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MAJOR RESEARCH PROJECT

SOPHIE LORRAINE HALL-STERLING BSc (Hons) MSc

PARENTING AND SOCIAL CAPITAL: PROMOTING CHILD MENTAL HEALTH AS A COMMUNITY

Section A: The impact of parental social capital upon child mental health: A systematic review

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Section B: “We all just want the best for our children”: A grounded theory of building social capital in a peer-led parenting intervention

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SALOMONS CANTERBURY CHRIST CHURCH UNIVERSITY

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Summary of MRP Portfolio

Section A: The mental health status of children and young people is of growing concern. Of the many social determinants of mental health, social capital is gaining interest for its association with health outcomes, particularly in families. Studies show that social capital, held by the child and/or their family may positively impact on the child's mental health. Through a systematic search of seven databases, 10 relevant empirical studies were identified, focusing specifically on how social capital as experienced by parents may impact upon their children's mental health. Implications for clinical practice and future research are discussed.

Section B: The study presents a critical realist grounded theory of parents' experiences of building social capital in a peer-led parenting programme. Parental social capital is important for children's mental wellbeing and so understanding how it builds is important. Semi-structured interviews were conducted with 14 mothers that attended a peer-led parenting programme. Analysis revealed a model comprised of fourteen categories, representing the processes and elements that resulted in four main themes. An understanding of these processes may contribute towards improving interventions for child mental health outcomes, in addition to building social capital amongst parents and families.

Section C: Appendices and Supporting Material

Contents

Acknowledgements	1
Summary of MRP Portfolio.....	2
List of Tables and Figures	8
List of Appendices	9

Section A

Abstract.....	11
1. Introduction.....	12
1.1 Child mental health	12
1.2 Social capital	12
1.3 The significance of SC and children’s mental health.....	14
1.4 Parental SC and children’s mental health	14
1.5 Rationale.....	15
2. Methodology	17
2.1 Design	17
2.1.1 Study features.....	17
2.1.2 Inclusion criteria.	18
2.1.3 Exclusion criteria.....	18
2.2 Literature Search.....	19

2.3 Quality assessment.....	21
2.4 Data extraction and synthesis.....	21
3. Results	23
3.1 Overview of selected papers	23
3.2 Internalising behaviours	36
3.3 Externalising behaviours.....	39
3.4 Self-esteem and self-worth.....	40
4. Discussion	44
4.1 Methodological issues	45
4.2 Clinical implications and future research	46
5. References	50

Section B

Abstract	61
1. Introduction.....	62
1.1 Social capital	62
1.2 Child mental health	63
1.3 Building social capital through intervention.....	64
1.4 Peer-led interventions	65

1.5 Rationale	66
1.6 Research questions	66
1.6.1 Primary research question/line of enquiry.	66
1.6.2 Secondary research questions/lines of enquiry.	67
2. Methodology	68
2.1 Design	68
2.2 Epistemology.....	68
2.3 Setting.....	69
2.4 Procedure.....	69
2.4.1 Sampling.	69
2.4.2 Participants.....	72
2.4.3 Data collection.	74
2.4.4 Data analysis.....	74
2.5 Quality Assurance.....	77
2.6 Ethical considerations.....	78
3. Results	80
3.1 Model summary	81
3.2 Personal Development	82

3.2.1 Acquiring skills.	82
3.2.2 Managing emotions	83
3.2.3 Gaining confidence	84
3.3 Making Connections	85
3.3.1 Meeting new people.	85
3.3.2 Strengthening existing relationships.	86
3.3.3 Friendship.	87
3.3.4 Sharing our stories.	87
3.4 Feeling Safe	88
3.4.1 Role of the facilitator.	88
3.4.2 Meeting in my community.	89
3.4.3 Having group rules.	90
3.5 Overcoming Differences	92
3.5.1 Having a common goal.	92
3.5.2 Breaking assumptions.	93
3.5.3 Finding similarities.	94
3.5.4 Embracing difference.	95
4. Discussion	97

4.1 Limitations	99
4.2 Clinical and research implications.....	103
5. Conclusion	102
6. References.....	105

Section C

Appendix 1: Terms used for literature search	109
Appendix 2: Critical Appraisal Skills Programme Checklists	111
Appendix 3: Initial interview schedule	114
Appendix 4: Coded transcript.....	115
Appendix 5: Example of memo writing for category development.....	136
Appendix 6: Research diary extracts	117
Appendix 7: Progression of theme development	121
Appendix 8: NRES approval letter	123
Appendix 9: R&D approval letter	118
Appendix 10: Participant information sheet and consent form	127
Appendix 11: NRES End of Study Form.....	128
Appendix 12: Summary report for ethics committees.....	152
Appendix 13: Author guidelines for Social Science & Medicine Journal.....	131

List of Tables and Figures

Section A: Literature Review

Figure 1: Flowchart of the process for selecting articles for reviewp. 23

Table 1: Quality ratings derived from CASP Checklists.....p. 24

Table 2: Summary of all studies includedp. 27

Section B: Empirical Paper

Figure 1: Flowchart of sampling processp. 73

Table 1: Aggregated Participant Characteristicsp. 75

Table 2: Three stages of data analysisp. 76

Figure 2: Grounded theory model of building social capital in parents attending a peer-led parenting programmep. 82

Figure 3: Network Theory of Social Capital (Lin, 1999)p. 100

List of Appendices

Appendix 1: Terms used for literature search

Appendix 2: Critical Appraisal Skills Programme Checklists

Appendix 3: Initial interview schedule

Appendix 4: Coded transcript

Appendix 5: Example of memo writing for category development

Appendix 6: Research diary extracts

Appendix 7: Progression of theme development

Appendix 8: NRES approval letter

Appendix 9: R&D approval letter

Appendix 10: Participant information sheet and consent form

Appendix 11: NRES End of Study Form

Appendix 12: Summary report for ethics committees

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MAJOR RESEARCH PROJECT

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Section A

The impact of parental social capital upon child mental health: A systematic review

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Abstract

Background Parenting is acknowledged as being one of the most impactful contributors to child mental health, with parents' knowledge, relationships and access to resources (also known as capital) being integral to this impact. Social capital (SC) in particular has gained increasing interest in recent years, including with regards to its association with mental health.

Objective This review will look specifically at parental SC, answering the questions: Is parental SC associated with child mental health outcomes? And, upon which aspects of child mental health does parental SC seem to have the most impact?

Methods A mixed-methods systematic review was conducted of articles published between January 1960 and December 2017, in which levels of parental SC were tested against child mental health outcomes (quantitative studies), or where parental SC was explored in relation to child mental health outcomes (qualitative studies). Textual narrative synthesis was used to make sense of the data presented.

Results A total of 10 studies were examined. Parental SC was mainly found to be positively associated with better child mental health outcomes, with three aspects of child mental health being the most impacted: internalising behaviours, externalising behaviours, and self-esteem and self-worth.

Conclusions Parental SC is instrumental in supporting good mental health outcomes in children. It would therefore be beneficial to focus upon building parental SC within the prevention and intervention stages of reducing mental ill health in children. Further research is required in order to understand how parental SC develops and therefore how it can be built.

Keywords: Parental social capital, parenting, child mental health, child wellbeing

1. Introduction

1.1 Child mental health

Child mental health has become an issue of growing policy concern in recent years (Department of Health, 2015; The Children's Society, 2017). Much of this policy centres around what services can do to improve the situation, but also indicates the role that parents, and society in general, can play in strengthening and maintaining children's mental health.

There are a number of parent attributes and behaviours that are well-documented in their relation to children's mental health. These include: parenting style (Singh, 2017), parents' own mental health difficulties (e.g. Reder & Duncan, 1999) and domestic violence (e.g. McCloskey, Figueredo & Koss, 1995). In addition, children's mental health has been linked to the level of resources, also known as 'capital', held both by their families and parents (Parcel & Dufur, 2001); and also by themselves as they approach adolescence (Rothon, Goodwin & Stansfeld, 2012). Evidence suggests that one of the most influential types of capital is social capital (De Silva, McKenzie, Harpham & Huttly, 2005).

1.2 Social capital

The term social capital (SC) has been used to describe a wide range of concepts, including social networks, social reciprocity, and family relations (Coleman 1988, 1990). Bourdieu (1986) first described SC in relation to other types of capital in order to demonstrate its role, stating:

“Capital can present itself in three fundamental guises: as economic capital, which is immediately convertible into money and may be institutionalised in the form of property rights; as cultural capital, which is convertible, on certain conditions, into economic capital and may be institutionalised in the form of educational qualifications; and as social capital, made up of social obligations ('connections'), which is convertible, in certain conditions, into economic capital and may be institutionalised in the form of a title of nobility.” (p. 243).

“[Social capital] is the product of investment strategies, individual or collective, consciously or unconsciously aimed at establishing or reproducing social relationships that are directly useable in the short or long term” (p.251).

SC has become an increasing focus of research in recent years (Ferragina & Arrigoni, 2017), and particularly its links with: Health (Almedom, 2005; Baum, 1999; Harpham, Grant & Rodriguez, 2004; Lindstrom 2004), social mobility (Li, Savage, & Warde, 2008), education (Teachman, Paasch & Carver, 1996), and family life (Parcel & Bixby, 2015). Most of this research has determined that the presence of ‘structural’ SC (e.g. social connections) increases one’s access to resources, and that the presence of ‘cognitive SC’ (e.g. trust in others) enhances perceptions of ‘togetherness’ and psychological wellbeing (Álvarez & Romani, 2017). Thus, higher levels of SC have been associated with more life opportunities and a better quality of life.

1.3 The significance of SC and children's mental health

McPherson et al. (2014) conducted a systematic review of the association between SC and the mental health of children and adolescents. This was a comprehensive review that revealed a number of associations between family and community types of SC and children's mental health with regards to: self-esteem and self-worth, internalising behaviours, and externalising behaviours. This review demonstrated that SC at both the family and community level can greatly influence mental health and problem behaviour in children and young people, giving credence to the statement by Putnam (2000), that "of all the predictive factors associated with children's wellbeing, social capital – second only to poverty – has the highest influence on children's development and attainment of future outcomes" (p.9).

Whilst this review did establish an association between SC and child mental health, it was inclusive of studies measuring SC in families and communities, with measurement of SC being taken from the perspectives of parents, schools, non-matched responders (e.g. via neighbourhood surveys), and children themselves. Due to the large range of ways in which SC was measured across the studies included, some caution should be applied to the interpretation of findings. In addition, this review made no distinction between the different perspectives from which measurement of SC was taken and did not acknowledge these differences in the synthesis of findings. Thus, the precise impact of SC perceived by particular individuals (e.g. children themselves versus parents) upon child mental health was not made clear.

1.4 Parental SC and children's mental health

Reviews such as that by McPherson et al. (2014) present a great deal of evidence to support the idea that the level of SC available to an individual has an impact on their own mental health, whether they are an adult (De Silva et al., 2005) or young person. However, what is much less clear is the association between SC experienced by parents specifically, and the mental health and wellbeing of their children. Some studies have demonstrated that children's own SC and experiences often have more impact upon their mental health than factors more removed from them, such as parental SC (e.g. Goyette & Conchas, 2002); however, this is usually once children are at the stages of developing autonomy – such as during adolescence - and experiencing the world on their own terms. Prior to this, children's experiences are predominantly determined by their parents' and caregivers' circumstances and choices (Runyan et al., 1998).

1.5 Rationale

To the author's knowledge, there has not been a review of studies focusing specifically on parental SC and how this may impact upon children's mental health. Directing the focus towards parental SC, rather than SC held by families as a whole or by children themselves, may give some indication of a *parents'* role in ensuring their children's mental wellbeing; and it might also be possible to determine the aspects of children's mental health most influenced by parental SC.

This review will seek to answer the primary question (1) “How are parental SC and children’s mental health associated?”; along with the secondary question (2) “Which clinical characteristics (if any) are most influenced by parental SC?”. By conducting a systematic search of the literature, this review will consider the empirical evidence pertaining to these questions. This review will collate, and synthesise, the existing published literature on this topic, with attention being drawn to the most salient findings, themes and issues. Both implications and ideas for future research and clinical practice will be presented.

2. Methodology

2.1 Design

2.1.1 Study features.

Papers were only included if they were empirical studies; therefore, conceptual papers were excluded. There were no exclusion criteria in relation to study design, so that a broader range of findings and information might be obtained. The papers included used a range of approaches, including experimental, observational cohort studies, and qualitative methods.

For the purpose of this review, “parental SC” is defined as the following elements, directly held or experienced by a parent or primary caregiver: social support networks, feelings of trust in social connections, and engagement in local community. Studies featuring the words “social capital”, or other description (e.g. “social support”) were only included where the concept at the centre of the study matched this definition. In the studies selected, elements of SC were explored in parents, caregivers and their families. Studies focusing exclusively on neighbourhood SC, not measured specifically in parents (e.g. Drukker, Kaplan, Feron & van Os, 200) were not included in this review. Studies measuring parental SC indirectly, such as by asking their children (e.g. Springer, Parcel, Baumler, & Ross, 2006), were also not included in this review.

Studies looking specifically at children’s own SC, built amongst peers or otherwise, were also not included in this review, as the impact of this has already been well-reported (Ferguson, 2006; McPherson et al. 2014). Due to recent reviews having been published to demonstrate the impact of family SC (i.e. SC between parents and children) upon children’s wellbeing (Ferguson 2006; Parcel & Bixby 2016), this area of the literature was also excluded from the present review.

Studies were only included if they examined the relationship between parental SC and their children's mental health. In the case of reported outcomes being indirectly linked to children's wellbeing, for example with outcomes such as parental health (e.g. Bassani, 2008; Carpiano & Kimbro, 2012) or parenting strategies (e.g. Byrnes & Miller, 2012), these studies were also not included.

2.1.2 Inclusion criteria.

Studies were included in the review if they:

1. Addressed an association between parental SC and child mental health as defined above.
2. Were empirical research.
3. Used quantitative or qualitative methods.
4. Were published in peer-reviewed journals.

2.1.3 Exclusion criteria.

Studies were excluded from the review if they:

1. Were not available in English.
2. Were conceptual papers.
3. Were not conducted with parents themselves.
4. Focused exclusively on SC not directly measured or examined in parents.
5. Did not comment on any aspect of child mental health as defined above.

2.2 Literature Search

Preliminary electronic database searches were carried out to identify relevant terminology for the systematic search. Appropriate search terms were obtained from relevant articles obtained through these initial searches. The following databases were searched: PsycINFO, PsycARTICLES, PubMed Central, EBSCO Host, Web of Science, Social Policy and Practice, and ASSIA. The searches were all conducted using suitable search operators for each database (Appendix 1), up until week 1, December 2017.

A four-stage process was employed in order to identify appropriate studies for this review; initial identification, screening, eligibility and inclusion. A flow chart of this process, as outlined by Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA; Moher, Liberati, Tetzlaff & Altman, 2009), can be found in Figure 1. At the eligibility and inclusion stage, papers were excluded if they did not meet the criteria. Duplicate citations were also removed, leaving the 10 papers included in the present review.

The final search terms used were "Parent* Social Capital" or "Parent* Social Support" or "Parent* Neighbour* Support" or "Parent* Neighbor* Support" or "Parent* Friend*" or "Parent* Connect*" and "Child* Mental* Health" or "Child* Psycholog* Health" or "Child* Psychiatr*" or "Child* Mental* Wellbeing" or "Child* Psycholog* Wellbeing".

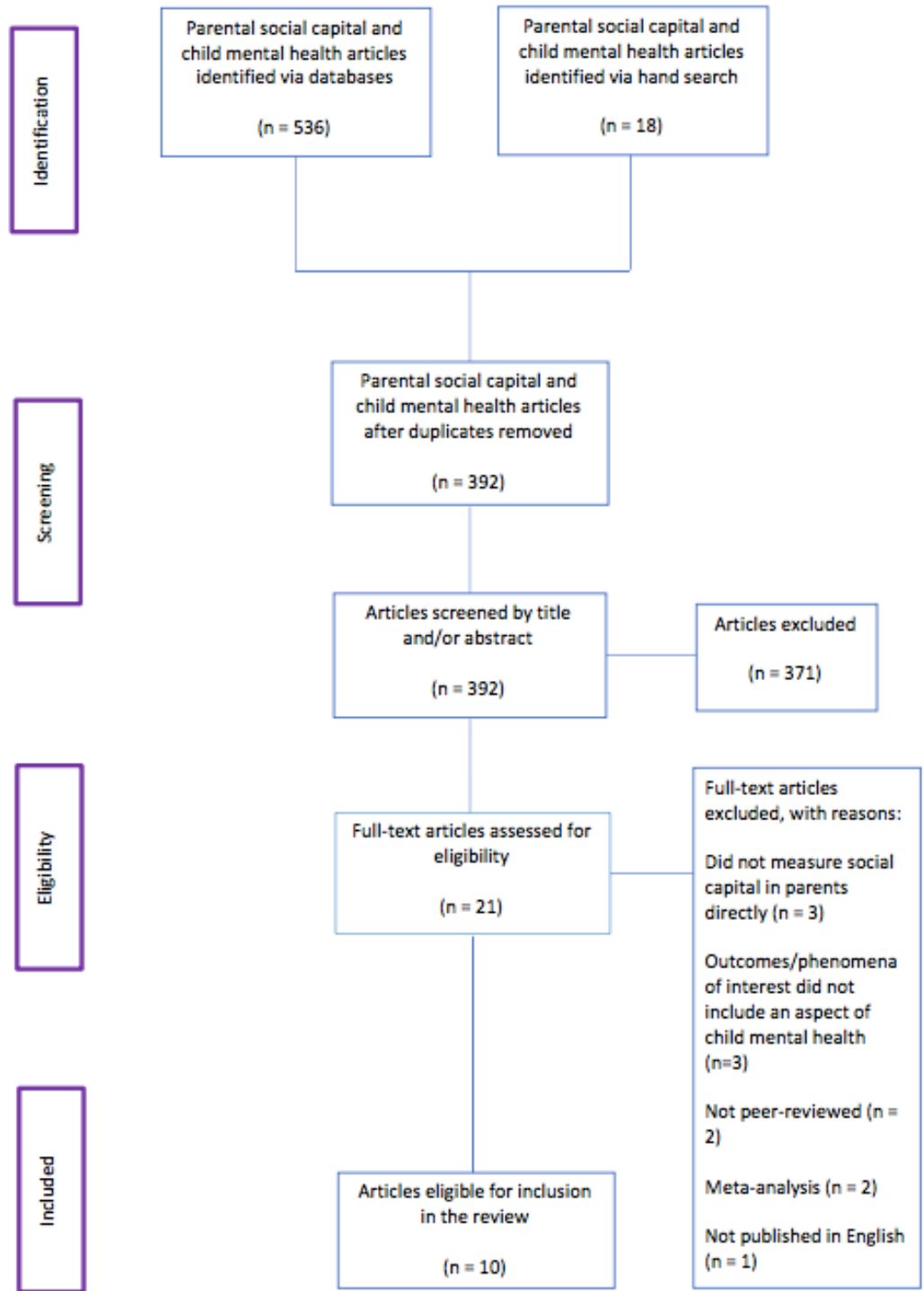


Figure 1. Flowchart of the process for selecting articles for review

2.3 Quality assessment

The quality of studies included was assessed using the Critical Appraisal Skills Programme (CASP) tools (Public Health Resource Unit, 2006). These tools were selected due to having been validated for use with all of the types of study included in this review, as well as having been implemented successfully in high quality systematic reviews of both quantitative and qualitative research (e.g. Clement et al., 2015). The CASP tools include checklists for case-control studies, cohort studies, and qualitative studies (Appendix 2). Whilst using the CASP tools as a 'scoring system' is not suggested, an arbitrary distinction was made in order to compare the varying levels of quality amongst the studies selected. In order to make this distinction, one 'point' was allocated to each study for each CASP criterion against which the study demonstrated good quality or adherence. Table 1 demonstrates the total number of criteria suggested for each type of study, along with the distinctions in quality as rated by the author.

Table 1. Quality ratings derived from CASP Checklists

CASP Checklist	Total number of criteria	Poor quality	Moderate quality	High quality
Case-Control	11	0-4	5-8	9-11
Cohort	12	0-4	5-8	9-12
Qualitative	10	0-3	4-7	8-10

2.4 Data extraction and synthesis

Data extraction and synthesis were conducted using a textual narrative approach, selected due to its ability to make sense of both quantitative and qualitative data (Snilstveit, Oliver & Vojtkova, 2012). Initially the results of each study were assessed systematically,

highlighting any important characteristics such as key similarities or differences between them.

The second part of this synthesis was comprised of an in-depth exploration of relationships in the data, both within and between the selected studies.

3. Results

3.1 Overview of selected papers

A majority of the studies identified used quantitative methodologies (n=7), with the remaining studies using a qualitative approach. Studies were conducted in the United Kingdom (UK; n=1), United States of America (USA; n=5), Sweden (n=1), Greece (n=1), Vietnam (n=1), and Canada (n=1). Authors came from a diverse range of occupational backgrounds, including: Sociology, teaching, social work, anthropology, psychiatry, psychology, paediatrics and general medicine.

Samples across all of the selected studies totalled 9596 child and parent/family units. Although not reported in one paper, children's ages ranged from 0 -18 years across the remaining studies, with a mean age of 6.4 years. Participants' race/ethnicities included: White (<1%), Black (11.2%), Hispanic/Latino (23.7%), Asian (51.6%), Mixed Heritage (<1%) and Other/Not stated (11%). Characteristics of each study, including how each study defined and measured (where relevant) parental SC and child mental health, can be seen in Table 1. In order to make optimum sense of the data, the findings are synthesised and presented according to the aspects of children's mental health they addressed.

Table 2. Summary of all studies included

	Author, Year of Publication, Country, Quality rating	Methodology	Participants	Measures used (Parental SC = PSC, child mental health = CMH)	Aspect of children's mental health and wellbeing	Key findings
1.	Beiser, Zilber, Simich, Youngmann, Zohar, Taa & Hou 2011 Canada Moderate quality	Quantitative Cross-sectional survey	N = 2031 Age of children: 4-6 years and 11-13 years Race/ethnicity: Chinese, Hong Kong Chinese and Filipino	PSC Parent About Family (PAF) section of New Canadian Children and Youth Study questionnaire <u>CMH</u> Emotional Problems Scale derived from Ontario Child Health Survey	Internalising behaviours	Parental SC significantly predicted the presence of children's internalising behaviours, such as sadness and depression ($\beta = -0.03, p < 0.05$).
2.	Björnberg 2011 Sweden Poor quality	Qualitative Semi-structured interviews Type of analysis not stated	N = 17 families Age of children: 9-18 years Race/ethnicity: From Afghanistan, Middle East, Iraq, Iran and Uzbekistan (numbers not stated)	PSC Described as social integration, along with the existence (and trust) of social support systems <u>CMH</u> Discussed in	Self-esteem and self-worth	Asylum-seeking parents in the study had little SC outside that of the immediate family unit. Most notably, not feeling able to "trust others" seemed to be a

				relation to resilience, self-worth and self-esteem.		huge barrier for parents to overcome in order to build SC in their new environment. The tendency to only look “inwards” at the family seemed to apply to children also, and family relationships were described as “strong”. This provided a type of emotional resilience for children, but they were often socially isolated and less resilient in situations outside of the family context. The relationship between parental and family SC and
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						children's resilience was described as a "complex one".
3.	Caughy, O'Campo & Muntaner 2003 USA High quality	Quantitative Cross-sectional survey	N = 200 Age of children: 3-4.5 years Race/ethnicity: Black African-American = 100%	PSC Parental psychological sense of community scale (Chavis, Florin, Rich & Wandersman, 1987) CMH Child Behavior Checklist (CBCL)	Internalising behaviours Externalising behaviours	Increased levels of parental SC were associated with reduced internalising behaviour problems, but only in the more affluent neighbourhoods. Increased support from, and stronger ties to, neighbours was found to be a risk factor for internalising problems in the most impoverished neighbourhoods.
4.	Dorsey & Forehand	Quantitative	N = 130	PSC Neighborhood Support for Work	Internalising behaviours	Increased parental SC was associated with

	2003 USA High quality	Cross-sectional survey	Age of children: 5-14 years Race/ethnicity: Black African-American = 100%	and Parenting Scale (Brody, 1996) CMH Child Behavior Checklist (CBCL)	Externalising behaviours	increased levels of positive parenting, which in turn was associated with decreased psychosocial problems in their children.
5.	El-Dardiry, Dimitrakaki, Tzavara, Ravens-Sieberer & Tountas 2012 Greece High quality	Quantitative Cross-sectional survey	N = 542 children Age of children: 8-12 years Race/ethnicity: Not stated	<u>PSC</u> Neighbourhood Social Capital – 1992 Health and Lifestyles Survey (Health Education Authority, 1995) Parental Social Support – 1993 Health and Lifestyles Survey (Health Education Authority, 1995) both as used by Mulvaney and Kendrick (2005) CMH	Internalising behaviours Self-esteem and self-worth	Higher levels of parental SC were found to be significantly associated with higher levels of children's wellbeing. In particular, both dimensions of parental SC measured were independently associated with children's mood and emotions [Neighbourhood SC ($\beta = 0.14$, $p \leq 0.01$) and Parental Social

				KIDSCREEN-52 HRQoL Questionnaire (Ravens-Sieberer et al., 2005)		Support ($\beta = 0.10, p \leq 0.05$) where R^2 adjusted = 0.06] as well as with children's relationships with parents and home life [Neighbourhood SC ($\beta = 0.18, p \leq 0.001$) and Parental Social Support ($\beta = 0.10, p \leq 0.05$) where R^2 adjusted = 0.08]
6.	Harpham, De Silva & Tuan 2006 Vietnam High quality	Quantitative Cross-sectional survey	N= 2907 mothers Age of children: 1 and 8 years Race/ethnicity: Not explicitly stated, 100% Vietnamese implied	<u>PSC</u> Shortened version of the adapted social capital assessment tool (A-SCAT; Harpham et al., 2002) CMH Strengths and Difficulties Questionnaire	Internalising behaviours Externalising behaviours	Among 8-year- olds, good mental health was significantly associated with high levels of both structural measures of SC (formal networks – OR 0.34 95% CI 0.15, 0.80; informal

				(SDQ; Goodman, 1997)		networks – OR 0.40 95% CI 0.18, 0.89) and cognitive measures of SC (OR 0.45 95% CI 0.24, 0.85) parental SC.
7.	Lopez Turley, Gamoran, McCarty & Fish 2017 USA Moderate quality	Quantitative Cluster-randomised design Intent-to-treat (ITT) and treatment-on-treated (TOT) analyses	N = 3084 families Ages of children: Stated as being in first grade Race/ethnicity: Hispanic = 71.5% (intervention) & 75% (control) Black = 10.8% (across both conditions) Other = 17.7% and 14.2%	<u>PSC</u> Non-standardised survey constructed specifically for this study CMH SDQ (Goodman, 1997)	Internalising behaviours Externalising behaviours	Increased parental SC was associated with a 1.84 standard deviation decrease in children's internalising behaviour problems (p < 0.001), and a non-significant slight decrease in children's externalising behaviour problems.

8.	Richardson, Johnson & St. Vil 2014 USA High quality	Qualitative Field observation and interviews Grounded theory	N = 15 boys Age of children: 12- 15 years (Mean age: 12.9 years at start of study) Race/ethnicity: Black - African- American = 100%	<u>PSC</u> Discussed in relation to both structural (e.g. practical support from extended family members) and cognitive (e.g. trust of social networks) elements. CMH Discussed in relation to externalising ("pre-delinquent") behaviours.	Externalising behaviours	With regards to parental SC, this study described a somewhat "vicious cycle" of association with their sons' pre- delinquent behaviour (e.g. fighting, petty theft & truancy). It was found that lack of SC meant that (often single) parents did not have the support they needed to "control" their sons' behaviour, but that also their sons' behaviour contributed to the "erosion" of any SC parents did have.
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						<p>Where levels of parental SC seemed to be higher, parents were given more options in terms of reducing their sons' pre-delinquent behaviour. This included being able to send children to stay with a trusted family member or enrolling them into constructive activity. When parental SC was weaker, parents were more likely to rely upon juvenile court and confinement of their sons to keep them "out of trouble"; resulting in</p>
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						worse outcomes for the boys, their wellbeing and their future prospects.
9.	Runyan, Hunter, Socolar, Amaya-Jackson, English, Landsverk, Dubowitz, Browne, Bangdiwala & Mathew 1998 USA High quality	Quantitative Cross-sectional case-control analysis Simple logistic regression model analysis	N = 667 children Ages of children: 2-5 years (Mean age = 4.4 years) Race/ethnicity: White = 30% Black African-American = 53% Hispanic = 3% Mixed race = 10% Other/unknown = 4%	<u>PSC</u> Social Capital Index created by the researchers according to the relevant literature CMH Battelle Developmental Inventory Screening Test (BDST) Child Behavior Checklist (CBCL)	Internalising behaviours Externalising behaviours	Children were more likely to be “doing well” the higher the score for SC, as measured in parents (OR 1.35 (95% CI = 1.11, 1.63). A dose-response relationship was also found, in that the percentage of children doing well increased from 15% in those whose parents scored a SC index value of 4, to 39% for those whose parents scored a

						<p>SC index value of 5.</p> <p>In the final logistic model, the odd ratio for the SC index was shown to be statistically significant (OR 1.29, 95% CI = 1.04, 1.59, p = 0.02), demonstrating that the addition of any one SC indicator increased the odds of children doing well by 29%. Adding any two indicators increased these odds by 66%.</p>
10.	Williams, Hewison, Wagstaff & Randall	Qualitative Group interviews	N = 46 fathers Ages of children: Not stated	PSC Described as membership of social networks in which assets and	Self-esteem and self-worth	Fathers expressed an acute awareness of "negative social capital"

	<p>2012</p> <p>UK</p> <p>High quality</p>	<p>Abductive reasoning (Blaikie 2007)</p>	<p>Race/ethnicity: Described as African, Caribbean, Afro-Caribbean, African- Caribbean, Nigerian, Zimbabwean, Black British, Black, mixed race, mixed heritage and mixed ancestry</p>	<p>resources are available to members.</p> <p>CMH Described as 'mental wellbeing', with the emphasis being on high self-esteem and the absence of diagnosed mental health difficulties.</p>	<p>and associated 'resources' available to their children (sons in particular), such as with gang membership. They expressed that they felt a duty to build strong SC amongst themselves as parents and fathers so that they might have access to more positive resources for their children.</p> <p>Fathers also spoke about the importance of SC between parents and the community as a whole, in order to create an environment</p>
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						that 'looks out' for its children and their wellbeing.
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3.2 Internalising behaviours

Internalising behaviours refer to a set of behaviours and mental health difficulties that are focused inwards; such as being withdrawn, experiencing somatic symptoms and presentations in line with anxiety and depression (Merrell, 2008). All of the seven studies that examined parental SC and internalising behaviours in children found a significant association in some way.

Lopez Turley, Gamoran, McCarty and Fish (2017) conducted the only intervention study included in this review. In this study, an intervention called Families and Schools Together (FAST; McDonald, Billingham, Conrad, Morgan, O, & Payton, 1997) was first tested for its ability to act as a proxy for parental SC. Measuring parental SC using 3 constructs (number of parents known at their child's school, reciprocity between them and shared expectations between them), FAST was demonstrated to increase parental SC by 0.52 standard deviations ($p < 0.001$).

Intent-to-treat (ITT) and treatment-on-treated (TOT) estimates supported the use of FAST as a proxy for parental SC in the second part of the study, which sought to examine the effects of parental SC on children's socio-emotional wellbeing. The second part of the study demonstrated that increased parental SC – as measured by participation in FAST – was associated with fewer internalising behaviour problems in their children by the end of the programme. An obvious limitation with this study is the use of an intervention as a proxy for parental SC. For example, there were problems with non-completion of the FAST programme, which therefore affected the levels of parental SC able to be inferred from implementation of the programme. In addition, it is possible that the FAST intervention produced other outcomes that affect children's socio-emotional wellbeing, such as parents' involvement in school life (Allen & Daly, 2002).

The remaining six studies demonstrating a significant association between parental SC and internalising behaviours in children were all cohort studies using various measures to capture these concepts. Runyan et al. (1998) described a cross-sectional study of 2- to 5-year-old children “doing well” and “not doing well”, which made use of data taken from one time point in the Longitudinal Studies of Child Abuse and Neglect Consortium in the US. Parental SC was measured using a ‘Social Capital Index’ based on 5 constructs (two parents or parent-figures in the home; social support of the maternal caregiver; no more than two children in the family; neighborhood support; regular church attendance), whilst the Child Behavior Checklist (CBCL; Achenbach, 1991) was used to measure the behavioural wellbeing of children. The Batelle Developmental Inventory Screening Test (Glascoe & Byrne, 1993) was also used to measure children’s functioning. They found that higher levels of parental SC were indeed associated with higher odds of children functioning well, with less internalising behaviours; however, “church attendance” (OR 1.71, 95% CI 1.09, 2.70) and “personal social support” (OR 1.69, 95% CI 1.07, 2.67) were the only SC indicators that were statistically significant.

El-Dardiry et al. measured parental SC on two separate constructs: SC within the neighbourhood and social support networks – both as perceived by parents. The findings demonstrated that on the neighbourhood construct parental SC was positively correlated with children’s overall psychological wellbeing ($\beta = 0.11$, $p \leq 0.05$, $R^2 = 0.01$), moods and emotions ($\beta = 0.16$, $p \leq 0.001$, $R^2 = 0.02$) and autonomy ($\beta = 0.12$, $p \leq 0.01$, $R^2 = 0.02$). Whilst on the social support network construct, parental SC was independently associated with overall psychological wellbeing ($\beta = 0.12$, $p \leq 0.01$, $R^2 = 0.01$) and moods and emotions ($\beta = 0.12$, $p \leq 0.01$, $R^2 = 0.02$).

Harpham et al. found that good mental health in 8-year-olds was significantly associated with high levels of both structural parental SC (OR 0.34 for formal networks, OR 0.40 for informal networks) and cognitive parental SC (OR 0.45). Whilst these results support the above findings that parental SC was positively correlated with reduced internalising behaviours, some caution should be applied to their interpretation. This study was conducted in Vietnam, yet mental health in children was measured using the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). While the SDQ is a valid and reliable measure of children's mental health, it was limited at the time of this study by having a lack of well-established international norms (Achenbach & Rescorla, 2007) – particularly in the country of study at that time (Weiss et al., 2014).

Most of the quantitative studies included throughout this review implemented adequate controls for potential confounding variables affecting the putative relationship between parental SC and children's mental health. This allowed the researchers to examine associations in various conditions in order to establish how other factors interact with these phenomena. One example of this in practice was demonstrated in the study by Caughy et al. (2003). By controlling for the potentially confounding variable of "impoverishment", this study was able to identify the somewhat unexpected finding that whilst parental SC was significantly positively associated with reduced internalising behaviours in children overall, in the most impoverished areas it was actually *reduced* parental SC that was significantly associated with reduced emotional problems in their children. Caughy et al. interpreted this finding as a possible indication of negative SC in highly impoverished neighbourhoods. For parents living in these neighbourhoods, having less connections with their neighbours was a *protective* factor for their children's mental health.

3.3 Externalising behaviours

Externalising behaviours can be described as emotional difficulties that manifest outwards in children's behaviour, such as aggression and hyperactivity, that often have a negative impact on the external environment (Campbell, Shaw, & Gilliom, 2000). The majority of the quantitative studies included in this review used composite measures to assess children's mental health. These measures included constructs for both internalising and externalising behaviours, and in three of the above-mentioned cohort studies (Dorsey & Forehand, 2003; Harpham et al., 2006; Runyan et al., 1998), internalising and externalising behaviours were not separated out or tested independently for their association with parental SC.

In the two quantitative studies that did examine parental SC and externalising behaviours in children, separate to internalising behaviours, there was no significant evidence to demonstrate an association between higher levels of parental SC and lower levels of externalising behaviour problems (Caughy et al., 2003; Lopez Turley et al., 2017).

The only qualitative study to examine parental SC and externalising behaviours in children was that by Richardson, Johnson & St. Vil (2014). They observed and interviewed low-income African-American families over the course of three years about the resources required, including SC, to parent boys presenting with pre-delinquent behaviour. Within this community, there was an overall sense that it was extremely difficult for parents to build and maintain beneficial levels of SC. Many worked more than one manual job, each of which did not seem to be a source of helpful SC for parents, serving merely to pay the bills. Others were signed off from work due to illness or disability. Across both of these groups a common theme was feeling "too tired" to

engage in anything that might strengthen SC, such as school meetings or becoming acquainted with parents of their children's friends. Where parental SC, both structural (e.g. extended family members) and cognitive (e.g. trust of social networks), were stronger, parents were given slightly more options in terms of reducing their sons' pre-delinquent behaviour. This included being able to send children to stay with a trusted family member, described as "exile" (Jarrett, 1997), or enrolling them into constructive activity. When parental SC was weaker, parents were more likely to rely upon juvenile court and other formal resources of social control to keep their sons "out of trouble". This was described as being likely to result in even worse outcomes for the boys' emotional wellbeing and future prospects, both due to stigma and the negative SC that they themselves would begin to build within their peer groups.

In thinking about the relationship between parental SC and children's externalising behaviours, parents in this study highlighted the difficulties of building and maintaining SC when they have a child presenting with pre-delinquent behaviour. This demonstrated that while, perhaps, a lack of SC to begin with might have contributed to their child's presentation, it is possible that externalising behaviours in children affect parental SC.

3.4 Self-esteem and self-worth

The only quantitative study to look at the association between parental SC and children's self-esteem was that by El-Dardiry et al. They found that parental SC, as measured on a construct of 'parental social support', was significantly associated with children's self-perception ($\beta = 0.13$, $p \leq 0.01$).

In a qualitative study, Björnberg (2011) looked at parental SC amongst asylum-seeking families in Sweden and how this might be related to resilience and self-esteem in their children. It seemed that asylum-seeking parents found great difficulty in building and maintaining SC within their new country and neighbourhoods. Given that this group of parents, along with families as a whole, had endured extremely negative experiences with others along their journeys, social ties were often not seen to be “beneficial” by parents. In addition, a very strong theme of “distrust” emerged throughout interviews with both parents and children. Thus, with SC being the result of social ties that are “reciprocal, trusting and involving positive emotion” (Morrow, 1999), relational patterns amongst participants were not conducive to building SC. In many cases parents used within-family SC to help deal with challenges and children often felt depended upon, by their mothers in particular. In order to be supportive of their parents, children “reduced their own needs”; a process that seemed to have a negative impact upon their own mental health.

This study highlighted the possible difficulties with applying Western concepts, such as Coleman’s and Putnam’s definitions of SC, to non-Western cultures. It was apparent that for the families in the study (who had fled from countries such as Afghanistan, Iraq, Iran, Uzbekistan and countries in the Middle East), social networks and capital may have operated quite differently. For example, many parents expressed disdain at the idea of being part of any supportive or “exchange”-type relationships outside of the family. Describing such relationships as “shameful”, it seemed that these views were perhaps culturally-rooted rather than acquired as a result of

negative experiences. There is also a possibility that parental SC may relate very differently to outcomes such as children's mental health, depending upon the cultures and norms of the group.

Also using qualitative methods, Williams, Hewison, Wagstaff and Randall (2012) studied the SC of African and African-Caribbean fathers in the UK, along with how this might relate to the mental wellbeing of their own children and other children within their communities. Williams et al. (2012) presented a rare insight into how African and African-Caribbean fathers in the UK employ SC, and other types of capital, in order to promote the mental wellbeing of their children. Participants demonstrated an acute awareness of the negative stereotypes surrounding Black men and boys in particular, and also of negative forms of SC available to them (e.g. gang membership) if they did not seek more positive, healthy forms of SC. Fathers, with seemingly high levels of SC, described having a strong sense of responsibility for not only their own children's self-esteem, but also that of children in the community. They also acknowledged the over-representation of people from African and African-Caribbean backgrounds in mental health services and felt that their role was to instil confidence and self-esteem into their children in order to overcome this. One father was quoted as saying:

“...I'm very concerned, as we all are, about mental health provision for our community and the issues that we face. So you're constantly aware of yes they need to have a self esteem but also... just mental sort of calm and, being able to express and sit down and talk”

Not only did this paper demonstrate *how* fathers' SC might positively impact upon their children's emotional wellbeing, it highlighted a previously under-acknowledged parental resource in African and African-Caribbean fathers. However, it might be important to acknowledge that both of these qualitative studies exploring parental SC and children's self-esteem used only ethnic minority samples.

4. Discussion

The above findings offer some understanding of the relationship between parental SC and child mental health. To answer the primary research question of “How are parental SC and children’s mental health associated?”, the findings demonstrated a clear association, in most cases a positive association, between parental SC and child mental health. To answer the secondary question of “Which clinical characteristics (if any) are most influenced by parental SC?”, the findings indicated three main clinical characteristics of child mental health associated with parental SC: internalising behaviours, externalising behaviours and self-esteem and self-worth. Of each of these areas of child mental health, the most compelling evidence was that for a strong association between parental SC and internalising behaviours (e.g. symptoms of depression and anxiety).

These findings are not surprising, given the wealth of previous research that has established a positive association between SC and good mental health (De Silva et al., 2005; McPherson et al., 2014). However, the link between parental SC and child mental health in particular raises additional questions around what might be facilitating this association. One potential mediator is that of ‘positive parenting’ (Dorsey & Forehand, 2003). It was suggested that parental SC enhances positive parenting techniques, which in turn reduces the likelihood of child mental health difficulties and behaviour problems. Another potential mechanism may be the ‘buffering’ of parents’ own mental health difficulties (e.g. Parrott, Jacobs, & Roberts, 2008), whereby parental SC reduces detriment to parenting and/or children’s experiences in the home,

resulting in less negative impact upon children's mental health. However, with very little established around the mechanisms in operation, this is an area for further research.

4.1 Methodological issues

Throughout the last few decades of literature published on SC, the same issue seems to arise; the heterogeneity of SC conceptualisation and measurement. Measurement of SC was conducted with different tools across each of the quantitative studies, and conceptualised slightly differently in each of the qualitative studies. This is acknowledged as a limitation of the review, due to difficulties with synthesising such varied data; however, this is also representative of the obstacles faced by many other researchers in this area (e.g. Harpham, Grant & Thomas, 2002).

An additional issue relating to the generalisability of results was the limited number of studies per country, particularly in the UK ($n = 1$). It may be that the range of countries in which research has been conducted offers some insight into differences in parental SC practices, and how they might impact differently upon children's mental health. However, it would be difficult to make inferences from these findings alone.

The issue of causality also remains a pertinent one. Whilst a number of studies demonstrated significant associations between parental SC and aspects of children's emotional wellbeing, cross-sectional studies do not address issues such as how the 'outcomes' themselves might have had an impact on SC. This was perhaps more salient in the findings related to children's externalising behaviour, as whilst each study sought to find the effects of parental SC

on children's emotional wellbeing, it was highlighted that children's mental health and behaviour can also affect their parents' SC (e.g. Richardson et al., 2014). To this end, more longitudinal and carefully controlled studies are required in order to clearly establish the relationship between these phenomena.

Another area of complexity seemed to arise out of difficulties with distinguishing SC from other types of capital (e.g. human capital) and also understanding how they interact. Many relationships between types of capital, and also other variables such as ethnicity, gender and social class, were only established with post-hoc analyses. Further research into these relationships is required in order to gain a greater understanding of, and therefore control for, these complex processes, particularly if positive change is to be made within disadvantaged groups.

4.2 Clinical implications and future research

Having established the pertinence of parental SC in many cases of children's emotional difficulties, it could be beneficial to think about how SC can be 'built' in and amongst parents. Whilst there are a vast number of direct and indirect interventions operating to improve children's emotional wellbeing (e.g. Coles, Cheyne & Daniel, 2015), many of these are behavioural in approach. They do not necessarily consider the impact of other factors, such as parental SC, upon their effectiveness. By focusing on ways to build SC particularly within such interventions, it may allow for practitioners and families alike to recreate the environment and

interaction necessary to have an increasingly positive impact upon the emotional wellbeing of children and their parents.

In addition, with particularly strong evidence for the association between parental SC and reduced internalising behaviours in children, it could prove extremely beneficial for clinicians to consider parental SC in the prevention of child mental health problems such as depression and anxiety. For example, public health campaigns and resilience-building programmes such as those implemented in schools (e.g. Hart & Heaver, 2015) could include education and opportunities to support parents in building SC. This could also be considered at the treatment stage for these types of mental health difficulties, such that services could incorporate elements of parental SC building as part of the interventions being delivered.

In practice, a school-based intervention, similar to FAST (Lopez Turley et al. 2017), might offer parents opportunities to build SC amongst each other and the school community by creating opportunities to interact on a more meaningful level than otherwise might be the case at the school gates for example. Peer-led interventions have also been demonstrated to be effective in building SC amongst other populations (e.g. Im & Rosenberg, 2016); and in a controlled trial demonstrating the effectiveness of a peer-led parenting intervention (Day, Michelson, Thomson, Penney, & Draper, 2012) for reducing problem behaviours in children, SC was mentioned as another possible outcome. Further research is required in order to establish how SC can be built through intervention, to identify the necessary elements and mechanisms, along with how it relates to other desired outcomes.

Parental SC has been demonstrated to be instrumental in relation to aspects of children's

mental health; however, the processes by which this occurs, and the conditions required for these processes to take place, are seemingly quite complex. The studies selected each go some way to illustrate the significance of parental SC, yet findings often gave rise to many more unanswered questions about the associations made and relationships observed. Findings such as those by Caughy et al. (2003) highlighted the complexities of parental SC and how it might be considered a protective factor, or a risk factor, for children's mental health difficulties, depending on the circumstances of the family. Further research is needed to seek clarity on complexities such as this, particularly around factors such as impoverishment and how they interact with parental SC.

Amongst these studies there was a sense that in relation to children's externalising behaviour, parental SC can have a positive impact, but that the association is not as strong as that between parental SC and internalising behaviours in children. With the average age of children included in the studies of externalising behaviour being higher than that of the children included in the internalising studies, it is very possible that the influence of parental SC somewhat decreases as children grow older. As children gain autonomy and build their own networks, SC, and therefore influences, it may be the case that parents' influences become less impactful on children's behaviour and wellbeing. This is also an area for further investigation.

Finally, with a relationship between parental SC and children's emotional wellbeing having been established, research into how exactly parental SC builds would be the next step. By identifying these processes, implementing SC-building elements into clinical practice as

mentioned above, and also into other places where children's wellbeing is paramount (e.g. schools), becomes much more of a practical reality.

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MAJOR RESEARCH PROJECT

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Section B

**“We all just want the best for our children”: A grounded theory of building social capital in a
peer-led parenting intervention**

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Abstract

There is a growing body of evidence to suggest that parental social capital may be beneficial for the mental wellbeing of children. While the mechanisms underlying this association may not yet be clearly established, the strong association alone presents an argument for building parental social capital as a way of preventing and/or overcoming difficulties with their children's mental health. However, in order to encourage the building of parental social capital, an understanding of the building process and what might contribute to its formation is required.

This study explores the processes involved in building social capital amongst parents attending a peer-led parenting intervention group. Participants were 14 mothers who each attended the inner city-based group for parents of children aged 2-11 years. The mothers were interviewed about their experiences of attending the parenting group, and a critical realist grounded theory approach was used to develop a framework for understanding the process of building social capital within this context.

Findings suggested that the following key processes were associated with building social capital: Personal Development, Making Connections, Feeling Safe, and Overcoming Differences. Each of these processes was facilitated by aspects of the intervention, as well as participant and facilitator attributes. These findings are described in detail, followed by suggestions for future research and implications for clinical intervention.

Key words: Parenting, Social Capital, Child Mental Health, Peer-Led, Intervention

1. Introduction

1.1 Social capital

Since its introduction as a concept by Coleman (1988), social capital (SC) has become a subject of intense interest and discussion within the social science and public health domains. Broadly defined as 'social connections that carry productive benefits', SC has been attributed to having an impact on a number of health-related issues (Kawachi, Subramanian & Kim, 2008), and has thus gained the attention of health professionals and agencies aiming to create positive change in these areas.

Throughout its conceptualisation and associated research, SC has been defined in a myriad of ways and in relation to a wide variety of populations, functions and outcomes (Bankston & Zhou, 2002). This has presented much difficulty with regards to understanding SC, what it can look like and its significance. In relation to child and family health and wellbeing, SC has most commonly been defined as "the connections between and among actors that produce social outcomes, including children's cognition and social adjustment" (Parcel & Bixby, 2016).

In addition, there have been three types of SC described consistently throughout the literature: bonding, bridging and linking (Patulny & Svendsen, 2007). This tripartite model is particularly helpful for understanding the different types of SC available to members of a family or community group and how they radiate outwards.

Bonding SC refers to the capital held in the close relationships between family members and members of other small groups (Woolcock, 2001). This type of SC gives family/group members a sense of belonging and cohesiveness; described as "communitas" by Terrion and

Ashforth (2002) in their study of temporary groups. Bridging SC describes the capital held in connections between social groups and individuals that are more distant in relational proximity to each other (e.g. neighbours, distant relations and friends; Woolcock, 2001). Described as being “horizontal” in its function, this type of SC connects people who share similarities in demographics such as socio-economic status and levels of existing capital. Linking SC refers to the type of capital that provides access to information and resources held by those in positions of power (Woolcock, 2001). It is described as being more “vertical” in nature and offering more in the way of “opportunity” than the other types of SC. Research has demonstrated that all three dimensions of SC are associated with healthy family functioning, including aspects of child psychological and developmental health (Putnam, 2000).

1.2 Child mental health

Child mental health is an issue of growing concern (The Children’s Society, 2017), with around one in four children and young people showing signs of mental ill health (Office for National Statistics, 2015). With children being the foundation of society, an understanding of what contributes to their mental health is paramount if effective preventative and intervention measures are to be put in place (Lovell & Bibby, 2018). There are a number of factors considered to be determinant of children’s mental health, and many of these are related to social circumstances (World Health Organisation, 2014); one of these social determinants is SC.

Many studies have indicated that SC, held by either the child/young person themselves, or their families/caregivers, has a significant impact on children’s mental health and wellbeing.

For example, a systematic review by Ferguson (2006) found that families with high levels of SC were more likely to produce children that fared better on wellbeing outcomes, including those relating to mental health. This finding was consistent across multiple studies and diverse academic disciplines. Another systematic review (McPherson et al., 2014) focused specifically on mental health outcomes in children and young people. This review demonstrated that SC at both the family and community level can greatly influence mental health and problem behaviour in children and young people.

Some research has indicated that children's own SC and experiences have more impact upon their psychological wellbeing and behaviour than parental SC (e.g. Goyette & Conchas, 2002); however, this tends to be when children and young people have more autonomy over choosing their peers and environment, such as during adolescence. Prior to this, the circumstances and choices of parents and caregivers are far more influential (Runyan et al., 1998).

1.3 Building social capital through intervention

Given the many benefits associated with high levels of SC, across aspects of child wellbeing and various other areas of the human condition, it is logical that many agencies and organisations would want to increase SC amongst their target populations. It would follow that in order to increase SC, an understanding of how it can be built through intervention is imperative.

Terrion (2006) conducted a thematic analysis of participants' experiences of a family support programme implemented in schools. This study identified "success markers" for this programme, particularly in relation to building SC in parents and their children who had been identified as being at risk for academic failure and social problems. The six success markers identified were: Building community for parents and family, better family connection, better parent relationship with the school, personal development of family and child, children's positive relational development, and children's positive behavioural changes. All of these markers were described as indicating the development of SC, due to their association with "greater social connectedness" (Terrion, 2006; p. 170). Whilst this study was valuable in offering an understanding of desired outcomes for a programme aimed at increasing SC amongst parents and families, the lines of questioning and analysis used resulted in themes that were mainly outcome-focused, with little understanding of the *processes* involved in building SC within this context.

1.4 Peer-led interventions

Peer-led interventions typically utilise facilitators who share commonalities with those receiving the intervention; such as ethnicity, social status or health challenge (Davidson et al., 1999). Through interaction, the sharing of skills and knowledge, and creating new social norms within the group, peer-led interventions have been shown to be effective in changing health behaviours and increasing positive health outcomes within the communities that they serve (Webel, Okonsky, Trompeta, & Holzemer, 2010). Due to the 'commonality factor', peer-led

interventions have demonstrated high levels of effectiveness with cultural minority populations, as well as those considered 'hard-to-reach' (Henderson, Kendall, & See, 2011). In addition, peer-led interventions have been shown to be particularly effective in building SC (Im & Rosenberg, 2016).

1.5 Rationale

There is growing evidence for the positive impact of parental SC on children's psychological health and behavioural outcomes (McPherson et al., 2014). However, there is a lack of understanding of the processes that underpin the development of parental SC in interventions, and how an intervention aimed at improving child psychological and behavioural outcomes might go about fostering this.

This study will endeavour to understand how parental SC builds through a peer-led parenting programme aimed at helping parents to overcome and prevent mental health and behavioural challenges in their children. Developing a model that is grounded in group attendees' experience may not only advance theoretical understanding of how SC builds in this context; but might also contribute towards designing the most effective interventions.

1.6 Research questions

1.6.1 Primary research question/line of enquiry.

How does SC develop among parents who participate in a peer-led parenting programme?

1.6.2 Secondary research questions/lines of enquiry.

What are the processes and conditions by which SC develops in peer-led parenting groups?

What dimensions of SC develop among parents who participate in a peer-led parenting programme?

2. Methodology

2.1 Design

This study was non-experimental and qualitative in design, employing a critical realist approach to grounded theory (Oliver, 2011). Urquhart (2012) suggested that this approach is particularly useful where no current theory exists, and where the aim is to construct a preliminary understanding of people's experiences of a specific event or circumstance. This study aimed to explore and understand the processes via which group participants developed SC within a peer-led parenting programme.

The grounded theory techniques, assumptions and underlying epistemology used in the study were most in line with those described by Strauss and Corbin (1998). One-to-one interviews with group participants were conducted, alongside an iterative coding process of analysis. Throughout this process, interview data were used to guide lines of enquiry, accumulating to form the basis of a theory.

2.2 Epistemology

A critical realist approach (Bhaskar, 1978) was applied to this research study. Whilst this approach is based upon the assumption that there is a "reality" that can be observed outside of the human mind, it acknowledges the complexities of this reality and how it is constructed by a number of interacting forces (Oliver, 2011). Critical realism therefore recognises the roles of human language, understanding and social power within these forces, despite being an approach considered to be more towards the positivist end of the positivism-interpretivism epistemic

continuum (Gorski, 2013). Applying this approach to grounded theory has been acknowledged for producing theory that is particularly accessible and applicable to clinical practice (Oliver, 2011).

2.3 Setting

The setting selected for this study consisted of four inner-city sites running the Being a Parent (BaP) programme concurrently. The BaP programme is a peer-led parenting programme, delivered by an organisation called Empowering Parents, Empowering Communities (EPEC; Day, Michelson, Thomson, Penney, & Draper, 2012), and is typically delivered in areas of social disadvantage. Designed for caregivers of children aged between 2 and 11 years, it primarily aims to: (i) improve relationships and interactions between parents and their children; (ii) reduce disruptive behaviour and other difficulties in children; and (iii) increase parents' confidence in their parenting abilities. BAP is delivered over a course of 8 2-hour sessions and is led by parents and caregivers who trained as peer facilitators following their own BAP programme completion.

2.4 Procedure

2.4.1 Sampling.

In accordance with the grounded theory method used, this study employed a theoretical sampling approach: whereby participants are sampled on the basis of concepts emerging from the data (Strauss & Corbin, 1998; p.214). However, in order to implement this approach, some data must first be collected and analysed; thus, purposive sampling (Coyne, 1997) was used in

order to select the first four participants. As data and analysis accumulated throughout the study, participants were then theoretically sampled in line with emerging concepts.

A total of 56 potential participants/group attendees were approached during a preliminary 'coffee morning' for attendees of BaP. Of these, 33 gave consent in the following week (first session) to be included in the study. This is also when routine measures were completed as part of the programme, including the Social Capital Scale (SCS; Looman, 2006). Of the 33, 2 group attendees later withdrew consent following non-completion of the BaP programme.

Demographic information and baseline scores on the SCS informed the purposive sampling (Coyne, 1997) used to select the first 4 interviewees from the remaining 31. In order to start with a range of background experiences, the 2 parents that had scored lowest on the SCS in the first week of the programme, and the 2 parents that had scored highest, were first invited to be interviewed. Theoretical sampling (Coyne, 1997) - based on demographic information, data from questionnaires, and initial analyses of the original interviews - was then used to select the remaining interviewees until theoretical saturation was reached. Using this information throughout the sampling process enabled the researcher to obtain a sample that could be deemed diverse in representing participants from a range of ages, ethnic and socioeconomic backgrounds. Figure 1 demonstrates the sampling process followed to obtain all interview participants.

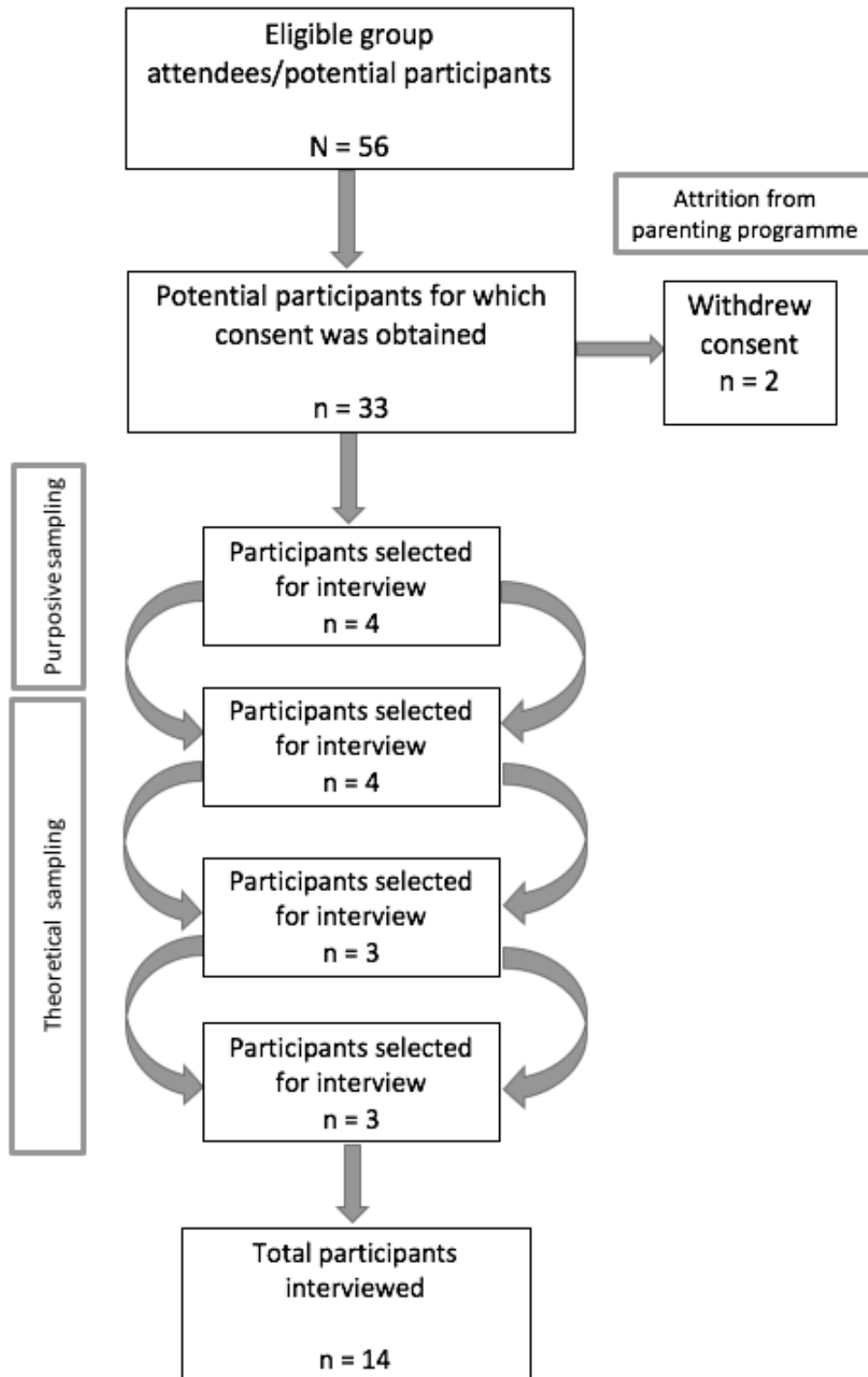


Figure 1. Flowchart of sampling process

2.4.2 Participants.

Fourteen participants, all mothers that had attended the BaP programme, were interviewed. With each participant having attended at least six sessions out of eight, all participants were considered 'completers' of the parenting programme. Participants were from a range of backgrounds and described a number of different behavioural challenges with their children. Due to interviews being conducted in English, participants were required to have a conversational level of the English language. Participant characteristics are presented in aggregated form, in order to preserve their anonymity (Table 1).

Table 1. Aggregated participant characteristics

Total number of participants	n = 14
Gender	Female: n = 14
Age	Mean: 34.4 years Range: 22-42 years Standard deviation: 5.8 years
Ethnicity	White British: n = 3 White Other: n = 2 Black African: n = 4 Black Caribbean: n = 1 Asian: n = 3 Other: n = 1
English as a first language	Yes: n = 6 No: n = 8
Lone parent	Yes: n = 4 No: n = 10
Number of children	1: n = 4 2: n = 6 3: n = 4
Age of index child (presenting with behaviour that challenges)	Mean: 4.3 years Range: 2-10 years Standard deviation: 2.2 years
Employment status	Full-time: n = 2 Part-time: n = 3 Student: n = 1 Looking after home/family: n = 4 Unemployed: n = 4

2.4.3 Data collection.

Data were collected via semi-structured interviews, which were aimed at exploring each participant's experience of the BaP programme. Conversations were initiated using questions adapted from the research questions (see Appendix 3 for initial interview schedule), followed by an open discussion during which participants' statements could be questioned and further explored. Interviews were between 37 and 88 minutes in length, and were audio recorded before being transcribed into text for analysis. Interviews were held at the centres (total of four) in which participants had attended the BaP programme where possible, or in participants' own homes if they preferred.

2.4.4 Data analysis.

Consistent with Straussian grounded theory, data analysis was conducted concurrently with data collection. The analysis process is described in three steps as demonstrated in Table 2.

	Stage	Description
1.	Open Coding	The first 4 interviews were coded in detail by separating out key words, lines, and phrases. At this stage, the role of the researcher was to become aware and familiar with overarching

		<p>concepts that might later be woven into the theory (see Appendix 4 for example).</p>
2.	Axial Coding	<p>During this stage, the aim was to build relationships within the data. Using a combination of inductive and deductive reasoning, connections were made between the open codes established in stage 1.</p>
3.	Selective Coding	<p>Central core categories that had emerged in axial coding were identified. This stage included the researcher following these five sub-steps in order to build towards a theory:</p> <ul style="list-style-type: none"> a) Story Line <p>A “descriptive overview” of the phenomenon under study (in this case ‘the building of SC’) was written.</p> b) Subsidiary Category Relationship Overview <p>Relationships between core categories and subcategories were identified, with attention given to any relational hierarchy such that: “A (conditions) leads to B</p>

		<p>(phenomenon), which leads to C (context), which leads to D (action/interaction, including strategies), which leads to E (consequences)” (Strauss & Corbin, 1990, p. 125).</p> <p>c) Dimensional Relationships</p> <p>Properties and dimensions of core categories were established.</p> <p>d) Validating Relationships with Data</p> <p>Any emergent theory was validated with selected part of the raw data to ensure adequate grounding within it.</p> <p>e) Conceptual Density Check/Theoretical Sampling</p> <p>Further sampling and data collection were conducted in an attempt to fill in any missing details or perceived ‘gaps’ in the data.</p>
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Codes for the first set of interviews were initially categorised according to the areas of questioning as used in the first interviews (Appendix 5). This was to make initial sense of the data

and emerging themes. As the research question was focused upon *how* SC was built within the BaP programme, subcategories relating to processes within the group were highlighted (as seen In Appendix 5) and used to inform lines of enquiry used in subsequent interviews. Analysis was carried out continuously, alongside the conducting of interviews. This included the use of a research diary (Appendix 6), completed immediately after interviews and to reflect on the analysis process where helpful. Subcategories relating more specifically to the processes within, and attributes of, the BaP programme lending themselves to SC development became more salient; thus it was possible to establish the links and relationships demonstrated in the final progression of theme development (Appendix 7).

2.5 Quality Assurance

In accordance with criteria outlined by Mays and Pope (2000), a number of steps were taken in order to ensure the quality of this study. In the first instance, the author completed a bracketing interview in order to identify potential biases. This interview made it apparent that the author considered SC to be a multi-faceted, “complicated” concept, and held feelings of worry around being able to understand and interpret concepts that might emerge from the data.

In addition, a research diary was kept in order for the author to note their responses to the interviews and data and to maintain a clear trail from initial codes through to theory progression (see Appendix 6 for research diary extract). The author also shared data, emerging codes, categories and theory development with supervisors and peers, in order to include alternative perspectives and ensure that interpretations were grounded in the data.

Respondent validation was also used in order to ensure that participants understood the developing theory and felt that it was a true representation of their experiences. Towards the end of analysis, the author met with three of the fourteen participants (in the same locations used to conduct research interviews) to present them with the emerging model and give them an opportunity to ask questions and offer feedback. Participants' comments were recorded, considered and incorporated into the final theory where possible.

2.6 Ethical considerations

This study received NHS ethics approval by the National Research Ethics Service (NRES) Committee South Central - Berkshire (Appendix 8). The Research and Development department of the NHS Trust attached to the recruitment site also granted permission for the study to go ahead (Appendix 9).

Participants were given a period of one week to consider their decision, before consent was obtained (see Appendix 10 for information sheet and consent form). The author attended 'pre-programme' coffee mornings organised as a means for parents attending the programme to meet each other and their facilitators. Here the study was explained to the group participants and they were each given the information sheet to take away with them. Consent was obtained a week later during the first group session. Issues around potential participants feeling coerced into participating were thought about carefully. For example, where participants had not attended the coffee morning (but had attended the first session of the programme), they were

given the information sheet during the first session, and consent was not obtained until the second session of the programme.

3. Results

Data analysis resulted in 63 open codes, 29 subcategories, 14 categories and 4 overall themes. Tables demonstrating the progression of each theme's development can be found in Appendix 7. The role of grounded theory is to create a theoretical understanding of how different constructs interact and impact upon each other, moving from a descriptive level of analysis to that of a working model (Urquhart, 2012). In line with this, a theoretical model was developed from the data, demonstrating the dynamic relationships between the constructs identified within the experience of building SC amongst participants in a peer-led parenting programme (Figure 2).

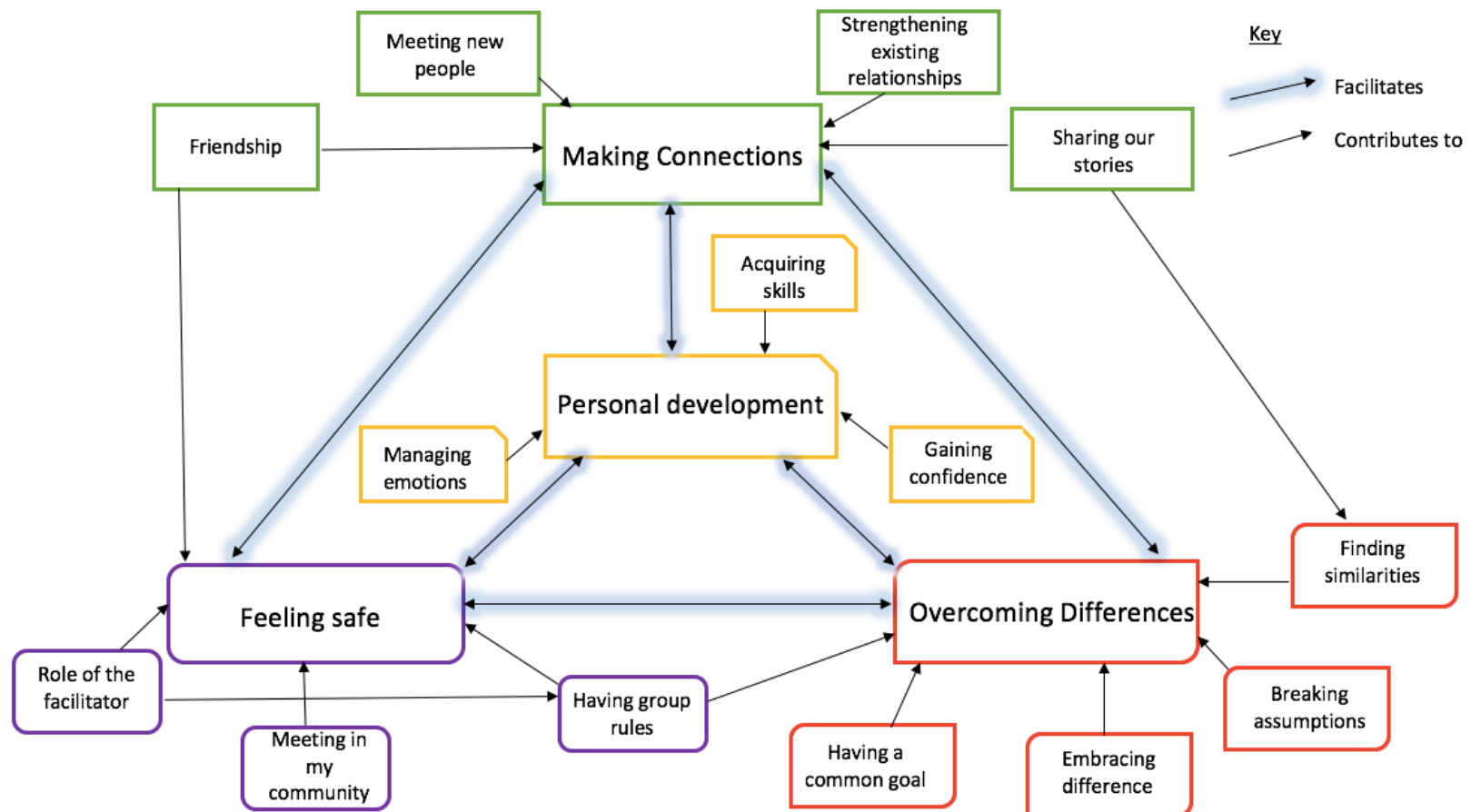


Figure 2. Grounded theory model of building social capital in parents attending a peer-led parenting programme.

3.1 Model summary

These results can be understood as the process group attendees go through as part of attending this peer-led parenting programme. They focus on *how* SC was built within this programme, including elements and characteristics of the programme and facilitators, along with actual processes that were part of SC development. This approach fits with the task of critical realist informed grounded theory, which is to build an explanation of social processes and practices by identifying the underlying causal powers and to explain how such powers interact with each other (Edwards, O'Mahoney & Vincent, 2014).

The first theme, Personal Development, seemed centrally-placed in that it both facilitated, and was facilitated by, each of the other three themes. These three themes, Making Connections, Feeling Safe and Overcoming Differences, seemed to have a close bidirectional relationship.

Personal Development was a theme that seemed to run through the middle of the BaP experience. Participants' descriptions of their experiences alluded to a process by which attending BaP enabled them to acquire skills, learn to better manage emotions and gain confidence. It seemed that this personal development in turn enhanced their interactions with facilitators and other groups members, allowing them to build SC via the other three processes identified: Making Connections, Feeling Safe and Overcoming Differences. In addition, these three processes also seemed to contribute to participant's personal development.

As demonstrated in Figure 2., some of the categories did not necessarily relate to only one theme (e.g. friendship > making connections and feeling safe), whilst other categories also

emerged as being linked with each other (e.g. sharing our stories > finding similarities). These relationships, demonstrated by the different types of arrows, were representative of the somewhat circular nature of SC-building within the BaP group. Participants' experiences did not reveal a linear process of how SC was built from the start of the BaP programme to the end, but rather a circular process facilitated by the group situation, content, participants and facilitators. The following information will summarise each of the concepts comprised within each category.

3.2 Personal Development

All participants spoke about their own personal development throughout the programme. They spoke about differences in how they felt about themselves by the end of the programme, as well as about things they had learned from the teachings and processes associated with the programme. Some participants spoke about having gained a great deal in the way of personal development, whilst others seemed to regard what they had 'learned' as more of a reminder of what they already knew; "But even if you know most things it's just nice to refresh it" (P3). Personal development held by participants, gained either through the programme or prior to the programme, seemed to impact upon the SC building process and *be* impacted by the process in a number of ways.

3.2.1 Acquiring skills.

Participants spoke about the skills and techniques they learned within the programme, how they helped in their relationships with their children and other people in their lives, but also how they impacted on their ability to connect with other parents in the group:

“...from the group I learnt reflective listening, and it has really, really helped me because lately whenever anyone is talking to me I drop everything I have to give the person my full attention” (P8).

Some participants also shared about how the skills they had acquired had helped them to build SC outside of the group, by using it to connect with others, in many cases also providing a source of SC for those around them:

“I kind of try to tell friends, share with friends and family “OK this is something that we learnt and maybe you could try this out,” like rewards and star charts, acknowledging feelings and so on. So in that sense it’s like the knowledge is getting transferred out of the country because I talk to friends in the Maldives because I spent quite a bit of time there, and I talk to my family back home. So in that way it is having a positive impact on others because of the fact that I was in the course” (P2).

3.2.2 Managing emotions

Some participants spoke about their personal development within the programme in terms of learning how to better manage their emotions: “Just being a bit more aware of it and again not being a hostage to your hormones or your moods” (P13). There was a sense that the guidance they received, around recognising and managing emotions, had a positive impact on participants’ ability to engage with others in the group; thus, building more connection and cohesiveness:

“They were all just honest about their emotions and I think that was really something that was quite key in that part, being more honest about it and not trying to hide it and not being scared of it, just facing it, and saying this is how I’m feeling, and not blaming other people for it but taking responsibility for it” (P13).

3.2.3 Gaining confidence

Many participants spoke about feeling increasingly more confident as they progressed through the programme. One participant spoke about being explicitly encouraged to talk within the group by facilitators, “yeah more confident because some people learn, especially if you are somebody who is very shy people don’t talk. But they encouraged other people to talk” (P14), whereas others spoke about the confidence they gained more in the context of being ‘part of the process’:

“I used to feel that it was all very different, and now I know how they do it here. So if I have to ask anyone for anything I know what to ask, or if I have to talk to anyone regarding parenting, I am quite confident now” (P12)

“I just think you feel more confident in yourself so when people ask you things or you feel you can offer advice, and I suppose trying to get more involved in the school, I have been trying to do that with [my daughter’s] school. Which is nice” (P11).

This element of personal development also seemed to positively impact upon participants' ability to connect with people outside of the group, as well as inside the group. There was a sense that increased confidence as a parent and as a communicator helped participants to feel able to express themselves, ask questions and build more meaningful, resourceful relationships.

3.3 Making Connections

This theme represents the element of participants' experiences on the programme relating to connecting with people and building relationships. This element seemed to be a key part of the SC-building process and could be seen in the categories outlined.

3.3.1 Meeting new people.

For many participants, attending the programme presented a unique opportunity to not only meet new people, but people with whom they quickly related to due to similarities such as being mothers: "I had not been with lots of mothers like some people had when they were younger. It was new to me" (P14). Participants expressed that this opportunity was unique due to the often-isolated lifestyle associated with being a parent, particularly when being the primary caregiver to young children, "It was nice to meet other people because as I said I am on maternity leave so I hadn't been with any other adults for a long time so that was quite nice" (P7). There was a sense that the programme encouraged the building of SC by providing a space for participants to make new connections, offering the foundations for building new relationships.

3.3.2 Strengthening existing relationships.

Due to the programme being run within participants' own communities, there were many connections that had already been made between group attendees, prior to the programme starting. However, there was a sense that many of these connections were somewhat 'weak' before the programme, not offering much in the way of SC or any other support or resources. Many participants spoke about these existing connections strengthening throughout the programme, developing into relationships that were closer in nature, more meaningful, and richer in SC:

"Yeah like a lady, we go to the same college together. Most times before school closes we will meet on the road and drop our children together and we will pick them up together. She will talk to me about her son and I will talk to her about [my child]. So, we discuss about that" (P4)

"There were one or two mums that were on the course that attended the school that I didn't actually know very well. So now if I see them in the playground we might chat, a bit of small talk kind of thing" (P3)

"We bump in to each other because we live in the community. Before we would have passed each other because we didn't know each other but now we can have something to share and we can talk about something. I can say hi how are things going? She can share" (P14)

3.3.3 Friendship.

'Making friends' was a concept that came up frequently throughout the interviews as something that the programme had provided participants with the opportunity to do, "I think it was an eight-week programme, so I joined, and I made friends with some of the people there. For the mums it was a good opportunity to come and socialise" (P12). This came with a sense that these new relationships would continue on past the programme ending, also providing participants with new sources of SC outside of the group environment:

"I made a good friend in Jill¹, the lady who goes there, so we went out a couple of times afterwards with the children and stuff and she was going to arrange something over the summer holiday. So that's quite nice that we got to meet" (P7).

3.3.4 Sharing our stories.

A key aspect of the programme, contributing to the building of SC within it, seemed to be the opportunity and encouragement for participants to share and listen to each other's stories.

"It was just nice meeting other mums and actually listening to their experiences as well because you don't really ever share your experiences with other people and we went quite in depth as well" (P3).

¹ Name has been changed in order to preserve anonymity

This process within the group seemed to offer validation for some participants, in addition to enhancing the connectivity between them, and giving each other insight into their strengths and weaknesses and access to resources.

3.4 Feeling Safe

This theme represents a key aspect of the experience with regards to participants building SC within the group. As demonstrated in the model, and as with the other main themes, this concept seemed to have a bidirectional relationship with each of the other themes. In this case, 'feeling safe' presented as both a facilitator and a result of the other SC-building processes and factors.

3.4.1 Role of the facilitator.

This was a pertinent concept to note, with all participants commenting on the importance of the facilitators not only being parents, but having previously completed the programme themselves:

"They're just like anyone else aren't they? They are just normal people that did exactly the same as what we were doing. So it makes you... I suppose you can just reflect to them as normal people I guess. It's not like they had loads of qualifications or degrees in childcare or anything like that" (P3).

The fact this programme was peer-led, rather than facilitated by 'trained professionals', seemed to contribute to participants' engagement and connection with all group members;

including facilitators. There was a sense that participants were able to feel safe around, and relate to, facilitators via aspects such as facilitators sharing their own parenting experiences (both successes and 'failures'), having children in the same schools or nurseries, and being from the same local area:

"You have a little coffee break and everyone has a chat and it sort of keeps it informal and then the facilitators would have a coffee with us. So they would show they would change from being a teacher to being just one of the parents and maybe that is also why it worked well because it was like OK they are teaching us and trying to keep us on track but then when we had the break they were much more relaxed and we would have a laugh and share stories or elaborate on what we had just learnt. I think that was a big part of the process." (P11)

Facilitators were true 'peers' in many senses of the word and this seemed to greatly support the development of meaningful relationships and SC within the group.

3.4.2 Meeting in my community.

Participants spoke about the programme being run within their communities, in some cases in buildings they were used to visiting for other purposes such as nursery and children's activities. The familiarity of being somewhere they recognised, often with people they recognised, seemed to enhance feelings of safety within the group and encourage the SC-building process:

“I just think you see the people seeing the mums that you did the course with and seeing their children getting bigger, you stop to have a chat it’s nice, it has built more of a community feel. In a big city, things can seem quite anonymous. A lot of the women live near me” (P11).

There was a sense that this concept also related to participants’ experiences of continuing to maintain and further build relationships and SC amongst each other outside of the programme:

“If I met them on the street I would recognise them like what has happened with this woman now, and I’m sure they will as well so I would say that if I was to meet them again I am probably on friendly terms with them all” (P9).

3.4.3 Having group rules.

This element of ‘feeling safe’ seemed to be particularly important in the context of participants feeling able to share their experiences, and more specifically their difficulties. Coming from such diverse backgrounds, participants were initially somewhat wary of interacting with each other, particularly on such sensitive and culturally-linked issues as childrearing. The process of creating group rules was mentioned as something that helped participants to feel safer and more able to connect in this context:

“When we start when they are doing the group rules and regulations everybody is involved so if there is something that is going to affect your culture I think everybody would say oh this is my rule” (P8)

‘Trust’ has long been documented as an integral part of SC, and it seemed that this was reflected within the SC—building process in this group; particularly in relation to setting group rules:

Participant: When I talk about we have to be honest, that was one of the ground rules, we have to be truthful because it will not make sense if we go there and not saying the truth about what we have been through or we are never going to learn anything and you will leave with the same problems you came in with. Honest was important. We had the courage to be honest about our experiences that we have been through. I trusted the people to tell them my story.

Author: So you feel like having the ground rules at the start to say ‘this is what we are going to do’ helped to establish that trust that you could all be honest?

Participant: Yeah. We accepted that we were going to be honest and truthful and share confidential stuff. We had that trust to share stuff. It was hard. It made me think about my past and bring it out. So it made me have confidence in other people to believe other people. (P14)

3.5 Overcoming Differences

As previously mentioned, group participants in all of the groups attended were from a diverse range of backgrounds, cultures, religions and traditions. Representative of the wider inner-city population, this level of diversity can often result in segregated communities, in which people move towards building relationships and SC only within the confines of their ethnicity or other demographic. Many participants spoke about the diversity in their programme groups and alluded to a process of overcoming various differences as part of building SC within the group.

3.5.1 Having a common goal.

One of the requirements for programme attendance was for parents to have at least one child presenting with behaviour that challenges. Whilst the programme content centred around parenting techniques, the goal was to reduce problem behaviours in their children. This was the goal that seemed to unite participants:

“People came from all parts of the world it is good. You know that this matter is universal, this children situation is everywhere” (P14).

“So being able to hear from other peoples’ experiences, which again because everybody was so different, different ages, different cultures, different backgrounds, different social circumstances, some were single parents, some were divorced, some were happily married some were living together. It kind of like made you realise that you are not alone that so many people go through this regardless of your age, your race, or anything else

we are all parents that are trying to do the best for our children and we are all trying to learn how to cope with it and how to do the best for our children” (P9).

3.5.2 Breaking assumptions.

Participants spoke about coming into the group with a number of assumptions about people from particular cultures, races and socioeconomic backgrounds. Whether positively- or negatively-associated, these assumptions had likely prevented participants from connecting with people in the wider community, perhaps out of fear or judgement.

“There is a lady that her religion allows her to be covered all over, in the past I have seen them as a person who doesn’t want to associate with other people they do their thing. But in that place when she comes she removes the one here, and I think she was one of the supportive member all of the way through. I kept saying Oh my god I thought this religion was they don’t even mingle with people what even brought her to this group in the first place? So it changes my mind concerning religion it doesn’t matter how your religion says you should dress it might be just the physical appearance but it doesn’t affect” (P8).

The process of breaking assumptions seemed to be powerful in establishing connection and building SC amongst group members. A few participants spoke about this process being transformational for them, not only in the sense of feeling accepted by and connected to people

outside of their culture or religion, but in that they felt much more likely to seek connection with people they consider 'other' outside of the group.

"It's just the fear of the unknown that would prevent others from getting to know, all right they might think, if the prejudices form that way, but if you have an open mind. Then they get to see the positives of the religion on the one hand, my religion and my culture and then they tend to, the beliefs and attitudes get more defined in a positive way because of that. So I could see that happening, and similarly for me I come back and when I talk to my husband I always say positive things about people and I say I'm really surprised that they are from different backgrounds, different countries and we are so very different in certain ways, but then to find that we are so very similar in certain other ways is really encouraging... I have been able to make a difference in the minds of people about what I project, my religion and my culture which is very important. And it makes me very happy to know OK this is who we are" (P2).

3.5.3 Finding similarities.

This process had a sense of not only being quite therapeutic for participants, but also contributing heavily to their relatability to each other and cohesiveness within the group:

"Regardless of where you're from you all have issues of tiredness and worry and love. You have all these emotions and worries no matter where you are from. So that is in a way the best way to bring people together. So it's good" (P13).

“And it was nice to hear other people saying the same things so to know that I wasn’t the only one doing that stuff, the only one struggling with all of those things, so that was quite nice” (P7).

“You can feel like it is just you in a situation, oh my god is it just me who’s child does this? But you come to realise it isn’t just your child other children do the same and other parents feel how you feel. So it is encouraging” (P14).

There was a sense that finding similarities not only brought participants together, but also helped them to feel safe and more able to share where they would like help.

3.5.4 Embracing difference.

For some participants, overcoming differences was not so much about breaking assumptions or finding similarities, but about finding value in each other’s’ differences and holding space for them, “Now what I learnt so meeting other people helped me to respect whatever they believe, whatever they are in to, like you will not oppose anybody” (P4).

This process of embracing difference seemed to enhance the richness of SC being built within the group, opening participants up to more and different resources, ideas and connections than they had prior to starting:

“When you attend such a group we had a mixture of every community down there, every religion, every race, every colour, every creed. So it was so good to see how people of different ethnicity and from different countries came over and shared their experiences

how they are bringing up their children together. that was the most exciting part about it, that you being from a certain society or from a certain mind-set, how people can come over and think on different levels. that was an exciting part of that course an exciting part of meeting other people” (P5).

4. Discussion

The primary aim of the study was to gain an understanding of how SC builds among parents attending a peer-led parenting programme. By exploring parents' experiences, both in and linked to the group programme, a theory was able to emerge that represented key elements from the individual and group contexts. The results indicated the pertinent aspects and processes of personal development, making connections, feeling safe and overcoming differences, each of which seemed to provide mechanisms for building SC in this context. These findings also contributed to answering one of the secondary aims of study, which was to understand the processes and conditions by which SC develops in a peer-led parenting group.

The model constructed bears some conceptual parallels with the initial stages of Network Theory of SC (Lin, 1999; see figure 3). The present model could be considered to represent the processes contributing towards the building of "collective assets". According to the Network Theory of SC, collective assets refers to the resources held by a group of individuals, consisting of trust, norms and networks (Lin, 1999). In comparing the present theory with the collective asset aspect of the Network Theory, there are clear similarities between the categories of Feeling Safe, Overcoming Differences and Making Connections, and trust, norms and networks respectively. Thus, it is possible that the present theory offers a process-based model for *building* SC describable as collective assets within a group intervention.

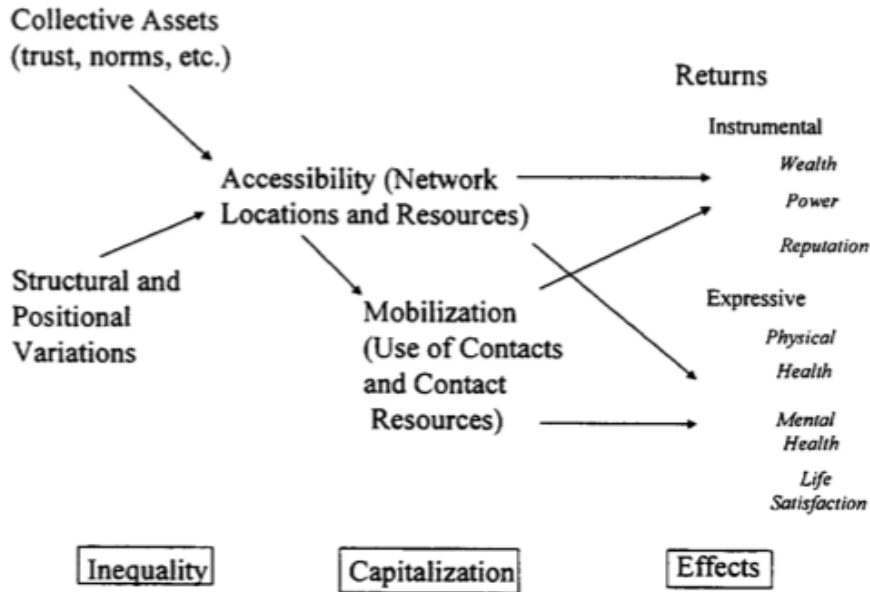


Figure 3. Network Theory of Social Capital – taken from Lin (1999)

The other secondary research question was aimed at understanding what dimensions of SC develop among parents who participate in a peer-led parenting programme. The findings from the present study would suggest that the primary dimension of SC developed was bonding SC (Terrion & Ashforth, 2002; Woolcock, 2001). The development of close relationships, sense of belonging and cohesiveness were evident throughout the processes described in the present model.

It also seemed, however, that there were other elements of bridging and linking SC developed. For example, it was found that many participants had, through the group intervention, built “horizontal” SC with group members who would not ordinarily be in their immediate networks. Differences in religion, ethnicity and socioeconomic background were

overcome to provide participants with increased sources of potential bridging SC. In addition, the peer-led element of the programme in particular seemed to offer participants the opportunity to build the more “vertical” linking SC, where relationships with peer-facilitators could potentially offer SC held in people or organisations of higher social power (e.g. mental health services; Stone & Hughes, 2002).

4.1 Limitations

The first limitation to consider is related to the sampling process for this study, such that only group members who completed at least six of the eight programme sessions were willing to be interviewed afterwards. This introduces the possibility of sampling bias, whereby the findings may only be applicable to parents who are willing to engage with such a programme and/or have a positive enough experience of it to see it through to completion. Unfortunately, this would render findings ungeneralisable to parents that would not engage in such a programme, or that had a negative experience of it.

Other limitations related to sampling included the inclusion criterion of participants needing to have a conversational level of English. Given the background evidence on the impact of immigration on parents’ experience of building SC (e.g. Bjornberg, 2011), it would have enriched the current study to have included non-English speaking parents by way of using an interpreter or other means. This is particularly true as the parenting programme was implemented in one of the most ethnically-diverse cities in the world, with a comparatively large migrant population.

It is also of note that only mothers were included in the study. It would therefore be worth considering that a father's, or other male guardian's, experience of this programme might be very different to that demonstrated in the model. Also, in a peer-led programme attended by only males, the process of building SC, if present at all, may look entirely different.

Additionally, although efforts were made to reduce the effect of researcher bias, the author's identity may have influenced participants' interactions, whilst the author's own beliefs could have influenced interviewing style and data interpretation.

4.2 Clinical and research implications

Peer-led interventions, such as BaP, have been found to be effective in improving child mental health outcomes in communities (e.g. Day et al., 2012). The present study has identified a number of elements and processes – specific to a *peer-led* intervention – that may underpin this effectiveness. In essence, these findings not only highlight how this type of intervention might go about building SC, but also that being peer-led may be integral to its effectiveness. The clinical implication of this could be that peer-led interventions are given priority as a way of supporting parents to improve their children's mental health and behaviour. Furthermore, the present model might also be used to inform the development of other peer-led programmes where increased SC is known to be helpful for the target clinical population.

With the main outcome of the programme at the centre of this study being to improve children's mental health and behaviour, another clinical implication of the resulting model is its possible application in building parenting interventions directly aimed at developing SC amongst

parents. Previous research has demonstrated that children tend to thrive in closer-knit communities (Coleman, 1988), where levels of SC are high and parents are able to depend upon each other for support and resources (Wallace, 2013). Therefore, by focusing on building parental SC as the primary aim of an intervention, guided by the principles of the present model, it may be possible to establish another clinical approach to improving child outcomes.

Whilst this study has demonstrated how SC might build within a peer-led parenting intervention, further research is needed in order to further explore how this relates to parental SC outside of the group. Whilst many of the participants in the present study hinted at increased SC outside of the group, this could not be explored in detail due to the constraints of the study design and phenomenon of interest.

Also due to the cross-sectional, qualitative design, the present study was unable to establish whether the SC developed amongst parents was of a significantly higher level than parents had access to prior to the intervention. Therefore, a study that is quantitative in approach might go some way towards establishing this.

5. Conclusion

The present study has demonstrated how SC can be built within a peer-led parenting intervention. Attributes and processes implemented as part of the intervention were identified as part of a model for building SC amongst parents in this context. Key parts of this model were personal development for the individual, new or enhanced relationships with other parents, feeling safe and supported, and overcoming perceived differences or obstacles to making new connections. Given what we know about the benefits of SC, not only for supporting positive behaviour and mental health in children, but in improving development and quality of life for the whole family, these findings can be used to inform further development of peer-led interventions as well as interventions that specifically focus on building SC as an outcome.

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MAJOR RESEARCH PROJECT

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Section C

Appendices of supporting material

A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology

APRIL 2018

SALOMONS CANTERBURY CHRIST CHURCH UNIVERSITY

Appendix 1: Terms used for literature search

Preliminary electronic database searches were conducted in order to identify suitable terminology for the systematic search. Pertinent search terms were obtained from relevant articles obtained through these initial searches. The terms used for the final search string were: "Parent* Social Capital" or "Parent* Social Support" or "Parent* Neighbour* Support" or "Parent* Neighbor* Support" or "Parent* Friend*" or "Parent* Connect*" and "Child* Mental* Health" or "Child* Psycholog* Health" or "Child* Psychiatr*" or "Child* Mental* Wellbeing" or "Child* Psycholog* Wellbeing". The following databases were searched: PsycINFO, PsycARTICLES, PubMed Central, EBSCO Host, Web of Science, Social Policy and Practice, and ASSIA.

The searches were all conducted using the appropriate search operators for each database, up to week 1, December 2017. The boolean operator 'OR' was used to ensure the results identified a Parental Social Capital Term ("Parent* Social Capital" OR "Parent* Social Support" OR "Parent* Neighbour* Support" OR "Parent* Neighbor* Support" OR "Parent* Friend*" OR "Parent* Connect*") and Child Mental Health Term ("Child* Mental* Health" OR "Child* Psycholog* Health" OR "Child* Psychiatr*" OR "Child* Mental* Wellbeing" OR "Child* Psycholog* Wellbeing").

The boolean operator AND was used to combine the two separate search terms; the parental social capital term ("Parent* Social Capital" or "Parent* Social Support" or "Parent* Neighbour* Support" or "Parent* Neighbor* Support" or "Parent* Friend*" or "Parent* Connect*") AND the child mental health term ("Child* Mental* Health" or "Child* Psycholog* Wellbeing").

Health" or "Child* Psychiatr*" or "Child* Mental* Wellbeing" or "Child* Psycholog* Wellbeing").

The truncation symbol (*) was used in the search terms, as detailed above, in order to expand the search and obtain a greater variety of terms.

Appendix 2: Critical Appraisal Skills Programme Checklists

Case Control Study Checklist

- A) Are the results of the study valid?
1. Did the study address a clearly focused issue?
 2. Did the authors use an appropriate method to answer their question?
 3. Were the cases recruited in an acceptable way?
 4. Were the controls selected in an appropriate way?
 5. Was the exposure accurately measured to minimise bias?
 6.
 - i. What confounding factors have the authors accounted for?
 - ii. Have the authors taken account of the potential confounding factors in the design and/or in their analysis?
- B) What are the results?
7. What are the results of this study?
 8. How precise are the results?

How precise is the estimate of risk?
 9. Do you believe the results?
- C) Will the results help locally?
10. Can the results be applied to the local population?
 11. Do the results of this study fit with other available evidence?

Cohort Study Checklist

A) Are the results of the study valid?

1. Did the study address a clearly focused issue?
2. Was the cohort recruited in an acceptable way?
3. Was the exposure accurately measured to minimise bias?
4. Was the outcome accurately measured to minimise bias?
5.
 - i. Have the authors identified all important confounding factors?
 - ii. Have they taken account of the confounding factors in the design and/or analysis?
6.
 - i. Was the follow up of subjects complete enough?
 - ii. Was the follow up of subjects long enough?

B) What are the results?

7. What are the results of this study?
8. How precise are the results?
9. Do you believe the results?

C) Will the results help locally?

10. Can the results be applied to the local population?
11. Do the results of this study fit with other available evidence?
12. What are the implications of this study for practice?

Qualitative Research Checklist

A) Are the results of the study valid?

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

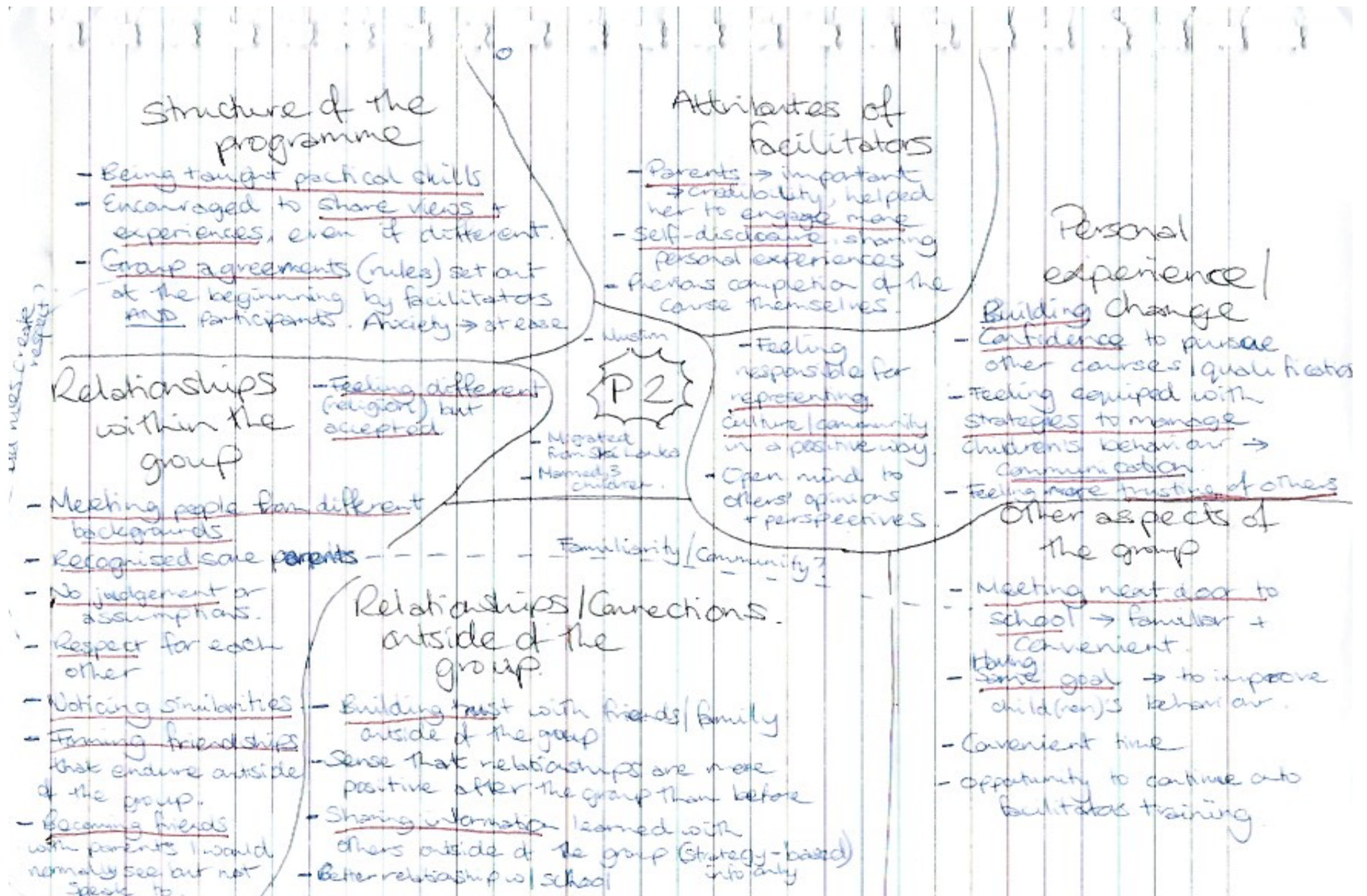
Appendix 3: Initial interview schedule

- What was the BaP programme like for you?
- What did you get out of it?
- What were the best things about attending a group with other parents?
- What difficulties arose about being in a group with other parents?
- How would you describe your connections to other parents in the group?
 - How did these change over the eight weeks of the programme?
 - What about BaP do you think may have contributed to this?
- How would you describe your connections to people outside of the group?
 - How did these change over the eight weeks of the programme?
 - What about BaP do you think may have contributed to this?
- Did attending BaP change things in your family?
 - How?
- What difference do you think it made that BaP facilitators were also parents?
- What difference do you think it made that BaP facilitators had also completed the programme at some point?
- What things outside of the group had an impact on your participation in BaP?

Appendix 4: Coded transcript

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Appendix 5: Example of memo writing for category development



Appendix 6: Research diary extracts

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Appendix 7: Progression of theme development

Open codes	First Order Categories	Second Order Categories	Final Themes
Active listening	Improving communication	Acquiring skills	Personal Development
Learned more English			
Practical tips	Learning new strategies		
Range of tools			
Talking with strangers	Speaking in the group	Gaining confidence	
Like a presentation			
Small wins	Feeling successful		
Beat my fear			
Understanding myself	Having self-compassion	Managing emotions	
Overcame feeling empty			
More patience	Taking control		
Letting go of unhelpful patterns			
Ok to say no			
Meet up with children	Keeping in touch		
Go for coffee			
Phone conversation			
They can come to me	Forming a bond		
Got to know each other			
Sat with strangers	Becoming acquainted	Meeting new people	
Familiar by the end			
Spoke to people that I wouldn't normally	Being in a new circle		
Different to my friends			
Went along together	Sharing the experience	Strengthening existing relationships	
Compared our progress			
Now say hello in the playground			

Didn't know that about her	Getting to know the mums from school/nursery		
Feel like I know her more			
Problems with children	Hearing about others' struggles	Sharing our stories	
Others have challenges too			
My own childhood	Trusting others with hearing my story		
Honest about my experience			
Respect for each other	Unwritten rules	Having group rules	
Hear each other			
Wrote rules on the board	Creating explicit group rules		
Agreed not to judge			
They were just like us	Sharing the parent experience	Role of the facilitator	Feeling safe
We heard their struggles			
They'd already been through it	Feeling understood		
They knew how we felt			
If they can, I can	Creating hope		
They're proof It's possible			
Mums from school	Recognising people	Meeting in my community	
We live close to each other			
Place of usual activity	Familiar meeting place		
Local to me			
Everyone wants their child to behave	Improving children's behaviour	Having a common goal	Overcoming differences
It was our children that brought us here			
Problem-solving together	Becoming a better parent		
Sharing methods that work			

My eyes were opened	Realising my presumptions were wrong	Breaking assumptions	
They weren't how I expected			
Feeling surprised			
I thought they...	Dispelling stereotypes		
I could show them who I really am			
Finding out about other cultures' parenting methods	Hearing about different ways	Embracing difference	
Different things work for different families			
Interesting to learn about other households			
Sharing different thoughts on one topic	Gaining other perspectives		
They helped me to think differently			
We all just want the best for our children	Being parents		
Mothers together			
The pain was the same	Shared struggle	Finding similarities	
Realising difficulties with children are universal			

Appendix 8: NRES approval letter

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Appendix 9: R&D approval letter

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Appendix 10: Participant information sheet and consent form



Salomons Centre for Applied Psychology

Participant Information Sheet

We would like to invite you to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish, such as family, friends or your GP. Ask us if there is anything that is not clear or if you would like more information.

Thank you for reading this.

What is the purpose of the study?

This research is looking at the effects of the "Empowering Parents, Empowering Communities" parenting project (or EPEC for short). In previous research, EPEC parenting groups were found to help mums and dads to learn positive parenting skills. Taking part in EPEC also helped to reduce child behaviour problems. We now want to look at how taking part in EPEC affects parents' social connections and support.

What will happen if I decide to take part?

We will invite you to answer some pen-and-paper questions at the beginning and end of the EPEC parenting programme (8 weeks later). One set of questions will ask about social support around you (e.g. friends, family, neighbours). A second set of questions will ask about being a parent and any difficulties you may be having with your children's behaviour. All parents that take part in EPEC are usually invited to answer the second set of questions as they are used to find out if EPEC has been helpful. Altogether, these questions will take around 15-20 minutes.

We would then like to interview a smaller number of parents in more detail. We want to speak with a range of parents from different backgrounds and with different experiences. The questionnaires and basic background information that are collected at the beginning of the programme will help us to decide who to interview.

If you are selected for an interview, a researcher will contact you towards the end of the EPEC programme. She will invite you to meet at a convenient time and place. The interview will last for up to an hour and will be audio recorded. The questions will be about your experiences of EPEC and social support. A £10 voucher (that can be used in a variety of shops) will be provided to reimburse your time.

Participants who are recruited to the interview will be offered the opportunity of returning for a further 30-minute interview to discuss preliminary results and to offer feedback. This short interview will be of assistance to the researcher.

Why have I been asked to take part?

We want to involve a range of parents who attend EPEC. All parents who take part in EPEC during the first part of 2014 will be invited to fill out questionnaires. As mentioned above, we will also invite a smaller number of parents to take part in more detailed interviews. This will give us more in-depth information about the types of social connections and support that parents have, and how this relates to attending EPEC.

Do I have to take part?

It is up to you whether or not to take part in this study. If you decide to take part, you will be given this information sheet to keep and asked to sign a form giving us your permission to be in the study. You can still change your mind at any time and leave the study without giving a reason. Not taking part or deciding to leave will not affect any services that are available to you.

What will happen with the information that I provide?

All information that is collected about you and your experiences during the research will be kept strictly confidential. No one will have access to recorded discussions except for members of the research team. Recorded discussions will be transcribed and made anonymous before they are analysed. With your permission, anonymous quotations may also be used in the study report.

Information will only be shared with other professionals, including those working for Social Services, under exceptional circumstances. For example, when there appears to be risk of harm to yourself or others. Wherever possible we will discuss this with you first.

The information that you provide will be stored on a computer after a researcher has removed your name and other personal details. When not in use, questionnaires and computer files will be stored securely according to the Data Protection Act.

What happens at the end of the research?

The results of the research will be written up in a report and published in a journal read by health professionals and researchers. We would expect a report to be published by the end of 2015. In addition, a summary of the results will be made available to all participants. None of your personal details will be mentioned in any publications or reports resulting from this research.

What are the possible benefits of taking part?

This study is designed to find out how the EPEC programme relates to social connections and support, which are believed to help well-being. If more can be understood about these processes, it is possible that we can gain a better understanding of how to improve services for individuals and communities.

What if something goes wrong?

It is possible that not every parent will find this study helpful. If for some reason you are not pleased about how you have been approached or treated during this study, you can make a complaint to Professor Paul Camic (Research Director at the Salomons Centre for Applied Psychology, Canterbury Christ Church University). He can be contacted by email at paul.camic@canterbury.ac.uk or by phone on 03330117114.

Who has reviewed this project?

All proposals for research are reviewed by an ethics committee before they can proceed. This project has been reviewed and approved by the ***** Ethics Committee.

Who do I contact for further information?

Please contact Sophie Hall (Trainee Clinical Psychologist) at Canterbury Christ Church University if you would like any further information about the research. If you would like to speak to Sophie, you can leave a message for her on a 24-hour voicemail phone line at *****. Please say that the message is for Sophie Hall and leave a contact number so that she can get back to you. Otherwise, she can be contacted by email at *****.

If you have no further questions and are happy to take part, please turn to the consent form on the next page.

Consent Form

Please read the following carefully and write your initials in the boxes to the left if you agree.

1. I confirm that I have read the information sheet for the study and I have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. Withdrawal from the research will not affect my legal rights.

3. I consent to the processing of personal information about myself, my child and my social networks for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act 1998.

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

5. I understand that I will complete questionnaires and may also be invited at a later time to take part in an interview.

6. I understand that the interview will be audio recorded.

7. I agree to take part in the above study, even if I leave the EPEC programme.

8. I agree to the publication of my anonymised quotes.

9. I would like to receive a copy of the results of the research.

Participant's statement: I agree that the research has been explained to me and I would like to take part. I have read the notes written above and the Information Sheet about the project and understand what the research study involves.

Participant's name: _____

Signed: _____ Date: _____

Researcher's statement: I confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research to the volunteer.

Researcher's name: _____

Signed: _____ Date: _____

Appendix 11: NRES End of Study Form

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Appendix 12: Summary report for ethics committees

1. Background:

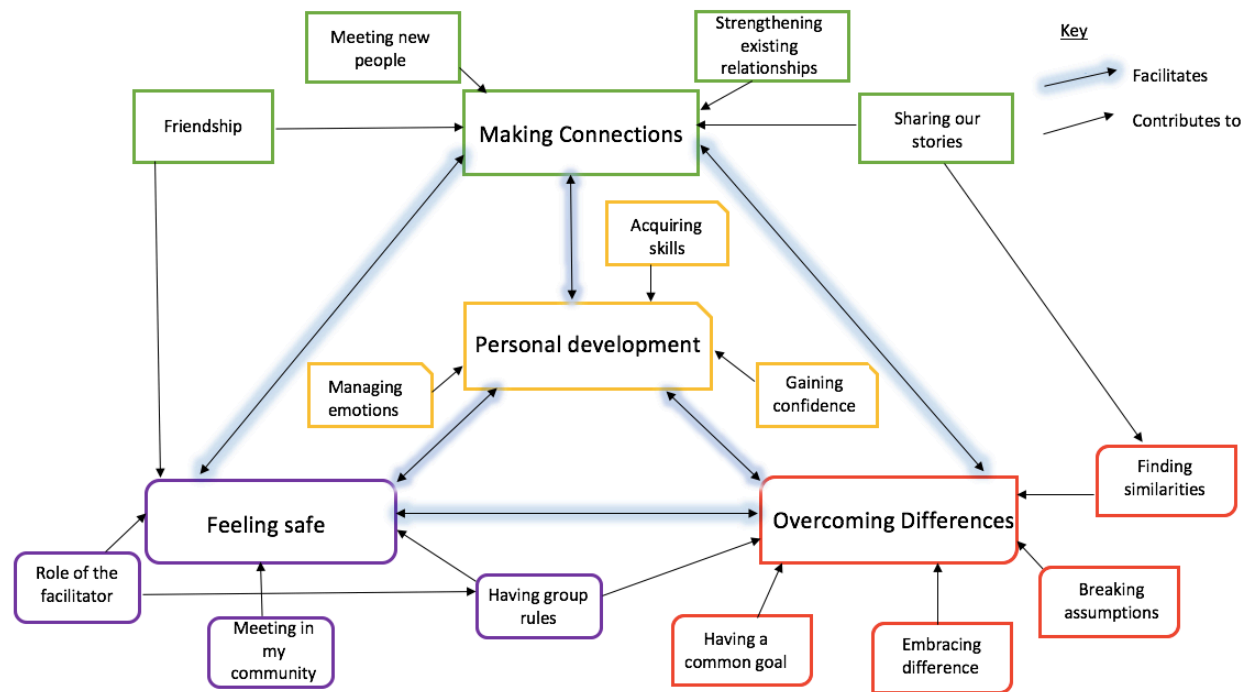
There is a growing body of evidence to suggest that parental social capital may be beneficial for the mental wellbeing of children. While the mechanisms underlying this association may not yet be clearly established, the strong association alone presents an argument for building parental social capital as a way of preventing and/or overcoming difficulties with their children's mental health. However, in order to encourage the building of parental social capital, an understanding of the building process and what might contribute to its formation is required.

2. Methods:

This study explored the processes involved in building social capital amongst parents attending a peer-led parenting intervention group. Participants were 14 mothers who each attended the inner city-based group for parents of children aged 2-11 years. The mothers were interviewed about their experiences of attending the parenting group, and a critical realist grounded theory approach was used to develop a framework for understanding the process of building social capital within this context.

3. Results:

Findings suggested that the following key processes were associated with building social capital: Personal Development, Making Connections, Feeling Safe, and Overcoming Differences. Each of these processes was facilitated by aspects of the intervention, as well as participant and facilitator attributes. A grounded theory model was constructed to demonstrate these processes:



4. Limitations:

Limitations of the study included the potential sampling bias associated with only being successful in engaging programme completers. It is possible that only positive experiences of the programme were represented within the resulting model. Another limitation was the inclusion criterion of participants needing to have a conversational level of English., as it may have enriched the study to have included non-English speaking parents by way of an interpreter or other means.

5. Clinical implications:

Peer-led interventions, such as BaP, have been found to be effective in improving child mental health outcomes in communities (e.g. Day et al., 2012). The present study has identified a number of elements and processes – specific to a *peer-led* intervention – that may underpin this effectiveness. Thus, the present model might also be used to inform the development of other

peer-led programmes where increased SC is known to be helpful for the target clinical population.

With the main outcome of the programme at the centre of this study being to improve children's mental health and behaviour, another clinical implication of the resulting model is its possible application in building parenting interventions directly aimed at developing SC amongst parents

6. Conclusions:

This study demonstrated how SC can be built within a peer-led parenting intervention. Attributes and processes implemented as part of the intervention were identified as part of a model for building SC amongst parents in this context. Key parts of this model were personal development for the individual, new or enhanced relationships with other parents, feeling safe and supported, and overcoming perceived differences or obstacles to making new connections. Given what we know about the benefits of SC, not only for supporting positive behaviour and mental health in children, but in improving development and quality of life for the whole family, these findings can be used to inform further development of peer-led interventions as well as interventions that specifically focus on building SC as an outcome.

Appendix 13: Author guidelines for Social Science & Medicine Journal

Guidelines for Qualitative Papers

There is no one qualitative method, but rather a number of research approaches which fall under the umbrella of 'qualitative methods'. The various social science disciplines tend to have different conventions on best practice in qualitative research. However SS&M has prepared the following general guidance for the writing and assessment of papers which present qualitative data (either alone or in combination with quantitative methods). General principles of good practice for all research will also apply.

Fitness for purpose

Are the methods of the research appropriate to the nature of the question(s) being asked,

i.e.

- Does the research seek to understand social processes or social structures &/or to illuminate subjective experiences or meanings?
- Are the settings, groups or individuals being examined of a type which cannot be pre-selected, or the possible outcomes not specified (or hypothesised) in advance?

Methodology and methods

- All papers must include a dedicated methods section which specifies, as appropriate, the sample recruitment strategy, sample size, and analytical strategy.

Principles of selection

Qualitative research is often based on or includes non-probability sampling. The unit(s) of research may include one or a combination of people, events, institutions, samples of natural behaviour, conversations, written and visual material, etc.

- The selection of these should be theoretically justified e.g. it should be made clear how respondents were selected
- There should be a rationale for the sources of the data (e.g respondents/participants, settings, documents)
- Consideration should be given to whether the sources of data (e.g people, organisations, documents) were unusual in some important way
- Any limitations of the data should be discussed (such as non response, refusal to take part)

The research process

In most papers there should be consideration of

- The access process
- How data were collected and recorded
- Who collected the data
- When the data were collected
- How the research was explained to respondents/participants

Research ethics

- Details of formal ethical approval (i.e. IRB, Research Ethics Committee) should be stated in the main body of the paper. If authors were not required to obtain ethical approval (as is the case in some countries) or unable to obtain ethical approval (as sometimes occurs in resource-poor settings) they should explain this. Please anonymise this information as appropriate in the manuscript, and give the information when asked during submission.
- Procedures for securing informed consent should be provided

Any ethical concerns that arose during the research should be discussed.

Analysis

The process of analysis should be made as transparent as possible (notwithstanding the conceptual and theoretical creativity that typically characterises qualitative research). For example

- How was the analysis conducted
 - How were themes, concepts and categories generated from the data
 - Whether analysis was computer assisted (and, if so, how)
 - Who was involved in the analysis and in what manner
- Assurance of analytic rigour. For example
 - Steps taken to guard against selectivity in the use of data
 - Triangulation
 - Inter-rater reliability
 - Member and expert checking
 - The researcher's own position should clearly be stated. For example, have they examined their own role, possible bias, and influence on the research (reflexivity)?

Presentation of findings

Consideration of context

The research should be clearly contextualised. For example

- Relevant information about the settings and respondents/participants should be supplied
- The phenomena under study should be integrated into their social context (rather than being abstracted or de-contextualised)
- Any particular/unique influences should be identified and discussed

Presentation of data:

- Quotations, field notes, and other data where appropriate should be identified in a way which enables the reader to judge the range of evidence being used
- Distinctions between the data and their interpretation should be clear
- The iteration between data and explanations of the data (theory generation) should be clear
- Sufficient original evidence should be presented to satisfy the reader of the relationship between the evidence and the conclusions (validity)
- There should be adequate consideration of cases or evidence which might refute the conclusions

Amended February 2010