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Objective: To explore the approaches taken by health visitors (HVs) to identifying problems in the parent-child relationship

Design: focus group study.

Setting: Glasgow, Scotland

Participants: 24 health visitors sampled purposively

Results: Multiple sources of information were used by health visitors in assessing parent-child relationships. These include use of known risk factors, knowledge of local norms, direct observations of behaviour, reflection on the relationship between the parent and health visitor, as well as more intuitive reactions. In many cases understanding difficulties in parent-child relationships involved piecing together a jigsaw over a considerable time span. Continuity of relationships appeared to be crucial in this task. Home visits were described as the most informative setting in which to develop an understanding of the parent-child relationship. Participants reported a lack of formal training in the assessment of parent-child relationships and were keen to obtain more training.

Conclusions: Health visitors use complex strategies to integrate information about parent-child relationships. These strategies are acquired in a variety of ways, but receive little emphasis during basic professional training.

Health visitors' assessments of parent-child relationships: a focus group study

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Abstract

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Conclusions: Health visitors use complex strategies to integrate information about parent-child relationships. These strategies are acquired in a variety of ways, but receive little emphasis during basic professional training.

What is already known on this topic

- Difficulties in attunement between parent and child can have profound effects on aspects of cognitive and social functioning

- Health visitors (public health nurses) are uniquely well placed to identify problems in the parent-infant relationship

- Little is known about how problems in the parent-child relationship are currently identified in the community

What this study adds

- Multiple sources of information were used by health visitors in assessing parent-child relationships

- In many cases understanding difficulties in parent-child relationships required continuity in the relationship between health visitors and families.

- Participants reported a lack of formal training in the assessment of parent-child relationships and were keen to obtain more training.

Introduction

There is a large body of literature on the crucial importance of parent-child interaction in the first years of life (Bailey et al. 2001; Goldberg 2000) . Difficulties in attunement between parent and child can have profound effects on aspects of cognitive and social functioning including stress responses and language development (Schore 1997; Trevarthen 2001). Research on post-natal depression has shown that children of depressed mothers may have lasting cognitive difficulties (Murray & Cooper 1997) and behavioural problems (Morrell & Murray 2003), and these are likely to be a consequence of difficulties in the early parent-child relationship. Harsh parenting is known to interact with child temperament in increasing risk for conduct disorder (Scaramella & Leve 2004). Other problems in the child-parent relationship may arise from neurodevelopmental disorders such as autism spectrum conditions which are characterised by distinctive patterns of social behaviour in the first year of life (Zwaigenbaum et al. 2005).

Health visitors (HVs), also known as public health or child health nurses, provide a near-universal community-based service to preschool children and their parents in the United Kingdom (Hewitt et al. 1989), Ireland (Butler 2007), the four Scandinavian nations (Ellefsen 2001; Larsson et al. 1996; Hakulinen et al. 1999; Skovgaard et al. 2005), Australia (Briggs & Briggs 2006), New Zealand (Wilson 2001), the Netherlands, France and Italy (Kamerman & Kahn 1993). Home visiting is a key component of services in these countries, but the number of visits and their timing varies between the nations (Kamerman & Kahn 1993): clinic-based immunisation and child health surveillance services provided by nurses are more generally available. In contrast, Germany has a

post-neonatal home visiting services provided by social workers and physician-led clinic-based child health services (Kamerman & Kahn 1993; Wendt 1999). Home visitation, often provided by nurses, is also provided to families perceived as vulnerable in many parts of the United States and Canada (Council on Child and Adolescent Health 1998; Drummond et al. 2002; Duncan 1992b; Powell 1993).

Since they have ongoing supportive contact with parents and young children in a range of settings, HVs have a unique opportunity to identify both problems in the parent-infant relationship and child mental health problems, for example during developmental screening, home visits and immunisation clinics. One study exploring pathways to a UK child mental health service found that 82% of the parents of children under the age of seven had discussed their problems with health visitors (Godfrey 1995). HVs are the professionals most likely to identify and refer children with autism spectrum disorders (Chakrabarti & Fombonne 2005). They have also been shown to recognise emotionally damaging family dynamics (Rushton 2005) and a Swedish study (Aurelius & Nordberg 1994) demonstrated that home visiting nurses are able to make valid assessments of the degree of psychological risk to infants during neonatal visits.

Service users have identified high levels of satisfaction with HV services and HVs are perceived as reliable, available and non stigmatising (O'Luanaigh 2002). Parents of young children with psychiatric problems often state that the HV is the only person with whom they can discuss their problems (Godfrey 1995).

There is substantial evidence that community-based nursing can have a major impact on the mental wellbeing of children and young people. For example, in a 15 year follow up

of a randomised trial of an intensive home visitation programmes to high risk families in the USA, (Olds et al. 1998), the intervention group had fewer instances of running away, fewer arrests, fewer sex partners and consumed less alcohol. A further trial using the same intervention demonstrated that much stronger effects were obtained when nurses delivered the visitation programme nurses than when it was delivered by lay home visitors (Olds et al. 2002), possibly as a result of greater emphasis by nurses on physical health and parenting advice (Korfmacher et al. 1999).   In a multi-centre trial in the UK, health visitors trained in the Family Partnership Model provided weekly home visits from six months antenatally to 12 months postnatally in the intervention group.   At 12 months, differences favouring the home-visited group were observed on an independent assessment of maternal sensitivity and infant co-operativeness (Barlow et al. 2007). The Solihull approach to infant mental health, in which health visitors play a pivotal role, has been shown to reduce parenting stress and health visitor ratings of the severity of behavioural problems (Milford et al. 2006).

Health visitors are thus in a good position to identify dysfunctional parent-child relationships and they are uniquely well placed to deliver effective interventions (Hakulinen et al. 1999; Olds et al 2002). It is therefore surprising that there appears to be so little peer-reviewed literature on how HVs identify those families to which they potentially have most to offer.. While there are a number of reports on the role of health visitors in identifying children in need of statutory protection (Appleton 1994a; Appleton 1994b; Duncan 1992; Ling et al. 2000) we have been unable to find any literature on how HVs identify, more subtle problems in the relationship between parents and children.

This paper reports on how HVs in one large Scottish city identify difficulties in the early parent-child relationship

Methods

We used focus group discussions which have been shown to be particularly successful in eliciting the views of professional peer groups by encouraging debate on sensitive issues within a supportive setting (Kitzinger & Barbour 1999).

Purposive sampling (Kuzel 1992) was used to recruit HVs with a range of characteristics, including age, gender, length of experience and locality (affluent or deprived) of employment. Participants, who had received an introductory letter from the investigators, gave details of their work and written consent for recording at the beginning of the focus group interviews. Apart from the male HV group, which was recruited city-wide, our samples were drawn from the HVs working in identified geographical areas of the city. The HVs who participated in the focus groups were employed in a range of settings – including specialist services for high-risk families, but most were attached to general medical practices working in defined geographical areas which also provided the sites for the focus groups.

We ran six focus groups comprising 24 HVs in total, including one group working in an affluent area, one group of newly qualified HVs and a group of male HVs. Participants represented 20-50% of the eligible HV population in each area. Four health visitors (two females working in the affluent area and two males) were invited but did not participate. Only one participant was non-white, reflecting the ethnic background of most HVs in the

city. One of the deprived areas has a substantial ethnic minority population, though even in this area the white population is in the majority. Most of the participants' clients were therefore white but some of the HVs had a substantial ethnic minority workload. Our sample included both newly qualified HVs and several with 20 to 30 years experience. Nevertheless, the youngest HV was in her early 30s. Several had worked in a variety of clinical posts and some had postgraduate qualifications reflecting the relative maturity of this professional group. Our sample size was determined by the capacity for comparison: the diversity covered in a relatively small number of focus groups allowed us to make meaningful and systematic comparisons with respect to a number of characteristics such as length of experience and socio-economic status of clients. The composition of the groups afforded the possibility of making both inter- and intra-group comparisons (Barbour, 2007).

A brief topic guide was developed to explore the range of approaches to identification of problems used by HVs. The topic guide was developed before the project began through extensive discussion within the research team which comprised two HVs, one general practitioner, a child psychiatrist, a child psychologist and a medical sociologist. Groups were facilitated by two members of the research team, one of whom (CG or MC) was a qualified HV. We aimed to look at routine practice in straightforward situations through to complex situations in which there was considerable uncertainty. We selected a video excerpt (from the BBC programme 'Baby Love') illustrating a family interaction likely to give rise to different interpretations. This involved a depressed mother who, while managing to perform basic care tasks, struggled to comfort her twins. The video was shown at the beginning of group discussions as stimulus material and facilitated

comparison between groups. Group discussions were recorded and transcribed verbatim. Coding and data retrieval were aided by use of the analytical package Atlas Ti (www.atlasti.de). Inter- and intra-group differences were explored using the constant comparative method of data analysis (Ruston et al. 1998).

The research team met on several occasions and developed a consensus coding frame, paying particular attention to differences in our interpretations, which often stemmed from our varying disciplinary backgrounds (Barbour, in press). Transcripts were coded using this frame and were subsequently cross-checked by at least one other team member to ensure that definitions of coding categories were being consistently applied. The analysis was conducted by PW and RB and elaborated by all the authors. The data were systematically interrogated in order to identify patterns and any exceptions or contradictions were closely examined (Barbour, 2001). This ensured that the data were fully mined and that alternative explanations were routinely considered.

The study was approved by the Greater Glasgow Primary Care Trust Research Ethics Committee in August 2003. Our use of quotations and the first draft of this paper were approved by participants. Pseudonyms are used throughout the paper.

Findings.

1. HV role and remit

Health visitors described their involvement in assessing relationships between parents and children during visits to new mothers and their babies, in routine child health surveillance at clients' homes or in clinical settings, and in immunisation sessions. HVs highlighted the large numbers attending immunization clinics and this was thought to

militate against opportunistic assessment activities. Virtually all of the discussion on identifying problems in the parent-child relationship focussed on home visits:

Lisa	I think when you do a two-year assessment where I am normally in the house, you are seeing the environment and you are seeing the interaction between the parent and the child and whoever is in the house.
	Focus group 1, deprived area

HVs also provided accounts of how they sought to augment their observations in cases where there were concerns about families. Interestingly, differences in approach were reported by health visitors working in deprived and affluent areas: opportunistic 'drop-in' visits being commonly employed in deprived areas whereas in more affluent areas scheduled appointments were deemed necessary. Some of the HVs had worked in both types of locality and were able to highlight these differences to the researchers.

2. Identification of problems

i) <u>Objective indicators of risk.</u> Although the health visitors were unable to specify which parts of their training had covered assessment of the parent-child relationship (with most claiming never to have received any relevant training) it was evident from their accounts that they were drawing extensively from the evidence base, including checklist-type approaches. Frequent mention was made of characteristics of parents which would alert HVs to the potential for problematic parent-child relationships. Such characteristics included having been in care; alcohol dependence or misuse; drug use; or living in sub-

standard housing. Not surprisingly, it was the recently-qualified health visitors who were most explicit about their use of such guidelines:

Moira	'Cause she would be more likely to be post-natal depressed wouldn't she if they were premature, caesarean section and twins?
	Focus group 5, new health visitor group

Debbie	… an older, slightly older mum, professional person, who was very anxious about her pregnancy and certain things didn't go well during her pregnancy
	Focus group 5, new health visitor group

Participants also drew on less clear-cut indicators:

Gail	When you go into a house I think the whole environment starts you thinking about the interaction. A lot of the houses are pitch dark and that initially makes me consider what is going on here. I can't see the child across the room and the child can't see me. That is one of the first things that makes you question what is happening. Music, if there is a lot of noise going on in the background, the telly is blaring or often really loud music which is quite inappropriate for a young baby and they are sat beside whatever it is that is blasting this out. That gives a first message as well.
Moderator	So kind of in home visits you feel that this is …?
Gail	Yes, I think so. Other things to consider is obviously the heating and things.

	If you go into a place that is really inappropriately hot or cold, like a cold environment and the child is in there and they are not dressed appropriately as well. I'm just thinking of examples that I have been in. Or the housing situation like the accommodation and the furniture and it's not appropriate for a large family, they have got minimal furniture.
	Focus group 1, deprived area

ii)   <u>A. Behavioural observations – Parents' behaviour with the child.</u> The most commonly mentioned indicator relied upon by the HVs was the way in which babies were held:

Fiona	I think it is particularly how they hold the baby. Do they look at the baby when they are talking to it? Are they holding it lovingly or are they holding it like this? [demonstrates holding the baby roughly]
	Focus group 1, deprived area

This was used as a potential discriminator between problematic and unproblematic relationships and some participants acknowledged that not all parents could use such skills instinctively. Interestingly HVs working in the affluent area reported that they had not encountered problematic patterns of holding.

Related factors which also gave cause for concern included attending to mechanical tasks (eg dealing with feeding or dressing) without looking at or interacting with the baby, not enjoying the baby, difficulty in showing affection. In response to the video clip some of

the HVs described the mother as behaving towards her children as she would towards a dog:

Andrea	They are kind of like two wee dogs around her I felt rather than children, it's like she's …
Sylvia	It is like a chore that she's got to perform, she's not actually, it isn't, she doesn't appear to be enjoying the task of feeding the children, certainly not really…
	Focus group 4, affluent area

Reassuring features included appropriateness, child centredness, showing affection, comforting etc.

Alarm bells were also triggered where mothers had what were seen as inappropriate expectations of their infants:

| Dougal | She sort of treated the child like an adult when he was just a baby, you know - 'You'll have, you'll have to wait till I get my breakfast' she would say and just leave him crying. |
| | *Focus group 6, male HVs* |

B. Behavioural observations: children's behaviour. Direct observations of the behaviour of young children, apart from disruptive behaviour among older preschool children and (in one case) screaming, were rarely mentioned as a useful source of information about

the relationship between parent and child. The physical health of children was also rarely acknowledged as a relevant factor.

C. Behavioural observations: parents' behaviour towards the HV. In some cases, participants talked about unusual types of relationships with the HV as the trigger for concern:

Dougal	… and she would just go absolutely thermonuclear, just [clicks fingers] in front of me with no warning, you know it was like, it was really incredible the change in this woman's whole personality. And then the way though that she would go from that to, "…and you were saying, Dougal" she was just exploding in front of you, and then reverting back to, it was very strange, you know. I'd not come across that before, I'd not come across that before.
	Focus group 6, male HVs

iii)   Emotional reactions

Some of the HVs talked about instinctive or emotional responses to situations which raised serious concerns:

Carol	When we are dealing with these and that is a difficult call to make when you think to yourself you know and you hear comments that 'the baby is doing this to me' and all this kind of stuff. It really it makes the hairs on your back rise and you begin to get seriously concerned and you begin to think to yourself now what is actually happening here? And it's just like anything else I suppose

	you eventually have to say, 'look, have you ever thought about harming the child, have you ever felt that you would do something like this?' Because that is really the final thing, isn't it?
Susan	Yes.
Carol	You have to address that question and you have to be sometimes a bit brutal about it and just say 'what is it we are dealing with here and does the child need to be safeguarded in some way?'
	Focus group 2, deprived area

Irritation with families was also described as a potential diagnostic tool:

Anne	… sometimes it is about the frustration of thinking 'why am I not able to, kind of, why is this person not giving me anything back why is it me that's doing all the kind of questioning and trying to pull things out of this person. Is there something that is kind of inhibiting this person? And I think it is harder to work with some families than others.
	Focus group 3, deprived area

3. Interpretation

Although, as we have seen in the previous section, the HVs drew on the evidence base in identifying potentially problematic situations, their work also involved considerable subtlety in interpretation in terms of taking the context into account. Several of the health

visitors, notably those with experience of working in both deprived and affluent localities reflected on how behaviour that would be viewed as problematic in one context is viewed differently when it occurs in another context. An example is provided by how HVs view parents who do not prepare adequately for the birth of a baby:

| Paul | The actual thought of sitting down and reading about it and trying to understand it and before you actually do it, or before the baby is delivered is something that you can see that a lot of parents don't necessarily do …. |
| | *Focus group 6, male HVs* |

Other mitigating factors related to the acknowledgement of the legacy of sub-optimal parenting patterns which were frequently presented as a feature of working with families in deprived communities. These factors led HVs, on some occasions, to explain a behaviour rather than to use it in order to identify problems in the parent-child relationship.

| Rona | The majority of the women probably don't realise that there is an issue and think it is absolutely fine to yell at your kid across the room, I think that is because that is all these women know. |
| | *Focus group 1, deprived area* |

Some of the HVs, however, were aware that this could skew their judgement with the potential to under-estimate problems for deprived parents, whilst perhaps amplifying concerns in relation to middle class parents.

There were different types of reports of problems in verbal communication among affluent and deprived families.

Susan	Quite often I find myself saying, especially if a Dad is there, to parents, I'll talk to the baby and I'll say 'you can repeat, you can recite a shopping list, it is just the way you say it'.
	Focus group 2, deprived area

Paul	Also, she kept referring to the children and communicating with them in a way that was far beyond their level of understanding for their age. *(referring to the middle class mother in the video stimulus material)*
	Focus group 6, Male HVs

HVs also spoke about the difficulty of identifying problematic patterns of behaviour against the backdrop of "generalized depression" (Dougal, male HV group)

As well as seeking to understand behaviour within the broader social class context, HVs often sought to augment information they held about families, drawing as a resource on the continuity afforded by the nature of their role and remit. One of the recently qualified HVs, for example, talked at length about the differences between relatively clear-cut situations and those where it took much longer to establish that a problem existed:

Lorna	I think if there's relationship problems, which sometimes smacks you in the face in your first visit, that you know you just instinctively can tell that things

	are just not all well. Other times it is months and months down the line but you know you might gradually draw out that things aren't great. That interferes greatly with how a mum interacts with their child because I think we then go into that balancing act of trying to, you know, rear this new baby and look after the baby's needs while maybe trying to keep their partner as part of the relationship and either involve them or keep them happy. And there is other wee part of sometimes when the mother completely excludes the partner from it and becomes very self involved with the baby and they have got no time for the partner and they don't even realise they have done it, I think. And they are the ones you tend to get a few months down the line that are coming in and telling you that the relationship is not going very well and he is blaming it on the baby.
	Focus group 3, mixed area

HVs recounted how they sometimes used situations opportunistically in order to allow them to build up a more complete picture of families:

Gail	I think you can look at an interaction between the parent and child in many different settings, the clinic or even if you met them in the street. You can look at them and the environment round about and how are they interacting with the child
	Focus group 1, deprived area

Rather than simply capitalizing on their repeated contact with mothers, HVs also actively sought supplementary information. The following excerpt from the discussion in the male health visitors' group provides an example of the lengths that they might go to, employing a number of strategies to this end:

Moderator	Well, I was wondering first of all if it was you that was the person who actually picked up that there was a problematic situation.
Dougal	It was, but it was like very complex. It was like, maybe if I had been there from the beginning I'd have picked it up earlier, but just going in after a year and the previous health visitor had always found her a bit strange, but it was just discussing between us that we really kind of started building up the whole picture, you know. It was like a jigsaw. And once we'd got the whole thing we just realised just how isolated she was, that how her mood swings were so dramatic in the space of under a second basically. You know you could be talking to her, the next things she just, you know even if you were in the room, in the house, she always left the ornaments at the perfect level for the toddlers, you know for the children, and you know there was advice, you know, about child safety and putting them out of reach and she never did, and you'd be there and one of the children would invariably go and take an ornament and it was invariably the one, you know the favourite one …
Moderator	So what was, what you were picking up was just the strange environment, strange interaction with you, strange interaction with the children …
Dougal	And the fact that whenever you tried to turn the conversation to the children

	she always brought it back to her. She didn't actually want to discuss the children, she just wanted to discuss herself. And she'd had this incident during the birth, she had an apnoeic event it was something she said, and she had been starved of oxygen for some time but there was no records of this and that she was very kind of definite about it and that's really all she wanted to discuss…
Moderator	So sounds like a very, very challenging situation altogether [DM laughs]. So you picked up something very strange which at first you couldn't explain and you went and discussed this with a colleague …
Dougal	And the GP, yeah.
Moderator	And the GP in order to try and
Dougal	Just build up a picture
Moderator	make sense of the situation?
Dougal	And the thing was the husband was never at home. So, one time when she ended up going in to hospital and I phoned her husband and made a, arranged a home visit just with him but she was in hospital so I went to see him and spent an hour just talking to him, the whole thing and then we got a much, much clearer picture you know of the whole... That went back years and years and years, that just went back to her childhood basically.
	Focus group 6, male HVs

Continuity of care was the most frequently cited factor in identification of difficulties:

Carol	That again is really all part of your relationship. They are not going to take that very well from a stranger but if they know you well and you have got a good history of supporting them and that kind of thing then they are much more likely to … maybe not initially but eventually they may well say 'yeah, you know there is some difficulty here'.
	Focus group 2, deprived area

Karen	But then there's other ones that, you know you pick up over a longer period of time like parents that have, Mums that have maybe had a very traumatic birth and, you know, want to explore that and want to talk about how, how awful that was, and how that, you know, like went against their bonding with the baby or, or they couldn't breast feed or they felt breast feeding was repulsive … or you know the different ends of the scales, you know. And it's the wee things that you pick up over repeated visits, you know that, that then like shed light on the fact that they are not bonding. A lot of people don't like to admit it straight away either, so if you don't develop that relationship as a health visitor with them, you're not going to find out about it. So a lot of it is picked up over time, isn't it?
	Focus group 5, new health visitor group

4. Learning models

<u>How do HVs learn to identify problems?</u> Regardless of how recently they had trained, HVs maintained that they had received no substantial formal training in understanding parent-child relationships, either in their basic professional training as nurses or their health visiting courses. Some confirmation of this is that the term usually used in academic discourse on the security of the parent-child relationship - 'attachment' - was only used once in all the focus groups, whereas the less precisely defined 'bonding' was frequently used. Several reported feeling ill-equipped for their role as newly-qualified HVs and sought help from multiple sources including colleagues:

Diane:	I think when I first started I was in a health centre with, you know, a couple of other health visitors who admittedly hadn't been in the job all that long but longer than me. And, it was the sort of parenting issues that troubled me the most, it wasn't kind of the physical care of children but it was more the kind of emotional aspect of it and I would often say to them 'Oh, I don't know how to give parenting advice' and you know what - 'I said this' and they would say 'Oh yeah, that was ok, that's the right thing to say' but you just didn't really have the confidence to, to know if you were doing it properly or not and it was only just feeding back to them and just sort of getting what they thought that reassured you a bit that what you were saying was right or, ok, you weren't saying the wrong thing. So that was helpful.
	Focus group 5, new health visitor group

Knowledge was held to be built up incrementally as health visitors acquired experience of the area and insights developed through comparing individual cases they encountered.

Linda	… I think it is very much a case of though, that it is so true what health visitors say that you don't know your case load and you gradually start to build up a relationship and you get to know people so you notice differences, whereas if you are meeting someone for the first time you wouldn't necessarily notice a difference. You get to know the area so you get to know about some of the pressures that impact on people. So I think it is fair to say that you do pick, it is knowledge that you acquire, definitely. And I think, I don't know, I think you just pick up a lot of instincts about things.
	Focus group 3, mixed area

'Multiple apprenticeships' were often described:

Margot	I mean I don't have children myself so, everything that I've kind of learned has come through my mentor and listening to other health visitors as I was doing the course and working as a HV Support. And I think some of the info, you're able to kind of work through the information that you think 'actually that doesn't sit too comfortably with me' or 'that's really good advice, I am going to remember that'. And it's the things and it's taking the good things and kind of reading around it more yourself so that you understand why you are doing it, and the same with the bad things so that you can modify that information to how you want to kind of give it out. That's kind of how I've done it. Working

	with different health visitors over the last sort of 3, 4 years you hear them all, relatively giving the same thing but saying it in a different manner, and it's kind of taking what you think sounds good and workable and being able to confidently give that…
	Focus group 5, new health visitor group

Several HVs acknowledged that their professional practice was informed by their own experience of parenting as well as experience and peer support:

Linda	I honestly have to say that I base quite a lot of what I know having been a parent myself. So in probably having read up quite a lot obviously, sick kids background so I know a wee bit about bonding and stuff like that. But I think it's very much that you learn greatly on the job and learn from your colleagues as well through peer support and through constantly going back yourself and re-evaluating the way you are going with things. I think the training just now, it would be more valuable to get a wee bit more core training. I think there's a big role for what we got but I think it would be more support. I wouldn't like to be coming out not having had the previous experience I'd had to do this job. I think it would have been a lot harder.
	Focus group 3, mixed area

Simon	Being parented and being a parent myself, learning from my peers and experiential learning as well, you know, working with interaction, interacting with families and reflecting on your observations builds on your personal knowledge as well, professional knowledge. It is a 'combination of the above'.
	Focus group 6, male HVs

Discussion

Our study was conducted in a single Scottish city, and it is possible that training and practices of health visitors may differ elsewhere, both within the UK and further afield. We believe, however, that many of the themes we have identified are likely to have broad relevance – some of these are addressed below.

In light of much current concern about the future of the profession, the presence of HVs as moderators may have helped the participants to trust the motives of the research team, while the presence of other professionals might have facilitated the process of articulating 'implicit' aspects of professional practice. It was noteworthy that the vast majority of group members were keen to describe their experiences to the moderators.

It was however also noteworthy that we needed to use stimulus material to define the field of discussion, and on several occasions group members described their work non-verbally (as exemplified by Fiona's quotation in focus group 1) or in terms of 'intuition'. Our observations support the view frequently expressed by participants that they had received little if any formal training in the analysis of social relationships between

parents and children. A strong desire for further formal training was also frequently expressed.

Multiple sources of information were used by health visitors in formulating their understanding of parent-child relationships (Appleton 1994a). These include use of known risk factors (Appleton et al. 2004), knowledge of local norms, direct observations of behaviour, reflection on the relationship between the parent and health visitor, as well as more intuitive reactions (Appleton 1994a; King et al. 1997; Paavilainen & Tarkka 2003). In many cases understanding difficulties in parent-child relationships involved piecing together a jigsaw over a considerable period. Continuity of relationships appeared to be crucial in this task (McIntosh & Shute 2007).

Home visits were described as the most informative setting in which to develop an understanding of the parent-child relationship (Vehvilainen-Julkunen 1994). We found it somewhat surprising that clinic contacts and, in particular, immunisation sessions, were not seen as being particularly useful. By definition, the attachment system is activated in stressful situations and can only be assessed by careful observation of the child's reaction to stress and the parents' capacity to help the child to moderate discomfort (Minnis et al. 2006). It is likely that time pressures during clinic and immunisation sessions make it difficult to use this potentially informative situation most effectively, but this may be an area worthy of observational research. The lack of emphasis given by participants to the value of child observation in the assessment of parent-child relationships is also noteworthy, and educational developments in this field could potentially be useful.

There are clear tensions between, on the one hand, performing observations of the parent-child relationship and assessing the need for further support or intervention and, on the other, the 'advice giving role' with which parents might feel more comfortable (McIntosh & Shute 2007; Taylor & Tilley 1989). These dilemmas will be explored in a further paper.

Conclusions

Health visitors use a range of techniques to make complex judgements about relationships between children and their parents. As well as checklists and guidelines (Appleton et al. 2004), HVs utilise their 'intuitive' responses (King et al. 1997; Paavilainen & Tarkka 2003) and other types of 'professional judgement' (Appleton et al. 2004). While this approach may be sensitive, there are potential dangers in uncritical use of such 'internal models,' particularly in terms of culturally sensitive practice. While the personal experience of professionals within their own family can be helpful in informing sound judgement, there are clearly great dangers in using this as the over-riding frame of reference. The more divergent the HV's background from that of his or her client, the more problematic we would expect the consequences of this approach to be. It may therefore be appropriate to consider whether a form of supportive supervision such as that used in social work or psychotherapy might be helpful (Byrne 1994). Informal arrangements analogous to apprenticeships were reported by group members but formal structures for discussing cases do not appear to be universally available. The peer group is nevertheless clearly a crucial resource in helping many HVs formulate their difficult cases.

Many participants identified a need for further formal training in the understanding of parent-child relationships. Areas of potential value might include the assessment of attachment behaviours and classification of parenting styles. Such training would, in addition to improving practice with families, help to avoid dysfunctional communications with other agencies such as social work services (SNAP Research Group 2006).

Internationally, there have been many initiatives designed to help HVs provide support to families with difficulties in parent-child relationships (for example Barlow et al. 2007; Collins & Reinke 1997; Emond et al. 2002; Hewitt & Crawford 1988; McIntosh & Shute 2007; Olds 2002; Sanders et al. 2003). There are however far fewer reports of how best to target the delivery of these interventions effectively towards those families who could gain most from them, and most of these have been based on simple demographics – for example Olds' seminal work on intensive home visitation was aimed at a target group of mothers who were in their teens, unmarried or living in deprived areas (Olds et al. 1998b). Guidelines, such as those developed for children who may require statutory child protection measures, appear to offer a slightly more sophisticated approach - but they may have limited value in practice (Appleton et al. 2004; Appleton 1994b). It is, moreover, unlikely that simple guidelines could ever form the sole basis of complex judgements about families who may benefit from more subtle types of intervention. There have been a few reported attempts to improve assessment through supporting the professional judgements of HVs. For example Solihull in the English Midlands (Milford, et al. 2006) but such initiatives certainly appear to be in the minority.

Continuity of care appears to play a crucial role in health visitors' ability to formulate problems in families. It may be even more important in engagement with families and in

therapeutic interventions than in assessment (paper in preparation). The Hall 4 Report "Health For All Children" (Hall & Elliman 2003) recommends that universal child health surveillance should be more effectively targeted. The implementation of these recommendations should pay regard to the value of continuity.

Ethics, Funding, Conflict of Interest.

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There is duplication of the authors in many of the references - please check carefully.
Apologies. We have corrected the relevant references.

Reviewer #1:

1. It appears to be logical, coherent and readable, but may benefit from being written in the 3rd person (ignore).
We prefer the use of the first person in this type of paper – we believe it implies responsibility for the findings

2. The international audience may not be familiar with the term 'health visitor', therefore an explanation would be helpful. Alternatively they could be referred to as Community Public Health Nurses.
We have added explanatory text to the Abstract, the "What is known" section and the second paragraph of the Introduction.

3. Although the sampling method has been described as purposive, it is not explicit in describing how participants were recruited and how the particular settings were selected. E.g. - were all Health visitors within a particular area/ borough invited to take part? Or was it just health visitors from a few settings within the borough that were approached? There was also no justification for the sample size, however the sample characteristics were well described.
We thought we had made the sampling strategy fairly clear in the text. The two HV members of the research team either:

- knew all the members of the HV teams in each defined geographical area (each containing 10-20 HVs) who were thus eligible to take part in the study
- or where there was no personal contact the HV research team members were able to identify potential participants from discussion with colleagues working in the areas in question.

They then invited participation from individuals with a range of characteristics as described in the text. The only exception to this was the male HV group. All the male HVs in the city were invited and two declined participation. To clarify this approach further we have stated in the paragraph about sampling that: "Apart from the male HV group, which was recruited city-wide, our samples were drawn from the HVs working in small geographical areas of the city."

Sample size was determined by the capacity for comparison. We were able to recruit health visitors with varying experience both in terms of length of time in professional practice and involvement in providing services in areas with differing levels of deprivation. Thus the diversity encompassed by a relatively small number of focus groups allowed us to make meaningful and systematic comparisons with respect to a number of criteria/characteristics. We have inserted text to clarify this (Methods, paragraph 3).

4. It is not clear as to how the research tool (topic guide) was developed and what source of information it was based on.
We have inserted the following text: "The topic guide was developed before the project began through extensive discussion within the research team which comprised two HVs, one general practitioner, a child psychiatrist, a child psychologist and a medical sociologist."

5. There was not enough detail about the research team - how many were they? Who were they?

We presume that the reviewers did not see the title page of the paper. The research team comprises the authors of the paper. See also our response to item 4 above.

6. Would benefit from stating "2 members of the research team" rather than the use of initials (PW and RB) on pg-6. (ignore)

We also prefer to ignore this point.

7. Quotation numbers and sources stated but if there were only 6 focus group interviews carried out in total, how can the quotations be labelled focus group 7, 11 etc?

Apologies. This resulted from a quirk in our analytical software which 'skips' numbers when documents were not loaded successfully. We had actually started to fix the problem in an earlier draft but did not finish the process. We have now renamed the groups 1-6, and wish to thank the reviewer for pointing out this important error in the manuscript.

8. Some reference made to further work. However, the strengths/ weaknesses could be made more explicit.

We were not quite clear what the reviewer was referring to here. We have greatly expanded our literature review, as described below. If the reviewer had something else in mind, we should be grateful for clarification.

Reviewer #2:

Previous literature of this area is lacking. I know that research of this area has been done (ed: we felt that the reviewer was perhaps unhelpful in not pointing out any of the work but we would like you to respond to this point if even if you refute it)

We have now incorporated a much fuller discussion of the literature into the Introduction and Discussion.

Analysis method and description of analysis process needs major work. According to my opinion, analysis is poor and almost totally missing. The authors do not describe, how analysis has proceeded - because of poor analysis, the findings are just description of data and presenting parts of raw data (ed: we feel that the perhaps overstates the case but some more detail should be given)

We have inserted the following text: "The research team met on several occasions and developed a consensus coding frame, paying particular attention to differences in our interpretations, which often stemmed from our varying disciplinary backgrounds (Barbour, in press). Transcripts were coded using this frame and were subsequently cross-checked by at least one other team member to ensure that definitions of coding categories were being consistently applied. The data were systematically interrogated in order to identify patterns and any exceptions or contradictions were closely examined (Barbour, 2001). This ensured that the data were fully mined and that alternative explanations were routinely considered."

Reviewer #3:

1. *The introduction is rather brief in relation to other sections. The potential value of attachment behaviour and parenting styles is mentioned in the conclusion and should be referenced and expanded in the introduction section. (ed: ignore - we feel that the previous reviewers comment about previous research on the topic is more important and we would like to see this referred to if it exists. In principle we are supportive of your brevity!)*

We have expanded the introduction with a fuller discussion of the literature on the health visiting role in relation to difficulties in the parent-child relationship but not the section on attachment and parenting styles.

2. In what way does the use of the word 'attachment' rather than 'bonding' imply formal professional training? (Findings, page 19).

The point we were trying to get across is that most academic discourse on the security of the parent-child relationship uses the term 'attachment' – a pattern of behaviours which, when secure, allows the child to separate as well as seek proximity – rather than 'bonding' which perhaps implies only the latter. We agree that we did not get this point across adequately and have expanded the sentence accordingly.

We think that more understanding of the meaning of 'attachment' could be very useful in helping health visitors understand parent-infant relationship and might not require much formal training. This point is made in the penultimate paragraph of the Conclusion

3. You have identified training programmes in one area of the UK that help HVs work with parent-child relationships (Discussion, page 22). How does this compare with training internationally? Some reference to international relevance is required.

We have expanded this section with a discussion of some of the international literature.

4. 'In many countries, HVs provide a universal community-based service_'(page 4) references needed. (ed: this is an important area to expand upon since we on the committee were rather surprised by it! Please give examples of countries where there is such a universal service and consider the extent to which your findings might apply to them in your discussion - clearly you cannot generalise but I think that you could legitimately raise questions on their behalf)

We agree that we some expansion of this issue is important and have introduced a substantial amount of text both in the Introduction and Discussion.

5. You have said (page 4) that HVs have ongoing supportive contact with almost all mothers and young children, but on page 5 'one of the deprived area has a substantial ethnic minority population but most of the participant's clients are white'. Are you saying that the ethnic families are not supported, hard to reach? This is important because the implication is that health visitors were only focussing on assessment of parent/child relationships in white families. There may be cultural difference not only internationally but also within the UK. A further consideration might be cultural differences between HVs in the criteria they use to make assessments.

Black and ethnic minority people constitute about 4.5% of Glasgow's population, and in the small area described in our study the figure is nearer 25%. Our statement that

most clients were white, but that there was a substantial ethnic minority population, is correct. In the draft we submitted to Archives of Disease in Childhood we made no mention of ethnicity but included the statement in light of comments from one of the reviewers (which we sent to you). We did actually raise the issue of ethnicity in all the groups (and it was in the topic guide) but relatively little discussion emerged in the groups. We have added a sentence to clarify this matter.

We have also expanded the section in the Conclusions where we discussed culturally sensitive practice.

6.In the methods you say that inter-and intra-group differences were explored. - what differences did you find? This is not discussed.
Although focus groups were convened to reflect similarities between participants, they spanned a range of characteristics. Groups were convened with individuals working in the same geographical area, with newly qualified HVs and with male HVs. Within the area-based groups there were HVs with varying lengths of experience and within the other two groups there were individuals working in different types of areas. Some individuals taking part in focus groups had experience of working in both affluent and deprived localities. This, therefore, afforded the possibility of making both inter- and intra-group comparisons (Barbour, 2007). We have alluded to this at the end of Methods, paragraph 3.

We are a little perplexed by the reviewer's statement that we did not report differences. There are several explicit statements throughout the Findings section where we compare both practice in affluent and deprived areas and practice among experienced and inexperienced health visitors.