Therapeutic Application of the Marschak Interaction Method (MIM): An Interpretative Phenomenological Analysis of Parents' Experiences and Reflections

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Chapter One: Systematic Review

Video-Feedback in Parenting Interventions: A Systematic Review

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Abstract

Objective: The therapeutic use of video-feedback in parent-child interventions has gained recognition in recent years. This paper builds on previous meta-analyses by exploring and summarising the most up-to-date evidence for the use of video-feedback in family programmes, and reports on the clinical efficacy of such interventions. **Method:** Following a systematic search of the literature, 11 articles were identified as being eligible for inclusion in the review, and a narrative synthesis of study findings was undertaken. The quality of included studies was assessed and areas for potential bias in the results were explored. **Results:** Studies employed a variety of different video-feedback interventions, all with the primary aim to improve parenting behaviour. The findings support those of previous reviews and provide further evidence for the efficacy of video-feedback interventions in enhancing parental sensitivity, and ultimately the quality of parent-child interactions. Interventions were found to be less effective in improving parent outcomes; however, there is evidence to suggest that parent-directed video-feedback interventions are effective in reducing child behaviour problems. **Conclusions:** These findings have important implications for mental health care providers and provide a strong argument for the use of video-feedback as a short-term intervention to promote positive parent-child outcomes. Further research is required to investigate the long-term effects of such interventions on child attachment security.

Introduction

The therapeutic use of video is a rapidly evolving and promising area of clinical practice. Video-feedback is widely recognised as a powerful therapeutic tool to educate, encourage self-reflection, and facilitate positive behaviour change (Fukkink, 2008). Such approaches are gaining recognition within the field of parent-child attachment research (Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2008). In this context, video-feedback programmes aim to increase parental sensitivity to their child's developmental and attachment needs by providing a 'visual medium' that enhances insight and self-reflection to support therapeutic change and encourage the development of more positive parent-child relationships (Fukkink, 2008).

Theoretical background

Secure attachment to a primary caregiver in the early years of life is believed to be of fundamental importance for healthy psychosocial development. Research evidence has shown that children who experience disruptions to these attachment relationships are at greater risk of developing psychological difficulties later in life (Sroufe, 2005). The likelihood of forming secure attachments has been linked to parental sensitivity, which refers to the parent's ability to accurately identify and appropriately respond to the child's emotional and behavioural cues (Ainsworth, Blehar, Waters, & Wall, 1978). Findings from a meta-analysis of parental antecedents to attachment security have presented empirical evidence for the importance of parental sensitivity in the development of child attachment security (de Wolff & van IJzendoorn, 1997). Parents' own attachment experiences have also been linked to their ability to form secure attachment relationships with their children. Research has found

that those parents, who present with insecure attachment representations, display less sensitivity and therefore a reduced ability to form secure attachments with their own children (van IJzendoorn, 1995; Shah, Fonagy, & Strathearn, 2010). In this sense, attachment difficulties are widely believed to be transmitted across generations (Shah et al., 2010).

Overview of video-feedback approaches

Video-feedback is used in parenting interventions in a number of ways (e.g. see Rusconi-Serpa, Sancho Rossignol, & McDonough, 2009), but most approaches appear to share the primary aim of supporting the development of more positive parent-child relationships by directly addressing the determinants of child attachment security, namely: parental sensitivity and parental attachment representations. In general such treatments fall into two broad approaches: behavioural or representational (Fukkink, 2008). Short-term behavioural interventions are most common (Fukkink, 2008). They involve the joint parent and therapist review of video recorded parent-child interactions, while the therapist highlights instances of successful interaction and provides positive feedback to reinforce the parent's performance (e.g. van IJzendoorn, Bakermans-Kranenburg, & Juffer, 2008). Such approaches are intended to enhance parental sensitivity and instil a greater sense of parenting competence to support positive behaviour change. Representational approaches, on the other hand, directly address the parent's own attachment representations. Such interventions are based on the assumption that reviewing video recorded interactions of one's self can serve as a "mirror" to enhance self-reflection, which in turn facilitates discussion around the parent's own attachment experiences (van IJzendoorn et al., 2008). Parents are then encouraged to consider how their own attachment representations may be played out in their interactions with their child and how they may negotiate future

interactions more successfully (e.g. Cummings & Wittenberg, 2008). In practice interventions often combine aspects of both approaches.

Evidence for the effectiveness of video-feedback interventions

Previous reviews have reported on the relative effectiveness of video-feedback approaches over other attachment focused interventions. Bakermans-Kranenburg, van IJzendoorn and Juffer (2003) published the results of a meta-analysis of 70 attachment-focused intervention studies within parent-child populations. Their findings indicated that brief and focused interventions that incorporated video-feedback were most effective in enhancing parental sensitivity; however, no significant effects on child attachment security were found at this time. A subsequent review (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2005) found that interventions directly targeting the development of parental sensitivity were more effective in reducing child attachment disorganization than those with a broader focus. This latter review concluded that child attachment security may improve as a consequence of enhanced parental sensitivity, which highlighted the need for interventions that target parental sensitivity.

In an attempt to further summarise the growing evidence base for the efficacy of video-feedback approaches within family populations, Fukkink (2008) conducted a meta-analysis of 29 studies published between 1998 and 2006 that concerned the use of parent-directed video-feedback interventions. It concluded that interventions that made use of video-feedback were effective in improving parental attitudes and behaviour. Specifically, a small to moderate effect of such interventions in reducing parental stress and increasing parenting confidence was reported. These findings supported Bakermans-Kranenburg et

al.'s (2003) "Less is More" hypothesis by clarifying that those interventions that were short in duration and focused in their aims were more effective in improving parental outcomes. Additional evidence for the positive effects of such interventions on child attachment security and development outcomes were also reported.

Limitations in existing evidence-base

A limitation of Fukkink's (2008) review was in the selection of studies. Within the reviewed studies, video-feedback was often part of a broader intervention protocol combining a number of different components. Therefore, any observed intervention effects cannot reliably be said to be the result of the video-feedback component alone, and further research is required to determine if video-feedback is indeed the crucial component of treatment. Moreover, research into the effectiveness of video-feedback interventions has primarily focused on mothers; but as Benzies et al. (2013) note, fathers may respond differently to interventions, and so any existing evidence cannot be reliably applied to fathers. Similarly, the studies included in Fukkink's (2008) review, focus primarily on populations of biological parents, and little is known of the effectiveness of interventions with foster and adoptive parents. More recently researchers have turned their attention to these gaps in the evidence base, and a number of recent studies have begun to explore the effect of video-feedback interventions with fathers (Magill-Evans et al., 2007; Benzies et al., 2013) and non-biological carers (Spieker et al., 2012).

Rationale for current review

The therapeutic use of video-feedback has gained increased recognition in recent years, particularly so within parenting intervention programmes (Rusconi-Serpa et al., 2009). This

is a rapidly evolving area of clinical practice and the emergence of new literature may have implications for the current evidence-base. It is therefore timely to re-investigate the clinical effectiveness of such interventions. This is in keeping with The Cochrane Collaboration's recommendations that reviews should be updated after two years to ensure that the best available and most current evidence is presented (Higgins, Green, & Scholten, 2011). This current review will help to ensure the reliability of reported findings and reduce the risk of out-of-date and misleading information being presented.

While the efficacy of video-feedback interventions may appear well established, previous reviews have been unable to separate the effect of video-feedback from other intervention components (Fukkink, 2008). In an attempt to offer further clarity to the efficacy of video-feedback in enhancing parent and child outcomes, this current review will include only those studies that identify video-feedback as the core intervention component. To ensure that only the best quality evidence is reported, only Randomised Controlled Trials (RCT) will be included. Additionally, much of the research into the effectiveness of video-feedback interventions has focused primarily on parent outcomes, and findings on the effects of video-feedback interventions on child outcomes are limited and somewhat inconsistent (e.g. see Bakermans-Kranenburgh et al., 2003; Fukkink, 2008). This review hopes to offer further clarification on the effects of video-feedback interventions on both parent and child outcomes.

Review objectives

This review aims to build on the work of previous meta-analyses by exploring and summarising the most up-to-date evidence for the use of video-feedback interventions in

therapeutic work with parents, carers and their children, and to report on the clinical efficacy of such interventions. This review focuses on three key research questions:

- Are video-feedback interventions effective in improving parent-child relationships?
- What are the outcomes of video-feedback interventions for parents?
- What are the outcomes of video-feedback interventions for children?

Method

Systematic search strategy

A systematic literature search was conducted in May 2014 by the primary researcher (DF) using the following online interfaces and electronic databases: Ovid (Medline, Embase), EBSCO (Psychology and Behavioural Sciences Collection, CINAHL, PsychINFO), Web of Science, PubMED, and The Cochrane Library. Databases were searched from January 2006 to May 2014 to identify any new research evidence since the publication of Fukkink's (2008) meta-analysis. Subject heading searches and keyword searches were performed using terms for the relevant intervention combined with terms for family populations as follows:

(video* *AND* feedback, playback, play-back, self-model, self-observation, self-confrontation, interaction guidance, parent training, video intervention, video therapy, video treatment)

AND

(parent, family, mother, father, maternal, paternal, carer, caregiver, care-giver, child, infant)

Boolean operators (OR and AND) were used to combine search strings and truncating was used to ensure the identification of search terms where spelling and word endings differ e.g. plural or adjectives. The search was limited to English language, journal publications and humans. Those journals yielding the greatest number of relevant articles were hand searched from 2006 onwards. This included: Archives of Women's Mental Health, Clinical Child Psychology and Psychiatry and Infant Mental Health Journal. Publications of the Video Interaction Guidance International Research Network were also reviewed. Finally, to increase the sensitivity of the search, the reference lists of included articles were hand searched for previously unidentified literature.

Study selection

All articles were screened against pre-defined inclusion criteria presented in Table 1 by the primary researcher (DF).

Table 1. Inclusion Criteria

Category	**Criteria**
Publications	Peer reviewed journal articles. English language. January 2006 - May 2014.
Study Design	Randomised controlled trials (RCTs).
Population	Participants are parents or primary caregivers to infants and/or children.
Intervention	Studies explicitly made use of video-feedback as a core component of a parent-directed intervention.
Comparison	Treatment as usual (TAU), an alternative intervention or an active comparison intervention that controls for non-specific therapeutic effects.
Outcomes	A minimum of one clinical outcome, including (but not restricted to), parental sensitivity, parental attitudes, parental behaviour, parent-child relationship, child outcomes and adverse effects.
Exclude	Studies that make use of video-feedback as part of a wider treatment protocol. Studies previously examined by Fukkink (2008). Studies concerning secondary or follow-up analysis of previously reviewed data.

Data extraction and synthesis

Following the systematic search strategy and study selection process, a narrative synthesis of study findings was undertaken. Narrative synthesis is defined as a systematic approach to the review of findings from multiple studies to provide a qualitative description of synthesised findings in relation to a particular review question (Popay et al., 2006). This process was undertaken by the primary researcher following guidance from by the Centre for Reviews and Dissemination (CDR, 2009). First, a standardised data extraction table was developed and data were extracted from the included studies. This included details of the participant sample, intervention and comparison conditions, assessment of outcomes, results, conclusions and limitations. Second, an initial descriptive synthesis of the included studies was produced, which detailed the characteristics of the study design, sample, interventions and outcome domains. This process helped to confirm that the included studies were similar enough in their approach for results to be reliably synthesised. Next, a quality appraisal of included studies was undertaken to assess the robustness of reported outcomes. Study findings were then organised and compared narratively according to their outcome domains and the questions posed by this current review to bring together the findings and draw conclusions based on the evidence presented.

Quality assessment

To assess the methodological quality of the included studies a modified version of the Clinical Trials Assessment Measure (CTAM; Tarrier & Wykes, 2004) was employed (Appendix 1.2). Based on the CONSORT guidelines (Consolidated Standards of Reporting Trials; Moher, Schulz, & Altman, 2001), the CTAM was developed to provide a tool to assess the quality of clinical trials of psychosocial interventions. It has been found to have good internal reliability and high concurrent validity with other quality assessment scales (Tarrier & Wykes, 2004; Wykes, Steel, Everitt, & Tarrier, 2008). Study quality is assessed across six areas of methodological design: sample characteristics, allocation to treatment, assessment of outcome, control groups, description of treatments and analysis. To further assess the risk

of bias within studies, additional items relating to homogeneity between groups, therapist training, validity and reliability of outcome measures, follow-up assessment, and the size of reported intervention effects, were added (see Appendix 1.2, modifications are indicated in italics). This modified version contained 20 items with a maximum total score of 122. To maintain consistency in the scoring, where an item was not reported, it was assumed that the quality criterion had not been met. Percentage scores were calculated and the following quality ratings were applied to provide an indicator of the overall quality of included studies: 'Good' (>75%), Moderate' (50-75%), 'Poor' (<50%). The primary researcher (DF) rated all included studies. A second researcher, a Doctorate of Clinical Psychology Trainee who was familiar with the CTAM measure and independent of the current review, provided secondary ratings for 6 of the included studies. There was a 95.6 % agreement between raters and any discrepancies were resolved through discussion.

Results

The electronic database search identified 1,680 articles. A hand search of key journals and publications yielded a further 6 articles, which upon closer inspection did not meet inclusion criteria for this review, thus confirming the sensitivity of the database search. A total of 1686 titles and abstracts were screened for relevance, of which 193 full-text articles were retrieved. Duplicates were removed and the inclusion criteria were applied. Two additional full-text articles were accessed following a hand search of the remaining article references, but these did not fulfil the inclusion criteria. A total of 11 articles were selected for inclusion in this review. The study selection process is outlined in Figure 1 below.

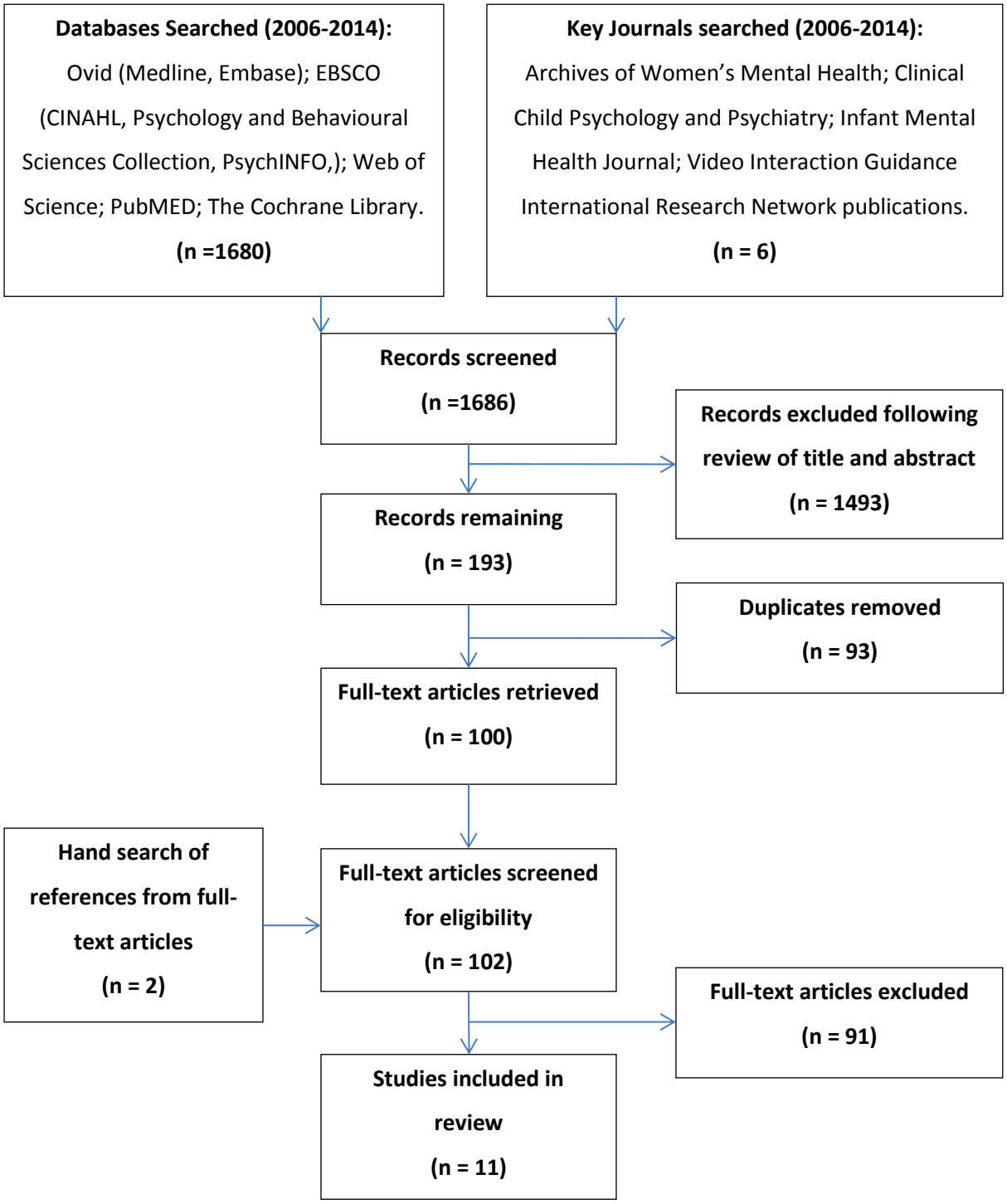

Figure 1. Flow diagram of study selection process

Studies were included in the review if they concerned the experimental investigation of a parent-directed intervention that explicitly identified the use of video-feedback as the core

treatment component. A number of identified studies made use of video-feedback as part of a wider intervention protocol. These studies were excluded from the current review on the basis that any experimental outcome could not reliably be attributed to the effects of video-feedback independent of other intervention components. Two identified studies were excluded on the basis that they were previously examined in Fukkink's (2008) meta-analysis. Studies that concerned the secondary or follow-up analysis of research data previously reviewed by Fukkink (2008) we also excluded. In addition, two identified studies (Bakermans-Kranenburg, van IJzendoorn, Mesman, Alink, & Juffer 2008; Bakermans-Kranenburg, van IJzendoorn, Pijlman, Mesman, & Juffer 2008) reported follow-up analyses of experimental data presented in van Zeijl et al. (2006) with the view to explore the moderating role of child genetic factors on intervention outcomes. These articles, about genetic factors, were deemed to be out with the scope of the current review and were excluded.

Description of studies

An overview of all the studies included in this review can be viewed in Table 2 (page 32 in text).

Study design

All of the included studies employed RCT design with participants randomised to intervention or control groups. Five of these studies employed a 3rd condition, which offered a treatment dose optimisation comparison (Benzies et al., 2013), an alternative treatment comparison (Bilszta, Buist, Wang, & Zulkefli, 2012; Jagermann & Klein, 2010), or comparison with another video-feedback intervention format (Klein Velderman, Bakermans-Kranenburg,

Juffer & van IJzendoorn, 2006a, 2006b). Two of the studies reported findings from the same intervention within the same population sample with a focus on different outcomes (Klein Velderman et al., 2006a, 2006b). All included studies reported pre-test and post-test comparisons, and three included follow-up assessment at 6 months or more (Cummings & Wittenberg, 2008; Klein Velderman et al., 2006b; Spieker et al., 2012).

Sample characteristics

Four studies were conducted in Canada, three were conducted in the Netherlands, and the remaining four were conducted in Australia, Israel, Lithuania and the USA. Sample sizes ranged from 37 to 237. Participants were mainly biological parents, primarily mothers, with two studies which employed first-time fathers (Benzies et al., 2013; Magill-Evans et al., 2007). Most studies recruited participants according to specific population variables, including; mothers screened for low sensitivity (Kalinauskiene et al., 2009) or insecure attachment representations (Klein Velderman et al., 2006a, 2006b), mothers with clinically significant psychological symptoms receiving inpatient psychiatric treatment (Bilszta et al., 2012), mothers of children with sensory processing difficulties (Jagermann & Klein, 2010), mothers of children screened for high externalising behaviour difficulties (Van Zeijl et al., 2006), parents of children referred for assessment of behaviour problems (Cummings & Wittenberg, 2008), parents reported for maltreatment of their children (Moss et al., 2011), or caregivers of children under state care who had experienced recent placement disruption (Spieker, et al. 2012). Where reported, children's ages ranged from 5 to 72 months across the entire sample, and overall there were slightly higher numbers of boys (54.3%) than girls (45.7%).

Interventions

All included studies employed video recorded footage of parent-child interactions followed by individualised therapist-guided feedback, with the primary aim of improving parental sensitivity and the quality of parent-child interactions. Most studies followed standardised treatment protocols, while others simply applied the broader video-feedback framework with adaptions for their specific population group. Consistent with Fukkink's (2008) observation, approaches were broadly categorised as behavioural or representational in focus, or a combination of both. Behaviourally focused approaches were used in all but one study that employed a relationally focused intervention (Cummings & Wittenberg, 2008). Bilszta et al. (2012) used a combined approach, and Klein Velderman et al. (2006a, 2006b) investigated the differential effectiveness of the two approaches.

Outcome domains

All but one study (Bilszta et al., 2013) directly measured the effects of intervention on the quality of the parent-child interactions and most applied well validated and structured observational tools. Broadly speaking, the purpose of these observational tools was to assess parental sensitivity. Over half of the studies also explored the impact of video-feedback interventions on parent outcomes, including measures of psychological wellbeing and parental attitudes and perceptions. Seven studies explored their chosen intervention's effects on child outcomes. Of these, two reported on child behaviour outcomes (Van Zejil et al., 2006; Cummings & Wittenberg, 2008), three reported on child attachment security (Klein Velderman et al., 2006a; Kalinauskiene et al., 2009; Spieker et al., 2012), and two reported on both (Klein Velderman et al, 2006b; Moss et al., 2011). Child behaviour was primarily assessed using the Child Behaviour Checklist (CBCL; Achenbach & Rescorla, 2000).

The CBCL is a well validated and widely used parent-report assessment of child behaviour problems (Nakamura, Ebesutani, Bernstein, & Chorpita, 2009). CBCL scores are broadly categorised into internalising and externalising difficulties. Internalising difficulties refer to anxious, withdrawn and depressed presentations; whereas externalising difficulties refer to oppositional, inattentive, and non-compliant behaviours. Child attachment security was primarily assessed using the Strange Situation Procedure (SSP; Ainsworth et al., 1978). This is the most widely used and validated assessment of child attachment security (Moss et al., 2004).

Quality appraisal of included studies

Using the modified CTAM measure, the median quality assessment score of included studies was 84, with a range of 61 to 105 out of a maximum score of 122 across studies. When quality ratings were applied, four studies were deemed to be of good quality and the rest were of adequate quality. A more detailed summary of study scores across the individual quality assessment items can be viewed in Appendix 1.3.

External validity

Most studies employed convenience samples, with participants recruited from clinics or via specialist agencies. These rather selective sampling procedures limit the degree to which outcomes can be reliably applied to the wider population. Two exceptions to this were Klein Velderman et al. (2006a, 2006b) and van Zeijl et al. (2006), who recruited participants from community records by identifying all parents of children born within a specified time-frame before screening for eligibility. While this sampling method enhances the generalizability of their findings; these studies were rated amongst the lowest quality of those included in this

review, with Klein Velderman et al. (2006a,2006b) employing a small sample size with associated reduction in power, and van Zeijl et al. (2006) including an over-representation of families from high socio-economic backgrounds in their sample. Most studies recruited participants according to specific population variables so the samples included in this review cannot be said to represent the general population. In addition, the presence of such variables suggests that participants were likely to have received additional psychosocial intervention and support, which may limit the degree to which post-treatment outcomes can be reliably attributed to the effects of the video-feedback intervention alone.

Internal validity

Allocation to treatment: All studies report random allocation to treatment and 7 describe adequate randomisation procedures; however, only 4 (Magill-Evans et al., 2007; Cummings & Wittenberg, 2008; Bilszta et al., 2012; Benzies et al., 2013) explicitly report independent randomisation. Therefore true randomisation concealment cannot be assumed across all studies. Pre-test homogeneity between groups was assessed in all studies and most reported no significant pre-test differences between groups. Exceptions to this were; Klein Velderman et al. (2006a, 2006b), who reported an unequal distribution in children's age between groups, and Spieker et al. (2012), who found that children in the intervention condition had experienced a greater number of placement disruptions than controls. Cummings and Wittenberg (2008) reported higher levels of child externalising behaviour problems in the comparison group, but employed adequate statistical analyses to control for this difference. Overall, it can be concluded that intervention and control groups were well balanced, which increases the likelihood that any observed post-test differences can be

reliably attributed to the effects of the intervention rather than inherent differences between groups.

Assessment of outcome: Most studies employed standardised assessments to measure outcomes and most reported on the internal validity and consistency of these. Two exceptions were: van Zeijl et al. (2006) who employed unpublished observational measures; and Bilszta et al. (2012) who did not provide descriptive details for their chosen assessment measures, so it is impossible to comment on the validity and reliability of these measures. Over half of the studies employed independent outcome assessors, but not all were blind to group allocation, which may increase the risk of bias in assessment of outcomes. This is especially relevant for the studies included in this current review, as most employed observational assessment methods; however, most studies made attempts to manage this risk of bias by employing secondary raters, and reporting high inter-rater reliability in the observational assessment of outcomes. Assessment of parent outcomes and child behaviour outcomes generally relied on parent-report data across studies. This method of assessment may limit the validity of findings as self-report measures are vulnerable to misinterpretation and limitations of memory and presentational biases (Kroes, Veerman, & de Bruyn, 2003). Objective therapist-assessed measures of such outcomes would have considerably enhanced the validity and reliability of outcome assessments.

Control groups: Over half of the studies employed adequate comparison conditions that could be said to control for the non-specific effects of interventions. These included, supportive parent-therapist discussions with verbal guidance (Magill-Evans et al., 2007; Bilszta et al., 2012; Benzies et al., 2013), or an alternative credible treatment (Cummings

and Wittenberg, 2008; Jagermann & Klein, 2010; Spieker et al. 2012). Klein Velderman et al (2006a, 2006b), van Zeijl et al. (2006) and Kalinauskiene et al. (2009) all employed non-treatment controls. Moss et al. (2011) compared the effects of video-feedback intervention to treatment-as-usual with no additional provisions.

Analysis: All studies reported statistical analysis that was considered appropriate to the study design and measures. All but two (Bilszta et al., 2012; Jagermann & Klein, 2010) reported on the effect size of observed outcomes. Attrition rates ranged from 0% to 15% at post-test and 3.7% to 39% at follow-up. While most reported adequate investigations of drop-outs to assess for any resultant imbalance between groups and to ensure that the validity of their results had not been compromised; only one study employed intention-to-treat analyses to account for incomplete participant data (Spieker et al., 2012). Bilszta et al. (2012) reported the highest attrition rate at post-test, but did not investigate this further. Cummings and Wittenberg (2008) reported high post-test and follow-up attrition rates (5.5% & 11% respectively), with non-completers found to be significantly more disadvantaged than completers. This pattern of attrition reduced the power of their analyses and may have wider implications for the validity of their reported findings.

Treatment fidelity: All of the included studies adequately described their intervention procedures to allow for replication, and most followed an established treatment protocol. Details of therapists' training were reported in all but two studies (Benzies et al., 2013; Bilszta et al., 2012) and were deemed sufficient to deliver the intervention in the rest. Only five of the studies reported investigations of treatment fidelity, so it is not possible to draw conclusions about the overall quality of treatment delivery, thus limiting the validity of the

current review findings. Those that did, however, reported adequate adherence to protocol with the exception of Cummings and Wittenberg (2008), who reported inconsistencies in the delivery of intervention, which may have influenced the validity and reliability of their observed treatment outcomes.

Summary of findings

For the purposes of this current review, study findings are discussed in relation to the three review questions: parent-child interactions, parent outcomes, and child outcomes. Additionally, a number of studies made initial attempts to explore the potential moderating role of parent and child variables on intervention outcomes, which are also discussed.

Parent-child interactions

Of those that assessed the quality of parent-child interactions, nine studies reported significant improvements following video-feedback intervention when compared to controls. The four highest rated studies reported medium to large effect sizes. Specifically, Magill-Evans et al. (2007) reported significant improvements in the overall quality of parent-child interactions following only two behavioural-focused video-feedback intervention sessions. Their sample consisted of first-time fathers and they measured the quality of interactions using the Nursing Child Assessment Teaching Scale (NCATS; Barnard, 1994). Analysis of participant scores across the NCATS subscales revealed significant improvements in fathers' cognitive growth fostering behaviours and sensitivity to their child's cues with medium and large effect sizes respectively. A later study by Benzies et al. (2013) used a comparable measure (Parent-Child Interaction Teaching Scale - PCITS; Sumner & Speitz, 1994) to assess the impact of a similar video-feedback intervention, also with first-time

fathers. They randomised participants to two or four dose intervention groups or a control group. They found improvements in the overall quality of parent-child interactions at post-test for both intervention groups; however, this difference was only significant for those who received the four dose treatment. Analysis of scores across the PCIT subscales revealed significant improvements with medium effect sizes on cognitive and social-emotional growth fostering behaviours, but unexpectedly, no significant effect on sensitivity to child cues was found. Spieker et al. (2012) also employed the NCATS measure to assess the impact of a ten session behavioural-focused video-feedback intervention on carers of children under state care, focusing primarily on carer sensitivity. They reported significant overall improvements at post-test with a medium effect size. While this effect was not maintained at six month follow-up, the direction of the effect continued to favour the intervention group.

Of the remaining studies that employed behavioural-focused video-feedback interventions, all reported significantly improved post-test parent-child interactions compared with controls. Moss et al. (2011) investigated the effects of an eight session video-feedback intervention for parents who had been reported for maltreatment. They found that those who participated in the intervention showed significantly increased sensitivity and improved quality of caregiving with a medium effect size, compared to treatment-as-usual controls. Jagermann and Klein (2010) reported similar effects of their six to eight session intervention on a population of mothers of children with sensory processing difficulties. They found significant effects of intervention on parental sensitivity and responsiveness to the child, as well as improved parental communication and teaching behaviours, compared to an alternative treatment comparison. Kalinauskiene et al. (2009) reported impressive

outcomes of an even shorter intervention with only five video-feedback sessions. Their sample consisted of first-time mothers screened for low sensitivity. They found that mothers randomised to the intervention condition, displayed significantly improved sensitivity at post-test compared to controls when controlling for confounding parental variables, with a large effect size demonstrated.

van Zeijl et al. (2006) took a slightly different focus and investigated the effects of a 6 session behavioural-focused video-feedback intervention on mothers' approach to discipline. The primary aim of their intervention was to enhance parental sensitivity to improve their management of child misbehaviour. They assessed the effects of intervention on maternal sensitive discipline, which is characterised by greater empathy for the child and consideration of the child's developmental stage. They found that this approach significantly enhanced the quality of parent-child interactions, with medium effect sizes. Unfortunately, the validity of their findings is somewhat compromised by an over-representation of participants from high socio-economic backgrounds and the use of unpublished and not well validated outcome measures.

Only one included study made use of a video-feedback intervention that was primarily representational in focus. Cummings and Wittenberg (2008) compared a sixteen session representational-focused intervention with an empirically supported behavioural parent-training programme that makes use of psychoeducational videos (Incredible Years Parenting Programme - IYPP; Webster-Stratton, 2001). They reported large effect sizes for post-test improvements in the quality of parent-child interactions in both groups, with no significant differences between groups. This effect was maintained, to a lesser extent, at one year

follow-up, but was found to have shifted in favour of the comparison treatment. The authors concluded that video-feedback was no more effective in improving the quality of parent-child interactions than a psychoeducational parent training programme that did not use video-feedback. These findings are limited by reduced statistical power due to high attrition rates at follow-up. There is also the potential for bias in the results due to differences in the demographic variables of participants at pre- and post-test, with those participants who completed the intervention found to be significantly more advantaged than those who did not.

Finally, Klein Velderman et al. (2006a) compared behavioural-focused and combined-focus (behavioural & representational) video-feedback interventions to a control group, in a sample of first-time mothers screened for insecure attachment representations. They found both intervention formats to be equally effective in improving maternal sensitivity, with medium effect sizes. A second report by Klein Velderman et al. (2006b) on the same study within the same population sample, did not find any significant long-term effects on parent sensitivity at two years follow-up. Both these findings are limited by small sample sizes and so reduced power to detect intervention effects.

Parent outcomes

Of those studies that examined parental outcomes, only three found positive intervention effects, two of which were amongst the most highly rated studies. All reported effect sizes for parent outcomes were small. Cummings and Wittenberg (2008) examined the effect of a representational-focused intervention on reported stress, psychological wellbeing, and parenting satisfaction for parents of children referred for assessment of behaviour

problems. They reported significant improvements with small effect sizes in parental stress and psychological wellbeing following intervention; however, these improvements were not maintained at one year follow-up. No significant effects of intervention on parenting satisfaction were found. Spieker et al. (2012) explored the effects of a behavioural-focused intervention on caregiver attitudes and perceptions for carers of children under state care. While they did not find any significant intervention effect on carer stress; they did report improvements in carers' understanding of the child's needs and perceived child competence, with small effect sizes. The intervention was not found to be successful in enhancing carers' commitment to the child. van Zeijl et al. (2006) also found that their behavioural-focused intervention, intended to enhance parental sensitive discipline, had positive effects on parent outcomes. They reported significant post-test improvements with small effect sizes in parents' attitudes towards sensitive discipline and sensitivity; however, as previously noted, these results lack validity due to their use of non-validated self-report assessment measures.

These positive effects on parent outcomes were not supported by other studies. Magill-Evans et al. (2007) examined intervention effects on measures of parents' self-efficacy and satisfaction; while Benzies et al. (2013) tested for effects on parenting stress and perceptions of parenting. Neither study found any significant post-test differences between intervention and control groups. Bilszta et al. (2012) exclusively examined the effect of their combined focus intervention on a variety of parent outcomes. While they found significant improvements in parent psychological functioning at post-test, these improvements did not differ between groups, and the video-feedback intervention was not found to be more effective than standard care or supportive parent-therapist discussions. Unexpectedly they

found that parents' sense of competence improved in the comparison groups only. The sample consisted of mothers with clinically significant mental health difficulties who were receiving inpatient care and the authors suggest that the presence of such difficulties may have limited the mothers' capacity for self-reflection, thus reducing their ability to benefit from intervention. In addition, they propose that the lack of improvement in the parents' sense of competence in the intervention group may be due to increased feelings of discomfort when viewing oneself on video.

Child outcomes

Seven of the included studies explored the effects of the parent-directed video-feedback interventions on child outcomes. Results were mixed, but where significant effects were found, effect sizes were large. Klein Velderman et al. (2006b) found that children whose parents participated in the video-feedback intervention displayed significant reductions in levels of externalising behaviour at two years follow-up. This effect was only observed in those children whose parents participated in the behavioural-focused intervention condition, and the combined focus intervention was not found to be as successful in influencing child behaviour scores. The sample size was small and so there may have been reduced statistical power to reliably detect any significant post-test differences. Furthermore, effect sizes were not reported, so it is not possible to determine the magnitude of observed effects. Cummings and Wittenberg's (2008) subsequent and more methodologically robust study, found significant post-test reductions with a large effect size in child externalising behaviour scores, following parent participation in a representational-focused intervention. These improvements were maintained at one year follow-up to a lesser effect; however, there were no significant differences between groups and the video-

feedback intervention was not seen to be more effective than the comparison intervention (IYPP; Webster-Stratton, 2001). This finding is at odds with that of Klein Velderman et al. (2006b), and suggests that interventions employing representational aspects can also effectively improve child behaviour outcomes. van Zejil et al. (2006) and Moss et al. (2011) also assessed the impact of intervention on child behaviour outcomes, but neither found any significant post-test differences between intervention and control groups. None of the included studies found any intervention effects for internalising child behaviour scores.

Of those studies that assessed the impact of intervention on child attachment security, only one found significant post-test improvements when compared to controls. Moss et al. (2011) reported significantly improved child attachment security and reduced attachment disorganisation following intervention, but effect sizes were small. Klein Velderman et al (2006a) reported a trend towards greater attachment security in the intervention group at post-test when compared to controls, but this was not found to be significant; while Kalinauskiene et al. (2009) found no intervention effect on child attachment security. Only Spieker et al. (2012) assessed child attachment security at long-term follow-up, but failed to find any significant improvements in child attachment security at six months post intervention. Unfortunately high attrition rates (39%) considerably reduced statistical power and thus the likelihood of any effect being detected.

Interaction effects

Klein Velderman et al. (2006b) examined the effect of child temperament on intervention outcomes. They found that parents of highly reactive infants showed significantly greater post-test improvements in sensitivity, with a medium effect size. They also reported a

significant positive correlation with a medium effect size between maternal sensitivity and infant attachment security at post-test; however, this was not present at two year follow-up. Benzies et al. (2013) found parental stress was significantly and inversely correlated with the quality of parent-child interactions, with a medium effect size. Finally, Kalinauskiene et al. (2008) found significant positive correlations between parental sensitivity and both parenting sense of competence and child attachment security, with small and medium effect sizes respectively.

Table 2. Summary of studies included in systematic review (listed in descending order of quality rating)

Study **Quality rating** **Country**	**Participants** **Sample size**	**Intervention** **Comparison**	**Outcome measures** **Assessment points** (attrition rates)	**Main findings** *(All effect sizes are reported in favour of the intervention condition unless otherwise stated)*
Cummings & Wittenberg (2008) **Good**	<u>Parent</u> 52 mothers, 2 fathers (including 7 adoptive parents) <u>Child</u> Children referred for assessment of behaviour problems Age range 26-72mnth (mean 50) 33 male (61%)	**Representational** Supportive Expressive Therapy-Parent-Child (SET-PC) 16 sessions	Parent-child interaction (Crowell Procedure) Parent psychological wellbeing (BSI) Parenting stress (PSI) Parenting satisfaction (PSS) Child behaviour (CBCL; ECBI)	<u>Parent-child interaction outcomes</u> • Sig. post-test improvements in parent-child interactions (Crowell Procedure) in both groups (np^2=0.77) • Sig. diff. between groups in favour of comparison on parent positive behaviour (np^2=0.160), maintained at follow-up (np^2=0.130) <u>Parent outcomes</u> • Sig. post-test improvements in parent psychological functioning (BSI: np^2=0.35) and parent stress (PSI: np^2=0.24, small effect) in both groups • No sig. post-test improvements in parenting satisfaction (PSS) <u>Child outcomes</u> • Sig. post-test reductions in child externalising behaviour (CBCL, np^2=0.50; ECBI, np^2=0.36) in both groups. • Child behaviour outcomes maintained at follow-up with a reduced effect (np^2=0.130) in both groups
Canada	<u>N=54</u> Treatment=27 Comparison=27	Alternative treatment: IYPP (Webster-Stratton, 2001)	Pre-test Post-test (+3mnth) (5.5%) Follow up (+1yr) (11%)	

Table 2. *continued*

Study **Quality rating** **Country**	**Participants** **Sample size**	**Intervention** **Comparison**	**Outcome measures** **Assessment points** (attrition rates)	**Main findings** *(All effect sizes are reported in favour of the intervention condition unless otherwise stated)*
Magill-Evans et al. (2007) **Good** Canada	Parent First time fathers Child Age range 5-8mnth 85 male (52.5%) N=162 Intervention=81 Control=81	**Behavioural** Brief educational-behavioural intervention. 2 home-visits 1 home-visit Videotaped interaction with no review or feedback. + discussion with home visitor re age appropriate toys.	Parent-child interactions (NCATS) Parenting sense of competence (PSOC) Pre-test (infant 5mnth) Post-test (infant 8mnth) (4%)	Parent-child interaction ・ Sig. intervention effect on parent-child interactions (NCATS) total score (np^2=0.07) ・ NCATS subscales: ・ Sig. intervention effect on Sensitivity to Cues (np^2=0.23) ・ Sig. intervention effect on Cognitive Growth Fostering (np^2=0.06) ・ No sig. intervention effect on Social-Emotional Growth Fostering Parent outcomes ・ No group diff. in parental self-efficacy or satisfaction (PSOC).
Spieker et al. (2012) **Good** USA	Parent Caregivers (56 biological parent, 65 kin, 89 foster carer) Child Children in state care with a recent placement disruption Mean age 18.3mnths 118 male (56.2%) N=210 Intervention=105 Comparison=105	**Behavioural** Promoting First Relationships (PFR) 10 home-visits Alternative treatment - Early Educational Support 3 home-visits	Carer sensitivity (NCATS) Care-child interaction (IPCI) Carer commitment to child (TIMB) Understanding of child behaviour (RAB) Care stress (PSI-SF) Child attachment security (TAS45, Child competence (BITSEA) Child behaviour (CBCL) Pre-test Post-test (17%) Follow-up (6mnth) (39%)	Parent-child interactions ・ Sig. intervention effect on parental sensitivity (NCATS, d=0.41) ・ Improvements not maintained at follow-up, but direction of difference favoured intervention group. Parent outcomes ・ Sig. intervention effect in improving carer's understanding of child needs (RAB, d=0.36) and perceived child competence (BITSEA, d=0.42) ・ No sig. intervention effects on caregiver stress (PSI-3) or commitment to child (TIMB). Child outcomes ・ No sig. intervention effects on child attachment security (TAS45)

Table 2. *continued*

Study **Quality rating** **Country**	**Participants** **Sample size**	**Intervention** **Comparison**	**Outcome measures** **Assessment points** (attrition rates)	**Main findings** *(All effect sizes are reported in favour of the intervention condition unless otherwise stated)*
Benzies et al. (2013) **Good**	<u>Parent</u> First-time biological fathers <u>Child</u> Healthy, singleton, late-preterm infants (34–36wk gestation) 63 male (56.8%)	**Behavioural** Brief educational-behavioural intervention using video-feedback 2 or 4 home-visits	Parent-child interaction(PCITS) Parent stress(PSI-3) Parent perceptions(WPL-R)	<u>Parent-child interactions</u> ・ Sig. overall intervention effect on total PCITS score (partial n^2=0.061) with greater improvements in 4-visit group. ・ PCITS subscale analyses: ・ Sig. intervention effect on Cognitive Growth Fostering (partial n^2=0.056) ・ Sig. intervention effect on Social-Emotional Growth Fostering (partial n^2=0.060) ・ No sig. intervention effect on Sensitivity to Cues ・ No sig. intervention effect on Total Child PCITS scores (interaction skills) <u>Parent outcomes</u> ・ No sig. intervention effect on PSI-3 scores ・ No sig. intervention effect on WPL-R scores <u>Interaction effects</u> ・ Parent PSI-3 scores sig. correlated with Total Child PCITS scores (r= -0.27)
Canada	<u>N=111</u> 2-visit intervention=46 4-visit intervention=23 Control=42	1 home-visit (video-taped interaction without feedback + educational hand-outs about age-appropriate play + telephone discussion with therapist about infant play)	Pre-test (infant 4mnth) Post-test (infant 8mnth) (1.8%)	

Table 2. *continued*

Study **Quality rating** **Country**	**Participants** **Sample size**	**Intervention** **Comparison**	**Outcome measures** **Assessment points** (attrition rates)	**Main findings** *(All effect sizes are reported in favour of the intervention condition unless otherwise stated)*
Moss et al. (2011) **Moderate**	Parent Parents reported for maltreatment Child Age range 12-71mnth (mean 40.2)	**Behavioural** Parent-child Interaction Therapy (PCIT) 8 home visits	Parental sensitivity (MBQS) Child attachment security (SSP) Child behaviour (CBCL)	Parent-child interaction • Sig. intervention effect on parental sensitivity (MBQS, d=0.47) Child outcomes • No sig. intervention effects on child behaviour scores (CBCL) • Sig. intervention effect on improvements in child attachment security (SSP) (r=0.36) and reductions in attachment disorganisation (r=0.37)
Canada	N=67 Intervention=35 Control=32	TAU (monthly visit by child welfare caseworker)	Pre-test Post-test (11%)	
Kalinauskiene et al. (2009) **Moderate**	Parent First-time mothers screened for low sensitivity. Child Highly reactive vs. less reactive temperament 28 male (51.9%)	**Behavioural** Video-feedback Interaction to Promote Positive Parenting (VIPP) 5 home-visits,	Parental sensitivity (ARSS) Parent stress (DHS) Parent sense of competence (PEQ) Parent psychological functioning (BDI) Child attachment security (AQS) Idiosyncratic measure of child temperament	Parent-child interaction • Sig. intervention effect on parental sensitivity (ARSS, *d*=0.78) Child outcomes • No sig. intervention effect on child attachment security (AQS) Interaction effects • Maternal sensitivity sig. correlated with parental sense of competence (r=0.32) and child attachment security (r=0.44) • No sig. diff. in high vs low reactive infants mothers' post-test sensitivity or infant attachment sensitivity
Lithuania	N=54 Intervention=26 Control=28	Telephone contact to discussion child development, no advice offered	Baseline (infant 6month) Post-treatment (infant 12mnth) (0%)	

Table 2. continued

Study **Quality rating** **Country**	**Participants** **Sample size**	**Intervention** **Comparison**	**Outcome measures** **Assessment points** (attrition rates)	**Main findings** *(All effect sizes are reported in favour of the intervention condition unless otherwise stated)*
Van Zeijl et al. (2006) **Moderate**	Parent Mothers Child Children with high levels of externalising behavioural problems Age range 13.58-41.91mnth (mean 29.99) 133 Male (56%)	**Behavioural** Video-feedback Interaction to Promote Positive Parenting - Sensitive Discipline (VIPP-SD) 6 home-visits	Child behaviour (CBCL) Parental attitudes towards sensitivity and sensitive disciplining (unpublished questionnaire) Parenting sensitivity (unpublished rating scale) Parental discipline (observation data and unpublished rating scale)	Parent-child interactions ・ Sig. intervention effect on parental positive discipline (n^2=0.03) Parent outcomes ・ Sig. intervention effect on parents' attitudes towards sensitivity (n^2=0.07) and sensitive discipline (n^2=0.02). Child outcomes ・ No sig. intervention effect on child behaviour Interaction effects ・ Sig. intervention effect on child behaviour in families with high marital discord (n^2=0.03) and high reported daily hassles (n^2=0.03)
Netherlands	N=237 Intervention=120 Comparison=117	6 x telephone discussion re child development, no advice or information provided	Pre-test Post-test (3.3%)	

Table 2. continued

Study **Quality rating** **Country**	**Participants** **Sample size**	**Intervention** **Comparison**	**Outcome measures** **Assessment points** (attrition rates)	**Main findings** *(All effect sizes are reported in favour of the intervention condition unless otherwise stated)*
Jagermann & Klein (2010) **Moderate**	<u>Parent</u> Mothers <u>Child characteristics</u> Children with sensory processing difficulties (SPD) Age range 12-18mnth 47 male (54.7%)	**Behavioural** Mediational Intervention for Sensitising Caregivers (MISC-SP) 6-8 sessions	Parent-child interaction (CIB; OMI)	<u>Parent-child interaction</u> ・ Sig. intervention effect on CIB Sensitivity and Responsiveness and Mutual organisation subscales ・ Sig. intervention effect on OMI Communication behaviour and Teaching behaviours subscales. ・ No. sig post-test diff. between SI and control groups CIB or OMI scores.
Israel	<u>N=86</u> MISC-SP intervention=30 Child intervention=28 Control=28	Alternative treatment SI- sensory integration (child-focused sensory integration treatment) *OR* Control (general developmental guidance provided to parents)	Pre-test Post-test (9.5%)	

Table 2. continued

Study **Quality rating** **Country**	**Participants** **Sample size**	**Intervention** **Comparison**	**Outcome measures** **Assessment points** (attrition rates)	**Main findings** *(All effect sizes are reported in favour of the intervention condition unless otherwise stated)*
Bilszta et al. (2012) **Moderate**	Parent Mothers with clinically significant psychological symptoms receiving inpatient psychiatric care Child Mean age 5.8mnth	**Combined approach** Video-feedback to improve maternal parenting. 1-7 (Mean 3.2) sessions	Parent mental health (EPDS) Parent perceptions of infant behaviour (NPI) Parenting sense of competence (PSOC)	Parent outcomes ・ Parental mental health (EPDS) improved in all groups - no sig. diff. between groups ・ Parental sense of competence (PSOC) improved sig. in comparison groups only ・ No improvements in parent perceptions of infant behaviour (NPI) across groups ・ Video mothers more likely to report no change in parenting confidence the more feedback sessions completed
Australia	N=74 Video=25 Verbal=26 Control=23	Verbal control (parent-child play interaction with no video-recording and verbal-only feedback + information on attachment) *OR* TAU control	Pre-test Post-test (15%)	

Table 2. continued

Study **Quality rating** **Country**	**Participants** **Sample size**	**Intervention** **Comparison**	**Outcome measures** **Assessment points** (attrition rates)	**Main findings** *(All effect sizes are reported in favour of the intervention condition unless otherwise stated)*
Klein Velderman et al. (2006a) **Moderate**	Parent First-time mothers screened for insecure attachment Child Highly reactive vs. less reactive Age range 7-10mnths	**Behavioural** Video-feedback Interaction to Promote Positive Parenting (VIPP) 4 home visits *OR* **Representational** VIPP- R 4 home visits	Parental sensitivity (ARSS) Child attachment security (SSP)	Parent-child interaction ・ Sig. intervention effect on maternal sensitivity (ARSS) for both VIPP (d=0.49) & VIPP-R (d=0.52) Child outcomes ・ No sig. intervention effects on child attachment security (SSP), but trend toward more securely attached children in intervention Interaction effects ・ Intervention mothers of highly reactive infants showed greater post-test improvements in sensitivity (d=0.47) ・ Positive correlation between maternal sensitivity (ARSS) and infant attachment security (SSP) (r=0.25, d=0.52) ・ No. sig. differences in high vs. low reactive infant's attachment security.
Netherlands	N=81 VIPP=28 VIPP-R=26 Control=27	Video-taped interactions only, no feedback	Pre-test (infant 6mnth) Post-test (infant 11mnth) Post-test (infant 13mnth) (5.5%)	
Klein Velderman et al. (2006b) **Moderate**	*As above.*	*As above.*	Child behaviour problems (CBCL) Parental sensitivity (ARSS, EAS) Child attachment security (AQS, SSP)	Parent-child interaction ・ No sig. long-term intervention effects on maternal sensitivity (EAS) for both groups. Child outcomes ・ Sig. long-term intervention effect on child externalising and total behaviour scores (CBCL) for VIPP group ・ No. sig intervention effect of VIPP-R on child behaviour scores (CBCL) Interaction effects ・ No sig. association between maternal sensitivity and child behaviour
Netherlands	*As above.*	*As above.*	*As above* Follow-up (child 40mnth) (3.7%)	

				scores ・ No sig. interaction effects of child temperament or attachment security on behaviour

Outcome measures: AQS- Attachment Q-sort; **ARSS-**Ainsworth's Rating Scale for Sensitivity**; BDI-**Beck's Depression Inventory; **BITSEA-**Brief Infant Toddler Social and Emotional Assessment; **BSI-**Brief Symptom Inventory; **CBCL**-Child Behaviour Check List; **CBI**-Coding Interactive Behaviour system; **DHS-**Daily Hassles Scale; **IPCI-**Indicator of Parent-Child Interaction; **EAS**-Emotional Availability Scales; **ECBI**-Eyberg Child Behaviour Inventory; **EPDS**-Edinburgh Postnatal Depression Scale; **MBQS**- Maternal Behaviour Q-sort; **NCATS**- Nursing Child Assessment Teaching Scale; **NPI-**Neonatal Perception Inventory; **OMI-**Observing Mediational Interaction system; **PCITS**-Parent Child Interaction Teaching Scale; **PEQ-**Perceived Efficacy Questionnaire; **PSI**-Parenting Stress Index (SF-short form); **PSOC-**Parenting Sense of Competence scale; **PSS**-Parenting Satisfaction Scale; **QKATP-**Questionnaire concerning Knowledge and Attitudes Towards Parenting; **RAB**-Raising A Baby; **SSP**-Strange Situation Procedure; **TAS45**-Toddler Attachment Sort-45; **TIMB-**This Is My Baby; **WPL-R**-What Being the Parent of a Baby Is Like-Revised.

Discussion

Key Findings

This review supports the findings of previous reviews (Bakermans-Kranenburg et al., 2003; Bakermans-Kranenburg et al., 2005; Fukkink, 2008) and offers further empirical evidence for the efficacy of video-feedback interventions in enhancing parental sensitivity. Ten of the included studies directly examined the impact of interventions on parental sensitivity and the quality of parent-child interactions. Of these, nine reported significant improvements following video-feedback intervention, with medium to large effect sizes. Those that found the largest effect sizes were amongst the most methodologically robust of the reviewed studies, thus increasing the validity of reported findings. The number of intervention sessions ranged from two to sixteen, with as few as two intervention sessions found to be effective in enhancing the quality of parent-child interactions.

Interventions proved to be less effective in improving parent outcomes. Only three of the included studies reported significant post-test intervention effects on parent outcomes compared to controls. These included: reduced stress and improved psychological functioning (Cummings & Wittenberg, 2008), greater understanding of child's needs and perceived child competence (Spieker et al., 2012); and improved attitudes towards sensitivity and sensitive discipline (van Zeijl et al., 2006). Reported effect sizes were small and, where assessed, effects were not maintained at long-term follow-up (Cummings & Wittenberg, 2008). Unfortunately, limitations in the methods used to assess parent outcomes and reduced power of analyses due to small sample sizes, mean that these findings are not sufficient to draw reliable conclusions.

Similarly, intervention effects for child outcomes were inconsistent. Interventions were found to be effective in reducing child externalising behaviour problems in three studies (Klein Velderman et al., 2006a, 2006b; Cummings &Wittenberg, 2008) and, where assessed, were maintained at long-term follow-up (Klein Velderman et al., 2006b). Only one study (Moss et al. 2011) reported significant improvements in child attachment security following intervention when compared to controls, and while another reported a trend toward greater attachment security, this was not found to be significant (Kalinauskiene et al. 2009).

Interventions with a behavioural focus were favoured over those with a representational or combined focus. One study would suggest that both behavioural and combined focus approaches are equally effective in improving parental-sensitivity and the quality of parent-child interactions; however, their behavioural-focused approach was found to be more effective in improving child behavioural outcomes than their combined approach (Klein Velderman et al. 2006b). One proposed explanation for this is that the combined focus intervention, with its emphasis on exploring parental attachment representations, occupies greater emotional attention and can result in increased feelings of tension in the parents, thus reducing the effectiveness of the behavioural component (Klein Velderman et al. 2006b). Only one study employed an intervention that was primarily representational in focus (Cummings & Wittenberg, 2008), therefore it is not possible to draw reliable conclusions about effectiveness of representational approaches from the studies appraised in this current review alone.

Interestingly, a number of significant interaction effects were found between a number of parent and child variables and intervention outcomes. Parents of children with more difficult temperaments were found to gain the most benefit from intervention in terms of enhanced sensitivity (Klein Velderman et al., 2006a). Increases in parents' sense of competence were associated with enhanced sensitivity (Kalinauskiene et al., 2008), and increased sensitivity was associated with greater attachment security (Klein Velderman et al., 2006b; Kalinauskiene et al., 2008). The latter is consistent with previous research in this area (e.g. de Wolff & van IJzendoorn, 1997), and offers promising evidence for the potential benefits of video-feedback interventions in enhancing attachment security in the long-term.

Limitations of this review

The current review is limited by a number of methodological factors. First, the exclusion of non-English language studies has potentially induced a language bias. This may be particularly relevant for this review, as video-feedback approaches appear to be widely researched worldwide, and a number of potentially relevant non-English language articles were identified following the systematic search strategy. Second, the exclusion of non-journal publications may have resulted in a publication bias. This could potentially lead to an overestimation of the effects of intervention, as studies reporting findings in support of their hypotheses are more likely to achieve publication (Ferguson & Brannick, 2012). Finally, the use of the CTAM to evaluate study quality potentially has its limitations. The CTAM is concerned primarily with the assessment of methodological quality, rather than the risk of systematic bias per se. Biases within the study design may result in an over- or under-estimation of true intervention effects. Attempts were made, however, to overcome this

limitation by adapting the CTAM measure to include additional items to assess the risk of bias within studies.

Conclusions

Video-feedback appears to be a useful therapeutic tool that has the potential to effect considerable therapeutic change when used with family populations. By supporting parents to reflect on their interactions with their child, and learn to accurately identify and promptly respond to their child's needs, video-feedback interventions are effective in enhancing the quality of parent-child interactions. Unfortunately, variability in the findings of included studies mean it is not possible to draw reliable conclusions about the effects of video-feedback interventions on additional parent and child outcomes from this review alone. There is, however, some promising evidence to suggest that behavioural-focused video-feedback interventions targeting parent sensitivity can protect children against the development of behavioural problems at pre-school age, when delivered within the 1st year of life (Klein Velderman et al., 2006b). Furthermore, correlational evidence from the reviewed studies appears to suggest that video-feedback interventions aimed at improving parent sensitivity can support changes in parent behaviour and perceived competence, which in turn facilitates the development of greater attachment security (Kalinauskiene et al., 2008). Importantly, none of the included studies reported any adverse effects of video-feedback intervention for parents or children.

Implications for clinical practice

The findings of this review have important implications for mental healthcare providers, particularly for those delivering support to families with young children within an early

intervention framework. The studies appraised in this current review confirm the findings of earlier reviews and add yet further support to the 'less is more' hypothesis (Bakermans-Kranenburgh et al., 2003), with as few as 2 intervention sessions found to be effective. The evidence is compelling that brief and focused interventions can lead to powerful and significant changes in parents' ability to successfully negotiate interactions with their children. Such interventions can be delivered in a cost-effective way to directly target those aspects of parent-child relationships that have been found to increase resilience and foster greater attachment security, thus potentially breaking the intergenerational cycle of poor outcomes.

Recommendations for future research

Many of the reviewed studies lacked power due to small sample sizes and high attrition rates. Larger sample sizes would allow for more reliable measures of intervention effectiveness, and the fair comparison of the magnitude of experimental effects from one study to another. Additionally, only three of the included studies provided long-term follow-up data, and those that did were limited by high drop-out rates and thus reduced power. One study found significant long-term effects on parent-child interactions (Cummings and Wittenberg, 2008). This finding is encouraging and it would be reasonable to expect that infant attachment security would improve gradually over time with the increasing accumulation of sensitive and attuned parent-child interactions. It may be that the studies included in this review did not follow-up outcomes long enough to observe this effect. More research is required to investigate this further and future studies should aim to monitor the long-term effects of video-feedback interventions on parent-child interactions, and ultimately, child attachment security. Furthermore, in this review, those studies examining

the effects of intervention on child attachment security did not recruit participants on this basis. As such, it may be that any effects of the intervention on attachment security were not detected due to limited scope for improvement. Future studies may wish to recruit on the basis of low attachment security and high disorganisation (Kalinauskiene et al., 2009)

Increasingly the focus of video-feedback studies appears to be shifting from the question of 'what works?' to 'what works for whom?', and many studies have begun to explore the effects of video-feedback interventions on different population groups (van IJzendoorn, Bakermans-Kranenburg, & Juffer, 2008). While the studies in this review primarily recruited mothers, interventions also appear to be effective for populations of fathers (Benzies et al., 2013; Magill-Evans et al., 2007) and non-biological carers (Spieker et al., 2012); however, more research is needed before reliable conclusions can be drawn. In addition, a number of studies have reported on the moderating role of participant variables on intervention outcomes. This is an interesting step forward in the research field, which may offer further insights into how interventions may be most effectively delivered and targeted to specific population groups.

Finally, much remains unknown about the mechanisms of change underpinning the success of video-feedback interventions (Doria, Kennedy, Strathie & Strathie, 2013). In the process of searching for studies for inclusion in the current review, a number of studies reporting qualitative data were identified. It may be that this qualitative data can shed some light on this question and qualitative explorations of service user experiences of interventions may offer valuable insights into the processes of change experienced during and following participation in video-feedback approaches.

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Chapter Two: Major Research Project

Therapeutic Application of the Marschak Interaction Method (MIM): An Interpretative Phenomenological Analysis of Parents' Experiences and Reflections

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Plain English Summary

Background

The importance of early relationships in supporting healthy child development is widely recognised; and difficulties in the quality of parent-child interactions are associated with an increased risk of social and emotional difficulties in the child. As such, therapeutic interventions in child mental healthcare settings are often aimed at supporting the parent to interact with their child more effectively, to reduce this risk. The Marschak Interaction Method (MIM) is a videotaped and play-based assessment of the nature and quality of parent-child relationships. The parent and the child are videotaped while they engage in a series of play-based tasks. The parent will then have the opportunity to watch the video footage with their therapist, who points out areas of strength and difficulty in their interactions. The MIM was originally intended for assessment purposes prior to delivering therapeutic intervention; however, it has been suggested that it may have additional benefits beyond this rather narrow application. Reviewing the videotaped footage of MIM is believed to lead to changes in parents' attitudes and understanding, which helps them to interact better with their child. Within the family therapy literature, there is a strong evidence base for the use video-feedback in this way, and such video-feedback approaches have been found to be effective in improving the quality of parent-child relationships.

Aims

This study aimed to explore parents and caregivers experiences of the MIM to provide a better understanding of how it may be used therapeutically. In-depth interviews with parents and primary caregivers were conducted.

Results

Detailed analysis of participant accounts revealed that the MIM was experienced as a valuable learning process that provided parents and caregivers with new insights, which increased their understanding and gave them more confidence in their parenting abilities. This process was emotive and participants emphasised the importance of a trusting relationship with their therapist to support them to manage any concerns that may arise.

Conclusions

These findings offer the first insights into how the MIM is experienced by parents and caregivers, which has important implications for its use in clinical practice.

Abstract

Background: The Marschak Interaction Method (MIM; Marschak, 1960) is a video-based observational assessment of parent-child interactions and relationships (Lindaman, Booth, & Chambers, 2000). Parents are videotaped while they engage with their child in a series of play-based tasks, followed by a therapist-guided reflective review of the interaction. This process is intended to highlight areas of strength and difficulty within parent-child interactions to be addressed in subsequent therapeutic intervention; however, initial reports suggest that the MIM may have additional therapeutic utility beyond this rather narrow application (Lindaman et al. 2000). There is a growing evidence base for the use video-feedback in family interventions to improve the quality of parent-child interactions (Fukkink, 2008). Such approaches are believed to enhance parental reflective capacity and sensitivity to their child's needs, thus supporting more positive parenting behaviour (Svanberg, 2009). The MIM is similar in its approach to other video-feedback interventions, and so conceivably may effect comparable therapeutic action; however little is known about parents' experiences of the MIM. **Aims:** This study aimed to explore the therapeutic nature of the MIM through interpretative phenomenological analysis (IPA) of parents' and caregivers' experiences. **Methods:** In-depth interviews were conducted with six parents and primary caregivers who had participated in the MIM as part of on-going therapeutic assessment and intervention with their child. **Results:** Analysis of participant accounts identified five key themes concerning; their experiences of the MIM interactional procedure, reflective and emotional processes and the therapeutic factors that supported these, and subsequent attitude and behaviour change. **Conclusions:** Findings suggest that the MIM has potential therapeutic utility as a brief video-feedback intervention to support

positive parent-child interactions. This therapeutic hypothesis is discussed in relation to current theoretical explanations for the efficacy of video-feedback interventions in child and family mental healthcare practice. Further research is needed to test the clinical effectiveness of the MIM in improving parent-child outcomes.

Introduction

The Importance of early relationships

The importance of early parent-child relationships is widely recognised, and the quality of such relationships has been shown to be predictive of later psychosocial outcomes (Sroufe, Egeland, Carlson, & Collins 2005). While disruptions within early caregiving relationships present a significant risk factor for the development of child emotional and behavioural difficulties (Greenberg, 1999); positive parent-child relationships are associated with improved emotional regulation, social competence and enhanced resilience throughout life (Svanberg, 1998). Within the attachment literature, parental sensitivity (Ainsworth, Blehar, Waters, & Wall, 1978; de Wolff & van IJzendoorn, 1997) and reflective capacity (Fonagy & Target, 1997; Slade et al., 2005) have been identified as being of fundamental importance to the development of positive parent-child relationships and greater attachment security. This has significant implications for mental healthcare research and practice, and family interventions are increasingly targeting these antecedents of attachment security with a view to enhance wellbeing and promote positive future outcomes (Rusconi-Serpa, Sancho Rossignol, & McDonough, 2009; Svanberg, 2009).

Video-feedback to promote positive parenting

Video-feedback interventions in clinical practice begin with the video recording of parent-child interactions, followed by a joint parent and therapist reflective review of selected video clips. Such interventions vary in terms of the focus of the feedback, but all share the primary aim to generate insight and strengthen parent-child relationships by reinforcing instances of positive reciprocal interactions (Svanberg, 2009). In general video-feedback

interventions fall into two broad approaches: those that support parents to develop greater sensitivity to their child's needs at a behavioural level; and those that encourage parents to consider how aspects of their own attachment representations are played out in interactions with their child (Fukkink, 2008). Often interventions combine efforts and those directed at the representational level, may address difficulties in the parent's own attachment organisation to enable subsequent change at the behavioural level (Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2008). There is a growing evidence base for the efficacy of video-feedback interventions in family programmes. Meta-analytic findings have reported that brief and focused interventions targeting parental sensitivity are the most effective in improving parent-child relational outcomes (Fukkink, 2008; Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003, 2005).

The proposed therapeutic efficacy of video-feedback approaches

A number of theoretical explanations have been offered for the success of video-feedback approaches. van IJzendoorn, Bakermans-Kranenburg, and Juffer (2008) propose that the power of video-feedback is in the positioning of the parent as an observer. This provides them with an objective view of their interactions with their child, which enables them to tune in to the child's signals and responses and become more sensitive to their needs (van IJzendoorn et al., 2008). Psychoanalytical perspectives emphasise the importance of video-feedback in developing parents' reflective capacity and mentallisation ability (Zelenko & Benham, 2000; Jones, 2006; Beebe, 2010; Lena, 2013). This refers to the parent's ability to hold the child in mind and reflect upon their internal states (Fonagy, Steele, Steele, Higgit, & Target 1994). Such capabilities in the parent are associated with increased empathy and attuned responsiveness, which have been identified as central to the development of

positive parent-child relationships and secure attachment (de Wolff & van IJzendoorn, 1997; Fonagy & Target, 1997; Slade 2005). Additionally, it has been proposed that the process of self-observation can accelerate access to early memories and support parents to become more self-reflective. This enables them to make sense of the factors guiding their interactions with their child in the context of their own attachment representations (Zelenko & Benham, 2000; van IJzendoorn et al., 2008). This process promotes insight, thus reducing the likelihood that disruptions in the parents' attachment relationships will be transmitted to their relationship with their own child (Beebe, 2010). In this sense increased reflective capacity in the parent is believed to increase resilience and reduce the risk of emotional and behavioural difficulties in the child (Fonagy et al., 1994).

From a behavioural perspective self-observation is widely regarded as an effective approach to encourage learning and subsequent behaviour change (Buggey & Ogle, 2012). Self-model theory proposes that cognitive processes associated with learning are more reactive when observing one's self as opposed to observing another (Dorwick, 2012). Video-feedback enables parents to directly observe their interactions with their child, rather than relying on memories. In this way parents are actively involved in a process of self-regulated learning (Benzies et al., 2013). Self-regulated learning requires an awareness of one's own behaviour in order to successfully appraise and adapt future performance accordingly. Dowrick (2012) proposes that video accelerates this process, as viewing one's self is associated with increased cognitive stimulation, more focused attention and higher emotional arousal, compared with viewing a model. When the feedback is focused on instances of positive and attuned interaction it can provide a behavioural reinforcement that enhances parents' self-efficacy (van IJzendoorn et al., 2008), which according to Bandura's (2001) social cognitive

theory, is crucial in determining behaviour change. Bandura proposes that in order to make changes in their behaviour, people must first believe that they are able to do so effectively (Bandura, 2001).

The Marschak Interaction Method (MIM): an overview

The Marschak Interaction Method (MIM; Marschak, 1960) is a semi-structured observational approach to assess the nature and quality of parent-child interactions (Lindaman, et al. 2000). It consists of a series of videotaped play-based tasks intended to elicit patterns of interaction that can be categorised across four dimensions of attachment behaviours: structure, engagement, nurture, and challenge. It assesses the parent's ability to set limits for the child and create feelings of safety and containment in the environment (structure); to support the child's achievement and instil a sense of self-efficacy by selecting developmentally appropriate tasks (challenge); to engage the child in reciprocal interactions and co-regulate the child's emotional state to create an optimal level of arousal (engagement); and to recognise and respond empathically to the child's needs for comfort and soothing (nurture). The MIM is also concerned with the child's ability to respond to the parent's behaviour and to communicate their needs. In addition, it employs a separation-reunion task to examine how the parent and child negotiate a brief period of separation and how they manage their reunion. The MIM concludes with a video-feedback session, whereby the parent and therapist jointly review the videotaped footage (Lindaman et al., 2000; Booth & Jernberg, 2010).

The MIM is primarily used for assessment purposes prior to delivering Theraplay; an attachment-based therapeutic model for clinical intervention that aims to facilitate the

development of positive parent-child relationships through play (Booth & Jernberg, 2010). In recent years the MIM has gained increased recognition as a valuable tool for assessing the quality of parent-child interactions (Hitchcock, Ammen, O'Connor, & Backman, 2008; Martin, Snow & Sullivan, 2008; Siu & Yuen, 2010; Bojanowski & Ammen, 2011). As an observational approach it provides a rich source of information and offers insights into the nature of parent-child relationships, which can be used to inform intervention planning. Participants are actively involved in a number of novel tasks that bring to light patterns of interaction that may be out-with their awareness, and so not accessible through more conventional interview and self-report methods. The structure of the MIM across the four dimensions of attachment behaviours provides a framework for assessment that enables interventions to be targeted towards specific areas of need. Videotaping the procedure allows for repeated viewing to ensure that important observations are not missed. The MIM may then subsequently be used to monitor the impact of therapeutic intervention on the parent-child relationship (Lindaman et al., 2000). Unlike other relational observation methods, such as Ainsworth's Strange Situation Procedure (SSP; Ainsworth et al. 1978), the MIM is suitable for use with children of all ages as tasks are selected to match the child's developmental stage. Furthermore, the MIM examines the overall quality of the parent-child relationship, with a view to identify both strengths and limitations within their interactions, rather than focusing solely on attachment security (Lindaman et al., 2000).

Therapeutic application of the MIM

During the video-feedback session of the MIM, the clinician carefully selects video clips that highlight both positive and problematic patterns of interaction, and guides the parent to reflect upon their own and their child's internal experiences. This process is said to generate

unique insights by allowing parents the opportunity to observe first-hand the factors that may be contributing to experienced difficulties in their interactions with their child (Booth & Jernberg, 2010). Parents are supported to reflect upon the influence of their own attachment experiences on their relationship with their child to support greater understanding. The therapist will highlight instances of positive interaction to enhance the parent's sense of competence and provide positive reinforcement to encourage future repetition of such behaviours. Parents are then encouraged to consider how they may negotiate future interactions more effectively to strengthen their relationship with their child (Lindaman et al., 2000; Booth & Jernberg, 2010). This procedure is in keeping with the video-feedback interventions discussed above, combining aspects of both behavioural and representational approaches. Much like other video feedback approaches the MIM aims to enhance the parent's reflective capacity and encourages greater sensitivity to the child's needs (Lindaman et al., 2000; Booth & Jernberg, 2010), suggesting that it may have considerable therapeutic utility beyond its primary application as an observational assessment method (Lindaman et al., 2000).

Existing evidence and anecdotal clinician reports offer some support to the use of the MIM as a therapeutic intervention. Participation in the MIM alone has been reported to have a positive impact on parent-child relationships (Lindaman et al., 2000). Clinicians have reported that the joint reflective review of videotaped MIM interactions with parents is often experienced as something of a "turning point" in therapy (S. Gleeson, personal communication, August 2012). Lindaman et al. (2000) report that this process appears to break down negative perceptions by encouraging parents to consider the child's perspective and develop greater empathy for the child's emotional and developmental needs. In

addition, Booth and Jernberg (2010) note that the MIM provides an opportunity for the therapist to express empathy for the parent's struggles, which can work to strengthen the therapeutic relationship and facilitate engagement. The MIM remains a relatively under-researched approach and little is known of how it is experienced from the perspective of parents and caregivers. Further research is required to explore the therapeutic nature of the MIM in order to understand how it may be most usefully applied clinically.

The importance of qualitative enquiry

Mental health-care research is increasingly recognising the role of the service user perspective in informing practice and shaping service delivery (Macran et al., 1999). This is important for a number of reasons. Researching client perspectives and experiences can help us to better understand the action and efficacy of therapy. Qualitative research with service users allows us to evaluate therapeutic interventions in a more collaborative way that supports clients to share their experiences and express their views (Macran et al., 1999). This can increase the reliability of existing evidence and offer new insights to previously unrealised therapeutic processes and outcomes (Hodgetts & Wright, 2007). It also ensures careful monitoring and thorough exploration of any adverse or unexpected effects (Macran et al., 1999). Not only is it useful to obtain client's perceptions and experiences of therapeutic processes, but it is also ethical to do so (Thornicroft & Tansella, 2005), and there is clear policy guidance that highlights the importance of involving service users in psychological research (e.g. Department of Health, 2001; British Psychological Society, 2005).

Aims

This study aimed to explore the therapeutic nature of the MIM, through qualitative analysis of parents and caregivers experiences, when applied in the context of interactional difficulties with their children.

Methods

Design

This cross sectional study employed interpretative phenomenological analysis (IPA; Smith, 1996). The primary aim of IPA is to understand the personal meanings that individuals ascribe to their experiences. IPA also acknowledges what the researcher brings to the interpretative process and considers how the researcher's prior knowledge and expectations, as well as their interactions with the participant, may influence how they make sense of the participant's account. In this sense it is a double hermeneutical process (Smith et al., 2009). IPA was chosen for this current study over other qualitative approaches because of this focus on individual meaning making. In addition, IPA has theoretical routes in psychology and is commonly used to explore clients' experiences of therapy (Smith, 2011), making it well suited to this current area of research.

Sample

The primary objective of IPA is to obtain "a detailed account of individual experience" (Smith et al., 2009, p. 51). The power of an IPA study is therefore determined by the quality of the insights that it derives (Smith and Osborne, 2008). The level and intensity of analysis of IPA means that it is best suited to a small sample size to allow for in-depth and detailed

analysis within cases and the exploration of themes across cases (Smith, 2011). Between four and ten participants has been cited as the desired sample size for IPA studies (Smith & Osborne, 2008; Smith et al., 2009; Smith, 2011). This study aimed to recruit up to 10 participants, with a view to achieve theme saturation; that is when the maximum number of meaningful perceptions has been explored and the analysis of new data does not produce new insights (Mason, 2010).

Participants were recruited from community paediatric and child and adolescent mental health services within NHS Ayrshire and Arran. Participants were identified on the basis that they were parents or primary caregivers to a child aged 0 to 12 years and had recently participated in the MIM as part of on-going therapeutic assessment and intervention to address interactional difficulties with their child. Each participant had engaged in one videotaped MIM procedure with their child and a second caregiver. This procedure involved each parent engaging with the child individually in a series of play-based tasks, followed by both parents interacting with the child together. Tasks were structured according to the four dimensions of the MIM as outlined above, and included such activities as: parent to build a block structure and child to copy; parent and child to play a game that they both know; parent and child to feed one another; parent to tell the child what he or she was like as a baby. Following the completion of the MIM procedure, the parents had attended a therapist-guided video-feedback session, during which they reviewed the videotaped footage of their MIM procedure, and engaged in a reflective discussion about areas of strength and difficulty in their interactions with their child. Parents and caregivers were considered eligible for participation if they spoke fluent English, were free from a diagnosed communication disorder, and were open to the service and in receipt of care at the time of

recruitment and data collection. Given the exploratory nature of this study, there was no specific focus on child or parent demographic variables. The eligibility criteria for study participants are outlined in Table 1 below.

Table 1. Participant eligibility criteria

Eligible participants
Parents or primary caregivers to a child aged 0 to 12 years.
Recent participation (<6 months) in the MIM as part of on-going therapeutic care.
Fluent in English language and free from diagnosed communication disorder.
Open to NHS Ayrshire and Arran Community Paediatric Service or Child and Adolescent Mental Health Service (CAMHS) and in receipt of on-going care.
Able to give informed consent.

Participants

A total of six participants were recruited. Of these five were biological parents (4 mothers, 1 father) and one was a maternal grandmother and primary caregiver (participant 1). All were two parent families. Children were aged between 6 and 12 years and all presented with a range of difficulties, including; diagnosed learning disabilities, pervasive developmental disorders, or clinically significant symptoms of emotional or behavioural difficulties. All of the participants had completed the MIM procedure within the six months prior to their research interview and in each case the MIM had been completed with the child and two parents. In the case of participant 1 the second parent was the child's biological mother, but for the purposes of this study, the second parents will be referred to as 'partners' from this point fourth. All parents were interviewed individually with the exception of participants 4

and 5, who were interviewed together as a marital couple. Unfortunately, due to technical difficulties, these same participants did not have the opportunity to review the videotaped footage of their MIM during the therapeutic feedback session; however, given the limited timescale of this current study, and anticipated difficulties recruiting further participants, a decision was taken to include them in this current study. Table 2 below provides a summary of participant details. To preserve the anonymity of participants, the clinical characteristics of the child are not reported and gender appropriate pseudonyms have been provided.

Table 2. Participant details

Participant	**Relationship to Child**	**Child's name & age**	**Partner**
1. Elaine	Maternal Grandmother	Katy, 6	Michelle (mother)
2. Anne	Mother	Beth, 9	Joe (father)
3. Kate	Mother	Ben, 12	Dave (father)
4. Susan 5. Michael	Mother Father	Emma, 8	~
6. Marie	Mother	Mikey, 6	John (father)

Research procedures

Participants were identified and approached in the first instance by a clinician within their existing clinical care team with whom they had on-going therapeutic contact. They were provided with a study information leaflet (Appendix 2.1) and given time to consider their participation before being asked to sign a response form to indicate their willingness to participate (Appendix 2.2). The primary researcher (DF) then contacted participants to discuss the study further and answer any questions. Written consent was obtained at the

time of interview by the primary researcher (Appendix 2.3). Interviews were conducted in private clinic rooms within an outpatient community paediatric service by the primary researcher using a predetermined interview schedule (Appendix 2.4). Consistent with IPA guidance (Smith et al., 2009), the interview schedule comprised a number of non-directive open-ended questions enquiring about participants' experiences of the MIM. The structure of this schedule was informed by the process of the MIM and began with more general and descriptive questions to settle participants into the interview process, before progressing to more personal and analytical questions once rapport was established. Specifically, participants were asked about their expectations and experiences of the interactional procedure and the therapist-guided video-feedback, and were encouraged to reflect upon any subsequent changes in their perceptions, attitudes or behaviour. The researcher was guided by the participants' discussion and so a degree of flexibility in the interview schedule was maintained. This allowed participants to present their experiences in a way that was meaningful to them. Following the first interview, the schedule was reviewed with a supervising researcher to ensure that it effectively elicited relevant information. It was deemed effective and no subsequent changes were made. Interviews were audio-recorded and transcribed verbatim. To maintain participant anonymity and confidentiality, names were changed and any personally identifiable information was removed during the transcription process.

Data Analysis

Interview transcripts were analysed following the IPA process as outlined by Smith et al. (2009). This involved the detailed examination of each case individually followed by a search for patterns of convergence and divergence across cases. This process can be summarised in

four key stages: 1) close and careful reading of the interview transcripts to become familiar with the data and highlight points of interest; 2) exploratory noting of initial thoughts and interpretations; 3) the identification of emergent themes; and 4) identifying and mapping connections between themes to create a set of over-arching superordinate themes. This procedure was followed for each case individually before exploring the relationships between themes across transcripts to produce a final list of super-ordinate and subordinate themes.

All interviews were analysed by the primary researcher. To assess the validity and reliability of the primary researcher's interpretations, two supervising researchers, experienced in qualitative analysis and blind to the findings of the primary researcher, provided independent analysis of one transcript. Identified themes were compared and a high level of agreement was achieved.

Researcher Reflexivity

IPA acknowledges the role of the researcher in interpreting the participant's experience. It is inevitable that the interpretation of participant accounts will be influenced in some way by the researcher's perceptions, and "the end result is always an account of how the analyst thinks the participant is thinking" (Smith et al., 2009, p.80). To address this and to help maintain transparency and balance in the analysis, a reflective diary was maintained to consider how the researcher's own attitudes, beliefs and experiences may have shaped the interpretation of participant accounts.

As a Trainee Clinical Psychologist, with an interest in child mental health, the researcher's interpretations were noted to be influenced by knowledge of parental factors involved in the development of positive parent-child relationships and an awareness of psychological processes of change, such as insight and self-reflection. It is possible that a researcher from a different theoretical background may have interpreted the research findings differently. While the researcher was not involved in the therapeutic delivery of the MIM; prior to beginning the research interviews, she had engaged in discussions with clinicians working within the community paediatric service where the research was conducted, to hear about the therapeutic application of the MIM in this setting. In addition, the researcher had familiarised herself with the process of the MIM by observing a videotaped therapy sessions. These experiences provided the researcher with expectations of the perceived therapeutic action of the MIM from the therapists' perspective. Such prior knowledge and expectations may have orientated the researcher towards aspects of participants' accounts that supported these hypotheses. Efforts were made to maintain an unbiased stance when interpreting research data by remaining aware of these issues and actively reflecting upon the implications of these throughout the research process. Furthermore, in an attempt to maintain objectivity and minimise any risk of interpretative bias, the researcher refrained from engaging in reading regarding the theoretical explanations for therapeutic effect of video-feedback until after the data had been collected and analysed.

Ethical Considerations

Approval to conduct this study was granted by the University of Glasgow, NHS Ayrshire and Arran Research and Development Management, and the West of Scotland NHS Research Ethics Committee 4 (Appendices 2.5 - 2.7). All approvals were obtained prior to participant

recruitment. Participation in this research study was voluntary, and it was made clear to participants that they had the right to refuse or withdrawn their consent at any time prior to or during the research process, and that this decision would not impact upon the therapeutic care that they received. Care was taken to ensure that participant confidentiality was maintained at all times and ethical issues were continually monitored and reflected upon throughout the research process.

Results

Throughout the interview process participants spoke at length about their child's difficulties, their journey through services and the challenges that they had encountered along the way. Participants were encouraged to speak openly about their experiences as it was important to them; however, for the purpose of this current study, the following narrative will focus only on those themes within participant accounts that relate to their experience of the MIM. This resulted in five major themes, which are outlined in Table 3 below.

Table 3. Super-ordinate and subordinate themes

Super-ordinate themes	**Subordinate themes**
1. Experiential factors	Apprehension Reflection of reality Discomfort with the MIM tasks
2. Reflective learning	Insight Empathy and understanding Recognition of strengths and capabilities Self-reflection
3. Emotional processes	Rumination and self-doubt Relief and validation Ambivalence
4. Therapeutic factors	Openness The therapeutic relationship Achieving a shared understanding
5. Attitude and behavioural change	Acceptance and positivity Parenting practices Roles and relationships

Experiences of the MIM

Anxiety

All of the participants reflected upon their expectations of the MIM and described feelings of anxiety and uncertainty prior to the interactional procedure. Their main concern appeared to be with being observed, and indeed video-recorded, in their interactions with their child. They spoke of worries about how they would be portrayed as well as the prospect of subsequently reviewing video footage of themselves during the feedback session.

"I think it was just the apprehension of...you're going into a room, cause there's someone- a camera videoing you. The other side of the room there was two people watching you through a window. Erm...then coming back and actually...just watching yourself on TV and then them telling you, stopping it and saying, right we'll watch this and then we'll tell you" (Elaine)

"I just thought I was going to look stupid in front of the camera" (Susan)

Not only did participants feel self-conscious about being video-recorded, but their anxieties appeared to be intensified by the knowledge that the MIM was part of an assessment process and that their behaviour was being observed and appraised by a therapist. There was a sense within participant discussions that this process was experienced as exposing, which resulted in feelings of vulnerability. Some participants reported that they felt scrutinised and were concerned about the possibility of being judged in their interactions with their child.

"cause as a parent you felt like <u>you</u> were under the microscope" (Susan)

"and I don't know whether that's just a natural reaction to have, to think...who are they actually scrutinising here?" (Michael)

Much of this anxiety appeared to be related to feelings of uncertainty and not knowing what to expect. For the most part this initial apprehension was short-lived, and participants reported feeling more at ease during the therapeutic process.

"Oh I didn't really know what I was going into no, so I didn't really know what to think. Aye, a wee bit worried, but it was alright once I was there" (Anne)

"after five minutes, and you engage with your child, usually you forget everything that's going on anyway" (Kate)

The need for prior preparation and explanation to appease this initial anxiety was emphasised.

"I didn't even know what it was. I know [the clinician] explained, but sometimes when people explain things that you've never ever done before, you kind of think, right, what is this?" (Elaine)

"it must be explained properly, that it's not a judgement, cause I think that would be the most thing that would put people off" (Kate)

Two of the participants reflected upon the experience from their partner's perspectives, describing how they continued to feel uncomfortable, which perhaps inhibited their behaviour and impaired their ability to fully engage with the therapeutic process.

"He just knew that- he just- because folk were watching him, do you know what I mean? He just felt uncomfortable" (Anne)

"my partner says that he felt that he was constantly under scrutiny doing it" (Marie)

Reflection of reality

Participants' reports of their experiences of the interactional procedure varied. While some described it as a largely positive experience that provided a realistic portrayal of their interactions with their child; others stated it to be contrived and unnatural, and believed that it provided a false representation of their own, their partner's and their child's behaviour.

"when I watched Dave I never seen- he wasn't acting or his voice hadn't changed, or his manner was the same, you know, and he knows the same for me" (Kate)

"But Emma didn't behave like Emma [...] she really...played up for that. I mean she was like, playing to the gallery! That's what it was like. It was all a show" (Susan)

"And it's running around in your head, thinking, is this a true reflection of how I would play with Emma? And probably not, no. Because I felt quite tense, I felt quite awkward, erm, enforced. It wasn't natural" (Michael)

It appears that the clinical environment and unfamiliarity with the MIM tasks contributed to participants' experience of the therapeutic process as unnatural. Two of the participants provided feedback suggesting how the process could be improved to provide a more naturalistic portrayal of family relationships.

"if you were able to kind of take it out of a clinical environment, and put it in a home, somehow [...] you might, well certainly for me, it would be more natural" (Michael)

"I think...it would have been more comfortable if the videoing had taken place at home...over a longer period, to get a better understanding, instead of just a one-off video" (Marie)

Discomfort with the MIM tasks

Four of the participants voiced their discomfort with certain aspects of the MIM tasks, particularly those concerned with nurturing behaviours, such as applying lotion to each other or feeding one another.

"we didn't like the other task, we were feeding each other, we don't do- that was a more awkward one...because that was just- I felt kind of...a wee bit uncomfortable doing that because we didn't do- we don't do that generally" (Elaine)

"It felt like enforced play, if that makes sense? I knew we were doing things that Emma didn't like, and I knew we were doing things that I would <u>never</u> ordinarily do with her" (Susan)

"what I found unnerving and unreal, was when we had to feed each other [...] I didn't get that. I didn't- I didn't- cause it's not something you would do at home" (Michael)

Much of this discomfort appeared to be related to the novelty of the tasks and the fact that these are things that the families were simply not used to doing; however, there was also a sense of deeper unease, perhaps related to the intimate nature of the tasks and the thoughts and feelings that this evoked. It is possible that, in the context of relationship difficulties, such tasks concerning intimate and nurturing behaviours are at odds with the nature of the relationship, and so are experienced as aversive. The prospect of being observed during such intimate tasks may also have contributed to feelings of discomfort. Participants may have worried about how they would be evaluated in their ability to negotiate these interactions effectively.

"me and Michelle aren't what you call very close...and I found that, the feeding part, hard [...] I just...because it shouldn't be...when I was doing that, it made me feel like, why am I even doing this with her. Why?" (Elaine)

"The other one that, erm...I felt quite awkward with – and I don't know why, because Emma is my own daughter, I bath her, I change her, I cuddle her – I had to put, erm...moisturiser on her, and I just kind of felt that was...I don't know" (Michael)

Reflective learning

Insight

It appeared that following their initial apprehension and anxiety about video-based aspect of the MIM, participants came to value the video and the observational perspective that it offered. They described how the position of looking from the outside in enabled them to see things that were previously out-with their awareness. This offered new insights which

guided participants to re-evaluate their expectations and beliefs. They expressed feeling surprised and enlightened.

"Michelle's interactions with Katy when we watched it back, that surprised me a lot, cause I did not for one second expect that" (Elaine)

"it is rewarding in the sense that you can see a lot of things that you wouldn't have seen normally" (Kate)

"we're all blind until we actually see what we're doing wrong" (Marie)

On the whole, the video-feedback was described as a positive and highly valued learning experience; however, some insights appeared to trigger deeper reflections, which were experienced as unsettling. Here, one mother describes how the interactions that she observed led her to reflect upon her relationship with her son:

"and with that it was as if somebody turned a light bulb on in my head, and I thought...does he love me?...And that was just like somebody going like that with my heart. And I <u>never ever</u> thought about that, until that moment in time, you know. And...I really struggled with that, for a long time, for a good month or so after that" (Kate)

Another mother described how her observations during the video-feedback session made her more aware of her son's communication style and the lack of emotional expression that he showed. She described her own emotional response to this:

"it felt quite sad (sighs) it felt sad in a way...seeing the lack of communication that Mikey has. And...in a way, the lack of feelings...that he shows. Whereas most kids would actually show a lot of feelings, kissing and cuddling...Mikey didn't really show a lot of that" (Marie)

Empathy and understanding

Participants reflected upon a tendency to get caught up in everyday life and overlook more subtle indicators in their child's communications. Here one mother explains how her observations during the video-feedback session helped her to tune in her son's behaviour and responses and become more sensitive to his needs:

"I mean it's...when you've got two kids, it's...you're like that, give me a wee bit of space, give me a minute. But...just watching it, and then the time that he actually spent with just me, his face lit up...which I don't see that often" (Marie)

"seeing the way he was in the video, when it wasn't anything structured...and how he was when it was something structured. Cause when it wasn't structured, he was lost. And you could see it in his face. He didn't know what to do or where to go; whereas in the structure he had a glow on his face cause he knew what he was doing, and he was getting praised for doing it" (Marie)

The insights that the MIM offered appeared to support participants to consider their child's perspective and to understand the different reasons for their behaviour. This helped to

identify misattributions in their perceptions of their child's behaviour, which seemed to result in a more compassionate and empathic view of the child.

"Okay Katy has her moments, and they can be sometimes violent moments, but the majority of the time she's so- she just wants your love and attention" (Elaine)

"I think what I also took from it...that actually she's just a wee girl" (Susan)

"if Mikey has a break down, it's not because he's being bad...it's because he doesn't understand something" (Marie)

Recognition of strengths and capabilities

Participants spoke of being supported to recognise strengths and capabilities that had previously gone unnoticed, particularly so in their partner. It appeared as though the video provided participants with an objective platform, removed from the situation, from which they could observe their partners interactions in a way that they would not normally be able to.

"It was good to see on the video the way Michelle did react with Katy, it was really nice to see" (Elaine)

"it was good watching me and her playing together and then seeing her dad and her playing together, cause her dad works a lot, so he never really does anything like that, so it was good to see" (Anne)

"I can also say, with the two parents...you can find...when you see- you can see other qualities that you've overlooked, you know, that you've obviously not seen they are there, but when you're actually looking at them on a TV, you can accept them and use them and appreciate them" (Kate)

This recognition appeared to trigger a shift in participants' perceptions of their partners, which was said to have wider implications for family roles and relationships. Here, one mother describes her observations of her partner and her son's interactions, which held great significance for her, and seemed to be experienced as freeing and rather liberating:

"I saw in the MIM...Dave can cope with him and Dave can handle him and Dave can get him to do things and Dave can have fun with him and relate to him. I don't need to be there at the back like the assessor making sure it's alright" (Kate)

Not all participants identified such strengths and capabilities. One mother described how the MIM highlighted difficulties in her partner and son's relationship, which she had previously underestimated:

"to see the lack of interaction between his dad and him was a bit of a shock. I knew there wasn't a great amount of interaction because there isn't at home, but it was less than what I thought" (Marie)

Self-reflection

Enhanced self-awareness and self-reflection was present within all but one participant account. Participants discussed how the MIM led them to look inwards and consider how their own thoughts and feelings had influenced their behaviour. Observations of their interactions appeared to trigger deeper reflections regarding the nature of their relationship with their child. While participants 4 and 5 did not experience the video-feedback aspect of the MIM, they too reported undergoing a process of reflection and self-inspection.

"I suddenly thought, oh my goodness, is she so needy because of us, because she had so much of our time, or at least my time" (Susan)

"I started thinking, I wonder if it's me, cause I felt that this is because I'd been away so often that I've kind of gone out of that...mode of ...dad" (Michael)

This act of self-reflection seemed to work to break down barriers and perceptual biases, allowing participants to re-evaluate their previous beliefs and assumptions to consider a new perspective, which ultimately resulted in an enhanced understanding.

"I thought that was like my role, and I had developed my own way of dealing with him and talking to him and getting him to understand me, and I had maybe just put a bit of a barrier up; whereas I shouldn't have been because I was putting it all, you know, all the stress all the impact of it on me, you know, and taking it off everybody else, which wasn't good for me, and obviously no good for Ben either. So that kind of taught me that" (Kate)

"what you visualise yourself doing is completely different from what you actually do […] to see it and be confronted with it on video...it's more of an eye-opener. You've got the evidence there that, look, it isn't working the way you're doing it [...] it's more a case of well...you've got to adjust the way...that you're thinking in relation to the way that you're actually doing things" (Marie)

Emotional processes

Rumination and self-doubt

Most of the participants reflected upon the challenges of parenting a child with additional needs. They spoke about their experiences prior to their participation in the MIM, which appeared to be fraught with ruminations, self-doubt and a lack of confidence in their parenting abilities. They described comparisons with other families, continual questioning, and the search for answers without any resolution.

"You think the worst, you think the best, you just, and then you get back to the middle and you're still in the same position, you know. You just don't know where to go" (Elaine)

"you know, you're bringing up this child and...you might think that you're doing right, and then you don't know if you're doing right for doing wrong [...] I was getting to the point that you're doubting yourself, and you're doubting your abilities as a person as well as a parent" (Kate)

"it almost felt as if we were failing as parents" (Susan)

"it wasn't pleasant. It wasn't happy thoughts. I was kind of thinking [...] have I contributed to...some of this? Is this something that we could have prevented? (Michael)

"there was a bit of me feeling, am I doing something wrong?" (Marie)

It was clear within participant accounts that when child developmental, emotional and behavioural difficulties impact upon the quality of parent-child relationships, parents can struggle greatly. Participants seemed deeply troubled by their child's difficulties, which they believed to be reflective of failures in their parenting abilities. They described on-going internal conflict as well as a battle to have their concerns heard and acknowledged by others. Participants spoke of their journey through services and the challenges that they had faced along the way. Much of their self-doubt appeared to be maintained by previous negative experiences with professionals, as one mother explained:

"Dave and I felt over the years that we were just repeating ourselves […] I had got to the point where I felt like saying, I wish I'd never started this, you know, why are you not listening to me? [...] it was as if I had to justify myself. And sometimes I think when you've got a child with special needs you feel like you have to do that, it's a battle" (Kate)

Relief and validation

All of the participants described the MIM as a positive experience and one that they found to be beneficial. One of the primary reasons for this appeared to be the therapist's acknowledgement of their concerns and the positive reinforcement received regarding their

performance. Following their participation in the MIM, parents reported feelings of relief and reassurance, and an enhanced sense of confidence.

"obviously it gives you a wee lift cause you knew you were doing what they, obviously the psychologist says that you're doing right, so it did give you a wee kind of boost" (Elaine)

"There was a positivity to it, it wasn't a case of, as I said, you were being judged or whatever. It left us both feeling...you know, we are doing alright, you know, we are getting there [...] so it was good in that way, that it gave us a bit of a sense of that, you know, achievement. You know, that we are doing things right in a lot of ways, you know, and not doubting ourselves or anything like that. So I think that's really good" (Kate)

"it was a relief to hear that somebody is recognising now, and has listened to all your lows, and acted on it and delivered on it" (Michael)

"having the feedback from [the clinicians], it's reassuring that I'm not doing anything wrong...and the way I'm doing it seems to be working" (Marie)

In many ways the objectivity of the video seemed to help parents to take a step back from their worries and see the bigger picture. This was experienced as both reassuring and normalising, as it enabled them to recognise strengths and resilience in their own abilities. This in turn and relieved the burden of uncertainty and doubt.

"seeing us with him, and seeing us being with him and seeing us happy, you know, and dealing with the way he is and talking and whatever…it's ordinary, because it's ordinary to us" (Kate)

"I always thought I was too dominating, but after seeing the video I've realised that Mikey needs the structure" (Marie)

Ambivalence

A degree of ambivalence was apparent in participant discussions. The process of the MIM, with its focus on parent-child interactions, is a sensitive one and participants described how this brought a number of conflicting emotions to the surface. Positive feelings of relief and validation were tainted by reflections upon the sadness of having a child with additional needs and the struggles that they had experienced as a family.

"I just think it was really good, as I said, I think we learnt a lot from it and we did take a lot away from it. I still think that it was, for me it was very painful. Quite painful. And I think that it was- it would have been- it was sad for Dave as well, because I know that he found it hard when you're going through and you're comparing it with somebody else telling you. Sometimes you realise, how the hell did I get here? How did I manage? How did we manage to overcome all they difficulties?" (Kate)

"I think it was emotive, you know it's like an emotional rollercoaster" (Susan)

"I don't know, it was...happy but sad at the same time [...] having to come to something like this to do it, to actually see that in him; whereas I should have been able to see that...in everyday life" (Marie)"

"I was always like, well I'm not doing this right am I the bad parent, is it something I did, is it something I'm doing? But then, to get the reassurance from [the clinician] that actually...I'm actually doing a good job here. It's...it's a bitter sweet thing. It's I should know that I'm doing a good job, but I can't see it cause I'm so caught up in everything else. And, I should see Mikey's doing good at something...but, if he's done something else earlier on, like two minutes before, that's what I see" (Marie)

Therapeutic factors

Openness

Participants emphasised the need for openness in order to experience therapeutic gain. This appeared to be a two-way process and they discussed the need to be ready and willing to share aspects of themselves, as well as being receptive to therapeutic input.

"But also if you're able to take on board, and not turn around and say, what you talking about, I know him better than you. You have to be very open to suggestion" (Kate)

This openness was viewed as essential for therapy to progress, and three of the participants described their partners' discomfort with the MIM, which they believed was due to a lack of openness. Some attributed this to differences in personality, stating that their partners were of more reserved and introverted nature; however, one participant stated that she believed

her partner was making a conscious effort to present herself in a particular light. This apparent guardedness and impression management appeared to be associated with a reduced ability to experience the benefits of therapy.

"He's one of they guys...he keeps things indoors, do you know what I mean?" (Anne)

"You know, with me it's what you see is what you get, I don't put on airs and graces for anybody (laughs) that, you know; where Michelle can change, where Michelle in the video totally changed" (Elaine)

The therapeutic relationship

The therapeutic relationship appeared to be extremely important, and a significant proportion of participant accounts were dedicated to discussing what they valued most in a therapist. It seems that for such a sensitive and potentially exposing process as the MIM, prior preparation and the development of a trusting therapeutic relationship is crucial. Participants valued a personal approach from their therapist, which helped them to develop a sense of safety within the therapeutic relationship. This in turn supported participants to adopt an open and honest approach to therapy.

"Trust as well. Trust in your psychologist or whoever. If there's families out there who've not got that trust, obviously you need to give them that trust, you know, help them along to- so that the trust is there" (Elaine)

"I think at least you need one or two sessions to actually speak to the person and feel comfortable. I think that's really, really important, I think so as to get a trueness" (Kate)

"I think the only other thing is I think that to get to the stage of the MIM, you've had to build up a relationship with that clinician the whole way through, and then...you know you've laid yourself bare, almost" (Susan)

"you've built up the trust. You've built up this, erm...bond" (Michael)

The development of a positive therapeutic alliance appeared to reduce feelings of defensiveness and helped participants to accept the therapist's feedback and advice. This was contrasted to previous encounters with professionals, which were found to be less helpful.

"when you go to hospital or you go to some things, they can be very clinical. And they can be...not textbook, but quite textbook. You know like the procedures, they follow procedures. And I think when you're working with a psychologist, and also the psychologist has worked with your child on their own, and they've got to meet your child and spend time with your child, and know your child and have interviews with you or appointments with you, and <u>then</u> they do that, I think that it makes it so much more relaxed, because you're not going in blind" (Kate)

"I know she's [the clinician] only got Mikey's best interests at heart. So any criticism that she has, or had, it was taken...well this is what Mikey needs. Whereas, with somebody else I'd

have been like that, wait a minute, you've only just met us and you think you can do this" (Marie)

Participants highlighted the need for a gentle and non-directive therapeutic stance, and one that balances constructive criticism with positive reinforcement. This was identified as necessary to avoid any potential feelings of judgement, and to reduce self-doubt in the parent.

"I think you've got to be really careful the way you word things when you're working with parents, and if you've got something to say, you have to balance it. Because if you don't get that balance right it can be misconstrued, do you know what I mean, and taken in a totally different context, you know. And I don't think there could be anything worse if you've got a child with special needs and they're looking at you as if- and you're thinking, do they think it's my fault?" (Kate)

Achieving a shared understanding

Participants told how they valued a collaborative approach to therapy. They described how they found the MIM to be a helpful medium through which to share their share their concerns with the therapist in a tangible way, and spoke of how they valued the professional perspective and the understanding that the therapist could bring to their situation.

"it felt as if there was something actually, physically happening, which it was, as opposed to just sitting talking about it. That there was actually an event, a compelling event that they could hopefully see things, erm, from it. And that we weren't mad (laughs)" (Michael)

"because they've got a trained eye, and they're trained in that and that's what they're looking for, they could interpret it differently from the way I saw it (Kate)

The importance of feeling heard was emphasised, and participants reported that throughout their therapeutic contact, they were given the opportunity to voice their concerns as the therapist listened and took this on board. Once again, this was contrasted with previous negative experiences.

"And that's what [the clinicians] did which the school never did, they listened to us, which is the most important thing" (Kate)

"the fact that she listened. You know, she listened to the whole picture, not just one aspect, and she- she- you know, it was like a big piece of- a big jigsaw, and she put all the pieces together and we filled in the bits of the jigsaw" (Susan)

Such a collaborative approach to therapy seemed to work to minimise any potential power imbalance between the parents and the therapist. The joint review of the video appeared to facilitate the process of achieving a shared understanding. Here, one mother explains why this was important to her:

"the way it's handled is really, really good. I really think it's good. And the videoing, I think that's the main thing. You've got to watch it together, you know. Even though they're analysing it, but you watch it together, you know. You're all making sense of it together. And it lets you know that it's not a judgement on you or your child or anybody else in your family. It's just an observation." (Kate).

"I would like to think that although they're extremely clever, when it comes to Ben, they're my equal, because he's my child" (Kate)

Attitude and behaviour change

Acceptance and positivity

Participants told how the MIM had helped them to adopt a more positive and accepting attitude towards their child and the challenges that they faced as a family. They expressed a shift in their focus, away from previous doubts and negative past experiences, towards a more hopeful future. In this sense the MIM was experienced as something of a turning point. Here one mother reflects on the challenges of parenting a child with additional learning and developmental needs, and tells how her experiences of the MIM have helped her to focus on the positives and appreciate the little things. This sentiment was echoed throughout all participants accounts:

"I think it just made us a bit- a bit more positive, you know about the way things are and our situation, that it's not- not that we thought it was doom and gloom, but sometimes it did feel like doom and gloom, cause it's hard- it's a hard job" (Kate)

"I look for what every day is. You know, when he hugs me and kisses me and I think, you know...I'm very lucky [...] so you appreciate what you've got. That's where it changes you, you know, you just appreciate what you've got" (Kate)

Parenting practices

Following completion of the MIM, participants reported changes in their approach to parenting. The insights that the video-feedback had provided resulted in an improved ability to adopt the child's perspective, which appeared to have wider implications for parents' management of their child's behaviour. All of the participants reported a better understanding of the reasons for their child's behaviour and described increased motivation to adapt their parenting practices to better suit the needs of their child. Overall parents described a more supportive approach to parenting, and one that placed greater emphasis on play and relationships.

"its about keeping it going, because to me, if you stop as soon as you walk out the door you get nowhere, there was no point in going; whereas if you continue to do it, you're going to get somewhere at the end of it, you know. Whether it be a- a big change or just that wee small change, and if you can make that wee small change, wee small changes add up to big changes" (Elaine)

"I saw that in the video, so I know not to ask her to do too much, and that's what [the clinician] says too" (Anne)

"obviously it's helped us with Ben, but it hasn't changed- as we say, it's not- Ben's not going to change, we've got to adapt to him rather than him adapting to us" (Kate)

"that's one thing that I learnt from it is, spend more time with her, spend more productive time with her...and understand, or think before you...react to a situation with her" (Michael)

"so now, it's trying to re-evaluate the way that...that I react to certain things with Mikey. Instead of focusing on the negative with him, I'm focusing on the positive" (Marie)

Roles and relationships

This increased focus on supportive and playful interactions appeared to be beneficial for parent-child relationships. Participants reported enhanced confidence in their ability to successfully negotiate interactions with their child, and described feeling more attuned to their child's internal experiences. Here, one mother describes how both she and her son obtained positive reinforcement from these interactions with one another:

"Before Mikey didn't show a lot of facial expressions, cause he doesn't understand feelings. But, the more that you work with him, and the more that he sees that you're willing to work with him the more joy he seems to be getting out of things" (Marie)

In addition, four of the participants spoke of how the MIM had prompted the re-evaluation and negotiation of parenting roles within their family. Participants reported that the MIM had given them a greater appreciation for their partners, which had encouraged them to work together to utilise one another's strengths. They described an increased

understanding of the parts that they played in their child's life, and reported striving to achieve a more united approach to parenting for the benefit of their own relationship and their respective relationships with their child.

"I think it's helped us move forward together. You know, and see our own capabilities, you know, and our strengths, you know and weaknesses- not so much weaknesses, but who's stronger at this side and that side, you know, and give us that more- that balance" (Kate)

"I think it's helped Dave and Ben, you know, in that they do more together. And I think it's helped my role, you know, it's helped me to step back a bit and know that Dave is capable and he does know what he's doing" (Kate)

"We have to be consistent...as parents. And you may, at times, one take a stronger lead or one take a back step or one is, erm, quicker to react than the other. And the messaging has to- has to be the same" (Michael)

"I think the realisation that it's not about us as parents, it's about Mikey and what Mikey needs in a parent. He doesn't need two people fighting all the time. He needs two people working together" (Marie)

Discussion

This study aimed to explore the therapeutic nature of the MIM when offered to parents and primary caregivers who were experiencing interactional difficulties with their children. To the researcher's knowledge, this study is the first to investigate the therapeutic application of the MIM, and the phenomenological approach has offered insight into parents' and caregivers' experiences of the MIM in a way that has not been explored before. Participants provided a rich account of their experiences and there was a high level of concordance across participant accounts. Analysis of the final interview did not reveal any previously unidentified themes, therefore it was concluded that theme saturation had been achieved.

Participant reflections are represented across five superordinate themes: experiential factors, reflective learning, emotional processes, therapeutic factors, and attitude and behaviour change. While each theme is distinct, participant accounts revealed a complex interplay between themes to explain the therapeutic action of the MIM, which is summarised in the conceptual model outlined in Figure 1 below. This model depicts participants' therapeutic journey through the MIM, from their experiences of the interactional procedure itself, through the reflective video-feedback session, to subsequent reported therapeutic outcomes. Despite initial anxiety, apprehension and discomfort with the interactive procedure; participants reported that the MIM provided valued insights and guided them through a process of reflection and emotional discovery to produce positive attitude and behavioural change. This process was facilitated by a number of therapeutic factors, which participants identified as being essential for therapy to progress.

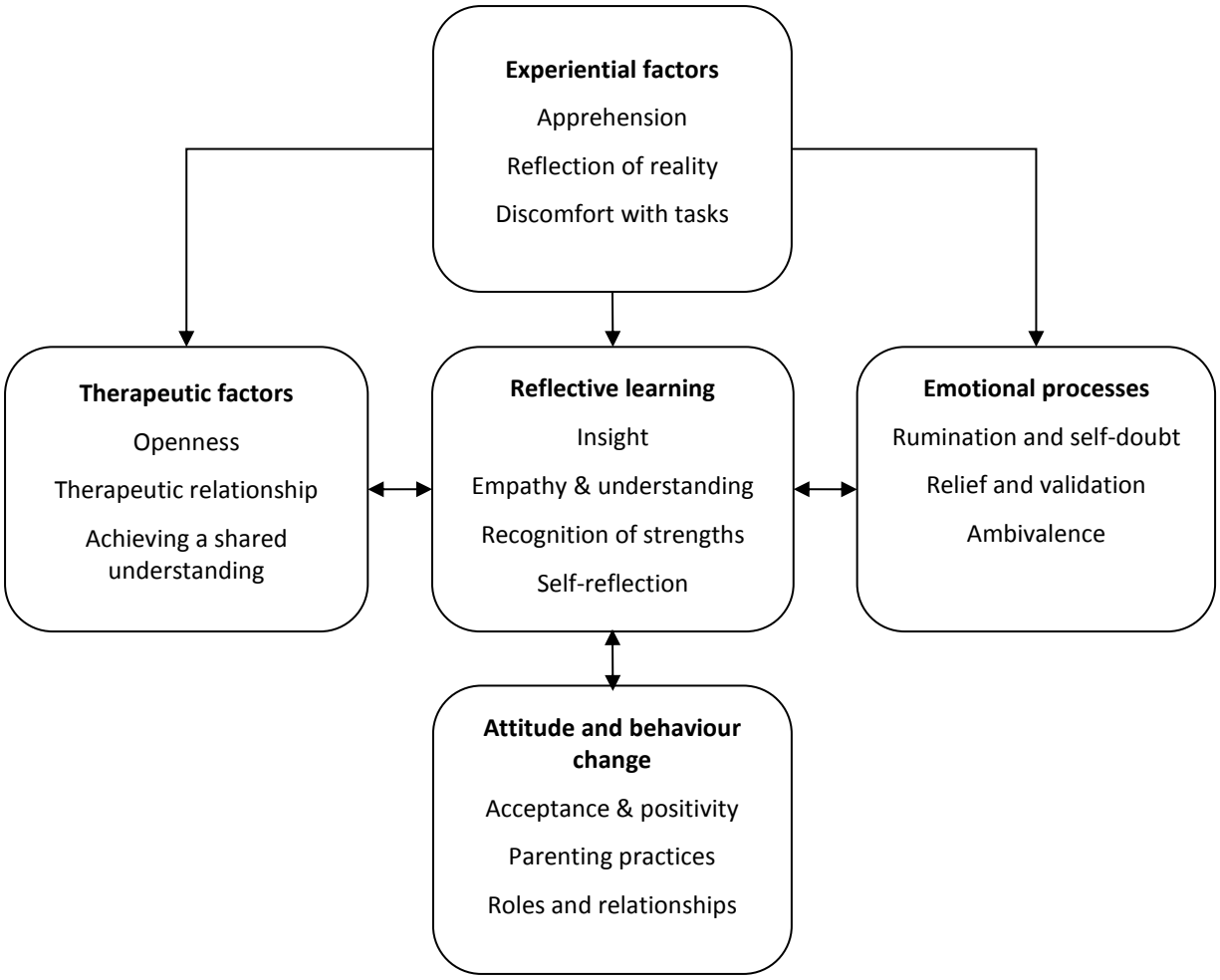

Figure 1. Conceptual model of emerging themes

The research context

Recently researchers have begun to explore the therapeutic action of video-feedback approaches through qualitative enquiry (Vik & Hafting, 2009; Doria, Kennedy, Strathie, & Strathie, 2013; Gibson, 2014; Vik & Rohde, 2014). Vik and Hafting (2009) and Vik and Rohde (2014) explored the therapeutic performance of a video-feedback intervention when offered to mothers experiencing post-natal depression. The intervention was Video Interaction Guidance (VIG), a technique that aims to enhance the quality of parent-child relationships by providing positive reinforcement for instances of sensitive and supportive interaction to guide the development of more positive parenting behaviour. In this sense,

VIG is comparable to the MIM in its efforts; however, with VIG the feedback is focused entirely on instances of positive interaction and intervention takes place over multiple sessions to support parents to gradually move towards a more positive pattern of interaction. Qualitative analysis of participant accounts before and after intervention revealed that the video-feedback facilitated the mothers' self-reflection and mentallisation ability, thus supporting them to interact more sensitively with their children. In addition, mothers reported reduced depressive symptoms and an enhanced sense of parenting competence. Gibson (2014) explored the application of VIG with parents of children with autistic spectrum disorder. It was reported that the reflective video review supported parents to develop greater awareness of their child's communication style, which resulted in enhanced parental efficacy.

Doria et al. (2013) attempted to provide a more detailed explanation for the mechanisms of change underlying VIG through qualitative interviews with parents and therapists, as well as content analysis of video-recorded therapy sessions. They presented an explanatory model for the success of VIG, which proposed that; success-focused self-observation and a supportive therapeutic relationship, triggers metacognitive processes of insight and reflection, to facilitate positive attitude and behaviour change. In many ways the findings of this current study are in keeping with existing theoretical explanations for the efficacy of video-feedback interventions, and the MIM would appear to share the therapeutic action of other such video-feedback approaches.

Findings and interpretations

Experiential factors

The theme of experiential factors relates to participants' accounts of their lived experience of the interactional procedure. Participants described the prospect of the MIM as anxiety provoking and reported worries about being judged in their interactions with their child. This finding is consistent with the existing literature on video-feedback approaches, with researchers warning that the camera may be experienced by parents as a "judgemental eye" (Lena, 2013, p.90). Jones (2006) suggests that such experiences may evoke defensive cognitive processes in the parent, which prevent them from fully engaging with the therapeutic process to achieve meaningful change; however, Beebe (2010) argues that the parent's natural motivation to engage with their child typically enables them to overcome their initial discomfort with being videotaped. The latter suggestion appeared to be the case for the participants in this current study; although, two of the participants reflected upon their partners' difficulties engaging with the process of the MIM, which they attributed to on-going feelings of discomfort. It is of interest to note that both of these partners were invited to participate in this current study, but declined to do so. This observation highlights that, when being watched in their interactions with their children, parents are placed in a vulnerable position and can feel extremely sensitive to perceived scrutiny.

Participants described feelings of unease during the interactional procedure and noted concerns that it provided an unrealistic portrayal of their family's interactions. Two of the participants made suggestions as to how the MIM could be improved to reduce this discomfort and to provide more realistic reflection of behaviour. This included bringing the MIM into the home to observe the parent and child in a more naturalistic environment, and

also the use of multiple video recordings to build up a more detailed picture of the family interactions over time. Such home-based delivery appears to be common in video-feedback approaches and has been reported to be successful (Bakermans-Kranenburg et al., 2003).

Reflective learning

The notion of reflective learning was identified as a central theme within participant accounts. Participants reported that the video-feedback provided them with new insights. They described becoming more attuned to their child's signals and responses, which supported them to develop greater empathy and understanding for their child's behaviour. They were also able to identify strengths in their partner's interactional style that they may have otherwise overlooked. In addition, the video appeared to facilitate increased self-awareness, and parents described undergoing a process of self-reflection. In this sense the MIM provided a visual medium that enhanced participants' reflective functioning and engaged them in a process of metallisation, thus supporting them to develop greater sensitivity to their child's needs. This finding is consistent with current psychoanalytical explanations for the efficacy of video-feedback interventions (e.g. see Zelenko & Benham, 2000; Jones 2006; Beebe, 2010; Lena, 2013).

Jones (2006) argues that video-feedback approaches work to create a "triangular space" that places the parent in the observer position, which creates a sense of distance and objectivity. This can offer insights into patterns of interactions that may be out-with the parent's immediate awareness, and provides compelling evidence that encourages parents to acknowledge different perspectives (Jones, 2006). Lena (2013) describes the therapeutic use of video as providing a "narrative container" (p.84), within which the parent is

supported to reflect upon their own state of mind, as well as that of their child, and to consider the interaction from the child's perspective. This supports parents to metallise and attune to their child's needs, which in turn provides parents with a better understanding of how to negotiate future interactions more effectively (Lena, 2013). This reflective process was evident throughout participant accounts and participants reported that the insights that they had gained during the MIM had taught them to adapt their parenting approach to better suit the needs of their child.

By involving two parents, the MIM appears to have offered additional insights that would not have been possible with only one parent, as is the case for most video-feedback approaches (van IJzendoorn et al., 2008). Early research evidence suggests that video-feedback interventions involving two parents are significantly more effective at improving the quality of parent-child interactions than those focusing on mothers alone (Bakermans-Kranenburg et al., 2003). This is keeping with arguments that difficulties in the parent-child relationship may be best understood in the context of the family system, and interventions targeting child emotional and behavioural difficulties should also seek to address the wider systemic factors that may be maintaining the problem (Cowan, 1997). Van IJzendoorn (2008) suggest that when two parents participate in parenting interventions they can provide one another with support and motivation to continue to implement therapeutic change after the intervention has ended. This certainly appears to be the case in this current study, and parents spoke of working together to achieve a more collaborative and supportive approach to parenting.

Somewhat unexpectedly, there was no evidence within participant accounts of parents reflecting upon their own attachment experiences. It may be that the MIM, employing only one reflective feedback session, did not provide sufficient opportunity for parents to reflect upon their own attachment representations; and so the focus of the reflective discussion was centred on the child within the present context. It could also be that the involvement of two parents inhibited this deeper level of reflection, which may require the development of a more intimate parent-therapist relationship (van IJzendoorn et al., 2008).

Emotional processes

A number of emotions were evident throughout participant accounts, and the process of the MIM appeared to represent a significant emotional journey for participants, who reported coming to the MIM with a great deal of self-doubt and worry with regard to their parenting abilities. All were parents or primary caregivers to children presenting with emotional and behavioural difficulties in the context of additional learning and developmental needs, making them difficult to parent. Participants spoke of a long journey through healthcare services that at times felt like they had to fight a battle to have their concerns acknowledged. They described how reviewing the videotaped footage during the MIM had enabled them to recognise strengths and resilience in their parenting abilities and their family relationships that had perhaps been overshadowed by the difficulties that they were experiencing. This served to relieve participants from the burden of self-doubt and anxiety, and instil them with an improved sense of parenting competence. In addition, they reported that praise and acknowledgement from the therapists was experienced as reassuring and validating. Similar findings have been noted by previous researchers (Vik &

Hafting, 2009; Vik & Rohdes, 2014) who conceptualised this as a process of emotional regulation.

Participant accounts were characterised by ambivalence. While they expressed a range of positive emotions and reflections regarding their experiences of the MIM; there was also a strong sense of sadness within their reflections. Participants described how the outside perspective that the MIM provided, brought with it a realisation of the struggles that they and their family had faced. Previous researchers have observed that self-observation can trigger strong emotional responses by guiding parents to reflect on the deeper meaning of their relationships (Beebe, 2010). In their writings on metallisation-based treatment for borderline personality disorder, Fonagy & Bateman (2007) point out that brief interventions that trigger reflections on attachment relationships without fully addressing these, may increase the risk of iatrogenic effects. That is, by interfering with a natural process of adaption, it is possible that the MIM may bring to light unresolved conflicts, and inadvertently cause psychological harm. Great care needs to be taken to manage such risks in clinical practice.

Therapeutic factors

Participants shared their thoughts on a number of factors that facilitated their ability to engage with the therapeutic process of the MIM. The joint review of the video appeared to serve the function of creating a visual formulation, which supported the parent and therapist to achieve a shared understanding. Similar processes have been discussed by previous researchers reporting on the action of video-feedback in parent-child treatments. Lena (2013) notes that the use of video enables parents to share their concerns with the

therapist by providing visual evidence of the difficulties that they are experiencing in their interactions with their child. The joint review of the video allows the parent and the therapist to co-construct meaning and negotiate therapeutic goals by observing together the interactional strengths and difficulties in the parent-child relationship (Lena, 2013).

Due to technical difficulties, two of the participants in this current study were unable to review the video footage of their MIM interactions; yet their accounts did not notably differ from the other participants, and they too described processes of insight, self-reflection and enhanced empathy and understanding. What these participants did appear to share with others, however, was the experience of a trusting and collaborative therapeutic relationship. The therapeutic relationship was identified as a prominent theme across participant accounts. This finding is in keeping with the proposed benefits of the MIM as noted by Booth and Jernberg (2010). The importance of the therapeutic relationship in video-feedback interventions has also been identified by previous qualitative studies (Vik & Hafting, 2009; Doria et al. 2013; Vik & Rohde, 2014). It has been suggested that the therapist's recognition of the parent's struggles serves an important therapeutic function by communicating empathy and acceptance, which in turn facilitates reflection within the parent (Vik and Rohde, 2014).

Attitude and behavioural change

Participants described the interactional procedure of the MIM and the subsequent video feedback as a powerful learning experience. They reported enhanced understanding and a greater appreciation for areas strengths and reliance in their family functioning. This appeared to instil a greater sense of confidence in their parenting abilities, which seemed to

motivate them to adapt their parenting approach to meet the needs of their child. Overall, participants described a more accepting attitude and a positive future outlook. This finding is in keeping with existing theoretical explanations for the efficacy of video-feedback interventions. Behavioural explanations propose that, when parents observe moments of positive and attuned interaction with their child, they experience a powerful behavioural reinforcement, which continues through a process of aggregation of subsequent positive interactions (van IJzendoorn et al. 2008).

Limitations

All of the participants were parents or caregivers to children with learning and developmental difficulties. The presence of such difficulties in the child is likely to impact on the quality of the parent-child relationship (van IJzendoorn et al., 2007). This was evident throughout participant accounts and all reflected upon the challenges of parenting a child with such additional needs. In this context the MIM appeared to serve a specific function in helping the parents to understand their child's individual difficulties and to recognise how to modify their parenting behaviour to meet their child's needs more effectively; thus enhancing their sensitivity. While this is an important finding, it pertains specifically to the current population. There is some evidence to suggest that parents of children with such clinical characteristics appear to obtain the most benefit form video-feedback interventions (Klein Velderman, Bakermans-Kranenburg, Juffer, & van IJzendoorn, 2006). Therefore, findings of this current study may not reliably generalise to the wider demographic of families presenting at healthcare services with relational difficulties. Additionally, the majority of the participants in this study were mothers, two of whom reflected upon their male partner's difficulties engaging with the therapeutic process of the MIM. This study

would have benefited from the inclusion of more fathers, interviewed individually, and parents of children without additional learning and developmental difficulties, to establish if their experiences differed in any way from the current population.

Conclusions and future directions

This exploratory study has provided insights into the therapeutic nature of the MIM from the perspective of parents and primary caregivers of children with additional learning and developmental needs. Findings offer some initial support to hypotheses for the potential therapeutic action of the MIM (e.g. Lindaman et al., 2000), which appear to be in keeping with current theoretical explanations for the success of video-feedback approaches within family treatments. These findings have important implications for clinical practice and suggest that the MIM may be effectively applied as a brief and focused video-feedback intervention to support the development of more positive parent-child relationships. This current study, however, does not provide a reliable assessment of therapeutic effect; and further research is needed to test this therapeutic hypothesis and examine the efficacy of the MIM in improving parent and child outcomes.

Participant accounts revealed that the observational use of video can be experienced by parents as exposing and may give rise to concerns about being judged in their interactions with their child. The MIM has the potential to stir up difficult emotions, and care needs to be taken to manage parents' concerns in a sensitive and containing way, so as to reduce further feelings of self-doubt and anxiety. A number of the participants spoke of their partner's discomfort with the therapeutic process of the MIM. This suggests that for some the MIM may be experienced as extremely aversive. Care needs to be taken to manage such

risks in clinical practice and video-feedback approaches should only be delivered within the context of a strong therapeutic relationship. Future research is needed to achieve a better understanding of what works for whom, and for whom the MIM may be helpful.

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Chapter Three

Advanced Practice I: Reflective Critical Account

Developing skills in clinical practice: A reflective account

Diane Fraser

Submitted in partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology (DClinPsy)

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Abstract

This reflective account considers the advancement of my clinical practice skills over the course of my clinical practice training, with a particular focus on my experiences of working within specialist child and adolescent mental health services. With reference to the Declarative Procedure Reflective model of therapist learning and skills development (DPR: Bennett-Levy, 2006); I drawn upon examples from each year of my clinical practice training to demonstrate the development of my interpersonal therapeutic skills with clients. To structure this account I apply Gibbs (1988) Reflective Cycle within the broad framework of Stoltenberg, McNeil and Delworth's (1998) Integrated Development model. I reflect upon the factors that have guided my learning and discuss my goals for my future professional development.

Chapter Four

Advanced Clinical Practice II: Reflective Critical Account

Managing communications and negotiating roles and responsibilities within the multi-disciplinary team

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Abstract

Within this reflective account I discuss my experiences of working within multi-disciplinary team (MDT) environments and consider how these have impacted upon my continuing professional development as a Trainee Clinical Psychologist. By drawing upon examples from my final year of clinical practice training, within a specialist Child and Adolescent Mental Health Service (CAMHS), I discuss what I have experienced as the challenges and benefits of MDT working. I reflect upon my personal reactions to these experiences and consider the multiple influences that have guided my learning. I summarise how the experiences that I have acquired throughout my training have led to changes in my thinking and influenced the development of my professional values and identity. Finally, I consider areas of strengths and limitations in my clinical practice and outline my personal learning goals in order to ensure continual improvement of my knowledge, competences and skills throughout my future career as a Clinical Psychologist.

Appendices

Appendix 1.1. Journal of Family Psychology Author Guidelines

Journal of Family Psychology®

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Visit the CONSORT Statement Web site for more details and resources.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6th edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's Checklist for Manuscript Submission before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a

type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**
  Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin, 139,* 133–151. http://dx.doi.org/10.1037/a0028566
- **Authored Book:**
  Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach.* Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
  Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

Permissions

Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

- Download Permissions Alert Form (PDF, 13KB)

Publication Policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Disclosure of Interests Form (PDF, 38KB)

Authors of accepted manuscripts are required to transfer the copyright to APA.

- For manuscripts **not** funded by the Wellcome Trust or the Research Councils UK
  Publication Rights (Copyright Transfer) Form (PDF, 83KB)
- For manuscripts funded by the Wellcome Trust or the Research Councils UK
  Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Other Information

- Appeals Process for Manuscript Submissions
- Preparing Auxiliary Files for Production
- Document Deposit Procedures for APA Journals

Appendix 1.2. Quality Rating Scale

Quality Rating Scale

(Adapted from the Clinical Trials Assessment Measure, Tarrier and Wykes 2004)

Paper:	
Rater:	
Date:	

Sample:

1. Is the sample a convenience sample (score 2), or a geographic cohort (score 5), or highly selective sample, e.g. volunteers (score 0)? (Convenience sample: e.g. clinic attendees, referred patients. Geographic cohort : all patients eligible in a particular area)	
2. Is the sample size greater than 27 participants per group (score 5) or based on adequate and described power calculations (score 5)?	
Score:	/10

Allocation:

3. Is there true random allocation or minimisation allocation to treatment groups? (score 10)	
4. Is the process of randomisation described?(score 3)	
5. Is the process of randomisation carried out independently from the trial research team? (score 3)	
Score:	/16

Assessment (of main outcome):

6. Are the assessments carried out by independent assessors and not therapists? (score 10)	
7. Are standardised assessments used to measure outcomes in a standard way? (score 6) (Idiosyncratic assessments of symptoms, score 3)	
8. Are the outcome measures valid and reliable? (score 0 if not, score 3 if poor validity/reliability, score 5 if valid and reliable)	
9. Was there a long-term follow-up of assessment outcomes (>6 months)? (score 3)	

10. Are assessments carried out blind (masked) to treatment group allocation? (score 10)	
11. Are the methods of rater blinding adequately described? (score 3)	
12. Is rater blinding verified? (score 3)	
Score:	/40

Control:

13. TAU is a control group (score 6) and/or a control group that controls for non-specific effects or other established or credible treatment (score 10)	
14. Are groups similar pre-test (or adjustments made)? (score 5)	
Score:	/21

Analysis:

15. Is the analysis is appropriate to the design and type of outcome measure? (score 5)	
16. Does the analysis include all those participants as randomised (sometimes referred to as an intention to treat analysis) (score 6)? Is attrition rate less than 15% or is there an adequate investigation and handling of drop outs from assessment if the attrition rate exceeds 15% ?(score 4)	
17. Was an effect size calculation reported (score 3) or is there sufficient information provided to allow effect sizes to be calculated (score 1)?	
Score:	/18

Active Treatment:

18. Was the treatment adequately described to allow replication (score 3) and/or was a treatment protocol or manual used? (score 3)	
19. Was information provided on the training of therapists (score 3) and were therapists adequately trained to deliver the intervention? (score 3)	
20. Was adherence to the treatment protocol or treatment quality assessed? (score 5)	
Score:	/17

Total Score / 122:	
Percentage Score:	
Quality Rating:	

Appendix 1.3. Detailed quality rating scores of included studies

Study	Quality Rating Scale Item Number																				Total Score / 122	% score
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20		
Benzies et al. (2013)	2	5	10	3	3	10	6	5	0	10	0	3	16	5	5	4	3	3	0	0	**93**	**76.2**
Bilszta et al. (2012)	2	0	10	3	3	10	6	3	0	0	0	0	16	5	5	0	0	3	0	0	**66**	**54.1**
Cummings & Wittenberg (2008)	2	5	10	3	3	10	6	5	3	10	3	0	16	0	5	4	3	6	6	5	**105**	**86.1**
Jagerman & Klein (2010)	2	5	10	0	0	0	6	5	0	0	0	0	16	5	5	4	1	6	6	0	**71**	**58.2**
Kalinauskiene et al. (2009)	2	0	10	0	0	10	6	5	0	10	0	0	6	5	5	10	3	6	6	0	**84**	**68.9**
Klein Velderman et al. (2006a)	5	5	10	0	0	0	6	5	0	0	0	0	6	0	5	4	3	6	6	0	**61**	**50**
Klein Velderman et al. (2006b)	5	5	10	0	0	0	6	5	0	0	0	0	6	0	5	4	3	6	6	0	**61**	**50**
Magill-Evans et al. (2007)	2	5	10	3	3	10	6	5	0	10	0	0	16	5	5	4	3	3	6	5	**101**	**82.8**
Moss et al. (2011)	2	5	10	3	0	10	6	5	0	10	0	0	6	5	5	4	3	6	6	5	**91**	**74.6**
Spieker et al. (2012)	2	5	10	3	0	10	6	5	3	0	0	0	16	0	5	10	3	6	6	5	**95**	**77.9**
Van Zeijl et al. (2006)	5	5	10	3	0	0	6	3	0	0	0	0	6	5	5	4	3	6	6	5	**72**	**61.5**

1. Sample recruitment
2. Sample size/power
3. Random allocation
4. Process of randomisation
5. Independent randomisation
6. Outcomes independently assessed
7. Standardised outcome measures
8. Valid/reliable outcome measures
9. Long-term follow up of outcomes
10. Blind assessment of outcomes
11. Methods of rater blinding
12. Rater blinding verified
13. Control group
14. Homogeneity of groups
15. Analysis appropriate to design
16. Management of attrition
17. Effect sizes reported
18. Treatment adequately described
19. Therapist training
20. Adherence to protocol assessed

Participant Information Sheet

Version 4 (20/01/14)

Title of Study: Exploring parents' experiences of a video-recorded play assessment.

Name of Primary Researcher: Diane Fraser (Trainee Clinical Psychologist).

This leaflet has been given to you by Rainbow House Community Paediatric Service at Ayrshire Central Hospital, on behalf of Diane Fraser (Trainee Clinical Psychologist).

I would like to ask you to take a few minutes of your time to read over this information sheet. My name is Diane Fraser and I am a Trainee Clinical Psychologist with the University of Glasgow. As part of my Doctorate in Clinical Psychology I am conducting a research project in partnership with Rainbow House Community Paediatric Service at Ayrshire Central Hospital.

I am contacting you to ask if you would be willing to participate in a research study. This leaflet is designed to give you all of the information that you will require to make this decision. If you have any questions about the research or would like to discuss any aspect of the study further, please do not hesitate to contact me.

What is the study about?
I am interested in hearing about parents' and carers' experiences of taking part in a video-recorded play assessment with their child.

Why am I being asked to take part?
You are being asked to take part because you have recently completed a video-recorded play assessment with your child at Rainbow House Community Paediatric Service.

Do I have to take part?
You do not have to take part in this study and your decision on whether or not to take part will not impact upon you or your child's on-going care or legal rights. If you do agree to take part, you are free to withdraw from this study at any time during the research process, and you do not have to give any reason for doing so.

What would I have to do?
If you agree to take part I will contact you to arrange an interview. This interview will be conducted within Rainbow House Community Paediatric Service at Ayrshire Central Hospital. It will be arranged at a time to suit you and will last approximately 60 minutes. During this interview I will ask you about your experiences of the video-recorded play assessment and the feedback that was given to you by your therapist.

What will happen to the information I provide?
Any information that you provide as part of this research will be stored anonymously and treated with the strictest confidence. The interview will be voice recorded. The recording will then be transcribed and any information that could identify you or your child will be removed or made anonymous. Once transcribed, the recording will be destroyed. The anonymous interview transcripts will be stored on an encrypted and password protected computer. This information may be kept for up to 5 years after the study has been completed.

The interview transcripts will be analysed and presented in the form of a report that will be submitted to the University of Glasgow in part fulfilment of my Doctorate in Clinical Psychology. This report may also be submitted for publication in a scientific journal. Within the report I may include some anonymous quotes of what you have said during the interview. Please be assured that these will remain anonymous and will not reveal your identity. All participants will be provided with a summary of the report if they wish.

Only my supervisors (Clinical Psychologists working for the University of Glasgow) and I will have access to the information that you provide. However, if during the interview you disclose any information that indicates that you or someone else may be at risk of harm, I will be required to share this information with a clinician within your child's care team. If this was to happen I would discuss this with you first.

Are there any benefits to taking part?
There are no direct benefits to you or your child if you take part in this study. However, the information that you provide will contribute to our understanding of parents' and carer's experiences of the play-assessment and any benefits or difficulties associated with this. If this study is published in a scientific journal, it could contribute to developments in the psychological care of patients and their families.

Are there any down sides to taking part?
It is possible that our discussion during the interview may trigger some upsetting thoughts or feelings that may be difficult to talk about. If this is the case, and you wish to stop, you can end the interview at any time. If you need a break during the interview, that is ok. You also discuss your experience of the interview with your therapist, who will be able to support you if any upsetting issues are raised.

Who has reviewed the study?
This study has been approved by the University of Glasgow, NHS Ayrshire and Arran Research and Development Team, and the West of Scotland Research Ethics Committee 4.

Who can I speak to about the study?
If you have any questions or would like any more information please do not hesitate to contact me or my supervisor at Rainbow House, Dr Sonia Gleeson (Clinical Psychologist). You may also contact Dr Julie Bennett (Principal Clinical Psychologist) who is independent of this study and will be able to provide you with some impartial information about taking part. Contact details are listed below.

What should I do now?
If you are happy to take part in the study, please complete the attached form and pass this back to your clinician or post it to me in the stamped addressed envelope provided. I will then contact you by telephone to answer any questions that you may have about the study and arrange a time to complete the interview. When we meet I will ask you to sign a consent form to show that you have read and understood the information that has been given to you and that you agree to take part in the study.

Thank you for taking the time to read this information leaflet and for any further participation that you may have.

Diane Fraser
Trainee Clinical Psychologist

Contact Details:

Researcher:
Diane Fraser, Trainee Clinical Psychologist
Mental Health and Wellbeing
Academic Centre
Admin Building, Gartnavel Royal Hospital
1055 Great Western Road
Glasgow, G12 0XH

Tel:
Email:

Project Supervisor:
Dr Sonia Gleeson, Clinical Psychologist

Address

Tel:
Email:

Independent Contact:
Dr Julie Bennett, Principal Clinical Psychologist

Address

Tel:
Email:

Participant Response Form

Version 2 (26/11/13)

Title of Study: Exploring parents' experiences of a video-recorded play assessment.

Name of Primary Researcher: Diane Fraser (Trainee Clinical Psychologist).

Please tick:

I have read the *Participant Information Sheet* and I am interested in taking part in the study. ☐

I am happy to be contacted by telephone to discuss the study further. ☐

I give consent for the researcher to leave a message if I am unavailable. ☐

Name (please print in block capitals):

Telephone number:

Name of Child:

Relationship to Child (please circle): Mother Father Legal Guardian

Other (please specify): ……

Participant Consent Form

Version 4 (20/01/14)

Title of Study: Exploring parents' experiences of a video-recorded play assessment.

Name of Primary Researcher: Diane Fraser (Trainee Clinical Psychologist).

Contact Address: Mental Health and Well Being
Academic Centre
Admin Building, Gartnavel Royal Hospital
1055 Great Western Road
Glasgow, G12 0XH

Please initial

I confirm that I have read and understand the participant information sheet dated 20/01/14 (version 4) for the above study and have had the opportunity to ask any questions. ☐

Please initial

I understand that my participation in the study is voluntary and that I am free to withdraw from the study at any time, without giving any reason, and without my care or legal rights being affected. ☐

Please initial

I understand that only the researcher and the supervising Clinical Psychologists will have access to any personal information that I provide. ☐

Please initial

I understand that my interview will be audio-recorded and transcribed, solely for the purposes of the above research study, and that all names and anything else that could identify me will be anonymised or removed from my interview transcript. ☐

Please initial

I give consent for the researcher to use anonymous extracts from my interview transcripts in any published reports resulting from the research. ☐

Please initial

I understand that if I disclose any information that causes concerns about risk of harm to myself or others, the researcher may be required to share this information with other professionals involved in my care (e.g. responsible clinician). ☐

Please initial

I give the researcher permission to inform my child's care team of my involvement in this study. ☐

Please initial

I understand that the data collected during this study may be reviewed by individuals from regulatory authorities or from NHS Ayrshire and Arran for the purposes of monitoring and auditing. ☐

Please initial

I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of researcher taking consent	Date	Signature

1 copy to researcher, 1 to participant, 1 to clinical records.

Interview Schedule

Version 3 (26/11/13)

Title of Study: Exploring parents' experiences of a video-recorded play assessment.

Orientation

- Can you tell me a bit about what brought you and your child along to the service?

Expectations

- Thinking back to before you completed the play assessment, what were your expectations of it?

Possible prompts:

- ~ What were you told about it?
- ~ How did you feel about doing it?
- ~ Did you have any concerns about doing it?
- ~ Did you understand why you were being asked to do it?
- ~ What did you hope to get out of it?

The play assessment

- Can you tell me was it like for you taking part in the play assessment?

Possible prompts:

- ~ What did you think of it?
- ~ Was it what you expected?
- ~ How did you feel?
- ~ Was there anything that you enjoyed?
- ~ Was there anything that was quite tricky?

- What do you think it was like for your child?

Possible prompts:

- ~ What do you think he/she thought about it?
- ~ How do you think they felt during it?
- ~ Was there anything that you think he/she enjoyed?
- ~ Was there anything that you think he/she found quite tricky?

The feedback session

- Can you tell me about the feedback session with your therapist?

Possible prompts:

- ~ What was it like watching the video recordings?
- ~ How did you feel during the feedback session
- ~ What stood out for you when watching the tapes?
- ~ Was there anything that was quite tricky to watch?
- ~ Was there anything that you enjoyed watching?
- ~ Did you notice anything that you hadn't noticed before (about your own behaviour/about your child's behaviour)?

The therapeutic letter

- Tell me about the therapeutic letter that you received about the play assessment?

Possible prompts:

- ~ What was it like reading the letter?
- ~ How did it make you feel reading it?
- ~ Was there anything that stood out for you?

Outcome

- Looking back on the whole experience (the play-assessment, the feedback session and the letter), what have you taken away?

Possible prompts:

- ~ Have you learnt anything from the experience?
- ~ Did anything stand out for you?
- ~ How do you feel about it now?
- ~ Overall, what was the most helpful aspect?
- ~ Was there anything that wasn't very helpful?

- Has anything changed since completing the play-assessment and receiving feedback?

Possible prompts:

- ~ Is there anything that has made you think differently?
- ~ Is there anything that you now do differently?
- ~ Do you feel there have been any changes in your relationship with your child?
- ~ Have there been any changes in your child's behaviour

Endings

- Is there anything else that you would like to talk about or feel is important to mention?

Appendix 2.5. University of Glasgow approval letter

University of Glasgow | College of Medical, Veterinary & Life Sciences

TMcM/LC

12th July 2013

Diane Fraser
[redacted]

Dear Diane,

Doctorate in Clinical Psychology Major Research Project
A qualitative exploration of parents' views and experiences of the Marschak Interaction Method (MIM)

The above project has been reviewed by your University Research supervisor and by a member of staff not involved in your project and has now been deemed fit to proceed to ethics.

Congratulations and good luck with the study.

Yours sincerely,

T M McMillan
Professor of Clinical Neuropsychology
Research Director

Doctorate in Clinical Psychology
Programme Director: Dr Hamish McLeod

Mental Health and Wellbeing
Admin Building, Gartnavel Royal Hospital
1055 Great Western Road
GLASGOW G12 0XH
Direct line: +44(0) 141 211 3920/0607 Fax: +44(0) 141 211 0356
Email: mhwb-dclinpsy-students@gla.ac.uk

Appendix 2.6. NHS Ayrshire & Arran Research and Development Management approval letters

Research & Development Office
58 Lister Street
Crosshouse Hospital
Kilmarnock
KA2 0BB

Miss Diane Fraser
Trainee Clinical Psychologist
NHS Greater Glasgow & Clyde
Institute of Health & Wellbeing
Admin Building, Gartnavel Royal Hospital
1055 Great Western Road, Glasgow
G12 0XH

Date	30 January 2014
Your Ref	
Our Ref	KF/KLB/AMK 2014AA003
Enquiries to	Karen Bell
Extension	25850
Direct line	01563 825850
Fax	01563 825806
Email	Karen.bell@aaaht.scot.nhs.uk

Dear Miss Fraser

Letter of access for research

This letter confirms your right of access to conduct research through NHS Ayrshire & Arran for the purpose and on the terms and conditions set out below. This right of access commences on 30 January 2014 and ends on 28 February 2015 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

The information supplied about your role in research at NHS Ayrshire & Arran has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to NHS Ayrshire & Arran premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through NHS Ayrshire & Arran you will remain accountable to your employer **NHS Greater Glasgow and Clyde** but you are required to follow the reasonable instructions of Dr Sonia Gleeson in this NHS organisation or those given on her behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with NHS Ayrshire & Arran policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with NHS Ayrshire & Arran in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on NHS Ayrshire & Arran premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Where required by law, your HEI employer will initiate your Independent Safeguarding Authority (ISA) registration, and thereafter, will continue to monitor your ISA registration status via the on-line ISA service. Should you cease to be ISA-registered, this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity. You MUST stop undertaking any regulated activity.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

NHS Ayrshire & Arran will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Dr Ken Ferguson
Assistant Medical Director

c.c. Dr George Ralston, NHS Greater Glasgow & Clyde

Research & Development
58 Lister Street
University Hospital Crosshouse
Kilmarnock
KA2 0BB

Miss Diane Fraser
Trainee Clinical Psychologist
NHS Greater Glasgow & Clyde
Institute of Health & Wellbeing
Admin Building, Gartnavel Royal Hospital
1055 Great Western Road, Glasgow
G12 0XH

Date 30 January 2014
Your Ref
Our Ref AG/KLB/AMK 2014AA003

Enquiries to Karen Bell
Extension 25850
Direct line 01563 825850
Fax 01563 825806
Email Karen.bell@aaaht.scot.nhs.uk

Dear Miss Fraser

A qualitative exploration of parents' views and experiences of the Marschak Interaction Method (MIM)

I confirm that NHS Ayrshire and Arran have reviewed the undernoted documents and grant R&D Management approval for the above study.

Approved documents:

Document	Version	Date
IRAS R&D Form	3.5	13 December 2013
IRAS SSI Form	3.5	17 December 2013
Protocol	9.0	26 November 2013
Participant Information Sheet	4.0	20 January 2013
Participant Consent Form	4.0	20 January 2014
Interview Schedule	3.0	26 November 2013
Health & Safety Risk Assessment Form	2.0	26 November 2013
Research Equip, Consumables & Expenses	/	/

The terms of approval state that the investigator authorised to undertake this study within NHS Ayrshire & Arran is: -

- Diane Fraser, *NHS Greater Glasgow & Clyde*

With additional investigator: -

- Dr Sonia Gleeson, NHS Ayrshire & Arran

The sponsors for this study are NHS Ayrshire & Arran.

This approval letter is valid until 28 February 2015.

Regular reports of the study require to be submitted. Your first report should be submitted to Dr K Bell, Research & Development Manager in 12 months time and subsequently at yearly intervals until the work is completed.

Please note that as a requirement of this type of study your name, designation, work address, work telephone number, work e-mail address, work related qualifications and whole time equivalent will be held on the Scottish National Research Database so that NHS R&D staff in Scotland can access this information for purposes related to project management and report monitoring.

In addition approval is granted subject to the following conditions: -

- All research activity must comply with the standards detailed in the Research Governance Framework for Health and Community Care www.cso.scot.nhs.uk/publications/ResGov/Framework/RGFEdTwo.pdf and appropriate statutory legislation. It is your responsibility to ensure that you are familiar with these, however please do not hesitate to seek further advice if you are unsure.

- You are required to comply with Good Clinical Practice (ICH-GCP guidelines may be found at www.ich.org/LOB/media/MEDIA482.pdf), Ethics Guidelines, Health & Safety Act 1999 and Data Protection Act 1998.

- If any amendments are to be made to the study protocol and or the Research Team the Researcher must seek Ethical and Management Approval for the changes before they can be implemented.

- The Researcher and NHS Ayrshire and Arran must permit and assist with any monitoring, auditing or inspection of the project by the relevant authorities.

- The NHS Ayrshire and Arran Complaints Department should be informed if any complaints arise regarding the project and the R&D Department must be copied into this correspondence.

- The outcome and lessons learnt from complaints must be communicated to funders, sponsors and other partners associated with the project.

- As custodian of the information collated during this research project you are responsible for ensuring the security of all personal information collated in line with NHS Scotland IT Security Policies, until the destruction of these data. Under no circumstances should personal data be stored on any unencrypted removable media e.g. laptop, USB or mobile device (for further information and guidance please contact the Information Governance Team based at Ailsa Hospital 01292 513693 or 513694).

If I can be of any further assistance please do not hesitate to contact me. On behalf of the department, I wish you every success with the project.

Yours sincerely

Dr Alison Graham
Medical Director

c.c. Libby Prentice, Sponsor contact
Lesley Douglas, Finance, Ailsa Hospital
Information Governance, Ailsa Hospital
Tommy Stevenson, NHS Ayrshire & Arran

Appendix 2.7. West of Scotland NHS Research Ethics Committee 4 approval letters

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

West of Scotland REC 4
Ground Floor, Tennent Building
Western Infirmary
38 Church Street
Glasgow
G11 6NT
www.nhsggc.org.uk

Date 20 January 2014
Direct line 0141-211-1722
Fax 0141-211-1847
e-mail wosrec4@ggc.scot.nhs.uk

Miss Diane Fraser
Trainee Clinical Psychologist
Institute of Health and Wellbeing, University of Glasgow
Admin Building, Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Dear Miss Fraser

Study title:	**A qualitative exploration of parents' views and experiences of the Marschak Interaction Method (MIM).**
REC reference:	**14/WS/0007**
IRAS project ID:	**141494**

The Research Ethics Committee reviewed the above application at the meeting held on 10 January 2014. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Ms Evelyn Jackson, wosrec4@ggc.scot.nhs.uk.

Ethical opinion

Ethical issues raised by the Committee in private discussion, together with responses given by the researcher when invited into the meeting:

1. The Committee asked you for more information regarding how potential participants would be identified and recruited.

   You explained that your field supervisor will identify participants who have been involved in the MIM task and that you would give them a Participant Information Sheet and a response form after they had completed the intervention.

2. The Committee asked how long potential participants will have to decide whether to take

part in the study.

You explained that potential participants would take the PIS away with them to read over in their own time and they would be asked to post the response form to you or to hand it in at their next clinical appointment.

3. The Committee asked what would be the age range of children involved in the study.

   You explained that the children would up to 12 years old.

4. The Committee asked whether crèche facilities would be available for children who attended with their parent.

   You explained that normally parents do not bring their children when they attend for interview and that there are no facilities in place to take care of children.

5. The Committee asked if the MIM is part of routine care.

   You explained that the MIM is part of routine care and that sessions are regularly video taped.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

1. In the Consent Form, add "please initial" above the boxes against each statement.

2. In the Participant Information Form, in the section headed "Who has reviewed the study?", change the reference to the Research Ethics Committee to "West of Scotland Research Ethics Committee 4".

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
REC application	-	13 December 2013
Protocol	9	26 November 2013
Investigator CV	-	05 November 2013
Participant Information Sheet	3	26 November 2013
Participant Consent Form	2	26 November 2013

Interview Schedules/Topic Guides	3	26 November 2013
Other: Health and Safety Risk Assessment Form	2	26 November 2013
Other: Research Equipment, Consumables and Expenses Form	-	-
Other: Letter from University of Glasgow	-	12 July 2013
Other: Email re Clinical Governance Research and Strategy Group approval	-	15 August 2013
Other: Dr Suzy O'Connor's CV	-	06 March 2013

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

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

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

14/WS/0007	Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely

***For* Dr Brian Neilly**
Chair

Enclosures: *List of names and professions of members who were present at the meeting*
"After ethical review – guidance for researchers"

Copy to: *Dr Karen Bell, NHS Ayrshire and Arran*

West of Scotland REC 4

Attendance at Committee meeting on 10 January 2014

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mr Gavin Bell	Lay plus member	Yes	
Ms Lynda Brown	Public Health Adviser	No	
Mr Thomas Byrne	Lay plus member	No	
Ms Cristina Coelho	Senior Pharmacist Clinical Effectiveness	Yes	
Dr Michael Fail	Consultant Geriatrician	Yes	
Dr Claire Fang	GP	Yes	
Dr Ken James	Consultant Anaesthetist	Yes	
Dr Grace Lindsay	Reader	No	
Miss Fiona Mackelvie	Lay plus member	Yes	
Mrs Karen McIntyre	Lay plus member	No	
Dr Brian Neilly	Consultant Physician	Yes	
Mrs Linda Renfrew	Consultant Physiotherapist in MS	Yes	
Dr Jackie Riley	Statistician	Yes	
Dr Giles Roditi	Consultant Radiologist	Yes	
Dr Ihab Shaheen	Consultant Paediatric Nephrologist	Yes	
Dr Gary Tanner	Consultant Psychologist	Yes	
Mrs Kathleen Tuck	Lay plus member	Yes	
Mr Iain Wright	Lay plus member	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Dr Judith Godden	Scientific Adviser
Ms Evelyn Jackson	Committee Co-ordinator

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

West of Scotland REC 4
Ground Floor, Tennent Building
Western Infirmary
38 Church Street
Glasgow
G11 6NT
www.nhsggc.org.uk

Date 23 January 2014
Direct line 0141-211-1722
Fax 0141-211-1847
e-mail Wosrec4@ggc.scot.nhs.uk

Miss Diane Fraser
Trainee Clinical Psychologist
NHS Greater Glasgow and Clyde
Institute of Health and Wellbeing, University of Glasgow
Admin Building, Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Dear Miss Fraser

Study title:	**A qualitative exploration of parents' views and experiences of the Marschak Interaction Method (MIM).**
REC reference:	**14/WS/0007**
IRAS project ID:	**141494**

Thank you for your email of 20 January 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 20 January 2014

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Participant Information Sheet	4	20 January 2014
Participant Consent Form	4	20 January 2014

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
REC application	-	13 December 2013
Protocol	9	26 November 2013

Investigator CV	-	05 November 2013
Participant Information Sheet	4	20 January 2014
Participant Consent Form	4	20 January 2014
Interview Schedules/Topic Guides	3	26 November 2013
Other: Health and Safety Risk Assessment Form	2	26 November 2013
Other: Research Equipment, Consumables and Expenses Form	-	-
Other: Letter from University of Glasgow	-	12 July 2013
Other: Email re Clinical Governance Research and Strategy Group approval	-	15 August 2013
Other: Dr Suzy O'Connor's CV	-	06 March 2013

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

14/WS/0007 **Please quote this number on all correspondence**

Yours sincerely

Ms Evelyn Jackson
Committee Co-ordinator

Copy to: *Dr Karen Bell, R&D, NHS Ayrshire and Arran*

Major Research Project Proposal

A qualitative exploration of parent views and experiences of the Marschak Interaction Method (MIM).

Abstract

Background: Many childhood emotional and behavioural difficulties may be understood by examining the attachment bond between the child and their caregiver, and it is argued that effective therapeutic intervention should address any difficulties in this attachment relationship (Crittenden, 2006). The Marschak Interaction Method (MIM) is a video-based observational tool that examines the nature and quality of parent-child relationships. During the MIM, parents and children in a series of play-based tasks, while their interactions are video recorded. Parents are then invited to review the video-recorded footage with an interpreting clinician, and are encouraged to reflect upon their behaviour and that of their child, and consider how they may negotiate future interactions more effectively to strengthen their relationship with their child (Lindaman et al, 2000). Using video-feedback in this way has been shown to increase parental sensitivity to their child's developmental needs, which is associated with the development of secure attachment and more positive parent-child relationships (Fonagy et al, 1994; Bakermans-Kranenburg et al, 2003). Early research evidence and anecdotal clinician reports suggest that the MIM may have use as a powerful therapeutic tool to enhance parent-child relationships and address childhood emotional and behavioural difficulties, as it creates a visual medium that helps parents to reflect upon their relationship with their child (Lindaman et al, 2000). However, further research is needed to better understand the processes of change that are experienced by those participating in the MIM. **Aims:** This current study aims to gain a better understanding of how the MIM may be used as a therapeutic intervention by exploring how

it is experienced by those taking part. **Methods:** Participants will be selected on the basis that they are primary caregivers to a child, and have participated in the MIM as part of their on-going therapeutic care. Semi-structured interviews will be used to gather information about parents/carers' experiences of the MIM and their perceptions of these. Interview transcripts will then be explored using Interpretive Phenomenological Analysis to identify key themes. **Applications:** It is anticipated that this study and the insights that it generates may form the beginnings of an evidence base for the use of the MIM as a therapeutic intervention tool to address problematic parent-child relationships.

Introduction

The attachment bond between a child and his or her caregiver is a special relationship that has a powerful and enduring influence on the child's future development and interpersonal functioning throughout life. Secure attachment to a primary caregiver in the early years of life is believed to be of fundamental importance for healthy psychosocial development, and children who experience disruptions to this attachment relationship are at greater risk of developing psychological difficulties (Greenberg, 1999).

Children who have experienced nurturing and sensitive caregiving will develop confidence that their caregiver will be available in times of need, and a secure attachment bond will develop (Dozier et al, 2001). The attachment bond forms an 'affectional tie' between the child and their caregiver (Ainsworth and Bell, 1970) that provides the infant with a 'secure base' from which to explore the world around them, safe in the knowledge that their caregiver is there to offer support, guidance and reassurance should it be required (Bowlby, 1988). Absence of such responsive caregiving however, may lead the child to develop defensive behavioural strategies, such as anxious-avoidant or ambivalent attachment behaviours (Crittenden, 1990).

Through a process of aggregation of experiences and interactions with their primary care-giver, the child develops an 'internal working model' of the attachment relationship (Bowlby, 1988). This provides the child with expectations of their own and of their caregiver's behaviour within the relationship (Crittenden, 1990). The internal working model serves to regulate the child's behaviour within the caregiving relationship and provides a strategy for negotiating all significant relationships throughout the individual's life, and ultimately their relationship with their own child (Fonagy, et al 1991). Parents who have who have experienced disruptions in their own attachment relationships may have had little opportunity to internalise adequate models of caregiving relationships and so may struggle to form secure attachment relationships with their own children (Fonagy et al, 1994). In this way the parent's internal working model of caregiving relationships influences their child's attachment security and so attachment difficulties can be said to be inter-generationally transmitted (Zeanah and Zeanah, 1989).

Crittenden (2006) argues that attachment theory provides a useful basis for formulation of emotional and behavioural difficulties within the context of familial and inter-generational attachment relationships. She describes patterns of attachment as protective interpersonal strategies that emerge out of a process of interaction between developmental changes and interpersonal experiences, and suggests that quality of attachment can change and evolve over time in response to social, emotional and developmental experiences. As such, it is argued that identifying and addressing individual attachment strategies is an important and necessary step in providing effective psychological treatment (Crittenden, 2006).

Originally developed by Marianne Marschak (1960), the Marschak Interaction Method (MIM) is a semi-structured observational approach for assessing the nature and quality of parent-child attachment relationships (Lindaman et al, 2000). It consists of a series of video-recorded play-based tasks intended to elicit patterns of everyday interactions that can be categorised across four

dimensions of attachment behaviours: Structure, Engagement, Nurture, and Challenge. It addresses the parent's ability to set limits for the child that create feelings of safety and containment, whilst allowing the child the freedom to explore (Structure); to support the child's achievement and instil a sense of self-efficacy by selecting developmentally appropriate tasks and encouraging the child to strive (Challenge); to engage the child in reciprocal interactions, experience shared joy, and create an optimal level of arousal (Engagement); and to respond empathically to the child's emotional needs for comfort (Nurture) (Booth and Jernberg, 2010). The MIM is also concerned with the child's ability to negotiate tasks independently within the boundaries set by the parent, to respond to the parent's behaviour, and to communicate their emotional needs. In addition to the four domains outlined above, the MIM employs a separation-reunion task that examines how the parent and child negotiate a brief period of separation from one another, and how they manage their reunion (Lindaman et al, 2000).

The MIM is primarily used for assessment purposes prior to delivering Theraplay. Theraplay is a therapeutic model for clinical intervention that aims to facilitate the development of positive parent-child relationships through play. It is an attachment-based approach that supports parents to engage with their child in a way that encourages greater empathy and attunement to their child's developmental needs. In therapeutic practice, parents are guided by the therapist to interact with their child in a playful and engaging way, while recognising their child's needs and co-regulating their behaviour and emotional responses to that of their child (Booth and Jernberg, 2010). These play-based interactions are intended to foster secure attachments by providing "corrective experiences" that model positive interactional styles believed to support healthy social and emotional development (Bojanowski and Ammen, 2011).

As a structured observation, the MIM has many advantages over more standard assessment approaches when addressing problematic parent-child relationships. Participants are actively

involved in a number of novel tasks that elicit patterns of interaction that may be out with their awareness, and so not always accessible through more conventional interview and questionnaire methods. As such, the MIM has the ability to generate unique insights into the nature and quality of the parent-child relationship, by enabling direct observation of problematic patterns of interaction. Moreover, the structure of the MIM across the four key dimensions of attachment behaviours provides a more targeted assessment of specific problem areas, and allows direct comparisons to be made across settings and between participants (Lindaman et al, 2000).

Following administration of the MIM, an interpreting clinician will review video-recorded footage with the parent, carefully selecting video clips that highlight both positive and problematic patterns of interaction. Throughout this process parents are encouraged to reflect upon their own behaviour and emotions, as well as that of their child. In addition, parents are invited to reflect upon their own attachment experiences and consider how these may be played out in their relationship with their child. This provides a unique opportunity for parents to observe first-hand the factors that may be contributing to their experienced difficulties. In this sense the MIM provides a visual formulation that offers powerful emotional insights into problematic interactions within the relationship. This processes aims to enhance the parent's reflective capacity, which is associated with increased empathy (Fonagy et al, 1994), and so supports parents to develop greater attunement to their child's needs (Booth and Jernberg, 2010).

The notion of self-reflection is central to psychoanalytic theory, which proposes that difficulties in our relationships with others often have roots in factors that are out with our awareness, although may be more apparent to others, often referred to as our "blind spots". It is argued that in order for true change to occur we must first be made aware of and understand the factors that maintain our difficulties (Luft, 1982). Fonagy and colleagues (1994) argue that the enhancement of self-reflection is central to therapeutic change and so should be at the core of all psychological intervention.

Research suggests therapeutic interventions that encourage self-reflection in this way can have significant and lasting benefits long after therapeutic intervention has ended (Shedler, 2010).

Following a series of attachment based studies Fonagy and colleagues (1994) reported that reflective capacity is the single best predictor of an individual's ability to form secure attachment relationships with others. In addition it has been shown to increase resilience and protect against the intergenerational transmission of insecure attachment (Fonagy et al, 1994). With this in mind, it is conceivable that, as a therapeutic method that aims to enhance reflective capacity, the MIM may have great potential in facilitating the development of secure attachment relationships. Furthermore, the MIM also provides opportunities to highlight the strengths of the adult and child in negotiating their interactions with one another, and to reflect upon these as a platform for intervention (Lindaman et al, 2000).

Research consistently reports positive effects of other such video-feedback interventions in therapeutic settings with parents and their children (for a review see Fukkink, 2008). Video-feedback approaches aim to increase parental sensitivity to their child's needs by providing a "visual medium" that enhances reflection and serves as a catalyst for therapeutic change (Fukkink, 2008; 905). Video-feedback interventions have been shown to be highly effective in enhancing parental sensitivity and responsiveness to their child's needs, and it has been demonstrated that parental sensitivity plays a causal role in attachment security (Bakermans-Kranenburg et al, 2003).

Existing evidence and anecdotal clinician reports offer some support to the use of the MIM as a therapeutic tool in this way. Participation in the MIM alone is often reported by parents to have a positive impact on their relationship with their child (Jernberg and De Lauriers, 1962; Lindaman et al, 2000). Clinicians have reported that reviewing video-taped recordings of MIM interactions with parents is often experienced as something of a 'turning point' in therapy. Lindaman and colleagues

(2000) describe how reviewing MIM tasks with parents appears to break down negative perceptions by encouraging parents to consider their child's perspective and recognise their child's emotional and developmental needs. In addition, parents are encouraged to consider how they may negotiate future interactions more effectively to strengthen their attachment relationship with their child (Jernberg 1992a cited in Lindaman et al 2000:396). The MIM may then be used to subsequently monitor the impact of therapeutic intervention on the parent-child relationship and their growing attachment to one another (Lindaman et al, 2000).

Aims

Early research evidence and anecdotal clinician reports suggest that the MIM may have use as a powerful therapeutic intervention tool to enhance parent-child relationships and address childhood emotional and behavioural difficulties by providing a visual medium that supports parents to reflect upon their relationship with their child. However, further research is needed to better understand the processes of change that are experienced by individuals following their participation in the MIM. We do not yet know how the MIM is experienced from the perspective of parents and carers, and what meanings are ascribed to these experiences. To gain a better understanding of how the MIM may be used as a therapeutic intervention tool, it is important understand how it is experienced by those taking part. This current study aims to explore parents' and carers' experiences of the MIM, and how they make sense of these experiences to implement therapeutic change and build more positive relationships with their children.

Plan of Investigation

Design

This study will adopt a qualitative research design. Individual semi-structured interviews will be conducted to gather participant information, which will then be analysed using Interpretive Phenomenological Analysis (IPA: as outlined by Smith et al, 2009).

Participants

Potential participants will be identified on the basis that they are primary caregivers to a child who currently attends NHS Ayrshire and Arran Community Paediatric Service or Child and Adolescent Mental Health Service, and who have participated in the MIM as part of their on-going therapeutic care.

Potential participants will be excluded from the study if they are deemed to be unable to provide informed consent to participants, if they have a diagnosed communication disorder, or if they do not speak English.

Justification of Sample Size

This study will employ qualitative Interpretative Phenomenological Analysis (IPA) to explore research data. The primary objective of IPA is to obtain a "detailed account of individual experience", and as such IPA studies benefit from a "concentrated focus on a small number of cases" (Smith et al, 2009: 51). The power of an IPA study is therefore determined by the quality of the insights that it offers (Smith and Osborne, 2008). Between four and ten participants has been cited as the desired sample size for IPA (Smith et al, 2009; Smith and Osborne, 2008). This allows for detailed analysis of each individual case, whilst also enabling similarities and differences across cases to be explored (Smith et al, 2009).

This study will aim to recruit up to 10 participants, however given that our aim is to gather the richest quality of data, the actual sample size will depend on the nature of the data obtained in the initial interviews. The same size should be sufficient enough to ensure that the maximum number of meaningful perceptions have been explored (Mason, 2010).Interview transcripts will be explored in detail as the data is collected, and data collection will continue until theme saturation has been

achieved; that is that the analysis of new data does not provide any new insights into the topic being explored.

Recruitment Procedures

Approval to conduct this study will be required from NHS Ayrshire and Arran Clinical Governance Research and Strategy Group, NHS Ayrshire and Arran Research and Development Management, and the West of Scotland NHS Research Ethics Service prior to beginning recruitment.

Participants will be identified by the Field Supervisor, a Clinical Psychologist employed within NHS Ayrshire and Arran Community Paediatric Service. The Field Supervisor will identify potential participants by liaising with her clinical colleagues to identify individuals who have recently participated in the MIM as part of their on-going clinical care within NHS Ayrshire and Arran Community Paediatric Service or Child and Adolescent Mental Health Services. Access to identifiable personal information and confidential patient records will not be required by anyone out with the individual's existing clinical care team.

Participants will be approached in the first instance by a clinician within their existing clinical care team, with whom they have contact with as part of their on-going therapeutic care. They will be provided with a written invitation to participate and a patient information sheet outlining the aims of the study and the nature of their potential involvement. Participants will have the opportunity to ask questions and discuss their potential involvement in the study with the Field Supervisor, Chief Investigator, or an independent clinician, who has knowledge of the research process but does not have any direct involvement in the study. A draft letter of invitation and participant information sheet can be viewed in appendix 1 and 2 respectively. Once participants have had adequate time to review this information and consider their participation in the study, they will be asked to provide

written consent to participate. Completed consent forms will be collected by the participant's responsible clinician during routine therapeutic appointments and passed to the Field Supervisor.
A draft participant consent form can be viewed in appendix 3.

Research Procedures

Once written consent has been obtained, participants will be contacted by the Chief Investigator to arrange to conduct the research interview at date and time that is convenient for each individual. Research interviews will take place following the participant's completion of the MIM and the MIM feedback session with their clinician, and after they have received a therapeutic letter summarising the feedback offered by their clinician. Interviews will be conducted in private clinic rooms within the Community Paediatric Service. Participants will be interviewed individually by the Chief Investigator, a Trainee Clinical Psychologist. Interviews will be voice recorded using a digital recording device and transcribed as soon as possible following completion of the interview.

The interview agenda will consist of a number of non-directive open-ended questions that will enquire about participants' experiences of the MIM. Specifically participants will be asked about their expectations of the MIM; their experiences of the MIM tasks, the feedback session and their thoughts on the therapeutic letter provided following completion of the MIM; and if they have experienced any resultant changes in their perceptions, attitudes or behaviour with regards to their child.

Consistent with IPA guidance, interviews will begin with more general and descriptive questions so as to settle participants into the interview process, before progressing to more personal and analytical questions once rapport has been established (as recommended by Smith et al, 2009). The researcher will be guided by the participants' discussion and may engage in further questioning around specific areas of interest that arise. The purpose of the interviews will be to allow the

participants to discuss their experiences in a way that is meaningful to them, and so a degree of flexibility in the interview schedule will be maintained. Care will be taken however to boundary the discussion within the limits of the research topic area. A draft interview schedule can be viewed in appendix 4.

Data Analysis

Qualitative methods are best placed to analyse data exploring individual perception and understanding (Smith and Osborn, 2008). IPA has been chosen as the most appropriate method for this study as the focus is on the experience of individuals within a specific situation. IPA uses an idiographic mode of enquiry that seeks to provide a detailed account of individual experience and the meanings that they ascribe to this in order to inform more generalised hypotheses (Smith et al, 2009).

Interview transcripts will be explored and analysed following the IPA process as outlined by Smith and colleagues (2009). This will enable the researcher to identify key insights and personally-salient features of the participant's discussion, which will then be compared across cases to look for any emerging themes. Secondary analysis will be provided by the Academic Supervisor with a view to enhance the reliability of the findings.

Health and Safety Issues

Research interviews will be conducted within the clinic setting at NHS Ayrshire and Arran's Community Paediatric Service. Interviews will be conducted during normal working hours when other members of staff are present in the building. Local health and safety procedures and policies will be consulted prior to beginning data collection and will be adhered to throughout the research process to ensure minimal risk is posed to both the researcher and the research participants. The

University of Glasgow's Health and Safety Risk Assessment Form for this proposed research project can be viewed in appendix 5.

Ethical Issues

The nature of the research topic is a sensitive one. Participants will be asked to discuss personal details about their relationship with their child and their experiences of therapy. This discussion may be emotive and will encourage participants to reflect upon a number of personal experiences and difficulties that could potentially be upsetting. Furthermore, within NHS Ayrshire and Arran Community Paediatric and Child and Adolescent Mental Health Services, families referred for therapeutic participation in the MIM tend to be those experiencing a number of complex difficulties.

The Chief Investigator, a Trainee Clinical Psychologist, will take care to manage and respond to any distress appropriately and sensitively. Efforts will be made to engage with participants in a respectful and sensitive manner so as to minimise any potential power imbalance that may inadvertently be created by the very nature of the interview process. If any concerns are raised or upset is experienced by the participants during the research interview, they will be directed to discuss this with their responsible clinician, who will be best placed to address this within their on-going therapeutic contact.

Care will be taken to ensure that potential participants to do not feel coerced or pressurised to consent to participate in the research. It will be made clear that their participation is voluntary, that they have the right to refuse or withdraw their consent at any time prior to or during the data collection process, and that their decision to do so will in no way impact upon the therapeutic care that they receive. Participants will be given information about the aims of the research and the nature of their involvement, as well as the possibility of the inclusion of verbatim extracts in any published reports, prior to providing informed consent. Participants will be given time to review the

participant information sheet and consent form privately so as to avoid any indirect pressure to consent. Throughout the interview process verbal consent will be sought to enquire about any unanticipated emerging issues further (as recommended in Smith et al, 2009).

Every effort will be made to ensure that patient confidentiality is maintained at all times in line with the NHS Code of Practice on Protecting Patient Confidentiality and the Data Protection Act (1998). No personal identifiable data will be used in the reporting of this study and access to personal patient records will not be required. All data gathered will be stored anonymously on a password protected and encrypted laptop provided by the University of Glasgow's Institute of Mental Health and Wellbeing.

Guidance published by The National Research Ethics Service (NRES) (2011) has been consulted for the design of participant information leaflets and consent forms for this current research study. Approval to conduct this study will be sought from NHS Ayrshire and Arran Clinical Governance Research and Strategy Group, NHS Ayrshire and Arran Research and Development Management, and the West of Scotland Research Ethics Service prior to embarking upon this research. Ethical issues will be continually monitored and reflected upon throughout the research process.

Financial Issues

The Chief Investigator will require access to a digital recording device and password protected and encrypted laptop provided by the University of Glasgow's Institute of Mental Health and Wellbeing. The Chief Investigator will be required to travel between NHS Greater Glasgow and Clyde and NHS Ayrshire and Arran localities for the purposes of data collection. It is anticipated that any travel expenses incurred will be personally covered by the Chief Investigator. The Research Equipment, Consumables and Expenses form for this project can be viewed in appendix 6.

Timetable

Application to ethics: November 2013.

Data collection and analysis: December 2013 to April 2014.

Write up: May to July 2014.

Practical Applications

It is anticipated that this study may form the beginnings of an evidence base for the use of the MIM as a clinical intervention tool to enhance parent-child relationships and address childhood emotional and behavioural difficulties. Existing evidence suggests that the MIM serves to facilitate parental insight and understanding, and encourages the development of a positive attachment relationship with their children. In this sense, the MIM may be used as an effective intervention tool to enhance the therapeutic endeavour, in the widest sense, within Child and Family Mental Health services.

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