A portfolio of study, practice and research

An investigation into parent’s perceptions of the process and outcome of a parent training group with reference to changes in self efficacy

Submitted for the Doctor of Psychology (Psych D) in Clinical Psychology

Conversion programme

by

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Acknowledgments

I would like to thank Clare Twigger for all her assistance with the research and Lorraine Nanke for her general help and support.

I would also like to thank all the mothers who kindly agreed to participate in the research.

This thesis is dedicated to Bently and Eleanor
A Review of the work of the deliberate self harm team at Kingston & District NHS Trust from January 1994 to July 1996

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Part 1

Title


Background

An important aspect of my work in the Child and Adolescent Psychology Department is my role on the Deliberate Self Harm Team. The team was first set up when I came into Post 6 years ago. Its principle role is to assess any adolescent who is admitted to the paediatric wards following a deliberate self harm attempt. The purpose of this is to assess the risk of a further self-harm attempt and to advise regarding therapeutic intervention. The team involves a number of different professionals with differing experience and backgrounds. The team uses a standardized format for interviewing the adolescents and their families which was developed over a number of years.

I have chosen to review this aspect of my work because it raises several important issues. Firstly the processes involves liaison between professionals with very different roles and backgrounds bringing different expectations and perceptions regarding deliberate self harm. Secondly unlike most of my other clinical work it is crisis led and therefore the families tend to be in state of turmoil. Finally it provides an opportunity to collate the data and thoroughly review the work of the team which has not yet been done and it is necessary to make decisions about future developments.
Aim

The aim is to demonstrate my clinical competence in the area of deliberate self harm with adolescents. To demonstrate my ability to critically evaluate services within the context of Child and Adolescent psychology and to provide information which will be useful in planning further developments of the team.

Objective

1. To describe the work of the child and adolescent Deliberate Self Harm Team of Kingston & District NHS Trust.

2. To collate and analyze the data recorded from deliberate self harm assessments during the period between January 1994 to June 1996.

3. To demonstrate by the use of case studies my clinical involvement in the Deliberate Self Harm Team.

4. To demonstrate the rationale of the procedures of the Deliberate Self Harm Team, with reference to the current thinking on clinical practice.

5. To highlight the importance of liaison with other disciplines.

6. To pinpoint areas of difficulty and discuss possible solutions.

Part 2

Aim

To provide evidence of post qualification development.

Objective

To document post qualification professional training.
Academic Dossier

Part 1

Title

Childhood bereavement: consequences and therapeutic interventions

Background

A part of my work that I find particularly challenging is working with families who have been bereaved. This has ranged from seeing a mother and her two young children where the father had committed suicide, to other cases where children seem to be having difficulty coping with the death of a grandparent. In addition to family bereavement I have also been involved in running a group for a class of children with physical disabilities where two of their class mates had recently died. This event brought up a number of very difficult issues for the children such as confronting them with their own vulnerabilities. Professionals working in Child services are frequently asked for advice regarding issues around bereavement for example whether to take the children to the funeral and how much a child should be told about the circumstances of the death. In my view, for this to be done effectively it is important to have a good knowledge of the psychology of bereavement. In particular an understanding of the way in which children understand the meaning of death and its impact on them.

The purpose of this review is to begin by discussing the developmental aspects of a child’s understanding of death and the effect it has on a child. I then go on to address therapeutic interventions. I hope this review will inform my work by improving my knowledge of the area and give me a greater understanding of effective therapeutic interventions.

Aim

1. To enhance my knowledge of the approaches to working with bereaved children.

2. To demonstrate my ability to critically evaluate the relevant literature in this area.

3. To demonstrate my ability to relate theory to clinical practice.
Objective

To complete a critical review of the literature of therapeutic approaches to children who have been bereaved.

Part 2

Title

Deliberate Self Harm in Adolescents: a review of the literature

Background

Deliberate self harm in adolescents is a challenge to mental health services. In order to improve my clinical practice I thought it would be helpful if I had a greater understanding of the literature surrounding this group of adolescents. Although I have considerable experience of working with adolescents who self harm I believe my work would benefit from my undertaking a thorough review of the literature. Aspects of particular interest are the motivational aspects of adolescents who harm themselves and evaluation of the interventions.

Aims

1. To enhance my knowledge of the literature on deliberate self harm in adolescents
2. To demonstrate my ability to critically evaluate the relevant literature in this area.
3. To demonstrate my ability to relate theory to clinical practice.

Objective

To complete a critical review of the literature on deliberate self harm in adolescents.
Research Dossier

Title

An investigation into parent’s perceptions of the process and outcome of a parent training group with reference to changes in self efficacy.

Background

One of the most common problems referred to a child and adolescent psychology department is children with behaviour problems. These children are typically under five years of age and are usually referred by their general practitioner or health visitor. The clinical picture is variable but typically includes behaviours such as non-compliance, aggressiveness and temper tantrums. These families are usually offered individual family work aimed at helping the parents cope more effectively with their child’s behaviour. An alternative approach which has been proved to be effective is to run groups for parents with behaviour problems known generally as “parent training groups”. However little evaluative work was undertaken by our department and that which has been done was limited to parental checklists about their children’s behaviour administered before and after the group. A further development of this evaluative work has been to explore the process of parent training. It is the aim of this study to explore this issue by using a combination of qualitative and quantitative measures designed to monitor changes during the course of the group as well as before and after. Another important theme of parent training is to change the parent’s perceptions of their abilities in relation to their children. A further aim of this study is to examine how attendance at a parent training group affects a parents self efficacy and how these changes might be brought about.

Aim

To design, execute and report on a study investigating the process and outcome of a parent training group. This piece of research will present a contribution of knowledge in this area.
Objectives

1. To run a parent training group.

2. To assess how the group affects the parents level of self efficacy.

3. To assess how the group affects the parents perceptions of their child’s behaviour.

4. To investigate the parents perceptions of the helpful aspects of the group.

5. To interpret and describe the findings of the study.

Course Director


Course Tutor


Introduction

Deliberate Self Harm in adolescents is a major concern, 18,000-19,000 adolescents take an overdose every year in England and Wales.

In the accident and emergency departments the adolescents who self harm have to compete with the other serious medical conditions. The Royal College of Psychiatrists Working Party (Baderman et al 1982) advised that all adolescent overdose cases are admitted for assessment by a member of a child psychiatric team. They stressed both the value of regular consultation with ward staff routinely involved in these cases and the importance of involving both parents and/or legal guardians in the assessment. They view hospital admission as a unique opportunity for assessment and treatment, since after discharge motivation may diminish rapidly.

It has also been found that adolescents tend not to comply with follow-up plans made in the accident and emergency department and therefore it is important that the adolescent has contact with a member of the deliberate self harm team before discharge and a thorough assessment is carried out. With this in mind the Kingston & District NHS trust set up the Deliberate Self Harm Team, using professionals working in the existing adolescent mental health services, to meet the needs of this group of adolescents. The purpose of this review is to examine the role of the deliberate self harm team in working with individuals, other professionals and the wider system and to discuss the issues that arise.

Organizational issues

The Deliberate Self Harm Team is staffed by 2 Child Psychiatrists, 3 Clinical Psychologists and 2 Community Psychiatric Nurses and 1 Family Therapist. The Psychiatrists,
Community Psychiatric Nurses and Family Therapists are from the Child and Adolescent and Family Clinic (CAFC) and the Clinical Psychologists are from the Child and Adolescent Psychology Department. The two teams are completely separate and are managed by different parts of the Community Trust but operate from the same building. The team operates a duty rota three days a week, Monday Wednesday and Friday. The policy is that when an adolescent is admitted to Kingston Hospital through deliberate self harm then the hospital doctor contacts the team to arrange an assessment. It has been agreed that the assessment should take place, as far as possible, at 11 o’clock on the paediatric ward. Therefore any adolescent admitted after the 11 o’clock assessment time has to wait until the following day to be assessed. The Hospital staff contact the parents or guardians to invite them to attend the assessment and inform them of the arrangements.

Numbers of cases seen by the team

For every adolescent assessed by the deliberate self harm team a assessment form is completed (see appendix). The form requests information about the name and address of adolescent, their date of birth and school they attend. It also contains information about the day, date and time of the admission and assessment. In addition it records the method used and the follow-up offered.

The following section contains a summary of the information collated between January 1994 and July 1996. There was a total of 76 cases assessed during this period and table 1 shows the number of cases assessed each month. It can be seen that there is a wide variation in cases assessed each month ranging from none (e.g. March 1995) to 9 (November 1995). Similarly there does not seemed to be any pattern about the number assessed for each month. For example in November 1994 there was one case and in the same month the following year there were 9 cases. It is difficult to understand the cause of this variation. However when the data is considered as a whole there is an average of 2.5 cases assessed every month or 0.6 cases per week.
Table 1 to show the number of DSH cases recorded each month

<table>
<thead>
<tr>
<th>Month</th>
<th>1994</th>
<th>1995</th>
<th>1996</th>
<th>Mean/month</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>February</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>March</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>2.3</td>
</tr>
<tr>
<td>April</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>May</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>June</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2.6</td>
</tr>
<tr>
<td>July</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2.3</td>
</tr>
<tr>
<td>August</td>
<td>1</td>
<td>0</td>
<td>N/A</td>
<td>0.5</td>
</tr>
<tr>
<td>September</td>
<td>4</td>
<td>0</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>October</td>
<td>2</td>
<td>1</td>
<td>N/A</td>
<td>1.5</td>
</tr>
<tr>
<td>November</td>
<td>1</td>
<td>9</td>
<td>N/A</td>
<td>5.0</td>
</tr>
<tr>
<td>December</td>
<td>3</td>
<td>2</td>
<td>N/A</td>
<td>2.5</td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>30</td>
<td>14</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Table 2 shows the cases sorted by age and sex. It can be seen that a total of 75% of the cases were female and 25% were male. These figures are similar to those found by a much larger study of 2282 cases of adolescent self harmers where 73% of their cases were female and 27% were male (Hawton & Fagg 1992).

Nearly 40% of cases were aged 15 and of these 70% were female and 30% male. Approximately three quarters (67%) of all cases were aged either 14 or 15. These figures differ markedly from those found by the Hawton and Fagg (1992) study. They found that 7% of their cases were aged 14 and 11% of their case were aged 15. The highest rated age
group was 19 year olds who accounted for 22% of their cases. Generally they seem to have many more cases in the older age group. The explanation for why our figures differed from those of a much the larger study may be due to the fact that in the hospital there is also an equivalent deliberate self harm team for adults. It is likely that the doctors tend to contact the adult team when an adolescent of 17 and above is admitted. The general rule that is used by the professionals involved to determine whether the adult or child team is accessed, is that child services see all young people up to 16 and any one aged between 17-19 if they are in full time education.

Table 2 to show the numbers of DSH cases by age and by sex.

<table>
<thead>
<tr>
<th>Age</th>
<th>Male</th>
<th>Female</th>
<th>Total each year</th>
</tr>
</thead>
<tbody>
<tr>
<td>-----</td>
<td>-----</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>15</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>17</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>8</td>
<td>5</td>
</tr>
</tbody>
</table>

25% | 78% | 100%
Team meetings of the Deliberate Self Harm Team

The team meets every three months to review its work and discuss any difficulties that have arisen. The meeting is attended by as many of the team members as possible, an Education Welfare Officer and a member of the management committee. The hospital doctors, paediatricians and paediatric nursing staff are invited but in practice they do not attend. When the team was first set up the meeting was held in the committee room on the paediatric ward. This was to encourage the ward staff to attend and to improve the communication between the team and staff on the paediatric ward. However the nursing staff were usually unable to attend the meeting due to their busy work commitments and it was therefore decided to change the location of the meetings for the convenience of the team members. The meeting is now held in the building where the two teams are based.

One of the main items that is discussed at the meeting is drawing up the rota. for the following three months. It is the usual policy for each team to take part of the week. For example the Clinical Psychologists cover Mondays and the CAFC cover Wednesdays and Fridays. The rationale for this is that proportionately more adolescents are admitted over the weekend than during the week and it was estimated that using this system the demand on both teams would be equivalent.

Table 3 shows the number of cases admitted each day of the week. There seems to be quite an even spread of cases with their being slightly more cases admitted on a Monday. In practice therefore the team covering Mondays undertake about 43% of the assessments and the team covering Wednesdays and Fridays undertake about 57% of the assessments (29% take place on a Wednesday and 28% take place on a Friday).
Table 3 to show the number of DSH cases admitted by day of the week

<table>
<thead>
<tr>
<th></th>
<th>1994</th>
<th>1995</th>
<th>1996</th>
<th>Total</th>
<th>%</th>
<th>Assessment day *</th>
<th>Proportion Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>14</td>
<td>18.4%</td>
<td>Wednesday</td>
<td>43% Mon.</td>
</tr>
<tr>
<td>Tuesday</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>8</td>
<td>10.5%</td>
<td>Wednesday</td>
<td></td>
</tr>
<tr>
<td>Wednesday</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>10</td>
<td>13.1%</td>
<td>Friday</td>
<td>29%. Wed</td>
</tr>
<tr>
<td>Thursday</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>11</td>
<td>14.5%</td>
<td>Friday</td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>9</td>
<td>11.8%</td>
<td>Monday</td>
<td>28%. Fri.</td>
</tr>
<tr>
<td>Saturday</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>12</td>
<td>15.8%</td>
<td>Monday</td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>12</td>
<td>15.8%</td>
<td>Monday</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>30</td>
<td>14</td>
<td>79</td>
<td>100%</td>
<td></td>
<td>100%</td>
</tr>
</tbody>
</table>

* if admission after 11 am

Another important function of the meeting is to review the numbers and types of self harms over the intervening period. The purpose of this is to detect whether there are any unusual trends in the type or incidence of deliberate self harm cases. For example in the past there has been a spate of cases in one particular school or that another school apparently has had no incidents of deliberate self harm cases over an extensive period. These issues can be discussed at the meeting and if necessary the Education Welfare Officer can follow it up with the particular school.

The liaison with other staff is also discussed and the Psychologist based on the Paediaictric ward usually provides feedback on any issues about the working of the team that have been raised by the ward staff. Teaching events and seminars for other professionals are also arranged at this meeting.

The team also organizes two training events for themselves each year. The purpose of this is to update the members on the recent literature surrounding deliberate self harm and
discuss the issues that arise. The team members take it in turns to arrange the teaching and take on the responsibility for selecting the relevant papers. The papers are presented at the meeting and any difficulties or interesting issues that are relevant to the team are discussed.

The Deliberate Self Harm Assessment

The role of the deliberate self harm team is to assess any adolescent that is admitted to Kingston Hospital because of a self harm attempt. On admission to the casualty department the adolescent is seen by the doctor who decides what treatment is appropriate and whether or not they should be admitted onto the paediatric wards. The doctor on duty usually contacts the DSH team and an assessment is arranged. A member of the paediatric staff then informs the parents about the arrangements of the assessment.

In cases of self poisoning the Paediatrician determines whether or not the young person has sufficiently recovered from the physical effects of the overdose, in order to prevent the assessment taking place when the adolescent feels confused and disorientated.

The member of the self harm team generally first interviews the adolescent on their own and then meets with the adolescent and her family together. The interview takes place in a private room off the ward. This is usually completed in about one and a half hours but this can vary considerably.

The deliberate self harm assessment has six main objectives:

1. to establish rapport with the young person and their family,
2. identify the factors which caused the adolescent to self harm,
3. to assess the likelihood of a further self harm attempt,
4. to identify possible psychiatric disorder,
5. to evaluate the young persons coping resources and supports and
6. to assess for future therapeutic needs of the adolescent and their family.
The purpose of the first part of the assessment, with the adolescent on their own, is to engage them. The adolescent may feel threatened and frightened by the hospital environment. Often it has not occurred to them at the time of harming themselves that it would result in a hospital admission. Sometimes the adolescent may have to wait in overnight for the assessment by which time they wish it had never happened and that they could go home.

An important aim of the assessment is to try to gain an understanding of the adolescent’s feelings about the act and why they took this course of action. It is important to try to understand what message the adolescent was trying to convey by harming themselves because self harm attempts are often a reaction to a situation that the adolescent feels unable to change. The assessment usually takes the form of asking detailed questions about the events that led up to their taking the overdose. This is a good way to establish the precipitants to the attempt for example an argument with parents, or falling out with a friend.

The final issues that needs to be addressed in this part of the interview is the extent to which the adolescent intended to commit suicide. There are several determinants of this, firstly the time prior to the act that the adolescent had first started thinking of harming themselves. Secondly, whether they had informed anyone else of their intentions and whether they had harms themselves at a time or place when they knew they would probably be found. Thirdly whether they had made any plans following their intended death, for example whether they had written any suicide notes.

These factors have been identified as characteristic of suicidal intent by Beck, Schuyler and Herman (1974). These authors suggest that there are 8 important factors and these are listed below:-

1. Carried out in isolation,
2. Timed so that intervention unlikely,
3. Precautions taken to avoid discovery,
4. Preparations made in anticipation of death,
5. Other people informed beforehand of the individual’s intention,
6. Excessive premeditation,
7. Suicide note left,
8. Failure to alert other people following the attempt.

The second part of the assessment takes place with the family present. Ideally both parents should attend but often in reality only one is present. This part of the interview is very important because it draws the whole family together and is often a time when the adolescent, with the help of the therapist, can try to convey their feelings about a situation to their parents.

The aim of this part of the assessment is to establish how the parents have reacted to the adolescent’s harm attempt and what they understand by this act. In order to do this the parents are asked how they first discovered that their son or daughter had harmed themselves and how they reacted to it once they found out. It is also useful to inquire whether they noticed any changes in their child’s mood or behaviour prior to the attempt and whether this caused them any concern. The assessment also seeks to establish whether there is any history of psychiatric disorder or suicidal behaviour in their family. Furthermore it is also important to find out whether the young person has ever made a previous attempt and if so to establish the circumstances, seriousness and consequences of the previous act(s). More generally an assessment should be made of the family dynamics, of who relates to who and how supportive they are of each other. Particularly, whether the young person has someone who supports them and in whom they can confide and whether this person is available.
It is also necessary to establish to what extent the parents have taken the self harm incident seriously and what measures they feel they can take in order to minimize the chances of it happening again. Their reactions to it depend on what they understand its meaning to be. For example if a parent feels that the self harm attempt is a way of gaining attention they can often feel angry and punitive towards their son or daughter and feel that admission to hospital is unnecessary. Alternatively, if they feel that the harm attempt was a sign of the child’s unhappiness and desperation then they are more likely to feel intense sympathy and guilt about why their son or daughter was not able to confide in them. In practice, however, it is seldom as clear as this and parents often experience feelings of sympathy, guilt and anger.

Following the assessment the member of the DSH team must decide whether or not the adolescent is safe to go home and what if any follow-up treatment should be offered. The decisions regarding follow-up work depend on a number of factors. It has to be decided if treatment is necessary and whether the young person and the family are amenable it. If the assessor and the family decide that on-going treatment may be beneficial a follow-up appointment is usually offered on an out-patient basis. Sometimes decisions regarding longer term therapeutic needs are difficult to establish at the time of the assessment and the young person and their family can be offered an outpatient appointment to make such decisions at a later stage. If it is felt that they do not require follow-up treatment the young person and their family are given a contact name and telephone number in case they decide that they need further help at a later stage. If the adolescent does not live in the catchment area and follow-up work is thought to be necessary then a referral has to be made to the local adolescent services.

Table 4 shows the number of cases admitted by the district of residence of the individual. It can be found that three quarters of cases come from within the district of Kingston and about a quarter of cases seen live outside the district. This obviously has a bearing on the amount of follow-up work offered by the team.
Table 4 to show the number of DSH cases by residential area

<table>
<thead>
<tr>
<th>Residential Area</th>
<th>1994</th>
<th>1995</th>
<th>1996</th>
<th>Total</th>
<th>%</th>
<th>% in/out area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>11</td>
<td>14.5</td>
<td>76% in area</td>
</tr>
<tr>
<td>Surbiton</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>9</td>
<td>11.8</td>
<td></td>
</tr>
<tr>
<td>Chessington</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>9</td>
<td>11.8</td>
<td></td>
</tr>
<tr>
<td>Tolworth</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>6.6</td>
<td></td>
</tr>
<tr>
<td>Worcester Park</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>5.3</td>
<td></td>
</tr>
<tr>
<td>New Malden</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>9</td>
<td>11.8</td>
<td></td>
</tr>
<tr>
<td>Claygate</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>Esher</td>
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<td>1</td>
<td>1</td>
<td>4</td>
<td>5.2</td>
<td></td>
</tr>
<tr>
<td>Thames Ditton</td>
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<td>0</td>
<td>2</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>East Molesey</td>
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<td>0</td>
<td>3</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Teddington</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Twickenham</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>Hampton</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>Ham</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>Raynes Park</td>
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<td>1</td>
<td>2</td>
<td>2.6</td>
<td></td>
</tr>
<tr>
<td>Wimbledon</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Sutton</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>Walton on Thames</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>Hersham</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>Chiswick</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1.3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>32</td>
<td>30</td>
<td>14</td>
<td>76</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Alternatively, if it is decided that the young person is not safe to go home then an alternative placement has to be sought. There are usually two main reasons for this: Firstly if it is felt that the young person is still at significant risk of harming themselves and/or that they need psychiatric inpatient treatment then they can be referred to the Adolescent Residential Unit. This decision is usually taken in conjunction with the District Child Psychiatrist. Secondly, if it is felt that it would not be safe for the young person to return home because of issues to do with the home environment then alternative accommodation has to be sought. In these cases Social Services are contacted to arrange an emergency placement. In practice the adolescents assessed by the team are frequently already involved with Social Services, in which case the assessor liaises with the relevant social worker.

Once the assessment is complete the assessor then informs the paediatrician of their decision who then has to make the ultimate decision regarding discharge. The assessor then writes to the family’s General Practitioner to inform them of the incident and the results of the assessment.

The assessment as an intervention strategy

As well as providing important information regarding the management of these cases, the deliberate self harm assessment may also be regarded as a therapeutic intervention in its own right. Often the parents, adolescent and doctors are inclined to believe that the adolescent should return home as quickly as possible with the intention of carrying on as if nothing has happened. This outcome is undesirable because the factors that caused the adolescent to harm themselves in the first place have not been addressed and therefore they may repeat the act. The admission onto the ward and the assessment give an important message to the family that the self harm attempt must be taken seriously and that it may be an indicator of underlying difficulties. Furthermore studies have shown that these cases are notoriously difficult to engage and one of the ways to increase the chance of successfully engaging with them is to meet them on the ward.
When the adolescent has harmed themselves and been admitted to hospital the family are usually in a state of turmoil. The incident has usually provoked powerful feelings in the family members of protectiveness, anger and guilt. It is therefore an opportunity when the family's patterns of interaction and their beliefs can be challenged in order to promote change. If the young person is discharged before they have had an opportunity for a family meeting then it is likely that they will revert to the original patterns of interaction and the opportunity for change will have been missed.

Types of Deliberate Self Harm Cases

The reasons why adolescents take overdoses is extremely varied and complex and there is not the space here to cover the relevant literature. However Hawton et al (1982) have devised a classification system for young suicide attempters which consists of the following three categories:

- **Group 1: Acute.**
- **Group 2: Chronic.**
- **Group 3: Chronic with Behavioural Disturbance.**

In the following section I will describe one example of an adolescent who falls into each of the three categories in order to demonstrate the purpose and outcome of the DSH assessment.

**Group 1: Acute.** The problems identified at the time of the overdose have persisted for less than one month, absence of behavioural disturbance. Their problems have largely resolved as a result of the attempt. The attempt itself may appear to have been an out-of character response to an acute stress in an otherwise normally adjusted young person.
Case example 1 - Girl T

**Background information** - An example of a young person who falls into this group is a young girl (T) aged 15. T lived with her mother, step-father and two younger sisters. She was admitted to hospital after taking twenty paracetamol tablets. It appeared that she was feeling pressurized by course work of her impending GCSE’s. She seemed generally to have a good relationship with her mother and step-father.

**The precipitants to the DSH attempt** - From the assessment it appeared that the DSH act had not been pre-planned and she informed her mother as soon as she had taken the tablets. The immediate precipitant to the act seemed to be the argument she had had with her mother but this has to be considered within the background stress created by her school work. It seemed T had found it difficult to alert others to the stress that she was feeling and the DSH attempt was T’s way of communicating her distress to those around her.

**The DSH intervention** - Her mother attended the appointment and there seemed to be a warm and confiding relationship between them. She seemed to be very shocked by T’s behaviour. She acknowledged that the argument she had had with T may have been the immediate precipitant but had noticed that T had recently become increasingly concerned about her schoolwork. Despite her anxiety T seemed to be doing quite well at school and her mother agreed to discuss T’s worry about her course work with her class teacher. Her mother’s obvious concern and decisive course of action seemed to have reassured T and she felt that her mother had taken her worries seriously. We agreed for them to have a follow-up appointment which they both attended and the situation seemed to have improved. No further work was offered but it was agreed that they could get back in touch should the need arise.
**Summary** - In this case the DSH act seemed to be an out of character response to a stressful situation which had evolved in the short term. The attempt, the resulting admission to hospital, and the assessment seemed to have alerted T’s mother to the immediate needs of her daughter. There seemed to be an appropriately close relationship between the mother and daughter which had enabled the mother to relate to her daughter’s sense of desperateness. The mother had taken her daughter’s concerns seriously and had planned an intervention to reduce her stress. These factors meant that there was little need for follow-up work.

**Group 2: Chronic.** The problems identified at the time of the overdose have persisted for one month or more; absence of behavioural disturbance. This group is likely to have symptoms of depression, to be lonely and isolated and to experience protracted conflict with and lack of support from other family members, especially their parents.

**Case Example 2 - girl F**

**Background information** - An example of group 2 is a girl (F) aged 14. She was admitted to hospital after cutting her wrists with a knife. She lived with her mother, father, and elder brother (18). At the assessment it became apparent that the family were experiencing difficulties. Her father was a chronic alcohol abuser and was finding it difficult to keep down his job. Her mother also drank heavily and worked most evenings and weekends in a pub. Her brother had a full time job and seemed to have a full social life outside the family. However he seemed to be close and supportive of F. The family were under considerable financial pressure which seemed to be causing arguments and conflict between the parents. Her mother seemed to view F as her main companion and confidante and found it difficult to accept F having her own interests and friends. She seemed to be overly protective of F for example not allowing her to see her friends at weekends. On many occasions her mother had threatened to leave and take F with her.
The precipitants to the DSH act - F herself seemed lonely and depressed. She felt guilty that her parents were arguing all the time and felt that this was partly due to her mother spending money on her. F found the relationship with her mother claustrophobic and wanted to have greater independence from her mother. However she felt that her mother would believe it to be rejecting and would not be able to cope. The stress resulting from the home situation seemed to be affecting her performance at school where she described that she was finding it difficult to concentrate and the standard of her schoolwork had fallen. The immediate precipitant to the self harm act was that F had overheard a serious argument between her parents where her mother had threatened to leave. It seemed that F felt unhappy and trapped in the situation and did not feel there was any other way to express her desperation.

DSH intervention - The family meeting seemed to be the first time that these issues had been discussed openly as a family. The parents appeared to be quite shocked by their daughter’s cutting and said that they had been unaware of how the tension within the family had been affecting her. However, the conflict between the parents was demonstrated within the session. F’s mother blamed her father for causing F to harm herself. During the interview it became apparent that F’s mother did not seem to talk directly to her husband and seemed to complain about him to F. F’s father seemed to find the open family discussion very threatening and said that he would stop drinking but was reluctant to expand on how he was going to achieve this. The rest of the family did not appear to have much faith in him as apparently he had made this promise on numerous occasions before.

In my view this family could have benefited from some family work exploring their patterns of communication and the ways they could meet each other needs. F’s harm attempt seemed to represent the distress that each of the family was feeling. However they all seemed to find the open discussion very threatening and were unwilling to engage in family work. F herself was keen to pursue individual therapeutic work and the parents
agreed to attend regular review session. There was also close liaison between myself and F’s school as they had been very concerned about her.

Summary In this case F’s DSH attempt seemed to be a reflection of the dysfunctional relationships between members of her family and the resulting distress she was feeling. The situation seemed to have been the same for a number of years although the frequency of the arguments between her parents seemed to have been increasing. Although the parents appeared to have taken F’s attempt very seriously and to some extent could understand its precipitating factors they found the thought of examining these issues very threatening. Despite their reservations about family work they did agree on her coming to see me on her own. They supported this work by bringing her to the individual sessions and they did attend the family review meetings when requested. In my view although we were unable to address the family relationships issues directly, the individual work with F served the important function of reminding the parents of their daughter’s difficulties. F seemed to use the sessions to explore the difficulties within the family and she learnt, to some extent, to separate herself off from the concerns of the parents. During the time I saw her, her concentration surrounding her school work improved and she successfully took her GCSE’s. She felt that her father reduced his drinking and managed to maintain his job. She also managed to confront her mother with her need for greater independence and her mother seemed to allow her more freedom.

Group 3: Chronic with Behavioural Disturbance. The problems identified at the time of the overdose have persisted for one month or more, there has been recent behavioural disturbance (such as stealing, repeated truancy, drug taking, heavy drinking, fighting, or being in trouble with the police). This group is likely to be in contact with social or welfare agencies. Very often they have already left, or have been removed from, their families because the home environment has become too unsupportive or hostile, or the family has disintegrated.
Case example 3 - girl P

**Background information** - An example of a young person who falls into the third category was a young girl P of 15 who has been assessed by the deliberate self harm team on two occasions. The first time she had been drinking and she had deliberately made cuts to her thigh and hands. On the second occasion she was admitted after taking alcohol and ecstasy tablets which caused her to have a drug induced psychosis.

P lives with her mother and brother of 17 and step brother of 6 years old. Her father lives a long distance away and she has moved up to live with him on two occasions but it has not been successful and she had returned to live with her mother. Her stepfather moved out recently. She has attended two secondary schools and been excluded from them both for reasons of bullying other pupils. She is now attending a school for pupils with emotional and behavioural difficulties. She has also been in trouble with the police on several occasions for shoplifting, mugging and robbing two people and for setting fire to someone’s hair.

P and her mother have a very tempestuous relationship frequently rowing and fighting with one another. Her mother has, on a number of occasions, said that she does not want P to live with her any more and threatened to have her placed in care.

**The precipitants to the DSH attempt** - The DSH attempts seem to be part of a pattern of increasingly risky and dangerous behaviour. They seem to be an expression of the chaos and anger that she is feeling. P has experienced an unsettled and insecure environment for most of her life and she seemed to have reacted to this by her aggressive behaviour. She has experienced difficult and rejecting relationships with both her parents, with her mother threatening to throw her out and her father leaving the family home. Her mother seems unable to contain P’s behaviour because of her own emotional needs and her responses to her daughter’s behaviour seem to escalate the situation.
**DSH intervention** - When P was interviewed she engaged well and was able to describe the events that led to the cutting. She said how angry she was with her mother who she feels does not love her and favors her younger brother. At the assessment P’s mother felt very angry with her and felt that the cutting was P’s way of manipulating her. P said that she would like the opportunity to see someone individually. In the joint session they became verbally abusive to one another to the point where they were unable to stay in the same room together. It was therefore difficult to use the joint session start to look at the relationship between them.

As a result of the assessment we decided to attempt another joint meeting with the social worker present. This meeting took place and a further argument ensued with it culminating in P’s mother refusing to allow P to return home and demanding for her to go into foster care. After P’s mother calmed down she agreed to take P home. It was decided to offer P and her mother separate individual sessions with two psychologists. The social worker’s role was to liaise between the workers and try to see P and her mother together. Unfortunately P’s mother did not attend any of her sessions and P attended a few sporadically making it difficult for any therapeutic work to take place.

Therefore the main intervention for P has been in the form of consulting and liaising with the social worker. She has recently been accommodated by a foster carer and her behaviour seems to have settled down. She is under a supervision order from the courts. She seems to be getting on better with her mother now that they are not living with one another. I have continued to be in close communication with the social worker who visits her regularly. I have offered her appointments when requested but there have not been sufficiently regular for therapeutic work be undertaken. It is hoped that once P has settled into a stable and consistent environment she will be able to use therapeutic help provided.

These three example demonstrate how the DSH encompasses a wide range of different problems. These vary from cases where it appears to be an “out-of-character” response to
an immediate stress to cases where it is part of much more profound and severe emotional
difficulty. Each case requires a thorough assessment so that the causes for the attempt can
be well understood in order for the treatment to be planned appropriately.

Issues relating to the Definition of Deliberate Self Harm

An important issue which relates to the working of the team is the classification of
deliberate self harm. It is important that all the professionals involved with the team have a
shared understanding of what constitutes DSH.

In the literature the following definitions have found to be useful

- **Deliberate self poisoning** - the deliberate ingestion of more than the prescribed amount
  of medicinal substances, or ingestion of substances never intended for human
  consumption, irrespective of whether harm was intended

- **Deliberate self injury** - any intentional self-inflicted injury, irrespective of the apparent
  purpose of the act.

For each DSH case that is seen by the team the type of method used is recorded. Table 5
shows the number of cases by method used and these are subdivided into sex. It can be
seen that by far the most common method used was overdose or self-poisoning accounting
for 59% of the cases. Of these 85% were female and 15% were male. There did seemed to
be an association of method by sex. For example all of those who cut themselves and the
majority of those who abused substances (62%) were female.

For the females 70% of them had taken overdoses and 11% of them had cut themselves.
For the males 32% had taken overdoses or self poisoned and 37% were admitted because
of alcohol intoxication.
Table 5 to show the numbers of DSH cases by sex and method used

<table>
<thead>
<tr>
<th>Age</th>
<th>Over-dose Poisoning</th>
<th>Cutting</th>
<th>Substance misuse</th>
<th>Alcohol</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
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<tr>
<td>11</td>
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<td>Total</td>
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<td>3</td>
</tr>
<tr>
<td>%</td>
<td>15%</td>
<td>85%</td>
<td>0%</td>
<td>100%</td>
<td>38%</td>
</tr>
</tbody>
</table>

The team use the definitions described above and try to encourage others to use the same. However when coming into contact with other professionals it is a commonly held belief that deliberate self harm should only be taken seriously if the individual actually intended to kill themselves. On some occasions the team hears about an adolescent who has arrived in casualty and been discharged without a thorough assessment. The reason for this is usually that the Causality Doctor decided that they had not intended to kill themselves and therefore it was not necessary to contact the deliberate self harm team.

If deliberate self harm is only viewed in terms of attempted suicide then it does not take into account some of the complex reasons why adolescents harm themselves, as described
in the case examples. For many of those who harm themselves death is not the intended outcome of their actions. Therefore it is too simplistic to judge the seriousness of the act by the degree of intention to cause death. The attempt may be an adolescent’s way of showing that they are not coping and they needed to take such a drastic action in order to change things. One example of this is a young man (15) whom I saw who was finding his final exam year at school difficult to cope with. He was also being bullied at school and extremely unhappy and desperate about his situation. I saw him in hospital after he had taken 30 aspirin tablets the day before he had to return to school after the holidays. His parents were deeply shocked by his harm attempt and said that they had been unaware of how desperate he had been feeling. As a result of the attempt they arranged a meeting in school to discuss these issues with his class teacher.

Therefore, assessment at the level of the degree to which the young person intended to kill themselves may miss important underlying issues. This young man said in the assessment that at the time of taking the tablets he wanted to die, however he took the tablets at a time and place that he knew he would be found. In fact he told a friend immediately after taking the tablets. This indicates the degree of confusion the young person is experiencing at the time of taking the tablets. If this individual had been discharged back into the situation he had come from without a thorough assessment then it is likely that he may have made another attempt.

This is supported by a study which showed that there was a higher incidence of repeated attempts in adolescents who were not admitted to hospital (Hawton et al 1982).

**Issues relating to staffing and supervision of the team**

Currently the team operates for three sessions a week and at any one time cover is provided by one member of the team. The review of the numbers seen over the past two years shows that the team see approximately 30 young people each year or 0.6 each week.
Limited resources mean that it is difficult to justify allocating any more time to the deliberate self harm team, particularly in view of the case load of clinical work and the pressure to reduce waiting lists. A further resourcing issue is that although time can be set aside for the assessment, these cases often require considerable follow-up and liaison with other staff which can be time consuming and unpredictable. It is often difficult to find urgent appointment times for emergency cases given the commitment of the rest of our work. These cases often require long term treatment and therefore place an added burden on an already full case-load.

For the therapist, dealing with these adolescents can be a significant source of stress. There is a potentially significant risk associated with letting the adolescents leave the paediatric ward. Because of this many teams from other districts work in pairs so the responsibility for making such decisions can be discussed and shared. In our team we have considered the possibility of doing this on many occasions but it has always been decided that we do not have sufficient resources to achieve this.

Another area of concern is the lack of availability of immediate supervision. Often assessment of these cases can be very worrying and anxiety provoking. It is rarely possible, following the assessment, to talk over the case with another colleague because in practice we have little contact with one another on an informal basis. However members of the team do receive regular supervision in relation to the rest of their clinical work and therefore this is an opportunity when any concern regarding DSH cases can be discussed.

Issues relating to liaison with other professionals

Liaison with Hospital Staff - An important issue in the working of the team is the liaison with the hospital staff; the team depends on close liaison between the hospital staff and the team. It relies on a shared belief about what constitutes a deliberate self harm. One of the common difficulties that arises is that some manifestations of deliberate self harm are not
be admitted to the paediatric wards. These adolescents are then usually sent home and the
doctor may or may not inform the team. A common example of this is young people who
arrive at accident and emergency drunk. The doctor may view alcohol intoxication as
trivial and may not consider that it could be a symptom of underlying difficulties. An
example of this is a boy (15) who arrived at accident and emergency after drinking three
quarters of a bottle of spirits. He was kept in overnight because of the physical effect of
the alcohol intoxication but discharged the following day without the DSH team being
contacted. The team were then informed and an out-patient appointment was offered. The
family canceled the first appointment offered and did not attend the next.

In order to ensure good liaison between the staff members, regular teaching sessions are
arranged with the junior hospital doctors. However the junior doctors are on six-monthly
rotations and therefore each new set have to be educated about deliberate self harm. The
teaching covers issues such as what is deliberate self harm, its incidence, the clinical
manifestations of DSH, assessment and the working of the DSH team. As a further
measure to inform the staff about the team a leaflet has been produced (see appendix)
copies of which are in accident and emergency. The doctors can give the leaflet to the
families of the young person to inform them about the procedure.

Good liaison between the two teams is also ensured by one of the Clinical Psychologists
being based on the Paediatric ward where she can attend the ward rounds and is in close
liaison with the Paediatric staff. She provides an important communication channel
between ward staff and the team.

The Paediatricians frequently express a desire that the deliberate self harm team should
assess the young person more promptly. In practice if an adolescent is admitted for
example at midday on Friday they will not be assessed before 11am the following Monday.
The reasons for the Paediatrician’s unease comes from two main sources. Firstly while the
adolescent is waiting to be assessed they are blocking a bed for another patient. Secondly
sometimes the nursing staff do not feel equipped, or that it is appropriate, to contain an acting-out adolescent on a ward where they are also caring for sick children. The ward is designed with two individual rooms but it has been known for the adolescent to invite their friends in or they leave the ward without informing the nursing staff. The issue over time between admission and assessment is primarily a resource issue and highlights one of the results of the hospital and community being separate trusts. In order to resolve this issue the managers of both services need to discuss it and decide on the extent to which they regard DSH as a priority.

Liaison with Schools - In many cases the first person to discover that an adolescent has harmed themselves is the teacher at their school. A common sequence of events is that the young person first admits to their harm attempt to a close friend at school who then informs a member of staff. The teacher then has to take the responsibility of deciding what action to take.

Many schools in the Borough invite the deliberate self harm team to contribute to their INSET training. The benefit of this is that the teachers then have knowledge about what constitutes DSH and what action to take should they discover one of their pupils has harmed themselves. The recommended policy is that a nominated teacher contacts the parents of the young person and informs them of what has happened. The young person is then taken to hospital either by a teacher, parent or ambulance. Then the deliberate self harm team is contacted as usual

In order to facilitate the liaison between education and the team the education welfare department send a representative to the DSH team meetings. They are also sent a copy of the deliberate self harm form if the parents give their consent. This ensures that they can detect if there are any patterns in the incidence of self harm cases in particular schools. This also provides them with information about individuals who may be a cause for concern at the school.
Conclusion

This review has attempted to summarize the work of the Kingston & District deliberate self harm team for adolescents. The aim was to highlight key issues concerning the effective running of the team in particular the crucial role of the on-ward assessment has been emphasized. The assessment is essential for the rapid collection of information needed to assess risk and to plan future therapeutic provision. It also provides the first and best opportunity to engage the family at a time when they are most amenable to help. As can be seen from the case histories presented here deliberate self harm can be a manifestation of a wide range of underlying problems. In many cases this crisis precipitates the first contact between the adolescent and mental health professionals and therefore an assessment by the deliberate self harm team is potentially valuable regardless of the severity of the act. Because of the importance of the assessment it is crucial that all the professionals who have contact with this group of adolescents should have a shared understanding of what constitutes deliberate self harm and a shared belief in the importance of admission.

The current policy of admitting adolescents until they can be seen by the deliberate self harm team means that beds on the ward may be occupied up to 48 hours by patients who do not need medical treatment. On the other hand reducing this waiting time would mean a significant increase in resources from the community child and adolescent mental health teams. This issue is further complicated by the fact that these two resources are controlled by different health trusts.
Appendix

If you have any comment about this service, please contact:

Child Adolescent and Family Centre
Tel: 0181 390 8151

or

Child and Adolescent Psychology Service
Tel: 0181 390 8445

Both are at

Elm House,
84 Ewell Road,
Surbiton
KT6 6EX.

The Community Health Council is also interested in your views. The CHC is an independent body that can represent your views to workers in the Health Service. You can contact Kingston CHC at

UMI House,
9-13 St. James Road,
Surbiton,
Surrey KT6 4QU
Tel: 0181 398 8467

Who do we see?
We see children and young people who have been admitted to Kingston Hospital for harming themselves. This includes any self inflicted injury, or misuse of drugs, alcohol or other substances.

Who are we?
The team is made up of professionals from the Child and Adolescent Psychology Service and the Child, Adolescent and Family Centre. We come from different professional backgrounds, and are all experienced in helping young people and their families deal with emotional and behavioural difficulties.

What do we do?
- Recommend to medical staff whether the young person is safe to be discharged from hospital.
- Identify short term changes which may make it safer for the child to be discharged.
- Find out if further help is needed and offer or arrange it if necessary.
- Work with other staff and agencies when this is needed.

What happens?
When a young person has been admitted and assessed by the doctor, a member of staff will get in touch with the Deliberate Self Harm (DSH) team member on duty.

We will arrange an assessment appointment, usually within 48 hours. The DSH team member will ask to see the young person and both parents. If the child is in the care of Social Services, the allocated social worker will also be invited to attend. We always need to see the adult with whom the young person lives, and who will be responsible for them on discharge.

The interviews are opportunities to explore the reasons behind the deliberate self harm, assess the risk of it happening again, and think about steps which might be taken to prevent this.

Follow up
- We may offer you a follow-up appointment on discharge. If necessary, we can offer further help to the individual or the family, or make a referral to another relevant service.
- The DSH member will make a recommendation about whether the child is safe to be discharged. The medical doctor in charge will make the final decision about when the young person is ready to leave hospital.
- Routinely, we will inform the young person’s GP about the hospital admission. With consent, we will also inform the Education Welfare Department. Sometimes, we may also contact other agencies involved with the young person, including the school they attend. We only do this with parental permission.
References


### Post Qualification Continuing Professional Development

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17th January  Gender issues in family therapy  Continuing professional development committee
19th March  Promoting effective parenting  Special Interest Group  Children & Young People
13th May  Autism & Asbergers - identification, assessment and intervention.  Continuing professional development committee
26th September  Children and bereavement  Special Interest Group  Children & Young People

Courses

October 1991 to July 1993  Psychotherapy skills with children & adolescents  Department of Child Psychiatry, St. George’s Hospital

Future training needs

Managerial aspects of Clinical Psychology.
A course in the systemic model of family therapy.
Academic Dossier
Childhood bereavement: consequences and therapeutic interventions

The aim of this review is to provide an account of the effects on a child of the death of a parent and the therapeutic interventions available to help such children. In the first part the developmental aspects of a child's understanding of death are considered. The effects of bereavement on children are then discussed and the factors which have been shown to influence the consequences of the bereavement are considered. Finally a review of the different therapeutic interventions with bereaved children are presented.

There are approximately 180,000 children under 16 or 3% of the school population who have lost a father or a mother through death (Cruse 1989). A number of studies have found that children experiencing the death of a parent are likely to encounter a wide range of problems both in the short term and possibly into adult life. Accordingly there have been numerous attempts to develop useful therapeutic interventions designed to alleviate these difficulties. In order to develop suitable therapeutic interventions one needs to have an understanding of how a child understands the concept of death and how the experience of the bereavement affects the child's behaviour.

In order to establish that a child has a fully developed concept of death it must be demonstrated that a number of key elements have been grasped; namely universality, irreversibility and inevitability. Considerable efforts have been made to establish how the concept of death is developed in children over time. However because of the complexity of the concept individual studies have varied in the methods used. For example in one study they asked children of different ages “Do you believe that some day you will die?” (Reilly et al 1983). They found that only 50% of 5 year olds said ‘yes’ and 100% of 8-9 year olds said ‘yes’ However it is unwise to assume from findings such as this that the child develops a concept of death around the age of 9, as many children younger than this have an understanding. Moreover it does not establish what the child understands by the word “die”. Kane (1979) also attempted to examine the children’s concept of death by
interviewing 122 middle class children aged between 3 and 12 to determine the nature and development of their concept of death. By interviewing the children she attempted to relate the child's concept of death to their stage of development as described by Piaget (Piaget 1926). She found that most three year olds can distinguish between dead and alive which she demonstrated by asking them to distinguish between pictures of dead and alive rabbits (Kane 1979). However she found that their thinking is prelogical (Piaget 1926) and often magical and as a result they may hold misconceptions and misinterpretations of the world around them. For example many children of this age tended to attribute a psychological motive to the cause of death, for example they may believe that they can make someone dead by their behaviour, thoughts or wishes. They also found it difficult to understand the permanence of death and therefore were likely to expect the dead person to return. She found that as children get older they gradually 'add in' more elements to develop a more realistic concept. She found that many 6 year olds and most 8 year olds believe that death is final and results in a complete cessation of bodily functions. In another study Lansdown and Benjamin (1985) looked at the concept of death in 100 children of different ages from rural and urban backgrounds. They presented the children with a short story about how an old lady who owned a sweet shop died. They asked the children a few questions about the story which were designed to establish what concepts of death were understood by the children. The authors interpret their results as suggesting that about 59% of five year old children have a good understanding of what death is all about and by about 8 years old nearly all children have a good understanding of death.

Research therefore has indicated that under the age of five most children do not have a fully formed concept of death. Children gradually develop a more realistic concept of death as they grow older and gradually add in new components of understanding. It appears that death is conceptualized first as a temporary and reversible state, like sleep or a separation, and later as an internal and universal biological process that results in the complete cessation of bodily functions. Between the ages of seven and nine most children
develop a more or less full concept of death, understanding its finality, irreversibility and gain knowledge that all life functions have ceased (Lansdown and Benjamin 1985).

While studies have shown that a child’s understanding of death is related to their age, it is also important to take into account the child’s concrete experience of illness and death. There is some evidence to suggest that children living in parts of the world where there is a great deal of violence e.g. in those parts of Northern Ireland where there have been a number of killings, seem to develop a full concept of death earlier (McWhirter 1980). Similarly Kane (1979) found that between the ages of 3 to 6 the children who had experienced death (i.e. the death of a parent, sibling or close friend) had a more developed concept of death than their inexperienced peers. However the there was no difference between the two groups in the older age groups.

There are a number of methodological difficulties with the studies on the development of the concept of death in children. Firstly one must be cautious in making inferences about a longitudinal process from cross-sectional data. The principle problem with cross-sectional studies is the impact of cohort effects; that is certain groups may have unique experiences associated with a certain time and place. Secondly, the studies described are based on verbal reports by the children. Thus interpretations of the child’s cognitions about death are critically dependent on their language development and communication skills. It is possible therefore that some of the studies mentioned above measure a child’s ability to communicate about death rather than the understanding itself.

Despite the methodological difficulties described above it seems clear that a child’s understanding of death is age related. In addition it appears that the effects of death on a child are also age related. Black and Urbanowicz (1985) found that there is a developmental trend in the kind of symptoms that bereaved children show. In general they found that, the under-fives had somatic symptoms; problems of sleep, of appetite and habit regulation. The children in the primary school years mainly displayed conduct problems
and it was only when the children became adolescents that they came to express their feelings in a very much more direct way as emotional symptoms. Thus the preschool children tend to react to the loss with bodily responses. They may become enuretic or encopretic or may become clingy or have difficulty in sleeping. Infections and other illnesses are commoner in young children following the loss of a parent (Raphael, Field and Kvelde 1980). Older children are more likely to develop psychosomatic complaints and cognitive disturbances which may manifest as academic difficulties or school refusal. Adolescents are more likely to show adult bereavement patterns with depressive symptoms such as sleep and appetite disturbance, suicidal thoughts and depressed mood (Black & Urbanwicz 1985, Balk 1983).

It therefore appears that a child's understanding of death is related to their age and even young children have quite well developed concepts relating to death and are able, with help, to understand that death is permanent universal and irreversible and has a cause and that a dead person is different to a living person in a number of respects. Furthermore it has been shown that young children can have fantasies or hold misconceptions about death. As to the question of how children are affected by the death of their parent studies have shown that children respond to the death by a variety of different behavioural and emotional responses and these too are related to the age of the child. This raises the question of whether the child's reaction to the death of a parent is in some way affected by their understanding. It seems likely that with a younger child the response to the bereavement is primarily centered around the loss and absence of a parent whereas in the adolescent, with the more highly developed concept of death, it may bring additional thoughts into play. For example for the adolescent the death of a parent may result in questions about their own mortality and the inevitability of their own death.

Although there seem to be characteristic bereavement reactions in different age groups more detailed studies examining the effects of bereavement produce contradictory evidence particularly concerning the long term effects. For example in a study by
Silverman and Worden (1992) they interviewed 125 children (age 6 to 17) and their surviving parents within 4 months of the death of their parent. They looked at a number of variables including the child's reaction to the death. They found that while the death was stressful and affected most areas of the child's life, the stresses did not seem to overwhelm most of the children and there was little evidence of serious dysfunctional behaviour in most of them. While some were sad and confused most carried on going to school and maintaining relationships with family and friends. Similarly in another study by Fristed et al (1993) where they compared the psychological functioning of 38 children who had lost a parent with 19 non-bereaved children and 38 children who were suffering from depression. They found that there were no differences between the bereaved and non-bereaved children (not including the group of depressed children) on school behaviour, interest in school, peer involvement and self-esteem. They also found that bereaved children functioned significantly better than the depressed inpatients. However this study examines the children's reactions 8 weeks after the death of the parent and is therefore relatively short term. One of the major shortcomings of this study is that the bereaved group are compared to an "extreme" matched control group of depressed inpatients. Therefore the finding that the bereaved children functioned significantly better than the depressed inpatients may be more a reflection of the relative dysfunction of the depressed group rather than an indicator of the normal functioning of the bereaved group. Despite the shortcomings these studies seem to indicate that the death of a parent does not lead to an increased risk of subsequent psychological problems, at least in the short term.

In contrast to these findings Elizur and Kauffman (1982) evaluated 46 Israeli children who had lost a father during the Yom Kippur war. They found that 45%, 48% and 39% of children at 6, 18 and 42 months post death respectively showed problematic bereavement reactions including overanxiety, overdependancy and unsocialised aggression. Similarly Van Eerdewegh et al (1982) reported that, during the year following the death of a parent, 50% of children under 17 are "noticeably hindered in their everyday functioning", due to symptoms of anxiety, depression learning difficulties and behavior problems. The latter
finding is also supported by the review by Berlinsky and Biller (1982) who argued that people who have suffered the death of a parent more often show increased delinquency in adolescence, dependent interpersonal style, introversion, suicidal ideation, and preoccupation with issues of loss. Furthermore these findings hold up when children whose parents have died are compared to children from intact families or to families where there has been a divorce (Berlinsky & Biller 1982). Similarly another study demonstrated that the negative effects of childhood bereavement can last into adult life, particularly the death of a mother (Marcoux and Kiely 1985). These negative effects include excessive elements of guilt and the tendency to be anxious, depressive and low in self-esteem. Brown, Harris and Bifulco (1986) also found that the death of a mother in childhood was associated with depression in adult women.

The studies reviewed here seem to indicate that in the short term there are no obvious adverse effects of parental death in children but in the longer term many children do show adverse effects, some of which manifest in adult life. However, there are difficulties in comparing results from different studies which may arise from factors such as differences in the samples and methods used. For example in the study by Silverman and Worden (1992) their findings are based on interviews with both the parents and the children whereas in the Elizur and Kauffman (1982) study the evidence was based solely on interviews with the parents. The parent's reports of their children's reactions to the death may have been biased by their own reactions to the death. There are also differences in the samples included in the studies.

While the literature suggests an increased long term risk of psychopathology in individuals who have experienced a bereavement it is important to recognize the heterogeneity that exists within a group of bereaved children. One must therefore give consideration to the factors which predispose children to longer term difficulties. There are many factors which may affect the way the child responds after their parent has died which are related to the characteristics of the loss situation. Several studies have attempted to identify what
factors in the child’s environment following the loss of a parent provide long-term protection. An important consideration is the quality of relationship between the child and the surviving parent. In a very interesting study Saler & Skolnick (1992) investigated adults who had experienced the death of a parent during their childhood. They found that individuals who described their surviving parents as empathetic, warm and as providing autonomy were less likely to report depressive symptoms than were others. They also found that individuals who had not been involved in the mourning process were at greater risk of depression. This study indicates that the quality of the relationship between the bereaved child and their surviving parent is an important factor determining how the child is affected by the death. However it should be borne in mind that this study is retrospective in nature. Other studies have also indicated the importance of the quality of care and emotional support offered by the surviving parent. More specifically studies have shown the importance of a warm relationship with the surviving parent as a protector against later psychopathology particularly depression (Bifulco, Brown and Harris; 1987, Harris Brown & Bifulco, 1986).

Reese (1982) found that an increased risk of developing behavioral problems was associated with lack of continuity in the child’s daily life after the death and the surviving parents inability to provide a stable home for the child. For example one study showed that an increased risk of psychopathology in bereaved children was associated with depression in the widowed mother (Van Eerdewegh, Clayton & Van Eerdewegh 1985) Several studies have shown that social support can help the child adapt to the death of a family member (Elizur and Kauffman 1983; Hilgard et al 1960).

There are also wide variations in the way children cope with bereavement which is related to the child’s temperament and personality characteristics. Research has identified a number of characteristics in children who despite adverse circumstances and deprivations can function well (Milgram & Palti 1993). Some children possess what Milgram and Palti (1993) have termed “support-seeking” and “support-attracting “characteristics that in
various ways secure social support. They tend to make friends easily with children and adults, help others and enjoy positive relationships with others. In addition the authors have noticed that these children possess cognitive abilities which buffer them from the adverse effects of environmental stress, for example they take initiative, function autonomously, are reflective, alert and self confident and relaxed.

Many studies have attempted to examine whether abnormal grief reactions can be prevented or modified by skilled intervention either before the death when possible or during the period following death. Although a variety of clinical programmes to help and support bereaved children have been described in the literature, few studies have been evaluated.

Black and Urbanowicz (1985) did a controlled study which showed that family based intervention for bereaved children can shorten the period of distress and that techniques designed to promote the children's grief appear to have been the factor which was associated with good outcome. Their study compared two groups of families where one of the parents died, leaving a child or children under 16 years of age. One group received a brief family intervention (six sessions) starting about two months after the death and the other group received no therapy. The intervention was designed to promote grief, force the mourning process and promote communication about the dead parent. Significant differences were found between the two groups in favour of the treatment group. There were fewer behavioural problems at the first year follow up and the children were in better health. They were able to cry more over their dead parent and had fewer learning problems. The surviving parents were less depressed and more able to talk about the dead parent. This work has clearly shown the value of family based intervention programmes with bereaved children and their parents. They found that the family intervention was associated with a less distressed parental mood. They argue that the children's improvement may be most attributable to the improved mood of the parents. Support for this hypothesis is evidence by Elizur and Kauffman who found that mental state of the
mother was the most important predictor for the outcome of the child in the 2-3 years following the bereavement. Furthermore the intervention described in this study was designed to promote grief. In order to establish whether it was the support and contact with the therapist or the therapy itself which helped the children a controlled study comparing different types of intervention would be necessary.

There have been a number of studies looking at the use of support groups for bereaved children although again there has been little evaluation of this work. (Berg 1984; Cocuzza-Zambelli 1981, Zambelli, Clarke & Heegaard 1989, Fleming & Balmer 1991). The aim of most children’s support groups is to help children cope with the death of a parent and to help them know that others are similarly affected by bereavement. The groups usually address such topics as reactions to death, funeral services, changes in the family and self and fears about the future. Most of the groups reviewed are short term and use a variety of techniques such as game playing, role play discussion and art making. Groups can be a useful support system for families when a parent dies since the death puts a strain on the families existing coping mechanisms. This was borne out in a study by Altschul (1988) who found that the availability of an adult to support and facilitate the child’s bereavement process has a direct impact on the child’s adaptive potential. His results suggest that bereaved families may need additional social support in order to provide the assistance and care a child requires for a continuing healthy development. He also argues that a support group can have the important function of helping the child understand the death and make sense of what has happened. The impact of the death shatters the child’s sense of family security and belief in parental omnipotence (Altschul 1988) and the way the child copes with the death may depend on explanations that help the child and family make sense of what has happened. McCubbin, Olson & Larsen (1987) argue that it is important to create a new social meaning for a death in order to render it less irrational, less unacceptable and more understandable in the context of the situation in which it occurred.
Zambelli and Derosa (1992) attempted to provide a theoretical rationale for how childhood bereavement groups work by applying Rutter’s model of the protective mechanisms that operate to counter risk (Rutter 1987). His model is based on the premise that psychological protection depends on the way one deals with the life change and stressful situation. He identified the four mechanisms that reduce the risk of an adverse reaction to the stressful event. These mechanisms are: (i) the reduction of risk impact, (ii) reduction of negative chain events, (iii) establishment and maintenance of self-esteem and self-efficacy and (iv) opening up opportunities. Zambelli and Derosa (1992) argue that these four protective mechanisms operate in childhood bereavement groups and that they help protect children from adversity, encourage adaptation and help them develop new social meaning for their losses.

The authors argue that bereavement groups can reduce the impact of risk by altering its meaning. For children who have been bereaved discussion about the loss of a parent and the resulting feelings they experience can be very painful and difficult to cope with. The bereavement group under the supervision of a leader can provide a supportive environment in which the stress of these discussions can be controlled. In such a group the leader can encourage the children to talk directly about the death and their resulting feelings and reactions. This allows the children to discuss their loss without becoming overwhelmed by their emotions. The presence of other children with similar difficulties allows for the sharing of coping strategies which also contributes to the reduction of stress. Reduction of risk impact may also occur through art making and play where the children can redirect their overwhelming emotions into the art or game and help them consider their reactions to the death in a concrete form without becoming overcome by them.

The second mechanism that operates in such a group is the reduction of the negative chain events that can follow a risk exposure i.e. the bereavement. The negative chain events may be reduced in bereaved families if parents are able to work through their grief and become free to support and parent surviving children in a healthy manner. This is often
very difficult for the surviving parent who has to care for the children at the same time as working through their own grief. In a child bereavement support group the group leader is able to provide the child with steady support and emotional holding because the leader is not personally overcome by the death. This also provides the opportunity to work through the grief without the disrupting the parent child relationship. The group can also serve to build up peer relationships.

The group can also serve to bolster the children's self esteem that may be temporarily lowered because of the grief. Their self esteem and self worth may increase as they learn to help others and themselves. They may also feel satisfaction and accomplishment when they complete an art project, increase their social competencies through play, or succeed at any type of task in a supportive environment (DeRosa & Patalano 1991).

The fourth mechanism that Rutter identified as a protective from long term effects was to open up opportunities. Children often have misconceptions and maladaptive fantasies about death. Therefore education about death is often part of the agenda for a bereavement support group. Education about death can open up opportunities for children to improve their knowledge and thus improve their understanding and make it less confusing and overwhelming. They give the example of children in the group who had fantasies and fears about their mother's death. particularly one girl who was extremely frightened as she thought she saw her mother as a ghost. The authors argue that it is important to explore the children's beliefs about death as they can be extremely troubling and horrifying in order to help them to differentiate between fact and beliefs about death which can help them gain more control over their fears.

This study provided an interesting description of the theoretical rationale and therapeutic techniques of a child bereavement support group. However the research was based on clinical impressions and was purely descriptive and no evaluative research has been carried out using this model. It is not clear from their account what size and type of clinical
sample was used to form the basis of their model. However they do attempt to demonstrate their model on a group of four children who have been bereaved. In order to test out this model more fully it would be necessary to attempt to measure the four mechanisms described. This could be achieved for example by interviewing the children and their surviving parents and by using standardized measures before and after the group in order to establish the effect of the group on the grieving process.

A related approach is the use of peer group counselling which has been used particularly with adolescents and there have been a number of studies examining the effectiveness of such an approach. One such study attempted to evaluate a series of peer group counselling sessions for bereaved adolescents in Ontario (Gray 1988). It was found that 40% of bereaved adolescents reported that 'the most helpful person' at the time of their loss was a peer, and also 76% of those who had taken part reported that they felt peers understood them after their loss compared to only 8% of bereaved teenagers interviewed who had not taken part in the support group. Gray concluded from this that the use of peer support groups is a valuable resource for helping those who are bereaved in their teens. Gray mentions that certain psychological tests and an objective depression inventory were administered to the participants he does not state which tests were used and when they were administered to the group members. Thus the evaluation seems to be mainly based on subjective impressions which are valuable but an objective measurement would have been useful.

Quarnby (1993) also attempted to measure the effectiveness of a peer group counselling with a group of teenagers who had lost either their mother or father. He used both the perceptions of the subjects and the group leaders and some empirical tests to measure the effectiveness of the peer group counselling. He found that the group members reported that non bereaved peers were generally unable to understand bereavement related feelings and there were strong indications that bereavement was perceived as imposing a loss of status amongst peers. He found that many bereaved adolescents will refrain from talking.
with friends, as they believe it will be too overwhelming for their friends or perhaps because they are afraid how their responses will be perceived by others. However there was no control group in this study and therefore the only measure to assess the significance of the change in test score is the subjective impressions of the participants. Furthermore this study is only based on one six week group for six participants who varied significantly in the time since the death of their parent (8 to 34 months). Earlier on in the essay the developmental aspects of the understanding of the concept of death and the bereavement reactions were discussed and it was suggested that the treatment should bear this in mind. It is generally accepted that one of the characteristics of the adolescent period is that the peer group is very important and therefore therapeutic interventions based on peer group support are particularly appropriate for this age group. Findings from the studies described seem to support this hypothesis.

The therapeutic approaches described above have been centered on direct work with the child or adolescent. An alternative approach has been to work with the surviving parent with the aim of providing them with the necessary skills and knowledge to help the child. Some authors have reviewed the use of prevention programmes with families where one of the parents is suffering from a terminal illness (Seigel et al 1990). These programmes are designed to provide parents with an understanding of the nature and range of children’s bereavement reactions. This in turn, it is hoped, will enable them to promote the necessary conditions to foster their children’s necessary grief reactions. Children of terminally ill parents can be helped by intervention programmes instigated before the death and providing follow-up after the death. These programmes have used brief psychological intervention which is based on parent guidance and has been used to enhance the children’s relationship with the existing parent. In these programmes the parents are provided with the knowledge and insight to help them understand and meet their children’s heightened needs for emotional support and physical care. These interventions are aimed to reinforce the parental competence and encourage open family communication about the illness and provide support and advice on maintaining rules and boundaries and a secure environment.
for the child. They also help the family prepare for the death and help them start the grieving process.

To summarize, childhood parental bereavement affects a significant proportion of the school population. In the acute phase the experience of bereavement can have profound effects the precise nature of which depend on age. The studies reviewed here indicate that bereavement is not associated with adverse effects in the short term. However, in the longer term bereavement in childhood does tend to be associated with psychopathology. The likelihood of an individual developing long term psychological problems as a result of bereavement appears to be dependent upon a number of factors such as the quality of the relationship between the child and the surviving parent, the mental health of the surviving parent and the stage of development and temperament of the child. It would be helpful to develop a theoretical model which could take these variables into account in order to predict which children are likely to go on to develop problems as a result of bereavement and what factors serve to protect these children from developing a psychopathology.

Since a proportion of children do go on to develop psychological problems therapeutic intervention is appropriate. The therapeutic approaches reviewed here seem to be promising, however, much of the work is based on clinical impressions and descriptive data. It seems that most of the therapeutic approaches with bereaved children have been derived empirically and relatively few attempts have been made to derive a theoretical model for the therapy. It appears that such models which have been developed have yet to be rigorously tested. It is hoped that further development of a theoretical model of bereavement work with children will lead to improved therapeutic approaches to post bereavement care. Ideally, the model would incorporate ideas about the child's concept of death and how children of different ages understand and react to the death of a parent.
References


Deliberate Self Harm in Adolescents: a review of the literature

The aim of this review is to provide a comprehensive account of the literature on deliberate self harm in adolescents. The review will begin with studies examining the prevalence and characteristics of self harm in adolescents. It will then cover literature pertaining to the causes of deliberate self harm both the immediate precipitants and the more general factors associated with this act. Finally discussion will turn to a critical review of the treatment strategies available to self harmers and their families.

Suicide is the second most common cause of death among people aged 15-24 years in England and Wales (Office of Population Census and Surveys 1990). Hawton reported an increase of 78% in the rate of suicide among males 14-24 years in England & Wales between 1980 and 1990 in the UK (Hawton & Fagg 1992). In the same period the rate of suicide in women fell nearly by one half. Approximately one third of adolescents who kill themselves have a history of previous attempts (Martunnen et al 1993). Attempting to understand the causes of suicide in adolescent is difficult because it has to be studied retrospectively. However one important area of research is that of deliberate self harm which may provide some important clues about the nature and causes of adolescent suicide.

One of the most informative studies on adolescent self harm has been conducted in Oxford by Hawton and Fagg (1992). They developed a system for monitoring adolescent attempted suicide referrals to a general hospital and were therefore able to study the trends over a thirteen year period (1976-1989). They found that during the late 70’s and early 80’s there was a decline in incidence of deliberate self-poisoning and self-injury among older females followed by an increase between 1986 and 1989. The rates among males and younger females remained relatively constant. The authors estimated that if the rates in Oxford were representative throughout England and Wales then nearly 20000 young
people would be referred to general hospitals each year as a result of self injury or self poisoning.

Attempted suicide by adolescents continues to be a problem in older teenagers, especially females. However this does not appear to be the case in all European countries. The World Health Organization’s current study of parasuicide demonstrated that in countries such as Holland (Prins & Kerkhof 1990) and Denmark (Bille-Brahe 1990) rates of attempted suicide by older teenagers are relatively low compared with rates in young adults.

In their study Hawton and Fagg (1992) found that self poisoning was the predominant method used in attempts, accounting for 86.5% of all those admitted for self harm, 10.8% involved self cutting and 2.8% involved self poisoning and self injury. Self poisoning alone was more common in females (88.8%) than in males (79.9%) whereas self injury (with or without self poisoning) was more common in males (20.1%) than in females (11.2%). They also found that during the period between 1976 and 1989 there were marked changes in the methods used for self poisoning. There was a considerable reduction in the use of minor tranquilizers and sedatives and a huge increase in the use of paracetamol. In 1976, 26% of all overdoses involved paracetamol and by the end of the study 48% of all overdoses studied involved paracetamol which is worrying considering the potentially harmful effects of irreversible liver damage. Earlier studies have indicated that young people taking paracetamol overdoses were largely ignorant of the dangers involved (Gazzard et al 1976). However more recent research indicates that most paracetamol self-poisoners today are aware of the dangers, and the main reason that they take the paracetamol is its ready availability (Hawton et al 1995). Interestingly in a very recent study of paracetamol self poisoners (including patients of any age), it was found that a greater proportion of patients took 25 or more tablets (associated with acute liver damage) when they used tablets from a bottle (69%) compared to when they used tablets.
from a blister pack (40%) (Hawton et al 1996). This seems to be because blister packs generally contain fewer tablets than loose containers.

Hawton and Fagg (1992) also found that alcohol consumption was quite often associated with the deliberate self harm act. Alcohol consumption during the 6 hours preceding the act was common (25.2%) but more so in males (38.7%) than in females (20.8%). It is likely that alcohol may increase the likelihood of the act and it can also seriously add to the danger of the overdose. They also found that alcohol was consumed as part of the act in 18.9% in males and 12.5% of females.

It therefore appears that deliberate self harm is common among adolescents and is on the increase in older adolescent girls. In order to develop effective treatment strategies for adolescents who harm themselves it is important to understand the causes of the self harm act. When considering the causes of deliberate self harm in adolescents, two aspects should be taken into account. These are the more immediate events and feelings which motivate the adolescent to self harm and the more general predisposing factors which tend to be associated with self harm.

There have been several attempts to examine what it is that motivates adolescents to harm themselves. Hawton and his colleagues (1982) looked at 50 adolescents who had presented at the hospital with an overdose. The adolescents were asked about their feelings that preceded the attempt, their explanations for the overdose, their view about the seriousness of the attempt and whether they would do it again. The method used in this study was for the adolescents to select from a list of alternative explanations which were taken from a previous investigation (Bancroft et al 1979). This method has the disadvantage of limiting the respondents to a pre-determined list and also that they may choose answers that they would not have considered spontaneously. However it does have the advantage of allowing systematic evaluation. The study also compared the
adolescents responses with those of the clinician who did the interview using the same pre-determined list.

They found that the main feelings that appeared to precede the suicide attempt by adolescents were feeling lonely or unwanted (54%), feeling angry with someone (54%) or feeling worried about the future (40%) which was particularly characteristic of the older age group. In relation to what they hoped the suicidal act would achieve the main reasons given were to “get relief from a terrible state of mind” (42%), “to escape for a while from an impossible situation” (42%) and “to make people understand how desperate you were feeling” (42%). In contrast the clinical assessors more often selected punitive and manipulative reasons for the overdose far more frequently than the adolescents (for example “make people sorry for the way they have treated you” or “to try to influence some particular person or to make them change their mind”). There are several possible explanations for the discrepancy between the adolescents and the clinical assessors view about the reasons given for the self harm act. For example, it may be the adolescent feels that punitive or manipulative reasons are likely to evoke unfavorable attitudes in the hospital staff or that the adolescents are unable to see the meaning behind their act and tend to focus on their immediate feelings preceding the event. Alternatively it could be argued that for cultural reasons the clinical assessors may interpret the deliberate self harm act in an unsympathetic light and see it as a means of exploiting others.

As to the intention of the adolescent to die, 34% of the adolescents said that they wanted to die at the time of taking the overdose and a further 42% said that they did not mind whether they lived or died. This was in contrast to the clinical assessors who thought that only 14% wanted to die and 18% did not care either way. Again there is a discrepancy between the adolescents and the clinical assessors views which may again be a reflection of the professionals attitude towards deliberate self harm. Despite their expressed intentions the events surrounding the overdose rarely suggested that the act was seriously intended to result in death as most of the overdoses were not planned (only 20% made plans for the
overdose) and the act usually occurred in circumstances which ensured that the adolescent would be found (86% had someone present or nearby when they had taken the overdose). It appears therefore that despite the expressed intentions of many of the adolescents who harm themselves their actual behaviour around the act appears to contradict this. This contradiction may simply arise from the fact that most deliberate self harm acts are impulsive in nature, are not planned and are immediate reactions to an adverse event.

Interestingly only 18% of adolescents said that they took the overdose to seek help from someone which may go some way to explain why many adolescents who attempt suicide are often difficult or reluctant to engage in treatment and follow-up (Morgan 1979 Kerfoot and McHugh 1992). This was in contrast to the 38% of the clinical assessors who gave this reason which again demonstrates the disparity in views between the adolescents and the professionals.

This study provides useful information about the adolescent’s perceptions of why they take overdoses and it seems as though many self harm attempts are an adolescents way of communicating the desperation they feel. This study is restricted to adolescents who poison themselves and it would be interesting to explore whether the views of this group are representative of the wider group of adolescents who harm themselves. It appears that the staff who care for the adolescents after their attempts often have different views about the causal factors of the self-harm act. It would be interesting to explore further how the attitudes and beliefs of the professionals who assess and treat this group of adolescents influence the way they behave towards them.

Having considered the immediate feelings that motivate an adolescent to harm themselves I am now going to consider the more general factors which have found to be associated with self harm in adolescents. There are several factors which have been shown to be associated with deliberate self harm in adolescents for example there is evidence to suggest that there are important links between depressive disorder and deliberate self harm.
Studies examining this link can be categorized into two sets: those that use their sample as adolescents who are depressed and then look at rates of deliberate self harm or suicidal thoughts, or alternatively the sample is adolescents who self harm and they look at the rates of depression. The difficulty with this research is that different studies vary in the criteria they use to identify depression.

In a study examining adolescents who are depressed, Myers et al (1991) found that suicidality was expressed in about 70% of adolescents with major depression during a three year longitudinal study. Similarly Kovacs et al (1993) reported that about 85% of children or adolescents with major depression had a life time history of suicidal ideation and 32% had attempted suicide. The risk of attempted suicide was higher among those who also had conduct or substance misuse disorder.

In a study looking at adolescents who have self harmed, Taylor and Stansfield (1984) found that depression (defined according to strict criteria) was more common among adolescent self-poisoners (26%) than non-suicidal adolescents (2%) referred to an adolescent psychiatric service. They also found that 60% of self-poisoners had a mental disorder. However in Hawton and Fagg’s (1992) study of adolescents who have self harmed they found that relatively few individuals (15.9%) had a history of psychiatric treatment (inpatient, day-patient or out-patient), only 6.4% were in psychiatric care at the time of their attempt and only 3.5% were diagnosed as having a psychiatric disorder although they do not report the actual incidence of depression. However from the description of the study it seems that these figures are based on interview with the clinical assessor and they do not specifically measure the incidence of depression.

The rates of mental disorder described above are much lower than those in another study by Andrews and Lewinsohn (1992). They found that about 80% of individuals who had attempted suicide suffered from a mental disorder, most commonly major depression and behavioural problems. One possible explanation for this discrepancy is that they may
reflect differences in the samples studied. Hawton and Fagg studied referrals to a hospital in Oxford whereas Andrews and Lewinsohn studied community cases in Oregon USA. Alternatively the discrepancy may also be due to differences between the diagnostic procedures.

Similar findings to Andrews and Lewisohn were found in a British study of adolescent self-poisoners. It was found that 67% of adolescent overdose cases were suffering from depression at the time of the attempt which was significantly higher than in community controls. (Kerfoot et al 1996). The diagnosis of mental disorder was made using the DSM-III-R criteria (American Psychiatric Association, 1987). The authors argue that 'major' depression following an overdose is often a transient psychological phenomenon as only 38% still had depression at the follow-up (average of 35 days later). However one needs to be cautious about drawing too many conclusions from these results as the study was based on a small sample size (40 subjects), even fewer were followed up (25 subjects) and the time of assessment and follow-up varied considerably (between 4 and 40 days for the assessment and between 23 to 77 days after the first assessment for the follow-up).

In another study Carlson and Cantwell (1982) used a standardized measure of depression, the Children's depression inventory, and measures of suicidal ideation and behaviour, to study a series of children and adolescents referred to a psychiatric unit. They found that suicidal ideation increased around puberty and correlated with severity of depression. When another factor "hopelessness" was also examined it appeared that this was associated both with suicidal ideation and suicidal behaviour and not depression per se (Kazdin, French, Unis, Esvolent-Dawson & Sherick 1983). An additional finding of this study was that there was only a slightly higher incidence of suicide attempts in the depressed group than the non depressed group.
The relationship between depression and suicidal behaviour is complex. From the studies reviewed it appears that a large proportion of adolescents who are depressed express suicidality and about one third attempt suicide. However when the study population is adolescents who harm themselves there is a great discrepancy in the rates of depression (26% to 80%). This may be due to differences in the diagnostic criteria. The studies indicate that in many self-harm cases the depression is a transient psychological problem and that many adolescents who harm themselves are not depressed. Nevertheless the presence of depression is an important factor as it may be an indicator of a repeated suicide attempt.

A second factor which has found to be associated with self harm in adolescents is a poor relationship with family members. It is interesting to note that in the study previously mentioned it was found that a common reason for young people harming themselves was in order "to make people understand how desperate you were feeling" (Hawton et al 1982). This explanation indicates that the adolescent may be finding it difficult to express their feelings to others around them in more appropriate ways and may be a reflection of underlying relationship difficulties.

In several studies examining adolescent self poisoners (Hawton & Fagg 1992, Hawton et al 1982b, Taylor & Stansfield 1984) relationship problems were common in adolescent attempters especially in females. There have been many studies showing that children and adolescents who poison themselves tend to come from families with disturbed relationships (Taylor & Stansfield 1984). These families are often coping with extremely high levels of interpersonal and social stress. The quality of communication within the family is often poor (Richman 1979) and their problem solving skills may be quite limited (Hawton 1986). Further evidence for this was shown in a controlled study of 91 suicidal inpatients. They found that stressful relationships with parents, particularly the mother, were significantly related to depression and suicidal ideation compared to the control group (Adams Overholser & Spirito 1994, Adams Overholser & Lehnert 1994). A more recent study
provides further support as Kerfoot et al (1996) found that poor intrafamilial relationships strongly correlated with self poisoning in adolescents. They also found a link between peer relationship difficulties and deliberate self harm.

In an attempt to further examine the link between attempted suicide and the quality of the relationship between the adolescent and their parents an interesting piece of research has been carried out on a student population. One of the aims of this research was to explore whether there are any predictors of attempted suicide in adolescents by examining the relationships between parenting style and suicidal thoughts, suicidal acts and depression among 681 school students (Martin & Waite 1994). Students completed a Parental Bonding Instrument (PBI) which assesses the adolescents’ views of their parent’s care and the Youth Self Report, which provides information about suicide ideation, deliberate self harm and depression. The Parenting Bonding Index consists of two sub-scales a care sub-scale and protection sub-scale. Each sub-scale is bipolar. One pole of the care sub scale is characterized by expression of affection, emotional support and fair treatment and the other pole by neglect and rejection. One pole of the protection sub-scale is defined by psychological autonomy and the other psychological control which includes intrusiveness and parental control through guilt. They found that the Parental Bonding Instrument was a reliable discriminator between students with and without depression, suicidal thoughts and deliberate self harm. Where adolescents had assigned their parents to the “affectionless control” quadrant of the PBI it was related to a fivefold increase in the relative risk of depression, a threefold increase in the relative risk for deliberate self harm and a doubling of the relative risk for suicidal thoughts. The authors argue that the PBI may play a role in identification of vulnerable adolescents and this study provides further evidence of the link between difficulties in the parent-child relationship and adolescent self harm.

When an adolescent is admitted to a general hospital because of a self harm act it is important that a very careful assessment is undertaken as soon as possible which can be
used as a basis for treatment. The assessment must take into account several important factors; the first important function of an assessment is to attempt to understand and identify the underlying factors involved in the psychological dysfunction which has become manifest in the self-harm act. Research described above has shown that family disruption and depression are common background factors. Furthermore according to the research based on interviews with the adolescent themselves the self-harm act is often preceded by feelings of loneliness and desperation. The second important function of the assessment is to determine to the seriousness and intent of deliberate self-harm attempt and to what extent the act is likely to be repeated and possibly prove fatal.

One important indicator of the seriousness of the deliberate self-harm attempt is the extent to which the attempt has been planned. As mentioned earlier the circumstances of many attempts by adolescents do not suggest high suicidal intent and often there has been little premeditation preceding the attempt. Many overdoses are impulsive (Brown, Overholzer Spirito & Frotz 1991). In the Oxford study (Hawton & Cole 1982) over half the adolescent self-poisoners reported thinking seriously about the act for less than a quarter of an hour and 16% for a period between 15 minutes and an hour. Only 8% had contemplated taking the overdose for more than 24 hours. In another British study, three quarters of a group of adolescent self-poisoners had contemplated taking their overdoses for less than two hours (Taylor & Stansfield 1984). In general the longer a particular act has been contemplated the more serious the suicidal intent is likely to be.

The assessment of an adolescent who has harmed themselves must attempt to identify whether the young person is at risk of further attempts. The Oxford study found a repetition rate of 9% within the year following the first attempt at suicide (Hawton & Fagg 1992). A similar figure was also found by Spirito et al (1992) among adolescents referred to a general hospital or to a psychiatric unit (10% with in 3 months). In a long-term study Pfeffer et al (1993) reported that prepubertal child psychiatric patients who had attempted suicide and were followed up for nearly 8 years were much more likely to make
another attempt than non-patient controls. Risk factors included previous suicide attempt, mood disorder, or substance use, adversity and poor social adjustment. These risk factors if they occurred in the period after the first suicide attempt were stronger risk factors than whether the subject had a history of suicidality - Children who attempted suicide in the follow up were three times more likely to have a mood disorder in the first year after the initial attempt than those who did not attempt suicide during this period. Therefore background risk factors such as previous attempt may be overshadowed by current mental health problems or current circumstances.

A further aim of the assessment is to establish, as far as possible, the risk of subsequent suicide. There is a considerable risk of eventual suicide following a self harm attempt. Within a year after a suicide attempt about 1% of adults die by suicide and this risk remains increased several years later (Hawton & Fagg 1988). The risk of suicide following parasuicide in adolescents, while lower than that of adults is probably of the order of 1.0 to 0.5 per cent over 10 years (Spirito et al 1989, Hawton et al (1993). Approximately one third of adolescents who kill themselves have a history of previous attempts (Martunnen et al 1993).

There have been a few studies in which adolescents and young people who attempted suicide have been followed up long term and the factors associated with death by suicide have been identified. In one such study by Hawton et al (1993) based on retrospective data from cases (N=62) who had died locally from either suicide or suspected suicide and had previously been admitted to the regional poisoning treatment centre. Each case was matched with two controls on sex, age and length of follow-up. The controls were selected by taking the previous and subsequent matched subject admitted to the regional poisoning treatment centre before and after the index case. They compared the groups on a number of different variables including sociodemographic data, family background, previous psychiatric treatment, drug and substance misuse and episodes of previous suicide attempts. They found that there is an association of suicide after parasuicide in young people with current substance misuse including the misuse of alcohol, drugs or both.
further factor associated with future suicide was previous inpatient psychiatric admission. However there were a number of shortcomings to this study, firstly the data was retrospective and was restricted to the monitoring forms used by the centre, secondly data was restricted to those people who died in the area and therefore nothing is known about those who moved away which could bias the findings. Furthermore the sample used in this study were aged 15 to 24 which obviously includes an older sample than the other studies discussed in this review. Despite these shortcomings the finding that substance misuse is a risk factor for suicide has important implications for prevention and treatment.

Although the Royal College of Psychiatrists (1982) states that follow-up help should be offered to all children and adolescents who attempt suicide, in practice this varies from district to district. There is a paucity of research into the treatment of adolescents who attempt suicide although Hawton and Fagg (1992) found that there were considerably higher repetition rates in the adolescents only seen in the accident and emergency department and not admitted to the general hospital (13.5%) than those who were admitted to a hospital bed (8.1%) It was also considerably higher in patients not referred to and assessed by the general hospital psychiatric service (13.6%). This may be an indicator of the beneficial effects of admission or it might reflect a weakness in the admission criteria.

Research has shown that adults and children who attempt suicide are difficult to engage in treatment and follow-up (Morgan 1979 Kerfoot and McHugh 1992). This may be a reflection of the difficult feelings that the attempt may elicit such as feelings of guilt, blame and embarrassment. The families may tend to deny the seriousness of the attempt and follow-up treatment may be seen as an unwelcome reminder of what has happened. It has also been shown that adolescent suicide attempters are likely to keep fewer appointments and remain in treatment more briefly than do other outpatients (Trautman et al 1993). The difficulty that these young people and their families have in engagement in treatment may be a further reflection of the earlier finding that young people who harm
themselves are more likely to come from families with disturbed relationships (Taylor & Stansfield 1984) and with poor communication (Richman 1979).

Previous research on the characteristics of adolescents who harm themselves gives us important clues about how the treatment interventions should be developed. For example as mentioned earlier research has found that adolescents who harm themselves are more likely to come from families with disturbed family relationship (Taylor & Stansfield 1984) and where communication is poor (Richman 1979) and their problem solving skills may be quite limited (Hawton 1986). Based on these findings Kerfoot et al (1995) have developed a brief home based intervention programme for young suicide attempters and their families. The main emphasis of this approach is that it is short term and focused and is based on insights gained from previous research studies and on extensive clinical practice. It aims to increase the family’s acknowledgment and acceptance of the reality and the seriousness of the suicidal episode by helping them know what actually happened. The treatment is based on the assumption that suicidal behaviour usually indicates that there has been a breakdown in communication and this approach aims to enhance the families existing communication skills and learn new ways of communicating. A further aim is that it helps to facilitate the development of problem-solving skills among the family members. The final aim is to help families understand adolescence as a normal period of development and to explore common parenting problems and issues that arise out of this period. The programme takes place with the adolescent and their family in the home and consists of five sessions each of which follows a structured format. This treatment approach is attractive in that it is based on the research into the area of adolescent suicide attempters and therefore there is a clear rationale for the work. However it has not yet been evaluated although it is part of a major controlled evaluative study. Once the evaluative research has been completed it will provide a useful insight into the effectiveness and suitability of this approach with adolescent suicide attempters and to what extent it has been successful in overcoming some of the recognized difficulties that clinicians have had in engaging this particular client group
To summarize, deliberate self-harm in adolescents is a worrying phenomenon particularly as it seems to be on the increase in older adolescent girls and also that there has been an increase in the suicide rate in young men. The research indicates a relationship between depression and self-harm although this seems to be complicated and warrants further examination. It seems that in most cases the depression at the time of a suicidal act will resolve rapidly although in a small minority of cases it persists there needs to be treatment as it can be an indicator of another suicidal act (Pfeffer et al 1993). Adolescents who harm themselves are attempting to communicate their feelings about themselves and their relationships. It is therefore essential that they are carefully assessed after the self-harm act in order to try to understand the message they are trying to convey. While it is recognized that many adolescents do not take up the offer of treatment, it is important that following the assessment individual or family work is offered as the deliberate self-harm attempt is often an indicator of family difficulties.
References


Research Dossier
Maternal Anxiety and confidence in relation to gestational age at birth

by

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Dissertation submitted for the degree of M.Sc. in Clinical Psychology

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The aim of this study was to investigate maternal anxiety and confidence in mothers of pre-term infants.

12 mothers of pre-term infants were compared to 12 mothers of full-term infants, matched for maternal age and parity. Maternal anxiety, confidence, and the mother's perception of her infant's behaviour was measured one and five weeks post-discharge. Perceived social support was also measured.

No differences were found between the two groups of mothers on anxiety, confidence, and perception of infant's behaviour. Weak associations were found between a number of infant variables and measures of maternal confidence. The size of the social support network was associated with maternal anxiety in the full term group only.

A further group of five mothers of pre-term infants who were visited when their infants were at the equivalent gestational age to those in the full-term group were included for the final analysis. The predictors of maternal mood from background and infant characteristics was investigated using the pooled data. Findings suggest that the mother's perception of her infant's behaviour, in particular unsettled-irregular behaviour, was a strong indicator of mother's lack of confidence.

The possible interpretations of these findings and their implications are discussed.
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INTRODUCTION

The birth of a preterm infant is likely to be a very stressful time for mothers. When an infant is born prematurely the mother may not be as psychologically and practically ready for parenthood as she would be had the pregnancy gone to term. The premature birth interrupts the normal process of pregnancy, requiring the mother to confront the reality of a fragile, often sickly infant at a time when she is psychologically depleted. She may experience a sense of failure, guilt, and loss of self esteem not only because she did not carry the baby to term but also because the baby differs from the one she had anticipated. When the baby is sick or preterm and has to be separated from the parents through admission to the special care unit, the reality of the delivery and post partum period deviates markedly from the one she expected. When the delivery goes badly and the baby has medical problems it can represent a severe emotional crisis for the mother (Caplan, Mason and Kaplan 1965).

Pregnancy should be viewed as a dynamic process. The first step in establishing a relationship with the newborn child, begins prior to birth and is quite intense during the third trimester of pregnancy. This identification process is accompanied in the mother by a growing emotional investment in the child. Images for the 'hoped for' idealised child are
common and various expectations about the child can be developed. Immediately postpartum is the process of 'letting go' whereby the mother must relinquish her prebirth fantasies and adjust to the realities of her new born infant. This is the beginning of the acquaintance/attachment phase. In the case of the preterm infant this phase may be delayed while the mother deals with the emotional sequelae created by this emergency. Kaplan and Mason (1960) have identified 4 psychological tasks which appear to be essential in assisting the mother to successfully master the situation of the preterm birth and which promote a sound basis for a future healthy mother-child relationship. Firstly, she has to prepare herself for the possible loss of the child, i.e anticipatory grief. Secondly she has to come to terms with her failure to deliver a normal baby. Feelings of sorrow, anger and helplessness are commonly expressed at this time. In addition guilt regarding the premature delivery and anxiety caused by ignorance of treatment administered to the baby have also been noted (Harris 1977). Later, when it appears that the baby is likely to survive, she has to resume the normal mother/infant relationship. Finally she has to acknowledge the special needs of the premature infant as a temporary state, later to be treated as normal.

Since preterm delivery frequently results in the infant being admitted to the special care baby unit and separated from its mother, there has been a growing interest in the possible consequences of separation of infants at, or soon after, birth.
for their subsequent development. The work on separation, associated with Klaus and Kennel (1976) proposes a 'sensitive period' which is the optimal time for the development of the maternal infant bond which facilitates good mothering. In recent years there has been an increasingly critical view of the 'sensitive period' thesis and the studies which support this stance. While there may be indications that there are short term advantages in giving the mother and baby time to get to know each other, recent reviews (Herbert et al 1982, Lamb 1983) do not support the notion that early and extended contact is crucial to the mother-infant bond; nor do they support the view that early contact has long-term benefits for the mother-child relationship.

The work on bonding placed considerable emphasis on the immediate post-partum period, viewing the bonding as being an end in itself rather than a small part of an ongoing process. With the growing acceptance of the developmental perspective there has been an increasing emphasis on the dynamic and individual nature of attachment.

Most studies looking at the effects of early separation have concentrated on the behavioural characteristics that can be observed in interaction situations; very little attention has been paid to the attitudes and feelings of the mother. When the baby is removed from the mother, she may perceive an implication that she is incapable of caring for her baby and
that its care must be entrusted to experts. It is therefore likely that she will feel less confident about her ability to look after her baby and as a result may experience increased anxiety.

The following section will form a discussion of some of the events which accompany preterm birth and which may have implications for the later development of the child. As a starting point the factors involved in preterm birth will be discussed within the framework of a general model of parenting which takes into account the characteristics of the parent, the child and the wider social network. The effects of early separation will then considered in detail. Finally the literature concerning anxiety and confidence in mothers of premature infants will be reviewed.
1. The effect of the pre-term birth on parenting.

In order to examine how the birth of a preterm infant may affect mother infant relationship, it is useful to examine the relationship within the wider contexts of parenting. Parenting should be considered in terms of an ecological perspective which recognises the family as a functional social system influenced by its internal composition and external forces (Belsky 1981, Belsky 1984, Bronfenbrenner 1979 & Rutter et al 1983). Belsky (1984) proposes a model of parenting which attempts to explain how parenting qualities are affected by the characteristics of the child, the characteristics of the parent and the marital relationship and by the social circumstances generally.

The model of parenting that Belsky (1984) proposes is called "a process model", which attempts to integrate the disparate findings in the literature into a coherent whole. He argues that there are three main forces which influence parental functioning - the personal psychological resources of the parent, the characteristics of the child and the contextual sources of stress and support. The psychological resources of the parents are determined by their own developmental history. Their personality and psychological well-being in turn influences their parental functioning. Therefore supportive developmental experiences give rise to a mature healthy personality that is then capable of providing sensitive
parental care which and thus fostering optimal child development. As for the child's influence Belsky cites evidence which support the view that neither temperament nor other child characteristics per se shape parenting, but rather the "goodness-of-fit" between parent and child determines the development of parent child relations (Lerner & Lerner 1983). As well as considering the parent and child contributions to parental functioning, the context of the parent-child relations is important. The literature on this subject points to the fact that parenting appears to be positively associated with social support. Social support functions in three ways: - by providing emotional support, by providing instrumental assistance and by providing social expectations (e.g Mitchell & Trickett 1980). The support can function to influence parenting both directly and indirectly. Direct effects are those which shape parental behaviour, whereas indirect effects are those which first influence individual psychological well being. The personality of the parent influences the contextual support/stress which in turn feeds back to shape parenting. Belsky identifies three distinct sources of stress and support that are likely to promote or undermine parental competence - the marital relationship, social networks and employment.

Since parenting is multiply determined it means that the parenting system is buffered against threats to its integrity when there are weaknesses in any single source. Belsky claims that parental functioning is most protected when the personal
resource system of the parents i.e. their personality and psychological well-being still functions to promote sensitive involvement. It regards good personal psychological resources as the most influential determinant of parenting not simply for its direct effects on parental functioning but also because of the role it undoubtedly plays in recruiting contextual support. Parental functioning is least protected when only the subsystem of the child's characteristics fulfil this function.

Belsky's model of parenting provides a context within which the case of the pre-term infant can be considered. Research in this area has mainly focused on the mother-premature infant dyad. However, there has been limited research which has compared mothers to fathers. For example it has been shown that mothers show more distress than fathers following the birth of a pre-term baby (Trause and Kramer 1983, Blake et al 1975, Jeffcoate et al 1979). Mothers have been shown to engage in more caregiving, talking and holding during initial contact but the disparity in maternal/paternal interactions decreased with time. In this study mothers perceived their infants be more difficult than fathers but fathers reported enjoying them more. Nevertheless, it has been suggested that fathers can indirectly affect early interventions with high-risk infants via the support they provide to the mothers (Herzog 1982).

The application of Belsky's model facilitates a consideration of the factors which are associated with the preterm baby and
which affect parenting. At one extreme of the continuum of 'good/bad' parenting lies the case of the abused or neglected child. There is evidence which suggests that premature babies are poorly parented more frequently than infants born after a normal gestation (Klein & Stern, 1971). Premature babies are over-represented among samples of abused and neglected children (Hunter, Kilstrom, Kraybill & Loda 1978). Although only a small proportion of premature babies are subjected to neglect or abuse it seems likely that there must be factors associated with pre-term infants which make parenting more difficult. By adopting Belsky's model it is possible to identify these factors. Three main sources of influences on parental functioning will be considered: (i) the child's characteristics of individuality, (ii) the parents' ontogenic origins and personal psychological resources, and (iii) contextual sources of stress and support.

(i) Characteristics of the child

One group of investigators has suggested that the parenting problems of preterm infants are due to the lack of responsiveness to social stimulation these small infants show, at least during the first year of life (Als and Brazleton 1981, Goldberg, 1978) The pre-term infant tends to be less organised, less alert and communicates less clearly than the full-term
Numerous studies have demonstrated the process whereby neonatal infant characteristics affect either concurrent or subsequent maternal care-taking behaviours in well (Lewis & Rosenblaum 1974, Osofsky & Danzger 1974) and high risk infants (Bakeman & Brown 1980; Green et al 1983). For example, some investigators have found mothers of pre-term infants interact more, and appear to stimulate their infants more than do mothers of full-term infants (Brown & Bakeman 1980; Field 1977, 1979). For example Crnic, Ragozin et al (1983) found mothers of pre-term 4-month old infants vocalised more to their infants than did mothers of full-term infants. They also found, however, that mothers of pre-term infants smiled less often than mothers of full-term infants which suggests that although mothers of pre-term infants worked harder, they found interactions less pleasant or rewarding. Field (1979) reported similar findings: mothers of pre-term infants tested at 4 months of age were more active in general but less responsive to some of the infant's cues. In another study, Levy-Shiff et al (1989) found that the infant's heightened levels of activity are likely to be associated with increased parental involvement in passive behaviours (i.e. holding, looking, and smiling) whereas infant's inactivity and distress were likely to be associated with parental involvement in active behaviours (talking, playing and stimulating). It therefore seems that parents
compensate for their infant's fragility and vulnerability by providing more stimulation or adapt to their lack of activity and responsiveness by being more active themselves in an effort to elicit a response.

However some investigators have found that the relative deficit in responsiveness of the pre-term infant causes the mothers of pre-term infants to smile at their infants less (DiVitto & Goldberg, 1979, Leifer, Leiderman, Barnett & Williams, 1972) and engage in less face to face contact (Klaus & Kennel 1970).

The premature infant's deficit in responsiveness may lead some mothers to gear their interaction more towards stimulation and others towards relative affective withdrawal than mothers of full term infants.

It seems that the interactions between mothers and preterm infants may be less optimal than those between mothers and full-term infants. However, as the infant matures and becomes better organised behaviourally and physiologically and is more able to communicate in other ways than crying and as mothers are given time to learn to interpret their baby's behaviour it is likely that some of the differences between mother infant dyads will disappear. In general, it is found that some of the effects of preterm birth will lessen with age. However there is some debate as to how long the differences between full and
pre-term infants exist. One study, comparing 20 full and pre-term matched dyads, found that the full-term infants were more active at 1 month but these differences had disappeared by 2 months (Minde, Perrotta & Marton 1985). This supports other findings that the differences between premature and full term infants disappear after 6 weeks (Beckworth & Cohen 1976, Parmalee, Kopp & Sigman 1976). In contrast other studies have found that the differences persist for up to 6 months (Als & Brazleton 1981). In Crnic, Ragozin et al's (1983) study of infants in the first year of life, mother-infant pairs were assessed at 1, 4, 8, and 12 months. In their sample, premature infants showed less positive affect throughout the first year than full-term infants. On global ratings of affect, both pre-term infants and their mothers received less positive ratings than did full-term infants and their mothers. These differences were present throughout the first year but were most noticeable at 12 months. There is some evidence that differences may persist beyond the first year of life. Field (1979) found that at 2 years, the pre-term infants in her sample had shorter mean length utterances, smaller vocabularies, and verbalised less than a comparison sample. The mothers of the pre-term infants used fewer statements and more imperatives than mothers of full-term infants. Thus it can be seen that differences may exist between full-term and pre-term infants in their interactions with their mothers.
It may not be simply differences in the infant's behaviours which affects how the mother interacts with them, but also the mother's perception of the infants behaviour. Stern and Karraker (1988) demonstrated that when mothers of premature infants were shown videotapes of 9 month old full term infants either labelled as premature or full-term, the mothers perceived the infants labelled as premature, as littler, finer featured, weaker, more passive and slower than infants labelled as full-term. In a study by Levy-Shiff et al (1989) mothers of pre-term infants perceived their infants as more difficult than normal infants and this increased over time. They also showed that maternal concern and perception of the infant as being difficult were likely to be associated with increased parental involvement in active behaviours (Levy-Shiff et al 1989).

Despite the differences between full and pre-term infants in their early interactions, most studies have found little impact of prematurity on the security of attachment (Brown & Bakeman 1980; Minde Corter & Goldberg 1984; Macey, Harmon & Easterbrooks 1987). This is consistent with Belsky's process model of parenting which claims that of the three determinants of parental functioning the subsystem of child characteristics has the least impact. Consequently premature birth does not compromise subsequent development when rearing takes place in homes where personal resources and support systems are still likely to function effectively (Sameroff & Chandler 1975) Thus, as the transactional model of development suggests the
ecological contexts and the individuals ongoing interactions within them are more predictive of developmental outcome than is the presence of some specific risk status (Sameroff & Chandler 1975). Therefore the caregiving system should be robust and flexible enough to accommodate a wide range of infant characteristics. Parents are able to adapt to the unique set of characteristics provided by their pre-term infants to promote sensitive interactions and thereby secure attachment. This interpretation is supported by the writings of Goldberg, Perotta, Minde & Corter (1986) in addition to Sameroff & Chandler's transactional model (1975).

(ii) Characteristics of the parents

Research on child maltreatment indicates that parenting may be influenced by enduring characteristics of the individual, characteristics that are partly a result of a person's developmental history. Detailed observational studies of very young infants reveal that cognitive-motivational competence and healthy socio-emotional development are promoted by attentive, warm, stimulating, responsive and non-restrictive caregiving (Belsky, Lerner & Spanier 1985). The literature linking personality and parenting indicates that personal maturity, psychological well-being and growth-facilitating parenting covary with each other (Belsky 1984). If age is taken as an indicator for maturity then the observations that primiparous mothers interact with their young
infants in a more positively affectionate, stimulating and sensitive manner the older they are (Ragozin, Basham, Crnic, Greenberg & Robinson 1982) provides some evidence for the relationship between personality and parental functioning. More evidence of the influence of personal psychological attributes on parental functioning can be found in the studies on psychologically disturbed parents. For example depressed mothers were shown to offer a disruptive, hostile, rejecting home environment to their children which undermined child functioning (Orraschel, Weisman & Kidd, 1980).

Belsky's model assumes that linkages between parents' psychological well-being and their parental functioning can be traced back to some extent to their own childhood experiences. Another group of authors has emphasised abnormal previous life experience of parents who inadequately care for their children (Hunter, Kilstron, Kraybill & Loda, 1978; Kempe & Heffer 1972). These investigators point out the high incidence of abuse and neglect that abusing parents experience during their own childhood and the lack of adequate present support systems for these parents.

Rutter and Quinton's (1985) long term study of parenting behaviour of mothers raised in care showed that girls who had shown emotional or behavioural disturbance in middle childhood were the ones most likely to be showing social impairment or parenting problems in later life. However severe childhood adversities do not have a once-and-for-all effect on
psychosocial functioning. They argue that the process of development continues well past the childhood years and that good experiences in adulthood can do much to reduce the ill effects of serious and prolonged adversities in childhood. Adverse childhood experiences and genetic predisposition are likely to be much more important in the origins of parenting problems that constitute part of a broader social impairment than in the origins of isolated parenting difficulties in the context of generally satisfactory social functioning.

Rutter and Quinton's findings portray a fluid view of the developmental process with both continuities and discontinuities in socio-economic development, but with most links indirect rather than direct. Childhood experiences had a powerful effect on the choice of spouse and the characteristics of the spouse which in turn had a strong effect on the quality of parenting. The adverse childhood experiences had left the women without the necessary resilience, emotional resources or social coping mechanisms to deal successfully with later life hazards.

Parenting constitutes a specific type of social relationship which is part of a broader set of social qualities (Rutter 1983). Socio-economic status may be a mediating factor on the effects of a premature birth because the developmental consequences of prematurity are more severe for children from
lower than from higher SES families (Sameroff & Chandler 1975, Sigman & Parmelee 1979).

(iii) Social Support and the Marital Relationship

The influence of stress and social support on an individual's physical and psychological well-being has been studied extensively and has demonstrated the role of social support as a coping resource and a protective factor during times of stress (Mueller 1980). Within families of normal children the evidence suggests that social networks affect parenting attitudes and behaviours, which in turn directly and indirectly influence children's development (Bronfenbrenner & Crouter 1983; Cochran & Brassard 1979).

In one study, Crnic, Greenberg et al (1983) reported that mothers who received social support from a variety of sources had more positive attitudes towards their infants, both full term and pre-term. This finding agrees with previous work where maternal social support was significantly related to security of the mother-infant attachment at 12 months (Crockenberg 1981). Similarly, in another study the availability of social support has been shown to play a role in how well parents adapt to the problems associated with caring for high risk infants (Afflek, Tennen, Allen & Gershman 1986; Crnic, Greenberg & Slough 1986). High levels of social support have also been related to better maternal health status and fewer psychiatric
symptoms in mothers of full-term babies (Carveth & Gottleib 1979).

Furthermore, maternal stress and support measured 1 month after a high risk premature infants were released from hospital, were found to be related to parenting, parent-infant interactive behaviour, and infant social and emotional functioning across the first year of life (Crnic, Greenberg & Slough 1986). The authors suggest that during early infancy, when the neonatal crisis of prematurity has not yet been resolved fully, both mothers and infants are more sensitive to the impact of stresses and are more responsive to their available supports because of the high risk nature of their infants and their own parenting of their infants. Consequently the impact of events that occur during this time may have long-term effects both for the mother and the infant, primarily as a function of their occurrence during a time of vulnerability.

Cochran & Brassard (1979) have suggested that social support networks outside the nuclear family influence parental attitudes and behaviour which in turn have both a direct and an indirect effect on child development. In addition it has been found that mothers needing more support found it more difficult to obtain the support they needed from family and friends (Affleck et al 1989).
Several studies have found that emotional support from a spouse had the most powerful effects on positive post-partum adjustment in the transition to parenthood (Wandersman 1980; Crnic et al 1983). Similarly, parents who gain emotional support from a satisfying marriage are likely to be able to interact more sensitively with their infants (Belsky 1981; Goldberg & Easterbrooks 1984). The birth of a premature infant is a potential strain on the marital relationship because it presents a violation of parental expectations and may stress emotional and financial resources (Leiderman, Leifer, Seashore, Barnett & Grobstein 1973; Leifer et al 1972). For example Leiderman et al found a higher incidence of divorce among parents of premature infants than among a full-term comparison group, particularly when parents were not allowed to visit their infants. The marital relationship can play an important role in how a family copes with a premature birth. Minde, Morton, Manning and Hine (1980) found that women who reported good relationships with the infant's father were more active with their infants both while the baby was hospitalised and at home. Similarly, intimate support at one month post discharge provided by the mother's spouse or partner was the most powerful predictor of both mother and infant functioning at 12 months (Crnic, Greenberg & Slough 1986). This provides support for Belsky's (1981,1984) argument that the marital relationship is a critical determinant of competent parenting and subsequent child development.
Social support has therefore been shown to have an effect on infant as well as maternal functioning. Research indicates that the effects of support and stress are likely to be mediated through the mother's attitudes and interactive behaviour (Crnic, Greenberg, Ragozin, Robinson & Basham 1983, Levitt et al., in press), rather than the influence of her social network. This provides evidence for Belsky's model of parenting as well transactional models within high-risk populations (Sameroff & Chandler 1975)

2. The effects of early separation on later parenting

A number of studies have been undertaken in which the progress of groups of separated and non-separated infants and their mothers have been compared. The first study was carried out by Klaus and Kennell (1976) but this has been followed by other studies (Seashore et al. 1973, de Chateau and Windberg 1977).

The ethological theory which is based on the work of Bowlby (1969) suggests that there is a sensitive period during which a mother is especially ready to form a good relationship with her baby. It was therefore suggested that the events which occur in the immediate post-partum period can have a substantial influence on parental behaviour and thus on subsequent child development. According to Klaus and Kennell the intimate mother-infant contact in the post partum 'sensitive' period gives rise to a host of innate behaviours. They claim that "a cascade of reciprocal interactions begins
between mother and baby (which) locks them together and mediates further development of attachment" Klaus & Kennell 1976). This idea was supported by a number of studies which claimed that mothers who had a greater or lesser amount of contact with their babies in the period following birth showed some differences in later maternal behaviour. Klaus and Kennel (1976) argued that separation of mother and baby during the first 3 days after delivery has an adverse effect from which a permanently damaged relationship might ensue. They postulated that increased interaction during this period facilitated good mothering.

These theories have since been seriously criticized because of their theoretical and empirical shortcomings. For example Lamb (1983), in his critical review of Klaus and Kennels work, has cited much evidence against the sensitive period hypothesis. Klaus and Kennel's claims regarding the existence of a sensitive period was based on evidence concerning the hormonal determinants of maternal behaviour in rodents (Lamb 1978) and on a sensitive period for maternal acceptance in ungulates (Gubernick 1980, Klopfer 1971). The animal literature provides no strong grounds for the hypothesis that hormonal triggers play an important role in the initiation of maternal behaviour or that a critical or sensitive period exists shortly after birth during which the mothers need to imprint upon their young (Lamb 1983). Hormonally based sensitive periods appear to occur only in species whose social organisation, reproductive patterns and infant characteristics are very different from our
own. Apart from the weak theoretical basis, the empirical evidence is inconclusive. At best the literature appears to suggest that early contact may have immediate positive effects but that long term effects occur less reliably. Furthermore the studies have many methodological problems, for example they have not been replicated and have used different measures. Lamb (1983), in his review of this work, concludes that early contact is shown in some circumstances to effect some mothers. Most of the studies emphasising the lack of early mother-infant contact in relation to later mother infant interaction were done more than a decade ago, when neonatal nurseries were still unlikely to involve parents in the day-to-day care of their premature infants (Klaus & Kennell, 1970; Leifer et al 1972). More recent work suggests that the effect of early contact is short lived and has no lasting effects on the mother-infant relationship (Lamb & Hwang 1982).

Therefore, recent research does not support the idea that brief episodes are likely to have long-term direct effects on the child and frequent attempts to find support for various sensitive periods have been largely unsuccessful (Rutter 1972). It is much more plausible to argue that single events can have relatively long-lasting effects on parental attitudes and behaviour towards their children and that such events are likely to be particularly potent when adults are making the transition to parenthood and are first evolving a mode of initiation and response to their babies. Therefore since styles of parenting
and caretaking will have a profound effect on a child development, single events acting indirectly through the parents attitude and behaviour could have very important long term effects for children.

3. Anxiety in mothers of premature infants

Although numerous studies have reported levels of high anxiety in mothers of preterm infants (Harper et al 1976; Jeffcoate et al 1979; Trause & Krammer 1979) others do not (Bidder et al 1974; Scheiner et al 1985). This discrepancy may be due to variation in when the anxiety was measured, differences in the conceptualisation of anxiety, or populations studied.

Trause & Krammer (1983), using the Parental Perception Inventory, studied postpartum distress in parents of term and pre-term infants. They found that parents of pre-term infants were more distressed in the first week following the infant's birth than parents of term infants. However, by the time the infants in both groups had been home 1 month, mothers of full-term infants reported more distress. At 7 months post-discharge there were no differences in reported distress between mothers of pre-term and full-term infants. The authors speculated that the mother of preterm infants had resolved their initial shock and had adjusted to the realities of caring for their infants at 1 month post-discharge while mothers of term infants were
still adjusting to the fact that child care involves more than they had anticipated.

Choi (1973) studied 20 mothers of premature infants who were matched with 20 mothers of term infants on the basis of race, sex of infant, hospital of birth, parity, and maternal age. She found that mothers of premature infants experienced significantly higher levels of depression and anxiety than mothers of term infants 3 to 5 days after delivery. Blumberg (1980) found that a woman's characteristic anxiety level and her more specific attitude towards the maternity cycle are both predictive of her level of post-partum anxiety. He concludes that a positive attitude towards pregnancy and a positive post-partum adjustment may reflect a sense of emotional well being.

Researchers have identified a number of variables associated with anxiety and these are discussed below.

(i) Changes over Time

Brooten et al (1988) found that mothers of preterm infants were significantly more anxious before their infants were discharged than they were when their infants were 9 months old. This finding supports the work of Trause and Krammer (1983) who found less distress at 1 and 7 months postdischarge in mothers
of pre-term infants than in the week following the infants' birth.

Other studies have shown that anxiety over a pre-term infant may have longer term consequences. For example Jeffcoate, Humphrey and Lloyd (1979) studied 17 families pre-term infants and 17 families of term infants and found that parents of pre-term infants were more anxious than parents of term infants a year after the baby was born particularly regarding decisions such as whether or not to leave the child with a baby sitter.

(ii) Parity

In addition to comparisons of affect between mothers of term and pre-term infants, multiparas have been found to be more emotionally prepared than primparas and to experience more stable emotional response to childbearing (Gruis 1977). However other studies have found no relationship between affect and parity (Handley, Dunn, Waldron & Blake 1980; Brooten, Gennaro et al 1988).

(iii) Maternal Age

Blumberg (1980), using the State Trait Anxiety Inventory, found that young mothers of high risk infants had higher anxiety levels than older mothers of comparably ill infants. However,
Brooten et al (1988) found no difference in anxiety between younger and older mothers.

(iv) Illness in the infant

Harper et al (1976) reported higher parental anxiety with increasing severity of illness. Similarly Blumberg (1980) showed that neonatal risk was significantly related to post-partum anxiety. He found that mothers of infants at higher levels of risk, relative to other mothers, experienced increased levels of depression and anxiety and more negative perceptions of their babies during the early post-partum period. The high levels of anxiety following the birth of a high risk baby was independent of previous mental health.

(v) Summary

There is considerable amount of discrepancy in the literature on anxiety in the mothers of preterm infants. However what seems to come across is that mothers of preterm infants are more anxious than mothers of full term infants, atleast in the few weeks post-partum and the anxiety seems to diminish over time. There seem to be no conclusive findings about what other factors influence the levels of anxiety in mothers of preterm infants.
4. Maternal Confidence

There have been very few studies looking specifically at maternal confidence in her ability to cope with her infant in mothers who have had premature babies. In one study (Jeffcoate, Humphrey & Lloyd 1979) which compared 17 mothers of preterm infants with 17 mother of term infants, it was found that although first-time mothers in both groups were nervous of handling their babies at first, 91% of the control group first-time mothers were confident by the time they took their babies home, while only 50% of first-time mothers of pre-term babies were confident at this time. Similarly Seashore et al (1973) found that separation had a negative effect on maternal self-confidence, but that those initially low in self-confidence were most vulnerable to this effect. Leifer et al (1972) suggested that mothers who handled their babies in incubators and who had participated in their care felt more confident of being able to look after them and felt emotionally closer to their infants in the first few weeks after discharge. One study by Bullock and Pridham (1988) looked at maternal confidence in 49 mothers of healthy newborns at 30 and 90 days after the infant's birth. It was found that the infants mood was most frequently reported either as a source of confidence or uncertainty at both 30 and 90 days. Furthermore infant's response to care as a source of confidence or uncertainty was positively related to perceived competence.
5. Summary of the literature review

This consideration of the evidence published to date, in the light of Belsky's model, suggests that there are behavioural differences between pre-term and full-term infants. The pre-term infant tends to be less organised, less alert and communicate less clearly than full-term infants (DiVitto & Goldberg 1979, Myers et al 1985). The deficits in responsiveness can affect how the mother interacts with the infant. Mothers of pre-term babies have been shown to be more anxious (Trause & Kramer 1983) and less confident (Jeffcoate Humphrey and Lloyd 1979) than mothers of full-term infants. The availability of social support has shown to relate to parenting and the mother's emotional well-being. Support can act as a buffer against the stress.

The aim of the present study is to examine the effects that the pre-term baby has on the mother's emotional state.
6. Hypothesis

The preceding sections have given an overview of some of the relevant research. On the basis of the findings it is proposed that :

(1) The mothers of pre-term infants will be less confident in their care-taking abilities than mothers of full-term infants measured one week after returning home.

(2) The mothers of pre-term infants will be more anxious than mothers of full-term infants, measured at one week after returning home.

(3) Mothers of pre-term infants will perceive their infants as less responsive and less alert than mothers of full-term infants.

(4) Levels of anxiety and confidence will be related to perceived social support.

(5) Differences between mothers of pre-term infants and mothers of full-term infants in terms of anxiety and confidence will diminish over time.

(6) Differences between the perceptions of mothers of pre-term and full-term infants will diminish over time.
METHOD

1. Sample

Recruitment criteria

Three groups of mothers were included in this study: -

Group 1 mothers of pre-term infants assessed at 1 week and 5 weeks post-discharge.

Group 2 mothers of full-term infants assessed at 1 week and 5 weeks post-discharge.

Group 3 mothers of pre-term infants assessed when their infants are at the same gestational age as those in group 2.

Time since discharge is controlled by comparing Group 1 with Group 2. Gestational age of child is controlled by comparing Group 1 with Group 3.

Mothers in all three groups were matched for age and parity of their infant.

General recruitment criteria for all mothers were as follows: -

- given birth at Kingston hospital
- aged between 19-35
- married/cohabiting
- no mental/physical handicap or congenital abnormalities.

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Those for the infant:
- singleton
- no physical or neurological defects

The specific recruitment criteria for each group were as follows:

**Group 1**
- infants of less than 38 weeks gestation
- admitted to the neonatal unit for more than 24 hours.

**Group 2**
- infants of 39-41 weeks gestation
- not admitted to the neonatal unit.

**Group 3**
- infants of less than 38 weeks gestation
- admitted to the neonatal unit for more than 24 hours.

**Final Sample Composition**

Of the 31 mothers who were approached 29 agreed to participate in the study.
Characteristics of the final sample

Table 1 Age characteristics of the sample

<table>
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<th>Mean Age</th>
<th>S.D</th>
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<td>24 - 37</td>
<td>12</td>
</tr>
<tr>
<td>Group 2</td>
<td>29.58</td>
<td>4.27</td>
<td>22 - 38</td>
<td>12</td>
</tr>
<tr>
<td>Group 3</td>
<td>26.60</td>
<td>3.98</td>
<td>20 - 30</td>
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</table>

Table 2 Characteristics of the sample in terms of Parity

<table>
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<th>2nd born</th>
<th>3rd born</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Group 2</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Group 3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>10</td>
<td>5</td>
<td>29</td>
</tr>
</tbody>
</table>
Table 3 Characteristics of the sample in terms of gestation

<table>
<thead>
<tr>
<th>Group</th>
<th>Mean</th>
<th>S.D</th>
<th>Range</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td>36.08</td>
<td>1.73</td>
<td>32-37</td>
<td>12</td>
</tr>
<tr>
<td>Group 2</td>
<td>39.58</td>
<td>0.52</td>
<td>39-40</td>
<td>12</td>
</tr>
<tr>
<td>Group 3</td>
<td>35.60</td>
<td>2.51</td>
<td>32-37</td>
<td>5</td>
</tr>
</tbody>
</table>

2. Measures

A. The Mother and Baby Scale (MABS)

The Mother and Baby Scale was developed by Wolke and St. James Roberts. The MABS III was based on the MABS I which was developed from the exploratory Mother and Baby Questionnaire (MABQ) (Wolke, 1983; Wolke and St James-Roberts, 1983; St James-Roberts & Wolke, 1983;1984) The MABS III consists of 5 sections incorporating 3 different response formats (specific behaviour ratings, global behaviour ratings, diary type measures).

For the purpose of the study a 53 item questionnaire was developed based on the MABS III. The questionnaire has 6
subscales measuring infant behaviour and 3 subscales measuring maternal behaviour. The infant behaviour subscales can be divided into Specific Behaviour Ratings:

I. Unsettled/Irregular (15)
II. Irritable during Feeds (6)
III. Alertness and Responsiveness (7)

and Temperament Impression Ratings:

I. Easiness (3)
II. Regularity (3)
III. Easy-Alert Feeder (3)

The Maternal Behaviour Subscales can also be divided into Specific Behaviour Ratings:

I. Lack of Confidence in Caretaking (9)
II. Maternity Blues (4)

and Global Ratings:

I. Global Confidence (3)

Mothers were asked to describe specific aspects of behaviour during the last 24 hour period, using six-point ratings. The Specific Behaviour Ratings are answered on a scale from 0 to 5, where 0 signifies 'not at all' and 5 signifies 'very much/often.

The Temperament Impression and Global Ratings do not refer to a particular time period. The aim is to obtain mothers' general view or impression of their infants' characteristics. Items such as 'Overall how alert and responsive is your baby' are
answered on a six-point rating scale, with the poles anchored by opposing adjectives (very drowsy-very alert).

The scale has been validated with a sample of 209 mothers and newborns, and examination of the reliability and discriminant validity of maternal ratings is described in St. James-Roberts and Wolke (1983, 1984). Descriptive statistics and internal consistency coefficients for each of the subscales are shown in the Appendix I. The questions under each sub-scale heading are listed in the Appendix II.

B. The State-Trait Anxiety Inventory (STAI).

The State-Trait Anxiety Inventory was devised by Speilberger, Gorsuch and Lushene (1970). It comprises of separate self-report scales for measuring state and trait anxiety. State anxiety scale consist of twenty items that evaluate how the respondent feels "right now, at this moment". The trait anxiety scale consists of twenty statements that assess how people "generally" feel. The state anxiety scale measures feelings of apprehension, tension, nervousness and worry. Trait anxiety refers to relatively stable anxiety. Each item is rated on a 4-point scale measuring intensity of anxiety.
C. The Perceived Support Network Inventory

The Perceived Support Network Inventory was developed by Oritt, Paul and Behrman in 1985. The scale can be used to obtain 'perceived network size' which is the number of supportive network members that a person believes is available during times of stress. The inventory then measures 6 variables relating to the network described: - Initiation, Availability, Satisfaction, Multidimensionality, Reciprocity and Conflict. The first is the initiation of support-seeking behaviours which is a measure of the extent to which an individual actively solicits support from network members during stressful times. The second is the 'perceived availability of support' which refers to the perception of how readily available network members are for providing support during those times. The third variable is 'satisfaction with support' which is viewed as the personal gratification resulting from the perceived effectiveness of the network members in reducing stress and restoring emotional and instrumental equilibrium. The fourth variable is termed 'multidimensionality' and refers to the number of types of support an individual believes she might expect to receive from a network member during a stressful event. The fifth variable, 'perceived support reciprocity' is the extent to which an individual believes reciprocity of support exists between her and the support network. Finally, the 'perceived network conflict' is the extent to which an
individual believes conflict exists between her and the members of the support network

3. Procedure

Before the study commenced it was given the approval of the ethical committee. The name, address and telephone numbers of each of the mothers in Group 1 and Group 3 was obtained from the admission book on the neonatal unit. Every mother whose infant was admitted to the neonatal unit and who fulfilled the criteria was approached. The names of mothers in Group 2 were obtained from the maternity ward. The subjects in this group were chosen to match those in group 1 in terms of age and parity.

Each mother was approached by telephone was asked if she would like to participate in the study. If she agreed a time was arranged for the interviewer to visit her at home.

The first 12 mothers of the premature infants who agreed to participate in the study were placed in group 1 and the remaining 5 were placed in group 3. There were only five subjects in group 3 because of the time constraints of the study.
In the case of Group 1 and 2 the author visited one week after the infant had been discharged from hospital. This time was chosen since it was thought that the mother would still be coping with the shock of getting home yet be settled enough to be able to be interviewed. In the case of group 3 the author visited when the infant was at the same gestational age as those in group 2.

During the first interview the mother, with the help of the author, completed an Information sheet, a Mother and Baby Scale, a Perceived Support Network Inventory and a State-Trait Anxiety Inventory.

The second assessment took place one month after the first visit. This interval was chosen as the greatest interval that could be practically implemented within the constrains of the present study. During this visit the Mother and Baby Scale and the State Trait Anxiety Inventory were completed.

4. Statistical Analysis

For the main part of the statistical analysis only Group 1 and 2 will be used in the comparisons since these two groups were matched for age and parity. The means scores of each group on the maternal and infant subscales will be compared using t tests. The relationships between the subscales will be compared using the Pearson's Product Moment Correlation Coefficient.
RESULTS

Comparison of the pre-term and the full term groups.

1. Background Information

During the main part of the results section the analysis will concentrate only on Group 1 and Group 2 only since the subjects in these groups were matched for maternal age and parity.

The mean maternal age, parity, weight of the infant and time spent in the neonatal unit are shown in table 1 below. As would be expected there are no significant differences in the maternal age and parity of between the two groups. There are significant differences ($P < 0.01$) between the two groups in the infant's weight and gestation.

The two groups were compared on the sex of the infant, using $\chi^2$ statistic. The results are shown in table 2 below. There is no significant difference between the two groups in terms of the sex of the infant.

The two groups were compared on whether they had had a caesarean birth. The results of the analysis are shown in Table 2. A significantly greater proportion of the pre-term group had had a caesarian birth when compared to the full-term group.
### Table 1

Mean and standard deviations of maternal age, infant's birthweight, parity and time spent in the neonatal unit.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>S.D</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Age</td>
<td>Group 1</td>
<td>12</td>
<td>29.42</td>
<td>4.14</td>
<td>-0.10</td>
</tr>
<tr>
<td></td>
<td>Group 2</td>
<td>12</td>
<td>29.58</td>
<td>4.27</td>
<td></td>
</tr>
<tr>
<td>Infant Weight</td>
<td>Group 1</td>
<td>12</td>
<td>2.85</td>
<td>0.45</td>
<td>-3.92</td>
</tr>
<tr>
<td></td>
<td>Group 2</td>
<td>12</td>
<td>3.76</td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>Parity</td>
<td>Group 1</td>
<td>12</td>
<td>1.67</td>
<td>0.78</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group 2</td>
<td>12</td>
<td>1.67</td>
<td>0.78</td>
<td></td>
</tr>
<tr>
<td>Gestation</td>
<td>Group 1</td>
<td>12</td>
<td>36.08</td>
<td>1.73</td>
<td>-6.72</td>
</tr>
<tr>
<td></td>
<td>Group 2</td>
<td>12</td>
<td>39.58</td>
<td>0.52</td>
<td></td>
</tr>
<tr>
<td>Days spent in neonatal unit</td>
<td>Group 1</td>
<td>12</td>
<td>7.67</td>
<td>7.31</td>
<td>3.63</td>
</tr>
<tr>
<td></td>
<td>Group 2</td>
<td>12</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

Group 1 = The pre-term group  
Group 2 = The full-term group

### Table 2

The number of male and female infants in each group.

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>$X^2$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Pre-term group</td>
<td>8</td>
<td>67</td>
<td>4</td>
<td>33</td>
<td>12</td>
</tr>
<tr>
<td>Full term group</td>
<td>6</td>
<td>50</td>
<td>6</td>
<td>50</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>58</td>
<td>10</td>
<td>42</td>
<td></td>
</tr>
</tbody>
</table>

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Table 3
The pre-term and full-term groups compared on the type of birth

<table>
<thead>
<tr>
<th></th>
<th>Caesarean Birth</th>
<th>Vaginal Birth</th>
<th>Total</th>
<th>$X^2$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Pre-term group</td>
<td>6</td>
<td>50</td>
<td>6</td>
<td>50</td>
<td>12</td>
</tr>
<tr>
<td>Full-term group</td>
<td>1</td>
<td>8</td>
<td>11</td>
<td>92</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>29</td>
<td>17</td>
<td>71</td>
<td></td>
</tr>
</tbody>
</table>

2. Maternal subscales

2.1 Confidence and Anxiety

On the basis of previous research it was proposed earlier that:

1) The mothers of pre-term infants will be less confident in their care-taking abilities than mothers of full-term infants measured one week after returning home.

(2) The mothers of pre-term babies will be more anxious than mothers of full-term babies, measured at one week after returning home.

The mothers of premature babies (group 1) were compared to mothers of full-term babies (group 2) on the specific and global behaviour rating scales using the t-test statistic. The
results are shown in table 4 below. There were no significant differences between the two groups on measures of lack of confidence in caretaking and global confidence at either one or five weeks post-discharge.

The two groups were compared on anxiety levels as measured by the state-trait anxiety inventory. The t-test statistic for the comparison is shown in table 4 below. There were no significant differences in anxiety between the two groups at either one or five weeks post-discharge.

The hypothesis that mothers of pre-term infants will be less confident and more anxious than mothers of full-term babies is not supported.

2.2. Changes over Time

Analysis of covariance was performed in order to assess whether there was any difference between the scores of the pre term group and the full term group over time. A summary of the analysis is shown in table 4. It is shown that there is no significant difference between the groups on changes in all measures of maternal and infant behaviour over time.
### Mean and Standard Deviations of Full term and Preterm subscale results.

<table>
<thead>
<tr>
<th>Infant Subscales</th>
<th>One Week Post Discharge (T1)</th>
<th>Five Weeks Post Discharge (T2)</th>
<th>TI</th>
<th>T2</th>
<th>ANOVA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>S.D</td>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>Irriteed</td>
<td>12</td>
<td>7.2500</td>
<td>5.659</td>
<td>12</td>
<td>6.0000</td>
</tr>
<tr>
<td>UI</td>
<td>12</td>
<td>16.9167</td>
<td>14.035</td>
<td>12</td>
<td>25.1667</td>
</tr>
<tr>
<td>Alert</td>
<td>12</td>
<td>22.5833</td>
<td>7.103</td>
<td>12</td>
<td>24.6667</td>
</tr>
<tr>
<td>Setul</td>
<td>12</td>
<td>11.1667</td>
<td>2.250</td>
<td>12</td>
<td>9.7500</td>
</tr>
<tr>
<td>Easy</td>
<td>12</td>
<td>11.3333</td>
<td>3.132</td>
<td>12</td>
<td>11.5000</td>
</tr>
<tr>
<td>Essalt</td>
<td>12</td>
<td>11.0000</td>
<td>3.075</td>
<td>12</td>
<td>11.7500</td>
</tr>
<tr>
<td>Maternal Subscales</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irriteed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alert</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setul</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Essalt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal Subscales</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confid</td>
<td></td>
<td>Lack of Confidence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matiblue</td>
<td></td>
<td>Maternity Blues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Globocon</td>
<td></td>
<td>Global Confidence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
<td>State Anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trait</td>
<td></td>
<td>Trait Anxiety</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend:**
- **Irriteed**: Irritable during feeding
- **UI**: Unsettled/Regular
- **Alert**: Alertness and Responsiveness
- **Setul**: Regularity
- **Easy**: Easiness
- **Essalt**: Easy-Alert feeder
- **Confid**: Lack of Confidence
- **Matiblue**: Maternity Blues
- **Globocon**: Global Confidence
- **State**: State Anxiety
- **Trait**: Trait Anxiety

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2.3 Relationship between maternal variables

In order to examine the relationship between confidence and anxiety, Pearson Product Moment Correlation coefficients were calculated. The results of this analysis are shown in table 5.

The results of this analysis indicate that at one week post discharge there is a significant correlation between both lack of confidence and global confidence with State anxiety for the pre-term and full-term groups. Similarly there is a significant correlation between both lack of confidence and global confidence and Trait anxiety for the pre-term group only.

At 5 weeks post-discharge there is a significant correlation between lack of confidence and State anxiety for the preterm group only.

Confidence at one week post-discharge is significantly correlated with anxiety four weeks later, for both the preterm and full-term groups.

These results confirm the hypothesis that anxiety and confidence are inversely associated.
Table 5

Pearson Product Moment Correlation Coefficients between Lack of confidence, Global Confidence and Anxiety.

<table>
<thead>
<tr>
<th></th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of Confidence</td>
<td>Global Confidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grp1</td>
<td>.732 **</td>
<td>-.660 **</td>
</tr>
<tr>
<td>Grp2</td>
<td>.608 *</td>
<td>-.567 *</td>
</tr>
<tr>
<td>Trait Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grp1</td>
<td>.668 **</td>
<td>-.594 *</td>
</tr>
<tr>
<td>Grp2</td>
<td>.430-</td>
<td>.431</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grp1</td>
<td>.665</td>
<td>-.597</td>
</tr>
<tr>
<td>Grp2</td>
<td>.588 *</td>
<td>-.700 **</td>
</tr>
<tr>
<td>Trait Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grp1</td>
<td>.534</td>
<td>-.726 **</td>
</tr>
<tr>
<td>Grp2</td>
<td>.588 *</td>
<td>-.646 **</td>
</tr>
</tbody>
</table>

Time 1 = one week post discharge  
Time 2 = five weeks post discharge  
Grp1 = The mothers of pre-term infants  
Grp2 = The mothers of full-term infants  

* p < .05  
** p < .01
2.4 Maternity Blues

The two groups of mothers were compared on measures of maternity blues using the t-test statistic. From table 4 it can be seen that there are no significant differences between the two groups on the measure of maternity blues.

The relationship between maternity blues and confidence were examined using the Pearson Product Moment Correlation. The results of the analysis are shown in table 6 below. Noteworthy are the significant correlations for the mothers of the preterm infants, between the confidence measures at one week post discharge and the maternity blues measure four weeks later.

The relationship between maternity blues and anxiety were examined using the Pearson Product Moment Correlation Coefficients. Table 7 shows the results of this analysis. At one week post discharge maternity blues is significantly correlated with State and Trait anxiety for both the mothers of pre-term and full-term infants. At 5-weeks post discharge maternity blues is significantly related to state anxiety for the preterm group only (at the 0.01 level). However, maternity blues is significantly related to trait anxiety for both groups (at the 0.01 level). For the preterm group only, anxiety one week post discharge is significantly related to maternity blues at 5 weeks post discharge. Similarly, maternity blues at one week post-discharge is related to anxiety 4 weeks later.
Table 6
The relationship between measures of maternal confidence and maternity Blues

<table>
<thead>
<tr>
<th></th>
<th>Time 1 Maternity Blues</th>
<th>Time 2 Maternity Blues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 1</td>
<td>Time 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-terms</td>
<td>NS</td>
<td>0.85 **</td>
</tr>
<tr>
<td>Full-terms</td>
<td>0.57 *</td>
<td>NS</td>
</tr>
<tr>
<td>Global Confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-terms</td>
<td>-0.64 *</td>
<td>-0.82 **</td>
</tr>
<tr>
<td>Full-terms</td>
<td>NS</td>
<td>NS</td>
</tr>
</tbody>
</table>

Table 7
Pearson Product Moment Correlation Coefficients between Maternity Blues and Anxiety.

<table>
<thead>
<tr>
<th></th>
<th>Time 1 Maternity Blues</th>
<th>Time 2 Maternity Blues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Time 1</td>
<td>Time 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-terms</td>
<td>.785 **</td>
<td>.847 **</td>
</tr>
<tr>
<td>Full-terms</td>
<td>.841 **</td>
<td>.220</td>
</tr>
<tr>
<td>Trait Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-terms</td>
<td>.859 **</td>
<td>.846 **</td>
</tr>
<tr>
<td>Full-terms</td>
<td>.712 **</td>
<td>.419</td>
</tr>
</tbody>
</table>

Time 1 = one week post discharge  * p < .05  
Time 2 = five weeks post discharge ** p < .01  

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2.5 The experience of the birth

The mothers were asked to rate whether they felt the birth was a positive or negative experience. The results are shown in Table 8 below. There is no significant difference between the two groups on their experience of the birth.

Table 8

A comparison of the mother's of the preterm and full term infants in terms of how they experienced the birth.

<table>
<thead>
<tr>
<th>Type of experience</th>
<th>Positive</th>
<th>Negative</th>
<th>Total</th>
<th>²</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-term group</td>
<td>7</td>
<td>5</td>
<td>12</td>
<td>3.56</td>
<td>0.06</td>
</tr>
<tr>
<td>Full term group</td>
<td>11</td>
<td>1</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>6</td>
<td>24</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Infant Behaviour

It was hypothesised that: Mothers of pre-term babies will perceive their babies as less responsive and less alert than mothers of full term babies.

The mother's perception of her baby on a number of subscales was compared between the two groups. The t-test values are shown in Table 4. There were no significant differences found between the behaviour of the infants in the preterm and the full term groups.
The hypothesis that the mothers perceive pre-term infants as more irritable and less responsive than full-term infants is not supported.

In order to examine the relationship between different subscales of infant behaviour the Pearson Product Moment Correlation coefficients were calculated. Table 9 shows the correlation coefficients for the different measures of infant behaviour.

Noteworthy is the fact that there are a greater number of significant correlations between measures of the infant's behaviour at Time 1 and infant's behaviour at Time 2 for the full-term group when compared to the pre-term group. This indicates a greater continuity of behaviour in the case of the full-term group.

At one week post-discharge there are strong correlations between the subscales of "irritability during feeding", "easiness" and "unsettled/irregular". Alertness and responsivness at one week post discharge is significantly correlated with the same measure four weeks later for both groups indicating that this behaviour is relatively constant. Likewise regularity and easy, alert feeding at one week post discharge is strongly associated with the same measure four weeks later, but only in the case of the full term group. Irritability during feeding, one week post-discharge, is negatively associated with regularity, easiness and easy/alert feeding four weeks later in the case of the full-term
**Table 1**

**Pearson Correlation Coefficients between different measures of Infant behaviour**

<table>
<thead>
<tr>
<th>Infant Characteristics</th>
<th>Time 1</th>
<th>Time 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IF</td>
<td>UI</td>
</tr>
<tr>
<td><strong>Irritable/feeding</strong></td>
<td>Gp1</td>
<td>Gp2</td>
</tr>
<tr>
<td>Gp1</td>
<td>.847**</td>
<td>.584*</td>
</tr>
<tr>
<td>Gp2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unsettled/irregular</strong></td>
<td>Gp1</td>
<td>Gp2</td>
</tr>
<tr>
<td>Gp1</td>
<td>.847**</td>
<td>.584*</td>
</tr>
<tr>
<td>Gp2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Alert/responsive</strong></td>
<td>Gp1</td>
<td>Gp2</td>
</tr>
<tr>
<td>Gp1</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Gp2</td>
<td>-.592*</td>
<td>NS</td>
</tr>
<tr>
<td><strong>Regularity</strong></td>
<td>Gp1</td>
<td>Gp2</td>
</tr>
<tr>
<td>Gp1</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Gp2</td>
<td>-.712*</td>
<td>.530*</td>
</tr>
<tr>
<td><strong>Easiness</strong></td>
<td>Gp1</td>
<td>Gp2</td>
</tr>
<tr>
<td>Gp1</td>
<td>-.912**</td>
<td>-.799**</td>
</tr>
<tr>
<td>Gp2</td>
<td>-.674**</td>
<td>-.665**</td>
</tr>
<tr>
<td><strong>Easy/Alert</strong></td>
<td>Gp1</td>
<td>Gp2</td>
</tr>
<tr>
<td>Gp1</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Gp2</td>
<td>-.511*</td>
<td>NS</td>
</tr>
</tbody>
</table>

**Gp1 = Preterm group**  
* = P < 0.05
group only. Regularity at five weeks post discharge is significantly correlated with all of the other measures of infant behaviour measured four weeks earlier for the full-term group only. Similarly the measure of 'Easy-alert feeder' at five weeks post discharge is correlated with all the other measures, bar one, taken four weeks earlier.

3.1 Gestation, sex, weight, days in neonatal unit.

Table 10 shows the correlation coefficients between measures of infant behaviour and the gestation, time spent in the neonatal unit and weight at birth. Only weight is shown for both the pre-term and the full-term group since it is not appropriate to calculate the other two measures for the full-term group. There is a significant correlation at the 0.01 level between gestation and alertness/responsiveness measured one week after the baby returns home from hospital. Time spent in the neonatal unit was positively correlated with irritability during feeding and negatively correlated with easiness. Weaker correlations were found between weight of the infant at birth and easy/alert feeding one week after discharge. Unexpectedly weight of the infant at birth was positively correlated with irritability during feeding for both the pre-term and full-term group. In the case of the full-term group there was a significant negative association between weight and regularity at one and five weeks post discharge.
Table 10

Correlation coefficients between gestation, weight and time spent in Neo-natal unit with measures of infant behaviour.

<table>
<thead>
<tr>
<th></th>
<th>Gestation</th>
<th>Days in neo-natal unit</th>
<th>Weight</th>
<th>Gp1</th>
<th>Gp2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritable during feeding Time 1</td>
<td>NS</td>
<td>.562*</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Time 2</td>
<td>NS</td>
<td>NS</td>
<td>.564*</td>
<td>.624*</td>
</tr>
<tr>
<td>Unsettled</td>
<td>Time 1</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Irregular</td>
<td>Time 2</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>.627*</td>
</tr>
<tr>
<td>Alert/Responsive</td>
<td>Time 1</td>
<td>.691**</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Time 2</td>
<td>NS</td>
<td>NS</td>
<td>.598*</td>
<td>NS</td>
</tr>
<tr>
<td>Regularity</td>
<td>Time 1</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>-.624*</td>
</tr>
<tr>
<td></td>
<td>Time 2</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>-.556*</td>
</tr>
<tr>
<td>Easy</td>
<td>Time 1</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Time 2</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>-.656*</td>
</tr>
<tr>
<td>Easy/Alert Feeder</td>
<td>Time 1</td>
<td>NS</td>
<td>NS</td>
<td>.662*</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>Time 2</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
</tbody>
</table>

NS = Not significant at the 0.05 level

* = P < 0.05

** = P < 0.01

4.1 Maternal Confidence

Table 11 shows the relationship between the levels of confidence in the mother and the behaviour of the infant. None of the correlations are significant at the 0.01 level. However at the 0.05 level of significance, lack of confidence of the mother one week post discharge is associated with unsettled/irregular infant behaviour for the preterm group and irritability during feeding for the full-term group. Four weeks later it is negatively associated with infant behaviour measures of easy/alertness for both the full-term and pre-term groups. It is associated with infant alertness for the full-term group only.

Global confidence at one week post-discharge is associated with infant measures of alertness and regularity for the pre-term group. At five weeks post discharge it is associated with easy/alertness for the full-term group.

Unsettled/irregular behaviour of the infant at one week post discharge is associated with lack of confidence of the mother four weeks later for both groups. Regularity and easy/alertness at one week post-discharge is negatively associated with lack of confidence of the mother four weeks later in the case of the full term group only.
<table>
<thead>
<tr>
<th>Maternal Characteristics and infant behaviour.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infant Characteristics</strong></td>
</tr>
<tr>
<td><strong>Time 1</strong></td>
</tr>
<tr>
<td>Irritable/feeding</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Unsettled/Irritable</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Alert/responsive</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Regularity</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Easiness</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Easy/Alert</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Time 2</strong></td>
</tr>
<tr>
<td>Irritable/feeding</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Unsettled/Irritable</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Alertness</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Regular</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Easy</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Easy/Alert</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

LC = Lack of confidence  
GC = Global Confidence  
MB = Maternity Blues  
SA = State Anxiety  
TA = Trait Anxiety  
* = P < 0.05  
Gp1 = pre-term group  
Gp2 = full-term group  
NS = Not significant at the 0.05 level
4.2 Maternal Anxiety

Pearson Product Moment Correlation Coefficients were calculated between measures of maternal anxiety and infant behaviour. There was a weak association, for the preterm group, between the infant's alertness measured one week after discharge and 'state' and 'trait' anxiety measured four weeks later. Apart from this, the analysis did not reveal any other significant correlations.

4.3 Maternity Blues

The relationship between maternity blues and infant behaviour are shown in table 11. In the mothers of the full-term infants maternity blues at one week post discharge is positively associated with the infant's irritability during feeding and negatively associated with infant measures of alertness, regularity and easy/alertness. Four weeks later it is associated with unsettled irregular behaviour of the infant for the same group.
4.4 Maternal Age

Pearson Product Moment Correlation Coefficients were calculated between maternal age and infant behaviours, maternal confidence and anxiety. In the case of the pre-term group there was a significant association between maternal age irritability during feeding measured five weeks after returning home ($r = -0.737, P < 0.01$). Weaker correlations were found between maternal age and measures of the infant's regularity ($r = 0.528, P < 0.05$) and easiness ($r = 0.499, P < 0.05$) taken one week after returning home. Four weeks later alertness was found to be correlated with maternal age ($r = -0.616, P < 0.05$).

There were no significant correlations revealed for the full-term group.
4.5 Gestation

Table 12 shows the Correlation coefficients between the gestation of the infant and measures of maternal confidence, anxiety and maternity blues for the pre-term group.

Global confidence measured one week after discharge was found to be associated with gestation at the 0.05 level of significance. 'State' and 'Trait' anxiety are both correlated with gestation the association being stronger when measured at five weeks post-discharge. Maternity blues, measured at one and five weeks post-discharge is associated with gestation.

Table 12
Pearson product moment correlation coefficients between gestation and measures of maternal anxiety, confidence and maternity blues.

<table>
<thead>
<tr>
<th>Maternal Subscale</th>
<th>Time since discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 week</td>
</tr>
<tr>
<td>Lack of confidence</td>
<td>NS</td>
</tr>
<tr>
<td>Global Confidence</td>
<td>.661 *</td>
</tr>
<tr>
<td>State Anxiety</td>
<td>-.552 *</td>
</tr>
<tr>
<td>Trait Anxiety</td>
<td>-.511 *</td>
</tr>
<tr>
<td>Maternity Blues</td>
<td>-.670 **</td>
</tr>
</tbody>
</table>

NS = not significant at 0.05 level
* = P < 0.05
** = P < 0.01
5. Levels of social support

In order to examine whether there were any differences between the pre-term and the full-term group in terms of levels of social support the two groups were compared using t-tests. The analyses are shown in table 13 below. There were found to be no significant differences between the pre-term group and the full term group on all scales of social support.

Table 13
Differences between the Pre-term and the full term group on measures of Social Support

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Pre-term grp</th>
<th>Full-term grp</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Network number</td>
<td>5.167</td>
<td>1.697</td>
</tr>
<tr>
<td>Initiation</td>
<td>4.369</td>
<td>0.793</td>
</tr>
<tr>
<td>Availability</td>
<td>5.905</td>
<td>0.495</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>6.316</td>
<td>0.611</td>
</tr>
<tr>
<td>Multidimensionality</td>
<td>3.133</td>
<td>0.876</td>
</tr>
<tr>
<td>Reciprocity</td>
<td>4.523</td>
<td>1.582</td>
</tr>
<tr>
<td>Conflict</td>
<td>6.393</td>
<td>1.007</td>
</tr>
<tr>
<td>Total Social Support</td>
<td>30.63</td>
<td>3.621</td>
</tr>
</tbody>
</table>
It was predicted that levels of perceived social support would be related to levels of anxiety and lack of confidence. A Pearson's Correlation was performed to test for this relationship. No significant relationships were found between measures of perceived social support and confidence or maternity blues for the pre-term group. However, there was a significant relationship between state and trait anxiety and conflict one week post discharge. A significant correlation was found between the size of the network and the state anxiety, trait anxiety, and maternity blues measured one week post-discharge in the case of the full-term group only. However, this correlation was in the opposite direction to that expected. Also at one week post discharge, a relationship was found between lack of confidence the number of different categories of support they received and the total social support measure. Finally, there was a significant correlation between global confidence and reciprocity. At five weeks post discharge, initiation measured four weeks earlier was inversely related to global confidence and maternity blues.
<table>
<thead>
<tr>
<th></th>
<th>One Week Post Discharge</th>
<th>Five Weeks Post Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>state Anxiety</td>
<td>trait Anxiety</td>
</tr>
<tr>
<td>Network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>grp1</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>grp2</td>
<td>.735**</td>
<td>.824**</td>
</tr>
<tr>
<td>Initiation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>grp1</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>grp2</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Availability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>grp1</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>grp2</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>grp1</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>grp2</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Multidimensionality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>grp1</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>grp2</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Reciprocity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>grp1</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>grp2</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Conflict</td>
<td></td>
<td></td>
</tr>
<tr>
<td>grp1</td>
<td>-.668**</td>
<td>-.581*</td>
</tr>
<tr>
<td>grp2</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Total S.S.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>grp1</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>grp2</td>
<td>NS</td>
<td>NS</td>
</tr>
</tbody>
</table>
Predicting maternal psychological characteristics from infant and background variables.

Since there were few differences between the pre-term and the full term groups in their measures the data was pooled in order to examine how the background variables and the infant's behaviour contribute to the mother's confidence, anxiety and mood.

A multiple regression was performed with each measure of maternal confidence, anxiety and maternity blues as dependant variables. A summary of the analysis is shown in table 15 below. The independent variables were added in a sequence, first gestation alone and then the background variables (parity, social support, age and socioeconomic status), and then the infant variables (alertness, easiness, regularity, irritability during feeding, easy/alertness and unsettled/irregular).

i. Lack of Confidence

The variable gestation on its own made up 4.7% of the variance of the lack of confidence, as indicated by the multiple correlation. When the background variables (i.e. parity, social support, age and socioeconomic status) are included they increase the prediction to 40.8% of the total variance.
When the variables associated with the infant behaviour are included they account for 72% of the variance.

Of the infant variables, the measurement of 'Unsettled/Irregular' had the strongest association with lack of confidence which is significant at the 0.05 level. The correlation between these two variables is significant at the 0.01 level ($r = 0.65$)

ii. Global Confidence

Table 15 shows a summary of the multiple regression analysis of the variable Global Confidence. Gestation alone accounts for 23% of the total variance of global confidence which is considerably greater than that of lack of confidence. When the variables parity, social class, social support and maternal age are included they account for 31% of the total variance. When the infant variables are included they only account for 46% of the total variance.

iii State Anxiety

Gestation alone accounts for only 7% of the total variance of 'state' anxiety. When the background variables are included, they increase the prediction to 32% of the variance. The infant behaviours are added to explain for 56% of the variance.
iii. Trait Anxiety

Gestation accounts for 13% of the total variance. When the background variables are included they increase the prediction to 25%. When the variables associated with the infant's behaviour are included they can explain 49% of the total variance of mother's trait anxiety. Of these variables, the infant being easy/alert seems to be the largest predictor of maternal anxiety (P < 0.05).

iv. Maternity Blues

Gestation alone accounts for only 1.8% of the total variance of maternity blues. Adding the background variables increases the prediction to 18%. When the infant behaviour variables are also included, they account for 48% of the total variance.
**Table 15**

**Multiple regression of the maternal measures of confidence, anxiety and maternity blues.**

<table>
<thead>
<tr>
<th>Background variables</th>
<th>Lack of confidence</th>
<th>Global Confidence</th>
<th>State Anxiety</th>
<th>Trait Anxiety</th>
<th>Maternity Blues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beta</td>
<td>P</td>
<td>Beta</td>
<td>P</td>
<td>Beta</td>
</tr>
<tr>
<td>Gestation</td>
<td>-0.35</td>
<td>0.07</td>
<td>0.44</td>
<td>0.09</td>
<td>-0.22</td>
</tr>
<tr>
<td>Parity</td>
<td>-0.09</td>
<td>0.60</td>
<td>0.13</td>
<td>0.57</td>
<td>0.02</td>
</tr>
<tr>
<td>SES</td>
<td>0.05</td>
<td>0.81</td>
<td>-0.13</td>
<td>0.67</td>
<td>0.02</td>
</tr>
<tr>
<td>Social Support</td>
<td>-0.20</td>
<td>0.32</td>
<td>0.08</td>
<td>0.75</td>
<td>-0.25</td>
</tr>
<tr>
<td>Maternal age</td>
<td>-0.08</td>
<td>0.70</td>
<td>-0.05</td>
<td>0.86</td>
<td>-0.19</td>
</tr>
</tbody>
</table>

**Infant variables**

<table>
<thead>
<tr>
<th></th>
<th>Lack of confidence</th>
<th>Global Confidence</th>
<th>State Anxiety</th>
<th>Trait Anxiety</th>
<th>Maternity Blues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alert</td>
<td>-0.19</td>
<td>0.34</td>
<td>0.32</td>
<td>0.24</td>
<td>-0.31</td>
</tr>
<tr>
<td>Easiness</td>
<td>0.08</td>
<td>0.78</td>
<td>0.28</td>
<td>0.51</td>
<td>-0.15</td>
</tr>
<tr>
<td>regularity</td>
<td>-0.10</td>
<td>0.61</td>
<td>-0.05</td>
<td>0.86</td>
<td>0.22</td>
</tr>
<tr>
<td>Irritable during feeding</td>
<td>-0.08</td>
<td>0.76</td>
<td>-0.33</td>
<td>0.35</td>
<td>0.56</td>
</tr>
<tr>
<td>Easy/alert</td>
<td>0.00</td>
<td>0.99</td>
<td>-0.34</td>
<td>0.38</td>
<td>0.36</td>
</tr>
<tr>
<td>Unsettled/irregular</td>
<td>0.74</td>
<td>0.02*</td>
<td>-0.03</td>
<td>0.94</td>
<td>0.17</td>
</tr>
</tbody>
</table>
DISCUSSION

Consideration of the results from the previous section allows us to draw the following conclusions.

1. There were no differences between the mothers of pre-term and full-term infants on measures of confidence one week after returning home.

2. There were no differences between the mothers of pre-term and full-term infants on measures of anxiety one week after returning home.

3. There were no differences between the two groups of mothers' perceptions of their infant's behaviour at one week post discharge.

4. When the relationship between measures of social support and maternal characteristics were investigated it was found that lack of conflict was related to State and Trait anxiety, one week post-discharge in the pre term group. In the case of the full term group size of the social network was related to State anxiety, Trait anxiety and maternity blues. Total social support was related to lack of confidence.

5. There were no significant differences between the two groups in changes of maternal characteristics over time.
6. There were no significant differences between the two groups in changes of infant characteristics over time.

The finding that there were no significant differences between the two groups on maternal and infant characteristics can be interpreted in two main ways. First, it can be taken to show that the behaviour of the pre-term infant does not differ dramatically from that of a full-term infant, and that there are no real differences between characteristics of the two groups of mothers. Alternatively there may have been methodological faults which masked any differences between the two groups.

Considering the methodological issues first. The reason that the study found no differences between the pre and full term group could be attributed to the fact that the numbers of subjects in the study was small and therefore may not have been representative of the total population. Alternatively the lack of differences could be due to the limitations of the measurement procedures which have led to a misrepresentation of the variables they were supposed to be measuring. Although the State-Trait Anxiety Inventory (STAI) has been well validated, many subjects in this study reported that the questions were unclear. For example 'I am a steady person'. Many of the respondents reported that the questionnaire was phrased in such a way that it was not directly relevant their feelings. Given these observation one has to bear in mind that
the results obtained with some subjects may have to be treated with caution. A further difficulty with the STAI is that the distinction between 'state' and 'trait' anxiety may be difficult to apply so someone who has been through 9 months of pregnancy and has just recently given birth.

Apart from methodological considerations the lack of differences between the two groups may be attributed to characteristics associated with this particular group of mother-infant dyads. The area where the study was conducted is a well resourced and predominantly middle-class area. Although it was not measured systematically, the subjects reported being very satisfied with the service they received from the hospital, and well supported by midwives and health visitors. It seemed that most mothers had been well prepared and the mothers of pre-term infants were very satisfied with the care their infants had been given on the special care baby unit. Babies were only included if they were of relatively good health so mothers in this study did not have to contend with the distress of looking after a very sick infant. Furthermore, all the mothers were in stable relationships and were therefore not burdened by such added stresses as single parenting. All the above factors may have protected the parents from additional pressures which make coping with the newborn baby more difficult.
This absence of difference is not supported by some of the previous studies which have reported higher levels of anxiety in mothers of pre-term infants. For example Choi (1973), and Blumberg (1980) found mothers of premature infants had heightened anxiety and depression in the first post partum week.

In a study by Generrro (1988) it was found that although there were significant differences in anxiety between mother of pre-term and full-term infants this difference diminished over time, such that there were no differences between the two groups during the second to the seventh post-partum week. Similarly, Scheiner et al (1985) found no significant differences between mothers of premature infants and mothers of full-term infants in their mood disturbance, caretaking difficulties or the parent-child relationship. It should be noted that they measured maternal mood when the infants were between 12 and 18 months old, considerably later than the present study.

Trause and Kramer (1983) found that parents of pre-term infants were more distressed than mothers of full-term infants in the first week after birth. They found that distress decreased once the babies were at home. When the babies had been home for one month the full-term mothers were reported to be more upset than the pre-term mothers, however, at 7-months the differences had disappeared.
On the basis of this study and previous findings it could be speculated that the time when the maternal anxiety is measured is the important factor for determining its level. It seems that anxiety in mothers of preterm infants is initially high, especially in the first week post-partum when the baby is still in hospital. In this study, however, the anxiety levels were measured one week after the baby had returned home. Allowing the baby to return home carries with it the implicit statement that the baby is healthy. It may, therefore, be possible to resolve the contradiction between this study and the studies for example of Choi (1973) and Blumberg (1980), by suggesting that once the health of the baby is established the mother experiences no more anxiety than the mother of a full-term child.

A further fact that must be taken into consideration is the risk levels of the pre-term infants. In this study the mean gestational age at birth was 36 weeks and the infants were all otherwise healthy. In Blumberg's (1980) study it was found that anxiety of the mother was related to risk level of the child. It may therefore be expected that any differences between this group of mothers and those of full-term infants would be small.

It was found that there no significant differences between mothers of pre-term infants and mothers of full-term infants in their confidence in caretaking. This result is in contrast with previous researchers who found that mothers of pre-term infants
were less confident than mothers of full-term infants (Jeffcoate Humphrey & Lloyd 1979). One possible reason for this discrepancy may be that the previous study was retrospective in nature. In this study mothers were asked to assess their confidence in handling their infant at the time of discharge, several weeks after the event. A study of this nature suffers from the disadvantage that the information may not be accurate or may have been selectively recalled.

Previous studies have found that pre-term infants are less organised, less alert and communicate less clearly than full term infants (Als & Brazleton 1981). Minde at al (1985) found that premature infants, at four weeks after the expected date of birth, show less motor activity and alertness than do full term babies. This difference was not found in the present study. A number of explanations may be proposed. First, despite the fact that there was no significant difference between the infants behavior in the two groups, it was found that the gestational age at birth of the pre-term group was significantly related to alertness and responsiveness post discharge. Since this study indicated that gestation relates to responsiveness, the absence of difference between the behaviour of the two groups may have resulted from an insufficient difference between the mean gestational ages at birth of the two groups.
Secondly, in the work by Minde et al the infant's behaviour was recorded by an outside observer. It is possible that mother's ratings are based on a global interpretation rather than an analysis of the child's behaviour at a molecular level.

Relationships between different variables

In addition to the comparisons between groups, the analysis also included a more detailed investigation of the relationships between parameters within each group which will be discussed in the next section.

i. Maternal characteristics

Associations were found between anxiety and confidence in the directions expected i.e increasing anxiety was associated with diminishing confidence. At one week post discharge there is a stronger correlation between measures of anxiety and confidence than there is 4 weeks later. One explanation for this could be that at one week post-discharge a large proportion of the mother's anxiety is directly associated with anxiety surrounding the care of the baby. Four weeks later mothers are better able to distinguish between their own general anxiety and anxiety associated with the new born infant. This correlation was found to be stronger in the case of the preterm mothers suggesting that greater stress involved in the
preterm birth makes it more difficult to distinguish between the two sources of anxiety.

Maternity blues is strongly associated with anxiety levels. This is as would be expected from the composition of the questionnaire (see appendix). Interestingly lack of confidence one week post-discharge is related to maternity blues 4 weeks later. Consistent with this is the similar relationship found between lack of confidence one week post-discharge and anxiety 4 weeks later. This may suggest a mother's perception of her confidence about caring for her baby soon after returning from hospital may be predictive of her mood four weeks later.

ii. Infant Behaviour

One week post discharge there are very strong correlations between the subscales of "irritability during feeding", "easiness" and "unsettled/irregular" for both groups of infants. The easiness subscale consists of three general questions about infants irritability, sleep and difficult behaviour. It is interesting that this is such a good predictor of the other two subscales which ask a greater number of more specific questions concerned with feeding and regularity. It seems likely therefore that mothers may perceive the easiness of their child largely in terms of their feeding and regularity.
After four weeks these associations were not so pronounced. One explanation for this may be that as mothers become more familiar with their infant and management of specific problems such as feeding, these behaviours have less impact on her overall impression on the easiness of her child.

When measures of infant behaviour one week post-discharge were correlated with infant behaviour five weeks post-discharge more significant correlations were found in the full-term group compared to the pre-term group. This is particularly apparent in the correlation of all measures of the full-term infant's behaviour one week post discharge with regularity four weeks later, indicating a continuity of behaviour. These results suggest that there is less stability in the behaviour of pre-term infants which may reflect the earlier developmental stage that the pre-term infants were measured.

The number of days in a neonatal unit was related to irritability during feeding. The reason for this may be that the longer the baby had spent in the unit the less familiar the mother was in feeding her infant and the more the infant would have been fed by nursing staff. It follows therefore that once the baby had returned home the mother was more likely to find the feeding of her infant difficult. The relationship was not significant four weeks later indicating that these difficulties do not continue. This is partially confirmed by the inverse
relationship between time spent in the neonatal unit and how easy the mother finds the infant.

Weight of the pre term infant at birth is related to a measure of "easy alert feeder". A possible reason for this could be that the mother whose infant is born with a low birth weight is likely to be more concerned about feeding. There may be two consequences of this; firstly the mothers anxiety may affect the infants feeding behaviour, and secondly since she is very aware about the necessity for her infant to gain weight she may perceive the feeding as more difficult than it is. However four weeks later the direction of the association is reversed i.e. the more the infant weighed at birth the more irritable the infant was perceived to be when feeding.

In the case of the full-term group, a greater weight at birth was related to irritability during feeding, being perceived as unsettled and less regular and easy, at five weeks post-discharge. This is similar to what was observed in the pre-term group at 5 weeks post discharge. A possible reason for this may be that a larger baby may appear to be more demanding and therefore more irritable.
iii. Relationship between Maternal Characteristics and Infant Behaviour

When the relationships between the maternal and infant characteristics were analysed it was found that maternal confidence was related to a number of infant variables. However, one must be cautious in interpreting the results too readily since they are only significant at the 5% level.

In the case of both the full and pre-term infant, it was found that there was a relationship between the child being unsettled and irregular one week post-discharge and lack of confidence in the mother four weeks later. When the multiple regression was performed it was found that unsettled/irregular behaviour was the greatest predictor of lack of confidence. One explanation for this may be that the infant being unsettled and irregular leads to the mother's lack of confidence. This causal relationship assumes that the measures are objective and mutually independent. However a more likely explanation is that the mother's perception of her own confidence and her baby's behaviour is affected by characteristics within the mother. Thus the mother who lacks confidence in her coping ability may perceive her infant's behaviour as more unsettled and irregular or, alternatively, the mother who perceives her infant as unsettled or irregular may feel that she is not coping and thus her confidence may suffer. In order to study this further it
would be necessary to have an outside observer to rate the baby's behaviour to determine if the mothers perceptions are accurate reflections of the behaviour. There have been a few studies which have compared maternal reports of newborn behaviour with researchers measures. Most of these studies show good overall agreement with discrepancies in particular areas. Dunn & Kendrick (1980) found mothers to rate their infants as more active than did observers. St James-Roberts and Wolke (1984) found mothers to underestimate difficult behaviour in the newborn and Field et al two studies found some mothers agree with researcher's measures (Field, Dempsey, Hallock & Schuman 1978), while others did not (Widmayer & Field 1980).

The gestational age at birth was significantly related to global confidence, state and trait anxiety and maternity blues. This confirms the finding by Blumberg (1980) who found that neonatal risk was significantly related to maternal anxiety and depression. However, they did not find a correlation between neonatal risk and pre-pregnant (trait) measures. Although these studies are not directly comparable, gestational age is an important determinant of neonatal risk.

In general, very few of the infant characteristics were found to be related to maternal anxiety. The only significant correlation found was between alertness and responsiveness one week post-discharge and anxiety 4 weeks later in the case of the pre-term group only. It seems, therefore, that the mother
who perceives her baby as responsive one week after returning home is likely to report that she is less anxious four weeks later. It was also found that "easy-alert feeder" was a strong predictor of trait anxiety 1 week post-discharge. This is compatible with the above finding.

The mood of the full-term mothers (as measured by maternity blues subscale) would seem to be more closely associated with their infant's behaviour one week post-discharge than the mood of the pre-term mothers. It must be said that the correlation is only significant at the 5% level and therefore one must be cautious in interpreting the findings. Nevertheless, because of the nature of the premature delivery and the worry over the health of her infant the pre-term mother has different stresses and worries associated with caring for the child in the first week at home. For example she may be relieved that the baby is healthy, or worries over the fact that she may have been separated from her infant while it was in hospital. It is possible that these extra variables may mask the association between the infant's behaviour and maternal mood.

**Social Support**

There were no significant differences between the two groups on all measures of social support. This is consistent with previous findings (Crnic et al 1984, Crnic et al 1984). When the relationship between the measures of social support and
maternal characteristics were investigated different patterns of relationships emerged for each group. In the case of the preterm group a negative correlation was found between lack of conflict and state and trait anxiety. Therefore those mothers who report little conflict with members of the support network also show low anxiety levels. This is as would be expected.

In the case of the full-term group there was a strong association between network size and state and trait anxiety. Network size was a measure of the number of people the mother would approach if she needed support during a stressful time in her life. A possible explanation is that an 'anxious' mother is likely to seek out more sources of support, or is more likely to view acquaintances as sources of support. Interestingly there was no correlation between satisfaction with support and anxiety. Consistent with these observations is the finding that total social support is correlated with lack of confidence. Those mothers who were less confident relied more on others for support.

Much of the previous work in this area has found that social support acts as a buffer against stress. However, in many of these previous studies social support was measured as a predictor of later parental attitudes (Bronfenbrenner & Crouter, Cohran & Brassard 1979) In this study perceived support and maternal characteristics were measured at the same time and it is possible that mother's perception of the support
that she receives may be a reflection of the amount of support she feels she needs which in turn may be related to her emotional state. It is possible that because this study measures perceived support the result may be a reflection of the mothers perceived need for support rather than the support actually received. For example a mother who is anxious and lacks confidence may be more likely to seek out health professionals or relatives as sources of support and are more likely to regard her relationships with them as supportive.
Conclusion

The main conclusion of this study is that, in the groups studied, premature birth does not lead to increased anxiety or reduced confidence in the mother. Possible reasons for this have been discussed. A further possibility that was beyond the scope of this research was that the care provided by this hospital went along way to compensate for the added stresses of prematurity. In order to study this it would be necessary to compare groups of mothers of premature infants from areas with different practices of health care.

One of the most interesting findings of this study is that infant characteristics account for a large proportion of the variance in the lack of confidence in the mother; in particular, unsettled-irregular behaviour was the strongest determinant of this maternal variable. To determine whether there is a causal relationship between these variables would require further study. However, it seems likely that a mother's perception of her infant's characteristics can throw light on her own state of mind. This finding has implications for health care professionals when a mother reports that she is having difficulty in looking after her infant. It is as important to consider the state of the mother as it is to consider the state of the infant. Precisely what the relationship between these variables is remains unclear. It would be of great interest to establish what factors determine the mother's perceptions of her infant's behaviour and how these relate to maternal characteristics.
APPENDIX I

Summary Details of the MABS III

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<th>SD</th>
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<td>1. Unsettled/Irregular (15)</td>
<td>34.5</td>
<td>13.6</td>
<td>.90</td>
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<td>2. Irritable during Feeds (16)</td>
<td>9.4</td>
<td>5.2</td>
<td>.74</td>
</tr>
<tr>
<td>3. Alertness &amp; Responsiveness (7)</td>
<td>29.4</td>
<td>4.7</td>
<td>.77</td>
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<td>B. Temperament Impression Ratings</td>
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<td></td>
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</tr>
<tr>
<td>1. Easiness</td>
<td>13.7</td>
<td>2.9</td>
<td>.79</td>
</tr>
<tr>
<td>2. Regularity</td>
<td>12.1</td>
<td>3.3</td>
<td>.83</td>
</tr>
<tr>
<td>3. Easy-Alert Feeder</td>
<td>10.2</td>
<td>2.7</td>
<td>.72</td>
</tr>
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</table>

Maternal Characteristics

| A. Specific Behaviour Ratings                |     |     |                  |
| 1. Lack of Confidence in Caretaking (9)     | 18.0| 7.1 | .86              |
| 2. Maternity Blues (4)                      | 5.4 | 3.9 | .74              |

B. Global Ratings

| 1. Global Confidence (3)                    | 13.0| 2.9 | .81              |
APPENDIX II

The Mother And Baby Scale III

The item numbers are shown in brackets. R indicates items whose scoring is inverted.

Infant Behaviour Subscales

A. Specific Behaviour Rating Scale

I. Unsettled/Irregular

1. My baby has fussed before settling down (15)
2. My baby has settled quickly and easily (7R)
3. During the last 24 hours I've needed to coax my baby to him/her to settle after a feed (11)
4. My baby has spent whole periods between feeds unsettled or only settled if held (17)
5. To settle my baby I've given him/her a top-up feed (14)
6. In between feeds my baby has been irritable (20)
7. After feeds my baby's mood has been fussing and crying (19)
8. My baby has varied in how easy s/he is to settle (8)
9. My baby's mood after a feed has varied from one feed to another (18)
10. During the last 24 hours my baby's sleeping and waking behaviour has been disturbed by wind/hiccups
11. My baby has fussed or cried at times when I know s/he is not hungry or wet (13)
12. After feeds I've used rocking or cuddling to settle my baby (16)
13. The length of periods between feeds has varied (21)
14. To settle my baby I've given him/her around (12)
15. In between night time feeds my baby was fussing and crying (10)

II. Irritable during Feeds

1. My baby has been irritable during feeding (1)
2. During the last 24 hours my baby has interrupted feeding by fussing and crying (3)
3. During feeds my baby has tended to fuss or cry (6)
4. The mood of my baby during feeds has varied (5)
5. During the last 24 hours my baby has interrupted feeding by wind hiccups or tummy ache (4)
6. During this period feeding has been easy (2R)
III. Alertness and Responsiveness

1. My baby is really alert and attentive (23)
2. My baby watches my face (33)
3. When my baby is feeding s/he gazes into my eyes (37)
4. When I talk to my baby s/he seems to take notice (38)
5. When I play with my baby s/he responds straight away (40)
6. At this age my baby is disinterested in interacting with people (35R)
7. I think my baby is responsive (25)

B. Temperament Impressions Ratings

I. Easiness

1. Overall how irritable is your baby (46)
2. Overall how difficult is your baby (44)
3. Overall how good a sleeper is your baby (53)

II. Regularity

1. Overall how regular are your baby's feeding routines (50)
2. Overall how regular are your baby's sleeping routines (51)
3. Overall how regular is your baby in his/her routines (48)

III. Easy-Alert feeder

1. Overall how alert and responsive is your baby (45)
2. Overall how good a feeder is your baby (49)
3. Overall how easy do you find the feeding of your baby (47)
Maternal Behaviour Subscales

A. Specific Behaviour Ratings

I. Lack of Confidence in Caretaking
1. I've felt confident about looking after my baby (22R)
2. It makes me feel insecure when my baby cries (32)
3. I've felt clumsy in caring for my baby (30)
4. I've felt unsure whether I've been doing the right thing whilst looking after my baby (31)
5. I think I've been coping alright with my baby (24R)
6. I've been feeling anxious (28)
7. Looking after my baby has been more difficult than I expected (34)
8. I cope well with my baby when s/he is unsettled (26R)
9. I think I've been making a good job of being a mother (27R)

II. Maternity Blues
1. I've been feeling lonely (29)
2. My mood has varied more than before my pregnancy (36)
3. I've been feeling weepy and miserable (39)
4. I've been feeling dissatisfied (41)

B. Global Ratings

I. Global Confidence
1. Overall how confident do you feel about coping with your baby (43)
2. Overall how stressful do you find it looking after your baby (42)
3. Generally how anxious a person do you think you are (52)
References


Crockenberg, S., 1981 Infant Irritability, Mother's responsiveness, and social influences on the security of the infant-mother attachment. Child Devlp. 52, 857-865


Quinton, D., & Rutter, M., 1985. Family pathology and child psychiatric disorder: a four year prospective study (pp 91-134)


An investigation into parent's perceptions of the process and outcome of a parent training group with reference to changes in self efficacy

by

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Dissertation submitted for the PsychD Conversion course in Clinical Psychology

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Abstract

This study explored the perceptions of mothers attending a parent training group aimed to help them cope with their children's behaviour problems more effectively. The group ran for six weeks and it was attended by 8 people. The format of the group was based on the collaborative model (Webster-Stratton & Herbert 1994). The principle aim of the study was to explore the parent’s perceptions of the relative helpfulness of various group factors and how these factors affected their own self-efficacy and the interactions with their children. A further aim was to explore how the parent’s perceptions changed during the course of the group. Data were collected before and after the group as well as during the group and analyzed using both quantitative and qualitative methods. The study was designed to test hypotheses concerning these mechanisms.

The mother’s self efficacy was measured before and after the group and it was found that the parents felt more efficacious in their parenting role following the group. Furthermore the parents reported that the group had enabled them to use behaviour management strategies successfully. In addition the parents reported that they were less worried about their children’s behaviour and more confident in handling it. They also reported spending more time enjoying their children following the group.

The parents were asked which aspects of the group they found most helpful after each session and when the group had finished. Generally the aspects that were rated as most helpful were meeting other mothers with similar or worse problems and having space away from the child to talk about parenting. Parents seemed to find the aspects of the group where the group leaders “taught” parenting skills less helpful. Analysis of the data suggested that the increase in self efficacy could primarily be attributed to factors associated with building up contact with other parents.

The extent to which the hypotheses were supported was discussed. The findings are further discussed with reference the future developments of parent training groups.
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Introduction

Prevalence of behaviour problems

Behaviour problems in young children are very common. For example Richman, Stevenson and Graham (1982) in a study of children in Waltham Forest found that 15% of three year olds had mild problems, 6.2% had moderate problems and 1.1% had severe problems. Thirty percent of GP consultations involving children are for behavioural problems, 45% of community child health referrals are concerned with behavioural disorders (Bailey, Graham and Boniface 1978).

Studies examining the prevalence of behaviour problems in pre-school children have generally determined their rates using a specified cut-off score on a standardized behaviour problem checklist for example the Behaviour Checklist (Richman 1977). However, when the level of parental concern about the child’s behaviour was examined it became apparent that the parents perceived the problems as being more severe than suggested by the checklist. This was demonstrated in a study by Stallard (1993) who looked at parental perception of problem behaviour by using an adaptation of the Behaviour Checklist (BCL) which incorporated questions designed to assess the level of parental concern about individual behaviours identified in the checklist. He found that 16% of parents reported a great deal of concern, and 66% expressed some concern about one or more aspect of their child’s behaviour. He comments that this is significantly higher than the 10% of children who would be identified as having behaviour problems using the usual Richman criterion score of 10 or more (Richman 1977). Thus although a standardized checklist of this kind is able to assess whether or not a behaviour exists it does not address the parent’s own perceptions of that behaviour and whether they see it as a problem. This study exemplifies the point that the level of parental concern is highly subjective and is determined by a number of factors in addition to the absolute severity of the behaviour problem.
Stability of behaviour problems

There has been much research to show that behaviour problems are not transitory (Jenkins, Owen, Bax and Hart, 1984; Richman, Stevenson and Graham, 1982). Richman et al (1982) also showed clearly the continuity and persistence of problems in children throughout the early years, with a significant proportion of children (61%) who presented with problems at three years, still presenting with problems at the age of eight. Furthermore, they found that the more severe the behaviour problems the more likely they were to persist. Similarly, Campbell (Campbell et al 1986, Campbell and Ewing 1990) studied two cohorts of hard to manage pre-school children aged 3 and 4. The children were identified via parent complaints that they were inattentive, overactive and difficult to discipline and these reports were confirmed by their teachers. The children were followed up at ages 4, 6, 9, and 13. At the age of 6, 50% of the problem group met criteria for Attention Deficit Disorder or were perceived by the parents to have significant problems as rated on the Child Behaviour Checklist and reported at interview. At the age of 9, 48% of the original problem group met the DSM-III criteria for attention deficit disorder and/or oppositional disorder or conduct disorder as compared with 16% of the controls.

There have been many studies examining what factors in the child and the family are associated with the persistence of problems into their later years. Tremblay and colleagues (1991) found that fighting among young boys in the pre-school years continued in families which experienced a high level of family adversity and instability, whereas boys who stopped being aggressive towards their peers came from more stable family environments (Tremblay et al 1991). Similarly, Campbell et al reported that persistent problems in hard-to-manage pre-school children could be predicted by continuing family stress and change (Campbell, 1994; Campbell et al 1991). Furthermore, continuing problems were also associated with self-reported maternal depression and observed negative maternal control (Campbell and Ewing 1990). A similar finding was reported by Egeland et al (1990) who showed that persistent problems, from pre-school to early primary school, were associated
with higher self-reported maternal depression, whereas children who improved came from families where mothers reported significant decreases in the levels of depression.

It has been shown, therefore, that children who are identified as having problems in the pre-school years often continue to have problems into the school years and that persistence of problems tends to be associated with ongoing family adversity and maternal depression.

**Developmental Issues**

Concerns about children's behaviour vary with their developmental level. Parents' and teachers' reports of problems tend to increase from the age of two to three (Crowther et al 1981; Jenkins et al 1980). In one study, parental concerns about toddler behaviour peaked at the age of 3 with particular concerns about eating, sleeping, discipline and toileting problems (Jenkins et al 1980). Over the later pre-school years behaviours such as tantrums, overactivity, attentional problems, and fighting with peers seem to decrease in non-clinical samples (Coleman, Wolkind and Ashley, 1977; Crowther et al 1981). In general, studies suggest that problems around management, self-control, and aggression decrease as the child gets older.

Many behaviours which parents find difficult to manage are age-appropriate and reflect conflicts or frustrations associated with the developmental level of the child. For example defiance and discipline problems are typical in three years olds and reflect the child's struggle for autonomy and independence while testing the boundaries of their parents. Similarly, difficulties with turn-taking or sharing when playing with other children can be normal in the early pre-school years as the children's pro-social abilities develop but may be more problematic in the older child.

It is therefore important to understand the child's behaviour from a developmental perspective in order to establish whether the behaviour that may be seen as a problem by
the parents is typical of a child of their age or is an indication of a potentially more serious problem. It is also important to consider the context of the family and their circumstances as the behaviour problem may be a transient phenomenon and reflect a transition such as the birth of a sibling or entry into nursery school or alternatively it may signal a more serious difficulty in the parent-child relationship.

Factors associated with Behaviour Problems in Children

It has been found that many factors contribute to the development and maintenance of behaviour problems in children. The following section will discuss these factors and attempt to establish their relative importance.

Maternal depression

Richman et al (1982) showed that children who presented with behaviour problems were more likely to have mothers who were depressed. 30% of mothers studied were recorded as scoring high on the “Malaise Inventory”, a questionnaire which measures feelings of sadness, tiredness, and irritability, and which seems to link well with other scoring systems for depression. These figures are similar to those found by Brown and Harris (1978) and by Nicol, Stretch, Fundudis, Smith and Davidson (1987).

While there has been much research linking child behaviour problems and depression the nature of the relationship is complicated. Many researchers (e.g. Anthony, 1983, Forehand et al 1986., Patterson, 1982) have suggested that maternal depression leads to negative perceptions of children, then to increased commands and criticisms, and finally to increased child conduct problems.

Mills, Puckering, Pound and Cox (1985) have studied parents interactions with their
children and shown that depressed mothers recognize and react less to their children’s cues than non-depressed mothers. Other workers have found that depressed mothers often increase the number of commands they give their children and in response the child displays an increase in non-compliance or deviant child behaviour (McMahon and Forehand 1988; Webster-Stratton and Hammond 1988). In a recent study comparing the interactions of depressed mothers and non-depressed mothers with their infants it was shown that the depressed mothers had poorer quality interactions and more negative affect when playing with their children than the controls (Lang et al 1996).

Research has shown that maternal depression can lead to negative perceptions of their child’s behaviour. For example, Webster-Stratton and Hammond in their controlled study of 46 depressed mothers of conduct disordered children they found that depressed mothers perceived their children as being more behaviourally disturbed than either non-depressed mothers or their husbands on the ‘Child Behaviour Checklist’ (Webster-Stratton and Hammond 1988). This finding supported other research (Brody and Forehand 1986; Forehand and Brody 1985; Forehand et al 1986, Lang et al 1996). However, in the Webster-Stratton and Hammond study the children of the depressed mothers were independently rated by teachers as being significantly less deviant than children of non-depressed mothers (Webster-Stratton and Hammond 1988). This finding supported another controlled study which found that depressed mothers’ behaviours actually suppressed or reduced children’s aggressive behaviours (Hops et al 1987). However, the authors warn that the lack of the relationship between depression in mothers and child conduct problems may be due to the fact that the children are very young and that it could be too early to see the long-term effects of chronic depression, negative attitudes, critical behaviours and physical punishment. The authors argue that if the parents continue to have non-reinforcing experiences with their children, their depression may worsen, their criticisms may increase, and their children may develop more serious behaviour problems.
Research into how parental depression influences parenting behaviours is therefore contradictory and clear relationships cannot be reliably determined. From the research showing the link between maternal depression and child behaviour problems it could be hypothesized that maternal depression and irritability indirectly lead to behaviour problems as a result of negative attention, reinforcement of inappropriate child behaviours, inconsistent limit setting, and emotional unavailability. However, the findings that depressed mothers perceive their children as having more behaviour problems should be borne in mind.

**Mother-child interactions**

Mother-child interactions have been observed in several studies in which children with problems have been compared with children without problems and the patterns of interaction explored. Campbell (1990, 1991) has reviewed this work and found that mothers with hyperactive or aggressive or non-compliant children are more impatient and power assertive as well as less consistent (Patterson 1980: Patterson, DeBarshye and Ramsey 1989). Similarly, Dumas and Wahler (1985) reported that mothers of ‘problem’ children were likely to ignore or punish prosocial behaviour and to attend to and reward aversive behaviour.

In several epidemiological studies, interviews with the mothers suggest that mothers who rate their children as having more behaviour problems at ages of 3 and 4 also report having a harder time disciplining their children and that interactions are generally more negative (Barron and Earls 1984: Richman *et al* 1982).

In another study, mother-child interactions were compared in a group of children agreed by both parents and pre-school teachers to be defiant, aggressive and difficult to manage (Gardner 1987: 1989) and a group of children with no behaviour problems. Detailed observations in the home revealed that mothers of problem children engaged in more
confrontations with their children than did mothers of the control group. In turn the children were less likely to comply with maternal requests. The children in the problem group were less skilled at amusing themselves and spent more time engaged in aimless activity or watching television. The authors also report that the usual pattern of interaction was maternal directive followed by child non-compliance and that the mothers were less likely to follow their commands through until they achieved compliance when compared with the control group. The children apparently learned to ignore their mothers instruction. Thus the children and mothers of the problem group had a different set of expectations about cooperation when compared to the control group. She also found that mothers and problem pre-school children were less likely to engage in joint play activities or joint conversations, mutual enjoyment or turn taking. These mutually positive experiences appear to be important for the development of mother-child reciprocity and for prosocial behaviour in the peer group (Greenberg and Speltz 1988). It is likely that the high rates of negative behaviour and low level of shared enjoyment in the mothers of the more difficult children go some way to explain the persistence of problems (Campbell 1990).

*Parental conflict and family functioning.*

Another factor shown to be associated with behaviour problems is parental conflict. Interparental conflict leading to and surrounding divorce is associated with child behaviour problems (Kazdin 1987). Mothers of problem children are more likely to report marital dissatisfaction (e.g. Dadds and Powell 1991 Richman *et al* 1982). In an interesting study by Jenkins and Smith (1991) they attempted to determine the features of parental disharmony which are damaging to children, it was concluded that overt parental conflict was the strongest predictor of children’s problems.

There have been many studies examining the family correlates of behaviour problems. Findings have been quite consistent in showing that children identified as showing
problems in early childhood come from more dysfunctional families. Studies have shown that children identified as showing problems in the pre-school years come from families coping with more adverse circumstances (Richman et al 1982; Webster-Stratton; 1989; 1990). Mothers of problem children report having experienced more stressful life events in the past year (Campbell et al 1991, Richman et al 1982) than mothers of children not seen as a problem. Furthermore, children identified as a problem in the pre-school period are more likely to come from single parent or reconstituted families than are children without problems (Richman et al 1982).

Research suggests that life stressors such as poverty, unemployment, crowded living conditions and illness can have a detrimental effect on parenting and can be related to problems in children (Rutter and Giller 1983, Kazdin 1986). Richman’s study (1982) suggested that although problems persisted in families with ongoing marital stress, stressful life events, and maternal malaise, family adversity in the early years of the child does not necessarily predict continuing problems.

Child’s Temperament

Some researchers hypothesize that the occurrence of behaviour problems in children is at least partly determined by biological, possibly genetic factors. Although the biological determinants of behaviour are poorly understood certain aspects of personality do show consistency over time and can be thought to be constitutional in nature. These aspects of personality are referred to collectively as temperament. Aspects of temperament might include the child’s activity level, emotional responsiveness, quality of mood and social adaptability (Thomas and Chess 1977). Research has indicated that there are links between the temperament of the child and their behaviour. In one longitudinal study, maternal reports of infant difficulties (at six months) and infant resistance to control (at one year) proved to be significant predictors of behaviour problems at ages six and eight years (Bates et al 1991). In another large scale study of temperament and behaviour
problems Sanson and colleagues (1991) reported that maternal ratings of temperament difficulties and perceptions of their infants as “much more difficult than average” were weakly associated with later maternal ratings of behaviour problems on the Behar Preschool Behaviour Questionnaire.

However, although studies have shown that early assessments of temperament can predict later behaviour problems, the amount of variance in terms of behaviour problems accounted for by temperament is relatively small. Factors such as degree of family conflict, level of support, and the quality of parent management strategies appear to interact with temperament to influence outcome.

Role of Parenting

Research shows that parenting behaviour may play a major role in the onset and persistence of behaviour problems in young children (Greenberg et al 1993 Webster-Stratton 1990). There is some agreement that parental warmth and responsiveness in combination with consistent and effective limit setting have implications for the quality of the mother-child relationship. Many studies have identified a relationship between inconsistent and harsh maternal control and young children’s defiant, oppositional and aggressive behaviour (e.g. Patterson 1980 Webster-Stratton 1990). Although it is widely recognized that there is a relationship between parenting style and behaviour problems the direction of the causality is less clear. The question to be asked is: does the parent respond to the difficult child by increasing their control attempts or conversely does the child’s misbehaviour stem from dysfunctional parenting techniques? Detailed work by Snyder (1991) tends to suggest that it is the parents aversive responses and failure to follow through with limit setting which drives the system although the relationship is clearly reciprocal.
While the discipline and management style of the parent are important in the development of behaviour problems they should be considered within the context of the parent child relationship. For example, Anderson Lytton and Romney (1986) demonstrated that mothers of conduct disordered boys were far more negative when interacting with their own sons than they were when interacting with another non-compliant child although the level of non-compliance in the child was similar. This highlights the importance of the history of the relationship and how it affects the current interactions.

Attempts have been made to integrate the predictions from attachment theory with the findings from research on parenting styles and discipline methods. The studies on attachment theory (Ainsworth et al., 1978) focus on the affective bond and responsive involvement between the parent and the child. The studies on parental discipline focus on how the parent responds to the child’s misbehaviour. However, these two aspects are related. Parents who tend to show warmth and involvement towards their child also tend to take the child’s perspective into account and set limits in a non-punitive but direct fashion. In contrast parents who show less warmth and affection towards their children also tend use inconsistent and arbitrary parenting constraints and are more likely to use shouting and physical punishment to control their children (Greenberg and Speltz 1988).

Furthermore, studies have shown limit setting and control appear to be most effective in the context of a positive affective relationship between the mother and the child (Macoby and Martin 1983). Similarly, Greenberg and Speltz (1988) from their work argue that young children with oppositional problems have often not experienced joint planning or sharing of internal states with their mothers and also have not practiced negotiation of joint goals which is an important aspect of socialization for the toddler. They hypothesize that children may use aggressive and non-compliant behaviour as a means of attracting the attention of uninvolved parents or a way to assert autonomy in the face of over-controlling parents.
There is, therefore, accumulating evidence to show that pre-school children are more likely to show aggressive, non-compliant or overactive behaviour in the context of harsh, uninvolved or rejecting parenting. However, it should be taken into account that parents are more likely to engage in these less optimal patterns of parenting when they are having to cope with stress and adversity. The stresses in the family can undermine parenting by leaving preoccupied and overwhelmed parents with fewer emotional resources to deal with age appropriate needs and the demands of the pre-school child. As a result, questions are ignored, tempers are short and the child has fewer opportunities to experience positive and reciprocal interactions with a warm supportive parent.

It has been shown that there is a relationship between the parental behaviour and the existence of behaviour problems in children. The research seems to point to the fact that children are more likely to show non-compliant aggressive or overactive behaviour in the context of rejecting, harsh or uninvolved parenting. It therefore follows that strategies aimed at helping parents adopt a warm and responsive relationship with their children as well as effective and consistent limit setting may serve to alleviate the behaviour problems in their children.
Treatment Strategies for behaviour problems in children

There are many treatment strategies aimed at helping children with behaviour problems and their families. The treatments employed range from child-centered approaches to family therapy. However, perhaps the most widely used treatments for pre-school children with behaviour problems is parent training

Parent Training

One of the major treatment strategies for treating early childhood behaviour problems involves parent training interventions. Parent Training has been defined by Fine (1980) as 'a systematic and conceptually based programme, intended to impart information, awareness or skills to the participants on aspects of parenting'. Although there are a wide variety of different parent training programmes, the treatment strategies are usually based on the assumption that a major factor causing and maintaining the behaviour problem is a deficit in the parenting skills. Therefore the treatment is directed toward the parent rather than the child. The aim is to change the child's behaviour by changing that of the parent, by teaching the parent more effective parenting techniques. The purpose of these treatments is to change the parent’s interpersonal antecedents and consequences that are eliciting and maintaining the child’s negative behaviours. The parents are taught the social learning principles and the procedures that follow from them. For example, they are taught how to identify and reward their children’s appropriate behaviours through praise and attention and how to decrease inappropriate behaviours through time out and ignoring.

The rationale for this approach is supplied by research which indicates that parents of conduct disordered children lack certain fundamental parenting skills as discussed in the previous section. For example, parents of conduct disordered children have been reported to exhibit fewer positive behaviours, to be more critical and violent in their use of
discipline, and be more likely to fail to monitor their children’s behaviours, and to be more likely to reinforce inappropriate behaviours and to ignore or punish prosocial behaviours (e.g. Patterson and Stouthamer-Loeber 1984; Webster-Stratton 1985 a,b).

Patterson (1982, 1986) has developed the “coercive hypothesis” which is based on social learning theory, which attempts to explain the process whereby conduct disorders are developed and maintained. Coercion refers to deviant behaviour on the part of one person (e.g., the child) that is supported or directly reinforced by another person (e.g., the parent). Aggressive or other deviant behaviour performed by the child and directed towards the parent may be reinforced when the parent gives in or complies. As this coercive training in a family increases over time, the rate and intensity of parent and child aggressive behaviours are increased. Thus both the parents and the child are caught in the “negative reinforcement trap” which has been shown by Patterson (1980) to be one of the most powerful processes contributing to child conduct disorders. The trap is that the parent may yield to end the child’s aversive behaviour in the short term but inadvertently increases the likelihood that the behaviour will happen again. The parent’s behaviour is negatively reinforced because of the termination of the child’s aversive behaviour. However, the child’s aversive behaviour is reinforced too. He argues that children learn to escape or avoid parental criticism by escalating their negative behaviours which, in turn, leads to increasingly aversive parent interactions. Moreover, as the child observes his parents increasingly engaged in angry and negative responses, he or she receives the opportunity for further modelling and learning of aggression. Furthermore, other research has shown that the coercive cycle can also be fostered by positive reinforcement, in that the parents attention positively reinforces the child’s misbehaviours so that they become victims of the “positive reinforcement trap” (Wahler 1976).
Content of the programmes

The principal aim of most parent training programmes is to teach parents how to change the interpersonal antecedents and consequences that are elicit and maintain the child’s negative behaviours. One of the most influential parent training programmes was developed by Patterson, Reid, and colleagues at the Oregan Social Learning Centre (Patterson, 1982: Patterson, Reid, Jones and Conger, 1975). They have done some valuable evaluative research based on their work with more than 200 families of children aged 3-12 years. Their programme consists of parents being taught in a step-by-step approach where the newly learned skill is the foundation for the next new skill to be learnt. First, parents are taught how to pinpoint and record the problem behaviours at home. Second, they are taught reinforcement techniques (e.g. praise, point systems etc.) and third, discipline procedures. They are taught how to use procedures such as “time-out” or the short term removal of privileges. Fourth, the parents are taught how to “monitor” their children - that is to know where their children are at all times, what they are doing and when will they be home. In the final phase of treatment, parents are taught how to problem solve and negotiate with their children with the aim that they are increasingly independent from the programme.

Another influential parent training programme was developed to treat non-compliance in young children aged 3-8 years. This programme was evaluated by Forehand and McMahon (1981). The aim of the first phase is to teach parents how to play with their children in a non-directive way and how to identify and reward prosocial behaviours through praise and attention. The second phase includes teaching parents ways to give effective commands and how to use Time-Out for non-compliance. The programme is conducted in the clinic setting with individual families.

The third example of a Parent Training Programme which has been evaluated is that developed by Webster-Stratton (1981a,b, 1982a,b 1984). The programme was developed
for parents with children aged 3-8 and includes components of the two programmes described above. The research has concentrated on developing the most effective method of parent training i.e. methods that are cost effective, widely applicable and sustained. This programme uses videotape modeling methods and is based on Bandura’s (1977) modeling theory. The basic parent training program includes a series of 10 videotape programmes of modeled parenting skills (250 vignettes which last 1-2 minutes) which are show by a therapist to a group of parents (8-12 a group). After each vignette, the therapist leads a discussion of the relevant interactions and encourages parent’s ideas and problem solving as well as role-play and rehearsal.

**Evaluation of Parent training programmes**

Evaluations of parent training programmes present many methodological difficulties. Many parent training approaches have not been evaluated while others have been evaluated using small samples or descriptive data. There are obvious methodological and ethical difficulties in carrying out large scale randomized controlled studies to evaluate the effectiveness of different parent training programmes. Furthermore, since parenting is such a complex, multifactorial process dependent on a wide variety of interrelated variables it is difficult to specify the desired outcomes of a parent training programme. As a result, the anticipated outcomes of a parenting programme are often difficult to quantify. Frequently, outcome measures have relied on parental self-report and have focused on changes in child’s behaviour measured using parental checklists. Others have used parental consumer satisfaction, assessments of the parent-child interactions and changes in parents’ knowledge and attitudes. In a useful review of parent training based on behavioural approaches Callias (1994) suggests that outcome measures at the level of child change, parental behaviour and parental satisfaction are not equivalent. “A sharper understanding is needed of both how they are interrelated and how they may be affected by different facets of an intervention” (Callias 1994). Furthermore, it is important when
evaluating the effectiveness of a parenting programme to consider the generalisability and sustainability of the change in behaviour or attitude.

However, given these limitations, reviews of parent training programmes suggest that they are very promising. From the evaluative studies the findings suggest that in comparison with waiting list controls almost all parent training studies which use a behavioural approach show immediate post-treatment gains on some outcome measures for parent and/or children despite the wide variety of problems tackled and methods used (Callias, 1994) Webster-Stratton 1984, 1991). Research suggests that parent training improves child management skills (Barkley, Guevremont, Anastopoulos and Fletcher 1992, Forehand and McMahon 1981). It has also been shown that parent training increases prosocial behaviour (Webster-Stratton, Kolpacoff and Hollinsworth 1988) and reduces conduct problems (Anastopoulos, Shelton, DuPaul and Guevrement 1993, Patterson Chamberlain and Reid 1982). Home observations have indicated that parents are successful in reducing children's level of aggression by 20-60% (Patterson, 1982, Webster-Stratton 1985c). In a controlled study by Mullin et al (1990,1994) it was shown that mothers who participated in a parent training programme perceived their children as having fewer and less intense behaviour problems as measured by the Eyberg Child Behaviour Inventory (ECBI; Eyberg et al 1978). They also found that the experimental group of mothers showed increases in their self esteem and social competence.

Parent training has also been shown to be effective in increasing parental confidence (Anastopoulos et al 1993 Pisterman e al 1992). Pehrson and Robinson (1990) compared parents who participated in a ten week parent education group with a control group who did not participate. They found that the treatment group showed significant increases in confidence and insight into the causation of their children's behaviour.

A controlled study by Lawes (1992) demonstrated that parents who underwent either group based parent training or individual parent training showed significant improvements
on the *Parental Attitude Scale* which is a scale designed to measure the degree of
ccontentment that parents had in their relationship with their children. Furthermore, the
parents involved in group training also showed improvements in their self-esteem and their
children showed improvements in their behaviour as rated by the staff at the nursery using
a child behaviour checklist.

Follow up studies have shown that the treatment effects of Parent Training on parent’s and
child’s behaviour are maintained over the short term (Anastopolulos *et al* 1993,
Cunningham *et al* 1995). For example, Webster-Stratton Hollinsworth and Kolpacoff
(1989) showed that the improvements in parent and child behaviours found immediately
after completion of the parent training programme were maintained at one year post
treatment. Furthermore, the continued benefits of treatment on non-compliant children
have been sustained up to 4.5 years later (Baum and Forehand 1981).

When parent training has been compared to other treatment methods favorable results
have been found. For example, in one study where they compared parent training to
family based psychotherapy, attention placebo (discussion) and no treatment conditions, it
was found that parent training is superior (Patterson, Chamberlain and Reid 1982).
Similarly Forehand and McMahon (1981) demonstrated that the improvement resulting
from their programme was more effective than a family systems therapy (Wells and Egan
1988). Furthermore Webster-Stratton has also shown that her Parent Training programme
based on the therapist led group discussion videotape modeling method was equally good,
if not more effective, than a parent training programme based on the highly individualized
"bug-in-the-ear" approach, a parent group discussion approach (without videotape
modeling methods) or a completely self-administered videotape modeling approach
(without therapist feedback or group discussion) (Webster-Stratton *et al* 1988, Webster-
Stratton *et al* 1989).
There is considerable evidence to suggest that parent training can be a useful intervention but more evaluative studies are necessary to establish its long term effectiveness.

**Factors influencing the outcome of parent training programmes**

Many studies have shown that there is a relationship between the family’s ability to benefit from parent training programmes and their psychological, interparental, and environmental characteristics.

Several investigators have found that the mother’s pre-treatment levels of depression were significantly related to treatment failure or relapse during follow-up evaluations (Forehand, Furey and McMahon 1984; McMahon, Forehand, Greist and Wells 1981, Webster-Stratton and Hammond 1990). Other studies have found treatment failure to be related to marital problems (Webster-Stratton 1985a, Webster-Stratton and Hammond 1990). Furthermore, it has been found that single-parent families were more likely to drop out of treatment and that intact families were more successful at maintaining the treatment effects over time than single parent families (Strain, Young and Horowitz 1981). Another study found that the combination of socioeconomic status and marital status made the greatest significant contribution to the prediction of the mothers’ critical and negative behaviours with their children post treatment.

It has also been shown that the families that were more likely to drop out of treatment were characterized by low socio-economic status (Webster-Stratton 1985a, Wahler 1980). Similarly Dumas and Wahler (1983) showed that parent training failure was related to socioeconomic disadvantage coupled with insularity or social isolation. Furthermore it has also been shown that the amount of ‘negative life stress’ which occurred during the year following the treatment by a parent raising programme was related to the parental reports of child maladjustment (Webster-Stratton and Hammond 1990).
It appears, therefore, that economically disadvantaged, socially isolated, single or depressed mothers whose children are at greatest risk are least likely to participate or benefit from parent training programmes (Webster Straatton and Hammond 1990, Kazdin 1990, Kazdin, Mazurick and Bass 1993). It seems, therefore, that the same features that led to the parents experiencing difficulties with their children are associated with less favorable outcomes of parent training. In order to address this problem different components have been added to parent training programmes for example, problem-solving, marital communication and anger management skills. There has been very little evaluative research into the effectiveness of adding other therapy components but the initial studies that have been done suggest positive results (Dadds et al 1987, Greist et al 1982).

**Parental consumer feedback on parent training**

Studies looking at the parent's experience of parent training show favorable results. Parents are shown to be enthusiastic and satisfied about the training (Forehand and McMahon 1981; Callis 1987; Webster-Stratton 1989). In more detailed studies it was found that mothers found group treatment (with or without video vignettes) more helpful than self-directed video training and the specific techniques of rewarding and Time-Out were perceived as most useful, whereas the technique of ignoring was regarded as most difficult to use and least useful (Webster-Stratton 1989).

There has been little evaluative research into the relationship between parental satisfaction and the change in the parent's or the child's behaviour. It is of interest that parents report being satisfied and supported by a training programme even when more objective outcome measures on child problems show very little change relative to the control group. This is also evident in some treatment studies of sleep problems in young children (Scott and Richards 1990).
Callias (1994) has put forward a number of explanations to explain the apparent discrepancies between small changes in child behaviour and high levels of parental satisfaction:

• parents and therapists may not have the same goals;

• small changes in a child's behaviour and progress may greatly vary the quality of family life;

• group data may obscure individual differences in both success and satisfaction;

• parental satisfaction may not be directly associated with amelioration of problems but may reflect a sense of feeling supported and of achieving some self efficacy and understanding of the child which is independent of actual changes in the child;

It therefore appears that outcome measures at the level of behaviour change in the child or the parent may not be related to the parental satisfaction with the treatment.

**The Collaborative Model**

In recent years Parent Training Programmes based on a collaborative model have become increasingly important in this area of work. Webster-Stratton and Herbert (1994) have been the main pioneers of this approach and have carried out many studies examining its use in groups for parents of children with conduct disorders. Since the parents are often seeking help at a time when they are feeling guilty and blaming themselves and have low self confidence, many interventions are unsuccessful because they can have the effect of further undermining the parent's self-confidence. This can result in the parents being resistant or dropping out of treatment. In order to counteract this one of the essential ideas behind the collaborative model is empowering parents so that they feel confident about themselves, their parenting skills and their ability to cope with new situations
In a collaborative relationship the therapist works with the parents actively using their ideas and feelings and involving them in a therapeutic process by inviting them to share their experiences, discuss their ideas and engage in problem solving. The therapists role as a collaborator is to understand the parents perspective, to clarify issues and to summarize important ideas and themes raised by parents, to teach and interpret in a way that is culturally sensitive and finally to teach and suggest possible alternative approaches or choices when parents request assistance and when misunderstandings occur.

As with other models of parent training it is necessary for the therapist to teach the parents specific child management skills so that the clients can assume the responsibility for solving their own problems. One of the aims of the training is for the parents to learn new behaviour management strategies to use with their children. There has been much written about the different behavioural techniques that are taught in parenting programmes for example, time out, planned ignoring and differential reinforcement (Herbert 1987, 1994a). In a non-collaborative approach the “teacher” presents the principles and skills to the parents in a prescriptive way in terms of right and wrong ways to manage their children effectively. The difficulty with this approach is that the parents may be unable to relate the skills taught to their particular circumstances. For example, the treatment goals may not be congruent with their particular goals, values and lifestyle and not take into account the specific circumstances of the family or the temperament of the child. It is likely to lead to higher drop-out rates and poor long term maintenance. Evidence for this has come from work by Patterson and Forgatch (1985) who analyzed the impact of the therapist on the client in individual parent training by analyzing client -therapist interactions on a moment by moment basis. They showed that directive therapist behaviours such as “teach” and “confront” increased the likelihood of parental resistance and lack of cooperation.

In contrast the collaborative model relies on the therapist stimulating the parents to generate their own ideas and insights based on their own experience and to generate appropriate solutions based on their own family’s circumstances so that the content of the
parenting programme is relevant, understood and used by the parents. The parents are seen as the experts concerning their child and have the responsibility for deciding what will be possible in their particular family. The therapists are experts in their knowledge about the child’s developmental needs, behaviour management skills and communication skills. The model implies a reciprocal relationship based on utilizing both the therapist’s knowledge and the parents own strengths and perspectives.

Webster-Stratton and Herbert (1993) have attempted to examine the therapeutic process of parent training based on the collaborative model with parents of conduct disordered children. They used videotaped transcriptions of over 100 hours of group discussion therapy sessions and have attempted to explore the on-going processes of what happens when a therapist tries to change a parent’s behaviour, attitude and practices in a parent training programme. They have described these processes in terms of the different roles that the therapist has to play. These include, building a supportive relationship, empowering the parent, teaching, interpreting, and prophesising. They argue that each of these roles is a more specific expression of the collaborative relationship and the therapist works with parents in these multiple roles so that the parents gradually gain knowledge, control and competence to cope more effectively with a child with behaviour problems.

In a related study, Spitzer, Webster-Stratton & Hollinsworth (1991) have examined the Parent Training Programme from the perspective of the parent rather than the therapist. They have attempted to identify the processes by which the parents learn to cope more effectively with their stresses related to their conduct disordered children. The investigators analyzed the transcripts from the intake interviews and the parent training group therapy sessions. On the basis of the transcripts they have proposed a model to explain how parents learn to cope more effectively.
They suggest that the process of learning is comprised of five core phases which they have labeled as:-

1. Acknowledging the family’s problem,
2. Alternating between despair and hope,
3. “Tempering the dream”
4. “Making the shoe fit”
5. Coping effectively

The first step in the process of change is for the parent to acknowledge that their child had behaviour problems that they did not know how to handle. They reported that the parents expressed feelings of anger, fear of losing control, guilt and blame and not being able to interact more effectively with their children. Once they began to implement the principles and strategies presented in the programme, they moved from despair into a second phase characterized by feelings of enormous relief and the belief that the program would provide an easy solution for their children’s and families’ problems. A third phase, involved limited improvement or regression in the children’s problems, conflicting family dynamics, resistance, and a realization of the substantial amount of work needed for long term improvement. These factors served to temper the parent’s unrealistic expectations for the programme and allowed them to refocus their energies on acquiring new parenting strategies. As the parents moved into the fourth phase they worked hard at adapting the techniques taught in the programme to their own situations and needs. In the final phase the parents express empathy and acceptance of their child’s problems and affirmed their ongoing commitment to maintaining progress.

This study has closely examined the processes of parent training using observational methods and the researchers have developed an important and useful model whereby the parent learns to cope more effectively with their children’s behaviour problems. The study has produced valuable evidence about the processes by which these changes take place.
However this study and the proposed model have several limitations, for example it does not attempt to explain whether it is necessary for all parents to start at stage 1 and move through all five stages for effective parent training to take place, or what happens if parents get stuck at a particular stage. The model has relied on the researchers interpretations of the transcripts of the groups sessions and the intake interviews. An interesting development of this approach would be to explore the parents’ own perceptions of being in a parent training group. It is the aim of the present work to study this area more fully in order to understand more about the parents own experience of parent training; and of the aspects of the group they find helpful and empowering.

**Parents’ Self Efficacy**

One of the essential ideas behind the collaborative model is to empower parents so that they feel confident about themselves, their parenting skills and their ability to cope with new situations. The partnership approach aims to give back to parents their dignity, self respect and a sense of control (Spitzer, Webster-Stratton and Hollinsworth 1991).

Webster-Stratton & Herbert (1994) have suggested a number of ways in which parent training based on the collaborative approach can increase a parent’s self-empowerment: *knowledge, skills and values.*

"First, by giving parents knowledge concerning children’s developmental needs, behaviour management principles, and individual or temperamental differences and how these affect social relationships.

Second, by helping parents learn the important skills involved in communication building, social relationships, problem solving, tactical thinking, and the use of behavioural management techniques."
Third, by accepting and respecting their values and beliefs and trying to understand how these impact on their family life, rules and relationships” (pages 159-160).

An important function of parent training is not only to provide the parents with the necessary knowledge and skills to manage their children’s behaviour more effectively but also to empower them to believe in their own abilities. The terms self empowerment and self-efficacy seem to have been used interchangeably in this literature. In this study, however, the term self efficacy will be used as it seems to be more clearly defined and its analysis is more sophisticated. Therefore, one of the aims of parent training using the collaborative model, which gives the parents the responsibility for developing solutions, is that it will increase the parent’s confidence and perceived self efficacy in themselves as parents.

The theoretical framework behind this approach comes from work on self-efficacy. Bandura (1982) defined self efficacy as expectations for successful coping in upcoming situations. It is a sense of conviction about ones own competence, a sense of security about ones own abilities and capacities. He has suggested that it is the mediating variable between knowledge and behaviour. Often people do not behave to their optimal level even though they know what to do. Therefore, how people judge their capabilities affects their motivation and behaviour. According to Bandura (1977,1982), perceptions of self-efficacy affect how much effort people will expend on a task and how long they will persist in the face of obstacles or adverse experiences. Bandura has argued that those who have low estimations of their own efficacy tend to give up easily, make internal attributions for failure, and experience high levels of anxiety or depression. In contrast those with high efficacy expectations are persistent, avoid self-denigrating attributions, and experience less anxiety and depression (Bandura, 1982).

In the parenting context, self-efficacy refers to the degree to which the parent feels competent and confident in handling child problems. Therefore, the parent’s level of
competence in dealing with their child's more challenging behaviour is dependent not only on their knowledge of what they should be doing but also on their judgment of their capabilities in a given situation.

Judgments of self-efficacy also determine how much effort people will expend and how long they will persist at tasks in the face of obstacles or aversive experiences. When presented with difficulties, people who have serious doubts about their capabilities reduce their efforts or give up altogether, whereas those who have a strong sense of efficacy exert greater effort to master their challenges (Bandura and Schunk 1981; Brown and Inouye 1978; Weinberg, Gould and Jackson 1979). Furthermore, high persistence usually produces high performance attainments. This concept is particularly relevant to parents dealing with their children's behaviour problems. It has been shown that parents who are consistent with their children and have clear and firm boundaries have children with fewer problems (Macoby and Martin 1983). Dealing with children can be very draining and where the parent doubts their own capabilities it is more difficult for them to remain firm and consistent in the face of a child's misbehaviour than if they have confidence in what they are doing.

People's judgments of their capabilities additionally influence their thought patterns and emotional reactions during anticipatory and actual transactions with the environment (Bandura 1982). Those who judge themselves inefficacious in coping with environmental demands dwell on their personal deficiencies and imagine potential difficulties as more formidable than they really are (Beck 1976; Lazarus and Launier 1978; Meichenbaum 1977). Such doubt about one's own abilities creates stress and impairs performance by diverting attention from how best to proceed with the undertaking to concerns over failings and mishaps. In contrast, people who have a strong sense of efficacy deploy their attention and effort to the demands of the situation and are spurred to greater efforts by obstacles (Bandura 1982). This is also relevant to the parenting tasks. According to this model where the parent has doubts about their own capabilities, they are more likely to
dwell on their own perceived inadequacies, and feel that they are incapable of managing the child's challenging behaviour. This is likely to cause them increased stress and anxiety which in turn is likely to impair their performance when trying to manage their child's behaviour. Bugental (1987; Bugental and Shennum, 1984) has shown that this sense of parenting efficacy functions as a moderator of parent-child relationships and that caregivers with low levels of perceived control over child behaviour are sensitized to and cope ineffectively with difficult child behaviour.

Bandura (1982) lists four sources of self efficacy beliefs: *performance attainments*, *physiological states*, *vicarious learning*, and *verbal persuasion*. He argues that *performance attainments* provide the most influential source of efficacy information because it can be based on authentic mastery experiences, where success leads to enhanced efficacy and failure leads to reduced self efficacy. He argues that people also rely on their *physiological state* in judging their capabilities and that a visceral arousal in stressful and taxing situations is an ominous sign of vulnerability to dysfunction. An individual's level of efficacy is also dependent on *vicarious learning* i.e. seeing others perform and succeed at a task and having the belief that one can also master a comparable activity. Vicariously derived information also conveys information about the nature and predictability of environmental events and also teaches the observer effective strategies for dealing with the challenging or threatening situation. The final source of efficacy, *verbal persuasion*, is widely used to get people to believe they possess capabilities that will enable them to achieve what they seek.

One of the aims of the parenting group using the collaborative approach, is that it will raise the parent's level of self efficacy. In a parenting group it is likely that the main sources for increasing the parents level of self efficacy will come from performance attainments, vicarious learning and verbal persuasion. Once the parents successfully master using different techniques with their children it is hoped that it will increase their self efficacy. Furthermore, watching the performance of others in the parenting role may shape
expectations of their own performance and direct statements of others concerning their own competence will influence the parent’s self efficacy beliefs.

There has been limited research into the role of self-efficacy in parenting. One of the main pioneers in this area is Bugental and colleagues. Bugental (e.g. Bugental, 1991, Bugental and Shennum, 1984) describes parents in terms of the amount of power they perceive themselves to have in their interactions with their child relative to the amount of power they ascribe to the child. In order to study this more fully she has developed a Parent Attribution Test (PAT). Bugental (1991) has proposed that beliefs about this relative control in relationships form a cognitive structure operating at the preconscious level that is triggered by the presence of a difficult child in an ambiguous or threatening situation. When faced with difficult children, adults with high control are prepared to engage in solution-orientated thinking which allows them to encourage the child to behave in the way they want. Adults with low control schemas experience negative affective reactions which leads them to behave in a way that is ineffective in eliciting responsivity from the difficult child. Thus the child's difficult behaviour is maintained and the validity of the adult’s low control schema is supported.

Bugental’s studies have shown that “low control” mothers have been observed to generate affectively confusing or inconsistent messages when interacting with difficult children for example, negative messages delivered in a sarcastic or condescending or joking manner, or positive messages with relatively low voice assertion. These patterns of behaviour send the children conflicting messages, reassurance on one hand and displeasure on the other. Thus the difficult child’s lack of responsiveness and non-compliant behaviour is maintained by the confusing messages given out by the parent. She has also found that low control mothers are also more likely to use abusive discipline such as spanking, pushing and slapping (Bugental, Blue and Cruzcosa 1989).
Other researchers who have studied self-efficacy are Teti and Gelfand (1991). They have studied self-efficacy by asking mothers to rate their feelings of efficacy in specific domains of infant care such as soothing a baby, understanding what it wants, and amusing it. They found mothers who are low in self-efficacy are less competent at parenting as determined by observers ratings of their sensitivity, warmth, flatness of affect and anger during free play and feeding interactions with their infants.

Therefore both Bugental and Teti and Gelfand report behavioural and affective correlates of parenting self-efficacy. However, Teti and Gelfand argue that depression is a cause of low self-efficacy rather than an outcome as Bugental believes. Further evidence to suggest that depression is a cause of low self-efficacy comes from the work of Kochanska et al (1987). They asked mothers to rate the relative importance of maternal rearing practices, personality, influences of the father and luck on child outcomes in a variety of specific domains. They found that depressed mothers were more likely to attribute child outcomes to uncontrollable factors than were non-depressed mothers which they argue provides evidence that low self-efficacy is a result of depression.

The link between parenting self-efficacy and child's behaviour has been examined in a number of studies. For example Mash and Johnston (1983) studied a group of 40 families with a hyperactive child and 51 families with a normal child. They found an inverse relationships between the parenting self-efficacy (measured by the Parenting sense of Competence Scale) and the mothers' ratings of their children's behaviour (using the Child Behaviour Checklist). Similarly, in a more recent large scale study of 297 families they found a significant correlation between self-efficacy and externalizing behaviour on the Child Behaviour Checklist. Research suggests, therefore, that parenting self-efficacy is related to parental perceptions of child's behaviour.

Therefore, the parent level of self-efficacy has an important function in the parent-child relationship. It determines the degree to which the parent feels confident and competent in
handling their child’s behaviour which in turn affects the way they manage their child’s behaviour. It is one of the aims of this study to determine whether being in a parent training group affects a parent’s level of self efficacy by using a standardized self-efficacy questionnaire before and after the group. An attempt will be made to relate changes in self efficacy to parents perceptions of the helpful aspects of the parent training group.

**Measurement of parenting self efficacy**

A variety of instruments have been designed to assess self-efficacy about different behaviours in a wide range of situations. Johnston and Mash (1989) used an instrument which attempted to measure parents satisfaction and efficacy. They found that the parents perceptions of child behaviour were significantly correlated with parents self efficacy and satisfaction.

Campis, Lyman and Prentice-Dunn (1986) developed a 47 item questionnaire containing a 10 item Parenting Efficacy factor. This factor was related to general measures of self efficacy and discriminated between parents of normal and problem children. However it had poor internal consistency and was not related to a general locus-of-control measure or to a parenting sense of competence as assessed by the Parenting Stress Index (Abidin, 1983). Guidubaldi and Cleminshaw (1985) developed a 50 item questionnaire assessing parenting satisfaction across several domains. They found satisfactory internal reliability for five factors and moderate correlation with life and marital satisfaction. In a recent study by Mouton and Tuma (1988) they used both the Campis *et al* measure and the Guidubaldi and Cleminshaw scale. In this study both measures discriminated between parents of problem children and parents of normal children. The measures were also interrelated, and both correlated with Abidin’s (1983) Parenting Stress Index.

Gibaud-Wallston and Wandersman (1978) developed the Parenting Sense of Competence (PSOC) scale, which includes two rationally derived scales, Skill-Knowledge and Value-
Comforting, which went on to be known as Efficacy and Satisfaction in later studies (Johnston and Mash 1989). Gibaud-Wallston and Wandersman found that general self-esteem correlated with efficacy for mothers of infants and with satisfaction for fathers of infants. In new mothers Cutrona and Troutman (1986) found Efficacy scores were correlated with general self-esteem and mediated the effects of infant temperament and social support on postpartum depression. Other studies have demonstrated the use of the PSOC with parents of older children and in clinical samples. Mash and Johnston (1983) compared PSOC scores in parents of younger and older hyperactive and normal children. Parents of hyperactive children obtained scores lower than those obtained by parents of normal children and the parents of older hyperactive children reported the lowest levels of efficacy. Mash, Johnston and Kovitz (1983) found that abusive mothers reported lower PSOC scores than those reported by non-abusive mothers.

Johnston and Mash obtained normative information on the parenting Sense of Competence Scale on 297 mothers and 215 fathers of 4-9 year old children. Analysis revealed two factors: Satisfaction and Efficacy. Satisfaction indicates an affective dimension reflecting the degree to which the parent feels frustrated, anxious and poorly motivated in the parenting role. The second factor Efficacy, reflects the degree to which the parent feels competent, capable of problem solving and familiar with parenting.

Parental perceptions of child behaviour correlated significantly with PSOC in several studies (Johnston and Mash 1989, Gibaud-Wallston and Wandersman 1978) Parents who reported more child behaviour problems also reported lower levels of parenting self-esteem, particularly on the satisfaction dimension. Johnston and Mash suggested that for mothers, perceptions of parenting self efficacy is a reflection of their estimates of their ability to handle child problems and how they feel compared to other mothers. This is different to fathers for who perceptions of parenting efficacy is partially based on the extent to which the child is perceived as problematic.
From the examination of the different instruments designed to measure parenting self efficacy the Parenting Sense of Competence Scale seems to be the most robust and appropriate. In this study, therefore, the Parenting Sense of Competence Scale will be used to determine the parents level of self-efficacy and satisfaction with the parenting role.

**The Group Approach to Parent Training**

There have been a number of studies comparing group to individual parent training. The major advantage of the individual approach is that it allows for a detailed assessment of the parenting problems which enables the treatment to be tailored to meet the specific needs of the family. Home based work has the advantage of allowing the therapist to plan the interventions in the setting in which the parent-child problems occur thus increasing the likelihood of the change being maintained. However, home-based work is time consuming and in some homes there are too many distractions. Individual family work seems to be the treatment of choice where families have more complex and multiple problems where the parenting issues are part of a wider range of problems, and where families who have more specific problems which do not require a broad based approach.

One of the main advantages of the group approach is that it can be more cost-effective. However, groups have other advantages in that they allow a more systematic coverage of the theoretical principles and techniques than individual work and that vicarious learning may occur through hearing how other parents deal with problems.

A number of studies have found the outcomes of small group parent training comparable to individual interventions (Brightman, Baker, Clark and Ambrose 1982; Christensen, Johnson, Phillips and Glasgow 1980; Kovitz 1976; Raue and Spence 1985) on a range of measures of efficacy, drop-out rates and parental satisfaction. Group approaches are almost always found to be more cost effective (Pevsner 1982) unless the individual training involves no therapist contact (Webster-Stratton et al 1988 Webster-Stratton,1990).
In a recent study comparing a large group community parenting programme with individual family treatments it was shown that the large groups showed greater reductions in child management problems and better maintenance of gains at follow-up (Cunningham et al 1995). The effectiveness of a group depends upon a complex combination of composition, process and leadership variables (MacKenzie 1990). Simply teaching parenting skills in a group may not activate the benefits of group membership. In the study by Cunningham they used a ‘coping modeling problem solving’ approach which encouraged parents to discuss the solution of common problems, collaborate in the formulation of child management strategies, share successes, and provide supportive feedback. In comparison to the more didactic parent training programmes, this model yielded more positive in-session participation, improved adherence, a greater sense of self advocacy and more favorable consumer evaluations (Cunningham et al 1993).

Smith and Pugh (1996) in their evaluation of group based parenting programmes sum up the strengths of a group-based approach as:

- groups are cost effective, delivering services to more than one person at a time;
- groups help socially isolated families meet people and make friends;
- groups tend to build a sense of cohesiveness among their members;
- groups provide opportunities for individuals to share their views with others, and learn from others;
- groups build empathy, by encouraging parents to listen to and respond to the needs and concerns of others;
- groups can provide appropriate role models;
- groups can provide parents with support and the opportunity to ‘network’;
• the group process can be powerful in terms of developing self-confidence and self-esteem.

To summarize, the choice between individual and group treatment will depend on the nature of the problems, the extensiveness of the treatment required and the seriousness of the parenting difficulties. Group treatments are advantageous in situations where families share common problems and resources are limited and they have other advantages associated with the group process.

Group Processes

Having discussed how the collaborative model can be applied to parent training and how a central theme of this is to help increase a parent's self efficacy, the discussion will now turn to a discussion of the mechanisms that are at work in a group whereby an increase in self efficacy can be achieved.

There has been considerable work looking at the effectiveness of the group as an agent for change. However group therapy seems to refer to any group level intervention designed to improve an individuals adjustment or psychological functioning. Therefore it is important to consider the different types of groups that exist. While some groups are primarily for hospitalized psychiatric inpatients, others are primarily for individuals who are seeking support from one another (support groups), learning social skills (social skills groups or T groups) or self understanding (encounter groups). Some groups are leader centered (psychoanalytic or Gestalt groups) while others are group focused (encounter and T groups). The groups activities can range from highly structured (for example social skills groups or anxiety management groups ) while others are unstructured (encounter groups).
This study focuses on the parent training group which could be considered as a structured group which aims to offer skills and support to the group members.

When considering the factors at play during a therapeutic group it is useful to consider them in two broad categories; the content i.e. the information passed from the therapist to the group members and the process i.e. the interactions between the group members and the therapist.

The factors contributing to the improvement in the patient's condition and the relative effectiveness of each of these factors has been the subject of detailed research. These have been described as therapeutic factors (TFs) and are defined as the processes which contribute to improvement of the patient's condition and is regarded as a function of the actions of the therapist, the other members of the group and the patient himself. Corsini and Rosenberg (1955) were first to classify TFs and subsequent attempts have been made by others including Yalom (1975) and Bloch et al (1979). Yalom (1975) identified the following "curative factors" based on clients' self-reports and prior clinical experience.

1. Instillation of hope
2. Universality
3. Guidance
4. Altruism
5. Family reenactment
6. Self-understanding
7. Identification
8. Interpersonal learning: feedback:
9. Interpersonal learning: relationship with others
10. Group cohesiveness
11. Catharsis
12. Existential factors
Empirical studies designed to establish the relative importance of therapeutic factors have largely relied on these classifications. The methods used have included a Q-sort based on Yalom’s factors (Yalom 1975), a structured questionnaire derived from the Q-sort (e.g. Maxmen 1973) and a minimally structured questionnaire, ‘the most important event’ which is then coded into a predetermined classification of factors (Berzon et al 1963).

Yalom had patients rank predetermined categories of “curative factors” in order of relative usefulness and found that feedback about ones own behaviour (i.e. interpersonal learning), catharsis, and group cohesiveness were the most helpful factors, while identification, guidance, and family reenactment were of least value to the patients (Yalom 1970). Another study assessing which specific factors are helpful in short term group psychotherapy found that instillation of hope, group cohesiveness, altruism and universality were believed to be the most useful (Maxmen 1973).

One of the main advantages of treatment in groups is the value of the group as an arena for interpersonal learning (Lieberman, 1980 Yalom 1975). Group members receive information not only from the group leaders but also from individuals. They “become aware of the significant aspects of their interpersonal behaviours: their strengths, their limitations, their parataxic distortions and their maladaptive behaviour that elicits unwanted responses from others” (Yalom 1975). Through feedback from the group leader, as well as from the other group members, individuals gain an increased understanding of their social selves, and this self understanding provides the basis for change in cognitions and actions. However, research has indicated that individuals tend to take more account of feedback when it is consistent with their own self concept (Ingram, Smith and Brehm 1983; Swann and Read, 1981). Furthermore, individuals tend to accept only positive feedback about themselves (Jacobs 1974). The parent training group will give parents the opportunity to discuss the problems they are having with their child with other parents and the group leaders. They will be able to receive feedback about the problems and alternative management strategies from the others in the group.
Cohesion has been identified as one of the most important "curative factors". It has been shown that people are more satisfied when they are members of cohesive groups rather than non-cohesive groups (Hagen and Burch 1985). The parent training group offers parents contact with others in a similar situation which can be important in reducing feelings of isolation.

Goldstein, Heller and Sechrest (1966) suggest that groups progress more rapidly if they are working towards clearly defined goals. Studies have shown that group performance and goal clarity are positively correlated (Zander 1980). In the parent training group based on the collaborative model the goals for each parent will be individualized and may be adapted as the group progresses. It will be interesting to explore whether working towards these individualized goals will be perceived as helpful in dealing with their children.

The studies described above have examined the patient's perceptions of the relative helpfulness of the different therapeutic factors in a therapeutic group. However, there do not seem to be any studies relating the perceived helpfulness of different group factors to the parent training group. The parent training group offers parents contact with others in a similar situation which can be important in reducing feelings of isolation, hopelessness and helplessness. The group provides an opportunity for sharing experiences of both problems and potential solutions and for mutual peer support and encouragement. It also provides information about different behaviour management strategies that the parents could use when dealing with their children's difficult behaviour. It is the aim of this study to explore the parent's experience of the parent training group and of which aspects of the group process they find most helpful.

Most other studies have evaluated the outcome of the group by comparing parents and/or children's behaviour before and after a group. While such outcome measures are important it is also useful to examine the process by which this change has taken place.
Parr (1996) suggests that this aspect of evaluation is particularly important for replication of interventions. Smith and Pugh (1996) in their evaluation of current parent training programmes running in this country argue that “process evaluation needs to include:

- Feedback from participants about their perceptions of interventions.
- Participants’ perceptions of any positive or negative impact of the intervention on their daily life in their family and community.
- Other services being used by participants.
- Characteristics shown by individuals who show interest in the intervention, who perceive that they have benefited or otherwise, and those who leave the intervention before its completion.
- Attendance and reasons for absence.
- Information (from facilitators) about the usefulness of interventions techniques and approaches and any modifications made during the intervention.”

This study will attempt to explore some of these issues more closely. It is aim of this study to explore the process of the group in order to establish what factors the parents perceive as helpful in managing their children’s behaviour. This will be assessed both during the course of the group and at the end of the group. An aim of this study to is examine how the parent’s perception of what is helpful changes during the course of the group. It is proposed that during the early sessions the parents will gain most from learning about new child management techniques. As the parents get to know one another and a cohesion is formed between them it is proposed that they will increasingly value the support they gain from each other. There will be an attempt to related these ‘helpful’ group processes to the self efficacy of the parents.
Aim of the Present Study

It is the aim of this study to investigate the parent’s own experience of parent training; in order to learn more about what aspects of the group they find helpful and empowering in helping them deal with their children’s behaviour problems more effectively. In order to achieve this aim the study will attempt to establish the relative importance of the different group processes as perceived by the parents in helping them feel more self efficacious. A further aim of this study is to determine whether being in a parent training group affects a parents level of self efficacy and an attempt will be made to relate these changes to the parent’s perceptions of the helpful aspects of the parent training group.
Hypotheses

The preceding section has given an overview of the relevant research into the area of parent training. On the basis of the findings it is proposed that:

1. Parents will perceive the most helpful factors of the group as being:
   i) the support they receive from the other group members.
   ii) learning new knowledge and skills about behavioural techniques and how to handle their children’s behaviour.

2. As people move through the course of the group their view about the most helpful aspects of group process change. During the early stages of the group the information and the didactic techniques will be perceived as most useful and as the group progresses in a collaborative model the group discussion and group support will be perceived as most helpful.

3. In keeping with Herbert’s collaborative model it will be possible to detect an increase in the parent’s level of self efficacy as a result of attending the Parent Training Group.

4. As a result of attending the group the parents will have learnt more effective ways of managing their child’s behaviour and feel more confident and less worried about managing their child’s difficult behaviour.

5. The changes in the parents self efficacy will be related to the perceived helpfulness of the group.
Method

Design

The study used a repeated measures design. Data were collected at six points during the course of the study. Additional data were collected before and after the intervention.

Sample

The sample for the study were sought from the waiting list of the Kingston & District Child and Adolescent Psychology Department. The parents of any child aged between two and five whose main difficulty was behaviour problems were approached. A letter was also written to all the Health Visitors in the district requesting them to refer any child who met the referral criteria. (letter and referral form in appendix 1).

A total of 24 children met the requirements of the referral criteria and of these 21 were obtained from the waiting list and 3 were obtained from the health visitors. The parents of these children were approached by telephone and they were told about the group and asked if they would be interested in attending. If they were interested an assessment interview was set up with the Clinical Psychologist. A total of 18 parents accepted interviews and of these 15 attended. The three parents who did not attend were written to and asked if they would like another opportunity for an assessment interview. None of them responded to the letter. At the interview the parents were informed about the group and they decided if they were interested in attending the six week group. At the interview it was stressed to the parents that if they chose to attend the group it was important to try to attend all six weeks. For one parent it was decided that the group was not suitable as her main concerns seemed to be her older son’s behaviour. A further two parents decided that they did not want to attend a parent training group. A total of 12 parents agreed to
attend and of those 10 attended the first week. Two dropped out after the first session leaving 8 regular attenders. A summary of the referral process is shown in table 1 below.

Table 1 showing the referral process towards attending the group.

<table>
<thead>
<tr>
<th>Source of referral</th>
<th>Total number approached</th>
<th>Acceptance of interviews</th>
<th>Attendance at interview</th>
<th>Assessment of suitability</th>
<th>Agreement to attend group</th>
<th>Attendance at 1st session</th>
<th>Committed to group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting list</td>
<td>24</td>
<td>18</td>
<td>15</td>
<td>14</td>
<td>12</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Health visitors</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

Measures

The following measures were used:-

1. Child’s Behaviour Interview schedule
2. The Parenting Sense of Competence Scale
3. Helpful aspects of parent training questionnaire
4. Perceived Helpfulness of a Group interview schedule

1. Child Behaviour Interview schedule

The Child Behaviour Interview schedule (see appendix 2) was designed by the author for the purpose of this study. The first part of this interview (questions 1 to 8) was designed is to gain a detailed description of the child’s behaviour that the parent is most concerned
about. This includes questions about the behaviour, its duration and the context in which it occurs. The second part of the interview (questions 9 to 15) was designed to gain information about the antecedents of the behaviour, the parents typical responses to the behaviour and the strategies they have used to deal with the behaviour. The third part of the interview (questions 17-18) aimed at ascertaining the parents desired change in their child's behaviour. The fourth part (questions 18-23) was designed to gain information about the effect that the child's behaviour is having on the parents sense of confidence and level of control and on the rest of the family. The final part (questions 24-25) examines the parents perceptions of the positive attributes of the child.

The schedule was piloted before the group on four mothers to test whether it was understandable and comprehensible to this client group. Small alterations to the language were made and a numerical scale was included on question 25.

2. The Parenting Sense of Competence Scale

The Parenting Sense of Competence scale (see appendix 3) is a 17-item scale developed by Gibaud-Wallston and Wandersman (1978) to assess parenting self esteem. Each item is answered on a 6 point scale ranging from strongly disagree (6) to strongly agree (1). Scoring for Items 1, 6, 7, 10, 11, 13, 15, and 17 is reversed so that, for all items, higher scores indicate greater self-esteem. The scale contains two dimensions of parenting self-esteem which are Satisfaction with Parenting (9 items) and Parenting Efficacy (8 items). Parents were asked to complete the PSOC thinking only about the target child in the family (i.e. the child who had been selected for the study).

Gibaud-Wallston and Wandersman (1978) reported alpha coefficients of .82 and .70 for the Satisfaction and Efficacy Scales, respectively. Similarly Johnston and Mash (1989) reported alpha coefficients .79 for the entire scale and .75 for the Satisfaction factor and
.76 for the Efficacy Scale. Cutrona and Troutman (1986) reported an internal reliability estimate of .72 for the Efficacy scale in a sample of mothers of infants.

3. Helpful aspects of Parent Training Questionnaire

The Helpful aspects of Parent Training Questionnaire (see appendix 4) was developed by the author for the purpose of this study. The aim of this questionnaire was to measure the helpfulness of various aspects of the group processes as experienced by the parents. This questionnaire was based on Herbert’s table which lists group processes that are the sources of self empowerment. From this list a checklist has been devised of 22 aspects of the group. The questionnaire finishes with a question about overall how helpful did they find the session. Each item is answered on a 5 point scale from 1 = very unhelpful to 5 = very helpful or alternatively didn't occur. The questionnaire is completed immediately after the group session by each parent independently.

These 22 items have been divided into three categories which have been labeled as

1. **Expert** ~ 6 items (questions 1, 2, 5, 10, 17, 18)
2. **Collaborative** ~ 6 items (6, 7, 8, 13, 19, 20)
3. **Parents** ~ 10 items (questions 3, 4, 9, 11, 12, 14, 15, 16, 21, 22)

The definitions of each of the three categories is given below.

1. **Expert** - includes any items which describe processes where the group leaders are directly “teaching” parenting techniques to the parents. Examples of this include

   2. Videos of how to do it, how not to do it.
   10. Being given strategies from the group leaders
   18. Receiving general advice on children’s behaviour
2. **Collaborative** - includes any items which describe processes where the group leaders and parents work together to find solutions to the problems the parents are experiencing.

It includes focused discussion about the difficulties of parenting that have been initiated by the group leaders. Examples of this include:

- 6. Discussions about the practicalities of parenting.
- 13. Finding solutions for problems with the group facilitators
- 20. Talking about the relationship between me and my child.

3. **Parents** - includes any item which describes processes where the parents facilitate each other regardless of the group leaders. It includes any items which describe the more general group processes for example feeling that they are part of a group. It also includes the factors which described about what the parents gain from meeting others in a similar situation with similar problems. Examples of the “parent category” include:

- 3. Group exercises to make you feel part of the group
- 11. Finding out that other people have the same problem as you
- 14. Helping other parent find solutions

The items were divided into the three categories using the criteria described above by the group leaders and three other independent assessors. There was close agreement (interrater reliability = 92%) between the assessors on the items that should be included for each category.
4. Perceived Helpfulness of a Group Interview Schedule (PHGIS)

The Perceived Helpfulness of Group Interview Schedule (see appendix 5) is a semi-structured interview and was designed by the author for the purpose of this study. The aim of this Interview Schedule was to ascertain what aspects of the overall group the members found most helpful and how this affected their interactions with the child outside the group.

The PHGIS consists of two parts. The first part consists of 9 questions about the way the group has affected their interactions with their child, their relationship with their child, their feelings about being a parent. It also explores what the parents found least helpful about the group and how the parents would have liked the group to be different. The final question asks whether there were any factors, not associated with the group, which may have affected their relationship with their child.

The second part of the PHGIS is based on the responses to the weekly “Helpful aspects of Parent Training Questionnaire”. This part of the interview schedule is aimed at exploring how each item identified as most helpful affected the way the parent responded to their child. The responses on the HAPTQ were analyzed and the three most helpful aspects were identified for each parent. If more than three items scored equally highly then the parents were asked to choose the item they found most helpful.

This interview schedule was piloted on two parents for understandability of the questions following which small adjustments were made to the language and the original question 7 was divided into two separate parts making question 7 and 8.
Procedure

Before the study commenced it was given the approval of the local ethical committee. Each of the parents who had been identified as a suitable candidate for a parent training group was contacted by telephone or in writing and invited to attend an assessment interview. Each parent was interviewed before the group by the author. The aim of the interview was to inform the parent about the group and to ascertain whether a parent training group was a suitable treatment strategy for the particular difficulties the parent was experiencing.

If the parent was interested in attending and it was felt that the group was an appropriate treatment approach then the parent was informed about the study and her consent to be included in it was requested. If she gave her consent the Pre Group interview was undertaken. This consists of two parts:

1. Child’s behaviour Interview schedule
2. The Parenting Sense of Competence Scale.

The group ran for 6 weeks from 10.00 to 12.00 on a Wednesday morning at a Health Centre located in the centre of the district. The parents were offered tea and coffee before the group started. The group was jointly run by two Clinical Psychologists and the content of the group is described below. At the end of each group session the parents were asked to complete “Helpful aspects of Parent Training Questionnaire”.

Following the group the parents were interviewed again. The post group interview consisted of three parts:

1. Child’s behaviour Interview schedule
2. The Parenting Sense of Competence Scale.
3. Perceived Helpfulness of the Group Interview Schedule
Following this there was a general discussion with the parent about whether they felt they wanted further help from the department and what sort of help would be most appropriate.

The Content of the Group

Session 1 - Introductions & Putting parenting into a context

The aim of the first sessions was for the parents to get to know one another and the group leaders and to establish the “group rules”. A further aim of this sessions was to provide the parents with the opportunity to think about what they were hoping to achieve as parents and what was challenging about being a parent.

1. Introductions of Group Leaders

2. Cover the overall aims of the Parent Training Group
   - Develop an understanding of why parenting is difficult
   - Think about and learn new strategies for dealing with child’s behaviour problems
   - To share ideas and brainstorm different ways of working

3. Introductions of the Parents
   In pairs talk to the parent next to you and find out their name, who is in their family and the main difficulties they are having with their child at present.
   Feedback the other parents responses to the rest of the group.

4. Group Rules
   To discuss and decide upon the rules that the group members will share. These included
   - Confidentiality
• Try to attend all 6 weeks
• Try to turn up on time
• Respect other members opinions

5. Parenting - putting it into a context, what are we trying to achieve?
Group exercise. In two groups discuss the question “Apart from physical needs what do children need from their parents and why are these aspects important?”

6. What makes parenting so difficult?
Group exercise in three groups discuss “what makes parenting so difficult”
1st group think about what it is about the child that makes parenting difficult
2nd group think about what it is about the parent that makes parenting difficult
3rd Group think about what it is about the living situation that makes parenting difficult
Feedback to the rest of the group followed by general discussion on the challenges of parenting.

7. Homework task
Over the next week look out for one incident of difficult behaviour and use as an example for next week.

Session 2 - Praise, attention & making good behaviour worthwhile

The aim of the second session was for the parents to review the basic child behaviour management principle and to practice the skill of observing the child-parent interactions. The session focused on how to use praise and differential attention to promote the child’s more ‘desirable’ behaviour.

1. Basic Child Behaviour Management Principles
Key Points

- Children learn their behaviour
- Children work for attention
- The way children behave is dependent on the way parents respond to them
- Children’s behaviour is formed by what you do before the behaviour and how you respond to the child’s behaviour.

2. Learning how to observe patterns in the mother-child interactions. Video extract of a mother shopping with child, the child has a tantrum in supermarket and the mother looses her temper.

In two groups complete ABC chart (see appendix 6) for the scene on the video i.e.
- describe the behavior,
- what sparked off the behaviour?
- how did the mother react?
- what did the child do then?

Feedback to the rest of the group

3. Show video again. In two groups
   1st group discuss “How could the mother have made the child’s good behaviour more worthwhile?”
   2nd group discuss “How could the mother have made the child’s bad behaviour less worthwhile ?”

Feedback to rest of the group and discuss.

4. Show second video extract depicting a similar scene in a supermarket where the mother uses various techniques for example distracting and involving the child in the shopping, to improve child’s behaviour whilst shopping.

Discussion of points raised by video linked to previous exercise.
5. In two groups facilitated by group leaders, discussion of examples difficult behaviour with their own children. Asking the question did they make the child's good behaviour worthwhile and the child undesirable behaviour less worthwhile.

6. Praise and attention
Go through with the parents the main points of praise and attention based on the handout

7. Homework task
Think of a way of making your child's good behaviour more worthwhile over and above what you are already doing. Complete the chart "what my child did well today", (see appendix 7).

Session 3 - What do you do when your child misbehaves?
The aim of the third session was to focus on helping the parents learn or consolidate on effective strategies to use when their child misbehaves. The emphasis is on combining these strategies with those learnt the previous week. The main strategies that the parents will be focusing on is attempting to distract to avoid situations deteriorating, and ignoring and time out.

1. Introductions

2. Review progress. In pairs discuss one thing that they have done or thought differently with their child since starting the group
feedback on partner

3. Surviving Parenting Checklist.-
How important it is to be observers of our own behaviour as criticism of the child and attending to the undesirable behaviour can so easily become a habit.
4. Praise & Attention homework task.
Each person to give one example and a discussion to follow based on:-

1. What was difficult about doing it
2. What it felt like for the mothers

5. Link between praise and attention go hand in hand with strategies for dealing with difficult behaviour. Discussion around this issue

6. Video extract of a child having a tantrum
In groups of 3 - imagine you are advisors to parents who have a child with difficult behaviour, as a group come up with the “Golden Rules for Dealing with a Difficult Child” Feedback to the rest of the group.

7. Watch the second part of the video where the parents are being advised and shown how to use different techniques such as distraction, differential reinforcement and time out.

8. Discussion about golden rules in relation to the video.

9. 2 handouts Time out and ignoring

Session 4 - About your child as an individual
The aim of the fourth session is to help the parents consider the events that have occurred, in their own lives and their child’s life, which have contributed to the way they understand their child and their behaviour. Factors may include issues such as the pregnancy and birth, illness in their child’s life early. The parents will be able to discuss how these factors have influenced the way they conceptualize their child’s behaviour and how this has affected how they behave towards their children.

1. Short discussion about the child’s behaviour since last week
2. Using the “Events in my Child’s Life “ (see appendix 8) diagram the parents were asked to think about and write down “what things in you child’s life has affected the way you parent them?”

3. Discussion about how different events in your child’s life can affect how you feel, think and behave towards them.

4. Homework task to discuss with partner the “Events in my Child’s Life Diagram” together

Session 5 - Playing & Fighting

The aim of the fifth session is to help parents find ways of encouraging their children to play cooperatively with one another and to avoid fighting using the methods reviewed in the earlier sessions.

1. Feedback on previous week

2. Quiz on the incidence of various behavioural difficulties for example hitting out and snatching toys, hurting younger siblings, temper tantrums.

3. Show a video depicting a scene where a two siblings are playing together and a fight ensues and the parents become involved which develops into a family row.

4. Group discussion in two groups about the do’s and don’ts of playing with your children

5. Handout on “Playing with Children”

6. Homework task To try to spend at least 10 minutes every day playing with your child.
Session 6 - Review of Progress and Ending

The aim of the final session is to examine the difficulties that each group member came to the group with and to review the progress they have made and how this can continue. A further aim of this session is to explore the parents continuing support and the type of follow up they would like.

1. Individual progress review. Each group member is asked to describe the problem they came with, what is their understanding of the causes of their child’s behaviour, how are they responding to it now, what progress has been made.

2. Ending -Discussion about what they will miss from the group and how will they continue with the changes they have made

3. Share telephone numbers and addresses

4. Final comments
Results

Characteristics of the Sample

A total of 8 mothers regularly attended the parent training group. Five of the parents attended all six sessions of the group and three attended four sessions.

All of the 8 mothers lived with their partner, the father of their children. All the fathers were in full time employment. Five of the eight mothers had two children, two had one child and one had three children. Six of the identified children were boys and two were girls. The ages of the identified children ranged from 2 to 5 inclusive.

Overall research question

An investigation into the parent’s perceptions of the process and outcome of a parent training group and how such a group affects their feelings of self efficacy in handling their children’s difficult behaviour.

Hypothesis 1

1. Parents will perceive the most important factors of the group as being:-

   i) the support they receive from the other group members which will be reflected by a high score on the 'parents' category

   ii) learning new knowledge and skills about behavioural techniques and how to handle their children’s behaviour which will be reflected by a high score on the 'expert' category
The parents completed a “Helpful Aspects of Parent Training Questionnaire” at the end of each group session. A total of 42 questionnaires were completed, and the mean scores for each item were calculated from all the competed questionnaires. The six most helpful aspects are listed in the Table 2 below.

Table 2 The items on the ‘Helpful Aspects of Parent Training Questionnaire’ that were perceived as most helpful by the parents across all sessions

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Having space away from your child to talk about parenting</td>
<td>4.68</td>
</tr>
<tr>
<td>22</td>
<td>Other group members having values and ideas about parenting that are different to yours</td>
<td>4.60</td>
</tr>
<tr>
<td>4</td>
<td>Group exercises to get to know group members</td>
<td>4.35</td>
</tr>
<tr>
<td>12</td>
<td>Finding solutions for problems with other parents</td>
<td>4.35</td>
</tr>
<tr>
<td>11</td>
<td>Finding out that other people have the same problem as you</td>
<td>4.33</td>
</tr>
<tr>
<td>14</td>
<td>Helping other parents find solutions</td>
<td>4.33</td>
</tr>
</tbody>
</table>

The mean scores for each item on the “Helpful Aspects of Parent Training Questionnaire” are listed in Table 3 below and shown in figure 1. The scores range from 2 to 5, and the rating of 2 was only given on three occasions (questions 4, 11, and 16).

The items were grouped together under three categories as described in the method section (see Table 3).

Parents - includes any item where parents have gained support from one another and from being in a group.

Collaborative - include any item where the parents and group leaders worked together to reach solutions to the problems the parents are experiencing.

Expert - includes any item where the group leaders are teaching parenting management skills.
Table 3  The mean score for each question on the Helpful Aspects of Parent Training Questionnaire and the mean score for the category

<table>
<thead>
<tr>
<th>Question number</th>
<th>Question</th>
<th>mean score (S.D)</th>
<th>Category mean</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parents</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Group exercises to make you feel part of the group</td>
<td>4.34 (0.68)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Exercises to get to know group members</td>
<td>4.35 (0.75)</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Having to talk about difficulties with people you don’t know very well in a group</td>
<td>3.89 (0.76)</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Finding out that other people have the same problem as you</td>
<td>4.33 (0.74)</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Finding solutions for problems with other parents</td>
<td>4.35 (0.65)</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Helping other parents find solutions</td>
<td>4.33 (0.65)</td>
<td>4.25 (0.74)</td>
</tr>
<tr>
<td>15</td>
<td>Finding out that some parents have more difficulties than you</td>
<td>3.98 (0.72)</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Finding out that some parents have less difficulties than you</td>
<td>3.59 (0.76)</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Having space without your child to talk about parenting</td>
<td>4.68 (0.53)</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Other group members having values and ideas about parenting that are different to yours</td>
<td>4.60 (0.50)</td>
<td></td>
</tr>
<tr>
<td><strong>Collaborative</strong></td>
<td></td>
<td></td>
<td>4.08 (0.69)</td>
</tr>
<tr>
<td>6</td>
<td>Discussions about the practicalities of parenting</td>
<td>4.10 (0.59)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Discussion about the positive feelings raised by parenting</td>
<td>4.16 (0.81)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Discussion about difficult feelings about parenting</td>
<td>3.9 (0.75)</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Finding solutions for problems with group facilitators</td>
<td>4.24 (0.66)</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Talking about child’s temperament</td>
<td>4.00 (0.69)</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Talking about the relationship between me and my child</td>
<td>4.04 (0.66)</td>
<td></td>
</tr>
<tr>
<td><strong>Expert</strong></td>
<td></td>
<td></td>
<td>4.07 (0.70)</td>
</tr>
<tr>
<td>1</td>
<td>Giving examples of how to manage a child’s difficult behaviour</td>
<td>4.10 (0.70)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Videos showing how to do it, how not to do it</td>
<td>3.79 (0.83)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Receiving handouts</td>
<td>4.00 (0.65)</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Being given strategies from group leaders</td>
<td>4.18 (0.68)</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Receiving specific advice about my problem</td>
<td>4.13 (0.63)</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Receiving general advice on children’s behaviour</td>
<td>4.13 (0.66)</td>
<td></td>
</tr>
</tbody>
</table>
The category that was perceived as most helpful was the "parents" category which includes the processes of being in a group and meeting other parents. A Wilcoxon Matched-pairs signed rank test was performed on all the combinations of category and it was found that the "Parents" category was found to be significantly more helpful than the "expert" category (z = -2.38 p = 0.017). Neither of the other combinations were found to be significant.

Figure 1 - Graph to show the mean score of each item on the Helpful Aspects of Parent Training Questionnaire

Figure 1 - Graph to show the mean score of each item on the Helpful Aspects of Parent Training Questionnaire

<table>
<thead>
<tr>
<th>Question number</th>
<th>Mean Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>4.8</td>
</tr>
<tr>
<td>4</td>
<td>4.7</td>
</tr>
<tr>
<td>5</td>
<td>4.6</td>
</tr>
<tr>
<td>6</td>
<td>4.5</td>
</tr>
<tr>
<td>7</td>
<td>4.4</td>
</tr>
<tr>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>23</td>
<td>3.4</td>
</tr>
</tbody>
</table>
The three most “helpful” items were identified for each individual, producing a total of 24 items (3 items $\times$ 8 individuals). It was found that the chosen items were mainly from the “Parents” category (22 items) the remaining two items were from the “Collaborative” category. At the post group interview each parent was asked to describe in more detail how the chosen items had affected the way they handled their child’s behaviour. The responses they gave are summarized in Table 4 below.

The most frequently occurring items were:-

“Other people having values and ideas that are different to yours”
“Having space away from your child to talk about parenting”
“Finding out that other people have the same problem as you”

The parents seemed to appreciate hearing the points of view of other parents and it seemed to be important that it was other parents giving ideas rather than friends or family. Many parents felt that they were unable to think about their difficulties while their child was around them and so they really appreciated having time away from their children to focus on their parenting skills. Most parents seemed to value meeting other parents with similar problems and finding out that they are not the only ones with difficulties. It seemed to provide them with confidence.
Table 4 showing the 3 items that were rated as most helpful for each parent and their explanations for why they found it helpful

<table>
<thead>
<tr>
<th>Subject</th>
<th>Item they found most helpful</th>
<th>The reason given for finding it helpful (Taken verbatim from the transcripts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>21. Having space away from your child to talk about parenting</td>
<td>It’s therapy &amp; refreshing. I can go back and be more positive with him. It doesn’t last long but I feel refreshed and more able to cope. Being able to talk to people that aren’t involved is helpful. If you talk to your family/friends it is very difficult because they are involved in your life and more inclined to judge, the group are less likely to judge.</td>
</tr>
<tr>
<td></td>
<td>11. finding out that other people have the same problem as you</td>
<td>It makes you feel better when you know you’re not the only person going through that. It helps you deal with things in a more confident way. someone else who can understand the problem</td>
</tr>
<tr>
<td></td>
<td>3. group exercises to make you feel part of a group</td>
<td>If you don’t feel part of a group you wont feel you can talk about your problems so easily. It always helps to talk about things rather than bottle it up</td>
</tr>
<tr>
<td>2</td>
<td>3. group exercises to make you feel part of a group</td>
<td>Listening to everyone with an open mind. When you’ve got the group there you really try to achieve the goals. The fact that we all got on so well was important and people weren’t frightened of saying the way they felt.</td>
</tr>
<tr>
<td></td>
<td>6. Discussions about the practicalities of parenting</td>
<td>The practicalities of what you want from your child and how parenting is going to be so different from what we dream about. I used to get disappointed that there wasn’t a day that went by when I hadn’t shouted or screamed. Now I have more of an open mind - its OK to have accidents and make mistakes.</td>
</tr>
<tr>
<td></td>
<td>9. Having space away from your child to talk about parenting</td>
<td>I think when you have kids around you all the time you do become brain dead. To be in a room to just have the parents there it actually gives you time to really relate to yourself and think. I used to go home and feel really confident with him.</td>
</tr>
<tr>
<td>3</td>
<td>22. Other people having values and ideas that are different to yours</td>
<td>...because they are parents with children with problems it helps you try it because they have a proven track record of it working for them.</td>
</tr>
<tr>
<td></td>
<td>21. Having space away from your child to talk about parenting</td>
<td>having space to sit back and get a perspective on it</td>
</tr>
<tr>
<td></td>
<td>11. finding out that other people have the same problem as you</td>
<td>Before the group I thought that everyone else manages better than I do. It gives you more confidence to keep trying. Things written by experts are all very well but they don’t fill you with huge amounts of confidence.</td>
</tr>
<tr>
<td>Subject</td>
<td>Item they found most helpful</td>
<td>The reason given for finding it helpful</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>4</td>
<td>9. talking to people in the group that you don’t know</td>
<td>they can see the problem from a distance and they can come up with an answer or advice, you can distance yourself from it as well and then its more easy to put it into practice. you also get more positive suggestions and ways to deal with it.</td>
</tr>
<tr>
<td>14. helping other parents find solutions</td>
<td>It gives you more confidence. If you give advice to someone else and they say good idea...you think if its good for someone else maybe I’ll try it for myself. So you feel more confident</td>
<td></td>
</tr>
<tr>
<td>12. finding solutions for problems with other parents</td>
<td>Its getting ideas from people who had similar problems, again because they could see it from a distance.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>22. Other people having values and ideas that are different to yours</td>
<td>its always good to hear other peoples points of view. you can learn from it. Like how people cope differently the strategies they use, you can think I can try that.</td>
</tr>
<tr>
<td>11. finding out that other people have the same problem as you</td>
<td>To know that I’m not alone and to know that she’s not the only one who screams—it goes on everywhere else.</td>
<td></td>
</tr>
<tr>
<td>7. discussions about the positive feelings raised by parenting</td>
<td>it can be nice to be a parent and that nice to feed back to people. I think I’d loose sight of the positively.</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>4. Exercises to get to know other group members</td>
<td>comparing notes, others giving different solutions, they’ve got children they know how stressful it can be</td>
</tr>
<tr>
<td>21. Having space away from your child to talk about parenting</td>
<td>I was able to concentrate more on what I was talking about, what I was doing. When I have J there my mind is always wandering. I could really think about it more, on what has happened and how to deal with it</td>
<td></td>
</tr>
<tr>
<td>22. Other people having values and ideas that are different to yours</td>
<td>It’s always good to hear different ideas &amp; opinions. It gives me new idea to try with J.</td>
<td></td>
</tr>
<tr>
<td>11. finding out that other people have the same problem as you</td>
<td>because you’re not on your own you’ve got support there, in a group like that they really understand what your going through</td>
<td></td>
</tr>
<tr>
<td>21. Having space away from your child to talk about parenting</td>
<td>You don’t have to worry about him. When your away from them you don’t have to worry about them and you’re concentrating on your own mind on the things you have to do</td>
<td></td>
</tr>
<tr>
<td>22. Other people having values and ideas that are different to yours</td>
<td>if you’ve got an outsider and they give you new ideas, you try really hard in a group, you don’t have to report back to your family, when you are in a group you know they are trying to help because they don’t know who you are.</td>
<td></td>
</tr>
<tr>
<td>22. Other people having values and ideas that are different to yours</td>
<td>I heard one parent whose father was constantly interfering and saying if he were mine I’d belt him. It made me think I definitely don’t want to be like that it cant be good for the child</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>9. Having space away from your child to talk about parenting</td>
<td>If she’s there you can’t concentrate. I made you allocate a couple of hours a week and made you think about the problem and try to find a solution to it. I had 2 hours to think about her and how I behave towards her</td>
</tr>
<tr>
<td>15. Finding out that some parents have more difficulties than you</td>
<td>It makes you think that it could be worse. It helped me appreciate what I have in my child more</td>
<td></td>
</tr>
</tbody>
</table>
Hypothesis 2

I. As people move through the course of the group their view about the most helpful aspects of group process will change. During the early stages of the group the 'expert' items will be perceived as most useful and as the group progresses the 'parents' items will be perceived as most helpful.

The mean score for each group process category was calculated and is given in Table 5 below and displayed in the graph below.

Table 5 - The mean category score for “expert”, “parent” and collaborative” for each group session.

<table>
<thead>
<tr>
<th>Session</th>
<th>Expert</th>
<th>Parents</th>
<th>Collaborative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.83</td>
<td>4.06</td>
<td>3.70</td>
</tr>
<tr>
<td>2</td>
<td>4.03</td>
<td>4.22</td>
<td>4.14</td>
</tr>
<tr>
<td>3</td>
<td>4.08</td>
<td>4.31</td>
<td>4.05</td>
</tr>
<tr>
<td>4</td>
<td>3.94</td>
<td>4.36</td>
<td>4.14</td>
</tr>
<tr>
<td>5</td>
<td>4.14</td>
<td>4.13</td>
<td>4.09</td>
</tr>
<tr>
<td>6</td>
<td>4.30</td>
<td>4.38</td>
<td>4.31</td>
</tr>
</tbody>
</table>

A Spearman correlation was performed to examine whether there was a relationship between each process and the number of the session. The perceived usefulness of the three categories tended to increase with the group session however this was not found to be significant. The category that was found to be most helpful was 'parents' at all but the 5th group session. During the early stages of the group the “parents” item was rated as more helpful than the “collaborative” or “expert”, whereas in the latter stages on the group the ratings of the different categories were more similar.
Figure 2- The mean category score for each group session

![Graph showing the mean category score for each group session with values for collaborative, expert, and parents sessions. The graph plots value against session number.]
Hypothesis 3

In keeping with Herbert's collaborative model it will be possible to detect an increase in the parent's level of self efficacy as a result of attending the Parent Training Group.

The scores for each parent on the sub-scales of satisfaction and efficacy and the total PSOC factor measured before and after the group are given in Table 6 below. The change in each of these three factors was calculated and a Wilcoxon Rank test was performed. It was found that there was a significant increase between the pre-group and post group scores for each of the three categories (p < 0.05).

The change in the mean Satisfaction score suggest that after attending the parent training group the parents had greater satisfaction in their parenting role. This indicates that the parents felt less frustrated and anxious, and more motivated in the parenting role.

The change in the mean efficacy score suggests that the parents felt they had greater efficacy in their parenting role following the parent training group. More specifically this suggests that the parents felt more competent, capable of problem solving and familiar with parenting.

When the figures found in this study are compared to the standardized norms obtained in Johnston & Mash study (1989) (n = 78) it can be seen that the parents started off with lower Satisfaction and PSOC scores. Following the group the parents had greater satisfaction, efficacy and total PSOC scores than the standardized norms.
Table 6 The Means and Standard Deviations for the Satisfaction, Efficacy and PSOC scores.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Satisfaction before group</th>
<th>Satisfaction after group</th>
<th>Change in Satisfaction</th>
<th>Efficacy before group</th>
<th>Efficacy after group</th>
<th>Change in Efficacy</th>
<th>PSOC before group</th>
<th>PSOC after group</th>
<th>Change in PSOC</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>29</td>
<td>19</td>
<td>-10</td>
<td>34</td>
<td>28</td>
<td>-6</td>
<td>63</td>
<td>47</td>
<td>-16</td>
</tr>
<tr>
<td>2</td>
<td>46</td>
<td>48</td>
<td>2</td>
<td>25</td>
<td>45</td>
<td>20</td>
<td>71</td>
<td>93</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>31</td>
<td>39</td>
<td>8</td>
<td>22</td>
<td>35</td>
<td>13</td>
<td>53</td>
<td>74</td>
<td>21</td>
</tr>
<tr>
<td>4</td>
<td>30</td>
<td>43</td>
<td>13</td>
<td>17</td>
<td>34</td>
<td>17</td>
<td>47</td>
<td>77</td>
<td>30</td>
</tr>
<tr>
<td>5</td>
<td>28</td>
<td>35</td>
<td>7</td>
<td>21</td>
<td>23</td>
<td>2</td>
<td>49</td>
<td>58</td>
<td>9</td>
</tr>
<tr>
<td>6</td>
<td>33</td>
<td>51</td>
<td>18</td>
<td>31</td>
<td>41</td>
<td>10</td>
<td>64</td>
<td>92</td>
<td>28</td>
</tr>
<tr>
<td>7</td>
<td>30</td>
<td>46</td>
<td>16</td>
<td>31</td>
<td>40</td>
<td>9</td>
<td>61</td>
<td>86</td>
<td>25</td>
</tr>
<tr>
<td>8</td>
<td>26</td>
<td>39</td>
<td>13</td>
<td>28</td>
<td>33</td>
<td>5</td>
<td>54</td>
<td>72</td>
<td>18</td>
</tr>
<tr>
<td>Mean</td>
<td>31.62</td>
<td>40.00</td>
<td>8.3</td>
<td>26.13</td>
<td>34.88</td>
<td>8.75</td>
<td>57.75</td>
<td>74.88</td>
<td>17.13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standardized mean **</th>
<th>37.40</th>
<th>25.52</th>
<th>63.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard deviation</td>
<td>6.16</td>
<td>9.99</td>
<td>9.05</td>
</tr>
<tr>
<td>Standardized S.D **</td>
<td>6.60</td>
<td>5.29</td>
<td>9.74</td>
</tr>
<tr>
<td>Z score</td>
<td>-2.24</td>
<td>-2.10</td>
<td>-2.24</td>
</tr>
<tr>
<td>p value</td>
<td>p=0.025 (2 tailed)</td>
<td>p=0.036 (2 tailed)</td>
<td>p=0.025 (2 tailed)</td>
</tr>
</tbody>
</table>

** Standardized norms taken from Johnston & Mash (1989) where n = 78 Boys age 6-8.
Figure 3  PSOC scores, Satisfaction and Efficacy Scores before and after the group for each individual

Total PSOC Score
- Before group
- After group

Satisfaction Score
- Before group
- After group

Self efficacy
- Before group
- After group

Case Number
Hypothesis 4

As a result of attending the group the parents will learn more effective ways of managing their child's behaviour and feel more confident and less worried about their child's behaviour.

The parent’s perceptions of the child’s behaviour was assessed using the Child’s Behaviour Interview schedule which was completed with each parent before and after the group.

As part of this interview, the parents were asked to rate on a 5 point scale certain aspects of their children’s behaviour and the effect is was having on them. The mean scores before and after the group and change in score are shown in Table 7 and figure 4 below. A Wilcoxon Matched-Pairs Signed-Rank test was performed on each of these scores and it was found that there was a significant change in each of these 4 measures following the group. This suggests that the parents felt less worried about their children’s behaviour and more confident about coping with it after they had attended the group. The parents also felt that they were more in control and they were enjoying their relationship with their child more of the time following the group as compared to before the group.
Table 7 - The mean scores for certain aspects of the parents perceptions of their children’s behaviour and their reactions to it.

<table>
<thead>
<tr>
<th>Question</th>
<th>Before Group Mean, (SD)</th>
<th>After group Mean, (SD)</th>
<th>Change score Mean, (SD)</th>
<th>z score</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>How worried are you about this behaviour 1 = not worried, 5 = very worried</td>
<td>4.13 (0.64)</td>
<td>2.13 (1.55)</td>
<td>-2.00 (1.51)</td>
<td>-2.00</td>
<td>p=0.03</td>
</tr>
<tr>
<td>How confident do you feel about coping with this behaviour? 1 = not confident, 5 = very confident</td>
<td>2.50 (1.20)</td>
<td>4.00 (0.93)</td>
<td>1.25 (0.89)</td>
<td>1.25</td>
<td>p=0.03</td>
</tr>
<tr>
<td>How much of the time do you feel in control of your child’s behaviour? 1 = none of the time, 5 = most of the time</td>
<td>2.63 (0.52)</td>
<td>3.75 (1.39)</td>
<td>1.13 (1.13)</td>
<td>1.13</td>
<td>p=0.04</td>
</tr>
<tr>
<td>How often do you enjoy your relationship with your child? 1 = none of the time, 5 = most of the time</td>
<td>2.63 (0.74)</td>
<td>4.25 (0.89)</td>
<td>1.63 (0.92)</td>
<td>1.63</td>
<td>p=0.02</td>
</tr>
</tbody>
</table>
4.1 Parent's level of worry about child's behaviour
1 = not worried  5 = very worried

4.ii Parent's level of confidence about managing their child's behaviour
1 = not confident  5 = very confident
4.iii  Amount of time in the parents feel in control of their child's behaviour
1 = none of the time  5 = most of the time

4.iv  Amount of time parents enjoy their relationship with their child
1 = none of the time  5 = most of the time
Part of the Child’s Behaviour Interview schedule consists of questions about the child’s behaviour, its antecedents and the strategies the parent has used to manage it. It also contains questions about how the parent explains the child’s behaviour and the effect it is having on them.

The responses to the questions on the Child’s Behaviour Interview schedule for each parent before and after the group are summarized in Table 8 below. It can be seen that the main concerns of the parents are their children being aggressive, non-compliant, defiant and having temper tantrums. The ‘difficult’ behaviour seemed to be occurring about once a day and for all but two of the children the frequency of the ‘difficult’ behaviour was less after the group when compared to before the group. The parents rating of the duration of the behaviour suggests an improvement in 5 of the 8 cases. The remaining 3 perceived the duration of the child’s behaviour not to have changed. The ratings of the severity of the children’s behaviour improved following the group in 7 out of the 8 cases and the 8th person did not feel that there had been any change.

For many of the parents their children’s ‘difficult’ behaviour provoked them to shout and threaten their children. Following the group many of the parents successfully used alternative strategies for example remaining calm, using distraction and ignoring. For most of the mothers they saw smacking and shouting as unsuccessful strategies in dealing with their children’s behaviour. Before the group the parents felt frustrated, angry and upset by their children’s behaviour. After the group most of the parents seemed to feel more positive and calmer about their children’s behaviour.

Many of the parents sought to explain their child’s behaviour in terms of temperament e.g. strong willed and attention seeking. Some, however explained their child’s behaviour by suggesting that it was a response to early illness and hearing difficulties.
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 pre</td>
<td>he snatches toys from other children screams if mum removes toy</td>
<td>most of the time when with other children</td>
<td>in between</td>
<td>in between</td>
<td>if another child is playing with a toy he likes</td>
<td>say to him he mustn't snatch, try taking the toy off him &amp; giving it to other child</td>
<td>most of the time he screams</td>
<td>1. put him in his cot</td>
<td>2. distraction</td>
<td>3. make him realize he has got to give the toy back</td>
<td>sometimes he gives up the toy, depends on his mood distraction (sometimes)</td>
<td>tried smack on hand put him in cot</td>
</tr>
<tr>
<td>1 post</td>
<td>he is hitting out more hits out at anyone</td>
<td>most of the time when with other children</td>
<td>in between</td>
<td>in between</td>
<td>hits out for no reason</td>
<td>take toy away &amp; give to other child</td>
<td>he screams</td>
<td>1. smacking - can work</td>
<td>2. hold his arms down</td>
<td>3. use threats</td>
<td>4. try challenging</td>
<td>if got the energy try to keep him entertained usually helps</td>
</tr>
<tr>
<td>2 pre</td>
<td>refuses to wear socks to school, kicks mother throws objects and won't stop crying until he has a cuddle</td>
<td>2-3/day</td>
<td>long</td>
<td>in between</td>
<td>putting socks on, child has a set idea about who helps him, and sometimes nothing</td>
<td>starts out calm, grabs him when he kicks her and says this is bad behaviour, and she sits on him and screams at him.</td>
<td>calm-none hold him - more crying sitting-scream and fighting scream at him - turns himself off</td>
<td>1. calm</td>
<td>2. being firm</td>
<td>3. time out</td>
<td>4. smacking</td>
<td>Time-Out being firm when there's time</td>
</tr>
<tr>
<td>2 post</td>
<td>Defiance</td>
<td>1 every 3 weeks</td>
<td>Very short.</td>
<td>Very mild.</td>
<td>Tiredness.</td>
<td>Joke; laugh about him. Reaction is not too short.</td>
<td>At first he looked surprised. Calmed down a lot quicker &amp; outbursts became shorter</td>
<td>HUMOUR and joking. Staying calm. Don't ask him to do things-give him a choice or make it into a game. Affection.</td>
<td>As 13</td>
<td>Sibling's behaviour deteriorated.</td>
<td>Childhood illness heightened mother's anxiety. Mother became very negative towards him.</td>
<td></td>
</tr>
<tr>
<td>3 pre</td>
<td>not responding to parents verbal requests scream and shout</td>
<td>3-5/week</td>
<td>long</td>
<td>very severe</td>
<td>mum asking him to do something</td>
<td>mother shouts at him continually and then physically intervenes isolating him</td>
<td>shouting has no effect. Physical intervention makes him cross. Isolating helps calm him down</td>
<td>1. Smacking 2. threatening to remove toys</td>
<td>3. isolating him</td>
<td>4. shouting</td>
<td>taking something away sometimes isolating him</td>
<td>smacking and shouting</td>
</tr>
<tr>
<td>3 post</td>
<td>not responding</td>
<td>3-4/week</td>
<td>long</td>
<td>time</td>
<td>in between</td>
<td>diet</td>
<td>stay calm and take him away</td>
<td>maybe he goes back to it</td>
<td>1. HUMOUR</td>
<td>2. try to get him to suggest solutions</td>
<td>3. stay calm</td>
<td>getting him to suggest solutions, staying calm &amp; not shouting</td>
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<td></td>
</tr>
<tr>
<td>4 pre</td>
<td>Mother asks him to do something and he says no, he mucks about at the dinner table and provokes his sister</td>
<td>4-5/day</td>
<td>in between</td>
<td>in between</td>
<td>when mother wants him to do something and he doesn't want to, provoked by sister</td>
<td>automatically shout, threatens to throw things out, sends him to bedroom</td>
<td>shouting-he shout back threatening can work bedroom depends on problem</td>
<td>1. separating siblings</td>
<td>2. sending him to bedroom</td>
<td>3. shouting</td>
<td>4. smacking</td>
<td>no idea, can't see what pleasure he gets out of it</td>
</tr>
<tr>
<td>4 post</td>
<td>defiant</td>
<td>1-2 week</td>
<td>short time</td>
<td>mild</td>
<td>when he's engrossed in something</td>
<td>appeal to his better nature e.g. say &quot;It would really help me if...&quot;</td>
<td>he usually says all right</td>
<td>1. shouting</td>
<td>2. send him to his bedroom</td>
<td>3. Keeping calm</td>
<td>4. Reasoning with him</td>
<td>lack of attention, needs a lot of attention because of older sister father was the same-very active (some inherited)</td>
</tr>
<tr>
<td>5 pre</td>
<td>throws herself on ground and screams</td>
<td>2/week</td>
<td>long</td>
<td>very severe</td>
<td>separation form mothers, stranger approaching her, when her mother asks her to do something</td>
<td>mother picks her up in public, distraction, at home she says I'm going to take you to your bedroom and does</td>
<td>distraction - scream talking calmly- scream time-out eventually calms her down</td>
<td>1. talking calmly</td>
<td>2. holding her</td>
<td>3. distraction</td>
<td>4. time out</td>
<td>like the fathers mother, delay in communication</td>
</tr>
<tr>
<td>5 post</td>
<td>Mother saying no, throws self on ground, temper tantrums &amp; avoiding.</td>
<td>6-10 times/day</td>
<td>short</td>
<td>very mild-calambs down more quickly</td>
<td>If someone looks at (speaks to) her - not too bad with family. If mother leaves then comes back.</td>
<td>If you talk to her it makes it worse. Distraction in shops.</td>
<td>Distraction, ignoring. When people look don't say anything to her-screams more.</td>
<td>Distraction, ignoring. Work round her more now, predict what might happen.</td>
<td>Talking to her, trying to calm her down</td>
<td>To punish mother for leaving her. Very angry towards mother, very clingy. Language problem. Very possessive.</td>
<td>Frustration, embarrassed, angry, sad.</td>
<td></td>
</tr>
<tr>
<td>6 pre</td>
<td>Aggression to Mother.</td>
<td>3/week (every day)</td>
<td>middle</td>
<td>in between</td>
<td>when don't give in to him</td>
<td>Hit back shout he shouts and hits back</td>
<td>1. Put him in his room 2. 5 min. Time-Out 3. Removing toys or rewards</td>
<td>Removing time rewards</td>
<td>shouting smacking Time-Out putting in room</td>
<td>likes attention can't tolerate sharing mum with his sister</td>
<td>Feel cross and frustrated like tearing my hair out</td>
<td></td>
</tr>
<tr>
<td>6 post</td>
<td>still demanding but much calmer</td>
<td>3/week</td>
<td>short</td>
<td>mild</td>
<td>attention seeking</td>
<td>divert attention and stay calm</td>
<td>distraction usually works tend to go out more to the park, try to not be so house proud and put the children first</td>
<td>distraction and being more relaxed</td>
<td>shouting smacking</td>
<td>attention seeking still finds it hard to cope with sister</td>
<td>I try to accept him for what he is, I feel calmer</td>
<td></td>
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</tr>
<tr>
<td>7 pre</td>
<td>Kicks thumps screams and throws things</td>
<td>2/day</td>
<td>long time</td>
<td>very severe</td>
<td>if mothers doing something else</td>
<td>she used to shout now picks him up and puts him in the hall outside</td>
<td>carries on., bangs on door, eventually calms down</td>
<td>1. screaming 2. shouting 3. putting him outside the door 4. smacking his legs.</td>
<td>outside the door gives mum time to calm down</td>
<td>smacking and screaming</td>
<td>wants everything his own way and mothers attention</td>
<td>very embarrassed; upset and sad; started to resent him and not like him; I felt trapped.</td>
</tr>
<tr>
<td>7 post</td>
<td>Calmed down - able to go to people’s houses.</td>
<td>1/week</td>
<td>in between</td>
<td>mild</td>
<td>Not getting enough attention.</td>
<td>Mother stays calm. Tries to ignore it.</td>
<td>He looks at me as though to say “aren’t you going to say anything?” Then he calms down.</td>
<td>Ignoring, reward chart.</td>
<td>Ignoring reward chart staying calm.</td>
<td>Putting him outside shouting and screaming at him.</td>
<td>He couldn’t cope with sharing his mother’s attention with his sister.</td>
<td></td>
</tr>
<tr>
<td>8 pre</td>
<td>aggression to self; hits her head against wall and grabs child’s and mothers face; squeezes child’s face and pulls hair kicking when nappy is changed.</td>
<td>6 /day</td>
<td>short time</td>
<td>very severe</td>
<td>mother not giving her attention; another child hits her.</td>
<td>if holding her she puts her down; cuddles her; smack her hand; put her in her room.</td>
<td>holding-she returns; cuddles she scratches mums face; smack-cry; room-headbang on cot and destroys room.</td>
<td>1. increasing distance between mum and child. 2. cuddle. 3. smack. 4. put in room</td>
<td>time in the room; smacking and cuddling</td>
<td>quick mood changes due to adrenaline; perhaps that’s how she feels I am to her as I had PND; she has a sense of being ignored.</td>
<td>really upset, angry, embarrassed, tearful, cries, spends time apologizing but needs to get out herself.</td>
<td></td>
</tr>
<tr>
<td>8 post</td>
<td>Doesn’t headbang aggression to mother much less frequent.</td>
<td>1/week</td>
<td>short time</td>
<td>very mild</td>
<td>Tiredness</td>
<td>Put her in her bedroom to calm down. Try to get her to apologize.</td>
<td>Calms down in bedroom.</td>
<td>Time-Out. Threaten to use time-out. Consistency between parents.</td>
<td>Time-Out. Threaten to use time-out. Consistency between parents.</td>
<td>Sitting on the stairs, smacking. Talking to her nicely.</td>
<td>She’s a lot calmer</td>
<td></td>
</tr>
</tbody>
</table>
In order to examine the relationship between the PSOC scores and the parental perceptions of the child’s behaviour Spearman correlation’s were calculated between PSOC and the parental perception scores (from the Child Behaviour Interview Schedule) for all parents before and after the group. These Correlations are presented in Table 9 and Table 10 below.

Before the group the Satisfaction scores were significantly correlated with the level of confidence the mothers perceived they had in coping with their child’s behaviour (p < 0.05). The efficacy scores and the total PSOC scores were significantly and negatively correlated with the mothers perception of how worried they were about their children’s behaviour (p < 0.05).

After the group a significant relationship was found between the mothers perceptions of how confident they feel about coping with their child’s behaviour and their satisfaction score (p < 0.01), their efficacy score (p < 0.05), and their total PSOC score (p < 0.01). Similarly the mother’s perceptions of the time they spent in control of their child’s behaviour was found to be significantly correlated with all three PSOC scores (p < 0.05). Furthermore their perceptions of how often the parents felt they enjoyed their relationship with their child was significantly related to the efficacy and the total PSOC score.
### Table 9  Correlations between the PSOC scores and the parent perception scores before the group

<table>
<thead>
<tr>
<th></th>
<th>satisfaction before grp</th>
<th>efficacy before grp</th>
<th>PSOC before group</th>
</tr>
</thead>
<tbody>
<tr>
<td>worried about behaviour</td>
<td>r = -0.45</td>
<td>r = -0.75</td>
<td>r = -0.78</td>
</tr>
<tr>
<td></td>
<td>p = 0.13</td>
<td>p = 0.017*</td>
<td>p = 0.01*</td>
</tr>
<tr>
<td>confident about coping with behaviour</td>
<td>r = 0.71</td>
<td>r = -0.15</td>
<td>r = 0.45</td>
</tr>
<tr>
<td></td>
<td>p = 0.024*</td>
<td>p = 0.36</td>
<td>p = 0.13</td>
</tr>
<tr>
<td>time in control of behaviour?</td>
<td>r = 0.28</td>
<td>r = 0.45</td>
<td>r = 0.62</td>
</tr>
<tr>
<td></td>
<td>p = 0.25</td>
<td>p = 0.13</td>
<td>p = 0.51</td>
</tr>
<tr>
<td>enjoy your relationship with child?</td>
<td>r = 0.68</td>
<td>r = 0.43</td>
<td>r = 0.68</td>
</tr>
<tr>
<td></td>
<td>p = 0.031*</td>
<td>p = 0.15</td>
<td>p = 0.03*</td>
</tr>
</tbody>
</table>

* = significant at 0.05 1 tailed test

### Table 10  Correlations between the PSOC scores and the parent perception scores after the group

<table>
<thead>
<tr>
<th></th>
<th>satisfaction after group</th>
<th>efficacy after group</th>
<th>PSOC after group</th>
</tr>
</thead>
<tbody>
<tr>
<td>worried about behaviour</td>
<td>r = -0.37</td>
<td>r = -0.47</td>
<td>r = -0.44</td>
</tr>
<tr>
<td></td>
<td>p = 0.18</td>
<td>p = 0.12</td>
<td>p = 0.13</td>
</tr>
<tr>
<td>confident about coping with behaviour</td>
<td>r = 0.87</td>
<td>r = 0.78</td>
<td>r = 0.86</td>
</tr>
<tr>
<td></td>
<td>p = 0.003**</td>
<td>p = 0.01*</td>
<td>p = 0.003**</td>
</tr>
<tr>
<td>time in control of behaviour?</td>
<td>r = 0.63</td>
<td>r = 0.75</td>
<td>r = 0.65</td>
</tr>
<tr>
<td></td>
<td>p = 0.048*</td>
<td>p = 0.02*</td>
<td>p = 0.04*</td>
</tr>
<tr>
<td>enjoy your relationship with child?</td>
<td>r = 0.74</td>
<td>r = 0.77</td>
<td>r = 0.77</td>
</tr>
<tr>
<td></td>
<td>p = 0.02*</td>
<td>p = 0.01*</td>
<td>p = 0.01*</td>
</tr>
</tbody>
</table>

* = significant at 0.05 1 tailed test
Hypothesis 5

The changes in the parents self efficacy will be related to the perceived helpfulness of the group.

In order to explore whether the change in the PSOC scores and the parent perception of helpful aspects of the group are related a Spearman correlation was performed between the PSOC scores and helpful aspect category score i.e. “Expert”, “Parents” and “Collaborative” (see Table 11 below). No relationship was found between these variables except that a weak correlation was found between change in PSOC scores and the “parent” items. However, given the number of Correlations carried out, this figure cannot be considered as significant.

Table 11 - Correlations between the change in PSOC score and the Parental ratings of the child’s behaviour scores with the helpful aspects category score

<table>
<thead>
<tr>
<th></th>
<th>“Expert”</th>
<th>“Parents”</th>
<th>“Collaborative”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in satisfaction score</td>
<td>r = 0.32</td>
<td>r = 0.34</td>
<td>r = 0.41</td>
</tr>
<tr>
<td></td>
<td>p = 0.43</td>
<td>p = 0.41</td>
<td>p = 0.32</td>
</tr>
<tr>
<td>Change in Efficacy Score</td>
<td>r = 0.62</td>
<td>r = 0.67</td>
<td>r = 0.62</td>
</tr>
<tr>
<td></td>
<td>p = 0.10</td>
<td>p = 0.07</td>
<td>p = 0.10</td>
</tr>
<tr>
<td>Change in PSOC Score</td>
<td>r = 0.69</td>
<td>r = 0.71</td>
<td>r = 0.69</td>
</tr>
<tr>
<td></td>
<td>p = 0.06</td>
<td>p = 0.047*</td>
<td>p = 0.06</td>
</tr>
<tr>
<td>Change in worry about child’s behaviour</td>
<td>r = -0.36</td>
<td>r = -0.42</td>
<td>r = -0.21</td>
</tr>
<tr>
<td></td>
<td>p = 0.38</td>
<td>p = 0.30</td>
<td>p = 0.62</td>
</tr>
<tr>
<td>Change in confidence about coping with behaviour</td>
<td>r = -0.06</td>
<td>r = -0.10</td>
<td>r = 0.08</td>
</tr>
<tr>
<td></td>
<td>p = 0.88</td>
<td>p = 0.81</td>
<td>p = 0.86</td>
</tr>
<tr>
<td>Change of time in control of behaviour?</td>
<td>r = 0.60</td>
<td>r = 0.66</td>
<td>r = 0.47</td>
</tr>
<tr>
<td></td>
<td>p = 0.12</td>
<td>p = 0.07</td>
<td>p = 0.24</td>
</tr>
<tr>
<td>Change in amount of time the relationship with child is enjoyed?</td>
<td>r = 0.31</td>
<td>r = 0.34</td>
<td>r = 0.28</td>
</tr>
<tr>
<td></td>
<td>p = 0.46</td>
<td>p = 0.40</td>
<td>p = 0.50</td>
</tr>
</tbody>
</table>
In order to explore whether there is any relationship between PSOC scores before and after the group and the parents perceptions of helpful aspects of the group another Spearman Correlation was performed (See Table 12 below). It was found that there was a significant correlation between the helpfulness of all three of the group processes and the Satisfaction with parenting score, the efficacy in parenting and the total PSOC score (sum of satisfaction and efficacy score) after the group.

Table 12 - Correlations between the PSOC scores before and after the group and the helpful aspect of the group score

<table>
<thead>
<tr>
<th></th>
<th>“Expert”</th>
<th>“Parents”</th>
<th>“Collaborative”</th>
</tr>
</thead>
<tbody>
<tr>
<td>satisfaction score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>before group</td>
<td>r= 0.61</td>
<td>r= 0.66</td>
<td>r= 0.63</td>
</tr>
<tr>
<td></td>
<td>p = 0.12</td>
<td>p = 0.08</td>
<td>p = 0.09</td>
</tr>
<tr>
<td>satisfaction score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>after group</td>
<td>r= 0.85</td>
<td>r= 0.86</td>
<td>r= 0.9</td>
</tr>
<tr>
<td></td>
<td>p = 0.008**</td>
<td>p = 0.006**</td>
<td>p = 0.002**</td>
</tr>
<tr>
<td>Efficacy Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>before group</td>
<td>r= 0.13</td>
<td>r= 0.14</td>
<td>r= -0.08</td>
</tr>
<tr>
<td></td>
<td>p = 0.75</td>
<td>p = 0.73</td>
<td>p = 0.84</td>
</tr>
<tr>
<td>Efficacy Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>after group</td>
<td>r= 0.77</td>
<td>r= 0.81</td>
<td>r= 0.76</td>
</tr>
<tr>
<td></td>
<td>p = 0.03*</td>
<td>p = 0.015*</td>
<td>p = 0.03*</td>
</tr>
<tr>
<td>PSOC Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>before group</td>
<td>r= 0.56</td>
<td>r= 0.57</td>
<td>r= 0.43</td>
</tr>
<tr>
<td></td>
<td>p = 0.15</td>
<td>p = 0.14</td>
<td>p = 0.29</td>
</tr>
<tr>
<td>PSOC Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>after group</td>
<td>r= 0.84</td>
<td>r= 0.86</td>
<td>r= 0.90</td>
</tr>
<tr>
<td></td>
<td>p = 0.009**</td>
<td>p = 0.007**</td>
<td>p = 0.002**</td>
</tr>
</tbody>
</table>

Further analyses were performed on the helpfulness of the group processes and the level of confidence, worry, time in control and amount of enjoyment with the child. The only relationships that were found to be significant were the group process “collaborative” and the level of confidence of the parent following the group (r=0.87, p=0.005).

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In order to explore in more detail how the parents were affected by attending the parent training group, two parents have been selected. The two individuals chosen were selected on the grounds that they showed the most extreme changes in their PSOC scores. The responses to a number of questions at the pre- and post-group interviews are presented alongside their scores for the PSOC scale on Table 13.

**Individual Profile of Person 4**

Person 4 showed the greatest improvement in their PSOC score of 30 points which was made up of an improvement in her satisfaction score of 13 points and an improvement in her parenting efficacy score of 17. Her main complaint about the difficulties she was having with her child’s behaviour was that he never does as he was told and he can be very disruptive. This seemed to happen 4 or 5 times a day. Her response to this seemed to be to shout at him, put him in his bedroom or threatened to throw his toys away. She said she felt ashamed of his behaviour and felt that it reflected on her not being a good mother. This was reflected in her other scores in that she felt unconfident in how to deal with his behaviour and little of the time in control of his behaviour. It also seemed that she did not enjoy her relationship with him much of the time.

This was a very different picture compared to after the group. She still felt that her child could be defiant but it was happening only once or twice a week. When asked how she responded to it she said that she tried to “appeal to his better nature” by saying that “it would really help her if he would….”. She seemed to try to praise his desirable behaviour and ignore his undesirable behaviour more. His misbehavior did not seem to provoke the same reactions in her as before the group. She said that she generally felt good about herself but still annoyed when he “plays up”. Similarly she seemed to feel quite confident in coping with his behaviour and seemed to feel in control of his behaviour most of the time.
Her level of enjoyment of her relationship with him rose from 2 to 5 on a scale where 1 signifies none of the time and 5 signifies most of the time.

**Individual Profile of Person 1**

Person 1 was selected because they were the only individual who showed a decrease in their PSOC score over time. They had a reduction in score of 16 points which was made up of a drop of 10 points in their satisfaction in parenting score and 6 in their self efficacy score.

Before the group her main concern was around her child’s interactions with other children. She was worried that he snatched toys from other children and would scream if she removed the toy from him. Following the group there had been no improvement and he was still having difficulties sharing toys. She was also worried that he was being aggressive to her and other children. Before the group she dealt with his behaviour by taking the toy away and giving it to another child. Following the group she still used this strategy but also tried to avoid the situation by keeping him busy.

Her feelings provoked by her child’s misbehavior did not seem to have changed as a result of attending the group. She said that it made her feel embarrassed, low, frustrated and resentful of him. This lack of improvement was also reflected in her other scores which remained the same (i.e. quite worried about his behaviour and not very confident about dealing with it ). It is worthy of note that when she was asked the question “Has anything else in your life made coping with you child either easier or more difficult” she was feeling under a great deal of stress for personal reasons.
### Table 13 - Individual Profile of person 4 and 1 based on their pre and post group interviews

Responses summarized from the Child Behaviour Interview Schedule

<table>
<thead>
<tr>
<th></th>
<th>Person 4 Before the group</th>
<th>Person 4 After the group</th>
<th>Person 1 Before the group</th>
<th>Person 1 After the group</th>
</tr>
</thead>
<tbody>
<tr>
<td>satisfaction in parenting</td>
<td>30</td>
<td>43</td>
<td>29</td>
<td>19</td>
</tr>
<tr>
<td>parenting self efficacy</td>
<td>17</td>
<td>34</td>
<td>34</td>
<td>28</td>
</tr>
<tr>
<td>PSOC score</td>
<td>47</td>
<td>77</td>
<td>63</td>
<td>47</td>
</tr>
<tr>
<td>Description of behavior</td>
<td>* He will not do as he is told *says no when asked to do something *disruptive behaviour</td>
<td>defiant behaviour</td>
<td>*he snatches toys from other children *he screams if mother removes toy</td>
<td>he still snatches toys from other children *he hits other children and his mother</td>
</tr>
<tr>
<td>Frequency of behaviour</td>
<td>4-5 times a day</td>
<td>1-2 week</td>
<td>whenever he is with other children</td>
<td>most of the time he’s with other children</td>
</tr>
<tr>
<td>Antecedents to behaviour</td>
<td>when mother asks him to do something when he is engrossed in something</td>
<td>if another child is playing with a toy he wants</td>
<td>same as before and he hits out for no reason</td>
<td></td>
</tr>
<tr>
<td>Mother’s reaction to child’s behaviour</td>
<td>mother shouts and threatens to throw things out or ends him to his bedroom</td>
<td>try to ‘appeal to his better nature’, staying calm praising his desirable behaviour and ignoring his undesirable behaviour</td>
<td>tell him off, remove toy and give it to other child</td>
<td>*tell him off, remove toy and give it to other child *hold his arms down if he tries to hit *try to keep him busy</td>
</tr>
<tr>
<td>Mothers feelings provoked by child’s behaviour</td>
<td>mother feels angry and ashamed and shown up for not being a good mother, and condemned for having an out of control child</td>
<td>generally feel good about herself but feel a little annoyed when he plays up</td>
<td>feel embarrassed that he is a poor reflection on her. feel tearful, low and sad</td>
<td>feel stressed, isolated, frustrated and resentful of him.</td>
</tr>
<tr>
<td>how worried are you about his behaviour?</td>
<td>5 = very worried</td>
<td>1 = not worried</td>
<td>5 = very worried</td>
<td>1 = not worried</td>
</tr>
<tr>
<td>how confident do you feel about coping with his behaviour?</td>
<td>5 = very confident</td>
<td>1 = not confident</td>
<td>5 = very confident</td>
<td>1 = not confident</td>
</tr>
<tr>
<td>how much of the time do you feel in control of his behaviour?</td>
<td>5 = most of the time</td>
<td>1 = none of the time</td>
<td>5 = most of the time</td>
<td>1 = none of the time</td>
</tr>
<tr>
<td>how often do you enjoy your relationship with your child?</td>
<td>5 = most of the time</td>
<td>1 = none of the time</td>
<td>5 = most of the time</td>
<td>1 = none of the time</td>
</tr>
</tbody>
</table>
Content analysis of the responses from the Perceived Helpfulness of a Group Interview Schedule (PHGIS)

The post group interviews were transcribed and a content analysis was performed. The responses were categorized according to different themes that emerged from the content. 12 categories were found and these are listed below. Examples of each of the 12 categories of response are listed in the section below. Table 14 shows whether the process occurred during the interviews with each subject.

The main processes which occurred in the helpful aspects of the group interview schedule

1. **Identification** - The group provides the opportunity to meet other mothers with similar problems and help them know that they are not the only one in the world with problems

2. **Favorable comparison** - The group provides the opportunity to meet other mothers with worse problems with their children's behaviour

3. **Distancing** - The group helped parents step back and look at their situation from a distance

4. **Parental Advice** - The group provided ideas and advice from other parents who were experiencing similar situations and can understand their difficulties.

5. **Leader Facilitation** - Group leaders input offering advice and facilitating discussion

6. **Insight into the Parent - Child Relationship** - The parent learns the relationship between the way they behave and the way their child responds. The group provided the
parents with strategies to help them deal with their children’s behaviour e.g. staying calm when your child misbehaves

7. **Learn the strategy of praise** - The group provided the parents with strategies to help them deal with their children’s behaviour, for example using praise

8. **Learn the strategy of distraction** - The group provided the parents with strategies to help them deal with the children’s behaviour e.g. using distraction techniques when the child misbehaves

9. **Group Encouragement** - The group gives them encouragement to attempt and to persevere with new ideas and new strategies

10. **Confidence** - The group increased the confidence of the parents to deal with their children’s behaviour

11. **Change perspective of their Child** - The group helped the mothers gain a different perspective on their child

12. **Change perspective of themselves** - The group helped the mothers gain a different perspective about themselves as parents.
Table 14: Summary of the responses of the Perceived Helpfulness of a Group Interview Schedule (PHGIS)

<table>
<thead>
<tr>
<th>Helpful Aspect</th>
<th>sd</th>
<th>lf</th>
<th>pw</th>
<th>kd</th>
<th>mr</th>
<th>ma</th>
<th>dc</th>
<th>ci</th>
<th>% of interviews where the process occurred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>100%</td>
</tr>
<tr>
<td>Favorable comparison</td>
<td>y</td>
<td>n</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>63%</td>
</tr>
<tr>
<td>Distancing</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>100%</td>
</tr>
<tr>
<td>Parental Advice</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>75%</td>
</tr>
<tr>
<td>Leader Facilitation</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>63%</td>
</tr>
<tr>
<td>Insight into the parent-child relationship</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>100%</td>
</tr>
<tr>
<td>Learn the strategy of praise</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>75%</td>
</tr>
<tr>
<td>Learn the strategy of distraction</td>
<td>n</td>
<td>y</td>
<td>n</td>
<td>n</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>50%</td>
</tr>
<tr>
<td>Group encouragement</td>
<td>n</td>
<td>y</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>75%</td>
</tr>
<tr>
<td>Confidence</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>88%</td>
</tr>
<tr>
<td>Change perspective of their child</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>100%</td>
</tr>
<tr>
<td>Change perspective of themselves</td>
<td>y</td>
<td>y</td>
<td>y</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>y</td>
<td>y</td>
<td>63%</td>
</tr>
</tbody>
</table>
Examples of each of the 12 categories of response from the Perceived Helpfulness of a Group Interview Schedule (PHGIS)

Below are shown sections of transcript illustrating responses falling into the categories described above. The codes used are as follows:- ......signifies pauses in the verbal response. ( ) signifies where the author has added a word to help the reader make sense of the response.

1. Identification

Meeting other mothers with similar problems and knowing that you are not the only one in the world with similar problems

LF “To actually listen and hear that there are other people going through the same thing. It makes you realize you’re not a bad mother— but you’re not doing your job the way it should be done.”

SD “I think being able to talk to other mums who are having problems. It was like a support network. It was the feeling of support”

MR “I think knowing that other people have difficult children because I hadn’t actually met other people who admitted that their child was a real pain at times.....Meeting other parents was helpful because you knew you weren’t the only one in the world who was suffering...”

CI…” just talking to other parents that have a child like you because you do feel at a loss when talking to other mothers when they say “I know what you mean” No one quite understood how awful it was...”
2. Favorable comparison
Meeting other mothers who have worse problems with their children’s behaviour

DC “It puts everything you’ve got in your life in perspective. Even though his behaviour was totally different when I’m in that situation I always think of other people and what they’re going through.”

CI “The lady that has a little girl who has tantrums I found talking to her helpful, her little girl seemed even worse to cope with and that was somehow helpful to me...”

SD “I think the main thing that has helped is knowing that there are other women out there that have the same problems or worse.”

3. Distancing
The group helped parents step back and look at their situation from a distance

KD “Sort of learning about other people and their situations, you can see why problems come about, which helps you to see why your problems come about. You can relate to others, and then you can look at your problems from further away rather than being in the middle of them...... I could see the way I was reacting towards him”.

PW “I don’t think I’m doing such a bad job. I’m feeling more confident about that. It was about standing back and getting a perspective on it and seeing that what you’re doing isn’t much different to what other people in the group are doing.”

LF “You know you’re going home with fresh ideas and new ways of handling it. I think it makes you think, without your child there you think more about the child and the situation. Like the tree thing...”
4 Parental Advice

The group provided ideas and advice from other parents who were experiencing similar situations and who can understand your difficulties

MR “In the group you learn from each other, because the only other person you learn from is your mother isn’t it? Whereas perhaps in your family your mothers and sisters tell you how to be a parent, whereas in a group you’re equals aren’t you and therefore you have more respect for each others suggestions”

LF “The positive feedback from other parents was important nobody said “ god you’re so bad, fancy doing that to your son”. There was more “yes I can relate to that”... Because it was parents that were having problems they weren’t saying “do this it will work” it was like “well this worked for my child it might work for yours” Outside the group they say “Do it, it will work” and then you get disappointed when it didn’t work. whereas in the group you didn’t feel a failure if it didn’t work because there was another door to open, other ideas.”

DC “The lady with “the hand idea”, I would have never have thought of that, When you’re in a group you literally know they are trying to help you because they don’t know who you are, whereas in a family they say “oh for goodness sake look at the state of your children”

5. Leader Facilitation

Group leaders input offering advice and facilitating discussion

SD “You just pointing out the steps we went through in the last session about being positive and trying to praise the child. It was helpful having you there bringing things out and talking together.”
DC “You going through it, putting questions to us, writing things down on paper……if it had just been us mothers the questions would have fallen apart.”

MA “It was the advice that you gave us for example when he did that painting I framed it and he thought it was absolutely marvelous”.

6. Insight into the parent-child relationship
The parent learns the relationship between the way they behave and the way their child responds. The group provided the parents with strategies to help them deal with their children’s behaviour e.g. staying calm when your child misbehaves

DC “I’m more calm and I stand there and talk to him and pick him up and try and calm him down....”

KD “You don’t immediately think “oh so and so does that therefore I’m not alone and I can keep calm about it “ I think its there in the back of your mind....That helps you keep calm and deal with it in a better way than just shouting or smacking.”

PW “I can now take a deep breath and step back, instead of shouting at him I’m calmer at times. I suppose I now feel that you have to be in charge of yourself before you’re in charge of your child. If you end up shouting and screaming and having a tantrum, then your child will have one.”

7. Learn the strategy of praise
The group provided the parents with strategies to help them deal with their children’s behaviour for example using praise to encourage ‘desirable’ behaviours

KD “I think it started with the praise and going over the top with the praise. That worked and I suppose by praising him he was getting better, I didn’t have to the need to shout so
much. It was like a vicious circle, the more I praised him, the better he was and then there was less need to shout.”

MA “How to tackle difficult behaviour e.g. how to praise them when they’ve done something good. I used to do it but not as often, now I do it on a regular basis”.

CI “One of the biggest things I found useful was the fact we all talked about the fact that we never praised them when they were doing things that were good and seemed only to take notice of them when they’re doing bad things... I’ve really noticed with C that she really loves praise.”

8. Learn the strategy of distraction

The group provided the parents with strategies to help them deal with the children’s behaviour e.g. using distraction techniques when the child misbehaves

CI “I think when she started to be naughty I would try and instantly divert her attention as opposed to, you know we talked about trying to get them onto something else rather than saying “No, don’t do this”...It’s much more difficult not to shout when she’s pouring something onto the floor and say “Why don’t you do this?”, but it does work...”

MR “It made me more tolerant of her behaviour and able to distract her more. If she screams in Sainsburys I cope with it a bit better. I think the distraction is the biggest change that has helped.”

DC “Whereas before if I was in a shop and he’d started I wouldn’t recognize it... I wouldn’t think to myself to distract him... I’d have just taken him outside and sat in the car fuming...and felt really dreadful that he’d ruined my day yet again”
9. Group Encouragement

The group gives the parents the encouragement to attempt and to persevere with new ideas and new strategies

KD - "It worked because we were all going away to try it and then you were going to report back with all those other people. If it had just been you and I doing it, you’d have said “try praising him”, I’d have gone home and tried it once and it wouldn’t have worked, gone back to shouting and said not it didn’t work.....because knowing there were other people with similar problems, worse problems who were all trying the same thing I think you stuck at it.....You also know that having to report back on it next week and if they all said “oh we’ve tried it and it worked” and I said “oh I didn’t bother trying it” I’d feel a bit silly.”

DC “I felt when we did the hand business OK the first couple of days it didn’t really work.... but after a while -a few days- he just kind of came round to it... I just persevered with it. Because I wanted to come back the next week and say “yes it worked” and have something positive to say so they think it works or her doing something like that then maybe I’ll try it, It gives encouragement.”

LF “I used to picture the group in my head. I didn’t want to let the group down. I picture them all in my mind, supporting me and saying “yes, you’re doing good”...If you’ve got the encouragement you’ll do it because of the other people knowing you’re trying it. Whereas if you’re on your own, you’re only letting yourself down and you’ve let yourself down so many times when you’re a parent anyway that one more time doesn’t matter.”
10. Confidence
The group provided the parents with confidence to deal with their children

LF “Talking to people about it is one of the most important things, because you really need that self-confidence. No one (outside) says “you’re a really wonderful mother, you’re really good at this, good at that” they pick up on the bad things and say “Isn’t he an awful child why is he behaving like that”

PW “It all goes back to confidence, If you’re struggling, you think it must be you doing something wrong, but there are other people similarly trying their best and not getting anywhere. It gives you more confidence to keep trying. It was a motivator. Things written by experts are all very well but they don’t fill you with huge amounts of confidence.”

KD “You might have thought about it before but not tried it because you didn’t have the confidence If you’ve given an idea to someone else and they think it’s a good idea then you feel more confident in yourself”

11 Change perspective of child
The group helped the mothers gain a different perspective of their child

DC “When J. came along, after a few months I just hated him., I didn’t love him at all. It’s learning to love him again, to bond with him as a mother not as this thing that has been sent to you....... I see him in a different light. He is so lovable now I didn’t realize how lovable he was.”

KD “I’m more able to separate K from his behaviour which I couldn’t do before, the behaviour was K. because he’s better its easier to separate the two.... Before I couldn’t see any of the good points. It was always marred by the bad bits.....All I could see before was the negative, if he did something good I virtually ignored it “
LF “I don’t see him as an adult any more I see him as a child. I really do love him to bits now. Before I loved him but I didn’t really like him. Now I really like him and I’m proud that he’s my son. I think the group helped me gain control so that I could see him in a different light.”

12. Change perspective of themselves

The group helped the mothers gain a different perspective of themselves as parents

LF “Once I came to the realization that I wasn’t a wicked witch, I wasn’t a bad parent, I knew things could be different.”

CI “The fact that other mother’s snap too helps you learn you’re not an awful mother the group did make me feel more positive. I think it is really difficult to think differently if your first child is a difficult child, other than I’m a lousy parent…..She improved and it gave me more confidence in my parenting skills.”

KD-“I didn’t feel like a mother when I didn’t like him very much. It just got me down because I couldn’t think of any other way to deal with him and also because I thought I would hurt him. I felt really awful about that. I thought things shouldn’t have to be like that… To go to a group and get all that feedback it does make you feel that you should be more of a mother.”

Summary of the responses to the “Perceived Helpfulness of a Group Interview Schedule”

There seemed to be close agreement between the parents on the aspects of the group they found most helpful. They all seemed to value the opportunity to meet other mothers experiencing similar difficulties. Many of the parents expressed how isolated they had been feeling in trying to cope with their children’s difficult behaviour. Many of them felt that the
group gave them the opportunity of “stepping back” from their situation and looking at it from a distance. Although some of them commented on the advice and input from the group leaders more of them cited how helpful it was gaining advice from other parents who could understand “what they are going through”.

During the interview they frequently cited examples of different strategies they had learnt to help them deal with their children’s behaviour more effectively. The most useful strategies seemed to be, staying calm when their child ‘misbehaved’, praising their child to encourage the good behaviour and distraction to avoid a temper tantrum.

The parents felt that the group encouraged them to persevere with new strategies and ideas and many of them mentioned how important it was having to report back to the group the following week. The group seemed to give many of the mothers a hope and determination that their situation could be different. As a result of attending the group all the mothers talked about how they saw their child differently and most of them perceived themselves as mothers more positively.

Unhelpful Aspects of the Group

Part of the “Perceived Helpfulness of a Group Interview Schedule” asks the parents about the aspects of the group they found unhelpful or the would have liked to be different. The responses to these questions and typical examples are displayed in Table 15 below.

The table below demonstrates that many of the mothers found particular video excerpts not very helpful usually because the parents did not feel that they related to their particular situation. However one mother particularly mentioned how she had found the video useful as it had made her think about how she handled her son.
The majority of parents felt that inviting their partners would have been helpful but some of them felt that this would necessitate the group meeting in the evening. Some of the parents felt that the partners could have attended one or two sessions so they could have been more involved.

One mother felt that the sessions should have been longer and more of them. Another mother felt that the sessions were not in a logical order. Perhaps more importantly one mother felt that the group highlighted the difference between the behaviour of her child and that of others, something she said she was aware of before the group. This seem to make her feel set apart from the others.
Table 15 To show the parents responses to the questions about the aspects of the group they found unhelpful or the would have liked to be different.

<table>
<thead>
<tr>
<th>Unhelpful Aspects</th>
<th>Example</th>
<th>Frequency (n=8)</th>
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</table>
| Video scenes did not relate to difficulties they were experiencing                | The playing video, although you do have a mum & dad there sometimes the most common situation is with the mum there on her own....So it wasn’t very helpful because it didn’t relate  
The video of the little girl shopping. It didn’t really apply to me as such...We don’t have that actual problem | 5 63%          |
| The husbands should have been invited to some of the groups                        | not having husbands there. Its like when you go to a group and you see the problem in a different way and I go home and tell my husband, I’m the one who knows it and then it’s dump it on her. Instead of listening to how he can do it.....If something goes wrong he’ll shout for me rather than thinking he has the power and control to deal with it himself. | 5 63%          |
| The group should have been longer                                                 | It could have been longer and more things might have come out of it, maybe to go over certain points of certain things that bothered certain people.....maybe each session needed to be a bit longer maybe 3 hours and more weeks | 1 13%          |
| The sessions did not progress in a logical order                                   | I don’t know if it progressed in a logical order really. When we had that session about what happened to ourselves and our child, I think that should have happened right at the beginning.....You could see why people had got into a mess. So maybe if you had done that before the group or in the first session it would have made it flow easier. It can give you a bit more of a philosophical attitude on it, it helps you to see this isn’t all your fault | 1 13%          |
| One parent felt that none of the other parents had the same difficulties as she was experiencing | I suppose personally I didn’t really think that anyone else had a child that was the same as E....I could relate to the other problems. I do feel that E’s problem is quite different. I don’t feel that I was getting anywhere. I felt that I was the odd one out a bit. It made me more aware that E. is different, but then my husband and I thought that anyway. I’d love to find something to explain it all | 1 13%          |


Discussion

General Overview

The parents seemed to come to the group because they wanted help in handling their children’s behaviour problems. At the pre-group interview the parents reported to have developed confrontational and negative patterns of interacting with their children and as a result most of them felt frustrated and unsuccessful in their parenting role. This study explored the perceptions of mothers attending a parent training group using both quantitative and qualitative methods. It was found that as a result of attending the parent training group the parents felt more efficacious in their parenting role and they felt more confident in handling their children’s behaviour. The group seemed to enable them to use behaviour management strategies successfully. Generally they felt more positive about their children following the group and more positive about their parenting role. The parents seemed enthusiastic and satisfied with the parent training group.

The situation before the group

On the basis of the responses to the Child’s Behaviour Interview Schedule conducted before the group it appeared that the parents came to the group because they were concerned about their children’s defiant and non-cooperative behaviour. Most of the parents seemed to respond to their children’s misbehaviour by confrontational strategies such as shouting, smacking and isolating their children even though many of them felt these strategies were unsuccessful. Most of the parents seemed to be able to suggest different strategies that they could use to manage their children’s more difficult behaviour but felt they were unable to implement them. They were left feeling angry and frustrated. The feelings elicited by their interactions with their children were similar to those described in an earlier study of parents attending a parent training group. Spitzer et al (1991) recorded the feelings described by parents of conduct-problems children during the intake
interviews for a parent training group. For example "they initially expressed despair, anger, shame, fear, and helplessness concerning their interactions with their children" (Spitzer et al 1991).

This pattern of responses has been found in earlier research for example Gardner reported that mothers of "problem children" engaged in more confrontations with their children that a control group (Gardner 1987;1989). Similarly, Campbell (1990, 1991) found that mothers with non compliant children are more impatient and power assertive and less consistent.

For these parents it seemed as though a pattern of interactions had been set up with their children where the children had apparently learnt to ignore the mother’s instruction and the parents used increasingly confrontational discipline methods with limited success. It is interesting to relate this to earlier research where it was found that mothers of conduct disordered boys were more negative when interacting with their own children than they were when interacting with other non-compliant children (Anderson Lytton & Romney 1986). This suggests the importance of the history of the relationship and how both mothers and children learn over time to interact.

The parents did not seem to enjoy their relationship with their child most of the time and also did not seem to feel in control of their child’s behaviour. This supports earlier research based on observations of mothers and pre-school children. It was found that mothers and problem pre-schoolers were less likely to engage in joint play activities or joint conversations, mutual enjoyment or turn taking (Greenberg & Speltz 1988). It seems likely that the pattern of more negative interactions and lack of enjoyment of the relationship serves to perpetuate the problems.

There was a general impression that the parents felt isolated in trying to deal with their child’s behaviour on their own. It appeared that they felt no-one understood how they
were feeling. This was a similar finding to a previous study on the process of a parent training group where they described “the parents sense of being stigmatized and isolated from other parents with similar aged children.” (Spitzer et al 1991). In this study the parent’s sense of isolation from other parents was due partly to a feeling that they had not been effective in producing a normal child and partly to a fear that if they were honest about their difficulties they would experience rejection or indifference (Spitzer et al 1991).

The parents’ explanations for the difficulties they were having with their children’s behaviour seemed to centre around temperament factors, for example, a common reason given was that the child is “strong willed”. This is an interesting finding in the light of previous research which has found that although early assessments of temperament can predict later behaviour problems, the amount of variance in terms of behaviour problems accounted for by temperament is relatively small (Sansun et al 1991). However, temperament is likely to interact with other factors e.g. parental management styles and level of support to affect outcome. For the parents, where their interactions with their children have left them feeling that they are failing in their parenting skills, this belief may serve an important protective function in that they see the problems primarily as due to the child’s temperament rather than as a reflection of something about themselves.
The Extent to which the Results Support the Hypotheses

In the introduction a number of hypotheses were put forward. The following section discusses whether these hypotheses were supported by the results.

Hypothesis 1

Parents will perceive the most important factors of the group as being

i) the support they receive from the other group members

ii) learning new knowledge and skills about behavioural techniques

As predicted by hypothesis 1 the aspect of the group the parents found most helpful was the “Parents” Category. This included aspects of the group that were associated with meeting other parents and being in a group. The parents seemed to value the opportunity to have space away from their child to discuss parenting issues which they seemed to have little opportunity to do in their lives generally. The parents’ explanations for how this aspect helped, was that time away from their children was refreshing and it gave them the time to think and reflect on their situations without the constant distraction of children around them.

They also seemed to find meeting others who were experiencing similar problems to themselves extremely helpful. The parents reported that it made them feel less isolated knowing that others were experiencing similar difficulties and that knowing that there are others who could identify with them and understand their situation provided them with support and confidence. Previous studies have also found that “universality” was rated as most helpful in a study of hospitalized patients views of the helpful factors in short term psychotherapy (Maxmen 1973). In this study they measured helpfulness using Yalom’s 12 curative factors. In this model Universality was defined as “the experience of de-isolation, i.e. the satisfying recognition that contrary to prior belief, one’s problems are not unique and are in fact shared by others, e.g., “Learning I’m not the only one with my type of problem, We’re all in the same boat” This feature has also been found in other parent
training groups for example Spitzer et al (1991) described how the “Parent group provided a tremendous sense of connection with other parents”.

The parents reported to value exercises and discussions with other parents which may have made them feel part of the group. This again mirrors findings from previous research. In the study by Maxmen (1973) the group members rated “Group Cohesiveness” as one of the four most helpful aspects of the group. “Group Cohesiveness” included statements describing a member’s sense of being accepted by the others in the group e.g. “Belonging to and being accepted by the group”. This provides evidence to support the strengths of the group based approach. For example Smith & Pugh (1996) in their review of parent training, described the value of group based parent training as “providing a valuable service to isolated parents and that the group builds a sense of cohesiveness and provides opportunities for parents to share their views with others and learn from others”.

Another aspect which parents rated as one of the most helpful was finding out that other group members have different ideas and values about parenting. Their explanations for this is that they appreciated hearing ideas and suggestions from other parents. It appeared that group members were more receptive to advice and suggestions from other parents. This is presumably because they felt that the other parents could understand and identify with their situation. As one parent put it “Things written by experts are all very well but they don’t fill you with huge amounts of confidence”.

Turning to hypothesis 1.ii it was predicted that the parents would rate learning the skills and knowledge about behaviour problems as very important. However the category “expert” was rated as the least helpful category. The parents did not rate aspects where the group leaders “taught” parenting skills highly. For example parents did not rate items such as “Being given strategies from group leaders” as particularly helpful. This finding is linked to earlier research into the impact of therapists behaviour on their client in parent training. It was found that the therapists behaviours of “teach” and “confront” are associated with
significant increases in the likelihood of client non-compliant reactions. The therapist
behaviours “facilitate” and “support” were followed by reliable decreases in the client non-
compliance. Although we did not measure client compliance it seems likely that a client’s
non-compliance may be a reflection of their finding the therapists approach unhelpful.

Hypothesis 2

As people move though the group their view about the most helpful aspects of the group
process will change from “expert” being most helpful to “parents” being most helpful.

It was found the group members rated the “Parents” item as most helpful in all but one
(session 5) of the sessions and therefore this hypothesis was not supported. At the
beginning of the group the “Parents” category was rated as more helpful than the
“Collaborative” or the “Expert” categories, whereas at the latter stages of the group the
ratings of the different categories were similar. One possible explanation for this trend is
that when the parents first came to the group their overriding feeling was that of being
alone and isolated in coping with their children’s behaviour. Thus at the early stages of the
group the parents valued most meeting others with similar experiences which may have
been reflected in their relatively high “Parents” scores. In the latter stages of the group (i.e.
sessions 4 and 5) the parents rated all three categories as equally helpful. This may be
because the parents were at the stage of using and successfully implementing some of the
ideas and techniques suggested by the group leaders and other parents.

Another explanation for why the different categories did not change as predicted may be
that the scores were influenced by the content of the sessions. In some of the sessions the
emphasis was on learning new strategies and other sessions were more experiential in
nature. For example session 4 was quite self-exploratory in its content as it aimed to help
the parents try and understand what factors in their child’s life had affected the way they
perceived and treated their children. This exercise proved to be very powerful and many of
the parents became quite emotional when describing their early experiences with their
children. Interestingly in this session the "Parents" category was rated as much more helpful than the other two categories. Furthermore, there was little formal teaching in this session which was reflected in the low "Expert" score.

**Hypothesis 3**

*In keeping with Herbert's collaborative model it will be possible to detect an increase in self efficacy as a result of attending the parent training group.*

As described in the introduction in the "Collaborative model" the therapist works with the parents actively using their ideas and feelings and involving them in a therapeutic process by inviting them to share their feelings, discuss their ideas and engage in problems solving. This group was based on the collaborative model of parent training. The group leaders attempted to cover certain skills for example praise and selective reinforcement but this was not done in a direct didactic way rather it was achieved through discussions, group exercises questions and videos. The group leaders encouraged the parents to generate their own ideas and generate solutions based on discussions within the group.

The rationale for this approach is that by the time most parents attend a parent training group they are low in morale and confidence. An approach aimed at "teaching" parents may be unsuccessful for it may have the effect of further undermining the parents self-confidence. The collaborative approach aims to give the parents back their dignity, self respect and a sense of control (Spitzer, Webster-Stratton and Hollinsworth 1991).

Parenting self efficacy refers to the degree to which the parent feels competent and confident in handling their children's behaviour. Their measured level of efficacy is dependent not only on their knowledge of what they should be doing but also on their judgment of their capabilities in a given situation. As predicted by the hypotheses the parents showed an increase in the level of self efficacy and an increase in their satisfaction with parenting as a result of attending the group.
The parents’ level of satisfaction and efficacy was measured using the “Parenting Sense of Competence Scale” which was made up of two sub-scales, Satisfaction and Efficacy. The results showed that following the group the parents felt more satisfied with parenting. This indicates that they felt less frustrated, anxious, and more motivated to do a better job as a parent. The parents also felt more efficacious, that is more competent, capable of problem solving and familiar with parenting.

The PSOC scale was also used in another evaluative study on parent training programmes. Cunningham et al (1995) also found a significant improvement in the parental sense of competence following attendance at a parent training group compared to the control group. Similarly using a different but related measure Mullin et al (1994) found that the parent’s self-esteem (measured by the Rosenberg Self Esteem Inventory) increased as a result of attending a Parenting Group as compared to a control group.

As predicted by the hypothesis the parents showed an increase in their level of self efficacy as a result of attending the group. It is likely that their increases in self efficacy came from a number of different sources. As outlined in the introduction Bandura described four sources of self efficacy, performance attainments, physiological states, vicarious learning and verbal persuasion.

From the post group interviews it appears that the group provided the parents with the motivation to try the ideas discussed in the group. Many of the parents said that they persisted with new behavioural techniques because they knew that they had to come back the following week and report on their progress. It is likely that as they persisted with certain techniques and they found them to be successful it increased their self efficacy in their ability which in turn increased their own sense of confidence. This is in agreement with Bandura’s model in which he argued that individuals with strong efficacy beliefs are more likely to persist at tasks with eventual success thereby confirming their own view of their ability. Thus according to Bandura’s model as the parents experienced more success
in managing the children’s behaviour their performance attainments increased which in turn increased their self efficacy.

Another source of self efficacy is vicarious learning, that is seeing others perform at tasks and having the belief that one can also master a comparable activity. This is likely to have been an important source of self efficacy in the group. As the parents saw other parents successfully tackle their children’s behaviour problems it gave them confidence that they could do it as well. In the post group interview many of the parents referred to one mother who was very enthusiastic about the ideas that were discussed. The enthusiasm she transmitted seemed to encourage the other parents to try ideas out.

Verbal persuasion was also important in the group as the parents encouraged each other to try out new ideas. The parents felt it was important the ideas were generated by other group members who they did not feel were judging them and who could relate to their experiences.

Hypothesis 4
As a result of attending the group the parents will gain a greater understanding of their child’s behaviour, their effect on their child’s behaviour and feel more confident about managing their child’s behaviour.

Many of the parents reported that as a result of attending the group they tried to change the emphasis of their interactions with their children by using praise and attention and distraction to encourage the child’s more desirable behaviour. Most of the parents seemed to place less emphasis on the child’s naughty behaviour and most of them felt more in control of their children. They seemed to feel that they were able to remain calm when their child misbehaved which prevented the situation from escalating out of control.
These findings support previous evaluation studies of the efficacy of Parent Training courses. For example, Mullin et al (1990, 1994) showed that parents who participated in a Parent Training programme rated their children as having fewer and less intense behaviour problems as measured by a standardized measure of child behaviour. Similarly, in a series of studies (Webster-Stratton 1981, 1984; Webster Stratton, Hollingsworth and Kolpacoff 1989) it has been shown that therapist led parent group discussion training based on videotape modeling was effective in improving parenting attitudes and behaviours and in reducing child conduct problems.

There was also an improvement in the parent’s feeling of confidence in coping with their child’s behaviour, their level of worry about their child behaviour, the amount of time they felt in control and the enjoyment of their relationship with their child. Although these aspects were all measured by single questions the changes in the scores were supported by the changes in the PSOC scores. Following the group close correlations were found between these measures (their level of confidence with coping with their children’s behaviour, the amount of time they felt in control of their children’s behaviour and the amount of time they enjoy their relationship with their child) and the PSOC scores of efficacy, satisfaction and total sense of competence. However, before the group there was only a relationship between satisfaction with parenting and confidence with coping and enjoyment of relationship with child. There was also found to be a relationship between the how worried they were about their children’s behaviour and their PSOC score.

The finding that the parents experienced an increase in their level of confidence as a result of attending the group was borne out in the Perceived Helpfulness of the Group Interview Schedule. The confidence seemed to come both from trying out ideas and techniques and finding they were successful and also from giving others ideas and finding others value and respect their opinions. This supports one of the strengths of group based approaches as described by Smith and Pugh (1996) in their review of parenting programmes. They propose that “the group process can be powerful in terms of developing self-confidence
and self-esteem”. These findings are also consistent with previous research which showed that participants of parent training showed increased confidence (Anastopoulous et al 1993; Pisterman et al 1992).

Similarly, Pehrson and Robinson (1990) compared parents who participated in a ten-week parent education group with a control group who did not participate and found that having completed the parenting courses the education group showed significant increases in their confidence and insight into the causation of children’s behaviour. Furthermore Mullin et al (1990, 1994) showed that parents who participated in a Parent Training programme saw themselves as having fewer psychological symptoms and increased levels of self esteem following the group as measured by a standardized measure of maternal well being.

One of the parents showed a decrease in her PSOC score, furthermore her scores on worry confidence, time in control and level of enjoyment had remained the same. In the post group interview she also felt that her child’s behaviour had not improved, in fact it had become worse. At this interview she appeared as quite depressed and despondent about the situation but she ascribed this to other issues relating to her relationship with her husband.

Hypothesis 5

*The changes in the parents self efficacy will be related to the perceived helpfulness of the group.*

No relationships were found between the change in the parents PSOC score and the process category they found most helpful. Thus there was no relationship found between the amount of change parental sense of competence and the type of ‘group process’ they found helpful. However, because of the small sample a change in PSOC score may mask the variation and not be sufficiently sensitive.
Significant relationships were found between all three process categories i.e. expert, parent and collaborative the three PSOC scores i.e. satisfaction, efficacy and competence. This suggests that the more helpful the parents found the group the higher were their levels of efficacy, satisfaction and total PSOC score following the group. There was no differentiation between type of process and the post group PSOC scores.

**Qualitative Data- the process of learning to use the skills**

The aim of the “Perceived Helpfulness of the Group Interview Schedule” was to explore the parent’s perceptions of helpful/unhelpful aspects of the group and the process by which the group had affected the parents feelings and behaviour.

One of the main features to come out of the interview was the sense of relief that the parents felt when they found other parents with similar problems to theirs. It seemed to provide the parents with a common problem which seemed to bind them together. They seemed to value sharing common experiences which meant that they worked constructively together offering and accepting suggestions and advice from each other.

They also found it helpful to meet others with worse problems than themselves. There was one parent who seemed to serve the role as being the member of the group who the others felt “sorry for” and who they seemed to compare themselves favorably against. Therefore she seemed to have an important function for the other group members but for her it made her feel that her child had more challenging behaviour than the other children. This begs the question of whether she should have been discouraged from attending. However, she seemed to have found the process of attending the group helpful and her PSOC scores improved slightly.

Many parents commented that the group provided them with the opportunity to step back from their situation and look at their problems from a distance. The continuous demands
of the children make it difficult for the parents to find the time or space to think about the problems they are experiencing and ways in which they could change them. For example one mother said “it just got me down because I couldn’t think of any other way to deal with him”. Many parents described how they seemed to be trapped in a vicious circle with their children where the children seek attention by misbehaving and the parents respond by shouting or smacking.

The parents seemed to value the advice and ideas from the other parents. It seemed that because the other parents were in the same situation as them they did not feel they were being judged and therefore could accept advice from each other. Many parents felt that they had often been offered advice in the past from others including family and friends but they seemed take this as being indicative of them being judgmental or critical of them. This in turn added to their feelings of inadequacy.

Some of the parents commented on the role of the group leaders offering advice and facilitating discussion. This process was not commented on as frequently as the advice from other parents indicating that they did not perceive it as important or helpful. Nevertheless, many of the parents talked about strategies they had learnt during the group sessions for example using praise or distraction. It seems that although many of the parents felt they had learnt to use new strategies they did not appear to attribute this to the group leaders or the group exercises which were designed to help them think about these issues. It appears that the parents did not feel they were being “taught” strategies but rather the ideas about strategies evolved from the discussions and exercises.

During the group the parents reported that they became more aware of the link between their own behaviour and their child’s behaviour. This was a theme which ran right through the course of the group and underpins most of the behavioural management strategies. The parents often commented on how they tried to remain calm when dealing with their children’s “difficult” behaviour and they felt this helped them considerably. This result
supports earlier research where the parent’s understanding of the social learning principles was directly measured using a standardized questionnaire. For example, Sutton (1992) found that parents gained a greater understanding of the social learning principles as a result of attending a parent training group. Similarly, Lawes (1992) using an adapted version of the Knowledge of Behaviour Principles (O’Dell, Tarler-Benlolo & Flynn 1979) found that mothers who had undergone individual parent training showed significant improvements in their scores.

In this study the other strategies that the parents reported to have found helpful were praise and distraction and they gave examples of how they used these two strategies. It appeared that these were not totally new ideas to the parents but that the group helped them be able to implement these strategies. It appeared that as the parents felt less stigmatized and more accepted, the group provided them with the motivation and courage to try some of the techniques out. Many of the parents had tried these techniques out before but the group provided them with the motivation to try them out again and to persevere until they were effective.

One of the most positive outcomes of the group was the parents’ description of how they perceived their children differently after attending the group. For example, one parent described the change in the way she felt about her son:-

“I didn’t love him at all, it’s learning to love him again, to bond with him as a mother not as this thing that has been sent to you...I see him in a different light. He is so lovable now, I didn’t realize how lovable he was.”

It appeared that as the parents became more confident and used the techniques successfully they were able to step out of the vicious circle they had been trapped in and start to experience more enjoyment with their children. The group seemed to help the parents rebuild their relationship with their child. Some of them described how the group
enabled them to separate the child from their behaviour which meant that they could learn to like and appreciate them more. They described how they were more able to appreciate their child’s prosocial behaviour. For example one woman said:

“I was more able to separate K from his behaviour which I couldn’t do before, the behaviour was K because he’s better its easier to separate the two. Before I couldn’t see any of the good points. It was always marred by the bad bits. All I could see before was the negative, if he did something good I virtually ignored it.”

Even though this mother’s report of how she responded to her child’s behaviour is retrospective in nature it does concur with previous studies on parental interactions with difficult children. For example, parents of conduct disordered children have been reported to exhibit fewer positive behaviours, be more critical and violent in their use of discipline and be more likely to reinforce inappropriate behaviours and to ignore or punish prosocial behaviours (e.g. Patterson & Stouthamer, Loeber 1984; Webster-Stratton 1985a,b).

Their perceived success and their acceptance by the other parents meant that they changed the view of themselves as parent. One parent said:

“Once I came to the realization that I wasn’t a wicked witch, I wasn’t a bad parent, I knew things could be different.”

There have been very few other studies examining the process of parent training groups. One of the most important studies was by Spitzer et al (1991) in which they examined the transcripts of intake interviews and group therapy sessions of parent training. From this data they developed a sequential model whereby the parents gain knowledge, control and competence. As previously mentioned in the introduction the model is comprised of 5 core phases:

1. Acknowledging the Family’s problem
2. Alternating Despair and Hope
3. Tempering the Dream
4. Making the Shoe Fit
5. Coping Effectively
Many of the processes described in this study are common to the present study. They described how initially the parents had to acknowledge that their children had behaviour problems they did not know how to handle. They expressed feelings of anger, fear of loss of control, guilt and blame at not being able to interact more effectively with their children. Once they began to implement strategies presented in the programme they moved from despair into a second phase characterized by feelings of enormous relief and a belief that the programme would provide an easy solution for the children’s problems. The third phase, involving limited improvement or regression in the children’s problems, conflicting family dynamics and a realization of the substantial amount of work needed for long-term improvement. The fourth phase involved the parents working hard at adapting the techniques taught in the programme to their own situations and needs. In the last phase, the parents expressed empathy and acceptance of their children’s problems and affirmed their ongoing commitment to maintaining progress. The authors give examples of extracts from the interviews and group sessions to demonstrate the different phases they identified. One of the limitations of this model is that it does not explain how individuals move from one stage to the next and whether it is necessary to go through all five stages for treatment to be successful. However, the examination of the process does provide information about how individuals use parent training programmes and contributes to an understanding of the reasons for treatment success or failure of the treatment. Many processes identified are common to those found in the present study, however in the study by Spitzer et al (1991) the source of the data is from the analysis of transcripts from the intake interviews and the group sessions whereas in this present study the data is derived from post group interviews where the parents are asked to reflect on the process that occurred in the group and the factors that they found helpful. This may have the advantage of providing a more of an insight into the parent’s explanations of what they found helpful and how the changes in their feelings and behaviour came about, rather than the researchers perception of this process. Furthermore, in the present study the qualitative data is presented along side and supported by the quantitative data.
The Parent’s Criticisms of the Group

As part of the “Perceived Helpfulness of the Group Interview Schedule” the parents were asked to state aspects of the group they felt were unhelpful and also how they felt the group should have been different.

One of the aspects the parents found less helpful was the videos. The main criticism was that they were not representative of their situation. However, they did seem to provide a useful discussion point and made the parents think about how their own situations are different to those portrayed in the video. They did provide the parents with concrete examples of how to use different techniques. It may be that the parents found it difficult to relate to the scenes in the extracts and therefore found it difficult to integrate into their own circumstances.

A further criticism of the group is that many of the mothers felt that their partners should have been invited to some or all of the groups. By only inviting the mothers to the group it implicitly implies that the main responsibility for child care lies on the mothers. However, there are practical drawbacks. If the fathers were to be invited then it would have been necessary to hold the groups in the evening as all of the fathers worked during the day. This would have raised other difficulties of child care if both parents attended the group. However it is an important issue and one possible solution could have been to hold some of the groups in the day and others in the evening. This suggestion should be considered in the planning of future groups.

One parent commented that the sessions did not progress in a logical order. Her main point was that the session where we focused on their early experiences with their children should have come at the beginning as it put everything else in context. Even though this is an interesting point it may have felt very threatening to the parents to have started with
such an emotionally laden session early on before the group members had got to know and trust one another.

The other criticism which has been mentioned earlier on in the discussion is the woman who felt that the group served highlight the difference between her child and that of the others.

**Theoretical Considerations**

The content of most parent training programmes, including the one described in this study, is based on social leaning theory. Social learning theory provides an intellectual framework which describes how behaviour problems in children are elicited and maintained by parental behaviour. The aim, therefore, is to teach parents social learning techniques, for example positive reinforcement (i.e. praise and encouragement) in order to develop more prosocial behaviour in their children. However, the success or failure of parent training depends also upon the emotional and cognitive aspects of parenting. This is supported by the finding of the present study that although the parents did learn various behavioural management techniques, the aspects that the parents valued most highly were those concerning group processes.

While social learning theory provides a rationale for the content of parent training it is clear that a framework for the process of parent training is also needed. Such a model must describe the process by which the parents acquire new ideas and go on to apply them to their interactions with their children. In order to ensure that this process occurs strategies must be adopted which take into account the psychological state of the mother. By the time a mother comes to a parent training group it is likely that she will be feeling low in self esteem, and have little faith in her ability as a parent, that is to say she will have low self-efficacy. The group described in this study was based in the collaborative model.(Herbert 1995). This model describes a process where the therapist and parents
work together drawing on both the parents understanding of the child in question and the therapists knowledge of child behaviour. It has been suggested that one of the main beneficial effects of the collaborative model is that it increases the parents self efficacy. In the present study it was hypothesized that attendance at a parent training group based on the collaborative model would result in a measurable increase in self efficacy. This did indeed prove to be the case. Analysis of both the quantitative and qualitative data suggested that the mothers perceived the most helpful aspects of the group were those related to interaction with other parents rather than those related to receiving information from the therapist. This indicates that the most helpful aspects of the group included many of those arising from the use of the collaborative model. However, highly rated items such as “meeting other parents with similar problems” and “finding out that other parents have worse problems than you” arise not from the application of the collaborative model but as a feature of group-work. Thus the results of this study support the use of the collaborative approach in parent training group. However, group processes are also of great importance in understanding the mechanisms at work in parent training group.

Methodological Issues

One of the main strengths of the present study is that it combines quantitative and qualitative data which have been shown to support one another. The quantitative data provides evidence for the efficacy of the treatment approach. The qualitative data provides information of how the changes shown by the quantitative data have come about. However, there are several limitations in the methodological design which are going to be described in the following section.

One limitation of the current research is that it is all based on parental report and not on observational data. It could be argued that it is not clear whether the parent’s perceptions of the improvements in their children’s behaviour and in their management strategies were due to actual changes in behaviour or changes in the parents perceptions. A useful
development of the study would have included independent observations of the parent-child interactions before and after the group. There is evidence from previous studies that parents can report being satisfied and supported by a training programme even when more objective outcome measures on child problems show very little change (Scott & Richards 1990). However, one could argue that what is important is that the parents feel as though they are coping better with their child’s behaviour and not that there has been an improvement in the behaviour per se. Furthermore, it was the aim of this study to examine the parents experience of being in a parent training group and how it affected their feelings about their child’s behaviour.

Another limitation of this study is that it was based on one parent training group consisting of 8 people. The study could have been improved if it had been based on a larger sample size, possible several groups running along the same format. This would have made the evidence more substantial and less dependent on individual differences.

A further shortcoming of this present study is that the post group interview (designed to explore the parent’s perceptions of the aspects of the group the parents found helpful) was undertaken by one of the group leaders. It is therefore possible that the parents were unwilling to make critical remarks in order to please the interviewer. The same applies for the questionnaire given out at the end of each session. In order to minimize the effect the interview contained questions about how the parent would have liked the group to have been different and also questions about the unhelpful aspects of the group. The parents seemed to answer these questions quite readily and were keen to provide feedback about how they felt the group could have been improved. Furthermore the post group interview was designed to be quite exploratory in nature and it aimed to gain an understanding of not just what aspects of the group the parents found helpful but how they were able to incorporate these aspects into their interactions with their child.
The final limitation of this study is that there was no control group which would have provided information about whether the changes detected were due to the group or due to other extraneous factors. It was not possible in the time allocated to run a control group along side the study. However, there are a number of arguments that could be put forward against the need for a control group. Firstly, the main focus of this study was to examine not only the outcome of a parent training group but also the process by which the changes took place. It could have shifted the focus away from exploring these processes if the emphasis had been on comparing changes between groups. Secondly, in order to take account of this aspect one of the questions in the PHGIS asked whether there were any other events in the parents lives which may have affected the way they cope with their children.

However, if there had been more time and resources data obtained from a control group could have proved to be an interesting comparison. An ideal control group would have been a group of similar composure which met with the same frequency but was not led by a group leader and did not have an imposed structure. A possible example could have been a support group for parents of young children where the main aim is to provide support rather than learning new strategies. It would have then been possible to detect to what extent the main value perceived by the parents was the support provided from other mothers in a similar situation or whether it was about the strategies they learnt in the group.

The Measures

The Helpful Aspects of Parent Training Questionnaire was designed by the author for the purpose of this study. It proved to be quite sensitive in picking up the parent view of the helpful aspects as there seemed to be an agreement between the responses to this questionnaire and the Perceived Helpfulness of a Group Interview Schedule. However most of the responses tended to lie in the upper part of the scale (i.e. 3-5 on a 5 point
A possible explanation for this is that the group members were reluctant to rate an aspect as unhelpful when they knew that the group leaders would read their responses. A possible way to avoid the ceiling effect would be for the questionnaires to be answered anonymously or for them to be administered by an independent person. Another possibility is that it is the design of the questionnaire that is at fault. A wider range of responses may have been produced if the scale was not marked 1 to 5 but rather they were asked to mark on a non-segmented line how helpful they found a certain aspect.

An alternative way of investigating helpfulness would have been to ask the group members the open questions of what they found helpful/unhelpful and left them to generate the different aspects. The problems with this approach is that the members may have found it difficult to generate their own list in the limited time available and it could have resulted in very sparse data.

The Child Behaviour Interview Schedule was also designed by the author for the purpose of this study. It proved to be successful in eliciting the parent’s perceptions of their children’s behaviour, the antecedents and the strategies that they use to manage the behaviour. The parents seemed to find the questions easy to understand and they could relate them to their situations. Many other studies use standardized measures of children’s behaviour (for example the Child Behaviour Checklist (CBCL) (Achenbach, 1991) to measure the effectiveness of parent training. If such a measure had been used in the present study it would have had the advantage of being standardized and validated and it would have been possible to compare the results between studies. However, it was the aim of the present study to gain more detailed information about how the group affected the parental perceptions of the child’s behaviour and how they cope with it and therefore a checklist type of questionnaire would not have been sufficient.
Future Developments

In order to review the progress of the group members a reunion group has been arranged. The purpose of this will be to provide an opportunity for the parents to provide an update on the progress they have made since finishing the group. Individual treatment will be provided for any member who feels that it is necessary.

Another development that is planned is the running of other groups based on the format described in this study. The feedback from the parents suggests that they found the group both helpful and supportive in helping them deal with their children’s behaviour. The group format appears to offer the parents the opportunity to meet other parents with similar problems and to work together to support and help one another. It therefore seems to be an extremely suitable treatment approach for this common problem as it provides added benefits over and above individual treatment.
Conclusion

Behaviour problems in young children are very common and research has shown that a large proportion of them are stable over time. There has been considerable research into the factors associated with behaviour problems and it has been shown that they are often associated with styles of parenting. Treatment strategies aimed at helping parents manage their children's behaviour more effectively are very important and parent training has been the most widely used and extensively studied approach.

Parents of children with behaviour problems tend to feel that their interactions with their children are unrewarding and frustrating and as a result they have low self efficacy and lack confidence in their abilities as parents. Such parents come to view their children in a negative light. Data obtained in the pre-group interview suggests that these generalizations apply to the parents selected for this study.

Most of the parent training programmes are based on a social learning model. That is to say that parents are taught to develop prosocial behaviour in their children by using social-learning techniques. In the present study the group leaders covered these topics and used exercises, videos and discussions to help the parents learn these techniques. In the post-group evaluative interviews many parents mentioned the skills they had learnt.

However, the findings from the present study suggest that the improvements perceived by the parents were not solely attributed by them to the acquisition of new skills. The pre-group interviews suggests that many parents seemed to be aware of many of the strategies covered by the group sessions but they found it difficult to implement these strategies. The key element to change seemed to be that the parents came to believe that they were able to apply these strategies.
The process by which parents can learn and then use behavioural management strategies is complicated. From this study it appears that the process started by them finding out that other people had the same problems as them. Once they were aware they were not the only ones in their situation it gave them the confidence and support to start to think about how they could change their interactions with their children. Once they started to use the skills, the group provided them with the encouragement and motivation to persevere and successfully implement these skills. This in turn built on their confidence and improved their self efficacy. They also started to view their children differently and to rebuild their relationships with them.

In keeping with previous studies, the present work suggests that a successful Parent Training programme involves more than teaching parents new skills. An individual’s parenting style depends on fundamental issues such as their core beliefs about their own identity, how they themselves were parented and the history of the relationship with their own children. An important aim of parent training is that it allows parents to incorporate new beliefs about themselves, their child and the relationship between them. The advantage of the collaborative model, adopted in this study, is that it ensures that parents explore their beliefs about parenting issues in an environment that provides support from the group leaders and other group members. The parents often perceive themselves as failing in their roles; the goal is to alter this perception so that they will believe that they are capable of successfully changing their child’s behaviour. At the same time the aim is to challenge the parents perceptions of their child, from one focused on weakness to one focused on strengths.

More research is needed to gain a full understanding of the processes involved in parent training. It is hoped that a greater understanding of this complicated topic will result in improvements in the help available to parents of children with behaviour problems.
MEMORANDUM

To: HEALTH VISITORS
From: Georgina Bell
     Fiona John
Date: 23rd January 1996
Subject: BEHAVIOURAL MANAGEMENT GROUP

We will be running a Behavioural Management Group for parents who are experiencing difficulties in managing their children.

The group will be for parents of children aged between 2 and 4 years. The purpose of the group is to provide a supportive environment for parents to learn effective ways of managing their children's difficult behaviour.

Venue: Hawks Road Clinic

Dates: Commencing beginning of April for 8 consecutive weeks on Wednesdays between 10.30 a.m. and 12.30 p.m.

Group Leaders: Georgina Bell
                Fiona John

We will be offering this group to parents who have been referred for their children's behavioural difficulties and are currently on our waiting list.

We would also like to hear if you have any other parents who you feel would benefit from this type of group and be able to commit themselves to the group sessions.

If you do, we would offer the parents a session to discuss the group with them and assess the suitability of the group for them.

If you would like to refer any families, please complete the attached form and send it back to us by the end of February.
REFERRAL FOR BEHAVIOURAL MANAGEMENT GROUP
(Parents of 2 - 4 year olds)

Name of Child: .................................................................

D.O.B.: .............................................................................

Address: ...........................................................................

Name of Parent(s): ...........................................................

Name & Address of GP: ......................................................

Name & Address of HV: ......................................................

Reason for referral to this group: ........................................

......................................................................................

Who else is in the family? ...................................................

Have they sought any other help in the past? .......................

If Yes, please comment: .....................................................

......................................................................................

Are there any other agencies involved? Yes/No .................

Please comment: ............................................................

......................................................................................

Relevant Information concerning the family: .....................

......................................................................................

......................................................................................

Name of Referrer: ......................................................... Date: ............................................

Chairman Mrs Patricia Gregory  Chief Executive Mr Frederick Little  Improving local health
Appendix 2

Child's Behaviour Interview Schedule

I am going to ask you a few questions about your child's behaviour so that I can have a detailed description about the sort of behavior that you are concerned about, and the effect it is having on you and your family.

Think of some of the difficult behaviours that your child shows and choose the behaviour that you would most like to change

1. Describe this behaviour in detail i.e. what does your child actually do?

2. How often does it occur?

3. Where is it most likely to occur?

4. When is it most likely to occur?

5. How long does it last? (in minutes)

6. Do you think that this is a long time, a short time or something in between?

7. How severe is the behaviour, very severe, very mild or something in between?

8. How long has your child behaved in this way?
9. Does it usually happen more when s/he is with one person than another?

10. What sorts of things usually spark off this behaviour?

11. When s/he does this how do you react?

12. What effect does that have on him/her?

13. What strategies have you used to deal with this behaviour?

14. What has worked?

15. What has not worked?

16. What explanations do you have about why s/he is doing it?

17. What change in behaviour would you like to see?

18. Has this change ever happened, if so when?

19. What do you feel when he behaves in this way?
20. How worried are you about this behaviour?
   1 = not worried
   5 = very worried

21. How confident do you feel about coping with this behaviour?
   1 = not confident
   5 = very confident

22. How much of the time do you feel in control of your child’s behaviour
   1 = none of the time
   5 = most of the time

23. What effect is this behaviour having on your family?

24. What are your child’s good points?

25. How often do you enjoy your relationship with your child?
   1 = none of the time
   5 = most of the time
Appendix 3

Parenting Sense of Competence Scale

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The problems of taking care of a child are easy to solve once you know how your actions affect your child, an understanding I have acquired. (E)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>2. Even though being a parent could be rewarding, I am frustrated now while my child is at his/her present age (S)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>3. I go to bed the same way I wake up in the morning, feeling I have not accomplished very much (S)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>4. I do not know why it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated. (S)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>5. My mother was better prepared to be a good mother than I am. (S)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>6. I would make a fine model for a new mother to follow in order to learn what she would need in order to be a good parent. (E)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>7. Being a parent is manageable, and my problems are easily solved. (E)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>8. A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one. (S)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>9. Sometimes I feel like I'm not getting anything done (S)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>10. I meet my own personal expectations for expertise in caring for my child. (E)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>11. If anyone can find the answer to what is troubling my child, I am the one. (E)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>12. My talents and interests are in other areas, not in being a parent. (S)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>13. Considering how long I've been a mother, I feel thoroughly familiar with this role. (E)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>14. If being a mother of a child were only more interesting, I would be motivated to do a better job as a parent. (S)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>15 I honestly believe I have all the skills necessary to be a good mother to my child. (E)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>16. Being a parent makes me tense and anxious. (S)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
<tr>
<td>17. Being a good mother is a reward in itself. (E)</td>
<td>1 2 3 4 5 6</td>
<td></td>
</tr>
</tbody>
</table>

(S) = Satisfaction Items

(E) = Self-Efficacy Items

Gibaud-Wallston & Wandersman (1978)
# Appendix 4

## HELPFUL ASPECTS OF PARENT TRAINING QUESTIONNAIRE

Please answer the following questions by circling the appropriate number indicating the level of helpfulness. All responses will remain **CONFIDENTIAL**.

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>Session number</th>
<th>Very Unhelpful</th>
<th>Very Helpful</th>
<th>Didn’t Occur</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1--2--3--4--5</td>
<td>1--2--3--4--5</td>
<td>0</td>
</tr>
<tr>
<td>*</td>
<td></td>
<td></td>
<td>1--2--3--4--5</td>
<td>1--2--3--4--5</td>
<td>0</td>
</tr>
<tr>
<td>E 1. Giving examples of how to manage a child’s difficult behaviour</td>
<td></td>
<td></td>
<td>1--2--3--4--5</td>
<td>1--2--3--4--5</td>
<td>0</td>
</tr>
<tr>
<td>E 2. Videos giving examples of how to do it and how not to do it.</td>
<td></td>
<td></td>
<td>1--2--3--4--5</td>
<td>1--2--3--4--5</td>
<td>0</td>
</tr>
<tr>
<td>P 3. Group exercises to make you feel part of the group.</td>
<td></td>
<td></td>
<td>1--2--3--4--5</td>
<td>1--2--3--4--5</td>
<td>0</td>
</tr>
<tr>
<td>P 4. Exercises to get to know other group members</td>
<td></td>
<td></td>
<td>1--2--3--4--5</td>
<td>1--2--3--4--5</td>
<td>0</td>
</tr>
<tr>
<td>E 5. Receiving handouts.</td>
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<td>C 6. Discussions about the practicalities of parenting.</td>
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<td>C 7. Discussion about the positive feelings raised by parenting.</td>
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<td>C 8. Discussions about the difficult feelings raised by parenting.</td>
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<td>P 9. Having to talk about your difficulties with people you don’t know very well in a group.</td>
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<td>E 10. Being given strategies from the group leaders.</td>
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<td></td>
<td>Very Unhelpful</td>
<td>Very Helpful</td>
<td>Didn't Occur</td>
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<td>11. Finding out that other people have the same problem as you.</td>
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<td>15. Finding out that some parents have more difficulties than you.</td>
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<td>16. Finding out that some parents have less difficulties than you.</td>
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<td>17. Receiving specific advice about my problem</td>
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<td>18. Receiving general advice on children’s behaviour.</td>
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<td>20. Talking about the relationship between me and my child.</td>
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<td>22. Other group members having values and ideas about parenting that are different to yours.</td>
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<td>23. Overall, how helpful was today’s session?</td>
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*KEY
P = Parents   C = Collaborative   E = Expert
Appendix 5

Perceived Helpfulness of a Group Interview Schedule

Part 1

1. Overall, what do you think were the most helpful aspects of the group?

2. Overall, what do you think were the least helpful aspects of the group?

3. In what way has the group made a difference to the way you handle your child?

4. In what way has the group made a difference to the way you think about your child's behaviour?

5. In what way has the group made a difference to your relationship with your child?

6. In what way has the group affected your feelings about being a parent?

7. If you were going to run a group, would there be anything that you would do the same?

8. If you were going to run a group, would there be anything that you would do differently?

9. Has anything else in your life made coping with your child either easier or more difficult?
Perceived Helpfulness of a Group Interview Schedule- Part 2

From the feedback questionnaires, what were the 3 most helpful aspects of the group?

Statement 1

How did this aspect of the group help you in handling your child’s behaviour?
Give examples of it in the group

Statement 2

How did this aspect of the group help you in handling your child’s behaviour?
Give examples of it in the group

Statement 3

How did this aspect of the group help you in handling your child’s behaviour?
Give examples of it in the group
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<th>DAY/TIME</th>
<th>SITUATION</th>
<th>WHAT SPARKED OFF HIS/HER BEHAVIOUR?</th>
<th>HOW DID YOUR CHILD BEHAVE?</th>
<th>HOW DID YOU REACT?</th>
<th>WHAT DID YOUR CHILD DO THEN?</th>
<th>HOW DID YOU FEEL?</th>
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<td>e.g. Fri p.m</td>
<td>We were in a supermarket</td>
<td>He asked for sweets &amp; I refused</td>
<td>He started screaming and lay on the floor</td>
<td>I shouted at him and then gave him some sweets</td>
<td>He ate the sweets and was quiet</td>
<td>Embarrassed</td>
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<td></td>
<td>WHAT MY CHILD DID WELL TODAY</td>
<td>HOW I SHOWED HIM/HER I WAS PLEASED</td>
<td>HOW MY CHILD RESPONDED TO PRAISE</td>
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Events in my child’s life

My Child Now

At Birth
References


developmental psychopathology (pp. 3-10). JCPP Book Supplement No. 4 Oxford: Pergamon Press.


