

Containment, reciprocity and behaviour management

Preliminary evaluation of a brief early intervention (the Solihull Approach) for families with infants and young children

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The present study's objective was to conduct a small-scale study to begin to examine the effectiveness of the Solihull Approach. The Solihull Approach employs a theoretical model that integrates psychotherapeutic, child development and behavioural concepts, supported with resource materials and an open learning course. It is related to the Tavistock Under 5's model and is designed to be used as a brief (five sessions or less) intervention for those working with infants and young children and their families. The sample consisted of thirteen families recruited over a six week period by health visitors. A within-subject (repeated measures) ANOVA design was used, utilising three measures at baseline, end of support and follow-up. Parents and health visitors rated severity of presenting difficulty and the parents' anxiety about the problem at all three points. In addition the parents completed the Beck Anxiety Inventory at all three points. Results showed significant decreases in presenting difficulty and the parental anxiety about the problem over an average of three sessions. In addition, there was also a significant decrease in parents' general anxiety as measured by the BAI: an overall decrease of 66.3%. It was suggested that further evaluation would be useful on general effectiveness, the characteristics of families with whom this brief intervention is effective and on teasing out the mechanisms through which this method has an impact. It was also suggested that more 'user friendly' psychometric measures for use with very young children need to be developed.

Introduction

The Solihull Approach is a model integrating psychotherapeutic, child development and behavioural approaches for working with children with sleeping, feeding, toileting and behavioural difficulties (Douglas, 1999). It began development in Solihull in the UK at the request of the local health visitors, who felt that they needed more help to work with families with children who have common difficulties. The project resulted in a theoretical model to inform practice and a comprehensive resource pack, which also functions as an accredited open learning course.

The model developed from the work of Dilys Daws and the Tavistock model of intervention for the Under 5's. Although primarily psychotherapeutic, other approaches are also integrated into practice as demonstrated in Daws (1993). The Solihull Approach makes this even more explicit. The theoretical model consists of three components, each from different disciplines: containment from psychoanalytic thinking, reciprocity from child development research and behaviour management from behaviourism. The links between these theories are being explored (Douglas, 2001).

It is interesting that we arrived at such an eclectic model, as though any one theory from one discipline is inadequate to cope with the complexity and immediacy of work with infants and their families. This was pointed out in a recent article in *Signal* (Scavo, 2000) the newsletter of the World Association for Infant Mental Health, by a child psychiatrist in Italy. She thought that psychoanalytical, interactional and behaviourist models converged in working with parents and young children, because of the demands of this particular type of work. It may be that therapists are using 'combined theory' in their work because the situation demands interventions at different points in the system all at once, when the therapist is faced with a mother, a child and the interaction between the mother and child, which is further complicated by the relationship between the mother and father, family and grandparents and the father and child, all at a time when the needs of the child demand rapid change. Scavo describes the different emphases of the different theories, 'the psychodynamic model focuses primarily on maternal representations, the behaviourist model focuses primarily on interactive behaviours, and those who observe the meaning of the affective exchanges from a dynamic point of view, focus on the nature of the relationship. Finally, infantile psychoanalysts and developmental psychologists focus on the child's qualities and the developing 'construction of his/her inner world'. It would be interesting to see if there is a particular movement in theory development across the world, as we become more experienced in working with infant mental health.

It is becoming increasingly imperative to provide intervention services

for infants and very young children as the research evidence accumulates about the deleterious effects of an adverse environment upon the developing brain and the positive impact that early interventions can make (Schore, 2001; Claser, 2000). Where a system already exists of universal contact with infants it seems sensible to optimise its effectiveness in the light of this research. Health visitors are provided by the National Health Service and are a universal service. Although there is some regional variation they see almost every baby born in the UK for basic developmental checks in the first five years of life, provide information on topics such as feeding and weaning and support the family. They therefore see many more families than any specialist mental health team could hope to see, do not stigmatise a family, as they see everyone, and provide a service in the home as well as in easily accessible local clinics. They are ideally placed to provide an early intervention for any difficulty (or an early referral for complex problems). Although the Solihull Approach was developed with health visitors in mind, it has now been designed for use by all professionals who work with families with young children, including social workers, psychologists, primary mental health care workers, Sure Start workers and educationalists.

Psychological therapies have been developed for use by other professionals (e.g. Thornton, Walsh, Webster and Harries, 1984; Brown, Rickleton, Tweddle and Nicol, 1985; Pritchard, 1986; Appleton, 1990; Nicol, Stretch and Fundudis, 1993; Davis and von Roenne, 1994). However, Davis et al (1997) point to the comparative lack of evaluation of such strategies. In order to avoid this, a programme of research is developing as we raise different questions about whether and how this approach works. Two small-scale studies have already been carried out since the inception of the Solihull Approach in 1999. The first study looked at whether training in the Solihull Approach led to any change in the practice of the 'trainee' (Douglas and McGinty, 2001). It showed that training did change their practice. An unexpected finding was that using the Solihull Approach increased the practitioners' confidence and job satisfaction. Many health visitors have reported that parents are able to find their own behavioural solutions once their ability to think is restored.

The present paper describes the second study, looking at clinical effectiveness. The third study commenced in September 2001, revisiting clinical effectiveness whilst also beginning to examine how the Solihull Approach works.

Aims

This study had three aims. The first was to discover what effect the use of the Solihull Approach had on the severity of the child's presenting

difficulty. The second was to see what effect it had on the parents' anxiety about the presenting difficulty. The third was to find out what effect it had on the general level of anxiety of the parent.

Method

Design

This is a small-scale research project using a within-subject (repeated measures) design. For each family measures were taken at baseline (condition 1), end of support (condition 2) and at follow-up (condition 3).

Dependent variables were formed from mothers' anxiety and levels of infant problem severity. Independent variables were formed from the conditions created by times of measurement. Similar procedures were undertaken for analyses of mothers' specific anxieties and infant problem severity. However, as mothers' self reports were measured alongside health visitors', the two groups were compared in two factor mixed analyses of variance (MANOVA), which tested for differences between groups and between time points within groups. Any differences in mothers' general anxiety were measured using a single factor analysis of variance (ANOVA) statistical design.

The relationship between mothers' anxiety and infant problem severity were tested by parametric correlations (Pearson's r) at the baseline condition. It was decided that this was the time point of least 'contamination' with which to test for any relationship.

Participants

Data was collected from thirteen families. The mean age of infants in the sample was 22.38 months (SD = 13.4). There were seven male and six female children. Seven sleep and five behavioural problems were identified. On all occasions the parental respondents were mothers or female main caregivers. Although the study originally attempted to measure dependent variables from fathers, only one had been present at the sessions. Twenty-two families were initially recruited over a six-week period. Health visitors were unable to collect data within the necessary time period from four families, two mothers declined further participation and contact with three families was lost during the data collection period.

All thirty-seven health visitors who had had some training in the Solihull Approach were asked to collect data when applying the intervention. Participants were recruited on an opportunistic basis when health visitors observed problems, or were told of difficulties by parents. They only included those problems for which the Solihull Approach had

been designed i.e. behavioural, sleep, feeding and toileting difficulties. Participants were recruited at any point within the same six week period. No new cases were included in the sample after this period.

In an attempt to avoid systematic bias, health visitors were instructed to collect, where the parents agreed to participate, all data when embarking upon an intervention, regardless of whether or not clinical change was anticipated.

Measures

Beck Anxiety Inventory

The present study measured parents' anxiety using the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown and Steer, 1988). This mainly assesses physiological indices of anxiety from a 21-item self-report inventory. The BAI's reliability, convergent validity to other measures of anxiety and discriminant validity from measures of depression has received substantial empirical support (Beck et al, 1988; Clark and Watson, 1991).

Infant Problem Severity

The intervention's outcome was measured by the use of a single item scale rating the severity of the infant's problem. The scale was a 'Likert' type, five point rating scale developed for the audit of clinical outcome by the local child psychology service (Figure One). This was rated by the health visitor (Health Visitor Problem Severity Rating: HPSR) and by the parent (Parents' Problem Severity Rating: PPSR) at each measurement point.

Figure 1: Problem Severity Rating Scale

1. Please rate how severe you think your child's problem is at the moment	
a) Very severe	<input type="checkbox"/>
b) Severe	<input type="checkbox"/>
c) Moderate	<input type="checkbox"/>
d) Mild	<input type="checkbox"/>
e) Non existent	<input type="checkbox"/>

Parents' (Infant) Problem-Specific Anxiety

As the BAI is a general measure of anxiety, there may be differences from parents' anxiety specific to their infants' problems. An additional measure was therefore employed. Figure Two depicts a similar scale to that used for the infant problem severity ratings in an attempt to assess parents' specific anxieties (PSA). This 5 point Likert scale, also developed for audit by the local child psychology service, was used to rate the parents' anxiety about the infant's difficulty, see Figure Two. This was rated by the parent (Parents' Specific Anxiety: PSA) and by the health visitor (PSA-H).

Figure 2: Parents' Rating Scale for Problem Specific Anxiety (PSA)

1. Please rate how severe you think your anxiety is about this problem.	
a) Very severe	<input type="checkbox"/>
b) Severe	<input type="checkbox"/>
c) Moderate	<input type="checkbox"/>
d) Mild	<input type="checkbox"/>
e) Non existent	<input type="checkbox"/>

Health visitors were also requested to rate their impression of parents' anxiety using a similar but appropriately adapted scale (PSA-H).

Both health visitor and mothers' forms therefore comprised these two questions to be administered at each point of data collection. The health visitors' rating form at baseline also included questions to indicate the nature of the infants' problem and age. Although these scales have not previously received standardised tests, their advantage lay in the speed of administration and lack of intrusion to the health visitors' role and to the participant.

Other data collection

The health visitors' form also included the age of the child, the nature of the infant's problem, the time between follow-up and the end of intervention visit and the number of visits made before the end of the intervention.

Research packs

To avoid contamination between the parents' and the health visitors' ratings, all the forms were contained separately in sealed envelopes within a research pack, which also made it easy for the health visitor to carry around.

The intervention

The underlying theoretical framework described in the introduction was put into practice by health visitors when encountering difficulties relating to behavioural, sleep, feeding and toileting problems from within their routine caseload of children under five years old. The intervention places particular emphasis upon:

- developing an understanding of the current situation together with the parent and helping the parent manage their anxieties and feelings about it
- assessing the reciprocity between the parent and child and making this explicit where relevant
- behavioural assessment and application of behavioural techniques

The intervention is applied mainly on a home visiting basis during sessions lasting for approximately an hour, although the initial session can take longer. Within the service health visitor sessions are normally conducted on a fortnightly basis.

Procedure

On all occasions health visitors were provided with identical instructions for data collection at each step of the study. An initial consultation with a sample of health visitors was undertaken to ensure that the instructions accurately reflected terms and phrases used by the profession. For example, sessions using the intervention were referred to as 'support visits' and the follow-up condition was referred to as the 'evaluation visit'. Consultations with health visitors were used at all stages to make the process of the research user friendly and to eliminate as much bias as possible.

The study was conducted by the health visitors presenting parents with rating forms at each point of data collection. These were in addition to their own ratings and within the context of their normal working practice. Opinion was divided between health visitors over whether an evaluation at the follow-up condition would normally occur. However, visits for this third data point were conducted for the purposes of the research.

These occurred within a four to eight week time period. The study was designed to be flexible in terms of the number of sessions required. This was because the Solihull Approach is designed to be used as a brief intervention over 5 sessions and it was not actually known at this point how many sessions practitioners were using. The length of time between the start and end of the intervention was also designed to be flexible to reflect the reality of work that depends upon both the availability of the family and the worker and intervening holiday periods.

Health visitors were asked to briefly explain the nature of the research and to ask for the parents' participation and written consent when the Solihull Approach appeared appropriate. This process informed parents of their ethical rights to confidentiality and permission to decline or withdraw consent at any time during the intervention. The first baseline data were then immediately collected before the Solihull Approach commenced. Data for the second condition (end of intervention) was collected when the health visitor decided that no more sessions were required or when the maximum of five sessions had been conducted. Data for the third condition (follow-up) were assessed at between four to eight weeks after the second condition. This was in order to provide an indication of the stability of intervention effects.

If the parent required any assistance in the completion of the rating forms it was suggested that they ask for the health visitor's help. Otherwise, to avoid potential bias neither the health visitor nor parents saw each other's responses as they were sealed in envelopes for return to the researchers.

In a further attempt to avoid bias, confidentiality was maintained for both parents and health visitors so that no identities were apparent upon collation of the data. This was also designed to prevent the possibility or suspicion that individual performances of health visitors would be inferred or compared from the results. Arrangements were made for health visitors to be able to contact participants to arrange further support if any of the results caused concern.

Arrangements were also made to feedback the results of the study to the health visitors.

Results

Intervention characteristics

The mean number of sessions for each intervention was 2.6 (minimum 2, maximum 4). The mean number of weeks between the end of the intervention and the follow-up period was 5.3 (SD = 1.4) weeks.

Aim One: Intervention effect upon infant problem severity

Figure Three and Table One depict comparison means between mother and health visitor ratings of infant problem severity over the times of measurement.

Figure 3: Infant Problem Severity: Parent (PPSR) and Health Visitor (HPSR) Ratings (n = 13; N = 26).

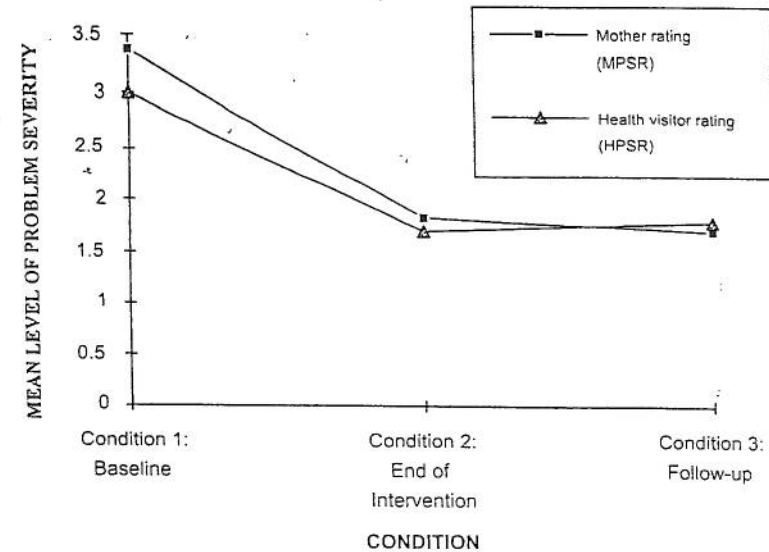


Table 1: Parent (PPSR) and Health Visitor (HPSR) Rating for Infant Problem Severity: Means, SDs and Pearson Correlations (n = 13; N = 26)

Condition	1: Baseline		2: End of Intervention		3: Follow-up	
	Mean	SD	Mean	SD	Mean	SD
PPSR	3.38	1.2	1.84	0.9	1.7	0.48
HPSR	3	1	1.76	0.72	1.84	0.80
Correlation	.768**		.836**		.517*	

** Pearson correlation is significant at .001 level (1-tailed)

* Pearson correlation is significant at 0.5 level (1-tailed)

Figure Three and Table One portray the mean ratings of mothers and health visitors for infant problem severity across conditions. As can be

seen from Figure Three, there was a fall in both parent and health visitor ratings. At baseline all ratings were between 'moderate' and 'severe', whereas all ratings were between 'non-existent' and 'mild' at the end of the intervention. The difference in aggregate scores across the three conditions was found to be statistically significant in a two factor MANOVA (3x2, Conditions 1/2/3 x health visitor/parent ratings) procedure ($F_{1, 24} = .38.93, p < 0.001$).

No statistical difference was found between the parent and health visitor ratings of infant problem severity ($F_{1, 24} = .154, p > 0.05$). As can be seen from Table One, both sets of ratings were highly correlated at baseline and end of intervention. There was a moderate correlation found at the follow-up condition. Therefore, parents and health visitors showed comparable estimations of infant problem severity.

These results suggested that there was a significant reduction in the severity of the child's difficulty, which was maintained at follow-up.

Aim Two: Intervention effect upon parents' anxiety about the presenting difficulty

Figure 4: Anxiety Specific to Infant Problems: Parent (PSA) and Health Visitor (PSA-H) Ratings ($n = 13; N = 26$)

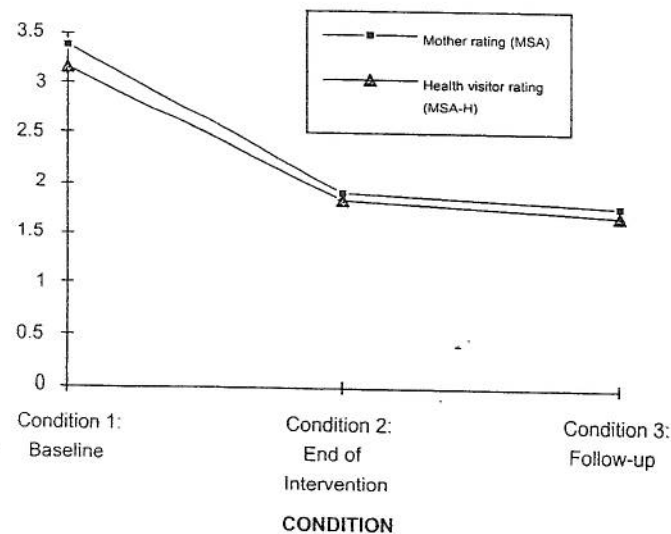


Table 2: Parents' Self-Rated and Health Visitor Rated Anxiety Specific to Infant Problem. Means, SD's & Pearson Correlations ($n = 13; N = 26$)

Measure	1: Baseline		2: End of Intervention		3: Follow-up	
	Mean	SD	Mean	SD	Mean	SD
PSA	3.38	1.36	1.92	1.03	1.76	0.6
PSA-H	3.15	0.98	1.84	0.80	1.69	0.63
Correlation	.805**		.586*		.458	

* Pearson correlation is significant at .05 level (1-tailed)

** Pearson correlation is significant at .001 level (1-tailed)

Figure Four and Table Two show comparisons of mean scores on PSA and PSA-H. Both health visitors' and parents' own ratings of problem specific anxiety appeared to follow a similar trend to that of the BAI measures of anxiety. Ratings were explored in a two factor MANOVA (3 x 2, Conditions 1/2/3 x health visitor/parent ratings). There was a significant main effect found for a reduction in anxiety within the ratings given by both groups ($F_{1, 4, 34.3=33.73, p < 0.001$). According to the Likert scale shown in Figure Two, specific anxiety decreased from 'moderate' to 'severe' ratings of anxiety at baseline, to 'mild' ratings at the end of intervention and follow-up.

No statistical difference was found between ratings made by the health visitors' group and parents' group across time periods ($F_{1, 24} = .203, p > 0.05$). They were therefore considered consistent in their estimation of mothers' specific anxiety.

Table Two also shows significant correlations between specific anxiety ratings at baseline, at the end of intervention but not at follow-up. It is proposed therefore that this analysis suggests that health visitors were successfully reflecting the mothers' specific anxiety.

In addition to the analysis of BAI measures, it is proposed that these results strongly suggest reliable reductions in anxiety about the problem over the time course of the intervention. Furthermore, the reduced levels of anxiety appeared to remain stable between the end of the intervention and follow-up without an elevation in anxiety after the support had been withdrawn. These are apparent for results on both the BAI and for anxiety specific to infant problems.

Aim Three: Intervention effect upon parents' general level of anxiety

One aim of the study was to find out what effect the implementation of the Solihull Approach would have upon the parents' general level of anxiety. Figure Four depicts a comparison of means for each time of measure-

ment on the BAI. Table One shows the related means, standard deviations and range of scores.

Figure 5: Parents' Mean Anxiety Scores on the BAI at Baseline, MEAN LEVEL OF ANXIETY (BAI)

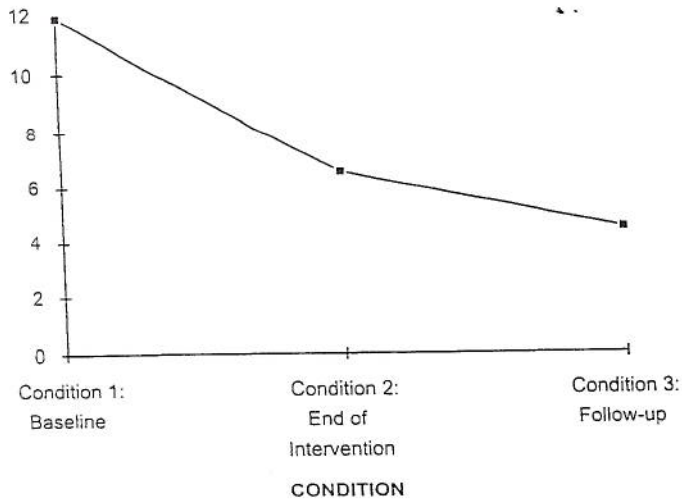


Table 3: Parents' BAI Means, SDs and Range of Scores at Baseline, Intervention and Follow-up Conditions (N = 13)

Condition	1: Baseline		2: End of Intervention		3: Follow-up	
	Mean	SD	Mean	SD	Mean	SD
BAI	11.9	8.5	6.7	7.2	4.5	5.2
Range	min : 2	max : 30	min : 0	max : 26	min : 0	max : 18

Figure Five and Table Three show a fall in the mean level of parents' anxiety between the baseline (difference in means = 5.2) and at the end of intervention and follow-up (difference in means = 2.5). A single factor ANOVA revealed a significant main effect ($F_{1,4, 16.4} = 13.79, p < 0.05$). The analysis of anxiety did not meet Mauchly's sphericity test of variance-covariance. The more conservative Greenhouse-Geisser test therefore calculated F with adjusted degrees of freedom. No difference in the final decisions was, however, apparent. Follow-up analyses using Bonferroni method t-tests with an adjusted alpha level suggested that significant differences ($p < 0.02$) lay between conditions 1 and 2 and between 1 and 3, but not between 2 and 3 ($p > 0.02$).

Hence, there was a significant decrease in the mean level of parents' anxiety between baseline and end of intervention. These levels remained stable between the end of intervention and follow-up conditions. The decrease-in anxiety between baseline and follow-up was 66.3%.

Relationship between parents' general level of anxiety and specific anxiety about the difficulty

Further exploratory analyses were performed to test for any differences or relationships between the two types of anxiety in the context of the study; parents' general anxiety as measured by the BAI and anxiety considered specific to the problem. At the baseline condition there was a moderate correlation ($r = .491, p < 0.05$) between scores on the BAI and mothers' reported anxiety about the infants' difficulties, so some variance appeared to be shared by the measures. However, although there appeared to be some relationship between the two variables, the absence of a stronger correlation indicated that there are some differences between what the two constructs measured. It is further suggested that the types of anxieties specific to childcare for parents may differ somewhat from that measured by instruments such as the BAI. The BAI may be sensitive to anxiety from a greater but less specific variety of sources. The correlation between health visitors' ratings of parents' specific anxiety and BAI scores was not significant.

Relationship between parent anxiety and infant problem severity

Exploratory analyses were also carried out on the relationship between mothers' anxiety and infant problem severity. Table Four shows the correlations calculated for anxiety and problem severity ratings at the baseline condition.

Table 4: Correlation Matrix Calculated for Parents' Anxiety (BAI), Problem Specific Anxiety (PSA & PSA-H) and Problem Severity Ratings (PPSR & HPSR) Made by Parents and Health Visitors

	BAI	PSA	PSA-H	PPSR	HPSR
BAI	1.00				
PSA	0.491*	1.00			
PSA-H	0.58	0.805**	1.00		
PPSR	0.413	0.890**	0.755**	1.00	
HPSR	0.588*	0.781**	0.675**	0.814**	1.00

* Pearson correlation is significant at .05 level (1-tailed)

** Pearson correlation is significant at .001 level (1-tailed)

Table Four shows that anxiety measured by the BAI correlated moderately with health visitors' ratings of problem severity ($r = .588, p < 0.05$) but not with ratings made by mothers. Parents' specific anxiety correlated significantly with infant problem severity when rated by health visitors ($r = .755, p < 0.001$) and by self-report ($r = .890, p < 0.001$).

There was, therefore, a relationship between parents' anxiety as measured by the BAI and infant problem severity, in that health visitor ratings of problem severity were predicted by BAI scores, but not parents' ratings of infant problem severity.

Problem specific anxiety appeared to predict problem severity when these were rated by both parents and health visitors. It was further suggested that this anxiety type had some differentiation from anxiety on the BAI and bore a stronger relationship with infant problem severity.

Discussion

The results provide some evidence that the health visitors' intervention based on the Solihull Approach was effective in reducing mothers' anxiety and the severity of their child's difficulty within three sessions.

The relationship between general anxiety, anxiety specific to the difficulty and the severity of the problem is interesting. There was a significant decrease across all measures. The moderate correlation between the results from the BAI and specific anxiety scale was significant, indicating a relationship, but with differences. One could postulate that specific anxiety about the difficulty contributed to the overall anxiety level of the parent, so that as the specific anxiety about the difficulty decreased as the child's presenting difficulty improved, so the overall anxiety of the parent decreased. The theory of containment would predict that as the general level of anxiety decreased, increasing the ability of the parent to function, so the severity of the infant's difficulty would decrease. However, it is not possible to tell from the present data whether the chicken or the egg came first. Although one suggestion from the results might be that the decrease in anxiety enabled the improvement in the child's difficulty, it is not possible to confirm any causal link from the present data about which came first, the decrease in symptom severity or the decrease in anxiety.

There are some methodological considerations. The single item rating scales are non-intrusive and easy to use. However they have not been formally investigated for reliability and validity. The researchers expected that the health visitors would rate symptom severity lower than the parents because of their wider frame of reference, but this was not the case. The strong correlation between the mothers' and health visi-

tors' ratings would suggest that they are a useful measure, but this needs to be formalised. They do, however, provide an indication of the trends. A more robust measure to use for validation and further studies would be one which provides more detail about the frequency, duration and intensity of the problem (e.g. Achenbach's Child Behaviour Checklist, 1992). However, there does appear to be a lack of easy-to-use psychometric measurements for use with infants and children under 5 years of age. Perhaps this is because child development research has tended to be university based, where complex and time-consuming methods like the Strange Situation can be used. There has not been much research by practitioners in busy clinics, unlike for adults, where a plethora of user friendly psychometric measures are available. Easy to use measures need to be developed for work with infants and preverbal young children. One example of this is PIPE (Paediatric Infant Parent Exam) described by Fiese et al (2001). This measure rates a two-minute interaction between the parent and infant. It has the advantages of being quick and easy to administer within a natural setting and of looking at the relationship between the parent and infant, not their separate characteristics.

To the authors' knowledge, there does not seem to be an alternative to the single item rating scale for parents' anxiety about the problem. Given the literature's emphasis upon maternal anxiety and infant psychopathology, there does seem to be a lack of specialised measures in this area.

A further methodological consideration in experimental design relates to the use of the single factor design without a control group. Without an attempt to employ a randomised comparison to, for example, controls of placebo or waiting list participants, changes due to the confounding effects of time alone cannot be wholly discounted. However, as anxiety and problem severity levels stabilised before therapy had ended, this would seem unlikely.

Some caution may be required when interpreting results from the present study's sample, in that families were recruited through the health visitors' routine contact with families. Tight control could not therefore be ensured to eliminate potential bias when selecting participants. However, with both mothers and health visitors blind to each other's responses and instructions given to health visitors to collect all data, it is thought that adequate control was exerted.

However, despite these methodological considerations, the level of significance of the results indicates that the findings are probably robust enough to outweigh any difficulties with the design. A further study on effectiveness is planned to commence in September 2001. This study will also begin to focus on how the Solihull Approach works. It will be

interesting in the future to look at the different theoretical components of the model to assess their contribution to effectiveness, although there is probably a Gestalt effect where the whole becomes greater than the sum of the parts.

It is likely that the Solihull Approach is effective with a subset of the parent-infant population with difficulties. This needs further elucidation. Our clinical experience suggests that if it has not worked within the five sessions then the practitioner needs to think about referring on or using a different approach. Some families need to be referred on immediately where the child is at serious risk and specialist input is required from various different professionals and support systems. However, where the family needs multi-agency support it may still be worth trying the Solihull Approach when the support is in place. We are constructing care pathways through the different agencies for children in difficulty. At present we have produced one for children suspected of having Attention Deficit and Hyperactivity Disorder which begins with the health visitor trying the Solihull Approach to sift out those active children (mainly boys) who require different management from their parents. We are also working on a single point of entry for children into all the main agencies and voluntary groups, so that services are put into place together and coherently. This would improve the provision of early intervention for children and their families. It would also increase the likelihood of having the right support in place for the child starting school. The single point of entry also includes the Solihull Approach. In this case it provides a sifting mechanism, dealing with the less complex cases, but also provides information for the next tier of service to more accurately pinpoint what the family might respond to.

Anecdotal evidence from health visitors who have become familiar with this approach suggests that they are able to pick up attachment difficulties between mothers and their infants in the first few weeks and months by observing the reciprocity between them. They have been able to use the Solihull Approach to listen to the mothers' concerns and to help the relationship in those crucial early months. A longitudinal study is needed to see if this forestalls later difficulties.

It would be interesting to examine whether it is the case that the demands of working with children under five years of age and their families are producing brief, eclectic models of working. Our experience is that the theoretical model underpinning the Solihull Approach slowly evolved in response to the demands of the working environment. In the tradition of parsimony, the minimum number of theories were included and only those which had an immediate practical application.

On the evidence of the research data so far, this does seem to have translated into having an effect on the work for both practitioner and family. The practice and subjective experience of the practitioner change, as well as the behaviour of the child and the anxiety of the parent. All the participants are involved and all are changed by the experience.

This was a preliminary evaluation, using a small, but statistically significant sample. Although the study has its limitations, as outlined above, the results are promising enough to encourage further research on both the effectiveness of this approach and on elucidating how it works.

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