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SIGNS OF INSECURE ATTACHMENT DEVELOPMENT IN INFANCY

- HOW DO CHILD HEALTHCARE NURSES
IDENTIFY THEM?

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Sarsfield, Amanda. Signs of insecure attachment development in infancy - How do child healthcare nurses identify them? Candidate dissertation in social work, 15 points. Malmö University, Health and society, social work undergraduate degree course, December 2013.

The objective of this study is to examine Swedish child health clinics (Barnvårdscentralen – BVC) interpretation and evaluation of mother-infant relationships. The study's empirical material is gathered using the vignette technique and the semi-structured interview technique. Analysis of the empirical material is undertaken using the thematic coding analysis technique. From the studies empirical material the following themes were identified: The roles of situational norm deviation and reoccurrence, the role of experience, routine & observation, the use of tools, straight forward open communication and trust and the child as an indicator for the mother's wellbeing. The conclusion of this study is that BVC interprets and evaluates mother-infant relationships using a combination of experience, routine and observation to determine the degree of norm deviant behaviour present during routine BVC controls.

Keywords: Attachment, BVC, child health, indicative prevention, risk factors, screening, semi-structured interview, theory of practice, vignettes

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INTRODUCTION

1.1 Background

A wealth of evidence exists to show that a secure and well-functioning attachment between mother and infant is a crucial ingredient in the positive development of the child. Research has linked insecure attachment styles with the development of aggressive behavioural problems (Lyons-Ruth, 1996), difficulties with peer group interaction, poor problem solving abilities and low self-esteem (Field et al, 1988). Serious psychological conditions such as psychopathology (Martin & Gaffan, 2000) and depression (Garber et al, 1985) have also been linked with insecure attachment styles.

A secure attachment can therefore be deemed an important protective factor in reducing the risk that a child experiences serious psychosocial problems in later life. Indeed, Lagerberg and Sundelin (2000) state that the parent-child relationship is amongst the strongest factors that affect a child's well-being, with the emotional quality of the relationship being paramount. This suggests that attachment, which serves as the foundation for the parent-child relationship is of the utmost importance when trying to create positive outcomes for children.

Whilst both mother-infant and father-infant attachments are important in the child's development research has shown that in times of stress a child will seek proximity to the mother rather than the father, suggesting that it is the mother who has the role of primary attachment figure (Lamb, 1976, Howe, 2011). In addition Main and Weston (1981) examined the quality of a child's attachment to both the father and the mother and found that, though the mother-child attachment did not predict the father-child attachment, the child fared better in responding to strangers' requests if the attachment with the mother was secure. Main and Weston's (1981) research would therefore seem to suggest that though both parents are important for a child's positive development, a secure attachment to the mother may be one of most important protective factors a child can have.

The term "good enough parenting" (Killén, 2009) has been used to describe factors considered to constitute a good parent-child relationship. According to Killén (2009) "good enough parenting" occurs when the physical and emotional care of the child stands in relation to his or her needs and not the needs of the parents. This is reflected in what Killén (2009) considers the four most important parental functions, which include seeing and accepting the child for who they really are, engaging positively in the child, showing empathy for the child and having realistic expectations about what the child can achieve.

When these conditions are not met to an adequate degree, problems can occur that threaten the mother-child attachment. Studies have shown that when parent-child interaction is dominated by control, unavailability, unpredictability and insensitivity children go on to develop insecure attachment styles (Egeland et al, 1993 & Egeland & Farber, 1984). Parents who fail to give "good enough parenting" and who do not engage in their children predictably, sensitively or with availability risk interacting with their child in such a way that the relationship could be deemed to be lacking in adequate amounts of care (Killén, 2009).

If the mother-child interaction follows this pattern and the child's needs go unaddressed or are simply poorly met then there is the very real possibility that

the child will not only develop an insecure attachment, but will also go on to develop poorly in general (ibid). Killén (2009) highlights a parent's irrational involvement in his or her child, lack of positive interaction, unpredictable living situation and unpredictable personality as risk factors associated with the development of a poor mother-child relationship and then later insecure attachment styles.

Due to the fact that the development of an insecure attachment can have such severe detrimental consequences for a child's future development and well-being, it is essential that preventative measures are undertaken as early as possible in the child's life to ensure that the child develops a secure attachment to at least one of the parents. According to Killén (2009) there are three types of prevention that can be undertaken in such instances. The first type of prevention is known as universal or primary prevention and aims to prevent a problem before it has even occurred. This type of prevention commonly addresses whole populations such as parenting classes aimed at all pregnant women with the purpose of educating them about how to create a good attachment to their child.

The second type of prevention named by Killén (2009) is selective or secondary prevention; the aim of which is to identify risk factors associated with the development of certain types of psychosocial problems. This type of prevention generally addresses groups considered to be at risk, such as mothers with a cocaine addiction; a risk factor which has long been associated with the development of the insecure disorganised attachment (Espinosa et al, 2001).

The third type of prevention taken up by Killén (2009) and the one which is of most importance to this study is indicative or tertiary prevention. This type of prevention is aimed at mitigating and limiting the severity of problems that have already occurred. An example of which would be the identification and treatment of families where a poor mother-infant interaction has been observed. This type of preventative action would aim to improve an already poor mother-infant interaction with the hope of preventing the child from going on to develop an insecure attachment.

Indicative prevention has thus, long been a function of Sweden's child health clinics (Swedish: Barnvårdscentralen – BVC). Here nurses are tasked with routine check-ups, the immunisation of infants and the encouragement of a healthy mother-infant bond (Johansson et al, 2011). Due to the fact BVC is responsible for the health of all infants in Sweden; it is in an excellent position to identify those mothers who interact poorly with their children and risk developing relationships in which the child receives inadequate care. It is therefore of the utmost importance that nurses responsible for the care of their infants are well equipped to identify risk factors associated with a poor mother-child relationship and take the appropriate steps to prevent the child from going on to develop an insecure attachment.

1.2 Objective

The objective of this study is therefore to examine Swedish child health clinics (Barnvårdscentralen – BVC) interpretation and evaluation of mother-infant relationships.

1.3 Problem statements

How do child healthcare nurses identify poor mother-infant relationships?

Which risk factors draw the most and least focus?

How are they interpreted?

1.4 Definitions

A risk factor is defined in this study as a social, psychological or biological relationship that can lead to problems with health, development, adaptation or behaviour (Lagerberg & Sundelin, 2000)

A child healthcare nurse is defined in this study as a qualified nurse who is responsible for the routine checks administered during the child's first few years of life.

The acronym BVC (Barnvårdscentralen) will hereafter be used instead of child health clinics.

1.5 Limitations

Due to time constraints this study is limited to the examination of the four key risk factors outlined by Killén (2009), namely; a parent's irrational involvement in his or her child, lack of positive interaction, unpredictable living situation and unpredictable personality.

The study is also limited to the examination of the mother-infant interaction and focuses solely on the father-infant interaction/dual parent interaction as a risk factor in the disruption of the mother-infant interaction. This is because the vast majority of research that exists on the topic of attachment concerns mother and child (Killén, 2009). The little research that has been done into father-child attachment suggests that though it is of importance, the mother's attachment to the child is of greater significance (Lamb 1976, Main & Weston, 1981, Howe, 2011).

The study will solely examine issues surrounding the child healthcare nurses identification and interpretation of the aforementioned risk factors and disregards the debate on the treatment of poor mother- infant interaction.

Furthermore, this study will focus on child healthcare nurses experiences of dealing with infants up to the age of one year so as to narrow the study's focus onto the very earliest signs of the development of an insecure attachment.

1.6 BVC – a short overview

Barnvårdscentralen or BVC has been an institution within the Swedish healthcare system since the 1930's, coming into being with governments realisation of the need for specialist support for parents and young children (Hallström, 2003). The early BVC were tasked with the vaccination of young children against infectious childhood diseases, but have grown to encompass a wide range of services and health examinations (ibid).

The main aims of BVC are to offer a support to new mothers and fathers and to cater for the specific needs of the new parents and their child as well as prevent problems relating to a child's physical and mental health (Johansson et al 2011).

As such, BVC offers a base program which is offered to all new parents. The base program includes regular examinations from the first few weeks of the child's life up until the age of about five or six years (www1). The base program includes vaccinations, developmental checks and general health examinations and also comprises of evaluations of the mother-infant relationship as well as advice and counselling for the mother (ibid).

BVC is staffed by both paediatricians and child healthcare nurses (ibid). Nurses who work in BVC are either nurses with a master's degree in paediatric nursing or a master's degree in district nursing (ibid). A degree in paediatric nursing consists of education in paediatric care and nursing as well as the health of children between 0-5 years and older children between the ages of 6-18 years (www2). A master's degree in paediatric nursing gives a nurse the ability to observe, evaluate and resolve complex care needs in children and give health examinations, describe health risks and health problems in children (ibid).

A master's degree in district nursing includes courses on the health, living conditions and ill health of children and youths (www3.) A master's degree in district nursing gives a nurse the ability to work in BVC and work communally within the local area amongst other things (ibid).

2. THEORY

The analysis and interpretation of this study's results will take place using a two pronged approach. The results will be analysed using Pierre Bourdieu's theory of practice in order to gain insight into the practices and procedures of BVC, as well as the individual child healthcare nurses' own practices for the interpretation and identification of mother-infant relationships.

The results will also be analysed in relation to attachment theory and risk factors theory. Both of which will aid in giving an overview of how the systematic and subjective practices of BVC relate to risk factors surrounding attachment dysfunction.

2.1 Bourdieu's theory of practice

Pierre Bourdieu was a French social anthropologist famed for his insights into the world of practice. Bourdieu's work was born out of a frustration with the theoretical and philosophical division that he perceived existed between objectivism and subjectivism (Ritzer, 2009). Bourdieu was determined to find a way to bridge the gap, whilst at the same time returning the individual to an active participant within society's structural realms. Bourdieu achieved this feat through examining the complex dualistic relationships that exist between the social agent (individual) and the various structural relationships present in society, with each one affecting the other (Grenfell, 2008).

Bourdieu's theory, which became known as the theory of practice, incorporated the concepts *habitus*, *field* and *capital* in order to explain these complex relationships. The first of these concepts, habitus, can be interpreted in many different ways and due to its abstract nature is notoriously difficult to define. Grenfell (2008) explores many different interpretations and definitions, but defines habitus himself, as a property of social agents that is structured by one's past and present circumstances, such as upbringing and educational experiences.

In addition Grenfell (2008) explains that habitus can also be viewed as structuring in that habitus helps to shape one's present and future practices. Another interpretation of habitus comes from Ritzer (2009), who defines habitus as cognitive structures through which human beings manage the social world and produce, judge and perceive their practices.

There is considerable debate about the fluidity and flexibility of the habitus concept, with some scholars' describing the habitus as objective rather than subjective, determined by our past history alone and immobile within the structures of the field (King, 2000). Grenfell (2008) offers however a more subjective and fluid interpretation of the habitus, stating that the structures of the habitus are not set in stone but do in fact evolve; they are durable and transposable but not absolute, thus susceptible to the influence of current experience. Grenfell's (2008) interpretation of habitus as a concept capable of evolution and influenced by recent experience is the one which this study will use in its interpretation and analysis of the empirical material.

Taking into account both Grenfell (2008) and Ritzer's (2009) interpretations we can conclude that an individual's frame of reference or schema determines how an individual acts in a given situation. A child healthcare nurse would in accordance with Grenfell (2008) and Ritzer (2009), have for example, a habitus which determines how he or she carries out routine tasks associated with his or her work. Bearing this in mind it is therefore reasonable to assume that a habitus exists for the purpose of evaluating mother-infant relationships and that this is different depending upon how the habitus is structured by the nurse's relationship to both the field and own internal regulation.

According to Rhynas (2004) the inherent nature of habitus means that it encompasses a reality that often goes unquestioned by the individual. As such, individuals can develop habitus that lead to both desirable and undesirable practice. It can be said that habitus both produce the social world we inhabit, yet are also a product of it. A child healthcare nurse may, for example, develop habitus for identifying poor mother-infant relationships through observing the practice of other child healthcare nurses and then go on to present these habitus for other child healthcare nurses who will also internalise it, thus becoming both a product of, whilst at the same time producing the field of paediatric healthcare.

The concept of field is described by Ritzer (2009) as a network of relations amongst the objective positions within a specific area. A field can constitute a series of structures, institutions, authorities and activities, which all relate to the people acting within the field (Rhynas, 2004). As such, a field can be construed as a system of social positions structured internally. A child healthcare nurse can, for example, be considered a social position within the healthcare institution; an institution which comprises of several other social positions. All these social positions are related to each other hierarchically and are affected not only by the structures that exist within the field but also from those that exist outside of it. This means that child healthcare nurses' practices can be affected by the organisational structures of BVC as well as from the wider structures of society such as politics and education.

According to Rhynas (2004) agents within the field interact with its structural aspects developing relationships and interacting with it in ways that have the

potential to alter its nature or future direction. This means that the field is an ever changing and even conflicting entity, which can provide a challenge for the agents within. Furthermore neither habitus nor field can exist without each other due to the dualistic nature of their relationship whereby the habitus is both changed by and changes the field (Grenfell, 2008).

When habitus and field are combined, however, with the concept of capital, practice is created. Capital is according to Ritzer (2009) the means by which agents in the field have of controlling their social positions. Capital can be divided into four categories: economic, cultural, social and symbolic. Economic capital signifies an agent's physical wealth, whilst cultural denotes an agent's manners and etiquettes (ibid). Social capital is representative of the value of an agent's social network and symbolic capital conveys an agent's honour and prestige (ibid). The more of each type of capital an agent possess the better he or she is able to manipulate the field and move up in the hierarchy of social positions.

According to Rhynas (2004) the theory of practice is based upon how these three concepts interact with each other. Habitus interacts, for example, with capital as individuals are motivated to earn economic capital and develop greater social capital, whilst being internally regulated by their habitus. Field, however, adds dimension to the interaction between capital and habitus and gives context. This interaction suggests Rhynas (2004), means that capital and field form the structure within the relationship that the agents habitus internally regulates.

With this in mind, Bourdieu's theory of practice can form the basis for the interpretation of the relationships that exists between the child healthcare nurse, the healthcare institution and the wider society. Bourdieu's habitus concept is of particular interest in how it relates to the nurse's development of habitus that aid in the evaluation and interpretation of mother-infant relationships.

2.2 Risk factors theory

Risk factors theory is based upon the assumption that statistically significant correlations between two or more variables can predict the likelihood of certain events or circumstances happening (Smith & Carlson, 1997). This phenomenon, known as cause and effect, depicts the relationship between certain variables, whereby one of the variables is necessary in order for the other to occur (Lagerberg & Sundelin, 2000). This cause and effect phenomenon is exemplified in attachment studies which endeavour to ascertain factors which can cause insecure attachments to occur. A probable causal relationship exists for example, between postnatal depression and the development of insecure attachments (Murray et al, 1997).

Problems with the cause and effect phenomenon exist, however, due to the fact that it can be very difficult to establish the validity of such relationships. Murray et al's (1997) interpretation of the relationship between postnatal depression and insecure attachments could in fact be invalidated if other statistically significant variables or covariates were found to have a casual effect. A mother could, for example, be trapped in an abusive relationship or have a bad relationship to her own mother at the same time that she is depressed. All or only one of these variables could be responsible for her child's insecure attachment. It could even be the case that a certain chain of variables had to occur in order for the insecure attachment to develop, such as the postnatal depression leading to the mother

abusing drugs, which led to the neglect of her child, which finally led to the child's development of an insecure attachment. It can be extremely difficult or even impossible to isolate which variable, covariate or chain of variables is directly responsible for the occurrence of a single specific event.

Thus correlation can establish probability but not causality. Correlation itself is defined by Robson (2011) as a measure of relationships between variables describing the direction and degree of the association between them. This means that a correlation can be positive, negative or neutral as well as strong or weak. Lagerberg and Sundelin (2000) state that ranking measured variables in individual tables can determine the type of correlation that exists. If, for example, two variables rank highly in their respective tables a positive correlation can be said to exist, whilst a negative correlation can be observed when one of the variables ranks highly and the other lowly. The strength of the correlation is determined however, through the degree of linearity that exists between the variables. A strong positive correlation is observed, for example, when the variables show a tight linear trajectory ranging from low to high (Robson, 2011).

The difficulty in determining causality between variables has led to the establishment of the term risk, which can be defined as a circumstance or event that increases the likelihood that something undesirable occurs (Lagerberg & Sundelin, 2000). Whilst it is impossible to say with certainty that a child will develop an insecure attachment due to the mother suffering from postnatal depression, we can however say that postnatal depression is strongly associated with insecure attachment and as a result constitutes a statistically significant risk factor for the child. The degree of risk a person experiences can rise and fall with the addition of more risk factors as well as with the intensity of each individual risk factor. This means that the risk of a child developing an insecure attachment increases if the child is surrounded by several factors linked with insecure attachment at the same time or if the risk factor(s) is/are particularly severe.

Risk can also be affected by both risk thresholds and latent risk factors. Latent risk factors are described by Lagerberg and Sundelin (2000) as dormant or hidden risks that have lain inactive for long periods of time, but become activated with the advent of future stressful situations. A risk threshold, on the other hand, is described as the effect of several risk factors occurring at the same time (ibid). An individual can, for example, be subject to two risk factors for postnatal depression and yet still not succumb. This, however, could change with the addition of a third risk factor, which subsequently, and in combination with the other two, leads to the individual developing postnatal depression. One could say that the individual's resistance to the first two risk factors was worn down to the point where it wasn't enough to withstand the presence of a third. Smith and Carlson (1997) state that a lone risk factor is rarely enough to cause an undesirable outcome, such outcomes are, they say, routinely the result of the cumulative effects of several risk factors at the same time.

2.3 Attachment theory

Attachment theory first came into being in 1969 with the publication of *Attachment and Loss*; the first in a trilogy of books by renowned developmental psychologist, John Bowlby. Through his work Bowlby sought to explain the social development of young infants with regards to their early relationships and interactions. Attachment theory originates in what Bowlby calls the attachment

system; a behavioural system with the sole purpose of ensuring that an infant regains both psychological and physical proximity to its caregivers (Howe, 2011). When an infant feels threatened or experiences danger a set of behaviours, such as crying and screaming, activate that should induce the parents to go to and comfort the child, thereby deactivating the attachment system. According to Bowlby (1969) the attachment system has an evolutionary function that gives children who remain in proximity to their parents a greater chance of survival from predators and other life threatening dangers.

Bowlby theorised that over time, a child will establish significant attachments to its primary caregivers and will begin to develop an internal working model based upon their responses to its attachment behaviour. This internal working model comprises of the impressions the child develops about itself and its caregivers (Killén, 2009). The child will then, based on its internal working model, develop an attachment behaviour or strategy that proves most successful in gaining its caregivers' attention in times of distress.

Bowlby developed his theory to include four phases of attachment. During phase one (birth to three months) Bowlby proposes that infant's caregivers are responsible for both proximity to and the protection of the child (Robinson, 2002). During the second phase (three months to six months) Bowlby states that the child becomes a much more active participant in the attachment process and assumes more responsibility for maintaining and gaining contact and interaction (ibid). Phase three (six months to nine months) however, consists of the infant directing his or her attachment behaviour toward a single or selected primary caregivers. The infant starts to become wary of strangers and develops a secure base in his or her attachment figure/figures (ibid). Whilst phase four (around four years of age), the last phase of attachment, comprises of the child and the parents having reached a mutual understanding with each other.

During the late 1960's and 70's Mary Ainsworth, a proponent of attachment theory, identified three types of attachment through the use of the innovative "Strange Situation Procedure" (Ainsworth & Wittig, 1969). Ainsworth named the three attachment types in accordance with the child's attachment behaviour, namely the secure attachment, the insecure avoidant attachment and insecure ambivalent attachment. A child will develop a secure attachment if he or she receives appropriate and reliable responses to their attachment behaviours. If, however, a child does not receive appropriate and reliable responses it will most likely fall into one of the categories depicting an insecure attachment style (Killén, 2009). The category into which the child falls depends almost entirely upon the type of the response the caregiver provides. The child's goal with whatever behaviour it displays is always to ensure that the caregivers respond when the child feels distress.

Insecure avoidant attachments occur, for example, when a child's caregiver is controlling and rejecting. A child with this type of attachment will typically try to hide its feelings and show a lack of trust (Howe, 2011). Children who exhibit insecure ambivalent attachment styles, on the other hand, are characterised by children with highly exaggerated attachment behaviours. Such attachment patterns occur, states Howe (2011), because a child has received inconsistent and unreliable responses to its attachment behaviour.

A third type of insecure attachment and fourth type of attachment behaviour was added to the classification scheme in 1990 by Mary Main and Judith Solomon. During a repetition of the Strange Situation Procedure Main and Solomon discovered that some children were very hard to categorise and fell into none of the three other categories. These children could react with exaggerated behaviours one minute and avoidant the next. Such children appeared confused and even scared when confronted with their caregivers. Main and Solomon (1990) named this fourth style as unstructured insecure disorganised attachment. According to Howe (2011) this type of attachment occurs when the child's caregivers respond to the child's attachment behaviours with unpredictable and sometimes frightening behaviour.

The type of attachment that a child develops has shown to impact upon the rest of its life. Howe (2011) states that the attachment style a child develops during infancy will most likely follow the child into adulthood. Children who develop insecure attachments, and in particular those who develop the disorganised variant, are at a much greater risk of developing serious psychological, emotional and behavioural issues as a result (ibid).

2. PREVIOUS RESEARCH

According to Killén (2009) a mother qualifies as having an irrational involvement in her child when her view of the child becomes unreasonably skewed or distorted. The child is assigned qualities that it does not have and is manipulated in such a way that it develops in accordance with the mother's own perceptions. Such parental behaviour is, proposes Killén (2009), often the result of immaturity, hostility and anxiety. Support for Killén's reasoning can be found in the work of Stevenson-Hinde et al (2011) who found that children to anxious mothers have a much higher incidence of insecure ambivalent attachments than children to non-anxious mothers. This would seem to lend support to Killén's theory that anxious mothers can project their own anxieties onto their children, causing them to develop the anxious attachment behaviour typified by the insecure ambivalent attachment pattern.

Killén's reasoning as to the causes of a mother's irrational involvement in her child finds additional support in Lounds et al's (2005) study of adolescent mothers. The result of the study found that children to young mothers had a strikingly high incidence of disorganised attachments (45 percent) in comparison to middle class, low-risk populations. Lounds et al (2005) suggest that such high incidences of disorganised attachment could be the result of a lack of knowledge, a tendency towards harsh and punitive parenting as well as problematic parenting attitudes prevalent amongst adolescent mothers. A result of which could be that the mother develops an irrational involvement in the child.

Another of the factors Killén (2009) highlights as a risk factor in the development of a problematic mother-child relationship is a mother's lack of positive interaction with her child. Killén describes mothers who display this type of behaviour as unavailable, both physically and psychologically. Such behaviour can, according to Killén (2009), occur due to the presence of many different factors. Psychosocial factors such as economic difficulties, unemployment, psychiatric disorders and mental and physical disabilities are all factors named by

Killén (2009) as increasing the probability that a mother lacks the ability to cope with her child and invest in the child both positively and emotionally.

Social factors such as economic difficulties and unemployment in mothers have long been risk factors associated with a child's poor development (Sydsjö, 1995, Levendosky, 2011), both in their own right and as casual or covariant risk factors for psychological conditions such as postnatal depression (Bernazzani et al 1997). Postnatal depression occurs in around 13 percent of woman during the first few months after the birth of the child (Wickberg, 1996) and has been strongly linked to attachment dysfunction. Murray et al (1996) found that maternal depression correlated strongly with a child's development of insecure attachment; 62 percent of children to mothers suffering from postnatal depression were found to have an insecure attachment, which contrasted greatly with the 26 percent found in the control group. In addition, Murray et al (1996) found that mothers suffering from both postnatal depression and personal adversity were less sensitively attuned towards their children and were less affirming and more negating of their infant's experiences; all of which can dramatically affect the mother-infant interaction and lead to the development of an interaction lacking in adequate amounts of care (Killén, 2009).

Whilst postnatal depression is a well-documented risk factor in the development of poor mother-infant interactions and later insecure attachments there is less research into the impact of the effects of other serious psychological disorders and even less on the impact of personality disorders, mental and physical disability. According to Killén (2009) psychological disorders such as schizophrenia can seriously impact upon a mother's ability to invest herself positively in her child. In 1987 Jody Shachnow researched the effects of a psychotic parents hospital stay on their children and found that small children suffered invariably from sleeping problems, anger, exaggerated attachment behaviour towards the remaining parent as well as other behavioural problems and learning difficulties. Shachnow's (1987) research demonstrates that children to psychotic parents are at risk for developing insecure attachments, either due to the parent's absence or as a result of the parent's inability to engage positively in the child.

Perhaps one of the most under researched and controversial risk factors associated with a mother's inability to interact positively with her child is mental disability. Research has shown that children born to mentally disabled mothers do not receive enough stimulation, are at risk for behavioural and emotional disorders and are often delayed in their development (SOU: 2005-123-3, Rönström 1981). In addition Gillberg et al (1983) found that mentally disabled mothers were less able to care for their children and that under the study's duration 50 percent of the children were taken into care. Killén (2009) suggests that mentally disabled mothers already have too much to cope with and that the addition of a child leaves them unable to invest themselves emotionally or positively into the child.

Psychological disorders can also be considered risk factors for a mother behaving in an unpredictable manor towards her child (killén 2009). According to Killén (2009) a parent's unpredictable personality can cause their child to live in fear of what she terms the "predictable unpredictability". Killén (2009) suggests that children who live with fear find themselves spending vast amounts of energy observing their caregivers in an attempt to try to pre-empt their behaviour.

Research surrounding the effects of maternal borderline personality disorders on child attachment is very sparse, yet Killén (2009) highlights it as an incredibly important risk factor in the category of unpredictable personality. Killén (2009) cites her experience as a social worker as evidence and suggests that maternal borderline personality can lead to a mother becoming emotionally unstable and thereby unpredictable. In addition Killén (2009) states that such mothers are often filled with aggression which they have difficulty controlling. This can lead to them reacting both physically and verbally aggressive towards their child. Borderline personality disorder often leads to self-destructive behaviour and can appear co-morbidly with other psychological disorders, such as depression, and drug addiction (Zimmerman & Mattia, 1999).

It is not uncommon that parents with unpredictable personalities are also subject to unpredictable living situations (Killén, 2009). Two of the most important risk factors associated with a mother's unpredictable living situation are domestic violence and drug addiction. Both of which have been shown to detrimentally affect the mother-infant relationship and attachment. Levendosky et al (2011) found that women who experienced domestic violence during pregnancy or for the first time during the first year of the child's life were likely to either maintain or develop an insecure attachment by the age of four. Domestic violence is also implicated as a causal factor in the development of postnatal depression (Bogat et al, 2003) and can appear co-morbidly with drug addiction (Killén, 2009). Both drug and alcohol addiction have been linked to the development of insecure attachments, particularly the disorganised variant (Espinosa et al, 2001)

Research into the identification of mothers and infants experiencing attachment disrupting psychosocial problems is also sparse. Most of the research on the topic surrounds postnatal depression, which is arguably one of the most common and serious factors affecting the mother-infant attachment. According to Killén (2009) mothers suffering from postnatal depression in Norway are rarely identified. This she suggests is owing to the assumption that a taboo exists around the subject. Killén (2009) argues that such a taboo affects mothers' willingness to open up and discuss how they are feeling as well as for health care personal to accept the seriousness of the situation. Killén's observations are supported by Johanson et al (2000) who found in a study of pregnancy related depression that only eight of the 31 women with postnatal depression were identified by their general practitioners as depressed. Johanson et al's (2000) research suggests that there exists a lack of either knowledge surrounding postnatal depression and or a lack of competent screening methods.

Screening methods such as the Edinburgh postnatal depression scale (EPDS) do however, exist and have been proven to be effective. Bågedahl-Strindlund and Monsen Börjesson (1998) found that use of the EPDS as a screening measure is well accepted both by the mother and the nurse and significantly increases the number of cases of identified postnatal depression. The EPDS is a self-screening technique that comprises of ten questions aimed at detecting how the new mother is feeling (ibid).

Child healthcare nurses also play an important role in the identification and support of mothers and infants who display abnormal interaction and worrying signs of attachment dysfunction. Tammentie et al (2013) found that child healthcare nurses helped to prevent postnatal depression through a child

healthcare nurse's holistic co-operation with an individual family. In addition Johansson et al (2011) found that child healthcare nurses rely upon a wealth of experience and trust in order to identify and support parents who experience difficulty in the parental role. In addition, Johansson et al (2011) found that child healthcare nurses are also essential for strengthening a parent's ability to connect and bond with their child.

4. METHOD

4.1 Methodological approach

In order to fulfil the study's objective of examining BVC's interpretation and evaluation of mother-infant relationships, as well as to respond to its problem statements, this study will employ a qualitative approach using both the vignette technique and the semi-structured interview technique. A qualitative approach to this study's objective and problem statements has been selected due to the fact that qualitative research generally uses inductive techniques in order to better understand an individual's world and how they relate to it (Kvale, 2009).

The qualitative paradigm is also well renowned for allowing the author to gather in-depth understanding of human behaviours and is more adept at answering the how and why of decision making (Bryman, 2011). Such an approach to this study's objectives would derive the best methods for understanding how child healthcare nurses relate to their work in identifying poor mother-infant relationships.

The vignette technique will form the basis for this study's methodological approach and will be used in conjunction with the semi-structured interview technique. The vignette technique is a fairly recent addition to the qualitative paradigm and consists of text, images or other material to which participants are asked to respond (Robson, 2011). Vignettes are often fictional scenarios based upon simulations of real events in which participants are asked to comment about how they view the vignette or how they would act in such a situation.

The vignette technique has both advantages and disadvantages attached to it. According to Robson (2011) Vignettes used alone or in conjunction with other techniques can provide a very valuable tool in the research and understanding of people's lives, their attitudes, perceptions and beliefs. Vignettes are, however, very much subject to their degree of believability (Bryman, 2011). It is also very difficult to ascertain how realistically the participants visualise the vignette and perhaps even more difficult to ascertain whether their responses truly reflect how they would react if actually confronted with the presented scenario (ibid). Nevertheless, vignettes do create the possibility for well thought through responses and offer the participant a chance to really reflect upon the information they are given (ibid).

The use of the vignette technique will aid in fulfilling this studies aims and problem statements due to the fact that it will allow for the construction of case studies whereby the child healthcare nurse is free to give an opinion and assessment of each case study, its level of concern and the risk factors presented within. The purpose of the vignettes is therefore to give the author a general

indication as to which risk factors draw the most and least focus and how they are interpreted. In responding to the vignettes the child healthcare nurse provides valuable information concerning how mother-infant relationships are evaluated, giving a greater understanding of how problems in the mother-infant relationship are identified and detected.

In order to increase the study's validity and develop a deeper understanding for the child healthcare nurses evaluation and interpretation of the vignettes, complementary questions will follow in the form of a semi-structured interview. Robson (2011) states that a semi-structured interview involves the author having an interview guide, which serves as a checklist of topics and a default wording and order for the questions. The default wording and order of the questions can, however, be manipulated and modified depending upon the flow of the interview. The semi-structured interview technique even allows for the addition of spontaneous questions in order to follow up on a participant's responses (ibid).

Due to the fact that this study will ask questions based upon the child healthcare nurses evaluation and interpretation of the vignettes, it is important that the interview schedule is flexible, whilst still providing a structure capable of generating comparable responses. The flexible and adaptable nature of the semi-structured interview comes with significant advantages, especially when carried out in person; allowing the author to observe the participants body language as well as allowing for the pursuit of interesting responses through adaptable questioning (ibid). The main disadvantages of semi-structured interviews are however the lack of standardisation and the impact of the authors own bias over the subject areas, all of which can reduce the generalisability and validity of the research (ibid).

4.1.1 Vignettes

In order to build as accurate a picture as possible of the child healthcare nurses evaluation and interpretation of mother-infant relationships, four vignettes were selected, each one depicting one of the four key risk factors associated with insecure attachment as outlined by Killén (2009); a mother's irrational involvement in her child, lack of positive interaction, unpredictable living situation and unpredictable personality. The vignettes are written in accordance with BVC's base program and depict a scenario in which a mother and infant visit BVC and display subtle signs relating to each of the four risk factors.

The first vignette (see appendix III) is constructed to depict a mother's irrational involvement in her child and includes several associated risk factors, namely an anxious mother (Stevenson-Hinde et al, 2011) who perceives her child as having an anxiety that really belongs to her. Killén (2009) states that mothers who assign characteristics to their children that are false or skewed often have an irrational involvement in the child. The child in the first vignette is also displaying mild signs of ambivalence in her attachment behaviour (Howe, 2011).

The second vignette (see appendix III) is constructed to depict a mother's lack of positive interaction in her child. This risk factor is displayed through signs relating to postnatal depression, namely that the mother is suffering from tiredness and is a little withdrawn (Killén, 2009). Postnatal depression is also depicted in this vignette through the child's behaviour, namely that the child does not seek

eye contact with the mother, is quiet, passive and inactive, all of which are behaviours consistent with an avoidant attachment pattern (ibid).

The third vignette (see appendix III) is constructed to depict a mother's unpredictable personality. In this vignette the risk factor is highlighted through a mother showing signs of borderline personality disorder. The mother is immature (Lounds et al, 2005), unpredictable, a little aggressive and displaying signs of instability in relationships, all of which are factors stated by Killén (2009) as consistent with a mother having an unstable personality and even borderline personality disorder. The child on the other hand is displaying watchful, observant and avoidant behaviour consistent with a child used to living in predictable unpredictability (ibid).

The fourth and final vignette (see appendix III) is constructed to depict a mother with an unstable living situation. Both the mother and the father in this vignette are unemployed, which is a risk factor associated with an unstable living situation (ibid) and during the visit to BVC both the mother and child display subtle signs that their home life is troubled. The mother is uncomfortable, distant and apathetic towards her child, which according to Killén (2009), are signs common with a mother burdened by problems, such as domestic violence, which leave her unable to cope and react appropriately towards the child's needs. The child depicted is a little late in development and is displaying subtle signs of ambivalent attachment behaviour, which are common in children growing up in environments where issues such as domestic violence are prevalent (ibid).

Presented along with each vignette is a line stretching underneath the text that depicts each scenario. On one side of the line are the words "not at all worried" and on the other side the words "very worried". Each line is the same length and accompanies the vignette with the aim of giving the author a general idea about how worrying the child healthcare nurses find the content in each vignette and thereby indications as to how the child healthcare nurses interpret and evaluate risk factors.

4.2 Sample

This studies sample consists of six child healthcare nurses from five different BVC located in small towns and villages within the region of Skåne. All participants are either qualified paediatric nurses or are qualified district nurses and have a minimum of five years' experience working in BVC. Three of the participants are very experienced with over 25 years of experience working in the field.

This sample was random and chosen based upon the child healthcare nurses availability and proximity to the author. This was due mostly to time constraints and difficulty in procuring willing participants. Issues such as sick leave and an upsurge in appointments in the run up to Christmas were prominent factors in the availability of the child healthcare nurses.

Ideally the sample should have consisted of some child healthcare nurses from larger towns and busier BVC in order to form a basis for comparison with those working in smaller towns and villages.

4.3 Approach

The study's interview consists of five phases. The first phase is the *introduction*, whereby the study's author introduces herself and outlines the purpose of the interview. An information letter (see appendix I) is presented to the participant, which depicts the study's objective and method, assures confidentiality and details the publication of the study, as well as the participant's right to abstain from the study and withdraw their data. After the participant has read through and understood the information letter, a form asking for the participant's informed consent (see appendix II) is presented for the participant to read and sign.

After the introduction phase of the interview begins the '*warm-up*' phase. During the 'warm up' phase the participant is asked easy non-threatening questions that are intended to break the ice and create a relaxed atmosphere (see appendix III for interview guide). After the 'warm up' phase has ended begins the *main body of the interview*. During this phase the participant is presented with the vignettes (see appendix III for vignettes) and is asked a series of questions relating to the content of each vignette. The participant is also asked to place a cross on the line stretching underneath each vignette giving a general indication of how worrying they find the content. A series of complementary questions are then asked after the completion of the vignette segment, aimed at developing the themes of each vignette and the broader theme of how BVC evaluates and interprets mother-infant relationships.

After the vignette segment and complementary questions have been completed the '*cool-off*' phase of the interview begins. During this phase the participant is asked a few straightforward questions to diffuse any tension that might have built up and is given the opportunity to add any additional information they think relevant as well as ask the author questions. After the cool-off phase has been completed the last phase begins. During the '*closure*' phase the participant is thanked, the recording device switched off and goodbyes are exchanged.

4.4 Reliability & validity

Reliability is defined by Bryman (2011) as the degree to which the study's results would be the same if the study was to be repeated. If the study is repeated and achieves similar results then the probability that the results obtained were due to random chance or momentary occurrences lessens and the degree of reliability increases (ibid). In qualitative research the term dependability is sometimes used in place of reliability to gauge how replicable the results are (ibid). Though reliability is not often a main concern of a qualitative researcher (Robson, 2011), it is important in terms of the study's internal and external generalisability.

In order to raise its degree of reliability this study, whilst maintaining a degree of flexibility, takes a standardised approach to the interviews. Each participant will receive the same vignettes and the interviews will follow the same interview schedule, ensuring that the participants are asked about the same topics and receive roughly the same questions.

Validity is defined by Robson (2011) as the degree of conformity between the study's objective and the study's results and or conclusions. Validity in a qualitative study is sometimes referred to as credibility and represents the probability that the results are correct and accurate (Bryman, 2011). According to Robson (2011) validity is an extremely difficult aspect to measure, however there

are he suggests measures one can take to increase the degree of a study's validity; namely the description of the data, the interpretation of the data and theories used. One can also minimise researcher bias and triangulate the results with the use of more than one data collection method, research paradigm, theory and or number of observers.

In order to ensure validity this study's data is recorded through the use of a dictaphone, which allows for an accurate description of what was heard and said during the interviews. The study also incorporates a traceable line of thought behind the interpretation of the results, ensuring that the conclusions drawn reflect the data collected. Data triangulation through the use of both the vignette technique and the semi-structured interview technique has also been employed to aid the degree of the study's validity.

4.5 The role of the researcher

The role of the researcher can play an important part in the results generated from a study. According to Robson (2011) a researcher can impact upon the study through bias, influencing the participant's responses through leading and biased questions. Robson (2011) states that remaining neutral in both the wording of the questions and the way in which they are presented is crucial for retaining the distance and objectivity necessary for ensuring both the study's validity and reliability.

In order to minimise the impact of the researcher's role on the results of this study, open-ended questions were written in advance with the aim of creating an interview schedule that would hold a neutral tone and avoid steering the participant in any particular direction under the interview's duration.

4.6 Ethical considerations

According to Bryman (2011) there are four fundamental ethical principles to take into consideration when carrying out a research study, namely deception, informed consent, confidentiality and exploitation. In order to ensure that participants in this study were not deceived about the purpose of the study or the study's method, participants received an information letter (see appendix I) disclosing the study's full objective as well as information on why the study is important and how it is carried out. Participants also received information explaining that their participation was entirely voluntary and that they could withdraw themselves from the study at any time and without explanation.

Participants were also given an informed consent form (see appendix II), which documents that they have received information pertaining to the study's objective and method and reiterates their right to withdraw at any time without the need for explanation. Confidentiality is also explained to the participants in the information letter and is guaranteed by this study's author. In order to ensure that the highest level of confidentiality is achieved the author of this study has coded all interview transcripts so that they are unidentifiable and entirely anonymous. The author has also stored the audio files and written transcripts on a password protected computer, of which only the author has the ability to access. With the study's completion all audio files and transcripts are deleted or destroyed ensuring that no unauthorised person can come in contact with the material. Furthermore all the data collected from the participants is used only in conjunction with this study, ensuring that the participants and their data are not exploited.

4.7 Method of data analysis

The thematic coding analysis technique is used in order to analyse and compare the data generated from this study. Robson (2011) states that the thematic coding analysis technique is a generic approach to the analysis of qualitative data and can be used either as a realist or constructionist method. The realist method focuses upon experiences, meanings and the participant's reality, whilst the constructionist method examines these phenomena in relation to the different discourses operating within society (ibid). This study incorporates the former of the two methods, taking a realist approach to the data analysis. This is because the objective of the study calls for an examination of the child healthcare nurses experiences, meanings and reality rather than the various discourses operating around them.

Thematic coding analysis is carried out using coding as the central tool in the analysis. Coding relates to the definition of the data that is being analysed and involves identifying one or more passages of text that display the same theoretical or descriptive significance (ibid). Once the data has been coded, themes can start to emerge, whereby different codes relating to a larger theme can be grouped together.

Once themes have been identified they are formalised into one or more maps or networks whereby they can be grouped according to their content (ibid). Themes relating to theory can be grouped into one network, for example, whilst themes relating to practice and experience can be grouped into another. After creating the thematic networks, comparisons between the data can then be drawn in order to exact meaning from the data collected (ibid).

5. RESULTS & ANALYSIS

Barnavårdscentralens (BVC) universal work with young children and infants provides a unique possibility for society to identify and support children at an early stage who are at risk of developing psychosocial problems in the future. Due to the fact that a child's attachment pattern is one of the earliest signs of a child's poor wellbeing and of disharmony in the family home, this study's main aim is to find out how BVC evaluates and interprets mother-infant relationships so as to gain a better understanding of how such a vital and valuable institution functions. In order to do this, problem statements were designed and examined, concerning BVC's identification of poor-mother infant relationships, focus on, and interpretation of risk factors.

In the following chapter each one of the problem statements will be addressed and analysed, culminating in a clarification of the results in terms of how BVC evaluates and interprets mother-infant relationships.

5.1 Which risk factors draw the most and least focus?

In order to gain an understanding of how Killén's (2009) four main risk factors for mother-infant relationship dysfunction are viewed by child healthcare nurses, each nurse was presented with four vignettes (see appendix III), each depicting a risk factor, and were asked to place a cross on a line ranging from 'not at all worried' to 'very worried' (the results of which are compiled in table 1 below). The nurses were then asked to identify the signs in the vignettes which they deemed most

attention worthy and to which they assigned the most amount of concern (the results of which are compiled in table 2. See appendix IV).

Table 1. The level of concern each child healthcare nurse assigned the vignettes.

	Vignette 1	Vignette 2	Vignette 3	Vignette 4
CHN 1.	Slight	Moderate	Strong	Mild
CHN 2.	None	Strong	Strong	Moderate
CHN 3.	Slight	Slight	Slight	Mild
CHN 4.	Slight	Strong	Strong	Moderate
CHN 5.	Mild	Strong	Strong	Mild
CHN 6.	None	Moderate	Moderate	Strong

From table one we can see that the risk factors which garnered the most concern from the child healthcare nurses were those depicted in vignettes two and three, namely a mother's lack of positive interaction in her child and unpredictable personality. All but one of the nurses reacted with either strong or moderate concern to both these risk factors, suggesting that of the four factors examined these two are perhaps most acutely observed. This, according to Killén (2009), stands in line with the level of damage current research suggests that these two particular risk factors can cause in relation to a child's attachment.

Killén (2009) states that a mother's lack of positive interaction in her child is probably one of the most devastating processes a child can be exposed to, especially if it starts early and continues over a long period of time. Killén's (2009) statement finds support from Murray et al's (1996) research which found that children to depressed mothers, a condition strongly associated with a mother's inability to engage positively with her child, had a 62 percent risk of developing an insecure attachment when compared to controls where the number totalled just 26 percent. Field et al (1988), however, highlight difficulties in school, low self-esteem and overall depressed behaviour as possible consequences for such children. All of which lends support to Killén's statement and suggests that the child healthcare nurse's interviewed in this study gave the risk factor depicting a mother's lack of positive interaction appropriate amounts of attention.

The other risk factor the nurses reacted strongly to was children living with mothers suffering from unpredictable personalities. Research suggests that children living with psychologically unpredictable mothers can face severe developmental consequences as a result. Killén (2009) highlights anxiety in the child as a concern, whilst Lagerberg & Sundelin (2000) suggest that children living with parents suffering from personality disorders, especially when the parents display aggressive behaviour, often experience problems at school. In the face of the possible consequences for a child's development we can deduce once again that the risk factor received appropriate amounts of attention from the interviewed nurses.

The child healthcare nurse's reaction to the fourth vignette differed somewhat, with three of the nurses reacting mildly to the vignette depicting a mother with an unpredictable living situation and three reacting either moderately or strongly. The vignette in question was intended to depict a mother in a violent relationship, a risk factor strongly associated with both an unstable living situation and attachment dysfunction (Levendosky et al, 2011). The vignette received however several different interpretations (see table three) and the level of focus it received depended entirely upon the individual interpretation of each child healthcare nurse. Two of the nurses who reacted most strongly to the vignette associated the signs within as a possible case of postnatal depression; underscoring once again the strong focus the nurse's attribute signs relating to a mother's lack of positive interaction in her child as a factor for insecure attachment.

Interestingly, however, was the fact that two of the nurses who reacted with least concern also interpreted the signs depicted in the vignette as a possible case of postnatal depression or lack of positive interaction, suggesting that they did not find the individual signs as alarming or as attention grabbing as those depicted in the second vignette. This could be explained by the difference in behaviour each child showed within the respective vignettes. In the second vignette all the nurses reacted strongly to signs of passivity, uninterested behaviour and lack of eye contact in the child (see table two, appendix IV), whilst the signs reacted to in the fourth vignette focused more on the mother's apathy and indifference. This suggests perhaps that the nurse's may react more and place more attention on signs displayed by the child rather than the mother. It could also suggest that passivity, uninterested behaviour and lack of eye contact in the child are signs to which the nurses are highly attuned, actively watch for and as a result automatically react to with strong levels of concern when presented with them. Johansson et al (2011) would seem to support the latter of two, stating that nurses should make it a point to note the nature of the eye contact between the parents and child during visits; suggesting that such checks are a part of a child healthcare nurse's routine.

The remaining two nurses differed greatly in their level of concern for the vignette, with one showing moderate concern and the other mild. Both nurses showed, however, concern for the family's unpredictable living situation and were the only two to interpret the vignette as intended. Perhaps of most interest regarding vignette four is the polarising levels of concern with which the nurses assigned the scenario. Whilst we can deduce that the amount of concern placed was based largely on how the vignettes were interpreted and the individual signs the nurses picked up on, the fact that the nurses all reacted differently shows that they used a different frame of reference in order to interpret what they read. This suggests that the nurses are perhaps not as familiar in interpreting factors relating to unpredictable living situations as, for example, mothers lacking positive interaction in their children.

A general consensus prevailed amongst the nurse's that the signs depicted in vignette one were of little or no concern (see table 2, appendix IV). Vignette one had been constructed with the aim of depicting a mother with an irrational involvement in her child. The child healthcare nurse's deemed, however, that both the child and mother's behaviour in the vignette was entirely normal and as such the risk factor drew very little concern and attention. The fact that the fictional child's behaviour could be interpreted as normal behaviour, typical of a child in

the same age was not intentional and can be construed as a methodological limitation.

A mother's irrational involvement in her child is according to Killén (2009), however, a very important risk factor for the development of relationship difficulties and insecure attachments. It can lead to controlling and invading behaviour on the part of the mother and occurs due to distorted perceptions of the child's nature (ibid). The mother assigns the child qualities that it doesn't necessarily possess, which can lead to the child becoming labelled and ultimately accepting and acting out in accordance with the label as per labelling theory (Repstad, 2005).

Furthermore since postnatal anxiety has been found to be even more prevalent than postnatal depression (Wenzel et al, 2003) and given the fact that maternal anxiety has been strongly correlated with insecure ambivalent attachments (Stevenson-Hinde et al, 2011), anxiety can be deemed an important risk factor for the nurses to be able to identify and treat. However, despite the fact that none of the nurses showed greater levels of concern in relation to the vignette, two of the nurses touched upon the subject of stress and overly ambitious mothers as factors which concerned them. Suggesting that whilst the anxiety depicted in the vignette may not have peaked their interest owing to its normal presentation, the nurses are aware of the effects of anxiety and do show concern for them.

In addition the fact that postnatal anxiety is such a common condition (Reck et al, 2008) could lead to the fact that the nurse's don't see the condition as all that concerning, due possibly to the fact that anxiety for new mothers is considered normal. However given the research connecting maternal anxiety to insecure attachment (Stevenson-Hinde et al, 2011) and the rise of maternal anxiety due to peer pressure (Bartell, 2006) it is reasonable to suggest that the topic warrants further investigation and greater recognition.

5.1.1 The roles of situational norm deviation and reoccurrence

A theme that emerged from the interviews in relation to the risk factors that drew the child healthcare nurses focus was the roles of situational norm deviation and reoccurrence. Situational norms are a part of the norm perspective; a set of theories belonging to the sociological paradigm (Repstad, 2005). According to Repstad (2005) norms are described as rules regulating the conduct of our behaviour within a certain role. Whilst a situational norm can be defined as a generally accepted belief about how individuals should behave in a particular situation, referring to our knowledge and mental representations of behaviours that are appropriate in certain situations and environments (Aarts & Dijksterhuis, 2003). One of the nurse's describes the phenomenon in the following terms (author's translation):

“When you're at a BVC control you are usually present and really want to talk about your child”

When situational normative behaviour is present the nurses do not show high levels of concern or worry as was the case with vignette one. However when the fictional characters displayed behaviour that defied the accepted situational normative behaviour the nurse's level of concern rose in accordance with the degree of norm deviation, which was the case with both vignette two, three and to

some extent, four. Johansson et al (2011) support this finding, suggesting that BVC nurses through their training can distinguish the normal from the abnormal and react accordingly.

In discussing norms it is important to raise the fact that the distinction between abnormal and normal is considered a somewhat grey area and that social norm theories garner much criticism because of this. Ritzer (2009) argues, for example, that it is unclear how norms both arise and are maintained by groups in society. Norms can even be culturally subjective and thus open to interpretation, meaning that what is considered normal in one societal group may in fact be considered abnormal by another (Ritzer, 2009), leading to questions surrounding the fairness to which people are societally judged. This is especially relevant given that an individual defined as “abnormal” or as displaying “abnormal behaviour” can suffer severe consequences in the form of social stigmatisation and labelling (Repstad, 2005).

A theme that ran in conjunction with situational norm deviation was the role of reoccurrence. During the interviews several of the nurses commented on the fact that the scenarios depicted in the vignettes could be momentary and not representative of how the situation truly is on a day to day basis; the amount of times that the abnormal behaviour is witnessed being the trigger that really draws the nurse’s focus:

“It could be something momentary that day which has affected them so I don’t think I’d be worried by one visit. I’d say it’s probably the amount of things altogether, which makes me worried.”

“You can’t too feel worried that a mother doesn’t respond to her child as she should with one occasion.”

Here we can see how the above nurses associate their level of concern with the reoccurrence of troubling signs, as well as with the occurrence of several troubling signs together. That these nurses are more concerned when presented with the occurrence of several signs stands in line with Lagerberg and Sundelin’s (2000) definition of the concept of risk thresholds; the fact that several risk factors occurring at the same time can raise the statistical probability that certain events occur, in this case insecure attachments and relationship difficulties.

Interestingly, however, was that though the nurses suggested that the reoccurrence of norm deviant behaviour was a strong factor in the level of concern they showed risk factors, all of the nurses even when they showed only mild amounts of concern for the events depicted in the vignettes, remarked that they would have investigated further and called the family back for further controls and checks.

“Yeah...I’d have probably done a home visit there because I’d have been worried”

This suggests that even singular episodes of norm deviant behaviour, especially when strong, are enough for a nurse to carry out further investigations. It is arguable therefore that though reoccurrence is an important factor in the level of concern a nurse shows deviant behaviour it plays more of a contributory or secondary role to that played by situational norm deviation.

5.2 The interpretation of risk factors

In order to gain an understanding of how Killén's (2009) four main risk factors for mother-infant relationship dysfunction are interpreted by child healthcare nurses, each nurse was asked to give an assessment of the possible problems and or issues depicted in the vignettes. The results of which are compiled below.

Table 3. The child healthcare nurses' interpretation of the signs observed in each vignette.

	Vignette 1	Vignette 2	Vignette 3	Vignette 4
CHN 1.	Normal interaction/attachment	Possible postnatal depression Lack of positive interaction in the child.	Immature, emotionally unstable mother Possible disorganised attachment.	Possible problem in parents relationship Mother possibly tired
CHN 2.	Normal interaction/attachment Mother may have less ability to cope	Possible postnatal depression	Immature, inexperienced and self-centred mother Possible insecure attachment	Possible postnatal depression Stressful living situation Possible ambivalent attachment
CHN 3.	Normal interaction/attachment	Possible postnatal depression	Issues with the mother's background	Parents lack positive interaction in child. Possible postnatal depression
CHN 4.	Normal interaction/attachment Mother may have less ability to cope	Possible postnatal depression	Issues with the mother's background	Family's living situation
CHN 5.	Normal interaction/attachment Mother may have less ability to cope	Lack of positive interaction	Issues with mother's background, mothers own attachment and immaturity	Family's living situation. Possible postnatal depression
CHN 6.	Normal interaction/attachment	Mother and child have not bonded	Mothers own attachment	Possible postnatal depression

From the above table we can see how each individual child healthcare nurse interpreted the risk factors in the vignettes. Vignette one was largely interpreted as a depiction of a normal well-functioning mother-infant relationship, whereby the child's attachment behaviour is met with appropriate and timely responses from the mother. Two of the nurses interpreted the vignette as suggesting that the mother's recent separation from the child's father may impact upon her ability to cope and leave her vulnerable for depression and in need of extra support.

Research has shown that relationship difficulties between a child's parents has long been identified as a risk factor in the development of postnatal depression (Wickberg, 1996) suggesting that the child healthcare nurses can not only pick up on symptoms of postnatal depression, but also risk factors surrounding its development. The nurses' strong focus on postnatal depression as a major factor in attachment dysfunction gives rise to the possibility that the two terms could even be viewed as synonymous by the nurses. This became apparent during the interviews when the nurse's referred to the EPDS survey as a screening tool for insecure attachment.

Emphasising furthermore the gravitas with which postnatal depression is viewed by the nurses is their interpretation of vignette number two, which received an almost universal interpretation as postnatal depression. This suggests in contrast to Killén (2009) that mothers suffering from postnatal depression are in fact well observed and identified by child healthcare nurses. This could reflect the recent implementation of the EPDS screening technique and the associated training the nurses receive in areas surrounding postnatal depression (SoS 1991:8).

In contrast to vignette two, vignette three received a somewhat mixed interpretation. The vignette was originally constructed with the aim of depicting a mother with an unpredictable personality. Two of the nurses interpreted the vignette as intended, whilst the vast majority interpreted issues in the mother's background as responsible for the observed behaviours. This suggests that background information on the mothers and families that attend BVC controls is an important factor in explaining and rationalising the behaviour that the child healthcare nurses witness. Killén (2009) herself points to parents with a so called "high-risk" background as a risk factor for the four main insecure attachment risk factors.

The behaviour displayed by the child in vignette three was also interpreted as intended by two of the child healthcare nurse's as indicative of an insecure attachment. Interestingly, however, was that two of the nurse's interpreted the mother's behaviour as stemming from her own probable insecure attachment. The nurses' interpretation is supported by Fonagy (1991) who found that the mother's own attachment pattern can predict the child's attachment pattern with up to 75 percent accuracy. In addition Klette (2007) found that a mother's ability to comfort her child depended largely upon the comfort she herself had received as a child.

The nurses' interpretation is very interesting in the sense that it supports Killén's (2009) major argument that childhood lasts for generations, owing to the fact that a mother will go on to repeat her own childhood, good or bad. It also suggests that the child healthcare nurses have a good understanding of just how important a secure attachment is, not only for the child but for the generations to come.

As well as interpreting the mother's own attachment as a possible cause for the events described in the third vignette, some of the nurses also interpreted the mother's age as a possible factor. This interpretation receives support from Lounds et al (2005), who found a strong correlation between adolescent mothers and disorganised attachments. Killén (2009) supports Lounds et al' (2005) findings by highlighting immaturity as a probable causal factor in a mother developing an irrational involvement in her child, something that is often found co-existing with mother's suffering from unpredictable personalities.

Vignette four as discussed above also received differing interpretations. Four of the nurses interpreted the vignette as a possible case of postnatal depression, whilst the remaining two nurses' interpreted the signs in the vignette as pertaining to the families living situation, one of the nurses even mentioning possible problems in the relationship between the parents as causal factor. The differing interpretations and levels of concern shown vignette four could be explained by the different frames of reference the nurses have developed owing to their

familiarity with the risk factors and signs depicted. The differing interpretations could also be a product of the vignettes ambiguous nature, which could be construed as a methodological limitation.

5.3 The identification of poor mother-infant relationships

In order to gain an understanding of how child healthcare nurses identify poor mother-infant relationships questions were asked during the interviews pertaining to the nurses' work with infants and their parents. From the analysis of the interview transcripts several themes emerged documenting how the child healthcare nurses identify poor mother-infant relationships.

5.3.1 The role of experience, observation and routine

One of the most prominent themes to emerge in relation to the child healthcare nurses' identification of poor mother-infant relationships was that of experience, routine and observation. This theme was evident in all the nurses that took part in the study and formed, according to them, a large part of their ability to identify mothers and infants with poor relationships.

Experience was described by the child healthcare nurses as an instinctive and intuitive phenomenon that enabled them to single out mothers and infants that deviated from the norm, a finding that is supported by Johansson et al (2011). Two of the nurses gave the following statements regarding how experience helped them with identification:

“When you've worked for quite a while you go with your intuition and gut-feeling... that something is perhaps not as it should be.”

“They can write zero points on every question so that there is nothing. But then I am suspicious... it's something that I keep in the back of my head.”

The statements above clearly demonstrate the importance experience holds for a nurse's ability to identify poor mother-infant relationships. It is arguable that the nurses, in accordance with Grenfell's (2008) interpretation of Bourdieu's habitus concept as evolving and subject to current experience, have developed habitus that enable them to judge norm deviation. If a mother-infant relationship does not fit in with the habitus that defines the expected normal progression of a mother-infant relationship then the nurse automatically makes use of other extant habitus that can perhaps define what he or she is observing and perhaps even define the level and thereby severity of the norm deviation.

If we take postnatal depression as an example we can clearly see that all the nurses in this study had developed a seasoned habitus for detecting cases of postnatal depression. All the child healthcare nurses interviewed were very familiar with and were very skilled at identifying postnatal depression in the vignette which depicted a mother suffering from the condition. It was also a recurrent theme during the interviews and something with which all the nurses strongly associated the detection of poor mother-infant relationships and insecure attachments.

In order to detect cases of postnatal depression, which occur in around 13 percent of women, (Wickberg, 1996), all the child healthcare nurses used a screening technique known as the *Edinburgh Postnatal Depression Scale* (EPDS) in

conjunction with the child's two month control. The EPDS has been found to significantly increase the number of detected cases of postnatal depression (Bågedahl-Strindlund & Monsen Börjesson, 1998) and has been a part of the Swedish child health clinics base program since the beginning of the early 2000's (Wickberg, 2005). All the nurses interviewed had received specialised training in the use of the EPDS and as such were much more versed in problems surrounding postnatal depression and its effects on attachment.

The relationship exemplified above, whereby the child healthcare nurses develop a habitus in relation to the education they receive from the healthcare institution is a clear example of how Bourdieu's concepts of habitus and field interact with each other in a dualistic relationship. According to Grenfell (2008) the nature of the relationship that exists between habitus and field means that they both create and are created by the other. In this case the education the nurses receive creates a habitus for identifying postnatal depression. The nurses then regulate this habitus internally and refine it. They then make adjustments to how the field teaches this habitus to new generations of child healthcare nurses and the process becomes circular in its nature. Manipulation of the field is thus one way in which methods to improve screening for relationship difficulties can be implemented and refined.

In addition the fact that habitus is also heavily influenced by past experiences, culture, tradition and education (Ritzer, 2009) would seem to suggest that the more experience a child healthcare nurse obtains in the region of identifying problematic relationships the more his or her habitus could develop in that area. As such Grenfell's (2008) interpretation of Bourdieu's theory could suggest that the problems most often experienced by the nurses are those best identified. This could be equated as experience produces familiarity due to the development and refinement of the nurse's habitus in specific areas.

The results from the vignettes in this study suggest that this would appear to be the case. If we again take postnatal depression as an example we can see how it is possible that habitus are better refined due to more frequent exposure. All the child healthcare nurses interviewed were very familiar with and were very skilled at identifying postnatal depression in the vignette which depicted a mother suffering from the condition. It was also the risk factor with which they associated the most concern and with which they were most afraid for in terms of a child's development of an insecure attachment. This was not the case with the vignettes depicting a mother with an unpredictable living situation and to a lesser extent a mother with an unpredictable personality, which were more frequently interpreted as other issues, garnering various levels of concern as a result of the interpretations. As such it is possible that the child healthcare nurses level of concern and skill in identifying the condition is correlated directly to the greater frequency with which they encounter it.

Observation is closely linked with experience and is also a prominent factor in the child healthcare nurses identification of relationship difficulties. Built up by experience and carried out through routine, a number of the nurses named their observational skills and ability to use their senses as perhaps their most vital tools. Two of the nurses described observation in the following terms.

"It is through looking, seeing and listening. Using the senses to take stock of everything."

“We observe how mothers interact with their children...how they hold them, their eye contact and so forth.”

The nurse’s observational methods as exemplified above were recurrent themes in all the interviews and focused on the nurse’s ability to detect signs that the mother and child in front of them deviated from the expected norms and could have difficulties in their relation to one another. Johansson et al (2011) found similarly in a study aimed at understanding how the child healthcare nurse supports and enhances the child’s attachment to their parents that nurses use what they see and hear in order to evaluate their families.

Furthermore, the observational process can be interpreted as the practical expression of the relationship between field and habitus, whereby the nurses use their field influenced habitus as a frame of reference when comparing the information garnered from their sensual observations. Thus enabling them a practical and physical way of assessing norm deviation.

Both the nurse’s experience and observation are grounded in a set of stringent routines, which create and recreate the nurse’s habitus. Routine can be likened to the concept of field, since routine encompasses the checks and controls that should be performed in accordance with the healthcare institutions regulations. As such routine can be described as the manifestation of field, in that it helps create the nurse’s habitus through defining what the nurses should consider normal respectively abnormal. Johansson et al (2011) state that during regularly scheduled appointments child healthcare nurses should perform a number of checks and controls as standard practice. These checks and controls are mandated as standard practice by social styrelsen (SoS 1991:8) and are an important feature of how field and habitus interact to create practice and in this case the practice of identifying poor mother-infant relationships.

Routine was exemplified by the child healthcare nurses through their adherence to procedure. One nurse exemplified routine through the description of a screening procedure.

“We have an EPDS conversation... that we have when the child is about two months old in order to see how the mother is feeling.”

When experience, observation and routine are combined, we can start to gain an understanding of how they interact to create the practices that allow the child healthcare nurses to identify mothers and infants with poor relationships. Experience and routine can be said to exemplify the dualistic relationship between habitus and field, whilst observation can be interpreted as the practice which they create.

5.3.2 The use of tools

Another prominent theme to emerge from the interviews was the nurse’s use of tools. The use of tools is strongly related to the theme of routine and comes in the form of the EPDS screening technique amongst others. One nurse described how she had become much more aware of relationship difficulties between mother and infant since its implementation:

“It’s made me more sensitive to seeing if there is something wrong with the mother-infant relationship.”

Here we can see an example of how the field creates habitus in the child healthcare nurses through developing their frames of reference and providing them with the techniques to detect norm deviation. The EPDS has proved to be very effective in helping child healthcare nurses to detect depression (Bågedahl-Strindlund & Monsen Börjesson, 1998) and is standard practice throughout BVC in Sweden. One nurse stated how it aided them in detecting cases that they might otherwise have missed:

“There are families where we think that everything is a dance, and then they fill in this questionnaire and the mother writes “crying every evening, life feels really tough”, but they haven’t dared voice it to me and have had a fantastic positive façade.”

The fact that observation skills alone do not always lead to nurses picking up on cases of postnatal depression shows that tools play an important role in aiding the nurses in their efforts to identify such women, especially those who try to hide their depressions and put on a positive face. Research has shown in concurrence with the nurses own beliefs that the number of cases of postnatal depression identified increases with the use of screening procedures (ibid)

5.3.3 Straightforward open communication and trust

Perhaps one of the most interesting themes to emerge from the interviews with the child healthcare nurses was the role that straightforward open communication played in their work in identifying mothers and infants with poor relationships. Several of the nurses suggested that being direct and to the point in their communication helped them to come nearer the family and obtain information crucial for the child’s wellbeing and the mother-infant relationship. Two of the nurses explained the phenomenon in the following terms.

“If there is something that I react to, I usually ask and take it up with them if that’s the case.”

“I know that the more direct I am the better able I am to come nearer the family.”

The above examples show how nurses use straight forward open communication to identify mothers and infants with poor relationships. Such a process can, according to Johansson et al (2011), require a delicate balancing act, the success of which is subject largely to the amount of trust and confidence that the family places in the particular child healthcare nurse. This is because, as one nurse pointed out, when BVC observes worrying behaviour they are required by law to inform social services, leading to the fact families move counties in order to avoid actions from both BVC and social services.

The creation of trust and confidence was therefore something which almost all the nurses interviewed identified as a crucial element in their ability to help troubled families. Trust was also identified as an important factor in the nurse’s ability to build a straightforward open dialog with a family and thereby identify poor mother-infant relationships. Johansson et al (2011) supports this fact suggesting that the establishment of trust confirms to the parents that they have a safe and

secure source of support when they are in need of it. The creation of such a trust and confidence makes it easier for the parents to accept and respond honestly when asked sensitive questions pertaining to their relationship with the child and possible psychosocial problems as well as accept help. One of the interviewed nurses described the process of building trust as an attachment process itself, whilst another revealed how the creation of a confidence can create open communication.

“I build an attachment to the parents... we learn to get to know one another.”

“Sometimes you can actually build up a confidence, where they tell us that they were a troubled child.”

Other nurses described how being open and honest themselves about the realities of child rearing helped enormously in gaining the family’s trust and provided the family’s with a secure base in which they can unburden themselves without the fear of judgement and recriminations.

“My colleague and I are very open ourselves. We say so here “It’s no dance through roses to have small kids. You have permission to say that it’s hard”. After that there usually comes a lot.”

“I think that if I just show that I am interested to know how they feel, gradually they might confide in me and tell me what is wrong.”

Due to the fact that creating trust is such a large factor in being able to ask direct questions and create straight forward open communication we can surmise that it is a crucial factor in the nurses ability not only to ask the questions which identify poor mother-infant relationships, but also in their ability to help the family and improve the bonding process. A finding which is supported by Johansson et al (2011) who found that the nurse’s ability to create a trusting relationship with a child’s parents was of paramount importance in empowering the parents to build a healthy relationship to their child.

Experience also plays a large role in the child healthcare nurses ability to ask direct questions and create the straightforward open communication necessary to find out about possible difficulties that could or already are affecting the mother-infant relationship. One nurse gave the following account of the role which experience plays in straight forward open communication.

“Those questions or assertions I’d never dared have made as newly qualified with this profession...”

Here we can see how the child healthcare nurse states that experience has given her the courage to ask questions pertaining to sensitive subjects that could help her identify mothers and infants with poor relationships and or psychosocial problems which would place them at risk. Gunn et al (2006) found that midwives comfort in asking sensitive questions relating to psychosocial problems ranged from moderate to fairly low, but improved significantly with training. If we generalise the results of Gunn et al’s (2006) study to child healthcare nurses; the possibility arises that child healthcare nurses could be similarly averse to asking

sensitive questions and thus be hindered in their attempts to identify and help mothers and infants with relationship problems.

However as the child healthcare nurse states, experience in the profession has helped create a habitus within her that enables her to ask the necessary sensitive questions. This raises the question that newly qualified child healthcare nurses may stand at a disadvantage when it comes to having the experience to be straightforward and open as they may not have developed an appropriate habitus. In addition Gunn et al's (2006) research suggest that the field can help improve nurses' abilities in this area through specific training aimed at creating or refining habitus to help the nurses achieve straightforward open communication.

5.3.4 The child as an indicator for the mother's wellbeing

Another interesting theme that emerged from the interviews was the child as an indicator for the mother's wellbeing. This theme expands upon the theme of observation and relates to infants, particularly those who exhibited passivity, lack of eye contact and lack of interest, as being seen by the nurses as a reflection of the mothers' state of health.

“Here I'd have gone directly to the mother and said “you don't feel well” and even if she had tried to argue that everything was ok I'd have said that I can see it in the child. That he feels bad because you do.”

“One can suspect a depression perhaps when the child is really passive”

Killén (2009) lends support to the nurses' observations, stating that whilst the rest of the world may not see the mother's depression, the child definitely does and reacts accordingly with passive, withdrawn behaviour. Such behaviour centres often on the degree of eye contact that exists between the mother and child, giving the nurses a clear indicator that all is not well with the mother.

Lack of eye contact between mother and infant was named by every child healthcare nurse as a clear indication that the mother and child did not have a good relationship. If the eye contact between the mother and infant was poor then the nurses almost always suspected that the mother could be suffering from depression (see table 2, appendix IV). Such is the degree to which the nurses have developed a habitus regarding signs in the child which reflect the mother's wellbeing.

“When the mother looks at the child, the child should look back and gladly smile, but if the child looks away or down then that child doesn't feel good and doesn't have a good attachment”

The habitus the nurse's form in regards to the signs emitted by the child is greatly influenced both by their own experience and by the education and routines they learn through the field. This approach of identifying mothers and infants with poor relationships is especially important given those mothers who try to hide that they are depressed or who do not even realise that they are. In these cases the child can be viewed as “the symptom carrier”, a concept belonging to Von Bertalanffy's general systems theory (Lundsbye et al, 2010).

General systems theory is a social theory often used in social work to explain how a family functions. According to general systems theory a family can be viewed as a system that functions much like any other biological organism (ibid). As such when there are difficulties within the family, the evidence is sometimes seen via a family member who exhibits symptoms, the so called symptom carrier (ibid). An infant's lack of eye contact and passive behaviour can be seen as symptomatic of a mother's depression and evidence that the family is not functioning well. Thus the nurse's use the information provided by the symptom carrier and their own habitus to identify problems within the mother-infant relationship.

6. SUMMARY OF RESULTS

The main objective of this study was to examine how BVC interprets and evaluates mother-infant relationships. In order to sufficiently address the study's main objective problem statements concerning BVC's interpretation of risk factors and identification of poor mother-infant relationships were fashioned to give the study direction and focus.

Four vignettes were then crafted depicting the four main risk factors as outlined by Killén (2009). These four risk factors; a mother's irrational involvement in her child, lack of positive interaction, unpredictable living situation and unpredictable personality are all strongly associated with the development of poor mother-child interaction and insecure attachment styles. Signs and risk factors associated with the four main risk factors were then woven into the vignettes in order to gain insight into how the child healthcare nurses interpreted, evaluated and identified them.

This study found in response to the nurse's interpretation of risk factors that the child healthcare nurses had an excellent grasp of signs and factors surrounding a mother's lack of positive interaction with her child. Postnatal depression was readily identified, easily interpreted and considered very worrisome, especially in terms of the child's attachment and the mother-infant relationship. The consequences postnatal depression can have on a child are well-documented, ranging from the immediate effects of insecure attachment (Murray et al, 1996) to more long term effects such as difficulties with peer group interaction and depressed behaviour (Field et al, 1988).

The nurse's strong focus on postnatal depression and expert understanding for the severe consequences it can bring about for the child mean however, that the condition becomes almost synonymous with insecure attachment and relationship difficulties; to the expense perhaps of other less frequently observed or well-known risk factors that can impact negatively upon attachment in equal or greater amounts.

Nevertheless the nurse's found the signs relating to a mother with an unpredictable personality as equally as worrying as those relating to a lack of positive interaction. The nurses found the behaviour exemplified by the mother with the unpredictable personality to be highly abnormal. Though fewer of the nurses interpreted the behaviour as stemming from an unpredictable personality the degree to which the described behaviour defied the accepted situational norms gave the nurses much cause for concern. This suggests that even when the nurse's cannot put a name to a risk factor their experience with expected situational norms

allows them to identify possible problems and issues relating to the mother-infant relationship. Johansson et al (2011) came to a similar conclusion regarding the role of the child health care nurse as a facilitator in the parent-child bonding process, suggesting that BVC nurses through their training can distinguish the normal from the abnormal.

The reoccurrence of troubling norm deviating behaviour was also found to be a significant factor in the nurse's interpretation of the severity of risk factors, with several nurses stating that the more a troublesome behaviour is observed the more the nurse's concern themselves for the mother and infants wellbeing. This study found that, whilst important, reoccurrence acted mostly as reinforcement for the more primary role played by situational norm deviation.

Another interesting finding in conjunction with the nurse's interpretation of risk factors relates to anxious mothers. Research has shown there is a strong correlation between anxious mothers and children with insecure ambivalent attachments (Stevenson-Hinde et al, 2011). Anxiety is a relatively common condition amongst mothers with small children and according to Wenzel et al (2003) it is more prevalent than depression. The fact that the nurses did not show greater amounts of concern for the anxiety displayed in the relevant scenario or, generally speaking, associate anxiety as being a risk factor for insecure attachment, suggests that the impact maternal anxiety can have on the mother-infant relationship is perhaps not as widely known or as screened for as depression. It could also suggest that anxiety due to its greater prevalence is viewed as more normative and therefore engenders less worry than the less prevalent postnatal depression.

Perhaps some of the most interesting findings to come from this study relate to how the individual nurses' identify poor mother-infant relationships. The role of experience, observation and routine proved to be a crucial theme in understanding not only how the nurse's create practice aimed at identifying poor mother-infant relationships but how they develop and cultivate it too. This study found that the nurse's experience could be likened to Grenfell's (2009) evolving interpretation of Bourdieu's habitus concept, whilst routine could be interpreted as Bourdieu's field concept. When combined, experience and routine create the practice of observation, which the nurse's use to identify poor mother-infant relationships.

Due to the dualistic nature of habitus and field is important to emphasise that the nurse's experience can be influenced by changes in routine, education and training and that routine can in turn be influenced by the nurse's experiences; all of which impact upon the nurses' practical skills of observation. A nurse's ability to spot situational norm deviations and deviations in the child's development and or attachment depend greatly upon the nurse's past experiences and education.

A nurse who has much experience of working with psychosocial risk mothers could therefore be said to be more familiar with the signs relating to individual risk factors. Since experience creates habitus can we deduce that nurses familiar with seeing more psychosocial problems find it easier to identify mothers and infants experiencing attachment difficulties than nurses who are not accustomed to dealing with such problems.

This was something that became apparent in this study's sample. All but one of the nurses was employed in a small village or town in rural Skåne. The nurse from the slightly larger town worked with a much more mixed population and as such had a greater working knowledge and experience of risk factors affecting attachment. Nurses who lack experience in working with psychosocial risk mothers can, however, obtain experience through education and training provided to them by the field, thereby developing habitus more equipped to aid them in their practice.

In relation to the theme of routine this study found that the administration of the Edinburgh postnatal depression screening (EPDS) survey in conjunction with the child's two or three month control was judged by the nurses to be an effective and valuable tool in catching cases of postnatal depression, especially when the mother is trying to hide that she is feeling unwell. This finding is supported by the results of Bågedahl-Strindlund and Monsen Börjesson's (1998) study which found that the EPDS has proved to be very effective in helping child healthcare nurses to detect depression.

Straightforward honest communication and trust was also a theme identified in this study and is closely related to the theme of experience, whereby the nurse's learn to ask difficult and sensitive questions in order to come nearer a mother or family experiencing difficulties. The study found that the more open the nurses were with themselves and the more straightforward they were in asking questions the easier it was for them to inspire trust and create a confidence with their mothers and families. This in turn led to mother's revealing problems and issues that could affect the child's attachment and led to them being more susceptible to help. This finding is supported by Johansson et al (2011) who found that child healthcare nurses can help parents to bond better with their children through creating a relationship with them built on trust.

Finally this study identified the child as an indicator for the mother's wellbeing as an important part of the nurse's observational practice. Infants, particularly those who exhibited passivity, lack of eye contact and lack of interest, were seen by the nurses as a reflection of the mother state of health, most notably in relation to postnatal depression. This evidence is supported by Killén (2009) who states that whilst the rest of the world may not see the mother's depression, the child definitely does and reacts accordingly with passive, withdrawn behaviour.

In conclusion the results of this study show that BVC interprets and evaluates mother-infant relationships using a combination of experience, routine and observation to determine the degree of norm deviant behaviour present during routine BVC controls.

7. DISCUSSION

From the results of this study can we see that BVC interprets and evaluates mother-infant relationships through a combination of experience, routine and observation. When combined, experience and routine allow for and regulate the nurse's observational skills in assessing norm deviant behaviour. In addition this study also found that of Killén's (2009) four main risk factors for the development of poor mother-infant interaction and insecure attachment, a mother's lack of

positive interaction was best observed, with the nurses very talented in identifying and interpreting postnatal depression.

An important tool for the nurse's in identifying postnatal depression is the Edinburgh postnatal depression screening (EPDS) survey, which is greatly appreciated by the nurses and according to their own perceptions aids them in their identification of mother's suffering from the condition, a finding which is supported by Bågedahl-Strindlund and Monsen Börjesson (1998). The fact that the EPDS has significantly improved the identification of mothers suffering from postnatal depression and is appreciated by both nurses and mothers alike, suggests that there could be benefits to the development and introduction of more screening procedures. This could be especially true in the case of anxiety, which according to Stevenson-Hinde et al (2011) is more prevalent than depression and can have equally as devastating effects on the mother-infant relationship, especially if the child is behaviourally inhibited. Reck et al (2008) came to a similar conclusion suggesting that the high prevalence of postnatal anxiety warrants urgent specialised programs for prevention and treatment.

Screening procedures targeted at identifying several psychosocial risk factors in pregnant women have proved successful in both Australia and America, where the *Antenatal Risk Questionnaire* (Austin mfl. 2011) respectively the *Prenatal Risk Overview* (Harrison mfl. 2011) have increased the identification of psychosocial risk pregnancies. The Prenatal Risk Overview found in addition that the use of a second screening with the questionnaire increased the rate of identification owing to the fact that the midwives had built a trusting relationship with their patients (ibid).

The success of screening procedures for multiple psychosocial risk factors during pregnancy suggests that the implementation of such screening procedures postnatal could be beneficial for both the mother and child. This is especially so given the impact psychosocial factors can have on the mother-infant relationship, child attachment pattern and the child's future development. A point underscored by Killén (2009) who states that the experiences a child receives during infancy affect not only the child's life but also future generations since childhood lasts for generations.

Since the findings from this study seem to suggest that the focus given to anxiety pales in comparison to that given postnatal depression, it is arguable that anxiety as a risk factor merits further investigation. Indeed an interesting point taken up by one of the nurse's was the impact of peer pressure on new mothers, a point discussed by Bartell (2006), who identified the perils of mother's engaging in what she terms the "milestone achievement war", whereby mother's desperately try to fit in with the group, push their children to develop faster and worry when they do not. Interestingly BVC plays a role in establishing such peer groups by creating mother and baby groups, whereby new mothers can meet and socialise.

Peer pressure is a relatively new phenomenon, which as a substantial source of anxiety warrants further investigation. This is especially true when one takes into account Killén's (2009) description of irrational parenting, whereby a mother can become invading and controlling. Killén highlights this factor as one of the four main risk factors in the development of a poor mother-infant interaction and

insecure attachment. As such the development and implementation of screening procedures for high levels of maternal anxiety could be a suitable measure.

In the absence of screening procedures and specific tools, such as the EPDS survey, this study found that child healthcare nurse's use a combination of experience, routine and observation to identify norm deviant behaviours exhibited during BVC controls. The fact that experience is such a vital factor in the nurse's ability to observe norm deviation queries the abilities of newly qualified nurses to observe subtle norm deviations indicative of problems in the mother-infant relationship. This study's sample consists of very experienced nurses, all of whom have worked many years with BVC. Given the crucial role experience plays in refining and developing the nurse's habitus it would be interesting to repeat the study using a sample consisting of nurses with more varied experience.

It is also important to note the role that the healthcare institution plays in developing the nurse's experience, through the implementation of standardised routines such as the EPDS, and through further training. All the nurses were extremely appreciative of the education and training they received through BVC, which included courses with BVC psychologists amongst others. The use of education and training should not be under appreciated, owing to the fact that it can add to the nurse's experience and develop their observational skills.

The role that BVC plays in evaluating and interpreting mother-infant relationships should not be underestimated. The nurse's preventative work in the early identification of children at risk of developing future psychosocial problems in response to relationship and attachment difficulties is of vital importance. BVC is the only organisation in Sweden that has universal access to small children and as such is uniquely placed to identify and help those with needs. Due to this fact it is essential that we as a society make the most of this most unique of organisations in order to prevent irreversible damage to children in the future.

BVC nurses are crucial elements in the BVC organisation and as this study has shown draw on a wealth of experience, routine and observation to evaluate and interpret mother-infant relationship difficulties. The roles played by experience, routine and observation allow the nurses to engender vital trust in their patients, spot norm deviations and take appropriate actions to help the families in question. As such it is crucial that nurse's receive education regarding attachment disorders and risk factors that can lead to them as well as tools in the form of screening procedures.

8. CONCLUSION

The results of this study found that BVC interprets and evaluates mother-infant relationships using a combination of experience, routine and observation to determine the degree of norm deviant behaviour present during routine BVC controls. The roles played by experience and routine allow for and regulate the nurse's observational skills in assessing norm deviant behaviour. The level of concern a nurse shows depends upon the severity of the norm deviations exhibited by mother and the child.

In addition this study also finds that of Killén's (2009) four main risk factors for the development of poor mother-infant interaction and insecure attachment, a

mother's lack of positive interaction was best interpreted, whilst factors relating to a mothers irrational involvement and unpredictable living situation were interpreted less well.

As a result of this study's findings comes the suggestion that the creation and introduction of screening procedures for multiple psychosocial risk factors, in particular anxiety could be of benefit. Further research in areas surrounding the effects of anxiety/peer pressure on attachment could also be beneficial since research in this area is sparse. This study also finds that the continuous education and training of the nurses in topics relating to attachment dysfunction and risk factors thereof is a vital and necessary function provided by BVC.

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APPENDIX I.

Information Letter

Informationsbrev	
Projektets titel: Tecken på otrygga anknytningsmönster hos spädbarn	Datum:
Studieansvarig: Amanda Sarsfield E-post: ae.sarsfield@gmail.com Tel: 0709299232	Malmö högskola, Fakulteten vid hälsa och samhälle, 205 06 Malmö, Tfn 040- 6657000 Utbildning: Socionomprogrammet Nivå: C
<p>Barnvårdscentralens arbete med spädbarn och mödrar innebär en unik möjlighet för samhället att fånga upp och hjälpa barn som riskerar utveckla framtida psykosociala problem på grund av dåligt fungerande mor-barn relationer. Eftersom en av de tidigaste varningstecknen på att någonting där hemma inte stämmer kan vara just mor-spädbarns relationen, vill jag, som syfte för studien, <u>undersöka BVC:s tolkning och bedömning av mor-spädbarn relationer.</u></p> <p>Studien består av fyra stycken vinjetter med tillhörande intervjufrågor. Vinjetterna beskriver fyra fall med mor och spädbarn som besöker BVC. Efter varje vinjett skall du sätta ett kryss på en linje som går från ”Inte alls orolig” till ”Mycket orolig” motsvarande hur du tror du hade reagerat om du var familjens barnsjuksköterska. Efter det kommer jag att ställa några frågor om vinjetten. Hela intervjun beräknas ta cirka en halvtimme att genomföra och ljudinspelning kommer ske. Vad som sagts i ljudinspelningen kommer sedan transkriberas och skrivas ut av mig författaren för att kunna sammanställas och analyseras.</p> <p>Största möjliga konfidentialitet eftersträvas i undersökningen genom att ingen obehörig får ta del av materialet. Materialet förvaras så att det bara är åtkomligt för författaren. I rapporteringen av resultatet i form av en examensuppsats på Malmö högskola kommer informanterna att avidentifieras så att det inte går att koppla resultatet till enskilda individer. Resultaten kommer att offentliggöras för en grupp som ska opponera uppsatsen innan dess godkännande. Ditt deltagande i studien är helt frivilligt. Du kan när som helst avbryta ditt deltagande utan närmare motivering.</p> <p>Du tillfrågas härmed om deltagande i denna undersökning</p>	

APPENDIX II.

Informed consent form

Samtycke från deltagare i projektet

Projektets titel: Tecken på otrygga anknytningsmönster hos spädbarn	Datum:
Studieansvarig: Amanda Sarsfield E-post: ae.sarsfield@gmail.com	Studerar vid Malmö högskola, Fakulteten vid hälsa och samhälle, 205 06 Malmö, Tfn 040-6657000 Utbildning: Socionomprogrammet Nivå: C
<p>Jag har muntligen informerats om studien och tagit del av bifogad skriftlig information. Jag är medveten om att mitt deltagande är frivilligt och att jag när som helst och utan närmare förklaring kan avbryta mitt deltagande.</p>	
<p>Jag lämnar härmed mitt samtycke till att delta i ovanstående undersökning:</p>	
<p>Datum:</p>	
<p>Deltagarens underskrift:</p>	

APPENDIX III.

INTERVJUGUIDE MED VINJETTER

Inledande frågor

Hur länge har du jobbat som barnsjuksköterska?

Tycker du att det är ett roligt jobb?

Är anknytningsteori någonting som ni lär er under er utbildning?

Har ni användning för anknytningsteori på jobbet?

Hur lär ni er att bedöma mor-barn samspel och anknytningsmönster?

Vinjett 1. Irrationellt engagemang i barnet.

Katrin, 34, kommer på sitt första besök hos dig med sin 8 månader gamla dotter Freja. Katrin är mycket trött och säger att Freja har jättesvårt att sova om nätterna. När Katrin lägger Freja på kvällen och hon lämnar rummet börja Freja skrika efter mamma och slutar inte tills att hon har kommit tillbaka och hållit i henne. Scenariet upprepar sig flera gånger varje natt och Katrin får väldigt lite sömn. Katrin undrar om inte Frejas sömnproblem kan bero på att pappan nyligen har lämnat dem och att detta har gjort henne ledsen och ängslig. Under besöket verkar Freja mycket lekfull och glad men även lite klängig och blyg. Katrin är väldigt uppmärksam på henne och tröstar henne så fort hon visar tecken på att hon kan komma bli ledsen.

Inte alls orolig _____ Mycket orolig

Följdfrågor

1. Finns det något i vinjetten som gör dig orolig för barnet?
2. Vilka tecken i vinjetten fäster du vikt vid?
3. Varför?
4. Vad skulle kunna vara problemet här?
5. Hur anser du att detta skulle kunna påverka barnets anknytning?

Vinjett 2. Bristande positivt engagemang i barnet.

Maria, 25, kommer med sitt första barn Måns för hans tremånaderskontroll och vaccination. Allting har gått bra för både mamman och barnet sedan födseln och Måns utvecklas normalt. Marias make, Jens, är mycket stödjande även om han är borta mycket och de verkar ha det bra hemma. Under besöket förekommer det

dock ganska lite samspel mellan Maria och Måns. Maria verkar vara lite trött och tillbakadragen men ändå ganska positiv. Måns däremot verkar någorlunda passiv och tyst trots sin hittills normala utveckling. Han rör sig knappt och verkar inte vara intresserad av varken sin omgivning eller sin mor och söker ingen ögonkontakt med henne. Maria har erbjudits en plats i en mammagrupp men säger att hon inte är intresserad eftersom att hon anser att hon får tillräckligt med stöd från familjen.

Inte alls orolig _____ Mycket orolig

Följdfrågor

1. Finns det något i vinjetten som gör dig orolig för barnet?
2. Vilka tecken i vinjetten fäster du vikt vid?
3. Varför?
4. Vad skulle kunna vara problemet här?
5. Hur anser du att detta skulle kunna påverka barnets anknytning?

Vinjett 3. Oforutsägbar personlighet.

Annika, 18, kommer med sitt första barn, Felicia, för hennes femmånaderskontroll och vaccination. Annika är ensamstående och pappan lämande henne redan när hon var gravid. Annika har inte mycket kontakt med sin familj, eftersom hon omhändertogs av staten som 3 åring och har placerats i en mängd olika familjhem under sitt liv. Annika får istället stöd från sina vänner och sin nya pojkvän, David, som flyttade in hos henne för bara två veckor sedan. Under besöket hos dig uppträder Annika som en väldigt glad och engagerad mamma. Hon gosar med Felicia mycket och verkar väldigt fäst vid henne. Felicia är dock väldigt tyst och lite stel i kroppen. Hon visar inte samma glädje som sin mamma i deras samspel men håller nästan konstant ögonkontakt med henne. När Felicia börjar gråta från sprutorna, tar Annika tag i Felicia lite hårdhänt, rycker till henne och skriker åt henne att vara tyst. Felicia tystnar snabbt och försöker dra sig undan. Efter några sekunder dock återvänder Annika till sitt tidigare beteende och kramar om Felicia med glädje.

Inte alls orolig _____ Mycket orolig

Följdfrågor

1. Finns det något i vinjetten som gör dig orolig för barnet?
2. Vilka tecken i vinjetten lägger du vikt vid?

3. Varför?
4. Vad skulle kunna vara problemet här?
5. Hur anser du att detta skulle kunna påverka barnets anknytning?

Vinjett 4. Oförutsägbar livsstil.

Lina, 28, kommer med sitt andra barn, Isak, på hans tolv månaders kontroll. Lina är gift med Jimmie och tillsammans har de Isak och hans äldre bror Oskar som är 3 år. Familjen har nyligen flyttat till staden och bägge föräldrarna saknar jobb. Under besöket uppträder Lina lite obekvämt och frånvarande. Hon kollar ofta på klockan och verkar lite undvikande i sina svar när det gäller frågor om Isaks utveckling, vilken är lite fördröjd. Han har friskförklarats av sin tidigare barnläkare men Isak har inte börjat prata än och står upp endast med Linas hjälp. Han verkar ganska klängig i övrigt och söker sin mammas närhet hela tiden fastän hon verkar reagera lite apatiskt mot hans försök att få hennes uppmärksamhet.

Inte alls orolig _____ Mycket orolig

Följdfrågor

1. Finns det något i vinjetten som gör dig orolig för barnet?
2. Vilka tecken i vinjetten lägger du vikt vid?
3. Varför?
4. Vad skulle kunna vara problemet här?
5. Hur anser du att detta skulle kunna påverka barnets anknytning?

Avslutande frågor

Hur känner man igen mammor och spädbarn med risksamspel? Vilka är tecknen?

Vilka tecken tror du är mest allvariga och varför?

Vilka problem hos modern anser du hotar barnets anknytning mest?

Ser du många mammor och barn med samspelsproblematik?

Hur viktig är det att man identifiera sådana barn?

Vilka problem skulle kunna uppstå i framtiden för dessa barn?

Har ni screeningsprocedurer för att identifiera sådana barn?

Är det lätt att känna igen sådana barn?

Hur identifiera du mammor och barn med samspelsproblematik?

Har du någonting du vill tillägga? Har du några frågor till mig?

APPENDIX IV.

Table 2. The signs each child healthcare nurse reacted to in the vignettes.

	Vignette 1	Vignette 2	Vignette 3	Vignette 4
CHN 1.	Parent's separation Child's anxiety Mother responds to child	Child's passivity, uninterested behaviour & lack of eye contact	Mother's background, mood changes & aggressive behaviour Child's watchfulness	Mother's indifferent behaviour & lack of reaction to her child.
CHN 2.	Parent's separation Mother responds to child	Child's passivity, uninterested behaviour & lack of eye contact Mother's tiredness and withdrawal	Mother's aggressive behaviour Child's lack of trust in mother	Mother's tiredness, avoidant behaviour & indifference. Child's late development
CHN 3.	Parent's separation Mother responds to child	Child's passivity, uninterested behaviour & lack of eye contact	Mother's background, mood changes & aggressive behaviour Child's quietness & stiffness	Mother's indifferent behaviour & lack of reaction to her child. Child's late development
CHN 4.	Parent's separation Mother responds to child	Child's passivity, uninterested behaviour & lack of eye contact	Mother's background, aggressive behaviour & age. Child's quietness & fear	Parent's unemployment. Mother's nervousness. Child's late development
CHN 5.	Parent's separation Mother's tiredness Child's anxiety Mother responds to child	Child's passivity, uninterested behaviour & lack of eye contact	Mother's background, age & aggressive behaviour Child's reservation	Parent's unemployment Mother's indifference Child's late development
CHN 6.	Parent's Separation Mother responds to child	Child's passivity, uninterested behaviour & lack of eye contact	Mother's mood changes & aggressive behaviour The child's fear	Mother's indifference Child's late development