

**Healthy Start, Happy Start: Fathers' experiences and engagement in an attachment-based  
parenting intervention**

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Name: Olivia Williams

Date: June 2017

## **Overview**

Emotional and behavioural problems frequently begin in early childhood. With fathers becoming increasingly involved in young children's care there is a need to understand the impact paternal parenting has on children's early development and to involve fathers in parenting interventions that so frequently leave fathers out. Part one of this thesis is a meta-analytic review examining whether paternal parenting is reliably associated with internalizing problems in young children. Part two of this thesis is a qualitative investigation into fathers' experiences of and engagement in an attachment-based parenting programme (Video-feedback Intervention to Promote Positive Parenting and Sensitive Discipline; VIPP-SD). Part two also sought to elucidate mothers' perspectives of fathers' involvement in VIPP-SD. Part two of this thesis formed a qualitative sub-study of a larger multi-site randomized controlled trial 'Healthy Start, Happy Start' (HS, HS). Part three is a critical appraisal of the research process which primarily considers the impact my dual role as clinician and researcher in HS, HS had on the research process.

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This thesis is written in loving memory of my grandparents, Joan and Bumpy, who would have been so proud.

## **Fathers' parenting and young children's internalizing problems: a meta-analytic review**



## **Abstract**

**Aim:** This review aimed to examine whether paternal parenting is reliably associated with internalizing problems in young children across studies conducted to date using meta-analysis.

**Method:** Systematic electronic searches were conducted in order to identify relevant studies examining associations between paternal parenting and young children's internalizing problems. Methodological quality of the studies was assessed using Crowe and Sheppard's (2011) critical appraisal tool.

**Results:** Twenty-three studies were identified ( $N=9,725$ ). Paternal parenting was found to be significantly associated with internalizing problems in young children ( $d=0.12$ ,  $k=22$ ). Of the specific parenting behaviours studied, paternal challenging parenting behaviour was found to have the largest effect on children's internalising problems ( $d=0.40$ ,  $k=5$ ). Harsh paternal behaviour was found to be associated with children's internalising problems ( $d=0.17$ ,  $k=5$ ). Paternal controlling behaviour was also found to be associated with children's internalising problems ( $d=.17$ ,  $k=16$ ). Paternal rejection was not found to be associated with children's internalising problems ( $d=.01$ ,  $k=9$ ). No significant moderators were identified.

**Conclusions:** Paternal parenting is associated with the development of internalizing problems in early childhood. This effect is generally small and of a similar size to the effects of maternal parenting on children's emotional problems. Harsh and controlling paternal parenting behaviours and less challenging paternal parenting are associated with increased risk for internalizing problems in young children. These findings indicate the need to engage fathers in parenting interventions, particularly given fathers are disproportionately left out of such programmes.

## **Introduction**

Internalizing problems in childhood include the following symptomology, either in combination or as isolated symptoms: somatic problems (e.g., feeling tired, nausea), social withdrawal (e.g., shyness), depression (e.g. crying) and anxiety (e.g., fear, worries) (Achenbach, Edelbrock, & Howell, 1987). Internalizing problems are amongst the most common difficulties in early childhood (Zahn-Waxler, Klimes-Dougan, & Slattery, 2000), and have been shown to have moderate to high stability over the preschool years (Bilancia & Rescorla, 2010) and to persist through into adolescence and adulthood (Hastings, Sullivan, McShane, Coplan, Utendale & Vyncke, 2008; Majcher & Pollack, 1996). Childhood internalizing problems are known precursors for both anxiety and mood disorders (Roza, Hofstra, Van der Ende & Verhulst, 2003). Such problems can impair children's functioning in numerous areas from learning, to leisure time and interpersonal interactions (e.g., Bufferd, Dougherty, Carlson, & Klein, 2011); and affect boys and girls equally (Klein, Otto, Fuchs, Zenger, & von Klitzing, 2013). To limit costs to the individual, their families and society, an understanding of factors that increase the risk of internalizing problems both within the child and their environment is needed for the development of preventative early interventions (Yap & Jorm, 2015).

### ***The evidence base linking parenting with emotional difficulties in childhood***

A widely recognized risk factor in the emergence and maintenance of childhood emotional problems are patterns of parent-child interactions and parenting characteristics (e.g. Loeber, Burke, & Pardini, 2009). The evidence highlighting this association is large and findings often vary considerably (McLoed, Weisz & Wood, 2007). Usefully, there have been a handful of reviews that have attempted to systematically synthesise and in some cases meta-analyse this evidence base (McLoed, Weisz & Wood, 2007; Yap, Pilkington, Ryan & Jorm, 2014; Yap & Jorm, 2015). For example, in their meta-analysis investigating parental factors associated with anxiety and depression in 12-18 year olds, Yap, Pilkington, Ryan and Jorm (2014) found that parenting factors which include less warmth, more over-involvement, inter-parental conflict, and aversiveness increased the child's risk for experiencing depression and anxiety. They also found that less autonomy granting and monitoring were associated with an increased risk of depression in offspring. An additional meta-

analysis (k=45). McLoed, Weisz and Wood (2007), examined the association between parenting and childhood depression. They found that 8% of the variance in childhood depression was accounted for by parenting, more specifically parental rejection and control. Moreover, their findings also indicated that the various sub dimensions of parenting were differentially associated with childhood depression; the most strongly related to child depression was parental hostility toward the child. Their analyses also showed that methodological factors (i.e., how childhood depression and parenting were conceptualised and assessed) moderated the association between parenting–childhood depression. They concluded that inconsistent findings within the evidence-base are partially explained by variations in measurement quality across studies.

Whilst useful, there are several limitations to these reviews that could be built upon. Firstly, both reviews focused on childhood depression and/ or anxiety. This is an important limitation given evidence that there is large overlap between anxiety and depression and that such difficulties are particularly challenging to disentangle in childhood (Yap & Jorm, 2015). Both clinicians and researchers alike are beginning to highlight the benefit of utilising the broader definition of internalizing problems to prevent the need to disentangle these difficulties; using the broader definition also allows researchers and clinicians to approach prevention and treatment transdiagnostically (Craske, 2012; Dozios, Seeds & Collins, 2009). Indeed, transdiagnostic approaches have more potential to increase generalizability, efficacy and cost effectiveness (Yap & Jorm, 2015).

Helpfully, a recent review has included anxiety, depression and internalizing problems in a meta-analysis on parental factors reliably associated with internalizing problems in children aged 6 to 11 years (Yap & Jorm, 2015). This study highlighted that parental factors such as low warmth, over-involvement, higher rates of abusive parenting and averseness were linked to child internalizing problems. Whilst this review accounted for internalizing symptoms, further research could build upon these findings by considering these associations at different phases of child development, for example early childhood, when parents have more influence over their children than other influences (e.g. peers or other adults) (Moller, Nikolic, Majdandzic & Bogels, 2016). Additionally, as Yap and Jorm (2015) highlight, many of the studies in their review involved mothers primarily. Consequently,

it was therefore unclear what the effects of fathering might have been because maternal parenting was overrepresented.

### ***The importance of considering fathers' roles in children's emotional development***

Parenting research and more specifically research into children's internalising problems, has until recently almost exclusively focused on mothers and largely neglected fathers. This is despite indisputable evidence that fathers make unique and significant contributions to their children's development (Lamb, 2004; NICHD Early Child Care Research Network, 2008). Examples of fathers' contributions come from cohort studies which have found that through infancy to adulthood, fathers' involvement can have a positive effect on children's psychological, behavioural, social and educational outcomes (Panter-Brick, Burgess, Eggerman, Mcallister, Pruett, & Leckman, 2014). Longitudinal research has also highlighted fathers' contributions to child's development. For example, sensitive responses from fathers in play with their two year olds has been found to be more significant in predicting childhood adjustment at age 10 than early mother-child attachments (Grossman, Grossmann, Fremmer-Bombik, Kindler, Scheuerer-Englisch, & Zimmermann, 2002). Further, with average levels of paternal involvement increasing and more women returning to work, fathers from industrialised countries are more involved with their children's early care than ever before (Cabrera, Tamis-LeMonda, Bradley, Hofferth, & Lamb, 2000). As researchers have begun to recognize fathers' increased involvement in childcare, they are beginning to focus more on the father and child relationship (Doherty & Beaton, 2003). Additionally, whilst in the past research has focused on measuring fathers' involvement (i.e. absence or presence), much broader conceptualisations of fathers' involvement are now being considered, such as a father's warmth, responsiveness, monitoring and control and the impact this has on child development (e.g. Pleck, 2010).

### ***Differences in parenting between mothers and fathers***

Although fathers are spending increasing amounts of time with their children than they have done historically, considerable evidence exists highlighting differences in paternal and maternal parenting styles and behaviors towards their children (e.g., Bogels & Phares, 2008; Moller, Majdandžić, Vente, Bögels 2013). Whilst on average mothers still spend more time than fathers with their children (Geary, 2010), fathers spend more time playing with their children than mothers

(Lawson & Mace, 2009). Qualitative differences have also been found between mothers' and fathers' parenting behaviours. For example, fathers' are more likely than mothers to stimulate risk-taking and challenge their children (Ishak, Tamis-LeMonda & Adolph, 2007). Mothers however, are more likely than fathers to use pretend play with their children (Lindsey & Mize, 2001) and be more sensitive (Lewis & Lamb, 2003), warm and more supportive in interactions with their children (Simons & Conger, 2007). Unfortunately, until relatively recently fathers influence on their children's development has largely been considered in relation to ways in which mothers typically interact with their children. Helpfully, recent research is beginning to shed light on the impact more typical paternal parenting behaviors are having on children's emotional development instead of solely focusing on considering fathers' parenting behaviours that are more common in mothers.

### ***Differential effects of maternal and paternal parenting on children's emotional development***

Crucially, one systematic review and meta-analysis has evaluated the effects of both maternal and paternal parenting separately on children's emotional development and has importantly included parenting behaviours that are considered more typical for fathers as well as the behaviours that are known to be more usual for mothers (Moller, Nikolic, Majdandzic & Bogels, 2016). In their review, both maternal and paternal parenting behaviors were found to be associated with anxiety in early childhood (0 to 5 year olds). Two meta-analyses were conducted one for fathers (k=12, N=1,019) and one for mothers (k=28, N=5,728). Small associations between parenting and child anxiety were found. Associations between child anxiety and overprotection, over control and over involvement did not significantly differ for fathers and mothers. However, associations between mothers' and fathers' challenging parenting did significantly differ; whilst mothers' challenging parenting was not significantly associated with child anxiety, fathers' challenging parenting was associated with less child anxiety. Importantly, they found that there was a stronger association between paternal parenting and child anxiety symptoms than maternal parenting and child anxiety symptoms. They concluded that fathers' parenting is as important as mothers' parenting, even though the role parenting was found to play in child anxiety was small.

Moller, Nikolic, Majdandzic and Bogels's (2016) review helpfully considered both mothers' and fathers' roles in their children's emotional development and also benefits from considering parenting

styles that are more typical of fathers. In addition, the focus on this young age group (zero to six years) is useful for a number of reasons. Firstly, as highlighted before, parents have more influence over their children than any other influences at this stage (e.g. peers). Secondly, this is important especially when considering that, during this period children have to undergo many developmental tasks such as developing self-regulation, tolerating increased separation from their parents and co-operating with people around them (Moller, Nikolic, Majdandzic & Bogels, 2016). Thirdly, early childhood has been identified as an “optimal time” to notice and limit the early signs of difficulties (Poulou, 2015,). Finally, given the high prevalence of internalizing problems in this period and its stability and risk for further difficulties, researching both risk and protective factors at this developmental period is crucial. Although this review has a number of benefits, further research could build upon these findings. For example, this review excluded studies that reported on children’s internalizing problems. In addition to the reasons provided for the importance of taking this transdiagnostic approach, this would also be helpful given evolving evidence suggesting that mothers and fathers play a different role in the development of children’s internalizing problems (e.g., Moller Majandzic, De Vente & Bogels, 2013).

### ***The current meta-analysis***

Given the literature presented, there is a clear need for a review of the evidence associating young children’s internalizing problems and paternal parenting. Previous reviews have largely focused on maternal parenting and when they have sought to include fathers, they have either not considered parenting behaviours that are more common to fathers than mothers (e.g. challenging parenting behaviours) or they have been limited to focusing on anxiety rather than focusing on broader internalising problems, which is arguably more clinically useful (Yap & Jorm, 2015). This meta-analysis focused on young children (0-6 years) because this period has been identified as an optimal time to limit early difficulties (Poulou, 2015). In summary the current meta-analysis aimed to assess reliable associations between paternal parenting and young children’s internalizing problems.

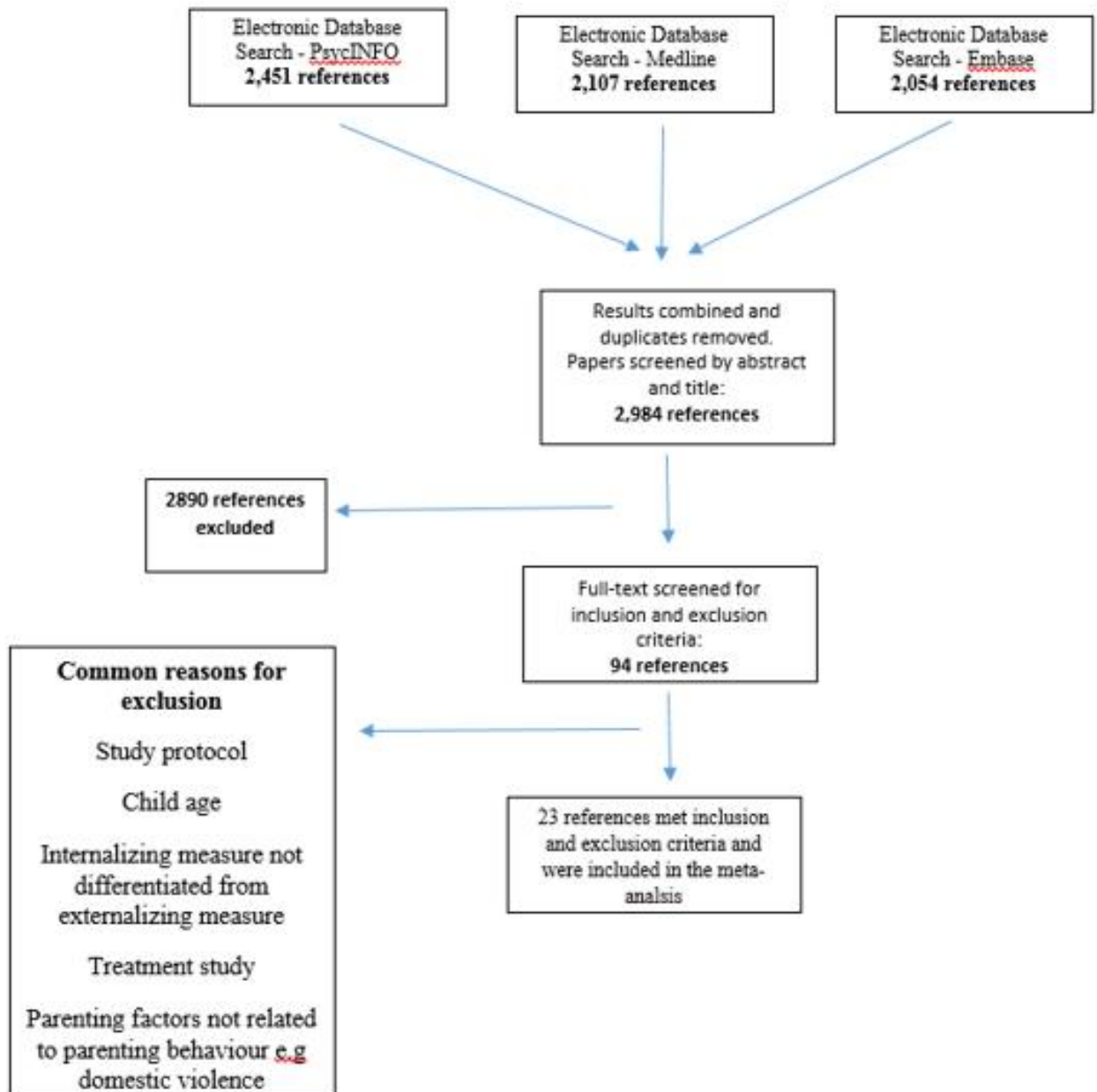
## Method

### *Selection of studies*

A systematic search of the literature was conducted. Electronic databases PsycINFO, Embase and Medline were searched. The following search terms were used: (Father\* or Paternal or Dad\*) in abstract OR (Father\* OR Paternal OR Dad\*) in title AND (sensitiv\* OR responsiv\* OR warm\* OR interact\* OR engage\* OR synchrony\* OR parenting OR caregiving\*) in title OR (sensitiv\* OR responsiv\* OR warm\* OR interact\* OR engage\* OR synchrony\* OR parenting OR caregiving\*) in abstract AND (internaliz\* OR internalis\* OR withdraw\* OR shy OR depressi\* OR fear\* OR emotion\* OR anxi\* OR sad) in abstract OR (internaliz\* OR internalis\* OR withdraw\* OR shy OR depressi\* OR fear\* OR emotion\* OR anxi\* OR sad) in title. Searches were limited to those written in the English language, written in or after 1996 and were from peer reviewed journals. The search was conducted in November 2016.

### *Study selection*

Studies were included if they reported on the relation between paternal parenting and child internalising symptoms and met the following inclusion criteria: (a) included one or more parenting variables as a predictor in the analysis; (b) included internalising symptoms or a diagnosis of anxiety or depression as an outcome variable in the analysis; (c) cross-sectional, longitudinal or case-control study design; (d) published in a peer reviewed journal; and (e) parenting was measured when the median or mean age of child participants was age six years or below. Studies were excluded if they met the following criteria: (a) published in a language other than English; (b) did not specify the child age range; (c) the outcome variable measured a temporary state or task anxiety; and (d) the paper was a narrative or systematic review, meta-analysis or discussion paper or reported a treatment/therapy intervention. Additionally, articles were excluded if they; (e) reported on constructs concerning temperament (e.g., behavioral difficulty); (f) were positively valenced constructs referencing healthy psychological adaptation (e.g., ego-resiliency, self-esteem); (g) used broad assessments of negative affect (e.g., negative emotion); and (h) used measures that blended internalizing and non-internalizing psychopathology assessments (e.g., the CBCL Total Problems scale). Figure 1 summarizes the results of the different phases of the literature search.



**Figure 1: Flow diagram of electronic search strategy**

### ***Information extracted***

Of the studies that qualified for inclusion, data was extracted by the main author guided by an extraction sheet developed by the main author and their supervisor. Information about the following variables was extracted from each study: (a) participant characteristics including child age, socio-economic status (SES), gender of the child (a 50% split was assumed when the gender composition was not reported); (b) type of parenting behavior; (c) measurement technology of parenting measure



(i.e., interview, questionnaire, observation); (d) parenting informant (i.e., parents, mother, father, teacher, researcher); (e) internalizing difficulty informant (i.e., mother, father, parents, researcher, teacher); (f) whether or not the participants were diagnosed with an anxiety disorder (i.e., yes, no). Extracted information also included descriptive information regarding the sample size, study design, details of the predictor and outcome variables and the p-values, direction of effects and unadjusted effect size. Another trainee clinical psychologist also independently extracted the above data to verify accurate extraction by the main author. They were given all the included journal articles with information about coding processes and a data extraction sheet. Discrepancies were resolved via discussion with the research supervisor and agreements were reached. Characteristics of the included studies can be found in Table 1.

### ***Childhood internalizing difficulties***

Internalizing difficulties were operationalised using the Child Behaviour Checklist (CBCL; Achenbach, Edelbrock, & Howell, 1987) as a reference. The CBCL focuses on internalizing constructs of somatic problems (e.g., feeling tired, nausea), social withdrawal (e.g., shyness) and depression and anxiety (e.g., fear, worries, crying) (either alone or in combination). Childhood internalizing difficulties were assessed using the following methods: 13 studies relied solely on questionnaires, two studies relied solely on interviews and two studies relied solely on observation. Four of these studies used multiple methods to assess internalizing problems (i.e. questionnaires in combination with either observation or interview). Regarding the internalizing difficulties informant, five exclusively relied upon mothers' reports, three exclusively relied upon fathers' reports, two relied exclusively on teachers reports and one exclusively relied upon researchers reports. 12 relied on combined reports from more than one informant (i.e. mother, father, teacher, researcher).

Table 1. Characteristics of studies included in the meta-analysis

Study	N	% female	Child age (months) at first time point	Parenting domain	Parenting method	Internalising method	Internalising informant	C diagnosis
Brook et al., (1996)	115	54%	24	2 and 3	Q	Q	F	N
Chen & Johnston (2012)	160	52.50%	34.87	2	Q	Q	M, F	N
Dougherty et al., (2013)	400	45.75%	43.2	3	Q	I	M	MIX
Fleik et al., (2015)	105	41.90%	51.24	3 and 4	Q	Q	M and D	N
Guimond (2012)	137	52.60%	30	3	Q	O	R	N
Hastings et al., (2008)	105	50%	42	2 and 3	Q and O	Q and O	T and M and F, R *	N
Karremman et al., (2010)	89	49%	36	3	O	Q	T and M and F	N
Lazarus et al., (2016)	138	56%	47.64	4	Q	I and Q	M	MIX
Lee et al., (2010)	2,269	48%	36	1	Q	Q	M	N
Liu et al., (2015)	311	49.51%	48	1	Q	Q	M and D	N
Mackenbach (2014)	4,015	50.1%	37.2	1	Q	I and Q	M	N
Majandzic et al., (2014)	74	44%	51.72	3	O	Q	T	N
McShane et al., (2009)	92	53.04%	42.36	3	O	Q and O	R, T and M and F **	N
Mezulis et al.,	350	52%	54	3	Q	Q	T	N

Key

Q= questionnaire, I= interview, O= observation  
M= mother, F= father, T= teacher, R= researcher  
Parenting domains: 1= abuse, 2= rejection, 3= control, 4= challenging  
\*\* T and F and M rated questionnaire, R rated observation  
\*\*\* R rated observation, T and F and M rated questionnaire  
\*\*\*F rated questionnaire, R rated observation

Table 1. Characteristics of studies included in the meta-analysis

Study	N	% female	Child age (months) at first time point	Parenting domain	Parenting method	Internalising method	Internalising informant	Internalising C diagnosis
(2004)								
Moller et al., (2015)	81	51%	11.88	3 and 4	Q	Q	M, F	N
Natsuaki et al., (2013)	269	43%	18	2	Q and O	Q	F, R ***	N
Natsuaki et al., (2013) b	353	50%	18	3	O	Q	M and F	N
Otto et al., (2016)	176	52%	62.53	3	Q	I	M	MIX
Sebre et al., (2014)								
<i>Latvian sample</i>	274	48%	45.18	1 and 3	Q	Q	M, F	N
<i>Lithuanian sample</i>	162	49%	45.18	1 and 3	Q	Q	M, F	N
Stroud et al., (2015)	149	46%	54.43	2	O	Q	F	N
Van der Bruggen et al., (2010)	35	54.43%	44.28	2, 3 and 4	Q	O	F	N
Wieke De Vente et al., (2011)	135	50%	11.88	2 and 3	Q	Q	M and D	N

Key  
Q= questionnaire, I= interview, O= observation  
M= mother, F= father, T= teacher, R= researcher  
Parenting domains: 1= abuse, 2= rejection, 3= control, 4= challenging  
\*\* T and F and M rated questionnaire, R rated observation  
\*\*\* R rated observation, T and F and M rated questionnaire  
\*\*\*F rated questionnaire, R rated observation

## ***Parenting***

Following a previous review by Yap and Jorm (2015) parenting variables were defined as behaviour toward the child that are potentially within the parent's control. The large variety of literature in this area meant that it was necessary to group the parenting variables into four parenting domains to ensure meaningful analyses could be run. Variables were grouped using definitions provided by previous reviews on parenting variables (McLoed, Weisz & Wood, 2007; Yap & Jorm, 2015). Following these reviews, two broad dimensions of rejection and control were used. Rejection included withdrawal, aversiveness and warmth. Control included over-involvement and autonomy granting. Harsh parenting included inconsistent discipline, permissive parenting, abusive and authoritarian parenting. Additionally, challenging parenting behavior was also included as a separate parenting theme; this construct refers to a child being playfully encouraged to push their limits (Majdandzic, Moller, de Vente, Bogels & van den Boom, 2014). Unfortunately, sub-dimension analyses were not possible due to the limited number of studies per sub-dimension. Therefore, only the four main parenting domains (i.e. rejection, control, harsh and challenging parenting) were utilised in the analysis.

## ***Ratings of methodological quality***

Methodological quality of studies was rated using a checklist developed by Crowe and Sheppard (2011). This checklist is suitable for assessing the quality of quantitative or qualitative health research (See Appendix 1). It contains reporting items in eight domains: Preamble, Introduction, Design, Sampling, Data collection, Ethical matters, Results, and Discussion. Each domain receives its own score on a 6 point scale, ranging from 0–5. The lowest score given to a category is 0, and 5 is the highest score. Only item descriptors, not domains may be marked 'not applicable'. For example, for this review some item descriptors were not applicable e.g. "gives precise details of intervention". The maximum score across domains is 40, studies are not penalised for descriptors that are rated as "not applicable". Crowe and Sheppard's (2011) guidelines on using this tool were followed. This tool has good construct validation (Crowe and Sheppard, 2011) and an inter-rater reliability of .74 has been found for the total score (Crowe, Sheppard & Campbell, 2012).

### ***Data preparation***

Before analysing the data, it was necessary to combine several data points. Firstly, when there were multiple informants for child internalizing difficulties these were averaged to create a single data point. Second, when there were multiple informants for parenting behaviors these were averaged to create a single data point. Thirdly, when multiple methodologies were utilized for child internalizing difficulties these were averaged to create a single data point. Similarly, when there were multiple methodologies assessing parenting behaviors these were averaged to create a single data point. When studies utilized a longitudinal data design, only the first time point were included in the analysis.

### ***Data analysis***

#### ***Effect size computation***

Studies were included in the meta-analyses if they provided an effect size measure that could be converted to a standardised effect size estimate. The correlation coefficient  $r$  was the most commonly reported statistic. When studies did not report a correlation coefficient, other effect size measures that are accepted by Comprehensive Meta-Analysis (CMA) Version 2.2.064 were used, which converts them into  $r$  (Borenstein et al., 2009). When an association statistic was not reported in the published findings, the authors were contacted and the researcher was given the necessary statistic. When a study compared two clinical groups (e.g. severe anxiety disorder, versus mild/moderate anxiety disorder) we took the weighted mean of the two groups. For the analysis, all correlation co-efficients were then converted into standardised mean differences.

#### ***Meta-analysis procedures***

Using CMA, five sets of meta-analyses were conducted. The first meta-analysis tested the overall association between paternal parenting and child internalizing problems, based on all available studies. The remaining four meta-analyses then examined each major domain of parenting in turn: the relation between paternal rejection and child internalizing problems; then the relation between paternal harsh parenting and child internalizing problems; then the relation between paternal control and child internalizing problems and finally one for the relation between paternal challenging parenting behaviour and child internalizing problems.

A random effects model was used throughout because we expected substantial heterogeneity (Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010). Such models allow for the possibility that random differences between studies exist and could be associated with variations in procedures, settings and measures beyond subject-level sampling error and could therefore indicate different study populations (Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010; Lipsey & Wilson, 2001). The  $Q$  and  $I^2$  statistics were calculated as indicators of heterogeneity; these were calculated to test the homogeneity of the specific sets of effect sizes as well as the overall effect size. Whilst an  $I^2$  value of 0% indicates no observed heterogeneity, the larger values indicate greater heterogeneity (25%=low, 50%=moderate, 75%=high) (Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010). Additionally, 95% confidence intervals (CIs) were computed around the point estimate of each set of effect sizes. This was based on random effect estimates. To assess differences between combined effect sizes for specific subsets of studies grouped by moderators,  $Q$  statistics and  $p$  values were also computed. Contrasts were only tested when at least three studies were consisted in at least two of the subtests.

The “trim-and-fill” method (Duval & Tweedie, 2000) was used to elucidate the effect of potential data censoring (publication bias) on meta-analyses outcomes. Using this method, a funnel plot was constructed with the sample size or the standard error against each study’s effect size (typically plotted as  $1/SE$ ). The plot is expected to take the shape of a funnel. The studies which include smaller sample sizes (larger standard errors) have increasingly larger variation in estimates of their effect size, whereas studies that include larger sample sizes have smaller variation in effect sizes, this is due to random variation being increasingly influential in smaller sample sizes (Sutton, Duval, Tweedie, Abrams, & Jones, 2000). If data censoring is absent, the plots are expected to take a funnel shape. However, given nonsignificant or smaller studies are commonly less likely to be published (the “file-drawer” problem; Mullen, 1989), studies considered to be symmetrically unmatched are often trimmed (Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010). In the current study, the trimmed studies were then replaced and their missing counterparts “filled” as mirror images of the trimmed outcomes or imputed. This allowed for the computation of an adjusted overall

effect size and CI (Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010; Gilbody, Song, Eastwood, & Sutton, 2000; Sutton, Duval, Tweedie, Abrams, & Jones, 2000).

Additionally, for each meta-analysis, the researchers calculated the fail-safe number. This pertained to the amount of studies needed with nonsignificant outcome and average sample size to bring the combined effect size of the meta-analytic findings to reach a nonsignificant level (Mullen, 1989). Rosenthal (1991) proposes a fail-safe number of more than  $5k + 10$  ( $k$  = number of studies included) as a general criterion for robustness; this criterion was utilized in the current review.

## **Results**

### ***Quality criteria results***

Scores for each study based on the Crowe and Sheppards' (2011) eight categories of quality are presented in Table 2. Overall, the quality of the studies was moderately high. However, Crowe and Sheppard (2011) highlight the importance of considering the eight categories separately to ensure that overall quality does not mask shortcomings or strengths in particular categories (Crowe & Sheppard, 2011). Generally, the quality of the introductions was high. This meant that each of the studies appropriately summarized the current relevant literature and were clear in their primary objectives. The quality of the study designs commonly fell short of high quality due to a lack of description of study design and most commonly a lack of explanation of why the design was considered appropriate in relation to the study's objectives. However, across the studies, the quality of the design was often increased by utilising appropriate measures along with written statements regarding the reliability and validity of measurement tools. Regarding the quality of sampling, common weaknesses in this area were insufficient detail in inclusion and exclusion criteria, a lack of information about how the sample size was calculated and a lack of explanation of why particular sampling methods had been chosen. However, a strength in the sampling category was that in

**Table 2: Methodological quality of studies**

Study	Preliminaries	Introduction	Design	Sampling	Data collection	Ethical matters	Results	Discussion	Total
Brook at al., (1996)	5	4	2	4	2	3	4	3	27
Chen et al., (2012)	5	5	3	3	4	5	4	5	34
Dougherty et al., (2013)	5	5	3	3	3	4	4	5	32
Fleik et al., (2015)	5	4	3	4	3	4	4	5	32
Guimond (2012)	5	5	4	3	4	2	4	5	32
Hastings et al., (2008)	5	5	3	4	3	3	4	5	32
Karreman et al., (2010)	5	5	3	3	3	2	4	4	29
Lazarus et al., (2016)	5	5	3	2	4	3	4	4	30
Lee et al., (2010)	5	5	3	4	3	3	4	5	32
Liu et al., (2015)	5	5	4	3	3	4	4	5	33
Mackenbach (2014)	5	5	4	3	4	4	5	5	35
Majandzic et al., (2014)	5	5	4	3	4	3	4	4	32
McShane et al., (2009)	5	5	3	4	4	2	4	5	32
Mezulis et al., (2004)	5	5	3	4	4	2	4	5	32
Moller et al., (2015)	5	5	3	3	4	4	4	5	33
Natsuaki et al., (2013)	5	5	3	3	4	4	4	4	32
Natsuaki et al., (2013) b	5	5	3	3	4	4	4	4	32
Otto et al., (2016)	5	4	3	4	4	4	4	5	33
Sebre et al., (2014)	5	5	3	3	3	4	4	4	31
Stroud et al., (2015)	5	5	4	3	4	3	4	4	32
Van der Bruggen et al., (2010)	5	5	4	2	3	3	4	5	31
Wieke De Vente et al., (2011)	5	5	4	4	4	3	4	5	34
<b>Mean score</b>	5	4.86	3.27	3	3.55	3.09	4.05	4.59	33.36



general the studies were good at providing sufficient detail about recruitment procedures. Regarding data collection, studies were typically good at describing the methods used to collect the data. A common weakness about data collection were limited descriptions of how non-participation, withdrawal and incomplete data/ lost data were managed.

Generally, the studies were poor at reporting on ethical matters including informed consent, ethical approval, subjectivities and conflicts of interest. Given the sensitive nature of both styles of parenting (particularly less favorable styles of parenting e.g. harsh parenting) and children's internalizing difficulties, it is disconcerting that some ethical matters were missing. This may be due to a lack of reporting on ethical matters rather than an absence of consideration of them but this it is currently unknown. For most of the studies the final two categories, the results and the discussions, were of high quality.

### ***Meta-analytic results***

**Table 3. Summary of meta-analytic findings**

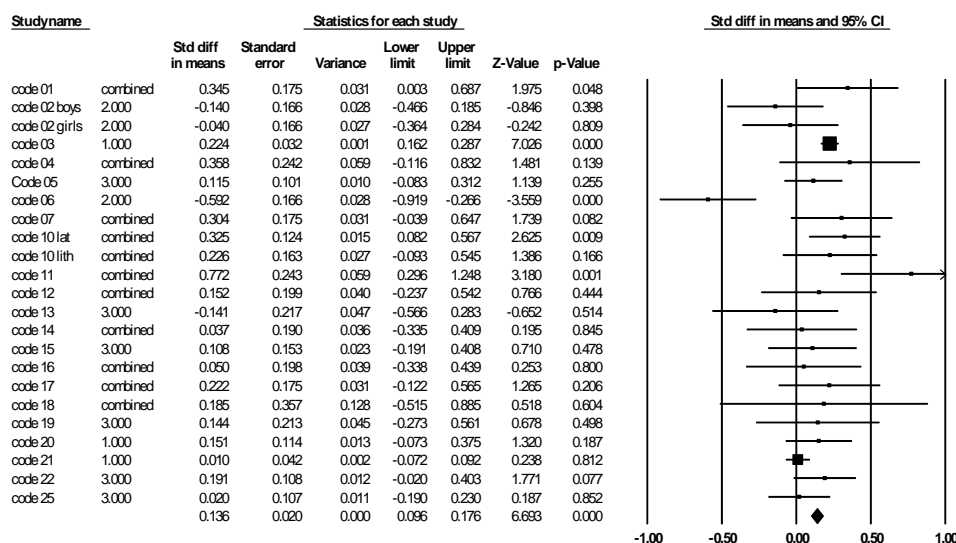
	<i>K</i>	<i>N</i>	<i>d</i>	<i>p</i>	Confidence interval 95%	Homogeneity <i>Q</i>	<i>p</i>	<i>I</i> <sup>2</sup>
Abuse total set	5	7031	0.17	.005	.034, .306	19.51	<.001	79.50
Rejection total set	9	1105	0.01	.886	-.180, .204	21.18	.006	62.24
Control total set	16	2683	0.17	<.001	.069, .261	21.13	<.001	29.01
Challenging parenting total set	5	433	0.40	<.001	.170, .626	5.17	.27	22.66
Paternal parenting total set	22	9456	0.12	.014	.036, .203	56.27	<.001	60.90

### *Is paternal parenting associated with more internalizing symptoms in offspring?*

The first meta-analysis concerned the association between paternal parenting and children's internalizing symptoms. In 22 studies including N=9456 participants, an association between paternal parenting and children's internalizing symptoms was reported. A significant combined effect size of  $d=0.12$  was found (95% CI:0.036, 0.203;  $P= 0.005$ ) suggesting a small effect of paternal parenting overall on children's internalizing problems. There was evidence of statistical heterogeneity ( $Q=56.27$ ,  $P=<.001$ ,  $I^2=60.90$ ). Moderator analyses were conducted to examine whether parenting domain explained between-study variability in paternal parenting. Parenting domain (i.e. parenting behavior e.g. harsh parenting) was associated with the overall effect size ( $Q = 11.1$ ,  $p = .011$ ). For the harsh parenting domain the combined effect size from 3 studies was  $d = .13$  (95% CI =[-.04,.29],  $p = .14$ ); for the rejection parenting domain, the combined effect size across 3 studies was  $d = -.26$  (95% CI = [-.59,.08],  $p = .13$ ); for the control parenting domain the combined effect size across 6 studies was  $d = .10$  (95% CI = [-.01,.20],  $p = .07$ ); for the group of 11 studies with combined outcomes the effect size was  $d = .27$  (95% CI = [.16,.37],  $p = <.001$ ). In the case of the rejection parenting domain, only three studies were included, one of which had a very large sample size and reported a negative association. Removing this group of studies entirely rendered the between-domain test of differences in effect size non-significant ( $Q = 5.11$ ,  $df = 2$ ,  $p = .08$ ).

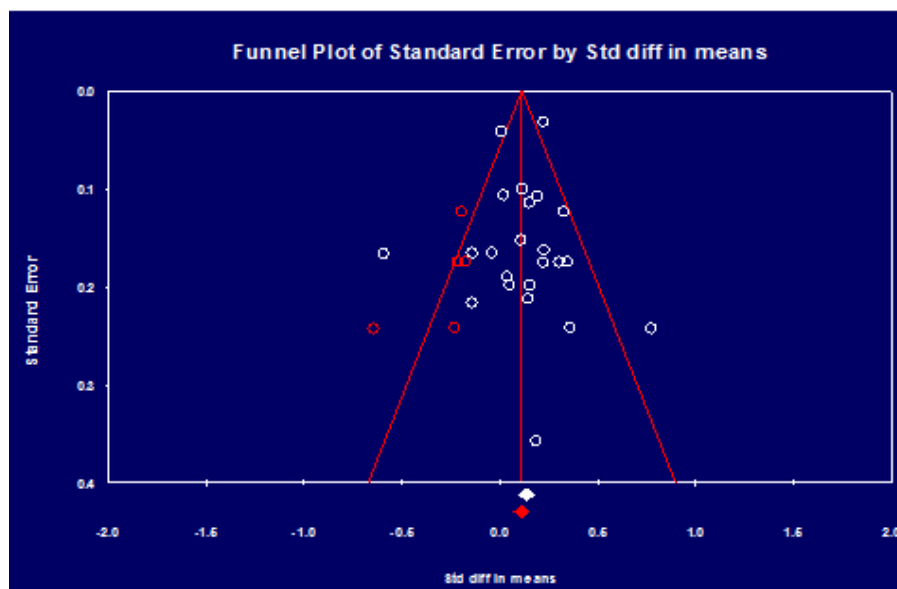
**Table 4. Forest plot for paternal parenting and internalizing problems**

\*Codes for studies can be found in the reference list



### ***Publication bias***

The failsafe number of studies reporting null results needed to reduce the effect size to non-significance was 117. This was just below Rosenthal's criterion, providing evidence that the effect size is not necessarily robust and could be accounted for by the 'file-draw problem'. As such, the overall effect size should be treated with caution. The trim-and-fill approach was employed to examine whether there was any evidence of publication bias or data censoring. 5 studies were trimmed and filled, with a resulting significant combined effect size of  $d = .12$  (95% CI=[.03, .20]). The funnel plot created using this method can be found in Figure 2.



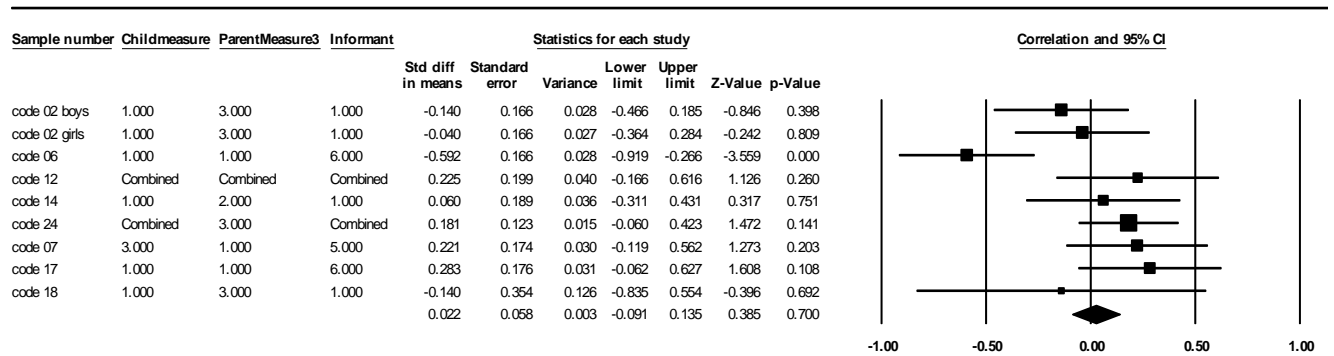
**Figure 1. Funnel Plot to Assess Publication Bias for paternal parenting across domains**

### ***Paternal rejection associated with more internalizing symptoms in offspring?***

The second meta-analysis concerned the association between paternal rejection and children's internalizing symptoms. In 9 studies including N=1105 participants no association between paternal rejection and children's internalizing symptoms was reported. A non-significant combined effect size of  $d=0.01$  was found (95% CI: -.180, .204 ;  $P=0.886$ ) suggesting no effect of paternal rejection on children's internalizing problems. There was evidence of statistical heterogeneity ( $Q= 21.18$ ,  $P= .006$

$I^2=62.24$ ). Due to the small number of studies, moderator analyses were not conducted for this outcome.

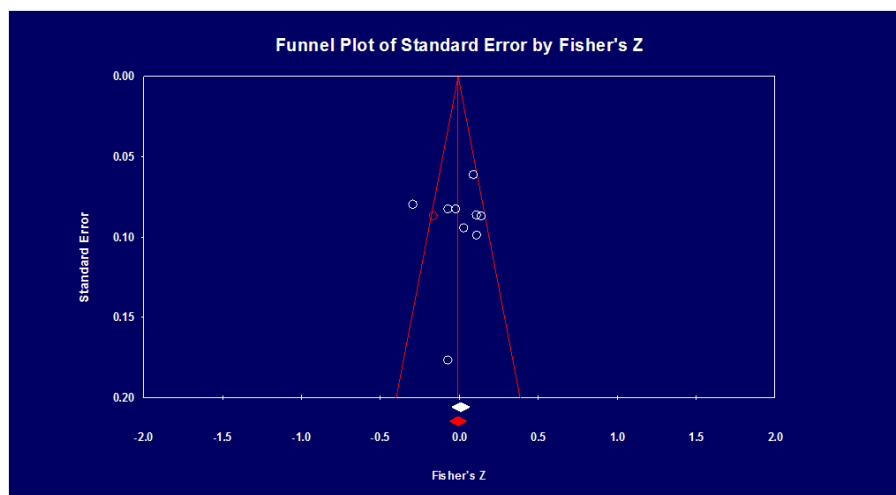
**Table 5. Forest plot for paternal rejection and internalizing problems**



### Publication bias

As the combined result was not statistically significant, the Fail-Safe N (which addresses the concern that the observed significance may be spurious) was considered irrelevant. The trim-and-fill approach was employed to examine whether there was any evidence of publication bias or data censoring. One study was trimmed and filled, with a resulting significant combined effect size of  $d = .008$  (95% CI =  $[-.05, .05]$ ). The funnel plot created using this method can be found in Figure 3.

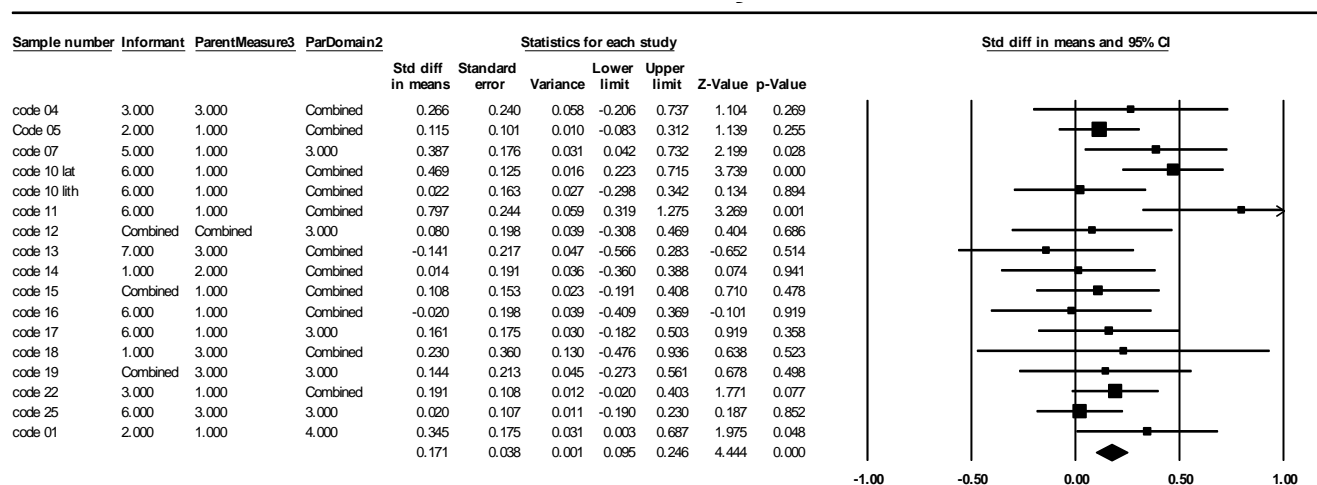
**Figure 2. Funnel Plot to Assess Publication Bias for paternal rejection**



### *Is paternal control associated with more internalizing symptoms in offspring?*

The third meta-analysis concerned the association between paternal control and children's internalizing symptoms. In 16 studies including N=2683 participants an association between paternal control and children's internalizing symptoms was reported. A significant combined effect size of  $d=0.17$  was found (95% CI=[.069, .261] ;  $p<0.001$ ) suggesting a small effect of paternal control on children's internalizing problems. There was evidence of statistical heterogeneity ( $Q= 21.13$ ,  $p=<.001$ ,  $I^2=29.01$ ). These results indicate a small effect of paternal control on children's internalizing problems, with higher levels of paternal control associated with higher levels of children's internalizing problems. Moderation analyses were also conducted on the way parenting was measured, to examine whether the type of measurement tool used, explained between-study variability in paternal control. Only two study types had sufficient numbers of studies to allow moderator analyses, namely those using questionnaires ( $k=9$ ) and those using direct observation ( $k=5$ ). The type of measurement tool used to measure parenting was not significantly associated with the overall effect size ( $Q = 2.63$ ,  $df = 2$ ,  $p = .10$ ). Despite the lack of significant differences, it was notable that only the group of studies using questionnaire measurements ( $k=9$ ) found a significant association ( $d = .22$ , 95% CI=[.09, .36],  $p = .001$ ).

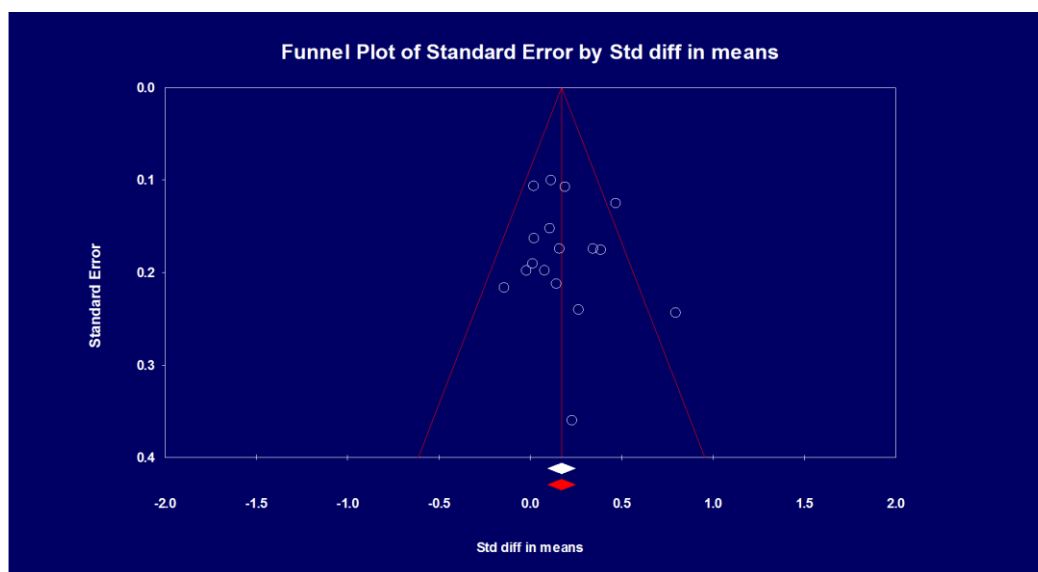
**Table 6. Forest plot for paternal control and internalizing problems**



### ***Publication bias***

The failsafe number of studies reporting null results needed to reduce the effect size to non-significance was 70, which does not exceed Rosenthal's criterion of 90 ( $5k + 10$ ), providing evidence that the effect size is not necessarily robust and could be accounted for by the 'file-draw problem'. The trim-and-fill approach was employed to examine whether there was any evidence of publication bias or data censoring. No studies were trimmed and filled. The funnel plot can be found in Figure 4.

**Figure 3. Funnel Plot to Assess Publication Bias for paternal control**

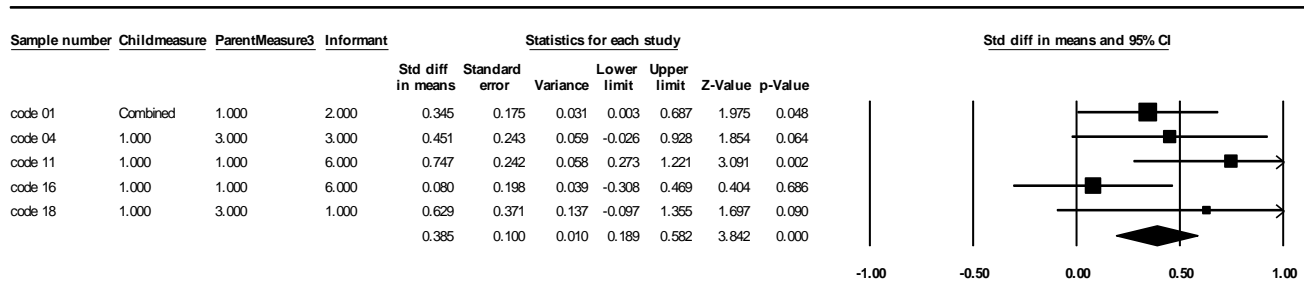


### ***Is paternal challenging parenting behaviour associated with more internalizing symptoms in offspring?***

The fourth meta-analysis concerned the association between paternal challenging parenting behaviour and children's internalizing symptoms. In 5 studies including  $N=433$  participants a significant association between paternal challenging parenting behaviour and children's internalizing symptoms was reported. A significant combined effect size of  $d=0.400$  was found (95% CI=[.170, 0.626],  $p<0.001$ ) suggesting a medium effect of paternal challenging parenting on children's internalizing problems. There was little evidence of statistical heterogeneity ( $Q= 5.17$ ,  $I^2=22.66$ ,  $p = .27$ ). These results indicate a medium effect of paternal challenging parenting on children's

internalizing problems, with higher levels of paternal challenging parenting associated with lower levels of children's internalizing problems.

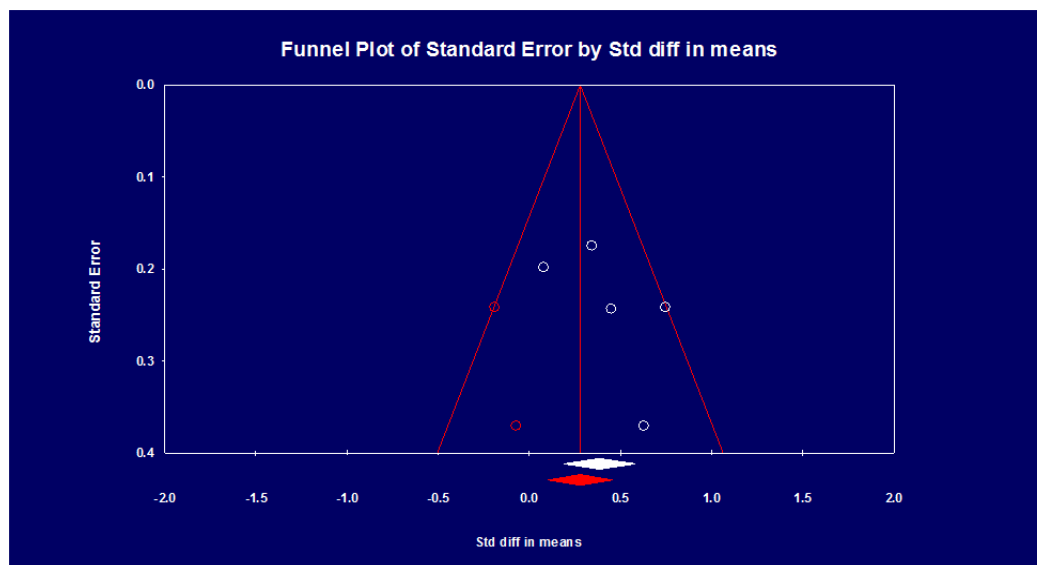
**Table 7. Forest plot for paternal challenging parenting behavior and internalizing problems**



### Publication bias

The failsafe number of studies reporting null results needed to reduce the effect size to non-significance was 17, which does not exceed Rosenthal's criterion of 35 ( $5k + 10$ ), providing evidence that the effect size is not necessarily robust and could be accounted for by the 'file-draw problem'. The trim-and-fill approach was employed to examine whether there was any evidence of publication bias or data censoring. Two studies were trimmed and filled, with a resulting significant combined effect size of  $d = .28$  (95% CI=[.03, .53]).

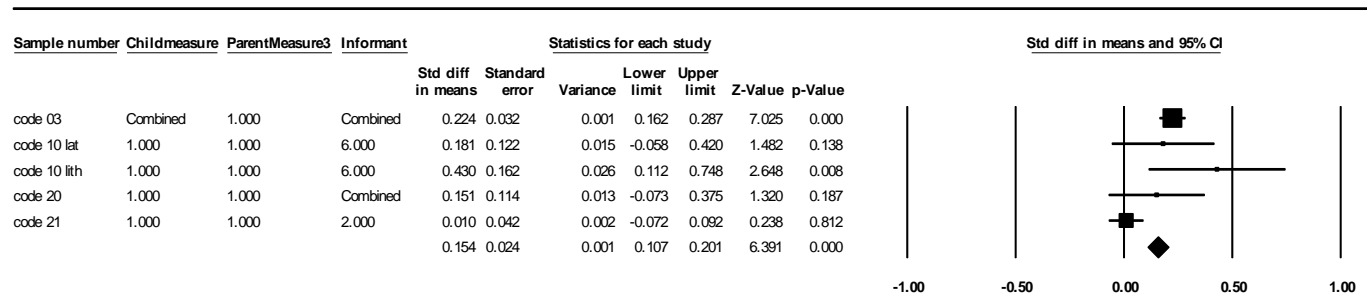
**Figure 4. Funnel Plot to Assess Publication Bias for paternal challenging behaviour**



### *Is harsh paternal parenting associated with more internalizing symptoms in offspring?*

The fifth meta-analysis concerned the association between paternal harsh behavior and children's internalizing symptoms. In 5 studies including N=7031 participants a significant association between paternal harsh behaviour and children's internalizing symptoms was reported. A significant combined effect size of  $d=0.17$  was found (95% CI= [.034, .306],  $p=0.014$ ) suggesting a small effect of paternal harsh parenting on children's internalizing problems. There was evidence of statistical heterogeneity ( $Q=19.51$ ,  $p<.001$ ,  $I^2=79.50$ ). These results indicate a small effect of paternal harsh parenting on children's internalizing problems, with higher levels of paternal harsh parenting associated with higher levels of children's internalizing problems.

**Table 8. Forest plot for paternal harsh parenting and internalizing problems**

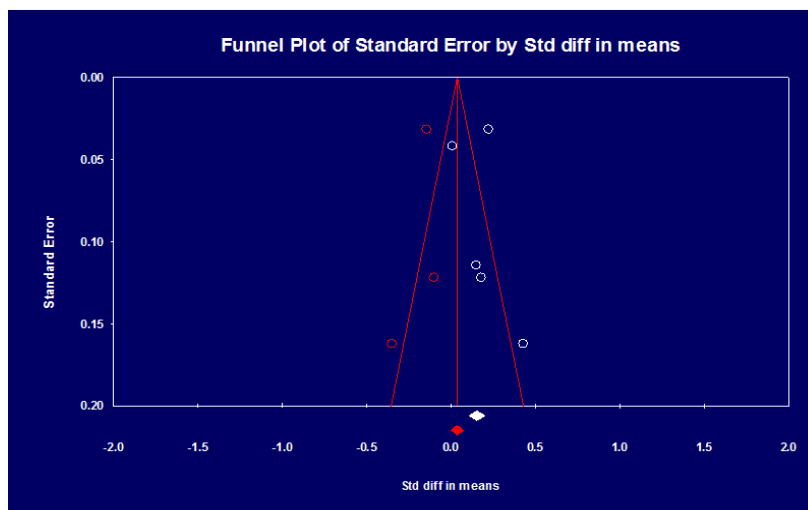


### **Publication bias**

The failsafe number of studies reporting null results needed to reduce the effect size to non-significance was 38, which exceeds Rosenthal's criterion of 35 ( $5k+10$ ), providing evidence that the effect size is quite robust and is unlikely to be accounted for by the 'file-draw problem'. The trim-and-fill approach was employed to examine whether there was any evidence of publication bias or data censoring. Notably however, three studies were trimmed and filled, with a resulting combined effect size of  $d = .05$  (95% CI = [-.10, .22]), with the 95% confidence intervals including zero.



**Figure 5. Funnel Plot to Assess Publication Bias for harsh parenting**



## Discussion

The primary aim of this meta-analysis was to examine whether paternal parenting behaviors were reliably associated with internalizing difficulties in young children across studies conducted to date using meta-analysis. The main findings were that: (1) paternal parenting behavior appeared to play a role in early childhood internalizing difficulties; (2) although this main effect was not moderated by parenting domain, some evidence was found that specific paternal parenting behaviors were differentially associated with childhood internalizing difficulties with challenging parenting behavior showing the largest association of the behaviors investigated; and (3) despite the burgeoning evidence in this field, more research is required to enable early preventative interventions to be appropriately targeted. This discussion considers these findings as well as reflecting on the strengths and limitations of this review. Recommendations for future research are also made.

### *Paternal parenting behavior and young children's internalizing difficulties*

Overall, this review found that paternal parenting behavior appears to play a role in early childhood internalizing difficulties. Across 22 studies, the overall association was equivalent to a standardized effect size of 0.12. This effect was not moderated by parenting domain and suggests a small association between paternal parenting behavior and young children's internalizing problems. This adds to a growing body of literature highlighting the significant role fathers have in their

children's emotional development and supports efforts to include fathers in early preventative interventions.

Notably the effect of paternal parenting was small. This finding is in line with evidence from studies of both anxiety and depression development that have often highlighted small effects of parenting (McLoed, Weisz & Wood, 2007; Yap & Jorm, 2015). There are several explanations that could account for these small effects. First, this meta-analysis included only a handful of studies with parents and/or children with clinical disorders. Parenting may play a larger role in clinical samples (Kendler, Neale, Kessler, Heath, & Eaves, 1992). Second, paternal parenting may become more important across the course of development; arguably fathers have more influence over older children's development as they are typically more involved with older children compared the young age group studied (0-6 years). Additionally, the impact parenting has on children's emotional development may accumulate as children get older, as children and parents mutually influence each other over time (Maccoby, 1992; Moller, Nikolic, Majdandzic & Bogels, 2016). Another explanation may be that internalizing symptoms could increase with age. Additionally, it may be that smaller, sub dimensions of parenting are more strongly associated with child internalizing problems (e.g. McLoed, 2007). For example, previous reviews have found stronger associations with child anxiety for certain sub dimensions of parenting (such as autonomy-granting) than for broader dimensions (e.g. control) (Moller, Nikolic, Majdandzic & Bogels, 2016). Future research might therefore benefit from examining relationships between child internalizing and narrower dimensions of paternal parenting. It is important to note that other parenting behaviors that were not included in the current review, could be more critical in the development of internalizing difficulties than those studied.

The last possibility is that paternal parenting may not be very important for child internalizing difficulties. However, there are a few cautions to drawing such conclusions at this stage. Firstly, only individual paternal parental factors were included in the calculated effects and thus it is possible that different paternal parental factors may have multiplicative or additive effects on child outcomes (Yap, Hui & Jorm, 2015), as has been found in studies primarily focused on maternal parenting (e.g. warmth and control; Bögels and Brechman-Toussaint, 2006). Secondly, parental factors may have indirect effects on child outcomes (Yap, Hui & Jorm, 2015). Taken together, it would seem premature and

inappropriate to conclude that paternal parenting is not important for the development of young children's internalizing difficulties.

### ***Challenging paternal parenting behavior***

The current review, in keeping with the review conducted by Moller, Nikolic, Majdandzic and Bogels (2016), found that paternal challenging parenting behavior was associated with less childhood emotional difficulties (although notably their review only looked at childhood anxiety). The effect size for this association was .40; larger than for the other parenting domains. This is in line with Bögels and Perotti (2011) theory which hypothesizes that the father's role may be to challenge his children and to encourage risk taking, and therefore paternal challenging parenting behavior might serve to decrease children's anxiety by pushing the child's limits, promoting self-confidence and self-efficacy. Thus, limited paternal challenging parenting may lead to greater internalizing difficulties on the part of the child (Bögels and Perotti (2011)). This has clear implications for early prevention programmes.

However, as the meta-analysis of Moller, Nikolic, Majdandzic and Bogels (2016) included only two studies investigating the impact of challenging parenting behavior and the current review only included 5 studies, more research is needed to assess the consequences of paternal challenging parenting behavior on children's internalizing difficulties. It is also important to note that most of the studies measuring challenging parenting in this review came from the same research group. This is also the same research group that developed the abovementioned theory on the effects of paternal challenging parenting behavior (Bogels & Perotti, 2011) and the same research group that conducted the Moller, Nikolic, Majdandzic and Bogels (2016) review. Further, in all these studies challenging parenting behaviours were solely measured using self-report measures which may be subject to bias and may exaggerate the true association between paternal challenging behaviour and child internalizing problems. This would be most likely in cases where the father also provided information regarding the child's internalizing problems (shared method variance). Future research could therefore benefit from developing more objective measures of challenging parenting behaviours and it may be helpful for this research to be conducted by a more independent, less invested research group. Despite these limitations, the inclusion of paternal challenging parenting and the ability to meta-

analyse this specific domain is a strength of this review. Contrary to most previous research, the addition of challenging parenting behaviour shows consideration for parenting behaviors that are considered more frequent in fathers than in mothers. It also provides some initial evidence that challenging paternal parenting may be particularly important in reducing the risk of young children developing internalizing difficulties.

### ***Paternal controlling parenting behaviour***

Overall, this review found that paternal controlling parenting behavior appears to play a role in early childhood internalizing difficulties. Across 16 studies, the overall association was equivalent to a standardized effect size of 0.17. These findings are in line with previous theory (Bögels & Perotti, 2011) suggesting that paternal controlling behaviors are associated with child emotional difficulties. This theory suggests that fathers play an important role in encouraging children to participate in the outside world as well encouraging independence, and in stimulating risk taking (Moller, Nikolic, Majdandzic & Bogels, 2016). Thus, if fathers engage in controlling behaviors, instead of encouraging independence, this would be expected to lead to an increased risk that the child may develop anxiety related difficulties (Bögels & Perotti, 2011; Moller, Nikolic, Majdandzic & Bogels, 2016).

However, it is important to remember that the effect of paternal control on child internalizing difficulties is small. Several explanations could account for this small effect. One explanation for this could be the need in this current review to combine several sub dimensions of parenting (including overcontrol and overprotection) to arrive at the ‘control’ domain. The smaller effect may arise from the fact that overprotection is associated with emotional difficulties whereas overcontrol is not always associated with emotional difficulties in young children (McLeod, 2007). More research is required to look at sub-dimensions of paternal controlling behaviours and their impact on young children. This would enable future reviews to look at sub dimensions of control and to consider how such sub dimensions could be differentially associated with child internalizing problems. Interestingly, the effect of paternal control was not moderated by parenting measurement. This could be due to a limited range of measurement tools, with questionnaires being primarily utilised.

### ***Paternal rejection***

Paternal rejection was not found to be associated with internalizing difficulties in childhood. This is in contrast to the effect of maternal rejection on children's anxiety and depression, finding small but significant effects (McLoed, 2007). Typically, reviews have found lower effect sizes for rejection than control for example, McLeod (2007) found that control was more strongly associated with anxiety than rejection. Crucially, there was high heterogeneity which may be due to a number of factors including the possibility that specific sub dimensions of these domains may differ in their association. If that were the case, this would clearly point to the need for further efforts to disaggregate parenting dimensions and their respective contribution to children's internalizing problems. This, in turn, would inform theory development and future research. Importantly, there was high heterogeneity within this domain, suggesting that there were differences between studies that led to wide differences on the size of the associations found. It will be important for future research to elucidate the causes of these between-study differences as this may suggest that studies in this area are collectively under- or over-estimating the association. The differences, once identified, may also help us understand factors involved in mitigating or accentuating when or how paternal parenting influences child internalizing problems.

### ***Harsh parenting***

Paternal harsh parenting was found to be associated with internalizing difficulties in childhood. The overall effect size was .17. In line with this finding, the long-term impact of harsh or abusive parenting on the internalizing outcomes of depression and anxiety are well established (Chen et al., 2010; Maniglio, 2010); with previous longitudinal and cross-sectional evidence indicating that harsh parenting accounts for small yet significant amount of variance in internalizing outcomes, approximately 1-2% (Yap & Jorm, 2014). As has been recommended in previous reviews, "translation of this evidence into preventative interventions for parents needs to focus on equipping parents with more effective and adaptive strategies to manage their child's challenging behaviors so that parents are less likely to use coercive tactics or engage in reactive aggression towards their children" (Yap & Jorm, 2014, p.436).

### ***Study quality***

A frequent criticism of meta-analytic reviews is what is commonly called “garbage in, garbage out”. This phrase pertains to concerns about the quality of studies included in meta-analyses and therefore concerns the quality of the results. The quality of the studies in this review were quite high overall, lending support to the findings. Generally, the outcome measures used had adequate validity and reliability and the statistical tests used to assess the outcomes were appropriate. Generally, the studies did not report conducting power analyses prior to recruitment and it is recommended that future studies conduct and report power analyses; this will be important to ensure studies can claim to have sufficient power to detect effects that exist. Most of the studies reported attrition rates. However, many of them did not describe the characteristics of participants lost to follow-up or report taking into account the losses of participants to follow-up. It is important that this is clearly reported in the future to enable selection bias in studies to be adequately assessed.

#### ***The decision to combine dimensional and categorical measures of childhood internalizing difficulties***

An additional important consideration for discussion was the decision to combine dimensional and categorical measures of childhood internalizing difficulties. This decision had both advantages and disadvantages. A disadvantage of this decision was that whilst dimensional measures of internalizing difficulties in this developmental period have fairly robust methodological qualities (Rey, Marin & Silverman, 2013), categorical measurement tools of childhood internalizing difficulties for this developmental stage have been shown to have only modest reliability estimates (Rey, Marin & Silverman, 2013). Additionally, categorical measures for this developmental period require further research into their validity and it is often felt that dimensional measures are a more valid tool in this very early developmental stage. Thus, including categorical measures may have decreased the reliability and validity of the analysis. However, categorical measures do have good convergent validity with dimensional scales such as the CBCL (Goodman, 1997; Rey, Marin & Silverman, 2013). The decision to include and combine both categorical and dimensional measures had the advantage of including more studies and therefore increased statistical power. In addition, in comparison to the studies utilising dimensional measures, the studies that utilised categorical measures of childhood

internalizing difficulties included children from both general and clinical populations. This enabled the meta-analysis to include participants from a broader range of participants and in doing so enabled the findings of the results to be more generalizable and arguably more clinically useful. It may be useful for future research to continue to utilise both dimensional and categorical measures of childhood internalizing difficulties in order to assess whether clinical diagnosis serves as a moderator for the association between paternal parenting and childhood internalizing difficulties; due to the limited number of studies included that used categorical tools, this was not possible in the current meta-analysis.

### ***Internalizing Informant***

A further important consideration for discussion is the potential impact of the informant of childhood internalising difficulties. It is widely acknowledged that using multiple informants on childhood internalising difficulties is the most robust, valid and reliable method (Rey, Marin, & Silverman, 2013). Usefully, over half of the studies included in the analysis included multiple respondents, which were then averaged for the purpose of meta-analysis. However, this review also included studies whose informant of internalising difficulties was either the child's mother or father; there are several advantages and disadvantages to responses from either of these respondents. Firstly, in relation to paternal reports of child internalizing, one potential disadvantage of this approach is the concern regarding shared method variance. This may have meant that the report of child internalizing difficulties was subject to bias and the true association between paternal parenting and child internalizing problems may have been exaggerated. It is suggested that rater bias could reflect parents' negativity bias which could influence both their perceived and actual parenting; if parents identify their child as having more difficulties, this may lead them to report more negative parenting behavior (Moller, Nikolic, Majdandzic & Bogels, 2016).

In relation to maternal reports on children's internalizing difficulties, an advantage of including these was that there were no concerns regarding shared method variance. In addition, by including these studies power was increased. However maternal factors such as maternal parenting, maternal mental health were not controlled for and this had the potential to limit the validity of maternal reports on child internalizing symptoms. It will therefore be useful for studies in the future to

include multiple informants of child internalizing symptoms in future research in order to obtain the most reliable and valid results.

### ***Limitations***

This meta-analysis is the first systematic attempt to meta-analyse the results of studies investigating paternal parenting and early childhood internalizing difficulties. However, the following limitations should also be considered. Firstly, whilst providing a macro-level synthesis of this burgeoning and diverse evidence base, distinctive and unique features at the micro-level in specific studies might have been obscured (Yap, Hui & Jorm, 2015). As has been noted, a common limitation of reviews in this area is that by coding studies under particular parenting domains, unique differences between methodologies and measures could not be examined (Yap, Hui & Jorm, 2015). The diversity of the measures used resulted in the need to average multiple measures and parenting domains which limited the ability to utilise moderation analyses to determine factors affecting the strength of the relationship between paternal parenting and child internalizing difficulties.

A further important limitation that will need to be addressed by future research is the fact that many of the findings could have been accounted for by the file-drawer problem. To ensure an accurate effect of paternal parenting on children's internalizing problems can be calculated, research findings that have non-significant results should also be published in the literature.

A further limitation of this review was that most studies utilized non-clinical samples of middle to high socioeconomic backgrounds. This places questions as to the generalizability of the findings for children presenting with clinical difficulties. Thirdly, the majority of the studies included in this review utilised questionnaire methods to assess internalizing difficulties and parenting. Questionnaire methods in this field have been criticised for potential rater bias. It is suggested that rater bias could reflect parents' negativity bias which could influence both their perceived and actual parenting; if parents identify their child as having more difficulties, this may lead them to report more negative parenting behavior (Moller, Nikolic, Majdandzic & Bogels, 2016). Relatedly, shared method variance could have accounted for some of the findings however, most studies did utilise different reporters' accounts. Nonetheless, future research will continue to benefit from using multiple methods to assess both internalizing difficulties and parenting behaviours.



Another limitation of this review is that causality could not be inferred from the results. Thus, the associations between parenting behavior and childhood internalizing should be interpreted bidirectionally. Studies using designs that permit causal conclusions to be drawn would be useful for future research. Additionally, all studies included in this meta-analysis that assessed parenting behavior focused on dyadic interactions between a child and a parent without providing insight into the role of triadic interactions. This review also did not control for potential confounds such as socioeconomic status or maternal parenting behavior. This is a significant limitation and not accounting for this may lead to underestimating the role played by paternal parenting on child outcomes. By not obtaining parallel results on maternal parenting, it is impossible to interpret the relative impact of paternal and maternal parenting.

### ***Summary, implications and conclusions***

As has been highlighted, there are several areas for future research that this review has brought to the fore. Most importantly, the review highlights the need to systematically include fathers in child development research as this body of evidence is still limited. This review came to similar conclusions drawn for reviews looking at depression and anxiety separately and reviews primarily considering the impact of maternal parenting on children's emotional difficulties. These findings support the need to include fathers' in parenting programmes that they are so often left out of.

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**Healthy Start, Happy Start: Fathers' experiences and engagement in an attachment-based  
parenting intervention**

**Empirical Paper**

## **Abstract**

**Aims:** Given the dearth of research exploring parenting programmes offered to couples and fathers, this study sought to investigate fathers' experiences of and engagement in an attachment based parenting programme (Video-feedback Intervention to Promote Positive Parenting and Sensitive Discipline; VIPP-SD). Mothers' perspectives of fathers' involvement in VIPP-SD were also sought. This study formed a qualitative sub-study of a larger multi-site randomized controlled trial 'Healthy Start, Happy Start'.

**Method:** Semi-structured interviews were conducted with 14 fathers and 11 mothers after they had completed the VIPP-SD programme.

**Results:** Thematic analysis generated sixteen categories of themes, which were organised into three domains. The first domain related to what fathers perceived they had gained from VIPP-SD, whilst the second domain reflected fathers' views on factors that facilitated their engagement in VIPP-SD. The third domain related to mothers' perceptions of fathers' involvement in VIPP-SD.

**Conclusions:** The findings highlighted that fathers experienced VIPP-SD as having a number of positive outcomes for their own confidence as a father, their understanding of their child and for their co-parenting. The findings also highlighted a number of factors that supported fathers' engagement. Mothers provided overwhelmingly positive views on fathers' involvement, and described benefits for themselves and their child. These findings highlight the importance of active attempts to engage fathers in parenting programmes, given that both mothers and fathers subjectively perceived a number of benefits to fathers' involvement in VIPP-SD.

## **Introduction**

Externalizing behaviour problems are the most frequently diagnosed psychological difficulty in childhood (Ramchandani, Domoney, Sethna, Psychogiou, Vlachos, & Murray, 2013). In the United Kingdom, 5-10% of children of pre-school age meet diagnostic criteria for such problems (Scott, 2007). When these difficulties are untreated, 40% of children will experience enduring behaviour problems (Petitclerc & Tremblay, 2009), with detrimental costs to the child, their family and society (Smith & Smith, 2010).

Crucially, a lack of sensitive parenting and secure attachment relationships have been shown to be a key risk factor in the development of behavioural problems (Petitclerc & Tremblay, 2009; Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley, & Roisman, 2010). Crucially parenting is amenable to change (Ramchandani, Domoney, Sethna, Psychogiou, Vlachos, & Murray, 2013). This has led to the development and implementation of parenting programmes with many early programmes focusing on promoting secure attachment relationships with caregivers through enhancing parental sensitivity and discipline (e.g. Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD; Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2008).

### ***VIPP-SD***

One such parenting programme is the ‘Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline’ (VIPP-SD; Juffer, Bakermans-Kranenburg, & van IJzendoorn, 2008). The ‘Video-feedback Intervention to promote Positive Parenting’ (VIPP) intervention is rooted in attachment theory and focuses on improving the parent-infant attachment relationship by increasing sensitive parenting capacities; parents are taught to recognise their child’s attachment signals and exploratory behaviours and to respond to these signals adequately and appropriately (Ainsworth, Bell, & Stayton, 1974). In addition to the aims of VIPP, VIPP-SD explicitly focuses on reducing aversive interactions and increasing positive interactions through sensitive discipline techniques and consistent boundary setting. Through video-feedback, VIPP-SD aims to strengthen parents’ observational skills, their ability to empathise with their child, to increase the parents’ knowledge and awareness of child development and their capacity to sensitively respond and discipline their child. VIPP-SD is a

manualised, brief (six sessions) home-based programme whereby a healthcare professional records a number of parent-child interactions and the professional then offers feedback based on the film clips. VIPP has a strong evidence base as an early preventative intervention and it has been evaluated systematically including six randomised controlled trials. The VIPP intervention has been shown to increase positive discipline strategies and maternal sensitivity as well as positively impacting child behaviour across a range of clinical populations (e.g., Juffer, Bakermans-Kranenburg & Van Ijzendoorn, 2005; Kalinauskiene, Cekuoliene, Van Ijzendoorn, Bakermans-Kranenburg, Juffer, & Kusakovskaja, 2009; Klein Velderman, Bakermans-Kranenburg, Juffer & Van Ijzendoorn, 2006; Stein et al., 2006; Van Zeijl, Mesman, Van Ijzendoorn, Bakermans-Kranenburg, Juffer, & Stolk, 2006).

***Make way for dad: The importance of including fathers in parenting interventions***

Parenting interventions often neglect fathers despite indisputable evidence that fathers make unique and significant contributions to their children's development (Lamb, 2004; NICHD Early Child Care Research Network, 2008). Support for fathers' contributions comes from cohort and longitudinal studies. For example, cohort studies have found that through infancy to adulthood, fathers' involvement can have a positive effect on children's psychological, behavioural, social and educational outcomes (Panter-Brick, Burgess, Eggerman, Mcallister, Pruett, & Leckman, 2014). Sensitive responses from fathers in free play with their two year olds has been found to be more significant in predicting childhood adjustment at age 10 than early mother-child attachments (Grossman, Grossmann, Fremmer-Bombik, Kindler, Scheuerer-Englisch, & Zimmermann, 2002). Indeed, from as early as 3 months old, remote and disengaged father-infant interactions have been shown to longitudinally predict externalizing problems in children (Ramchandani, Domoney, Sethna, Psychogiou, Vlachos, & Murray, 2013). Further, paternal and maternal reciprocity have each been shown to uniquely predict preschoolers' levels of aggression. Literature exists suggesting that in comparison to mothers, fathers may make greater contributions to the development of childhood behavioural problems (Biernbaum, Speltz, and Greenberg, 1998; DeKlyen, Speltz, and Greenberg, 1998; Lewis & Lamb, 2006; Ramchandani, Stein, Evans, & O'Connor, 2005).

Crucially, in a meta-analytic review of early childhood interventions aiming to increase infant attachment security and parental sensitivity a far greater effect size ( $d=1.05$  versus  $0.42$ ) was found when studies involved both mothers and fathers in a parenting intervention compared to those only including mothers (Bakermans-Kranenburg, Van IJzendoorn, & Juffer, 2003). Among those interventions that included fathers, significantly greater levels of sensitivity were found than those focusing on mothers only. There were only a handful of studies in this analysis which actually included fathers so the conclusions one can draw are limited. Whilst the added effectiveness of fathers' involvement remains unclear, fathers themselves report feeling they benefit from involvement in parenting interventions. For example, in a systematic review of interventions with fathers with young children, fathers who had experienced support were found to perceive their child more positively: they reported having less behavioural difficulties, feeling more confident in fathering and having more knowledge with greater reported levels of self-competence in their interactions with their infants (Magill-Evans, Harrison, Rempel & Slater, 2006).

Increasingly researchers are focusing more broadly on other relationships in children's early lives, such as those between father and child, the mother and father and the triadic interactions between both parents and their infant (Doherty & Beaton, 2003). Crucially, fathers are known to significantly influence the quality of co-parenting interactions (i.e. the degree of conflict or competitive dynamic) and the quality of these interactions can have an impact on the development of the infant, with both poor co-parenting and high relationship discord being associated with increased behavioural problems and other psychological difficulties (Teubert & Pinquart, 2010). Research suggests that including two caregivers and particularly fathers, in early interventions, could lead to increased efficacy (Lundahl, Tollefson, Risser, & Lovejoy, 2008; Tiano & McNeil, 2005).

### ***Barriers to engaging fathers***

Whilst it has been evidenced that fathers make significant contributions to their children's development and that there is value in including fathers in parenting interventions, it is widely recognised that fathers are difficult to recruit to parenting programmes (Bayley, Wallace & Choudhry, 2009;) and that barriers still exist in engaging them in such interventions (Panter-Brick Burgess, Eggerman, Mcallister, Pruett, & Leckman, 2014). This is clear from the fact that in a systematic

review of interventions with fathers of young children, only 14 studies could be identified, with 11 from the United States (Magill-Evans, Harrison, Rempel, & Slater, 2006). Recognizing the challenges of recruiting fathers into parenting programmes, Panter-Brick, Burgess, Eggerman, Mcallister, Pruett, and Leckman (2014) sought to review the global evidence into factors affecting fathers' engagement. Their review highlighted concerns about how the design and delivery of interventions serve to limit fathers' engagement (Panter-Brick, Burgess, Eggerman, Mcallister, Pruett, & Leckman, 2014). The authors suggested that "with respect to design, we identified seven major issues in terms of cultural, institutional, professional, operational, content, resources, and policy biases that work to marginalize fathers from the outset" (Panter-Brick, Burgess, Eggerman, Mcallister, Pruett, & Leckman, 2014, p.1206). They also point to features of logistical and programmatic delivery that limit fathers' engagement e.g. location and timings. The review emphasized that practitioners need to be involving "fathers early on, offering flexible hours or visiting at home, being persistent in communicating the positive gains to children of father involvement, being explicit in welcoming them personally to participate" (Panter-Brick, Burgess, Eggerman, Mcallister, Pruett, & Leckman, 2014, p.1207). Moreover they highlighted that it is not yet known how to effectively deliver programmes with fathers and co-parents given that studies very often do not differentiate parents by gender. They therefore suggest that we have limited understanding of fathers' participation and/ or impact in parenting programmes.

### ***Using VIPP with fathers***

Importantly, one study that has included fathers in a parenting programme piloted VIPP-SD with a sample of five non-clinical fathers (Lawrence, Davies & Ramchandani, 2013). The purpose of this pilot study was to assess, using a self-completion questionnaire (including primarily Likert scales), the acceptability of VIPP-SD with fathers. The results revealed that fathers felt the intervention helped to improve the relationship they had with their infants and their ability to communicate with them. Fathers also felt that the intervention significantly contributed to their understanding of their child's thoughts and feelings. Overall, the fathers generally provided positive feedback and said that the flexibility of the sessions was crucial for engagement. Fathers suggested

that having joint sessions with their partners would be beneficial. This pilot study suggests that this approach might be acceptable with fathers.

Whilst this pilot study yielded some important findings there are several limitations to this research that could be built upon. Firstly, this pilot study did not include fathers whose children were identified as at risk of behavioural problems and it may be that fathers who have children presenting with clinical problems may have qualitatively different responses to VIPP-SD. Given the small sample of only five fathers it seems important to gather a larger number of fathers' responses to ensure rich descriptions of their experiences as well as richer descriptions than those afforded by questionnaire measures. As this intervention was developed for use with mothers, any information fathers can offer as to the acceptability of the approach appears important. Whilst the pilot study looked at fathers' responses to the positive parenting and sensitivity components it did not focus on the sensitive discipline.

### ***The value of documenting fathers' experiences of parenting programmes***

Qualitative studies documenting mothers' experiences of parent programmes have yielded important insights into the processes underlying mothers' engagement and perceived outcomes and have enabled rich, subjective experiences to be captured. For example, Kurtz Landy, Jack, Wahoush, Sheegan, & MacMilan, (2012) looked at parents' experiences of the Nurse Family Partnership (NFP) programme. Their results highlighted that when parents had strong therapeutic relationships with the health care professionals they engaged better and had more positive overall experiences of the programme. Additionally, Kane, Wood and Barlow (2007) highlighted that parents felt more empathic, more able to confidently manage their children's behaviour and less guilty through the knowledge, skills and understanding they had obtained from parenting programmes. Insights such as these, provide crucial information for the development and future success of effective parenting programmes.

Given that it is well documented fathers are difficult to engage in parenting programmes it seems important to gain rich data on fathers' experiences of what has helped them to engage in programmes when they are known to be taking part in a particular programme. Such opportunities should also be used to gather fathers' perceptions of what they feel they have gained from such



programmes, particularly as little is known about fathers' subjective experiences of programme outcomes. This also seems important given that there is meta-analytic evidence suggesting that fathers, in comparison to mothers, respond differently and may not achieve as many benefits from parenting interventions as mothers (Lundahl, Tollefson, Risser & Lovejoy, 2006). Qualitative insights could help ensure parenting programmes are developed and implemented as effectively for fathers as they can be for mothers. Factors that are known to affect mothers' engagement in parenting interventions should be considered when gaining qualitative feedback from fathers. For example, it is well documented that the quality of the therapeutic alliance is fundamental to the success of intervention work (Sexton & Whiston, 1994) and this should be explored when looking at factors that impact engagement and change with fathers also. Additionally, when considering fathers' views and engagement in parenting programmes, many researchers and clinicians argue that it is important to document both both mothers' and fathers' perceptions, given that mothers often act as gatekeepers to fathers' involvement with children (Potter & Carpenter, 2010). Indeed service providers, are being encouraged to take account of both fathers' and mothers' perceptions, even when fathers are the foremost focus of engagement (Potter & Carpenter, 2010).

### ***Current study***

The current study aimed to gather rich insights into fathers' experiences of VIPP-SD, an evidence-based parenting programme. This study was a qualitative sub-study of a larger randomised controlled trial (RCT), *Healthy Start, Happy Start*, which is evaluating the effectiveness and cost-effectiveness of delivering VIPP-SD in the National Health Service (NHS). The current study aimed to build on the findings of Lawrence, Davies and Ramchandani's, (2013) pilot in several ways. Firstly, by using qualitative methods more detailed descriptions of fathers' experiences of VIPP-SD were more likely to be achieved. Secondly, unlike the pilot study, the current study included only families presenting as at risk of developing externalizing difficulties and used a larger sample of fathers. Thirdly, the current study aimed to elucidate fathers' perceptions of the sensitive discipline elements of VIPP-SD and taking part in VIPP-SD as a co-parent, neither of which were assessed in the initial pilot study.

Given the insights from qualitative research with mothers involved in parenting programmes, a greater understanding of the processes underlying fathers' engagement and their perceptions of VIPP-SD was likely to be acquired through a qualitative study of their experience. Indeed to gain a better understanding of therapeutic processes as well as outcomes, the use of qualitative methods within RCT evaluations of interventions have been recommended (Lewin, Glenton & Oxman, 2009). Understanding factors that facilitate fathers' engagement and outcomes from their own perspectives, is crucial for the development and potential success of adapting VIPP for use with fathers and co-parents, particularly if it is found to be effective and offered in the NHS and/or other health services. It was additionally important to have an understanding of mothers' views on fathers' involvement in VIPP-SD.

The current study therefore aimed to address the following research questions, from the perspectives of the fathers receiving VIPP-SD:

1. What do fathers perceive facilitates or hinders their engagement with the programme?
2. What if anything, do fathers perceive they gained as a result of the programme?

A secondary aim of the study was to address the following research question, from the perspective of the mothers receiving VIPP-SD:

3. What are mothers' views on fathers' involvement in VIPP-SD?

## **Method**

### ***Healthy Start, Happy Start***

As indicated, the current study was a qualitative sub-study of *Healthy Start, Happy Start* (HS,HS), a wider, multi-site RCT. HS, HS is aiming to test whether VIPP-SD is more clinically effective and cost effective than treatment as usual (TAU) in the NHS for children identified as at risk of behavioural difficulties (at age 12-36 months). This is the first time VIPP-SD has been trialled in the UK. The trial aims to include 300 families, randomly allocated to either the intervention group receiving VIPP-SD or TAU (150 in each group). HS, HS is also trialling a new adaptation of VIPP-SD with co-parents. Whilst co-parents' sessions mirror the content and themes of the VIPP-SD

manual, there is an additional emphasis on triadic interactions and positive co-parenting. This is the first RCT to include fathers and co-parents in a VIPP intervention. The trial is running between 2014-2018 across three London boroughs and Oxfordshire.

### ***Ethical approval***

Ethics was obtained from Riverside NHS ethics committee (see Appendix one).

### ***Participants***

HS, HS recruit participating families via health visiting services and through children's centres. To be included in the trial parents need to be aged 18 years and over, the child needs to be aged between 12-36 months and the child needs to score in the top 20% for behavioural problems on the Strengths and Difficulties Questionnaire (SDQ), based on population norms. Exclusion criteria includes children who have a severe sensory impairment or learning disability, a carer who is unable to complete questionnaire assessments due to language barriers, siblings participating in the trial, families participating in active family court proceedings, and/ or parents/carers participating in another research trial.

All fathers randomized to the treatment arm of HS, HS were invited to participate in the current sub-study. This included fathers that had received VIPP-SD alone and those who received VIPP-SD with a co-parent. A total of 15 fathers met these criteria and were invited to participate; 14 of whom agreed to take part. One father had recently moved abroad and did not feel he had the time to be interviewed. Twelve of the fathers had received VIPP-SD with a co-parent and two fathers had completed the programme without a co-parent. Parents who took part as co-parents, were both invited to take part. All of the fathers' co-parents were mothers and out of the 12 mothers invited, 11 agreed to take part. One mother explained that she was unable to participate due to time commitments however her partner did participate. In total, 14 fathers and 11 mothers were interviewed. Importantly, the sample was considered an appropriate size to provide a rich and in-depth data set for analysis

(Sandelowski, 1995); most importantly saturation was reached. Recruitment for this qualitative study took place between June 2016 and March 2017.

### ***Participant characteristics***

The following participant characteristics were collected within the first week of participants' initial VIPP-SD session. To ensure the confidentiality of participants was preserved, participant characteristics had to be summarised based on all participants. This was also to ensure that intervenors were not able to identify family members they had worked with. Fathers ranged in age from 26-52 and had a mean age of 37 years. Four of the fathers were stay-at-home parents, the other ten fathers were employed full time. Six fathers had achieved college level education, four had achieved undergraduate level education and four had achieved postgraduate level education. Eight fathers described themselves as 'white British', two described themselves as 'black other', three described themselves as 'white other' and one described themselves as 'Asian other'.

Mothers ranged in age from 26-46 and had a mean age of 36 years. Six mothers were in full-time work, two were in part-time work and three were stay-at-home parents. Three mothers had achieved college level education, three had achieved undergraduate level education and five had achieved postgraduate level education. Five mothers described themselves as 'white British', four mothers described themselves as 'white other', one mother described herself as a 'Caribbean' and one mother described herself as 'African'. All of the fathers resided with the child's parent and the child. All fathers described themselves as either married or cohabiting with the child's mother. This included fathers that took part in VIPP-SD without a co-parent. Children ranged in age from 13-31 months old and had a mean age of 22 months. Half of children were girls. Nine of the children had no siblings.

### ***Procedure***

HS, HS participants receive three assessment visits in which a number of measures are taken (e.g. demographic details, information on caregivers' mental health, child functioning). The first

assessment visit takes place before families receive VIPP-SD; during this visit the participant characteristics detailed above were collected. The second assessment visit occurs 4 months after the first visit and thus after the family has completed VIPP-SD; families then receive a follow up assessment visit two years after completing VIPP-SD. In the current study, families were sent an information sheet (Appendix 2) as soon as the second assessment visit had taken place. These families were then given 10 days to contact HS, HS to opt out of being contacted with further information about the sub-study. None of the families contacted HS, HS to opt out of receiving further information about the sub-study.

Following this, a brief telephone conversation then took place with all fathers receiving VIPP-SD in order to provide further information and to arrange a time to conduct the research interview. For parents receiving VIPP-SD as co-parents, a brief telephone conversation with either the mother or father took place. During these brief conversations, parents were asked to confirm with their co-parent whether they were happy to take part.

All interviews were conducted at the participants' homes. During the interview meeting, participants were given additional copies of the information sheets and time to answer any questions or concerns they had about participating. Time was set aside to ensure that the parent who had not been spoken to over the telephone, had time to answer questions and be given the same information the co-parent had over the phone. Participants were then asked to complete a consent form (Appendix 3). Participants were informed that identifiable information from their interviews would be confidential and were informed of their right to withdraw at any point.

### ***Positioning myself as an HS, HS interviewer and clinician***

To gain direct insight and understanding into both the theory and practice involved in VIPP, I was an intervenor in HS, HS. I did not interview any families that I had any prior contact or clinical engagement with. The impact of this dual position is explored later in this thesis.

Before the interview, I informed participants that there is limited information, on couples' and fathers' experiences of parenting interventions. I explained that their views of what was both helpful and less helpful would be extremely valuable in thinking about how VIPP could be designed and implemented with fathers and couples in mind. I informed participants that this sub-study formed a part of a doctoral thesis. Participants were informed that I was a member of the HS, HS research team and that I had also worked as an intervenor. I was clear with families that my position in HS, HS was based on hearing the views and experiences of participants rather than being invested in the programme's effectiveness. I explained that I would not be sharing identifiable views with the research team and I explicitly stated that their intervenors would not be aware of any identifiable perspectives.

### ***Interviews***

To capture rich descriptions of parents' experiences of the programme, a draft semi-structured interview schedule of open-ended questions was developed in line with established guidelines (DiCicco-Bloom & Crabtree, 2006) (Appendix 4). The questions were written collaboratively with the research supervisor and the HS, HS trial manager. The interview schedule covered four broad areas of questions concerning fathers': (1) initial engagement; (2) general views of most helpful/ unhelpful aspects of the program; (3) relationship with intervenor; (4) perceived gains. The second part of the interview was directed at both co-parents and broadly covered (1) mothers' general views of most helpful/ unhelpful aspects of the program (2) parents' views on helpful/ unhelpful aspects of doing the intervention as co-parents (3) parents' views on fathers' involvement in the program. The order in which these questions were asked was partly based on the material provided by the participants. Participants were encouraged to provide examples and expand on their comments and the schedule was used flexibly to encourage engagement rather than being seen as a prescriptive and/or an incoherent process. In order to gather rich descriptions about their experiences, prompts and follow up questions were utilised when appropriate.

The draft interview schedule was piloted with two families. Following these pilot interviews, the schedule was further refined alongside the research supervisor and additional questions were added based on feedback from the pilot interviews. Based on the pilot feedback, shorter and clearer questions were asked, to ensure participants could easily understand questions asked (e.g. ‘what do you like about the programme?’ rather than ‘what helped you to stick with or engage with the programme?’). In the pilot interviews, participants had difficulty answering questions about their relationships with intervenors and they suggested the questions be simplified. Based on this feedback, these questions were simplified in ways that made more sense to participants (e.g. “how do you get along with them (intervenor)?”, “were there any times that you felt you got on particularly well?” rather than “what was your relationship like with them (intervenor)?”).

In every interview meeting, fathers were interviewed first before the couple (both co-parents) were interviewed together. Except for one interview, the mother was not present during the fathers’ interview. The interviews ranged from one to two hours. Typically two thirds of the time was spent interviewing fathers alone and a third was spent interviewing the parents together (with the obvious exception of the two fathers who participated in VIPP-SD alone and were therefore interviewed without a co-parent). Children were present in all of the co-parent interviews and were largely absent in the fathers’ interviews. After the interview, participants were given vouchers and thanked for their time. The quality of the initial interview was checked (via tape recording) by the RCT manager, to ensure high interview standards were upheld.

### ***Qualitative analysis***

All interviews were transcribed verbatim. The initial three interviews (P1-3) were transcribed by the researcher and the remaining 11 were transcribed by research assistants, all of whom were psychology undergraduates. In order to check the accuracy of the transcription, the researcher listened to each transcript alongside the transcription. A sub-section of the researcher’s transcription accuracy was checked by the RCT manager.

Transcripts of the interviews were analysed following Braun and Clarke's (2006) thematic analysis. Their approach aims to identify patterns (themes) within a data set. Through coding and labelling transcripts, an understanding of the complex meanings conveyed by the research participants can be constructed. The identified themes aimed to encompass the complexity and richness of the participants' experiences in HS, HS. Braun and Clarke's (2006) six stages of analysis were followed in an iterative rather than linear fashion. Braun and Clarke's (2006) analytic method was selected for a number of reasons. Firstly it is flexible and pragmatic and can provide results that are accessible and are thus easily disseminated (Braun & Clarke, 2006). Secondly this approach was also deemed suitable for achieving an inductive, data-driven approach to the data, with the aim of offering a rich description of the data set as a whole (Braun & Clarke, 2006). Thirdly this approach allowed the analyst to comment on how their personal experiences may be influencing the analysis despite taking a primarily inductive approach to the analysis (Braun & Clarke, 2006).

The initial stage of the analysis involved "familiarising" myself with the data. This process included transcribing some of the scripts, listening back to the recordings as well as reading and re-reading each transcript to immerse myself in the data. This was an active processes that involved looking for and noting down recurring patterns and meanings in the data. I then went on to code each of the transcripts (word documents) using the 'tracked changes' function in Microsoft Word. This involved numbering and reporting on (in 'tracked changes' comment boxes) any interesting pattern and/ or meanings in the data as well as data that did not appear to fit with the other data. Minimal interpretation was done at this point and participants' own words were mainly used as initial codes.

These initial codes and data extracts were then transferred into an excel spreadsheet (a separate one for each transcript) to capture the main ideas for that transcript. Each of these summary sheets, and associated codes fed into the development of the initial categorisation of the data as a whole, the richness of the data set was maintained through this process (Braun & Clark, 2006).

These initial categories were then approached with the research questions in mind. A word document for each transcript was created with sections for each of the research questions. Codes and



extracts that appeared to be relevant to each of the research questions were copied over. Categories that did not seem to fit with the research questions were also included in these documents. I then began searching for themes. I looked for codes across the transcripts and began to note down how these combined to provide themes that answered the research questions as well as looking for any themes that did not answer the research questions but were nonetheless important. I drew mind maps at this stage to sort the codes into themes. Similarities and connections within and between these categories were then analysed further (Braun & Clarke, 2006), resulting in the domains, themes and subthemes presented in the results section. Appendix 5 illustrates the steps of the analysis.

### ***Researcher's perspective***

As noted, to gain direct insight and understanding into both the theory and practice involved in VIPP, I was an intervenor in HS, HS. This involved attending a five day training in VIPP and delivering the intervention for the RCT. I worked with five families including using VIPP-SD with three mothers, VIPP-SD with one father and VIPP-SD with one family as co-parents. Through this experience I became aware of some of the familys subjective experiences of VIPP. As a VIPP clinician I also held my own views about what I considered to be the more helpful and the less helpful aspects of the program. For example, I assumed that focusing on early attachment relationships would be useful for both parent's and children's wellbeing. Whilst the interview schedule and study were designed prior to my clinical experience in VIPP, it was important to bear in mind the biases I could bring to the interview and analysis, given that I had delivered VIPP by this point in time.

### ***Bracketing***

Given the subjective nature of qualitative research and with my dual role as clinician and researcher in HS,HS, bracketing was important at all stages of the research process. Whilst definitions of bracketing vary (Tufford & Newman, 2010), the following quote is used to define the use of bracketing in this research project; the researcher "must be honest and vigilant about her own perspective, pre-existing thoughts and beliefs, and developing hypotheses ...engage in the self-

reflective process of “bracketing”, whereby they recognize and set aside (but do not abandon) their apriori knowledge and assumptions, with the analytic goal of attending to the participants’ accounts with an open mind” (Starks and Trinidad, 2007, p. 1376). I therefore attempted to be consciously aware of how my views of the programme and other beliefs and assumptions influenced my interpretations, whilst I made significant efforts to remain objective and be led by participant narratives.

### ***Credibility checks***

With consideration for my position as a clinician in HS,HS, and following good practice guidance for assessing the credibility of qualitative research (Barker & Pistrang, 2005; Elliott Fischer & Rennie, 1999) credibility checks were used to increase the quality and validity of both the analysis and the conclusions that could be drawn. Initially, this involved the researcher and HS, HS manager coming together to discuss and reach consensus on our initial coding of a transcript. A Trainee Clinical Psychologist who had not worked in HS, HS nor had had any previous experience of parenting programmes also coded one transcript and we came together to discuss and reach consensus on our coding of this transcript. When initial thematic maps had been created, these were shared with two research supervisors, who reviewed these and commented on any interpretations I had come to that could have been influenced by my own experiences and beliefs. The HS, HS manager also looked at the Excel file and the results write-up to check the accuracy of what was being presented. Multiple discussions were had with the research supervisors, and a consensus approach was then adopted to agree the final thematic framework.

## **Results**

The analysis produced 16 central themes (with some of the 16 themes including subthemes), organised into three domains (Table 1). The first domain describes fathers’ perception of any gains brought about by their involvement in HS, HS. The second domain describes what helped fathers engage with VIPP-SD. The third domain presents mothers’ views of fathers’ involvement in the programme. Identification numbers are noted alongside each participant’s quote.

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**Table 1: Themes and subthemes**

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**Domain 1: Fathers' perceived gains**

**1.1 Reassurance**

“Okay, you’re not too bad at this”

The wider context

Different is OK

“I am important to her”

Reassurance is not enough

**1.2 Understanding and reflecting on my child**

“Your baby can communicate with you”: Realising and noticing my child’s communications

Mentalizing my child

**1.3 Quality, focused interaction**

Following the child and letting them lead

**1.4 Practical parenting tips**

**1.5 “Post-Match analysis”**

**Domain 2: Engagement**

**2.1 Healthy Start, Happy Start programme factors**

**2.2 “Spotlight away from me”**

**2.3 Intervenor characteristics**

**2.4 Mothers’ involvement**

Mothers as gatekeepers

Be where I am and talk to me

“We do this together”

**2.5 Societal attitudes on fathers’ roles**

**2.6 Where are my strategies for managing my specific concerns? What’s the point in this if don’t get them?**

**Domain 3: Mothers’ views on fathers’ involvement**

**Table 1 continued**

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**3.1 “It’s a shared responsibility”**

**3.2 Consistency and parenting together**

Encouraging conversations

Shared time together

**3.3 Understanding my role**

**3.4 Changes in the father-child relationship**

Encouraging fathers involvement

**3.5 Dad’s worries about being in the spotlight**

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***Domain 1: Fathers’ perceived gains***

All fathers reported gaining something through the programme but there were some gains that were particularly common among fathers. Specifically, fathers spoke about feeling reassured about their parenting as well as gaining a better understanding of their child. Knowledge gained by fathers about how to manage their children’s challenging behaviours was frequently discussed and the extent of the perceived knowledge gained was variable.

***1.1 Reassurance***

Every father emphasized feeling reassured in some way by the programme. Commonly fathers spoke about feeling reassured about the quality of their parenting and feeling assured that they are important to their children.

***“Okay, you’re not too bad at doing this”***

Fathers reported that they appreciated hearing about what they were doing well with regard to their parenting and they said that the intervenor’s feedback helped them feel reassured and more confident that they were doing a good job as a father. Fathers noted that both hearing this feedback

and watching their child's positive responses to them on video, helped them to feel reassured about their parenting and translated into feeling more confident in their role.

*I think having that quite early video feedback it was like, okay, you're not too bad at doing this. I think that gave me a little bit more confidence in playing with [daughter]. (F5)*

*It's kind of reassuring I guess that we're doing things alright. I'd say that was the main takeaway for me. (F6)*

Fathers often spoke about their reasons for wanting reassurance. These varied from viewing reassurance as something that is most helpful to them as a first-time father, through to circumstances in which fathers were the primary caregiver. Fathers also spoke about feeling less confident about childcare than their partners and thus feeling more in need of reassurance. This lack of confidence was often attributed to their partners' more frequent involvement in child care.

*I do think it's a very useful thing... umm and should be made available to people, you know because it's really scary (referring to parenting) but perhaps with the first kid I would say it's probably where you need it. (F1)*

### ***The wider context***

Many fathers spoke about the program providing the reassurance and support that they might have otherwise received from family, had their social and familial support been closer. This was often attributed to living in the city.

*Not really knowing whether I am doing a good job or not and maybe if we got a wider family and family networks around I would have been, I'd have had that knowledge I suppose and experience already. (F14)*

### ***Different is OK***

Fathers also commented on how prior to VIPP-SD, a common source of tension in the relationship with their co-parent would be differing views on the best ways to interact and play with their children. Fathers commented that they felt reassured by intervenors, that both styles of parenting were OK.

*Realising there is no kind of right nor wrong... it's just that's we do things differently. (F5)*

### ***"I am important to her"***

Fathers commented that through the programme, they had noticed how important they were to their child. Specifically, fathers often commented on feeling surprised, touched and reassured that their child often sought their reaction, approval or praise or simply smiled at them; fathers commented that these moments might have been unnoticed by them, if not captured on film or pointed out by the intervenor.

*That sense of kind of reassurance that she does enjoy it when I play with her... she does quite enjoy spending time with me...noticing I am important to her. (F2)*

For many fathers, and particularly those who felt less confident, these moments helped them see the extent that their child valued their interactions.

*It was nice, knowing how much he valued our attention. (F3)*

*The videos where she would kind of look up and we would get eye contact... or when she was kind of playing parallel but just seeing that having me sat next to her was kind of comforting...that was kind of nice. (F2)*

### ***Reassurance isn't enough***

Whilst reassurance was deemed a useful outcome for fathers, many spoke about feeling that the program often spent too much time focussing on reinforcing what parents were doing well, instead of focusing on what they could change or do differently.

*Whilst it's nice to be told 'that was great', you tend to want to skip to, right, what can I do differently? What can I improve? (F11)*

*Being told the things I was doing well I somehow didn't find the most useful moments of watching the (video). (F12)*

### **1.2 Understanding and reflecting on my child**

Fathers commented on the ways in which VIPP-SD had helped them develop more understanding of their children. Fathers emphasized that the comments made by the intervenor whilst watching the video clips, the 'observer perspective' facilitated by the video viewing, and having an allocated time to reflect, were central to these new and/or developed understandings.

#### **“Your baby can communicate with you”: Realising and noticing my child's communications**

Fathers noted that through VIPP-SD, they had a better understanding of their child's communication. Fathers spoke about the helpfulness of receiving video feedback on their child's non-verbal communication (which would have been done through 'speaking for the child'), noting how this helped them to understand and interpret their child's needs better. Some fathers expressed surprise at the fact that their child was trying to communicate with them; this was also true for more experienced fathers. Many fathers said that since the intervention they understood their child's communication more and were looking out for their child's nonverbal communications. Fathers also commented on the positive impact this increased understanding had on their relationship with their child.

*That understanding, that your baby can communicate with you ... I feel like four kids down already and I still didn't know that they could, that toddlers can communicate as much as they can from such a young age...I didn't know. I do feel like I am closer to him because of it.*  
(F9)

*She'd (referring to intervenor) just explain from [child's] point of view, she'd say (referring to intervenor) "look dad, look how clever I am"...when he'd put his hand together you know what I mean and its things like that that I wasn't noticing. He was waiting for my praise for him and sometimes I was missing the point...because I never used to really understand him.*  
(F4)

### ***Mentalizing my child***

Some fathers reported that their capacity to reflect on their child's experiences, actions, thoughts and feelings were increased as a result of the programme.

*Reminds you to really look at them in the face and look at what they must be thinking and putting yourself in their shoes. (F1)*

*It's definitely made me more open to what (child) could be feeling or experiencing... I think it's just made us a little bit more open to experiencing what (child) might be experiencing.*  
(F9)

### **1.3 Quality, focused interaction**

Fathers reflected on the VIPP sessions as a unique opportunity to focus solely on playing and interacting with their child, describing it as a “good excuse” (F10) and “protected space” (F1). Through this focused time fathers noted that they felt appreciative of the importance of play and exploration for their child’s development but also for both of their enjoyment. Whilst quality time was recognized as being important, many fathers said that they had found this a challenge to keep up.

*The nicest thing for me was that it was a focused sort of hour where I wasn’t going to get distracted by having to go and do something else. (F7)*

### **Following the child and letting them lead**

Fathers spoke about allowing their child to lead interactions more, in comparison to “being too directive” (F7) or “not involved enough” (F8). Fathers often attributed this change to watching themselves interacting with their child on film.

*I think being forced to slow it down and watch their reaction carefully and let them learn it at their speed is something I really took away that probably a bit of a way I’m trying to adapt...we are observing more, listen more, slow down, um let the child lead I think that was another big one as well as slowing down its letting them decide how the plays gonna progress. (F6)*

### **1.4 Practical parenting tips**

Among many fathers, there were some initial and/or continued hopes that they would gain some practical strategies to manage their children’s’ more challenging behaviours. Impressions among fathers varied about the extent to which they felt they had gained these strategies as well as varying views amongst fathers about the importance they placed on gaining them.

Some fathers felt they gained these practical parenting tips. Fathers appeared to particularly benefit from seeing the positive impact praising their child had when watching the video clips and seeing their child’s response from this advice.

*Praising him instead of telling him off, I think that worked actually, because he started doing more positive behaviour. (F11)*



Taking a step back, explaining things to their child and positively reinforcing good behavior appeared to be the most widely remembered and used tip received by parents. Many of the fathers highlighted that they did not receive as much feedback or direction in terms of managing specific behaviours they were struggling with (e.g. feeding, temper tantrums). Many fathers also noted that they did not feel more confident in managing difficult behaviours than they had done before the programme.

*I don't really get a sense that very much was suggested....it felt very non directional. So in terms of us having strategies to change ....I didn't get them and still haven't got them. (F14)*

### **1.5 “Post-match analysis”**

Many fathers spoke about the programme encouraging parents to talk together about co-parenting, labelled by one father as a “post-match analysis”. However, most families reported that this was hard to keep doing consistently after the visits finished.

*Useful in just kind of prompting us to have a conversation when we would have probably otherwise would have just watched tv. (F14)*

*Actually the most useful thing was probably the conversations afterwards between me and [co-parent] about it. (F4)*

## **Domain 2: Engagement**

Fathers spoke about a range of factors that encouraged their engagement in the programme and facilitated the changes described above.

### **2.1 HS,HS programme factors**

Fathers commented on certain aspects of the programme that facilitated and hindered their engagement with it. Many said that they appreciated that the programme could be delivered on weekends and evenings and that without this, they could not have engaged. Stay-at-home fathers spoke about feeling that they would “not have had the time if not the primary caregiver” (F13). Some of the parents also commented that their initial engagement in the programme stemmed from an

interest in research and many appreciated that the advice would come from “*a respected research institution...advice from a place you could trust*” (F1).

## **2.2 Spotlight away from me**

Many fathers explained that during initial sessions, they felt “*worried about being judged*” (F3) or “*a bit nervy*” (F4). Fathers sometimes compared their own initial confidence to their partners’, and attributed their own lack of confidence to less involvement with their child generally and/or to the ways in which they were asked to play or interact with their child in the sessions. They noted that the ways they were asked to play, differed from their typical ways of interacting with their child. Noticing that the spotlight was not on their parenting and was instead largely focused on the child helped fathers overcome these concerns and facilitated their engagement in the programme.

*I was working full time, and I wasn’t as confident about looking after them...I think men tend to be more awkward about it, even people that are good with kids, just being in the spotlight, I suppose, analysing ... worried about doing things wrong (F6)*

Fathers noted that a key concern for them considering such programmes would be their concerns about being judged on the quality of their parenting.

## **2.3 Therapist characteristics**

Fathers explained that when they received feedback on their parenting the intervenor’s approach was key to their engagement. In particular, all fathers felt that their practitioner’s approach was non-judgemental and that this allowed them to feel “comfortable” and “to act naturally”. The importance of the practitioner-child relationship was also identified as important to fathers’ engagement.

*If she didn’t make us feel comfortable then I don’t think we would have carried on... she was just really friendly and she seemed really genuine, she actually did care (F12)*  
*[Intervenor’s name] and [child’s name] got along like a house on fire, that helped from the outset (F2)*

## **2.4 Mothers’ involvement**

Fathers placed considerable emphasis on the ways in which mothers’ involvement in HS,HS impacted on their engagement.

### ***Mothers as gatekeepers***

Fathers commented on their varying degrees of involvement, particularly in the recruitment and initial decision to be involved in HS, HS. Specifically, some fathers noted that mothers were often the ones approached about taking part in HS, HS and were the ones to decide that the family would take part.

*She made the decision for me... She said these ladies are coming and that's it. I was like alright, whatever (F5)*

Some fathers commented that whilst the mother had been the one who was approached to take part they had felt more interested and keen to take part than their partners. Interestingly some fathers commented that as long as the mother arranged things, due to time, they would have happily taken part by themselves.

### ***Be where I am and talk to me***

There were exceptions to mothers being the gatekeeper. Indeed, for some fathers they had been approached to take part and had made the decision to participate either alone or with a co-parent. Fathers spoke about the importance of “*actively recruiting fathers*” (F14). This took many forms including attending venues that fathers are more likely to be at “*you are just not in the places that men are*” (F2) and fathers being directly verbally recruited “*I wouldn't just pick up a leaflet*” (F13).

*I think most dads probably would (do VIPP). The problem is that most dads don't seem to be in the places where you guys are offering it (F14)*

### ***We do this together***

Engaging in the program with their partner was central to many fathers' engagement.

*I don't think most dads would do it on their own, I think they would do it with the mothers as well. (F12)*

Beliefs about parenting as a “*shared responsibility*” (F7) played a role in fathers signing up to, or agreeing to be involved in HS,HS. Crucially many fathers remarked that they would not have done the intervention without their partner, as this was “*something we do together or not at all*” (F8).

Additionally, fathers spoke about VIPP-SD being “a more enjoyable experience for both myself and child” to do it with their co-parent. Fathers also spoke about reflecting more on the

sessions as a result of doing VIPP-SD with a co-parent. Fathers also noted that “doing it together” facilitated conversations about parenting and mothers “acted as a reminder” about things learnt in the sessions

*Because (mother) has prompted a lot .... there was a lot of stuff that I forgot pretty much straight away and (mother) would point, would bring them back up again so yeh...I don't think I would have come away with as much if it was just me. (F1)*

*It would have been quite weird if...if one of us and not the other.... urm just because it's not the way family life works (F3)*

On the other hand, amongst the fathers that completed the intervention alone, they neither saw any particular benefit to their partner being involved and did not feel that there were any costs of participating alone.

## **2.5 Societal attitudes on fathers' roles**

Some fathers pointed to the role of stereotypes in their decision to engage in the programme. Some felt that attending parenting programmes “is a mum thing” (F6) although interestingly, the fathers that held these attitudes did still decide to engage but suggested that others fathers may disengage because of societal attitudes.

*Due to the stigma thing in the society...there's going to be some guys who are a bit embarrassed to do it I suppose, it's seen as a motherly thing (F1)*

Others showed confusion about being asked their thoughts on fathers' involvement; considering fathers involvement as equally important as mothers and assuming other fathers shared this view

*It's the 21<sup>st</sup> century, surely most are involved (F14)*

## **2.6 Where are my strategies for managing my specific concerns? What's the point in this if don't get them?**

As mentioned previously, a common expectation from fathers was that they would learn new strategies to manage their children's more specific challenging behaviors through VIPP-SD. Fathers typically spoke about the manualised approach limiting their ability to discuss their families' individual concerns (e.g. temper tantrums) and that this sometimes felt frustrating and inflexible.

*Expected it to be more individualised, like help with certain things we were struggling with. Some tailoring or flex....making it individual to us would have been good, not just manual...like feeding, at the time would have been helpful (F2)*

When fathers did not feel that their initial assumptions were met, they spoke about feeling confused about what the aim of the programme was, if not to gain individual practical parenting strategies.

*I wasn't 100% sure what anyone was meant to be getting out of it... I think perhaps a bit more clarity at the start on exactly what was being achieved (would have been helpful) (F9)*

### **Domain 3: Mothers views on fathers' involvement**

Almost all mothers spoke about fathers' involvement in the programme being essential and were overwhelmingly positive about their involvement.

#### **3.1 "It's a shared responsibility"**

Many of the mothers held strong views that fathers should be as involved in parenting programmes as mothers. Whilst some mothers commented that they would have still engaged without the father present, many reported that it would make VIPP-SD less effective and/or that they would feel frustrated if the programme was not considered "*a shared responsibility*" by both mothers and fathers. Some mothers noted that they would not have taken part if their co-parent had not.

*I do believe that it's a shared responsibility... I would have been resentful if it had been a study just aimed at me. Im not sure I would have signed up for it. (M1)*

*Would be hugely different without dad... because you raise that child together and then it's like only doing erm weight lifting with your right arm if only one of the two does it... needs to have both parents on board, I think it's fairly useless otherwise. (M7)*

#### **3.2 Consistency and parenting together**

Mothers also viewed fathers' involvement as important for helping to approach parenting consistently and to do more parenting together.

*If you want to erm toe the same line as parents, I mean it's not very productive to have one person professionally trained and the other not. (M4)*

*For once we were both in the same...We were both in the same team, both being fun and playing and interactive. (M5)*

*That's another thing we learnt here, if one parent put a boundary and put something for the child to do, and if another parent comes along and changes it then there's no point and that parent's effort's gone to waste...I remember [intervenors name] telling us we really need to stay on the same page.. (M1)*

### **Encouraging conversations**

Mothers spoke about the sessions helping facilitate conversations between co-parents with regard to parenting and disciplining their children. They also spoke about discussing together what they had learnt from the sessions as well as what they had learnt from watching each other.

*It was quite good that we learnt from each other. (M11)*

Some of the mothers discussed how they felt that father's involvement in VIPP-SD helped them to raise topics sensitively. Mothers also mentioned the anticipated challenges of discussing the tips learnt from VIPP-SD, had fathers not taken part.

*I think it's made me feel more comfortable when I have issues. with something, with say how dad parents like if I have an issue but I am kind of afraid to bring it up to come out with a suggestion in case he takes it the wrong way ...Its helped in a sense that I can say "do you remember when that person came over and she pointed this out" it's like a kind of a gentle way of trying to bring a topic up if there is an issue...it was nice having that third person because if I was the one that said that it could have caused conflict between us. (M10)*

*If I had the session and were to say to him "oh, we should do this", he'd think its nagging, whereas him being there...so that Dad can sort of be there and do it as well, then he's experienced the same as me, so we stay on the same page, so he doesn't feel like I'm saying "oh, you're a bad Dad 'cus you didn't do this sort of thing. (M9)*

*I think it's important for him to be involved as well, because even if I explain to him later on it wouldn't be the same. (M3)*

### **Shared time together**

Mothers often referred to VIPP-SD as an opportunity to have non-distracted time as a family. Many of the mothers commented on the enjoyment they had from doing the sessions with the father present and noticing how much their child enjoyed playing with both parents together. Many mothers spoke about attempting to engage in triadic play more frequently since VIPP-SD finished.

*It was really nice...having the time for the three of us to not do anything else...just seeing how she (child) really enjoy that, she's so happy about having us, the two together, being here... it makes it more fun. (M6)*

*we sort of think afterwards, oh that was really nice,we should make a point of having a little bit of time when we all play together(after VIPP-SD) we sometimes spend time together in her bedroom when she is playing now. (M8)*

### **3.3 Understanding my role**

Some mothers commented that the programme gave couples the opportunity to understand the difficulties involved in being a primary caregiver to young children.

*It's nice to show them (referring to fathers) that, you know, that actually stress levels of being a mum go as high as, through the roof just like having a job.... even if it's the other way round and it's the mum the one who works and the dads the full time parent, it's nice for the other couple to see that its actually very difficult and tantrums aren't very easy. (M11)*

### **3.4 Changes in the father-child relationship**

Many mothers commented on the changes they had noticed in the father-child relationship that they felt were a result VIPP-SD. Typically mothers spoke about fathers' increased understanding of their child's communications as a result of the programme. Mothers spoke about perceiving this increased understanding to have a number of benefits including the child feeling more understood by the father, and willing to go more frequently to father, than mother, for their needs. Mothers spoke about these continuing after VIPP-SD had finished.

*Makes a difference with their bond...because before(child) was always like mamamama like he wants to come to me and ask me for something whereas now it's like he is sharing it, now he is going to dad and trying to explain... I think it's because he probably feels comfortable that okay dad can kind of understand what I am trying to tell him. (M9)*

*I don't think I prompt him that much anymore... I don't have to do it that often because I think you (gesturing to father) understand him pretty well now. (M7)*

Mothers also reported that fathers were more confident about caring for their children after VIPP-SD.

*Its helped a bit with you looking after her... helped you feel better about getting her ready and things... you're more competent at looking after her....So I think you are much more relaxed about what you can do with her (M5)*

The programme was often seen by mothers as a way to encourage fathers to be more involved with their young children.

*Sometimes if he gets home from work and he's tired or whatever sometimes he will just sit down and let the kids get on with it. Whereas this was actually, not forced him but gave them a real opportunity to sit down and purposefully do a task and a game together. Whereas he might have just sat down and watched rather than actually get involved. (M2)*

*I like the fact that it is trying to encourage dads to be involved in very young children's lives. (M10)*

### **3.5 Dads worries about being in the spotlight**

Mothers often commented that fathers would be “put off” or have more difficulty engaging in parenting programmes than mothers, because of worries about being “*in the spotlight*” (M9) or “*criticized*” (M3).

*Think they (fathers) can be more defensive about things like that. So if they feel like they're being judged or they're gonna be judged then like [father] said he's not gonna get involved 'cause if he's not gonna do something if he's gonna be judged by it or pressured (M5)*

Some of the mothers highlighted that, in order to help engage fathers, programmes should explain that the programme will be non-judgemental and will not be critical of their parenting.

*Just make it more clear, it's about building their relationship rather than trying to sort of criticize what they're doing. (M6)*



## Discussion

Fathers have disproportionately been left out of parenting programmes and, when they have been involved, there have been limited attempts to document fathers' in-depth experiences of such programmes. *Healthy Start, Happy Start* (HS,HS) offered an important and exciting opportunity to address these gaps. The primary research aims of this qualitative study were therefore to gather fathers' in-depth perceptions of what they achieved from VIPP-SD as well as what had facilitated their engagement in the programme. Additionally, this study aimed to elucidate mothers' perceptions of father's involvement in VIPP-SD, as little is known about mother's perspectives on fathers' involvement in parenting programmes. Mothers' views have been seen as important for fathers' involvement previously (Potter & Carpenter, 2010).

Overall, this qualitative study highlighted that fathers perceived a number of gains from their involvement in VIPP-SD. In particular, fathers spoke about feeling reassured about their parenting abilities, understanding their child better, appreciating the opportunity for non-distracted quality time and engaging in conversations about parenting with their co-parent. Fathers' views varied in the extent to which they had learnt practical parenting tips. Additionally, fathers identified a range of factors that affected their engagement in the programme. Specifically, for many fathers, mothers' involvement was perceived as key to their engagement at varying stages of VIPP-SD. The focus being largely on the child and a range of other programme factors (e.g. flexible timings) were also identified as affecting fathers' engagement. Therapist characteristics and fathers' expectations and perceptions of the aims of HS, HS were also important for engagement. In relation to mothers' view of fathers' involvement, mothers generally perceived fathers' involvement positively, with mothers noticing similar benefits of fathers' involvement to those perceived by fathers (e.g. understanding their child better, discussing parenting as a couple more). However, mothers placed additional emphasis on fathers' involvement promoting more consistent co-parenting as well as mothers feeling that the role of primary caregiver was better understood when a secondary caregiver takes part.

### *Father's perceptions of gains made*

In line with the Lawrence, Davies and Ramchandani, (2013) pilot study into fathers' experiences of VIPP-SD, fathers in the current study felt that their ability to communicate with their

child and to understand their child's thoughts and feelings had increased. However, the current study builds on the Lawrence, Davies and Ramchandani's (2013) by gathering in-depth accounts of fathers' experiences of the above mentioned gains as well as noting their experiences of engaging in the intervention as a co-parent and their experiences of the sensitive discipline aspects of the programme as well as offering insights from the perspective of fathers who have children at risk of externalising problems.

Importantly, fathers' perceptions of the gains made from VIPP-SD appeared to closely mirror the aims of VIPP. Specifically, fathers' increased attempts to be more "child led" as well as their increased attempts to understand their child's thoughts, feelings and communications could be seen to suggest that fathers were increasing their sensitive parenting capacities, empathizing more with their child and increasing their knowledge and awareness of child development. From their descriptions, fathers appeared to have been making use of "speaking for the child" even when the intervenors were not present. Whilst it cannot be known whether fathers were *accurately* recognizing their child's attachment signals and responding adequately and appropriately (in line with Ainsworth, Bell, & Stayton's (1974) description of sensitive parenting), fathers do appear to be trying to mentalize their child more, perceive themselves to be understanding their child better, and in some cases, noticing these new understandings having an impact on their relationship with their child. Importantly, both mothers and fathers' spoke about fathers increased understanding of their child's needs and communications positively impacting the father-child relationship and children being more open to approach fathers when they might have previously approached mothers. This might suggest that fathers were becoming a more secure base for their child.

In addition to the primary aims of VIPP-SD, fathers reported some additional gains from their involvement. For example, fathers commonly spoke about feeling reassured and more confident about their parenting as well as noticing both their own and their child's enjoyment in their interactions. These additional findings are in line with the Magill-Evans, Harrison, Rempel and Slater (2006) systematic review of interventions with fathers of young children, who report that fathers often gain self-confidence in their fathering roles and report greater levels of competence in their interactions with their children following engagement in parenting interventions. Additionally, mothers and

fathers reported fathers' increased involvement with their children. Whilst fathers noted a number of perceived gains, it is important to note that fathers were interviewed soon after the programme had finished. Future research would benefit from longitudinal follow-up interviews to see whether such gains persist over time.

Importantly, fathers' accounts of the sensitive discipline component of VIPP-SD were mixed. Whilst some fathers commented on utilising aspects of this component (e.g. increasing positive interactions and praising the child), many fathers reported that they did not feel they received direction in disciplining their child effectively. Crucially, this appeared to be in contrast to some fathers' expectations of HS, HS, as a programme that would offer direction on managing more challenging behaviours. Fathers sometimes noted that they felt confused about what the outcomes of the programme should be. There a number of hypotheses that could account for the expectations fathers had and why these anticipated outcomes differed from fathers' expectations. Firstly, the programme was marketed by asking parents "are you having difficulties managing your child's behaviour?"; therefore it makes sense that fathers might have interpreted this as implying that they would gain strategies to manage their child's behavior. As psychologists, it might be taken for granted that understanding children and sensitively responding to their cues, can in turn impact children's challenging behaviours; however this was not made explicit to families and arguably this could have contributed to fathers confusion about the content of the sessions. Secondly, whilst there were some practical discipline strategies in the programme, previous research highlights that fathers are often particularly keen for programmes to be more practical and strategy focused (Magill-Evans, Harrison, Rempel & Slater, 2006).

Father's reports that they felt no more confident in managing their children's behavior is an important observation as it points to the programme not fully meeting parents' needs. This is interesting, as VIPP was originally designed as an early preventative programme where distinct presenting problems would arise quite infrequently. In contrast, this project worked with parents who had reported some concerns about their child's behaviors, and hence fathers expected explicit advice and guidance about that. In that sense, fathers' goals appear to be more in line with an intervention-oriented programme than one framed as prevention.

The above considerations offer important reflections for the ways in which VIPP-SD is marketed and explained to families if it is found to be effective. For example, these results suggest that parents need to be offered clearer explanations of the aims of the programme. Further, it is also important to recognize that given the programme was designed to be preventative rather than interventive, it will be important for families to be signposted to more interventionist services should their needs not be met by VIPP-SD.

It is also important to note here that some of the fathers felt that through the programme they gained reassurance about their parenting and more confidence that they were “doing OK”. It could be argued that for some fathers, the initial expectation of achieving practical strategies may have felt less important when they felt reassured about their own parenting abilities.

Importantly, in their meta-analytic review, Lundahl, Tollefson, Risser, and Lovejoy (2008) suggest that fathers respond differently to mothers to parenting interventions and may not achieve as many benefits from them. Whilst the Lawrence, Davies & Ramchandani’s, (2013) pilot study and the current research are unable to compare mothers’ and fathers’ perceptions of outcomes and benefits, it is clear from fathers’ subjective experiences in both studies, that for many fathers, substantial gains were made as a result of their involvement in an evidence-based parenting programme. This further supports the need to recruit fathers into parenting programmes given they themselves, perceive a number of benefits to be gained.

### ***Fathers’ engagement***

Many of the factors affecting fathers’ engagement in VIPP were consistent with previous studies documenting factors that facilitate and hinder fathers’ engagement in parenting programmes. For example, the need to offer flexible hours (e.g. Lawrence, Davies & Ramchandani, 2013) and make explicit attempts to encourage fathers to participate through ‘dad friendly recruiting’ (Panter-Brick, Burgess, Eggerman, Mcallister, Pruett, & Leckman, 2014) have been documented. Further, fathers’ concerns about their parenting being judged and being ‘in the spotlight’ have been noted to affect fathers’ engagement in previous programmes. Fathers highlighted two main factors that helped reduce their worries about being in the spotlight; firstly fathers spoke about the importance of interveners’ non-judgemental and genuine dispositions. These attributes have also been noted as

facilitating maternal engagement in previous parenting programmes (e.g. Kurtz Landy, Jack, Wahoush, Sheegan, & MacMilan, (2012). Secondly, the focus in VIPP-SD being predominantly based on the child, which allowed fathers to feel less “in the spotlight”, which in turn facilitated their comfort and engagement in VIPP-SD.

Additionally, many fathers noted that their interest in being involved in research and their confidence in the advice coming from a respected research institution facilitated their engagement, particularly in the initial recruitment phase. It is noteworthy that over half of the fathers interviewed were university educated. The sample’s high level of education could account for the interest in research acting as a facilitator to engagement and may be a highly specific engagement facilitator for this sample.

Importantly, some fathers felt that the programme was not flexible or individualized enough to meet their families individual concerns. Both flexibility and an ability to individualise parenting programmes have been documented as supporting parent’s engagement in parenting programmes in previous studies (Grayton, Burns, Pistrang, & Fearon, 2017). Some families suggested that VIPP-SD could benefit from offering parents a space to discuss specific difficulties that they were having with their child (e.g. feeding, sleeping, temper tantrums) and then tailoring some of the advice to help with these specific concerns. Allowing this space may also facilitate a shared expectation and aim between parent and intervenor, which could improve parent’s clarity with regards to the aims of VIPP-SD. Alternatively, through discussing families specific concerns, this may simply support clinicians in formulating and signposting appropriately should more distinct presenting problems arise. The ability to tailor aspects of VIPP-SD to families’ individual difficulties with their child is an important consideration for research and clinical practice. The role that mothers’ involvement played in fathers’ engagement is documented in the following section on ‘mothers perspectives’ given that mothers’ and fathers perspectives’ converged on this topic.

### ***Mothers’ perspectives***

Mothers’ perspectives of fathers’ involvement in the programme were overwhelmingly positive. At this point, it is important to acknowledge that mothers were interviewed when fathers were present. This could have limited mothers discussing negative aspects of fathers’ involvement.

However many mothers were critical of their co-parents' parenting and/ or involvement before the programme and were often open about concerns they had about fathers' involvement in the programme (e.g. fathers' nerves becoming a barrier); this could be seen to suggest that mothers may in fact have felt comfortable openly expressing more negative views on fathers' involvement. As a female interviewing both co-parents this may have also helped mothers to feel more relaxed in order to speak about both the benefits and costs of paternal involvement in VIPP-SD.

Mothers spoke positively of HS,HS being novel in including fathers. This is in line with a recent review suggesting that mothers are particularly keen for father's involvement in parenting programmes (Potter & Carpenter, 2010) but builds on this finding by highlighting mothers' views when fathers have participated. Fathers' involvement appeared to facilitate some mothers' engagement; indeed some mothers spoke about feeling that they would not have participated if their co-parent had not done so or that they might have "resentfully done so". Other mothers, and fathers, simply spoke about finding the programme "more enjoyable" to engage in with their co-parent. Fathers, more so than mothers, said that they would have not done the programme without their co-parent, although this was not true for all fathers. Some mothers felt that the programme helped fathers to understand their role better.

There were many similarities in fathers' and mothers' perceptions of joint co-parent involvement. Both often perceived their joint involvement as "crucial" to both their engagement in the programme and to the gains they made. Mothers noted changes to the father-child dyad; these changes were often in line with fathers' views on how their interaction style and/or amount of involvement with their child had changed after the programme. Mothers and fathers both spoke about the need for more self-conscious fathers to view the programme as focused mostly on understanding the child rather than concerning the father that they would be criticized. Both mothers and fathers spoke about their joint involvement facilitating consistency and encouraging them to parenting together more, although it was notable that mothers placed more emphasis on the importance of this than fathers.

Future research could interview mothers about their perceptions of fathers' involvement without the father present. This could result in mothers feeling more open to discuss any more

negative aspects of fathers' involvement in such programmes. Previous research has found that when fathers become more confidently involved with their children, some mothers can feel that what they might consider as their role as primary caregiver, is being impacted (Potter & Carpenter, 2010).

### ***Limitations***

There are limitations to this study that should be acknowledged. Firstly, my dual role as both an intervenor and researcher in HS, HS could have impacted parents' openness to describe less positive aspects of VIPP-SD. To limit the impact of this dual role, I openly told participants that I was keen to hear both the positive and negative aspects of the programme; they were also reassured about confidentiality. Additionally, although not an aim of the study given the nature of qualitative research, the perspective of the participants cannot be considered generalizable. Further, given most fathers in this sample were highly educated and married or co-habiting with the child's mother, it could be argued this was a highly selective sample. It might therefore be interesting for further research to gather experiences from fathers who are from less well-educated backgrounds and do not reside with the child's mother. This would enable researchers to consider whether these families receive the same benefits of attending and to consider whether similar factors impact on engagement.

Additionally, it is important to highlight that only around 10% of families randomized to the intervention arm of HS, HS decided to take part as co-parents and even smaller numbers of fathers opted to take part in VIPP-SD alone. I therefore interviewed all of the families (except one family) who had taken part in VIPP-SD as a father alone, or as co-parents. Given the small number of families who opted to take part as co-parents or have fathers participate alone, it could be argued that the sample interviewed may have held particularly positive views of co-parent and father involvement in such programmes. These views may not be representative of the majority of families that took part in VIPP-SD overall. Future studies could benefit from speaking with families when only the mother decides to take part, and discussing their perceptions of costs and benefits to fathers' involvement and the factors that may have hindered co-parenting or father involvement. For example, it has been found

in previous research that when mothers have engaged in programmes without fathers, mothers' negative views of father involvement has acted as a barrier to fathers' engagement in such programmes. Such findings can help inform efforts to address barriers to fathers' involvement in programmes.

A further key limitation of the present study was that given that the fathers who participated in the interviews had engaged in the full VIPP-SD programme (as they had completed all sessions), this study was not able to answer questions about what stopped fathers from engaging. Future research could benefit from speaking to fathers about their reasons for opting out or disengaging from parenting programmes. This could help elucidate factors that prevent fathers from engaging in such programmes in the first place. This seems particularly important given findings in the current study suggesting that when fathers are involved, significant benefits are found from mothers, fathers and potentially children.

An additional limitation is that the concept of factors that facilitate engagement, can often be difficult for participants to describe (Weissman, Roun-saville, & Chevron, 1982). More objective measures and/ or interviews with therapists have also been found to provide useful data on factors that facilitate engagement and could be used in conjunction with participant reports (Weissman, Roun-saville, & Chevron, 1982).

### Strengths

A key strength of the current study was that it utilized an all too rare opportunity to document fathers' experiences of an evidence-based parenting programme. Almost every father that received the intervention was interviewed about their experience and a culturally diverse group of families made up the sample. Taken together, this allowed for rich descriptions of experiences from a multi-cultural sample that allowed us to reach saturation. Additionally, gaining mothers insights was another strength of the study and to our knowledge is a novel addition to research focused on fathers' engagement. The need to obtain both co-parents' experiences is becoming increasingly important as clinicians and researchers begin to move away from focusing solely on dyadic relationships and begin to broaden their perspective on children's development to systemic factors such as triadic interactions. Importantly, my own experience as an intervenor enabled me to have a good grasp of the theory,



research and clinical practice behind VIPP-SD. Such insights helped the researcher consider to what extent the findings mapped on to the aims of VIPP-SD. This experience also enabled the researcher to consider more pragmatically, the feasibility of clinical and research implications that could be suggested as a result of the findings from this study. The clinical experience in delivering the programme provided the researcher with a good grasp of the aims and theory behind VIPP. This was crucial in allowing me to reflect on the similarities and discrepancies between the aims of the program and what was subjectively achieved by families and through what processes these were achieved.

### ***Clinical implications***

Quantitative analysis on the effectiveness of VIPP-SD compared to TAU is due to be completed in 2019; these qualitative findings will support interpretation of the quantitative results. From this qualitative study it is clear that fathers felt that there are ways in which they can be supported to engage in such programmes and all the factors found to support engagement in this study would benefit from being maintained if VIPP-SD is found to be effective and delivered in the NHS. More broadly, such factors should also be considered when appropriate, in other parenting programmes hoping to engage fathers. Nonetheless it will be important for fathers to continue to be asked about perceived factors affecting their involvement as this study focused on a fairly small number of fathers' subjective experiences of a specific parenting programme. It could be argued however, that many of the factors found to affect their engagement are in line with findings in the literature and many are non-specific factors (e.g. therapist characteristics, flexibility of timings). As has been noted, communicating the aims of VIPP-SD and the extent to which the programme becomes more individualized requires consideration. The ways in which fathers would like to be invited to participate varied considerably, with some fathers happy to be informed via their co-parents and others suggesting fathers be approached themselves; a mixture of these methods therefore seems important for professionals hoping to involve fathers in parenting programmes. Importantly, this study highlights that both mothers and fathers highlighted a number of perceived gains from fathers' involvement in an evidence-based parenting programme; with benefits perceived by fathers and mothers. This study adds support to attempts made by clinician and researchers alike to ensure fathers are involved in such programmes.

The current study highlights the importance of gaining a rich understanding of fathers' and mothers' experiences of parenting programmes. These experiences are a crucial aspect of evaluating whether programmes are meeting participants' needs. Gathering such rich insights is particularly important for understanding how to engage fathers in such programmes, given their importance in child development and for informing the development of parenting programmes to ensure it is suited to both mothers' and fathers' needs and, ultimately, in designing programmes that are most effective for adaptive child development.

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## **Critical appraisal**



## **Introduction**

This critical appraisal primarily set out to offer my perspective on the experience of ‘Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline’ (VIPP-SD) as an intervenor in Healthy Start, Happy Start (HS,HS), with the aim of acknowledging how these experiences, as well as other relevant experiences, could have impacted different stages of the research process. This appraisal also sought to outline the steps taken to limit these potential biases. Further, I sought to reflect on the benefits, for me personally and for the research, of being both a clinician and a researcher for HS,HS.

### ***Considering the potential impact of previous experience on qualitative research***

Throughout the different stages of the research process, was that my interpretations of the research findings could be influenced by my own experiences, values and beliefs (Tufford & Newman, 2010). Therefore, whilst conducting this qualitative research, reflexivity and ‘bracketing’ was critical for enabling me to reflect on factors that could have been influencing me at different stages of the research process (Willig, 2008). Tufford and Newman (2010) recommend utilising ‘bracketing’ to evaluate how ones preconceptions could have both positive and negative influences on the research process. With this recommendation in mind, throughout the research process I reflected on how my experiences could have had both positive and negative influences. This critical appraisal sought to capture these reflections. I will begin by detailing my relevant previous experiences before considering how these experiences could have impacted the different stages of the research process.

### ***Previous experiences***

#### ***Preconceptions about the challenges and benefits of recruiting fathers in early childhood research***

During my undergraduate studies I completed a research dissertation seeking to assess the impact of fathers’ depressive symptoms on pre-school aged children’s feelings of guilt and on their emotional regulation abilities. Besides working on my undergraduate dissertation, I was employed as a research assistant in a study looking at how rumination in dysphoric mothers affects mother–infant interactions. My primary role was the recruitment of mothers. Whilst recruiting for these projects I

became aware early on that fathers, in comparison to mothers, were significantly more challenging to recruit.

Compared to mothers, attempts to recruit fathers from children's centers, nurseries and independent parenting groups was often unsuccessful, oftentimes due to fathers not being present in such locations. To facilitate recruitment, I ran a focus group with fathers to hear their suggestions on ways to recruit fathers and to hear their perceptions of what may influence fathers' decisions to participate, or not, in research. Amongst many other helpful insights, fathers commonly suggested going to more "dad friendly" locations e.g. swimming pools and parks as well as letting them know that timings can be flexible. They also suggested that fathers may be more "awkward" or "a bit anxious" when taking part in research. Following through on these recommendations contributed to a significant increase in the recruitment of fathers into the study. Interestingly, amongst fathers who took part, there was considerable positive feedback, from both mothers and fathers, about the fathers being included in a study, rather than the focus being exclusively on mothers.

The abovementioned research experiences gave me both positive and negative preconceptions that could have affected the current study's research process. For example, this experience led me to an initial preconception that it would be difficult to recruit fathers into the current study. Additionally, the positive feedback from both mothers and fathers regarding fathers' involvement in my undergraduate research led to preconceptions that when fathers had taken part in HS, HS, they were likely to view their involvement positively given it might be a more novel experience for them to participate in such programmes and research.

### ***Experience as a Healthy Start, Happy Start intervenor***

Prior to interviewing families for the current study, I worked as an intervenor in HS, HS. As well as attending a five day training course, I worked with 5 families, delivering VIPP-SD with three mothers, one father and one family who I visited as co-parents. All of these families completed the six session programme. From these experiences I developed my own ideas and expectations about

what the most useful aspects of the programme are, as well as what aspects I believe to be less helpful.

In general my experience as an intervenor was positive. The video aspect of the programme and bringing new toys along for home visits felt novel and enjoyable to me and the families I worked with clinically. Children I saw were often excited about the sessions, keen to find out what toys I had with me and were initially intrigued by the prospect of being recorded. Contrary to my expectations, children and parents seemed to adapt to being filmed very quickly. The child's excitement was often a way to engage parents in small talk at the beginning of the initial sessions. There were aspects of the sessions that I thought the parents I worked with found particularly useful. For example, parents often commented on seeing their child smiling and seeing how important they were to their child in the video recordings. All of the families I worked with described these recorded moments as memorable and touching moments. I noticed changes in all of the parents' abilities to follow their child more in play and to let their child lead in activities (e.g. in tidying up, playing) either through taking a step back or being more involved (dependent on what the child needed) or to slow down their pace and to praise their children more. Overall, I felt the programme benefitted parents' capacity to take their child's perspective. Additionally, I often noticed parents utilising "speaking for the child" spontaneously within and outside of the filming.

Although my overall experience of delivering VIPP-SD was positive, there were certain aspects of the programme that I felt less positive about. I sometimes felt restricted by the manualised nature of the programme. For example, I felt restricted in providing constructive video feedback about what parents could improve on. I felt this was difficult for two reasons. Firstly, only one piece of 'corrective feedback' (i.e. a suggestion on what the parent could do differently) could be given per video and, secondly, this corrective feedback could only be given if a parent had also shown that they were capable of doing the desired behaviour (i.e. earlier on in the video the parent had to have displayed the desired behaviour in order to show they are able to do the behaviour). Sometimes the desired corrective message would be a tip in the manual that intervenors were expected to read to the

parent. However, delivering the message in this way often appeared less relevant for parent's than seeing an example of themselves. Whilst focusing on the positive aspects of parenting and limiting corrective messages felt important for the first few sessions, for families who I felt I had a strong therapeutic alliance with and for those families who were experiencing more challenging interactions, I felt that both myself and the families might have viewed the programme as helping them in managing such scenarios more easily if I could have provided more corrective feedback than the manual allowed. Additionally, all of the families I worked with, asked for support with individual difficulties they were experiencing in relation to their child's behaviour (e.g. difficulties with behaviour during nappy changing, mealtimes). Given the manualised nature of the programme, I felt that both myself and the families would have benefitted from VIPP-SD being more flexible and individualised. The lack of flexibility at times felt as though it could have impacted on the therapeutic alliance. Having said this, the difficulties I experienced could have come from my training as a formulation driven psychologist and might not have reflected my clients' views.

### ***Designing and conducting the study***

It was important for me to reflect on the possible impact the abovementioned experiences had on the current research. I had some concerns about how these experiences could negatively influence the study. In particular, I was concerned that my own preconceptions as an intervenor could lead me to make assumptions about what fathers would gain and not gain as a result of the programme. I was also aware that these preconceptions could affect the ways in which the interview schedule was constructed; the way I conducted the interview; and how I analysed and made sense of the data. Keeping a research journal to reflect on my observations and thoughts during the research process (Cutcliffe, 2003) helped to limit these negative influences. An example of the impact of this reflection occurred during recruitment. I observed that, although arranging interviews sometimes took longer than expected, contrary to my preconception this was not due to fathers' ambivalence or reticence to participate, but rather due to the challenges of scheduling a time when both co-parents and I could meet. What follows are my reflections on my process of identifying and understanding how my

preconceptions and beliefs could, and sometimes did, influence the research process and the attempts I made to limit the negative influences (Tufford & Newman, 2010). This includes considerations in regard to recruitment; the development of the interview schedule; conducting the interviews, analysing and interpreting the data.

### ***The recruitment of fathers***

In light of my expectations of fathers being difficult to recruit to research, I utilised aspects of the advice I had been given by fathers in the focus group. This involved initially sending an opt-out letter to ensure fathers felt able to opt-out impersonally if they did not want to take part or if they did not feel that they had the time to do so. No fathers opted out at this stage. I then contacted fathers directly and ensured that I was flexible with timings, primarily visiting on weekends or evenings at their homes. Given I had also been informed in the focus group that fathers in particular may feel “awkward” or “a bit anxious” about taking part in research, I felt that suggesting to fathers that I could interview them in their homes may help them feel more relaxed about taking part.

### ***Designing the interview***

Given my own preconceptions about what families may find helpful about the programme, it was important that the interview schedule was designed to facilitate fathers’ in-depth feedback about all aspects of the programme. I therefore asked fathers broad questions about what they found “most helpful” and “least helpful” before asking them about more specific aspects of the programme. I developed this interview schedule along with my research supervisor who was independent of HS, HS and was able to provide feedback on any aspects of the schedule that could be broadened to ensure open ended detailed feedback was obtained; feedback that was led by the participant instead of my being led by my own biases.

### ***Conducting the interviews***

As well as being conscious of my preconceptions influencing the design of the interview schedule, I was also conscious of my pre-conceptions influencing the way I conducted the interviews. Given that any prompts for further details could have been influenced by my preconceptions, I was

therefore reflective and mindful of which questions I chose to follow up on, at what points I chose to prompt for more detail or ask for examples. Additionally, the HS, HS trial manager listened to a randomly chosen interview recording. This was done to ensure that the interviews were of a high quality and that my biases in my questioning were limited, though it is also likely that the trial managers' biases may in fact influence her evaluation of my interviews as well.

Another consideration when conducting the interviews was the extent to which parents could be open with regard to their experiences of HS,HS, given my role as both interviewer and intervenor. I was mindful that parents might have difficulty in providing open feedback about any negative experiences of HS,HS. In an attempt to overcome this potential barrier, time was spent building rapport and explaining confidentiality to parents. This appeared to enable them to engage more and provide open ended responses about both their positive and negative experiences. I prompted, reflected back, actively listened and showed interest to allow in-depth exploration of participants' experiences. The issue of confidentiality was repeated when asked about their relationships with intervenors. I assumed that this may be an area fathers may feel particularly concerned about especially in my role as an intervenor, and I explicitly shared this potential concern with participants before reassuring them of their confidentiality.

As mentioned previously, interviewing parents in their homes was a further way to facilitate parents' openness during the interviews. Interviewing parents in their homes had several costs and benefits. An advantage was that being in their homes facilitated a greater understanding of the social environment in which participants were embedded (e.g. the living environment, the local area, meeting their child and co-parents). It was also interesting to observe parents interacting with their children. For example a handful of times parents were putting into practice what they were speaking about during the interview. For example, on one occasion I observed a father praising his child and he commented afterward "I have been doing that (praising) more since (intervenor's name) came round". One challenge, as well as a benefit, was the presence of other family members during the interview. When fathers were interviewed alone mothers took their children into other rooms in their home so that they were less of a distraction for fathers. However children often wandered back into the room

and mothers typically collected them. This sometimes caused fathers to become distracted but it may have also limited what fathers felt able to say.

### ***Interviewing couples***

Whilst there were benefit to gathering both and fathers perceptions on fathers involvement, there were several challenges to interviewing couples. Firstly, the child was present during couple interviews and both parents were understandably more distracted. Secondly, during the couples interview, mothers were often more talkative then fathers. This may have been in part due to fathers separate interview being conducted first and fathers potentially feeling a need to give the other co-parent a space to offer their own views. To ensure that both mothers and fathers offered their views , fathers were explicitly asked the same questions as mothers or asked what their views were on what mothers had said (e.g. “what do you make of that, does that sound a bit different or a bit similar to what you thought about X”). Thirdly, during some interviews with both parents, mothers were sometimes critical of the fathers' “lack of involvement, in general, with parenting duties”. I was mindful of the possibility that these mothers might assume I was in allegiance with them because of my gender. I was also mindful of the possibility they would not be making comments like this if the interviewer was male; that my gender, through some sort of identification, prompted the mothers to make certain critical comments. I was therefore careful to ensure that I was seen as a neutral interviewer and sensitive to both parents’ opinions.

### ***Analysis***

Given my preconceptions about what families might achieve from the programme and what might help fathers engage, I was mindful of the need to share my thinking at different stages of the analysis and to use a consensus approach with my research supervisors. I also made use of my reflective journal. An example of being influenced by my pre-conceptions occurred whilst analysing data about the mother’s role in father’s engagement. I noticed myself giving less weight to fathers who viewed mothers as gatekeepers. When discussing fathers’ engagement there was a discrepancy between my analysis and another researcher’s interpretation of what the important factors were for fathers’ engagement during the interviews (e.g. we differed in how important the mother’ gatekeeping

was). When reflecting and discussing this discrepancy, it was clear that my own pre-conceptions about fathers needing to be actively recruited instead of being recruited through mothers was evident. A further challenge when analyzing the data was how interpretative to be of the data. The current study took an inductive approach to the analysis. However, within this approach it was recognised that it is impossible to be completely data-driven given that the analysis would be influenced somewhat by my personal ideas and beliefs and experiences (Braun & Clarke, 2006). Throughout the analysis I was often faced with the dilemma of being data-driven whilst needing to make sense of the data through some interpretation.

One area that was particularly challenging in terms of interpretation was the issue of whether fathers had experienced changes in their sensitive attunement to their child in line with Ainsworth, Bell and Stayton's (1979) definition. This is a complex concept with many layers and thus fathers did not always report changes that were in line with Ainsworth's definition whether that be because there were not these changes or because it may be less conscious or difficult to articulate. I tentatively concluded from fathers' accounts that there had been changes in their sensitive parenting capacities. However it is difficult to know if this was an over-interpretation. Helpfully, sensitivity as measured using researcher observations of the video-clips, is being tested as part of the wider randomized controlled trial (RCT). This highlights the value of utilizing multiple methods in RCTS, with both qualitative and quantitative data hopefully informing one another (Lewin, Glenton & Oxman, 2009).

## ***Conclusions***

The current study was influenced by my previous experiences of parent-child research and my experiences of being an intervenor on the HS, HS trial. These experiences held the potential to positively and negatively impact the study; my ability to reflect on these experiences was essential at all stages of the research process.



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## **Appendix 1: Crowe and Sheppard (2011) critical appraisal tool**

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## Appendix 1. Ethical approval

Below is the letter giving ethical approval for this study. An ethical amendment to the larger RCT was made, the letter refers to the sub-study under the title ‘ParentExpSubStudy’



20 June 2016

Dr Paul Ramchandani  
Centre for Mental Health  
Commonwealth Building  
Hammersmith Hospital  
London  
W12 0NN

Dear Dr Ramchandani,

**Study title:** Preventing enduring behavioural problems in young children through early psychological intervention: Healthy Start, Happy Start.  
**REC reference:** 14/LO/2071  
**Protocol number:** 14HH2370  
**Amendment number:** 3.0  
**Amendment date:** 27 May 2016  
**IRAS project ID:** 160786

The above amendment was reviewed at the meeting of the Sub-Committee held on 18 June 2016 via correspondence.

### Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Copies of advertisement materials for research participants [Poster A_V3_200416_ONLINE]	3.0	20 April 2016
Copies of advertisement materials for research participants [Poster A_V3_200416_ONLINETABS]	3.0	20 April 2016
Copies of advertisement materials for research participants [Poster_Flyer C_V2_200416_ONLINE]	2.0	20 April 2016

## Appendix 1. Ethical approval letter continued

Copies of advertisement materials for research participants [Poster_Flyer D_V3_200416_TABSONLINE]	3.0	20 April 2016
Copies of advertisement materials for research participants [Poster_Flyer D_V3_200416_ONLINE]	3.0	20 April 2016
GP/consultant information sheets or letters [Letter to GP_V2_200416_Clean]	2.0	20 April 2016
GP/consultant information sheets or letters [Letter to GP_V2_200416_Tracked]	2.0	20 April 2016
GP/consultant information sheets or letters [Letter to HV_V2_200416_Clean]	2.0	20 April 2016
GP/consultant information sheets or letters [Letter to HV_V2_200416_Tracked]	2.0	20 April 2016
Letter from statistician [PHQ-9_V2_200416_Tracked]	2.0	20 April 2016
Letter from statistician [PPACS_V2_200416_Clean]	2.0	20 April 2016
Letter from statistician [PPACS_V2_200416_Tracked]	2.0	20 April 2016
Letter from statistician [R-DAS_V2_200416_Clean]	2.0	20 April 2016
Letter from statistician [R-DAS_V2_200416_Tracked]	2.0	20 April 2016
Letter from statistician [SDQ Phase 2_V2_200416_Clean]	2.0	20 April 2016
Non-validated questionnaire [AUDIT-C_V2_200416_Clean]	2.0	20 April 2016
Non-validated questionnaire [AUDIT-C_V2_200416_Tracked]	2.0	20 April 2016
Non-validated questionnaire [CA-SUS_V2_200416_Clean]	2.0	20 April 2016
Non-validated questionnaire [CA-SUS_V2_200416_Tracked]	2.0	20 April 2016
Non-validated questionnaire [CBCL_V2_200416_Clean]	2.0	20 April 2016
Non-validated questionnaire [CBCL_V2_200416_Tracked]	2.0	20 April 2016
Non-validated questionnaire [Demographic Interview_V2_200416_Clean]	2.0	20 April 2016
Non-validated questionnaire [Demographic Interview_V2_200416_Tracked]	2.0	20 April 2016
Non-validated questionnaire [Feedback Questionnaire_V2_200416_Clean]	2.0	20 April 2016
Non-validated questionnaire [Feedback Questionnaire_V2_200416_Tracked]	2.0	20 April 2016
Non-validated questionnaire [GAD-7_V2_200416_Clean]	2.0	20 April 2016
Non-validated questionnaire [GAD-7_V2_200416_Tracked]	2.0	20 April 2016
Non-validated questionnaire [Parenting Scale_V2_200416_Clean]	2.0	20 April 2016
Non-validated questionnaire [Parenting Scale_V2_200416_Tracked]	2.0	20 April 2016
Non-validated questionnaire [PHQ-9_V2_200416_Clean]	2.0	20 April 2016
Non-validated questionnaire [SDQ Phase 2_V2_200416_Tracked]	2.0	20 April 2016
Notice of Substantial Amendment (non-CTIMP) [AmendmentForm_ReadyForSubmission]	3.0	27 May 2016
Participant consent form [Consent Form B_V4_200416_GEN_Clean]	4.0	20 April 2016
Participant consent form [Consent Form B_V4_200416_GEN_Tracked]	4.0	20 April 2016
Participant consent form [Consent Form B_V4_200416_WHITT_Clean]	4.0	20 April 2016
Participant consent form [Consent Form B_V4_200416_WHITT_Tracked]	4.0	20 April 2016
Participant consent form [ParentExpSubStudyConsent form_V1_200416]	1.0	20 April 2016
Participant information sheet (PIS) [PIS B_V4_200416_GEN_Clean]	4.0	20 April 2016
Participant information sheet (PIS) [PIS]	4.0	20 April 2016

## Appendix 1. Ethical approval letter continued

B_V4_200416_GEN_Tracked]		
Participant information sheet (PIS) [PIS B_V4_200416_WHITT_Clean]	4.0	20 April 2016
Participant information sheet (PIS) [PIS B_V4_200416_WHITT_Tracked]	4.0	20 April 2016
Participant information sheet (PIS) [ParentExpSubStudy_InfoSheet_V1_200416]	1.0	20 April 2016
Research protocol or project proposal [HSHS Protocol V4_200416_clean]	4.0	20 April 2016
Research protocol or project proposal [HSHS Protocol V4_200416_tracked]	4.0	20 April 2016
Research protocol or project proposal [ParentsExpSubStudy_Protocol_V1_200416]	1.0	20 April 2016

### Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

### R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

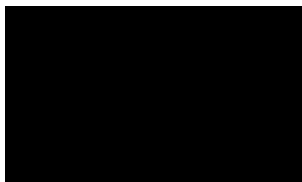
### Statement of compliance

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.

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/>

<b>14/LO/2071:</b>	<b>Please quote this number on all correspondence</b>
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Yours sincerely



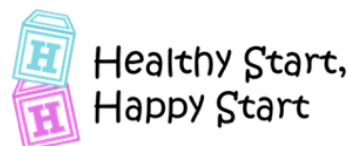
**REC Assistant**

**Dr Margaret Jones**  
**Chair**

E-mail: [nrescommittee.london-riverside@nhs.net](mailto:nrescommittee.london-riverside@nhs.net)

*Enclosures: List of names and professions of members who took part in the review*

## Appendix 2. Participant Information sheet



Parents' experiences of Healthy Start Happy Start

### Participant Information Sheet

#### **Study Background**

As part of the Healthy Start, Happy Start study we would like to offer parents the opportunity to take part in a sub-study about their experiences of the home-based programme. We are keen to find out about parents' views of the programme, both positive and negative. As well as mothers, we are also keen to find out about fathers experiences as they are rarely asked about their thoughts and views of programmes offered to parents. In asking both parents' views, we hope this will help us to improve our understanding of the unique experiences mothers and fathers may have in participating in such programmes. It is hoped that documenting these experiences will help to increase our knowledge of how to make programmes like this as relevant and helpful for both mums and dads as possible. The study is being carried out by researchers at Imperial College as part of the larger Healthy Start Happy Start study.

#### **Why have I been invited to take part?**

You have been invited to take part because you are a parent who is participating in the Healthy Start Happy Start study. We hope that around 15-30 parents will take part in this sub-study investigating parents' experiences of the home-based programme.

#### **What does taking part involve?**

A researcher will contact you to arrange a time for the interview. The interview could take place at your home or a more convenient location for you (such as your workplace). During the interview you will be asked what you think about the programme that the Healthy Start, Happy Start study is investigating. The interview will last approximately one hour and what you say will be taped to make sure that we do not miss anything.

#### **Do I have to take part?**

Participation in the sub-study is entirely voluntary, so it is up to you whether or not you would like to take part. Before you decide, it is important that you know what the sub-study is for and what it would involve. We are happy to answer any questions you have about the sub-study, and to talk to you about what it would involve for you if you would like to take part. You may wish to discuss the sub-study and taking part with your partner, family or friends. If you decide to take part you will be asked to sign a consent form. You can ask to stop the interview at any point or withdraw from the study after your interview has taken place and this will not affect yours or your child's healthcare or your participation in the wider Healthy Start, Happy Start study in any way. You do not need to give a reason for withdrawing.

**What are the possible benefits of taking part?** It is hoped that your views will help us to improve the ways in which programmes for parents can be delivered to both dads and mums.

#### **What are the possible disadvantages and risks of taking part?**

The disadvantages of taking part are likely to be small. You would need to put aside time for the interview, approximately one hour. We are happy to be flexible about where and when this takes place (evenings and weekends are fine).



## Appendix 2. Participant Information sheet continued

Although we hope the interview will be a positive experience, it is possible that some people may find some parts of this interview difficult, as we will talk about things which mean a lot to you (such as your relationship with your child, and things that may have been challenging to try out). If you find the interview difficult at any point, you can take a break or ask to stop the interview completely. You will not have to answer any questions that you do not want to, and at the end you will be able to talk to the researcher about how you found the interview.

### **Will my taking part in the study be kept confidential?**

As with the wider Healthy Start, Happy Start study anything that you say during the interview will be kept strictly confidential (which means we will keep it private), unless you tell us something that makes us worry about your safety, the safety of someone else, or the safety of a child. If this happens we may have to break this confidentiality (tell someone what you have told us), but we will try to talk to you first. All information will be collected and stored in accordance with Data Protection Act 1998 (which means it will be kept private). Tapes made during interviews will be password protected and destroyed once the sub-study is complete. Names and any other information which could identify you will be removed from the written versions of the tapes to make sure that you cannot be identified. In accordance with Imperial College Policy, we will store the written versions of the interview in a secure location for up to 10 years. Quotations from interviews may be used in publications and/or presentations, but never in a way that could identify you or your family.

### **What will happen to my information?**

The tape of your interview will be listened to and typed out; we will then delete the tape when the sub-study is complete. A couple of researchers will review anonymised interview transcripts to identify the main views that mothers and fathers share. The results of this process will be written up as part of a professional university degree, and may be made public in scientific journals, reports, and/or presentations. No personal information about you, like names, addresses or other details that could identify you or your family, will appear in any of these reports. As part of the interview, you will be asked what you think about the member of the Healthy Start Happy Start programme team that visited you – none of your answers will be passed on to the programme team member.

If you give us permission, we will use quotes from the interviews and these may be written in scientific journals and may be presented at conferences. Any quotes used will be fully anonymised, so you or your family would not be identified.

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

We will publish the results of the current study in scientific journals and may present them at conferences. We will also send all participants a summary of our findings at the end of the study. You may also be contacted after the interview to comment on the accuracy of the main messages that have been identified from your interview.

### **Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, in order to protect your wellbeing, rights and dignity.

### **Payment**

You will be given a £20 voucher in recognition of the time you put into the study.

### **What if there is a problem or something goes wrong?**

## Appendix 2. Participant Information Sheet continued.

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[Insert Trust Logo]

As with the wider Healthy Start, Happy Start study, it is unlikely that anything will go wrong as part of your participation in this sub-study, but it is important that you have this information in case it does. If you are harmed due to someone's negligence, then you may have grounds for a legal action. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way in which you have been treated during the course of this study then you should immediately inform the investigator using the contact details at the bottom of this information sheet. The normal National Health Service complaints mechanisms are also available to you. If you are still not satisfied with the response, you may contact the Imperial AHSC Joint Research Compliance Office.

### **What happens next?**

If you would like to take part, please read the consent form. If you are interested in taking part in the research please let us know and a member of the research team will make contact with you and will be happy to answer any questions you may have about the sub-study. If you decide you are happy to take part, they will then arrange a time and place to meet for the interview.

### **Further information and contact details**

If you would like more information about the study or would like to discuss it with one of our researchers, please phone or email us using the contact details below.

Olivia Williams (Trainee Clinical Psychologist) [Olivia.williams14@ucl.ac.uk](mailto:Olivia.williams14@ucl.ac.uk)

Healthy Start Happy Start Main office number: 0208 383 8401

Paul Ramchandani (Chief Investigator): 0208 383 4167

**Thank you for your time and interest in this study**



## Appendix 3. Participant Consent form



Healthy Start,  
Happy Start

Parents Experiences of Healthy Start, Happy Start

### Consent Form

Consent to take part in the research study

Trial ID: \_\_\_\_\_ Version 1.0 dated 20th April 2016

Please initial box:

I confirm that I have read and understood the Information sheet

I have had the opportunity to consider the information and ask any questions, which have been answered satisfactorily.

I agree to take part in the study. This means I will be interviewed by a researcher and will be asked about my experiences of the Healthy Start, Happy Start programme; both positive and negative.

I understand that participation is voluntary and that I am free to withdraw from the study at any time, without having to give a reason and without it affecting my or my child's medical care.

I understand my withdrawal will not affect my involvement in the wider Healthy Start, Happy Start study.

I agree to be audio-recorded for the purposes of the study.

I agree that quotations from my interview may be used in anonymised form in publications or presentations for research purposes and agree to this.

I understand that my personal data will be stored and may be used for future related research.

I understand that sections of any of my own and my child's research notes may be looked at by responsible individuals from the NHS Trust, Imperial College London or from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to access my records that are relevant to this research.

I understand that all information I provide will be kept strictly confidential and will be stored securely on Imperial College London and NHS Trust computers for a minimum of 10 years

PARENT/CAREGIVER:

YOUR NAME

SIGNATURE

DATE

RESEARCHER'S NAME

SIGNATURE

DATE

When completed:

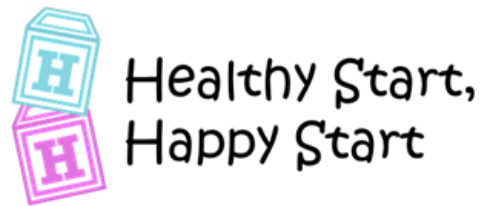
1 copy for participant, original copy to be retained in research file.

[Type here]

REC Ref: 14/LO/2071; IRAS: 160786

Parent's Experiences Sub-Study Consent form: Version 1.0, dated 20 -04-16

## Appendix 4. Interview schedule



### Interview Schedule

#### *1. Initial Engagement*

How did you find out about the Healthy Start, Happy Start?

When you first heard about it, what were your initial reactions/ thoughts?

What made you decide to be involved? Could you tell me about how you made that decision – what things did you weigh up in your mind?

-what appealed?

Did you have any reservations about being involved? Who did you speak to? Were there practical issues? Other things that initially put you off?

Did your partner have any views on your involvement in the programme as a father? Tell me about that – was it something you discussed?

If you told anyone about your involvement in the programme, what did other people think when you told them? Did you have any reservations about telling anyone about your involvement?

What did you hope to gain from the sessions? In what ways were these hopes/ goals similar or different from your partners?

#### *2. Engagement with the programme: what helped, what didn't*

Once you got started what did you think about the sessions?

What do you think was most helpful about the sessions?

What do you think was least helpful about the sessions?

#### **Appendix 4. Interview schedule continued**

Are there any things that have put you off or made you not want to stick with the program?

How did you respond when the discipline strategies were suggested?

How you been able to put the feedback into practice? What made it easy/ difficult to do so? Barriers/ facilitators/ how did you overcome these?

##### *3. Relationship with intervenor*

What was your intervenor like?

Did you feel understood by [insert name(s) of workers]?

Did you ever feel judged by [insert name(s) of workers]?

Were there any times when you felt that you and intervenor got on particularly well? Were there any times when you felt you did not get on as well?

How much did you feel you could trust them?

##### *4. Perceived changes*

Thinking back, what do you think has changed for you after having these sessions?

Do you approach things differently with your child? What's been most important to you in relation to your child?

How has it affected how you discipline/ communicate with your child?

In what ways has this impacted your understanding of how you think of your child, if at all?

Is there anything that you wanted to change that hasn't?

##### *5. Interview with both parents*

*Initial explanation to both parents that I started speaking to dad first as very little is known about dads experiences of parent programmes. But also really keen to hear from mum what it was like for her and what she felt about dad being involved and what it was like for the two of you doing this as a couple. Keen to hear about both positive and negative experiences so we know how to make useful changes.*

#### **Appendix 4. Interview schedule continued**

*Following section primarily targeted at mothers:*

What did you hope to gain from the intervention? In what ways were these hopes/ goals similar or different from your partners?

Once you got started what did you think about the visits?

What do you think was most helpful about the intervention?

What do you think was least helpful about the intervention?

Are there any things that have put you off or made you not want to stick with the program?

What was your intervenor like?

Have you managed to put the feedback into practice? What made it easy/ difficult to do so? Barriers/ facilitators/ how did you overcome these?

What has been difficult to put into practice?

#### **6. Co-parenting**

How have you found it having these sessions together?

What was good about having them together?

What wasn't so good?

What would it have been like for mum just doing it alone? And for dad? (what might have the benefits and/ or losses to doing this without your partner?)

Did you decide to have the feedback sessions together (What was your thinking about that? What was that like?) Did you like having them together or prefer them separately?

Did you talk about the sessions together in between visits? What sorts of things did you discuss? Did you have a different take on them? or disagree on things that were said?

Did you have different ideas about how to discipline/ play/ interact with child?

Has that changed since you've been having these sessions?

Do you think it has changed the way you parent together? (in what ways)

#### **Appendix 4. Interview schedule continued**

Overall as a family, what's changed do you think in the way you spend time together?

##### **7. General feedback from co-parent interview**

In general, what did you think about dads being involved in these kinds of sessions?

If you were going to get your male friends to be involved in it too, how would you do that? Any ideas? If you were going to tell other dads about the programme what would you say?

Were there many parts of the visits that you felt were not relevant for dads/ mums? Or were more useful for mums?

Is there anything you felt would have made it more relevant for you as a dad/ mum?

What would you change about Healthy Start, Happy Start programme?

## Appendix 5. Stages of analysis

### Example from initial stage of analysis: annotating/ coding the transcript of participant 8 using track changes

I: Ok and in general what do you guys think about dad's being involved in these sorts of sessions?

M: it's such a good idea because so many of the courses that I've gone on it's all women and that's great because a lot of the women they are the primary care givers and they need to have that reassurance and that help behind them. But if they're doing it and the dads not on the same page sometimes it can be ineffective and it's impossible for dads to do stuff like that during the day and this is the first time I've come across something like this that's in the evening. |

F: I mean it does sort of enlighten you as a parent, as father and what you're actually missing out on if you know what I mean? cause you take it for granted that your kids are at home and [mother] is dealing with the stuff, you come home and to a certain extent you don't really hear her moaning about the kids a lot. You know what I mean? |

**Olivia Williams**  
Good idea to have fathers involved

**Olivia Williams**  
Different to other courses that usually leave fathers out

**Olivia Williams**  
Important for mothers to be involved

**Olivia Williams**  
Might be not on same page if father not involved

**Olivia Williams**  
Need to be flexible with timings

**Olivia Williams**  
Programmes are usually inflexible

**Olivia Williams**  
Appreciating mums job from dads side

**Olivia Williams**  
Enlighten you on what you are missing out on

**Olivia Williams**  
Take for granted

## Appendix 5. Stages of analysis

Example of later stage of analysis: under domain headings, clustering data under tentative themes across the transcript using participant quotes

### What helped them engage(facilitated)?

I think I would have kept on doing it just because therapist was really nice  
 she was really friendly, mmm, it was I can't say anything bad about her to be honest, urm she  
 was awesome, really friendly really patient... I can't say anything bad about her  
 we gave her a little gift afterwards because she was fantastic... couldn't fault her  
 if she didn't make us feel comfortable then I don't think we would have carried on... she was  
 just really friendly and she seemed really genuine, she actually did care |  
 Child would get really excited  
basically get an analysis of how your child is trying to communicate  
 what hoped for- I a better understanding of child and urm and how he and early stages of  
 communication really |  
 (what had to weigh up?) the only thing was whether or not it would clash with work... Which  
 to be fair it didn't, we always worked around my rota, it wasn't an issue  
 (asking dad what did wife think about his involvement) she had two other children from a  
 previous relationship and I know that urm the father back then wasn't very active with them,  
urm in the upbringing of the kids so urm I know she was happy that we were doing it  
together...urm veh

Olivia Williams  
Therapist characteristics

Olivia Williams  
Child's enjoyment

Olivia Williams  
Initial hopes were to have a better understanding of child's communication

Olivia Williams  
Flexibility important

Microsoft Office User  
Knowing his involvement in the programme was important to the partner/ makes partner happy

### Factors hindering engagement?

I think remembering it was the hardest part  
its like somethings go in one ear and out the other so I don't know maybe it would have been  
 nice if could have kind of like a summary to read over afterwards |

Olivia Williams  
Not hindering as such, but difficulty retaining the session information

### What gained/ what was useful?

understanding what child was trying to get across  
 having stuff pointed out that you wouldn't normally see, little look or glances and stuff  
 for me it would probably be about being in tune with child

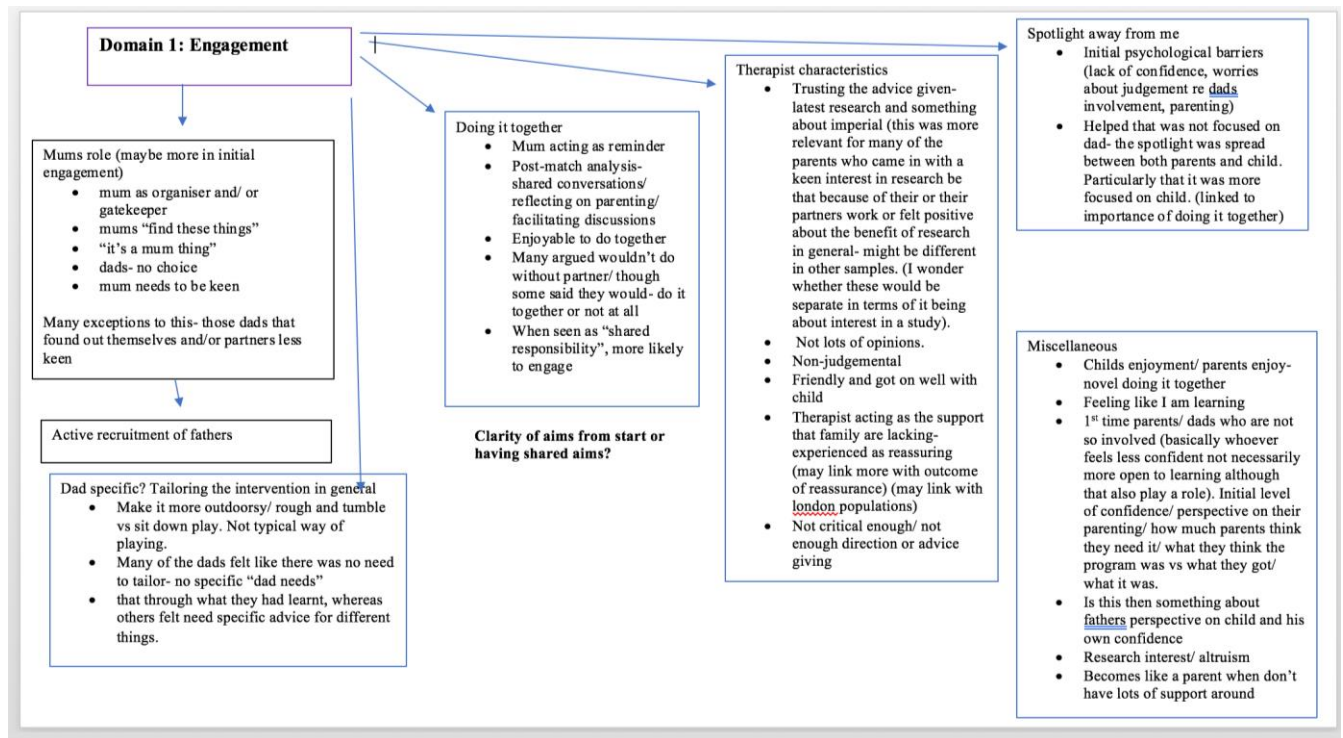
Olivia Williams  
Understanding child's communication

Olivia Williams  
Noticing different things about child such as non-verbal communication

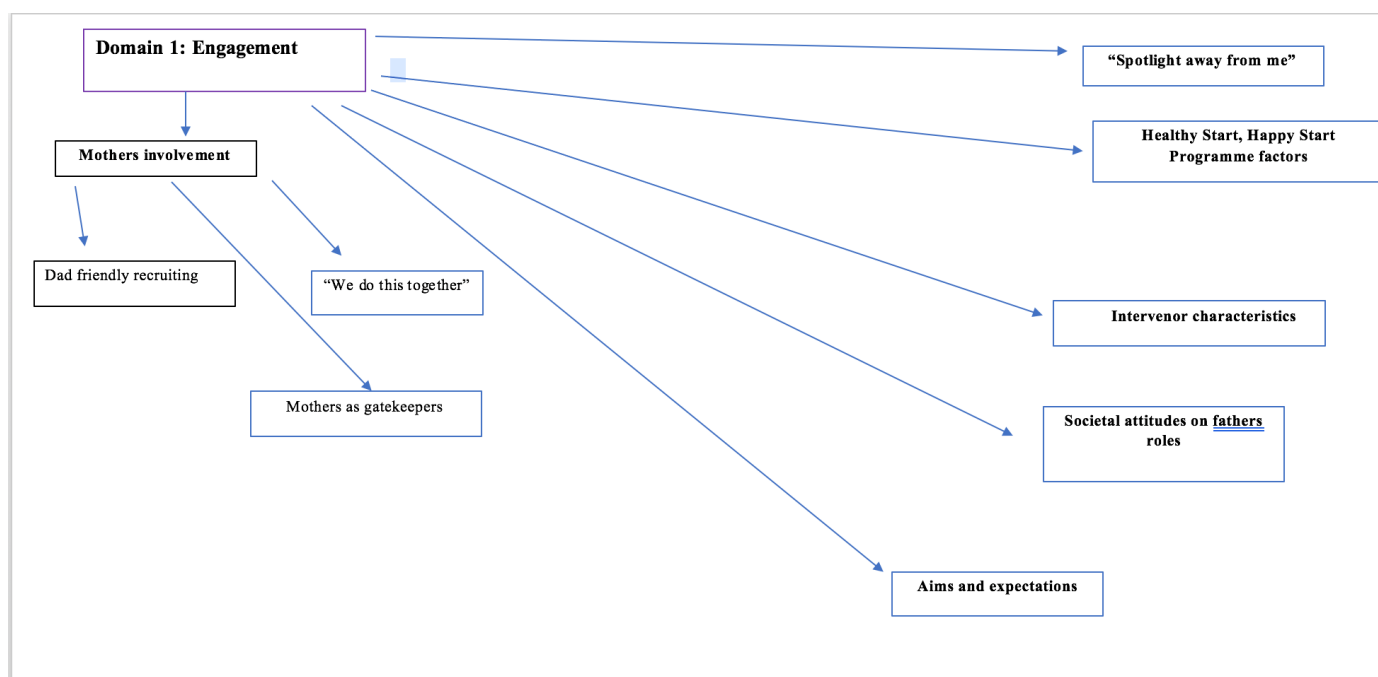
Olivia Williams  
In tune with child

## Appendix 5. Stages of analysis

### Initial thematic map for Domain 1: Engagement



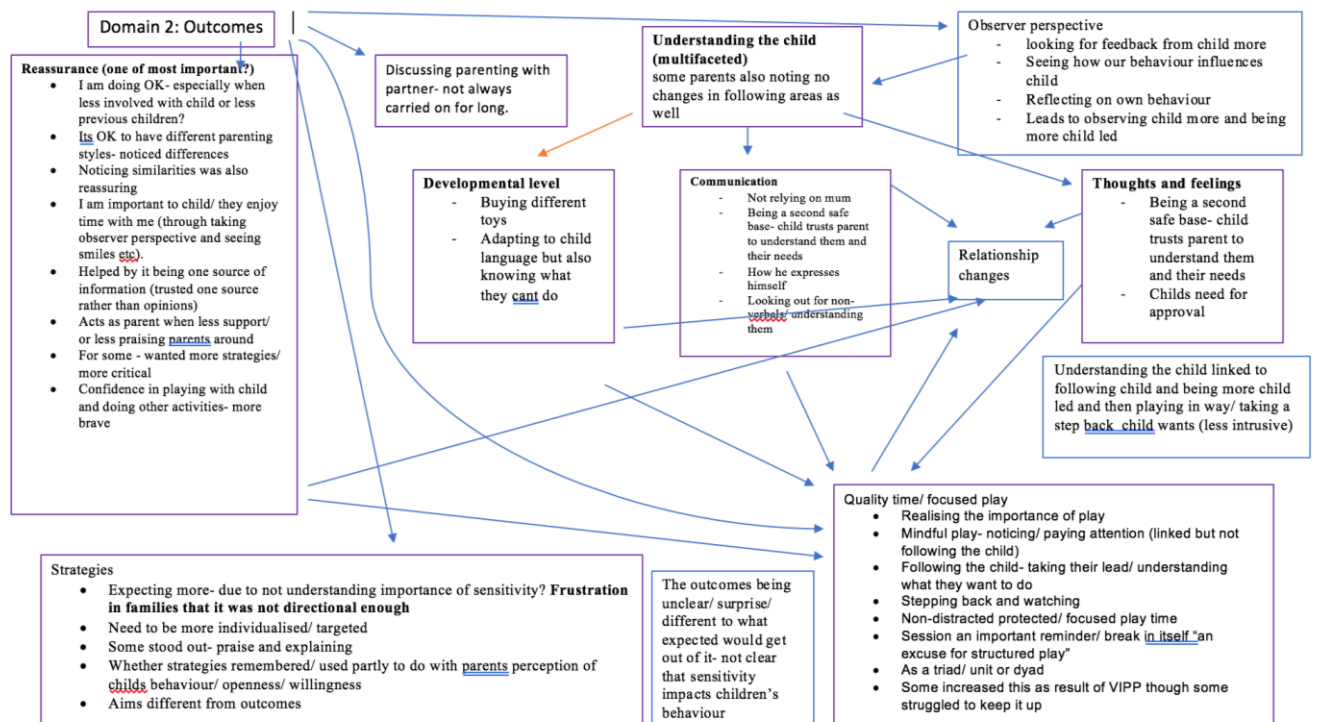
### Final thematic map for Domain 1: Engagement



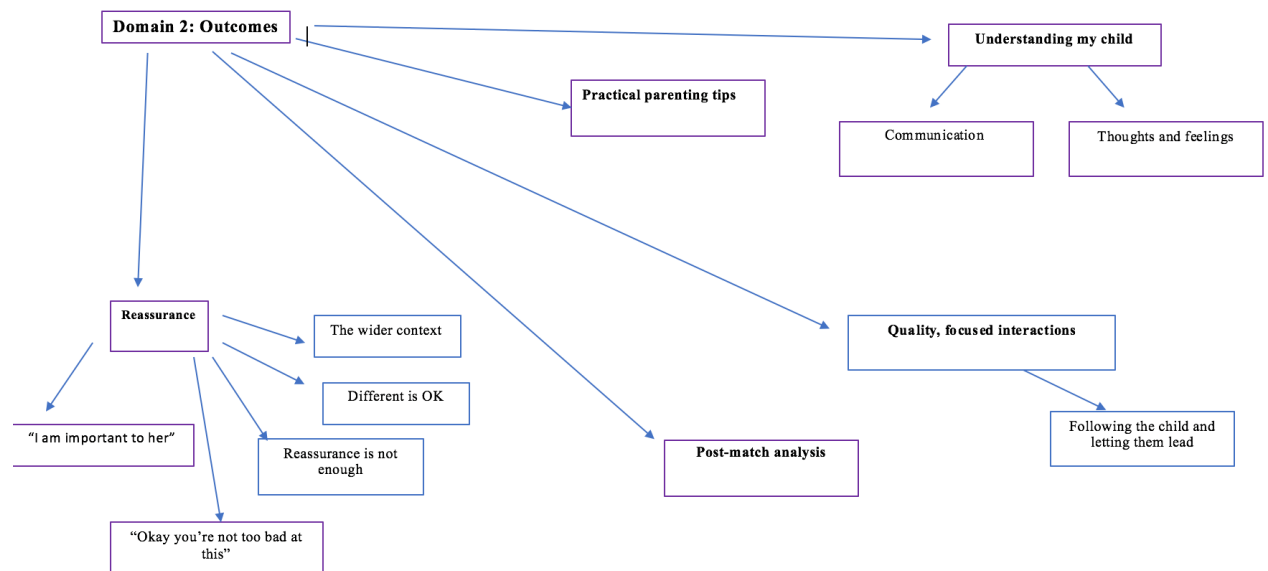


## Appendix 5. Stages of analysis

### Initial thematic map for Domain 2: Perceived gains

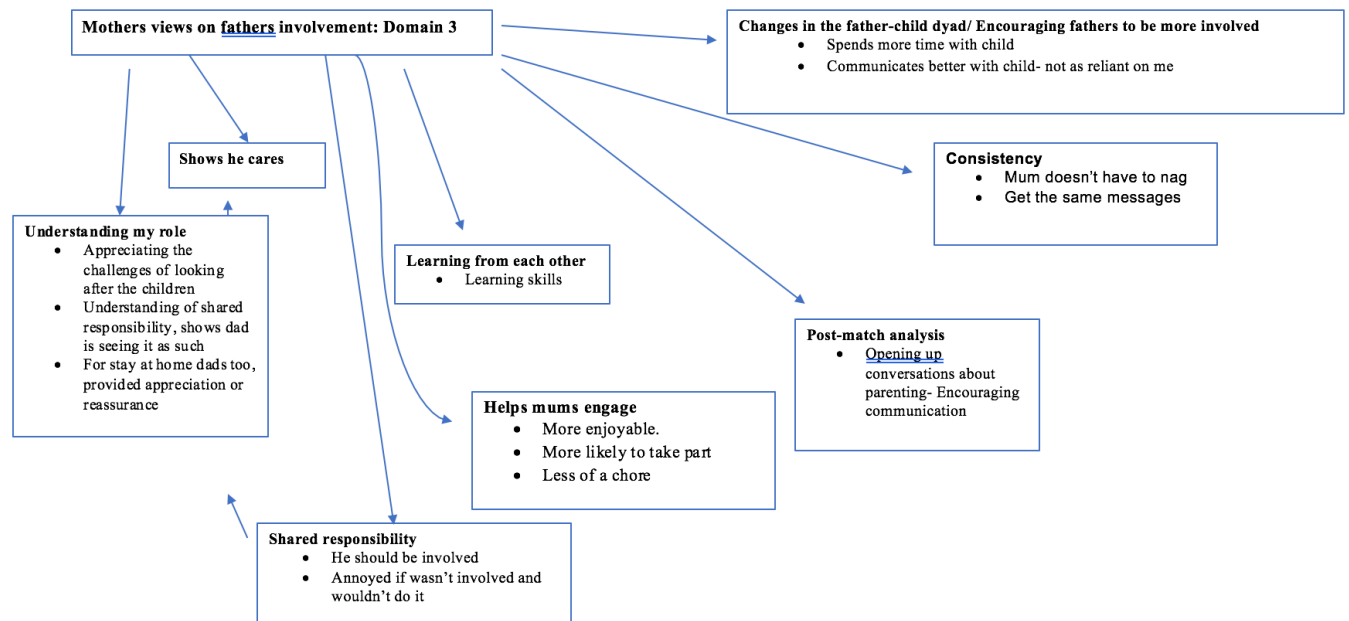


### Final thematic map for Domain 2: Perceived gains



## Appendix 5. Stages of analysis

### Initial thematic map for Domain 3: Mothers perceptions of fathers' involvement



### Final thematic map for Domain 3: Mothers perceptions of fathers' involvement

