EARLY COPARENTING PROGRAMMES WITH PARENTS OF INFANTS WITH A HIGHLY REACTIVE TEMPERAMENT: A RANDOMISED STUDY USING 'PARENTS AS PARTNERS' (PasP).

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Abstract

This randomised controlled trial presented a two-group design and sought to examine whether the 'Parents As Partners' (PasP) coparenting programme (Casey et al., 2017) delivered to parents who described their infants as having a highly reactive temperament, helped the parents strengthen their couple and coparenting relationships, and enabled them to use more effective parenting strategies which would in turn help to reduce the infants' level of reactivity. Participating couples (n=52) were Maltese speaking parents who described their 8 to 12 month old infants as having a highly reactive temperament on the Infant Behaviour Questionniare-Revised (IBQ-R) during a post-natal visit to a Well Baby Clinic in their local Health Centre. All the couples completed the Parenting Stress Index – Short Form (PSI-4-SF), and Coparenting Relationship Scale (CRS) measures pre- and post-intervention. The age-appropriate Early Childhood Behaviour Questionnaire (ECBQ) was completed for both groups post-intervention. Couples randomized into the intervention group (n=30) were offered the PasP programme for 16 weeks, whereas the remaining couples (n=25) belonged to the control group, with both groups followed by a case manager. Significant results post-intervention showed that participating parents in the intervention group reported reduced conflict in the couple relationship occuring in front of their child, a reduced parent-child dysfunctional interaction as well as decreased negative reactivity in their child. Implications for supporting parents, involving fathers, and reduction of risks of future child behavioural difficulties and child maltreatment are pertinent to this study.

KEYWORDS: Coparenting relationship, Stress, 'Parents as Partners', Highly Reactive Temparament, Randomised Controlled Trial, Father involvement.

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To my dearest children,

who made me appreciate the experience of parenting.

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ABBREVIATIONS

Analysis of Variance	ANOVA
Attention Deficit Hyperactive Disorder	ADHD
Child and Young People's Services	CYPS
Consolidated Standards of Reporting Trials – Social and Psychological Interventions	CONSORT-SPI
Coparenting Relationship Scale	CPS
Clinical Outcomes in Routine Evaluation	CORE
Early Childhood Behaviour Questionnaire	ECBQ
Enhanced Group Triple P	EGTP
General Data Protection Regulations	GDPR
Group Worker Interview	GWI
Home-Based Therapeutic Services	HBTS
Incredible Years Programme	IYP
Infant Behaviour Questionnaire – Revised	IBQ-R
Intention-To-Treat	ITT
National Child Traumatic Stress Network	NCTSN
National Obstetric Information System	NOIS
National Statistics Office	NSO
Negative Emotionality	NEG
Orienting/Regulatory Capacity	ORC
Parenting Stress Index – Short Form	PSI-4-SF
Parents as Partners	PasP
Positive Affectivity/Surgency	PAS
Randomised Controlled Trial	RCT
Standard Group Triple P	SGTP
Statistical Package for the Social Sciences	SPSS

Tavistock Centre for Couple Relationships	TCCR
Template for Intervention Description and Replication	TIDieR

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CHAPTER 1

INTRODUCTION

Overview

The transition to parenthood is one of the most important and challenging processes in the life of many who become parents. This transition can be met with a multitude of reactions such as joy, fear, anxiety, and parents try to carry out their new roles in ways they believe are appropriate. Many times, their choices are based on what they have been exposed to themselves as children, and most often they proceed without any form of training. Parents who have an infant with a highly reactive temperament are faced with an added challenge, one that frequently impacts one or both parents negatively, though differently, and places a strain on the couple relationship as they try to cope with the stress that this creates (Burney & Leerkes, 2010). Parenting programmes have a positive impact on the parents' ability to parent (Barlow & Coren, 2017; Sanders & Morawska, 2014), nevertheless, there is no evidence to show the impact of such programmes in situations where an infant shows a highly reactive temperament. Neither is there any related evidence on specific outcomes of parents' wellbeing, stress and relationship as partners following a parenting programme – either for the parents or for their highly reactive infants. Therefore, this study sought to conduct and evaluate a randomized clinical trial of a couples' group intervention for parents who described their infants as having a highly reactive temperament. Specifically of interest to this study was whether a coparenting programme intervention focusing on the couple-parenting relationship of these parents, helped them to become more effective in their parenting, and whether their infant's behaviour was also impacted positively as a result.

This chapter will introduce the author's position in the research, the knowledge connected to the transition to parenthood, as well as introductory literature about infants with a

reactive temperament and the implication of parenting such an infant. The conceptual framework informing the study is then presented. The aims of this study follow.

Locating Myself in the Research

As a parent of two sons, and a professional in the field of counselling psychology and family therapy, I have always expected and hoped to be the best possible parent for my children, considering that I have some understanding about child development and attachment. Little did I know and discover over the years that the latter task is not so simple and straightforward as I imagined, despite my extensive reading about becoming a parent. The importance of the parenting relationship has become more evident to me over time, and whilst from prior to the birth of my first son, I was already doing my best to involve his father in taking an active role in being a dad, our different beliefs, expectations and previous experiences of being parented gradually came to the forefront. Years later they still do!

Moreover, a realisation for me as a parent was that my boys were actually very different from each other. Our older son was pretty relaxed, somewhat uncoordinated, and overall easily adaptable as an infant and young child, whereas my younger son appeared to make up for the first in every possible way, being very energetic, temperamental and moody, very sensitive, and having a creative mind of his own from when he was just a baby. He was the one I was sent for by the school, mostly because of something he had or had not done, or because he decided to put his own mark on whatever it may have been he was or was not doing.

Therefore when deciding to pursue my studies further, and choose which area I wished to delve into, parenting certainly stood out to me as that area. I believe the reason I was particularly drawn to parenting was because of the realization of how important the quality and working together of the couple relationship was in this regard. It was a realization of the 'fine-tuning' that is a necessary part of parenting. From my own experience, the couple/parenting relationship is crucial from the very beginning of a child's life, from the time of planning a conception through the transition to parenthood and beyond. Understanding the importance of this relationship, motivates me further to support couples and parents in my work. Furthermore, acknowledging also that children from the same parents are often very different, makes me curious to explore how a parenting programme can possibly create a difference for parents in their relationship together and in their parenting of their more challenging child, and how the two impact one another constantly and inevitably.

The Transition to Parenthood

The transition to parenthood is considered to be one of the most significant and challenging of all transitions for the majority of adults. This major challenge faced by many parents tends to increase the level of stress and strain on the couple relationship (Doss & Rhoades, 2017; Walker, 2014). Hence it is indeed considered to represent a critical period in the life of couples (Delicate, et al., 2018).

This transition requires that a number of adjustments be made in order to allow space for the new family member (McGoldrick, et al., 2013). Cowan and Cowan (2012) describe this

transition as a long term process, which results in 'a qualitative reorganisation of both inner life and external behaviour' (Balfour, et al., 2012, p. 5). The transition to parenthood challenges the parents' ideas and views about themselves. In fact, not all parents feel ready for the transition, and for some it comes as a shock, where the feeling of losing control impacts their level of confidence and self-efficacy (Solmeyer & Feinberg, 2011). Notwithstanding the fact that both parents are going through the same transition, the experience may well be very different for mothers and fathers, where a mismatch can exist between the expectations of each and the reality of what the transtion presents (Reynolds, et al., 2014).

Parents rarely receive information about the meaning and impact that a child will have on their relationship as a couple, nor are they informed enough about the new changes that their roles will involve, and thus sufficient support and attention to the relationship of the couple as they become parents has not always been given its due importance (Baldwin et al., 2018). Whilst this important life transition may bring about more closeness between some partners, the quality of the relationship often begins to deteriorate when they become parents (Doss & Rhoades, 2017; Walker, 2014). With the added stress as a result of parenthood, without any particular intervention the average couple relationship's level of satisfaction tends to decline across time, impacting negatively the couple relationship and the parent-child relationships (Cummings & Schatz, 2012; Delicate et al., 2018; Solmeyer & Feinberg, 2011). A study by Krishnakumar and Buehler (2000) also indicated that as a result of the parents' preoccupation with conflict in their marriage, most dimensions which were connected to child-rearing practices were impaired.

Carlson et al. (2011) found that parental relationship quality was indeed a predictor of how well both mothers and fathers were able to engage with their infant, and that the better the

quality of the parental relationship, the better the engagement with the child. The couple's level of relationship satisfaction and quality also affects the parent-child relationship, and is a strong direct predictor of a child's behaviour problems over the span of time (Linville et al., 2010). Other authors highlight the couple relationship and its quality before as well as during the transition to parenthood and emphasize its importance in connection to mental health and well-being not only of the parents, but also of other existing children and other members forming part of the family context (Grevenstein et al., 2019; McHale & Lindahl, 2011; Redshaw & Martin, 2014).

One explanation for the change in partners' relationship when becoming parents may be connected to a shift in the level of investment placed in the parental roles. It is not uncommon for men to withdraw emotionally during the transition to parenthood because of feeling resentful about the attention given to the child, and because of feeling unprepared about their new role as fathers, and the changes that result in the couple relationship because of the transition (Baldwin et al., 2018). This withdrawal is likely to be met with further withdrawal or detachment from the mother, who would be feeling hurt because of the husband's focus on himself rather than on her and the baby. The level of marital satisfaction is significant because its decline minimizes the parents' sensitivity, the extent to which they are able to invest in their child, and above all the quality of their parent-child relationships. As Glade et al. (2005) state in their article, 'the state of the marital relationship after the birth of a child is especially important because the couple dyad becomes the attachment and socialization environment in which the child will be nurtured and taught' (p. 322), hence the detrimental effects when the couple relationship begins to suffer.

How well the couple manages to adjust and support each other during the transition to parenthood, and their ability to coparent, inevitably impacts the quality of their relatonship as co-parents as well as the child's well-being (Walker, 2014).

Defining Coparenting

There is no one clear definition for coparenting. Van Egeren and Hawkins (2004) define coparenting as 'a complex construct' (p. 165), being systemic in nature considering its similarity to other dimensions within a family. Feinberg (2003), who was instrumental in designing the Coparenting Relationship Scale, mentioned that coparenting was made up of different components, namely childrearing agreement, the division of labour, the supportive or undermining component, and joint family management. The level of conflict between parents and their ability to achieve a balance between themselves and their child was also included along with these components, influencing the effectivity of the components.

Defined also as 'an enterprise undertaken by two or more adults who together take on the care and upbringing of children for whom they share responsibility' (McHale et al., 2002, in McHale & Lindahl, 2011, p. 3), it is argued that in actual fact, the coparenting relationship differs from the couple relationship, considering that its development sets off prior to the birth of the child, and at times prior to conception (https://search-proquest-com.ejournals.um.edu.mt/docview/1660671298?accountid=27934). It includes parents living under one roof and may also include separated and/or divorced parents who are raising a child together. Other coparenting arrangements would include single mothers or fathers parenting with their mothers (the grandmothers), and gay and lesbian parents.

An important implication of coparenting is the link between its effectiveness and supportive qualities, which may be considered as a buffer for children's externalizing and problematic behaviours (Schoppe Sullivan et. al., 2009). In fact, research by Leary and Katz in 2004 provided evidence that an interaction existed between the coparenting relationship and the emotional regulatory abilities of the child, supporting further research that reflects an interactional focus and understanding of coparenting (Kochanska, Askan & Joy, 2007).

In view of the demands, challenges and strain experienced by couples connected to becoming parents, what might be considered as the normal level of strain when having a child is inevitably increased when parents have an infant that presents with a highly reactive temperament and is difficult to soothe.

Not all Infants are the Same: Infants with a Reactive Temperament

Temperament has been portrayed and understood in different ways across time. Understanding and identifying infant temperament became important particularly because of how it was found to be related to later developmental and childhood difficulties (Costa & Figueiredo, 2011; Kozlova et al., 2019; Sidor et al., 2017). Difficulties associated with negative characteristics include problems with attachment (Gartstein, 2014), internalization and externalization of problematic behaviours (Abulizi et al., 2017; Karreman et al., 2010; Pitzer et al., 2011), hyperactivity (Nigg, 2006**;** Nigg et al., 2004), depression (Gartstein & Bateman, 2008 in Costa & Figueiredo, 2011), anxiety disorders (Buss & Kiel, 2013; Lindhout et al., 2009), and autistic spectrum disorders (Clifford et al., 2013), to mention just a few. Personality is also

connected to, and includes in it temperament, the latter being considered as an early foundation to later developing personality (Bornstein et al., 2014).

From as early as the 1950s, authors Thomas et al. (1968) began the New York Longitudinal Studies, part of which involved interviewing mothers about their young infants. Infants were classified across nine dimensions of temperament, from which more distinct profiles were created. These authors had made a distinction between infants that could be described as having 'easy', 'difficult', 'slow-to-warm-up' or 'average' temperaments or profiles (Thomas & Chess, 1977). Infants who were classified as showing an easy temperament were described as being positive in mood, easy to adapt, approaching new situations in a positive way without or with little intensity in their reactions. Infants that were classified as 'difficult' (Thomas et al., 1982) were described as being negative in mood, and were slow to adapt, approaching new situations by tending to withdraw, whilst showing highly intense reactions. Infants who were classified as slow-to-warm-up were also described as being negative in their mood, similar to difficult infants, and they were also slow to adapt, also withdrawing from new situations, yet showed low to moderate rather than high intensity in their reactions. Finally, those infants that were classified as being average were the ones who did not fit any of the previously described temperaments. From this study, 10% of infants had fit into the 'difficult temperament' classification. According to Neu (1997), 16% to 26% of U.S. infants are likely to be diagnosed as irritable or colicky. It may be assumed that a percentage of these infants described as irritable may be infants with a difficult temperament.

In Malta, according to the National Obstetric Information System (NOIS) Annual Report (2018), the total number of births in Malta during 2018 was 4,491, representing an increase of

118 births over the previous year 2017. The majority of these infants were born to mothers between the ages of 30 to 34 years old, with the average age of the parent giving birth being 30.5 years. The National Obstetric Information System (NOIS) – Malta mentioned that during 2018, 30% of infants that were delivered were to single mothers who had never been married, whereas 66.8% and 2.8% of infants were born to married mothers and widowed, separated or divorced mothers, respectively (Gatt & Cardona, 2019). The Maltese context does not provide us with statistics on the number of infants that present with a highly reactive temperament, although if one were to calculate 10% of the 4491 births, this could indicate that 449 such infants.

Moreover, specific age-appropriate measures on child behaviour used nowadays highlight three key factors that bring out an infant's or child's temperament. These factors include 'Surgency', which represents the infant's level of activity, impulsivity, sociability, etc., 'Negative Affectivity', which represents the infant's frustration, sadness, unsoothability, etc., and the third factor is that referred to as 'Effortful Control', which represents an infant's attentional focus, ability to inhibit control, etc. (Putnam et al., 2014). In global research on temperament, which included datasets from 51 countries including Malta, it was interesting to observe that Malta scored significantly higher than 15 other countries on 'Surgency', higher than most countries on 'Effortful Control', whereas it scored in the median range on 'Negative Affectivity', but not as low as other places in Europe (Putnam, et al., 2019), implying cultural variances in temperament.

Yet another definition of temperament came from researchers Rothbart and Bates (2006), who defined temperament as 'individual differences in reactivity and self-regulation' (p. 13). Rothbart (2011) added that temperament also referred to and included 'tendencies,

dispositions, or capacities' of the individual concerned, which were not expressed all the time, but which depended on the right conditions, situations and context that would elicit these. Hence, this implied a systemic development in the definition of temperament, from one that was attributable to the infant, to one that included the context in which the infant was developing. Similarly, Lerner et al. (2011) refer to the importance of goodness-of-fit between the child and the environment in which he or she develops. They point out that for a child to adjust successfully, the interaction between the child's/infant's temperament and his or her environment is crucial. Whether an infant's temperament is labeled as highly reactive or considered as difficult, depends on how well the parents are able to respond sensitively to the behaviour displayed by that infant. The same would be true for a child who is less reactive or labelled as having an easy temperament. Such a child might still experience problems as a result of parents' lack of understanding, excessive demands and insensitivity. According to a study that focused specifically on the interactive effects of parents with their child's temperament, it was found that even with 'emotional and angry children' there was more family cohesiveness when mothers were more emotionally stable, implying a consistency with the goodness-of-fit hypothesis (Hong et al., 2015). Other research on early parenting precursors connected to their child's self-regulatory abilities indicated that the strongest predictor of the child's regulatory abilities was in fact the parent-child relationships (Carlon et al., 2010). These findings continue to suggest the importance of both parents' ability to adapt and relate sensitively to their child's temperament, as this is predictive of child adjustments in the long-term (Bornstein et al., 2014; Kozlova, et al., 2019).

Parenting an Infant with a Highly Reactive Temperament: The Interactional Systemic Context.

While the literature on infant temperament focuses almost entirely on parent-child relationships, the studies that I have described so far suggest that the connections between mothers, fathers, and infants with a reactive temperament exist in a system of bi-directional relationships. Couple relationships affect parenting, and disagreements about parenting affect the couple. Both couple relationships and parent-child relationships affect children's development and well-being, while a difficult to manage infant affects the quality of mother-child and father-child relationships, and may have a significant negative impact on the couple. The environment and context in which the infant grows is not only known to influence the infant's temperament and expression of how he or she reacts, and how well he/she is able to self-regulate (Rothbart & Derryberry, 1981), but may also affect the child's cognitive abilities in the future (Suor et al., 2017).

Understanding the Interactional Exchange Between Parent and Child

It is highly likely that infant characteristics are associated with how parents begin to behave from early on in the parenting relationship. Crockenberg and Leerkes (2003) took on a transactional approach in order to understand and elicit the interactional nature of exchanges that exist between a parent and child. That is, the infant's behaviour elicits or evokes a particular response or reaction from the parent/s, whose reaction in turn impacts the infant's behaviour or response accordingly. Hence, one might expect that if an infant has a reactive temperament and

becomes difficult to soothe, a parent's nervous or irritable reaction to this behaviour will most likely aggravate the infant's behaviour further, which continues to affect the coparenting relationship. This is especially so if the two parents are in conflict between them about their respective reactions to the infant, which may then bring about additional tension between the parents. In the same manner, when children are perceived to be 'well-behaved' or easier to manage by their parents, parents are more able to reciprocate with behaviour that is warm and supportive, as well as to experience less conflict between them (Hong et al., 2015).

Therefore the interactional nature of the parents/infants' relational impact on the parents' relationship quality cannot be ignored, and 'goodness-of-fit' between the infant and the context in which he or she develops is of the essence. In fact, in a study carried out by Davis et al. (2009), a interactional relationship was found to exist between the parents' coparenting ability and early infant temperament, where less cooperation in coparenting behaviour was associated with early infant difficulty. The results of this research were supported by Cook et al. (2009) who stated that 'parents of children higher on levels of negative affect demonstrated greater undermining coparenting behaviour' (p. 606). These findings serve as a useful theoretical base consistent with the systemic theoretical model (Schulz et al., 2006) for conducting the coparenting programmes in this thesis, as designed by Cowan and Cowan (1995, 2000) in their previous research using coparenting programmes.

Father Involvement

Until recent years, most of the research connected to parenting was focused predominantly on mothers, many a time leaving fathers at the periphery of parenting

programmes and child-related efforts, evidently reflecting a gender bias (Amato, 2018). However, current research shows conclusively that fathers also effect their children's development differently, and in important ways, as well as providing support to mothers (Tohki et al., 2018; Tully et al., 2017).

Since coparenting involves both parents, fathers are inevitably an important part of the equation. Men, like women, are also physiologically prepared for parenting and are changed by the experience of parenthood (Carter, 2005; Gettler et al., 2011). They learn to adapt both physiologically as well as behaviourally (Lamb & Lewis, 2010). It is in fact important to keep in mind that in reality, it is the father's own infancy and childhood that plant the seed to fatherhood through their own experiences of being fathered, and hence their needed involvement in parenting (McHale & Phares, 2015). Research shows that the earlier a father becomes involved with his child, the more likely it is for him to remain involved in that child's life. In fact, 'engaging the father early on in a child's life is implicitly related to coparenting' (McHale & Lindahl, 2011, p. 88), where it is found that parents who tend to share the same belief about the importance of the father's involvement are much more likely to stay together as a couple (Hohmann-Marriott, 2009), thus linking to a better quality relationship between the parents (Pleck, 2010).

Parenting in the Maltese context has predominantly been the mother's domain, with father's involvement standing on the periphery especially in more traditional families. This has also been reflected through services provided for children when mothers rather than fathers are sent for more often. In more recent years there has been a shift with increasing father involvement particularly as a result of women's increased participation in the workforce,

although most child-rearing and caring duties are still the mother's domain (Camiller, 2001; Abela, 2014; Abela, 2016).

Father involvment has been found to have multiple benefits for children as well (Lamb, 2010), substantially impacting their development and future outcomes (Panter-Brick et al., 2014). Children's level of self-esteem and independence, as well as psychological wellbeing, are all positively associated with their father's positive involvement in their lives (Allgood et al., 2012). Moreover, children have also been found to benefit from increased functioning on a cognitive level, are more able to be empathic, have less stereotypical beliefs, as well as an improved internal locus of control when their fathers are more involved (Clark, 2009). Evidence continues to show that when a father is involved in their child's life, this augurs well for the child, providing both protective as well as positive effects in the short and long term (Panter-Brick et al., 2014). The relationship that develops between a father and child as a result of father's involvement in that child's life has a interactional influence. It involves a two-way process where not only is the child supported by his/her father, but also the father is influenced by the same relationship with the child in a positive way, allowing him to become more sensitive and understanding (Cowan & Cowan, 2000). Mothers also benefit from fathers' involvement with their children. They feel more supported, and are less tired and stressed as a result (Burgess, 2009; Coltrane & Adams, 2008).

Quality of the Coparenting Relationship and Child Adjustment

The relationship between the caring adults is also deemed to be of great importance, since the presence of conflict in this latter relationship can be positively correlated with more

difficulties in child adjustment. Based on a large body of research, Lamb (2012) asserts that the factors that contribute to a child's adjustment in life are the quality of relationships that exist between parents, other significant carers, and the children throughout the different stages of their life, from birth through to adolescence. So much so, in their study on marital conflict and children, Cummings and Davies (2010) pointed out that when conflict between the couple is high, they are more likely to indicate externalizing as well as internalizing problems in their children. Golombok (2015) goes on to confirm how important relationship quality is, indicating that what matters most is what happens within families, whether conflict is present or not, and not how families are made up. Therefore considering the important implications that the relationship between the parents has on children's well-being and development (Cummings & Davies, 2010), and also the evidence to show that children raised in one-parent families are more likely to experience difficulties in their adjustment than those in two-parent families (Lamb, 2012), a focus on the parenting relationship is underscored.

In view of the systemic circular relationships that evidently come into play when considering the complexity of the parent-child relationships, and the long-term impact that the quality of the early years have on the child's future development and wellbeing (Center on the Developing Child at Harvard University, 2016), an early intervention using a coparenting programme with parents of infants having a reactive temperament was the focus of this study.

Aim of the study

This study examined whether a coparenting programme delivered in the early stages following the birth of an infant presenting with a highly reactive temperament, could enhance the parenting relationship, and whether there was also a resulting positive change in the infants' temperament.

The aim was to carry out a coparenting programme with parents living together. There was also a control group, randomly assigned, who were not offered the intervention but had access to services as usual in their community. All parents in the study were identified as having an infant that presented with a highly reactive temperament.

Research Questions

The research questions for this study were:

- Does participation by parents of infants with a highly reactive temperament in a coparenting programme affect the infant's level of reactivity?
- Will attendance to a coparenting programme that focuses on the couple-parent relationship help the parents to use more effective parenting strategies with their young children?

Considering that highly reactive infants are described as being more intense, fussy and inflexible because of their heightened sensitivity (Kagan, 2010), the quality of parenting through nurturing, responsiveness, ability to soothe, following the intervention, was expected to lower the

intensity of the infants' reactivity. As a result of less reactivity on the part of the baby or young child, it was expected that the level of parental stress, and the parenting relationship would be positively impacted. It was hoped that parents would be able to manage the infants' reactivity better, and hence feel more successfully in control, and empowered.

Choosing a Family Systems Theoretical Framework

The study examined whether the coparenting programme impacted the quality of each of the parent-child relationships, their parenting relationship, and whether their highly reactive infants' behaviour changed as an outcome of the programme, such as by being more easily soothed by the parents. In terms of the theoretical framework adopted for the study, the importance of relationships and their quality was vital in understanding why such an intervention could potentially carry so much weight and possibly leave its mark. Relationships can be understood systemically through Family Systems Theory, which was a key theoretical framework in this thesis.

The introduction of Family Systems Theory by psychiatrist Murray Bowen in the 1950s brought about a totally new way of looking at families, where it was assumed that the family and relationships within it form part of a system in which individuals are interconnected to other individuals. Moreover, the individuals are continuously impacting and being impacted through the pattern of interactions that develops among all the relationships in the particular family and its environment, determining in turn the impact of the family on each individual. Interactions that take place within a family system do so simultaneously and interdependently with and of each

other (Schermerhorn, Cummings, & Davies, 2008). Family Systems Theory takes a non-linear understanding to family and relationships, recognising complexity and reciprocity in systems (Plate, 2010), as well as its embeddedness within an ecological system (Bronfenbrenner, 1986). Hence, taking a family systemic view implies that it is not possible to consider what goes on or happens in one dyad in isolation. This notion is reflective of the interactional nature of individuals in families (Crockenberg & Leerkes, 2003), and thus when considering a topic such as parenting of infants with a highly reactive temperament, one can appreciate the complexity of relationships, their quality, dynamics, functioning, and how the relationship between the parents is an interconnected part of the system and influential on the infant. In the same way, the infant too, as another part of the family system impacts the relationships of his/her parents. Therefore through Family Systems Theory, and other approaches stemming from it, every individual in the family plays an important part (Brown, 2008).

Moreover, in the context of this study, the nature of the 'Parents as Partners' coparenting programme is highly representative of a Family Systemic Theoretical framework with the integration of 5 systemic relational domains, as is described in more detail in the Literature Review chapter. Considering that change in one part of the system effects other parts of the system/s (Bronfenbrenner, 1986), an intervention such as a coparenting programme inevitably influences and transforms the system with which it interacts, because the system (couple, family) is not static but open to external forces (Meadows 2008). The outcome of this study presented in the chapter on Results, is evidence to such a systemic component.

Summary and Implications

Family systems theory assumes that individuals, dyads, and the family as a whole all show interactional effects. Changes in one part of the system are thought to induce changes in the system as a whole (Davis et al., 2009). Correlational studies support the view that the quality of the coparenting relationship is interconnected with the quality of each parent's relationship with the child (Cowan & Cowan, 2018). Furthermore, the temperamental characteristics of the child both influence and are influenced by the ability of the parents to collaborate in response to a difficult to manage child (Hong, et al., 2015). All of this research suggests that an intervention with co-parents of infants with reactive temperaments could have a beneficial effect on the family.

This study tested a new intervention model for parents of children described as having a reactive temperament by working not only with mothers, but with fathers, considering the beneficial effect of their involvement in their children's lives. What was new about this study was testing of the intervention 'Parents as Partners' in another culture and language, and more importantly testing the intervention with a specific target population – parents of infants with a reactive temperament.

The hope was that the results of this study would inform us about whether an intervention for parents of highly reactive infants can reduce parenting stress and family relationship distress and reduce the parents' as well as children's need for help from medical or mental health systems. Recognizing the contribution of the child's/infant's temperament, as well as distress in both parents and offering help early on in a preventive way - would allow us to know better what is most important to address when the children are young. The provision of coparenting

programmes would be expected to fill the existing gaps in the present care, health and social systems.

The following chapter gives an introduction to evidence-based programmes, where support offered to parents in the context of Malta is presented, as well as the rationale for the ‘Parents as Partners’ coparenting programme as the intervention used in this study. A focus on the coparenting relationship and how it exists in different forms is also highlighted.

CHAPTER 2

LITERATURE REVIEW

Introduction

Infants that are considered to be highly reactive provide a particular challenge to any parent where it is considered that 'a difficult baby brings helplessness, strain and burden for the parents' (Thomas et al., 1982 in Bornstein et al., 2014, p. 459). This study evaluates whether the 'Parents as Partners' coparenting programme offered to parents of an infant with a highly reactive temperament affects their ability to parent together more effectively and also whether the infant's behaviour changes.

Over the years, the increased recognition of the parenting role responsibility has contributed to greater sensitivity towards parental support (Sanders & Morawska, 2014). Hence the development of parenting skills programmes.

Contemporary parenting programmes are not only looked at from the perspective of parenting skills, but a much greater shift has occurred with more importance being given to positive parenting, which is defined as "parental behaviour based on the best interests of the child that is nurturing, empowering, non-violent and provides recognition and guidance which involves setting of boundaries to enable the full development of the child" Daly (2007, p. 144). Positive parenting supports families that are defined as being at risk because of disadvantaged living circumstances (Daly, 2013).

This chapter introduces a brief overview of positive parenting programmes, taking a look at services offered to parents in Malta, followed by programmes with an evidence base that are offered in the US and the UK. The 'Parents as Partners' (PasP) coparenting programme is introduced in detail along with the rationale for choosing it as the intervention in this study.

An original search in 2015, and a further search up to 2020 for relevant, related and recent literary material was carried out. The University of Malta's search gateway HyDi was predominantly used, as were a number of other databases particularly Wiley On-line Library, Pro Quest Social Sciences, Springer Standard Collection, EBSCOhost, Elsevier SD and Freedom collection. Moreover, a number of studies were directly referred to me by my respective tutors because of their recency, familiarity and relevance.

Terms used for my searches in relation to this particular chapter included positive parenting, positive parenting programmes, couple relationship quality and parenting and child wellbeing, infant temperament and parenting, infant temperament and couple relationship, parenting Malta, NSO, Malta statistics, Parents as Partners (PasP), coparenting programmes and father involvement, and parenting and couple relationship.

Positive Parenting Programmes

Positive parenting programmes such as the Triple-P Positive Parenting Programmes were developed, bringing about as a result, recognized improvements in parent-child communication (Sanders, 2008). These programmes also took into consideration parents' diverse cultural backgrounds as well as different groups of parents and children, a number of which belonging to high-risk groups (Hidalgo, et al., 2018). Another important programme that was developed was the Incredible Years Programme (IYP) developed by Carolyn Webster-Stratton (The Incredible Years, 2013). The programme, which was based on social learning theory, was specifically designed in order to 'promote emotional and social competence and to prevent, reduce and treat

aggression and emotional problems in young people' (The Incredible Years Fact Sheet). Similar to the Triple-P programme, the main focus of the IYP is to enhance parenting skills, increase knowledge about child development, help to enhance the child's positive behaviour, and improve the relationship between parent and child. Most of the literature on the IYP focuses on pre-school and school-aged children that have already been assessed as having behavioural problems. Griffith (2011), in her evaluation of the IYP, mentioned that findings 'demonstrated modest improvements for intervention families in terms of parental well-being, negative parenting practices, and reductions in child deviance' (p. 119). Evaluation and building an evidence base for 'Baby Triple P' (Popp et al., 2019), and IYP for babies are still in the preliminary stages (Jones et al., 2014). Both of these intervention programmes are attended primarily by mothers.

In fact, father's absence from parenting classes has been seen as a limitation (Hidalgo et al., 2018; Jones et al., 2012; Ruiz-Zaldibar et al., 2018). Cowan and Cowan (2008) also state that interventions by Webster-Stratton and others focusing primarily on mothers 'have found that the therapeutic treatment often fails to work until fathers are involved and the relationship between the parents is addressed directly' (p. 6). Evidence shows that how well children fare is related to the relationship quality of their parents (Davies et al., 2004 in Cowan & Cowan, 2008; Goldberg & Carlson, 2014; Hughes et al., 2019). This connection was also supported by Schoppe-Sullivan et al. (2006), who state that ultimately it is the quality of the couple relationship that affects the wellbeing of the whole family, a connection that cannot be undermined. The sad reality is that in most parenting classes, fathers are not participants, and moreover, most classes pay very little attention if any, to the couple relationship, which is so crucial for the coparenting relationship to work well.

Given this context, it seems that parents with an infant who has a highly reactive temperament are faced with additional burdens, especially if their relationship is already strained and the father is not collaboratively involved as a co-parent. Research shows that under 'normal' circumstances, the couple's relationship is already greatly affected by the birth of their child as they transition to parenthood (Delicate et al., 2018). Having an infant with a highly reactive temperament will add more of a challenge. This strain is likely to provide additional disruptions of the parent-child relationships, and in turn produce negative impacts on the child's wellbeing and development. Fathers' lack of attendance to parenting classes is also the situation in Malta.

Services Offered to Parents in Malta

Offered as part of the antenatal service at Mater Dei Hospital, parents can make use of 'Parent Craft Services' (Parent Craft Services, 2020). The main aim of the Parent Craft Services is to educate and support parents as part of primary health care and prevention. The courses offered through these services are usually held at Mater Dei Hospital, Health Centres as well as 'Unit Ghozza' (a service for pregnant teenagers) in collaboration with other services in the community. The services include education and information for parents-to-be about what to expect early in pregnancy, in addition to preparation for labour and delivery of the baby through specific childbirth classes that are organised. Sessions are also offered to support grandparents who are often involved in the care of grandchildren. The latter mostly focus on the best practices when caring for an infant, aimed at educating parents/grandparents on a number of issues connected to a new born infant (Parent Craft Services, 2020). There are also plans to have 'father only' classes in the future. Such programmes are run by midwives but do not focus on actual

parenting skills, the coparenting relationship or whether the child has special needs, or presents with a highly reactive temperament, although there are classes for those expecting multiple births.

A high percentage of infants are taken to post-natal well-baby clinics in the main hospital Mater Dei, or in community clinics. Based on personal communication with V. Farrugia Sant Angelo (March, 2016), the Medical Co-ordinator at the Primary Health Directoriate, the attendance is in the region of 83%, which is very high. The focus of these clinics is 'monitoring and recording of children's development and advice on immunisation and feeding' (Primary Child and Youth Health and Immunisation Unit, 2019).

Besides the standard state-run services provided to all parents who have an infant as per above, there are a number of other initiatives and services offered to parents in Malta. These will be outlined in more detail below:

Services Offered by the Foundation for Welfare Services in Malta

'Inrabbu 'l Uliedna Ahjar'. Until recently, parenting programmes in Malta were primarily presented through the Foundation for Social Welfare Services (FSWS), under Agenzija Sedqa. The parenting skills course referred to as 'Inrabbu 'l Uliedna Ahjar' follows the teachings of Michael Popkin (2014) of USA, and consists of a total of six sessions held once weekly. The main topics that are covered include leadership styles, children's psychological development, effective communication within the family, involving children responsibly in the family, sexuality, and substance misuse. Another course that is offered by the same agency is for parents

of adolescents, with the aim of equipping parents with skills to cope with this developmental phase. Topics include understanding the developmental phase of adolescence, instilling courage and positive self-esteem, communicating effectively, challenges connected to drug and alcohol abuse, parenting, and sexuality (Parental Skills Courses, 2019). Based on personal communication with a facilitator of these groups, I learned that these programmes are attended more heavily by mothers, especially when held in the mornings. Fathers attend less, although more fathers tend to be present when programmes are held in the evenings. Not much distinction is made with regard to the family's socio-economic status, or specific risks or conditions, let alone considering parents whose infants are highly reactive.

Positive Parenting Course. In 2017, the FSWS launched another two parenting programmes as part of the Positive Parenting National Strategic Policy 2016 – 2024 (Abela & Grech Lanfranco, 2016). The first one is referred to as the 'Positive Parenting Course' (Parental Skills Courses, 2019). This course was accredited and originally facilitated by The Parent Practice UK, and consists of 5 sessions of 3 hours each, with the aim of generating discussion in an interactive and non-judgemental environment amongst parents and/or caregivers who may wish to build on already existing skills. It is not specific to new parents, and does not emphasize that parents/caregivers need to attend together. The topics include descriptive praise, emotion coaching, setting up children for success, family values, rules and rewards, and dealing with unwanted child behaviour. There is no published local evaluation for this programme to date.

Parenting When Separated. The second programme, also offered by Agenzija Sedqa within the FSWS, is referred to as the 'Parenting When Separated' programme and follows the 'Parents Plus Parenting when Separated Programme' (Parents Plus, n.d.), which is an evidence-

based programme. It consists of 6 sessions of 3 hours each, along a six week period, and is aimed at parents who are separated or divorced, or in the process of doing so, focusing mainly on helping them to keep the best interest of their child/ren as a priority, whilst educating them about more effective communication in order to do so. Parents do not attend the same group together, but attend simultaneously in separate groups with other parents. It is however, not always the case that both parents attend the course. Although this programme is not designed specifically for parents of infants, the main focus is the children. The Parents Plus-Parenting when Separated Programme was evaluated through a randomised trial in Ireland, indicating that the intervention helped to increase the parents' level of satisfaction and adjustment, as well as decrease their conflict and child behaviour difficulties (Keating et al., 2016). An inbuilt evaluation system takes place for this programme with each group in Malta, although there is no published local information to date. Both programmes, the 'Positive Parenting Course' and the 'Parenting When Separated Programme', are ongoing and provided in the community as well as in schools (A. Mizzi, personal communication, April, 2020).

Home-Based Therapeutic Services (HBTS). During 2017, the FSWS also began to offer Home-Based Therapeutic Services (HBTS Report Launch (2018), which is an outreach service directed at families who are considered to face multiple stressors, families experiencing difficulty to engage with the more mainstream office-based services, families where there is a plan for integration or the improvement of access arrangements, in situations where there is risk of a child's placement breakdown, as a prevention of a care order, families receiving active support from social workers, and to prevent family deterioration and child abuse. Although both parents would be encouraged to attend, it is not a pre-requisite to receive the service, and parents

are free to attend with another significant person such as a grandparent. In addition to offering family therapy and counselling, HBTS also offers the Incredible Years Programme (IYP) for toddler, pre-school and Child Dina (child behavioural problems ranging from age 3 to 8), which are held both within the family's home as well as in groups (L. Aquilina-Gauci and C. Sammut, personal communication, April, 2020). The programme is also offered to families with babies, notwithstanding that the IYP for babies is still building evidence (Jones et al., 2014). The IYP mentioned earlier as a positive parenting programme will be elaborated on in more detail later in this chapter.

Specialized Services for Children with a Disability, Those on the Autistic Spectrum and Children with Attention Deficit Hyperactive Disorder (ADHD).

Besides the above programmes offered by the FSWS, Agenzija Sapport that previously belonged to the same foundation also offers support groups and workshops for parents who have children with a disability (sapport.gov.mt). Moreover, a similar programme known as CYGNET is offered to parents of children diagnosed with autistic spectrum disorder by the Child and Young People's Services (CYPS) within the Department of Health in Malta. CYGNET is still in the process of gaining evidence abroad (Ayyash, 2019). A nonrandomised evaluation of this programme showed that parents attending CYGNET, experienced increased satisfaction in parenting as well as an improvement in their child's behaviour (Stuttard, L. et al., 2016). The same Department of Health also recently began to offer the IYP for parents in groups specifically for those whose children have behaviour/conduct problems (A.Zammit Said, personal communication, April, 2020).

Although not falling under the remit of the Department of Health, another programme for parents in Malta is for those whose children are diagnosed with ADHD. This service rather than programme, developed by Barnardo's North East, is offered by the non-governmental organisation Family Support Group for families having a child with ADHD. It aims at helping parents of these children understand their child's ADHD diagnosis and treatment, develop strategies to support the child, and advocate for their child where necessary (Borg, 2019). There is no focus on the quality of relationship between the parents or on the child's temperament, although it is highly likely that a number of these children could well have been highly reactive temperamentally as infants if they had been screened. One therefore wonders, how would it have been different for such parents had there been the existence of a coparenting programme for them during their child's infancy rather than at a later stage when the ADHD diagnosis was reached?

More recently, the Cana Movement in Floriana, a Catholic organisation, also started to offer a positive parenting programme referred to as 'Parenting Toolbox Top-Up', which follows the 'Parenting Place Tool Box' course in the UK (Parenting Place, 2018). It is described as a reflexive and positive approach to parenting where the main focus is on developing effective parenting strategies and building 'a strong relationship' with the child. The course consists of a total of 8 sessions of 2 hours each, and again does not put emphasis on the couple attending together or the qualities/behaviours of the child (January, 2020). These programmes are once again not specifically focused towards parents of very young children, with no evaluations to date.

On-line for Parents : KidsMalta

Available on-line is a resource for parenting known as 'KidsMalta' (Kidsmalta.com, n.d.), which advertises different courses and seminars for parents. The focus is predominantly on understanding about pregnancy, keeping healthy, the labour, breast feeding and baby care, potty training, speech language development, and support groups connected to child development. 'Parent Support Groups' are also offered through the education sector to interested parents, where the focus is mostly connected to children's educational milestones and transitions. These latter groups are usually facilitated by a counsellor (S. Galea, personal communication, April, 2020).

A Strategy for the Way Forward in Malta

What is offered at present in Malta, can certainly be considered as a significant contribution in the development of supporting parents, especially with the introduction of the evidence-based IYP in the Health and Social Welfare sectors. Services that have so far been set up and those in the pipeline do indeed make a difference to most parents to care for their infants, and older children. With the 'Positive Parenting National Strategic Policy' launched in November 2016, priority is given to the premise 'that a positive approach to parenting is considered an investment in the future of Maltese Society' (Abela & Grech Lanfranco, 2016, p. 6). The strategy includes building on already existing services on offer, including parenting programmes that provide both an interventive as well as a preventive quality, and taking into consideration different stages of the family life cycle. Attention will also be given to creating

synergy between different stakeholders so that there is better co-ordination and collaboration between services offered, therefore enhancing their effectiveness and quality. Moreover, considering that those families who usually need most help tend to be the ones who least use services provided, specialised services which target these harder-to-get families will also be implemented.

Attachment-focused programmes highlight the importance that by improving parents' sensitivity to their infant through positive parenting, more positive and secure attachments are created, and hence also a reduction of risks (Moss et al., 2011). In view of this, considering the importance of the parenting relationship quality for the benefit of a child's development, and the impact that this can have on the child's wellbeing, a coparenting programme for both parents of infants having a highly reactive temperament is still missing, both locally and abroad in spite of the later difficulties for these children who are considered to be children-at-risk (Maltby et al., 2019).

In the next section I summarize the available evidence-based programmes originating and offered outside Malta, and then discuss why one of these intervention programmes has been selected for the present study.

Evidence-based Parenting Programmes offered in the United States and England

A literary search of the MEDLINE Proquest and PsycINFO databases was initially carried out in 2015, using the terms 'parenting programmes and couple relationship', 'parenting programmes and infant temperament/and infant reactive temperament', 'coparenting

programmes', 'preventive parenting programmes', and finally 'parenting programmes with parents of infants', 'parenting programmes involving fathers'. Other studies resulted from independent searches on the University of Malta search gateway, HyDi, using an advanced search where similar terms were used for more recent studies between 2015 and 2020.

The studies were considered to be relevant based on their reference to the effectiveness of a particular programme, use of randomized trials highlighting their effectiveness, presence of systematic reviews relating to programmes, their use with parents of infants aged 0 to 3 years, and the programmes' reference to children's temperament. The most highly cited programmes were the Triple P-Positive Parenting Programme, the Incredible Years, Family Foundations, Sure Start, Star Parenting Programme, CARE, Mother-Infant Transaction Programme, Maternal Education Programme, Baby Business, and Nurse Family Partnership (NFP). On further exploration of these programmes, not all were group-based, none focused on child temperament, both parents were not always considered, the programmes were not necessarily designed for parents of infants, and not all were evidence-based. For this reason, programmes that more closely fit the search criteria are reviewed in more depth.

I shall focus primarily on the most frequently mentioned programmes, namely the Triple P Positive Parenting Programme, the Incredible Years Programme, Family Foundations, Sure Start and 'Parents as Partners' (also called Supporting Father Involvement).

Triple P- Positive Parenting Programme

Triple P is a behavioural evidence-based parenting programme which is based on both developmental and social learning theories. It is a multi-level programme, comprising five levels that pertain to different severities of need (Sanders, et al., 2003).

1. Level 1 is based on giving brief information to parents about child development through the media.
2. Level 2 involves intervening briefly with parents who have specific concerns about developmental or behavioural issues connected with their children.
3. Level 3 involves parent training with concerned parents, through which they are able to receive consultations as well as be helped to acquire active skills in parenting.
4. Level 4 takes a broader focus on training parents. The training, which is more intensive in positive parenting, is specifically aimed at parents who are experiencing more severe behaviour difficulties in their children. In parallel, at the same level, a structured 10 session programme is also delivered individually to parents having a child with a disability. Sessions usually last between 60 to 90 minutes each.
5. Finally, level 5 of the Triple P consists of different modules with respective family behavioural interventions. This level is designed for parents of children who stand to be at a higher risk of child protection, as well as for parents where child behaviour problems are present, as well as where there is an incidence of family dysfunction and conflicts. This level requires much more intensive intervention with the families involved and is individually tailor-made (Sanders, et al., 2003).

The relationship between the parents is only mentioned in level 5 of the Triple P during the third module, which is designed for those having difficulties in communication and adjustment as a couple/co-parents. During this specific module, parents are exposed to different skills that help them to parent more as partners and develop better team work between them. Whilst improving communication, and making use of positive parenting techniques, parents learn to support each other better in the face of difficult situations (Sanders et al., 2003). In a study exploring the impact of Triple P parent training on marital functioning with parents whose children show signs of early-onset conduct disorder (Ireland, et al., 2003), parents were randomly assigned to one of two versions of Triple P-Positive Parenting Programmes. One version was the Standard Group Triple P (SGTP) consisting of 8 sessions in total, four of which were group and the other four were telephone contacts. The SGTP focused on helping parents to identify and manage their child's behavioural problems, and learning how to manage conflict, using a contingency plan to avoid future high risk situations from developing. The other version that parents were assigned to, referred to as the Enhanced Group Triple P (EGTP), consisted of the same SGTP, but also included two additional group sessions, which focused on information and communication skills, teaching parents to discuss and support each other, whilst also focusing on improving the happiness in their relationship. Parents reported significant changes in their marital relationship from before to after they attended programmes, regardless of whether they attended the SGTP or the EGTP. According to the authors, their study supports their conclusion that parenting programmes do have an impact on a couple's marital functioning, decreasing their level of stress, whilst improving their efficacy and functioning as parents and as a couple. It needs to be mentioned that from the 37 couples that participated in the randomised assignment to one of the two versions, all were already experiencing child behavioural problems

as well as conflictual marital relationships before the intervention began. Improvements were sustained up to a three month post-intervention follow-up, although it was not made clear whether this was sustained in the long-term.

Moreover, in a comprehensive meta-analytic study of the Triple P-Positive Parenting Programme in which 55 studies were analysed for effectiveness and other variables that could moderate results, the more intense the programme delivered, the greater were the resulting positive changes in the children's problem behaviour, parents' well-being, and parenting skills (Lindsay, et al., 2011; Nowak & Heinrichs, 2008). It is unclear whether changes that were produced were a result of the particular version of Triple P, or whether, for instance, the exposure to a group of other parents influenced the result. The fact that there was no control group, that is, a group that did not receive the Triple P, is lacking in this study. In a more recent RCT / pilot study by Popp et al. (2019), Baby Triple P was compared to 'care as usual' amongst parents of infants who already showed early behavioural problems. Parents were asked to provide self-reports about how competent they felt as parents and about the quality of their relationship with their partner. Self-reports were assessed prior to the birth of the infant, and then again when the infant was 10 weeks and 6 months old. Preliminary findings showed that those parents who were randomly assigned to Baby Triple P reported that their infants cried significantly less 6 months after the birth than did those in the 'care as usual' group. There were, however, no outcomes with regard to the parents' sense of competence, or the quality of their relationship. It was also noted, that besides a small sample size of 49 couples, most of those participating were of a high level of education.

The Incredible Years Programme

The evidence-based Incredible Years Programme (IYP) was developed by Caroline Webster-Stratton (1985). It was created specifically for parents of children of different ages with behavior problems, and conducted in parent groups. The main focus of the programme is to help parents develop more effective and positive ways of parenting, as a result of which their children's development, behaviour and education are expected to be positively impacted and enhanced. The group intervention also helps parents to manage behavioural problems in their children better. By their nature, it has been argued that group interventions carry positive outcomes because parents are more likely to identify with other parents in their group who would be experiencing similar difficultes to their own (Bavolek, 2002; Garvin, et al., 2004). A systematic review also supported the use of group-based parenting intervention programmes as these indicated emotional as well as behavioural improvements in children's adjustments (Barlow, et al., 2014).

The IYP group sessions occur weekly for a period of 12 to 20 weeks, depending on the programme being followed, where each group session lasts between 2 to 3 hours. Each of the groups have their own specific focus ranging from infants to school aged children as follows:

1. Parents and babies program (0 to 12 months). The focus of the parenting programme is to help parents learn about how to nurture infants and keep them safe. It includes knowing one's infant, stimulation, gaining support as well as understanding more about the infant's mind, intelligence and sense of self. Development of early language is also encouraged through this basic programme.

2. From when the child is aged 12 months until 20 months, parents are able to attend a basic programme for parents and toddlers. This programme focuses on helping parents to help their toddlers to feel loved, as well as instill security in them. There is also an emphasis on language, emotional and social development of the child, and management of misbehaviour through the adoption of a positive parenting approach.
3. Parents of pre-schoolers aged 3 to 6 years also have their own group programme. The focus of this is to strengthen the interactions as well as attachment relationships between the parents and their children. Children's social, emotional and language development are enhanced, and harsh disciplining is reduced by positive approaches to discipline in situations of children's inappropriate or troubling behaviour. Through this group, parents learn how to help their children prepare for school by networking also with the school system.
4. Finally, parents of school-aged children aged 6 to 12 years focus on continuing to strenghten interactions between parents and children, as well as to enhance the child's development further, as in the previous age group. Parents learn more about monitoring their children, setting rules, supporting them as they do their homework, and working along with teachers to promote their child's academic, social and emotional skills (incredibleyears.com//programs/parent/).

In addition to the above basic programmes, more specific groups also exist for parents with children having ADHD or conduct disorder, or as a prevention of these more serious disorders when behavioural difficulties are already apparent, such as oppositional/aggressive behaviour. The range of programmes besides parent training also includes teacher training, child

training and home visits where most of the focus has been on interventions with *mothers* of children either at risk of developing or already showing conduct disorder, or those with emerging behavioural problems. Studies (Furlong & McGilloway, 2015; Hutchings et al., 2017) using IYP were also specific to disadvantaged families or those who are at risk of child protection or child maltreatment. In another study evaluating the IYP for the 'parents and babies group programme' it was concluded that whilst the IYP for babies did have the potential to be beneficial to participants, further evaluation was still needed ideally through an RCT. The need for further studies was felt even more when those opting into the study appeared to hold above-average well-being mentally, higher levels of confidence, and had infants that were already developing well (Jones, et al., 2014).

Whilst it is evident that the IYP group intervention helps parents to manage behavioural problems in their children better, neither the relationship between the parents nor the idea of collaborative coparenting have been mentioned. However, from 1985, Webster-Stratton did explore the implication of involving both parents rather than only one (usually the mother). Since then, there has been more evidence to show that the programme is more effective when both parents are involved. A study by Bagner (2013), which focused on the role of the father in parent training programmes in situations where children presented with developmental delay, reflected a decrease in the children's externalised behaviour problems when the father was involved, when compared to training where single mothers attended alone. Researchers such as May, et al., (2013) explored the participation of fathers with mothers in a particular programme known as Signposts, which reflected a better outcome in terms of the children's behavioural difficulties, than programmes with mothers alone. These results were also confirmed in a previous meta-analytic study carried out by Lundahl, et al. (2008), who analysed the father's involvement in

parent training, reflecting that when interventions were carried out with both the mother and father rather than just with the mother as was usually the practice, outcomes that included children's more positive behaviour and more desirable ways of parenting produced better results. These studies are however not specific to the Incredible Years Programmes. A more recent evaluation of the effectiveness of the IY Toddler Parenting Programme which was carried out with parents of 1 to 2 year olds living in disadvantaged areas of Wales (Hutchings et al., 2017), reflected that whilst some improvements were observed in parents' mental wellbeing, home environment and child development, only 2 fathers vis-a-vis 87 mothers took part, with still no focus on the couple or coparenting relationship.

Family Foundations

The previous chapter has made reference to the importance of the transition to parenthood as an early point of intervention. This is a crucial time in the life of expectant parents, particularly those who experience the birth of their first child. Redshaw and Martin (2014) refer to the couple relationship prior to and during the transition to parenthood, indicating a decline in the quality of their relationship in the absence of intervention.

Feinberg (2002), who founded the Family Foundations Programme, highlighted the importance of the coparenting relationship, and indicated that the ideal time for an intervention to take place was particularly around the time of the birth of the first child as the couple made the transition into parenting. An intervention taking place at such at time was considered to be important as it would have preventive qualities, enhancing the relationship between the parents and impacting subsequent parenting behaviour, the parents' wellbeing, and that of their child.

The Family Foundations Programme is an evidence-based programme that consists of 8 sessions which are delivered before and after the birth of the child - four carried out prior to the birth, and four post-natally. According to Feinberg and Kan (2008), it is a programme that has built on the concept of coparenting used by the Professors Phil and Carolyn Cowan (Schultz et al., 2006). However, apart from having fewer sessions, it does not focus on the couple's intimate relationship. Its main aim is to help parents to work more collaboratively together as parents, prior to the time when expected stress is likely to become more present with the birth of the first child. The risks connected to the transition to parenthood are kept in mind, and hence, emphasis on developing better communication between the partners, managing conflict, and solving difficultes more effectively are the main focus of the eight sessions.

Sessions are carried out in groups of 6 to 10 couples, and facilitated by male and female co-facilitators. According to an evaluation of this programme, a positive impact on the coparenting relationship was evident at 3 and a half years post intervention. A parenting intervention made at such a critical time in the life of couples at their transition to parenthood was expected to have substantial long-term effects that positively impacted both the parents' and child's wellbeing (Feinberg et al., 2010). Although results from a follow-up study, 5 to 7 years after the baseline intervention of Family Foundations did show positive outcomes for child's adjustment, more evidence was required since participant attrition rates were high, where from a total of 169 randomised families, only 98 families reached the final analysis (Feinberg et al., 2014).

In addition to the programmes mentioned above, frequently mentioned in a number of studies was Sure Start. Although this is not a programme in its own right, but a government

initiative developed in the UK, it is mentioned here because of its contribution to parents and families.

Sure Start as a Government Initiative

A United Kingdom government initiative, Sure Start, was implemented as an attempt to integrate different services, namely from the sectors for health, education, and welfare services. These services were encouraged to work collaboratively in a more integrated way for the benefit of children, particularly those considered to be mostly at risk. Moreover, a focus on the early child developmental years makes the interventions within Sure Start preventive of later problems such as behavioural, health, and education outcome. Interventions take place across a range of services which include home visits, child care, support, and skills training for parents (Roberts, 2000).

Parenting programmes offered through Sure Start vary according to the focus of what kind of help parents may require or request. Hence, one of the programmes in Sure Start is known as ‘Families Share’, in which parents can share their thoughts and ideas around issues that are connected to parenting. Also offered within Sure Start is the ‘Triple P’, which as mentioned earlier, is used as prevention for behavioural difficulties as well as once emotional and developmental problems have been identified in children.

Other programmes offered within Sure Start include ‘Get Crafty’, ‘Mellow Parenting’ and ‘Freedom Programme’. As the title of the programme indicates, ‘Get Crafty’ teaches skills and creative ideas and activities to parents, enabling them to build on their confidence. On the

other hand, 'Mellow Parenting' is a 14-week one day weekly programme that focuses on positive parenting where support is offered to families that experience problems in their relationships with their young children. Finally, 'Freedom' programme is specifically designed for women who were or could still be victims of domestic violence. The aim of this programme is to enable these women to recognise abusive patterns, as well as teach them ways to protect themselves and their children from abuse (Sure Start, n.d.).

Despite the important initiative with Sure Start, incorporating a number of different programmes, a focus on the couple or coparenting relationship was lacking.

A Shift to Coparenting – Keeping the Couple Relationship in Mind by Supporting Father Involvement

Considering that in the past positive parenting programmes did not focus on the parents' relationship as partners, coparenting programmes were developed to address this gap during the transition to parenthood and beyond. Evaluation of such programs also addressed low-income families as well as including fathers as important participants (Cowan et al., 2009b). Families with low incomes are particularly at risk of stress, relationship dysfunction, and children's behaviour problems. An intervention targeted for this group could function to prevent further potential difficulties, whilst also supporting and understanding the coparenting relationship with its own challenges (Green et al., 2007).

The parenting relationship is of utmost importance particularly because it affects how well parents cope, as well as its impact on the infants' emotional development. In fact, Belsky et

al. (1996), indicated that it was both the quality of parenting received as well as whether mutual support was present between the parents that impacted the child's early emotional development. Moreover, the quality of the early parent-infant relationship was found to contribute to the child's early resilience and emotional regulation, which is considered to be developed and shaped within the context of the relational dynamics surrounding the child and parents (Beeghly & Tronick, 2011). Supporting parents to support each other as co-parents has consistently been found to reduce not only the couple relationship difficulties during the early years of child-rearing, but also to have an effect on child behavioural outcomes at a later age (Parkes et al., 2019). Hence, as a result of such consistent evidence the development of coparenting programmes was given more importance.

Of particular significance in considering the choice of interventions for low-income parents that include fathers and focus on the couple and coparenting relationships, has been the research conducted since the late 1970s predominantly by Philip Cowan and Carolyn Pape Cowan from the University of Berkeley, California, United States of America. Their studies evolved from a focus on the couples' transition to becoming parents (Cowan et al., 1985; Cowan & Cowan, 1995; Cowan & Cowan, 2000; Schulz et al., 2006) to 'who does what when partners become parents' (Cowan & Cowan, 1988). Research continued on parenting interventions with parents of pre-school and elementary school children (Cowan et al., 1998; Cowan et al., 2005a; Cowan et al., 2005b; Cowan et al., 2009a). The team's focus on low-income couples emerged from a collaboration with Marsha Kline Pruett and Kyle Pruett from Smith College and Yale University, respectively (Cowan et al., 2009b). What was predominant in these studies was that through the 'Supporting Father Involvement' programme more importance has been given to

involving a coparenting framework in parenting programmes where attention is also given to the quality of the couple relationship and not simply to parental skills (Cowan et al., 2009b).

Moreover, Cowan, et al. (2009b) suggested that when involving the father in coparenting groups, it was possible that "the parents' experience of the groups themselves, the discussions of children's development, and the relatively greater couple satisfaction and couple communication combined to protect the children against the rise in aggression, hyperactivity, depression, and shy or withdrawn behaviors reported by parents in the . . . comparison condition" (p. 676). Moreover, in a recent study on 'supporting father involvement' amongst couples referred through child-welfare services, the same intervention was found to have a positive effect on couples by reducing the level of conflict in their relationship, enabling them to parent less harshly, hence improving their child's outcomes (Pruett et al., 2019).

Parents as Partners

The Cowan-Pruett parenting programmes were carried out with parents of infants or children without specific health or behavioural problems. The 'Parents as Partners' (PasP) coparenting programme, which directly models the latest U.S. version of the 'Supporting Father Involvement' programme (Casey et al., 2017), stems from the understanding that children's ability to adapt and develop in a healthy way is primarily based on the quality of the relationships of their parents and/or carers, and that relational interactions exist across five domains of family life (Cowan et al., 1985; Cowan & Cowan, 2008; Cowan et al., 2009b). These domains on which the PasP curriculum is based are as follows:

1. The quality of the mother-child and father-child relationships
2. The quality of the relationship between the parents, including communication styles, conflict resolution, problem-solving, coparenting, and emotion regulation
3. The patterns of both couple- and parent-child relationships transmitted across the generations from grandparents to parents to children
4. The level of adaptation of each family member, his or her self-perceptions, and indicators of mental health and psychological distress
5. The balance between life stressors and social supports outside the immediate family

(Taken from Cowan & Cowan, 2008, p. 7).

The PasP programme consists of 2 hour couple sessions taking place weekly across 16 weeks. An average of 6 to 8 couples meet in a group that is facilitated by a trained man and woman who act as co-facilitators/leaders. The participating couples are well screened prior to entry into the group, to eliminate any confounding difficulties such as current intimate partner violence or child abuse.

The sixteen sessions follow a set structure, with 14 of the sessions having the couples together, and two sessions with fathers and mothers separately. In the two separate sessions, the youngest child in each family meets with the fathers for one of the two hours. The sessions of the PasP take on a different focus addressing parental involvement, the couple/coparenting relationship, the skills of parenting, relationships between the parents and the child, parents' individual wellbeing, parenting styles, couple communication, three-generational issues to consider in this new family, setting boundaries and receiving support. Table 2.1 outlines the

summary forming the curriculum covered in the group sessions (Tavistock Centre for Couple Relationships [TCCR], 2014).

Table 2.1

Parents as Partners Group Curriculum Overview

WEEK NUMBER	THEME OF SESSION	DESCRIPTION OF THEME
1	Introduction and goals for change	Best experiences with child The Pie – psychological investment in different roles
2	Father involvment	Involved fathering, video of children's views, homework activities with the children
3	The couple	Thinking of a couple they admire, how well do they know each other, or child's other parent. Homework task to budget a date or something to nurture their relationship
4	Parenting Skills	Parenting styles, film clips of parent-child interactions, discussing examples of supportive and effective parenting interactions
5	Parent-child relationships	Mothers and Fathers in separate groups. Fathers alone and with children doing activities. Mothers in group, asked to describe their child's father. Thinking of

		way they encourage or obstruct partner's participation. Taking care of themselves
6	Individual – emotional health and wellbeing, strengthening self-esteem	Discussing in a group important ideas or moments, exercise and activity in group, looking into emotional, mental health and nurturing their wellbeing.
7	Couple/co-parent communication 1.	Talking about problem solving, principles of communicating and managing conflict effectively. Activity discussing a problem in relationship and trying to make some progress on it.
8	Transmission of parenting styles and approaches to discipline	Family Circles. Physical discipline vs abuse.
9	Serious conflict and domestic abuse	Impact of unresolved conflict on adults and children
10	Couple/co-parent communication 2.	Body language and positive communication Gender differences in expression of feelings, meeting needs.
11	Parent-child relationships	Fathers attend alone for first hour and with youngest child in the second hour. Mothers attend female group. Activity on positive changes. Father activity with child. Mothers group, on positive things noticed in fathers.
12	The couple- division of parenting responsibilities	Supporting each other in parenting roles. Who does what? Decisions. Father's increased involvement.

13	The individual – life events and keeping healthy	Life events as stressors Keeping healthy
14	Boundaries with parents and in-laws	Three-generation family relationships. Looking at similarities and differences across generations. Family rituals. Impact of extended family on relationship and parenting.
15	Support from outside the family	Ecomaps. Relationships and resources viewed as supportive.
16	Check-in/ Discuss review of group.	Help needed to continue being more effective parents. What next? Goodbyes.

Also of importance in the PasP programme, especially in situations of a low-income, higher risk population, is the involvement of case managers throughout the duration of the group sessions. Cowan et al. (2009b) refer to services provided by case managers that involve carrying out referrals to additional services according to issues concerning the couple, such as employment, medical, and legal. The case managers also follow up with participants whenever a session is missed, and keep contact going between one group session and another, providing an important liaison with the group leaders, as well as a unique feature to the programme.

How do Other Evidence-Based Programmes Compare with PasP?

PasP and Triple P. Both the Triple P-Positive Parenting as well as the PasP programmes have shown changes in the marital relationship from before to after the programme. In fact, as

mentioned with Triple P-Positive Parenting, improvements such as decreased stress levels, more efficacy and better functioning as a couple were reported regardless of which type of Triple P programme parents were assigned to. Whilst Triple-P refers to 10 sessions of 60 to 90 minutes each in level 4 (total 10-15 hours), and more intensive interventions for those needing extra support in level 5, the PasP consists of 16 sessions lasting two hours each (total – 32 hours), which is of longer duration overall.

Moreover, an important consideration with PasP is that it also has the potential to be implimented as an early intervention given its focus on the coparenting relationship, with the possibility of doing so prior to the presence of any serious behavioural problems in the children. Thus, parents could be in a better position to cope well if and when a diagnosis of conduct problems or other challenging behaviours had to surface. On the other hand, the early level programmes with parents attending the Triple P-Positive Parenting, including Baby Triple P, do not seem to place any focus on the couple or coparenting relationship, but instead provide information to parents on child development, and give brief interventions on any concerns or child-related issues (Sanders et al., 2003). It is only when serious difficulties are already identified in the family, that Triple P focuses on the couple, and therefore in such circumstance it cannot be considered as a primary preventive intervention. It is also notable that almost all of the validation studies carried out, and the services offered in the Triple P, have included mostly mothers, which is unlike PasP that focuses on both parents simultaneously.

PasP and Incredible Years Programme. Whilst both are definitely strong and valuable programmes in their own right, the main difference between the IYP and PasP is that the IYP focuses mostly on the existence of child difficulties and not on the couple relationship per se, whereas the PasP is distinguished by its focus on strengthening the parents' relationship as

partners and as co-parents as one of its potentially preventive qualities. Moreover, IYP continues to focus predominantly on mothers' participation, unlike PasP where both parents participate throughout.

PasP and Family Foundations. Both Family Foundations and PasP focus on coparenting, encouraging a more collaborative relationship between the parents at an important period in the life of their family. Both clearly possess preventive qualities; however, the PasP takes more time with and delves deeper into the intimate marital and/or coparenting relationship. In addition to this, the timing of the intervention by Family Foundations focusing on the transition to parenting, would not be relevant to parents in my study whose infants of 8 months present with a reactive temperament, which is considered to be the indicated time when temperament emerges more clearly (Rothbart, 1981).

PasP and Sure Start. Clearly, the different programmes offered by Sure Start attempt to reach different parents according to their needs. 'Mellow Parenting' appears to be the closest to being a parenting programme, considering that a structured number of sessions take place over a duration of time with positive parenting in mind. It lacks a preventive quality however, and does not focus on the marital/coparenting relationship at any point, but on the already problematic relationship with the child.

The duration of both the Mellow Parenting Programme and PasP indicates a good level of number of sessions and intensity. Both give importance to positive parenting, and parenting skills. However, the marital relationship is neglected in Mellow Parenting where problems in the relationship with the child are already present. Thus the preventive quality in Mellow Parenting

regarding the parents' relationship is more limited than what is presented in the PasP programme.

Table 2.2 gives an outline of each of the previously mentioned programmes. From this table it is possible to see the variation in session duration, where PasP presents with the greatest number of sessions along with IYP. Focus on the couple relationship is only present in PasP and not the aim of the intervention in the other programmes mentioned. Whilst all the mentioned programmes teach about parenting skills, the intensity of each varies according to the presence of a child's already identified behavioural problems, whereas PasP remains intense and an excellent candidate for mitigating more serious problems further down the line for babies with a reactive temperament. In this respect, the programme's potential for prevention is high.

Table 2.2

Characteristics Across 5 Programmes/Initiatives

PARENTING PROGRAMMES	**PROGRAMME CHARACTERISTICS**				
	Parenting Skills	**Duration**	**Intervention on marital relationship**	**Intensity of intervention**	**Preventive quality of programme prior to concerns**
Parents As Partners	Yes	16 Sessions heterogenous group of parents. No specific indentified problem	Focus of the programme	Intense with regards to duration of each session	Highly preventive particularly considering early years before and after transition to parenthood and beyond
Triple P Parenting Programme	Yes	10 sessions in level 4 when there are concerns.	Level 5 only, when there is the presence of children's severe	Increased intensity when problems are present in the child	Some with regards to information on child development but

			challenging behaviour		not on couple relationship
Incredible Years Programme	Yes	12 to 20 sessions for 2 to 3 hours duration	Not indicated	Intensity is increased with specific special problem behaviours in the children	Some with regards to indentifying families at risk of child maltreatment especially those in disadvantaged situations, not couple relationship
Family Foundations	Yes	8 sessions with expectant couples prior to the birth of their infant and early during post-natal period	Focus on coparenting but not on the intimate couple relationship	Intense over few sessions	Some with regards to coparenting, working collaboratively as a couple, developing better communication, problem solving and conflict management
Sure Start Mellow Parenting Programme	Yes	14 session one day weekly	Focus on positive parenting, offering support to parents experiencing difficulties in their relationship with their children, not the couple relationship	Intense over the duration indicated	Some with regards to positive parenting, however, happening in the context of already existing problems.

Choosing 'Parents as Partners'

This section aims to answer a fundamental question about this study's choice of intervention for parents of young children with reactive temperaments. Why choose 'Parents as Partners' (PasP) programme and not another intervention? What makes this programme the ideal intervention of choice over other programmes in use? In order to answer these questions, the literature on different parenting programmes was reviewed and presented in this chapter.

Selecting the ideal programme for parents of highly reactive infants is of paramount importance, given the added stress and potential for lasting difficulty of having a child with a challenging temperament, and therefore choosing PasP has been made on the basis of the criteria that:

1. The programme be evidence-based.
2. Because extensive research indicates that parenting programmes that include fathers and address the relationship between the parents produce more benefits, the programme needs to include fathers and take the coparenting relationship into consideration.
3. Because studies show that early intervention yields more positive outcomes for children, the intervention chosen is offered at an early stage of family life.
4. The programme is of a long enough duration to expect positive results.

The Evidence-Base and Early Intervention of the PasP

PasP is a programme that has been used successfully with different populations from different ethnic and socioeconomic backgrounds, such as with Mexican American, African American, and European American low-income families, with couples during the transition to parenthood before and after birth, with families of pre-schoolers making the transition to school. In these variations of the intervention, some of the parents have been parents of infants (Schulz et al., 2006). It has been systematically evaluated, producing positive outcomes for both the parents and the children in the U.S.A, in the U.K., and in Canada (Casey et al., 2017; Cowan & Cowan, 2008; Pruett, et al., 2019). The programme serves as a prevention to the development of

further difficulties that are likely to arise in both the parenting relationship as well as the child's development and wellbeing (Cowan & Cowan, 2002; Cowan et al., 2009b). The fact that it can be used with parents of infants supports the flexibility and early interventive and preventive quality of the programme.

Establishing the Coparenting Relationship by Including Fathers

Carlson et al. (2011) refer to the importance that a strong couple relationship goes hand in hand with supportive parenting roles, which is reflected in better parent-child engagment for both parents that live together. McClain and Brown (2017) refer to the role of father involvement in parenting programmes as being of utmost importance not only for child's well-being, but also for the coparenting and couple relationship quality. Moreover, engaging fathers along with mothers in the group sessions was found to be a significant ingredient in the PasP programme, providing very positive outcomes, such as observing the fathers become significantly more involved in caring for their children, and reports from both parents of using less violent problem strategies (Cowan et al., 2009b). The involvement of the father is an essential component of the PasP that makes it the optimal choice over others as a parenting programme for parents with children with challenging temperaments.

Dosage of the Intervention

Another factor that makes the PasP the intervention of choice is that, added to its other attributes mentioned above, namely including fathers, having an evidence base, focusing on the

relationship between the parent figures, and providing intervention early in the life of the child, it is also of longer duration than a number of other programmes.

According to different meta-analytic studies, the greater length and intensity of the latter programme may have contributed to greater effectiveness (Barth, 2009; Lindsay et al., 2011; Nowak & Heinrichs, 2008; Pinquart & Teubert, 2010). In fact, a number of studies suggest that a programme with longer duration, a more intense focus on the aspects of the curriculum, and clinically experienced facilitators will be more effective. Usually at least 12 sessions are recommended, between 25 to 40 minutes each. This is because of the reality that families might fail to attend all sessions, or take considerable time to put what they have learnt in the context of the intervention group into practice when they go home (Garland et al., 2008; Hurlburt et al., 2007). It is also suggested that if one were to choose between duration or intensity, the latter appears to carry a greater positive impact on parenting outcome than duration *per se* (Shannon, 2003).

Conclusion

This chapter set out to answer the fundamental question about why the PasP was chosen over other programmes as the intervention of choice for this study. The rationale for choosing the PasP programme and its clear description were presented, including an overview of the group curriculum across sessions.

Different frequently mentioned and relevant programmes were highlighted, namely the Triple P-Positive Parenting Programme, the Incredible Years Programme, Family Foundations, and Sure Start Mellow Parenting Programme. Their characteristics were presented, followed by a

comparison/contrast with the Parents as Partners coparenting programme (PasP) as the basis for the intervention of choice.

PasP was the intervention of choice for this study. It is the ideal programme on many levels, as has already been referred to in more detail in the criteria for choosing PasP.

The next chapter focuses on the methodology that was used in this quantitative study, where a Randomised Controlled Trial was the method of choice, and ‘Parents as Partners’ coparenting programme was the intervention. This intervention was carried out with parents living together, all of whom had in their care an infant with a highly reactive temperament, as assessed systematically at 8 months.

CHAPTER 3

METHODOLOGY

Introduction

This chapter presents a detailed description of the methodology undertaken to conduct a randomised study in which the researcher sought to assess whether the 'Parents as Partners' coparenting programme with parents of infants having a highly reactive temperament brought about the desired change of helping parents in their couple and parenting relationship, enabled them to use more effective parenting strategies, and impacted the infant's level of reactivity.

A Randomised Controlled Trial

The decision to carry out a Randomised Controlled Trial (RCT) was based on the fact that this kind of design is the "gold standard" of intervention evaluation research (Sibbald & Roland, 1998). Moreover, making use of an appropriate experimental design is a key feature to strengthen the internal validity of a study (Field & Hole, 2003). In this study, a comparison was made between parents of infants with a highly reactive temperament, who attended the 'Parents as Partners' coparenting programme (as the intervention), and similar parents with a similarly challenging child not offered the programme. According to Lee et al. (2017), the process of randomisation in an RCT is "the only commonly accepted method of ensuring an unbiased estimate of the treatment effect" (Lee, et al., 2017). Moreover, an RCT is also considered to be a 'bias-controlling measure' through which there is no bias of self-selection of participants in the control and intervention groups respectively, resulting in a much more accurate estimation of what is actually being measured (Schulz & Grimes, 2002). An RCT is considered to be a rigorous way of establishing whether or not a relationship between a treatment and its outcome is

causal in nature (Sibbald & Roland, 1998).

For better transparency and clarity in way of reporting the details of this randomised research study, I followed the 2018 Consolidated Standards of Reporting Trials - Social and Psychological Interventions (CONSORT-SPI 2018) (Montgomery et al., 2018), which is a reporting guideline used specifically for interventions that are social and psychological in nature. This guideline is also highly recommended to ensure that reporting of the methodology used in an RCT is done transparently, accurately and in a comprehensive manner in order to allow for replication of research (Grant et al., 2018).

The following sections describe the trial design, the participants, randomisation, the intervention, control group, measures and analytic methods.

Trial Design

Since the randomisation sought to compare two groups of parents with infants having a highly reactive temperament, a two-group design was appropriate. The allocation ratio for each group was originally intended to be that of 8:8, with 32 couples potentially in the intervention group and 32 couples in the control group. However, just before randomisation took place some couples withdrew, hence impacting the ratio to 8:6, with 32 couples potentially in the intervention group and 25 couples in the control group. Those couples who withdrew prior to the randomisation were included in a third comparison group. On the other hand, couples who chose not to participate or withdrew their participation post-randomisation were still included in the intervention – control groups according to how they were assigned, using the 'Intention to

Treat' (ITT) principle in order to reduce intervention effect bias (McCoy, 2017). The trial was designed to assess whether the intervention, namely the 'Parents as Partners' coparenting programme carried out with parents of infants described by the parents as having a highly reactive temperament, was superior to no intervention in the control groups with similar parents (Nesrin Turan & Senocak, 2007).

Participants

Inclusion Criteria

1. Parents living together/caring for their infant together, who were attending their infant's standard second outpatient post-natal visit at one of the Well Baby Clinics in Malta. In the case of married and cohabiting couples, it was expected that couples with very young infants were less likely to be separated at that point in their relationship, and therefore the chances of finding couples living together was more reflective of the population of parents with young infants. In fact, the NOIS report (2017) indicated that only 3.8% of all births during that year were born to mothers reported to be either widowed, separated or divorced. Although same sex couples were not excluded from the study, the legalization of these relationships had only come into force in September 2017 following legislation in 2014 (Civil Unions Act, 2014), and therefore the likelihood of recruiting same sex couples who were bringing up an infant was very low. In fact, only 200 same sex civil unions had been registered by June, 2017 (Times of Malta, 6th June, 2017).
2. Infants that were described by either parent present at the wellbaby clinic as having a highly reactive temperament (obtaining a score of 4.78 and over on the negative affect scale of the IBQ-R) fit the selection sample if they were aged between 8 months and one

year old, coinciding with their standard second out-patient post-natal Well Baby Clinic appointment.

3. Parents who were able to speak and/or understand the Maltese language well (considering most of those attending Well Baby Clinics were Maltese nationals and the research intervention was to be carried out in the Maltese language). Foreign parents that were able to speak Maltese or understood the language were included.
4. Infant Behaviour Questionnaire – Revised (IBQ-R), Parenting Stress Index Short Form (PSI-4-SF) and Coparenting Relationship Scale (CRS) was required to be filled in by both parents.

Exclusion Criteria

1. Despite a 25% increase in foreign nationals attending the Well Baby Clinics in Malta (V. Farrugia Sant Angelo, personal communication, March 21, 2016), parents who did not speak or understand the Maltese language were excluded. The reasons for this were twofold. Primarily, foreign nationals were not being included so as to eliminate language barriers within the intervention groups, and secondly because it was expected that they would be less likely to remain committed to the service of the Well Baby Clinics. The latter reason was based on evidence from within the Well Baby Clinics' attendance reports, where it was reported that more often than not these parents did not reside in Malta long-term (V. Farrugia Sant Angelo, personal communication, March 21, 2016), thus decreasing their ability to commit to the 16-week parenting programme. In fact, through records kept by the clinics, it was noticed that the attendance of foreign nationals

to the Well Baby Clinic appointments usually declined following their second visit when the infants were aged around 8 months.

2. Single parents that were parenting alone, or that were no longer romantically involved with their infant's other parent, given the nature of the parenting programme, which focused on relationships between the parents.
3. Infants whose IBQ-R score fell below the 4.78 mark on the negative affect scale and were thus not considered as fitting the description of a highly reactive temperament.
4. Potential participants were not included if the questionnaires referred to above were not filled in by both parenting figures.

Recruitment of Participants

Recruitment began with the author's daily visits over a total of 8 cumulative full months between June 2017 and November 2018, to all the Well Baby Clinics in Malta, according to the scheduled roster in each locality for the outpatient post-natal follow-up appointments of 8-month-old infants. In fact, in general the clinics, which are set up in Health Centres, offered three types of appointments, one for 6 week old infants, one for 8 month old infants and another for 18 month old children. The reason for focusing on 8 month old infants was because the infant's temperament would be established by this time period (Gartstein & Rothbart, 2003). Until September 2018, there were a total of 5 Well Baby Clinics in Malta, falling under the Primary Child Health Section in the Primary Health Care division. The clinics were situated in Mosta, Floriana, Paola, Rabat and Qormi. In October, 2018, a new clinic started to operate in Kirkop that relieved some of the load from the very busy clinic of Floriana. Recruitment took place at all

of these clinics, where each scheduled slot of infant appointments lasted approximately 2.5 hours, with a total of 7 slots per week. It is also to be noted that Gozo, Malta's sister island, had a separate system that was run by paediatricians within the Gozitan hospital setting, and which did not form part of the Maltese Well Baby Clinic set-up. For the latter reason, it was decided not to include Gozo in this research study.

The recruitment process took place in three phases as outlined in Table 3.1. Each of these 3 phases took place four times over in order to end up with four sets of parents randomised into the intervention and control groups, as well as include parents in the comparison groups. For example recruitment that took place during June and July 2017, produced the first randomised participants for the first group of Parents as Partners which started in October 2017, September and October 2017 for the second group which started in February, 2018 etc. In this way all infants in each group were the same age at recruitment and follow-up. During the first phase, parents (predominantly mothers) attending any one of the Well Baby Clinics for their infant's standard 8 month post-natal out-patient appointment were approached by the researcher in the waiting area. They were told about the study and invited to fill in the IBQ-R, and told that they would be given feedback (by phone, email, or by post when email address was unavailable) about their infant's temperament, based on their own descriptions of their infant's behaviour in the same questionnaire. Those accepting to do so were given an information form (Appendix A) and signed a formal consent (Appendix B) and were provided with the IBQ-R (Appendix I), a pen and a hard surface for comfort. Some were offered assistance by way of holding the questionnaire for them, or holding the baby such as, in circumstances when they were holding

their infant because of a feed, having a crying infant that needed comforting, not having a pushchair handy to place their infant in, or not being literate.

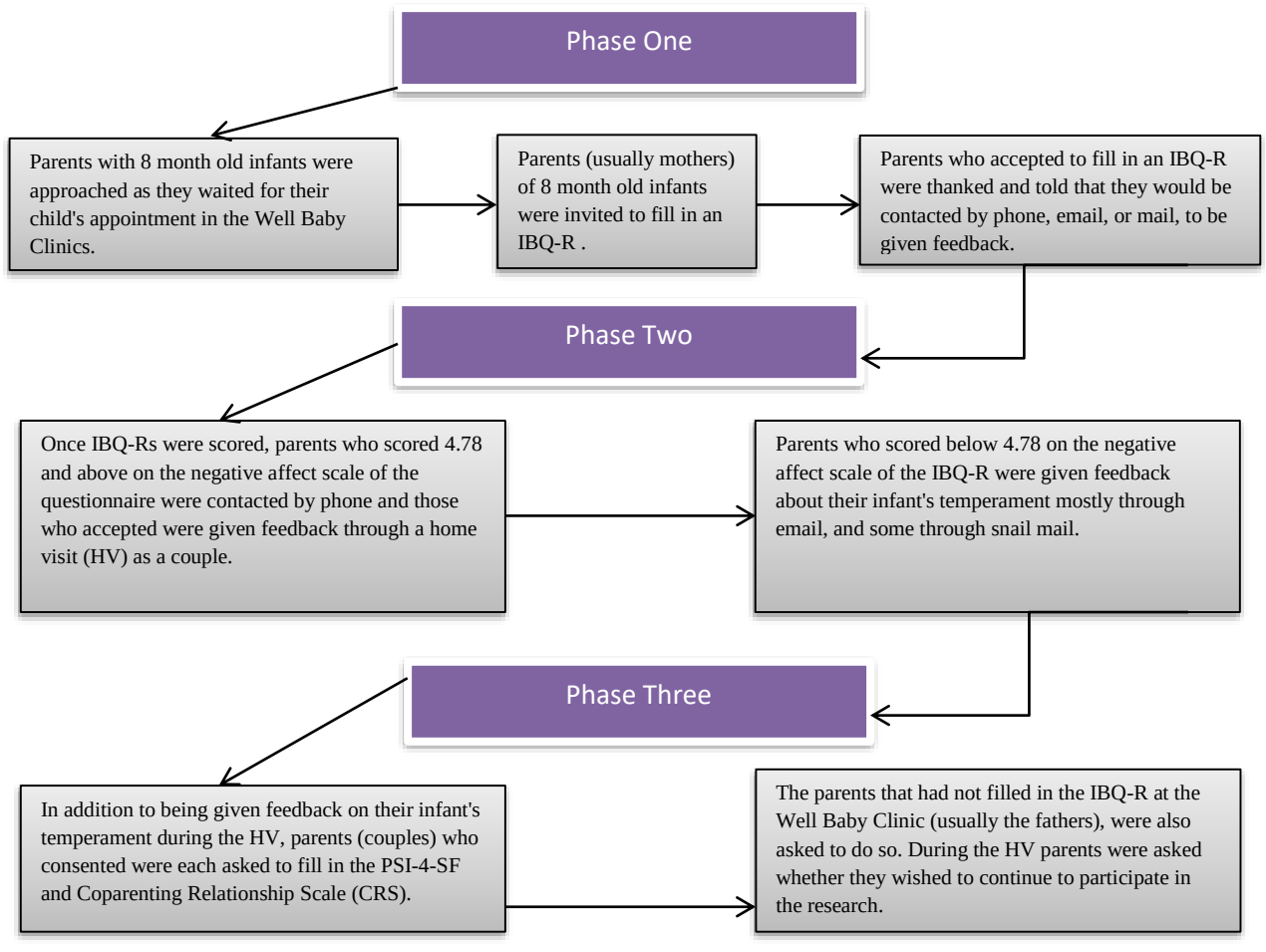
At the second phase of the recruitment process, parents who described their infants as highly reactive, specifically those obtaining a score of 4.78 and above on the negative affect scale of the IBQ-R, were contacted by phone. Among those who were contacted, parents who accepted to meet were given feedback about their infant's temperament as a parenting couple during a home visit that was arranged at their convenience. Feedback consisted of highlighting their own descriptions of their infant's behaviour, and having a conversation about this. No labels or diagnoses were ever given. On the other hand, those parents who scored below 4.78 on the negative affect scale of the IBQ-R were given feedback about their infant's temperament through email in the majority of cases, and by post for those who did not have an email account. Those parents who experienced difficulty reading had been asked how they wished to receive feedback during the Well Baby Clinic visit. This was mostly given by phone, or through written communication when they indicated that someone would read the results to them.

The third phase of the recruitment process focused on the home visits. Apart from being given feedback about their infant's temperament based on the way in which the IBQ-R had been completed at the Well Baby Clinic, during the home visit the parents were both asked to fill in further questionnaires, namely the Parenting Stress Index Short Form (PSI-4-SF) (Appendix J) and the Coparenting Relationship Scale (CRS) (Appendix K). Parents were asked to fill in the questionnaires separately and not together and were told that there were no right or wrong answers. In addition to providing an opportunity to enter into a face-to-face conversation with the parents in their homes, couples were invited to continue to participate in the research study,

with the possibility of being randomised into a group offering the 'Parents as Partners' coparenting programme. During the home visit, parents were also given an information form about the questionnaires they were completing (Appendix C) and a consent, which they signed to indicate their agreement to do so (Appendix D). All parents were also asked whether they were willing to fill in a similar set of questionnaires approximately 8 months later (approximately two months after the end of each intervention group) following completion of the randomised trial intervention.

Table 3.1.

Outline of Phases Involved in Recruiting Process of Participants



Recruitment Staff

Nearly all the recruitment process was carried out by myself as researcher, except for a few occasions (approximately 8) when I was unable to attend one of the scheduled Well Baby Clinic appointment slots. There were also a few evening clinics when I was accompanied by a volunteer recruiter owing to a larger number of infant appointments being scheduled at the clinic. In the latter circumstances, following an invitation sent to them through email, ex-students from the Master in Family Therapy course (qualified family therapists) from the University of Malta, and couple counsellors from Cana Counselling Services in Floriana, Malta, volunteered to support me in this recruitment effort. Before the clinic visits, volunteers were briefed during two sessions of 2 hours each, where in addition to a presentation on the recruitment phase at the Well Baby Clinics, they also had the opportunity to role play situations in the clinic and how best to approach parents in the waiting area. The briefing sessions were done with the intention of establishing a consistent approach by different recruiters when approaching parents at the clinics.

In addition to the volunteers at the Well Baby Clinics above, two experienced and qualified counsellors also carried out a total of 8 of the home visits between them with the couples, after accompanying me during several home visits in order to provide them with a model of the process expected during the third recruitment phase.

Randomisation

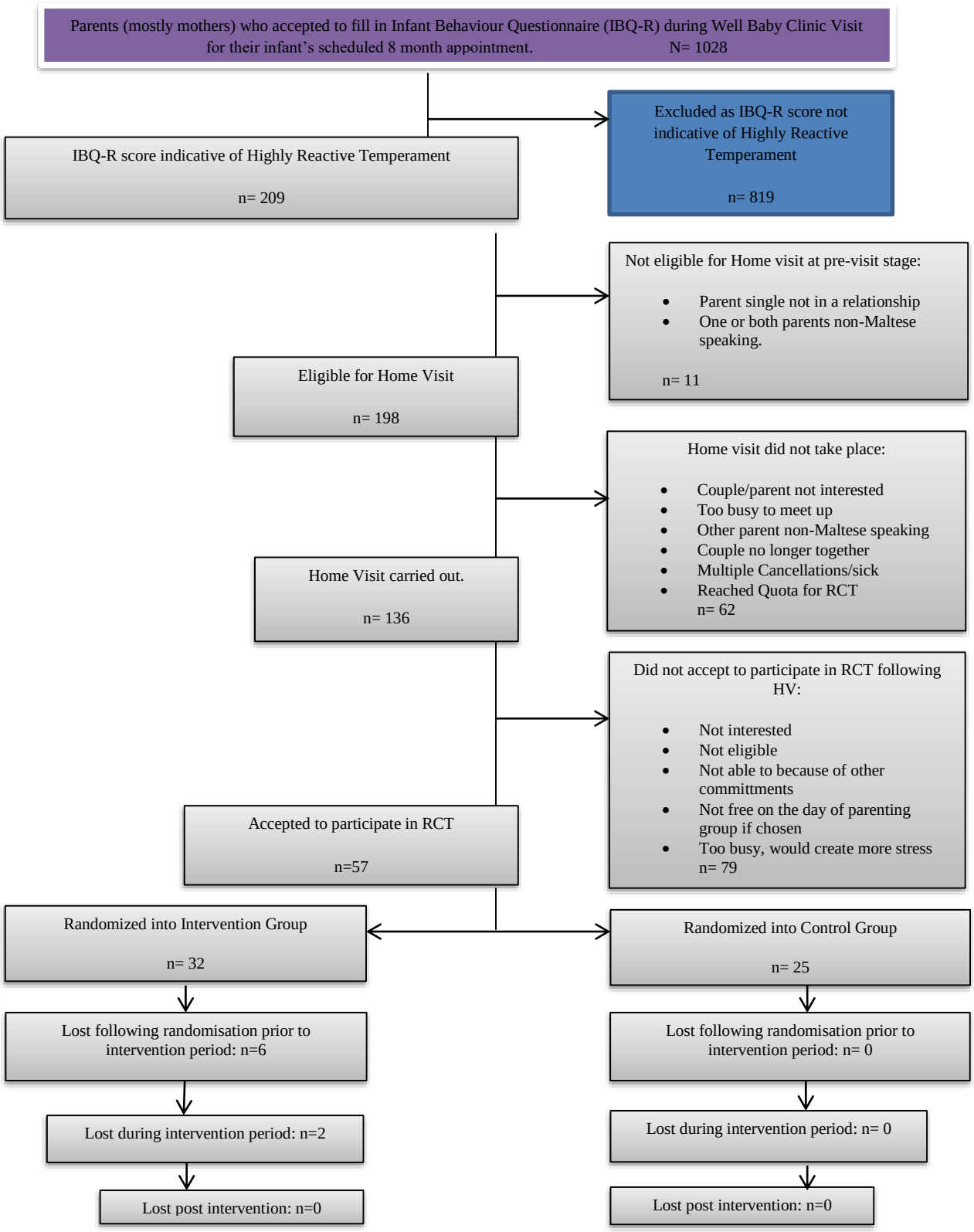
After having established a pool of parents that were interested in participating in the research, the randomisation process was set in motion. The allocation of participating parents to

either the intervention group or control group was done by asking an uninvolved third party individual to draw numbers out of a container. This method of randomisation sequencing was used in order to avoid risk of bias by the researcher with regard to allocation of participants to either group. Thus, all was left to chance, making it more possible to attribute result outcomes following the programme intervention to the actual programme and not to other influences or changes (Dynarski & Del Grosso, 2008).

Every couple had been assigned a number at recruitment stage, and those who agreed to participate had their respective number placed into a container. Numbers were drawn, first for the intervention group and then for the control group. Considering that the interventions needed to happen over four smaller-sized groups having a maximum of 8 couples in each group totalling the projected 32 couples (refer to Intervention No. 6 below), this process needed to be repeated four times in the same manner across the recruitment/randomisation period. Once the numbers were drawn, they were tallied with their respective participants' identities. Participants who were randomised into the intervention group (those who attended the 'Parents as Partners' coparenting programme as well as receiving a monthly phone call from a case manager) and the control group (those who received a monthly phone call from the same case manager), were informed of the randomisation outcome by text message first. Those participating in the coparenting programme were then followed up with details pertaining to the intervention as described in more detail in the 'Intervention' section below.

Table 3.2. outlines the trial flow from the point of recruitment through to post randomisation.

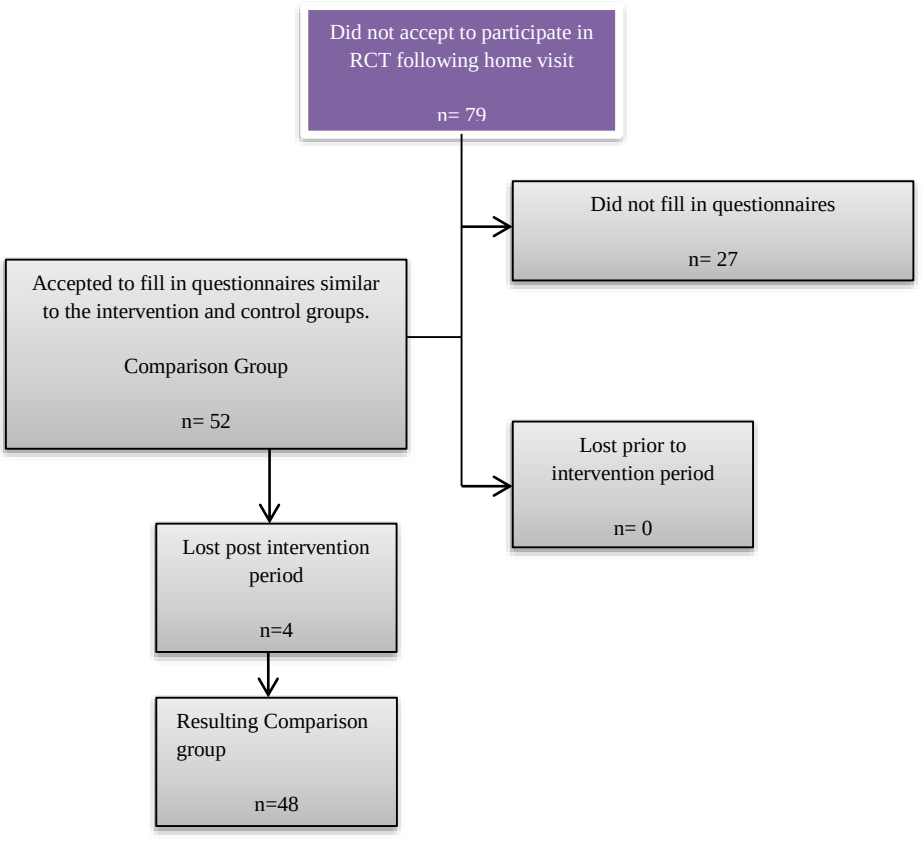
Table 3.2. *Trial Flow Chart*



Also notable was that there were a number of parents who had agreed to complete the measures during the pre- and post- intervention periods, but were not in a position to participate in the randomisation for varied reasons, such as incompatible work schedules, lack of interest and having no time. A number of these couples lived in dire situations, from financial pressures, working long hours, living with in-laws, alcohol problems, living in a cave-like environment, or in a home coated in mould, in addition to having an infant with a reactive temperament. Some of these couples were already having relationship difficulties at pre-intervention period, and a few had split up by the time the post-measures were collected. These parents were placed into a comparison (no treatment) group as reflected in Table 3.3.

Table 3.3.

Trial Flow Chart (Those not participating in RCT but completing pre- and post- measures only).



In summary, there were a total of 30 intervention group couples (with ITT), 25 control group couples, and 48 comparison group couples included in the statistical analyses.

The Intervention

In order to describe in detail the intervention with the participants who were randomised into the group receiving the 'Parents as Partners' coparenting programme, the Template for Intervention Description and Replication (TIDieR) checklist was adherred to as presented below (Hoffman, 2014).

1. Intervention name: The 'Parents as Partners' coparenting programme was the intervention for this study.
2. Why this intervention?: Choosing the intervention was based upon the knowledge that focusing on the parenting relationship and involving fathers in the coparenting programme has had positive outcomes in parenting such as more collaboration between the parents, coping more effectively with children and managing stress better (See Chapter 2 for the detailed rationale).
3. What was the intervention about?: Participants who were randomised into the intervention group were offered the 'Parents as Partners' coparenting programme, which took them through 16 sessions that focused on five family domains, namely: the individual, the parent-child relationship, the couple/coparenting relationship, the three generational relationships, and stress and support outside the family relationships. Couples had the opportunity to discuss, observe and put into practice different concepts

that were presented, and were also given homework assignments between one session and another according to the particular session plan. The precise details of each session's outline, materials needed, handouts and group worker tips, can be found in the 'Parents as Partners Groupwork Manual' (Tavistock Relationships, 2017). Refer to Table 2.1.

4. Procedures used in intervention: Couples that were randomised into the intervention group were initially each given an appointment lasting 2 hours with their respective co-facilitating group leader couple. This appointment, referred to as the Group Worker Interview (GWI) (Appendix P), happened prior to the commencement of the 'Parents as Partners' programme, and served as a pre-group interview to give the parents a sense of what the group would involve and to help the co-facilitators connect with the couple and evaluate whether or not participating was in the couple's and group's best interest. Amongst questions about their relationship, children, and family, the couples were also asked about domestic violence and child protective issues. During this meeting, besides being given an information and consent form pertaining to the programme (Appendix E and F), they were also each given the Clinical Outcomes in Routine Evaluation (CORE) brief questionnaire (Appendix M) to tap into the level of psychological distress if this was present. The GWI and the CORE were requirements established by the Tavistock Relationships as part of the assessment of each parenting partner's well-being and preparation for the parenting programme. The intervention that followed consisted of a 16-week group-based coparenting programme called 'Parents as Partners' which was designed by Professors Philip and Carolyn Cowan and Professors Kyle and Marsha Pruett (2009b). Participating couples met for weekly sessions along the duration of the coparenting programme. Each group was co-facilitated by male-female group leaders,

and all sessions were video-recorded. In addition to the coparenting sessions, all participants were also contacted monthly by the same female 'case manager', who offered support if and when needed through a brief check-in, responding to any difficulties, reinforcing their continued attendance and participation to the weekly programme, liaising with the group co-facilitators. A 'Parents as Partners' supervisor from the Tavistock Relationships who spoke Maltese also followed the co-facilitators during the intervention periods.

5. Intervention providers: A total of 7 co-facilitators (4 males and 3 females – researcher included) were involved in the delivery of the intervention. All were specifically trained by Tavistock Relationships staff in the UK, who were the licensed trainers for 'Parents as Partners' coparenting programme for Europe. Moreover, all of the Maltese co-facilitators were experienced psychologists, family therapists or counsellors by profession, and one was a social worker. The case manager who contacted all parents was also a qualified family therapist and a clinical psychologist with experience in working with families and children. The 'Parents as Partners' supervisor from the Tavistock Relationships who was of Maltese origin, was also a qualified and experienced counselling psychologist and couples' therapist.

6. How intervention was delivered: The coparenting programme's sessions took place in the context of groups. In order to reach the intended number of couples for both intervention and control groups (30 and 25), a total of four successive 'Parents as Partners' coparenting groups holding a maximum of 8 couples in each were required. The decision for this sample size was taken mostly to balance the need for an adequate sample within the realistic time constraints and available funding. Each of the four participant groups

came together face-to-face each week with their respective co-facilitating pair. Having the latter smaller group sizes followed the same programme format carried out by Cowan et al., 2009b, as well as groups carried out by Tavistock Relationships in the U.K. (Casey et al., 2017) in which group sizes were similar. Moreover, the practice of keeping to a small group size supports established findings that increase the level of intimacy, cohesion, committment, participation and expression amongst its members (Wheelan, 2009). In addition to the group meetings**,** participants were contacted individually by phone once monthly by the case manager, whilst supervision of Malta co-facilitators with Tavistock Relationships happened through a Zoom video conference on average every fortnight.

7. Where did it take place?: Three of the coparenting groups with participating parents took place at the University of Malta Psychlab, whereas one group took place within the Faculty for Health Sciences Audio/Speech Lab at Mater Dei General Hospital. The settings were chosen because of their recording facilities and privacy, both being situated in central Malta, with easy access to direct bus transport for anyone who had no personal transportation, and easily arranged parking for those who did. Both locations were situated within a few metres walk from Tajra childcare that was provided to participants who needed the service. The Mater Dei General Hospital Audio/Speech Lab was utilized for one of the groups instead of the Psychlab at the University of Malta because the session dates of two of the groups overlapped slightly due to logistics, availability of co-facilitators, and avoiding having sessions during the month of August because of the hot weather in Malta and holiday season that would have impacted participants' attendance.

8. When and how much intervention:The intervention consisted of a 2 hour weekly session for the duration of the 16 weeks for each intervention group. The first group met between October 2017 and February 2018, the second ran between February 2018 and June 2018, the third group ran between April 2018 and July 2018, whilst the fourth group ran between February 2019 and May 2019.
9. Tailoring of intervention: Each co-facilitating couple followed the 'Parents as Partners Group Work Manual' (Tavistock Relationships, 2017) to deliver their sessions. Sessions were adapted to Maltese-speaking participants, most of whom were also familiar with the English language. The same materials were used across the four intervention groups.
10. Modifications to intervention: No modifications were made to the coparenting programme as designed.
11. Adhering to intervention: All 7 co-facilitators attended a 4-day course on 'Parents as Partners: Training for Group Leaders' at Tavistock Relationships in Warren Street, London prior to the intervention period. Whilst referring to the same 'Parents as Partners Group Work Manual' (Tavistock Relationships, 2017), fidelity to the programme was supported through the supervision provided to each co-facilitating pair. The supervision created an opportunity to discuss the group programmes, explore any difficulties or challenges, and served as a point of reference for all co-facilitators. It also helped to create more cohesiveness and consistency between groups. The manual provided co-facilitators with a structure and relevant materials for each session, that were also discussed in regular supervision. Although there could not be any guarantee that co-facilitators approached or delivered the programme materials in identical ways, the main aim for all facilitators was to keep the function or scope of each session in mind.

The Control Group

Unlike the intervention group, those participants who were randomised into the control group did not receive the 16-week 'Parents as Partners' coparenting programme (Appendix G & H). They were still contacted once monthly by phone by the same case manager, mostly for ethical reasons, especially considering the possibility of having some of the parents who may have been struggling with their infants. The monthly call also meant that the only difference between the intervention and control groups was attendance to the 'Parents as Partners' coparenting programme for the former group. Therefore, any significant difference between pre- and post- measures between groups could be assumed to be attributable to the parenting programme. Control group participants were also contacted at the same time period as the intervention group participants, in order to complete post-intervention measures.

Measures

Both before the commencement of the intervention and after it was completed, all participants were given the same set of questionnaires to fill in, except for the CORE Outcome Measure that was only given to intervention group participants prior to the commencement of the 'Parents as Partners' coparenting programme. The measures used at pre- and post-intervention periods are all reliable and valid instruments. Moreover, keeping in mind that participants were all likely to prefer filling in a Maltese version of the questionnaires, measures were translated and back-translated from English to Maltese and again from Maltese to English by separate translators, in order to ensure that the Maltese version of all the measures used was the correct representation of the English original version (Rode, 2005; van der Vijver & Leung, 1997).

For the sake of reliablity and validity of the translated English version measures into Maltese, a validation process was carried out for the IBQ-R, PSI-4-SF, CRS and ECBQ. The CORE did not form part of the statistical analysis, and was not validated since it did not form part of the study outcome. In order to be eligible to participate in the validation process, interested volunteering individuals needed to be parents over the age of 18 of either an infant aged between 3 and 12 months, or of a child aged between 1 year an 3 years so as to be given the appropriate measures according to the child's age, considering the use of the IBQ-R and ECBQ. Recruitment took place by first providing professional colleagues with the information sheet (Appendix R). They acted as gatekeepers and were able to approach potential participants as well as make use of snowballing, so as to complete the required number of questionnaires to reach the 10 to 15 quota per questionnaire. Responses were collected through email or scanned to researcher due to safety measures because of the Covid-19 pandemic. A separate application to the Faculty Research Ethics Committee was also presented and approved for this process to take place (Appendix Q).

The validation required that between 10 to 15 questionnaires of each measure needed to be filled in first in English, and again after a lapse of at least 5 days in Maltese. Each participating parent was given the option to fill in between 1 and 3 questionnaires in both the English and Maltese versions. Only scores of each participating parent were used and inputted into a database on SPSS, that provided the Cronbach's Alpha, the Intra-Class Correlation Coefficient and p=value for each item on each test. Overall test results for each measure were also provided. It is noted that translation reliability for each item can be measured in two ways, either by providing the Cronbach's Alpha or providing the intra-class correlation between the

rating scores given for the Maltese and English versions. The Cronbach's Alpha ranges from 0-1 where a Cronbach's Alpha of >0.7 indicates acceptable reliability. A Cronbach's Alpha between 0.5 and 0.7 indicates questionable internal consistency, and a Cronbach's Alpha < 0.5 indicates unacceptable reliability. On the other hand, the intra-class correlation for absolute agreement ranges between 0 and 1, where the larger the intra-class correlation coefficient, the higher is the reliability. Satisfactory reliability is accepted when the p=value is < 0.05 level of significance. Internal itemized discrepancies were most likely the result of a small number of participating volunteers, and questions that required a negative response, in addition to individual perceptions across time.

The measures were chosen because of their specificity with regards to what aspects were being measured in connection to the focus of this research, as well as because they are all used cross-culturally. The IBQ-R specifically measured temperament, the PSI-4-SF measured parenting stress, and the CRS evaluated the coparenting relationship quality. The CORE Outcome Measure given to intervention group participants prior to the start of the intervention groups was used for the sake of risk assessment.

As explained earlier in the 'Recruitment Phase' section, potential participants attending the Well Baby Clinics with their infants were initially asked to fill in the IBQ-R.

The Infant Behavioural Questionnaire – Revised

The Infant Behaviour Questionnaire, which specifically serves as an infant temperament measure based on parents' reporting, was developed by Mary Rothbart in the 1980s and revised

in 1998 (Gartstein & Rothbart, 2003). The revision brought about more refined scales by combining these for better internal consistency with Cronbach Alpha at >.70 for mothers and fathers (Parade & Leerkes, 2008), following an analysis of each item, as well as the addition of other levels, hence referring to the questionnaire as the Infant Behaviour Questionnaire-Revised (IBQ-R).

This study made use of the 37-item version of the IBQ (Putnam et al., 2014), permission for which was received from Associate Professor Sam Putnam on behalf of the Mary Rothbart Temperament Lab (c) 2006. Different versions and languages of the IBQ-R have also been established. In Malta, a study carried out by Borg (2014) made use of the same 'very short' version of IBQ-R, where the questionnaire was translated into Maltese through a back-translation to ensure greater accuracy (Klein et al., 2009). The validation of the Maltese translated version of the measure, rendered a Cronbach Alpha at 0.854, intra-class correlation at 0.758, and p=value 0.00. The 37-item 'very short' version of the IBQ-R took on average under 12 minutes to be completed (Putnam et al., 2014). This measure has also been used across different cultures. A cross-cultural study on temperament during the first year of a child's life was carried out using the IBQ-R with a US and an Italian sample. The Italian sample was found to match that of the US, where the former resulted in a Cronbach Alpha ranging between .73 and .92, whereas the latter US sample ranged between .78 and .90 (Montirosso et al., 2011).

Used predominantly with infants aged 3 months to 1 year, a number of different dimensions were assessed through the IBQ-R. These are depicted in the following Table 3.4.

Table 3.4.

Scale definitions: Infant Behavior Questionnaire—Revised

Scale	Description
Approach	Rapid approach, excitement, and positive anticipation of pleasurable activities. ("When given a new toy, how often did the baby get very excited about getting it?")
Vocal Reactivity	Amount of vocalization exhibited by the baby in daily activities. ("When being dressed or undressed during the last week, how often did the baby coo or vocalize?")
High Intensity Pleasure	Pleasure or enjoyment related to high stimulus intensity, rate, complexity, novelty, and incongruity. ("During a peek-a-boo game, how often did the baby smile?")
Smile and Laughter	Smiling or laughter during general caretaking and play. ("How often during the last week did the baby smile or laugh when given a toy?"; shorter and different in content from the original IBQ scale)
Activity Level	Gross motor activity, including movement of arms and legs, squirming and locomotor activity. ("When put into the bath water, how often did the baby splash or kick?" similar in length/content to the original IBQ scale)
Perceptual Sensitivity	Detection of slight, low intensity stimuli from the external environment. ("How often did the baby notice fabrics with scratchy texture (e.g., wool)?")
Sadness	Lowered mood and activity related to personal suffering, physical state, object loss, or inability to perform a desired action; general low mood. ("Did the baby seem sad when the caregiver was gone for an unusually long period of time?")
Distress to Limitations	Fussing, crying or showing distress while (a) in a confining place or position; (b) in caretaking activities; (c) unable to perform a desired action. ("When placed on his/her back, how often did the baby fuss or protest?"; shorter, but similar in content to the original IBQ scale)
Fear	Startle or distress to sudden changes in stimulation, novel physical objects or social stimuli; inhibited approach to novelty. ("How often during the last week did the baby startle to a sudden or loud noise?"; different in content from the original IBQ)

Falling Reactivity/rate of recovery from distress	Rate of recovery from peak distress, excitement, or general arousal; ease of falling asleep. ("When frustrated with something, how often did the baby calm down within 5 min?")
Low Intensity Pleasure	Amount of pleasure or enjoyment related to low stimulus intensity, rate, complexity, novelty and incongruity. ("When playing quietly with one of his/her favorite toys, how often did the baby show pleasure?")
Cuddliness	Expression of enjoyment and molding of the body to being held by a caregiver. ("When rocked or hugged, during the last week, how often did the baby seem to enjoy him/herself?")
Duration of Orienting	Attention to and/or interaction with a single object for extended periods of time. ("How often during the last week did the baby stare at a mobile, crib bumper or picture for 5 min or longer?"; similar in length/content to the original IBQ scale)
Soothability	Reduction of fussing, crying, or distress when soothing techniques are used by the caregiver. ("When patting or gently rubbing some part of the baby's body, how often did s/he soothe immediately?"; similar in length/content to the original IBQ scale)

Note: Table adapted from Garnstein & Rothbart, (2003), p. 72.

The 37-item form of the IBQ-R was evaluated by Putnam et al. (2014). Positive Affectivity/Surgency (PAS), Negative Emotionality (NEG) and Orienting/Regulatory Capacity (ORC) factor scores were calculated by eliciting averages from the IBQ-R standard format scale scores and these corresponded accordingly with the shorter version, following which correlations for each were carried out. In their evaluation of the very short form of IBQ-R, results by Putnam et al. (2014) showed that Cronbach's alphas, as well as scale correlations between the short and very short versions of the IBQ-R, were both greater than .70. Moreover, inter-parent agreement between these versions was also considered to be moderate in both forms, producing an average

score of .41. With regard to the presence of convergent and predictive validity of the IBQ-R very short form, it was noted that this was very similar to the same validity in the standard IBQ-R (Putnam et al., 2014).

When parents in this research study completed the IBQ-R 37-item form pre-intervention, they were asked to read the description pertaining to their infant's behaviour. Following the reading of their infant's behavioural description, parents were asked to indicate the frequency of the behaviours during the previous week by using a 7-point Likert Scale that measured their response from never (the behaviour never occurs) to always (the behaviour is one that always occurs). Different averages were elicited for the Surgency, Negative Affect and Effortful Control scales for each parent filling in the measure. Scores that stood at one standard deviation higher than the average were considered to reflect a highly reactive temperament on the Negative Affect scale. In the Maltese context, this was established as being a score of over 4.78. with a cultural average established score of 3.82 and standard deviation of 0.96 on Negative Affectivity (Putnam et al., 2019). The cultural average was achieved following the scoring of the first batch of 126 questionnaires collected in June 2017. Parents whose babies' Negative Affect score reflected a highly reactive temperament were asked to fill in additional measures, namely, the Parenting Stress Index-4-Short form, and the Coparenting Relationship Scale respectively.

The Parental Stress Index – 4th Edition - PSI-4 short form

The Parental Stress Index 4th Edition (PSI–4-SF) (Abidin, 2012) is a shorter 36-item version of the original 120 item inventory evaluating stress in the parent-child relationship, having an internal consistency with a Cronbach Alpha of 0.92, which is consistent with the original longer version of the scale (Aracena et al., 2016). This measure has also been used reliably cross-culturally (Dardas & Ahmad, 2014). The inventory focuses on child, parent and situational stress, quickly identifying any parent-child problems amongst parents of children between the ages of 0 to 12 years (Abidin, 2012; Zaidman-Zait et al., 2010). The test items are divided into three domains, namely Parental Distress, Parent-Child Dysfunctional Interaction and Difficult Child. These domains combine to bring out a total stress scale (Abidin, 2012). Examples of questions include 'Since having a child, I feel that I am almost never able to do things that I like to do' and 'I feel alone and without friends'.

A theoretical model determining what was considered to consititute dysfunctional parenting set the guidelines for the construction of the original full-length PSI-4. A number of child characteristics are seen as being associated with parental stressors, grouped by the PSI into 4 subscales, namely, adaptability, demandingness, mood, and distractability/hyperactivity. The PSI-4-SF reflects a revision of 14 items that was carried out through a multi-stage process, and the new test was standardized on a sample of 1056 adults, which included 534 mothers and 522 fathers that represented a wide area encompassing 17 states in the US. Correlation coefficients ranging between 0.87 and 0.94 were present between the different domains of the longer and shorter versions of the PSI. Percentiles which were based on the frequency of raw score distributions of the said sample served as the basis for interpreting the PSI-4-SF. As a result of a

factor analysis it was possible to confirm that the test carried the same distinct factors pertaining to the different domains as did the original full-length PSI-4. According to the Parenting Stress Index/Short Form – National Child Traumatic Stress Network (NCTSN) Measure Review Database, using a normative sample of 800 parents, the Cronbach's alpha reflected at .91 for Total Stress, .87 for Parental Distress, .80 for Parent-Child Dysfunctional Interaction and .85 for Difficult Child (Abidin, 2012).

Respective items for parent and child domains on the PSI-4-SF are shown in Table 3.5. below:

Table 3.5.

Child and Parent Domain Items on the PSI-4-SF

Child Domain Items	**Parent Domain Items**
Distractiability/hyperactivity	Competence
Adaptability	Isolation
Reinforces parent	Attachment
Mood	Role Restriction
Acceptability	Depression
Demandingness	Spouse/parenting Partner Relationship
	Health

Parents participating in the research were given the PSI-4-SF to fill in during the third phase of the recruitment process during the home visit. This measure was completed both at

pre- and post-intervention periods. The Maltese version of this measure, previously translated from English to Maltese and back-translated by Borg, 2014 (Klein et al., 2009) was used. The validation of the Maltese translated version of the measure, rendered a Cronbach Alpha at 0.750, intra-class correlation at 0.593, and p=value 0.00. With regard to the use of the PSI-4-SF, permission was not necessary since this is a standardized test that could be purchased on-line.

The Coparenting Relationship Scale (CRS)

A final measure also completed at pre- and post-intervention periods was the Coparenting Relationship Scale (CRS), having an excellent internal consistency ranging between 0.91 and 0.94 (Feinberg, 2003), and used also cross-culturally (Ramos de Carvalho et al., 2018). This tool is based on Feinberg's concept of coparenting (2003), through which four domains were structured, namely (1) childrearing agreement, (2) coparental support or undermining, (3) division of labour and (4) joint management of family dynamics. The scale used for the purposes of this research involves a self-report measure of coparenting within the family, made up of a total of 35 items and 7 sub-scales, and can be used in diverse coparenting contexts. Hence it is appropriate not only for heterosexual couples, but also for other parenting dyads (Feinberg, 2003). The 35 items across the Coparenting Relationship Scale represent the 7 sub-scales, a breakdown of which is presented in the following Table 3.6.

Table 3.6.

Coparenting Relationship Scale – 7 Subscales (Feinberg, 2003)

Coparenting Relationship Sub-scales	Examples of Questions Reflected in the Sub-scales
1. Coparenting Agreement	My partner and I have the same goals for our child. My partner and I have different standards for our child's behaviour.
2. Coparenting Closeness	My relationship with my partner is stronger now than before we had a child. We are growing and maturing together through experiences as parents.
3. Exposure to Conflict	How often in a typical week, do you argue with your partner about your child, in the child's presence
4. Coparenting Support	My partner asks my opinion on issues related to parenting. My partner appreciates how hard I work at being a good parent.
5. Coparenting Undermining	My partner sometimes makes jokes or sarcastic comments about the way I am as a parent. My partner undermines my parenting.
6. Endorse Partner Parenting	I believe my partner is a good parent. My partner is sensitive to our child's feelings and needs.
7. Division of Labor	My partner does not carry his or her fair share of the parenting work.

This multi-domain self-report measure of coparenting quality, is indicated as having good psychometric properites, such as excellent internal consistency, having good reliability and stability, whilst also being administered in a flexible manner (Feinberg et al., 2012). In fact, the CRS reflects "excellent internal consistency, with Cronbach's alphas ranging from .91 to .94" (Feinberg et al., 2012, p. 11). Moreover, the translation of the CRS into Maltese and its back-translation for ensuring accuracy (Klein et al., 2009) was carried out by myself as researcher together with a well-versed graduate in the Maltese Language. The validation of the Maltese

translated version of the measure, rendered a Cronbach Alpha at 0.824, intra-class correlation at 0.463, and p=value 0.00. The scale was easily accessible on-line, and required no prior permission for use. As with the previous measure on parenting stress, the CRS was given to participating parents at pre- and post-intervention periods.

The Clinical Outcomes in Routine Evaluation (CORE) Outcome Measure

Administered only at pre-intervention period, those participants who were randomly invited into the 'Parents as Partners' coparenting programme were asked to fill in the CORE Outcome Measure (Barkham et al., 2010). This was done during the Group Worker Interviews when group co-facilitators met up with respective participant couples before the intervention set off. This was requested by the Tavistock Relationships (London) as an initial tool for screening individual parent's level of global distress.

Consisting of 34 self-report items, it presents a brief and easy to use format. Moreover, this measure is not used for diagnostic purposes but as a form of risk assessment. Having been extensively used and piloted, the standardized measure has 'supportive validity and reliability' (CORE User Manual, p. 5), with an internal consistency of 0.89, besides also being used internationally (Zeldovich & Alexandrowicz, 2019).

The 34 items that form the CORE Outcome Measure cover 4 dimensions as follows:

1. Subjective Wellbeing (4 items)

   Example: 'I have felt like crying'
2. Problems/symptoms (12 items)

Example: 'I have felt tense, anxious or nervous'

3. Life Functioning (12 items)

   Example: 'I have achieved the things I wanted to'

4. Risk/harm (6 items)

   Example: 'I have threatened or intimidated another person'

   (Evans et al., 1998)

This measure was not repeated during the post-intervention phase.

Post-Measures

The PSI-4-SF and CRS were once again given to all the participants two months after the completion of the intervention. The Early Childhood Behaviour Questionnaire (ECBQ) was given as the age-appropriate post-measure replacing the IBQ-R, considering infants had by then grown to the age of around 1.5 years (Refer to Demographic Tables 4.1 – 4.12 in the next chapter on Results).

The Early Childhood Behaviour Questionnaire (ECBQ)

At post-intervention period the Infant Behaviour Questionnaire-Revised (IBQ-R) needed to be replaced with the Early Childhood Behaviour Questionnaire (ECBQ), which was developed to fill a gap for assessing temperament in children aged between 1 and 3 years (Putnam et al., 2006). The short version of the ECBQ has an internal consistency of 0.71 (Putnam et al., 2010).

It has also been developed into several non-English versions and is used across different cultures, such as Japan (Sukigara et al., 2015) and the Czech Republic (Potmesilova & Potmesil, 2019). The validation of the Maltese translated version of the measure, rendered a Cronbach Alpha at 0.608, intra-class correlation at 0.506, and p=value 0.007. The ECBQ is also represented by a three-factor structure, namely Surgency, Negative Affect and Effortful Control, similar to the IBQ-R. It also possesses stability of the assessment of temperament from one measure to the other longitudinally (Putnam et al., 2008). Notably, the ECBQ 'is based on a definition of temperament that includes reactive processes involving not only emotion, but also motor and sensory systems' (Putnam et. al., 2006, p. 387). It also places an emphasis on the processes involved with self-regulation that interact with a child's reactivity (Rothbart et al., 2001).

The ECBQ (very short form version) consists of a total of 6 items, 12 of which focus particularly on Negative Affectivity. The latter dimensions include Falling Reactivity, Fear, Frustration/Distress to Limitations, Sadness, Discomfort and Motor Activation and are outlined in Table 3.7.

Table 3.7.

ECBQ - Negative Affect Labels and Definitions

Label	**Definition**
Falling Reactivity	Rate of recovery from peak distress, excitement, or general arousal; ease of falling asleep. Also includes soothability items in ECBQ.
Fear	Negative affect related to anticipated pain, distress and/or threat. Includes startle and reactions to novelty social stimuli in IBQ-R.

Frustration/distress to limitations	Negative affect related to confinement, interruption of ongoing tasks or goal blocking.
Sadness	Negative affect, tearfulness or lowered mood related to physical state, disappointment, loss , and/or response to other's suffering.
Discomfort	Negative affected related to sensory qualities of stimulation, including intensity, rate or complexity of light, sound, and texture.
Motor activation	Repetitive small motor movements; fidgeting.

Adapted from Infant and Child Development, 17;387-405 (2008). John Wiley & Sons, Ltd. (p. 389)

Time Elapsing and Effect Size

The reason for allowing some time to elapse between the termination of the coparenting programme and the post-measures was based on evidence from meta-analytic studies indicating that the effect size was typically larger as more time elapsed following an intervention (Cowan & Cowan, 2014; Hawkins et al., 2008; Hawkins & Fackrell, 2011; Hawkins et al., 2013).

All the post-measures were obtained from participants by myself as researcher, after all participants were contacted first by phone. This was done in order to verify correct postal addresses where measures needed to be sent with specific instructions on what and in which manner these needed to be completed. Couples were asked to fill in measures separately and base their responses on the last week. On completion of the post-measures, a very brief home visit followed so as to check and collect completed questionnaires, or help any of the participants who may have needed support completing the respective measures.

Analytic Methods

All measures used at pre- and post-intervention periods provided the data for the analysis. Data were inputted into IBM SPSS Statistics Version 25 according to the respective participant number given at the time of recruitment and randomisation. This was done for all intervention, control and comparison group participants.

This research sought to answer the question about whether participation in the 'Parents as Partners' coparenting programme helped to improve parents' coparenting relationship, enabled them to use more effective parenting strategies, and/or impacted their infant's level of reactivity. Individual datasets were used to account for significant differences between measures administered at pre-intervention with measures taken at post-intervention. Pre- and post- means and standard deviations for all the measures were compared and analysed between the respective groups, namely for the intervention, control and comparison group participants. Comparative analyses were also carried out between fathers and mothers pre- and post- across all groups. In the case of this study, the Paired Sample T-Test was used since the distribution was normal (parametric).

A One-Way Anova was also carried out to compare mean scores between the 3 independent groups since the distribution was normal. The p-value considered for this study was that of <. 0.05.

Note that the group totals constitute relatively small samples and therefore a low power to detect statistically significant differences. Therefore, the results could represent an underestimate of the effect of the intervention on participating couples. I attempt to compensate for this problem by including an analyses of effect sizes, which are independent of sample sizes and represent another method for measuring the impact of the intervention.

More elaboration of the statistical methods is given in the next chapter on the presentation of results. The final section of this chapter looks into retention of participants as well as ethical considerations.

Retention – Keeping Them Committed

A number of efforts were made during the study in order to increase participants' engagement and retention in the PasP coparenting programme. Apart from its focus on the coparenting relationship, the PasP programme carried an important feature with its involvement of the case manager. This study made use of the case manager to address any difficulties or concerns faced by parents in the intervention and control groups if the need arose, such as attendance at sessions and providing emotional or informative support. This aspect made it quite distinct from other parenting programmes, and was significant with regard to its instrumentality in helping participants stay on and remain committed as well as to address any new stressors or crises arising along the duration of the 16 weeks.

Research on the engagement and retention of participants in parenting programmes mentions the importance of a number of considerations that need to be taken care of for the successful running of such programmes (Axford et al., 2012). This study took care to implement these considerations as much as possible.

In the case of this study, parents who had described their infant as having a highly reactive temperament were offered an opportunity to help them to cope more effectively with their infants. By helping these parents to use more effective ways of parenting their child, who was considered to be challenging at times, it was expected that they would benefit from the

intervention, and so in turn would their infants. Sessions were held in the evenings so that both parents would be able to attend, considering that evenings were usually the most popular time for most families to get together following a working day. Despite not being possible to choose different localities to accommodate different participants owing to the nature of the study, the locality chosen was central for most participants, with sufficient parking and accessibility. The importance of choosing a site strategically has also been mentioned by Cooney et al., (2007) as influencing attendance. This study also considered avoiding as much as possible the hospital, social welfare service or church-run settings in order to avoid any associations made with these settings, that could in some way have influenced participants' decision not to attend. Only one group had to be carried out within a very quiet section of the General Hospital that provided sufficient privacy for the participants and was within walking distance to parking and childcare for those who made use of it.

Free childcare was the most crucial service provided to support the parents' attendance at their weekly session. Tea, coffee and biscuits, were also offered free to participants before every session to make it more attractive for them, especially keeping in mind that some may not have had time to go home after a day's work. The short mid-session break also helped to create an enticing environment for parents. Providing food and refreshments is deemed as one of the strategies to foster retention in parenting programmes (Cooney et al., 2007).

To engage and retain parents' participation, it was essential to build friendly relationships with them. McDonald et al. (2012) and Axford et al. (2012) also refer to how building such friendly relationships with the parents attending the parenting programme helps to establish trust. In this study, these goals were enhanced through the process of recruitment, home visits with

those fitting the eligibility criteria, the case manager keeping contact with each family and checking in on them if they were unwell, having clinically skilled co-facilitators, and the nature of the coparenting programme itself with its consistency, exercises that involved participants in a semi-therapeutic environment and a closed group setting.

Also mentioned by Axford et al., 2012 was the importance of engaging the providers of the programme, most specifically the group co-facilitators, as well as the case manager. The childminders were involved in weekly communication through the childcare manager, as were the caterers providing the food. Engaging providers was considered to be particularly significant because when appropriately engaged and trained, those facilitating the sessions as well as others involved in its implimentation, tended to believe in the programme and to convey that to the participating parents. Engaging the providers also meant that they would remain more committed and consistent (Cooney et al., 2007). These considerations were supported moreover by the fact that all those involved in facilitating the groups (the 7 group co-facilitators) received regular supervision from prior to the start of the first group sessions until their completion, as was mentioned earlier on in the intervention section of this chapter.

Ethical Considerations and Procedures

A number of ethical considerations were taken into account throughout the course of the study. They are elaborated on below:

1. Application to the University Research Ethics Committee (Appendix O) was made to ensure that all ethical considerations were in line with ethical requirements. Forms were

also updated according to the changes in the General Data Protection Regulations (GDPR) that took place during the course of the research. A separate application to the Faculty Research Ethics Committee was also made for the validation of the Maltese translation of research measures (Appendix Q).

2. Permission was taken from Mr. Mario Vella, the data protection officer for Primary Health Care in order to gain access to Well Baby Clinics. The study was outlined and procedures clearly indicated in a 'Request For Approval to Access Subjects' document (Appendix N).
3. Signed Consent clearly indicating an opt-in option were given to all participants from the recruitment phase until randomisation (Appendices B, D, F, H).
4. The use of the case manager sought to follow through the participants' wellbeing during the whole process of the interventions. Those participants that needed further follow-up and care after the completion of the programme were referred to appropriate services such as couple therapy or social work intervention. These included the couples or individuals (from the intervention or control groups respectively) that were still struggling with the stresses connected to parenting or other stressors that the case manager may have identified accordingly. This was particularly important for control group participants considering that they too may have been struggling or feeling stressed with an infant they had described as highly reactive.

Conclusion

This chapter put forward in detail the methodology used in this study. An introduction into randomised controlled trials, as well as a description of the trial design, the participants, and elaborate recruitment process was presented. The stages involved in the randomisation of participants into the intervention and control groups were highlighted and reflected through a flow chart. The intervention of the study, namely, the ‘Parents as Partners’ coparenting programme was described in great detail to allow for replication of the study. The different measures that were used pre- and post- intervention period included the IBQ-R, the PSI-4-SF, the CRS, the CORE Outcome Measure, and the ECBQ. These measures formed the basis for the analysis that was described briefly. Finally, keeping participants on board was addressed through a section on retention, whilst important ethical considerations were also included. The next chapter presents the findings of the study.

CHAPTER 4

RESULTS

Introduction

This chapter presents the findings that emerged from the Randomised Controlled Trial that investigated whether participation in the 'Parents As Partners' (PasP) coparenting programme delivered to parents in the early stages following the birth of an infant showing a highly reactive temperament, enhanced the parents' ability to coparent, and also whether there was positive change in the infants' behaviour.

Sample for the Randomized Controlled Trial

A total of 198 couples were eligible for a home visit following the initial process of recruitment of parents/couples from the Well Baby Clinics, out of which 136 couples accepted a home visit. At this stage the couples were all unaware that they would be offered the possibility of being randomized into an intervention or control group. From the 136 couples visited in their homes, a total of 79 couples did not agree to be randomized, mostly because they were not interested in participating in the 16-week intervention, they were unable to commit because of other committments, and/or above all, because they felt they were already too busy with what they had to cope with at the time, and felt that being part of the programme could/would increase their stress further. Despite not agreeing to participate in the randomization, 52 of the 79 couples still agreed to fill out the questionnaires at the beginning of the study and once again approximately 8 months later after the intervention would have taken place, when their children were aged 1.5 years. From the 60 remaining couples agreeing to the randomization, 3 couples dropped out just before randomization took place because they changed their mind, or had a

change in life circumstances that did not allow them to commit to the programme if randomized into the intervention group. Thus, from the remaining 57 couples, 32 were randomized into the 'Parents as Partners' intervention group, 6 of whom were lost just following the randomization, prior to the start of the 16-week coparenting programme, whereas another 2 couples dropped out in the early sessions of the programme, around the 2nd/3rd session, resulting in 30 couples in the intervention group. 25 of the 57 couples were randomized into the control group and received a monthly phone call from the assigned case manager, as did the intervention group participants. There were no drop outs from the control group at any stage. Tables 4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 4.11 and 4.12 show the demographic details for all intervention, control and comparison group parents and their infants, all of which were Maltese.

Table 4.1

Parents As Partners – Group A (Randomized Intervention Group Participants – Demographic Details)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1.	Father	Tertiary	Podiatrist	Female	8 months	17 months
	Mother	Tertiary	Teacher			
2	Father	Post - Sec	Chef	Female	8.5 months	18.5 months
	Mother	Tertiary	Nurse			
3	Father	Tertiary	Police Inspector	Male	8 months	18 months
	Mother	Tertiary	Senior Management Bank			
4	Father	Secondary	Health & Safety officer	Female	8 months	17 months
	Mother	Tertiary	Teacher			
5	Father	Secondary	Army	Male	8 months	17 months
	Mother	Tertiary	Project Manager			
6	Father	Tertiary	Banker	Male	8 months	17 months
	Mother	Tertiary	Teacher			
7	Father	Secondary	Factory work	Female	8 months	17 months
	Mother	Secondary	Sales assistant			
8	Father	Secondary	Delivery man	Female	8 months	18 months
	Mother	Tertiary	Pharmacist			

Table 4.2

Parents As Partners – Group B (Randomized Intervention Group Participants – Demographic Details)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1.	Father	Secondary	Deliveryman	Male	8 months	18 months
	Mother	Secondary	Housewife			
2	Father	Post - Sec	Technician	Female	8 months	18 months
	Mother	Tertiary	Nurse			
3	Father	Post - Sec	Policeman	Female	8 months	18 months
	Mother	Post - Sec	Childcarer			
4	Father	Post - Sec	Businessman	Male	8 months	18 months
	Mother	Tertiary	Air Steward			
5	Father	Tertiary	Family Therapist	Female	8.5 months	18.5 months
	Mother	Post - Sec	Office administrator			
6	Father	Tertiary	Programme manager	Male	9 months	19 months
	Mother	Tertiary	Architect			
7	Father	Secondary	Carpenter	Female	8 months	17 months
	Mother	Tertiary	Social Worker			

Table 4.3

Parents As Partners – Group C (Randomized Intervention Group Participants – Demographic Details)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1.	Father	Tertiary	Legal procurator	Female	8 months	18 months
	Mother	Tertiary	Medical Rep			
2	Father	Tertiary	IT/musician	Male	8 months	18 months
	Mother	Tertiary	Accountant			
3	Father	Tertiary	Teacher	Female	8 months	17.5 months
	Mother	Tertiary	Teacher			
4	Father	Post - Sec	Banker	Female	8 months	17.5 months
	Mother	Post - Sec	Kinder teacher			
5	Father	Tertiary	Nurse	Female	8 months	18 months
	Mother	Tertiary	Physiotherapist			
6	Father	Secondary	Policeman	Female	8 months	17.5 months
	Mother	Post - Sec	LSA			
7	Father	Post - Sec	Farmer	Female	8 months	17.5 months
	Mother	Secondary	Clerk			
8	Father	Tertiary	Accountant	Female	8 months	17.5 months
	Mother	Tertiary	Architect			

Table 4.4

Parents As Partners – Group D (Randomized Intervention Group Participants – Demographic Details)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1.	Father	Secondary	Sales Manager	Female	8 months	18.5 months
	Mother	Tertiary	Social Worker			
2	Father	Secondary	Logistic Manager	Female	7.5 months	18 months
	Mother	Post - Sec	Nurse			
3	Father	Post - Sec	IT administration	Male	9 months	19 months
	Mother	Tertiary	Teacher			
4	Father	Post - Sec	Compliance anaylst	Male	8 months	18 months
	Mother	Tertiary	Disability			
5	Father	Tertiary	IT	Female	8.5 months	18.5 months
	Mother	Post - Sec	Administration/planning			
6	Father	Secondary	Gypsum	Female	8 months	18 months
	Mother	Secondary	Housewife			
7	Father	Post - Sec	Technician	Female	8 months	18 months
	Mother	Secondary	Administrative work			

Table 4.5

Parents As Partners – Group A (Randomized Control Group Participants – Demographic Details)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1.	Father	Tertiary	Diplomat	Male	8 months	17 months
	Mother	Tertiary	Notary			
2	Father	Secondary	Manager	Female	8 months	18 months
	Mother	Post - Sec	Secretary (h'wife)			
3	Father	Tertiary	Teacher/ Lecturer	Female	8 months	18 months
	Mother	Tertiary	Learning Support Assistant			
4	Father	Secondary	Property Executive	Male	8 months	17 months
	Mother	Post - Sec	Bank Manager			
5	Father	Secondary	Army	Female	8 months	17 months
	Mother	Secondary	Sales assistant			
6	Father	Tertiary	Asst. Director	Male	10 months	18.5 months
	Mother	Tertiary	Podiatrist			
7	Father	Post - Sec	Web designer	Female	8 months	17 months
	Mother	Tertiary	Marketing research			

Table 4.6

Parents As Partners – Group B (Randomized Control Group Participants – Demographic Details)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1.	Father	Tertiary	physiotherapist	Male	8 months	18 months
	Mother	Tertiary	Accountant			
2	Father	Post - Sec	Airline steward	Male	8 months	17 months
	Mother	Post - Sec	Airline steward			
3	Father	Secondary	Shipping	Female	8 months	17 months
	Mother	Post - Sec	LSA			
4	Father	Tertiary	Accountant	Male	8 months	17 months
	Mother	Tertiary	Accountant			
5	Father	Post - Sec	Printing Firm	Female	8 months	17 months
	Mother	Post - Sec	Beautician			

Table 4.7

Parents As Partners – Group C (Randomized Control Group Participants – Demographic Details)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1.	Father	Post - Sec	Office work	Male	8 months	17.5 months
	Mother	Post - Sec	Admin govt			
2	Father	Tertiary	Accountant	Male	9 months	18.5 months
	Mother	Tertiary	Lawyer			
3	Father	Post - Sec	ICT Educ syst	Female	8 months	17.5 months
	Mother	Post - Sec	ICT			
4	Father	Tertiary	IT software	Femaile	8 months	17.5 months
	Mother	Tertiary	Accountant			
5	Father	Post - Sec	Banker	Female	8 months	17 months
	Mother	Tertiary	Student MSc			

Table 4.8

Parents As Partners – Group D (Randomized Control Group Participants – Demographic Details)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1.	Father	Secondary	AFM	Male	8 months	18.5 months
	Mother	Tertiary	Social Worker			
2	Father	Post - Sec	Electrician	Male	9 months	19 months
	Mother	Tertiary	Accountant			
3	Father	Post - Sec	Airplane Technician	Male	8.5 months	18.5 months
	Mother	Secondary	Learning Support Assistant			
4	Father	Tertiary	Accountant	Female	7.5 months	18 months
	Mother	Tertiary	Teacher			
5	Father	Tertiary	IT technical support	Male	8 months	18 months
	Mother	Tertiary	Teacher			
6	Father	Secondary	Administration	Male	8 months	18 months
	Mother	Secondary	Waitress in cafeteria			
7	Father	Tertiary	Pharmacist	Male	8 months	18 months
	Mother	Tertiary	Pharmacist			
8	Father	Post - Sec	Project manager	Female	8 months	17.5 months
	Mother	Secondary	Housewife			

Table 4.9

Group A (Comparison Group Participants – Demographic Details)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1.	Father	Secondary	Delivery man /photographer	Female	8 months	17 months
	Mother	Secondary	Salesperson			
2	Father	Post - Sec	Pastry Chef	Female	8 months	17 months
	Mother	Tertiary	Teacher			
3	Father	Post - Sec	Technician	Male	8 months	17 months
	Mother	Secondary	Housewife			
4	Father	Secondary	Soldier	Male	8 months	17 months
	Mother	Tertiary	Nurse			
5	Father	Secondary	Firefighter	Female	10 months	17 months
	Mother	Tertiary	Nurse			
6	Father	Tertiary	Gen. Manager	Male	8 months	17 months
	Mother	Post - Sec	Salesperson			
7	Father	Tertiary	Software dev	Female	8 months	17 months
	Mother	Tertiary	Counsellor			
8	Father	Tertiary	Diplomat	Male	8 months	17 months
	Mother	Tertiary	Housewife			
9	Father	Tertiary	Executive fund	Female	8 months	18.5 months
	Mother	Tertiary	Teacher			
10	Father	Secondary	Carpenter	Male	10.5 months	17 months
	Mother	Post - Sec	Clerk			
11	Father	Secondary	Machine Oper	Male	8.5 months	17 months
	Mother	Secondary	No info given.			
12	Father	Post - Sec	Businessman	Female	8 months	17 months
	Mother	Tertiary	Teacher			
13	Father	Post - Sec	Staff nurse	Male	8 months	17 months
	Mother	Secondary	Housewife			
14	Father	Secondary	Bldg. Contractor	Male	8.5 months	17.5 months
	Mother	Tertiary	Teacher			

Table 4.10

Group B (Comparison Group Participants – Demographic Details)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1.	Father	Tertiary	Co-director	Male	8 months	18.5 months
	Mother	Post - Sec	Beautician			
2	Father	Tertiary	Lecturer	Male	8 months	18 months
	Mother	Tertiary	Economic Analyst			
3	Father	Tertiary	Doctor	Male	8 months	18 months
	Mother	Tertiary	Doctor			
4	Father	Secondary	Construction	Male	8 months	18 months
	Mother	Secondary	Salesgirl			
5	Father	Secondary	Tile layer	Female	10 months	19.5 months
	Mother	Post - Sec	Nurse			
6	Father	Secondary	Maintenance	Male	8 months	18 months
	Mother	Tertiary	Housewife			
7	Father	Post - Sec	Shift leader facory	Female	8 months	18 months
	Mother	Secondary	Carer			
8	Father	Secondary	System admin	Male	8 months	18 months
	Mother	Post - Sec	Nurse			
9	Father	Tertiary	Physiotherapist	Female	8 months	18 months
	Mother	Secondary	TEFL teacher			
10	Father	Tertiary	Teacher	Male	10.5 months	19.5 months
	Mother	Tertiary	Teacher			
11	Father	Post - Sec	Technician	Male	8.5 months	18 months
	Mother	Tertiary	Social worker			

Table 4.11

Group C (Comparison Group Participants)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1.	Father	Post - Sec	Technician	Female	8 months	18 months
	Mother	Tertiary	Podiatrist			
2	Father	Secondary	Delivery man	Female	8 months	18 months
	Mother	Secondary	Housewife			
3	Father	Post - Sec	Chef	Female	8 months	18 months
	Mother	Tertiary	Radiographer			
4	Father	Secondary	Maintenance	Female	8 months	17.5 months
	Mother	Post - Sec	Accounts clerk			
5	Father	Post - Sec	Sprayer	Female	8 months	18 months
	Mother	Post - Sec	Dental assistant			
6	Father	Tertiary	Manager	Female	8 months	18 months
	Mother	Tertiary	Teacher			
7	Father	Secondary	Sport trader	Female	10 months	20 months
	Mother	Tertiary	Speech Therapist			
8	Father	Tertiary	Business cons	Female	8.5 months	18.5 months
	Mother	Tertiary	Nurse			
9	Father	Tertiary	Unknown	Male	8 months	18 months
	Mother	Tertiary	Unknown			
10	Father	Secondary	Salesman	Female	8 months	18 months
	Mother	Post - Sec	Web Developer			
11	Father	Tertiary	Accounts clerk	Male	8 months	17.5 months
	Mother	Post - Sec	Admin Clerk			
12	Father	Tertiary	Dance teacher	Male	8 months	17 months
	Mother	Tertiary	Housewife			
13	Father	Tertiary	Vet	Male	8 months	17 months
	Mother	Post - Sec	Housewife			

Table 4.12

Group D (Comparison Group Participants – Demographic Details)

Couples	Parents	Education level	Career/job status	Sex of Baby	Age of Baby (Pre-test)	Age of Child (post-test)
1	Father	Secondary	Businessman	Male	8 months	18 months
	Mother	Secondary	Housewife			
2	Father	Tertiary	Property management	Female	8 months	18 months
	Mother	Tertiary	Statistician			
3	Father	Secondary	Freeport	Male	8 months	18 months
	Mother	Secondary	Careworker			
4	Father	Post - Sec	Police	Male	10 months	20 months
	Mother	Post - Sec	Police			
5	Father	Secondary	Petrol Station attendant	Male	8 months	18 months
	Mother	Post - Sec	Hairdresser			
6	Father	Post - Sec	Designer	Female	8 months	18 months
	Mother	Tertiary	Teacher			
7	Father	Tertiary	Nurse	Female	8 months	18 months
	Mother	Tertiary	Nurse			
8	Father	Secondary	Construction	Female	8 months	18 months
	Mother	Post - Sec	Ceramic Artist			
9	Father	Post - Sec	IT	Female	10.5 months	19.5 months
	Mother	Tertiary	Teacher			
10	Father	Tertiary	Accountant	Male	8.5 months	18 months
	Mother	Tertiary	Lab Scientist			

A Chi Square Test was carried out to see whether the three groups showed any demographic differences. This was possible to do with the participants' level of education, since there was enough detail to conduct such analysis. It was however not possible for job status owing to the wide variation, and especially because a large number of mothers were still on parental leave at pre-intervention stage, or in transition to re-enter employment. The data collected did not cater enough for this detail.

The Chi Square revealed that around 47% of all the participants had tertiary level education, 27% had post-secondary level of education and the remaining 26% had a secondary

level of education. These percentages varied only marginally between the 3 groups (Intervention – Control – Comparison), because the p-value (0.755) of the Chi-Square test exceeded the p = > 0.05 level of significance. Hence it is possible to generalize that there was no significant educational level discrepancy between the three groups. Table 4.13 shows the percentages for education level for each group.

Table 4.13

Education Level Across Participants of Intervention, Control and Comparison Groups

			Group			
			Intervention	Control	Comparison	Total
Education level	Secondary	Count	15	10	28	53
		Percentage	25.0%	20.0%	29.2%	25.7%
	Post-Secondary	Count	15	16	25	56
		Percentage	25.0%	32.0%	26.0%	27.2%
	Tertiary	Count	30	24	43	97
		Percentage	50.0%	48.0%	44.8%	47.1%
Total		Count	60	50	96	206
		Percentage	100.0%	100.0%	100.0%	100.0%

$X^2(4) = 1.894$, p = 0.775

Questionnaires were filled in by all the intervention and control group mothers and fathers at baseline and 2 months post intervention. From the 52 couples who did not participate in the randomisation but who agreed to fill out the questionnaires at baseline and 8 months later, 4 couples failed to complete post-measures. Notwithstanding the missing questionnaires, all the data were included as part of the statistical analysis through SPSS, and analysed in an 'Intention-

to-Treat' (ITT) analysis, according to the group that the respective participants were randomized into initially (McCoy, 2017). The inclusion and analysis of missing data through the ITT principle allows for a more accurate and unbiased evaluation of the intervention used in this RCT (Gupta, 2011; Montori & Guyatt, 2001).

Analysis of Pre- and Post- Data of Experimental, Control and Comparison Groups

Following the randomisation of participating parents into intervention (PasP), control, and comparison groups, pre- and post- data elicited from the questionnaires completed by the parents were analysed first by Two-way ANOVAs (Intervention/No-intervention x Time) with repeated measures, followed by post-hoc t-tests. Data for the analyses are based on a total of 55 couples forming part of the randomisation (the experimental and control groups), and another 48 couples in the comparison group who did not participate but agreed to fill in questionnaires. Baseline data for means and standard deviations for mothers and fathers across the three groups are provided in Table 4.14.

At this point the IBQ-R was used since children were still infants under 12 months of age.

Table 4.14

Pretest Baseline Means, Standard Deviations of Mothers and Fathers across Measures for all Groups

	Pre-test Baseline							
	Experimental		Control		Comparative		*p*-value	
	Mother	Father	Mother	Father	Mother	Father	Mother	Father
Infant Behaviour							.374	.119
M	5.40	5.09	5.26	5.13	5.25	4.81		
SD	.442	.793	.382	.582	.594	.815		
Parenting Stress Index							.060	.070
M	2.16	2.19	2.28	2.12	2.01	1.97		
SD	.472	.474	.580	.390	.438	.424		
Coparenting Agreement							.460	.681
M	4.69	4.63	5.04	4.56	4.86	4.78		
SD	1.074	1.027	.786	1,217	1.106	1.164		
Coparenting Closeness							.875	.042
M	4.81	4.83	4.67	4.42	4.73	4.99		
SD	1.018	.828	1.033	1.092	1.138	.887		
Exposure to Conflict							.183	.455
M	1.38	1.45	1.74	1.57	1.20	1.22		
SD	1.028	1.017	1.330	1.393	1.204	1.176		
Coparenting Support							.375	.034
M	4.67	4.59	4.29	4.21	4.72	4.89		
SD	1.447	.975	1.255	1.225	1.203	.996		
Coparenting Undermining							.135	.778
M	3.88	3.87	3.70	3.94	3.93	3.92		
SD	.482	.478	.571	.414	.423	.391		
Endorse Partner Parenting							.159	.735
M	4.77	5.51	4.78	5.38	5.13	5.47		
SD	.992	.530	.911	.808	.965	.513		
Division of Labor							.029	.440
M	4.15	5.15	3.78	4.66	4.67	4.93		
SD	1.318	.902	1.458	1.891	1.451	1.375		
Brief Measure of Coparenting							.438	.424
M	3.58	3.85	3.61	3.78	3.74	3.91		
SD	.519	.351	.489	.567	.660	.353		

Considering that two different measures (IBQ-R and ECBQ) were used for measuring child behaviour at baseline and follow-up owing to children's developmental age (refer to Methodology chapter under section on post-measures), the data were converted to z-scores. This was carried out by subtracting the mean from the actual score, and dividing this by the standard

deviation. The IBQ-R z-scores were then subtracted from the ECBQ z-scores in order to yield difference scores. Table 4.15 presents the post-test data, at which point the ECBQ was used since the children were over 12 months of age.

Table 4.15

Post-test Means, Standard Deviations of Mothers and Fathers across Measures for all Groups

	Post-test							
	Experimental		Control		Comparative		*p*-value	
	Mother	Father	Mother	Father	Mother	Father	Mother	Father
Child Behaviour							.732	.137
M	3.00	2.92	3.05	3.22	3.13	3.24		
SD	.622	.702	.860	.724	.748	.695		
Parenting Stress Index							.887	.598
M	2.08	2.07	2.14	2.13	2.09	2.02		
SD	.358	.470	.534	.421	.460	.452		
Coparenting Agreement							.499	.743
M	4.91	4.75	4.61	4.51	4.90	4.66		
SD	.845	.997	1.166	1.160	1.140	1.215		
Coparenting Closeness							.197	.042
M	5.06	4.89	4.55	4.21	4.76	4.85		
SD	.747	.919	1.360	1.351	1.043	1.103		
Exposure to Conflict							.023	.317
M	1.05	1.04	1.95	1.52	1.37	1.39		
SD	.729	.846	1.563	1.265	1.228	1.337		
Coparenting Support							.286	.017
M	4.84	4.94	4.35	4.14	4.57	4.81		
SD	1.043	.922	1.219	1.372	1.174	1.028		
Coparenting Undermining							.336	.495
M	.56	1.02	.67	1.35	.88	1.05		
SD	.616	1.209	1.216	.944	1.016	1.189		
Endorse Partner Parenting							.118	.294
M	4.83	5.42	4.79	5.17	5.17	5.26		
SD	.856	.392	.952	.798	.829	.588		
Division of Labor							.117	.676
M	3.87	5.08	4.10	4.82	4.54	5.06		
SD	1.358	1.001	1.384	1.593	1.508	1.151		
Brief Measure of Coparenting							.440	.651
M	3.64	3.91	3.56	3.85	3.71	3.93		
SD	.448	.270	.511	.479	.516	.388		

The significance of main effects and interaction effects of both the between-subject factors (intervention vs control) and the within-subject factors (pre-test vs follow-up) were tested for the Repeated Measures ANOVA models. Repeated Measures ANOVA models differ from General Linear models because the former accommodates correlated repeated measurements, while the latter assumes that the measurements are independent. The within-subject factors include the phase (pre/post), and the two parents (mothers/fathers), while the between-subject factors include group (experimental, control, comparison).

The ANOVAs revealed that for two out of ten measures, the experimental group improved significantly over time, whereas the control and comparison groups did not. The measures that showed statistically significant intervention effects for the experimental group (**Phase x Group)** were 'Infant/Child Behaviour' ($F(2,98)=4.443$, $p=0.014$) and 'Exposure to Conflict' ($F(2,95)=5.747$, $p=0.004$).

Interaction effects were also found to be significant for **Gender x Group** for 'Coparenting Closeness' ($F(2,99)=3.462$, $p=0.035$), 'Endorse Partner Parenting' ($F(2,99)=2.047$, $p=0.053$) and 'Division of Labor' ($F(2,99)=4.303$, $p=0.016$).

Whereas **Phase x Gender** interaction was significant for 'Coparenting Undermining' ($F(1,98)=8.193$, $p=0.005$), 'Endorse Partner Parenting' ($F(1,99)=5.121$, $p=0.026$), and 'Division of Labour' ($F(1,99)=3.927$, $p=0.050$).

Finally, **Phase** was found to be significant for 'Child Behaviour' ($F(1,98)=11.641$, $p=0.001$).

There were also statistically significant differences between fathers and mothers in their responses to three out of ten scales, namely Coparenting Agreement, Parental Distress, and Division of Labour. For the scale Coparenting Agreement, mothers were significantly more likely to agree with the statement that "*my partner and I have the same goals for our child"* (*F* (1,99) =4.880, *p*=0.029). This difference between mothers and fathers was also evident in the scale 'Parental Distress', where fathers were significantly more likely than mothers to agree with the statement that '*I often have the feeling that I cannot handle things very well',* (*F* (1,99) = 7.183, *p*=0.009). 'Division of Labor' also brought about this difference between the parents, where fathers scored significantly higher than mothers, reflecting greater involvement on their part (*F*(1,99)=29.334, *p*=0.000), and less likely to agree with the statement *'my partner does not carry his or her fair share of the parenting work (R)'.*

Post Hoc Tests: Gender Differences in Intervention Effects for Experimental, Control and Comparison Groups

Significant **Group x Phase** interactions were found for 'Child Behaviour' (F=4.443, p=.014), and for **Group x Phase** interaction for 'Exposure to Conflict' (F=5.747, p=.004). Figures 4.1 and 4.2 show the difference in mean scores from pre- to post- for each group. Figure 4.1 (Mothers) clearly shows a large decline from pre- to post- troubling child behaviours for the intervention group and stability over time in the control and comparison groups. The differences in mean scores for mothers on Child Behaviour from pre- to post- intervention were as follows: intervention 0.27, control 0.02 and comparison 0.03 at pre-, to intervention -0.018, control -0.10 and comparison 0.01 at post-.

Figure 4.1

Mean Score Differences Across Groups for Child Behaviour (Mothers)

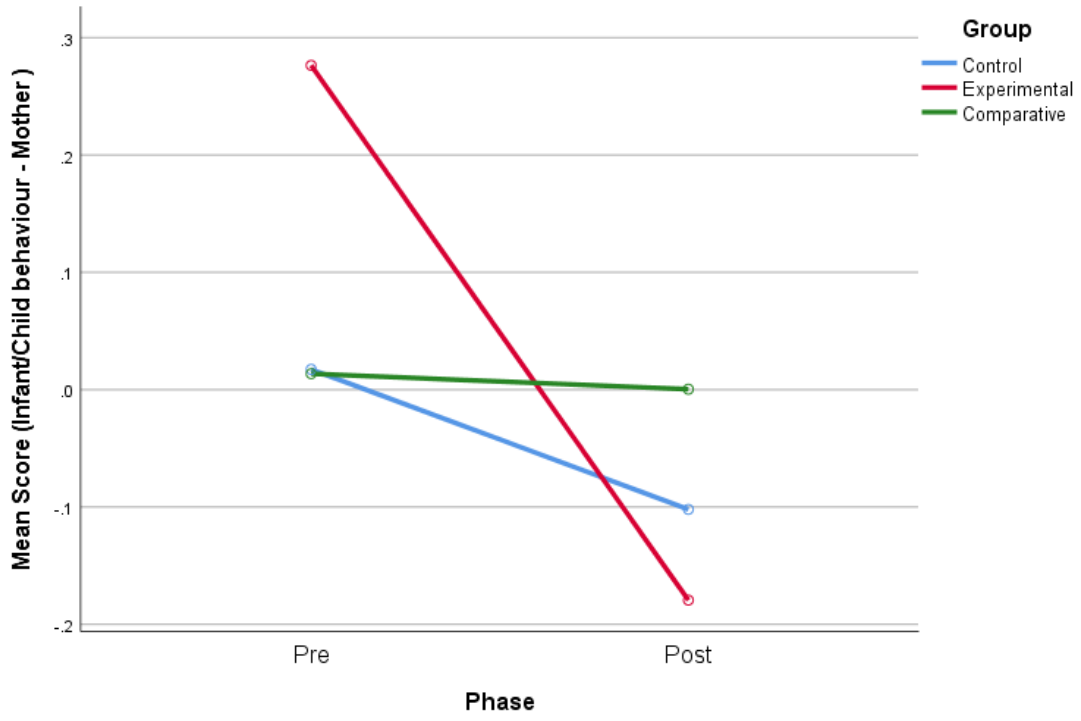


Figure 4.2 also shows a similar shift in the way that fathers described their child's behaviour from pre- to post-intervention, with the experimental group showing significant declines, and the control and comparison groups showing little (non-significant) or no change, respectively. The differences in mean scores for fathers on Child Behaviour from pre- to post-intervention were as follows: intervention 0.33, control 0.40 and comparison 0.00 at pre-, to intervention -0.46, control -0.02 and comparison -0.01 at post-.

Figure 4.2

Mean Score Differences Across Groups for Child Behaviour (Fathers)

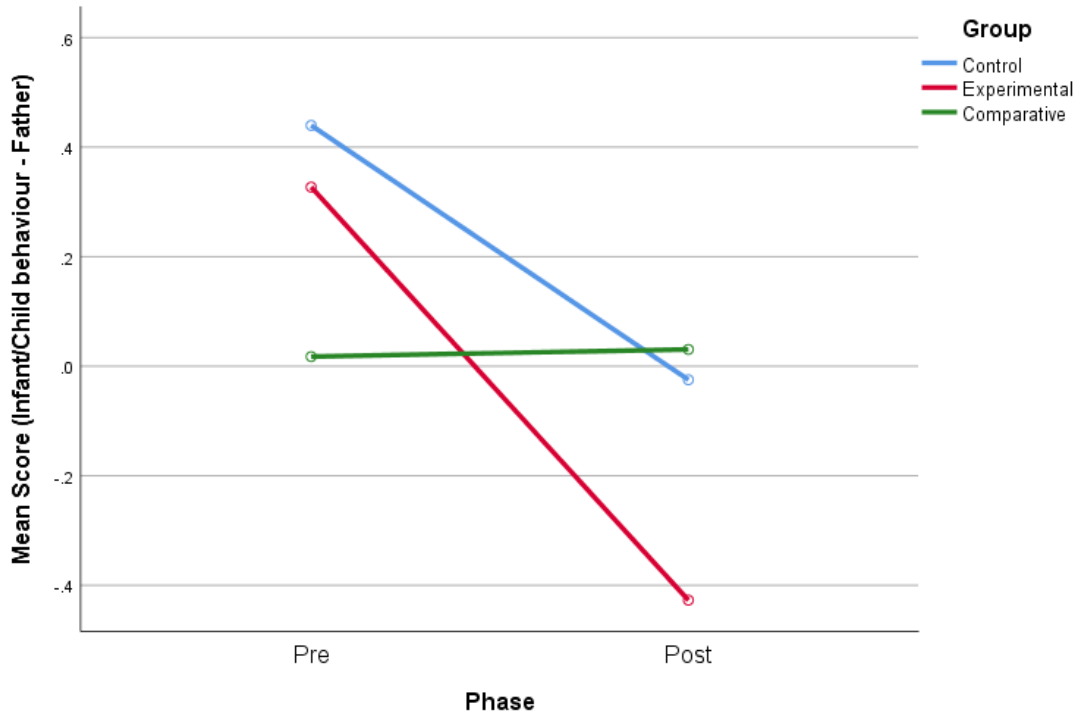


Figure 4.3 shows pre- and post- mean scores for mothers on 'Exposure to Conflict' across the three groups where the level of conflict between the parents reported by mothers in the experimental group decreases significantly, whereas mothers in the control and comparison groups report an increase in conflict between the parents. The differences in mean scores for mothers on Exposure to Conflict from pre- to post-intervention were as follows: intervention 1.32, control 1.75 and comparison 1.17 at pre-, to intervention 1.05, control 1.96 and comparison 1.36 at post-.

Figure 4.3

Mean Score Differences Across Groups for Exposure to Conflict (Mothers)

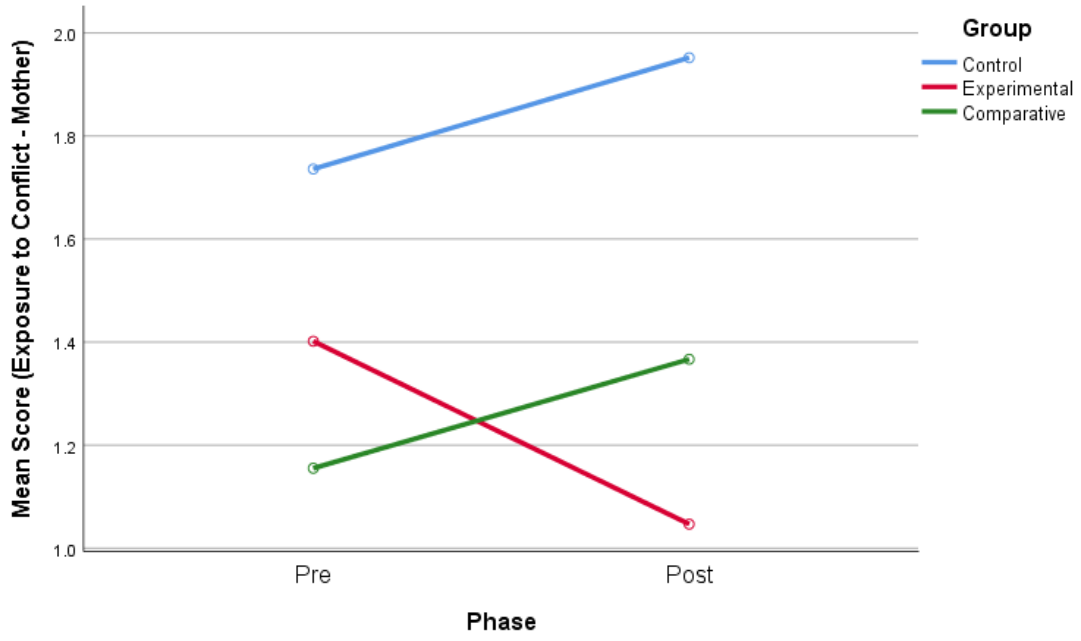
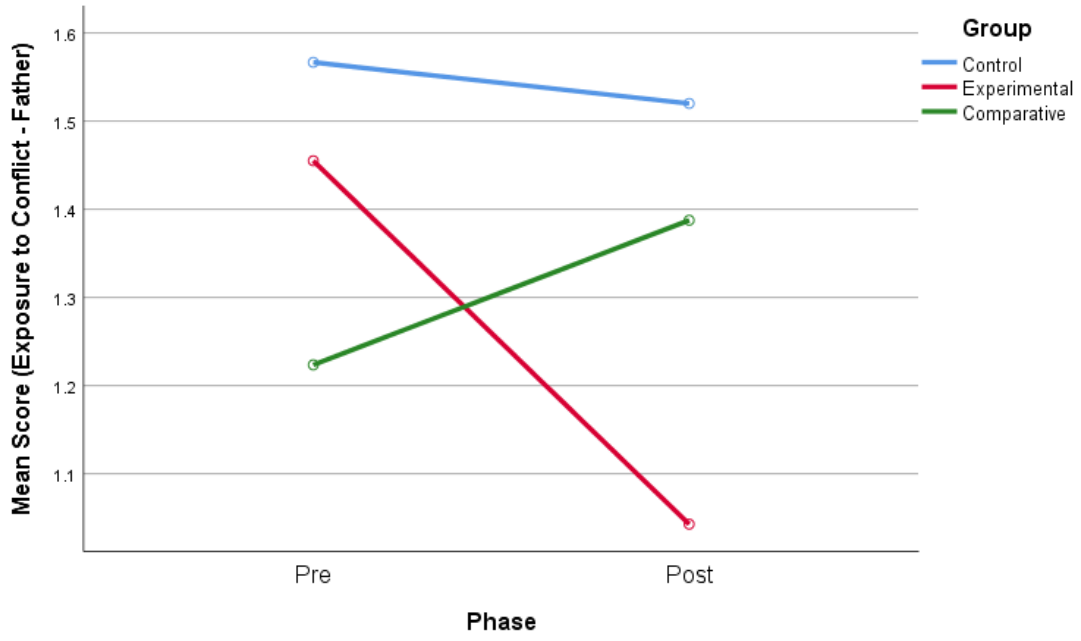


Figure 4.4 shows pre- and post- mean scores for fathers on 'Exposure to Conflict' across the three groups where the level of conflict between the parents reported by fathers decreases significantly in the experimental group, with a slight but not significant decrease in the control group, and an increase in the comparison group fathers. The differences in mean scores for fathers on Exposure to Conflict from pre- to post-intervention were as follows: intervention 1.50, control 1.57 and comparison 1.19 at pre-, to intervention 1.04, control 1.57 and comparison 1.38 at post-.

Figure 4.4

Mean Score Differences Across Groups for Exposure to Conflict (Fathers)



Intervention Effect Size

In current intervention studies, researchers have not been content simply to note whether intervention effects are statistically significant but to determine the size of the intervention effects (Cowan & Cowan, 2014).

Following the post hoc test, the Cohen's *d* effect size statistic was calculated for intervention effects. According to Cohen (1988), a *d* of 0.2 is considered to be a small effect size, whereas *d* statistics of 0.5 and 0.8 are considered to reflect medium and large effect sizes, respectively. The average effect size for couples group interventions of the type investigated in this study is approximately *d* is 0.25 (Cowan & Cowan, 2014). The effect size tests indicated that

notwithstanding the sample size of this RCT, participating in the intervention (experimental group) had a positive effect on Coparenting Support (d = 0.26 fathers in experimental group), Coparenting Agreement (group x phase interaction d = 0.39), Exposure to Conflict (group x phase x gender d =0.41), as well as Child Behaviour (group x phase interaction d = 0.43).

Analyzing the Relationship Between Exposure to Conflict and Child Behaviour

In view of the higher d on 'Exposure to Conflict' and 'Child Behaviour', a Correlation Analysis was carried out between these two variables to know whether change in one was related to the change in the other. Keeping in mind, the interactional effect in relationships, I wanted to know whether a reduction or change in conflict between the parents occurring in front of their child affected the child's reactive behaviour, and whether this in turn influenced parents' conflict in their child's presence (Pardini et al., 2008; Shaffer et al., 2013). For 'Exposure to Conflict', a positive value implied an increase in conflict happening in front of the child, while a negative value implied a reduction of conflict between the parents. For the 'Child's Behaviour (negative reactivity), a positive score implied an increase in negative behaviour, while a negative score implied a decrease in child's negative reactivity.

Only the experimental group scores were considered since this is where the significance was most evident. The post-measures were subtracted from the pre-measures to find the difference for both 'Exposure to Conflict' and 'Child Behaviour'. Doing so gave a score for 'change', thus generating a new variable for easier use in the analysis. The correlation analysis was carried out with the scores representing change.

Table 4.16 below displays a positive relationship between the two variables, which implies that an increase in exposure to couple conflict is associated with the child's negative reactivity, and vice versa. However this positive relationship was not found to be significant since the *p*-value exceeds the .05 level of significance (p-value .262).

Table 4.16

Correlation Analysis Between Child's Negative Reactivity and Exposure to Couple Conflict

		Exposure to Couple Conflict
Child's Negative Reactivity	Pearson Correlation	.150
	P-value	.262
	Sample Size	55

Despite there not being a statistically significant relationship between 'Exposure to Conflict' and 'Child Behaviour' (negative reactivity), Table 4.17 shows that there are more negative scores for 'Exposure to Conflict' (31 couples) than positive scores (17 couples), indicating a larger proportion of couples whose conflict was happening less in front of their child/ren. There are also more negative scores for child's negative reactivity (33 couples), rather than positive scores (15 couples over 0), indicating a larger proportion of children described by the participating parents as showing reduced negative reactivity. A total of 7 couples indicated scores on the border between high and low conflict exposure to their child (0 score), although 5 of these couples scored low when describing their child's reactivity.

Table 4.17

Distribution of Randomised Couples who Scored on Negative Reactivity and Exposure to Conflict at Post-Intervention Period.

	Low Exposure to Conflict	High Exposure to Conflict
High Negative Reactivity	9	6
Low Negative Reactivity	22	11
On the border between High and Low Negative Reactivity	7	

How Intervention Effects Produce Change in Children's Behaviour

Direct and indirect effects of change were examined in the present study using the SmartPls structural equation model. Structural Equation Models (SEM) are statistical techniques that enable us to trace the pathways through which interventions have their effects. One advantage of these models is that instead of examining one measure at a time, they allow for the creation of multiple measures of a single construct encapsulated in what is called a latent variable. Multiple regressions can determine whether a number of independent variables are related to a given outcome, but they cannot determine the relationships among the independent variables. Secondly, although Structural Equation models are essentially sets of multiple regressions, they have the added flexibility of being able to examine the links among all the latent variables in the equation, not simply whether ABC are related to D, but whether A is

related to B, C, and D, and whether B is related to C and D, and whether C is related to D. A third advantage is that they enable us to determine whether the direct effects of an intervention (e.g., on personal distress or co-parent communication) also leads to indirect effects. That is, instead of examining intervention effects one at a time, we can determine whether there is a statistically significant pathway leading from participation in PasP through the effects on Coparenting Conflict, Dysfunctional Parent-Child Interaction and Reactive Child Behaviour. What has been relatively ignored in intervention analyses is that tests of direct effects do not pay attention to anything else we know about the data set. That is, they simply ask whether, if all we know about the children of participants is whether their parents were in an program group or a control group, could we predict whether they will have higher or lower scores on a behavior problem checklist? (Hair et al., 2016). But a number of additional key things are known about the participants in this study that can flesh out the story of Coparenting Conflict, Dysfunctional Parent-Child Interaction and Reactive Child Behaviour as they change over time.

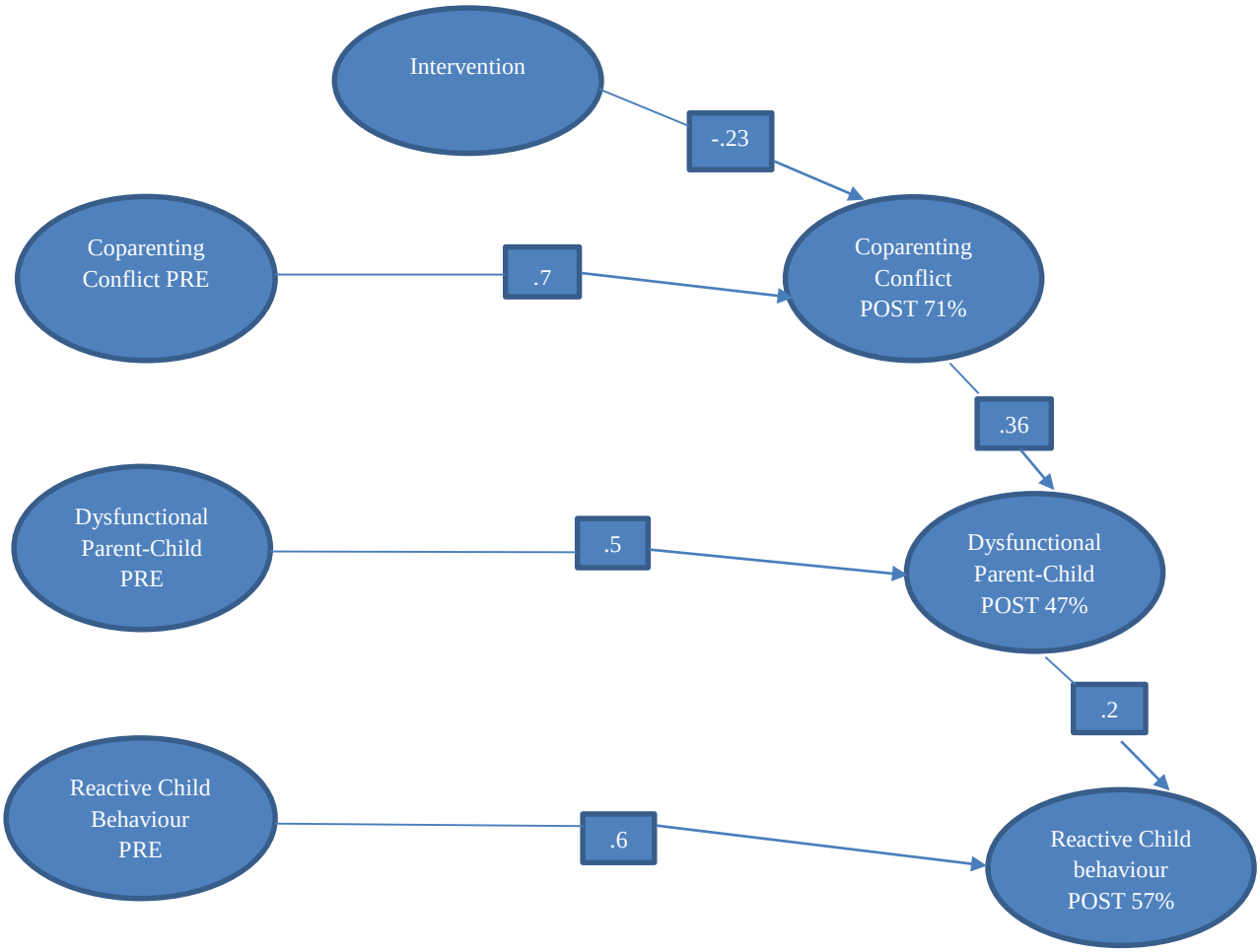
The decision to choose SmartPLS software for conducting SEM analyses was because (1) it is very user-friendly and (2) the Partial Least Squares approach to SEM is particularly strong compared to other approaches in assessing the amount of variance in the outcomes predicted by the independent latent variables (Hair et al., 2016).

The ellipses in Figure 4.5 represent latent variable measures of each construct at pre- and post- intervention, with each latent variable comprised of mothers' scores and fathers' perceptions of coparenting conflict, dysfunctional parent-child relationship, and reactive child behavior. A dummy variable was used to differentiate participants in the intervention from participants in the control condition. All the paths in the model were statistically significant.

The model shows that baseline measures of each construct are significantly associated with post-test measures (Beta weights .78, .56, .61). Most importantly, as in the previously mentioned Repeated Measures ANOVAs, the path model revealed that there was a statistically significant direct effect on reductions in coparenting conflict, one of the main foci of the intervention (Beta=-.23). The path model describes how when participants reported a decrease in couple conflict, they showed a significant reduction in dysfunctional parent-child interaction. Moreover, when they showed a significant reduction in dysfunctional parent-child interaction, they also reported a reduction in child behaviour problems (negative reactivity). As can be observed in the 'Path Model' for this RCT, the percentages shown in the POST constructs represent the amount of variation in the particular measure accounted for by the previous measures entered into the structural model at PRE.

Figure 4.5

Path Model for RCT Data



Conclusion

This chapter has highlighted the salient findings emerging from the RCT, the most significant of which reflected a positive change (reduction) in the parent participants' reporting of conflict between them happening in the presence of their child/ren, a positive change in the child's behaviour (reduction in negative affectivity), an overall improvement on couple

coparenting, and support for significant changes in the parents who participated in the intervention. A discussion of these findings follows in the next chapter.

CHAPTER 5

DISCUSSION

Introduction

This chapter gives an overview of the main objectives of this study. Salient findings from the RCT are discussed in light of existing research. Implications of the findings for family intervention policy are discussed. Narrative examples from the interventions will illustrate some of the main points. The study's strengths and limitations are also put forward, and directions for future research are highlighted.

Main Objective of the Study

The main objective of this study was to evaluate whether the 'Parents as Partners' coparenting programme offered through an RCT impacted parenting effectiveness and their infants' behaviour. The intervention was delivered to participating parents of infants who were described by them as having highly reactive temperaments during the standard 8-month post-natal visit to Well Baby Clinics across Malta, and the intervention parents' and their babies were compared to a control and a comparison group, neither of which received the parenting programme. The control group were followed by the same case manager as the intervention group participants, whereas the comparison group were not followed, considering that they had only accepted to fill in questionnaires and not to participate in the RCT. This particular cohort of parents was chosen based on research indicating that infants with a highly reactive temperament and their parents are at greater risk of developing behavioural and mental health problems. The main findings of this RCT are outlined below.

Salient Findings

An analysis of variance (ANOVA), post-hoc tests, and the examination of intervention effects between the different measures across the experimental, control and comparison groups to establish whether there were any differences in outcome for parents attending the PasP coparenting programme vis-a-vis those who did not, indicated that the intervention positively affected both mothers and fathers and their infants. The intervention helped parents to become more effective in their parenting abilities particularly through their reported decrease in conflict as a couple and as co-parents, which reduced the level of dysfunctional parent-child interaction. This change in dysfunctional interaction between parent and child was also related to decreased negative reactivity in the child, a positive change in the child's behaviour as reported by the parents. Such a significant change in trajectory was not found in the control and comparison groups, with only a minor non-significant difference in the control group, and a deterioration in the comparison group.

Mothers and fathers in the control group both reported a non-significant decrease in child's negative behaviour, whereas mothers and fathers in the comparison group reported an increase in the child's exposure to the parents' conflict. It was initially considered that the improvement in child behaviour could have been connected to the child's maturational process and stability across time (Bornstein et al., 2015), yet if this were to be the case, the comparison group would have also shown a similar increase, which was not the case. Thus, it is suggested that the slight improvement in child behaviour as reported by parents randomly assigned to the control group may possibly be reflective of parents who were already originally motivated to change or invest in their parenting considering their interest in the study. These parents were

being supported by the same case manager in a similar way as the intervention group parents. The case manager used to attempt to check-in with both parents in the control group whenever she called in. Therefore, in addition to the parents' original motivation to change, the case manager's support appears to have had a positive effect on the control group participants, unlike the comparison group parents who received no additional support from the case manager, and who reported no change in their child's negative behaviour over time. These latter parents represented 48 couples in total vis-a-vis the experimental and control group couples who totalled 55 couples.

Moreover, mothers as well as fathers in the comparison group also reported a substantial but not significant increase in child's exposure to conflict between the parents. As already mentioned in the Methodology chapter, the parents belonging to this group had particular characteristics. The stress levels in the comparison group were clearly likely to have been higher overall, and this makes sense of the negative effect this had on conflict in their relationship as couples. This outcome supports existing research by Berryhill et al. (2016) suggesting that parenting stress was considered to be a mediating factor in the relationship between the parents' perception of their child's emotionality, and their couple relationship quality. This research suggested that parental stress and their negative perception of the child as having negative emotionality was predictive of relationship difficulties (Berryhill et al., 2016).

Interestingly a slight non-significant increase in exposure to conflict was also reported by mothers in the control group. Similar to a number of intervention group participating mothers at pre-intervention stage, not all were having adequate support from their husbands/the fathers, so that a number of these mothers were having to care for a highly reactive infant for long stretches

of hours alone. Yet unlike the intervention group participating mothers, whose partners became more supportive throughout the PasP coparenting programme, the control group mothers did not have the opportunity to experience the same support from their partners, which may reflect the increase in conflict that they reported at post-intervention stage. So, despite the case manager support that was beneficial in some way on reported non-significant improvements in child behaviour, it was not enough to make a difference to conflict in the couple relationship.

These findings suggest that when participants were supported as partners and as parents, the level of conflict in their relationship decreased. This enabled them to be more supportive of each other, reduce their conflict in front of their child, which was followed by their descriptions of reductions in their child's negative reactivity and behaviour.

Understanding the Findings in the Maltese Context within a Family Systems Theoretical Framework

The findings support the relevance of the Family Systems Theoretical framework, especially considering the interactive nature of systems and the way that one part of the system effects other parts of the system. The intervention 'Parents as Partners' (PasP) carried out with the couple system, not only reduced coparenting conflict, improving each parent's relationship with the child, but also effected the child system through the perceived change in the child's behaviour. This clearly reflects a transformation in the system as a result of interacting with it (Meadows, 2008). These findings support other research using PasP or 'Supporting Father Involvement Programme' (as it is referred to in the United States) where the intervention with

parents has had a similar effect, such as in the US with couples referred by the community and child welfare (Pruett et al., 2019) and the UK with low-income families (Casey et al., 2017).

Such an implication in the Maltese context cannot be underestimated. The Maltese context is one that has transitioned as a result of globalisation, education and changes in the labour market especially as a result of women's increased participation (Abela, 2016). With this comes the necessity for more support to balance more effectively work and family life, hence the importance of the father's increased involvement in parenting. The Maltese fathers who belonged to the intervention group were more openly involved and supportive of the mothers as became evident from their responses at post intervention stage.

The following section discusses the findings in the context of existing research.

Relevance and Meaning of Findings to Existing Research

Supporting couples in their role as parents by involving fathers (Cowan, et al., 2007; Cowan & Cowan, 2008; Cowan & Cowan, 2018) and nourishing both the couple relationship and the relationship of each parent with their child was the main focus of the PasP coparenting programme. According to previous research by Pruett et al. (2019) (p. 63), the intervention appeared to help 'parents systemically by linking their behaviour toward each other to their behaviour toward the child'. As the findings of this present study suggest, parents in the Maltese intervention groups also became more supportive towards each other, reduced their conflict in front of their child, and described their child as less reactive in their second year of life. Previous studies using PasP in the United States and the United Kingdom, (Casey et al., 2017; Cowan et

al., 2005a; Pruett et al., 2019) showed that when an intervention is carried out with both parents as couples, this has a direct effect on reducing couple conflict, which in turn has an effect on the quality of the parent-child relationships, resulting in reductions in negative child behavior. From a family systems perspective, it is evident that change in one aspect of the family has cascading effects throughout the system (Masten, 2018). Supporting couples in their coparenting and couple relationship, interactional effects on coparenting and involving fathers will be further highlighted and discussed in view of the findings and existing research.

Supporting Couples in their Coparenting and Couple Relationship

The challenges and stresses for couples who become parents is widely known, yet many a time, not enough attention is given to supporting them in their role. Frequently they are left to their own devices to cope and figure things out during the child's formative years. Daily stressors, couple relationship difficulties and challenges, in addition to having a child with a reactive temperament, accumulate and become additional risk factors that have been found to be detrimental to their coparenting ability and quality (McDaniel et al., 2018). Coparenting quality is impacted by different stressors, which is associated with mothers' and fathers' perceptions of their child's temperament as being more negative. This was especially the case in the context of mothers' dissatisfaction with their coparenting relationship, and fathers' unhappiness with the quality of their marital relationship (Burney & Leerkes, 2010). The latter is also reflected in this study's results, where mothers in the control and comparison groups reported an increase in exposure to conflict between the parents post intervention, as did fathers in the comparison group. The findings of this research suggest that when parents are given support to strengthen

their relationships as partners and as co-parents, their relationship quality improves to the point of reducing conflict happening in front of their child and enhancing their coparenting effectiveness. Higher levels of conflict between the parenting partners has serious implications not only for the well-being of the couple and their relationship sustainability, but for their tendency to use harsh parenting practices, placing their child/ren at even greater risk for developing problematic behaviours and abuse (Cummings & Davies, 2010). In fact, while a study by Hong et al. (2015), suggested that 'difficult' children elicited more negative control from their parents because of dysregulation problems, including restrictive control and withdrawing warmth, it is also true that the child's ability to self-regulate is also affected by the quality of the parent-child relationship/s in a bi-directional manner (Carlon et al., 2010), an outcome even more crucial for children with highly reactive temperaments that are considered from early on to be children-at-risk (Bayer & Rozkiewicza, 2015).

An Interactional Effect on Coparenting

The interactional effects of the mother-father / couple relationship and the relationship of each parent with the child, are complex and influence the child's developmental outcomes (Cowan & Cowan, 2006; Shaffer et al., 2013). For instance, couple and parental distress, when not alleviated, may bring about or exacerbate other difficulties such as depressive symptoms in the parents. We could observe this in one of the couples groups:

> In one of the parenting groups, a young mother struggled with parenting her child, feeling incompetent and depressed, as well as unsupported by her husband, who

> in turn withdrew because he did not know how to cope with her and with the baby who was frequently inconsolable and extremely demanding. Their distress as a couple was high, and they were considering separation. The maternal depression, the uninvolved father, the 'difficult' baby, were all interacting with each other, making it extremely difficult for this family to cope, let alone co-parent effectively.

A longitudinal study on parental depressive symptoms and coparenting suggested that depressive symptoms in the mother were more likely to influence coparenting, with the risk of jeopardizing healthy family relationships. This negative spillover from parent to couple relationship is crucial for the wellbeing and development of the child (Tissot et al., 2017). Furthermore, a similar study on coparenting behaviours postpartum suggested that coparenting support was an important mediator between depressive symptoms in mothers and symptoms in the child (Tissot et al., 2016). Yet more importantly, this negative cascade of maternal depression on children can be buffered if fathers have a positive parenting relationship with the child. (Vakrat et al., 2018).

Involving Fathers

From the previous couple example, considering the impact of depression on the coparenting relationship, and the impact of the latter on depressive symptoms and child outcome, supporting the couple by involving the father through enhancing his self-efficacy, and focusing on the relationship between the partners was crucial. A cross-sectional study carried out in Hong Kong found that the satisfaction in the couple relationship was also considered to having a

moderating effect on fathers' sense of self-efficacy and involvement with the child (Kwok et al., 2012).

The majority of parents who attended the PasP in this study reported improved support from their partners, who endorsed each other's parenting. The results also showed a reduction in fathers endorsing the mothers' parenting in both the control and comparison groups. A number of couples who participated in this study's intervention group commented that they had begun to support each other more, to spend more quality time together, and to validate each other's efforts, *despite having different ways of parenting*. Two of the fathers actually made drastic job changes so they could be more involved in their role as parents. A few had never participated in the care of their infant, not even with basic tasks such as feeds, nappy changes, bath times, leaving mothers to care for the infants mostly alone. What was interesting to notice in the parents' reporting post-intervention was how fathers in the intervention group tended to show even more favourable outcomes than mothers, particularly on their reports of reduced conflict in front of the child, and on endorsing their partner's parenting and coparenting support. This can be linked to previous literature which states that when men are given the opportunity to be involved in parenting, they do well (Burgess, 2009; McHale & Lindahl, 2011).

Research continues to show and confirm the importance of the father's positive involvement in the family, and the positive impact this has not only on the child's development, and the father-child relationship, but also for the mother who feels more supported by him in her own relationship with her child (Burgess, 2009; McHale & Lindahl, 2011). Involving the father

also supports the couple relationship, which is the basis on which to build the coparenting relationship, which ultimately has the power to affect the child's development and well being. Unfortunately, many fathers are excluded, marginalized, and not supported to take on this role more actively. It is not uncommon that fathers, notwithstanding their own motivation to be involved, are hindered from taking on an active role in parenting because of structural or individual factors (Norman, 2017). How might parenting programmes understand the importance of having both parents present? How might it be different if services for children, that are usually predominantly attended by mothers with children, decided to start involving fathers more? Evidence of father's attendance in parenting programmes shows that they are under-represented (Tully et al., 2017), and that there may be a number of factors that need to be considered that would support better participation of fathers (Glynn & Dale, 2016). Furthermore, how might professionals also be trained to keep fathers in mind in their practice? Gatekeeping by mothers as well as professionals may at times be one of the main impeding factors to fathers' participation in parenting programmes and other services attended mostly by mothers (Glynn & Dale, 2016; Torr, 2003). Finally, what implications do these findings have for policy and practice?

Implications for Policy and Practice

There are a number of implications for policy stemming from this study's results. In contrast with all the funds devoted to establishing parenting programmes attended by mothers, there are clear benefits for both parents and their infants/toddlers when attending the 'Parents as Partners' coparenting programme. The intervention in this study began when the children were aged approximately one year old, and post-measures took place two months following the end of

the 4 month (16-week) programme, when the children were approximately 1.5 years of age. Parents were well engaged throughout the programme and talked about how attending a group with clinically trained facilitators where they shared their experiences with other parents was beneficial for them and provided them with support. Moreover, the fact that measures post research took place two months after the groups had ended, reflected that not only did parents remain engaged, but that positive outcomes were present after the termination of the intervention. An implication for policy is that of providing couples with the opportunity to benefit from the professionally-run 'Parents as Partners' coparenting programme at an early stage of their parenting experience. As a result of the National Strategic Policy for Positive Parenting put forward in 2016 (Abela & Grech Lanfranco, 2016) a number of parenting programmes have already started to be implemented as was mentioned earlier in the Literature Review chapter under the section on local services.

Second, the early interventive and preventive nature of this programme elicited a lot of interest from the majority of parents. Parents want these programmes, and they want them early, at the start of their parenting experience. This was communicated by most of the parents themselves in this study as well as in the study by Borg (2014). Intervening early, moreso in circumstances where there are additional potential risks of having infants with a reactive temperament, or couples that may be struggling in their relationship as they attempt to cope as partners and as parents is important for supporting parents early to avoid couple and relationship stress and breakdown, as well as to avoid potential risks for the child's development. The findings suggest that targeting young couples as they transition into parenthood, and during their first year as parents, particularly those who may already show signs of a conflictual relationship

or a challenging child, is crucial. In fact, a pilot study using an RCT will be set into motion in Autumn 2020, where parents of infants recruited from the Maltese Perinatal Clinic, will be offered the possibility of attending the PasP, if they would be experiencing conflict in their relationship. This study will be led by the Department of Family Studies within the Faculty for Social Wellbeing at the University of Malta, in conjunction with the Perinatal Clinic within the Ministry of Health, at Mater Dei Hospital. The intervention will be carried out online because of the Covid-19 pandemic. The programme can also be offered within childcare settings to similar couples as another possibility for further implementation.

Third, this research has highlighted the positive impact of the intervention on the couple relationship and on coparenting more effectively. When couples parent more effectively together, they tend to be more satisfied with their family relationships and their child stands to benefit. The impact on the child's future wellbeing and development is multifold, providing increased family stability, reducing behavioural risks, enabling better self-regulation, and ultimately providing a healthier future citizen. Investing in supporting parents to coparent their child/ren more effectively is therefore an investment that is cost-effective, given its benefits for parents, children, their families and society.

A fourth implication connected to the positive impact on the couple as parents of highly reactive infants/toddlers is that because of the potentially greater challenges involved in parenting such a child, the 'Parents as Partners' coparenting programme has shown that the child's behaviour was positively impacted by the intervention with parents. This means that such a programme ultimately helps to reduce risks of potential child maltreatment, placing less pressure on child protective services.

A fifth implication is supporting professionals working with parents and children in their practice, by encouraging them to involve different members of the system, most especially keeping fathers in mind. This research has provided evidence that involving fathers does work and is important for relationships with mothers and children. Professional training and practice must emphasize and reflect this, especially in the context of services that focus or work more with mothers, where fathers have typically been excluded. In Autumn 2020, the Tavistock Relationships, London, in collaboration with the Ministry for the Family, Children's Rights and Social Solidarity in Malta, will be offering a 'train the trainers' course online for the existing professionals who co-facilitated the PasP intervention groups in this study, following which other professionals can continue to be trained to deliver the same programme.

The intervention in this research was carried out with couples. Notwithstanding this, gender-role expectations were present, and gatekeeping mostly by mothers over father's involvement was still somewhat present. Breaking the mould of traditional gender-role expectations in parenting is necessary in order to give space for both mothers and fathers to be more equally involved in their developing family. Hence, a sixth implication is that of starting them young, starting to educate our children early in life, in our homes, workplaces and within the education system, as well as through media messages, that parenting in the context of heterosexual relationships is not connected to one gender, but is about the participation of both mothers and fathers or other parenting figures.

The intervention PasP also poses a number of challenges in connection to its implementation. The programme is expensive to run considering the fact that it is facilitated by clinically trained professionals. It would require a hefty budget or sufficient funding to put

forward, also considering the backup support needed by childminders, a service that was priceless during the intervention. Moreover, the PasP is a lengthy programme of 16 weeks of 2 hour weekly sessions, involving a lot of hours of preparation, planning, and consulation behind the scenes, making it extremely time-consuming. Notwithstanding the lengthy programme, where most of the time parents initially wondered whether they were able to commit to 4 months of weekly sessions, the majority of parents did not want the programme to end and wished to be able to continue to meet up or keep contact. The latter point reflects an aspect of the beneficial effects of a longer duration programme, that provides parents with a good level quality of the support they so much needed.

Study Strengths

This research has a number of strengths, with regard to the process involved prior to the intervention, the parenting programme in use, mode of delivery, supporting system, and measures.

Participants were recruited from all 6 Well Baby Clinics in Malta, covering the whole island. Most parents representing primarily the middle to lower strata of society attend these clinics for their infants' post-natal visits, implying that the vast spectrum of parents were reached during the recruitment phase, for which response was high.

Recruitment was carried out almost exclusively by the researcher, which allowed for consistency in the way people were approached, what they were told about the study, and how they were randomised and followed up.

Randomisation followed an appropriate design and procedure to ensure that allocation to the different groups (intervention and control) were carried out in an organised manner and time frame. Blind random assignment was made use of in order to avoid any risk of bias in selection to the study conditions.

All co-facilitators followed the same training in 'Parents as Partners' in the UK, all having prior clinical experience in the field, and all following the same manual for the sake of fidelity to the programme. Moreover, all co-facilitators received regular supervision through Zoom by the same Tavistock Relationships supervisor along the duration of the parenting programmes. Notably, the supervisor was also Maltese, which gave the added advantage of language and culture attunement. All parenting group sessions were videotaped and used for the sake of the supervision sessions.

The case manager, a clinical psychologist by profession, was an integral part of the support system along the process of the 16 parenting programme sessions. The fact that the same case manager carried out this role across all four intervention groups and collaborated with all of the group facilitators allowed for consistency in support provided and observations made.

Another strength in the research was further provision of support through childminding services as well as snacks provided to welcome participating parents at each group meeting. These helped create a welcoming atmosphere for the participants and co-facilitators, which helped with the retention of participants in the programme, made all the more possible through funding received.

Finally, appropriate assessment measures were used prior to and following the intervention, measures that were previously standardized and sensitive to culture.

Study Limitations

A major limitation of this study was the size of the sample, which was for practical reasons rather small. Ideally more couples could have been recruited, and more parenting programme groups carried out with pre- and post- measures in order to build a larger evidence base. Nonetheless, even with the present sample size, statistically significant findings emerged that provide important evidence with regard to the underlying rationale and outcomes of the study, and for detailing some important implications of the results.

Another limitation was the duration of two months used for post-testing following the completion of the intervention. Ideally follow-up could have taken place at a later point in time to measure whether effects of the programme were longer lasting, but practical considerations made this impossible.

Measures used, whilst being the appropriate choice for the study, were all translated into the Maltese language to avoid the risk of diminished understanding of certain language used, and this was supported by careful attention to back translation for the sake of consistency. Nevertheless, despite the validation process through a statistical analysis, some discrepancies on individual test items would need further refinement.

A potentially biasing and limiting factor was that as researcher and group co-facilitator in the PasP, I was not totally blind to the conditions of the research because of my involvement, despite all the attention to limiting bias throughout the process of study.

Also a potential limitation was that despite the co-facilitators receiving the same training from the Tavistock Relationships, having the same supervision provided by the same Maltese supervisor, and following the same PasP manual, each co-facilitator came with his or her own individuality, as did also each co-facilitating pair, implying a possible bias and/or qualitative difference in the group delivery.

Finally, it was also a limitation not to include parents from private clinics and Gozo in the recruitment phase. This would have ensured a more complete representation of all sectors of the Maltese population including the population of the island of Gozo, which forms part of the Maltese archipelago.

Directions for Future Research

In view of the study outcomes, implications, strengths as well as limitations, I make a number of potential recommendations for future research and directions for family services.

A longitudinal study with the participating parents from this research would be ideal. Participants gave their consent to a five-year follow-up, which provides sufficient time to administer follow-up measures across the intervention, control and comparison group participants. It would be interesting to see how each of these group participants are coping in their relationship as a couple, their coparenting, and their separate relationships with their

developing child and what those have to do with their assessments of their child's behaviour. Longer range follow-up data would give the opportunity to know whether the effects of the intervention are longer lasting, whether couples are still parenting together, and whether their children have developed any new behavioural strengths or difficulties, among other things, in light of the known potential difficulties experienced later on by those who were babies with a challenging temperament.

A qualitative study could also be carried out with previous participating parents either through a focus group/s or through examination of video recordings of the sessions, to understand more about parents' experiences in a group setting as part of 'Parents as Partners'.

Depictions of superpower parents were made by all mothers and fathers in the respective groups, and pictures of these depictions were kept. These pictures could provide an interesting basis of understanding with regard to how mothers and fathers perceived their role as parents through art, at least when the babies were young, and what these messages might bring to the parenting as partners enterprise.

Case manager notes could provide another interesting source of material that helps to generate the experiences of intervention and control group participants through phone calls; these notes might be examined to see whether this experience was similar or different for each group.

An interesting contribution to future professional training would be that of exploring different co-facilitating experiences with different group facilitators in Malta and the UK. How does the experience of co-facilitating the PasP change when facilitating with different partners? How do the facilitators' own parenting and partner experiences affect their contribution and

position in the parenting programme? These and further questions could be explored qualitatively.

A longitudinal qualitative study with the comparison group can give us more insight about a group of parents who are hard to reach and who end up in a dire situation. Why would they find it difficult to take preventive measures and what would change their mind with hindsight? What kind of interventions would they consider more attractive for them? Some parents evidently may never end up participating in a preventive programme as a result of the severity of issues they face, and may require different and more intensive forms of intervention (Benzies & Barker, 2016).

Finally, 'Parents as Partners' as a parenting programme, which places importance on the involvement of fathers, the couple relationship, parenting styles, and three-generational patterns could also be tested with parents across other different contexts, and with specific populations. An interesting area would be to explore PasP with foster or adoptive parents, parents of transgender children, parents of children on the autistic spectrum, same sex parents, other forms of co-caring dyads such as that of a lone parent and her mother, as well as parents of different cultural backgrounds and beliefs.

Conclusion

Supporting couples in their relationship as partners and parents is fundamental to the future of the family and child wellbeing. The study findings reveal that when parents feel supported, they report less conflict happening in front of their child, and they experience their

child's behaviour as less negative and challenging. Decreased conflict between parents reduces the level of risk of harsh and/or abusive parenting, more so, when a child's highly reactive behaviour may be more likely to challenge parents' patience owing to the bi-directional nature of those relationships (Cowan & Cowan, 2006; Shaffer et al., 2013). Hence, parents' reduced conflict, may also reduce the risk that the child will continue to develop behavioural problems as he/she grows. The unique contribution of this study is reflected in a change in the way parents experienced and described their highly reactive infants at follow-up, implying that with this specific group of children, change was evident, notwithstanding the fact that the intervention was directed to the relationship between the parents. This provides evidence that focusing on the couple and their relationships as partners and as parents fosters their coparenting capacity and eventually, their young children's outcomes.

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APPENDICES

APPENDIX A

INFORMATION FORM

PARENTS INITIAL (1R) DOCUMENT B1

Title of Study: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?*

Name of researcher: Ms. Ingrid Grech Lanfranco (Counselling Psychologist & Family Therapist, Department of Family Studies, University of Malta)

Name of Supervisor: Prof. Angela Abela (Clinical Psychologist & Family Therapist, Department of Family Studies, University of Malta).

Purpose of data collection: PhD.

The Research:

To date there have been no studies of parenting programmes with parents or co-caring adults of infants that study how parents with different styles react to infants with different temperaments. Considering the fact that infant temperament affects the future development of the child, and the fact that parents and children affect each other continuously, I am interested in measures of infant temperament as well as parental stress, alongside parents' ability to work together as parents.

At this stage of my research I am interested in assessing how you see your infant's temperament. The appropriate age for measuring infant temperament is estimated to be around the time the child reaches 8 months of age, and therefore I kindly ask that you complete the Infant Behaviour Questionnaire – Revised (IBQ-R) which is a standardized test measuring temperament.

I will contact you again to give you feedback on the test outcome, with the possibility of inviting you to further participate in my research and any future study that might be of interest and relevance to you. Your personal details and information will be kept private and protected at all times. Should you have any further queries you are free to contact me on: ingrid-grech-lanfranco@um.edu.mt

Signature of Researcher	Signature of Supervisor
Ms. Ingrid Grech Lanfranco	Prof. Angela Abela.

FORMOLA TA' INFORMAZZJONI
ĠENITURI BIDU (1R) DOKUMENT B1

Titlu tal-istudju: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?' –* ***'Programmi ta' parenting flimkien li jsiru kmieni, jgħinu r-relazzjoni bejn it-temperament tat-trabi u l-istili ta' parenting li jintużaw?'***

Isem ta' min qed jagħmel ir-riċerka: Ms Ingrid Grech Lanfranco (Psikologa & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Isem is-Supervisor: Prof. Angela Abela (Psikologa Klinika & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Raġuni għall-kollezzjoni ta' informazzjoni: PhD.

Ir-Riċerka:

Sal-lum ma kien hemm ebda studji ta' programmi mal-ġenituri jew adulti ta' trabi li qed irabbu flimkien, li jistudjaw kif il-ġenituri bi stili differenti jirreaġixxu għat-trabi b'temperament differenti. Meta wieħed iqis il-fatt li t-temperament tat-tarbija taffettwa l-iżvilupp futur tat-tfal, u l-fatt li l-ġenituri u t-tfal jaffettwaw lil xulxin b'mod kontinwu, ninsab interessata fil-miżuri ta' temperament tat-trabi kif ukoll l-istress tal-ġenituri, flimkien mal-ħila tal-ġenituri li jaħdmu flimkien bħala ġenituri.

F'dan l-istadju tar-riċerka tiegħi jien interessata fil-valutazzjoni ta' kif tara t-temperament tat-tarbija tiegħek. L-età xierqa għall-kejl tat-temperament ta' trabi huwa stmat li jkun madwar iż-żmien ta' meta t-tarbija tilħaq tagħlaq 8 xhur, u għalhekk jien ġentilment nitolbok li timla l-'Kwestjonarju fuq l-Imġiba tat-Tarbija – Riveduta' (IBQ - R) li huwa kalkulatur li jkejjel test standardizzat tat-temperament.

Nerġa' nikkuntattjak darb'oħra biex nagħtik feedback dwar l-eżitu tat-test, bil-possibbiltà li tiġi mistiedna tieħu sehem aktar fir-riċerka tiegħi u f'każ li fil-futur ikun hemm xi studju li jkun ta' interess u relevanza għalik. Dettalji personali tiegħek u informazzjoni tinżamm privata u protetta f'kull ħin. Jekk għandek xi mistoqsijiet oħra inti liberu li tikkuntattjani fuq: ingrid-grech-lanfranco@um.edu.mt

Firma tar-riċerkatriċi	Firma tas-supervisor
Ms Ingrid Grech Lanfranco	Prof. Angela Abela

APPENDIX B

CONSENT FORM

PARENTS INITIAL (1R) DOCUMENT B2

Title of Study: *'Early Coparenting Programmes with Parents of Infants with a Highly Reactive Temperament:A randomised study using 'Parents as Partners' (PasP).*

Name of researcher: Ms. Ingrid Grech Lanfranco (Counselling Psychologist & Family Therapist, Department of Family Studies, University of Malta)

Name of Supervisor: Prof. Angela Abela (Clinical Psychologist & Family Therapist, Department of Family Studies, University of Malta).

Purpose of data collection: PhD.

By signing this Consent Form you are agreeing to the following:

1. That you have read the information form describing this stage of the research
2. That you understand what is expected from you at this point in time
3. That you understand that your participation is voluntary and that you are free to withdraw at any time
4. That you understand that the information, data and questionnaire results will be protected at all times and used for research purposes only by the researcher

CONSENT

	YES
- I am aware of what my participation involves at this stage	
- I give my consent	

Demographics and Information		
Name		
Address		
Telephone / mobile		
Email		
Status	Single: Cohabiting: Married:	

	Separated/divorced: Other:	
Other information	Age of parent/s: Age of infant:	Mother _____ Father _____ DOB_____

Date	**Participants' names**	**Participants' signatures**

Researcher: Ingrid Grech Lanfranco	**Supervisor: Prof. Angela Abela**
Signature:	Signature:

Please note that in order to protect your data this form will be kept separately from other data connected to testing.

Should you have any further queries you are free to contact me on: ingrid-grech-lanfranco@um.edu.mt

FORMOLA TA' KUNSENS
ĠENITURI BIDU (1R) DOKUMENT B2

Titlu tal-istudju: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?' –* ***'Programmi ta' parenting flimkien li jsiru kmieni, jgħinu r-relazzjoni bejn it-temperament tat-trabi u l-istili ta' parenting li jintużaw?'***

Isem ta' min qed jagħmel ir-riċerka: Ms Ingrid Grech Lanfranco (Psikologa & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Isem is-Supervisor: Prof. Angela Abela (Psikologa Klinika & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Raġuni għall-kollezzjoni ta' informazzjoni: PhD.

Bl-iffirmar ta' din il-Formola ta' Kunsens inti taqbel ma' dawn li ġejjin:

1. Li inti qrajt l-informazzjoni ta' hawn fuq li tiddeskrivi dan l-istadju tar-riċerka
2. Li inti tifhem dak li huwa mistenni minnek f'dan il-punt fiż-żmien
3. Li inti tifhem li l-parteċipazzjoni tiegħek hija volontarja u li inti liberu li tirtira fi kwalunkwe ħin
4. Li inti tifhem li l-informazzjoni, dejta u riżultati tal-kwestjonarju ser ikunu protetti fil-ħinijiet kollha u użati għal għanijiet ta' riċerka biss mir-riċerkatriċi.

KUNSENS

	IVA
- Jiena konxju ta' dak li tinvolvi l-parteċipazzjoni tiegħi f'dan l-istadju	
- Jiena nagħti l-kunsens tiegħi	

Demografija u Informazzjoni		
Isem		
Indirizz		
Numru tat-telefon / mowbajl:		
Email		
Status	Waħdi:	

	Nikkoabita: Miżżewweġ: Separat/ divorzjat: Oħrajn:	
Informazzjoni oħra	Età ta' ġenitur / i: Età tat-tarbija:	Mara _____ Raġel _____ DTT (dob) _____

Data	**Ismijiet tal-Parteċipanti**	**Firem tal-Parteċipanti**

Riċerkatriċi: Ingrid Grech Lanfranco	**Supervisor: Prof. Angela Abela**
Firma:	Firma:

Sabiex id-dettalji tagħkom jiġu protetti, din il-formola ser tinżamm f'post separat minn kull informazzjoni oħra konnessa jew relatata ma' testijiet.

Jekk għandkom xi mistoqsijiet oħrajn, tistgħu tikkuntattjawni fuq: ingrid-grech-lanfranco@um.edu.mt

APPENDIX C

INFORMATION FORM

PARENTS/ CO-CARERS 2 (ST/CP) DOCUMENT D1

Title of Study: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?*

Name of researcher: Ms. Ingrid Grech Lanfranco (Counselling Psychologist & Family Therapist, Department of Family Studies, University of Malta)

Name of Supervisor: Prof. Angela Abela (Clinical Psychologist & Family Therapist, Department of Family Studies, University of Malta).

Purpose of data collection: PhD.

The Research:

Considering the implications of infant temperament on future child development, and the way infants and parents impact each other continuously, I am interested in measures of infant temperament as well as parental stress, alongside parents' ability to coparent.

To date measures of infant temperament have been carried out with your kind selves.

At this stage of my research I am interested in finding out how you describe your stress as well as your evaluation of the coparenting relationship. For the scope of these measures I kindly ask that you complete the Parenting Stress Index – Short Form (PSI-4-SF) and the Coparenting Relationship Scale (CRS) respectively.

I will once again contact you to give you feedback and to invite you to further participate in my research. Your personal details and information will be kept private and protected at all times.

Should you have any further queries you are free to contact me on: ingrid-grech-lanfranco@um.edu.mt

Researcher's Signature	Supervisor's Signature
Ms. Ingrid Grech Lanfranco	Prof. Angela Abela.

FORMOLA TA' INFORMAZZJONI
Ġenituri / Co-carers 2 (ST / CP) DOKUMENT D1

Titlu tal-istudju: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?' –* ***'Programmi ta' parenting flimkien li jsiru kmieni, jgħinu r-relazzjoni bejn it-temperament tat-trabi u l-istili ta' parenting li jintużaw?'***

Isem ta' min qed jagħmel ir-riċerka: Ms Ingrid Grech Lanfranco (Psikologa & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Isem is-Supervisor: Prof. Angela Abela (Psikologa Klinika & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Raġuni għall-kollezzjoni ta' informazzjoni: PhD.

Ir-Riċerka:

Meta wieħed iqis l-implikazzjonijiet li t-temperament tat-trabi għandu fuq l-iżvilupp tat-tfal fil-ġejjieni, u l-mod kif trabi u ġenituri jkollhom impatt kontinwu fuq xulxin, jien interessata f'miżuri ta' temperament tat-trabi kif ukoll fuq l-istress tal-ġenituri, flimkien mal-ħila li l-ġenituri għandhom biex irabbu flimkien.

Sal-lum il-miżuri tat-temperament tat-tarbija tagħkom twettqu bil-kooperazzjoni ġentili tagħkom.

F'dan l-istadju tar-riċerka tiegħi interessata li niskopri kif intom tiddeskrivu l-istress tagħkom kif ukoll f'evalwazzjoni tagħkom dwar ir-relazzjoni ta' co-parenting (trobbija flimkien tat-tarbija). Għall-iskop ta' dawn il-miżuri jiena ġentilment nitlobkom li timlew 'l-Indiċi Parenting Stress - Formula l-Qasira' (PSI - 4- SF) u 'l-Iskala fuq Relazzjoni Co-parenting' (CRS) rispettivament.

Jien se nerġa' nikkuntattjakom biex nagħtikom feedback u biex nistedinkom biex tipparteċipaw aktar fir-riċerka tiegħi. Dettalji personali tagħkom u informazzjoni kollha tinżamm privata u protetta fil-ħinijiet kollha.

Jekk għandkom xi mistoqsijiet oħra intom liberi li tikkuntattjawni fuq: ingrid-grech-lanfranco@um.edu.mt

Firma tar-Riċerkatriċi	Firma tas-Supervisor
Ms Ingrid Grech Lanfranco	Prof. Angela Abela

APPENDIX D

CONSENT FORM

PARENTS/ CO-CARERS 2 (ST/CP) DOCUMENT D2

Title of Study: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?*

Name of researcher: Ms. Ingrid Grech Lanfranco (Counselling Psychologist & Family Therapist, Department of Family Studies, University of Malta)

Name of Supervisor: Prof. Angela Abela (Clinical Psychologist & Family Therapist, Department of Family Studies, University of Malta).

Purpose of data collection: PhD.

By signing this Consent Form you are agreeing to the following:

1. That you agree that that you have read the information above describing this stage of the research
2. That you understand what is expected from you at this point in time
3. That you understand that your participation is voluntary and that you are free to withdraw at any time
4. That you understand that the information, data and questionnaire results will be protected at all times and used for research purposes only by the researcher

CONSENT

	YES
- I am aware of what my participation involves at this stage	
- I give my consent	

Date	**Participants' names**	**Participants' signatures**

Researcher: Ingrid Grech Lanfranco	**Supervisor: Prof. Angela Abela**
Signature:	Signature:

Please note that in order to protect your data this form will be kept separately from other data connected to testing.

Should you have any further queries you are free to contact me on: ingrid-grech-lanfranco@um.edu.mt

FORMOLA TA' KUNSENS

Ġenituri / Co-carers 2 (ST / CP) DOKUMENT D2

Titlu tal-istudju: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?' –* **'*Programmi ta' parenting flimkien li jsiru kmieni, jgħinu r-relazzjoni bejn it-temperament tat-trabi u l-istili ta' parenting li jintużaw?*'**

Isem ta' min qed jagħmel ir-riċerka: Ms Ingrid Grech Lanfranco (Psikologa & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Isem is-Supervisor: Prof. Angela Abela (Psikologa Klinika & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Raġuni għall-kollezzjoni ta' informazzjoni: PhD.

Bl-iffirmar ta' din il-Formola ta' Kunsens intom taqblu ma' dawn li ġejjin:

1. Li intom taqblu li qrajtu l-informazzjoni ta' hawn fuq li tiddeskrivi dan l-istadju tar-riċerka
2. Li intom tifhmu dak li huwa mistenni minnkom f'dan il-punt taż-żmien
3. Li intom tifhmu li l-parteċipazzjoni tagħkom hija volontarja u li intom liberi li tirtiraw fi kwalunkwe ħin
4. Li intom tifhmu li l-informazzjoni, dejta u riżultati tal-kwestjonarju ser ikunu protetti fil-ħinijiet kollha u użati għal għanijiet ta' riċerka biss mir-riċerkatriċi.

KUNSENS

	IVA
- Jiena konxju ta' dak li l-parteċipazzjoni tiegħi tinvolvi f'dan l-istadju	
- Nagħti l-kunsens tiegħi	

Data	**Ismijiet tal-Parteċipanti**	**Firem tal-Parteċipanti**

Riċerkatriċi: Ingrid Grech Lanfranco	**Supervisor: Prof. Angela Abela**
Firma:	Firma:

Jekk jogħġbok innota li sabiex nipproteġi d-dejta tagħkom din il-formola ser tinżamm separatament minn dejta oħra konnessa mal-ittestjar.

Jekk għandkom xi mistoqsijiet oħra intom liberi li tikkuntattjawni fuq: ingrid-grech-lanfranco@um.edu.mt

APPENDIX E

INFORMATION FORM 3 - DOCUMENT G1

PARENTS (Programme Participation)

Title of Study: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?*

Name of researcher: Ms. Ingrid Grech Lanfranco (Counselling Psychologist & Family Therapist, Department of Family Studies, University of Malta)

Name of Supervisor: Prof. Angela Abela (Clinical Psychologist & Family Therapist, Department of Family Studies, University of Malta).

Purpose of data collection: PhD.

The Research

Following your most valuable co-operation with completing the previous measures on infant temperament (IBQ-R), Parental Stress (PSI-4-SF) and Coparenting Relationship (CRS) you have been chosen to attend a unique coparenting programme.

This programme known as 'Parents as Partners' is a free 16-week programme of group sessions that explore how you and your co-parent can become the kind of parents that the two of you want to be.

You will be in a small group along with other couples and followed by a case manager to support you throughout the whole duration of the programme. UK- trained male and female facilitators will conduct the group sessions.

If you accept you will be expected to attend regularly as a couple. You will be provided with onsite child care to help you with your attendance, as well as given a snack during a mid-break.

The programme will take place at the University of Malta Psychology Lab which is easily located on the University grounds (enclosed map), where parking is also available, as well as a bus service to most destinations.

The group sessions will be video-taped in order to help the group leaders review the progress of the participants, and to facilitate UK-based supervision of the group leaders. The videotapes will only be seen by project staff, and can only be used for the purpose of supervision and research. At the end of the 16-week parenting programme, you will be asked to complete the same three

measures you did originally, the ECBQ, the PSI-4-SF and the CRS. Your participation is greatly appreciated.

Once again I wish to assure you that your personal details and information will be kept private and protected at all times.

Should you have any further queries you are free to contact me on: ingrid.grech-lanfranco@um.edu.mt

Signature of Researcher	Signature of Supervisor
Ms. Ingrid Grech Lanfranco	Prof. Angela Abela

FORMOLA TA' INFORMAZZJONI 3 - DOKUMENT G1

Ġenituri (Parteċipazzjoni Programm)

Titlu tal-istudju: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?' –* ***'Programmi ta' parenting flimkien li jsiru kmieni, jgħinu r-relazzjoni bejn it-temperament tat-trabi u l-istili ta' parenting li jintużaw?'***

Isem ta' min qed jagħmel ir-riċerka: Ms Ingrid Grech Lanfranco (Psikologa & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Isem is-Supervisor: Prof. Angela Abela (Psikologa Klinika & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Raġuni għall-kollezzjoni ta' informazzjoni: PhD.

Ir-Riċerka:

Wara l-kooperazzjoni tant siewja tagħkom biex jitlestew il-miżuri preċedenti fuq it-temperament tat-trabi (IBQ - R), l-Istress tal-Ġenituri (PSI 4 - SF) u l-Iskala fuq ir-Relazzjoni Co-parenting (CRS), ġejtu magħżula biex tattendu programm uniku fuq it-trobbija flimkien (co-parenting).

Dan il-programm magħruf bħala "Parents As Partners" (ġenituri bħala msieħba) huwa programm ta' 16-il ġimgħa ta' sessjonijiet fi gruppi bla ħlas li jesploraw kif intom li qed trabbu tarbija flimkien tistgħu ssiru t-tip ta' ġenituri li t-tnejn li intom tixtiequ li tkunu.

Intom ser tkunu fi grupp żgħir flimkien ma' koppji oħra li jrabbu t-trabi tagħhom flimkien u tkunu segwiti minn maniġer li jappoġġjakom matul it-tul kollu ta' dan il-programm. Faċilitaturi rġiel u nisa Maltin imħarrġa fl-Ingilterra ser iwettqu s-sessjonijiet tal-grupp.

Jekk intom taċċettaw tkunu mistennija li tattendu b'mod regolari bħala koppja. Intom ser tkunu pprovduti bil-kura tat-tfal fuq il-post biex tiġu megħjuna fl-attendenza tagħkom, kif ukoll tiġu mogħtija snack żgħir matul il-waqfa tan-nofs fil-brejk.

Il-programm se jsir fl-Università ta' Malta fil-laboratorju tal-Psikoloġija li jista' jinstab faċilment fl-Università (mappa mehmuża), fejn il-parkeġġ huwa wkoll disponibbli, kif ukoll ċentrali bħala servizz ta' xarabank għal ħafna destinazzjonijiet.

Is-sessjonijiet tal-grupp se jkunu rrekordjati sabiex jgħinu lill-mexxejja tal-gruppi jirrevedu l-progress tal-parteċipanti, u biex jiffaċilitaw superviżjoni bbażata fir-Renju Unit mill-mexxejja tal-gruppi. Ir-rekording se jitqies biss minn persuni fuq dan il-proġett, u jista' jintuża biss għall-iskop ta' superviżjoni u din ir-riċerka.

Fl-aħħar tal-programm "Parents As Partners" (ġenituri bħala msieħba) ta' 16-il ġimgħa, intom ser tintalbu sabiex timlew l-istess tliet miżuri li għamiltu oriġinarjament, l-ECBQ, il-PSI 4 - SF u l-CRS. Il-parteċipazzjoni tagħkom hija apprezzata ħafna.

Għal darb'oħra nixtieq nassigurakom li d-dettalji personali tagħkom u kull informazzjoni oħra tinżamm privata u protetta fil-ħinijiet kollha.

Jekk għandkom xi mistoqsijiet oħra intom liberi li tikkuntattjawni fuq: ingrid.grech-lanfranco@um.edu.mt

_____	_____
Firma tar-Riċerkatriċi	Firma tas-Supervisor
Ms Ingrid Grech Lanfranco	Prof. Angela Abela

APPENDIX F

CONSENT FORM 3 - DOCUMENT G2

PARENTS (Programme Participation)

Title of Study: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?*

Name of researcher: Ms. Ingrid Grech Lanfranco (Counselling Psychologist & Family Therapist, Department of Family Studies, University of Malta)

Name of Supervisor: Prof. Angela Abela (Clinical Psychologist & Family Therapist, Department of Family Studies, University of Malta).

Purpose of data collection: PhD.

By signing this Consent Form you are agreeing to the following:

1. That you agree that you have read the information above describing this stage of the research connected to the parenting programme
2. That you understand what is expected from you at this point in time
3. That you understand that your participation is voluntary and that you are free to withdraw at any time, although you are asked to attend regularly
4. That you understand that the information, data and questionnaire results will be protected at all times and used for research purposes only by the researcher

CONSENT

	YES
- I am aware of what my participation involves at this stage	
- I give my consent	

Date	**Participants' names**	**Participants' signatures**

Researcher: Ingrid Grech Lanfranco	**Supervisor: Prof. Angela Abela**
Signature:	Signature:

Please note that in order to protect your data this form will be kept separately from other data connected to testing.

Should you have any further queries you are free to contact me on: ingrid.grech-lanfranco@um.edu.mt

FORMOLA TA' KUNSENS 3 - DOKUMENT G2

Ġenituri (Parteċipazzjoni Programm)

Titlu tal-istudju: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?' –* ***'Programmi ta' parenting flimkien li jsiru kmieni, jgħinu r-relazzjoni bejn it-temperament tat-trabi u l-istili ta' parenting li jintużaw?'***

Isem ta' min qed jagħmel ir-riċerka: Ms Ingrid Grech Lanfranco (Psikologa & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Isem is-Supervisor: Prof. Angela Abela (Psikologa Klinika & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Raġuni għall-kollezzjoni ta' informazzjoni: PhD.

Bl-iffirmar ta' din il-Formola ta' Kunsens intom taqblu ma' dawn li ġejjin:

1. Li intom taqblu li qrajtu l-informazzjoni ta' hawn fuq li tiddeskrivi dan l-istadju tar-riċerka marbut mal-programm fuq parenting
2. Li intom tifhmu dak li huwa mistenni minnkom f'dan il-ħin
3. Li intom tifhmu li l-parteċipazzjoni tagħkom hija volontarja u li intom liberi li tirtiraw fi kwalunkwe ħin, għalkemm intom mitluba li tattendu b'mod regolari
4. Li intom tifhmu li l-informazzjoni, dejta u riżultati tal-kwestjonarju ser ikunu protetti fil-ħinijiet kollha u użati għal għanijiet ta' riċerka biss mir-riċerkatriċi.

KUNSENS

	IVA
- Jiena konxju ta' dak li l-parteċipazzjoni tiegħi tinvolvi f'dan l-istadju	
- Nagħti l-kunsens tiegħi	

Data	**Ismijiet tal-Parteċipanti**	**Firem tal-Parteċipanti**

Riċerkatriċi: Ingrid Grech Lanfranco	**Supervisor: Prof. Angela Abela**
Firma:	Firma:

Jekk jogħġbok innota li sabiex id-dejta tiegħek tiġi protetta din il-formola ser tinżamm separatament minn dejta oħra konnessa mal-ittestjar.

Jekk għandkom xi mistoqsijiet oħra intom liberi li tikkuntattjawni fuq: ingrid.grech-lanfranco@um.edu.mt

APPENDIX G

INFORMATION FORM 4 - DOCUMENT H1

PARENTS (Case worker Participation)

Title of Study: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?*

Name of researcher: Ms. Ingrid Grech Lanfranco (Counselling Psychologist & Family Therapist, Department of Family Studies, University of Malta)

Name of Supervisor: Prof. Angela Abela (Clinical Psychologist & Family Therapist, Department of Family Studies, University of Malta).

Purpose of data collection: PhD.

The Research:

Following your most valuable co-operation with completing the previous measures on infant temperament (IBQ-R), Parental Stress (PSI-4-SF) and Coparenting Relationship (CRS) you have been chosen to participate a little further in the research.

For a duration of 16 weeks you will be followed by a case worker to support you with your parenting. At the end of the 16-week period, you will kindly be asked to complete the same three measures you did originally, the ECBQ, the PSI-4-SF and the CRS. Your participation is greatly appreciated.

Once again I wish to assure you that your personal details and information will be kept private and protected at all times.

Should you have any further queries you are free to contact me on: ingrid.grech-lanfranco@um.edu.mt

Signature of Researcher	Signature of Supervisor
Ms. Ingrid Grech Lanfranco	Prof. Angela Abela.

FORMOLA TA' INFORMAZZJONI 4 - DOKUMENT H1

Ġenituri (Parteċipazzjoni ta' Case Worker)

Titlu tal-istudju: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?' –* ***'Programmi ta' parenting flimkien li jsiru kmieni, jgħinu r-relazzjoni bejn it-temperament tat-trabi u l-istili ta' parenting li jintużaw?'***

Isem ta' min qed jagħmel ir-riċerka: Ms Ingrid Grech Lanfranco (Psikologa & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Isem is-Supervisor: Prof. Angela Abela (Psikologa Klinika & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Raġuni għall-kollezzjoni ta' informazzjoni: PhD.

Ir-Riċerka:

Wara l-kooperazzjoni l-aktar siewja tiegħek biex jitlestew il-miżuri preċedenti fuq it-temperament tat-trabi (IBQ - R), fuq l-Istress tal-Ġenituri (PSI 4 - SF) u fuq ir-Relazzjoni ta' trobbija flimkien (co-parenting) (CRS), ġejtu magħżula biex tipparteċipaw ftit aktar fir-riċerka.

Għal perjodu ta' 16-il ġimgħa intom ser tkunu segwiti minn case worker biex tappoġġjakom fit-trobbija tat-tarbija tagħkom. Fl-aħħar tal-perjodu ta' 16-il ġimgħa, intom ser tkunu ġentilment mitluba biex tlestu l-istess tliet miżuri li għamiltu oriġinarjament, l-ECBQ, il-PSI 4-SF u l-CRS. Il-parteċipazzjoni tagħkom hija apprezzata ħafna.

Għal darb'oħra nixtieq nassigurakom li d-dettalji personali u l-informazzjoni tagħkom ser jinżammu privati u protetti fil-ħinijiet kollha.

Jekk għandkom xi mistoqsijiet oħra intom liberi li tikkuntattjawni fuq:
ingrid.grech-lanfranco@um.edu.mt

Firma tar-Riċerkatriċi	Firma tas-Supervisor
Ms Ingrid Grech Lanfranco	Prof. Angela Abela

APPENDIX H

CONSENT FORM 4 - DOCUMENT H2

PARENTS (Case worker Participation)

Title of Study: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?*

Name of researcher: Ms. Ingrid Grech Lanfranco (Counselling Psychologist & Family Therapist, Department of Family Studies, University of Malta)

Name of Supervisor: Prof. Angela Abela (Clinical Psychologist & Family Therapist, Department of Family Studies, University of Malta).

Purpose of data collection: PhD.

By signing this Consent Form you are agreeing to the following:

1. That you agree that that you have read the information above describing this stage of the research connected to being followed by a case worker
2. That you understand what is expected from you at this point in time
3. That you understand that your participation is voluntary and that you are free to withdraw at any time
4. That you understand that the information, data and questionnaire results will be protected at all times and used for research purposes only by the researcher

CONSENT

	YES
- I am aware of what my participation involves at this stage	
- I give my consent	

Date	Participants' names	Participants' signatures

Researcher: Ingrid Grech Lanfranco	**Supervisor: Prof. Angela Abela**
Signature:	Signature:

Please note that in order to protect your data this form will be kept separately from other data connected to testing.

Should you have any further queries you are free to contact me on: ingrid.grech-lanfranco@um.edu.mt

FORMOLA TA' KUNSENS 4 - DOKUMENT H2

Ġenituri (Parteċipazzjoni ta' Case Worker)

Titlu tal-istudju: *'Do early Co-Parenting Programmes enhance the relationship between infants' temperament and parenting styles?' –* ***'Programmi ta' parenting flimkien li jsiru kmieni, jgħinu r-relazzjoni bejn it-temperament tat-trabi u l-istili ta' parenting li jintużaw?'***

Isem ta' min qed jagħmel ir-riċerka: Ms Ingrid Grech Lanfranco (Psikologa & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Isem is-Supervisor: Prof. Angela Abela (Psikologa Klinika & Terapista tal-Familja, Dipartiment tal-Istudji tal-Familja, Università ta' Malta).

Raġuni għall-kollezzjoni ta' informazzjoni: PhD.

Bl-iffirmar ta' din il-Formola ta' Kunsens intom taqblu ma' dawn li ġejjin:

1. Li intom taqblu li intom qrajtu l-informazzjoni ta' hawn fuq li tiddeskrivi dan l-istadju tar-riċerka fejn tgħid li se tiġu segwiti minn case worker
2. Li intom tifhmu dak li huwa mistenni minnkom f'dan il-mument
3. Li intom tifhmu li l-parteċipazzjoni tagħkom hija volontarja u li intom liberi li tirtiraw fi kwalunkwe ħin
4. Li intom tifhmu li l-informazzjoni, dejta u riżultati tal-kwestjonarju ser ikunu protetti fil-ħinijiet kollha u użati biss mir-riċerkatriċi għal għanijiet ta' riċerka.

KUNSENS

	IVA
- Jiena konxju ta' dak li l-parteċipazzjoni tiegħi tinvolvi f'dan l-istadju	
- Nagħti l-kunsens tiegħi	

Data	**Ismijiet tal-Parteċipanti**	**Firem tal-Parteċipanti**

Riċerkatriċi: Ingrid Grech Lanfranco	**Supervisor: Prof. Angela Abela**
Firma:	Firma:

Jekk jogħġobkom innotaw li sabiex tiġi protetta d-dejta tagħkom, din il-formola ser tinżamm separata minn dejta oħra konnessa mal-ittestjar.

Jekk għandkom xi mistoqsijiet oħra intom liberi li tikkuntattjawni fuq:
ingrid.grech-lanfranco@um.edu.mt

APPENDIX I

Infant Behavior Questionnaire – Revised

Very Short Form

Subject No. _____ Date of Baby's Birth _____ ____ _____

day month year

Today's Date _____ Age of Child _____ _____

mos. weeks

Sex of Child _____

INSTRUCTIONS:

Please read carefully before starting:

As you read each description of the baby's behavior below, please indicate how often the baby did this during the LAST WEEK (the past seven days) by circling one of the numbers in the left column. These numbers indicate how often you observed the behavior described during the last week.

1	2	3	4	5	6	7	NA
Never	**Very Rarely**	**Less Than Half the Time**	**About Half the Time**	**More Than Half the Time**	**Almost Always**	**Always**	**Does Not Apply**

The "Does Not Apply" (X) column is used when you did not see the baby in the situation described during the last week. For example, if the situation mentions the baby having to wait for food or liquids and there was no time during the last week when the baby had to wait, circle the (X) column. "Does Not Apply" is different from "Never" (1). "Never" is used when you saw the baby in the situation but the baby never engaged in the behavior listed during the last week. For example, if the baby did have to wait for food or liquids at least once but never cried loudly while waiting, circle the (1) column.

Please be sure to circle a number for <u>every</u> item.

1. When being dressed or undressed during the last week, how often did the baby squirm and/or try to roll away?

1 2 3 4 5 6 7 NA

2. When tossed around playfully how often did the baby laugh?

1 2 3 4 5 6 7 NA

3. When tired, how often did your baby show distress?

1 2 3 4 5 6 7 NA

4. When introduced to an unfamiliar adult, how often did the baby cling to a parent?

1 2 3 4 5 6 7 NA

5. How often during the last week did the baby enjoy being read to?

1 2 3 4 5 6 7 NA

6. How often during the last week did the baby play with one toy or object for 5-10 minutes?

1 2 3 4 5 6 7 NA

7. How often during the week did your baby move quickly toward new objects?

1 2 3 4 5 6 7 NA

8. When put into the bath water, how often did the baby laugh?

1 2 3 4 5 6 7 NA

9. When it was time for bed or a nap and your baby did not want to go, how often did s/he whimper or sob?

1 2 3 4 5 6 7 NA

10. After sleeping, how often did the baby cry if someone doesn't come within a few minutes?

1 2 3 4 5 6 7 NA

11. In the last week, while being fed in your lap, how often did the baby seem eager to get away as soon as the feeding was over?

1 2 3 4 5 6 7 NA

12. When singing or talking to your baby, how often did s/he soothe immediately?

1 2 3 4 5 6 7 NA

13. When placed on his/her back, how often did the baby squirm and/or turn body?

1 2 3 4 5 6 7 NA

14. During a peekaboo game, how often did the baby laugh?

1 2 3 4 5 6 7 NA

15. How often does the infant look up from playing when the telephone rings?

1 2 3 4 5 6 7 NA

16. How often did the baby seem angry (crying and fussing) when you left her/him in the crib?

1 2 3 4 5 6 7 NA

17. How often during the last week did the baby startle at a sudden change in body position (e.g., when moved suddenly)?

1 2 3 4 5 6 7 NA

18. How often during the last week did the baby enjoy hearing the sound of words, as in nursery rhymes?

1 2 3 4 5 6 7 NA

19. How often during the last week did the baby look at pictures in books and/or magazines for 5 minutes or longer at a time?

1 2 3 4 5 6 7 NA

20. When visiting a new place, how often did your baby get excited about exploring new surroundings?

1 2 3 4 5 6 7 NA

21. How often during the last week did the baby smile or laugh when given a toy?

1 2 3 4 5 6 7 NA

22. At the end of an exciting day, how often did your baby become tearful?

1 2 3 4 5 6 7 NA

23. How often during the last week did the baby protest being placed in a confining place (infant seat, play pen, car seat, etc.)?

1 2 3 4 5 6 7 NA

24. When being held, in the last week, did your baby seem to enjoy him/herself?

1 2 3 4 5 6 7 NA

25. When showing the baby something to look at, how often did s/he soothe immediately?

1 2 3 4 5 6 7 NA

26. When hair was washed, how often did the baby vocalize?

1 2 3 4 5 6 7 NA

27. How often did your baby notice the sound of an airplane passing overhead?

1 2 3 4 5 6 7 NA

28. When introduced to an unfamiliar adult, how often did the baby refuse to go to the unfamiliar person?

1 2 3 4 5 6 7 NA

29. When you were busy with another activity, and your baby was not able to get your attention, how often did s/he cry?

1 2 3 4 5 6 7 NA

30. How often during the last week did the baby enjoy gentle rhythmic activities, such as rocking or swaying?

1 2 3 4 5 6 7 NA

31. How often during the last week did the baby stare at a mobile, crib bumper or picture for 5 minutes or longer?

1 2 3 4 5 6 7 NA

32. When the baby wanted something, how often did s/he become upset when s/he could not get what s/he wanted?

1 2 3 4 5 6 7 NA

33. When in the presence of several unfamiliar adults, how often did the baby cling to a parent?

1 2 3 4 5 6 7 NA

34. When rocked or hugged, in the last week, did your baby seem to enjoy him/herself?

1 2 3 4 5 6 7 NA

35. When patting or gently rubbing some part of the baby's body, how often did s/he soothe immediately?

1 2 3 4 5 6 7 NA

36. How often did your baby make talking sounds when riding in a car?

1 2 3 4 5 6 7 NA

37. When placed in an infant seat or car seat, how often did the baby squirm and turn body?

1 2 3 4 5 6 7 NA

Kwestjonarju dwar l-Imġiba tat-Tfal Żgħar - Rivedut

Forma mqassra

Numru tas-Suġġett: _____ Id-Data tat-Twelid tat-Tarbija: ____ ____ _____

Id-Data tal-Lum: _____ ġurnata xahar sena

Età tat-Tifel/Tifla: _____ _____

xhur ġimgħat

Is-Sess tat-Tarbija:_____

ISTRUZZJONIJIET

Jekk jogħġbok aqra sew qabel tibda.

Int u taqra d-deskrizzjoni tal-imġiba tat-tarbija hekk kif indikat hawn isfel, jekk jogħġbok indika kemm-il darba matul din l-aħħar ġimgħa (l-aħħar sebat ijiem) it-tarbija ġabet ruħha bil-mod indikat u uri dan billi timmarka b'ċirku wieħed min-numri hawn isfel indikati fil-kolonna tax-xellug. Dawn in-numri jindikaw kemm-il darba int tkun osservajt din l-imġiba fit-tarbija f'din l-aħħar ġimgħa.

1	2	3	4	5	6	7	MJ
Qatt	**Rari**	**Inqas minn nofs id-**	**Nofs id-**	**Iktar minn nofs**	**Kważi**	**Dejjem**	**Ma**

		drabi	**drabi**	**id-drabi**	**dejjem**		**japplikax**

Il-kolonna 'Ma Japplikax' (X) tintuża meta fl-aħħar ġimgħa ma osservajtx it-tarbija ġġib ruħha bil-mod hekk kif deskritt. Pereżempju, jekk is-sitwazzjoni ssemmi li t-tarbija kellha tistenna l-ikel u x-xorb u ma kienx hemm żmien matul din l-aħħar ġimgħa li fiha t-tarbija kellha tistenna, agħmel ċirku fil-kolonna mmarkata (X). 'Ma Japplikax' m'għandhiex l-istess tifsira ta' 'Qatt' (1). 'Qatt' tintuża meta osservajt lit-tarbija fis-sitwazzjoni imma t-tarbija qatt ma ġabet ruħha bil-mod indikat f'din l-aħħar ġimgħa. Pereżempju, jekk it-tarbija kellha tistenna l-ikel u x-xorb tal-inqas darba imma qatt ma bkiet waqt l-istennija, immarka l-ewwel (1) kolonna b'ċirku.

Jekk jogħġbok ara li tagħmel ċirku ma' numru għal kull għażla.

1. Meta tiġi biex tlibbes jew tneżża' lit-tarbija, kemm-il darba matul din l-aħħar ġimgħa t-tarbija wriet reżistenza u/jew ippruvat taħrablek?

   1 2 3 4 5 6 7 MJ

2. Meta lgħabt mat-tarbija kemm-il darba daħqet it-tarbija?

   1 2 3 4 5 6 7 MJ

3. Meta t-tarbija tegħja, kemm-il darba wriet skonfort (li ma kinitx komda)?

   1 2 3 4 5 6 7 MJ

4. Meta t-tarbija ltaqgħet ma' persuna adulta mhix familjari magħha, kemm-il darba ggranfat mal-ġenituri?

   1 2 3 4 5 6 7 MJ

5. Kemm-il darba f'din l-aħħar ġimgħa t-tarbija ħadet pjaċir meta xi ħadd qagħad jaqralha?

   1 2 3 4 5 6 7 MJ

6. Kemm-il darba f'din l-aħħar ġimgħa t-tarbija lagħbet b'ġugarell jew b'xi oġġett ieħor għal 5-10 minuti?

   1 2 3 4 5 6 7 MJ

7. Kemm-il darba matul din il-ġimgħa t-tarbija mxiet (jew inġibdet) bil-ħeffa lejn xi oġġett ġdid?

   1 2 3 4 5 6 7 MJ

8. Kemm-il darba tidħaq it-tarbija meta tniżżilha fil-banju?

   1 2 3 4 5 6 7 MJ

9. Meta f'ħin li tieħu nagħsa jew f'ħin l-irqad it-tarbija ma riditx tmur torqod, kemm-il darba bkiet jew qerdet?

   1 2 3 4 5 6 7 MJ

10. Wara li t-tarbija raqdet (u qamet mir-raqda), kemm-il darba bkiet f'każ fejn xi ħadd ma jmurx ħdejha fi ftit minuti?

    1 2 3 4 5 6 7 MJ

11. F'din l-aħħar ġimgħa, waqt li kont qiegħed/qiegħda titma' lit-tarbija fuq irkopptejk (jew fuq il-highchair), kemm-il darba t-tarbija wriet ix-xewqa li tiċċaqlaq minn fuqek wara li tmajtha?

    1 2 3 4 5 6 7 MJ

12. Meta tkun qiegħed/qiegħda tkanta lil jew titkellem mat-tarbija, kemm-il darba t-tarbija, immedjatament, irrispondiet bi ħsejjes li juru li t-tarbija qiegħda tieħu pjaċir u tirrilassa?

    1 2 3 4 5 6 7 MJ

13. Meta t-tarbija tpoġġiet fuq daharha, kemm-il darba ppruvat tiċċaqlaq u/jew iddawwar ġisimha?

1 2 3 4 5 6 7 MJ

14. Waqt li tkun qiegħed/qiegħda tilgħab peekaboo mat-tarbija, kemm-il darba daħqet it-tarbija?

1 2 3 4 5 6 7 MJ

15. Kemm-il darba tħares 'il fuq it-tarbija meta, waqt li tkun qiegħda tilgħab, idoqq it-telefon?

1 2 3 4 5 6 7 MJ

16. Kemm-il darba t-tarbija dehret irrabjata meta ħallejtha ġos-sodda tagħha?

1 2 3 4 5 6 7 MJ

17. Kemm-il darba matul din l-aħħar ġimgħa, it-tarbija dehret aġitata u sorpriża minħabba kambjament immedjat f'xi pożizzjoni tal-ġisem (eż. meta t-tarbija ġiet imċaqalqa f'salt)?

1 2 3 4 5 6 7 MJ

18. Kemm-il darba matul din l-aħħar ġimgħa t-tarbija ħadet pjaċir tisma' l-ħsejjes tal-kliem tan-nursery rhymes?

1 2 3 4 5 6 7 MJ

19. Kemm-il darba matul din l-aħħar ġimgħa t-tarbija qagħdet tħares lejn kull waħda mill-istampi f'xi ktieb jew magażin għal 5 minuti jew iktar?

1 2 3 4 5 6 7 MJ

20. Meta mort iżżur xi post ġdid, kemm-il darba t-tarbija wriet eċitament għall-fatt li qiegħda tesplora ambjent ġdid?

1 2 3 4 5 6 7 MJ

21. Kemm-il darba f'din l-aħħar ġimgħa t-tarbija tbissmet jew daħqet meta ngħatat ġugarell?

1 2 3 4 5 6 7 MJ

22. Fl-aħħar ta' ġurnata eċitanti, kemm-il darba bkiet it-tarbija?

1 2 3 4 5 6 7 MJ

23. Kemm-il darba matul din l-aħħar ġimgħa, it-tarbija pprotestat kontra l-fatt li tpoġġiet f'xi spazju ristrett (infant seat, play pen, car seat, eċċ.)?

1 2 3 4 5 6 7 MJ

24. F'din l-aħħar ġimgħa, meta żammejt it-tarbija fuqek, it-tarbija dehret li qiegħda tieħu pjaċir?

1 2 3 4 5 6 7 MJ

25. Meta wrejt xi ħaġa lit-tarbija, kemm-il darba rreaġixxiet mill-ewwel?

1 2 3 4 5 6 7 MJ

26. Meta ħsilt xagħar it-tarbija, kemm-il darba semmgħet leħinha?

1 2 3 4 5 6 7 MJ

27. Kemm-il darba t-tarbija rreaġixxiet għall-ħoss ta' ajruplan li jgħaddi minn fuqna?

1 2 3 4 5 6 7 MJ

28. Meta introdużejt lit-tarbija għal xi adult li mhix familjari miegħu, kemm-il darba rrifjutat li tmur għand dik il-persuna?

    1 2 3 4 5 6 7 MJ

29. Meta kont qiegħed/qiegħda mħabbta b'attività oħra tant li t-tarbija tiegħek ma setgħetx tattiralek l-attenzjoni, kemm-il darba bkiet?

    1 2 3 4 5 6 7 MJ

30. Kemm-il darba matul din l-aħħar ġimgħa, it-tarbija ħadet pjaċir b'attivitajiet ġentili u ritmiċi bħal pereżempju tbandil (rocking/swaying)?

    1 2 3 4 5 6 7 MJ

31. Kemm-il darba matul din l-aħħar ġimgħa, it-tarbija ċċassat lejn mowbajl, crib bumper jew stampa għal 5 minuti jew aktar?

    1 2 3 4 5 6 7 MJ

32. Meta t-tarbija riedet xi ħaġa, kemm-il darba wriet id-dispjaċir tagħha minħabba l-fatt li ma setgħetx tieħu dak li xtaqet?

    1 2 3 4 5 6 7 MJ

33. Kemm-il darba t-tarbija ggranfat mal-ġenituri tagħha fil-preżenza ta' persuni li ma kinitx familjari magħhom?

    1 2 3 4 5 6 7 MJ

34. Meta bandalt jew għannaqt lit-tarbija din l-aħħar ġimgħa, it-tarbija dehret li qiegħda tieħu pjaċir?

    1 2 3 4 5 6 7 MJ

35. Meta tmelles jew ġentilment togħrok ġisem it-tarbija tiegħek, kemm-il darba tirreaġixxi mill-ewwel?

    1 2 3 4 5 6 7 MJ

36. Kemm-il darba t-tarbija lissnet ħsejjes li jixbhu l-kliem meta tkun riekba f'xi karozza?

    1 2 3 4 5 6 7 MJ

37. Meta titpoġġa f'infant seat jew car seat, kemm-il darba t-tarbija tipprova tiżgiċċa u ddawwar ġisimha?

    1 2 3 4 5 6 7 MJ

APPENDIX J

PARENTING STRESS INDEX – 4 – SHORT FORM

Instructions:

On the inside of this form, write your name, gender, date of birth, ethnic group, and marital status: today's date, and your child's name, gender, and date of birth. This questionnaire contains 36 statements.

Read each statement carefully. For each statement, please focus on the child you are most concerned about and circle the response that best represents your opinion. **Answer all questions about the same child.**

Circle **SA** if you **Strongly Agree** with the statement

Circle **A** if you **Agree** with the statement

Circle **NS** if you are **Not Sure**

Circle **D** if you **Disagree** with the statement

Circle **SD** if you **Strongly Disagree** with the statement

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies SA A NS D SD

While you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. Your first reaction to each question should be your answer.

Circle only one response for each statement, and respond to all statements. Do not erase! If you need to change an answer, mark an 'X' through the incorrect answer and circle the correct response. For example:

I enjoy going to the movies SA A NS D SD

ANSWER SHEET

Name_____Gender_____Date of birth(DOB)_____

Ethnic Group_____Marital Status_____Today's date_____

Child's name_____Child's Gender_____Child's DOB_____

SA= Strongly Agree **A**=Agree **NS**=Not Sure **D**=Disagree **SD**=Strongly Disagree

1. I often have the feeling that I cannot handle things very well

   SA A NS D SD

2. I find myself giving up more of my life to meet my children's needs than I ever expected

   SA A NS D SD

3. I feel trapped by my responsibilities as a parent

   SA A NS D SD

4. Since having this child, I have been unable to do new and different things

   SA A NS D SD

5. Since having a child, I feel that I am almost never able to do things that I like to do

   SA A NS D SD

6. I am unhappy with the last purchase of clothing I made for myself

   SA A NS D SD

7. There are quite a few things that bother me about my life

   SA A NS D SD

8. Having a child has caused more problems than I expected in my relationhsip with my spouse/parenting partner

   SA A NS D SD

9. I feel alone and without friends

SA A NS D SD

10. When I go to a party, I usually expect not to enjoy myself

SA A NS D SD

11. I am not as interested in people as I used to be

SA A NS D SD

12. I dont' enjoy things as I used to

SA A NS D SD

13. My child rarely does things for me that make me feel good

SA A NS D SD

14. When I do things for my child, I get the feeling that my efforts are not appreciated very much

SA A NS D SD

15. My child smiles at me much less than I expected

SA A NS D SD

16. Sometimes I feel my child doesn't like me and doesn't want to be close to me

SA A NS D SD

17. My child is very emotional and gets upset easily

SA A NS D SD

18. My child doesn't seem to learn as quickly as most children

SA A NS D SD

19. My child doesn't seem to smile as much as most children

SA A NS D SD

20. My child is not able to do as much as I expected

SA A NS D SD

21. It takes a long time and it is very hard for my child to get used to new things

SA A NS D SD

22. I feel that I am: (Choose a response from the choices below) **1/2/3/4/5**

    1. A very good parent

    2. A better-than-average parent

    3. An average parent

    4. A person who has some trouble being a parent

    5. Not very good at being a parent

23. I expected to have closer and warmer feelings for my child than I do, and this bothers me

    SA A NS D SD

24. Sometimes my child does things that bother me just to be mean

    SA A NS D SD

25. My child seems to cry or fuss more often than most children

    SA A NS D SD

26. My child generally wakes up in a bad mood

    SA A NS D SD

27. I feel that my child is very moody and easily upset

    SA A NS D SD

28. Compared to the average child, my child has a great deal of difficulty in getting used to changes in schedules or changes around the house

    SA A NS D SD

29. My child reacts very strongly when something happens that my child doesn't like

    SA A NS D SD

30. When playing, my child doesn't often giggle or laugh

    SA A NS D SD

31. My child's sleeping or eating schedule was much harder to establish than I expected

SA A NS D SD

32. I have found that getting my child to do something or stop doing something is: (Choose a response from the choices below). **1 2 3 4 5**

1. Much harder than I expected

2. Somewhat harder than I expected

3. About as hard as I expected

4. Somewhat easier than I expected

5. Much easier than I expected

33. Think carefully and count the number of things which your child does that bothers you. For example, dawdles, refuses to listen, overactive, cries, interrupts, fights, whines, etc.

1. 1-3

2. 4-5

3. 6-7

4. 8-9

5. 10+

34. There are some things my child does that really bother me a lot

SA A NS D SD

35. My child's behaviour is more of a problem than I expected

SA A NS D SD

36. My child makes more demands on me than most children

SA A NS D SD

INDICI FUQ L-ISTRESS TAL-ĠENITURI

Istruzzjonijiet

F'din il-formola ikteb ismek, is-sess, id-data tat-twelid, il-grupp etniku, u l-istat matrimonjali; id-data tal-lum, u isem ibnek/bintek, is-sess, u d-data tat-twelid. Dan il-kwestjonarju fih 36 mistoqsija.

Aqra kull mistoqsija bil-galbu. Għal kull mistoqsija, iffoka jekk jogħġbok fuq it-tifel/tifla li int inkwetat/a fuqu/fuqha u agħmel ċirku madwar it-tweġiba li l-aktar taqbel magħha. **Wieġeb il-mistoqsijiet kollha dwar l-istess tifel/tifla.**

Agħmel ċirku madwar **NĦ** jekk **NAQBEL ĦAFNA** mal-mistoqsija.

Agħmel ċirku madwar **N** jekk **NAQBEL** mal-mistoqsija.

Agħmel ċirku madwar **MŻ** jekk **M'INIEX ŻGUR/A** mal-mistoqsija.

Agħmel ċirku madwar **MN** jekk **MA NAQBILX** mal-mistoqsija.

Agħmel ċirku madwar **MNĦ** jekk **MA NAQBILX ĦAFNA** mal-mistoqsija.

Pereżempju, jekk kultant tieħu pjaċir tmur iċ-ċinema, għandek tagħmel ċirku madwar N biex twieġeb din il-mistoqsija:

Jien inħobb immur iċ-ċinema (NĦ, N, MŻ, MN, MNĦ)

Jekk ma ssibx tweġiba li taqbel eżattament miegħek, jekk jogħġbok agħmel ċirku ma' dik li taħseb taqbel l-eqreb għal dak li tħoss. **L-ewwel reazzjoni għal kull mistoqsija għandha tkun it-tweġiba tiegħek.**

Agħmel ċirku wieħed biss għal kull mistoqsija. Tħassarx! Jekk ikollok bżonn tbiddel tweġiba agħmel 'X' fuq it-tweġiba mhux korretta u agħmel ċirku madwar it-tajba. Pereżempju:

Inħobb immur iċ-ċinema: (NĦ, N, MŻ, MN, MNĦ)

Karta tat-tweġibiet

Isem _____Sess_____Data tat-twelid _____

Grupp etniku_____Stat_____Data tal-lum_____

Isem it-tifel/tifla_____Sess_____

Data tat-twelid tat-tarbija_____

NĦ (Naqbel Ħafna) **N** (Naqbel) **MŻ** (Mhux Ċert/a) **MN** (Ma Naqbilx) **MNĦ** (Ma Naqbilx Ħafna)

1. Ta' spiss inħoss li ma nistax nimmaniġġja l-affarijiet sew.
   NĦ N MŻ MN MNĦ

2. Insib lili nnifsi li qed inċedi minn ħajti aktar milli bsart minħabba l-bżonnijiet ta' wliedi.
   NĦ N MŻ MN MNĦ

3. Inħossni f'nasba minħabba r-responsabbiltajiet tiegħi ta' ġenitur.
   NĦ N MŻ MN MNĦ

4. Mindu kelli lil ibni/binti ma kontx kapaċi nagħmel affarijiet ġodda jew differenti.
   NĦ N MŻ MN MNĦ

5. Mindu kelli lil ibni/binti nħoss li kważi qatt ma jien kapaċi li nagħmel affarijiet li jogħġbuni.
   NĦ N MŻ MN MNĦ

6. M'iniex ferħan/a bl-aħħar xirja ta' ħwejjeġ li xtrajt għalija nnifsi.
   NĦ N MŻ MN MNĦ

7. Għandi affarijiet mhux ħażin li jdejquni f'ħajti.
   NĦ N MŻ MN MNĦ

8. Il-fatt li kelli iben/bint ikkaġuna aktar problemi milli bsart fir-relazzjoni tiegħi ma' żewġi/marti/sieħbi/sieħba.
   NĦ N MŻ MN MNĦ

9. Inħossni waħdi u mingħajr ħbieb.
   NĦ N MŻ MN MNĦ

10. Normalment meta mmur xi party nistenna li mhux ħa nieħu pjaċir.
    NĦ N MŻ MN MNĦ

11. M'għadnix interessat/a fin-nies bħalma kont qabel.
    NĦ N MŻ MN MNĦ

12. M'għadnix nieħu pjaċir b'affarijiet bħal qabel.
    NĦ N MŻ MN MNĦ

13. Ibni/binti rari ħafna jagħmel/tagħmel affarijiet li jġagħluni nħossni tajba/tajjeb.
    NĦ N MŻ MN MNĦ

14. Inħoss li l-isforzi li nagħmel ma' ibni/binti mhumiex apprezzati ħafna.
    NĦ N MŻ MN MNĦ

15. Ibni/binti ma jitbissimlix/titbissimlix daqskemm kont nistenna.
    NĦ N MŻ MN MNĦ

16. Kultant inħoss li ibni/binti ma nogħġbux/nogħġobhiex u ma jridx/tridx ikun/tkun viċin tiegħi.
    NĦ N MŻ MN MNĦ

17. It-tifel/tifla tiegħi huwa/hija emozzjonali ħafna u jirrabja/tirrabja malajr.
    NĦ N MŻ MN MNĦ

18. Ibni/binti ma jidhirx/tidhirx li jitgħallem/titgħallem malajr daqs tfal oħra.
    NĦ N MŻ MN MNĦ

19. Ibni/binti ma jitbissimx/titbissimx daqs tfal oħra.
    NĦ N MŻ MN MNĦ

20. Ibni/binti mhux kapaċi jagħmel/tagħmel daqskemm stennejt li jagħmel/tagħmel.
    NĦ N MŻ MN MNĦ

21. Ibni/binti jieħu/tieħu żmien twil u huwa diffiċli għalih/għaliha biex jidra/tidra affarijiet ġodda u jadatta/tadatta għal bidliet.
    NĦ N MŻ MN MNĦ

22. Jien inħossni li jien (agħżel tweġiba minn dawn ta' taħt):
    1. Ġenitur tajjeb ħafna
    2. Aħjar minn ġenituri oħra
    3. Ġenitur bħall-oħrajn

4. Persuna li għandha problemi biex tkun ġenitur
5. Ma tantx jien tajjeb/tajba bħala ġenitur

23. Jien stennejt li kien se jkolli aktar affett għal ibni/binti u illi nħossni aktar qrib tat-tarbija (tifel/tifla) milli fil-fatt inħossni, u dan jinkwetani.
    NĦ N MŻ MN MNĦ

24. Xi kultant ibni/binti jagħmel/tagħmel affarijiet li jdejquni sempliċement biex ikun/tkun kattiv/a.
    NĦ N MŻ MN MNĦ

25. Ibni/binti donnu/a jibki/tibki u jagħmel/tagħmel għaġeb aktar minn tfal oħra.
    NĦ N MŻ MN MNĦ

26. Ibni/binti iqum/tqum bin-nervi.
    NĦ N MŻ MN MNĦ

27. Inħoss li ibni/binti jbati/tbati bin-nervi u malajr jitilgħulu/jitilgħulha.
    NĦ N MŻ MN MNĦ

28. Meta nqabbel lil ibni/binti ma' tfal oħra, ibni/binti għandu/għandha ħafna diffikultà biex jidra/tidra tibdiliet fl-iskeda u t-tibdiliet fid-dar.
    NĦ N MŻ MN MNĦ

29. Ibni/binti jirreaġixxi/tirreaġixxi b'mod qawwi meta tiġri xi ħaġa li ma togħġbux/togħġobhiex.
    NĦ N MŻ MN MNĦ

30. Meta jkun/tkun qed jilgħab/tilgħab, ibni/binti ma tantx jidħaq/tidħaq.
    NĦ N MŻ MN MNĦ

31. L-iskeda tal-irqad u l-ikel ta' ibni/binti kienet ħafna aktar iebsa milli stennejt.
    NĦ N MŻ MN MNĦ

32. Skoprejt li biex inġiegħel lil ibni/binti jagħmel/tagħmel xi ħaġa jew inżommu/inżommha milli jagħmel/tagħmel xi ħaġa hija (agħżel tweġiba minn dawn t'hawn isfel):
    1. Ħafna itqal milli stennejt
    2. Ftit itqal milli stennejt
    3. Pjuttost tqila kif stennejt
    4. Eħfef milli stennejt
    5. Ħafna eħfef milli stennejt

33. Aħseb sew u għodd in-numru ta' affarijiet li ibnek/bintek jagħmel/tagħmel li jdejquk. Pereżempju, joħodha/toħodha bil-mod wisq, ma jridx/tridx tisma', attiv/a żżejjed, jibki/tibki, jinterrompi/tinterrompi, jiġġieled/tiġġieled, jeqred/teqred, eċċ. (agħżel tweġiba minn t'hawn isfel):
    1. 1-3
    2. 4-5
    3. 6-7
    4. 8-9
    5. 10+

34. Hemm xi affarijiet li jagħmel/tagħmel ibni/binti li veru jdejquni.
    NĦ N MŻ MN MNĦ

35. L-imġiba ta' ibni/binti hija aktar problematika milli bsart.

NĦ N MŻ MN MNĦ

36. Ibni/binti jitlob/titlob minni aktar minn tfal oħra.

NĦ N MŻ MN MNĦ

APPENDIX K

The Coparenting Relationship Scale

For each item, select the response that best describes the way you and your partner work together as parents:

0	1	2	3	4	5	6
Not true of us		A little bit true of us		Somewhat true of us		Very true of us

1 I believe my partner is a good parent.
2 My relationship with my partner is stronger now than before we had a child.
3 My partner asks my opinion on issues related to parenting.
4 My partner pays a great deal of attention to our child.
5 My partner likes to play with our child and then leave dirty work to me. **(R)**
6 My partner and I have the same goals for our child.
7 My partner still wants to do his or her own thing instead of being a responsible parent. **(R)**
8 It is easier and more fun to play with the child alone than it is when my partner is present too.
9 My partner and I have different ideas about how to raise our child. **(R)**
10 My partner tells me I am doing a good job or otherwise lets me know I am being a good parent.
11 My partner and I have different ideas regarding our child's eating, sleeping, and other routines. **(R)**
12 My partner sometimes makes jokes or sarcastic comments about the way I am as a parent.
13 My partner does not trust my abilities as a parent.
14 My partner is sensitive to our child's feelings and needs.
15 My partner and I have different standards for our child's behavior. **(R)**
16 My partner tries to show that she or he is better than me at caring for our child.
17 I feel close to my partner when I see him or her play with our child.
18 My partner has a lot of patience with our child.
19 We often discuss the best way to meet our child's needs.
20 My partner does not carry his or her fair share of the parenting work. **(R)**
21 When all three of us are together, my partner sometimes competes with me for our child's attention.
22 My partner undermines my parenting.
23 My partner is willing to make personal sacrifices to help take care of our child.
24 We are growing and maturing together through experiences as parents.
25 My partner appreciates how hard I work at being a good parent.
26 When I'm at my wits end as a parent, partner gives me extra support I need.
27 My partner makes me feel like I'm best possible parent for our child.
28 The stress of parenthood has caused my partner and me to grow apart. **(R)**
29 My partner doesn't like to be bothered by our child. **(R)**
30 Parenting has given us a focus for the future.

These questions ask you to describe things you do when both you and your partner are physically present together with your child (i.e. in the same room, in the car, on outings).
Count only times when all three of you are actually within the company of one another (even if this is

just a few hours per week).
0 1 2 3 4 5 6
Never Sometimes Often Very Often
(once or twice (once a day) (several times
a week) a day)

How often in a **typical week**, **when all 3 of you are together**, do you:

31 Find yourself in a mildly tense or sarcastic interchange with your partner?
32 Argue with your partner about your child, in the child's presence?
33 Argue about your relationship or marital issues unrelated to your child, in the child's presence?
34 One or both of you say cruel or hurtful things to each other in front of the child?
35 Yell at each other within earshot of the child?

L-iskala tar-relazzjoni ta' trobbija flimkien

Għal kull suġġett agħżel tweġiba li l-aħjar tiddeskrivi l-mod kif int u s-sieħeb/sieħba tiegħek taħdmu flimkien bħala ġenituri:

0	1	2	3	4	5	6
Mhux veru dwarna	Ftit veru dwarna			Pjuttost veru dwarna	Verissimu dwarna	

1 Nemmen li s-sieħeb/sieħba tiegħi huwa/hija ġenitur tajjeb/tajba.

2 Ir-relazzjoni tiegħi mas-sieħeb/sieħba tiegħi ssaħħet aktar minn mindu kellna tarbija.

3 Is-sieħeb/sieħba tiegħi jitlob/titlob l-opinjoni tiegħi dwar kwistjonijiet li għandhom x'jaqsmu mat-trobbija.

4 Is-sieħeb/sieħba tiegħi jagħti/tagħti attenzjoni kbira ħafna lil uliedna.

5 Is-sieħeb/sieħba tiegħi jħobb/tħobb jilgħab/tilgħab ma' wliedna u jħalli/tħalli x-xogħol kollu għalija. **(R)**

6 Jien u s-sieħeb/sieħba tiegħi għandna l-istess ambizzjonijiet għal uliedna.

7 Is-sieħeb/sieħba tiegħi jrid/trid jibqa'/tibqa' jagħmel/tagħmel li jrid/trid minflok li jkun/tkun ġenitur responsabbli. **(R)**

8 Huwa iktar faċli u aktar pjaċevoli li nilgħab ma' wliedi meta nkunu waħedna milli jekk is-sieħeb/sieħba jkun/tkun preżenti wkoll.

9 Jien u s-sieħeb/sieħba tiegħi għandna ideat differenti dwar kif inrabbu lil uliedna. **(R)**

10 Is-sieħeb/sieħba tiegħi jgħidli/tgħidli meta nkun qed nagħmel biċċa xogħol tajba jew alternattivament jgħidli/tgħidli meta nkun qed inkun ġenitur tajjeb.

11 Jien u s-sieħeb/sieħba tiegħi għandna ideat differenti dwar ir-rutina tal-ikel, irqad u rutini oħrajn ta' wliedna. **(R)**

12 Xi kultant is-sieħeb/sieħba tiegħi jiċċajta jew jgħaddi/tgħaddi kummenti sarkastiċi dwar il-mod kif jien inġib ruħi bħala ġenitur.

13 Is-sieħeb/sieħba tiegħi ma jafdax/tafdax l-abbiltà tiegħi bħala ġenitur.

14 Is-sieħeb/sieħba tiegħi huwa/hija sensittiv/a dwar l-emozzjonijiet u l-bżonnijiet ta' wliedna.

15 Jiena u s-sieħeb/sieħba tiegħi għandna standards differenti dwar l-imġiba ta' wliedna. **(R)**

16 Is-sieħeb/sieħba tiegħi jipprova/tipprova juri/turi li hu/hi aħjar minni għal dak li jirrigwarda l-attenzjoni li tingħata lil uliedna.

17 Inħossni qrib mas-sieħeb/sieħba tiegħi meta narah/naraha jilgħab/tilgħab ma' wliedna.

18 Is-sieħeb/sieħba tiegħi għandu/ha ħafna paċenzja ma' wliedna.

19 Ġieli niddiskutu l-aħjar mod kif nistgħu nissodisfaw il-bżonnijiet ta' wliedna.

20 Is-sieħeb/sieħba tiegħi ma jġorrx/ġġorrx is-sehem tiegħu/tagħha tax-xogħol ta' ġenitur. **(R)**

21 Meta nkunu lkoll flimkien, xi kultant is-sieħeb/sieħba tiegħi j/tikkompeti miegħi għall-attenzjoni ta' wliedna.

22 Is-sieħeb/sieħba tiegħi jwaqqa' l-mod kif inġib ruħi bħala ġenitur.

23 Is-sieħeb/sieħba tiegħi huwa/hija lest/a sabiex jagħmel/tagħmel sagrifiċċji personali sabiex ikun/tkun jista'/tista' jieħu/tieħu ħsieb ta' wliedna.

24 Qed nikbru u nimmaturaw flimkien permezz tal-esperjenza ta' ġenituri.

25 Is-sieħeb/sieħba tiegħi japprezza/tapprezza kemm nistinka sabiex inkun ġenitur tajjeb.

26 Meta tkun ser ittini rasi bħala ġenitur, is-sieħeb/sieħba tiegħi jagħtini/tagħtini s-sapport addizzjonali li jkolli bżonn.

27 Is-sieħeb/sieħba tiegħi ġġegħelni nħoss li jien l-aħjar ġenitur possibbli għal uliedna.

28 L-istress tar-rwol ta' ġenituri kkawża firda bejni u bejn is-sieħeb/sieħba tiegħi. **(R)**

29 Is-sieħeb/sieħba tiegħi ma jħobbx/tħobbx li wliedna jdejquh/jdejquha. **(R)**

30 Li sirna ġenituri tatna mira għall-ġejjieni tagħna.

Dawn il-mistoqsijiet jitolbuk tiddeskrivi dak li tagħmel meta kemm int kif ukoll is-sieħeb/sieħba tiegħek tkunu fiżikament preżenti flimkien ma' wliedkom (i.e. fl-istess kamra, karozza, matul ħarġiet).

<u>Għodd biss dawk id-drabi meta t-tlieta li intom</u> tkunu attwalment fil-kumpanija ta' xulxin (anki jekk għal ftit sigħat kull ġimgħa).

0	1	2	3	4	5	6
Qatt	Xi kultant		Ta' Sikwit		Ta' Sikwit Ħafna	
(darba jew darbtejn, darba f'ġurnata)			(ta' sikwit f'ġimgħa, f'ġurnata)			

Kemm ta' sikwit matul **ġimgħa tipika, meta t-tlieta li intom tkunu flimkien**, inti:

31 Issib lilek innifsek fi skambju kemxejn ta' tensjoni jew sarkastiku mas-sieħeb/sieħba tiegħek?

32 Targumenta mas-sieħeb/sieħba tiegħek <u>dwar uliedek</u>, fil-preżenza ta' wliedek?

33 Targumenta dwar kwistjonijiet relazzjonali jew matrimonjali mhux relatati ma' wliedek, fil-preżenza ta' wliedek?

34 Wieħed jew it-tnejn minnkom tgħidu affarijiet krudili jew li jweġġgħu lil xulxin fil-preżenza ta' wliedkom?

35 Tgħajtu ma' xulxin fil-viċinanza ta' wliedkom?

APPENDIX L

Early Childhood Behavior Questionnaire Very Short Form

Child's name: _____ Child's birthdate: Mo:____ Day:____ Yr:____

Today's date: Month:____ Day:____ Yr:____ Child's age: _____Yrs, _____Months

Relation to child: _____ Sex of child (circle one): Male Female

INSTRUCTIONS: Please read carefully before starting.

As you read each description of the child's behavior below, please indicate how often the child did this during the last two weeks by circling one of the numbers in the right column. These numbers indicate how often you observed the behavior described during the last two weeks.

Never	Very rarely	Less than half the time	About half the time	More than half the time	Almost always	Always	Does not apply
1	2	3	4	5	6	7	NA

The "Does Not Apply" column (NA) is used when you did not see the child in the situation described during the last two weeks. For example, if the situation mentions the child going to the doctor and there was no time during the last two weeks when the child went to the

doctor, circle the (NA) column. "Does Not Apply" (NA) is different from "NEVER" (1). "Never" is used when you saw the child in the situation but the child never engaged in the behavior mentioned in the last two weeks. Please be sure to circle a number or NA for every item.

1. When approached by an unfamiliar person in a public place (for example, the grocery store), how often did your child cling to a parent?

1 2 3 4 5 6 7 NA

2. While having trouble completing a task (e.g., building, drawing, dressing), how often did your child get easily irritated?

1 2 3 4 5 6 7 NA

3. When a familiar child came to your home, how often did your child seek out the company of the child?

1 2 3 4 5 6 7 NA

4. When offered a choice of activities, how often did your child decide what to do very quickly and go after it?

1 2 3 4 5 6 7 NA

5. During daily or evening quiet time with you and your child, how often did your child enjoy just being quietly sung to?

1 2 3 4 5 6 7 NA

6. While playing outdoors, how often did your child choose to take chances for the fun and excitement of it?

1 2 3 4 5 6 7 NA

7. When engaged in play with his/her favorite toy, how often did your child play for more than 10 minutes?

1 2 3 4 5 6 7 NA

8. continue to play while at the same time responding to your remarks or questions?

1 2 3 4 5 6 7 NA

9. When told that loved adults would visit, how often did your child get very excited?

1 2 3 4 5 6 7 NA

10. During quiet activities, such as reading a story, how often did your child fiddle with his/her hair, clothing, etc.?

1 2 3 4 5 6 7 NA

11. While playing indoors, how often did your child like rough and rowdy games?

1 2 3 4 5 6 7 NA

12. When being gently rocked or hugged, how often did your child seem eager to get away?

1 2 3 4 5 6 7 NA

13. When encountering a new activity, how often did your child get involved immediately?

1 2 3 4 5 6 7 NA

14. When engaged in an activity requiring attention, such as building with blocks, how often did your child tire of the activity relatively quickly?

1 2 3 4 5 6 7 NA

15. During everyday activities, how often did your child pay attention to you right away when you called to him/her?

1 2 3 4 5 6 7 NA

16. seem to be irritated by tags in his/her clothes?

1 2 3 4 5 6 7 NA

17. become bothered by sounds while in noisy environments?

1 2 3 4 5 6 7 NA

18. seem full of energy, even in the evening?

1 2 3 4 5 6 7 NA

19. While in a public place, how often did your child seem afraid of large, noisy vehicles?

1 2 3 4 5 6 7 NA

20. When playing outdoors with other children, how often did your child seem to be one of the most active children?

1 2 3 4 5 6 7 NA

21. When told "no", how often did your child stop the forbidden activity?

1 2 3 4 5 6 7 NA

22. become sadly tearful?

1 2 3 4 5 6 7 NA

23. Following an exciting activity or event, how often did your child

seem to feel down or blue? 1 2 3 4 5 6 7 NA

24. While playing indoors, how often did your child run through the house?

1 2 3 4 5 6 7 NA

25. Before an exciting event (such as receiving a new toy), how often did your child get very excited about getting it?

1 2 3 4 5 6 7 NA

26. When s/he asked for something and you said "no", how often did your child have a temper tantrum?

1 2 3 4 5 6 7 NA

27. When asked to wait for a desirable item (such as ice cream), how often did your child wait patiently?

1 2 3 4 5 6 7 NA

28. When being gently rocked, how often did your child smile?

1 2 3 4 5 6 7 NA

29. While being held on your lap, how often did your child mold to your body?

1 2 3 4 5 6 7 NA

30. When a familiar adult, such as a relative or friend, visited your home, how often did your child want to interact with the adult?

1 2 3 4 5 6 7 NA

31. When asked to do so, how often was your child able to be careful with something breakable?

1 2 3 4 5 6 7 NA

32. When visiting a new place, how often did your child not want to enter?

1 2 3 4 5 6 7 NA

33. When s/he was upset, how often did your child cry for more than 3 minutes, even when being comforted?

1 2 3 4 5 6 7 NA

34. become easily soothed?

1 2 3 4 5 6 7 NA

35. When you were busy, how often did your child find another activity to do when asked?

1 2 3 4 5 6 7 NA

36. When around large gatherings of familiar adults or children, how often did your child enjoy playing with a number of different people?

1 2 3 4 5 6 7 NA

Kwestjonarju dwar Imġiba ta' Tfulija Bikrija

Formula Qasira Ħafna

Isem it-tifel/tifla: _____

Data tat-twelid tat-tifel/tifla: Jum:____Xahar:____ Sena:____

Id-data tal-lum: Jum:____ Xahar:____Sena:____ **Età tat-tifel/tifla:** ____ Snin____Xhur.

Kif tiġi mit-tifel/tifla:_____ (omm/missier)

Sess tat-tifel/tifla (agħmel ċirku madwar l-għażla tiegħek): Maskil / Femminil

ISTRUZZJONIJIET: **Aqra sew qabel tibda.**

Waqt li tkun qed taqra d-deskrizzjonijiet t'hawn taħt dwar l-imġiba tat-tifel/tifla tiegħek, nitolbok tindika kemm sikwit it-tifel/tifla ġab/et ruħu/a b'dan il-mod matul dawn l-aħħar ġimagħtejn billi tagħmel ċirku madwar wieħed min-numri fil-kolonna l-leminija. Dawn in-numri jirrappreżentaw kemm-il darba inti osservajt l-imġiba deskritta **matul dawn l-aħħar ġimagħtejn**.

Qatt	Rari ħafna	Inqas minn nofs id-drabi	Madwar nofs id-drabi	Iktar minn nofs id-drabi	Kważi dejjem	Dejjem	Mhux applikabbli
1	2	3	4	5	6	7	MA

Il-kolonna 'Mhux Applikabbli' (MA) tintuża meta inti m'osservajtx lit-tifel/tifla fis-sitwazzjoni deskritta matul dawn l-aħħar ġimagħtejn. Pereżempju, jekk is-sitwazzjoni tindika li t-tifel/tifla mar/marret għand it-tabib u dan qatt ma seħħ f'dawn l-aħħar ġimagħtejn, agħmel ċirku madwar il-kolonna (MA). Il-kolonna 'Mhux Applikabbli' mhijiex l-istess bħal 'Qatt' (1). Il-kolonna 'Qatt' tintuża meta inti rajt it-tifel/tifla fis-

sitwazzjoni iżda hu/hija qatt ma ġab/et ruħu/a bl-imġiba msemmija f'dawn l-aħħar ġimagħtejn. Nitolbuk tassigura li tagħmel ċirku madwar numru jew MA għal kull mistoqsija.

Meta ġie/t avviċinat/a minn persuna mhux familjari ġewwa post pubbliku (pereżempju, għand tal-ħaxix), kemm-il darba t-tifel/tifla tiegħek

1. Iggranfa/t ma' ġenitur? 1 2 3 4 5 6 7 MA

Meta t-tifel/tifla tiegħek kellu/a diffikultà sabiex ilesti/tlesti kompitu (pereżempju, j/tibni, i/tpenġi, j/tilbes), kemm-il darba t-tifel/tifla tiegħek

2. Ġie/t urtat/a faċilment? 1 2 3 4 5 6 7 MA

Meta tifel/tifla familjari ġie/t id-dar tiegħek, kemm-il darba t-tifel/tifla tiegħek

3. Fittex/fittxet il-kumpanija ta' dak/dik it-tifel/tifla? 1 2 3 4 5 6 7 MA

Meta ngħata/t għażla ta' attivitajiet, kemm-il darba t-tifel/tifla tiegħek

4. Iddeċieda/iet x'ser j/tagħmel malajr u għamilha/litha?
1 2 3 4 5 6 7 MA

Waqt perjodu ta' skiet bejnek u bejn it-tifel/tifla tiegħek matul il-jum jew filgħaxija, kemm-il darba t-tifel/tifla tiegħek

5. Ħa/det pjaċir sempliċement meta inti kantajtlu/ilha fis-skiet?
1 2 3 4 5 6 7 MA

Waqt li kien/et qed j/tilgħab barra kemm-il darba t-tifel/tifla tiegħek

6. Għażel/let li j/tieħu riskji sempliċement għall-pjaċir u eċitament li j/tagħmel dan?
1 2 3 4 5 6 7 MA

Meta t-tifel/tifla tiegħek kien/et qed j/tilgħab mal-ġugarell favorit tiegħu/tagħha, kemm-il darba

7. Lagħab/et għal iktar minn għaxar (10) minuti? 1 2 3 4 5 6 7 MA

8. Kompla/iet j/tilgħab waqt li fl-istess ħin irrisponda/iet għar-rimarki jew mistoqsijiet tiegħek?
   1 2 3 4 5 6 7 MA

Meta ġie/t infurmat/a li adulti tal-qalb kienu ser jiġu jagħmlu żjara, kemm-il darba t-tifel/tifla tiegħek

9. Eċita/t ruħu/ha ħafna? 1 2 3 4 5 6 7 MA

Matul attivitajiet fil-kwiet, bħall-qari ta' storja, kemm-il darba t-tifel/tifla tiegħek

10. Lagħab/et b'xagħru/ha, bi ħwejġu/ġitha, eċċ? 1 2 3 4 5 6 7 MA

Waqt li kien/et qed jilgħab ġewwa d-dar, kemm-il darba t-tifel/tifla tiegħek

11. Ħa/det pjaċir j/tilgħab logħob goff u storbjuż? 1 2 3 4 5 6 7 MA

Meta t-tifel/tifla tiegħek ġie/t mbennen/na jew mgħannaq/qa b'mod ġentili, kemm-il darba t-tifel/tifla tiegħek

12. Deher/et ħerqan/a li j/titlaq 'l hemm? 1 2 3 4 5 6 7 MA

Meta kien/et qed j/tesperjenza attività ġdida, kemm-il darba t-tifel/tifla tiegħek

13. Involva/iet ruħu/ha immedjatament? 1 2 3 4 5 6 7 MA

Meta t-tifel/tifla tiegħek ġie/t involut/a f'attività li tirrikjedi attenzjoni, bħall-bini bil-blokok, kemm-il darba t-tifel/tifla tiegħek

14. Xeba'/xebgħet mill-attività relattivament malajr? 1 2 3 4 5 6 7 MA

Matul attivitajiet ta' kuljum, kemm-il darba t-tifel/tifla tiegħek

15. Tak/tagħtek attenzjoni immedjatament meta għajjattlu/ilha?
1 2 3 4 5 6 7 MA

16. Deher/et urtat/a mit-tabelli fi ħwejġu/itha? 1 2 3 4 5 6 7 MA

17. Iddejjaq/et minn ħsejjes meta kien/et ġo ambjent storbjuż?
1 2 3 4 5 6 7 MA

18. Deher/et mimli/ja enerġija, anki filgħaxija? 1 2 3 4 5 6 7 MA

Meta kontu f'post pubbliku, kemm-il darba t-tifel/tifla tiegħek

19. Deher/et beżgħan/a minn vetturi kbar u storbjużi?
1 2 3 4 5 6 7 MA

Meta kien/et qed j/tilgħab barra ma' tfal oħra, kemm-il darba t-tifel/tifla tiegħek

20. Deher/et li huwa/hija wieħed/waħda mill-aktar tfal attivi?
1 2 3 4 5 6 7 MA

Meta ngħad il-kelma 'le', kemm-il darba t-tifel/tifla tiegħek

21. Waqaf/et mill-attività miċħuda? 1 2 3 4 5 6 7 MA

22. Tbikkem/et? 1 2 3 4 5 6 7 MA

Wara attività jew avveniment eċitanti, kemm-il darba t-tifel/tifla tiegħek

23. Deher/et imdejjaq/a? 1 2 3 4 5 6 7 MA

Meta lagħab/et ġewwa, kemm-il darba t-tifel/tifla tiegħek

24. Ġera/ġriet mad-dar kollha? 1 2 3 4 5 6 7 MA

Qabel avveniment eċitanti (bħal meta kien/et ħa j/tirċievi ġugarell ġdid), kemm-il darba t-tifel/tifla tiegħek

25. Eċita/t ruħu/ha ħafna talli kien/et ser j/tirċevih? 1 2 3 4 5 6 7 MA

Meta t-tifel/tifla tiegħek talbek/talbitek xi ħaġa u inti għedtlu/tilha 'le' kemm-il darba

26. Għamel/et xenata (temper tantrum)? 1 2 3 4 5 6 7 MA

Meta ġie/t mitlub/a j/tistenna għal xi oġġett mixtieq (bħal ġelat), kemm-il darba t-tifel/tifla tiegħek

27. Stenna/iet b'mod paċenzjuż? 1 2 3 4 5 6 7 MA

Meta ġie/t imbennen/na b'mod ġentili, kemm-il darba t-tifel/tifla tiegħek

28. Tbissem/met? 1 2 3 4 5 6 7 MA

Meta nżamm/et fuq ħoġrok, kemm-il darba t-tifel/tifla tiegħek

29. Tgħannaq/et ma' ġismek? 1 2 3 4 5 6 7 MA

Meta adult familjari, bħal qraba jew ħbieb, għamlu żjara d-dar tiegħek, kemm-il darba t-tifel/tifla tiegħek

30. Ried/et j/tirrelata mal-adult? 1 2 3 4 5 6 7 MA

Meta ġie/t mistoqsi/ja li j/tagħmel dan, kemm-il darba t-tifel/tifla tiegħek kien/et kapaċi

31. J/toqgħod attent/a b'oġġett li jinkiser? 1 2 3 4 5 6 7 MA

Meta żortu xi post ġdid kemm-il darba t-tifel/tifla tiegħek

32. Ma riedx/riditx j/tidħol? 1 2 3 4 5 6 7 MA

Meta kien/et imdejjaq/a, kemm-il darba t-tifel/tifla tiegħek

33. Beka għal iktar minn tliet minuti, anki meta ġie/t imfarraġ/ġa?

	1	2	3	4	5	6	7	MA
34. Ġie/t faċilment ikkalmat/a?	1	2	3	4	5	6	7	MA

<u>Meta inti kellek x'tagħmel, kemm-il darba t-tifel/tifla tiegħek</u>

35. Sab attività oħra x'j/tagħmel meta ġie/t mitlub/a li j/tagħmel dan?

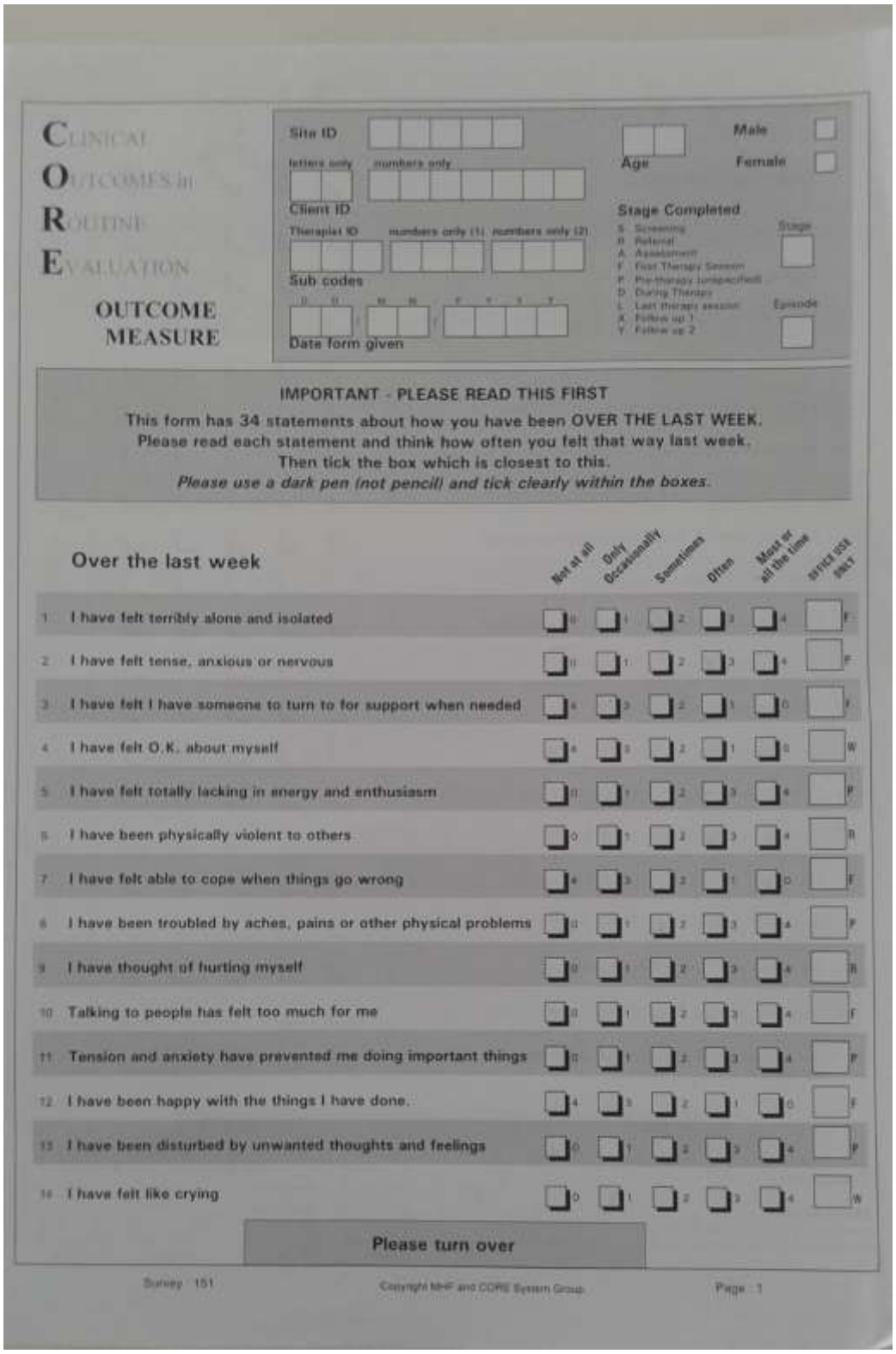
1 2 3 4 5 6 7 MA

<u>Meta t-tifel/tifla tiegħek ġie/t imdawwar/ra b'folla kbira ta' adulti jew tfal familjari, kemm-il darba t-tifel/tifla tiegħek</u>

36. Ħa/det pjaċir j/tilgħab ma' numru ta' nies differenti?

1 2 3 4 5 6 7 MA

APPENDIX M



CLINICAL
OUTCOMES in
ROUTINE
EVALUATION

OUTCOME MEASURE

Site ID
letters only | numbers only
Client ID
Therapist ID | numbers only (1) | numbers only (2)
Sub codes
Date form given

Age
Male
Female
Stage Completed
Stage
Episode

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	(office use only)
1 I have felt terribly alone and isolated	0	1	2	3	4	
2 I have felt tense, anxious or nervous	0	1	2	3	4	
3 I have felt I have someone to turn to for support when needed	4	3	2	1	0	
4 I have felt O.K. about myself	4	3	2	1	0	
5 I have felt totally lacking in energy and enthusiasm	0	1	2	3	4	
6 I have been physically violent to others	0	1	2	3	4	
7 I have felt able to cope when things go wrong	4	3	2	1	0	
8 I have been troubled by aches, pains or other physical problems	0	1	2	3	4	
9 I have thought of hurting myself	0	1	2	3	4	
10 Talking to people has felt too much for me	0	1	2	3	4	
11 Tension and anxiety have prevented me doing important things	0	1	2	3	4	
12 I have been happy with the things I have done	4	3	2	1	0	
13 I have been disturbed by unwanted thoughts and feelings	0	1	2	3	4	
14 I have felt like crying	0	1	2	3	4	

Please turn over

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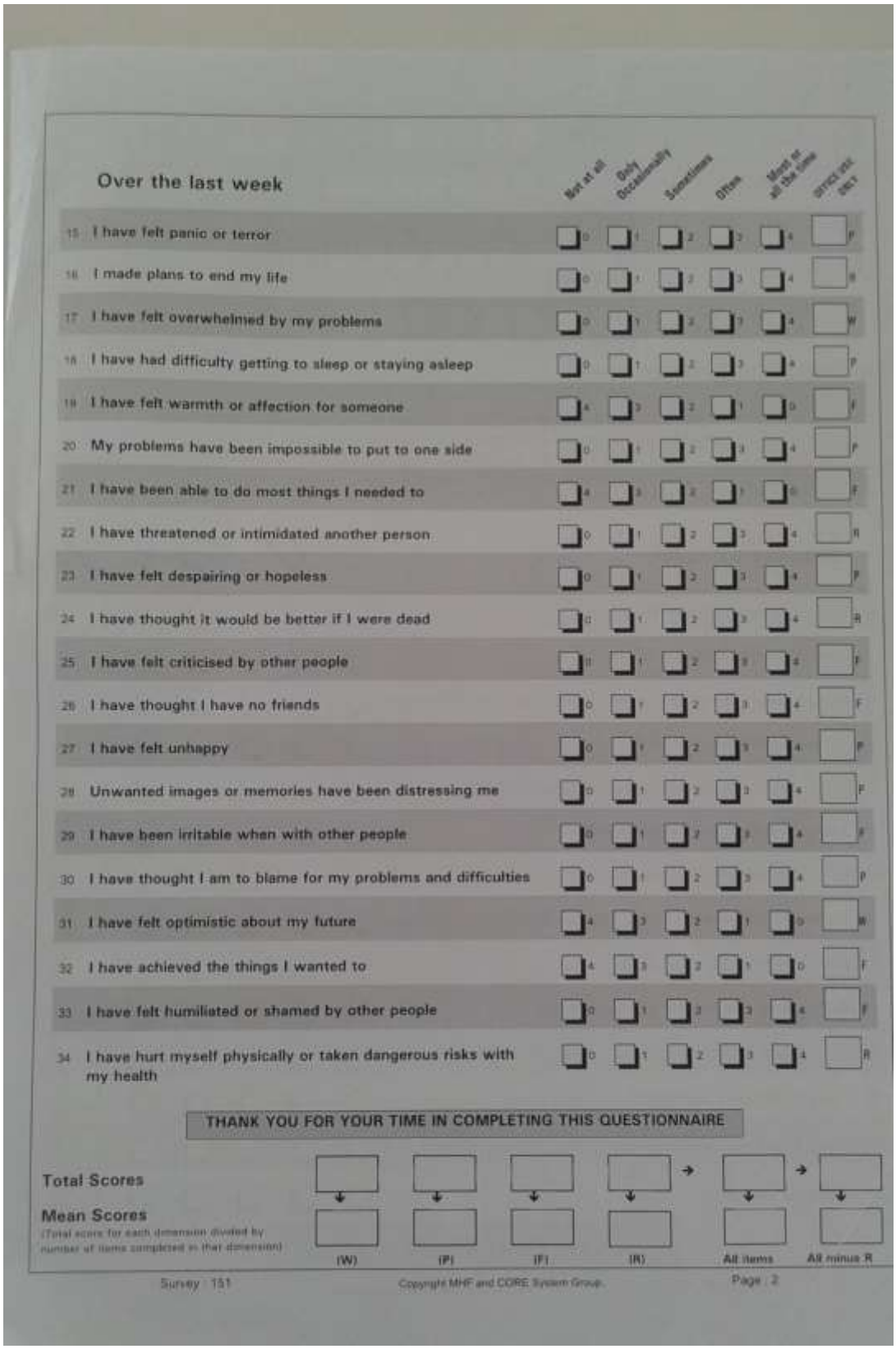


Over the last week

		Not at all	Only Occasionally	Sometimes	Often	Most or all the time	(mark all that apply)
15	I have felt panic or terror	0	1	2	3	4	P
16	I made plans to end my life	0	1	2	3	4	R
17	I have felt overwhelmed by my problems	0	1	2	3	4	W
18	I have had difficulty getting to sleep or staying asleep	0	1	2	3	4	P
19	I have felt warmth or affection for someone	4	3	2	1	0	F
20	My problems have been impossible to put to one side	0	1	2	3	4	P
21	I have been able to do most things I needed to	4	3	2	1	0	F
22	I have threatened or intimidated another person	0	1	2	3	4	R
23	I have felt despairing or hopeless	0	1	2	3	4	P
24	I have thought it would be better if I were dead	0	1	2	3	4	R
25	I have felt criticised by other people	0	1	2	3	4	F
26	I have thought I have no friends	0	1	2	3	4	F
27	I have felt unhappy	0	1	2	3	4	P
28	Unwanted images or memories have been distressing me	0	1	2	3	4	F
29	I have been irritable when with other people	0	1	2	3	4	F
30	I have thought I am to blame for my problems and difficulties	0	1	2	3	4	P
31	I have felt optimistic about my future	4	3	2	1	0	W
32	I have achieved the things I wanted to	4	3	2	1	0	F
33	I have felt humiliated or shamed by other people	0	1	2	3	4	F
34	I have hurt myself physically or taken dangerous risks with my health	0	1	2	3	4	R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Total Scores

Mean Scores
(Total score for each dimension divided by number of items completed in that dimension)

(W)	(P)	(F)	(R)	All items	All minus R

Survey 151 Copyright MHF and CORE System Group Page 2

CORE

ID tas-Sit

ittri biss numri biss

ID tal-Klijent

ID tat-Terapista numri biss (1) numri biss (2)

Kodiċijiet ta’ taħt

Data meta tingħata l-formola

Età **Maskil**

Femminil

F’liema stadju wasalna

L-Ittestjar tal-bidu

Ir-Riferiment

L-Assessjar

L-Ewwel Sessjoni tat-Terapija

Qabel it-Terapija (mhux speċifikat)

Waqt it-Terapija

L-Aħħar Sessjoni tat-Terapija

Follow up 1

Follow up 2

Stadju

Episodju

IMPORTANTI – JEKK JOGĦĠBOK L-EWWEL AQRA DIN

Din il-formola għandha 34 dikjarazzjoni dwar kif inti ħassejtek TUL DIN L-AĦĦAR ĠIMGĦA.

Jekk jogħġbok aqra kull dikjarazzjoni u aħseb dwar kemm-il darba ħassejtek b’dak il-mod tul il-ġimgħa l-oħra.

Wara mmarka l-kaxxa li l-aktar tqarreb għal dak is-sentiment.

Jekk jogħġbok uża bajrow sewda u mmarka b’mod ċar ġewwa l-kaxxi.

Tul l-aħħar ġimgħa

Xejn affattu

Xi kultant biss

Għal xi drabi

Ħafna drabi

Kważi dejjem jew il-ħin kollu

Għall-użu amministrattiv biss

1. Ħassejtni waħdi u iżolat b’mod tal-biża’
2. Ħassejtni tens, anzjuż jew nervuż
3. Ħassejt li hemm xi ħadd li jista’ jgħinni meta jinqala’ l-bżonn
4. Ħassejtni tajjeb miegħi nnifsi
5. Ħassejtni nieqes għalkollox mill-enerġija u l-entużjażmu
6. Kont fiżikament vjolenti ma’ oħrajn
7. Ħassejtni kapaċi nfendi kieku l-affarijiet ġew ħżiena
8. Kont mikdud b’ħafna wġigħat jew problemi fiżiċi oħra
9. Bdejt naħseb li nweġġa’ lili nnifsi
10. Sibtha diffiċli biex nitħaddet man-nies
11. It-tensjoni u l-ansjetà ma ħallewnix inwettaq affarijiet importanti
12. Kont kuntent bl-affarijiet li għamilt
13. Kont imħawwad bi ħsibijiet u sentimenti mhux mixtieqa
14. Ħassejt li kelli bżonn nibki

Jekk jogħġbok aqleb il-paġna

15. Ħassejt paniku jew twerwir
16. Għamilt pjanijiet biex intemm ħajti
17. Ħassejtni mgħarraq fil-problemi tiegħi
18. Sibtha iebsa biex norqod jew li nibqa’ rieqed
19. Ħassejt ġibda jew imħabba lejn xi ħadd
20. Kien impossibbli li ninsa l-problemi tiegħi
21. Kont kapaċi nagħmel ħafna mill-affarijiet li kelli bżonn nagħmel
22. Heddidt jew beżżajt persuna oħra
23. Ħassejtni fi stat ta’ disperazzjoni
24. Ħsibt li kien ikun aħjar li kont mejjet
25. Ħassejt li persuni oħra bdew jikkritikawni
26. Ħsibt li xejn m’għandi ħbieb
27. Ħassejtni mdejjaq
28. Viżjonijiet jew memorji mhux mixtieqa bdew iqabbduni d-dwejjaq
29. Ħassejtni nervuż fil-kumpanija ta’ ħaddieħor

30. Ħassejt li jien għandi x'naħti għall-problemi u d-diffikultajiet tiegħi
31. Ħassejtni fiduċjuż dwar il-ġejjieni tiegħi
32. Irnexxieli nagħmel l-affarijiet li ridt inwettaq
33. Ħassejtni umiljat jew imkażbar minn nies oħra
34. Weġġajt lili nnifsi fiżikament jew ħadt riskji perikolużi fejn għandha x'taqsam saħħti

GRAZZI TALLI ĦADT IL-ĦIN BIEX TIMLA DAN IL-KWESTJONARJU

Punti Totali

Punti Medji

APPENDIX N

Dr. Mario Vella

Data Protection Officer for Primary Health Care

Malta.

Date:22nd August, 2016

REQUEST FOR APPROVAL TO ACCESS SUBJECTS

Dear Dr. Vella,

I am currently conducting a quantitative research study as part fulfillment of my PhD in Family Therapy and Systemic Practice at the University of Malta.

The title of the research is *'Do early Co-Parenting Programmes with Parents of Temperamentally Reactive Infants help and with whom? Randomised control trials with parents living together, and single mothers parenting with their mothers'.*

Through this study I hope to investigate the impact of attending a co-parenting programme for those parents who are found to have an infant that presents with a highly reactive temperament. Randomised control trials with eligible parents will be carried out, and attention will be given to support parents throughout the whole process.

As part of this study, I will be interested in measures of infant temperament as well as parental stress, alongside parents' ability to coparent. Considering that an appropriate age of measuring infant temperament would be around the time the child reaches 8 months of age, assessment and subsequent recruitment of participants will take place around the second visit to the well-baby clinics when infants attend for their standard immunization. Assessment will take place through the use of standardized tests, administered by myself and authorized students. Those parents found to be eligible will be invited to participate and will be randomly assigned to different coparenting programme groups for 16 weeks, throughout which they will all receive support from case workers. Groups will be carried out in the evenings, and child care will also be provided to enable participants to attend.

This research study will be supervised locally by Prof. Angela Abela from the Department of Family Studies within the Faculty of Social Wellbeing at the Univeristy of Malta, as well as by well known researchers Professors Phil and Carolyn Cowan from the Department of Psychology, University of Berkeley in California, USA.

I hereby ask you to kindly consider giving me permission to carry out my research study within the well-baby clinics in Malta. Through your permission and support, you will be providing a unique opportunity to address what is considered to be one of the risk factors amongst infants in the development of future psychopathology, as well as supporting parents to parent more effectively together, with the hope of minimizing this risk to their children's health and development.

All personal information of participants will be protected at all times and kept in a safe place. Audio recordings of group sessions will also be kept for the duration of the research, and used for supervision reasons. These will be only be accessible to the researcher and supervisors and used only for the purposes of research.

Should you require any further information or clarification on the study, you are kindly asked to contact the researcher below.

Yours Faithfully,

Ingrid Grech Lanfranco

ingrid.grech-lanfranco.95@um.edu.mt

ingrid.grech-lanfranco@um.edu.mt

Mobile: 99862272.

DIVIZJONI TAS-SAHHA PRIMARJA
7 Sqaq Harper,
Furjana
FRN 1940

Telephone: + 356 21239993
Telefax: + 356 21222856

Sahha Primarja

PRIMARY HEALTH DIVISION
7 Harper Lane,
Floriana
FRN 1940

Telephone: + 356 21239993
Telefax: + 356 21222856

Website: http://www.health.gov.mt

23 August 2016

Ingrid Grech Lanfranco
No. 4, 'Wakefield'
Triq F. X. Ebejer,
Ta' L-Ibragg, SWQ 2172

Re: Your request to carry out a research within the Primary Health Department.

Dear Ms Grech Lanfranco,

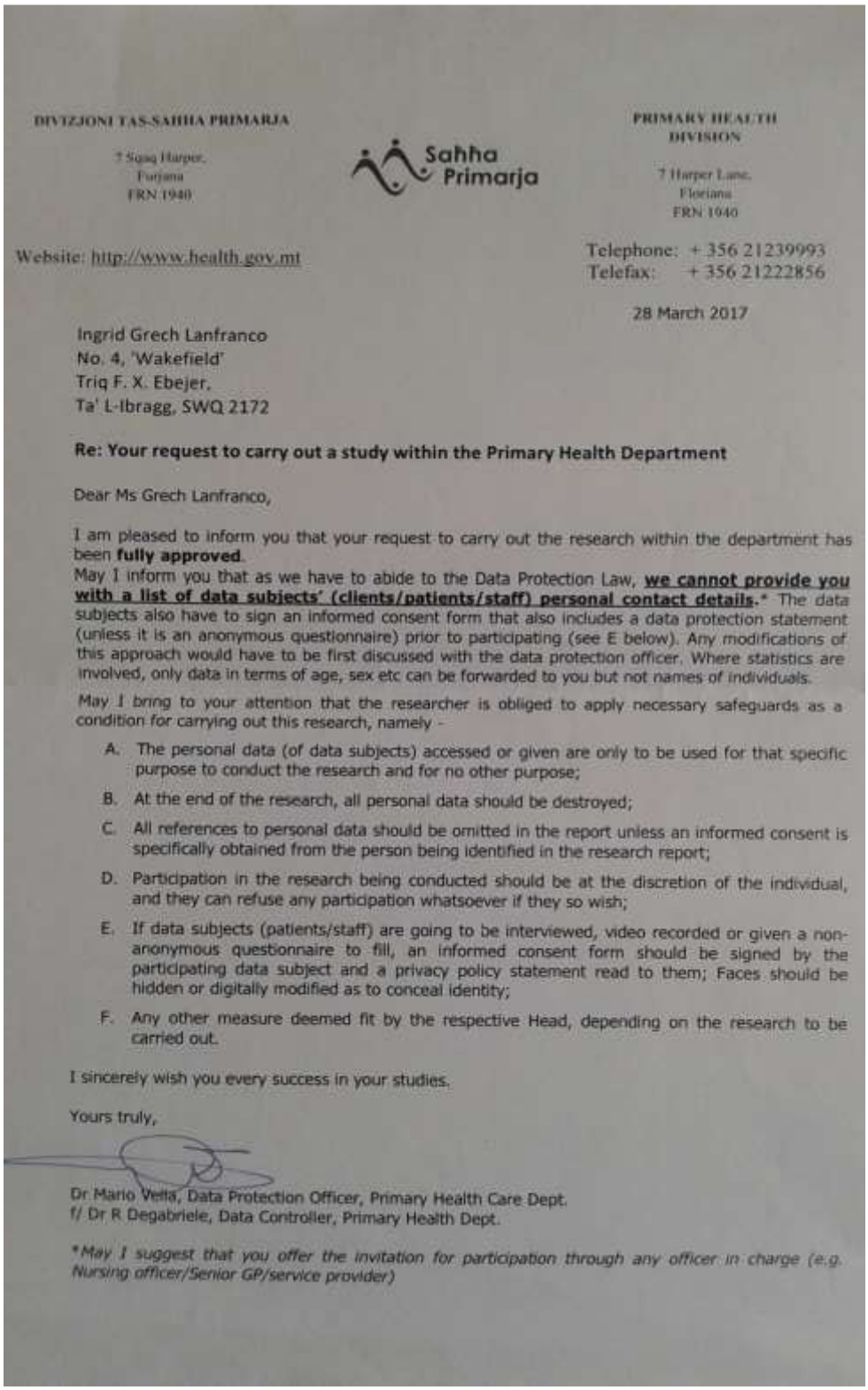
Your request to carry out the research within the department has been **temporarily granted** on the proviso that you furnish our department with a copy of the approval from the University Research Ethics Committee (UREC) ***prior*** to the actual commencement of your study.

Please be informed that as we have to abide to the Data Protection Law, we cannot provide you with a list of data subjects' (clients/patients/staff) personal contact details so in your methodology you should take this into consideration and make it clear within your application with UREC.*

Following approval from the University Research Ethics Committee we will furnish you with a final permission and you may proceed. If the department does not receive a copy of the approval from the University Research Ethics Committee, this temporary permission to conduct the study/research will automatically be declared as void.

Yours truly,

Dr M. Vella DPO,
F/CEO, Data Controller
Primary Health Department



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FRN 1940

Sahha Primarja

PRIMARY HEALTH DIVISION

7 Harper Lane,
Floriana
FRN 1940

Website: http://www.health.gov.mt

Telephone: + 356 21239993
Telefax: + 356 21222856

28 March 2017

Ingrid Grech Lanfranco
No. 4, 'Wakefield'
Triq F. X. Ebejer,
Ta' L-Ibragg, SWQ 2172

Re: Your request to carry out a study within the Primary Health Department

Dear Ms Grech Lanfranco,

I am pleased to inform you that your request to carry out the research within the department has been **fully approved**.
May I inform you that as we have to abide to the Data Protection Law, **we cannot provide you with a list of data subjects' (clients/patients/staff) personal contact details.*** The data subjects also have to sign an informed consent form that also includes a data protection statement (unless it is an anonymous questionnaire) prior to participating (see E below). Any modifications of this approach would have to be first discussed with the data protection officer. Where statistics are involved, only data in terms of age, sex etc can be forwarded to you but not names of individuals.

May I bring to your attention that the researcher is obliged to apply necessary safeguards as a condition for carrying out this research, namely -

A. The personal data (of data subjects) accessed or given are only to be used for that specific purpose to conduct the research and for no other purpose;

B. At the end of the research, all personal data should be destroyed;

C. All references to personal data should be omitted in the report unless an informed consent is specifically obtained from the person being identified in the research report;

D. Participation in the research being conducted should be at the discretion of the individual, and they can refuse any participation whatsoever if they so wish;

E. If data subjects (patients/staff) are going to be interviewed, video recorded or given a non-anonymous questionnaire to fill, an informed consent form should be signed by the participating data subject and a privacy policy statement read to them; Faces should be hidden or digitally modified as to conceal identity;

F. Any other measure deemed fit by the respective Head, depending on the research to be carried out.

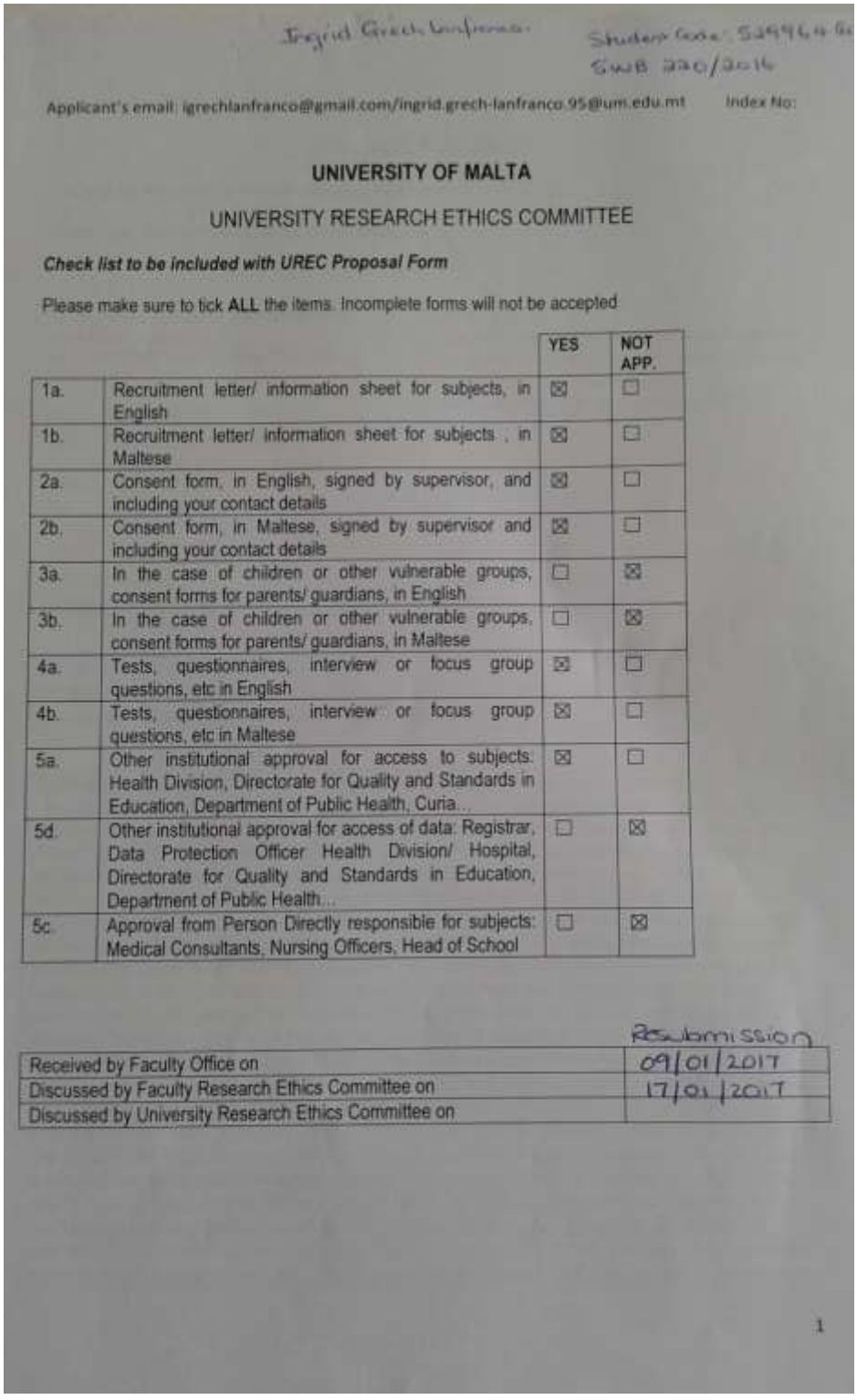
I sincerely wish you every success in your studies.

Yours truly,

Dr Mario Vella, Data Protection Officer, Primary Health Care Dept.
f/ Dr R Degabriele, Data Controller, Primary Health Dept.

**May I suggest that you offer the invitation for participation through any officer in charge (e.g. Nursing officer/Senior GP/service provider)*

APPENDIX O



Ingrid Grech Lanfranco Student Code: 529964(M)
GwB 220/2016

Applicant's email: igrechlanfranco@gmail.com/ingrid.grech-lanfranco.95@um.edu.mt Index No:

UNIVERSITY OF MALTA

UNIVERSITY RESEARCH ETHICS COMMITTEE

Check list to be included with UREC Proposal Form

Please make sure to tick **ALL** the items. Incomplete forms will not be accepted

		YES	NOT APP.
1a.	Recruitment letter/ information sheet for subjects, in English	☒	☐
1b.	Recruitment letter/ information sheet for subjects , in Maltese	☒	☐
2a.	Consent form, in English, signed by supervisor, and including your contact details	☒	☐
2b.	Consent form, in Maltese, signed by supervisor and including your contact details	☒	☐
3a.	In the case of children or other vulnerable groups, consent forms for parents/ guardians, in English	☐	☒
3b.	In the case of children or other vulnerable groups, consent forms for parents/ guardians, in Maltese	☐	☒
4a.	Tests, questionnaires, interview or focus group questions, etc in English	☒	☐
4b.	Tests, questionnaires, interview or focus group questions, etc in Maltese	☒	☐
5a.	Other institutional approval for access to subjects: Health Division, Directorate for Quality and Standards in Education, Department of Public Health, Curia…	☒	☐
5d.	Other institutional approval for access of data: Registrar, Data Protection Officer Health Division/ Hospital, Directorate for Quality and Standards in Education, Department of Public Health…	☐	☒
5c.	Approval from Person Directly responsible for subjects: Medical Consultants, Nursing Officers, Head of School	☐	☒

Resubmission

Received by Faculty Office on	09/01/2017
Discussed by Faculty Research Ethics Committee on	17/01/2017
Discussed by University Research Ethics Committee on	

1

UNIVERSITY OF MALTA

Request for Approval of Human Subjects Research

Please type. Handwritten forms will not be accepted

FROM: *(name, address for correspondence)* Ingrid Grech Lanfranco *No. 4, 'Wakefield' Triq F.X. Ebejer,Ta' L-Ibragg SWQ2172*	PROJECT TITLE: Do early co-parenting programmes with parents /co-caring dyads of infants with a highly reactive temperament help and with whom? A randomised study using Parents As Partners
TELEPHONE: 99862272	
EMAIL: igrechlanfranco@gmail.com / ingrid.grech-lanfranco.95@um.edu.mt	
COURSE AND YEAR: PhD 2nd Year	
DURATION OF ENTIRE PROJECT: From 04/11/2014 To 04/11/2020	FACULTY SUPERVISOR'S NAME AND EMAIL: Professor Angela Abela angela.abela@um.edu.mt

ANTICIPATED FUNDING SOURSE:
(Include grant or contact number if known)
Endeavour, Academic Work Resources Fund and personal.

1. Please give a brief summary of the purpose of the research, in non-technical language.
Research on whether early co-parenting programmes are helpful with parents of temperamentally reactive (difficult to soothe) infants, is an innovative and highly valuable area of study, not only for Malta but also internationally. Besides filling an important and crucial research gap that exists between the co-parenting relationship quality and such infants presenting with a reactive temperament, this research carries strong preventive qualities in terms of risks of development of child psychopathology (such as ADHD, Conduct Disorder, Autistic Spectrum Disorder and other child behavioural difficulties). The intervention to be used, namely the Parents As Partners Programme (PasP), an evidence-based parenting programme, is also expected to greatly enhance the quality of relationships in young families who may be experiencing stress and may also be at the brink of breakdown. This becomes all the more threatening with infants that are more challenging to manage. Therefore a research of this quality and nature is important not only for our families, but for our children and future society. In light of the positive impact of previous co-parenting programmes that were carried out with parents at different points in their coparenting relationship, with different aged children from prior to birth at the transition to parenthood, up to adolescence, with low-income families, and including the father specifically in such programmes, a positive impact is also hoped for in circumstances where coparenting programmes are carried out with infants that are considered to be temperamentally reactive (difficult to soothe) representing at least 10% of all infants born. It is hoped that the implications of this intervention would be that the infants show less irritability post-parenting programme, and that parents/co-carers are able to parent more effectively. Owing to the bidirectional nature of relationships, the couple and parenting relationship, and the infant's temperament, are expected to constantly impact each other, meaning that a change

2

in one effects the other and vice versa. The stronger and more positive the couple relationship quality, the more effective the parenting relationship, and the better the infant fairs.Therefore, whilst infant temperament has been linked to child psychopathogy, it is therefore expected that if the infants show a lower level of irritability following the delivery of the coparenting programmes, the parents are expected to have less stress as parents, and the risk for developing further childhood problems reduced with the infant more able to adjust positively.

2. Give details of procedures that relate to subjects' participation

(a) How are subjects recruited? What inducement is offered? (*Append copy of letter or advertisement or poster, if any.*)

Following a clear definition of the characteristics that the participants are expected to fullfill as per the selection criteria below, a number of measures need to be set into place in order to enable the researcher to begin the recruitment process of potential participants for the study. Participants will be selected from the Mosta, Floriana and Paola well-baby clinics in Malta whilst these parents are attending their standard second post-natal follow-up visit with their infants. There are a total of 5 well-baby clinics in Malta that fall under the Primary Child Health section in the Primary Health Care division. These are situated in Mosta, Floriana, Paola, Rabat and Qormi, the busiest being the first three because they cover a larger catchment area. This was also confirmed through a personal communication with Dr. Farrugia Sant Angelo, the Medical Co-ordinator at Primary Health Directorate in Malta. Gozo has a separate system run by paediatricians within the hospital setting and not part of the well-baby clinic set-up. For the latter reason it is being decided to leave Gozo out of the study. Maltese speaking parents of infants aged between 8 months to one year are being considered for this study. Gay/Lesbian couples who will be attending the clinics will also be included.

The reason for focusing on this specific age (8 months to one year max) is because the infant's temperament would be established by this time period (Gartstein & Rothbart, 2003).

Furthermore, there are two reasons for focusing specifically on Maltese speaking parents despite a 25% increase in foreign nationals attending the clinics (personal communication with Dr. Victoria Farrugia Sant Angelo on 21st March, 2016). First, foreign nationals are not being included so as to eliminate language barriers within the intervention groups, and second because they are less likely to remain committed to the service of the Well Baby Clinics. The latter reason is based on evidence from within the Well Baby Clinics' attendance reports, where it was reported by Dr. Farrugia Sant Angelo, that more often than not these parents would not reside in Malta long-term, thus decreasing their ability to commit to the study. In fact, through records kept it was noticed that their attendance to the Well Baby Clinics usually declined following their second visit when the infants are aged around 8 months.

(b) Salient characteristics of subjects – number who will participate, age range, sex, institutional affiliation, other special criteria

1. Parents living together, and caring for an infant described as having a highly reactive temperament on the Infant Behavioural Questionnaire (IBQ-R).
2. Single mother-grandmother dyads, conjointly caring for an infant described as having a highly reactive temperament.
3. Either one of the parents/co-caring dyads scoring highly on the Parenting Stress Index (PSI-4-SF).
4. Infants aged between 8 months and one year old, coinciding with their standard second out patient post-natal well-baby clinic visit, and found to score high on temperament reactivity.
5. Understand the Maltese language well.

Considering that the parenting programme groups will be run through twice over with different participants, it is estimated that each intervention group will hold 8 couples/dyads (16 persons). That means that with 2 intervention groups in one intervention phase there will be a total of 16 couples (i.e. 32 participants). Therefore two interventions means 64 participants. Besides this it is expected that there will be as much as 64 or over who will be in the control groups over both programme periods. All participants would be parents or co-caring dyads of an infant with a highly reactive temperament.

(16 persons). That means that with 2 intervention groups in one intervention phase there will be a total of 16 couples (i.e. 32 participants). Therefore two interventions means 64 participants. Besides this it is expected that there will be as much as 64 or over who will be in the control groups over both programme periods. All participants would be parents or co-caring dyads of an infant with a highly reactive temperament. -
EXCLUSION CRITERIA: The participants will be screened to identify whether there is the presence of domestic violence (DV). Couples where there is the presence of DV will be excluded because of safety issues. Couples where infants were born to mothers who were drug users during their pregnancy will also be excluded because of infant withdrawals as a result of drugs which may mimic high reactive temperament.

(c) Describe how permission has been obtained from cooperating institution(s) – school, hospital, organization, prison, or other relevant organization (*append letters*). Is the approval of another Research Ethics Committee required?
Permission has been requested from the Primary Health Care Dept., 7, Harper Lane, Floriana to make use of the Wellbaby clinics. A letter requesting access to participants was sent to the data protection officer Dr. Mario Vella (Document A), and this was also followed up with a phone call.
Permission has been temporarily granted pending UREC.

(d) What do subjects do, or what is done to them, or what information is gathered? (*Append copies of instructions or tests or questionnaires)* How many times will observations, test, etc., be conducted? How long will their participation take?
Parents will be approached by two recruiters simultaneously in the waiting area of the clinics, and asked whether they wish to answer a few questions (Document B1). Following signed consent (Document B2) by the parents, parents will be moved to a quieter location in the same area that will be set up purposely to create some privacy for them whilst being asked some initial information and questions (names, contact details, age of infant). Two rather than one recruiters shall work together so that if the parent needs help with his/her infant whilst filling out documentation, this can be facilitated. Recruiters will be students from the University of Malta either in their final year of the Master in Family Studies course, or in their 2nd year of the Bachelor Degree in Psychology. The reason for the choice of recruiters is that they will have an introduction to RANDOMISED CONTROLLED TRIALS (RCTs), and would not be lectured at any time by researcher to avoid any duplicity of roles. Only after an introduction to RCTs will they be asked if they voluntarily wish to participate as recruiters. At this initial stage, the parents of 8 month to one year old infants will be asked whether they wish to answer some questions about their infant and to fill in the short form of the Infant Behaviour Questionnaire – Revised (IBQ-R) (Document C). Through this questionnaire it would be possible to establish which of the infants can be described as having a highly reactive temperament. Following the identification of infants with a highly reactive temperament through the IBQ-R, their parents/ co-caring single mother-grandmother dyads WILL BE CONTACTED BY RESEARCHER through the phone and invited to participate in a study about what can help families cope. An appointment will be set with those who accept, and a new consent (Document D1/2) will be signed by the parents/ dyads. At this stage they will each be asked to complete the Parental Stress Index short form (PSI-4-

(c) Describe how permission has been obtained from cooperating institution(s) – school, hospital, organization, prison, or other relevant organization (*append letters*). Is the approval of another Research Ethics Committee required?
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In order to create a between group design, the use of Randomised Controlled Trials (RCTs) is deemed to be the most appropriate research design. RCTs are considered to be a rigorous way of establishing whether or not a relationship between a treatment and its outcome is cause-

effect in nature (Sibbald & Roland, 1998). The aim of this research is to determine whether a connection exists between participation in the coparenting programme and the parenting or co-carers' ability to make use of more effective parenting strategies, reflected in the coparenting relationship. It is also of interest to the researcher to note whether there would be any change or difference in the level of infant's reactivity, and parental/co-carer stress level from before to after the programme delivery. At this stage of the research the selected participants will be randomly assigned into an intervention group or a control (no intervention) group through assigning odd or even numbers to the participants who accept, and with the help of a computer, generate odd numbered participants to one group, and even numbered ones to another group accordingly. This way of random assignment would also help to avoid bias of the researcher with regards to which participants enter which group.The random allocation of participants to either one of the groups, would mean that they would stand an equal chance of being assigned to the treatment condition.

Group A: consisting of parents living together receiving PasP intervention (8 couples)

Group B: consisting of single mother – grandmother co-caring dyads receiving PasP intervention (8 dyads)

Group A1: consisting of parents living together – no intervention (remaining couples)

Group B2: consisting of single mother – grandmother dyads – no intervention (remaining dyads)

At the termination of the respective intervention groups, participants in all groups, A, A1, B, and B1, will once again be asked to complete the IBQ-R, PSI-4-SF and Coparenting Relationship (CRS) measures. Questionnaires are filled out by the parents (participants) both prior to the intervention and then again at post intervention stage. It is planned that the latter questionnaires will be completed two months following the end of the interventions, so as to allow for effect size.The same process to recruit new eligible participants and assign them to either intervention and control groups will be carried out again with new groups C, C1, D and D1, following completion of interventions with the first groups. This will be done for the sake of increasing validity and reliablity of the study by having a larger number of participants representing each group. The reason for doing so is because the bigger the sample, the more it will be representative of similar parents in the population (Field & Hole, 2003).

The experimental groups, namely A, B, C and D will attend a free16 week group- based co-parenting programme as designed by Cowan, & Cowan, Pruett and Pruett (2009), namely the Parents As Partners Coparenting Programme. Each of these groups would meet separately for 2 hours weekly at the University of Malta psychology lab, and shall be co-facilitated by male and female coleaders who are clinically competent and have been trained in the facilitation of the PasP coparenting programme at the TCCR, London. The sixteen sessions, will be carried out with strict adherence to the manual of procedures for the Parents As Partners Coparenting Programme. Every session shall also be video-taped with the participants' knowledge and consent as indicated in the signed consents. Parents in the control groups, namely group A1, B1, C1 and D1, will not receive the intervention but will complete the before- and after-intervention questionnaires/indexes (IBQ-R, PSI-4-SF, CRS).

5

(e) Which of the following data categories are collected? Please tick where appropriate.

Data that reveals:

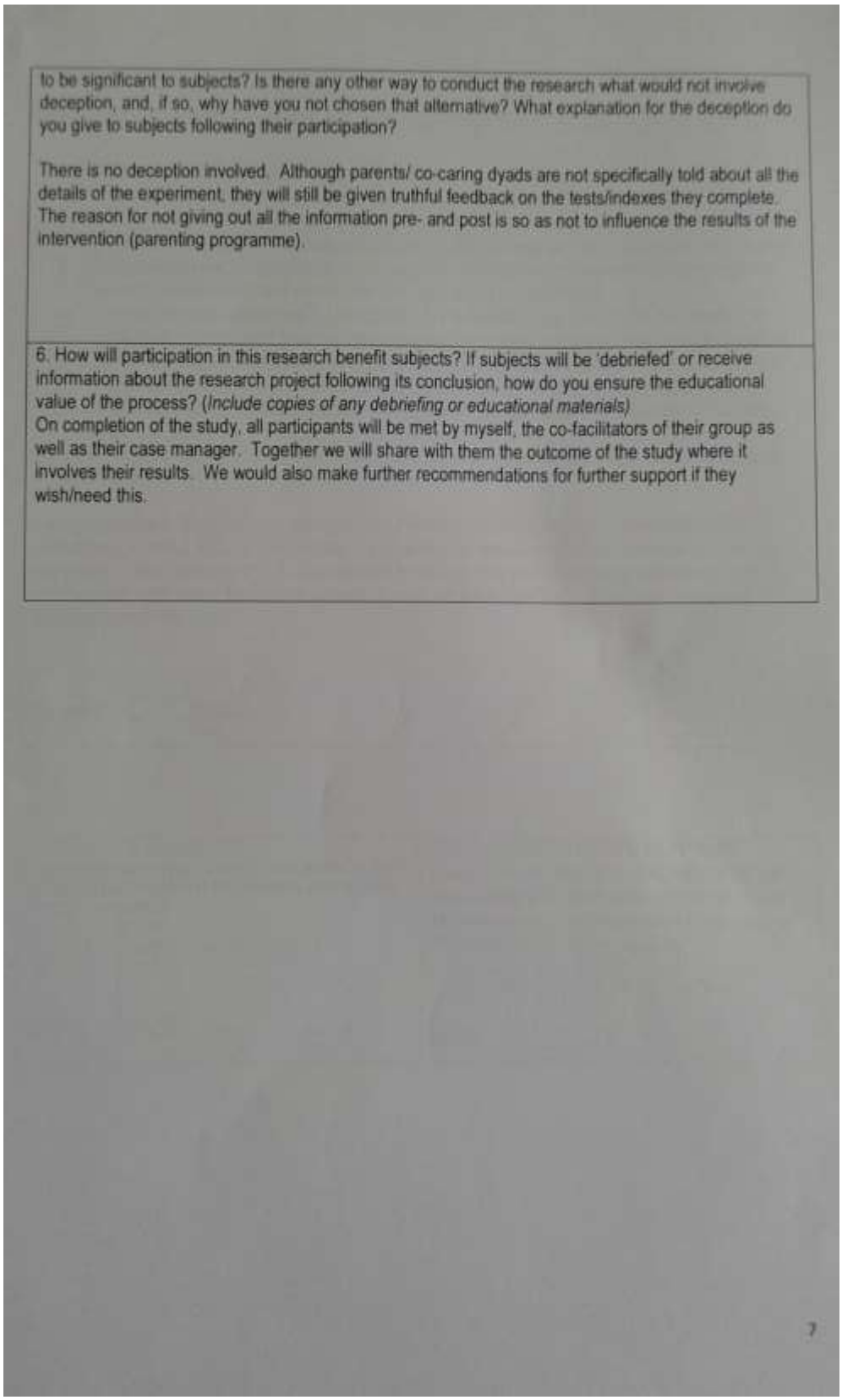
Race and ethnic origin	☐
Political opinions	☐
Religious and philosophical beliefs	☐
Trade union memberships	☐
Health	☒
Sex life	☐
Genetic information	☐

3. How do you explain the research to subjects and obtain their informed consent to participate? *(If in writing, append a copy of consent form.)* If subjects are minors, mentally infirm, or otherwise not legally competent to consent to participation, how is their assent obtained and from whom is proxy consent obtained? How is it made clear to subjects that they can quit the study at any time?

Information and Consent forms are attached:
Documents B1/B2,D1/D2, G1/G2 and H1/H2.
The consents clearly indicate that the participant is free to withdraw from the study at any time.

4. Do subjects risk *any* harm – physical/ psychological/ legal/ social – by participating in the research? Are the risks necessary? What safeguards do you take to minimize the risks?
From the onset of the 16 week programme, all the participants belonging to both intervention and control groups respectively shall also be offered the support of case managers. A different case manager will be appointed for each group in order to offer further support if and when this is needed. Control groups will also be offered this support for ethical reasons. The role of the case manager will be carried out by family therapy students as part of their practice experience. Case managers would keep regular contact with the parents/co-carers, supporting them to carry out any group-related assignments, responding to their difficulties, reinforcing their continued attendance and participation to the weekly programme, as well as making referrals to other pertinent services whenever necessary.

5. Are subjects deliberately deceived in *any* way? If so, what is the nature of the deception? Is it likely



to be significant to subjects? Is there any other way to conduct the research what would not involve deception, and, if so, why have you not chosen that alternative? What explanation for the deception do you give to subjects following their participation?

There is no deception involved. Although parents/ co-caring dyads are not specifically told about all the details of the experiment, they will still be given truthful feedback on the tests/indexes they complete. The reason for not giving out all the information pre- and post is so as not to influence the results of the intervention (parenting programme).

6. How will participation in this research benefit subjects? If subjects will be 'debriefed' or receive information about the research project following its conclusion, how do you ensure the educational value of the process? (*Include copies of any debriefing or educational materials)*
On completion of the study, all participants will be met by myself, the co-facilitators of their group as well as their case manager. Together we will share with them the outcome of the study where it involves their results. We would also make further recommendations for further support if they wish/need this.

7

TERMS AND CONDITIONS FOR APPROVAL IN TERMS OF THE DATA PROTECTION ACT

- Personal data shall only be collected and processed for the specific research purpose.
- The data shall be adequate, relevant and not excessive in relation to the processing purpose.
- All reasonable measures shall be taken to ensure the correctness of personal data.
- Personal data shall not be disclosed to third parties and may only be required by the University or the Supervisor for verification purposes. All necessary measures shall be implemented to ensure confidentiality and where possible, data shall be anonymized.
- Unless otherwise authorized by the University Research Ethics Committee, the researcher shall obtain the consent from the data subject (respondent) and provide him with the following information: The researcher's identity and habitual residence, the purpose of processing and the recipients to whom personal data may be disclosed. The data subject shall also be informed about his rights to access, rectify, and where applicable erase the data concerning him.

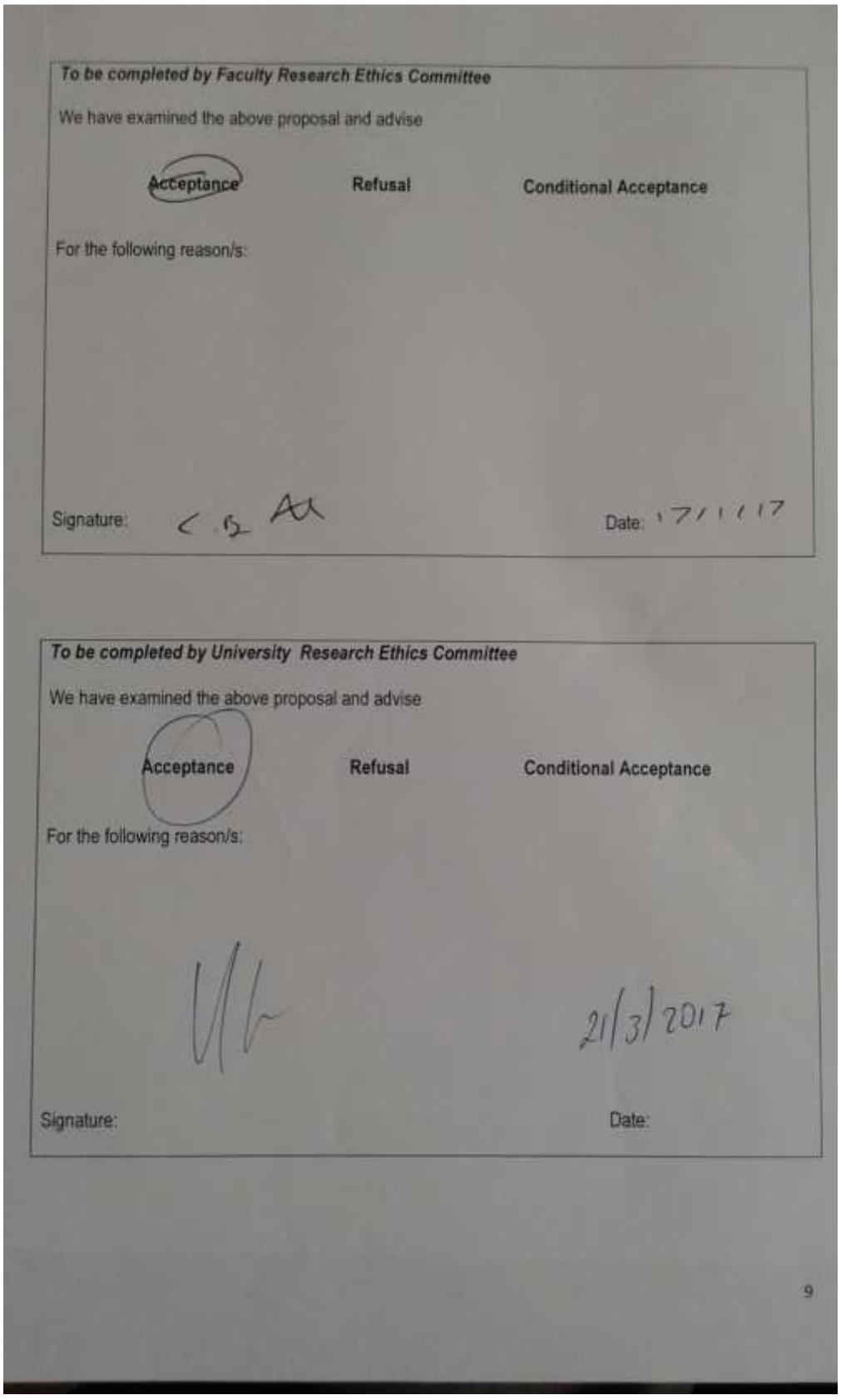
I, the undersigned hereby undertake to abide by the terms and conditions for approval as attached to this application.

I, the undersigned, also give my consent to the University of Malta's Research Ethics Committee to process my personal data for the purpose of evaluating my request and other matters related to this application. I also understand that, I can request in writing a copy of my personal information. I shall also request rectification, blocking or erasure of such personal data that has not been processed in accordance with the Act.

Signature:

APPLICANT'S SIGNATURE	FACULTY SUPERVISOR'S SIGNATURE
I UNDERSTAND THAT I WILL NOT INITIATE MY RESEARCH PRIOR TO RECEIVING APPROVAL FROM THE UREC.	*I have reviewed this completed application and I am satisfied with the adequacy of the proposed research design and the measures proposed for the protection of human subjects.*
DATE 5th January 2017	DATE 5/1/17

8



To be completed by Faculty Research Ethics Committee

We have examined the above proposal and advise

Acceptance Refusal Conditional Acceptance

For the following reason/s:

Signature: Date: 17/1/17

To be completed by University Research Ethics Committee

We have examined the above proposal and advise

Acceptance Refusal Conditional Acceptance

For the following reason/s:

21/3/2017

Signature: Date:

9

APPENDIX P

PasP ID : TPAP Interviewer ID ___ ___ Date

Groupworker Interview

(This interview is done with both group leaders and both parents.)

We'd like to get to know a bit about the two of you and your children, and for you to get to know us a bit too. The meeting today will take about 2 hours. The first hour or so we'll spend together, and then take a little time separately before coming back together at the end.

We've got some questions we'd like to ask you and there will be time at the end for any questions you'd like to ask. This will help us decide together whether we all think this group is right for you both.

We will write down notes from the meeting today which we will keep confidential and only share with members of the PasP team, except if there is any information you share about harm of yourself or others that may need to be shared with other agencies.

1. First, how long have the two of you known each other?

Father	***Mother***

2. How many children do you have? *(Details of children have already been collected at Initial Screening Interview, and you should have familiarized yourself with this, so no need to repeat this at length)*

Any additional comments?

3a. Can you tell us about your relationships with your child(ren)? First, what do you see as the really good parts of each of your relationships with your child(ren)?

Father	***Mother***

3b. What do you see as the hard parts of each of your relationships with your child(ren)?

Father	***Mother***

3c. This programme recognises how important fathers and mothers are in their children's lives. It helps us to get a sense of some of the ways you are each involved with your children.

How would each of you describe (Father's Name)'s involvement with (Child's Name)? How would each of you describe (Father's name)'s involvement with his other children?

(eg what kinds of things does he do with the child/ren? How much time does he spend with the child/ren? Is he involved in feeding, bathing, comforting, choosing clothes, school, outings, paying for things, decision-making, discipline, or other areas?)

Father's answer(about father involvement)	***Mother's answer(about father involvement)***

3d. How would each of you describe (Mother's Name) involvement with (Child's Name)?

How would each of you describe (Mother's Name)'s involvement with her other children?

Father's answer (about mother involvement)	***Mother's answer (about mother involvement)***

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4. Some parents find it harder to share parenting than they thought they would. How do the two of you share parenting now? Do you ever think about how that might change as your child(ren) grow older?.

Father	***Mother***

5. What happens when the two of you disagree about what to do with your child(ren)?

Father	***Mother***

6a. Are there people you can count on to support you as a parent?

Father	***Mother***
Who? _____	

6b.Who would you turn to when you are having trouble – financial difficulty or emotional difficulty or when you need advice about bringing up children?

Father	***Mother***

7. Are there friends or family members whose attitudes lead to some stress or tension for either of you around parenting?

Father	***Mother***
Who? _____	Who? _____

8. How would you describe the relationship between the two of you as a couple /co-parents?

(Probe for the strongest and most difficult parts of the relationship.)

Father	***Mother***

Thank you for very much for going through those questions with us. As part of the group sessions we take time to think about each of you individually, and spend time with just the dads and just the mums. We're going to do something like that now, and talk for a bit with each of you separately.

(AT THIS POINT: male group worker goes with the father and female group worker with the mother to separate rooms.)

Individual session as part of group worker interview

In this part I would like to ask you some questions and talk with you about making sure coming on this programme feels safe and is the right thing for you and your family. This is a routine part of the programme.

Firstly we are going to go through two questionnaires. The first asks questions about communication as a couple and the second is about how you feel about daily life.

(*Ask the parent to complete the questionnaires. You may prefer to ask the questions and write the answers, use you own judgment to decide what is better according to the parent's needs. Check if all questions are answered and ask permission to talk more about any risk issues that have arisen (if applicable).)*

Now complete Couple Communication and CORE questionnaires.

*(*If clear concerns about domestic abuse arise please see the guidance sheet below.)*

Last thing I would like to ask a few questions about family life with your children. All agencies that work with families have a responsibility to think about children's welfare. (Some of this information may be on the referral form or have emerged in Initial Screening).

'Has your Family had any recent involvement with a children's social worker?'

YES/NO

If YES,

What were the concerns?

Was/ is a child protection plan or a child in need plan in place?

What changed/ is changing following social services involvement?'

Are you ever worried that any of your children (or your partner's) children are being harmed by anyone?

(NOW REJOIN)

Back together as a couple

Just a brief section together to finish the interview.

9a. What are your main sources of stress or worry these days?

Father	***Mother***

9b. (If not mentioned) Do you have any worries right now about your work or school life, or about not having enough work?

Father	***Mother***

10. What are your hopes for yourself in the next year?

Father	***Mother***

11. What are your hopes for your family in the next year?

Father	***Mother***

12. What was it like for each of you talking about these things with us today?

Father	***Mother***

(If it feels relevant ask the couple at this point how they feel about going home together after the things we've discussed today)

13. Participating in this group involves taking part in an evaluation of how helpful the group is. You would need to sign a consent form and to complete some questionnaires with your family case worker before we start meeting, and after the group sessions have finished. Before we do that is there anything you would like to ask us about the Parents as Partners group, or your participation in it?

Father	***Mother***

We wonder if from what you've heard so far you are still interested in joining the group?

YES/NO

If NO, what are the reasons?

*(If YES, please **discuss the consent form**, at this point show the consent form and mention the filming of the sessions to the couple/co-parents)*

Thank you very much for taking the time to talk with us today. After our meeting today we will take some time to think if the group is the right step for you at the moment and we will get back to you by…. At that point we will let you know about next steps, which, in case you are joining the group, is for you to meet with the caseworker to complete some questionnaires and sign the consent form before the group starts.

If, after we have met today, you or we don't think the group is the right step for you at the moment, we can think with you about any other services that may be relevant for you and your family at this time.

GUIDANCE FOR DISCUSSING DOMESTIC ABUSE / VIOLENCE

If discussion with one partner indicates that there is ongoing violence, that needs a response, ask the following safety questions:

Are you afraid that your partner will hurt you today?	Yes	No
Are you afraid to go home?	Yes	No
Does the abuse seem to be getting worse?	Yes	No

What to do if ongoing violence is revealed in the interviews (in separate discussions).

To abuser:

This is what I see (hear).

These are my concerns.

Is this how you want it to be? Is this working for you?

To other partner:

This is what I see (hear).

These are my concerns.

Are you safe now?

Are you afraid that your partner will hurt you today?

Do you have somewhere safe to go to now, or do you need help finding a safe place?

If no, do you want to talk to someone about all this and help you work out ways to keep you and your children safe?

YOU SHOULD HAVE A LIST OF REFERRAL SOURCES FOR IPV / DV, INCLUDING THE REFERRING SOCIAL WORKER (IF APPLICABLE). DO NOT GIVE THE PRINTED LIST TO TAKE HOME WITH AN INDIVIDUAL WHERE THERE MAY BE SEVERE VIOLENCE, PAST OR PRESENT AS THAT MAY INCREASE THE RISK TO THE VICTIM IF FOUND BY THE OFFENDER

Considerations for screening of whether this family is appropriate

FAMILIES WITH ONGOING IPV / DV ARE NOT LIKELY TO BE APPROPRIATE FOR THE STUDY AND THE REFERRAL WILL NEED TO BE CONSIDERED WITH THE PROGRAMME MANAGER AND HEAD OF CLINICAL SERVICES.

Things to consider:

Does the (perpetrator) accept responsibility for past violence without:

Self-justification, Blame, Denial, Minimization

Does this person now show high controlling behaviour of partner or children?

Is there a level of entitlement to be violent or to be boss?

APPENDIX Q

Research Ethics Proposal - Approved by FREC, no UREC decision needed

PHD RECRUITMENT

SWB FREC

Mon, 5 Oct, 15:31

to me, Angela

Unique Form ID: 6481 29.09.2020

Dear Ms Ingrid Grech Lanfranco,

Your ethics proposal with regards to your research titled *Early Coparenting Programmes with Parents of Infants with a Highly Reactive Temperament: A randomised study using 'Parents as Partners' (PasP)* has been **approved**.

Faculty Research Ethics Committees are authorised to review and approve research ethics applications on behalf of the University of Malta, except in the case of sensitive personal data. In this regard, your ethics proposal **does not need to be sent to UREC**. Hence, **you may now start your research**.

Regards,

L-Università ta' Malta

Faculty Research Ethics Committee

Faculty for Social Wellbeing
Room 115, Humanities B
+356 2340 3192, +356 2340 2237
um.edu.mt/socialwellbeing/students/researchethics

APPENDIX R

Validation of Maltese Translations of Assessment Measures

28th September, 2020.

Information about the study

My name is Ingrid Grech Lanfranco and I am a PhD student at the University of Malta. The title of my research is 'Early Coparenting Programmes with Parents of Infants with a Highly Reactive Temperament: A randomised study using 'Parents as Partners' (PasP)'. My supervisors are Prof. Angela Abela from the University of Malta, and co-supervisors Profs. Phil and Carolyn Pape Cowan from the Univeristy of Berkeley, California.

I am presently conducting a validation process of Maltese translated measures that were used at pre- and post- intervention stages as part of a Randomised Controlled Trail. The measures, namely the Infant Behaviour Questionnaire-Revised (IBQ-R) (Putnam et al., 2014), the Early Childhood Behaviour Questionnaire (ECBQ) (Putnam, 2010), the Parenting Stress Index 4 Short Form (PSI-4-SF) (Abidin, 2012), and the Coparenting Relationship Scale (CRS) (Feinberg, 2003) are all validated tests in the English language and used widely cross-culturally. Since my research involves a Maltese population, tests were translated and back-translated into Maltese from English (Rode, 2005).

For the validation to take place, between 10 to 15 questionnaires of each measure (IBQ-R (for 3mt to 12mt old), ECBQ (for 1 year to 3 year olds), PSI-4-SF, and CRS) need to be filled in first in English, and again after a lapse of at least 5 days in Maltese. Only scores of each participating parent will be used and inputted into a data base, following which a statistical analysis to compare the reliablity and validity of the Maltese translated measures will be carried out. Each participating parent will fill in between 1 and 3 questionnaires in both the English and Maltese versions.

In order to be eligible, interested participants need to be a parent over the age of 18 of either an infant aged between 3 and 12 months, or of a child aged between 1 year and 3 years so as to be given the appropriate measures according to the child's age. Prospective participants must also be fluent in both English and Maltese. Recruitment will take place by first providing professional colleagues with the information sheet. They would then be able to approach potential participants, as well as make use of snowballing.

Your Participation

Any data collected from this research will be used solely for the purposes of this validation. Only scores (numbers) will be used.

Should you choose to participate, you will be asked to fill in between 1 and 3 questionnaires according to your choice and available time. You would first fill in the questionnaire/s in English and after a lapse of 5 days fill in the Maltese version of the questionnaires. Questionnaires take on average 10 to 12 minutes each to complete at most.

Data collected will be gathered through use of email/scan for the sake of pairing the English and Maltese questionnaires. Owing to the present Covid-19 pandemic, hard copies are being avoided. Participating parents can also choose to give their responses over the phone if they prefer.

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason.

You are also free to withdraw from the validation process at any time, without needing to provide any explanation and without any negative repercussions for you. Should you choose to withdraw, any data collected from your contact or communication with the researcher will be erased for as long as this is technically possible (for example, before it is anonymised or published), unless erasure of data would render impossible or seriously impair achievement of the research objectives. The latter directly reflects the exemptions provided for in the GDPR Article 17(3)(d).

If you choose to participate, please note that there are no direct benefits to you, however you will be part of an important test validation process. These measures will continue to be used widely and more reliably with the Maltese population in the future.

Your participation does not entail any known or anticipated risks.

Data Management

The data in the form of your responses to the measures you fill in will be treated in full confidentiality and coded by the researcher, being the only person to manage the data and communicate with participating parents. Once both the English and Maltese versions of measures are received and paired responses entered into a database by using only scores connected to your responses, any connection to your identity will be erased immediately, leaving only numbers. The scores will be stored in a table on the researcher's computer in order to analyse statistically.

Please note also that, as a participant, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify and where applicable ask for the data concerning you to be erased.

All data collected will be stored in an anonymized form following publication of results in June 2021.

Your identity will be revealed only with your consent.

There should not be any specific incidental findings from this process, except the statistical validation of measures.

Participant's consent

□ I hereby declare to have read the information about the nature of the study, my involvement and data management.

□ I have had the opportunity to ask questions about the study and my questions have been satisfactorily answered.

□ I declare that I am 18 years or older.

□ I understand that should I have any further queries, I can contact Ms. Ingrid Grech Lanfranco on ingrid.grech-lanfranco@um.edu.mt (Mobile 99862272) or Prof. Angela Abela on angela.abela@um.edu.mt.

□ I agree to participate in this validation process.

INGRID GRECH LANFRANCO

_____ _____

Participant's name (in block) Researcher's name (in block)

_____ _____

Participant' signature Researcher's signature

Validazzjoni ta 'Traduzzjonijiet Maltin ta' Miżuri ta 'Valutazzjoni

28 ta’ Settembru 2020

Informazzjoni dwar l-istudju

Jisimni Ingrid Grech Lanfranco u jiena studenta tal-PhD fi ħdan L-Universita’ ta’ Malta. Irriċerka tiegħi hija ntitolata ‘Early Coparenting Programmes with Parents of Infancts with a Highly Reactive Temperament: A randomised study using ‘Parents as Partners’ (PasP)’. Issuperviżuri tiegħi huma Prof. Angela Abela mill-Universita ta’ Malta filwaqt li l-ko-superviżuri huma Profs. Phil u Carolyn Pape Cowan mill-Universita’ ta’ Berkeley, California.

Bħalissa qegħda nikkonduċi proċess ta’ validazzjoni tal-miżuri Maltin li kienu użati fl-istadji kemm ta’ qabel kif ukoll ta’ wara bħala parti mir-Randomised Controlled Trial. Dawn ilmiżuri, il-kwestjonarju rivedut dwar il-komportament tat-trabi (IBQ-R) (Putnam e tal., 2014), il-kwestjonarju dwar il-komportament fi stadju bikri ta’ tfal (ECBQ) (Putnam 2010), l-Indiċi 4 Short form dwar l-istress tal-ġenituri (PSI-4-SF) (Abidin, 2012) u l-Iskala dwar ir-relazzjoni talkoparenti (CRS) (Feinberg, 2003) huma kollha misuri rikonoxxuti fil-lingwa Ingliża u huma utilizzati fuq medda wiesa kulturalment. Peress illi r-riċerka tiegħi tirrigwarda l-popolazzjoni Maltija, it-testijiet ġew tradotti u tradotti lura fil-lingwa Maltija minn dik Ingliża (Rode, 2005).

Sabiex issir din il-validazzjoni, huwa meħtieġ illi jiġu ikkumpilati bejn 10 u 15-il kwestjonarju dwar kull miżura (IBQ-R) (bejn l-eta’ ta’ tlett xhur u tnax-il xahar), ECBQ (bejn sena u tlett snin), PSI-4-SF, u CRS) inizjalment bil-lingwa Ingliża u sussegwentement wara ħamest ijiem billingwa Maltija. Il-marki biss ta’ kull ġenitur li jkun qed jipparteċipa jiġu nseriti ġewwa database, fejn wara dan, isir analiżi permezz tal-istatistika ta’ dawn ir-riżultanżi sabiex titqabbel l-affidabilita’ u l-validita’ tal-miżuri tradotti bil-Malti. Kull ġenitur parteċipant ikollu jimla bejn 1 u 3 kwestjonarji kemm bil-verżjoni Ingliża kif ukoll dik Maltija.

Biex persuna tkun eliġibbli għal dan l-istudju, parteċipanti interessati jinħtieġu li jkunu ġenituri jew ta’ tarbija bejn l-eta’ ta’ tlett xhur u tnax-il xahar jew tifel jew tifla bejn l-eta’ ta’ sena u tlett snin biex b’hekk jingħataw il-miżuri xierqa skond l-eta’ tal-wild. Parteċipanti prospettivi għandhom ikunu jafu sew kemm bl-Ingliż kif ukoll bil-Malti. Ir-reklutaġġ isir billi lewwel tiġi pprovduta l-formula informattiva lill-

kollegi professjonali. B'hekk dawn ikunu jistgħu javviċinaw parteċipanti prospettivi, filwaqt li jagħmlu użu wkoll mill-kampjuni elevati (snowballing).

Il-Parteċipazzjoni tiegħek

Kull informazzjoni miġbura matul din ir-riċerka ser tintuża unikament għall-iskopijiet ta' validazzjoni. Ser jintużaw biss marki numeriċi.

Jekk tagħżel illi tipparteċipa, ser tiġi mitlub timla bejn 1 u 3 kwestjonarji skond l-għażla magħmula u l-ħin disponibbli tiegħek. L-ewwel tibda billi timla l-kwestjonarju bil-lingwa Ingliża u wara l-iskadenza ta' ħamest ijiem trid timla l-verżjoni Maltija tal-kwestjonarji. Sabiex jiġi ikkumpilat, kull kwestjonarju jieħu massimu ta' bejn madwar 10 sa 12-il minuta kull wieħed.

L-informazzjoni ser tingħabar permezz ta' email/scan sabiex jiġu maqbula il-verżjonijiet Ingliżi u dawk Maltin tal-kwestjonarji. Kopji fil-forma ta' karta qed jiġu evitati fid-dawl tassitwazzjoni tal-pandemija kurrenti tal-Covid 19. Il-ġenituri parteċipanti għandhom ukoll lgħażla illi jipprovdu t-tweġibiet tagħhom permezz tat-telefon.

Il-parteċipazzjoni f'dan l-istudju huwa wieħed volontarju u fi kliem ieħor inti liberu illi taċċetta jew tirrifjuta li tipparteċipa, mingħajr il-ħtieġa li tagħti raġuni għad-deċiżjoni tiegħek.

Tista' anki liberament toħroġ mill-proċess ta' validazzjoni f'kull stadju, u dan mingħajr ilħtieġa li tagħti spjegazzjoni u mingħajr l-ebda impatt negattiv fuqek. F'din l-eventwalita', kwalunkwe dejta miġbura mill-kuntatt jew il-komunikazzjoni tiegħek mar-riċerkatur titħassar sakemm dan ikun teknikament possibbli (pereżempju, qabel ma tkun anonimizzata jew ippubblikata), sakemm it-tħassir tad-dejta ma jagħmilx impossibbli jew ifixkel serjament il-kisba tal-għanijiet tar-riċerka. Dan tal-aħħar jirrifletti direttament l-eżenzjonijiet previsti flArtikolu 17 (3) (d) tal-GDPR.

Jekk tagħżel illi tipparteċipa, innota li dan l-eżerċizzju m'huwa ta' l-ebda gwadann għalik, iżda madankollu, inti tkun parti minn proċess importanti ta' validazzjoni ta testijiet. Dawn il-miżuri ser jitkomplew jintużaw fuq medda wiesa u b'aktar affidabilita' fost il-popolazzjoni Maltija filġejjieni.

Il-parteċipazzjoni tiegħek ma ġġorr l-ebda riskji magħrufa jew ipprospettati.

Immaniġġjar ta' data

L-informazzjoni pprovduta permezz tat-tweġibiet tiegħek skond kif ikkompilati ser jiġu ttrattati b'kunfidenzjalita' sħiħa u kodifikati mir-riċerkatur illi ser ikun l-unika persuna li timmaniġġja l-informazzjoni u l-komunikazzjoni mal-ġenituri parteċipanti. Ġaladarba jiġu pprovduti l-verżjonijiet kemm bil-lingwa Ingliża kif ukoll dik Maltija tal-miżuri u jiġu maqbula, it-tweġibiet jiġu nseriti ġewwa database bl-użu biss ta' marki marbuta mat-tweġibiet tiegħek u kull rabta mal-identita' tiegħek tiġi mħassra

immedjatament, fejn jitħallew biss numri. Ilmarki ser jiġu miżmuma f'tabella fuq il-kompjuter tar-riċerkatur sabiex din tiġi analizzata blistatistika.

Ġentilment innota wkoll illi, bħala parteċipant, inti għandek id-dritt taħt ir-regolamenti ġenerali tal-Protezzjoni tad-Data (GDPR) u skond leġislazzjoni nazzjonali sabiex taċċedi, tbiddel u fejn applikabbli titlob illi d-data li tikkonċernak tiġi mħassra.

In segwitu għall-pubblikazzjoni tar-riżultati f'Ġunju tas-sena 2021, kull informazzjoni pprovduta ser tiġi miżmuma ġewwa formula anonima.

L-identita' tiegħek tiġi mgħarrfa biss bil-kunsens tiegħek.

M'għandux ikun hemm xi sejbiet inċidentali speċifiċi minn dan il-proċess għajr għall-miżuri għall-finijiet ta' validazzjoni statistika.

Kunsens tal-parteċipant

ϖ Niddikjara illi qrajt l-informazzjoni dwar in-natura tal-istudju, l-involviment tiegħu u limmaniġġjar tad-data.

ϖ Niddikjara illi jiena kelli l-opportunita' illi nsaqsi mistoqsijiet dwar l-istudju u lmistoqsijiet tiegħi ġew imwieġba b'manjiera sodisfaċenti.

ϖ Niddikjara illi għandi tmintax il-sena jew aktar.

ϖ Nifhem illi jekk ikolli aktar mistoqsijiet, nista' nikkomunika ma' Ms. Ingrid Grech Lanfranco elettronikament fuq l-indirizz Ingrid.grech-lanfranco@um.edu.mt (Numru tal-mobajl 99862272) jew Prof. Angela Abela elettronikament fuq l-indirizz angela.abela@um.edu.mt.

ϖ Naqbel illi nipparteċipa f'dan il-proċess ta' validazzjoni.

INGRID GRECH LANFRANCO

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Isem il-parteċipant b'ittri kbar Isem ir-riċerkatur (ittri kbar)

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Fimra tal-parteċipant Firma tar-riċerkatur

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