMH and another had declared a special interest in the topic being researched. These views were contrasted by participants who felt under-confident and ill-informed about the subject. Beyond this, there were significant limitations on theoretical sampling. Due to the time restrictions of the project and the ethical constraints imposed, I was not free to explore the IMH perspectives of different professional groups. The views of paediatricians, CAMHS workers, speech and language therapists and staff employed by social services, all referred to by the study participants, would have been valuable for two reasons. Firstly, to clarify the health visitor perspective as unique or in common with other professional groups, and secondly, to test out an emerging hypothesis that the IMH terminology was not particularly well understood and had limited utility in a clinical setting. This problem has been recognised by Pope *et al.* (2006), who concur the practical application of Grounded Theory within a clinical setting may be very difficult, as the flexibility required to sample theoretically may not be amenable to the technical process governing the conduct of research. They have discussed the phenomenon of ‘modified grounded theory’, which describes the reality many researchers face as they use inductive and deductive methods.

## **5.2 Being open to my data**

One of the first themes to emerge during the early stages of analysis was the different ideas participants had about IMH and the relative utility of the terminology. Grounded theory prescribes concurrent data collection and analysis to ensure that emerging themes are explored and pursued during the data collection phase (Charmaz,



2006). I was able to test out these emergent categories in subsequent interviews and the outcome of this line of investigation formed an important part of the final discussion. I had not anticipated that data relating to the conceptualisation of IMH would be so significant but I allowed myself to be guided by my participants and the data I was collating. On reflection, I think I held a view of IMH, largely based on attachment theory, which was derived from clinical experience and reading of the wider literature. I did not anticipate the expertise I perceived my participants to have and was unprepared for the range of ideas I attempted to synthesise into my model. What particularly strikes me in this process is that, by being open to the data, fresh perspectives on old concepts can bring greater understanding. For example, this participant group offered a developmental focus, which included thinking about physical health markers for emotional and mental health development.

### **5.3 Raising the category of ‘unravelling a story’ to core category**

During the analysis I noted the frequency with which participants spoke about understanding what was going on for a family. I was immersed in metaphors such as ‘unpacking’, ‘building up a picture’, ‘teasing out’, ‘unpicking’, ‘pulling out the strands’ and ‘getting to the bottom’. I felt these metaphors worked on lots of levels and helped me to think about participant process in relation to identifying problems, but also typified a shift in focus which amounted to intervention. I began to think about the power of these insights to affect change. The metaphors also resonated with what seemed to be occurring at the point of referral. This process involved seeking a new perspective on a problem – ‘enriching the story’. I considered elevating ‘relationship’ as this related to participant process on many levels. Ultimately,

‘unravelling’ seemed the best fit for my data and seemed to best represent the experience of working with IMH as I understood it.

#### **5.4 The model emerges.**

I had heard expressions such as ‘immersion in the data’ and ‘living and breathing the data’ but could not relate to these ideas until I found myself in this position. I had been assured that the formation of a diagrammatic model would just ‘happen’ and I found this hard to believe. I lacked faith. In the end, I found the process of generating a model incredulous. On reflection, it clearly did not ‘pop up’ out of thin air, despite seeming to do so. Important time-consuming procedures were adhered to in preparation for this ‘eureka’ moment. Detailed transcript analysis, involving different levels of coding, was at its foundation. Listening again to each interview recording and writing a representative thematic story for each of my participants helped me to focus and make decisions about higher order categories (see appendix for an example). Finally, I drew on a range of techniques to foster my creative thinking. The outcome was an initial model ripe for review and amendment in consultation with subsequent participants.

I learnt here that having faith in the process is essential. Experienced researchers have shared their research journeys and the hard graft and preparation in the early stages always seems to come to fruition in the creative phase of the process. My own journey was no different in this respect but the phrase ‘light at the end of a very dark tunnel’ of groundwork has never felt so true.

## 5.5 Language

The decision to use the term ‘infant mental health’ was problematic. I opted to use this language because it was prevalent within the early intervention literature. Indeed one of the key journals relevant to the study is ‘The Journal of Infant Mental Health’. During formal presentations of research proposals to my peer group, I noted particular feedback regarding this terminology and the confusion it seemed to evoke. I was aware at this early stage that the term held a variety of meanings for people not directly connected with the field. I considered using different language during my interviews such as ‘emotional wellbeing’, ‘attachment security’ and ‘psychological wellbeing’ but realised I risked imposing my own conceptualisations of infant mental health, derived from the literature, on my participant group. I therefore decided to use the term but explore its meaning with my participants. I did not anticipate that a significant part of my analysis would focus on conceptualisation and that some of my key findings would relate to the utility of this language.

As the research progressed I gave considerable thought to the ongoing repercussions of the choices I had made. There were times when I felt the language alienated my participants and aligned me too closely with the academic world. I questioned my judgment and was concerned that data collection was inhibited by the language.

I was very sensitive to connotations associated with the term ‘mental health’. Participants referred to the stigma of mental illness and challenged the relevance of such a term for thinking about the wellbeing of very young children. For some participants the language catapulted them into extremes of behaviour, disorder and

illness and they struggled to think about everyday incidences of mental health difficulties. On this basis, mental health expertise existed among ‘others’ and could not be claimed by them, even for the young age group with which they had considerable expertise. Interestingly, some participants engaged with the broader debate surrounding the stigmatisation of mental illness. They cited the benefits of using the language to promote openness about the realities of mental ill-health in society and the importance of caring for mental health and wellbeing across the lifespan.

## **5.6 Power**

Through supervision and my own reflective diary I considered issues of power in the research I was undertaking. The participants spanned different generations and had different relationships with the field of research. More recently qualified practitioners appeared very comfortable with research language but for others my language may have contained jargon and appeared alienating.

My role as researcher may also have been problematic. Participants were aware of my ‘trainee clinical psychologist’ title and this undoubtedly had an impact on the proceedings. There were examples during interviews when participants asked me for the ‘answer’, suggesting to me they perceived the interview process as my attempts to test their knowledge from a position of holding superior knowledge. In reality, it may or may not be true I have knowledge about IMH, but the focus of my interviews was individual health visitor process, about which I had very little knowledge. This required me to reflect on my own communication. Did I effectively communicate the reason for my research? Did my participants understand or take on

board my explanation? Do wider issues of power and control play a part in this dynamic? I used supervision to reflect on these questions and came to realise the research process is full of such biases. It is true that as the trainee clinical psychologist I was seen as an expert, but the impact this had was variable. For example, one participant commented on how much she enjoyed the process. Rather than feeling threatened, she felt 'challenged' and 'stimulated' in a good way. As the interviews progressed I felt more confident and was able to share power more effectively, loosening my own pre-conceptions about how the interview should proceed.

## **6. Writing up**

Writing the analysis chapter was the final step in my data analysis. The opportunity it afforded to clarify my ideas and produce a succinct representation of my findings is well documented (Charmaz, 1990, 2003; Willig, 2003). I took this final opportunity to collapse codes and tighten the final analytical categories. It enabled me to edit repetitive sections and ensure my final model was as clear and succinct as it could be.

I found this stage in my research a real struggle and felt very tired as I approached the task. This led me to reflect on the link between fieldwork and dissemination. It is easy to become immersed in the practical side of research but the format in which ideas are presented to the world is very important. This prompted me to think about the story I wanted to tell with my research findings.

## **7. Extended timescale.**

I extended my clinical training in order to care for my two young children. This certainly impacted upon the research process. Firstly, as a mother I have a personal interest in the period of infancy and have witnessed first-hand the rapid development undertaken by a baby and the power of attachment to facilitate this. I think this would have been particularly pertinent had my original research project progressed, but interviewing professionals enabled me to step away from my own experiences to a large degree. Although it may be thought 'part-time' research means more time, I did not find this to be the case. I was very grateful for the extended timescale to complete my clinical training part-time but was only too conscious of how little could be achieved in half a study day when on placement. As I watched my peer group in the grip of panic as submission dates arrived, were postponed and postponed again, I felt reassured by my decision to extend training. However weeks later, as I geared up for data collection and analysis, I was envious of them as they left training behind. Ultimately, I felt my research journey followed the footsteps of my cohort. I had learnt so much from their process and I tried to apply this to my own endeavours.

## **8. Personal impact of the research**

I approached this research with considerable interest in the mental health and wellbeing of very young children and I feel one of the outcomes of it is I have sustained my passion for this work and feel strengthened in my convictions about its value for society.

In the course of answering my research question, I have acquired fresh insights and felt the impact of the learning process personally at times. I was particularly struck by how experienced my participant group was and this has shaped my respect for the health visiting profession. I am aware this bias has filtered through to my discussion chapter and I have considered this carefully. I do feel this research has provided me with an opportunity to raise awareness about the skills held within the health visiting profession. If I am honest, I thought I would be arguing for more training and expertise, but my findings have in fact led me to the role of advocate. Interestingly, as a specialist mental health practitioner, I have to ask myself how can I best support their work and I think raising the profile of current IMH practice is a valuable intervention.

I could not have anticipated the depth of knowledge and skills I encountered, which were exemplified by a participant with 36 years' health visiting experience. She was open about her professional journey and the changes she has witnessed in the course of her career. She emphasised to me that the world may change but the needs of babies remain constant. Thus, her remit and essential tasks have barely altered in all those years. Although she was not particularly vocal about attachment theory, she referred to her bible that had served her well in training and continued to inform her current practice. She even offered to lend me this dog-eared copy of 'Attachment and Loss' by John Bowlby. Her testimony resonated with me and I thought about the work of Bowlby, which seems to have stood the test of time.

It led me to think about how much I could learn from these individuals, not just in terms of the research process but also as a clinician. This is interesting because although multi-disciplinary working is heralded as beneficial it is not always an easy path. I felt that understanding the perspective of this professional group was hugely beneficial for future collaborative working.

I would also like to reflect on professional growth and development, which was precipitated by the data collection process. Listening to my transcript recordings, I was stunned by my own lack of clarity when posing questions at times. I had been warned that inexperienced interviewers may become unstuck, but I felt very unforgiving about some of my ambiguous and leading questions. Charmaz (2006) described how she chooses questions very carefully and poses them very quickly in order to encourage the participant to reflect more easily. Striving for a naturalistic conversational exchange appears an equally valid approach, but at times I struggled to adhere to either.

In the early interviews I noted my own idiosyncratic interview style. I was aware that I had a bad habit of answering my own questions, and hoped this would be kept to a minimum for the purpose of research objectivity. I was horrified to find my early transcripts were littered with examples of my bad practice. This came as an urgent warning for me to work hard to clarify my questioning and be more succinct. I wondered what I was afraid of in my avoidance of straightforward simple questions. Being too abrupt? Being too direct? Unfortunately such reservations resulted in confused questions at times. I questioned my own fear of silence and my need to fill in gaps. The transcripts provided evidence to me that I was able to tolerate silences



but I recognised a tendency to not give time for participants to process what I had said, jeopardising valuable data. During the subsequent interviews, I worked hard on this aspect and felt I made good progress.

## **9. Conclusion**

In appraising my own research process, I have tried to focus on important decisions I had to make and the significant learning opportunities I was presented with. I feel fortunate that my research was in an area in which I have a clinical interest. This helped to sustain motivation and commitment at times when I felt progress was slow. I am certain in the future I will be able to draw on the knowledge and experience I have gained through undertaking this research.

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