Indispensable Interaction

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Parents' perspectives on parent–child interaction
interventions and beneficial meetings

ABSTRACT

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The aim of this thesis was (a) to describe families taking part in parent–child interaction interventions and examine short term and long term changes in their problem loads, (b) to examine the parents' perspectives on what persons and contexts within and outside the intervention they considered beneficial for the child or the family and (c) to examine the understanding that the parents and key figures generated of these processes in joint interviews.

The parents in the 101 families who took part in the intervention showed considerable problem loads at the outset of treatment, and the children displayed problems of a nature and degree otherwise found in psychiatric populations, with a dominance of aggressive behaviour. There was a clear trend towards a positive development after six months for parents and children, and this positive development was reinforced after 18 months. There were few unplanned interruptions of the treatment.

In the families with two biological parents, all the mothers and 89% of the fathers participated in treatment. The fathers' average problem load was lower than that of the mothers, and their improvements were less extensive. The fathers attributed the improvement to the treatment, but also highlighted, to a greater extent than the mothers, outside contributing factors to the improvement.

Parents described persons who had been of special importance for the family and for the development of the children, both within the framework of the intervention and in several other contexts such as preschool, child health care and social services. In subsequent joint interviews with the parents and these key persons it transpired that when the parents perceived that e.g. the teacher, the social worker, or the nurse was guided by good intentions, confident relations could develop even though conditions in other respects were unpromising. Expressions of personal commitment from these "important persons" overcame obstacles such as the parents' or children's previous negative experiences. These "important meetings" contributed to the creation of more positive (self)images of the children and/or the parents.

At the outset of treatment in the parent–child interaction interventions there was a "gap" between the parents and their family therapists, caused by the parents' fear and an unequal power balance, but both the parents and the therapists contributed to bridging this gap. An image of the good therapist emerged as being "normal, friendly, knowledgeable, and capable of admitting that he/she might be wrong".

The conclusions are that these parent–child interaction interventions have reached both mothers, fathers and children beset by considerable difficulties in relation to interaction, offering them a treatment which an overwhelming majority of the families have chosen to follow through and which has made a difference to the families. The empirical material as a whole highlights the significance of beneficial relationships, not only within the intervention but also in other professional contexts, for the enhancing of children's development.

Keywords: parent–child, interaction intervention, Marte Meo, attachment, parents' perspectives, fathers, child development, narratives, intersubjectivity, hermeneutic phenomenology, therapeutic relationship.

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LIST OF PAPERS

This thesis is based on the following original papers, which will be referred to in the text by their Roman numerals:

I.   Neander, K., & Engström, I. (2009). Parents' assessment of parent–child interaction interventions – a longitudinal study in 101 families. *Child and Adolescent Psychiatry and Mental Health* 3:8.

II. Neander, K., Kling, A-M., & Engström, I. Fathers' involvement in parent–child interaction interventions – a prospective, naturalistic study. Submitted.

III. Neander, K., & Skott, C. (2006). Important Meetings with Important Persons. Narratives from Families Facing Adversity and their Key Figures. *Qualitative Social Work*, 5(3), 295-311.
     (Neander, K., & Skott, C. (2006). Quell' operatore tanto speciale: storie di relazioni efficaci *Lavoro sociale*, 6(3), 353-365.)

IV. Neander, K., & Skott, C. (2008). Bridging the Gap – the Co-creation of a Therapeutic Process. Reflections by Parents and Professionals on their Shared Experiences of Early Childhood Interventions. *Qualitative Social Work*, 7(3), 289-309.

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INTRODUCTION

Sensitive and predictable interaction with a caring parent (or another care-giver) is indispensable for a child's development. For families facing difficulties in this respect, parent–child interaction interventions is a promising way to support and enhance the relationship between children and their parents.

The interventions can either be in the form of treatment or of indicated prevention (Mrazek & Haggerty 1994). Indicated prevention implies interventions directed towards individuals who are in a risk category for some kind of negative trajectory. The distinction between indicated prevention and treatment is determined by whether the child has manifested symptoms or not. If, however, the relationship itself is seen as "the real patient" as Sameroff (2004) suggests, it would be appropriate to speak about interaction treatment even if the difficulties in the relation have not (as yet) led to symptoms in the child.

Parent–child interaction interventions can be described either by accounting for the emerging of different interventions or from a conceptual, theoretical perspective. These two perspectives are intertwined and they mutually influence each other. The following survey starts with an historical background and continues with a description of the theoretical roots and particularly important concepts. A summary of current research concludes the introduction.

Parent–child interaction interventions

Parent–child interaction interventions can be regarded as a part of the wider field of *early childhood interventions,* designed to promote child health and wellbeing, enhance the development of competence, and prevent psychological illness and other negative patterns (Shonkoff & Meisels 2000), and these endeavours are since 1989 supported by the UN Convention on the Rights of the Child, article 6.2 where it is stated that "States Parties shall ensure to the maximum extent possible the survival and development of the child."

Backing to the time before this convention a large-scale and well-known example of early childhood interventions is the Head Start program, which was introduced in the U.S.A. in the early 1960s, based on the idea that it was possible, through interventions, to compensate children growing up in less beneficial circumstances (poverty). Since then, the development of early childhood interventions has been intense in Western societies (Shonkoff et al. 2000). Such interventions were previously directed towards the children themselves – and their aim was often to increase cognitive skills and achievement – whereas nowadays they are predominantly directed towards both mother and child, or in some contexts towards the whole family

(Peterander 2004). Head Start was followed in the 90s by Early Head Start with a key goal of enhancing early relationships.

Parent–child interaction interventions directed towards infants and toddlers are often referred to as infant mental health interventions. One of the pioneers in this particular field was Selma Fraiberg (1980), who in the 1970s created the Child Development Project at the University of Michigan, Ann Arbor. After moving to San Francisco she continued to develop the Infant–Parent Psychotherapy (IPP), a psychoanalytic approach which postulates that disturbances in infant–parent relationships are the manifestation in the present of unresolved conflicts between the parent and important figures from her/his own childhood. By the concept "ghosts in the nursery" Fraiberg and her collaborators (Fraiberg, Adelson & Shapiro 1975) understood the obstacles that these conflicts may create. The aim of this kind of therapy is to give the parent the courage to explore the feelings evoked by difficult childhood experiences and to help the parent to connect these experiences to feelings of ambivalence, anger, and rejection toward her own infant (Berlin, Zeanah & Lieberman 2008).

One of Fraiberg's colleagues, Alicia Lieberman (2004), expanded IPP into Child-Parent Psychotherapy by including focus on the parents' current stressful life circumstances and on the parents' culturally derived values. CPP is a manualized intervention, delivered primarily to impoverished and traumatized families with children younger than five years of age. The themes in the unstructured sessions are determined by the interaction between the parent and the child and by the parent.

The findings from the Minnesota Longitudinal Study, a study of high risk children and their families which began in 1975, have been used to develop Steps Toward Effective Enjoyable Parenting (STEEP), a preventative intervention program beginning in 1987 for high risk parents and their infants. The program involves bi-weekly home visits, as well as bi-weekly groups for mothers and babies. Videotaping is considered a useful tool for promoting sensitivity and engaging parents in a process of self-observation. Reflecting the relationship-based approach, the same person who conducts the home visits also serves as group leader. The families are offered to take part in the programme at least until the child's second birthday (Erickson & Egeland 2004).

Watch, Wait, and Wonder (WWW), developed in Toronto by Nancy Cohen and Elisabeth Muir (Cohen, Muir, Parker, Brown, Lojkasek, Muir & Barwick 1999), is an infant-led psychotherapy including both the behavioural and the representational levels. For half the session the mother is instructed to get down on the floor with her infant, in the second half of the session, the mother and the therapist discuss the mother's observations and experiences of the play with the infant. In the first part

the mother is instructed to observe the infant – watching and interacting only at her infant's initiative – and to wait. The therapist's role is to engage in a parallel process of watching, waiting, and wondering about the interaction between mother and infant. In the subsequent discussion about the mother's observations, thoughts, feelings, interpretations of her infant's activity and their relationship, the therapist and the mother attempt to understand the themes and relational issues that the infant is trying to master (Cohen et al. 1999).

Minding the Baby (MTB) is a home visiting program targeting first-time very-high-risk mothers (Slade, Sadler & Mayes 2005). The services are provided by a team of clinicians: a paediatric nurse practitioner and a licensed clinical social worker. The theoretical underpinnings of MTB are attachment theory and social ecology theories, with a specific and novel emphasis on building mothers' reflective functioning, a construct developed by Fonagy and his colleagues (see *Theoretical perspectives and concepts* below), which is reflected in the name of the program. The endeavours to develop the reflective functioning can also be expressed as helping the mothers keep their babies (and themselves) "in mind" in a variety of ways. As the mother learns to ask, "Why is my baby doing this?", she begins to see the world from the baby's point of view and can provide more sensitive and responsive parenting.

More than twenty years ago Juffer, Bakermans-Kranenburg, van Ijzendoorn and colleagues at the University of Leiden started to videotape parental behaviour in order to enhance parents' sensitivity to their children's signals. They have now developed and evaluated several versions of Video-Feedback Intervention to Promote Positive Parenting (VIPP) (Juffer, Bakermans-Kranenburg & van Ijzendoorn 2008). VIPP is a short-term, behaviourally focused intervention delivered during four home visits each lasting approximately 90 minutes, to parents of infants less than one year of age. The intervener aims at promoting maternal sensitivity through a presentation of written material and a review of videotaped infant–parent interactions. There is an expanded version called VIPP-R, which adds a three hour home visit session focusing on parents' internal working models through discussion of the parents' childhood attachment experiences. Finally VIPP-SD is a behaviourally focused version of VIPP, emphasizing sensitive disciplinary practices to decrease externalizing problems in children with the ultimate aim to prevent the development of later antisocial behaviour (Mesman, Stolk, van Zeijl, Alink, Juffer, Bakermans-Kranenburg, van Ijzendoorn & Koot 2008). The intention is to enhance parents' ability to take into account the child's perspective and signals – the essential part of parental sensitivity – when discipline is required. Sensitive discipline includes the adoption of more ade-

quate and child-oriented discipline methods, such as distraction, induction, and empathy for the child when he/she is frustrated or angry.

The Circle of Security (COS) is a 20-week, group-based, parent intervention program, directly derived from attachment theory and research (Cooper, Hoffman, Powell & Marvin 2005). The program is designed to alter the developmental pathway of at-risk parents and their young children. The COS begins with assessments of the child's attachment and the parent's internal working models of attachment in order to guide the individualization of treatment. The centrepiece of treatment, delivered in 75-minute weekly sessions, is a pictorial depiction of attachment with the key constructs secure base and safe haven. The two principle parenting tasks are defined as providing closeness and facilitating exploration in response to the child's needs. Videotapes of child–parent interaction are reviewed, carefully guided by the group leaders, in the group consisting of six to eight parents. The group leaders aim at tailoring the intervention to each parent–child dyad's specific needs, determined by the initial assessments and the videotapes.

A psychodynamic interaction intervention, developed at the University of Haifa and explicitly involving fathers in the treatment of relational disturbances in childhood, is based on the assumption that children develop specific types of relationships with each parent, as well as with the parenting couple. The same therapist meets with the mother–child and father–child dyads on a weekly basis, and also with regular meetings with the parental dyad (Harel, Kaplan, Avimeir-Patt & Ben-Aaron 2006).

Elisabeth Fivaz-Depeursinge and colleagues (Fivaz-Depeursinge, Corboz-Warnery & Keren 2005) at Lausanne University Centre for family studies developed a method for therapeutic assessment of "triangular" relationships, between new parents and their first child, referred to as the Lausanne Trilogue Play (LTP) paradigm. The family is videotaped sitting in a triangular formation. The LPT scenario is divided into four parts; (1) one parent plays with the infant, while the other parent is the third party, (2) the parents reverse roles, (3) the three partners play together and (4) the parents interact with each other, and the infant is the third party. The intervention is built upon this observation and assessment, and focuses on both the family triad and the three dyads, where threesome relationships are seen as distinct from twosome ones. Video-feedback is an important element as well as direct intervention on interactions, which may be conducted immediately within the interactive setting and/or by means of prescriptions or rituals to be carried out at home in between sessions.

In the Nordic countries the Nic Waal Institute (Lange 2002) in Oslo has had a vanguard position in the field of infant mental health interventions. In 1978, the Viktoriagården in Malmö, Sweden, under the auspices of child psychiatry, started the first group of interaction treatment for mothers and their infants. The treatment was based on a broad theoretical basis of developmental psychology and on the findings from modern infant research (Brodén 1989, Brodén 1992). Fifteen years later, according to an inventory made by the National Board of Health and Welfare (1993), there were 26 out-patient units working with treatment of early disturbances in the parent–child relationship. Interaction treatment (description follows below) in different forms was the dominant feature of these centres. Most of the centres fell under the auspices of the County Council, but joint responsibility between the municipality and the County Council was also available. The concentration on such interventions has since ceased and some centres have been obliged to close when resources have been transferred to, for example, the ordinary child psychiatry outpatient work (Broberg, Risholm Mothander, Granqvist & Ivarsson 2008). The current situation is marked by an ambition to unite the experiences acquired with the methods having achieved the best effects in empirical studies (Skagerberg 2009).

Theoretical perspectives and concepts

Attachment theory (Ainsworth 1969, Bowlby 1969/1982) is generally acknowledged as the main theoretical basis for parent–child interaction interventions; hence a brief presentation of some of its basic concepts will open this survey. Being of special relevance to the therapeutic work with infants and toddlers and their parents the concepts of intersubjectivity and mentalization will also be presented here. The ecological and transactional perspectives complement attachment theory by adding the influence of the surrounding world for a child's development and point to the dynamic interactions between the child and his/her family and social context. A description of the special conditions for interventions at hand in parent–child interaction interventions will conclude the survey.

Attachment theory

Attachment theory describes the aspect of the child's relation to his/her care-giver with a primary aim of promoting safety in infancy and childhood (Crowell, Fraley & Shaver 2008). Bowlby emphasizes the evolutionary function of infant–caregiver attachment in enhancing the likelihood of infant survival. The attachment is of a "compulsive" nature, i.e. the child cannot choose not to attach to his/her care-giver. The attachment behaviour system is activated in times of danger, stress and novelty,

and has the goal of gaining and maintaining proximity and contact with an attachment figure. Attachment behaviour refers to an infant's signals, such as crying and smiling, in order to engage the caregiver (Bowlby 1969/1982). In the parent this corresponds to the care-giving system being activated by these cues.

Bowlby and other theorists have clearly stated that an infant can form an attachment to more than one caregiver at a time, which is not in contradiction with an infant's tendency to establish a hierarchical organization with one *principal* attachment figure who is sought preferentially in times of trouble. This is referred to as the concept of "monotropy" (Bowlby 1969/1982).

Through the interaction between the infant and the care-giver(s) the infant conceptualizes how the world works and begins developing "internal working models", which shape the framework for how a child later understands him/herself and relates to others. For example, a child who is given good care, listened to, encouraged, and praised is likely to have an internal representation of self as "good, loveable, and successful" (Cornell & Hamrin 2008). Internal working models of self and other in an attachment relationship serve to anticipate, interpret, and guide the interaction (Bretherton & Munholland 2008). These models can and must be updated as the child develops.

A child benefits from experiencing interaction with a reasonably sensitive and sufficiently predictable parent able to provide a secure base from which the child can comfortably engage with the world, balancing his/her inquisitiveness with his/her need for a "safe haven" to return to for comfort and proximity in case of danger. If the care-giver cannot provide this, children adapt their strategies, with respect to the prevailing conditions, in order to get the best possible access to protection.

These strategies can be studied when the attachment system is being activated. Mary Ainsworth created the Strange Situation Procedure (SSP) (Ainsworth, Blehar, Waters & Wall 1978), an experimental situation for children from 12 to 20 months, in which the child is exposed to separation from its caregiver which, at that age, is experienced as a menace. Three basic patterns of organized attachment were described, labelled "secure" (B), "avoidant" (A), and "ambivalent/resistant" (C). A securely attached child uses the care-giver as a secure base and displays a balance between exploring and proximity-seeking. A child with avoidant attachment explores readily, but avoids proximity with the parent, whereas a child with ambivalent/resistant attachment fails to engage in exploration, may alternate bids for contact with rejection, and fails to find comfort in parent.

The SSP and the three categories are frequently used in research but there were about 15% of children in a normative sample, and much higher percentages in high-

risk samples, which were difficult to classify in these categories. Main and Solomon (1986) examined such cases and described a fourth classification group termed "disorganised/disoriented" (D). Children in this group seem to lack a coherent attachment strategy and show a diverse set of behaviours, such as incomplete, interrupted movement, freezing, and confusion (Solomon & George 2008). Attachment disorganization is thought to be the result of an internal conflict between perceptions of the parent as a source of fear and as a haven of safety (Main & Hesse 1990). There is yet another category labelled "cannot classify" (CC), applicable when the infant displays aspects of more than one classification, without being disorganized.

Infant attachment security is a protective factor for future development (Niccols 2008), whereas disorganized attachment is a serious risk factor for later behaviour problems (van Ijzendoorn, Schuengel, & Bakermans-Kranenburg 1999) and child psychopathology (Juffer, Bakermans-Kranenburg & van Ijzendoorn 2005). Attention is now given to socially indiscriminate forms of attachment behaviour, often seen among institutionally reared children, which may constitute an even greater risk factor for future negative development (Lyons-Ruth, Bureau, Riley & Atlas-Corbett 2009).

Since attachment security, defined as "the state of being secure or untroubled about the availability of the attachment figure" (Ainsworth et al. 1978), is such an important asset to a child the question concerning what constitutes attachment security is of interest. The core concept in respect to attachment security precursors is maternal sensitivity, defined by Ainsworth (Ainsworth, Bell & Stayton 1971). The sensitive mother is able to see things from her baby's point of view, perceive the infant's signals, interpret them correctly, and respond to them promptly and appropriately. The wider concept of maternal behaviour consists of four dimensions of importance: acceptance–rejection, co-operation–interference, accessibility–ignoring and sensitivity–insensitivity (Ainsworth et al. 1971). Nowadays, the concept "maternal sensitivity" is occasionally complemented by the synonymous concept "parental sensitivity". In the subject index of the second edition of Handbook of attachment (Cassidy & Shaver 2008) there were ten references to *parental* sensitivity whereas in the first edition (Shaver & Cassidy 1999) the only reference given was "*see* Maternal sensitivity".

According to Bowlby (Ainsworth 1990) the attachment system is active throughout life. In middle childhood, attachment to parent(s) is still salient, but availability of the attachment figure has become more important than proximity. The internal working models of attachment continue to play a role in relation to parents, to partners, and to friends. Twenty-five years ago George, Kaplan & Main (1985) de-

veloped the Adult Attachment Interview (AAI) in order to determine an individual's state of mind with respect to attachment. Participants are classified as "secure/autonomous" when their way of presenting and evaluating attachment-related experiences is coherent and consistent and their responses are clear, relevant, and reasonably succinct. They are classified as "dismissing" when they describe their parents in highly positive terms that are unsupported or that are contradicted later in the interview, and "preoccupied" when they show a confused, angry, or passive preoccupation with attachment figures. Participants may be classified as "unresolved/disorganized" with respect to potentially traumatic experiences involving loss or abuse. The different "states of mind" are related to the organized categories of infant attachment, described above, in the following way: secure-autonomous (F) is related to secure attachment (B); dismissing (Ds) to avoidant (A); preoccupied (E) to resistant/ambivalent (C). Unresolved/disorganized state of mind (U) and unorganized/cannot classify (CC) are related to infant disorganized (D) attachment and cannot classify (CC). There is also a concept of "earned" security which refers to persons judged secure/autonomous, in spite of negative childhood experiences (Hesse 2008).

Intersubjectivity

The concept of intersubjectivity – which refers to the sharing of experiences and feelings with another person – is central within parent–child interaction interventions as it has a bearing upon both the child's development and the therapeutic process. Intersubjectivity has to do with human beings' dependence on others for the experience of existing, and implies that 'I know that you know that I know' or 'I feel that you feel that I feel' and is thus connected to the relationship of mutuality between people and the satisfaction of being together with others (Stern 2004b).

Bowlby (1969/1982) described the attachment system as a motivational system, and Sterns claims that intersubjectivity is another motivational system – equally fundamental. The intersubjective motivational system that regulates psychological intimacy can be considered separate from and complementary to the attachment motivational system that regulates fear and curiosity. A person can develop a relation of attachment without experiencing intersubjectivity – e.g. a child with autism – and people can be intersubjectively intimate without being attached, or both, or neither (Stern 2004a).

The concept of "primary intersubjectivity" implies the child's innate biological readiness to be part of a reciprocal dialogue with an adult (Trevarthen & Aitken 2001). This preparedness manifests itself in the tight mutual coordination of infant

and mother: the timing of their movements, their vocalizing, and their anticipation of the other. Stern (2004b) concludes that infants are born with minds that are especially attuned to other minds.

In Stern's (1985) description of the child's development of senses of self, the feeling of an intersubjective self appears from about nine months of age, which means that the child is then capable of deepened intersubjective interaction. The sub-aspects mentioned by Stern are inter-attention, inter-intentionality and inter-affectivity. Affect attunement implies that the parent reads the child's state of emotion, "responds" or mirrors the child and that the child in turn reads this response as something that has to do with his/her initial emotional experience and not merely as an imitation. Through affect attunement the parent continually, and in a great number of various ways, offers the child new experiences of how to share feelings lying behind behaviour, an early and important aspect of the development of empathy. According to Stern, the importance of intersubjectivity also lies in the fact that the basis for development is the growing field of intersubjectivity presenting itself between child and care-giver.

The Boston Change Process Study Group has adapted findings from infant research to the clinical situation. The intersubjective field mentioned above is crucial also in the therapeutic process, viewed as "occurring in an ongoing intersubjective matrix", which implies that intersubjectivity is no longer considered merely as a useful tool, but as the core of psychotherapy.

Mentalization or reflective functioning

The importance of parents' understanding of and reflection on the infant's internal world is highlighted by Fonagy and colleagues (Fonagy & Target 1997). This capacity is referred to as "mentalization" or "reflective functioning". The latter concept is operationalized for research (usually based on AAI narratives) in the context of attachment.

Mentalization implies the ability to understand the mental state of oneself and others. It could also be described as a form of imaginative mental activity, which allows us to perceive and interpret human behaviour in terms of intentional mental states e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons (Bateman & Fonagy 2004). This means that we have the ability to understand that other people may have intentions, information and opinions different from ours, and that phenomena therefore may be perceived differently. One important aspect of mentalization is consciousness of the fact that it is not possible to know with certainty what goes on in the mind of the other.

In parenting, reflective functioning is related to the parent's capacity to take care of his/her own child emotionally, to show interest in the child's inner state of mind and to adapt to prevailing outer circumstances. Connection between the outer reality and the inner world of feelings is established through "small talk" which is a natural part of parent–child interaction. In his/her emotional development the child benefits from seeing his/her own experiences mirrored in the parent's mind, especially when the parent neither rejects nor takes over the child's feelings (Fonagy 2001).

In a prospective study (Fonagy, Steele, Steele, Moran & Higgit 1991) comprising 100 couples expecting their first child, it turned out that parents with a good capacity for mentalization had three to four times greater chances of having a securely attached child, at the age of one, compared with those parents who had a poor capacity of mentalization.

According to Fonagy, these results and recent research indicate that reflective functioning is decisive in the transgenerational transmission of attachment patterns, and thereby it is one answer to "the mystery of the transmission gap" (Fonagy & Target 2005). This is also the basis for Minding the Baby (described above), a programme that differs from others in pronouncing the reflective functioning itself as the intervention target (Slade, Grienenberger, Bernbach, Levy & Locker 2005).

The ecological and transactional perspectives

The ecological perspective (Bronfenbrenner 1977) draws attention to a broader social context of human development, thus placing the child and the child–parent dyad in social systems on different levels (e.g. family, day-care, neighbourhood, welfare system, legislation and culture). The ecological environment is conceived topologically as a nested arrangement of structures, each contained within the next.

This perspective highlights both the interaction of the child as a biological organism within its immediate social environment in terms of processes, events and relationships as well as the interaction between social systems (the mesosystem) (Bronfenbrenner 1977). Contextual factors, both positive and negative, such as social support and poverty, exert most of their effects not directly on the child but by influencing the parent and the parent–child interaction (Belsky & Fearon 2008).

According to the transactional perspective (Sameroff 2004), the development of a child is viewed as a product of the continuous dynamic interactions between the child and his/her family and social context. Equal emphasis is placed on the child and the environment, since the individual differences in the child play an important role in what the child elicits from the environment and what he/she is able to take

from it. This means that the child is no longer seen as a passive receiver but as an agent who exerts influence upon his/her environment.

The clinical system

Parents and infants with interaction problems represent a new clinical population requiring new therapeutic approaches (Stern 2004a). The concept of the "motherhood constellation" refers to the observation that mothers rapidly evolve a different psychological organization when they have a baby, which alters her sensibility, fantasies, preferences, life priorities, basic fears, and mental engagement with her own mother (Stern 1995). This mental organization demands a positive, validating and accompanying therapeutic environment.

The relationship between the infant and the parent should be understood in terms of both the representations of the parents and the overt interactions between the parent(s) and the infant – constantly influencing each other. As a consequence of this, the clinical system offers different "ports of entry" to achieve change; the parent's representations, the interaction, the infant's competency, or the family context (Stern 2004a).

Current research

The following survey begins with a short description of three important reviews of parent–child interaction interventions (van Ijzendoorn, Juffer & Duyvesteyn 1995, Egeland, Weinfeld, Bosquet & Cheng 2000, Bakermans-Kranenburg, van Ijzendoorn & Juffer 2003). The selection of studies which follows, most published after 2003, has been based upon an assessment of the relevancy of the issues and outcomes of the issues treated in this thesis.

"Breaking the intergenerational cycle of insecure attachment" is the title of the first systematic review of the effects of attachment-based interventions (van Ijzendoorn et al. 1995). Sixteen studies have been included in a narrative review, and twelve of these in a meta-analysis. A short intervention, focusing on 100 highly irritable infants, by van den Boom (1994) was by far the most effective in this meta-analysis. The authors conclude that interventions are effective in enhancing maternal sensitivity to infant's attachment cues, but the effect on the children's attachment was, however, surprisingly weak. They also found that short-term interventions with a clear focus appeared to be more effective than long-term broad-band interventions.

The results from van Ijzendoorn's et al. (1995) meta-analysis draw attention to the origins of individual differences in child–parent attachment. In connection with a meta-analysis of the predictive value of the Adult Attachment Interview, van Ijzen-

doorn (1995) presented the attachment "transmission model" which implies that parenting behaviours contribute directly to the quality of the child–parent attachment and are largely driven by the parent's internal working models of attachment. The "transmission gap" refers to the fact that sensitive parenting, however, accounts for an unexpectedly small proportion of the association between parental internal working models and child attachment, implying that there are other pathways between parental attachment representations and children's attachment.
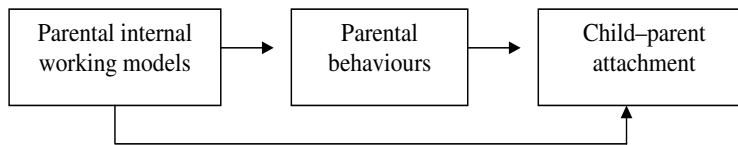
Figure 1. The transmission model

Since these findings are of importance for prevention and intervention, the transmission gap is often referred to and discussed in the literature (Cassidy et al. 2008), for example in a meta-analysis from 2006 which examines the links between unresolved states of mind, anomalous parental behaviour, and disorganized attachment (Madigan, Bakermans-Kranenburg, van Ijzendoorn, Moran, Pederson & Benoit 2006). This analysis reveals that there are moderate effect sizes for the associations between anomalous parental behaviour, and disorganized attachment, but only a small part of the association between unresolved states of mind and disorganized attachment relationships was explained by the mediation of this parental behaviour. The authors underscore the need of further exploration of possible mediating factors.

In 2000, Egeland et al. (2000) published a narrative review of 15 attachment-based interventions. Their conclusion is that most programs did not include an ecological perspective in the design of the intervention, which they find crucial in order to meet the participants' needs at different ecological levels. The authors recommend flexible broad-based interventions – particularly for high-risk samples – designed to make services available that can meet both attachment-related and other needs of high risk families; e.g. enhancing parental well-being and providing and promoting social support.

This conclusion was in contrast with both the study by van Ijzendoorn et al. (1995) described above, and the meta-analysis conducted in 2003 in part by the

same group of researchers (Bakermans-Kranenburg et al. 2003). The common features of the interventions were that they started before the children's mean age of 54 months and that their purpose was to enhance parental sensitivity and/or child attachment security. The selection criteria were in other respects broad in order to include as many studies as possible, both preventive interventions directed towards middle-class samples of healthy children, indicated prevention for at risk populations, and therapeutic interventions targeting clinical samples. The findings of this meta-analysis, comprising 70 studies, were summarized in the title of the article: Less Is More, based on the fact that the most effective interventions – in high risk families as well as families without problems – used a moderate number of sessions and applied a behavioural focus. The analysis revealed that the interventions had an impact both on the mothers' sensitivity and – to a lesser degree – on the children's attachment. Interventions that were more effective in enhancing parental sensitivity were also more effective in enhancing attachment security, which supports the notion of a causal role of sensitivity in shaping attachment.

Questions about dosage and duration have thus been central, summarized in the concepts "less is more" and "more is better". Greenberg (2005) stated that these concepts can be understood only as contextualized within populations. Lisa Berlin (2005) pointed out that there is a need for research into "What works for whom?" since it is likely that "less is more" for some whereas "more is better" for others. Ziv (2005) foresaw that future studies would find both conclusions valid, but for different population groups.

One reason can be that short interventions might provide lower levels of drop-out from treatment. A randomized controlled trial concerning parent management training, including children 2-12 years with oppositional, aggressive, and antisocial behaviour, showed that parents who received a brief intervention (compared to treatment as usual) had greater treatment motivation, attended significantly more treatment sessions, and demonstrated greater adherence to treatment according to both parent and therapist reports (Nock & Kazdin 2005).

In accordance with the standpoint that there is a need for variation of intensity The Triple P Positive Parenting Program is a multilevel parenting program. This Australian program, based on social learning principles aims at preventing and treating severe behavioural, emotional, and developmental problems in children. The levels range from universal preventing (level 1) to enhanced behavioural family intervention (level 5). A meta-analysis assessing level 4, an intensive, 8 to 10-session group or individual parent training programme for parents of children with more severe behavioural difficulties or who are at risk of developing such problems, indi-

cates that the interventions reduced disruptive behaviours in children. These improvements were maintained well over time, with further improvements in long-term follow-up (de Graaf, Speetjens, Smit, de Wolff & Tavecchio 2008).

The UCLA Family Development Program is a home visiting program based on previous literature and evaluations of other home visiting programs. The positive outcomes in the first year of life – the children in the intervention group were more secure and their mothers more responsive to their needs (Heinicke, Fineman, Ruth, Recchia, Guthrie & Rodning 1999) – are included both in the meta-analysis mentioned above (Bakermans-Kranenburg et al. 2003) and in (Bakermans-Kranenburg, van Ijzendoorn & Juffer 2005) which will be mentioned subsequently. In a follow-up study the results showed that group intervention made a significant positive impact during the child's first two years of life with regard to the mother's responsiveness, the mother's encouragement of her child's autonomy, and the mother's encouragement of her child's task involvement. The intervention mothers used methods of control that were verbally persuasive, as opposed to coercive intrusive methods of control, and their children responded more positively to that (Heinicke, Rineman, Ponce & Guthrie 2001).

The UCLA program is included in a review of preventive interventions conducted by Olds, Sadler & Kitzman (2007), and is identified as a program that is carefully developed. The authors are otherwise mainly critical in their conclusions about programs for parents of infants and toddlers, meaning that such programs to date have not achieved the considerable promise they hold for improving children's life-course trajectories and for reducing health and development problems and associated costs to government and society. The authors state that programs need to be grounded in theory and epidemiology, carefully piloted to ascertain program feasibility, participant engagement, and behavioural change prior to testing them in randomized trials. Neither Triple P nor the Incredible Years are included in the review conducted by Olds et al. (2007), partly because they tend to be applied once parenting problems have emerged.

Even though the Webster-Stratton 14-week parenting programme The Incredible Years only addresses parents, the results from a randomised controlled trial is still of interest since the study includes children aged 2-9 (n=76) referred for conduct problems, and measures outcomes at 6 and 18 months. Post-treatment improvements were found in child problem behaviour, child independent play, observed negative and positive parenting, parent-reported confidence and skill. At the assessment after 19 months changes appeared to remain (Gardner, Burton & Klimes 2006). This programme has been introduced in Sweden, and an evaluation showed significant

reduction of behaviour management problems in the children (3-9 years) in all relevant measures (Axberg, Hansson & Broberg 2007).

The same problem area was targeted in a randomised controlled effect study of a four-session psychoeducational group for parents of preschoolers (3-4 years) with behaviour problems. The study showed that the parents who received the intervention reported significantly greater improvement in parenting practices and a significantly greater reduction in child problem behaviour than the control group. The gains in positive parenting behaviours were maintained at the one-year follow-up in a subset of the experimental group (Bradley, Jadaa, Brody, Landy, Tallett, Watson, Shea & Stephens 2003).

In another randomized study (Feinfield & Baker 2004), the efficacy of a manualized multimodal treatment program for young (4-8 years) children with externalizing symptoms was evaluated. Both parents and children participated in this intervention. Parents involved in treatment reported statistically and clinically significant reductions in child behaviour problems, improved parenting practices, an increased sense of efficacy, and reduced parenting stress. There was a trend toward parental attitudes. Five months following treatment, teachers reported significant improvements in child behaviours, and parents reported that reductions in child behaviour problems and parenting stress were maintained.

From externalizing problems we now change focus to children living in high-risk situations. In a study examining the question whether it is possible to foster secure attachment in infants in maltreating families through preventive interventions, one-year-old infants from such families (n=137) and their mothers were randomly assigned to one of three intervention conditions: (a) infant–parent psychotherapy (IPP), (b) psychoeducational parenting intervention (PPI), and (c) community standard (CS) controls. A fourth group of infants from normal-treating families (n=52) and their mothers served as an additional low-income normative comparison (NC) group. At baseline, infants in the maltreatment groups had significantly higher rates of disorganized attachment than infants in the NC group. At post intervention follow-up at age 26 months, children in the IPP and PPI groups demonstrated substantial increases in secure attachment, whereas increases in secure attachment were not found for the CS and NC groups. Moreover, disorganized attachment continued to predominate in the CS group (Chicchetti, Rogosch & Toth 2006).

Another kindred problem, "Do early childhood interventions prevent child maltreatment?" is highlighted in a review that includes 15 studies of 14 programs for children from birth to five years (Reynolds, Mathieson & Topitzes 2009). The major conclusion the authors draw is that the evidence base for programs in early

childhood to prevent child maltreatment remains relatively weak. Although five studies reported reductions in either substantiated or parent-reported maltreatment, only three programs showed consistent evidence of enduring effects. Common elements of these effective programs included implementation by professional staff, relatively high dosage and intensity, and comprehensiveness of scope.

As mentioned earlier in this introduction, infant disorganized attachment is a major risk factor for problematic stress management and subsequent problem behaviour issues. Therefore the review and meta-analysis of 15 interventions (Bakermans-Kraneburg et al. 2005) that includes infant disorganized attachment as an outcome measure is of special interest. (Out of these 15 interventions 13 are included in Bakermans-Kraneburg et al. 2003) The researchers asked the question: Can the emergence of attachment disorganization be prevented? The effectiveness of the interventions ranged from negative to positive, with an overall effect size of d=0.05 (ns). Four important contrasts were found: effective interventions started after six months of the infant's age rather than before six months; sensitivity-focused interventions appeared to be more effective than interventions with a broader focus; interventions in samples with children at risk were more effective than interventions in samples with at-risk parents; and in samples with a higher percentage of disorganization in the control group, the interventions were more effective.

The group of researchers behind this and two of the above mentioned meta-analyses has developed the video interventions VIPP, VIPP-R and VIPP-SD (described above) evaluated in a number of studies. A summary of the results show that VIPP is effective for clinical samples of families and in families with psychological or health problems. VIPP-R, the modality which is supplemented with representational discussions, has not shown better results than VIPP (Juffer et al. 2008). In a randomized controlled trial with 237 families, VIPP-SD, which adds a module of "sensitive discipline", was tested and proved to be effective in enhancing maternal attitudes toward sensitivity and sensitive discipline and in promoting sensitive discipline interactions, resulting in a decrease of overactive problem behaviours in the children (van Zeijl, Mesman, van Ijzendoorn, Bakermans-Kranenburg, Juffer, Stolk, Koot & Alink 2006).

These interventions form part of the basis for a meta-analysis (Fukkink 2008) of interventions with video feedback, including in all 29 studies (n=1844 families). The design of the interventions varied; there were studies with and without control groups, random assignment, and alternative treatment. The authors conclude that interventions with video feedback are effective in families with young children. The parents get more skilled in interacting with their children and have a more positive

perception of parenting, and the development of the children is enhanced. The experimental outcomes were reduced at child level if the parents belonged to a high-risk group. A limit of this study, however, is that video feedback is often combined with various other treatment components, which makes it impossible to determine if the video feedback is the crucial component.

The same goes for a Swedish study, where the video feedback method Marte Meo was combined with coordination meetings based on systemic theory and practice. The results showed significant decrease in reported symptoms both at school and at home in children who displayed externalizing behaviour problems (Axberg, Hansson, Broberg & Wirtberg 2006).

The large majority of attachment research has focused exclusively on child-mother attachment (Cassidy et al. 2008), and Madigan et al. (2006) state that there is a notable dearth of knowledge and research regarding the role of the father's state of mind and behaviour in the development of attachment relationships, especially since the mechanisms involved in the development of attachment relationships may differ for mothers and fathers. Accordingly fathers are rarely included in parent–child interventions. Out of the 70 studies in the meta-analysis referred to earlier (Bakermans-Kranenburg et al. 2003) only three included fathers.

There is, however, a systematic literature review of interventions with fathers of young children including twelve interventions presented in 14 papers that met the inclusion criteria: included a control group or used a pre-test and post-test design; measured an aspect of father–child interaction; analysed father outcomes separately from mother outcomes; had a sample greater than one; and included infants or toddlers. There was a variety of interventions designs, for example kangaroo care and observation and modelling of interaction behaviour, and discussion groups. The authors conclude that there is evidence that the intervention may be effective in enhancing the father's interaction with the child and a positive perception of the child if interventions involve active participation with or observation of the father's own child (Magill-Evans, Harrison, Rempel & Slater 2006). Two of the studies concerning the same intervention reported that a parent education intervention which included discussion of videotaped vignettes of parent–child interactions and weekly written homework was more effective for mothers than for fathers, for whom there was no significant influence at three months (Gross, Fogg & Tucker 1995) or at one year (Tucker, Gross, Fogg, Delaney & Lapporte 1998).

A randomized experimental design was used to examine whether a group educational intervention during the transition to parenthood can enhance the quality of father–child interaction and increase paternal involvement. The study included 165

couples who were first-time parents, beginning during the second trimester of pregnancy and ending at five months postpartum. The intervention had positive effects on fathers' skills in interacting with their babies and their involvement on work days but not on home days (Doherty, Erickson, & LaRossa 2006).

An intervention for first-time fathers consisting of video self-modelling with feedback delivered during two home visits, when the child was five and six months, was evaluated in a randomized controlled study. The fathers in the control group discussed age appropriate toys with the home visitor. Both the intervention and the control groups reported increased competence in parenting over time, but fathers in the intervention group were significantly more skilled in fostering cognitive growth and maintained their sensitivity to infant cues when the baby was eight months old (Magill-Evans, Harrison, Benzies, Gierl & Kimak 2007).

A majority of the interventions in the reviews are conducted in western societies. It is not self-evident that intervention programs can be easily transferred from one cultural context to another. From that point of view a review that integrates maternal responsiveness studies from both developed and developing countries (Eshel, Daelmans, de Mello & Martines 2006), e.g. Jamaica, Colombia and Brazil is of special interest. A limitation, however, was that articles were restricted to the English language, which excludes relevant research from considerable parts of the world. The authors conclude that responsive parenting has wide-ranging benefits for the child, from psychosocial development to improved health and physical growth, and that interventions in both developed and developing countries have been modestly effective in enhancing maternal responsiveness, leading to better child health and development, especially for at-risk children. This review includes a pilot study of a mother–infant intervention in an indigent peri-urban South African context. Recently published results from a randomized controlled study of the same intervention show that mothers in the intervention group were significantly more sensitive and that the intervention was associated with a higher rate of secure infant attachments at 18 months. The authors conclude that if these effects persist, and if they are replicated, this intervention holds considerable promise for use in the developing world (Cooper, Tomlinson, Swartz, Landman, Molteno, Stein, McPherson & Murray 2009).

An evaluation based on 63 dyads of mother and infant, aged 0-6 months, in a Swedish 6-week intervention programme for mothers at psychosocial risk and their infants, indicated positive development of the mother–child interaction both according to staff and to external psychologists. Retrospective interviews with the mothers revealed that the number of mothers who had a positive attitude towards the inter-

vention increased from 34 before the intervention to 56 after treatment (Wadsby, Sydsjo & Svedin 2001).

Another question of interest, related to the fluid limits between prevention and intervention, is whether and how an efficacious clinical intervention can be transferred to a universal prevention intervention. In a study by Zubrick, Ward, Silburn, Lawrence, Williams, Blair, Robertson & Sanders (2005) this issue is tested concerning a group behavioural family intervention BFI. A quasi-experimental two-group longitudinal design followed preschool aged children and their parents over a 2-year period. BFI was associated with significant reductions in parent-reported levels of dysfunctional parenting and parent-reported levels of child behaviour problems. Effect sizes on child behaviour problems ranged from large (d=.83) to moderate (d=.47). Positive and significant effects were also observed in parent mental health, marital adjustment, and levels of conflict with regard to child rearing.

The choice of time for assessment of outcomes can be of importance in evaluating the effects of an intervention. A study where the effect of an infant-led psychotherapy Watch, Wait, and Wonder (WWW) was compared with a more traditional psychodynamic psychotherapy (PPT) showed measures post treatment of positive effects in both treatment groups. WWW had a better effect than PPT with regard to infant–mother attachment security among other things. At a follow-up six months later the effects were maintained or reinforced, and at this point of time there were no differences between the two treatment methods. The conclusion drawn by the authors is that change emerged at different pace (Cohen, Lojkasek, Muir, Muir & Parker 2002).

In the intervention studies presented above focus has been on the method of intervention, dosage and duration and to a certain extent on the theoretical foundations. In the adjacent field of psychotherapy, Lambert (1992) has conducted a meta-analysis assessing factors of importance for the outcome of treatment. The analysis highlighted the importance of a series of other factors than the ones related to the specific method used. There is support for the notion that the ingredients that different therapies share – the common factors – may be of great significance. One of the factors discussed is the therapeutic relationship. In a comment on early preventive intervention and home visiting Stern (2006) is of the opinion that there is no reason to believe that the exact intervention technique accounts for much of the variability. The overwhelming non-specific, positive factors lie in the relationship between the visitor and the family, especially the mother. Zeanah, Larrieu, Boris & Nagle (2006) conclude their article by saying, "In sum, we believe that it is the 'person' of the nurse, and her capacity to form a caring and supportive relationship with the

mother and her baby, that is an essential element in the success". Other researchers emphasize the secure-base aspects of the relationship (Ammaniti, Speranza, Tambelli, Muscetta, Lucarelli, Vismara, Odorisio & Cimino 2006). The notion of "parallel process" is used by Slade et al. (2005b), referring to the relationship between on one hand the therapist and the mother and on the other hand the mother and the child.

The relational aspect is expressed as "the mother's ability to work with the home visitor" in a study about UCLA Family Development Project, and the antecedents of this ability are examined (Heinicke, Goorsky, Levine, Ponce, Ruth, Silverman & Sotelo 2006). In an overview of prevention and intervention programmes Berlin et al. (2008) conclude that both Child–Parent Psychotherapy (CPP) and the UCLA program provide tentative support for the role of the intervener–mother relationship in driving the positive outcomes of these programmes.

How the interventions are experienced by parents partaking in parent–child interaction interventions is only exceptionally accounted for (e.g. Wadsby et al. 2001) and then often in terms of "consumer satisfaction" (Gardner et al. 2006) or parental satisfaction and acceptability (Taban & Lutzker 2001). Among the rare studies focusing on parents' perspectives, most cases concern families with children having special disabilities and not on experiences of parent–child interaction interventions.

The mothers' perspective of infant mental health interventions is however the subject of a phenomenological study (Olson 1999). The most common subthemes were the positive, caring nature of the therapeutic relationship with the intervener, and the empowering nature of the intervention strategies employed.

Anna´s story (Kretchmar, Worsham & Swenson 2005) is a qualitative analysis of an at-risk mother's experience in an attachment-based foster care program, Children's Ark, which reunited children with their mothers in a supervised home environment. The study displays Anna's growing connection to the people at the Ark and the importance of these relationships to the changes she made over time. However, the study does not focus solely on the mother's perspective just as much as on the process of change from a perspective of attachment theory.

A study on two different approaches to treating reactive attachment disorder (RAD), on one hand relationship-based attachment therapy and on the other holding therapy, sought to identify a treatment package based on the views of parents whose children with RAD had made and sustained considerable progress. The parents highlighted parental commitment and availability, ability to find strengths, strong environmental structure, and emotional attunement as sources of change (Drisko & Zilberstein 2008).

To sum up, parent–child interaction interventions have thus been subject to a large body of studies, and a conceivable conclusion is that it is possible, through interventions, to enhance the "indispensable interaction" between children and their parents as well as the development of the children. However, many questions remain in connection with "what works for whom?" with the extension "under which circumstances?". What aspects of the interaction are most important to target in order to make a child experience that he/she is provided with a secure base, and how do we attain this? What role does cultural context play? Most of the knowledge accounted for here is based on interventions in U.S.A., Great Britain, and the Netherlands. What works in other cultural contexts, for example in Sweden, with our specific cultural and legislative prerequisites? Is father involvement desirable in parent–child interaction interventions, and in that case, what is required to implement it? How do the participating parents and children experience the interventions, and how can their opinions benefit the designing of future parent–child interaction interventions?

Aim of this thesis

The aim of this thesis was (a) to describe families taking part in parent–child interaction interventions and examine short term and long term changes in their problem loads, (b) to examine the parents' perspectives on what persons and contexts within and outside the intervention they considered beneficial for the child or the family and (c) to examine the understanding that the parents and the key figures generated of these processes in joint interviews.

CONTEXT

The four centres for parent–child interaction interventions

The families included in this study have participated in treatment at one of the following four centres for parent–child interaction interventions in Sweden: Gryningen in Karlskoga (ages 0–6), Lindan in Lindesberg (ages 0–5), Lundvivegården in Skövde (ages 0–12) and Björkdungen's family centre in Örebro (ages 0–12). Gryningen is run by the Department of Child and Adolescent Psychiatry in collaboration with the Social Welfare authorities, Lindan by the Department of Child and Adolescent Psychiatry while Lundvivegården and Björkdungen fall under the auspices of the Social Welfare authorities. They are all outpatient departments.

The parents may contact the centres or be referred to them by for example maternal health care, child health care, social services, child day-care, or psychiatry. A common feature for all the families attending the centres is difficulties associated with parenting, and the contact cause is always related to the interaction between the child and the parent(s) in some way. Most of the families have a genuine motivation for change, but some families feel obliged to comply with the expectations of social authorities that they participate in the intervention, even though the intervention is defined as voluntary.

The families vary greatly in terms of nature and severity of problems and general life circumstances – some of the families may be functioning well socially but are experiencing specific difficulties in parenting, while others may carry a history of generations of multiple problems. For some families, the major issue is the parents' mental health problems manifested in worry, anxiety or depression, which entails that they are less emotionally available for their children. Some families are collapsing under the pressure of external factors, e.g. the uncertainty related to seeking political asylum, while others struggle with the consequences of a child's neuropsychiatric disorder, major conflicts between parents, the absence of a parent, lack of support from social networks, or intellectual limitations.

The theoretical foundation employed at these four centres is provided by attachment theory, along with an ecological, transactional perspective (described above in the Introduction).

The work assignment

The linchpin of the therapeutic work is the collaborative relationship between the parent(s) and the therapist. The goals of intervention are based on the parents' description of the problem and are established through a dialogue concerning what changes they desire. This leads to an agreement about a work assignment, which also entails clarification of the roles of the practitioners and the parents. On the basis of these discussions the professionals endeavour to shape the treatment according to the pronounced needs of each family.

Elements in the programme

The intervention comprises a number of elements combined on the basis of the needs of the family. The first element – which is *always involved* but which *never* constitutes the entire intervention – is parental counselling. The next element – which comprises the main element of the intervention – *is interaction treatment* which can be carried out in different forms as described below; "in video", "in vivo" (live), and "in verbis" (verbally; a combination of these three forms is frequently used. Another element is collaboration with the family's social network, applied when required.

Interaction treatment "in video" – Marte Meo

Marte Meo is a video feedback method, developed in the Netherlands in the 1980s (Aarts 2000). The description of the problems and the desired changes guide the Marte Meo intervention. The therapist makes a video recording of the child, in most cases interacting with the parent. If a parent is hesitant or against the idea of being recorded it is possible to focus merely on the child. The therapist analyzes the recording with respect to the problems described and to a number of features usually found in a natural supportive dialogue, i.e. if the child experiences support from the parent. The therapist is looking for whether and how (1) the child's focus of attention is recognized by the parent, (2) the child's states, initiatives and feelings are acknowledged by the parent, (3) the child is given the time and space to react, (4) the child's ongoing actions, experiences and feelings are interpreted, punctuated and named by the parent, (5) the child is assisted to experience structure and predictability, (6) the child is guided by well-adjusted information and gets approving confirmation when a desirable behaviour is emerging, (7) the child is assisted through inevitable unpleasantness, (8) the child is encouraged to take an interest in other persons and their actions and feelings/sentiments, and (9) the child is helped to start and close an activity or a dialogue (Hafstad & Ovreeide 2007).

The therapist chooses sequences that create a link between the parent's initial description of the problem and the therapist's idea of what kind of support the child needs. When the therapist and the parent review the sequence, attention is drawn to the child's cues revealing his/her need of support. Sequences selected by preference contain "moments of solutions" where the child is provided with the support he/she needs and the parent thus becomes a model for him/herself in the forthcoming interaction with the child. The second best choice of sequences is where the needs of the child are clearly displayed.

Interaction treatment "in vivo"

In interaction treatment "in vivo" the parent and the therapist use ordinary everyday situations arising for example when changing nappies, at meal-times, when trying to comfort a crying infant or to making a recalcitrant two-year-old leave the playground. The intervention is framed by the work assignment and the situations can be planned by the therapist and the parent(s) together or utilized as they arise, and are always accompanied by moments of joint reflection on what goes on, or, retrospectively, on what happened. As treatment "in vivo" is guided by the same understanding of a child's need for dialogue described above, and as a great proportion of the families are simultaneously involved in interaction treatment "in video", Marte Meo, both parents and therapists are used to drawing attention to small details in the interaction, i.e. to doing micro-analyses (Stern 2004b) of what is going on.

The aim of the interaction treatment "in vivo" is to enhance an ongoing dialogue between parent and child. Parents are encouraged to become attentive to the child's expressions of emotions, initiations of contact, need of assertion, and guidance. "Shimmering moments" (Neander 1996) involving the parent and the child, or moments of intersubjectivity, are considered indispensable for the child's development, hence one of the aims of the treatment in vivo is to create conditions for such moments and to highlight them when they arrive. Reflections on how different situations can be experienced from the child's perspective are ever present, and these in combination with discussions on what that, in turn, might arouse in the parent, are meant to raise the parent's ability to mentalize. The child's need of experiencing that he/she is provided with a secure base and a safe haven is always a central theme, brought to the fore as soon as the child's needs for comfort or support in the exploration of the world present themselves.

Interaction treatment "in verbis"

The parents' inner pictures of themselves as parents, of the "ideal parent", of their children, and of their interaction are examples of themes which are brought to the

fore when mental representations are chosen as the port of entry, which is the case in interaction treatment "in verbis" (verbally). Parents' thoughts about how they want to take care of and educate their children are often based on their experiences of their own childhood. As the intervention addresses families facing adversity in parenting, the parents often describe troublesome experiences expressing a wish *not* to repeat what their parents did to them. This can be a necessary first step towards breaking the intergenerational cycle of parenting patterns. The issue might for example be not using violence or threats of violence or not abandoning the child in times of trouble, yet a great difficulty for the parent might be the absence of a "map" giving him/her ideas about how to act – not merely what actions and attitudes to avoid.

In interaction treatment "in verbis" space is given to deepened reflection on the parents' often mixed feelings for their child, their fears and hopes for the child's future development and fantasies of how the child experiences the world and the most immediate relationships. Problems in the relation between the parents can also be a subject for treatment, just like a parent's own problems such as social phobias, anxiety or depression when these issues have a bearing upon parenting.

Collaboration with the families' social network

Children are part of dyadic and/or triadic relationships in their families, but they are also involved in other social micro-systems like child care. Good development for children is influenced both by the conditions within these systems and by the interaction between them. The staff at the centres and the parents might, for instance, invite child care staff in order to exchange knowledge and experiences about the child's special needs of developmental support, displayed in connection with the intervention and in day care. These meetings may also facilitate continued confident collaboration between child-care staff and parents when the intervention is terminated.

Grand-mothers, grand-fathers and other relatives often play an important – and sometimes complicated – role in the everyday life of the families. The possibility for parents and relatives to express their expectations regarding each other, in the company of a family therapist, can contribute to making the relatives' commitment an asset for the child in a less ambiguous way.

A great number of "helpers" may be involved in certain families, but their action may not always be totally coordinated which can be experienced as a load for the family. In network meetings at the centres the roles can become clarified.

EMPIRICAL STUDIES

This section is introduced by a description of what preceded the studies – pre-understanding and design discussions – followed by a table presenting the four studies. Being of a different character the specific research questions formulated required different research approaches – both quantitative and qualitative ones – and this combination of scientific methods was judged to reinforce the outcomes of the studies.

In view of the fact that Study I and Study II are linked to each other, which is also the case for Study III vis-à-vis Study IV, the subsequent presentation of aims, participants, methods and results is structured in two blocks comprising, respectively, Study I & II and Study III & IV.

Pre-understanding and considerations in relation to the design of the studies

The researcher's presuppositions exercise influence in both quantitative and qualitative research, and at all stages of the research process – design, choice of method, choice of measuring instruments, interpretation and presentation of data. In order to remain open, a way of dealing with this for the researcher is to be aware of his/her presuppositions and to give an account for his/her pre-understanding, even though it can never be fully grasped (Nystrom & Dahlberg 2001).

My pre-understanding was made up of my own fundamental values and professional experiences. In the meeting with families facing adversity, I was guided by a conscious endeavour to carry out an intervention characterized by qualities that I myself would like to have access to in times of trouble, i.e. high competence, clarity, and cooperation with respect to goals and means. My experience was that an inquisitive stance, advocated by e.g. Fonagy & Bateman (2006), is much more beneficial for the therapeutic relationship than a traditional expert role.

In our clinical work, my colleagues and I experienced that the intervention often made a lasting difference for many families whereas other families seemed to function better for a period of time but eventually fell back again into serious trouble. We felt an increasing need for a systematic examination of issues in relation to the intervention; it was a question both of investigating whether the families showed measurable changes over time in relation to the intervention and of utilizing the parents' experiences of what had been of importance for the children's development. The choice to prioritize the parents' perspective was a natural consequence of the emphasis attributed to the parents' way of describing the problems and to their de-

sire of change in the intervention context. The choice not to limit questions at issue to the intervention itself corresponds to the ecological perspective.

A prospective design with three assessments, using questionnaires to evaluate the outcome was chosen to investigate the issue of changes over time. The consideration made when choosing instruments is accounted for below.

In order to gain a deeper understanding of the parents' and the key figures' perspectives on beneficial processes we opted for van Manen's (1997) hermeneutic phenomenological method, as it is a qualitative method according to which people's lived experience is the focus and which acknowledges that the meaning of a phenomenon is multi-dimensional and multi-layered and cannot be grasped in a single definition.

Considerations made when choosing instruments

When planning Study I & II we found it important not to make the research process interfere with the intervention or counteract its aims, why the choice of measuring instruments was subject to discussion. It soon became apparent that "the perfect instrument" does not exist, so we listed a number of requirements.

The first requirement of the instrument was that it should measure what is important for parenting. Here we based ourselves on our clinical experience and on current research; these two perspectives held no contradictions.

Secondly we agreed to use scientifically tested instruments already applied in other studies. This may seem self-evident, but contacts with other centres indicated that many of them had formulated their own questionnaires which were gradually modified when certain questions turned out to be not doing what was required. In a systematic literature review of interventions with fathers of young children (Magill-Evans et al. 2006) the authors point out the fact that outcome measures were frequently developed for specific studies, with limited information on reliability and validity of the measures making it difficult to synthesize the findings.

Thirdly we considered it important that the questions be understandable and relevant for the families in their life situation. Questions about family relations would certainly have been of interest, but to ask a single mother with an infant to take up a stand on e.g. a statement like "Nobody in our family seems to be able to make out what tasks to tend to" would not have been very relevant.

Finally we wanted the questionnaires to be in harmony with the basic values of the treatment, not undermining the preconditions for good, therapeutic meetings. Supported by the ideas of Daniel Stern (1995) about infant mothers' vulnerability and likelihood to feel inadequate or even harmful to the infant, referred to as "the

motherhood constellation", we decided to avoid a questionnaire containing a great amount of questions in relation to symptoms of psychological problems. A confrontation with a battery of questions concerning her own mental health problems might be experienced by the mother as a confirmation of her very worst apprehensions – e.g. "I am harmful to my own child as I am not healthy and happy". The questionnaire SPSQ was designed for individuals living in a couple relationship. We did not want to expose the great portion of single parents to a feeling of being "wrong" and not being able to answer seven of the items as those items concerned the relationship with the partner. We solved this problem by elaborating a "single version" after having consulted the author of the Swedish version of the instrument.

Table 1. Overview of the four papers presented in this thesis

Study	Participants	Data collection	Analysis
I	101 families	Self-report questionnaires Background data Treatment journal	Student's t-test Chi-Square test Wilcoxon's Signed-Rank test Cohen's d
II	101 families	Self-report questionnaires Background data Treatment journal	Svensson's method Wilcoxon-Mann-Whitney test
III	8 parents 13 key figures	Qualitative interviews with parents Joint qualitative interviews with parents and key figures	Max van Manen's hermeneutic phenomenological method
IV	9 parents 10 family therapists	Qualitative interviews with parents Joint qualitative interviews with parents and family therapists	Max van Manen's hermeneutic phenomenological method

Study I & II

Aim (Study I)

The aim of the first study was

• to describe families – who had participated in parent–child interaction interventions at four centres in Sweden – with respect to social characteristics and the parents' experience of parental stress, parental attachment patterns, the parents' mental health and life satisfaction, the parents' social support and the children's problems at the outset of the treatment

• to examine long term changes (18 months after beginning of treatment) and short term changes (6 months after beginning of treatment) regarding the same aspects as those assessed at the outset of the treatment.

Aim (Study II)

The aim of the second study was to investigate aspects of father involvement in parent–child interaction interventions at four centres in Sweden with regard to initial problem load, degree of participation in treatment, changes in problem load and evaluation of the intervention. Special emphasis was placed on the parents' subjective perspective on problems, changes and the intervention.

The more specific research questions were:

- To what extent did fathers participate in the intervention?
- How did the self-assessed problem-loads of fathers and mothers and their assessment of the children's problems vary at the outset of treatment?
- How did fathers and mothers assess the problem load, attainment of aims and importance of the intervention *after* treatment?
- Did the participation of fathers in the treatment carry any significance for mothers' outcomes?
- What factors both in and outside the intervention were described by the fathers as important and what did they think about the centres?

Participants (Study 1)

Study I is based on a consecutive sample of all parents who commenced treatment during three years at either of these four centres.

119 families
start treatment

Excluded for health
reasons: 5 families

114 families
eligible for the study

Attrition: 13 families[a]

T1
101 families
(94 ♀; 60 ♂)

Attrition: 6 families[b]

T2
95 families
(89 ♀; 55 ♂)

Return to the study: 2 families[c]

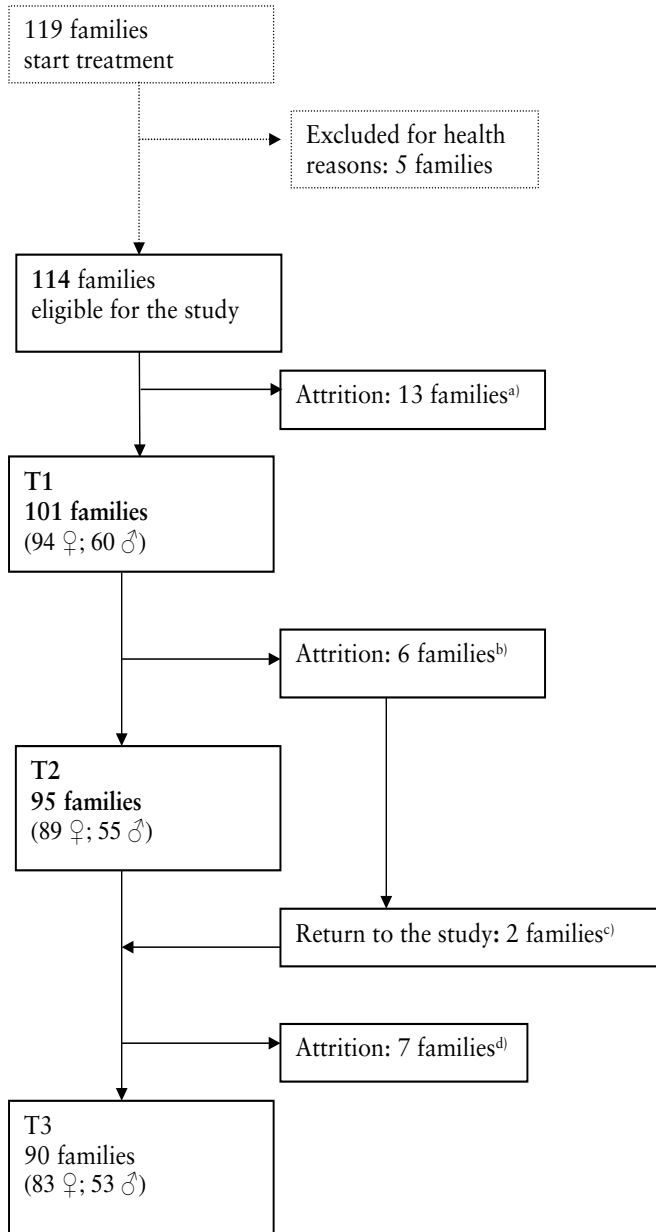Attrition: 7 families[d]

T3
90 families
(83 ♀; 53 ♂)

Figure 2. Flowchart

As displayed in the table, 119 families started treatment. The study excluded parents displaying substantially impaired cognitive capacity due to acute and serious mental reactions. Of the five families excluded for that reason, four were refugees seeking political asylum.

Consequently, there were 114 families eligible for the study, but out of these there were 13 families[a] who were not included in the study. The attrition of these 13 families was parent-related in ten of the cases; five of the families stated that they were too burdened to participate, three were hesitant about their own ability to fill in the questionnaires, one family stated a desire to protect their private life and one family indicated lack of time as the cause. The reasons for attrition for three of the families were staff related; in two cases the uncertainty whether the family would start treatment or not confused the staff, and in one case the staff forgot to ask the family.

In the 13 families making up the primary attrition there were 14 children – nine girls and five boys. Their median age was 3½, ranging from 1½ to 12 years (missing data for one child). Nine of the 13 mothers were born in Sweden, whereas the corresponding proportion among the children was eleven out of 14. Four of the children lived with their two biological parents, five (including a pair of siblings) lived with a single mother, two with mother and stepfather, one in alternating residency (sharing her time between the mother's and father's homes, living at least ten days a month with each of them and one was in foster care (missing data for one child). As to the mothers' occupation four of them were employed, three unemployed, four on long-term sick leave, one was seeking political asylum and information was missing for one of them. There are data concerning the fathers/stepfathers/foster father in ten of the families, presented here regardless of their later participation in treatment. Among these ten fathers eight were employed, one unemployed and one on long-term sick leave. Contact with the centres was initiated by the social services in six cases, by the parents themselves in three families – in one of these cases also by child psychiatry, child health care in one case and data missing for three of the families. To sum up, the social characteristics indicate that a somewhat larger proportion in this group than in the study group was living under less privileged circumstances.

In the remaining 101 families there were in all 154 parents (94 mothers; 60 fathers) who agreed to participate in the study. In these families there were 118 children taking part in the intervention, 44 girls (37%) and 74 boys (63%). The children's ages varied from unborn (the treatment started towards the end of pregnancy) up to 12-year-olds, with a median age of 3. Of the 154 parents in the study 131 (77 mothers; 54 fathers) were born in Sweden. There were ten foreign-born parents

(seven mothers; three fathers) from European countries and eleven parents (ten mothers; one father) from countries outside Europe (data are lacking for two of the fathers). In 54 families the children were living with their biological fathers and mothers, in 26 with a single mother, four with a single father, ten in a stepfamily, and one in a foster home. In six of the families the practice was one of alternating residency for the children.

The occupational status differed with regard to gender, insofar as there was a higher proportion of fathers (68%) who were in employment than mothers (37%). The differences were even bigger when it came to long-term sick leave and pension – 25% among the mothers and only three percent among the fathers, but the discrepancy was reduced with regard to unemployment, mothers 16% and fathers 18%.

The social services had initiated the contact with the centres for almost half of the families and the second most frequent contact initiators were the parents themselves.

At the second assessment (T2) 95 of the 101 families remained in the study. Two of the families did respond, but too late, two families decided not to participate, one family was expelled from the country, and with reference to the last of the six families[b] the staff did not manage to establish contact.

Two of these families[c] returned to the study at the final assessment (T3), but another seven families[d] did not participate. One of the families had left the country, one was hiding to avoid expulsion from the country, one family was in poor health, one declined and in one case the staff did not find a way to get in contact. Information is missing concerning the two other families.

Drop out from treatment, or rather treatment interruption, occurred in ten families, of these three for staff reasons; the therapist either being on sick leave or had given notice. When interruption was family-related the reason given in five cases was that the family had moved from the area or even from the country (expelled) and in the case of two families the social services had initiated an investigation. The median length of treatment for these ten families was eight months. There were no other drop-outs from treatment.

The relation between attrition from the study and treatment interruption is displayed in this table:

Table 2.

Attrition from the study – treatment completed	Attrition from the study and interrupted treatment	Interrupted treatment – retained in the study
8 families (one of them returned to the study at T3)	5 families (one of them returned to the study at T3)	5 families

Participants (Study II)

Study II was based on the same consecutive sample, but in this study attention was focused primarily on the fathers. The table below illustrates the fathers' and the mothers' intentions, at the outset, to participate in treatment and who actually did participate in treatment and also in the study.

Table 3.

Child´s residence	Single Mother		Mother & Step-father		Mother & Father		Father & Step-mother		Single father		Alter-nating residence		Foster Home		Σ	
	26		**9**		**54**		**1**		**4**		**6**		**1**		**101**	
	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂	♀	♂
Intention to participate Certain (hesitant)	26	4	9	6 (1)	54	42 (6)	1	1	-	4	5	3 (2)	1	1	**96**	**70**
Participated in treatment	26	5	9	8	54	48	1	1	-	4	5	3	1	1	**96**	**70**
Participated in the study	26	3	9	6	52	42	1	1	-	4	5	3	1	1	**94**	**60**
Both parents participated in the study	3		6		40		1		-		2		1		**53**	

Some of the fathers who planned to participate in the intervention did not, while others who did not have the intention to participate did so. A detailed account of this can be found in the manuscript (Study II).

Instruments

The Swedish Parenthood Stress Questionnaire (SPSQ) (Ostberg, Hagekull & Wettergren 1997) is based on the Parent Domain of the Parenting Stress Index (Abidin 1990). The total experience of stress is measured by a general parenting stress scale consisting of all items. The instrument has been used in several studies and has displayed good psychometric properties (Ostberg et al. 1997). Since about half of the families seeking help at the four centres are single parents a special "single version" was designed for them in which the questions regarding the sub-scale on spouse relationship problems had been removed.

The Relationship Questionnaire (RQ) (Bartholomew & Horowitz 1991) is a self-report instrument designed to measure four categories of attachment (avoidant/dismissive; secure/autonomous; ambivalent/preoccupied and disorganized/fearful), using combinations of a person's self-image (positive or negative) and image of others (positive or negative). On the RQ the respondent is asked to rate, on 7-point scales, how well he/she feels the description of the four patterns apply to their own experiences. The psychometric properties of the Swedish version have proved to be satisfactory (Backstrom & Holmes 2001).

The instrument used to measure psychological health was the General Health Questionnaire 12 (GHQ12) (Goldberg 2000), a questionnaire with 12 questions. The index can vary between the values 0 and 12, with a low value indicating good psychological health. The threshold value for poor psychological health is 3 (Lindstrom, Moghadassi & Merlo 2006). The instrument has displayed good psychometric properties (Goldberg 2000).

Cantril's Self-Anchoring Ladder of Life Satisfaction (Cantril 1965) is a measure of an individual's overall assessment of life satisfaction. Subjects are asked to evaluate their life at the present time, one year ago and one year from now on a ladder, with the bottom (0) representing the worst possible life and the top (10) the best possible life. The Cantril Ladder has been reported to have good validity and stability and reasonable reliability (Atkinson 1982).

In order to obtain a measure of perceived availability and adequacy of support from intimates and the wider social network we used a brief version of The Interview Schedule for Social Interaction (Henderson, Byrne & Duncan-Jones 1981). The Swedish version (Undén & Orth-Gomér 1989) consists of 30 items measuring both the availability and the adequacy of attachment and social interaction. The ISSI has displayed good psychometric properties (Eklund, Bengtsson-Tops & Lindstedt 2007).

Table 4. Instruments

Instrument *Assessing parents or children*	Scales *subcsales*	Items	Index	In Study
SPSQ The Swedish Parenthood Stress Questionnaire *Parents*	General parenting stress *incompetence role restriction social isolation spouse relationship problems health problems*	34	1-5	I II
SPSQ (Single version) The Swedish Parenthood Stress Questionnaire *Parents*	General parenting stress *incompetence role restriction social isolation health problems*	27	1-5	I II
RQ The Relationship Questionnaire *Parents*	*avoidant/dismissive secure/autonomous ambivalent/preoccupied disorganized/fearful*	4	0-7 0-7 0-7 0-7	I
GHQ 12 The General Health Questionnaire *Parents*	Total score	12	0-24	I II
Ladder of Life Cantril's Self-Anchoring Ladder of Life Satisfac- tion *Parents*	*present time one year ago one year from now on*	3	0-10 0-10 0-10	I
ISSI The Interview Schedule for Social Interaction *Parents*	Total score *availability of social integration (AVSI) adequacy of social integration (ADSI) availability of attachment (AVAT) adequacy of attachment (ADAT)*	30	0-30 *0-6 0-8 0-6 0-10*	I
SDQ The Strengths and Difficulties Question- naire *Children*	Total difficulties score Impact *emotional symptoms conduct problems hyperactivity/inattention peer relationship problems prosocial behaviour*	33	0-40 0-10 *0-10 0-10 0-10 0-10 0-10*	I II

The Strengths and Difficulties Questionnaire (SDQ) (Goodman 2001) is a brief behavioural screening questionnaire concerning 3–16 year olds. It exists in several versions: the versions used in this study were questionnaires for completion by the parents of 4–16 year olds. All versions of the SDQ incorporate statements regarding 25 attributes, some positive and others negative. These 25 items are divided into five sub-scales: emotional symptoms; conduct problems; hyperactivity/inattention; peer relationship problems and prosocial behaviour. The first four sub-scales produce a total difficulties score. The SDQ also includes an impact supplement. The instrument has been translated into Swedish and its psychometric properties are considered good (Smedje, Broman, Hetta & von Knorring 1999, Malmberg, Rydell & Smedje 2003).

Procedures

The first assessments were made at the outset of treatment (T1), as soon as the parents had decided to take part in the intervention. The staff at the four centres supplied information about the families' social characteristics, causes for contact, contact initiators, and the therapeutic work assignments. All this information is being referred to as *Background data*.

The second point of assessment (T2) took place six months after T1, and the final assessment (T3) one year later, i.e. 18 months after the beginning of treatment. At T2 and T3 the staff supplied information about the content of the intervention in a Treatment journal.

The staff contacted the families at T2 and T3, if they were not still in treatment, and asked them to come to the centre to complete the questionnaires. The rationale for this mode of procedure was to minimize attrition. If the families could not come to the centres, the questionnaires were sent home to them.

Statistical analyses (Study I)

In the description of the families taking part in the intervention, data from available community and clinical samples in other studies were used as a basis for comparison with the results of the assessments made at the outset of treatment (T1) in this current study. Since the accessible studies used for this comparison were based on reports of means and standard deviations, and no individual data were accessible, using non-parametric tests was not feasible. Student's t-test was therefore carried out to analyse the statistical significance of differences. A chi-square test for non-parametric data was used to determine the significance of differences in proportions.

The long term changes (T1 to T3) and short term changes (T1 to T2) were analysed with the help of Wilcoxon's Signed-Rank test. To complete the description of this study and to enable comparison with other intervention studies Cohen's d was used, with the definitions small (0.20–0.49), moderate (0.50–0.79), and large effect size (≥ 0.80).

Since a relatively large number of statistical tests were performed, the possibility of the random significance of some results cannot be ruled out. A threshold p value of 0.01 was therefore deemed statistically significant.

Statistical analyses (Study II)

In order to evaluate the agreement between mothers' and fathers' self-assessed problems, we used Svensson's method for paired ordered categorical data (Svensson & Starmark 2002), which enables to distinguish between systematic and individual disagreement.

The number of couples who have the same problem level is expressed as "percentage of agreement" (PA), i.e. the relationship between the number of these couples and the total number of couples.

Lack of total agreement (PA<100%) is evaluated by studying the pattern of discrepancy from the main diagonal. The quantification of the disagreement is calculated using the measure for systematic disagreement in relative position (RP). Possible values of RP range from -1 to 1, where RP=0 means a total lack of systematic disagreement between mothers' and fathers' assessments.

Apart from a possible systematic disagreement in the parents' assessment of problems within the family, there may be individual variations between the couples i.e. heterogeneity in the group of parents. Individual variations between the couples is measured by relative ranking variance (RV), with possible values from 0 to 1, where the RV-values close to zero are a sign of homogeneity between the couples.

The changes over time for mothers and fathers respectively from the outset of treatment and 18 months after the intervention were analyzed with the help of Svensson's method.

Comparisons between improvements for mothers where a father took part in the intervention versus mothers where no father took part were analyzed by comparing the group's RP values, RP_{diff}.

In order to test the differences in all fathers' and mothers' opinion of the extent to which they had reached the goals they had set up for the treatment and the factors to which greatest importance was ascribed for the change we used the Wilcoxon-Mann-Whitney test.

Results (Study I)

The comparison of the parents' assessments from the outset of treatment in Study I and samples from other studies showed that the parents differed significantly from community samples in all areas examined, and displayed, in some aspects, higher problem loads than other clinical samples. Both the mothers' and the fathers' rating of general parenting stress was, for example, significantly higher than corresponding ratings in a sample consisting of 104 families seeking help for their children from a Specialist Child Health Centre. The lone parents displayed even higher degrees of parental stress. The children's problems, according to the mothers' assessment with SDQ, deviated significantly from a Swedish community sample, and the children displayed more severe problems than a sample from child psychiatry outpatient units in every subscale except emotional symptoms. The difference was statistically significant only in relation to conduct problems. This corresponds with the fact that one of the most common causes for contact with the centres was children displaying aggressive behaviour.

One of the aims of the study was to examine changes in problem loads, and the results showed a clear general trend towards positive short term development (from T1 to T2) and this development was also reinforced in the longer perspective (from T2 to T3). The experience of parental stress was significantly reduced for both spouses, with an effect size of Cohen's d=0.45, and for single parents displaying an effect size of 0.73.

The parents' states of mind with respect to attachment, as measured with RQ, underwent changes in the desirable directions but the effect sizes were small (0.28; 0.27) concerning secure and fearful attachment respectively. The proportion of individuals with good mental health (cut off=3) altered significantly (p<0.001) from 35.3% at T1 to 61% at T3. There was also a significant change towards more satisfactory social support from T1 to T3 (p=0.008), but the effect size was small (0.30).

The children's total symptom charge as well as the impact of the problems were significantly reduced from T1 to T3 (p<0.001) and the effect sizes were of medium size (0.68; 0.67). The most marked changes concerned conduct problems.

There were few undesired or unplanned interruptions of the treatment, and the attrition from the study was low.

Results (Study II)

The aim of this study was to investigate aspects of father involvement in the intervention at the four centres. In the families with two biological parents 89% of the fathers took part, compared to 100% of the mothers. There was a gender difference

in the degree of problem loads at the outset of treatment, insofar as the mothers showed higher ratings than the fathers on almost all scales. The differences, studied in the families with two parents partaking, were statistically significant concerning for example mental health problems (GHQ 12), general parenting stress, experience of incompetence, and role restriction (SPSQ).

Both fathers and mothers displayed changes over time in a desirable way, with a more pronounced trend for mothers. The difference between the changes of the mothers and the fathers was statistically significant in relation to psychological health problems (GHQ12) and with regard to the children's emotional problems.

The proportion of fathers who assessed the degree of attainment of the therapeutic assignment as very high (47%) fell below the proportion of mothers (64%), but the difference was not statistically significant. When responding to a question concerning to what they attributed the changes attained – the intervention or other factors – the fathers attached significantly less weight (p=0.023) to the intervention than did the mothers.

A majority of the fathers high-lighted the guidance in everyday interaction with their children when asked about what aspects of the treatment they found most important. Among factors outside the intervention one third of the fathers responding referred to their own contribution. Overall, the fathers expressed positive, or very positive, opinions about the centres.

Study III & IV

Aim (Study III)

The aim of the third study was to examine the understanding constructed by parents, who had earlier taken part in parent–child interaction interventions, and "important persons", identified by the parents, in joint interviews from processes parents considered beneficial for the development of their children or families.

Aim (Study IV)

The aim of the fourth study was to explore parents' and therapists' joint retrospective reflections on the nature of the therapeutic relationship and the therapeutic process they had been part of within the framework of parent–child interaction interventions.

Participants

Families who had participated in the intervention at either of the four centres, and had completed treatment at least three years earlier, formed the basis for the third

and the fourth study, which implies that none of them were included in Study I or II. It also implies that the families were in no position of dependence vis-à-vis the centres.

The staff members made the initial contact with the families, with the only instruction to seek families with different types of problem, social background and ethnic identity. This choice was guided by the fact that the area had been so little explored, that it was not possible to predict which factors would be of particular importance in the selection of parents. That was how ten mothers and six fathers from 13 different families came to participate in the study. There was no survey made of their social characteristics, since such issues were not considered of importance with respect to the aims of the studies. One mother, with a background of substance abuse, agreed to participate, but eventually changed her mind. She thought that it would be too painful to talk about the past, and had come to the conclusion that an interview could jeopardize the psychological balance she had reached, a decision that I concurred with. One parent failed to appear at two planned appointments, why another parent was contacted by the centre.

The two studies also include "key persons", identified by the parents. Since it was not possible to contact all of the important persons mentioned in the interviews with the parents, the guiding principle of the second stage selection process was the significance the parents attached to the person/situation regarding the benefit for the child or the family. There were certain significant people, usually relatives, who were not selected for invitation since the parents – particularly the fathers – were not keen to bother those who they felt had already helped them so much. All of the key figures contacted agreed to participate.

The key persons in Study III were all professionals, with the exception of a couple in a support family. The other interviewees were three social workers, one nurse, two youth leaders, one personal assistant, one teacher, two pre-school teachers, and one headmaster. In Study IV ten family therapists from either of the four centres and eight parents participated in joint interviews.

Table 5.

16 first phase interviews with parents…	…that led to… →	…24 second phase joint interviews with the parent(s) and their key person(s)…	
		Participating	Study
Mother	→	Mother and teacher (male)	III
Father			
Mother	→	Mother and social worker (female)	III
	→	Mother and family therapist (female)	IV
	→	Mother and relative (female)	-
Mother	→	Mother and nurse (female)	III
	→	Mother and family therapist (female)	IV
Father	→	Father and relative (male)	-
	→	Father and relative (female)	-
Mother	→	Mother and youth leader (female)	III
	→	Mother and personal assistant (male)	III
	→	Mother and youth leader (female)	III
	→	Mother and family therapist (female)	IV
Father			
Mother	→	Mother and two family therapists (females)	IV
Mother	→	Mother and social worker (female)	III
	→	Mother and relative (female)	-
	→	Mother, father and two family therapists (male and female)	IV
Father	→		
Father	→	Father and principal (male)	III
	→	Father and social worker (female)	III
Mother			
Mother	→	Mother and family therapist (female)	IV
Mother	→	Mother and two pre-school teachers (females)	III
	→	Mother and family therapist (female)	IV
Mother	→	Mother and support family (female and male)	III
	→	Mother and relative (male)	-
	→	Mother and family therapist (female)	IV
Father			

Procedures

The interviews were conducted in two phases. The first phase involved individual interviews with parents, the second phase joint interviews with the parents and the key figures they had identified.

The core question in the first-phase open-ended interviews was whether any particular persons or situations had played a beneficial role in the children's or family's development. That question initiated a variety of narratives from different settings, for example child health care centres, social services offices, and pre-school.

In the second-phase joint interviews with the key figures and the parents, the parents acted as both informants and to some extent as co-researchers. The purpose of these joint interviews was to gather narratives, recollections, and reflections from the key figures and the parents, about what had happened and the ways in which each party understood this. In order to prepare ourselves for the interview, the parents and I met briefly prior to the meeting with the key person. The interviews opened with an invitation from me to the key persons to talk about their contact with the parent, and subsequently tended to evolve into a discussion between the parent and the key person.

Interpretation

Interpretation in the two studies was carried out using Max van Manen's (1997) hermeneutic-phenomenological method, which is described as a dynamic interplay involving six research activities: (1) turning to a phenomenon which seriously interests us, (2) investigating experiences as we live them rather than as we conceptualize them, (3) reflecting on essential themes, (4) describing the phenomenon through the art of writing and rewriting, (5) maintaining a strong relation to the phenomenon, and (6) balancing the research context by considering parts and whole.

The interpretation involved different ways of approaching the text. The first mode, called the holistic or sentencious approach, consists of several naive readings of the text. The writing process, which had started already in connection with the interviews, at this stage implied the noting of ideas that were prompted by this reading. If there were sentencious formulations that seemed to capture the meaning of the interview these were also noted.

The subsequent 'selective or highlighting approach' involved a search for narratives, expressions or phrases that seemed particularly significant. The occurrence of narratives was more marked in the texts that formed the basis for Study III than for Study IV. During the systematic interpretation in this phase the themes of the texts were discerned. The formulations of the themes were tested against the totality, and

then rejected, retained or reformulated in a process of writing and rewriting. This process continued until the themes together constituted a totality that captured the meaning of the text. In the final "detailed approach", the themes were again tested against each sentence or paragraph.

Throughout the process of interpretation, I was responsible for most of the writing, but the cooperation with the second author (CS) was close in every step and consisted of discussions, rewriting, rereading, new discussions, thinking, more writing – constantly returning to the text.

Results (Study III)

The participants in this study provided narratives in which a trusting, beneficial relationship between parents and professionals in a variety of different contexts did evolve even when conditions did not seem promising. Even contacts which at the outset were experienced as threatening, for example with social services, had developed into something positive. An additional factor to be taken into consideration, which highlights the strength of these processes, is that most of the parents in this study had a history of negative experiences from contacts with e.g. childcare, social services, schools, and mental health care.

In the processes described in this study the parents felt that their helper was motivated by good intentions, something which they perceived in tone of voice, facial expression and different proofs of commitment which were felt to lie outside what was purely professional. Most of the narratives had to do with the everyday contact; specific spectacular events were mentioned to a lesser degree.

The professionals in their turn highlighted the contribution of the families, for example how their openness regarding the adversities they struggled with facilitated collaboration. The professionals described their own acting as being naturally guided by clear aims, which could be expressed in ways like, "what is best for the child". They made efforts to create good conditions for the development of the children rather than focusing upon changing their behaviour. In summary, it may be said that the experiences of 'important meetings' between the families and the key figures prompted the creation of new and more positive narratives of the persons involved, altering negative perceptions of self as a parent. In one instance a person who had seen herself as very demanding now got an image of herself as a parent who stood up for her child in a way that many children would benefit from.

Results (Study IV)

This current study involves parents and their family therapists at the centres. Several parents described how they had experienced a strong sense of fear at the beginning of the contact, a fear of being harmful to their child, of not being able to cope as a parent or of being questioned in their parent role, and as an ultimate consequence, lose custody of their child. The strength and depth of these emotions had not been apparent to the therapists who, instead spoke about the confidence they had felt in the parents' capability. This difference in experience, combined with the differences in balance of power and in the familiarity with the environment, created a gap between parents and therapists, a gap which both parties shouldered the responsibility to bridge. The parents did so by trying to understand the context/environment, by asking questions and by opening up and being willing to test new ways of dealing with the children suggested by the therapists. The therapists contributed to the process by listening to the parents' description of their problems, by highlighting the parents' importance for their children and by naming and acknowledging the interplay between parent and child. The therapeutic process led up to change of the parents' inner images of the child and/or of themselves as parents. In their joint reflection about the nature of the contact between parent and therapist, several parents used phrases such as "pal" or "like a friend", while the therapists used words like a "special" or "mutual" relationship. An image of good therapists emerged as being "normal, friendly and knowledgeable and capable of admitting that they might be wrong".

DISCUSSION

This chapter is introduced by a discussion on what came out of the four studies, followed by a discussion on the methodological aspects of the same studies.

Reflections on the results

As the four studies in this thesis treat different aspects of the same phenomenon – parent–child interaction interventions – the results will be discussed thematically, covering the four studies, a structure which will facilitate further discussion.

Children displaying aggressive behaviour

Aggressive behaviour displayed by the children was the most important cause of contact in Study I & II. Physical aggression in children is considered a major public health problem, particularly since longitudinal studies have shown that they are of high risk of being violent in adolescence and above (Tremblay, Nagin, Seguin, Zoccolillo, Zelazo, Boivin, Perusse & Japel 2004). By 17 months of age the large majority of children display aggressive behaviour towards peers, siblings, and adults. Most children, however, learn to regulate their aggressiveness, but in a random population sample of 572 families with a newborn child a proportion of approximately 14% followed a rising trajectory of high physical aggression (Tremblay et al. 2004).

Study I points to a possibility of an early detection of and an influence on the development of these children – the reduction of conduct problems according to the parents was statistically significant – which is especially important in view of the fact that it is precisely the pronounced aggressive behavior in early childhood that predicts a continued negative development (Haapasalo & Tremblay 1994). Studies have shown that it is possible to achieve significant reductions in children's aggressive behaviour, e.g. through parenting programs (Barlow, Parsons & Stewart-Brown 2005), school-based programs (Wilson, Lipsey & Derzon 2003) and family interventions (Brotman, Gouley, Huang, Rosenfelt, O'Neal, Klein & Shrout 2008).

Drop out/retention

Drop out from treatment is a considerable problem in relation to treatment of children with conduct problems of the type described above and to early childhood interventions in general, but in the intervention described in Study I (& II) the level of drop out was low. Olds et al. (2007) point out that interventions will fail if they are not designed in ways that ensure parental engagement and retention. Cook, Little & Akin-Little (2007) state that data on consumer satisfaction are essentially nonexis-

tent and Gray & McCormick (2005) point to the need of studying attrition and retention with the help of both qualitative and quantitative methods. A study in connection with a psychosocial intervention at postnatal depression has however addressed the issue of engagement to the intervention (Wheatly, Brugha & Shapiro 2003). Qualitative interviews with three groups of participants – compliers, non-compliers and refusers – showed that factors having importance for the maintaining of engagement with the intervention were for example the possibility of sharing experiences with others and the intervention's normalizing function. These themes are also present in Study II in the fathers' descriptions of important factors in treatment, in the same way as the description from the above mentioned study is stating that the participants had gained in confidence and developed the ability to generate different perspectives on problems.

Problem load at the outset of treatment

Study I showed that the parents – especially the mothers – had a problem load deviating significantly from a normal population in all areas measured. The mothers' poor psychological health is of importance since there is evidence from a range of studies suggesting that maternal psychosocial health can have a significant effect on the mother–infant relationship, and that this in turn can have consequences for both the short and long-term psychological health of the child (Barlow & Coren 2004). Children of depressed parents are at risk in terms of psychopathology and other difficulties (Beardslee, Gladstone, Wright & Cooper 2003). The results from a study by Leinonen, Solantaus & Punamaki (2003) confirm that parental mental-health problems can compromise a mother's and father's parenting abilities and represent a threat to their children's adjustment. The results suggest that the different types of parental mental health problems initiate specific paths between parental and child mental health problems.

Changes over time, durability and the possibility of self-healing

The parents improved in practically all fields measured in Study I. This is a positive thing in itself and it brings to the fore an important question whether improvements in a parent, in relation to for example mental health, automatically lead to an improvement of the child's present situation and possibilities of development. Forman, O'Hara, Stuart, Gorman, Larsen & Coy (2007) have proved in a randomized controlled study that this was not the case for post partum depression, and conclude that treatment for depression in the postpartum period should target the mother-infant relationship in addition to the mothers' depressive symptoms.

The one dimension which was not improved (Study I) was spouse relationship problems, which were considerable at the outset of treatment, compared to a clinical sample in another study (Ostberg 1998). The association between inter-parental conflict and parenting was examined in a meta-analysis including 39 studies, and the conclusion drawn from this was that high levels of marital conflict were associated with poor parenting. Parents' preoccupation with their marital conflict seem to impair most dimensions of their child-rearing practices and the strongest impact was found with respect to increased levels of harsh discipline and decreased acceptance, i.e. expressed love, support, and sensitivity (Krishnakumar & Buehler 2000) .

The relationship between the parents, with a maintained focus on co-parenting – how parents coordinate their parenting, support or undermine each other, and manage conflict regarding child rearing (Feinberg & Kan 2008) – might be suggested as an area of improvement for the centres in the study.

Study I showed that the positive development at assessment after six months (T2) had been reinforced at the following assessment, one year later (T3). This durability of the improvements is in harmony with a series of other studies, displaying a corresponding maintained effect (e.g. Bradley et al. 2003, Brotman et al. 2008, Gardner et al. 2006, van den Boom 1995).

In a five-month-follow-up of a treatment program for families of young children with externalizing problems, Feinfeld et al. (2004) found evidence that improved parenting practices mediated reductions in child behaviour problems and that child improvements mediated changes in parent attitudes and stress. What seems to happen is thus a negative spiral being turned into a positive one, and the reciprocal, dynamic influence described by Feinfeld harmonizes with the ideas underpinning the transactional model (Sameroff 2004).

These findings are also connected to the issue of whether self-healing could result in improvements equally important as the ones achieved by the intervention, an issue which is primarily discussed in studies without a control group. There are examples of studies speaking against the idea that problems might disappear by themselves. A meta-analysis (Wilson et al. 2003) has shown that aggressive behaviour tends to remain stable in all age groups when untreated. In a three-year follow up of the prospective 1999 British Child and Adolescent Mental Health Survey, latent mental health scores (i.e. combined information from multiple informants) for a sample of 2587 children showed strong stability over time. The authors conclude that there is a need for effective intervention with children with impairing psychopathology, since they are unlikely to improve spontaneously (Ford, Collishaw, Meltzer & Goodman 2007). However, it is worth noticing that some of the fathers (Study II)

attribute the positive changes to the fact that their children have grown older and matured.

Goals versus outcome

The work assignment, guiding the treatment of the families at the four centres, is mainly worded in concrete terms of child–parent interaction. However, the studies in this thesis suggest that the changes after the intervention are more global than the narrow focus of the work assignment. Study I shows improvement in relation to various aspects, while Study II and IV give evidence of how parents' self-image has changed – both as to parenting and in terms of improved self-esteem.

The phenomenon that interventions provide positive effects in other fields than the specific aim is not unique. Barlow et al. (2004) have carried out a systematic review of parent training programs in order to investigate if there is evidence of effectiveness in improving outcomes for mothers. Although only a small number of the interventions had the specific aim of improving the mothers' mental health or their self-esteem, the results of the meta-analysis of 26 studies showed statistically significant results favouring the intervention group in relation to depression, anxiety/stress, self-esteem, and relationship with spouse.

The fathers' accounts of increased understanding of their children's problems and changed view of self (Study II) correspond to experiences described in a study about at-risk mothers' change through intensive intervention by Worsham, Kretchmar-Hendricks, Swenson & Goodvin (2009). Biringen, Matheny, Bretherton, Renouf & Sherman (2000) claim that surprisingly little emphasis has been put on the parent's representations of the child or of self as parent, even though they have proved to be of importance; for example George and Solomon (1996) found that maternal representations of greater expressiveness and security and less helplessness, uncertainty, or rejection were connected to security in 6-year-olds. In a study based on 40 mother-child dyads Biringen et al. (2000) examined predictors of maternal representations. The authors concluded that maternal self-esteem is a particularly salient aspect of the parenting role, and that maternal structuring during interactions (i.e. setting limits and creating boundaries) appeared to be the consistent predictor of maternal representations.

In a study by Morawska & Sanders (2007) a total of 126 mothers of toddlers completed a self-report assessment battery, examining child behaviour, parenting style and confidence, as well as broader family adjustment measures. The study found that maternal confidence and dysfunctional parenting were interrelated, and

the authors concluded that parenting style and confidence are important modifiable factors to target in parenting interventions.

The role of mentalization

When mechanisms for change in child behaviour are discussed the role of change in parenting skills is often mentioned (e.g. Feinfeld et al. 2004, Gardner et al. 2006). The importance of "new tools" is also highlighted by the fathers in Study II. In the following section, however, I want to discuss if the treatment at the four centres can be described in terms of enhancing the parents' capacity for mentalization or reflective functioning.

An individual's capacity for awareness of his or her mental states and the mental states of others can, like many other human capacities, be described with the help of a continuum. Where a person finds himself/herself at a given moment along this continuum is determined both by genetic conditions (the example of autism), experiences from the attachment relationship, and how the person's current situation presents itself (threat and stress reduce the capacity of mentalization).

In treatment at the four centres each parent has his/her "own" therapist and the intervention is based upon ideas of parallel processes implying that the same qualities sought for in parent–child interaction should also characterize the relation between parent and therapist (Neander 1996). This does not mean that the therapist takes on a mother/father role in relationship to the parent, but rather that the therapist comprehends the parent (or rather the parent and the child) in his/her mind and that the therapist offers the parent the possibility of an attachment relationship in the therapeutic context. The notion of parallel processes in attachment-based parenting interventions is expounded in a qualitative study by Wong (2009).

The interaction treatment in its three forms, "in vivo", "in video" and "in verbis" aims at making the parent more interested in and more sensitive to the child's focus of attention, emotional expressions, signals and needs of support in the form of security, comfort, guidance, encouragement and limits. The fathers' ways of responding to the open-ended questions (Study II) suggest that these processes do occur. Another way of expressing this is that treatment might enhance the parents' reflective functioning (RF) in relation to their children. The interaction treatment in "verbis" offers an opportunity for the parent to reflect on himself/herself and on his/her own reactions.

There is, however, a focus on the child, and this has partly to do with the Marte Meo method where one works "with the child as a key" (Hafstad et al. 2007) in the interaction work in order to avoid a normative way of thinking about "right" and

"wrong" parent behaviour and an eagerness in the parents of wanting to be "acknowledged" by the therapist. On the contrary, the child's reactions should guide the parent, and the parents get help to see and reflect on what lies behind the behaviour of the child – the child is mentalized and not problemized (Hafstad et al. 2007).

In a review (Madigan et al. 2006) examining the links between unresolved representations of attachment, anomalous parental behaviour, and disorganized attachment relationships, the authors suggest that when parents are taught to focus on their child's behaviour more closely, thus leaving less room for absorption or dissociation into past traumatic experiences in the presence of the child, the probability of the emergence of disorganization might be reduced.

Significant factors in treatment

In Study II & IV several parents highlighted the significance of the therapist and of the relationship between the parent and the therapist. As was mentioned in the introduction the question about what factors are of importance for the outcome of the treatment has been to a large extent limited to methods, dosage and client factors (the age of the children, the social situation of the families, problem load). Research on psychotherapeutic treatment has shown that other factors than those may be of greater importance (Wampold, Mondin, Moody, Stich, Benson & Ahn 1997, Messer & Wampold 2002), one of them being precisely the therapist (Luborsky et al. 1997), but his/her importance is rarely discussed. In the meta-analysis by van Ijznedoorn et al. (1995) an intervention by van den Boom (1994) was by far the most effective one, but when this intervention was replicated on two occasions, it had no effect at all in one of the instances (Meij 1992). What was then discussed is a ceiling effect in relation to the safe attachment of the child. The possibility that it could be a question of effect achieved by a capable therapist – it was van den Boom who carried out the whole intervention – was not at all discussed.

The role of the intervener–mother relationship is however discussed and highlighted among others by Stern (2006) who is of the opinion that "all agree that the non-specific effect lies in the therapeutic relationship between home visitor and mother".

Berlin et al. (2008) conclude in a review of preventive and intervention programmes supporting early attachment security that both CCP and UCLA programme (both described in the introduction) have yielded some evidence that the quality of the intervener–parent relationship contributes to positive programme outcomes, and state that this is an important area for future research. In one of the studies referred to (Heinicke et al. 2006), this issue is described in terms of "the

mother's ability to work with the intervener", implying that in this case too, the focus is not on the therapist. Alicia Lieberman describes the therapeutic relationship in child–parent psychotherapy (CPP) as "the matrix for treatment" (Lieberman 2004), referring to the corrective attachment experiences provided by the therapeutic relationship.

Study III treats an adjacent theme i.e. the families' meetings with persons who have become significant for the children's development. The importance of sources of emotional support available to the child has been shown in large-scale longitudinal studies (Werner 2005), but the processes are less described. The notion of "ordinary magic" (Masten 2001), which refers to everyday, normal interpersonal events in a child's life rather than extraordinary incidents, epitomizes what the parents describe in Study III. My opinion is that "ordinary magic" is related to the concept of intersubjectivity, highlighted by Stern as a vital ingredient in a therapeutic relationship.

The four centres (Study I, II & IV) provide "less" for some families or "more" for others in terms of e.g. treatment duration (ranging from one month to more than 18 months) and number of sessions. Further analysis of data will shed light on the question whether the families attending the intervention for a long time and/or many sessions differ from those with short treatment duration and/or few sessions in terms of for example problem load at the outset and patterns of change, i.e. if it seems likely that these families needed what Alicia Lieberman refers to as "a broad web of care" (Slade et al. 2005b).

The fathers

"Is it possible or desirable to involve fathers in attachment-based interventions?" This issue was brought up by the group of researchers who created the VIPP-programmes (Juffer et al. 2008), and their attitude to the question of desirability is ambiguous, even though they earlier had concluded that interventions involving fathers appear to be significantly more effective than interventions focusing on mothers only (Bakermans-Kranenburg et al. 2003). This conclusion was drawn from three studies, two of which are from 1980 and one from 1992. One of the studies, including 16 families in the intervention group and the same number of families in a control group, examined the effects of a four weeks postpartum training programme with neonatal bathing and massage (Scholz & Samuels 1992), and found increased paternal involvement. Their infants greeted them with more eye contact, smiling, vocalizing, reaching, and orienting responses and displayed less avoidance behaviours. In a specific language stimulation programme infants were divided into three

groups, a control group, a group of mothers taking part in the programme, and a group of mothers and fathers taking part in the programme simultaneously. The infants whose parents received simultaneous training exhibited the greatest gain over time (Metzl 1980). Finally, the third intervention aimed at increasing parental competence to assess, predict, elicit, and contingently respond to infant behaviour. Training was found to increase both parents' and infants' competence in the parent–infant dyad, in this study comprising 19 couples randomly assigned to a training or control group (Dickie & Gerber 1980).

The hesitation expressed by Juffer and colleagues on the issue whether it is desirable or not to involve fathers is mainly built upon findings from the study by Dickie et al. (1980), since it indicated a reciprocal relationship between increases in the trained fathers interactions and decreases in the trained mothers' interactions. In the study by Scholz et al. (1992) the mothers showed much less improvement than the fathers.

With such a limited empirical foundation I find it hard to understand how one could speak in terms of "a suggested counterproductivity of paternal involvement as far as the mothers are concerned". Metzl's study (1980) is not mentioned in this line of discussion since separate data for mothers and fathers could not be computed, but this raises questions on what outcomes are most important, since Metzl's study showed greatest gains for the infants when both parents participated.

However, since our Study II showed similar "disappointing findings" (Juffer et al. 2008) concerning the mothers' results, these authors' call for replications is further strengthened. The issue whether it is *possible* to involve fathers or not is not discussed by the authors who formulated the question, but in this respect Study II provides an affirmative answer.

The unsure attitude towards fathers' involvement in parent–child interventions is reflected in literature on parent–child interventions by the relative, yet obvious, absence of the topic (Berlin, Ziv, Amaya-Jackson & Greenberg 2005, Juffer et al. 2008, Sameroff, McDonough & Rosenblum 2004).

Methodological considerations

The methodological considerations in this section are structured following the same principle as the results discussion, i.e. thematically. Since ethical aspects are of relevance during the whole research process I have chosen to insert the ethical considerations in the respective contexts where they arise, instead of lifting out the ethical dimension and discussing it under a special heading.

Critical opinions on questionnaires in general

The use of questionnaires should be problemized since there are a number of general critical opinions on this methodology, expounded by Hane & Wennberg (2002). These authors state that questionnaires treat persons who mark their replies with a cross as "naive informants" and not as persons who actively interpret, engage in, reason about, and formulate their view on questions asked. This means that as an informant one is guided to give too simple answers to complex questions. The room for reflection is as a rule very limited, but many people answer, even though they have not really taken up a definite position. The channelling of the answers into specific categories makes it difficult for those who want to give a well-reasoned answer but where the alternatives do not correspond.

It is the demand for presentation in statistical terms that turns people into naive informants since the statistical procedures make it important to press the answers into pre-determined categories. Thereby all other lines of reasoning that the informant may have been pursuing and all other considerations made by him/her are made irrelevant and invisible. The way of presenting the often "approximate" answers in digits with several decimals, medians and standard deviations provides an image of exactitude which can be questioned.

The reason why people still want to answer, according to the authors (Hane et al. 2002), is related to what Asplund (1987) calls our "social responsiveness". A qualitative interview situation is considered as a social event, where the interviewer has an impact on what happens, but the authors mean that the act of filling in a questionnaire is also in itself an act of communication and thereby it is a social event with strong links to the identity of the participant. There are several influential factors in this event; the relation to the person asking the question, what one thinks the result will be used for, what values are transmitted by the questions through the wording and the image of himself/herself the informant wants to give. There is consequently no support for the assertion that questionnaires should be more "objective" or void of values than interviews.

An important objection to questionnaires is that they seldom manage to capture the unexpected. They are based on the constructor's way of thinking about a phenomenon – even though the questions could be well founded and be developed from for example interviews with other informants.

Some retrospective reflections on the instruments adopted (Study I & II)

According to my experience difficulties may arise even if one is very careful in the choice of instruments. On analysis of the answers it appeared that it was not possi-

ble to account for the results of one of the instruments. Information about the construction of the scale and how to interpret it was contradictory in the few studies where it had been used, and despite our efforts it was not possible for us to get into contact with its authors.

What we had not foreseen in terms of ethical considerations was that the instrument measuring access to a social network and social support (ISSI) would create certain problems. The staff at the centres realized that it was painful for some parents to answer, in the negative, item after item about the kind of support they could get in their social network. Apart from the fact that it is in itself problematic not to be able to get help, a possible interpretation is that in our cultural context, defining oneself as alone and without a rich network is shameful. From an ethical point of view, ISSI was thus the most awkward instrument for the staff.

The question in Study I & II concerning to what factors fathers and mothers attribute changes achieved, is an example of the fact that questions are based on the constructor's way of thinking. In our formulation we assumed "either or" and wanted answers with a cross on a Likert-scale where one extreme was the treatment and the other one represented other factors. Some parents chose to answer by ticking two boxes, indicating that both the treatment and other factors had played an important role, which is a possible standpoint. The question is of interest, but should naturally have been split up into two.

Yet another consideration concerns the number of items an informant can be introduced to on one occasion. The booklet of items presented to the parents in this study held approximately 100 items (depending on whether single or, etc.) which may have been somewhat excessive, at least for parents having language and/or reading problems.

The results of the study indicated improvements in nearly all the fields measured. The overall agreement can be seen as a cross validation, which strengthens the results of the study. It is possible, however, that the different instruments, to some extent, measured the same thing – related aspects of the parent's current life situation. If that is so, this weakness may not only be valid for the instruments used in this study; it is quite possible that many instruments are somewhat less specific than we imagine them to be. However, the fact that the improvements in this study did not develop at the same pace indicates that different aspects are reflected. There are also a few dimensions where the development goes in another direction than the general trend.

A central question is also the one about the validity of the instruments, i.e. if they measure what they are meant to measure. The Relationship Questionnaire is meant

to measure attachment styles in adulthood. The gold standard for measuring adult attachment is the Adult Attachment Interview (AAI). Crowell, Treboux & Waters (1999) made a comparison between RQ and AAI, and they are of the opinion that results indicated a trend towards a relation between AAI and RQ, but also that classifications derived from the measures are not equivalent. Eighty-one percent of women classified as Secure with the AAI identified themselves as Secure with the RQ, but only 42% of AAI-Insecure women identified themselves as Insecure with the RQ. Secure and Insecure AAI groups did not differ in their reports of mothers or partners, whereas Secure and Insecure RQ groups did.

Yet another reflection is that the classification in RQ is based on the *contents* of the descriptions of different ways of relating to other people whereas AAI is concerned with *how* people speak about their experiences, which contradicts the assumption that they measure the same thing. What could speak in favour of RQ measuring something that has do with attachment patterns is the fact that the distribution between the different patterns in our study deviates from a normal population in an expected way and that it is a dimension showing a higher degree of stability than other dimensions measured.

The choice of statistical methods of analysis (Study I & II)

The data generated by Study I & II are on an ordinal level, which means that they lack mathematical properties. Moreover it would not be correct to presuppose that the dimensions measured are normally distributed. These two circumstances should be guiding in the choice of statistical methods and they imply certain limitations. In Study I we carefully contemplated this situation, but in order to be able to make comparisons with other populations we finally chose to calculate e.g. mean value and standard deviation, and to use Student's t test. In Study II the purpose was not to make comparisons with other populations and so we reconsidered the issue. As a method, developed especially for paired ordinal data, is in existence (Svensson et al. 2002) we found it appropriate to use it.

On interviews (Study III & IV)

The aim of Study III & IV was to investigate the experiences and the understanding parents had of processes that they had considered helpful for the child or the family. The choice of open-ended interviews was guided by the fact that the knowledge of the field was limited. This type of interview offers a possibility to get hold of the unexpected. As we tend to create meaning through narratives, the questions were asked in a way to encourage story telling.

In a second phase of selection those persons identified as important were asked if they were willing to participate. The parents were invited to partake in these interviews in a somewhat altered role – not only as informants but also to some extent as co-researchers. The reason why I wanted the parents to be present at these interviews was that thereby I thought it would be easier to maintain focus on "the beneficial process" itself thus avoiding the risk of getting into descriptions of the family, which was not the aim of the interview. Ethical considerations also contributed insofar as it would have been complicated to handle information about the families which had not been communicated to them. Nothing contradicts these considerations, and moreover, an unforeseen and significant consequence was that the meeting between the parent and the important person aroused memories and thereby opened the way for richer narratives than would otherwise have been possible. Nearly without exception both the parents and the important persons were of the opinion that the interviews had been very interesting and rewarding for them.

From the beginning there was no plan for the grouping of and accounting for the interviews in relation to interpretation, as I could not foresee what would come out of them. During the course of work three types of joint interviews crystallized – the ones with persons from the professional network (Study III), the ones with family therapists at one of the four centres (Study IV) and finally interviews with relatives. Since there were only five interviews with relatives the material was considered insufficient to serve as an empirical basis for a paper.

It is worth noticing that the interviews with the mothers led on to joint interviews to a higher extent than the ones with the fathers, Some of the fathers mentioned important relatives, but they did not want to go on "disturbing" their relatives more than they had already done. This raises questions that will remain unanswered. Is there a gender difference insofar as women and men think in different ways about "helpers", making it easier for women to identify them in their surroundings? How important is the gender of the interviewer in the interview situation and for the interpretation? Was I more disposed to follow the "track" of the mothers, than that of the fathers? Ethical objections can be raised against my claims on persons' (important relatives') time and commitment by carrying out interviews that have not been used in the study.

One reflection on my role as interviewer concerns the different ways this role took form in the different interviews. The interviewer's role in the joint interviews, where both the parents(s) and the key person(s) took part was considerably less active than in the first-phase interviews with the parents. In the joint interviews my role was to

introduce the goals of the interview, to set the frames for it, and facilitate the dialogue between the parent and the key person when necessary.

Another reflection has to do with my degree of acquaintance with the context. My professional background made it more difficult for me to ask "naive" questions about the therapeutic process (Study IV), which might be considered a drawback. Most probably the parents and the therapists were also influenced in their way of telling their stories, knowing that I, as an interviewer had my own experiences of the subject. This is possibly reflected in the interviews insofar as the interviews in Study III contain mores narratives whereas the interviews in Study IV are of a more reflective kind.

In the interpretation process the second author (CS) discovered that the voices of the parents had taken priority over those of the therapists, which might reflect professionals' therapeutic stance, being one which gives priority to the parents and their accounts and reflections. The fact that I myself (KN) had not noticed this – neither during the interviews nor at the first readings of the text – might be interpreted as my being partly "blind" to my own work, a consequence one ought to be aware of when doing research within one's own field, something which in this study, however, was balanced by the fact that the second author represented another professional context.

On the process of interpretation

When the interviews had been transcribed the interviewees were offered the possibility of reading the text, in order to have the opportunity to correct what might have been misunderstood. I was prompted to do this as I considered it important that the interviewees be correctly understood, i.e. that they could verify that the transcription corresponded to what they wanted to express. This procedure created a complication related to the difference between spoken and written language. A dialogue which, when taking place, is totally understandable and coherent may give a completely different impression when written down. Even though I tried to give careful information on this point, several of the informants – both parents and professionals – were terrified at "seeing" how they had expressed themselves. It seems to me that for some of them this was such a negative experience that it was not in proportion to the benefit of the clarifications. This was an unexpected ethical complication which I will carefully consider in future interview studies.

Yet another aspect with ethical dimensions is the delicacy of doing justice to a rich interview material when presenting it in scientific writing. Although qualitative studies, in contrast to quantitative studies, are often built on full-bloodied stories

about peoples' lived experiences, there is an element of risk that they result in general, "bleak", and thin descriptions of e.g. "categories". This may be a consequence of the process of interpretation and/or an issue of the informant integrity. The ethical dilemma is that the richness of the informant's narratives and the complexity of their reflections do not appear.

It was in the light of these facts that we chose van Manen's hermeneutical phenomenological method, which acknowledges the significance of the interviewees' narratives and expressions, and introduced the presentation of Study III by four narratives. As described above, the interviews in Study IV had a somewhat different character, and so the form of presentation was designed accordingly, still based however on relatively long narratives and reflections. Qualitative studies like this one do not make the claim that they can be used for generalization, but the possibility of transferring is central. The very fact that the narratives are specific and detailed increases the possibility of recognition and of being transferable for the reader in comparison to more abstract concepts illustrated by shorter quotations.

Describing the method in the research process with collection of data, transcribing, and interpreting of a text often gives an impression of being a linear process following a number of steps or phases. My experience, however, is that the process is a much more complicated and dynamic one. The interpretation for instance starts already in the interview situation and affects the continued "collection of data", the different readings interlock and even the research questions may be modified in the course of the process. I do not see this as a problem in itself, and the oscillation is in accordance with the hermeneutic circle. It can however be problematic if we continue to apply a usage which presents the research process as a linear one not reflecting its dynamic aspect.

The nature of the empirical studies

The four studies in this thesis are naturalistic which means that what has been studied is the ordinary clinical everyday life at the four centres. The need for naturalistic studies was emphasized already by Bronfenbrenner (1977, p. 513) who stated that "much of contemporary developmental psychology is the science of the strange behaviour of children in strange situations with strange adults for the briefest possible periods of time". Even though what Bronfenbrenner says does not primarily refer to therapeutic interventions, it is in concordance with an expressed need for naturalistic studies in the field of parent–child interaction interventions (Greenberg 2005) as these may reveal something about the effectiveness of an intervention – not merely about it's efficacy.

The difficulties in relation to naturalistic multi-centre studies are on the methodological level, as they imply a series of challenges concerning how to relate to a process which is not guided by the needs of research or whose dynamics are not controlled by the researcher. Another methodological difficulty lies in the fact that the participants in the study are often marked by heterogeneity and that the intervention can be composed of various elements in different proportions, something which may complicate the interpretation of the results. A well-known problem is the risk of high attrition in multi-centre studies, something to which the studies in this thesis were however not subjected. If it is possible, in spite of all these challenges, to carry out a naturalistic study, the main advantage is that we acquire inestimable knowledge of how an intervention works in practice.

The subtitle of this thesis indicates a choice of perspective, namely the parents', as described above under the subheading "pre-understanding". In this thesis the meaning of the concept "perspective" is a limited one. The parents have not been given the opportunity in any way to influence the design of the different studies. Study I & II are based on the parents' self reports, but as these reports are contained in questionnaires with mainly pre-determined categories the parents' space to express themselves is limited. In Study III & IV the parents occupy more of a subject position in the second phase interviews. All informants were also invited to a seminar where the results were presented and discussed. Finally one parent participated in two workshops where the studies were presented and gave an account of her experiences of taking part in a study in the form of a "research partnership".

Trustworthiness

Doing research on an intervention in which one is oneself involved can raise questions about one's neutrality in relation to the results. There is also certain evidence showing that the positive expectations of the researcher may influence the results of the study. This is called allegiance bias (Leykin & DeRubeis 2009, Luborsky, Rosenthal, Diguer, Andrusyna, Berman, Levitt, Seligman & Krause 2002) and has above all been discussed within psychotherapy research.

Yet another circumstance complicating the interpretation of the results is the fact that there is certain proof that the informants evaluate more positively when asked repeatedly, a test-order effect (Lucas 1992). If that is the case for this study – and other studies as well – then this is something that must be taken into consideration when evaluating the outcomes.

A strength in Study I & II is the low attrition from the study, which implies that the trustworthiness of the results increases. The low attrition is a consequence of the

low rates of drop-out from treatment and the commitment of the staff in relation to collecting data.

When the studies have been presented in papers a guiding principle has been to describe in detail all the different steps of the research process and to account for data as fully as possible, e.g. in relation to persons who have declined to take part in the study, as a high degree of transparency increases the credibility of the studies.

Implications for practice

It is apparent from Study I that the families, both parents an children, coming to the four centres were struggling with major problems, which cannot be described as everyday cares, a situation calling for high competence among the staff. The fact that children with problems of a nature and a degree otherwise found in child psychiatry populations took part in interventions at centres falling under the auspices of the Social Welfare authorities, which was the case for two of the centres, also indicates that children's problems are often hard to define in terms of social or mental ones, as they can equally well be "both/and" as "either/or". We here see the need of interventions bridging the gap between child psychiatry and social welfare. It is possible that this is especially valid for children displaying aggressive behaviour, as causes for such behaviour are to be found both in the social and the psychological spheres, and consequences of such a complex of problems have an impact on various aspects of the child's life.

From Study IV it transpires that the therapists had not fully comprehended what feelings inhabited the parents at the outset of treatment. Remaining aware of the fact that one never knows for sure what goes on in another person's mind, irrespective of professional experience, helps the therapist to maintain an inquisitive stance. The research method applied in Study IV, with joint reflections, could be a useful one also within clinical work by providing the therapist with the parent's experiences of what in the intervention and in the relationship is of significance, for example what lies behind a decision whether to pursue or to drop out. Buvik & Wächter (2003) have developed a similar methodology and the benefit of processing the therapeutic relationship is discussed by Hill & Knox (2009).

The parents in Study II & III highlight the relation between the parent and the therapist in a way that strengthens the notion of this relationship as an important common factor, i. e. a factor that is not related to a certain intervention method. The results suggest that it is precisely those relationships that contribute to the low level of treatment interruptions and the low attrition from the study. It is essential

that the knowledge about the importance of the relationship between the intervener and the parent be a guiding principle for everyday practice in the field.

Relationships in other contexts than in parent–child interaction interventions are focused upon in Study II. The parents in this study describe how their ability to recognize the good intentions of another person facilitated the emerging of a confident relationship also against heavy odds, which is an important lesson for professionals facing demanding tasks in relation to families, e.g. within the Social Services. The most imperative implication is, however, that utmost care should be taken to safeguard these relationships when they arise, and – in relation to the knowledge of their importance for a child – not jeopardizing them by giving priority to organizational or other considerations.

Future research

"Breaking the intergenerational cycle of insecure attachment" was the title of a systematic review quoted in the opening of the survey of current research in this thesis. Research with respect to this goal is still a core task in the field of attachment-based interventions. The pathways of intergenerational transmission have been subject for research for a long time, but as very complex processes are at hand, e.g. the interaction between genetic and environmental factors, much remains to be explored.

In designing interventions it is crucial to deepen the knowledge of the precursors of infant attachment security in order to know what the intervention should target. Cassidy, Woodhouse, Cooper, Hoffman, Powell & Rodenberg (2005) hypothesize that if the goal is promoting secure attachment, the intervention should focus primarily on secure-base provision, not on parental sensitivity. If this is the case, the Circle of Security with is focus on "secure base" and "safe haven" is a particularly interesting programme which, from our perspective ought to be tested scientifically in Sweden and adapted to our cultural context.

It is however essential that future research does not focus on methods only, but that the intervener–parent relationship is also taken into account, not least because of the centrality in attachment theory of the relationships as engines of change (Berlin et al. 2008). Video recordings of the interplay between child and parent(s) are frequently used both in the interventions and in research, and should be equally applicable in research on the interplay between intervener and parent.

The parents' perspectives on parent–child interaction interventions also need to be highlighted, and then not only in terms of consumer satisfaction. Studies with a qualitative design can generate valuable knowledge on e.g. the reasoning of parents who are offered treatment and decide to decline it reason.

In Study III & IV the parents played a somewhat more salient role in the research process than in traditional research (Study I & II). A considerably more develop parent participation might generate new and interesting questions and findings.

The lack of studies on fathers in parent–child interaction interventions has already been commented upon/addressed/taken up in this thesis; nevertheless I would like to further highlight it here. Research on paternal involvement has shown that the way fathers influence their children's development is largely similar to that of the mothers, contrary to what was formerly imagined (Lamb 2004) when the differences between fathers and mothers were focused. Empirics from this field need to be linked up with intervention research.

As focus has been on the parents' perspectives the children have been invisible in this thesis. One difficulty in research on small children is the lack of scientific instruments, translated into Swedish and tested here, in order to measure development and health in infants and toddlers. Another and yet greater challenge is capturing small children's experiences of taking part, together with their parents, in parent–child interaction interventions.

SVENSK SAMMANFATTNING (SWEDISH SUMMARY)

Syftet med denna avhandling var (a) att beskriva familjer som deltagit i samspelsinterventioner mellan föräldrar och barn och undersöka förändringar i deras problembörda på kortare och längre sikt, (b) att undersöka föräldrarnas egna perspektiv på vilka personer och sammanhang inom och utanför interventionen de funnit gynnsamma för barnet och familjen och (c) att undersöka den förståelse av dessa processer som föräldrarna och nyckelpersonerna kom fram till i de gemensamma intervjuerna.

Föräldrarna i de 101 familjer som deltog i interventionen uppvisade avsevärd problemtyngd då behandlingen började och barnens problem var av den art och grad som man annars återfinner inom barnpsykiatrisk behandling, och bestod företrädesvis i aggressivt beteende.

Efter sex månader konstaterades en tydlig trend i riktning mot en positiv utveckling för föräldrar och barn, och denna positiva utveckling förstärktes efter 18 månader. Mycket få familjer avbröt behandlingen.

I familjer med två biologiska föräldrar deltog alla mammor och 89% av papporna i behandlingen. Pappornas genomsnittliga problembörda var lägre än mammornas, och deras förbättring var mindre omfattande. De var positiva i sina omdömen om behandlingen, och tillskrev behandlingen betydelse för den förbättring som ägt rum, men papporna lyfte i högre grad än mammorna också fram faktorer utanför behandlingen som bidragande till förbättringen.

Föräldrar, som minst tre år tidigare avslutat sin behandling, beskrev i intervjuer personer som varit betydelsefulla för familjen och för barnens utveckling, både inom ramen för behandlingen och i en rad andra sammanhang såsom förskola, barnhälsovård, skola och socialtjänst. I gemensamma intervjuer med föräldrarna och dessa betydelsefulla personer framkom det att när föräldrarna uppfattar att t. ex. läraren, socialsekreteraren eller bvc-sköterskan handlade utifrån goda avsikter kunde förtroendefulla relationer växa fram även om förutsättningarna i övrigt inte var gynnsamma. Det var de professionellas vardagliga uttryck för ett personligt engagemang som övervann hinder i form av till exempel föräldrarnas eller barnens tidigare negativa erfarenheter. Dessa "viktiga möten" bidrog till att skapa mer positiva (själv)bilder av barnet och/eller föräldern.

Vid behandlingens början fanns det ett avstånd mellan föräldrarna och deras familjeterapeuter, orsakad av bland annat föräldrarnas rädsla och skillnader i makt, men såväl föräldrarna som terapeuterna bidrog till att minska detta avstånd och skapade på så sätt en terapeutisk process. Bilden av den goda terapeuten framträdde som en "normal, vänlig och kunnig person som kan erkänna att han/hon har fel".

Slutsatsen är att dessa samspelsinterventioner för föräldrar och barn har nått mammor, pappor och barn med betydande svårigheter som har med föräldraskap och samspel att göra, erbjudit en behandling som en överväldigande majoritet av familjerna valt att fullfölja och som har inneburit en förändring för familjerna. Det empiriska materialet i dess helhet understryker relationens betydelse, inte enbart inom ramen för behandling, utan också utan också i andra sammanhang där barn och deras föräldrar möter professionella, relationer som kan vara av stor betydelse för att främja barns utveckling.

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