An Exploratory Study of Parent Experiences on the Circle of Security – Parenting (COS-P) Programme

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Declaration

I hereby declare that this project is entirely my own work, other than the counsel of my supervisors. Any contributions made by other authors have been recognised appropriately. The work herein has not been submitted for any academic award or part thereof at this or any other establishment.

______________________  ______________________
Noreen Gilhooly                      Date: 18th April 2018
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Abstract

Introduction
Despite global uptake of the ‘Circle of Security Parenting Programme’ (COS-P), limited research on its effectiveness has been carried out to date and implementation now exceeds its evidence-base. Dissemination of COS-P has been ongoing in Ireland since the autumn of 2016 and emerging evidence suggests it to be a potentially powerful intervention tool for enhancing parent-child relationships and addressing childhood emotional and behavioural difficulties. The primary focus of the current study was to elucidate the lived experience of parents who have participated in the COS-P and to explore potential mechanisms of change.

Method
The method of inquiry involved a qualitative design. Semi-structured interviews were conducted with nine parents (eight mothers and one father) within seven weeks of completing the COS-P. Interviews were audio recorded and transcribed for analysis. A subsidiary quantitative investigation, involving the completion of standardised psychometric questionnaires at baseline, post-intervention, and again, following a six-month interval, was included to explore the feasibility of future hypothesis testing studies.

Results
Interpretative Phenomenological Analysis (IPA) was applied and the interview data culminated in the uncovering of six themes including ‘Seeking Help and Engaging with the Programme’, ‘Learning to be Vulnerable’, ‘Learning to Manage Emotions’, ‘An Improved Parent-Child Relationship’, ‘A New Experience of Parenting’ and ‘Evaluating the Experience’. Participants appeared to have developed more sensitive and reflective parenting practices and greater emotion regulation capacities. Participants expressed their immense satisfaction with the programme as well as its potential utility for wider audiences.

Conclusion
In-depth examination of parental experiences revealed that COS-P appears successful in its key objectives. Parental practices and affective change following COS-P appeared to occur through several interactive processes, some of which are common to other parent training programmes. Implications for practice, policy and future research are discussed.
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<tr>
<td>COS</td>
<td>Circle of Security</td>
</tr>
<tr>
<td>COS-P</td>
<td>Circle of Security Parenting Programme</td>
</tr>
<tr>
<td>RCT</td>
<td>Randomised Controlled Trial</td>
</tr>
<tr>
<td>PT</td>
<td>Parent Training</td>
</tr>
<tr>
<td>RF</td>
<td>Reflective Functioning</td>
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<td>PRF</td>
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<td>Emotional Reasoning</td>
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<td>Community Psychology</td>
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<tr>
<td>CFCP</td>
<td>Child and Family Clinical Psychology</td>
</tr>
<tr>
<td>ASD</td>
<td>Autism Spectrum Disorder</td>
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<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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Chapter 1: Introduction

1.1 Clinical Area

Research to date has shown that the likelihood of children exhibiting behaviour problems is significantly increased in instances where exacting and/or physical forms of punishment are customarily dispensed by their parents (Halpenny et al., 2010; Larzelere, Cox, & Smith, 2010; McGilloway et al., 2012). Extant literature in the field indicates that approximately one quarter of Irish parents habitually engage in harsh or intimidating disciplinary practices with their children (Halpenny, Nixon & Watson, 2010). Approximately 7,000 children below the age of 17 were awaiting a Health Service Executive psychology service at the end of July 2017 (Children’s Rights Alliance, 2018). While this is a resounding illustration of the acute need for the provision of effective evidence-based support for parents and families, determining how to best deliver clinical psychology services to such children and families continues to present considerable challenges to public health services (Maupin, Samuel, Nappi, Heath & Smith, 2017).

The Child and Family Agency Parenting Support Strategy (2013) advocates for supporting Irish parents to raise their children by means of practices which can enrich psychosocial outcomes and overall child well-being. Enhancing and investing in parenting support inheres many far-reaching benefits, from improving child and family well-being, community well-being, and social cohesion, to reduced inequality, improved use of public resources, and the promotion of both human and social capital (Tusla, 2013).

Parenting programmes are often the first line of evidence-based treatment used by psychological services to prevent or treat a variety of emotional and behavioural problems (Barlow, Smailagic, Huband, Roloff & Bennett, 2014). As such, they primarily operate by changing parent behaviours through exchanges with their child, in addition to addressing parents’ beliefs and feelings about their child (Scott & Gardner, 2015).

Evidence for the effectiveness of parent training (PT) has been demonstrated in numerous randomised controlled trials and in meta-analyses (Furlong et al., 2013). Much of the evidence supporting the efficacy of PT stems from behaviour-based approaches which concentrate on teaching parents strategies to enhance positive child behaviours. Regrettably, in spite of the robust evidence which promotes behavioural approaches, PT remains unsuccessful in up to one third of cases (Scott & Dadds, 2009).
Emerging research is therefore drawing attention to a paradigm shift in parent training, with movements towards the emergence of more complex and integrated models based on attachment and social neuroscience (Schore, 2012; Siegel, 2012). Attachment-based parent training can be used to address any difficulties within the parents’ own attachment system, which in turn, may facilitate subsequent behavioural changes (Juffer, Bakermans-Kranenburg & Van IJzendoorn, 2012). Integrated models which focus on the improvement of parent-child relationships may offer greater agency to respond to complex family situations; namely, where such difficulties are embedded in intergenerational histories of disadvantage (Coyne, 2013; Hughes & Baylin, 2012).

The Circle of Security (COS) is one such attachment-based parenting programme, (Marvin, Cooper, Hoffman & Powell, 2002) which has demonstrated promising outcomes for increased parental sensitivity, decreased negative parental attributions, and more secure child attachment (Cassidy et al., 2010; Hoffman, Marvin, Cooper & Powell, 2006). Certain difficulties which emerged regarding the implementation of the original 20-week COS programme culminated in the development of a shorter version known as the ‘Circle of Security Parenting P’ (COS-P). In spite of global uptake of COS-P, only limited research on its actual effectiveness has been carried out to date (Maupin, Samuel, Nappi, Heath & Smith, 2017) and implementation now exceeds its evidence-base.

1.2 Aims of the Current Study
The primary focus of the current study was to elucidate the lived experience of parents who have participated in the Circle of Security Parenting programme (COS-P) (Cooper, Hoffman & Powell, 2009) and to explore potential mechanisms of change. A qualitative research design was applied. While qualitative evaluations of COS-P to date have been rare, they could provide significant ancillary findings to its growing evidence-base (Kane, Wood, & Barlow, 2007; Moran, Ghate, Van Der Merwe, & Bureau, 2004). In addition, this pilot study presented an opportunity to consider the feasibility of conducting larger hypothesis testing studies in the future through the inclusion of a subsidiary quantitative component.

1.3 Outline of Thesis
Building on this introduction, Chapter Two synthesises the relevant literature relating to COS, parent-training, and the research question.
Chapter Three presents details of the methodology, specifically the research design, data collection, and subsequent data analysis.

Chapter Four expounds on the principal research findings through a combination of illustrative excerpts and interpretative discussion.

Chapter Five evaluates the study findings in the context of the literature reviewed in Chapter Two. The study’s strengths, limitations, and implications for future research and practice are also presented in this concluding chapter.
Chapter 2: Literature Review

2.1 Literature Search Strategy

An extensive literature review was undertaken in order to identify studies on the Circle of Security (COS). Published research was located through a comprehensive search of the following databases: PsycINFO (n=53); PubMed (n=23); ERIC (n=10); Web of Science (n=29); CINAHL Plus with First Text (n=25); Cochrane Database (n=8); ProQuest Dissertations and Theses A&I (n=4); Scopus (n=20); and Google Scholar (n=96). The search terms used in each search engine included various combinations of the following: “circle of security” (n=268) and related variants (e.g., circle of security-parenting; COS; COS-P); “lived experience” (n=3) and related terms (e.g., personal narrative, subjective experience, qualitative); “parenting intervention” (n=26) and other variants (e.g., parent training, parenting programmes); “mechanisms of change” (n=1) and associated terms (e.g., change mechanisms, therapeutic change).

To be eligible for inclusion, studies must have administered a version of the COS or COS-P as a group intervention. Case studies whereby versions of COS were used on a one-to-one or dyadic basis were excluded as participants in the current investigation were administered COS-P as a group. Studies where aspects of the COS/COS-P were used in tandem with other interventions or research whereby some but not all of the COS materials were used were excluded from the current investigation. Qualitative and quantitative studies were included in the review.

A number of additional items of relevance came to light in the course of the initial literature search. Ancillary searches were therefore conducted across the aforementioned databases to identify supplementary published articles connected to the aims of the study. The reference lists of all COS studies included in the review were diligently monitored to ensure that no such articles were overlooked during the preliminary searches. Articles were initially screened by title and abstract and relevant articles thereby identified for a more in-depth reading and critique.

The search extended beyond the academic literature to take account of the grey literature including conference presentations (n=12), dissertations and theses (n=7) and unpublished works (n=12). Only relevant and credible works were included in the final study. This was carried out in order to limit the effect of publication bias. Following the removal of duplicates,
a total of 130 COS references were reviewed and 17 studies were determined to be eligible for inclusion.

2.2 The Epidemiology of Emotional and Behavioural Difficulties in Childhood

Emotional and behavioural difficulties in children are highly prevalent (Barlow et al., 2016; Erol, Simsek, Oner & Munir, 2005; Furniss, Beyer & Guggenmos, 2006) with reported occurrence rates of between 10%–20% (Attride-Stirling, Davis, Markless, Sclare & Day, 2001; Emerson & Einfeld, 2010). Problems with conduct, including oppositional, aggressive, and hyperactive-inattentive behaviours are common in early and middle childhood and such incidences are on the rise (Collishaw, Maughan, Goodman & Pickles, 2004; McGilloway et al., 2012). In fact, conduct disorders remain the most frequent reason for referral to psychology services in childhood (NICE, 2013).

The ‘Growing up in Ireland’ study documented that 15% of Irish children experience substantial social, emotional, and/or behavioural difficulties (Williams et al., 2011), while in the United Kingdom, the 2004 national survey of young people found that 10% of children and young people aged five to sixteen years of age had a clinically diagnosable mental disorder (Green, McGinnity, Meltzer, Ford & Goodman, 2005). They observed that older children were more likely to be affected, with rates of 12% identified, (i.e., those aged eleven to sixteen years) compared to that of up to 8% in younger children (i.e., those aged between five and ten). Prevalence rates were higher amongst children living within disrupted family systems, such as single parent families, or reconstituted families, or those whose parents had no educational qualifications, limited income, and lived in disadvantaged areas (Beardsmore, 2015). Recent investigations by Fink et al. (2015) found similar levels of mental health difficulties (i.e., 19.7% and 19.0%) when equating prevalence rates in two distinct cross-sectional studies of children aged eleven to thirteen years in both 2009 and 2014 (Fink et al., 2015).

Despite these alarming statistics, children frequently do not meet the criteria necessary for a clinical diagnosis, such as conduct disorder, or reactive attachment disorder. Nonetheless, they display sufficient emotional and behavioural difficulties to exert a considerable long-term impact on their future (Cabaj, McDonald & Tough, 2014), including poor academic achievement (Reid, Gonzalez, Nordness, Trout & Epstein, 2004), drug and alcohol misuse, depression, substance misuse, poor employment and marital outcomes, and criminal activity (Barlow et al., 2016; Champion, Goodall & Rutter, 1995; Farrington, 1991; Kazdin, 1990).
2.3 The Significance of Early Relationships

Cabaj at al. (2014) demonstrated that factors related to greater risk of behavioural difficulties in childhood were not restricted to the conventional determinants of socioeconomic status. Disturbances in early caregiving relationships represent a considerable risk factor for the development of emotional and behavioural difficulties in children (Greenberg, 1999). Two areas of difficulty where parenting has been most strongly implicated include insecure attachment and conduct problems (Scott & Gardner, 2015).

Children are at the greatest risk of behaviour difficulties when their security ratings are low for both parents (Boldt et al., 2014; Kochanska & Kim, 2013). Limited parental involvement, low levels of supervision, and inconsistent or harsh punishment are strongly associated with peer rejection and antisocial behaviour (Ladd, Birch & Buhs, 1999).

Existing research purports that up to one quarter of Irish parents engage in harsh or coercive disciplinary practices with their children (Halpenny, Nixon & Watson, 2010). Children of parents who engage in more frequent practice of exacting and/or physical forms of punishment have a greater likelihood of exhibiting behaviour problems (Halpenny et al., 2010; Larzelere, Cox & Smith, 2010; McGilloway et al., 2012). Parental depression has also been associated with increased risk for emotional and behavioural problems manifesting through less positive parenting behaviours, such as impaired parental sensitivity, less warmth, physical punishment, fewer rules, and a lack of routine (Flouri et al., 2015). Depressed mothers may be less capable of interpreting their child’s distress signals and engage less consistently with their child, thereby resulting both in a less secure child attachment (Martins & Gaffan, 2000; Tomlinson, Cooper & Murray, 2005) and a deterioration in child behaviour (Shelton & Harold, 2008). Parents and caregivers need to be able to identify and understand their infants’ signals and respond appropriately to meet their child’s needs (Vu, Hustedt, Pinder & Han, 2014). When compared to more involved or authoritative parenting styles, a positive parent-child relationship has been shown to provide the most consistent buffer against risk factors (Flouri et al., 2015).

2.3.1 Attachment Theory

A child’s bond with its primary caregiver is arguably the most significant relationship established following birth (O'Hara, Barlow, Livingstone & Macdonald, 2016). Attachment theory (Bowlby, 1969; Bowlby, 1982) concerns the degree to which this relationship affords a child with a sense of emotional security and protection from harm, resulting in the formation
of a “secure base” from which to negotiate and mediate the world. Attachment theory hypotheses that the quality of caregiving, such as responding sensitively to a child’s emotional needs, supports a parent-child relationship which is characterised by the mutuality of warm communicative interchanges and results in a secure attachment to the parent (Scott & Gardner, 2015). With repeated exposure to warm and sensitive responsiveness throughout child development, these attachment bonds evolve into the blueprint for an ‘internal working model’ which informs expectations for all future relationships (Scott & Gardner, 2015).

Frightening and abusive parenting styles are particularly destructive to the development of attachment security and are associated with “disorganised” attachment styles. Meta-analytic evidence also affirms robust links with maltreatment (Cyr, Euser, Bakermans-Kranenburg & Van IJzendoorn, 2010). While attachment disorganisation is generally associated with child psychopathology, and conduct problems in particular (Fearon, Bakermans-Kranenburg, Van IJzendoorn, Lapsley & Roisman, 2010), incident rates of approximately 15% are also reported in the wider population (Scott & Gardner, 2015).

Research on attachment theory has traditionally focused on the specific phases of infancy and adulthood, yet emerging evidence attests that representations of secure attachment experiences are also consolidated during middle childhood (Demby, Riggs & Kaminski, 2017; Waters & Cummings, 2000). Less sensitive parenting (Matias, O’Connor, Futh & Scott, 2014; Scott, Briskman, Woolgar, Humayun & O’Connor, 2011) and insecure attachment is consistently linked with greater psychopathology both in middle childhood (Futh, O’Connor, Matias, Green & Scott, 2008) and adolescence (Scott et al., 2011; Scott & Gardner, 2015). During middle childhood, attachment becomes less reliant on the need for contact and proximity to the primary caregiver (Marvin & Britner, 1999) and more reliant on the need for the availability of the parent (Bosmans & Kerns, 2015). Security during this stage is associated with more cooperation on behalf of the child, increased parental monitoring, fewer symptoms of anxiety, and better emotion regulation (Brumariu & Kerns, 2008; Kerns, Abraham, Schlegelmilch & Morgan, 2007; Kerns, Aspelmeier, Gentzler & Grabill, 2001).

### 2.3.2 Caregiver Sensitivity

Ainsworth, Blehar and Waters (1978) described parental sensitivity as the ability to both attend and respond in a manner that is accurately attuned to infant needs. Longitudinal studies demonstrate that attachment security does not deterministically define later outcomes, but rather interacts with several child and family influences (Sroufe et al., 2009). Within the parent-
child dyad sensitivity is influenced by child factors such as prematurity (Singer et al., 1999) the child’s predisposition to anger (Ciciolla, Crnic & West, 2013), and a disproportionate degree of distressed infant behaviour (Leerkes & Crockenberg, 2002). Parental sensitivity can be compromised by maternal depression (Karl, 1995; Murray & Cooper, 1997; NICHD, 1999) personality disorder (Laulik, Chou, Browne & Allam, 2013), history of maltreatment (Pereira et al., 2012), substance dependency (Eiden, Godleski, Colder, & Schuetze, 2014), domestic violence (Levendosky, Leahy, Bogat, Davidson & von Eye, 2006), low self-esteem (Leerkes & Crockenberg, 2002; Shin, Park, Ryu & Seomun, 2008), maternal preconceptions concerning parenting (Kiang, Moreno & Robinson, 2004; Leerkes, 2010), and social isolation (Belsky & Fearon, 2002; Kivijärvi, Räähä, Virtanen, Lertola & Piha, 2004).

2.3.3 Emotional Regulation

Research has drawn attention to parents’ capacity to be flexible in terms of regulating the expression and experience of both their own internal emotional states and those of their child during caregiving interactions (Gross, 1998; Gross & Thompson, 2006). The way in which parents react to and discuss their children’s emotions may be instrumental to their child’s emotional and behavioural well-being. Emotional Regulation (ER) is typified by moments of attunement alongside those of rupture and repair. Less optimal interactions, wherein parents are preoccupied with either self-regulation, as with depressed parents, for instance, or interactive regulation, as in the case of anxious parents, are directly related to the development of insecure and disorganised attachments (Beebe et al., 2010; O’Hara et al., 2016; Rutherford, Wallace, Laurent & Mayes, 2015).

The ability to regulate emotion appears to fluctuate across the human lifespan (Bariola, Hughes & Gullone, 2012; Steinberg, 2005; Steinberg & Morris, 2001). While some evidence cites a genetic influence for this phenomenon (Eisenberg & Morris, 2002), a growing consensus underscores the influence of the family, and parents in particular, in the development of adaptive and maladaptive ER skills (Bariola et al., 2012; Bridges, Denham, & Ganiban, 2004; Kopp, 1989; Thompson, 1994; Zeman, Cassano, Perry-Parrish & Stegall, 2006). Bariola et al. (2012) found that children were likely to engage in emotional suppression practices similar to those of their parents as a means of regulating their emotions. This resonates with a study of 454 mothers which found that maternal ER difficulties were significantly linked to their children’s ER difficulties (Crespo, Trentacosta, Aikins & Wargo-Aikins, 2017). Emerging evidence from PT programmes such as “Tuning in to Kids” (Havighurst, Wilson, Harley &
Prior, 2009) further suggests that targeting parents’ emotional awareness and ER can lead to overall improvements in children’s ER and behaviours (Havighurst, Wilson, Harley, Prior & Kehoe, 2010).

The tripartite model (Morris, Silk, Steinberg, Myers & Robinson, 2007) proposes three contributory aspects of parenting which are of crucial importance for the development of ER skills in children. Firstly, children learn by observing their parents’ and other family members’ ER practices through the emulations of direct modelling (Silk, Shaw, Skuban, Oland & Kovacs, 2006). Secondly, parenting styles are influential and authoritative parenting is related to both internalising and externalising problems (Fletcher, Walls, Cook, Madison & Bridges, 2008). Conditional parental regard, whereby the degree of parental attention and affection given to their child fluctuates in alignment with the desirability of the child’s behaviour, is also associated with ER difficulties in children (Roth, Assor, Niemiec, Ryan & Deci, 2009). Finally, the emotional climate within the family of origin, in terms of the parents’ romantic attachment, marital conflict, and the parent-child attachment, can also have a substantial bearing on the development of ER capacities in children (Rutherford et al., 2015; Volling, McElwain, & Miller, 2002).

### 2.3.4 Reflective Functioning

Reflective functioning (RF) is understood as the capacity to keep others’ minds in mind (Allen, Fonagy & Bateman, 2008; Fonagy, Steele, Steele, Higgitt & Target, 1994; Luyten, NijsSENS, Fonagy & Mayes, 2017). This ability, also known as ‘mentalising’ or ‘mind-sight’, entails the ability to think and feel about thinking and feeling, to consider oneself from an external stance and others from an internal stance, and is a key function for the successful navigation of the social world (Luyten, Fonagy, Lowyck, & Vermote, 2012; Luyten et al., 2017). Impairments in reflective functioning abilities are frequently observed across various psychological disorders, such as, for example, within autism spectrum disorder and in certain forms of psychosis (Brent & Fonagy, 2014; Kovács, Téglás & Endress, 2010), personality disorders (Bateman & Fonagy, 2004), eating disorders (Skårderud, 2007) and depression (Lemma, Target, & Fonagy, 2011; Luyten, van Houdenhove, Lemma, Target & Fonagy, 2012).

Parental reflective functioning (PRF) manifests a parent’s ability to understand their child’s behaviours with regard to the internal mental states of their feelings, aims, aspirations, and intentions (Slade, 2005). PRF ability is associated with the heightened empathy and more attuned responsiveness considered axiomatic to the promotion of optimal parent-child
relationships and more secure attachment systems (Fonagy et al., 1994; Slade, 2005; Wolff & Ijzendoorn, 1997). PRF also examines how mental states alter as a consequence of parent-child interactions and considers how they may have a causative impact on a caregiver’s thoughts, feelings, and behaviours, toward a child (Ensink & Mayes, 2010; Luyten et al., 2017; Sharp & Fonagy, 2008; Slade, 2005).

Evidence suggests that since RF first develops within the attachment relationship, a parent’s capacity for PRF may play a pivotal role it how it develops in the child (Fonagy, Gergely, & Target, 2007; Sharp & Fonagy, 2008; Slade, 2005). Greater PRF has been linked to more positive maternal parenting practices, such as responsiveness, flexibility, and use of the primary caregiver as a secure base, whilst low PRF has been related to less emotionally responsive maternal practices such as hostility, withdrawal, or intrusiveness (Kelly, Slade & Grienenberger, 2005). PRF fosters insight and decreases the likelihood of the transmission of the parents’ own disrupted attachment experiences to their child (Beebe, 2010). As such, promoting PRF is agreed to improve resilience and lower the risk of emotional and behavioural problems in childhood (Fonagy et al., 1994). Attachment-based interventions have demonstrated improvements in PRF and maternal sensitivity (Sadler et al., 2013; Suchman et al., 2010).

2.4 Parenting Programmes

Parenting programmes have become a principal vehicle for improving parenting practices. The National Institute for Health and Clinical Excellence (NICE, 2013) endorses their use with parents of children aged up to ten years who present with behavioural or conduct difficulties (Furlong et al., 2013). Parent training (PT) programmes aim to enhance the parent-child relationship and to prevent or treat a variety of emotional and behavioural problems (Barlow et al., 2014). Such programmes are understood to primarily operate by changing parent behaviours through exchanges with their child, in addition to addressing parents’ beliefs and feelings concerning their child (Scott & Gardner, 2015).

The efficacy and usefulness of PT as a means to enhance parenting competence and family adjustment in real-world community settings is widely acknowledged, particularly in instances of severe socioeconomic disadvantage, (McGilloway et al., 2012). Meta-ethnographic studies draw attention to the many benefits for mothers participation in such group programmes (Barlow, Bergman, Kornor, Wei & Bennett, 2016; Kane et al., 2007), including reduced anxiety and/or depression, and boosted self-esteem (Barlow et al., 2014) in the short-term (Scott & Gardner, 2015).
Behaviour-based PT has accrued a more extensive evidence-base than any other intervention in child mental health (Scott & Gardner, 2015). For example, 50 randomised controlled trials (RCTs) attest to the beneficial effects of the Incredible Years programme (Webster-Stratton & Reid, 2003). Similarly, more than 50 RCTs (by the developer) indicate positive outcomes for the Triple P (Sanders, 1999), albeit three impartial replications failed to reproduce the effects (Scott & Gardner, 2015). Several RCTs by the developer, in addition to independent evaluations, have demonstrated the effectiveness of Parent-Child Interaction Therapy (Eyberg, Boggs & Algina, 1995). The Parent Management Training Oregon (PMTO) (Forgatch & Martinez, 1999) programme has also reported effectiveness through RCTs conducted both independently and by the developer. Three further RCTs conducted on the Nurse Family Partnership (Olds, Hill, O'Brien, Racine & Moritz, 2003) have demonstrated varied and enduring effects (Scott & Gardner, 2015).

A meta-analysis of 54 RCTs of programmes for the prevention or treatment of conduct difficulties in children aged three to ten years was carried out by the NICE Institute (NICE, 2013). The results confirmed a moderate effect size of 0.54 SD on parent-rated outcomes. These effects persisted at follow-up one year later but had halved in magnitude. Comparable findings indicating improvements in positive parenting and harsh disciplining were reported by the Cochrane Collaboration (Furlong et al., 2013).

Despite these findings, evidence of the longer-term effects of these interventions is less conclusive as very few long-term randomised comparisons with waiting list groups have been carried out (Bywater et al., 2009; Gardner, Burton & Klimes, 2006). More recently a Cochrane review (Barlow et al., 2016) suggesting improvements in children’s emotional and behavioural adjustment, concentrated solely on cognitive and behavioural-based PT but presented poor quality and insufficient evidence to support the long-term effectiveness of such programmes.

2.4.1 Limitations of Behaviour Based Programmes

Social learning theory (Bandura, 1977) defines parental behaviour as a ‘reward’ when it reinforces the child behaviour it follows, or a ‘punisher’ when it diminishes it. However, behaviour-based PT rarely includes real appraisals of the precise parent behaviours experienced as rewarding or punishing by the child. They operate on the assumption that since attention is gratifying, its removal (e.g., ‘time out’) must be penalising. Such approaches do not provide a definitive elucidation as to how attention, particularly derived from a primary caregiver, may
be construed as rewarding. Attachment theory may offer a clearer explanation for this, in particular when attention fails to function as a reward (Scott & Gardner, 2015).

Behaviour-based PT focuses almost exclusively on outwardly observable behaviour, thereby overlooking the influence of the psychic world. Very often parents know how they should act to optimise their child’s behaviour, but are prevented in following through on these actions due to entrenched (mis)conceptions regarding their child, (e.g., ‘she’s doing this to wind me up, so why should I be nice to her?; or, ‘he’s so delicate and fragile, I will damage him if I hurt him by being strict’). Behaviour-based PT does not explicitly address how to engage these problematic belief structures (Scott & Gardner, 2015). Furthermore, very few studies have directly compared parenting programmes founded on the principles of social learning theory with other non-behavioural, approaches. Moreover, despite growing evidence that certain aspects of parenting follow patterns of intergenerational transmission (Madden et al., 2015), this is not addressed by behaviour-based programmes.

Furthermore, fathers exert a considerable influence on their children’s development and on family functioning in general. Yet conspicuously few parenting interventions focus on fathers or appear to endeavour to include them in the process (Panter-Brick et al., 2014; Scourfield, Allely, Coffey & Yates, 2016). A systematic evaluation of evidence for father engagement in parenting interventions highlighted that the inclusion of fathers in parenting interventions and subsequent evaluations is often hindered by the timing and location of programme delivery, in addition to factors such as programme content, service resources and institutional, operational, professional, policy and cultural biases (Panter-Brick et al., 2014).

### 2.4.2 Interventions Derived from Attachment Theory

Notwithstanding the robust evidence supporting PT, evaluations of even the most effective evidence-based programmes have found that between a quarter and a third of children and families show no improvements (Scott & Gardner, 2015; Scott & Dadds, 2009). Practitioners anecdotally report that behaviour-based approaches are frequently unsuccessful (Coyne, 2013), and a growing body of evidence indicates that several factors, including therapist, parent, child, family, culture, and intervention characteristics, all play a part in the overall effectiveness of PT (Furlong et al., 2013; Scott, 2005).

Evidence supporting the use of relational programmes, founded in attachment theory is still catching up with practice. Attachment-based programmes aim to assist parents to enhance
relationships with their child through the development of more sensitive caregiving, ER, and RF skills. The extant research proposes that early interventions targeting greater parental sensitivity and attachment may be valuable in supporting healthy child development (Lieberman & Zeanah, 1999; O'Hara et al., 2016; Schore, 2001) and preventing child maltreatment (Barlow et al., 2010).

Barlow and colleagues (2016) conducted a review of systematic reviews and purport that video feedback, parent-infant psychotherapy, and mentalisation-based PT approaches are proving to be promising in terms of improving attachment difficulties in high-risk infants. Findings from their review show that such approaches, in conjunction with home visiting programmes, are successful in the realisation of attachment-related outcomes, PRF, and maternal sensitivity. Meta-analytic studies have also favoured the effectiveness of brief and focused interventions which target these practices as means to improve parent-child relational outcomes (Bakermans-Kranenburg, Van Ijzendoorn & Juffer, 2003; Bakermans-Kranenburg, Van IJzendoorn & Juffer, 2005).

2.4.3 Limitations of Attachment-Based Programmes

While support for the use of relational PT continues to grow, the evidence is limited when compared to behaviour-based PT, and indeed the rigour of some research studies conducted to date has been questionable (Barlow et al., 2016). Recent systematic reviews have focused only on evaluations from the last decade and predominately concentrated on the parents of infants. However, the evidence upholds the findings of prior systematic reviews (Bakermans-Kranenburg et al., 2003). The effectiveness of relational approaches with parents of older children is less clear as attachment-based approaches are often met with barriers to implementation, such as the lengthy duration, and/or they require the parent-child dyad to be recorded. Mortensen and Mastergeorge (2014) demonstrated that attachment PT provided to low-income mother-child dyads was more effective when it was shorter in duration, worked directly with the parent-child dyad, involved professionally qualified facilitators, and used free-play tasks to assess parent-child interactions (Barlow et al., 2016).

Despite the promising benefits of attachment based PT, certain intrinsic facets of parenting, such as consistent discipline or cognitive stimulation, are not considered in these approaches (O'Hara et al., 2016). However, research on child (Matias et al., 2014) and adolescent (Scott et al., 2011) security levels, revealed that consistency of parental discipline independently predicted secure attachment bonds, over and above sensitive responsiveness. Consequently,
attachment-based PT could arguably benefit from targeting limit-setting skills in parenting, in addition to sensitive responding (O’Connor, Matias, Futh, Tantam & Scott, 2013; Scott & Gardner, 2015).

2.5 Qualitative Investigations of Parenting Programmes

Notwithstanding the undeniable interest in PT in terms of frequent systematic reviews, and mounting research on impact evaluation, much of what makes PT beneficial and meaningful to parents remains undetermined (Kane et al., 2007; Moran et al., 2004). Furthermore, although the effectiveness of PT for two thirds of those who avail of it has been established, barriers to treatment still remain (Lundahl, Risser, & Lovejoy, 2006; Reyno & McGrath, 2006). Qualitative investigations of parents’ perspectives following PT have prompted the identification of a number of less well understood but influential components (Grimshaw & McGuire, 1998; Webster-Stratton & Spitzer, 1996).

There is a noticable paucity of qualitative research on parents’ perceptions of PT. Kane et al. (2007) used a meta-ethnographic method to synopsise and synthesise the available qualitative literature investigating parents’ experience and perceptions of PT and endeavoured to create a framework illustrating the fundamental aspects of PT, from parents’ perspectives (Kane et al., 2007). Key findings from this synthesis stressed that many parents feel powerless and ill-equipped to manage their children’s behaviours prior to completing PT (Kane et al., 2007). Parents reported that PT helped them acquire new knowledge and skills, develop better coping strategies, and made them feel supported and accepted by other group members. These changes led to less social isolation and reduced feelings of personal guilt, along with enriched empathy and confidence in coping with their children’s behaviours. However, only four studies were included in this synthesis and the theoretical orientation of each investigation was different (Kane et al., 2007).

A number of qualitative studies have explored barriers and facilitators to engagement and retention in PT (Mytton, Ingram, Manns & Thomas, 2014) which illuminate parental concerns regarding participating in PT. These anxieties, which include fears of being perceived as an inadequate parent, potential stigmatisation, and/or feelings of guilt, clearly have far-reaching implications for parental engagement (Mytton et al., 2014). However, much of this research is predicated on the viewpoints of professional service providers rather than in eliciting parents’ perceptions of their experience (Moran et al., 2004; Mytton et al., 2014).
Vella and colleagues (2015) investigated the experiences of parents attending the relational programme, ‘Solihull Approach Parenting Group: Understanding Your Child’s Behaviour’ (Douglas, 2006) by conducting an IPA analysis of interviews at two consecutive time points. The interviews revealed four major themes, including development as a parent, improved self-belief, two tiers of satisfaction with the PT, and the so-called ‘Matthew effect’, whereby parents who were satisfied at time one, retained satisfaction at time two, and vice versa (Vella, Butterworth, Johnson, & Urquhart Law, 2015). Parents reported valuing the experience of social support and containment as well as observing improvements in their child’s behaviour and confidence in parenting. This in-depth analysis revealed that parents apparently engaged in more empathic and reflective interactions with their children following the PT (Vella et al., 2015).

Their study emphasised the value of ascertaining parent perspectives for the development of PT and was considerably strengthened by including the follow-up interviews with parents. Nonetheless, failure to include either a control group or accounts from those parents who withdrew from the programme arguably compromises the outcomes. Furthermore, the Strength’s and Difficulties Questionnaire, (SDQ) proved an unsuitable assessment instrument for parents with children of less than three years of age (Goodman, 1997). Moreover, not all participants completed the questionnaires at time two, while a number of parents completed the SDQ in respect of different children at each timepoint. That being said, the study provided a rare and valuable insight into parents’ lived experience of PT.

Holtrop and colleagues (2014) drew attention to the critical gap in the understanding of change processes in PT. They conducted an in-depth analysis of interviews with parents who had participated in the PMTO using grounded theory principles (Holtrop, Parra-Cardona & Forgatch, 2014). The outcomes indicated that parents made intentional efforts to attempt, appraise, and apply the intervention strategies across contexts, which contributed to adjustments in their parenting practices. The findings also foregrounded the role of the therapist/facilitator, the PT content, and mode of delivery as key factors in the change process (Holtrop et al., 2014). However, their investigation was based on subjective retrospective parental accounts. This may have affected parents’ recollections of their experiences and intervening events may have introduced a certain level of interference. In addition, their findings were limited to parents who had completed PMTO and is therefore ungeneralisable to other PT programmes.
2.6 The Circle of Security Intervention

The Circle of Security (COS) is an attachment-based parenting programme which incorporates principles from both psychodynamic theory and object relations theory (Klein, 1948; Masterson, 2013; Siegel, 1999) and is specifically devised to improve caregiver-child relationships (Marvin et al., 2002). The COS consists of a 20-week intervention programme suitable for group or individual settings which uses video feedback of the parent-child dyad to assist in developing an improved understanding of child behaviour and PRF as illustrated in Table 2.1 (Beebe, 2010; Lena, 2013).

While globally, the dissemination of COS approaches has surpassed their evaluation (McMahon, Huber & Schneider, 2016) it has nonetheless shown significant efficacy in increased parental sensitivity, decreased negative parental attributions, and more secure child behaviours (Cassidy et al., 2010; Hoffman et al., 2006).

A US investigation of 75 parent-child dyads demonstrated a 35% shift from disordered to ordered child attachment (Marvin et al., 2002) and a convenience sample study of 65 parents in preschool programmes highlighted improvements in 69% of disordered attachments (Hoffman et al., 2006). As both of these investigations were carried out and the results interpreted by developers firmly implicated in the COS programme, the findings of a comparable randomised controlled trial (RCT) of 80 mother-child dyads currently underway in Germany, are now anticipated with considerable interest (Ramsauer et al., 2014).

Table 2:1 Summary of Circle of Security Goals

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<tbody>
<tr>
<td>1.</td>
<td>Enhance caregivers internalised secure base script by giving them a roadmap (COS graphic) of children’s attachment needs</td>
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<tr>
<td>2.</td>
<td>Help caregivers to develop more accurate internal representations of the self and others (especially targeting negative attributions of the child).</td>
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<tr>
<td>3.</td>
<td>Support caregivers’ appropriate and sensitive responses to children’s emotions.</td>
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<tr>
<td>4.</td>
<td>Increase caregivers’ reflective functioning.</td>
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<tr>
<td>5.</td>
<td>Support caregivers’ emotion regulation through their understanding of ‘Shark Music’ (COS term for painful feelings that arise during parent-child interactions which can inhibit the parent’s ability to meet their child’s attachment needs) and help caregivers to develop more empathy for the distress that unregulated parental emotions cause in children.</td>
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<tr>
<td>6.</td>
<td>Increase caregivers’ secure base/safe haven provision.</td>
</tr>
<tr>
<td>7.</td>
<td>Improve attachment outcomes for children at risk for insecure attachment.</td>
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(Adapted from Cooper, Hoffman, & Powell, 2011).
Three studies conducted with 83 families attending a clinical family support service found that parents with who initially rated higher parenting stress and psychological symptoms showed significant improvements post-intervention. Lower parenting stress was associated with decreased child behaviour difficulties. Improvements in psychological symptoms were not associated with improvements in behaviour problems and were considered to be influenced by a greater understanding and a reframing of children’s problematic behaviours (Huber, McMahon & Sweller, 2016). While such parent and teacher ratings suggested improvements in child behaviour, no significant changes were observed in child attachment classifications (Huber et al., 2016).

It is clear that the overall available evidence is circumscribed by the absence of control comparisons, RCT studies, and the disproportionate contributions of COS developers and advocates. Additional limitations to the above findings include inconsistencies in the reporting of pertinent participant information, response and completion rates, and the inclusion of follow up data (Caruana, 2016).

2.6.1 The Circle of Security Parenting Programme (COS-P)

Owing to feasibility difficulties in implementing the original COS intervention, Cooper et al. (2009) developed a more concise eight-week version of the parent education programme. The resultant Circle of Security-Parenting (COS-P) remains firmly grounded in the core principles of COS. COS consists of ten days of training and continuing supervision following the training phase, and also places considerable demands on resources due to equipment requirements and the time and skills needed to edit the videos. COS-P training is condensed to four days and instead of using video recordings of the parent-child dyad, it employs handouts, graphics, and DVD presentations. However, the goals remain the same as the original protocol (Cooper et al., 2009) and as such, facilitators guide parents through examples of effective and ineffective parent-child interactions by means of an eight-chapter DVD programme.

COS-P facilitators are hypothesised to function as a “safe haven” or secure base to provide both a supportive and exciting context in which to explore parenting. A number of accessible metaphors are used to assist parents in meeting their child’s relational needs. These include the idea of being the “hands” on the circle and reflecting on the task of being “bigger, stronger, wiser, and kind”, learning that “being with” is an empathetic state of mind which shapes caregiving, and normalising parent’s vulnerabilities, such as ‘shark music’, which prevent them from meeting their child’s needs (Cooper et al., 2009).
COS-P privileges optimal and problematic parent-child interaction patterns and guides the parent towards reflecting on both their own and their child’s, internal experiences. In so doing, it seeks to enhance PRF which is associated with increased empathy (Fonagy et al., 1994) and which enables parents to become more attuned to their individual child’s needs (Booth & Jernberg, 2009). Parents are encouraged to consider the influence of their own attachment experiences and how this influences their relationship with their child. They are supported to think about how they interact with their child, and how they could approach future interactions more effectively to improve the parent-child relationship.

2.6.2 COS-P Evidence Base

Research supporting the COS-P is still in its infancy (Steele & Steele, 2017), and to date, very few quantitative studies examining changes in parenting practices following participation in COS-P, have been published. Using a pre-post design, Horton and Murray (2015) studied a sample of 15 pregnant and postpartum mothers of children under the age of 12 who had completed the COS-P during residential treatment for substance abuse. Their findings indicated that, amongst the nine mothers who attended at least 80% of the COS-P sessions, a significant number demonstrated improvements in their self-rated disciplinary practices, such as overreaction, or excessively harsh or lax disciplinary practices. On average, the study also indicated improvements in mothers’ self-rated emotional regulation and hostile attributions of their child’s behaviours. However, the number of participants demonstrating improved scores was not significant. Due to the absence of RCT design, small sample size, and limitations to the internal validity, the results from the Horton and Murray (2015) study should only be considered preliminary.

Kohlhoff and colleagues (2016) conducted a pilot study on COS-P to examine pre- and post-intervention changes in 15 mothers of children aged under two years presenting to Primary Care services (Kohlhoff, Stein, Ha & Mejaha, 2016). Their results indicated lower levels of caregiver helplessness, decreased feelings of fear, anger, and/or rejection towards their child, and decreased levels of stress post-intervention. In terms of PRF, the results indicated that mothers had become more certain about their child's mental states, along with their own, following completion of COS-P (Kohlhoff et al., 2016).

Nonetheless, the study inhered several limitations, including a lack of a control group to monitor observed improvements not directly attributable to the intervention. As the sample size was particularly small, results should be also interpreted with caution. In addition, no follow-
up data was collected meaning that evidence concerning the longer-term effectiveness of the programme is not available. Although significant changes were found post-treatment for aspects of PRF (i.e., certainty about mental states), mother helplessness, and stress ratings, the actual extent of these outcomes was not reported. It is therefore challenging to precisely estimate treatment effects. This study also relied on self-report measures which may provide a narrowed indication of changes in PRF.

When Maupin et al. (2017) explored the feasibility and acceptability of disseminating COS-P to 131 mothers at multiple Secure Start Network sites in the community they encountered numerous barriers to service delivery at participant, provider, and agency levels which inevitably encumbered participant retention, evaluation, and dissemination. Pre- and post-intervention data were collected to evaluate COS-P and maternal caregiving functioning (i.e., depressive symptoms, RF). While participants reported fewer depressive symptoms following COS-P, no significant differences were found for RF scales, the parent-child relationship scales, or the sense of parental competency scales. It is consequently difficult to draw conclusions regarding the efficacy of COS-P from this investigation, particularly in terms of delivery in a delimited community setting.

Cassidy et al. (2017) conducted the first RCT design study to examine the treatment effects of COS-P amongst low-income mothers and their preschool age children who were enrolled in the head start programme in Baltimore, Maryland. The dataset consisted of 141 mothers; 75 currently participating in the COS-P intervention group, and a further 66 in a waiting-list control group. Mothers who participated in COS-P reported giving fewer unsupportive responses to their preschool children's distress than mothers in the control group, suggesting that COS-P was successful in one of its key aims of nurturing parental empathy.

Additional findings by Cassidy et al. (2017) included the main effect of treatment on child inhibitory control, (i.e., one area of child executive functioning) and no effect on cognitive flexibility. As inhibitory control pertains to the control of attention and behaviour, this is an important finding, since greater levels of child inhibitory control are related to greater school readiness (Bull, Espy & Wiebe, 2008). The impact on child inhibitory control was not observed when factors such as marital status and maternal age, were not controlled.

Increases in executive functioning and decreases in maternal unsupportive responses yielded small to medium effect sizes. Furthermore, the main effect on child inhibitory control was moderated by maternal self-reported attachment style. However, the differential between COS-
P and control groups was not sustained when mothers self-reported high levels of attachment anxiety (Brennan, Clark & Shaver, 1998) was controlled.

Whilst no main effects of COS-P were indicated for child attachment classification or child behaviour difficulties, the results indicated that maternal depressive symptoms and maternal attachment style acted as important moderators of treatment effects, such as child attachment security, internalising but not externalising behaviours, and attachment disorganisation. In mothers with high self-reported attachment avoidance, completion of COS-P was linked to increased child attachment security and reduced disorganising as compared to those in the control groups. Conversely, in mothers with low self-reported attachment avoidance, completion of COS-P was related to decreased child attachment security as compared to those in the control groups. Maternal attachment anxiety and maternal depressive symptoms each moderated the effects on children’s internalising behaviour difficulties (i.e., children of mothers with lower reported depressive symptoms or maternal attachment anxiety demonstrated fewer internalising behaviour difficulties than the control group) (Cassidy et al., 2017).

Yaholkoski and colleagues (2016) undertook a meta-analysis of ten quantitative studies which identified four medium effect sizes for changing insecure attachments to secure, improvements in quality of caregiving, reductions in caregiver depression, and a significant effect in improving caregiver self-efficacy. Although COS-P shares its resources and theoretical structure with COS, its implementation model varies considerably. The analysis was therefore arguably limited by the use of a combination of COS approaches (e.g., COS-P, COS-PP, COS-HV41) which skewed the findings. Moreover, the sample sizes were relatively small, psychometric measures noticeably varied, and attrition rates were high in most of the studies included.

Both the COS and COS-P aim to enhance PRF. However, conspicuously few studies have investigated this outcome as a potential change mechanism. Huber et al. (2015) evaluated caregiver RF following dissemination of COS. Caregivers with low RF scores at baseline showed clinically and significantly improved RF post-intervention. Nevertheless, changes in caregiver RF did not correlate to changes in child attachment, casting doubt on the role of RF in the context of COS and in the replication of these outcomes in COS-P. Furthermore, a quasi-

1 Circle of Security Home Visiting 4 (COS-HV4); Circle of Security Perinatal Protocol (COS-PP) (Cooper, Hoffman, & Powell, 2003);
experimental study on 34 family childcare providers found no significant changes in reflective functioning as measured by the Parental Reflective Functioning Questionnaire (Luyton et al., 2017) following COS-P (Gray, 2015). However, as the measurement of RF in the context of childcare is under-researched, it is difficult to conclusively interpret these findings.

Despite the established risk factors between parenting and child well-being, much COS research has neglected to explore the potential effects on parental psychopathology, (Bennett, Barlow, Huband, Smailagic & Roloff, 2013). One such study reported significant improvements in parental depressive symptoms following COS, most notably for those with more severe symptoms at baseline (Huber et al., 2016). Comparable improvements were observed in mothers in a jail diversion programme following the delivery of the Circle of Security Perinatal Protocol (COS-PP; Cooper et al. 2003) twice weekly for 15-months (Cassidy et al. 2010). However, the study did not include a control group, rendering it difficult to measure precise intervention effects on outcomes. Social support fostered in the group environment may also have contributed to the reduction in symptoms. Nevertheless, these preliminary results underscore the potential for attachment-oriented PT to alleviate parental depression symptoms (Shaw, Connell, Dishion, Wilson & Gardner, 2009).

Although there are indicators that COS and COS-P is being disseminated to fathers (Palm, 2014), their absence from the available evidence base as noted in the vast majority of COS research to date has focused on mothers. Few published studies have included fathers in their investigations despite the growing evidence supporting the importance of the paternal-child relationship in childhood emotional and behavioural outcomes (Williams et al., 2011). Five fathers participated in one of the original investigations of COS (Hoffman et al., 2006), seven participated in a quantitative investigation of COS-P (Rostad, 2014) and a single case study included a father who received the COS-P individually (Pazzagli et al., 2014). COS has been adapted for use with incarcerated fathers (Palm, 2013) and the unpublished evaluation of this adaptation suggests that considerable changes occurred in father’s attachment behaviours, as well as in their understanding of “being with” their child and their “shark music”.

Since the available evidence on COS and COS-P is subject to considerable variability, both in terms of the participants investigated and the outcome measures used across studies, drawing precise conclusions regarding its effectiveness has proved to be extremely contingent and problematic. In addition, with the exception of Maupin et al. (2007) who investigated parents of children between age one and eight, and Horton and Murray (2015), who included parents
of children up to age 12, many such studies restricted their focus to parents of preschool aged children.

2.6.3 Qualitative Studies of COS and COS-P

Although numerous quantitative studies have examined COS and COS-P, comparatively few qualitative investigations have been published to date. Existing qualitative investigations have concentrated on obtaining facilitator feedback (Berntsen & Holgersen, 2015; McMahon et al., 2016), a combination of participant and facilitator feedback (Horton, 2013), or individual case studies (Page and Cain 2009; Marvin et al., 2002).

Lee et al. (2010) conducted a case study with three mothers who participated in the 20-week COS adaptation, ‘The Boomerangs Aboriginal Circle of Security Parenting Camp Program’. Findings from the follow-up interviews eight-weeks post-PT indicated improvements in mothers’ sensitivity, awareness, and responsiveness. However, the results were constrained both by the particularly small sample size and the necessary COS reconfigurations, making it difficult to generalise findings. In addition, the lengthy eight-week gap between interviews may have impinged on the accurate recall of the mothers’ experiences as well as introducing confounding factors.

Horton (2013) used a mixed method action research methodology to determine the impact of COS-P on mothers in residential treatment for substance abuse. Nine participants offered reflections after each session and in a focus group following the last session, along with the researcher’s own weekly reflections. Content analysis revealed improvements in the mothers’ ER, parental attributions, and parenting discipline, in addition to increased awareness of the connection between their emotional states and their personal attachment histories. Nevertheless, these findings were restricted in that the qualitative analysis served to supplement the quantitative analysis and lacked the in-depth personal accounts of individual participants’ experiences. Moreover, the revelations elicited from the weekly reflections were not followed up with more comprehensive participant interviews which could have explored other factors contributing to its success.

Kimmel et al. (2016) conducted a mixed method assessment of COS-P delivered to 12 women with mood and anxiety disorders attending a primary care paediatric clinic. All data were derived from participant feedback forms (Kimmel, Cluxton-Keller, Frosch, Carter &
Subsequent thematic analysis revealed improved parenting skills and understanding of their child’s behaviour, caregiver sensitivity, social support, self-efficacy and emotional regulation. The study was limited by the failure to include in-depth interviews with mothers. Instead, it relied on evaluations of their experiences from semi-structured questionnaires which may have curtailed the elaboration of participants experiences.

Jonsditter and Coyne (2016) conducted an exploratory study of group process in a 16-session delivery of COS in a university health clinic in New Zealand. Three mothers consented to the use of transcribed video sessions for this study. The researchers analysed the ensuing commentary from the ‘observing mothers’ in the group for themes that could provide insight regarding parents’ experiences. Their analysis revealed that in-session commentary based on observations of parents may be an important contributory factor in the change process of COS since witnessing the intervention process for others may provide a meaningful learning experience for parents, even if the other parents’ circumstances do not directly match their own.

Jonsditter and Coyne (2016) purported that immersion in the group environment may lend to parents’ increased understanding of their own relational style. As such, they may benefit from the impressions of others within the group, thereby enhancing their personal relationships. Furthermore, any uncomfortable feelings triggered in the group setting may be perceived as beneficial by participants if such emotional processing is well managed. Nevertheless, their exploratory study was compromised by the small sample size, an unclear method of analysis, insufficient demographic information, and the fact that poor sound quality rendered a considerable proportion of the recordings unusable. Additionally, the analysis was conducted from the standpoint of the practitioner, rather than gathering the direct perceptions of parents. As such, the parents’ felt sense pertaining to personal learnings and change processes may have been neglected or misconstrued, and the investigation would doubtless have profited from the addition of in-depth interviews with the three mothers.

2.7 The Current Study

Evidence of harsh parenting practices and emotional and behavioural difficulties (Williams et al., 2011) reveal that a considerable proportion of families in Ireland could benefit from PT (Halpenny et al., 2010; McGilloway et al., 2012). However, a number of services have intimated concerns that behaviour-based PT does not achieve improvements in parents’ negative perceptions of their children and their role in supporting their child’s emotional development. Practitioners describe considerable challenges for their work when parents have
not had an opportunity to address difficulties in their own experiences of being parented (Gilhooly, 2016). The need for a relationship-based programme which could specifically target lower-level attachment difficulties was acknowledged. Considering its promising evidence base, the COS-P was adopted by services in the Midwest in a bid to address this gap and afford an intervention strategy which could improve caregiver sensitivity and mitigate negative perceptions of their children’s behaviour.

A review of the existing research revealed several gaps in the literature. To date, just one RCT investigation of COS-P has been conducted. At the time of writing, no published investigations of COS-P within an Irish context were available. Moreover, few studies have explored the COS-P with parents of children in middle childhood, with the majority focusing on infancy and toddlerhood. Father’s experiences have thus far been conspicuous by omission. Furthermore, studies investigating changes in PRF and parental depression following COS-P remain scarce and effects on parental ER have not been examined.

Qualitative evaluations are a rare yet invaluable accompaniment to the growing evidence-base for parenting programmes like COS-P (Kane et al., 2007; Moran et al., 2004). While several studies have reviewed the perceptions of COS-P ‘facilitators’, as yet, in-depth research which aims to elicit parents’ perspectives on the programme, father’s perspectives, and the potential mechanisms of therapeutic change in COS-P, is largely absent. Considering the cost to services in relation to training, resources and waiting lists, and the need to provide effective support to parents, it is essential that intervention tools such as COS-P are investigated and evaluated on an on-going basis to inform best clinical practice (Byrne, 2012).

### 2.7.1 Theoretical Framework

Attachment theory (Bowlby, 1969; Bowlby, 1982) provides a useful framework for systematising the research to date on experiences of group-based PT. From an attachment theory perspective, psychoeducational group-based interventions such as COS-P may create the opportunity for parents to explore former relational wounds which have adversely affected their ability to sustain closeness in relationships or to tolerate distance. Attachment-based PT may provide the setting to foster the internal capacities necessary to cope with overwhelming emotions and thereby enable parents to construct a consistent narrative to assist them in understanding their anxieties regarding their children’s behaviours (Marmorosh & Tasca, 2013; Wallin, 2007).
PT can provide a safe space in which to explore current parent-child relationships within the group setting and revisit early influential attachment injuries that impact on the ability to trust (Tasca, Ritchie & Balfour, 2011). Yalom and Leszcz (2005) outline several therapeutic components which facilitate change, many of which are embedded in attachment theory. These include group cohesion, interpersonal learning, recapitulation of the early family, corrective emotional experiences, and RF and ER (Tasca et al., 2013).

Group cohesion is a fundamental therapeutic factor in group psychotherapy (Burlingame, Clendon & Alonso, 2011; Yalom & Leszcz, 2005) and is also relevant for psychoeducational groups. Group cohesion embodies the extent to which participants experience the group as a secure base, comparable to a primary caregiver, and a source of comfort to turn to in times of distress (Mikulincer & Shaver, 2007). The greater the sense of belonging in the group and that the group can be relied on for support, the greater the participants’ sense of trust and willingness to take risks within the group. The sense of being in it together or “we-ness” experienced in a group is an essential prerequisite to change (Yalom & Leszcz, 2005) and creates a foundation for withstanding the affective states evoked during sessions (Marmarosh & Tasca, 2013).

From an attachment standpoint, the corrective emotional experience (Alexander & French, 1946) entails how individuals within the group can experience and internalise more secure attachment relationships which contradict previous traumatic attachment relationships. Such corrective experiences are particularly potent in a group setting as they occur with both the facilitator and the group participants.

2.8 Research Question

The primary research question for exploration in the current study is:

"What are the lived experiences of parents' participating in the COS-P, and how do they experience change on the programme?"

The overarching aim of the investigation is to explore parents’ lived experience of COS-P and, in so doing, to elucidate potential underlying mechanisms of change. The investigation is the first of its kind to be carried out with parents participating in COS-P in Ireland. It endeavours to provide a unique perspective on how COS-P is received by parents. The study also afforded an opportunity to assess the feasibility of recruitment, randomisation, participant retention, assessment procedures and self-report measures for future hypothesis-based investigations.
Chapter 3: Methodology

3.1 Chapter Overview

This chapter presents the rationale underlying the qualitative approach to the present study. It begins with an overview of the epistemological and methodological considerations informing the investigation. This is followed by a description of the sampling procedure and participants. A detailed description of the procedures used during data collection and analysis is also provided. The chapter concludes with a commentary on quality and relevant ethical concerns.

3.2 Epistemological and Methodological Considerations

The current study is positioned within the post-positivist paradigm of critical realism. In representing a constructivist epistemology critical realism considers a world formed through our individual perspectives and insights (Creswell, Klassen, Plano Clark & Smith, 2011). This is placed within a conventional realist ontology in which reality can exist beyond awareness (Maxwell & Mittapalli, 2010). A critical realist position imbues qualitative research with a perspective which embraces both the diversity and convergences of human experiences and ideas (Willig, 2013; Willig & Stainton Rogers, 2017). The critical realist stance considers parent-child relationships as tangible and generalisable phenomena that present many challenges to objective examination, whether observed by means of self-report measures or semi-structured interviews (Willig, 2013).

3.3 Research Design

3.3.1 Rationale for Qualitative Design

As previously discussed in the literature review, attachment theory provides a useful framework for theorising and describing the personal experiences and potential psychological mechanisms of change which are involved in group-based PT such as COS-P. Serving as a pilot, this study was viewed as the requisite first step in examining the application of COS-P in the Midwest of Ireland. Preliminary pilot investigations are an established means of examining feasibility and pinpointing any modifications necessary for the design of subsequent and more extensive, hypothesis-testing studies (Leon, Davis & Kraemer, 2011). The overarching aim of the current study was to explore parents’ lived experience of the COS-P and by so doing, elucidate potential underlying mechanisms of change.

Quantitative approaches commonly entail a process of hypothesis generation and theory-testing. Such practices actually seek to disconfirm the theory, and by eliminating untrue claims, to edge closer to the truth (Pietkiewicz & Smith, 2014). Methodologies of this kind ordinarily
focus on quantifying incidences or effect sizes and thus impose a requisite reduction of experiential phenomena to numerical values in order to facilitate statistical analysis (Pietkiewicz & Smith, 2014). In contrast, qualitative research is focused on how a particular individual makes sense of their world or the meanings they attribute to a given phenomenon. It extends beyond causal relationships and impact on outcomes and privileges a fundamental concern with the quality of individual experience (Grix, 2010).

Gathering client perceptions and experiences of intervention processes are regarded as ethical, beneficial (Thornicroft & Tansella, 2005) and good clinical practice (Byrne, 2012). The value of qualitative enquiry in mental health-care research is gaining increasing recognition, particularly for its efficacy in capturing service-user perspectives for informing practice and moulding service delivery (Macran, 1999). It is now widely accepted that capturing client viewpoints and experiences can help practitioners to better appreciate the action of interventions.

 Qualitative research frequently endeavours to contextualise data collection and interpretation by relinquishing emphasis on empirical precision and control. As the data in such approaches is generally gathered from naturalistic settings, the subjectivity of both participants and researchers is taken into consideration. Reflecting on phenomena in context allows for the discovery of meanings, processes and connections which, while sometimes central to real-life conditions, may not have been anticipated or prepared for during the quantitative phase.

Qualitative perceptions can enhance the reliability of existing evidence and provide new insights into previously unidentified therapeutic developments and outcomes (Hodgetts & Wright, 2007). Moreover, qualitative enquiry ensures the monitoring and thorough consideration of potential adverse or unanticipated effects (Macran, 1999). While qualitative studies seek to educe rich or ‘thick’ individualised and illustrative explanations of the particular phenomena (Geertz, 1973), quantitative research conversely yields comparatively ‘thin’, norm-referenced data for ease of comparison between populations (Willig & Stainton Rogers, 2017).

3.3.2 Rationale for an Interpretative Phenomenological Approach

As outlined in the literature review, much of the existing qualitative investigations of COS-P have concentrated on individual case studies (Page and Cain 2009; Marvin et al., 2002) or obtained a combination of participant and facilitator feedback (Horton, 2013). Often the method of analysis in these studies was unclear and much of the limited number of qualitative
investigations of COS-P have been conducted from the practitioner’s viewpoint, rather than gathering the direct perceptions of parents.

Although several qualitative methodological approaches were initially considered for the current study, given the exploratory nature of the research, which aimed to reveal a comprehensive understanding of the subjective lived experiences of parents who had completed the COS-P, an interpretative phenomenological approach, specifically Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2012), was applied to the data. The central focus of the investigation related to exploring participants’ own experiences of the COS-P intervention as delivered in the Midwest. In essence, the study was concerned with the processes utilised by participants in generating meaning from their experiences and aimed to reflect on the experience of the intervention from the participating parents’ perspective.

Thematic analysis (Braun & Clarke, 2006) was considered at the outset of the study and during recruitment however it was not used for several reasons. Thematic analysis presents an adaptable approach to qualitative inquiry that is not bound to established theoretical frameworks and allows researchers to assume constructionist, essentialist/realist, or contextualist approaches as considered fitting to the research query (Braun, Clarke, & Terry, 2014). However, following reflection, further consideration of the research question underscoring this study revealed that a traditional IPA approach was more suitable due to its idiographic nature and its emphasis on the subjective lived experience of participants, which was unattainable by means of thematic analysis.

Grounded theory was given consideration but deemed unsuited to the aims of the current investigation. The objective of Grounded theory (Charmaz & Belgrave, 2012) is to produce a credible and functional theory of the phenomena founded in the data (McLeod, 2011). However, rather than attempting to create a clear theory to potentially explain experience, the principal aim of the current study was to capture the lived experiences of parents and how they experience change in the programme. Consequently, Grounded theory (Charmaz & Belgrave, 2012) was considered unsuitable for the present inquiry. Furthermore, the requisite theoretical sampling and data saturation in a Grounded Theory approach, whereby data is gathered until no new themes emerge, conflicted with the purposeful sampling technique employed in the current study. In contrast, the use of an IPA framework permitted an in-depth consideration of subjective experience and meaning making (Shinebourne, 2011).
Discourse analysis was also considered unsuitable due to its emphasis on the regulatory and constructionist function of the language used by participants to depict their experiences. Thus, Discourse Analysis represented a stark contrast to the aims of the investigation and an IPA approach whereby the nature of the experiences themselves are elucidated (Silverman, 2010).

Table 3.1 Overview of Qualitative Approaches Considered

<table>
<thead>
<tr>
<th>Approach</th>
<th>Rationale for Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thematic analysis:</td>
<td>Thematic analysis (Braun &amp; Clarke, 2006) was considered at the outset of the study and during recruitment. Thematic analysis presents an adaptable approach to qualitative inquiry that is not bound to established theoretical frameworks and allows researchers to assume constructionist, essentialist/realist, or contextualist approaches as considered fitting to the research query (Braun, Clarke, &amp; Terry, 2014). However, further consideration of the research question underscoring this study revealed that a traditional IPA approach was more suitable due to its idiographic nature.</td>
</tr>
<tr>
<td>Grounded theory:</td>
<td>The objective of Grounded theory (Charmaz &amp; Belgrave, 2012) is to produce a credible and functional theory of the phenomena founded in the data (McLeod, 2011). Rather than attempting to create a clear theory to potentially explain experience, the principal aim of the current study was to capture the lived experiences of parents and how they experience change in the programme. Therefore, Grounded theory (Charmaz &amp; Belgrave, 2012) was considered unsuitable for the present inquiry.</td>
</tr>
<tr>
<td>Discourse Analysis; Narrative Analysis:</td>
<td>A limited focus on the nature of experience and greater emphasis on the regulatory and constructionist purpose of the language used to depict events indicated that Discourse Analysis was unsuitable for the current investigation (Silverman, 2013). Narrative methodologies were not used due to their emphasis on the content and structure of participant life stories (Creswell, 2014).</td>
</tr>
</tbody>
</table>

Table 3.1 provides an overview of the approaches considered.

Firmly positioned within established psychological discourse, IPA is buttressed by the touchstones of phenomenology and hermeneutics and characterised by idiography, experience, and interpretation (Willig & Stainton Rogers, 2017). It delivers a detailed framework for understanding how people mediate their personal and social worlds (Smith, Flowers & Larkin, 2012). IPA makes an unequivocal commitment to appreciating phenomena from a first-person standpoint and ascribes to the inherent value of obtaining psychological knowledge through idiosyncratic information (Willig & Stainton Rogers, 2017).

Smith et al. (2009) highlight the twofold phenomenological and hermeneutic framework underpinning IPA in asserting that ‘without the phenomenology, there would be nothing to
interpret; without the hermeneutics, the phenomenon would not be seen.’ (Smith et al., 2009, p. 37). Building on Husserl’s (1952, 1970) phenomenological fundamentals Heidegger (1962) further elucidated the duality of appearances (Smith, Flowers & Larkin, 2009). He theorised that both visible and hidden meanings necessitate attention during an interpretative process which is largely concerned with what is disguised. This involves examining any emergent meanings intrinsically linked with the latent phenomena.

Inherent to hermeneutic theory is the concept of the hermeneutic circle which addresses the dynamic association between the part and the whole. To comprehend any selected part, such as a nominated quote, it is essential to consider the whole, such as the entire transcript. In short, making sense of the whole requires an examination of all component parts. This conceptualisation reiterates the dynamic, iterative process of interpretation in IPA (Smith, Flowers & Larkin, 2012).

IPA is also concerned with the double hermeneutic (Smith & Osborn, 2008) in which analysis requires the researcher to make sense of individualised attempts to generate meaning from the experiential reality of participants (Smith & Osborn, 2008). IPA researchers are ever-mindful of their own particular biases, prejudices, assumptions and preoccupations, and aim to reflect on how they influence the inquiry (Willig & Stainton Rogers, 2017). In order to augment their understanding, they attempt to identify and offset undue influences by maintaining a questioning and dialectical stance.

IPA is dedicated to the comprehensive examination of the individual case (Smith, Flowers & Larkin, 2009) and is therefore resolutely idiographic. This approach to data collection enables the researcher to assume a flexible style which permits participants to share unanticipated aspects of their experiences (Willig, 2013). A further strength of IPA is the potential to derive original concepts or unearth associations not yet considered in existing theories (Brocki & Wearden, 2006).

3.3.3 Research Design and Present Study

The current pilot study applied a qualitative research design to the investigation (Willig & Stainton Rogers, 2017). Parents from four different groups who had completed the COS-P were invited to participate in one-to-one semi-structured interviews. Qualitative data was collected at the post-intervention timepoint only.
3.4 Sampling

3.4.1 Method of sampling

The present qualitative research study used a purposive and homogenous approach to sampling. Thus, in effect, only participants who could provide insight into the specific phenomena being explored were considered for selection (Smith, Flowers & Larkin, 2012). Participants were invited to take part on condition that they had been identified as suitable for the group by a clinician and had self-nominated to attend a group delivery of COS-P at one of the designated study sites in spring 2017.

3.4.2 Sample Size

The strength of an IPA investigation is measured by the quality of the revelations of the phenomena that it provides (Smith & Osborn, 2008). Smaller sample sizes are held to yield more detailed analysis of each individual experience, and thus facilitating a review of the parallels and divergences amongst cases (Smith, Flowers & Larkin, 2012). To this end, a sample size of between four and 10 participants is deemed appropriate for IPA studies (Smith et al., 2009; Smith & Osborn, 2008), and six to eight participants are considered sufficient for clinical doctoral research (Turpin et al., 1997).

The current study, therefore, sought to recruit 10 participants for semi-structured interview. While 11 participants provided initial consent, two withdrew prior to the interview, and the remaining nine comprised the ultimate interview dataset.

3.4.3 Eligibility Criteria

Parents’ were identified for participation in the COS-P in respect of reported difficulties with the perception of their child’s behaviour and/or a need for guidance in supporting their child’s emotional development. Participants were required to have attended a minimum of 80% of the COS-P sessions to be eligible for inclusion in the evaluation. Parents were also required to be over the age of 18 to participate. Participants believed to be unable to provide informed consent, diagnosed communication difficulties, or unable to speak fluent English, were deemed ineligible for inclusion the study.
3.5 Participants

3.5.1 Recruitment

Participants were recruited to the study between April 2017 and September 2017. All parents currently awaiting services at a CFCP service, a CP service and a CAMH service in the Midwest of Ireland were initially notified in writing approximately four weeks prior to the commencement of the COS-P intervention. The concurrent research project was outlined in this correspondence and accompanied by an information leaflet outlining the study in greater detail. See Appendices A, B and C for information leaflet and consent form.

Parents were requested to contact the service to express their interest in attending COS-P. Interested parents attended a pre-programme screening interview with a COS-P facilitator to determine the suitability of the intervention for their current needs. Parents were then invited to partake in the research during their pre-programme interview with the COS-P facilitators who were provided with a script to assist an explanation of the research.

3.5.2 Sample Characteristics

Parents who participated in the qualitative interviews (Table 3.2) consisted of one male and eight females between 32 and 49 years of age (mean = 37.1, SD = 5.8). The age of the target child ranged between four and nine (mean = 7.1, SD = 1.9), while the number of children in each family ranged between one and six (mean = 2.8, SD = 1.6).
Table 3.2 Participant Profiles: Semi-Structured Interviews

<table>
<thead>
<tr>
<th>Participant</th>
<th>Group</th>
<th>Age (years)</th>
<th>Sex</th>
<th>Ethnicity</th>
<th>Relationship status</th>
<th>Education</th>
<th>Employment Status</th>
<th>Age of child (years)</th>
<th>No. children</th>
<th>Sex (child)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ruth</td>
<td>1</td>
<td>49</td>
<td>F</td>
<td>WI</td>
<td>Single</td>
<td>Primary Level</td>
<td>Unemployed</td>
<td>9</td>
<td>(n=6)</td>
<td>M</td>
</tr>
<tr>
<td>Daisy</td>
<td>1</td>
<td>39</td>
<td>F</td>
<td>WI</td>
<td>Separated</td>
<td>Primary Level</td>
<td>Part-Time</td>
<td>8</td>
<td>(n=3)</td>
<td>M</td>
</tr>
<tr>
<td>Noelle</td>
<td>1</td>
<td>32</td>
<td>F</td>
<td>WI</td>
<td>Co-habiting</td>
<td>Leaving Cert</td>
<td>Homemaker</td>
<td>9</td>
<td>(n=2)</td>
<td>M</td>
</tr>
<tr>
<td>Caroline</td>
<td>2</td>
<td>32</td>
<td>F</td>
<td>WI</td>
<td>Widowed</td>
<td>Third Level</td>
<td>Homemaker</td>
<td>4</td>
<td>(n=2)</td>
<td>M</td>
</tr>
<tr>
<td>Martha</td>
<td>3</td>
<td>42</td>
<td>F</td>
<td>WO</td>
<td>Single</td>
<td>Third Level</td>
<td>Self-Employed</td>
<td>8</td>
<td>(n=2)</td>
<td>M</td>
</tr>
<tr>
<td>Harriet</td>
<td>3</td>
<td>38</td>
<td>F</td>
<td>WI</td>
<td>Married</td>
<td>Leaving Cert</td>
<td>Part-Time</td>
<td>7</td>
<td>(n=4)</td>
<td>M</td>
</tr>
<tr>
<td>Heather</td>
<td>4</td>
<td>33</td>
<td>F</td>
<td>WI</td>
<td>Single</td>
<td>Primary Level</td>
<td>Carer</td>
<td>4</td>
<td>(n=1)</td>
<td>F</td>
</tr>
<tr>
<td>Tina</td>
<td>4</td>
<td>32</td>
<td>F</td>
<td>WI</td>
<td>Single</td>
<td>Leaving Cert</td>
<td>Unemployed</td>
<td>7</td>
<td>(n=4)</td>
<td>M</td>
</tr>
<tr>
<td>Fergal</td>
<td>4</td>
<td>37</td>
<td>M</td>
<td>WI</td>
<td>Divorced</td>
<td>Third Level</td>
<td>Full-Time</td>
<td>8</td>
<td>(n=1)</td>
<td>M</td>
</tr>
</tbody>
</table>

†WI, White Irish; WO White Other.
3.6 The Circle of Security Parenting Programme (COS-P)

3.6.1 Intervention Description

The COS-P DVD manual (Cooper, Hoffman & Powell, 2009) contains eight treatment modules. Each chapter contains approximately 15 minutes of stock video excerpts which were viewed and discussed in each session. The video excerpts presented parent-child interactions, as well as reflections from previous COS-P participants (Cassidy et al., 2017). The video and intervention manual signpost where to pause, what to discuss, and how to assist parents to reflect on their own parenting. Each DVD chapter includes up to six recommended pauses in which the facilitator stops the recording and offers process questions or reviews the content. Handouts were also provided to the group (Horton & Murray, 2015). Table 3.3 (Appendix D) presents the weekly content and learning objectives.

3.6.2 Intervention Delivery Procedure

Eligible participants were assigned to one of the four COS-P intervention groups for the spring 2017 dissemination. The facilitators, who consisted of clinical psychologists, social workers and clinical nurses, had each completed the four-day COS-P training in September 2016. Each group was delivered weekly at the same time for nine weeks. The session lasted two hours, included a 15-minute break, and all participants were provided with relevant weekly handouts. One additional session was held to allow additional time to reflect on the content of “Rupture and Repair”.

3.7 Research Procedure

3.7.1 Data Collection: Semi-Structured Interviews

Individual semi-structured interviews were carried out with parents who had completed the programme. Nine participants were interviewed between one and 49 days post-intervention (mean = 21.6, SD = 16.9). These sessions took place at one sitting in private clinic rooms of participants’ preferred service locations and adhered to a predetermined interview schedule (Appendix K). The average interview length was 58.6 minutes (SD=10.6) and all interviews were audio-recorded and subsequently transcribed verbatim. To preserve participant anonymity and confidentiality all names were changed, and any personally identifiable information removed during the transcription process. Information concerning the interviews is shown in Table 3.4 (Appendix M). Reflective notes regularly recorded by the author for the duration of the study were referred to during analysis and the write up phase (Appendix L).
3.7.2 Interview Schedule

The schedule was devised using a dynamic, reiterative approach which entailed an examination of the prevailing literature and reflection. It was assessed by both academic and field supervisors to ensure the optimum elicitation of relevant data. A pilot study of three initial interviews was carried out in order to critically review the schedule and to become familiar with the interview format. Following the pilot, the schedule was reviewed during supervision. However, with the exception of certain minor adjustments to phraseology in consideration of participant responses and feedback, it remained largely unchanged. The schedule was not followed rigidly during the interviews, but rather functioned as a guide to reflection.

The schedule began with general descriptive questions in order to establish rapport and then progressed to more personal and investigative queries. Participants had been provided with the interview questions in advance of the interviews and in accordance with IPA guidance (Smith, Flowers & Larkin, 2009) the schedule incorporated several non-directive open-ended questions to explore participants’ experiences of COS-P. Participants were encouraged to reflect on any resultant changes in their perceptions, beliefs, feelings, and/or behaviours.

The author maintained a friendly and curious tone throughout the interview and where relevant, prompted participants to provide more detailed accounts of their personal insights. The author endeavoured to preserve flexibility throughout the interview by following the lead of interviewees. Participants were provided with the opportunity to ask questions and give feedback at the end of the interview and also given a verbal debrief by the author and a list of contacts for further support.
3.8 Data Analysis

Table 3:5 Overview of Qualitative Analysis Process

| Step 1: | **Immersion in the original data**: Listening to the audio recordings; reading and re-reading the transcript to ensure participant is the focus of the analysis. Bracketing of my recollections of the interview experience and my observations. Active engagement with the data through repeated reading, locating richer detail and/ contradictions. |
| Step 2: | **Examining semantic content and language use** by taking initial exploratory notes, remaining open-minded and noting anything of interest to gain familiarity with the transcript and understand how the participant talks about experiences. Comprehensive and detailed commentary on the data. Developing a description of the interviewees’ key concerns and the meaning given to them. Developing more interpretative commentary based on the language used, social context and abstract concepts (i.e. descriptive, linguistic and conceptual commentary and deconstruction). |
| Step 3: | **Detecting emergent themes**: Reducing the volume of data whilst preserving its complexity (mapping connections, relationships and patterns in exploratory notes). Analysing exploratory notes to identify themes (analysing the parts in relation to the whole and vice versa; hermeneutic circle). Involving the author’s central role in the analysis of the interviewees’ lived experience. |
| Step 4: | **Identifying connections between emergent themes (superordinate themes)**: Seeking a way to draw themes together to create a framework of the key aspects of the interviewees account. Patterns sought using abstraction, polarization, contextualization, numeration and function. |
| Step 5: | **Bracketing emergent ideas** from the first interview and through an idiographic approach carrying out steps 1-4 with each remaining case, treating each case in its own terms. |

(Adapted from Smith, Flowers & Larkin, 2009)
3.8.1 Qualitative Analysis of Semi-Structured Interviews

Qualitative data in the form of interview transcripts were analysed by the author following the IPA process as outlined by Smith and colleagues (2009) and detailed in Table 3.5. All audio files were carefully listened to, transcripts read and re-read on a case-by-case basis, and reflections recorded to gain familiarity with the data. Each interview was formatted in Microsoft Word according to the guidelines provided by Smith et al. (2009) with three columns created for emerging themes, original transcript, and exploratory comments (Appendix N). Moreover, the connections between the coded themes for each transcript were distinguished to generate a thematic framework for each interview. Overarching subordinate and superordinate themes were identified through comparisons of the thematic structures.

3.9 Assessment of Quality and Validity

Yardley’s criteria to establish trustworthiness and credibility in qualitative methodologies were applied as the recommended alternative to more traditionally prescriptive frameworks (Yardley, 2000).

3.9.1 Sensitivity to Context

Sensitivity to context was demonstrated in several ways throughout this study. The predominant commitment to the value of the idiosyncratic lived experience of participants shaped and permeated all aspects of the research design. The author ensured knowledgeability and familiarity with the key concepts of the IPA method prior to data collection. Awareness of the interactional nature of data collection within the interviews was also acknowledged. This was cautiously addressed throughout in the interview process by maintaining a reflective log of the interview process outlining how each participant presented and how the interview process was experienced by the author. Difficulties or ease in establishing rapport with each parent was acknowledged and efforts were made to mitigate obstacles. Both the methodology and underlying research remained closely engaged with all extant literature pertaining to COS-P at all times, while arguments were supported and contextualised by the accompaniment of verbatim excerpts during the write-up phase. A sample of the analytic process is outlined in Appendix N.
3.9.2 Commitment and Rigour

Considerable emphasis was placed on developing rapport and remaining alert to potential distress. In their role as the experiential expert, placing the participant at ease in order to glean how they made sense of their experience was deemed essential. Each participant’s unique presentation at the time of interview and the interview process was logged (Appendix M) and reflected upon during the analytic process. Each phase and branch of analysis was undertaken with particular adherence to the IPA guidelines and sufficient time was allocated for immersion in the data prior to drawing conclusions. Within the constraints of collecting ‘real-world’ data, and following discussions in supervision, every care was taken in the selection of a sample deemed suitable for the research question. The quality of the interview schedule was scrutinised through a process of piloting and reflection by the author and through discussion in supervision. A selection of codes and analyses were reviewed by the academic supervisor who, following discussion to ensure that the analysis remained close to the emerging phenomenon, confirmed the author’s final interpretations to be satisfactory. The thematic structure was similarly reviewed and agreed. Appropriate time was allocated to enable full immersion in collected data prior to deriving the final interpretations. The author attended additional academic workshops on Interpretative Phenomenological Analysis as well as consulting with peers engaged in IPA analytic research and academic supervision.

3.9.3 Transparency and Coherence

Transparency and coherence were largely demonstrated by providing a comprehensive account of the research process including recruitment, data collection, and analysis, while extracts from the analysis were also provided for review (Appendix N). Throughout the process, sustained efforts were made to maintain consistency between the research question and the epistemological basis of IPA, whilst remaining mindful of the philosophical rationale for combining methods. In addition, an independent peer audit of the data was carried out to evaluate the accuracy of the audio transcriptions and suitability of initial note-taking and coding, in addition to an examination of how faithfully the overarching themes represented the transcript. Issues pertaining to transparency and coherence were discussed in supervision during the analysis process. Further, the author maintained a reflective log over the course of the project to record personal motivations, biases, concerns and judgments in order to critically reflect on the research conducted.


3.9.4 Impact and Importance

Given the clear need for access to effective parenting supports nationally, psychology services in the Midwest would benefit from understanding what it is like, from the perspective of parents accessing their services, to receive intervention in the form of the under researched COS-P. The author aimed to illuminate the subjective lived experience of parents who have completed the COS-P, specifically in relation to underlying mechanisms of change. In response to the conspicuous lack of knowledge on what works for whom in the context of COS-P, the current research aims to address this disparity and inform future research. It is further envisioned that this research will serve as a starting point from which to gain an enhanced understanding of the COS-P programme from the perspective of parents.

3.9.5 Intervention Fidelity

Programme integrity was upheld by consistent adherence to the structured COS-P facilitator DVD Manual version 5.0 and COS materials, including supplemental handouts. Facilitators closely followed the specified goals and activities in the manual and maintained weekly reflective logs. Each group was led by a COS-P trained psychologist and co-facilitated by COS-P trained social worker or nursing staff. To safeguard both process and content fidelity, each of the facilitators also participated in regular supervision with a COS-P supervisor. This ensured that the intervention was delivered as intended. Group attendance was monitored, and action was taken to encourage attendance and introduction to all material. For instance, participants were telephoned to encourage attendance, and catch-up sessions were facilitated, and a weekly review of the previous week’s topics at the outset of each session was built in.

3.10 Ethical Considerations

Ethical approval for the present study was granted by the Health Service Executive (HSE) Mid-Western Regional Hospital Research Ethics Committee Limerick, Tusla Child and Family Agency (Appendix O), and from Clarecare (following HSE approval and ratification by the Board of Management). Participation was voluntary, and all participants were informed of their right to refuse or withdraw their consent at any time, whether prior to or during the research process and that such a decision would not adversely impact their participation in the group or the level of care received. Ethical concerns were continually monitored and reflected upon throughout the research process.
The potential for interviews to harm participants emotionally is noted in some research, however this is often set against potential therapeutic benefits. In the current investigation the author noted that participants consistently expressed appreciation for the opportunity to discuss their experiences of the COS-P after its completion. On reflection, and through discussion in supervision this phenomenon was understood as a beneficial opportunity for parents to consolidate and reflect on their learning from the programme as well as discussing their experience with a professional who was not directly involved in the COS-P, thus providing parents with a space to explore their experience freely.

3.10.1 Informed Consent

Participants for each treatment group were screened by a COS-P trained facilitator. During this screening process, the programme details were explained, and parents presented with the research information and a consent form outlining the nature of participation in the study. Participants were accepted into the study only upon submission of written informed consent. Consent was explained again in person at the time of the interview. Participants were also given the opportunity to contact the author or the relevant service at any stage during the research process.

3.10.2 Confidentiality and Anonymity

Confidentiality and anonymity were maintained by the allocation of unique pseudonyms to each participant. The author had sole access to the participant coding system. All identifying information concerning participants, children, named professionals, and locations were removed from transcripts. The pseudonymised paper data collected during both pre-and post-intervention phases was stored in a locked cabinet in a secure office at the main research site. Irrevocably anonymised computerised data, audio files, and audio transcripts were also stored for the duration of the project via secure Cloud Storage provided by the University of Limerick. The parameters of confidentiality ringfencing the safety of participants and children was explained both verbally and in writing. With the exception of a peer review to perform an impartial audit of analysis, transcripts were solely reviewed by the author. Certain segments of the transcripts were also viewed by the academic supervisor.
3.10.3 Potential Distress

The author was attentive to any signs of potential unease during data collection and participation. Interviews were conducted with sensitivity and respect and the author remained alert for indications of emotional distress. The protocol for managing distress in the context of interviews for this research was adapted from the Draucker and colleagues (2009) guidelines (Draucker, Martsolf & Poole, 2009) (Appendix P). As such, in the event of emotional discomfort, participants were offered the opportunity for breaks, to reschedule, or to withdraw. All participants were given a verbal debrief following their interview in addition to an information sheet outlining contact details for further support as required. In line with the limits of confidentiality explained prior to consenting to participate, staff teams were contacted in cases where psychometric measures flagged concerns and measures taken to ensure the safety of the individual and/or children involved.

3.11 Researcher Reflexivity

IPA recognises the role of the investigator in the interpretation of participant experience. As such, some degree of influence of the researcher’s interpretation on participant accounts is inevitable (Willig & Stainton Rogers, 2017). As IPA research is a dynamic activity, committed researchers strive to curb the influence of their position and biases in the dual process of data collection and analysis (Smith, Flowers & Larkin, 2012). Paradoxically, researcher beliefs both facilitate and constrain the quality of IPA analysis (Smith, 2004) and may thus influence each stage of the research (Berger, 2015). By openly acknowledging and noting personal biases and opinions through a reflective log, the potential impact of such influences is minimised.

The assumptions, estimations and beliefs afforded by the investigator can either inhibit or facilitate the quality of the analysis in IPA (Smith, 2004) and these factors can be influential in each phase of the research process (Berger, 2015). Explicit documentation and acknowledgement of the potential biases can assist in accounting for these influential factors during the data collection and analysis process.

As a thirty-five-year-old white middle-class woman, the author remained cognisant of her current stage of competence as a Psychologist in Clinical Training, her interest in the clinical application of attachment theory, and the potential impact of her personal values, preconceptions and opinions upon the research throughout the process (Yardley, 2000).

The author was particularly cognisant of her lack of personal experience of being a parent, in addition to her limited professional experience in relation to the delivery of attachment-based
parenting programmes, and as such any preconceptions regarding this population and these factors were noted.

To address this obstacle and ensure analytical transparency, a reflective log (Appendix L) was maintained. More specifically, to assist impartiality, the author did not personally partake in either the delivery of the COS-P groups or the facilitator training at any stage during the research process.

During research design, and as discussed in supervision, the author considered that this population may be difficult to engage in detailed discussion, and that interviews may need to be flexible to facilitate parents needs and time constraints and potentially occur over more than one session to safeguard comprehensive data collection. Every effort was made to accommodate parents needs in order to facilitate the interviews and ensure quality in the data collection process.

The authors’ personal interest in this investigation was enhanced following findings from a small-scale research study conducted within a child a family service (Gilhooly, 2016). Interviews with staff regarding the complexity of case presentations and the challenges to implementing therapeutic care highlighted the significance of the intergenerational transmission of attachment difficulties. Participants in that study highlighted that often parents have not been parented in a healthy way and unless they have an opportunity to address their own trauma, the intergenerational abuse continues and thus presents a considerable challenge for practitioners providing therapeutic input.

The authors’ curiosity into how parents presenting with their own attachment histories would experience and benefit from the COS-P may have influenced to some degree her application of IPA to the data. Thus, the author considered the steps taken to ensure trustworthiness and credibility as outlined in the sections above as fundamental to minimising the potential impact of such biases. Notably, IPA does not claim to present definitive participant accounts, rather it intimates analysis as dually constructed between participant and analysist (Osborn & Smith, 1998).

3.12 Subsidiary Quantitative Analysis

In addition to the qualitative investigation the current pilot study provided an opportunity to conduct an ancillary assessment of the feasibility of recruitment, randomisation, participant retention, assessment procedures and measures for future hypothesis testing studies. This subsidiary quantitative aspect of the study used a four-group repeated measures design.
Participants completed standardised psychometric questionnaires at baseline, post-intervention, and again, following a six-month interval to explore changes in parent perceptions, as illustrated in Figure 3.1.

![Figure 3:1 Subsidiary Quantitative Investigation Process](image)

### 3.12.1 Recruitment for Subsidiary Quantitative Investigation

Parents were invited to participate in either the qualitative or quantitative arm of the study, or in both. Parents of children on the service waiting list who had also been identified as suitable for subsequent dissemination of the COS-P were invited to partake in the waiting-list control group. For inclusion in the descriptive analysis, participants were required to have completed questionnaires at two timepoints.

Approximately 70 participants were contacted for participation in the intervention and control groups. Three COS-P groups in the Midwest were initially selected for the study and a fourth was subsequently approached to supplement the limited uptake from the original cohorts. As the fourth group had already commenced prior to confirmation of final ethical approval it was not possible for them to participate in the quantitative phase of data collection. Figure 3.2 provides an overview of participants through each stage of the investigation.
Thirty-five parents began the COS-P in spring 2017. Eight parents completed questionnaires at baseline, five post-COS-P, and a further two six months post-intervention. Thirty-five participants on the programme waiting list were requested to complete questionnaires for the control group, of whom just six agreed to take part. The remaining 29 declined participation in the research. Parents in groups three or four did not participate in the quantitative study.

Figure 3:2 Overview of Participants through each Stage of the Investigation
3.12.2 Sample Characteristics

Two male and six females from the COS-P intervention groups between 23 and 49 years of age (mean = 34.4, SD = 8.2) completed questionnaires at baseline. The age of the target child\(^2\) ranged between four and 13 (mean = 7.4, SD = 3.2). Participants for the Waiting List control group consisted of six females between 35 and 52 years of age (mean = 43.7, SD = 5.7). The age\(^3\) of the target child in the control group ranged between eight and 15 years (mean = 11.8, SD = 2.6). Further demographic information is presented in Table 3.6.

\(^2\) Target child is defined as the child the parent had in mind when starting the intervention.

\(^3\) In this study, middle childhood is defined as 4-11 years and adolescence is defined as 12-19 years, as per the centres for disease control and prevention (CDC) categorization.
### Table 3:6 Participant Demographic Profile for Questionnaire Data at Time 1

<table>
<thead>
<tr>
<th></th>
<th>COS-P (N=8)</th>
<th>Control (N=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parent Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>34.4 (8.2)</td>
<td>43.7 (5.7)</td>
</tr>
<tr>
<td>Median</td>
<td>33.5</td>
<td>43.5</td>
</tr>
<tr>
<td>Range</td>
<td>23-49</td>
<td>35-52</td>
</tr>
<tr>
<td><strong>Child Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>7.4 (3.2)</td>
<td>11.8 (2.6)</td>
</tr>
<tr>
<td>SD</td>
<td>8.0</td>
<td>12.0</td>
</tr>
<tr>
<td>Range</td>
<td>4-13</td>
<td>8-15</td>
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</tbody>
</table>

<table>
<thead>
<tr>
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<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
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</thead>
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<td>Male</td>
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<td>25.0</td>
<td>0</td>
<td>0.0</td>
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<tr>
<td>Female</td>
<td>6</td>
<td>75.0</td>
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<td>100.0</td>
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<th>%</th>
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<th>%</th>
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<td>Single</td>
<td>4</td>
<td>50.0</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>Married</td>
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<td>25.0</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>12.5</td>
<td>2</td>
<td>33.3</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>12.5</td>
<td>0</td>
<td>0.0</td>
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</table>

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<tr>
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<th>n</th>
<th>%</th>
<th>n</th>
<th>%</th>
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<td>25.0</td>
<td>0</td>
<td>0.0</td>
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<tr>
<td>Junior Certificate</td>
<td>1</td>
<td>12.5</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Leaving Certificate</td>
<td>3</td>
<td>37.5</td>
<td>3</td>
<td>50.0</td>
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<tr>
<td>Third Level</td>
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<td>25.0</td>
<td>3</td>
<td>50.0</td>
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</table>

<table>
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<tr>
<th><strong>Employment status</strong></th>
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<th>%</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
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<td>25.0</td>
<td>3</td>
<td>50.0</td>
</tr>
<tr>
<td>Homemaker</td>
<td>2</td>
<td>25.0</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td>Carer</td>
<td>1</td>
<td>12.5</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Part-Time</td>
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<td>25.0</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td>Full-Time</td>
<td>1</td>
<td>12.5</td>
<td>1</td>
<td>16.6</td>
</tr>
</tbody>
</table>
3.12.3 Description of Measures

3.12.3.1 Demographic Questions
A summary of the measures administered to the intervention and control group across the three timepoints is outlined in Table 3.7. Demographic questions are outlined in Appendix E.

Table 3:7 Measures for administration across times of testing (pre, post, and follow-up)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Time 1</th>
<th></th>
<th>Time 2</th>
<th></th>
<th>Time 3</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Intervention</td>
<td>Control</td>
<td>Intervention</td>
<td>Control</td>
<td>Intervention</td>
<td>Control</td>
</tr>
<tr>
<td>DQ</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRFQ</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>DERS</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>PHQ-9</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>SDQ</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Note: DQ = Demographic Questionnaire; PRFQ = Parental Reflective Functioning Questionnaire; PHQ-9 = The Patient Health Questionnaire-9; DERS = The Difficulties in Emotion Regulation Scale; SDQ = Strengths and Difficulties Questionnaire

3.12.3.2 Rationale for Self-Report Questionnaires
The quantitative study provided a means of exploring the validity of some of the core assumptions underlying COS-P, namely reflective functioning and emotional regulation capacities in addition to some of the potential moderating factors (e.g. maternal depression) and outcomes (e.g. perceptions of child behaviour). Following a review of the literature, four self-report measures were chosen for the study on the basis that they were, 1) freely available for use by practitioners without the requirement of additional permission costs and 2) demonstrated good reliability and validity, 3) corresponding with measures used in the quantitative investigations carried out with COS and COS-P to date. Details on the scoring method of each questionnaire are outlined in Table 3.8 (Appendix F and see Appendices G-J for a list of test items).

3.12.4 Quantitative Analysis of Self Report Measures
Paper and pencil data were scored, entered, and stored using the Statistical Package of the Social Sciences (SPSS), SPSS version 22 (IBM, 2013) for descriptive analysis. All data was further verified by checking the actual ranges against possible ranges prior to analysis.
3.12.5 Reliability of Psychometric Measures

Internal consistency reliability relates to how well each scale item reflects a common, underlying construct (Spector, 1992). This can be determined by calculating a Cronbach’s alpha coefficient (DeVellis, 2016). A Cronbach’s alpha value of .70 and greater is considered very good. However, Cronbach’s alpha values ranging between .65 and .70 are also acceptable (DeVellis, 2016). The Cronbach’s alpha coefficients for the measures used in this study are presented in Table 3.9.

Table 3:9 Reliability Analysis for Questionnaires Administered

<table>
<thead>
<tr>
<th>Scale</th>
<th>Subscale/Total Score</th>
<th>Cronbach’s Alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRFQ</td>
<td>Pre-Mentalizing Mode</td>
<td>.64</td>
</tr>
<tr>
<td></td>
<td>Certainty of Mental States</td>
<td>.64</td>
</tr>
<tr>
<td></td>
<td>Interest &amp; Curiosity in Mental States</td>
<td>.64</td>
</tr>
<tr>
<td>DERS</td>
<td>Total Score</td>
<td>.92</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>Depression</td>
<td>.83</td>
</tr>
<tr>
<td>SDQ</td>
<td>Total Difficulties</td>
<td>.45</td>
</tr>
</tbody>
</table>

Note: PRFQ = Parental Reflective Functioning Questionnaire; PHQ-9 = The Patient Health Questionnaire-9; DERS = The Difficulties in Emotion Regulation Scale; SDQ = Strengths and Difficulties Questionnaire

3.13 Conclusion

This chapter presented a comprehensive overview of the methodological design and approaches used. It highlighted several concerns regarding qualitative research, including trustworthiness and credibility, researcher reflexivity, issues of reliability and validity in quantitative research, and ethical concerns.
Chapter 4: Results

4.1 Chapter Overview

This chapter provides a detailed presentation of the findings from the qualitative investigation used to address the research question. Following extensive familiarisation with the interview data by means of listening, transcribing, reading, analysing, and collating, a number of significant themes surfaced from the nine interviews. In an effort to provide a coherent response to the principal research objective, these themes were then positioned within emergent mechanisms of change. The chapter closes with a review of the auxiliary quantitative findings.

4.2 Qualitative Analysis

4.2.1 Overview of Qualitative Analysis

In respect of the complex and multifaceted nature of the construct under review in this case of parent-child relationships, the qualitative findings are presented in detail. A dynamic, schematic representation of the superordinate and subordinate themes and the underlying mechanisms of change emerging from parent’s accounts of the programme are presented in Figure 4.1. This diagram illustrates the various mechanisms operating at the different levels, individual, facilitator, content and group, where change processes emerge within participant narratives for the superordinate and subordinate themes.

4.2.2 Presentation of Data

Illustrative data excerpts are presented to elucidate the participants’ accounts of their experiences. These are accompanied by the author’s analytical comments and reflections which serve to offer an interpretation of each emergent theme. Direct quotes are presented in italics. Locations and other identifiable data have been removed and denoted with this [symbol]. Names have been replaced with pseudonyms or [symbol]. A sequence of three dots within these excerpts is used to denote the removal of non-essential text. These technical changes have been systematically undertaken in order to facilitate greater clarity regarding the meaning of the presented quotations, to promote a sense of immersion in the participants’ experience which aids readability, and to ensure and maintain participant confidentiality at all times.

As the schematic representation of themes is a dynamic model, the interplay of content, individual, facilitator, and group factors are of critical importance throughout all themes. Mechanisms prevalent throughout the interviews indicate that change following COS-P occurs through at least ten interactive processes. These consist of: bringing emotions into awareness;
reactivating old memories; working with defences; experiencing the facilitator as a secure base; group cohesion; emotional regulation; reflective functioning; engaging in new emotional experiences; interpersonal learning; and, practicing a new way of behaving.
### Superordinate Themes

#### Theme 1: Seeking Help and Engaging with the Programme
- Struggling in the Parenting Role
- Social and Cultural Influences
- A Safe Space to Share Experiences

#### Theme 2: Learning to be Vulnerable
- Remembering Being Parented
- Sitting with Difficult Emotions
- Increasing Self-Awareness

#### Theme 3: Learning to Manage Emotions
- A Language to Describe Emotions
- Understanding 'shark music'
- Managing Emotions

#### Theme 4: An Improved Parent-Child Relationship
- Seeing the child in a new light
- Deeper connections
- Noticing Positive Change

#### Theme 5: A New Experience of Parenting
- An Improved Experience of Parenting
- Being 'a Good Enough Parent'
- A Sense of Hope for the Future

#### Theme 6: Evaluating the Experience
- A Positive Experience of Parent Training
- The Wider Relevance of COS-P
- Valued Content and Practicalities

### Subordinate Themes

**Mechanisms of Change operating in Themes 1-5**

- Working with defences; group cohesion; experiencing the facilitator as a secure base
- Reactivating old memories; interpersonal learning; bringing emotions into awareness
- Reflective functioning; emotional regulation; practicing a new way of behaving
- Engaging in new emotional experiences; practicing a new way of behaving; bringing emotions into awareness
- Practicing a new way of behaving; engaging in new emotional experiences

---

**Figure 4:1 Schematic Representation of Research Findings including Emergent Themes and Mechanisms of Change**
4.3 Overview of Qualitative Research Findings

Repeated examination of and sustained immersion in the interview data culminated in the detection of six dynamic superordinate themes.

The first of these themes is entitled ‘Seeking Help and Engaging with the Programme’. This refers to parents’ experiences prior to participating in COS-P, particularly their struggles with their parenting role, and other factors which influenced their ongoing engagement in the intervention. Participants’ conceptualisation of their experiences in terms of this theme could be attributed to a perceived inability to cope and a sense of isolation. Engagement was enhanced by the facilitators’ creation of a safe space and a sense of group togetherness in which parents felt they could share their struggles without fear or judgement. The social contexts wherein the participants in this study exist, and the perceived societal pressures permeating their experience, are addressed throughout this theme.

The second theme, entitled ‘Learning to be Vulnerable’ explores participants’ accounts of identifying and confronting their own defences and core sensitivities during the programme. Participants confided their experiences of revisiting attachment wounds during the process. Such reactivation of old memories was considered key to the entire transformational process and precipitated several changes for participants including an intensification of their emotional self-awareness and ability to cope with uncomfortable affective states.

The third theme of ‘Learning to Manage Emotions’ addresses participants’ accounts of finding a language to express their emotions and learning to reflect on the impact of their state of mind on that of their children. Significant developments in the acknowledgment of emotional trigger's and emotional regulation skills dominated this theme and will be discussed in detail in terms of the participants’ negotiation and explanations of these occurrences.

The fourth theme is entitled ‘An Improved Parent-Child Relationship’. As such, it examines participants’ perceptions of the changes in their relationship with their child. The fundamental experiences discussed through this theme include how participants began to see their children in a whole new way, as well as experiencing a deeper sense of connection with them. Parents changing perceptions of their children’s emotional and behaviour difficulties will be discussed. Theme five is designated ‘A New Experience of Parenting’ and focuses on the degree of the participants’ perceived personal growth in their parenting roles. The principle issues discussed in this theme include a shift in the perception of what it means to be ‘a good parent’, in addition to participants’ emergent sense of hope for the future following completion of the programme.
The theme considers how participants have developed an improved sense of agency in their parenting roles.

The sixth and final theme to be discussed is entitled ‘Evaluating the Experience’, and as the title would suggest, it engages with the participants’ overall appraisal of the COS-P. Key issues discussed in this section include the wider relevance of COS-P for these participants, in addition to valued content and practical aspects of the programme.

4.4 Theme 1: Seeking Help and Engaging with the Programme

Participants spoke at length about the significant challenges that predated their participation in COS-P. The meaning ascribed to these difficulties had, to a certain extent, become internalised by participants in their parenting roles and examination of the comments within the context of their stories draws attention to their significance. These challenges can be conceptualised as struggles within their role as a parent as well as individually attributed social prejudices, which while different for each parent, directly influenced their engagement with the programme.

4.4.1 Struggling in the Parenting Role

A common feature in participants’ narratives was the experience of struggling in their role as a parent. The following section will describe their struggles, outlining how they felt prior to the COS-P. The use of metaphors inferring that time was running out emerged in a number of participants’ narratives. This underscored the importance of the timing of the programme in the context of their lives and the sense that they had reached the limits of their ability to cope:

“I was at the end of my tether with him, my son, at that stage.”
(Caroline)

“It was like depression, anger, and everything was one big ticking time bomb...I was like, I just can't do this anymore. I can't be like this for her. I'm a mum, I'm a single parent. I need to step up.”
(Heather)

These powerful descriptions speak to the psychological battle that Heather and Caroline were experiencing in their parenting roles prior to participating in the programme. Their parental self-efficacy had been marred and they had reached a crisis point.

In her interview, Martha, a single mother, conveyed the sense of helplessness that had preceded her participation in the programme. She had spent a considerable length of time engaging with a variety of services in a desperate attempt to help her son:
“I was doing a lot of different things trying to help him and, em... it came along at a time when I was feeling... ah... a little bit... sort of... [pause... sigh] I guess, are we ever going to find a solution to this?”

Daisy spoke of the strength of her general emotional reaction to her child’s behaviour and her lack of confidence in her parenting ability:

“I would always come out in a sweat. I would always come out in a panic attack. Panicking. So, I would stop bringing him places, basically.”

Participants reported questioning themselves and their ability to cope with their child’s difficulties and gave voice to the inner turmoil that many suffered. For Heather this meant feeling “like a failure”, questioning her actions, and describing her emotional state as an obstacle to meeting her child’s needs. These images go at the heart of her struggle and the sense of uncertainty she carried at that time:

“What am I doing wrong? What am I doing? I think that was really holding me back, you know? I was feeling insecure towards her. It was like as a barrier between me and my daughter, and I couldn't understand her, and I couldn’t get that barrier to go down”.

Ruth spoke of her propensity for self-blame on hearing reports about her son:

“When you're told something about your child, yeah, and you go, straight off, what did I do? What did I do wrong?”

While others reported struggling with an ongoing sense of self-doubt:

“It’s something I struggle with constantly, like. Oh, my god, am I doing, do you know, the right thing? You’d often be like; could I do better? ... You'd be constantly questioning yourself, and especially when there is Autism or ADHD...”

(Noelle)

4.4.2 Social and Cultural Pressures

The influence of social and cultural pressures suffused the participant’s personal narratives. Participants relayed their expectations for the programme and how their incorrect presumptions about COS-P were contradicted early on.

Many addressed the impact of the pressure to be ‘the perfect parent’. Others spoke of feeling judged and of the stigma associated with seeking help. Since the majority of participants in this study are raising their children as single parents, the ramifications of parental status are discussed in light of emerging phenomena.

A number of the parents described their fears about the programme:

“Being honest with you, I was kind of afraid of doing a parenting course...terrified.”

(Tina)
Several participants assumed the programme would be concerned with limit-setting and disciplining their child, while some held the implicit fear of having their parenting skills judged. For Tina this meant:

“Parent courses - they’ve got to do with discipline...How to put them in time-out, and how to do this, and how to do that.”

Caroline shared these preconceptions:

“I felt that it’s going to be telling me now... ‘Oh, you’re parenting wrong’...which it wasn’t. It was completely different to what I thought it was going to be.”

The influence of social media and other sources of societal pressures relating to the idea of ‘the perfect parent’ were also evident throughout the interviews. Martha described the sense of bombardment she felt from these external pressures prior to participating in COS-P:

“It was overwhelming at times...because it’s on Facebook. It’s on the internet. It’s on TV. It’s in the movies, you know? It’s ‘[a] perfect life.”

She spoke of her experience as a single mother and how, despite her best efforts, she frequently felt pressure to be both mother and father to her children:

“Because I’m a single mom and I was feeling like I can’t do all of this. This is like...I felt, kind of, a little bit hopeless at that point and, em, I was beginning to be aware of the fact that, you know, that the only consistent thing in my son’s life is me.”

Fergal, a single father, spoke of his weariness of the ill-judgements he perceived in relation to enrolling on a parenting programme:

“They assume I'm bad dad or there's something wrong with [child]...Why are you doing that, like? And this is the problem...but that's just like, a societal thing...It's really frustrating.”

His repeated comments about being perceived as a bad father underscore how he had internalised much of the adverse societal inferences often suffered by single fathers and the guilt he carried because his son was without a mother. His comments echo his sense of how single fathers are often left voiceless and subjected to stereotyping and isolation:

“Most people, like, a lot of people that I tell as well, aren’t into the parenting or whatever, they may be more closed minded. The first thing they say is... they look at me and they assume there's something wrong with me.... They assume I'm a bad dad.”

These experiences have clear implications for parental engagement with the programme. The interviews confirmed the importance of patiently and consistently neutralising parents’ assumptions and preconceptions by fostering a non-judgemental ‘safe haven’ from the outset of the COS-P as a crucial step in the change process for all participants.
4.4.3 A Safe Space to Share

Participants spoke of a holding environment, in which they felt welcome, nurtured, and comfortable to impart their experiences. Participants educed their conceptualisation of this safe space by explaining the meanings they ascribed to their relationship with the group facilitators and other members of the group.

Heather is a single mother caring for a child with a suspected developmental disorder, as well as tending to her ailing parents. Her personal childhood narrative was dominated by exposure to her mother’s depression. In her interview she referred to her mother’s repeated suicide attempts, family conflict, her own intellectual disability, and her struggle to cope with her daughter’s behaviours. In the context of her family system, Heather likened the COS-P group to a refuge:

“It felt like an escape, you know? Well, not escape to be exact, but, you know, somewhere I could go and finally just breathe.”

During her interview Heather made several references to her positive impression of the facilitators:

“They were so open and honest...never judging from the minute we walked in that door to the minute we left. They were always so supportive.”

Participants described how the group facilitators made everyone feel comfortable and included:

“...they made you feel at ease, and the group we had, they were fantastic.”

(Ruth)

“They were very compassionate and nice, and, you know, the way they delivered it, they seem to...they gave everyone a chance to say their story. To apply the course to their lives, and their kids, and children.”

(Fergal)

There was an appreciation of the continuous provision of support from the facilitators, such as contact between sessions:

“She rang me after, and that was so, so nice of her. She spent about twenty minutes on the phone, and she was trying to get me to just speak about it...and that really helped.” (Noelle)

A predominant impression of support and safety within the groups characterised the participants’ narratives:
“At first you were there, and you were kind of quiet and... not knowing others in the room. Do you know? They were all chatting away, and you kind of got confidence then to open up.” (Tina)

Participants referred to feeling a connection with others in the group and a strong sense of cohesion:

“Everybody was very comfortable with each other.” (Daisy)

“A connection happened between us all.” (Ruth)

This feeling of being supported was echoed by Martha. For her, the connection within the group meant sharing a common goal despite individual differences:

“There were people around me that had different family dynamics...but we were all there in the same place trying to help our children. And it was the sense of support too from the group. I made connections with people, you know? That was really beneficial.”

Most participants found it reassuring to learn that other parents faced similar difficulties. This lessened their sense of isolation and feelings of inadequacy and further contributed to the sense of group cohesion:

“You felt, ‘I'm not the only one’. And for that two hours...it was like, it was just like a relief. You could talk, and no-one judged you.” (Harriet)

Participants also felt the benefit of having their own experiences normalised and reassured by the reminder that the ideals disseminated on social media seldom reflect the realities of actual parenthood:

“I think when you're in the group and you see that there are other parents who are going through similar stuff. It's not something people talk about. There's so many...I call them ‘the amazing Facebook moms’. You know, everything looks amazing and you've got all that...so it's nice to see that there are...other parents who are not 'amazing Facebook mums’.” (Daisy)

While their exact personal circumstances may have varied considerably, participants found that other parents’ histories resonated with their experiences and contributed to their sense of validation and cohesion and interpersonal learning:

“I won't say everyone was the same but as they were explaining their experience, you could understand where they were coming from. Like mine might not be identical but I could relate to what it was.” (Noelle)

“It was the other people. The other peoples’ stories. I was there, and I was...my God, I've had that!” (Ruth)
4.5 Theme 2: Learning to Embrace Vulnerability

This stage presents the participants’ experience of confronting emotions that they habitually defend against through the reactivation of old memories of significant childhood attachments. Through learning to sit with difficult emotions participants developed an enhanced awareness of their own state of mind, along with their positive intentionality as parents.

4.5.1 Remembering Being Parented

It was commonly acknowledged by interviewees that revisiting old childhood memories was one of the most challenging aspects of the programme:

“...going into my childhood...I found that very hard.” (Caroline)

“We had to go back to our own childhood. And that really definitely struck a bit of a chord.” (Daisy)

The desire to provide a different and better experience for their own children was widely expressed across the interviews:

“I found the hardest part of it...was thinking back in your own childhood. It was just stuff that you just did not want to remember...we do not want our kids to have the same.” (Ruth)

Participants spoke of the emotional toll of not being permitted to express their emotions as children:

“And that’s the biggest thing that I learned. Because I didn’t get that as a child. My mom was always like, ‘Toughen up’, ‘Stop crying’, ‘You’re fine’. Or you know, ‘Everything is ok, what are you worried about? What’s your problem?’ But I wasn’t feeling that and, so I didn’t feel like she understood. And so, I learned to...well...that bad feelings are not good and that we don’t share those. We don’t talk about those, you know. When you’re crying go away. Hide. Nobody wants to see you.” (Martha)

For Fergal, “there was things like shame” that wasn’t allowed be dealt with:

“...I was really ashamed to bring friends over to my house because my dad was fond of the drink and things.”

Despite the pain of revisiting these memories, participants alluded to the value of their reactivation:

“It made you see stuff that you weren’t willing to actually see.” (Ruth)
“It just triggered things in me ...it made me way more insightful.”
(Fergal)

“It was a really good exercise though. Because that was the start of, I guess the course, and the opening-up thing.”
(Fergal)

There was recognition of the benefits of discussing these painful attachment experiences within the context of the group for developing a more compassionate understanding of their own parent’s shortcomings:

“I always kind of had a grudge at my parents for my upbringing...and especially when I was talking and everyone else was giving their opinion [group and facilitators]...that they grew up in different times and that's all they knew... maybe that's a lot of the reason...you might not have been brought up in the way that you might have liked...”
(Noelle)

**4.5.2 Sitting with Difficult Emotions**

Participants recounted the challenge of having to tolerate difficult emotions during the group sessions.

Caroline explained that she:

“...felt like I'd been let down as child...Why wasn't that person there for me?”

She went on to describe the aftereffects of discussing this experience in the group:

“I was very tired. I found it very heavy...I had to go home and sleep. I was mentally... So much mental stuff...”

Similar experiences were recounted by several participants. Opening up to these painful feelings within the group brought Harriet to the realisation that she needed to explore them further through individual therapy:

“That was a big thing for me - dealing with all that emotion...It's still raw, like. I was saying to [facilitator] I'm going to go myself for counselling to talk about it.”

Others reported learning about how their child’s emotional needs made them uneasy and mirrored their own needs as children:

“The coming back in [on the circle] was so uncomfortable for me sometimes, because I didn’t have that support, that connection, that nurturing part with my mom, because my mom was emotionally overwhelmed.”
(Martha)

For Martha, sitting with difficult emotions allowed her to observe first-hand how challenging it was for the parents to open up and share their emotions with the group:
“I could feel their energy change and see how difficult it was...difficult for them to show emotion too. Difficult for them to cry in the group.”
(Martha)

Nevertheless, despite their obvious discomfort, participants agreed on the benefits of sharing their feelings with the group:

“As the weeks went on it got very kind of intimate...like...em, probably, like I said, I embarrassed myself a few times. Like, ‘Oh, did I just say that?’ Like, you know? [laughter] And I just said, ‘arra, feck it’. I know deep down that it’s healthy to get these things out.”
(Fergal)

4.5.3 Increasing Self-Awareness

Learning to be vulnerable in the group led to considerable changes in participants’ emotional awareness. Harriet particularly recalled a session where she was:

“...really upset and crying. The emotions came through about my mum, and I was like...that's when I realised that's why I am the way that I am.”

For Martha it meant she now understood why it was hard for her to accept either her own or her son’s emotions:

“I know how damaging it has been for me and how I’ve struggled with the negative emotions in my life. Always be strong and just do what you got a do, and I negate them or avoid them or stuff them down, and that’s not helpful...I was afraid to share my emotions because I never did with my mom...so it was a huge eye-opener.”

Participants also shed light on the relief which accompanies an increased awareness of the emotions that were prone to surface during their responses to their children:

“Awareness is the big thing...that you actually admit it and become aware of it. And then the problem starts to go away. Because you can acknowledge it. It’s not still this big fearful monster.”
(Fergal)

The process of revisiting painful childhood memories engendered many moments of realisation for the participants:

“I realised I'm trying to please everybody and to make everyone happy, and like, you don't have to be like that all the time. That was so clear. And I was like, ‘Oh my God. I should have seen this a long time ago’. And I hadn't.”
(Harriet)

Fergal interpreted this realisation to mean that in allowing himself to confront these difficult emotions, he could also do the same for his son:
“That’s one of the main things, ‘being with’ your feelings, because then when I saw what we were being recommended for the kids, like, and my son, ‘being with’ his feelings. Then I was like, that’s what we should do too...You’re not supposed to, you know, push things away or whatever.”

(Fergal)

In revisiting these painful recollections from the past participants become increasingly cognisant of how the defences which they had unknowingly erected to protect themselves from historic attachment wounds influence their relationships with their own children. This, in addition to working with defences and increasing emotional awareness, represents an important catalyst for change.

**4.6 Theme 3: Learning to Manage Emotions**

Parents benefited from having the opportunity to freely express their emotions in the safety of the group. Supporting the capacity to tolerate and regulate emotional experiences was a key mechanism in the change process. The developing emotional regulation skills emerging through participant narratives included identifying and labelling emotions, permitting and tolerating emotions, along with learning self-soothing techniques and breathing skills. The development of parental reflective functioning capacities is observed in this theme as the parents demonstrated their understanding of how their state of mind shapes their caregiving.

**4.6.1 A Language to Describe Emotions**

Another common feature amongst participants narratives involved the value they placed on being given words to describe the difficult emotions they were experiencing in response to their children’s expressed needs.

“I had a name for it.”

(Martha)

“...it's just easier with, with the words, do you know? The explanation of where they are on it [the circle].”

(Ruth)

As Fergal expressed it:

“I guess the programme kind of put words to it and simplified it. It's actually very helpful.”

When discussing his ‘shark music’, which he had likened to a traumatic experience, he emphasised how the intensity of his emotional response had diminished during the programme:

“At least I have a word for it now, and I can have a laugh, and kind of have a joke about it.”
Finally equipped with a language to voice their affective state of mind meant that parents were less inclined to become overwhelmed by their emotions, could attain more distance and perspective in relation to their feelings, and avail of the opportunity to reflect on them.

As Noelle clarified:

"It's like 'shark music'. Ah, that's one that I'm delighted I have the label for because, like, I would be a very anxious person. I do have a lot of anxiety."

She went on to explain that having a language meant that she could make sense of what was happening to her in response to her child’s needs:

"Like he was constantly miscuing. It wasn't just like one or two times a week...It's the fact that...I can put a label on it, that it makes sense."

For some parents having a language to describe their emotions meant that they could make different choices about their behaviour and regain a sense of agency in their parenting roles:

"I wouldn't have really picked up on that [miscuing]... It’s good to have a label ...you can go, ‘ok, I know now what to do here.’” (Ruth)

"That’s my shark music. I’m going to stop right now, and I’ve gotta set that aside and just be there for my son in this moment. And whether that means I have to go to my room and take a few breaths and relax and do that for myself before I help him then that’s what I need to do. Being able to just be conscious of that’s what was happening, and I can make a choice to change it.”

(Martha)

4.6.2 Understanding 'Shark Music'

The COS term, ‘shark music’ refers to the internal alarm which parents hear in response to the needs being expressed by their child. As such, ‘shark music’ represents the emotional reactions emanating from parents’ procedural memories and internal working models.

Many parents gave voice to the psychological power of these procedural memories on their current state of mind. Fergal likened his ‘shark music’ to a traumatic experience:

“I get kind of, 'shark music'. Do you know? Em...It’s associated with him and his welfare... It’s like PTSD or something. It’s horrendous.”

While every participant agreed on the concept and existence of ‘shark music’, the parents’ actual experience of this internal alarm was highly individuated and varied.

“I hadn’t noticed till they started saying it... That was your anger coming out.”

(Tina)
“...where I feel shark music and where I think my son feels the shark music... would be the same place...”
(Caroline)

It was clear from participant narratives that they had acquired a clearer understanding of the origins of these intense emotional reactions, a heightened awareness of when and how these reactions would be triggered, and how they could respond to their child’s needs differently:

“It’s nervousness...he definitely brings on my shark music. Very much so...but I mean, I’m learning how to, as I said, be a bit more prepared.”
(Daisy)

Harriet described her awareness of this internal signal and her willingness to tune into it:

“He was in and out of the bed like five times...I was like, okay, listen to my shark music.”
(Harriet)

Ruth noted:

“I found mine was anxiety. But it could be anger. And with anger, the child suffers. Anxiety...you could just turn either way. You could get weak, mean...But, if it's anger...you lash out and your child suffers.”

Martha revealed that her experience of ‘shark music’ brought her back to her own childhood when her mother could not meet her emotional needs:

“...automatically going back into the dynamic that I had as a child. My mom’s like, ‘I don’t have time for this...em, go away from me. Stop crying. I don’t want to hear this’. “

Although it was difficult to bring these procedural memories and defences into awareness the participants acknowledged that it was a worthwhile exercise:

“The best thing that I've learnt in the circle of security was the shark music...that so works because you can feel it. You can feel your anger starting to rise”
(Harriet)

4.6.3 Managing Emotions

Increasing emotional awareness and regulation was a common feature amongst participant narratives. Martha explained the value of this awareness and the dangers of not understanding the impact of a parent’s state of mind on a child’s emotional and behavioural functioning:

“As parents, we’ll give up our food for them, we’ll give up our last few euros to buy them something they want or need. But we aren’t aware that our emotional health is actually affecting them every day, and you don’t know how it’s doing that or how to change it. So, it brings about awareness, and how that single thing can do so much more than spending your last dollar.”
She went on to explain how she had learned to regulate her own emotions effectively and comfortably co-regulate her children’s’ needs:

“I had time to reflect and I had time to, you know, take a break, and take a minute and breathe in some cases, and you know, well, we don’t need to do that right now. We can just stop right here and manage this, and deal with it right now.”

A clear change in her perception of her ability to cope and manage her children’s affective states became evident:

“...by showing your children that we can be that for them they’ll always know that they can come to us when they are upset...”

When discussing her adult daughter, she emphasised her conviction in being able to support her emotional needs in the same way:

“I can be there for her in the same way without having to fix it for her. Without having to judge how she’s feeling, or tell her to be a different way, I can just hold the space for her and be there with her in that place.”

Tina noted that, as she began to feel different she observed a corollary change in her children:

“As I levelled out, the kids’ kinda levelled out with me...as the more relaxed I was getting, the kids were getting better.”

Daisy admitted that even with this new level of emotional awareness, regulating her emotions remained challenging. However, she did perceive certain changes in how she was dealing with her affective states:

“It sounds awful easy but it’s very hard. And I suppose I would just have been frustrated at not being able to figure out what was his need...So, I'm really kind of being more aware of that...I suppose trying to be more understanding... I'm trusting him, basically.”

Fergal underscored his improved understanding of his son’s emotional states and how in allowing both his son and himself to feel difficult emotions, he enabled greater tolerance of them:

“These little triggers. Then, the more I expose myself to those the easier it gets.”

“...recognise, you know like, when [child] was feeling sad he’s missing his mother and it’s just being there for a while, and then it goes away, no more than myself.”

Fergal went on to describe the positive effects he had observed as a result of his increased emotional awareness and regulation capacities:
“I learned when [child] is or has an attitude, or whatever, is looking for attention. It’s not. He’s not. He’s having trouble organising his feelings. If you sat down and relaxed and gave him time to chill out, he’s not angry, he’s not sad. He doesn’t kinda know...it might be a loneliness because he misses [step-sibling]... ‘being with’ him like, it’s so important. It has such a positive effect on him.”

His improved reflective capacities meant that he could clearly see the effect of his state of mind on his son and his ensuing emotional and behavioural difficulties. The concept of ‘gone’ for Fergal meant that he was preoccupied with a past relationship and unable to be present for his son:

“Once you’re aware of it, everything kinda just clicks into place. That first step of putting your hand up and saying, ‘yeah, I messed up. I was ‘gone’ that day’... [child] might have misbehaved or had an attitude that day but it’s not really attitude. It’s just because I was ‘gone’. My mind was elsewhere. I was upset and he’s picking up on it then."

The value of the programme content is substantiated in this theme and represents, along with increasing emotional regulation capacities and reflective functioning, a critical component of the change process. Although not explicit, the role of facilitators in teaching participants the COS-P content, thinking about their affective states and offering them words to describe their emotions coincides with the programme content in facilitating change.

4.7 Theme 4: An Enhanced Parent-Child Relationship

This theme outlines the observable changes described by parents following their participation in the programme. The extent of these changes is presented in the three subordinate themes of seeing their children in a new light, having deeper parent-child connections, and seeing positive emotional and behavioural changes in their children. A key change mechanism emerging from the interview data within this theme involved engaging in new emotional experiences.

4.7.1 Seeing the Child in a New Light

Participants elucidated that both during and after the programme they began to see their children in a new light. For Fergal, this meant a re-evaluation of his child’s need for proximity and comfort:

“I noticed that actually, he’s a very, very affectionate child.”

Noelle described how her perception of her children and their behaviours had undergone a change and how following COS-P she feels she can “help them better”:
“I’ve changed how I see them. Like I know now he’s not intentionally bold, and I know I have to factor in autism as well...Whereas prior to this I was just like, ‘Oh my God…how come I just can't get past this? It was just like a barrier. Whereas...I can maybe get past it now.”

Martha enthused that her son “shines now”. She went on to describe the sense of joy she has begun to experience in her relationship with him since putting the COS-P guidance into action:

“I remember so many times like watching my son in the last few months with just pure joy and I’ve never felt that before... It was a burden. It was hard, confusing, overwhelming but now... all of a sudden, I see how amazing he is because I can see he’s just a little boy and he’s learning, and he sees wonder, and joy, and even sadness and fear. They’re all good things. So, it’s been...a really eye opening and...and wondrous experience for me because I see him in a different light.”

Harriet agreed that she had also grown to like her daughter more:

“We’ve got a lot closer. I felt not that I disliked her but she just we just couldn't have a conversation. It was always an argument and it was very hard for me...if someone says to me of your children who do you dislike, or do you have less time for it would have been her...I felt really bad saying that, but it was the truth... I felt guilty saying it...but now I don’t have that for her anymore...I kind of understand now why she is the way that she is, and we can work through it.”

4.7.2 Deeper Parent-Child Connections

Participants’ narratives conveyed how their connections with their children had improved. Daisy reported, “things have improved between my son and myself”. As she went on to explain:

“...we're closer. Definitely yeah, we're having plenty of chats and we go for our walks together and stuff.”

For Tina, this improved connection with her daughter manifested itself as:

“...she’s kind of more interactive with me now than she was... lately, she’s been sitting down. She’s been talking away to me.”

Heather noted her daughter’s observation of the changes in their relationship:

“She said to me one day, ‘Mum, I was scared before but now I'm not anymore’. And I'm like, ‘Scared of what?’ And she was like, ‘You used to be very angry.’” I know [child], mummy has to be good’. And she's like, ‘Yeah, but I love the mummy now’.”

Participants confirmed how they are now delighting more in their children:

“I’ve learnt in it about being there for him, and ‘being with’ him, and delighting in him. That’s all happening now much better.”

(Martha)
Martha explained how much she appreciates this deepening connection with her son and acknowledged its importance:

“So many changes and, em, taking joy in the cuddles actually, and the connection. Whereas before when I first started, it was like, I just want time for me. But I have to do this because this is what he needs.”

Several participants characterised their child as increasingly affectionate and loving:

“He has got more affectionate, um, because that’s when I brought him here first... I just thought he had no emotions. He was just stiff... The kiss was just, and even when he holds it was just stiff, all this and whatever, and he was just sitting beside me. Now he wants to cuddle and when he gives me the hug, he gives me the proper hug...We've never had that before.”

(Ruth)

4.7.3 Positive Emotional and Behavioural Change

Participants depicted emotional and behavioural improvements in their children. Caroline, a widowed mother of two had struggled to manage her son’s behaviour in the wake of her husband’s death and the parent-child relationship had become fractured:

“It’s getting better, the relationship. He knows I’m there for him...my sister...she even noticed that he's not as clingy...that he can go out and explore...because [he]used to be ‘come on mammy, come with me now, now, now!’”

Heather observed:

“We haven't had a tantrum in so long. Oh my god, I can't remember the last time we did. It's so good.”

Fergal also reported that following COS-P:

“...there’s no strife. There’s no shouting. [child] was happier.”

He went on to enthusiastically explain that learning from the programme had had:

“...a really, really positive effect on him. He’s just happier.”

Indeed, many participants reported elevations in their children’s happiness:

“They seem to be way happier than they were.”

(Tina)

“I can see that my girl was getting that little bit happier then she was before.”

(Heather)

Heather happily reported that COS-P had helped both she and her daughter to achieve an important developmental milestone which up to that point they had struggled with:
“...and she's toilet-trained and all this, and she's made a huge change.”

Martha also saw positive changes:

“...he’s sleeping better, he’s happier, he’s hugging me more, he’s more content, em, you know, and again, like I said, he’s giving back to me.”

Harriet spoke of improvements in her daughter’s anxiety:

“Her moods, like, were so emotional. She was very OCD... like she had to have particular knickers... and that's not as bad now. She still might look for certain things, but it's not as bad.”

Fergal noted his son’s growing confidence:

“He gets more confident from spending time with me...productive time and not TV time... going for a walk in the woods with the dogs or building something together.”

Caroline added a sobering counterbalance to the majority of participants accounts of improvements in their children’s behaviours. While she acknowledged that some change had occurred, she stated:

“...he is getting a little bit easier, but he still has his bad days.”

However, she cited an example of when she had been both firm and kind in setting limits with him and noted the difference:

“He said, "I'm sorry mommy I shouldn't have done that’. That was a big step.”

4.8 Theme 5: A New Experience of Parenting

In addition to describing improvements in the parent-child relationship, participants recounted experiencing their role as a parent in a new and rewarding fashion.

The extent of this new experience is presented in the three subordinate themes of an improved experience of parenting, being a good enough parent, and having a sense of hope for the future. Important mechanisms for change revealed from participant narratives include improved emotional awareness, practicing a new way of behaving and engaging in new emotional experiences.
4.8.1 An Improved Experience of Parenting

Participants reported numerous significant transformations in their experience of parenting. Many described how they are availing of more quality time with their children since the programme:

“Yes! It's working! And now I'm... Before I used to get down on the floor and play around with her but now I'm, I'm doing it a lot more.”
(Heather)

“I'm doing more stuff with them as well. And lately, I have been doing a one-to-one with them.”
(Tina)

Tina and others gave an account of taking time to manage their own emotions differently:

“...before it was...[laughs]...what way would you put it...before I was kind of a bit stressed out and a bit panicky...how to do this and how to do that...and then as the course when on I was trying to be more relaxed with the kids as well.”

“As long as it's safe I would like, 'okay, I'll just take a couple of seconds [to] kind of gather in my thoughts and come back in again.”
(Noelle)

Participants also reported allowing more time to care for themselves:

“I noticed a lot since I've been doing the course that I have done things for myself. That I have changed an awful lot as well.”
(Tina)

Tina’s account demonstrated how she had learned to step back and consider how she had changed:

“I’m not as angry as much...em...you kind of notice it...you notice it then. You check your breathing and your time-out or whatever, and then you go can go back in calm...Instead of flying off the head, we’ll say your kind of more calmer cause you’d know what to do.”
(Tina)

Several parents cited improvements in their psychological well-being:

“...parenthood is a scary place. For me personally. I've been suffering from depression since I had her. This programme has a literally wiped that clean. I feel like, janey mac, the big problems are not so big anymore.”
(Heather)

“My ex-wife is coming next week to see [child’s name] for the first time in a few years. And em, do you know before I would have been all stressed out and worried. Now I’m not like... The course has even helped with that like. I’m able to...to be kind of relaxed.”
(Fergal)
“Normally in the summer when it's just before they get their holidays I'm starting panicking. And I was like, 'oh my god, it's all day every day, where we go... whose house can we... and em, I'm actually very. I'm really feeling very calm.”

(Daisy)

While many reported increased feelings of happiness since completing COS-P:

“Watching them. Knowing that it’s there...seeing them happy...Feeling happy, do you know?”

(Ruth)

For Fergal this meant:

“Life is easier, more fun... because like, parenting is way easier.”

He went on to state:

“I wake up in the morning and I’m really happy.”

4.8.2 Being a Good Enough Parent

Almost all participants expressed their immense relief at being able to shed the pressure to be the perfect parent:

For Harriet this meant:

“I feel like I don't have to be perfect all the time...I don't have to be this persona this perfect mum. Supermum.”

Indeed, the metaphor of having a weight lifted from their shoulders was used by several participants to illustrate the sense of liberation which the COS-P has afforded their parenting.

“It’s like a weight off my shoulders. You can kind of be yourself more. In a nice way. The course kind of helps you with that.”

(Fergal)

“I'm so glad that that feeling that I had has gone. It's like someone just lifted a load of bricks off you.”

(Harriet)

After one particularly tough session, Caroline reported:

“I felt like a weight has been lifted off me”

Others noted feeling more confident in their parenting roles:

“...going away you felt confident as a parent.”

(Harriet)

“As each week went on I started to feel a little bit more confident.”

(Heather)

Harriet described how she felt when she noticed COS-P was working for her and her children:
“It was great for me because I felt I’d done a great job because he, I mean, there was no bad words, there was no cross words, and it worked!”
(Harriet)

This improved self-belief was echoed by several others:

“In the course, it actually told you, there is no blame. There actually is no blame. You are allowed to take time-out. You don’t always have to be right...when you do wrong, you know you can come back and do it again... And you know you will get it right.”
(Ruth)

“...if you can just, you know, do your best a lot of the time. Basically, I’m going to take that on board.”
(Daisy)

The meaning that Martha ascribed from her experience on the programme meant that she had permission to be compassionate towards herself:

“So, by taking the course, there telling me it’s okay, you’re going to make mistakes, but to reflect on when that happens instead of beating yourself up...”
(Martha)

This kinder stance enabled her to feel more efficacious in her role as a single parent:

“I have the skills, I have the tools, I just need to, next time, do it a little bit different. And I felt empowered I guess.”
(Martha)

### 4.8.3 A Sense of Hope for the Future

Considering the knowledge they had gained from the programme, several parents alluded to a growing sense of hope for the future.

Participants emphasised their sense of relief at knowing that they could utilise what they have learned from COS-P to make positive changes in their relationship with any of their children, regardless of their age:

“And I figured out they're never too old...it really made me see it is never, never too late to work with your kids... I feel so relieved. I feel so good.”
(Ruth)

“...they were saying, you know, that it's never too late to start again...I was there for my little son, but I think some of the sessions really made sense for me for my older son.”
(Daisy)

For Martha this meant:

“You can make mistakes when they’re babies...but as the scars have been made you’ve got to work twice as hard to work back. But yeah...it doesn’t matter. It’s never too late.”
Not only did Martha share this feeling of relief that she too could be there for her adult daughter, but for her this meant that she had the power to positively impact future generations in her family and break the negative intergenerational patterns that had existed to this point:

“I feel like I’m at the precipice of changing not only my children’s lives, but their children’s lives, and their children after them, because your kids teach what they learn. So, if I can make changes it’s not just affecting me and them. It can be generations of people. And that’s exciting.”

Several important mechanisms of change, such as ER and RF, also noted in earlier themes permeate this superordinate theme. Most notably, change occurs on several overlapping elements pertaining to the facilitators, the group, the programme content as well as individual factors.

4.9 Theme 6: Evaluating the Experience

Each of the nine participants conveyed their immense satisfaction with the programme. Their appreciation of COS-P reflected the three domains of a positive experience of parenting training, the wider relevance of COS-P, and valued content and practicalities, which are discussed as follows.

4.9.1 A Positive Experience of Parenting Training

Participants volunteered exceptionally positive descriptions of the COS-P, describing the intervention as “amazing”, “healing”, “loving”, “inspiring” “life changing” and “helpful”. Numerous participants enthused that the programme has worked extremely effectively and provided a welcome solution to their difficulties.

For Martha it meant she had been provided with:

“...solutions or tools or different ways to interact with your children. Simple things.”

She went on to explain how she and other parents in the programme could freely discuss their progress within the safety of the group and delight in their achievements:

“We had time to practice them throughout the nine weeks, so we could share; ‘well, this is where I really struggled’, or ‘this is where I fell down’ and ‘I made mistakes this week’...this is where we had huge things happen...you know...it works!!”

Several participants spoke of participating in other parent training programmes in the past and how COS-P was such a different experience for them:

“I’d done a good few courses, like my son has ADHD, and my youngest son has autism... so even though they were beneficial at the time, em, they never kinda
focused on me as a person. Like how you help the child, how you overcome this, and this happens.” (Noelle)

A common thread amongst participants was the desire to share the knowledge and learning from the programme with others and a belief that more parents should complete the COS-P.

“I really and truly think it should be compulsory. As young parents, it should be compulsory. I really do feel that strongly about it.”

(Ruth)

“I would recommend that it's rolled out more, definitely. I would definitely recommend other people to do it.”

(Harriet)

“If I ever have more kids like I’d be back... and, and even at work I tell everyone about it”

(Fergal)

Others commented how they began making recommendations to friends and family members as the programme progressed:

“...sharing it and telling other people. Like not telling people, ‘this is how you parent’, just tips that I have learnt from it.”

(Caroline)

“I found myself thinking about my friends who have children ...and sharing the information that I had with them.”

(Martha)

4.9.2 The Wider Relevance of COS-P

Many participants alluded to the wider relevance of the programme beyond that of the intended parent-child relationship. For example, while each parent started the group with one target child in mind, participants reported bringing their learning into their relationships with each of their children, regardless of their age.

“I felt that this programme could relate to all children of all ages which a lot of parenting programmes don't gear towards the whole family.”

(Daisy)

In doing the COS-P Ruth noted that participants:

“…are thinking of all the kids, it's not just the one.”

Three of the nine interviewed participants reported having at least one child with a developmental disorder and a further three parents reported having at least one child for whom a developmental disorder diagnosis was being considered or were undergoing assessment. These parents purported that the COS-P provided sufficient support for their level of difficulties as well as typically developing children.
“I do think it applies to all children not just kids with special needs or extra needs.”
(Noelle)

4.9.3 Valued Content and Practicalities

When considering the programme content, participants described their satisfaction with the ease of understanding the material and how the COS-P principles were delivered in the form of practical advice:

“It’s encompassing all this broad complex thing that we are, and all our emotions and all that, and it’s simplifying it into practical stuff that works.”
(Fergal)

Although the terminology was initially difficult to grasp for some, once the concepts were explained participants reported that the programme jargon was very accessible:

“Some of the lingo at the start was difficult for us...not to understand, but it was just because it’s very Americanised. Certain things were like...do you know, ‘filling your cup’? Once it was explained, you understood, and I found the leaflets were great.”
(Harriet)

Several parents reported using the COS terminology on a regular basis to aid their parenting practice both within and outside of the group setting. When promoting the programme to her friends Caroline reported how she attempting to live by the COS-P principles:

“I was a bigger, stronger, wiser, kinder...this is my new mantra.”
(Caroline)

Several parents remarked on the suitability of the group size with a number asserting that the smaller, more intimate groups were of benefit to them:

“I just thought the group size was perfect.”
(Daisy)

“I had a lot more confidence to talk when it was just the smaller group [than] in the larger group.”
(Heather)

Caroline offered a unique comment on the inclusion of couples in the group and noticed the difference when they withdrew:

“I don't think it works for couples because they're ...trying to match up their stories...they should be in two different classes....”

She further stated her preference for homogeneity:

“It actually felt better because...they were single mothers...dealing with the same age children.”
Several parents commented on the usefulness of DVD materials to explain some of the key concepts of the programme:

“…the DVD’s…em…I really found the snapshots of the families, like the parents and their children, very interesting.”
(Martha)

“…the DVDs struck a chord.”
(Noelle)

Others reported the benefits of being given materials to take away:

“…they gave us little notes each week, like handouts and different things, ..., which was great.”
(Harriet)

On the other hand, others suggested providing materials that were more practical and appealing:

“…not just a brown folder to put it in. Like a book that you actually put it in that has a cover on it cause brown folders just get turfed. So, it’s something that people will look at and go, ‘oh, I’ll look through that.’”
(Martha)

**Critical Reflection**

I found myself taken somewhat aback by the overwhelming positivity towards the programme. This was compounded by the number of participants who stated that COS-P applies to all relationships, wished they had known the COS-P principles years ago, and how they fervently believed that everybody should take this programme starting in secondary school. Even with further probing participants did not provide feedback to suggest that it was unhelpful or problematic. One parent reported that her child’s behaviours had only improved somewhat, however her perception of these behaviours and her child had improved. The inclusion of parents who withdrew earlier in the intervention process may provide greater insight as to the less favourable aspects of the programme.
4.10 Descriptive Statistics for Self-Report Measures

Data from the four intervention groups were clustered, and only cases wherein time one and two data were available were included in the descriptive analysis. Inferences were not extrapolated from the quantitative data due to the small sample size and because the investigation functioned as a pilot study. Table 3.8 (Appendix F) presents details of the scoring and interpretative processes for each measure. The descriptive analysis of parental depressive symptoms and parent perceptions of child behaviour is presented in Table 4.1. Descriptive analysis of parental reflective functioning and emotional regulation is presented in Table 4.2.
Table 4:1 Descriptive Statistics of Outcome Measures for Parental Depressive Symptoms and Perceptions of Child Behaviour at Time 1, 2 & 3

<table>
<thead>
<tr>
<th>Group</th>
<th>Participant</th>
<th>Parent</th>
<th>PHQ-9_T1</th>
<th>PHQ-9_T2</th>
<th>PHQ-9_T3</th>
<th>Child</th>
<th>SDQ_T1</th>
<th>SDQ_T2</th>
<th>SDQ_T3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Age</td>
<td>(n=5)</td>
<td>(n=5)</td>
<td>(n=2)</td>
<td>Age</td>
<td>(n=5)</td>
<td>(n=5)</td>
<td>(n=2)</td>
</tr>
<tr>
<td>COS-P</td>
<td>1†</td>
<td>32</td>
<td>Mod.</td>
<td>Moderate</td>
<td>Severe</td>
<td>4</td>
<td>Very High</td>
<td>Very High</td>
<td>Very High</td>
</tr>
<tr>
<td>COS-P</td>
<td>2†</td>
<td>49</td>
<td>Moderate</td>
<td>Mild</td>
<td>Mild</td>
<td>9</td>
<td>Average</td>
<td>Average</td>
<td>Average</td>
</tr>
<tr>
<td>COS-P</td>
<td>3†</td>
<td>39</td>
<td>Minimal</td>
<td>Mild</td>
<td>-</td>
<td>8</td>
<td>High</td>
<td>Very High</td>
<td>-</td>
</tr>
<tr>
<td>COS-P</td>
<td>4†</td>
<td>32</td>
<td>Mild</td>
<td>Moderate</td>
<td>-</td>
<td>9</td>
<td>Very High</td>
<td>Very High</td>
<td>-</td>
</tr>
<tr>
<td>COS-P</td>
<td>5</td>
<td>39</td>
<td>Moderate</td>
<td>Minimal</td>
<td>-</td>
<td>8</td>
<td>Very High</td>
<td>High</td>
<td>-</td>
</tr>
</tbody>
</table>

Median
Mean
SD
Range

<table>
<thead>
<tr>
<th>Group</th>
<th>Participant</th>
<th>Parent</th>
<th>PHQ-9_T1</th>
<th>PHQ-9_T2</th>
<th>PHQ-9_T3</th>
<th>Child</th>
<th>SDQ_T1</th>
<th>SDQ_T2</th>
<th>SDQ_T3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Age</td>
<td>(n=3)</td>
<td>(n=3)</td>
<td>(n=3)</td>
<td>Age</td>
<td>(n=3)</td>
<td>(n=3)</td>
<td>(n=3)</td>
</tr>
<tr>
<td>Control</td>
<td>9</td>
<td>41</td>
<td>Minimal</td>
<td>Minimal</td>
<td>-</td>
<td>15</td>
<td>Average</td>
<td>Raised</td>
<td>-</td>
</tr>
<tr>
<td>Control</td>
<td>10</td>
<td>47</td>
<td>Minimal</td>
<td>Minimal</td>
<td>-</td>
<td>12</td>
<td>Raised</td>
<td>Raised</td>
<td>-</td>
</tr>
<tr>
<td>Control</td>
<td>11</td>
<td>43</td>
<td>Minimal</td>
<td>Minimal</td>
<td>-</td>
<td>12</td>
<td>Very High</td>
<td>Very High</td>
<td>-</td>
</tr>
</tbody>
</table>

Median
Mean
SD
Range

*Group: CP= Participants assigned to a COS-P group; WL=Participants on the waiting list of the COS-P group. †Participants that completed both quantitative and qualitative arms of the study. **WI, White Irish; WO White Other. §NC: not completed. PHQ-9 scoring classification: 0-4=Minimal Depression; 5-9=Mild Depression; 10-14=Moderate Depression; 15-19=Moderately Severe Depression; 20-27=Severe Depression. SDQ scoring classification for total difficulties:0-13=close to average,14-16=slightly raised 17-19=high and 20-40=very high.
Table 4:2 Means of COS-P and Control Groups at Times 1, 2 & 3 for Parental Reflective Functioning and Emotional Regulation

<table>
<thead>
<tr>
<th></th>
<th>COS-P</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T1 (N=5)</td>
<td>T2 (N=5)</td>
</tr>
<tr>
<td>PRFQ - Pre-mentalizing – (potential range 12-36)</td>
<td>Mean</td>
<td>14.8</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>7.2</td>
</tr>
<tr>
<td></td>
<td>Median Range</td>
<td>16.0 (7-25)</td>
</tr>
<tr>
<td>PRFQ – Certainty - (potential range 12-36)</td>
<td>Mean</td>
<td>18.2</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>4.0</td>
</tr>
<tr>
<td></td>
<td>Median Range</td>
<td>19.0 (14-22)</td>
</tr>
<tr>
<td>PRFQ - Interest and Curiosity – (potential range 6-42)</td>
<td>Mean</td>
<td>34.8</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>6.6</td>
</tr>
<tr>
<td></td>
<td>Median Range</td>
<td>36.0 (24-41)</td>
</tr>
<tr>
<td>DERS – Total – (potential range (36-180)</td>
<td>Mean</td>
<td>98.2</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>24.6</td>
</tr>
<tr>
<td></td>
<td>Median Range</td>
<td>94.0 (75-138)</td>
</tr>
</tbody>
</table>

Note: T1 = Pre-treatment. T2 = Post-treatment, 6 weeks after T1. T3 = Six months follow-up. Mid-range scores on PRFQ subscales = 24.
4.11 Integration of Qualitative and Quantitative Findings

Analysis of the combined quantitative measures with the qualitative interviews was the final component of the subsidiary quantitative analysis. Tables 4.3 and 4.4 provide illustrative examples of the integration of findings for the four participants who completed questionnaires in addition to the semi-structured interviews. Examples of divergent and corroborative findings for each measure are presented.
### Table 4: Illustration of Integration of Qualitative and Quantitative Findings

<table>
<thead>
<tr>
<th></th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>Description of Quantitative Outcome</th>
<th>Qualitative Theme and Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Caroline</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PRFQ Prem</td>
<td>25</td>
<td>19</td>
<td>15</td>
<td>Improvement consistent with interview data.</td>
<td><strong>Subtheme: Understanding 'Shark Music'</strong></td>
</tr>
<tr>
<td>PRFQ Certainty</td>
<td>14</td>
<td>28</td>
<td>23</td>
<td>Deterioration not consistent with interview data.</td>
<td>“where I feel shark music and where I think my son feels the shark music... Would be the same place”</td>
</tr>
<tr>
<td>PRFQ Curiosity</td>
<td>41</td>
<td>37</td>
<td>31</td>
<td>Deterioration not consistent with interview data.</td>
<td><strong>Subtheme: Managing Emotions</strong></td>
</tr>
<tr>
<td>DERS</td>
<td>138</td>
<td>124</td>
<td>91</td>
<td>Improvement consistent with interview data.</td>
<td>“the COS thing has got me thinking more about the way I was parenting. I was rupturing too fast and there was no repair. So now if he ruptures I know that I have to repair it and get back on the circle.”</td>
</tr>
</tbody>
</table>

| **Ruth** |    |    |    |                                     |                                          |
| PRFQ Prem | 9  | 18 | 15 | Improvement consistent with interview data. | **Subtheme: Understanding 'Shark Music'** |
| PRFQ Certainty | 22 | 15 | 25 | Deterioration not consistent with interview data. | “I found mine was anxiety. But it could be anger. And with anger, the child suffers. Anxiety...you could just turn either way. You could get weak, mean...But, if it's anger...you lash out and your child suffers.” |
| PRFQ Curiosity | 39 | 36 | 33 | Improvement consistent with interview data. | **Subtheme: Managing Emotions** |
| DERS | 82 | 106 | 96 | Deterioration not consistent with interview data. | “what I found was...that I find it's time to step back. Take time out. And when you take your time out and you come back now are you feeling um, calmer, so I can deal with the situation” |

T1 = Pre-treatment. T2 = Post-treatment, 6 weeks after T1. T3 = Six months follow-up. Mid-range scores on PRFQ subscales = 24. PHQ-9 scoring classification: 0-4=Minimal Depression; 5-9=Mild Depression; 10-14=Moderate Depression; 15-19=Moderately Severe Depression; 20-27=Severe Depression. SDQ scoring classification for total difficulties:0–13=close to average, 14–16=slightly raised 17-19=high and 20–40=very high.
<table>
<thead>
<tr>
<th>T1</th>
<th>T2</th>
<th>T3</th>
<th>Description of Quantitative Outcome</th>
<th>Qualitative Theme and Illustrative Quote</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Daisy**

|PRFQ| Prem| 17  | 14   | Improvement consistent with interview data. |

Subtheme: Understanding 'Shark Music'

|PRFQ| Certainty| 19  | 19   | No change. Consistent with interview data. |

“it's nervousness...he definitely brings on my shark music, very much so...but I mean, I'm learning how to, as I said be a bit more prepared”

Subtheme: Managing Emotions

|PRFQ| Curiosity| 24  | 31   | Improvement consistent with interview data. |

“I'm calmer because I just feel that I'll just stop and let them say what they need to say”

Subtheme: Managing Emotions

|DERS| 75  | 71  | Improvement consistent with interview data. |

**Noelle**

|PRFQ| Prem| 7   | 9    | Deterioration not consistent with interview data. |

Subtheme: Understanding 'Shark Music'

|PRFQ| Certainty| 22  | 27   | Deterioration not consistent with interview data. |

“you need to be in control and strong to get your point across and to be kind as well...not to go out and intentionally hurt their feelings. So yeah that one was another one that struck a chord because I know...I'm constantly going from one way to the other”

Subtheme: Managing Emotions

|PRFQ| Curiosity| 36  | 37   | Minimal change. Consistent with interview data. |

Subtheme: Managing Emotions

|DERS| “if you go out and come back in again, you have kind of calmed down, they've calmed down even a little bit and you kind of coming in with the new head” |

T1 = Pre-treatment. T2 = Post-treatment, 6 weeks after T1. T3 = Six months follow-up. Mid-range scores on PRFQ subscales = 24. PHQ-9 scoring classification: 0-4=Minimal Depression; 5-9=Mild Depression; 10-14=Moderate Depression; 15-19=Moderately Severe Depression; 20-27=Severe Depression. SDQ scoring classification for total difficulties: 0–13=close to average, 14–16=slightly raised 17–19=high and 20–40=very high.
4.12 Chapter Summary
Participants in this study encountered considerable changes both emotionally and within their parenting practices following COS-P. Their experiences were conceptualised within emergent mechanisms of change and reflected throughout participant narratives. Affective change occurred within the context of the programme content, individual, group, and facilitator factors. Six themes have been discussed in detail and illustrated with direct quotations. High levels of consistency between participant experiences are noted with some diversity in the individual meaning making of particular phenomena. The current findings will be considered in relation to previous literature in the concluding chapter.
Chapter 5: Discussion

5.1 Chapter Introduction

This concluding chapter presents a critical account of the enquiry’s principal findings positioned within the extant literature discussed in Chapter Two. The unique contributions of the present study are elucidated. Consideration of the study’s methodological strengths and weaknesses, and the author’s critical reflections on the research enquiry will also be addressed. Clinical practice and policy implications will be considered together with recommendations for future research. The chapter concludes with a summary of the study.

5.2 Summary of Qualitative Findings

5.2.1 Theme 1: Seeking Help and Engaging with the Programme

Each participant provided a rich account of their experiences in their parenting roles prior to their participation in COS-P and illuminated elements of the programme which maintained their ongoing engagement. The acknowledgment of struggling in the parenting role, feeling supported in the group, and social and cultural influences were not unique to this study, with comparable experiences conveyed in several studies (Kane et al., 2007; Mytton et al., 2014). Nevertheless, although the importance of the interventionist is acknowledged in PT research (Holtrop et al., 2014), experiencing the facilitators as a secure base is understated in the literature.

In their qualitative synthesis, Kane et al. (2007) demonstrated that parents often feel helpless and ill-equipped to cope with their children’s behaviours prior to completing PT (Kane et al., 2007). In addition to the potential stigmatisation, the current study reiterates findings that PT participants often fear being perceived as an inadequate parent (Mytton et al., 2014). The notion of feeling supported and accepted by other group members is widely referenced in the literature (Kane et al., 2007). Vella et al. (2015) particularly noted how parents valued the experience of social support and containment, while Holtrop and colleagues (2014) emphasised the role of the facilitator as a key element in the process of change. Similar to the current findings, Jonsditter and Coyne (2016) reported that witnessing the intervention process for others may provide a meaningful learning experience for parents, even if the other parents’ circumstances do not directly match their own.

The facilitation of a secure base and group cohesion from the outset were considered particularly important mechanisms of change in the current study. Facilitators provided
participants with security through a sensitive, non-judgemental, and compassionate approach which may have been deficient in previous interpersonal experiences. Sharing personal experiences and struggles within the group afforded opportunities for interpersonal learning and normalisation of their struggles.

5.2.2 Theme 2: Learning to Embrace Vulnerability

Participant narratives within this theme featured dialogue on learning to embrace their vulnerabilities through reflecting on their own upbringing, learning to sit with difficult emotions within the group, and developing their emotional awareness. Reactivating old attachment memories laid the foundations for rehabilitating prior emotional experiences and appeared to act as another key component of the change process. This reconsolidation of old memories with new experiences entailed the incorporation of new affective events developed within the group which were later reinforced through interactions with their children.

Within the confines of the literature review, this theme and subthemes are exclusive to a particularly narrow selection of selection of COS studies. Current findings mirror those of Horton (2013) whereby parents demonstrated increased awareness of the connection between their emotional states and personal attachment histories following COS-P.

5.2.3 Theme 3: Learning to Manage Emotions

Participant narratives within the third theme were principally centred on the provision of a language to describe emotions, learning to manage their own and their children’s affective experiences, and forming a deeper understanding of their emotional triggers through the metaphor of ‘shark music’.

Analysis of the interview data underlined the perception that the facilitators, along with the programme content, aided the development of RF by assisting the articulation of parents’ unspoken affect, nurturing participants’ understanding of the emotions that may underlie behaviours, demonstrating that others’, in particular, their children’s, internal experiences may contrast with their own and may not be immediately comprehensible, as well as fostering moment-to-moment interpersonal feedback within the group (Marmarosh & Tasca, 2013; Tasca et al., 2011). Participants interviews were peppered with accounts of improved sensitive responsiveness.
The limited body of research available is consistent with the current findings. In alignment with a study undertaken by Vella et al. (2015) participants engaged in more empathic and reflective interactions with their children following the PT intervention. Indeed, an enriched capacity for empathy following COS-P was also observed in parents by Kimmel et al. (2016) and Horton (2013). Kimmel et al. (2016) also revealed improved caregiver sensitivity and understanding of their child’s behaviour in their investigation of COS-P. Moreover, in their adapted version of COS, Lee et al. (2010) observed a particular increase in mothers’ awareness, responsiveness and sensitivity. Nevertheless, the value of having a language to voice their difficult emotions is not explicitly acknowledged in the available body of COS or PT research and represents a unique finding within the current investigation.

5.2.4 Theme 4: An Enhanced Parent-Child Relationship

Participant narratives illustrated the positive changes they had noticed in their relationship with their children following COS-P. These significant transformations included seeing their child in a new light, developing a deeper connection with their child, and noticing positive emotional and behavioural changes. Another important change mechanism emerging from the interview data within this theme involved parents engaging in new emotional experiences with their children.

Similar to the findings of Vella et al. (2015) and common to many forms of PT, participants illustrated their observations of emotional and behavioural improvements in their children. Notably, such improvements have proved difficult to capture within the available quantitative investigations of COS-P (Cassidy et al., 2017).

Participants improved perceptions of and connection with their children represent a distinctive finding within the existing qualitative investigations of COS. These accounts support one of the core COS-P objectives to reduce negative parental attributions. Analysis of the interview data revealed that following COS-P parents were able to separate ‘the child’ from ‘the behaviour’. Participants no longer viewed their children as ‘bold’ or ‘attention seeking’, instead seeing their behaviours as an expression of a relational need.

5.2.5 Theme 5: A New Experience of Parenting

Together with improvements in the parent-child relationship, participants depicted how they were experiencing parenting in a new and rewarding fashion. Being a ‘good enough’ parent was more acceptable to them, and after COS-P, many carried a newfound sense of hope for the
future. Participant narratives depicted improved emotional awareness, practicing new ways of behaving in their relationships with their children and engaging in new emotional experiences as key mechanisms for change.

Parental reports of increased self-belief and confidence in parenting have been noted in other PT programmes (Vella et al., 2015) as well as decreased feelings of personal guilt (Kane et al., 2007). Kimmel and colleagues (2016) also found improvements in parental self-efficacy following COS-P. Nevertheless, participant narratives in the current study add considerably to these findings with accounts of increased confidence and self-belief, improved psychological well-being and greater happiness and relief at not having to be ‘the perfect parent’. A finding that is unique to the present enquiry relates to the sense of hope for future conveyed by participants. Parents were emphatic in their attempts to explain that, no matter how old the child, it is never too late to repair and enhance the relationship.

5.2.6 Theme 6: Evaluating the Experience

Consistent with the findings of qualitative investigations of other PT, participants conveyed their satisfaction with the programme (Vella et al., 2015). Indeed, participants provided extremely positive accounts of their experience, both within the group and through applying the COS-P principles to their relationships with their children. Most notably participants believed that the intervention worked for them and they were eager to share their knowledge with friends and family and strongly recommended more extensive dissemination of the programme. Participants reported their satisfaction with the COS-P content and materials, in particular, the suitability of the DVD footage to aid their learning.

Another distinctive finding in the current investigation points to the wider relevance of COS-P. Parents emphatically stated that it was suitable for parents of children of all ages, including adult children. Participants who had children with Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD) diagnoses, or were undergoing assessment, reported the suitability of COS-P for assisting them in understanding their children’s behaviours and accordingly responding to their needs with greater sensitivity.

5.2.7 Integration of Qualitative and Quantitative Findings

Combining qualitative findings with the subsidiary quantitative data within the current study accounted for apparent contradictions in the effect of COS-P on participants’ ER and PRF capacities. Considering the questionnaire completion errors detailed in the following section,
more weight has been given to the first-hand accounts provided by parents and any interpretations of potential iatrogenic effects of the intervention were overruled. In their own words, and of their own volition, parents articulated their experience of COS-P and the changes which had occurred in their lives and parenting practices as a result of participation. Thus, within the confines of the current sample, in-depth examination of parental experiences superseded questionnaire data and revealed that COS-P appeared successful in its key objectives to develop ER and PRF capacities.

5.3 Summary of Quantitative Findings

Notwithstanding considerable efforts to gather a sizeable sample, the implementation of the supplementary quantitative aspect of the pilot study was impacted by several obstacles. Recruitment was hampered by high levels of attrition from the intervention programme, as a number of parents were unable to continue due to unanticipated employment and/or childcare commitments, or unforeseen circumstances, such as illness or personal crisis incidents. Several participants opted to attend the COS-P during the autumn delivery instead, while others chose to withdraw from the research study, or not participate at all. In addition, a number of potential participants were lost as two facilitators forgot to administer the questionnaires at baseline and a further potential group had started prior to the granting of ethical approval. Recruitment of a control group also proved challenging as few parents were willing to engage in the research.

Completion of the questionnaires also proved problematic. Despite efforts to provide clear written instructions and an explanatory script for facilitators, several parents completed the questionnaires incorrectly. For example, one participant completed the parent measures from the perspective of the child at timepoint one and four parents completed pre- and post-COS-P measures for different children at each timepoint.

Furthermore, since data within the groups were clustered it cannot be assumed that all the intervention groups were equal. For example, while each group included a clinical psychologist, the interventions were delivered by different facilitators from diverse professional backgrounds and with varied levels of experience of delivering COS-P. As dissemination also took place across a number of different services, the composition of the groups likewise varied in terms of participant age, child age, gender, socioeconomic status (SES), level of education, relationship status, group size, level of attrition, and inclusion or exclusion of couples. Comparisons with the control group were also impacted by considerable differences in parent and child age ranges.
Consequently, few conclusions can be drawn from the current descriptive analysis as the results were biased by a small sample size, scores were not uniformly distributed, and groups were not strictly comparable.

5.4 Theoretical Framework

Change processes and mechanisms in psychotherapy are recognised as multifaceted and complex (Orlinsky, 2001) with explanations for these mechanisms often fiercely contested (Holmes, 2015). The attachment theory framework provided a fitting lens through which to understand the mechanisms of change emerging from the participants’ narratives. Within this gestalt, re-experiencing both existing interpersonal patterns and earlier relational experiences in the group appeared to be an important factor for participants in the current study.

Acknowledging feelings of inadequacy in their parenting skills prior to participation in the intervention represented an early step towards the corrective emotional experiences that would occur during the COS-P. Other key components for change in these parents’ narratives appeared to include experiencing both the facilitator and the wider group as a secure base from which to explore and identify their feelings.

Often, although of course not always, single mothers and fathers live in comparatively disadvantaged circumstances, have low education levels, poor earning capacity, and may struggle to support their family independently. For many participants in this study, the COS-P may have represented a welcome counterbalance to the burden of external influences from their individual personal social contexts and the internalised working models of how they are viewed and how they relate to others in the world.

Insight and RF were facilitated through the observation of DVD’s, discussion and reflective dialogue with each parent in the group, and the receipt of interpersonal feedback and validation in the present moment. These processes drew attention to empathic failures and fostered awareness into how some participants may inadvertently cause ruptures in their relationships with any or all of their children. Participants were afforded the opportunity to confirm or disconfirm their perceptions of their children’s thoughts and emotional states, an important process for those parents who struggled to accurately interpret the thoughts and feelings of their children prior to participating in COS-P.

As such, participants had the opportunity to examine issues obstructing intimacy in the parent-child relationship through exploration within the group and the programme content. Participants could reflect on their perceptions of the facilitators who may have been
experienced comparably to unreliable primary caregivers. In the safety of the group, and within the facilitators’ empathic non-judgemental ‘holding space,’ participants appeared to learn how misconstrued underlying fears of rejection or abandonment may result in submission or withdrawal in their interactions with their child and discover how these familiar uncomfortable feelings are triggered by their children’s behaviours. New and real relational experiences with the facilitators, the group, and with their children may have had the potential to amend prior internal representations of the self and others (Marmarosh & Tasca, 2013).

5.5 Strengths and Limitations

5.5.1 Methodological Strengths

Conducting a pilot investigation is good clinical practice as it can inform the fine-tuning of materials, methods, and procedures, particularly in more complex studies such as those involving multiple sites (Leon at al., 2011). The current study was the first of its kind to be carried out with parents participating in COS-P in Ireland. It was designed to address a number of significant gaps in knowledge regarding the COS-P and the methodological shortcomings in prior research in the area, much of which focused on obtaining facilitator feedback, combined participant-facilitator accounts, or individual case studies, small sample sizes, and/or inadequate follow-up periods. In previous research, lengthy time lapses between completing COS-P and conducting interviews may have confounded the findings of some studies. Whilst qualitative data in other enquiries were limited to supplementing quantitative outcomes, previous investigations would arguably have benefited from the addition of in-depth participant interviews.

Thus, the current enquiry addressed a critical gap in the PT evidence base by contributing a noteworthy qualitative lens to the study of parent experiences and change mechanisms within COS-P. It further combined the principles of attachment theory and an interpretative phenomenological approach, which offered a thorough methodology for describing parents’ lived experience and latent change mechanisms occurring in COS-P. This was the first study to utilise this type of research design to investigate COS-P, rendering the current findings highly relevant for informing this area of scholarship. By way of illustration, the data proposed that parents experience a global change process which is shaped by facilitator and group factors, programme content and methods of delivery, and life contexts. These findings may provide further insights for continued research into the processes of change which take place within attachment-based parent training programmes.
Several factors contributed to the methodological rigour of the current study. The design enabled the author to explore parents’ interpretations of psychosocial issues which may not have been raised through quantitative evaluation alone. These included the value of establishing a shared understanding with other parents and the effect of COS-P on other significant relationships beyond that of the target parent-child relationship.

IPA is essentially person-centred and non-judgemental, making it highly suited to explore parents’ perceptions of COS-P. By affording participants greater scope to voice their unique insights on the programme, the design facilitated an exploration of the potential therapeutic ingredients underlying outcomes. That parents attributed positive changes to their participation in the COS-P goes some way to ruling out the effect of the passage of time on the findings observed in the questionnaire data.

IPA facilitated a thorough understanding of the power of parents’ experiences and the meaning generated on an individual, and ultimately a collective, level. The interpretative element of this investigation can be considered a strength in terms of the study’s original contribution to the literature. However, the interpretation of the data represents one interpretation of the author-participant interaction which renders alternative interpretations plausible.

Despite the fact that the intervention was implemented across several services by different facilitators, every effort was made to achieve consistency by maintaining the same number of sessions in each group. Intervention fidelity was further assured by adhering to the COS-P DVD manual and the use of self-monitoring through ongoing supervision for facilitators.

5.5.2 Methodological Limitations

The current findings should be considered in the context of several methodological limitations. As a predominately qualitative investigation, the findings presented here are not proposed to be widely generalisable. The study faced many challenges in relation to recruitment and retention resulting in a smaller and less representative sample than anticipated. Consisting predominantly of parents of white Irish ethnicity, a lack of racial diversity also merits consideration when interpreting the findings. On the basis of the eligibility criteria used, only one father was included in the analysis, and only parents who had completed at least 80% of COS-P were eligible for the study. This constrained the potential to draw direct comparisons with a control group over a given time. Confirmation of the current findings using wider sampling frames and randomisation methods could substantially bolster the transferability of the findings.
Further, given the small sample size, the study was laid open to the conceivable social desirability bias of self-report. Restricting the study sample to only those parents who had completed at least 80% of the programme may have limited the examination of factors impeding other parents from completing the programme such as content, delivery, individual or group factors, or other characteristics of COS-P. In effect, the criterion potentially skewed the sample towards those who had a positive experience of the intervention.

Another potential limitation to the investigation pertains to conducting participant interviews at one timepoint only. It is possible that, had the participants been interviewed several months after completing the programme, alternative data would have been discussed. It is also likely that had individuals been interviewed at a number of additional timepoints potentially richer data may have been uncovered since interviewing participants on successive occasions may have generated greater rapport and increased confidence resulting in richer narratives. Indeed, while every effort was made to establish a connection with participants, it is arguable that data collected by a familiar staff member would have yielded a deeper or alternative depth of findings.

The limitations of the function and interpretation of pilot studies should also be noted. Pilot results rarely generalise beyond the inclusion and exclusion criteria stipulated in the study design. Ancillary aspects such as efficacy, effectiveness, and/or safety are not usually evaluated at this stage, and the sample size is often centred on the practicalities of the recruitment process and the requirements for judging feasibility.

Similarly, the author acknowledges that her own personal biases and preconceptions may have inadvertently impacted on the current findings and explores this issue further in section 5.7. IPA acknowledges the role of the researcher in the interpretative process, understanding that the researcher’s personal interactions with the participant, in addition to their previous knowledge and expectations, may colour the process of making sense of a participant’s interpretation. Several precautions were diligently observed to limit the influence of these personal biases, including supervision and maintaining a reflective log.

Finally, the subsidiary quantitative enquiry did not include all the salient emerging constructs identified by parents in the interviews and adequate data was unavailable to examine potential variations between subgroups, such as differences due to the age of the child or parent. Ordinarily, designs that allow for the inclusion of a control group provide an explanation for the anticipation of an intervention, the passing of time, and the added attention obtained in the
investigation (Klerman, 1986). However, this was not possible in the current study due to the divergence between the control and intervention groups.

5.6 Critical Reflection

I have attempted to remain cognisant of my centrality throughout the course of this study, identifying and declaring my prejudices wherever possible. Nevertheless, my interests, life experiences, and personal values may have unintentionally permeated the project, and potentially influenced the interpretation and presentation of the findings.

My initial exposure to the basic tenets of the COS occurred whilst on my first placement as a psychologist in clinical training. I was intrigued by what I believed was a welcome alternative to the dominance of behaviour-based approaches and the practical applications of attachment theory in clinical work. This interest culminated in my decision to research the newly adopted COS-P in the Midwest.

At its inception, the objective of this research was to conduct an infant mental health study. This soon evolved into an investigation with parents of children in middle childhood given the presenting needs and target population in the services delivering COS-P.

I was quickly drawn to the idea of learning how this intervention could be applied to parents of older children, particularly given that middle childhood is relatively under-researched within the attachment literature. Listening to the anecdotal accounts of my field supervisor and other facilitators I was enthused by their passion for the intervention and became intrigued by the potential change processes at play.

The recruitment phases were undoubtedly challenging and fraught with many disappointments, including issues of attrition, withdrawal from the research, and difficulties in obtaining a control group. The data collection phase also presented a number of challenges. However, the subsequent interview process was both an informative and enjoyable experience.

Transcribing the interviews enabled me to become totally immersed in the participants’ experiences and transport me right back to those initial exchanges with each participant. I noticed how my confidence and familiarity with the schedule grew with each interview and how this led me to access richer detail regarding participants’ experiences of the intervention.

The data analysis was indeed challenging. Deciphering the quantitative data was problematic due to the errors detailed in earlier sections, and I occasionally felt inundated by the shear
volume of data and the desire to do justice to the meanings of the experiences portrayed by the participants.

Based on the COS-P goals I had expected to see parents’ capacity for reflection or reflective functioning visibly improve over the course of the programme. I also became aware of my preconception that parents of children in middle-childhood would dislike or reject the course material since the materials, in particular, the DVD footage, are aimed at toddlers. I, therefore, assumed that parents of older children would find it difficult to relate this to their child.

I also realised a presumption that the programme would only apply to the target child. However, the interviews quickly contradicted this notion as parents reported using their COS-P knowledge with all of their children, whether they were infants, toddlers, children in middle childhood, teenagers, and even into early adulthood. Parents in this study confirmed the relevance of the COS-P application across all ages.

I had to confront my preconceived notion that fathers would not engage with the programme as willingly, or as effectively as mothers. I must admit my discomfort regarding this preconception in particular, and I am pleased to say that, as with every other assumption regarding this project, it has been thoroughly contested.

Throughout the interview and analysis process I felt nothing but admiration for the participating parents. In light of the obstacles they face in their daily lives, their ability to learn to reflect and make positive changes in both their own and their children’s lives was admirable. I felt both humbled and deeply moved by the sadness that hung in the room when certain participants confided their own experiences of being parented and where they are on ‘the circle’. In fact, I was often struck by the heart-warming reflections of the parents that I was privileged to meet during this project and was in awe of their unearthing of greater joy in their relationships with their children, and again moved by their renewed sense of hope for the future.

Throughout the research process I was aware of my growing curiosity in relation to my own attachments. I found myself reflecting on my own defences and how I relate to others in the world. I learned that COS-P presents an accessible tool for the practical application of attachment theory across contexts. What stood out for me is how relevant this programme is for working as a clinical psychologist not only within children’s services, but also its potential utility for intellectual disability services as well.
5.7 Implications for Clinical Practice

With a reasonable degree of confidence in the findings, it is important to consider the possible clinical implications of the study. COS-P provided an opportunity to directly address parents own experience of being parented in an unhealthy way and, as such, addresses the potential for the intergenerational transmission of trauma. The current study highlights the value of PT for both parent and child wellbeing and may present a stepping stone for parents to access their own personal therapy.

Participant narratives in the current study highlight the potential utility of COS-P for parents of children with particular developmental needs (e.g., ASD). However, practitioners should be mindful in cases where children present with more severe difficulties, parents may struggle to make comparisons with families with typically developing children and could potentially become distressed.

Several participants indicated the benefits of smaller groups and although the presenting difficulties were divergent, a reasonable degree of homogeneity in the groups worked well. For example, offering groups specific to couples or allocating them to alternative groups may be more beneficial.

Participants voiced their requests for additional intermittent refresher sessions for parents who have already completed COS-P. This could help to maintain learning and social support.

In cases where participants demonstrate improvements in negative attributions following COS-P, yet behaviour difficulties remain unchanged, additional behaviour-based supports could be considered.

The author recommends the facilitation of an information session for all interested parents prior to commencing COS-P. This session could provide a sample of the COS-P programme material and allow for a question and answer session provided by the facilitators in addition to outlining research goals and the current evidence base as well as enabling parents to decide if the programme is for them at this point in time. This may assist retention and prevent unnecessary disruption in group composition during dissemination.

It is difficult to speculate regarding the utility of the SDQ measure in terms of the current findings, given factors such as the small sample size and the issue that measures were completed for different children at different timepoints. NICE (2013) guidelines recommend the SDQ as a useful screening tool for conduct disorder, rendering it a useful measure for selecting suitable participants for intervention and observing change over time. Given the
strong associative evidence for the impact of maternal depression on child psychosocial outcomes, and the improvements in parental psychological well-being cited in the interview data, continued use of a brief measure of parental depressive symptoms, such as the PHQ-9 in future data collection is recommended.

5.8 Implications for policy

From a policy perspective, and in keeping with the Child and Family Agency Parenting Support Strategy (2013), the current study provides encouragement for the delivery of parenting supports through several agencies, statutory and community. The potential wider utility of COS-P, voiced by the current participants, speaks to objectives of delivering universal supports for all parents, perhaps alongside more tailored services to assist parents in various contexts and differing parenting relationships. The struggles experienced prior to completing COS-P recounted by participants, and indeed the loss of participants in some instances, points to the importance of providing parents with access to these supports before they reach a crisis point. In addition to assisting parents in diverse social contexts, the current inquiry advocates the importance of encouraging and supporting fathers to avail of such approaches.

5.9 Implications for Future Research

The findings from the current study suggest several possible directions for future research. It would be valuable to extend the current approach with parents participating in repeated interviews and assessments before, during, and after their participation in COS-P so as to more systematically capture how they experience the programme and monitor how change mechanisms operate over time. In addition, by relaxing the COS-P 80% completion eligibility criterion future research could consider an examination of parents who discontinued the programme and potentially elicit a more exhaustive consideration of issues of resistance to COS-P.

Future research should examine the use of COS-P with parents of children with developmental difficulties (e.g., ASD or intellectual disabilities) as well as its utility with parents who themselves have intellectual or learning difficulties. Further, only parents’ experiences were captured in this enquiry. Future investigations could ascertain a more thorough understanding of latent change mechanisms by augmenting the parent perceptions revealed in the current study with supplementary reports from their children, facilitators, and other family members. The current qualitative study can inform future quantitative evaluations of effectiveness in a number of ways. In-depth examination of parental experiences revealed that COS-P appeared
successful in its key objectives, that is, improving caregiver sensitivity, emotional regulation and reflective functioning capacities. However, many of the key variables under investigation are difficult to capture in self-report measures. Future research could focus on the development of new self-report measures that more accurately reflect these variables and are specifically targeted for parents of children in middle-childhood. Improvements in parenting self-efficacy, increased happiness and hope in addition to improved perceptions of their children’s behaviour and wellbeing were also noted in the current investigation. Future quantitative investigations could consider targeting these variables in both mothers and fathers (e.g., parenting stress/satisfaction, self-efficacy, parent and child wellbeing). In addition, future quantitative investigations could explore the potential change mechanisms unearthed in this study, over and above those pertaining to the COS assumptions. Given the satisfaction with the programme expressed by parents, comparisons with other PT programmes should be considered.

The failures of the auxiliary quantitative study (e.g., difficulties with recruitment, attrition, accurate completion of measures) provide valuable information for the designing of a more widescale quantitative evaluation. Participants and facilitators need consistent education and support with regards to the research objectives, the value of conducting this research as well as guidance on the accurate completion of questionnaire measures. Barriers to implementation and retention need to be investigated to improve participation and to assist retention of participants, in particular fathers, on the programme. Further, the author recommends a national survey with all COS-P trained facilitators in order to ascertain who is receiving the programme, how outcomes are being measured and to establish continuity in measurement prior to conducting an extensive hypothesis-based investigation in order to maximise the feasibility of evaluation.

Questionnaire completion errors in the current study and limited available evidence for the use of ER measures with COS-P impede the recommendation of the DERS in future COS-P studies. However, feedback from participants suggests that overall briefer measures are more favourable. Future research should consider using the short form of the DERS. Supportive evidence for the use of questionnaires to measure PRF demonstrates considerable variability. Measurement of the PRF construct with larger samples may yield more conclusive evidence for the utility of the PRFQ with COS-P.

The study faced many challenges in relation to recruitment and retention resulting in a much smaller sample than anticipated. However, the inclusion of a control group educated a more
realistic consideration of barriers and facilitators to recruitment, randomisation, intervention implementation, and assessment protocols. It also helped to inform the consistency and acceptability of procedures. Future studies should include a comparative group repeated measures design with an adequate follow-up period, random group assignment of cases and a larger sample size.

Participant engagement and retention could be improved by providing additional opportunities to outline the nature of the research (e.g., in a pre-programme information session). Efforts could be made to recruit a control group during an information session by providing direct information on a one-to-one or group basis. Where randomisation is not possible, efforts should be continued to enable experimental data collection from multiple groups at different timepoints, and with an adequate follow-up period.

5.10 Conclusion

The primary aim of the investigation was to address a critical gap in the COS-P evidence base by capturing how parents experience the intervention and learn about the processes through which the intervention may lead to changes in their parenting practices. Interview data culminated in the unearthing of six key themes including ‘Seeking Help and Engaging with the Programme’, ‘Learning to be Vulnerable’, ‘Learning to Manage Emotions’, ‘An Improved Parent-Child Relationship’, ‘A New Experience of Parenting’ and ‘Evaluating the Experience’.

Within the confines of the current sample, in-depth examination of parental experiences revealed that COS-P appeared successful in its key objectives. PT like COS-P is more likely to have the power to respond to complex family situations (Hughes & Baylin, 2012; Coyne, 2013) and may assist in preventing the intergenerational transmission of child maltreatment (Guild et al., 2017). Participants conveyed considerable satisfaction with the programme. Facilitators were central to the establishment of a non-judgemental ‘safe haven’ and fostering cohesion within the group. Participant accounts endorsed increased awareness of the connection between their emotional states and personal attachment histories. Parents appeared to have developed more sensitive and reflective parenting practices and greater emotion regulation capacities.

Several subordinate themes emerging in the current study pointed to a number of important findings that provide a useful addition to the growing body of COS-P literature. Participants recounted the value of being offered a language in which to voice their difficult emotional experiences. Assisting participants in verbalising affect and enhancing cognitive processing may have supported the downregulation of intense emotions. Participants conveyed improved
perceptions of and connection with their children perceiving what they previously believed were ‘bold’ or ‘attention seeking’ behaviours as an expression of a relational need. Parents expressed a sense of hope for the future which represents a finding that is unique to the present enquiry. Another distinctive finding pertains to the reported wider utility of COS-P, for parents of children of all ages. Indeed, participant accounts suggest that COS-P may be especially useful to assist parents of children with a diagnosis of ASD, ADHD or other developmental difficulties.

Parental practices and affective change following COS-P appeared to occur through at least ten interactive processes. These include bringing emotions into awareness, reactivating old memories, working with defences, experiencing the facilitator as a secure base, group cohesion, emotional regulation, reflective functioning, engaging in new emotional experiences, interpersonal learning, and practicing a new way of behaving.

A critique of the research process, in addition to the strengths and limitations of the investigation, has been presented. Implications for clinical practice, policy, and future research have been identified and discussed.
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Appendices

Appendix A: Participant Information Sheet

Title of Study: Exploring parents' experiences of the Circle of Security Parenting Programme

Please take a few moments to read this information sheet.

My name is Noreen Likely and I am a Psychologist in Clinical Training at the University of Limerick. As part of my Doctorate in Clinical Psychology I am conducting a research project in partnership with HSE West, Tusla Child and Family Agency and Clarecare.4 I would like to invite you to participate in my evaluation of the Circle of Security Parenting Programme.

Why am I being asked to take part?
Because you are participating in the Circle of Security Parenting Programme, you are being asked to help us understand how well the programme works. This leaflet is designed to give you all the information that you will need to make this decision.

What is the study about?
I am interested in learning about parents’ and carers’ experiences of taking part the Circle of Security Parenting Programme.

What is the purpose of the evaluation?
The purpose of this study is to see the ways in which the Circle of Security is helping families and the ways that it is not. Not all people respond to the programme in the same ways, and I would like to learn about your unique experience in the group. The study will involve your input before and after the programme and a brief follow-up at the end of the year. This will allow me to see how the Circle of Security as affected your outlook on parenting.

What will happen if I take part in this evaluation?
You will be asked to complete questionnaires about your thoughts, feelings and behaviours before the programme begins, after the programme and 6-months after you have finished the programme. These will take approximately 25 minutes to complete.

I am also interested in hearing about parents and carers experience of taking part in the group. After the last session, I would like to invite you to participate in an interview to find out about your experience in the group.

What would I have to do?
If you agree to take part in the interview I will contact you to arrange a time to suit you. This interview will be conducted at {name of service} and will last approximately 60 minutes.

Do I have to take part?
You do not have to take part in this study and your decision on to take part will not impact your participation in the Circle of Security programme. If you do agree to take part, you are free to withdraw from this study at any time during the research process, and you do not have to give any reason for doing so.

What will happen to the information I provide?
Any information that you provide as part of this research will be stored anonymously and treated as strictly confidential. What you say in the interview will be voice recorded to make sure we don’t lose any of the information you may offer. Once I have transcribed this recording it will be destroyed. Any

4 This leaflet has been given to you by {service name} on behalf of Noreen Likely, Psychologist in Clinical Training.
identifying details will be completely removed from the written transcript so that neither you nor your child is identifiable in any way. The information gathered may be kept for up to 5 years after the study has been completed. The questionnaires and interview transcripts will be analysed and presented in the form of a report that will be submitted to the University of Limerick in part fulfilment of my Doctorate in Clinical Psychology. This report may also be submitted for publication in a scientific journal. Within the report, I may include some anonymous quotes of what you have said during the interview. Please be assured that these will remain anonymous and will not reveal your identity. All participants will be provided with a summary of the report if they wish.

**Limits to confidentiality**

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

**Are there any benefits to taking part?**

There are no direct benefits to you or your child if you take part in this study. However, the information that you provide will contribute to our understanding of parents’ and carer’s experiences of the Circle of Security programme and any benefits or problems associated with this.

**Are there any risks to taking part?**

It is possible that items on questionnaires or discussions during the interviews may trigger some upsetting thoughts or feelings. If this occurs, and you wish to stop, you can end the interview at any time. If you need a break during the interview, that is ok. You also discuss your experience of the interview with your group facilitators, who will be able to support you if any upsetting issues are raised.

**Who has reviewed the study?**

This study has been given ethical approval by {to be confirmed}

**Who can I speak to about the study?** If you have any questions or would like any more information, please do not hesitate to contact me or my supervisor at the contact details listed below.

**What should I do now?**

If you are happy to take part in the study, please complete the attached consent form and pass this back to your group facilitator. This form is to show that you have read and understood the information that has been given to you and that you agree to take part in the study. Once you have completed the Circle of Security programme I will then contact you by telephone to answer any questions that you may have about the study and arrange a time to complete the interview.

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

If you have any questions about the research or would like to discuss any aspect of the study further, please do not hesitate to contact me.

**Noreen Likely**

**Psychologist in Clinical Training**
Appendix B: Participant Consent Form

Study title: Exploring parents' experiences of the Circle of Security Parenting Programme

Please initial boxes:

1. I confirm that I have read and understand the information sheet dated {to be confirmed} for the above study and have had the opportunity to ask questions. All my questions have been answered to my satisfaction. I understand that I will receive a copy of this Written Informed Consent Form.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

3. I have been assured that any information I give will be used for research purposes only and will be kept completely confidential.

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

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

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

7. I understand that I will be invited to complete questionnaires at the beginning and at the end of the programme and then 6 months later.

8. I consent to being contacted in writing 6-months after the programme to complete questionnaires.

9. I understand that data related to me collected during the study will be processed and analysed as is required by this clinical study and per the Data Protection Act.

10. I agree to take part in an interview for the above study.

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

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

13. I agree to take part in the above study.

__________________    ___________    __________________    ___________
Name of participant               Date                  Signature                 Phone no.

____________________    ___________     ________________    ___________
Name of witness                   Date                  Signature                  Phone
Appendix C: Participant Interview Contact Form

**Study title:** Exploring parents’ experiences of the Circle of Security Parenting Programme

- I am happy to be contacted by telephone to discuss the study further and arrange a time for interview.

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

Name (please print in block capitals): 

Telephone number: 

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

Other (please specify): .........................
# Appendix D: COS-P Weekly Content and Learning Objectives

## Table 3: COS-P Weekly Content and Learning Objectives

<table>
<thead>
<tr>
<th>Weeks 1 &amp; 2</th>
<th>Introduced parents to key concepts of attachment, how to use the COS graphic as a map for parent–child interaction and learn about children’s requirement for a secure base and safe haven.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weeks 3 &amp; 4</td>
<td>Addressed the core concept of ‘being with’ children emotionally. The essence of ‘being with’ is to provide an emotional safe haven by responding to children’s emotional states (Cassidy et al., 2017)</td>
</tr>
</tbody>
</table>
| Week 5      | Parents consider the importance of reflecting on their own caregiving struggles. COS uses the metaphor of ‘shark music’ to provide parents with a vocabulary for understanding and talking about defensive processes that influence their parenting but occur beyond their conscious awareness.  
Parents discover that these defensive processes, often originating from their own attachment relationships, can lead them to experience their child’s expressed needs as threatening. By giving these threatening experiences the label “shark music,” parents can suspend their usual reaction, calm themselves (e.g. by naming their feelings or taking a few breaths), and respond to their child's momentary needs, rather than reacting to their own fears.  
Parents are introduced to the concepts of avoidant and ambivalent attachment patterns and these are explored in the context of insensitive parenting (Cassidy et al., 2017). |
| Weeks 6, 7 & 8 | Concentrated on learning about disorganised attachment by discussing parenting from the point of being mean (hostile), weak (helpless) or gone (neglecting) (Cassidy et al., 2017; Lyons–Ruth, Yellin, Melnick, & Atwood, 2005). The value of rupture and repair in the parent-child relationship was discussed particularly how it can support the development of emotional regulation. |
| Week 9      | The final week consisted of a summary of each of the modules, a group discussion regarding parents experiences of the group and an acknowledgement of parents’ accomplishment (Cassidy et al., 2017).  
(Adapted from Cassidy et al., 2017; Cooper, Hoffman, & Powell, 2009) |
Appendix E: Demographics Questionnaire (DQ)

<table>
<thead>
<tr>
<th>Name of Respondent:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of completion:</td>
<td></td>
</tr>
<tr>
<td>Relationship to child:</td>
<td></td>
</tr>
</tbody>
</table>

**Information on respondent:**
(please circle or describe as appropriate)

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender:</td>
<td>Female Male</td>
</tr>
<tr>
<td>Nationality:</td>
<td></td>
</tr>
</tbody>
</table>

**What concerns about your child brought you to the service?**

<table>
<thead>
<tr>
<th>Anxiety</th>
<th>Social Problems</th>
<th>Aggressive behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Attention problems</td>
<td>Rule-breaking behaviours</td>
</tr>
<tr>
<td>Physical complaints</td>
<td>Emotional problems</td>
<td>Other (please specify)</td>
</tr>
</tbody>
</table>

**Relationship status:**
Single Married Other (please specify)
Separated Divorced In a relationship
Widowed In a Civil Partnership

**Education History:**
No formal education completed Junior Cert/Inter Cert completed Third level Education completed
Primary school completed Leaving Cert completed Post-Graduate Education completed

**Employment status:** (please circle)
In full-time employment Currently unemployed Student
In part-time employment Retired Other
## Appendix F: Description and Scoring Criteria for each Psychometric Measure

### Table 3:8 Description and Scoring Criteria for Each Psychometric Measure

<table>
<thead>
<tr>
<th>Psychometric Measure</th>
<th>Description and Scoring Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parental Reflective Functioning:</strong></td>
<td>The PRFQ is an 18-item tool that uses ratings on a Likert scale ranging from 1 (strongly disagree) to 7 (strongly agree) assessing curiosity about mental states, attempts to comprehend mental states and how they are linked to behaviour, and refusal to acknowledge mental states and their influence on behaviour. The PRFQ contains three subscales (1) the “Pre-mentalizing” subscale quantifies non-mentalizing modes (e.g., “When my child is fussy he or she does that just to annoy me”); (2) the “Certainty” subscale assesses the inability to recognise that mental states are not transparent (e.g., “I always know why my child acts the way he or she does”); and (3) the “Interest and Curiosity” subscale captures parental interest in their infant’s mental states, (e.g., “I am often curious to find out how my child feels”). Higher scores on the Pre-mentalizing scale suggest increased difficulties in holding the target child in mind. Higher Certainty scores reflect a higher level of perceived certainty of the target child’s mental states. Higher Interest and Curiosity scores reflect higher levels of curiosity and interest in what the child is thinking and feeling (Luyten, Nijssens, Fonagy, &amp; Mayes, 2017). The Cronbach’s alpha for all three factors were .82, .80 and .80 respectively. There is preliminary evidence for the reliability and validity of this tool for its use with parents of children in middle childhood, however further research evidence is required (i.e., comparative studies with the parent development interview).</td>
</tr>
<tr>
<td><strong>Parental Emotional Regulation:</strong></td>
<td>The original DERS was designed to measure six aspects of emotion regulation: non-acceptance of emotional response, difficulty in goal directed behaviour, impulse control, emotional awareness, limited access to emotion regulation strategies, and lack of emotional clarity (Gratz &amp; Roemer, 2004) Participants respond to items on a 5-point scale (1 = almost never, 5 = almost always) rating how frequently they adopt each strategy. The internal consistency of the subscales has been evidenced using clinical and non-clinical samples with Cronbach’s alpha of 0.77. This is the most comprehensive emotional regulation tool currently available as it has excellent internal consistency and good construct validity.</td>
</tr>
<tr>
<td><strong>Parental Depressive Symptoms:</strong></td>
<td>The Patient Health Questionnaire (PHQ-9; Kroenke et al. 2001) is a screening measure for symptoms of depression based on DSM-IV diagnostic criteria. Parents responded to 9 questions on a 4-point scale ranging from 0 (not at all) to 3 (nearly every day) on how regularly they experienced depressive symptoms over the past 2 weeks (“little interest or pleasure doing things,” “poor appetite or overeating;” α=.86–.89). Higher scores reflect higher ratings of depressive symptoms. The internal consistency of the subscales has been evidenced using clinical and non-clinical samples with Cronbach’s alpha of 0.85.</td>
</tr>
<tr>
<td><strong>Child Behaviour:</strong></td>
<td>The Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997) provides a brief 25 item behavioural screening tool for parents of children aged 4 to 16. It concentrates on 25 psychological attributes, 20 positive and five negative (scoring is from “not true”, “somewhat true” or “certainly true”). The 25 items are shared across five scales: Emotional symptoms, Conduct problems, Hyperactivity, Peer relationships and Prosocial behaviour. The first four scale items scores are added together to produce a total difficulties score. The fifth scale generates a positive score. The resultant score ranges from 0 to 40. ‘Externalising’ and ‘internalising’ scores between 0 to 20 can also be calculated (Goodman &amp; Goodman, 2009). Scores can be categorised into a four-fold classification for total difficulties:0–13=close to average,14–16=slightly raised 17-19=high and 20–40=very high. The internal consistency of the subscales has been evidenced with Cronbach’s alpha of 0.88. The SDQ has excellent sensitivity (85%) and specificity (80%).</td>
</tr>
</tbody>
</table>
Appendix G: PRFQ Questionnaire

Listed below are a number of statements concerning you and your child. Read each item and decide whether you agree or disagree and to what extent. Use the following rating scale, with 7 if you strongly agree; and 1 if you strongly disagree. The midpoint, if you are neutral or undecided, is 4.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

1. __ The only time I’m certain my child loves me is when he or she is smiling at me.
2. __ I always know what my child wants.
3. __ I like to think about the reasons behind the way my child behaves and feels.
4. __ My child cries around strangers to embarrass me.
5. __ I can completely read my child’s mind.
6. __ I wonder a lot about what my child is thinking and feeling.
7. __ I find it hard to actively participate in make believe play with my child.
8. __ I can always predict what my child will do.
9. __ I am often curious to find out how my child feels.
10. __ My child sometimes gets sick to keep me from doing what I want to do.
11. __ I can sometimes misunderstand the reactions of my child.
12. __ I try to see situations through the eyes of my child.
13. __ When my child is fussy he or she does that just to annoy me.
14. __ I always know why I do what I do to my child.
15. __ I try to understand the reasons why my child misbehaves.
16. __ Often, my child’s behaviour is too confusing to bother figuring out.
17. __ I always know why my child acts the way he or she does.
18. __ I believe there is no point in trying to guess what my child feels.
Appendix H: Patient Health Questionnaire-9 (PHQ-9)\textsuperscript{5}

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use “✓” to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Feeling down, depressed, or hopeless</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Trouble falling or staying asleep, or sleeping too much</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Feeling tired or having little energy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Poor appetite or overeating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FOR OFFICE CODING $0 + ____ + ____ + ____$

$= \text{Total Score: } ____$

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
<tbody>
<tr>
<td>…</td>
<td>…</td>
<td>…</td>
<td>…</td>
</tr>
</tbody>
</table>

\textsuperscript{5} Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.
Appendix I: Difficulties in Emotion Regulation Scale (DERS)

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item.

<table>
<thead>
<tr>
<th>Number</th>
<th>Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1)</td>
<td>I am clear about my feelings.</td>
</tr>
<tr>
<td>2)</td>
<td>I pay attention to how I feel.</td>
</tr>
<tr>
<td>3)</td>
<td>I experience my emotions as overwhelming and out of control.</td>
</tr>
<tr>
<td>4)</td>
<td>I have no idea how I am feeling.</td>
</tr>
<tr>
<td>5)</td>
<td>I have difficulty making sense out of my feelings.</td>
</tr>
<tr>
<td>6)</td>
<td>I am attentive to my feelings.</td>
</tr>
<tr>
<td>7)</td>
<td>I know exactly how I am feeling.</td>
</tr>
<tr>
<td>8)</td>
<td>I care about what I am feeling.</td>
</tr>
<tr>
<td>9)</td>
<td>I am confused about how I feel.</td>
</tr>
<tr>
<td>10)</td>
<td>When I’m upset, I acknowledge my emotions.</td>
</tr>
<tr>
<td>11)</td>
<td>When I’m upset, I become angry with myself for feeling that way.</td>
</tr>
<tr>
<td>12)</td>
<td>When I’m upset, I become embarrassed for feeling that way.</td>
</tr>
<tr>
<td>13)</td>
<td>When I’m upset, I have difficulty getting work done.</td>
</tr>
<tr>
<td>14)</td>
<td>When I’m upset, I become out of control.</td>
</tr>
<tr>
<td>15)</td>
<td>When I’m upset, I believe that I will remain that way for a long time.</td>
</tr>
<tr>
<td>16)</td>
<td>When I’m upset, I believe that I will end up feeling very depressed.</td>
</tr>
<tr>
<td>17)</td>
<td>When I’m upset, I believe that my feelings are valid and important.</td>
</tr>
<tr>
<td>18)</td>
<td>When I’m upset, I have difficulty focusing on other things.</td>
</tr>
<tr>
<td>19)</td>
<td>When I’m upset, I feel out of control.</td>
</tr>
<tr>
<td>20)</td>
<td>When I’m upset, I can still get things done.</td>
</tr>
<tr>
<td>21)</td>
<td>When I’m upset, I feel ashamed at myself for feeling that way.</td>
</tr>
<tr>
<td>22)</td>
<td>When I’m upset, I know that I can find a way to eventually feel better.</td>
</tr>
<tr>
<td>23)</td>
<td>When I’m upset, I feel like I am weak.</td>
</tr>
<tr>
<td>24)</td>
<td>When I’m upset, I feel like I can remain in control of my behaviours.</td>
</tr>
<tr>
<td>25)</td>
<td>When I’m upset, I feel guilty for feeling that way.</td>
</tr>
<tr>
<td>26)</td>
<td>When I’m upset, I have difficulty concentrating.</td>
</tr>
<tr>
<td>27)</td>
<td>When I’m upset, I have difficulty controlling my behaviours.</td>
</tr>
<tr>
<td>28)</td>
<td>When I’m upset, I believe there is nothing I can do to make myself feel better.</td>
</tr>
<tr>
<td>29)</td>
<td>When I’m upset, I become irritated at myself for feeling that way.</td>
</tr>
<tr>
<td>30)</td>
<td>When I’m upset, I start to feel very bad about myself.</td>
</tr>
<tr>
<td>31)</td>
<td>When I’m upset, I believe that wallowing in it is all I can do.</td>
</tr>
<tr>
<td>32)</td>
<td>When I’m upset, I lose control over my behaviour.</td>
</tr>
<tr>
<td>33)</td>
<td>When I’m upset, I have difficulty thinking about anything else.</td>
</tr>
<tr>
<td>34)</td>
<td>When I’m upset, I take time to figure out what I’m really feeling.</td>
</tr>
<tr>
<td>35)</td>
<td>When I’m upset, it takes me a long time to feel better.</td>
</tr>
<tr>
<td>36)</td>
<td>When I’m upset, my emotions feel overwhelming.</td>
</tr>
</tbody>
</table>
Appendix J: The Strengths and Difficulties Questionnaire (SDQ)

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months.

Child's Name .................................................................................................................. Male/Female
Date of Birth..............................................................................................................

<table>
<thead>
<tr>
<th>Item</th>
<th>Not True</th>
<th>Somewhat True</th>
<th>Certainly True</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considerate of other people's feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restless, overactive, cannot stay still for long</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often complains of headaches, stomach-aches or sickness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shares readily with other children (treats, toys, pencils etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often has temper tantrums or hot tempers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rather solitary, tends to play alone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generally obedient, usually does what adults request</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Many worries, often seems worried</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helpful if someone is hurt, upset or feeling ill</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constantly fidgeting or squirming</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has at least one good friend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often fights with other children or bullies them</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often unhappy, down-hearted or tearful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generally liked by other children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easily distracted, concentration wanders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous or clingy in new situations, easily loses confidence</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kind to younger children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often lies or cheats</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Picked on or bullied by other children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Often volunteers to help others (parents, teachers, other children)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinks things out before acting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steals from home, school or elsewhere</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gets on better with adults than with other children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Many fears, easily scared</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sees tasks through to the end, good attention span</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any other comments or concerns?
Appendix K: Interview Schedule

Study Title: An Exploratory Study of Parent Experiences in the Circle of Security – Parenting (COS-P) Programme

Interview Protocol

Introduction and scene setting

- Welcome the participant, establish rapport, indicate location of refreshments, bathroom and general housekeeping information.
- Discuss consent form again and provide a plain language statement to ensure participants are clear about the research aims and study background.
- Acknowledgement of audio device; explain how data will be stored and used
- Revise terms of consent - explain limits of confidentiality again and remind participant participation is voluntary and free to withdraw.

Interview Questions

Background to attending the COS-P programme

1) Can you tell me about what brought you and your child to the service?

Possible prompts:
~ What were the reasons that you and your child became involved with the service?
~ What is your understanding of your child’s referral to the service?

Pre-programme expectations

2) Thinking back to before you completed the COS-P programme, what were your expectations of it?

Possible prompts:
~ What were you told about it?
~ How did you feel about doing it?
~ What were your concerns about doing it?
~ Did you understand why you were invited to attend the group?
~ What did you hope to get out of attending it?

*The COS-P Intervention*

3) Can you tell me was it like for you taking part in the COS-P programme?

Possible prompts:
~ What did you think of it?
~ Was it what you expected?
~ How did you feel?
~ What did you enjoy about it?
~ What did you find difficult?
~ What was it like being in a group?
~ What was it like working with the facilitators?

*Post-programme outcomes*

4) Looking back on the whole experience, what have you taken away from it?

Possible prompts:
~ What have you learned from the experience?
~ What stood out for you?
~ How do you feel about it now?
~ Overall, what was the most helpful aspect?
~ What wasn’t very helpful?

5) Has anything changed for you since completing the COS-P parenting group?

Possible prompts:
~ Is there anything that has made you think differently?
~ Is there anything that you now do differently?
~ Do you feel there have been any changes in your relationship with your child? If so, how has it changed?
~ Have there been any changes in your child’s behaviour?

*Closing comments and check-in*

6) How did you find this interview today?
Possible prompts:

~ What was doing this interview like for you?

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

Thank participant and advise that if they have queries or require a follow-up that they can contact their group facilitator on {service number} or contact the psychology department on {service number}
Appendix L: Research Log and Reflective Notes

Meeting with Field Supervisor 11/11/16
Meeting with [Field supervisor] to discuss the possibility of conducting research on the Circle of Security DVD program. She indicated that ID services are about to start rolling out COS-P. She indicated that there are a number of groups that will be running in the first and second quarters of 2017 in [Location], a fostering group in [Location], a [service name], a group in [Location] and a Springboard group in [Location]. Some of the measures being used by these services so far to evaluate the groups include the caregiver questionnaire, a COS specific questionnaire that doesn't have normative data, and evaluation using the SDQ measure of children's behaviour, however is not a behaviour-based program. [Field supervisor] spoke about an interest in parents increased self-awareness and how would they manage their own activities in the fences. At some point during the program there is a shift for the parent. Parents start out by being convinced that something is wrong with their child but this changes at some point.

Determining the waiting list group specifically the population of under 7s those of more complex needs presentations are more typical primary care cases. They're aiming to have 8-10 participants in each group, mothers and fathers and to get one parent of the dyad at least. Consider research to target the core sensitivities separation, esteem etc. What is the Struggle for the parent? Review the COS-P book, Enhancing attachment in early parent child relationships. The parent’s ability to see what they're doing, knowing themselves, do their defences change? Note COS-P is a parent education program, not a psychotherapy programme. Next COS-P meeting 14th December 2:30.

Telephone contact with [Field Supervisor] 20/03/2017
The [Location] group is now gone it's no longer running. I can't use the group in [Location] as a pilot study. It has already started, it's in week 3, so it's not suitable for a quantitative pilot study. The adoptive parents group in [Service name] is due to finish soon. It's being evaluated by an assistant psychologist but it's available for qualitative study. I can consider it for interviews. I might be able to consider this in the main study that is having a comparative study between adoptive parents and biological parent’s experiences. [Facilitator] is running the [Service Name] group for parents of 8 to 12-year olds and Joanne is running the [Service Name] group for parents of 5 to 8-year olds.
Meeting with [Field Supervisor] and [Research Supervisor] in [Location] 2/05/2017
Discussed the problem of attrition and very low numbers for recruitment. It was agreed to wait until the end of the intervention (end of June 2017) to get a firm idea of numbers. It was suggested that if I don't have enough parents plan B would be to recruit facilitators instead and interview them. The plan now is for me to follow up with [Psychologist] regarding participants. The completed [Location] group is my best option for a pilot study. I will only be able to run a pilot on the qualitative arm of the study. 3 people completed the [Location] group. This is the best available group to get to see if my questions will yield enough data and if enough is outlined in relation experience of the programme and change. The plan is to meet again in Monday 3rd July at 11:30 with [Field supervisor] and [Research supervisor] to discuss these concerns further.

Personal Reflections 16/11/2017
At this point I am considering if it would be of benefit to do more interviews. I had hoped to have interviews with more participating fathers and I was disappointed that the two of the three have stopped attending the group due to work commitments. I am concerned that the findings may be somewhat unbalanced as a result.

Critical Reflections 16/11/17
I need to acknowledge my centrality to the project or the study. How do my life experiences, my personal values and expectations influence how I interpret the data? Possible preconceived notions into the fact that I am a married female, in my mid-thirties and I don't have children. I worried I wondered if I would be able to relate effectively to the participant because of this.
Appendix M: Participant Interview Information

Table 3.4 Participant Interview Information

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Duration</th>
<th>Presentation</th>
<th>Post-interview Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caroline</td>
<td>64 minutes 46 seconds</td>
<td>This participant was very eager to engage and started talking about her experience even before the interview had formerly started. Her rate of speech was very fast, and I found that I needed to slow the pace of the interview a few times and interject to do so. She was very open about her experience in the group and provided some good reflections.</td>
<td>I felt this was a positive interview today. The participant discussed her feelings and provided some depth around her experience within the group and how her learning on the programme has impacted her life for the better. It was an enjoyable interview. The participant laughed often as well as expressing the emotional pain experienced in her own childhood. I am more familiar with the content of my interview schedule and the direction that the research is taking. I was really struck by the sadness that hung in the room when his parent talked about her experience of being parent and where she is on the circle. I was so rapt by her ability to reflect on this. Her empathy and sympathy for the child when she the parent “is gone” was very evident. Her mood changed quite often over the course of the interview and it was evident that she had a strong sense of achievement and accomplishment from what she had learnt and taken from circle of security. I also found myself reflecting on my own defences and my own attachment experiences and how I relate to others in the world considering reflections provided by this individual.</td>
</tr>
<tr>
<td>Ruth</td>
<td>70 minutes 26 seconds</td>
<td>This participant was eager to engage. She was very nervous at first however and needed reassurance. She had some difficulty articulating herself and finding the right words to express herself.</td>
<td>This participant was open to share her emotions and experiences. Rapport was easily established however I found myself becoming somewhat irritated by the end of the interview due to the repetitive use of particular phrases.</td>
</tr>
<tr>
<td>Fergal</td>
<td>58 minutes 14 seconds</td>
<td>This participant was quite talkative and insightful. He spoke length regarding his personal learning and reflections. He warmed up even more as the interview progressed and it was very easy to build rapport but this individual.</td>
<td>This was a very positive interview. I was pleasantly surprised by the comments and reflections provided. I feel a little embarrassed by the implicit biases/expectations that I was holding prior to interviewing this male participant. I had wondered how a father would reflect on his experience of the group and how that would differ to the mothers’ I have met to date. I found the interview enjoyable and easy to follow the schedule without having to redirect the participant in any way. A sense of sadness and heaviness in the room was very evident at times. I found this participants openness heart-warming.</td>
</tr>
<tr>
<td>Pseudonym</td>
<td>Duration</td>
<td>Presentation</td>
<td>Post-interview Commentary</td>
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<tr>
<td>Heather</td>
<td>58 minutes</td>
<td>The participant was friendly and talkative and eager to participate. She was very open about her experience. It was somewhat difficult to get depth in the interview.</td>
<td>This was a positive start to the interview process. It was very easy to talk to this individual and to gather information from her. No concerns raised regarding the recording or the content of interview schedule. I feel more familiar with the interview schedule will aid this going forward.</td>
</tr>
<tr>
<td>Tina</td>
<td>40 minutes</td>
<td>It was difficult to understand her speech at times (she has a strong accent). I found that she persisted in giving generic in personal accounts of her experience. It was difficult to get depth with additional probing. Rapport did develop as the interview progressed.</td>
<td>The participant laughed often throughout the interview. She tended to talk about others in the group rather than herself; even went directly probed. I felt that this was a disappointing interview. I got a sense that I could not press issues and that this individual was not providing much debt and it would be unfair to press her to watch. I felt that it was not easy for this position to open up about her personal experiences. I considered if she difficulty elaborating on her feelings or perhaps just limited emotional literacy.</td>
</tr>
<tr>
<td>Noelle</td>
<td>62 minutes</td>
<td>The participant was very talkative. He speech was fast paced. She was very open to sharing her experiences with her children. She laughed frequently during the interview.</td>
<td>This was a positive interview. I am feeling more confident with the interview process and less reliant on the interview schedule. Participants are forthcoming with their experiences and the interviews are taking on a natural flow. Some minor changes to the wording will be considered. Participants feedback is positive.</td>
</tr>
<tr>
<td>Martha</td>
<td>67 minutes</td>
<td>This participant was highly articulate and insightful. She spoke at length about personal reflection and learning. It felt comfortable and easy to build rapport.</td>
<td>I was very happy with his interview. There was a heaviness in the air in the room initially and a strong sense of sadness which shifted over the course of the interview. I was taken aback by the level of insight and reflection offered by this participant. It was a very enjoyable interview, it flowed easily with a sense that topics are being covered naturally. I feel much more comfortable with the interview schedule now. I was emotionally affected by the sadness expressed as well as feeling slightly irritated by the intellectualization at times but then I was given much more detail on the feelings and thoughts occurring as well as the personal stories.</td>
</tr>
<tr>
<td>Pseudonym</td>
<td>Duration</td>
<td>Presentation</td>
<td>Post-interview Commentary</td>
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<tr>
<td><strong>Harriet</strong></td>
<td>64 minutes 37 seconds</td>
<td>This participant was very open and talkative and reflective. She spoke at a very fast pace. She was articulate and formed rapport easily. The interview felt comfortable.</td>
<td>This was a positive interview. The participant spoke of learning about herself and being able to let go of trying to be perfect as well as having a sense of achievement.</td>
</tr>
<tr>
<td><strong>Daisy</strong></td>
<td>42 minutes 11 seconds</td>
<td>This participant spoke at a slow pace in a monotone voice but became more animated as the interview progressed. Rapport took longer to establish.</td>
<td>There was a heaviness in the room from the outset and remained for most of the interview. I felt I had to work harder to elicit her emotions and thoughts. It was a positive interview overall however and more examples were provided as she became more at ease with the process.</td>
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Appendix N: Sample Of IPA Analytic Process

Emergent Themes

<table>
<thead>
<tr>
<th>Struggling in the Parenting Role</th>
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<tbody>
<tr>
<td>Sense of hopelessness</td>
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<tr>
<td>Increasing Self-Awareness</td>
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<tr>
<td>Self-reflection</td>
</tr>
<tr>
<td>Remembering Being Parented</td>
</tr>
<tr>
<td>Reactivation of old memories</td>
</tr>
<tr>
<td>A Safe Space to Share Experiences</td>
</tr>
</tbody>
</table>

Interview 9: Original Transcript

R: What were your expectations of the course?

I: Am… I didn’t really have any expectations. Am I just knew that it was based on child development and that am for the last two years… two and a half years my son has been struggling a lot and, so I have been doing a lot of different things to try to help him and regulate him I guess am. He was having emotional and behavioural issues and there was a psychological assessment done and in the last two ½ years that brought to light possible reasons for that am but there wasn’t any actual diagnosis. So, am it was doing a lot of different things trying to help him and am it came along at a time when I was feeling… ah… a little bit… ah… sort of [pause] [tutting noise] I guess are we ever going to find a solution to this? He’s still struggling, he still wasn’t in school full time and still going to OT play therapy and am at that point actually when I was invited to the group about right around the same time his school said we need more help. We need some more support am because you know there’s things that aren’t changing. An I was feeling very conscious of that too. And I was doing so much. Like play therapy every week for over almost a year and a half now. Am OT every three or four weeks. Am and psychologist once a month. I had this huge list of recommendations. Reading books I took a [service name] parenting course am I was getting therapy as well because I’m a single mom and I was feeling like I can’t do all of this. This is like I felt kind of a little bit hopeless at that point and am I was beginning to be aware of the fact that [noise of interviewee’s phone in background] … sorry I should have turned that off… that you know that the only consistent thing in my son’s life is me. And really you know going ok well. We’ve been doing all this other stuff and he’s still struggling. So, is it my stuff? Is it stuff that I need to work on? And I consider myself a very good parent. Am but what the circle of security kind of help me understand is that we parent the way we were parented and am it’s conditioning stuff… it’s stuff that… its core stuff that we learned as children am… um… although I felt that I was miles ahead of my mother it putting her down in any way but I recognised in the course that, yeah, that’s what is was. That I needed to make some changes in myself and it was like every week it was like these huge, “oh my gosh, ah-ha!” moments that… the way it was presented was that this is about your children but throughout the course I recognised that it was a roundabout way of helping us understand our own childhood. In a safe place. And solutions or tools or different ways to interact with your children. Simple things. And we had time to practice

Exploratory Comments

son has been struggling a lot emotional and behavioural issues
Sense of hopelessness
Hesitancy in expressing how hopeless she was feeling
we need more help
I was doing so much - Overwhelming
Getting her own therapy
Took a parenting course
Single mom Important social context
Struggling as a single parent
Can’t do all of this
R: How did it feel to be brought, in that roundabout way as you put it, to reflecting and thinking about your own childhood?

It…it was overwhelming at times…But in the timespan since my son was struggling I went through a lot of things too. You know I sort of ended up pushing my professional life aside because my son was struggling so much and am ah I felt like he really needed me, but I was also floundering a lot like…I didn’t know what to do…you know there isn’t a guide book. That helps you with every situation am so am I was kind of at a point where I had kind of already become aware that you know I needed to make some changes and it was…am it was like the magic guidebook because it’s sort of said well this is what you can do and it you know there was no need to be perfect. I was feeling like that from lot of other places. You know, that you need to do more. You need to do this, and you’ve got to try and try this, and it was so much. It felt like it was a whirlwind of do, do, do and that almost felt like it was making things worse because of the pressure of it all. Whereas the COS they said a number of times you only need to do it right 30% of the time (laughter) And I’m like…oh that leaves 70% !!I’m there! [Laughter] you know. So, it wasn’t this pressurised sort of situation. it’s just these are some solutions or some helpful sort of ideas or tools and you’re not going to get it right every time, but you know working on it and you know every little bit makes a difference to connecting with them. And that’s ultimately what I wanted because I love my son so much and he deserves that. You know. And so, I did a lot of healing through that as well and I think like I said I was in a really different place because I had been working on so much stuff. I had the opportunity to because I wasn’t working I wasn’t like running around like a chicken with my head cut off trying to do this and all those other things that everybody else wanted. I had time to reflect and I had time to you know take a break and take a minute and breathe in some cases and you know well we don’t need to that right now. We can just stop right here and manage this and deal with it right now.
Appendix O: Ethical Approval Letter

9th February, 2017.

Mrs. Noreen Likely,
108 Kylemore,
School House Rd.,
Monaleen,
Limerick.

Re: Protocol Title:
A mixed-method prospective evaluation of “Circle of Security Parenting” a 10-week relationship based parenting group programme.
REC Ref: 022/17

Dear Mrs. Likely,

I am in receipt of your proposal as above submitted for review by our Research Ethics Committee. I have reviewed the contents of same.

I wish to advise that I have given your study Chairperson ethical approval.

You should note that your study cannot commence until you also receive AON approval which will issue from the Quality and Safety Department shortly. You are obliged to inform us as soon as your study is completed or if it terminates early for any reason.

I wish you every success with your study.

Yours sincerely,

Páit Dillon,
Consultant Anaesthetist,
Chairperson, Research Ethics Committee.
Appendix P: Distress Protocol

The protocol for managing distress in the context of interviews for this research have been taken from Draucker et al (2009) guideline document “Developing Distress Protocols for research on Sensitive Topics”.

Prior to or during the interview process if a participant indicates they are experiencing a high level of stress or emotional distress or the exhibit behaviours that suggest that the topic under discussion is too stressful such as uncontrolled crying, shaking etc. the following responses will be implemented in a stepped approach:

| Step 1: Response | Stop the interview (or don’t start the interview)  
|                 | Offer immediate support  
|                 | Assess mental status and level of risk to participant e.g. Tell me what thoughts you are having? Tell me what you are feeling right now? Do you feel you are able to go on about your day? |
| Step 2: Review | If participant feels able to carry on continue with the interview  
|                 | If participant is unable to carry on go to step 2 response |
| Step 3: Response | Discontinue the interview  
|                 | Encourage the participant to contact their GP or mental health provider  
|                 | Or offer, with participant consent, for the lead or co-researcher to do so  
|                 | Or with participant consent contact a member of the health care team treating them at for further advice/support |
| Step 4: Follow-up | Follow up with courtesy call to the participant (if the participant consents to this)  
|                 | Or encourage the participant to call the researcher/co-researcher/facilitators either if he/she experiences increased distress in the hours/days following the interview. |

All participants were provided with a list of supports and contacts such as Samaritans, Aware, Adapt and other local supportive agencies.