Journal of
Clinical Nursing

ORIGINAL ARTICLE

A survey of parental self-efficacy experiences: maximising potential through health visiting and universal parenting support

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Aims. To examine parental self-efficacy experiences for users of a parenting support programme and consider the pertinence of self-efficacy theory to health visiting (public health nursing) practice.

Background. Commonly, successful parenting training programmes are underpinned by social learning principles and aim to strengthen parental self-efficacy. However, research examining programme effectiveness rarely discusses how self-efficacy outcomes are achieved.

Design. A descriptive survey was completed as the first part of a realistic evaluation study examining how a UK parenting support programme worked.

Method. The first part of the realistic evaluation involved validating outcome measures (the Parenting Self-Agency Measure and Self-Efficacy for Parenting Tasks Index subscales) and administering a questionnaire survey. The questionnaire was completed by adults accessing a parenting support programme during a 10-month period ($n = 168$). Data were analysed using descriptive and inferential statistics.

Results. Women were the main users of the programme, which included informal drop-in groups as well as more formalised health visiting services and parenting training courses. The Parenting Self-Agency Measure results indicated good general parental self-efficacy; however, the task-specific Self-Efficacy for Parenting Tasks Indexes scales suggested that parents were less self-efficacious in disciplining children. Lower self-efficacy scores correlated with high ratings for 'feeling tired', 'receiving negative comments' and 'giving-in to a child's demands'.

Conclusions. Study results indicate that the domain general and task-specific measures provide different, but helpful, insights into parental self-efficacy experiences. By identifying factors associated with the levels of general and task-specific parental self-efficacy, health visitors can gain a fuller appreciation of support needs.

Relevance to practice. To maximise potential through parenting support, attention should be given to addressing factors associated with poorer self-efficacy experiences, including parental tiredness. Equally, practice should be directed at developing community environments that offer exposure to positive praise and the opportunity to practice new skills without facing criticism.

Key words: child discipline, health visiting, parenting, self-efficacy, universal services

Accepted for publication: 18 December 2011

Introduction

Family life and parenting practices are critical factors impacting on the growth and development of young children (Center on the Developing Child at Harvard University 2010). Support for families, particularly in the early years, has been internationally identified as a priority for improving a nation's health and not least, its economic prosperity

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(Heckman & Masterov 2007, Mustard 2007). Programmes designed to improve early life experiences often aim to impact on parenting self-efficacy, as a means of encouraging positive parenting practices (Gross *et al.* 2003, Sanders & Woolley 2005). In England, support for parents has been made available through a variety of means, and currently, the health visiting workforce is particularly being invested in to deliver, locally, a continuum of services for families (Department of Health [DH] 2011). In this paper, findings from a survey of self-efficacy experiences completed as part of a larger realistic evaluation of parenting support are drawn on to discuss how practising health visitors' seeking to enhance family well-being needs to act opportunistically to influence potential sources of self-efficacy present in communities. The UK term health visiting will be used throughout to represent titles for similar roles elsewhere, such as child and family health nurse and public health nurse.

Background

The organisation of support for parents

In England, the Department of Health (2011) indicates that families should be able to access different levels of support including help with parenting from health visiting services in convenient local settings as well as the home. Health visitor practice described in a 'new service model' (DH 2011) involves engaging with informal community networks that can provide a foundation of support for all parents and simultaneously leading the universally available Healthy Child Programme (DH 2009). This puts all parents in touch with formal healthcare services relevant to supporting early life (universal level service) and provides an opportunity for identifying when families have either short-term additional needs (universal plus level service) or complex needs that warrant focused help over a longer period (universal partnership plus level service).

For parents, social support often exists as a complex web of formal and informal sources of help (Ghate & Hazel 2002). Importantly, different sources can have a complementary function extending social networks and availability of help (Cochran & Henderson 1990, Edwards & Gillies 2005), but equally, may provide contradictory messages and undermine what might otherwise be helpful sources of influence (Whittaker & Cowley 2010). With this complexity, support for parents is often identified by the mode of contact, hence described as home visiting, group or increasingly, electronic media support.

Formal contact in the home for parents of preschool children has been provided on a universal basis by health visitors in several industrialised nations both in Europe (Kamerman & Kahn 1993, Skovgaard *et al.* 2005, Cowley *et al.* 2007) and elsewhere (Wilson 2001, Briggs 2006, Williams *et al.* 2008). Alternatively, home visitor support may only be offered on a selective basis to high-risk groups, such as teenage parents, as is more common in the United States (Council on Community Pediatrics 2009). International evidence now shows that sustained home visiting enables parents to develop trusting relationships with practitioners (Olds 2007, Appleton & Cowley 2008, Kardamanidis *et al.* 2009). Practices based on principles of respect, as for example recommended by the 'Family Partnership Model (FPM)' (Davis & Day 2010), enable parents to disclose sensitive information and visitors to be responsive to parent's needs (Hogg & Worth 2009). Practitioners therefore, through home contact, have the opportunity to develop parents' personal resources, such as self-esteem and self-efficacy.

By contrast, group contact provides support through structured parenting training programmes or more informally through parent–child community groups. In England, both forms of support are universally available via local public bodies known as Children's Centres (DH 2009). The structured programmes delivered by trained facilitators, including health visitors, offer parents preventive guidance by focusing on understanding and responding to children's needs (Barlow & Underdown 2005). By learning appropriate discipline practices, parents help children develop self-control (Stewart-Brown 2008), an important factor for managing later risk (Moffitt *et al.* 2011). Informal groups, generally led by lay or paraprofessional workers, aim principally to bring parents and children together to socialise and play, thus learning emerges as a by-product of the social experience.

The remaining mode of contact is via media methods. This increasingly means universal provision of information and peer support through discussion boards at dedicated internet sites (Long 2004). In the UK, social networking sites like mumsnet.com offer peer support, with netmums.com, operating an additional professional service, with health visitors hosting an online drop-in clinic (Netmums 2010a).

Social learning as a theoretical basis for parenting interventions

An early review identified that successful parenting programmes were generally underpinned by the theoretical principles of 'modelling', 'behavioural rehearsal' and 'positive reinforcement feedback' (O'Dell 1974). These principles, along with emotional arousal, translate as vicarious

experiences, performance mastery and verbal persuasion, as sources of influence on beliefs about personal capabilities or self-efficacy, a component of social learning theory (Bandura 1997). Contemporary parenting interventions continue to be underpinned by social learning principles (Sutton *et al.* 2004, Olds *et al.* 2007), and improvements to parents' personal resources, as indicated by higher parenting efficacy, are regarded as a viable outcome from programmes such as the 'Incredible Years' (Gross *et al.* 2003, Kim *et al.* 2008), 'Triple-P Positive Parenting' (Sanders & Woolley 2005) and the nurse–family partnership (Olds *et al.* 2007). This body of research, however, offers little discussion on the sources of influence that generated improved parenting self-efficacy. Furthermore, self-efficacy theory, although identified as pertinent to health visiting practice (Bloomfield *et al.* 2005, Whittaker & Cowley 2006, Bloomfield & Kendall 2010), has been little used in this field.

Research suggests that parents' self-efficacy beliefs can be central to their parenting practices (Bloomfield *et al.* 2005, Sanders & Woolley 2005). With poor parental self-efficacy, there is an increased susceptibility towards learned helplessness and thus a poor motivation to address difficulties (Donovan *et al.* 1990). Furthermore, it is a fragile experience that can be disrupted by maternal mood, particularly postnatal depression (Zayas *et al.* 2005, Weaver *et al.* 2008), and can be enhanced by stronger informal social support (Leahy-Warren *et al.* 2011).

Evidence for parenting interventions

A variety of reviews questioning evidence for parenting intervention efficacy are available (Woolfenden *et al.* 2002, Barlow *et al.* 2005, Dretzke *et al.* 2009), but they provide an incomplete picture for those developing universal preventive services. First, despite knowing that group parenting interventions can be effective in having a positive impact on parental well-being, less certainty can be expressed about the factors involved in outcome achievement (Barlow *et al.* 2003, Hastings & Beck 2004). A second concern is that primary studies examining parenting interventions typically involve parents with very high-level needs associated with caring for children with behaviour disorders. Less attention has been given to the larger population of parents accessing support available at the universal end of the service provision continuum. The purpose of the research reported here was to identify the common experience of parental self-efficacy for those accessing universal parenting services. This work was completed as the first part of a larger realistic evaluation (Pawson & Tilley 1997) concerned with understanding

how a parenting programme worked and achieved outcomes.

Methods

Design

A descriptive survey to establish the context for service provision was used.

Study methods

The first part of the study started with the development and pilot test of a questionnaire incorporating outcome measures for parental self-efficacy. The questionnaire survey was targeted at adult users of a multi-component parenting support service available in two geographical wards in a North of England city. For the most part, parents self-referred to service drop-in groups and parenting courses or were recommended by health visitors to receive additional home visiting. The self-referral option created uncertainly about exact numbers accessing services, so non-probability purposive and chunk sampling methods (Aday & Cornelius 2006) were used to include all adults using the parenting service over nine months.

Ethics and governance

Permission to proceed with the realistic evaluation was granted by an NHS Research Ethics Committee and the NHS organisation hosting the parenting service. Guidance with field management of the research came from a stakeholder advisory group consisting of five local parents, two practitioners, three University academics and a regional representative from the charity, Parenting-UK. The group met regularly and debated a range of study issues including ethical practice, questionnaire and information sheet design, field access, interpretation of results and dissemination.

The survey questionnaire

The survey questionnaire (available from the first author) was piloted over a period of six months with assistance from advisory group members who reviewed early drafts and debated results that have already been reported (Whittaker & Cowley 2006). Three differently coloured versions were designed for parents either caring for a baby (< 13 months), a toddler (1–4 years) or a school child (5–11 years). Illustrations were included to improve the visual appeal of the questionnaire and divided it into sections containing self-efficacy scales, questions about sources of self-efficacy and demographic details.

Self-efficacy scales

The Bandurian position that assessment of self-efficacy requires a focus on a domain of functioning (Bandura 2006) was adopted, which led to the selection of parenting domain measures rather than measures for general self-efficacy. Those used were the Parenting Self-Agency Measure (PSAM) (Dumka *et al.* 1996) and subscales from the Self-Efficacy for Parenting Tasks Indexes (SEPTI) toddler and school versions (Coleman & Karraker 2000, 2003). The PSAM, a five-itemed measure, requires the respondent to identify on a 5-point Likert scale how often they felt or thought like each statement representing the domain of parenting. Response categories range from never = 1 – always = 5, with lower scores indicative of lower parental self-efficacy. For the toddler (SEPTI-TS) and school child (SEPTI), only three subscales with content most relevant to the service parenting course were selected for the questionnaire. All the items were rated on a six-point likert scale with possible responses ranging from strongly agree to strongly disagree, with higher scores being indicative of higher self-efficacy. Satisfactory internal consistency had been previously established by the authors of the scales, and the alpha coefficient score results were at acceptable levels when tested with the UK pilot sample. These were as follows: PSAM = 0·76; SEPTI-TS subscales for discipline = 0·66 (improved to 0·79 with questions 4 and 7 removed), play = 0·84 and routine = 0·7; SEPTI School subscales for discipline = 0·86, recreation = 0·88 and nurturance = 0·58 (Whittaker & Cowley 2006).

Self-efficacy source questions

The second section focused on the four main sources of self-efficacy identified by Bandura (1997). This component was included to identify parent exposure to sources of influence that may impact on parenting self-efficacy experiences. Two questions were applied to each of the four known sources of self-efficacy, mastery of experience, vicarious experience, verbal persuasion and physical/psychological state. Each pair of source questions, with the exception of the vicarious experience source, contained a negative and positive statement to reflect the double-sided nature of these sources. Participants were asked to identify how often they had had this experience using an ordinal scale with the categories 'often', 'sometimes', 'rarely' and 'never'. For analytical purposes, these were later coded from 104, with 1 = 'often' and 4 = 'never'.

Data analysis

A log of questionnaire return was kept using a Microsoft Excel spreadsheet, and questions were coded and inputted into an SPSS ~~version 10~~ for Windows database~~.~~ Descriptive **4** statistics were computed to describe the sample. Inferential statistics were used to check for relationships between self-efficacy scores, demographic variables and questions about sources of self-efficacy. Specifically, the internal reliability of PSAM and SEPTI subscales was assessed by computing alpha coefficient scores. The unrelated *t*-test was used to assess self-efficacy mean scores against particular demographic variables, and a one-way analysis of variance (one-way ANOVA) was applied to test for differences between categories of parent participants (parents of children who were babies, toddlers and school aged) all completing the PSAM. To assess for relationships between the self-efficacy source questions and scale scores, correlation coefficients were computed.

Survey administration

Advance notice of the survey was provided through the study advisory group and field researcher visits to each of the health visiting teams in the designated geographical area. To improve study participant recruitment advisory group, parent stakeholders and practising health visitors assisted the field researcher in distributing study information sheets and a total of 278 questionnaires at parenting drop-in groups, parenting courses and the start of a period of health visitor one-to-one parenting support. Parents were asked to complete the questionnaire thinking about one particular child. The survey objective and instructions for completion were detailed on the questionnaire front sheet. They could be completed anonymously, although participants were asked to sign a separate consent form. In total, 168 questionnaires were returned, achieving a sixty per cent response rate. Of these, 62 (37%) had been distributed by professionals, 56 (33%) by parents and 50 (30%) by the researcher.

Results

Demographic details of the study participants provide an insight into who was accessing the parenting service, whilst results from the scales are used to examine parenting self-efficacy experiences and exposure to sources of influence.

Demographic features

Forty-five per cent (*n* = 75) returned toddler questionnaires, 35% (*n* = 59) baby and 20% (*n* = 34) school-aged questionnaires. As shown in Table 1, most of the survey participants, and therefore people accessing the parenting service, were women, were not in paid employment and half were aged between 21–30 years. A sizeable proportion of participants

Table 1 Demographic details for participants

Demographic features	Frequency, $n = 168$	
	n (%)	Missing, n (%)
Gender – female	159 (95)	–
Age		
16–20 years	19 (11)	3 (2)
21–30 years	83 (49)	3 (2)
31–40 years	57 (34)	3 (2)
41–50 years	3 (2)	3 (2)
≥51 years	1 (0·5)	3 (2)
Have a partner	141 (84)	2 (1)
Lives with partner	124 (74)	1 (0·6)
Lone adult household	36 (21)	1 (0·6)
Currently working	40 (24)	10 (6)
Minority ethnic origin	78 (46)	
Non-minority ethnic origin	91 (54)	–
Services accessed at point of questionnaire completion		
Parenting training courses (positive parenting training, baby massage training)	84 (50)	–
Drop-in groups (parent and toddler, teenagers parents group, dads group)	51 (31)	–
Health visiting services (baby clinics, home visits)	19 (11)	–
Not stated	14 (8)	–
An additional service accessed	105 (62·5)	17 (10)

($n = 105$, 62·5%) were making use of more than one form of parenting support and those accessed at the point of questionnaire completion included formalised courses ($n = 84$, 50%) and individual contact ($n = 19$, 11%) as well as drop-in groups ($n = 51$, 31%).

Almost half of the participants ($n = 78$, 46%) were of minority ethnic origin and many of whom were of South Asian descent. The average household size was four people, but this varied between 2–11 people. When cross-tabulated with ethnicity and age, it was apparent that those living in lone adult households ($n = 36$) were typically white British participants ($n = 29$) ($\chi^2 = 13·42$, df $= 1$, $p < 0·001$) and tended to be aged 16–25 years ($n = 20$) ($\chi^2 = 8·787$, df $= 1$, $p = 0·012$). The mean number of children (aged 0–16 years) living with participants was two.

Parenting experiences of self-efficacy

Reliability testing with the whole sample produced a Cronbach's alpha coefficient of 0·67 for the PSAM. Similarly, sufficiently internal reliability was also found for the toddler and school versions of the SEPTI scales with Cronbach's alpha coefficients calculated for toddler subscales: discipline (five items) $= 0·87$; play (seven items) $= 0·85$; routine (six items) $= 0·76$ and for school subscales: discipline (eight items) $= 0·84$; recreation (seven items) $= 0·75$; nurturance (seven items) $= 0·61$.

The PSAM was the only scale to be completed by all participants (Table 2), and the one-way ANOVA result indicated that there was no significant difference in PSAM scores between the baby, toddler and school groups [$F(2, 166) = 0·628$, $p = 0·535$]. The mean and median PSAM results suggest a good level of parenting self-efficacy across all participants although it appeared that there were some small demographic differences. Specifically, the unrelated *t*-test indicates differences in response to minority (mean $= 21$) and non-minority (mean $= 20$) ethnic origin parents ($t = -2·23$, df $= 162$, $p = 0·027$). Differences were also found depending on whether the respondent lived with their partner (mean $= 21$) or not (mean $= 20$) ($t = 2·22$, df $= 162$, $p = 0·028$).

Table 2 Mean PSAM, SEPTI-TS and SEPTI-school scores

Measure	N	Minimum	Maximum	Median	95% Confidence interval	Mean	SE
PSAM							
All parents	166	1	25	21	20–20·9	20	0·20
Parents with							
Child <13 months (baby)	59	15	25	20	19·6–20·9	20	0·35
Child 1–4 years (toddler)	73	13	25	21	19·9–21	20	0·29
Child 5–11 years (school)	34	15	25	21	20–21·8	21	0·45
SEPTI-TS							
Discipline	71	6	30	18	16·9–19·9	18	0·76
Play	72	12	42	35	32·4–35·5	34	0·77
Routine	72	12	36	28	26–28·8	27	0·70
SEPTI-School							
Discipline	32	20	48	34	31·9–37·6	35	1·4
Recreation	32	12	41	34	29·1–33·8	31	1·16
Nurturance	33	28	42	39	36·6–39·2	38	0·63

PSAM, Parenting Self-Agency Measure; SEPTI, Self-Efficacy for Parenting Tasks Index.

The advantage of including the domain-specific SEPTI subscales was that experiences related to specific aspects of parenting could be considered. The results (Table 2), with the exception of those for the toddler discipline subscale, indicated good levels of parenting self-efficacy across specific areas of parenting toddlers and school-aged children. No relationships were found between the demographic variables and any of the SEPTI-school subscales, but some weak and inversely related relationships were found with the toddler subscales. These were for the play subscale scores ($n = 67$) with household size ($r = -0.25$, $p = 0.04$) and with number of children ($r = -0.26$, $p = 0.03$) and for routine subscale scores ($n = 68$) with the number of adults in the household ($r = -0.35$, $p = 0.003$).

Parenting experience of the sources of self-efficacy

To examine whether there was any relationship between participants sense of self-efficacy and exposure to different community experiences, the PSAM scores were correlated with the questions aimed at exploring the sources of self-efficacy. To accommodate the ordinal level of measurement used here, the nonparametric Spearman rho statistic was calculated (Hicks 1990). The results detailed in Table 3 show very weak relationships, principally with sources concerned with feeling successful, criticised and tired (questions 1, 6 and 7). In addition, different efficacy experiences were suggested by relationships between the source questions. Here, 'feeling tired' positively correlated with often 'giving-in' and negatively correlated with 'often feeling successful in efforts', although again, these relationships were very weak.

Only one of the source questions (feeling tired) showed a weak relationship with the school discipline subscale ($n = 32$) ($r_s = 0.388$, $p = 0.028$). Stronger relationships were found between SEPTI-TS subscale scores and some self-efficacy source questions (Table 4). It appeared that 'feeling successful in parenting efforts' did to some degree correlate with higher SEPTI-TS scores for routine, discipline and to a lesser degree play. Opposite to this, those who often felt they 'gave-in' to their child's demands had lower routine and discipline scores. 'Feeling tired' accounted for some scores across all of the subscales, and this source seemed more influential than 'having patience'.

Table 3 Correlation between PSAM scores and self-efficacy sources questions

Spearman's rho (r_s)	PSAM score, $n = 164$	Source questions, $n = 164$							
		1	2	3	4	5	6	7	8
1 Feel successful in efforts as a parent	−0·259**								
2 Feel you 'give in' to child's demands	0·152	0·166*							
3 See someone successfully calm child	−0·035	−0·010	−0·017						
4 See someone successfully teach child	−0·151	0·082	0·030	0·385**					
5 Receive positive comments	−0·029	−0·006	−0·090	0·270**	0·163*				
6 Receive negative comments	0·235**	−0·208**	0·144	0·196*	0·043	0·139			
7 Feel too tired to deal with difficult behaviour	0·257**	−0·285**	0·308**	−0·021	−0·007	−0·165*	0·207**		
8 Have the patience to deal with difficult behaviour	−0·186*	0·134	0·073	0·024	−0·001	0·118	−0·104	−0·204**	

PSAM, Parenting Self-Agency Measure.
*Correlation is significant at the 0·05 level (two-tailed).
**Correlation is significant at the 0·01 level (two-tailed).

Table 4 SEPTI-TS correlations with self-efficacy sources

Self-efficacy source questions	SEPTI-TS subscales, Spearman's rho (r_s)		
	Discipline, $n = 70$	Play, $n = 71$	Routine, $n = 71$
Feel successful in efforts	−0·408***	−0·298*	−0·559***
Often 'giving-in'	0·315**	0·147	0·513***
Given negative comments	0·197	0·224	0·243*
Feel too tired	0·429**	0·38**	0·434***
Feel do have patience	−0·341**	−0·379**	−0·215

SEPTI, Self-Efficacy for Parenting Tasks Index.
*$p < 0.05$, **$p \leq 0.01$, ***$p \leq 0.001$.

Discussion

In the background to this paper, the nature of parenting support and health visitor involvement was set out. The rationale for this area of public health activity rests on the need for early investment in the lives of children, even in developed societies. Indeed, action to support families, particularly parents, to meet the challenges of raising children is identified as essential for working towards strengthening population health and economic prosperity (Mustard 2007).

To assist families, there are various modes of parenting support, which commonly aim to strengthen parental self-efficacy and competence. This study identified women as primary users of universal parenting support and was interested in how self-efficacious they felt as parents and the contextual factors that could be shaping these experiences. The findings are consistent with arguments that several contextual factors are important to personal self-efficacy experiences and provide several indications of the relevance of self-efficacy theory to contemporary health visiting practice.

Common parental self-efficacy experiences

In exploring common experiences of parental self-efficacy, it was apparent that parenting needs might not always be what they seem and hence personalised assessment is as important in health visiting, as it is in others spheres of nursing. This is illustrated in data concerning living situations, where participants from larger households tended to have poorer self-efficacy for managing toddler routines or offering play opportunities. That is, in households with more adults and theoretically carers, the parental load was not necessarily lightened. This challenges assumptions that those in lone parent households are the most vulnerable and marks out the need for practitioners to seek a complete picture when defining needs for additional support.

Examination of self-efficacy scores in the specific domains of parenting also shows how initial impressions can be misleading. Here, the difference in the domain general PSAM and task-specific SEPTI scale totals suggests that whilst parents experienced relatively good general parental self-efficacy, they were less sure of their capability in particular areas. Specifically, less confidence was expressed in managing child discipline. Furthermore, examination of experiences acting as sources of influence on self-efficacy showed that those who often 'felt tired' or who 'gave-in' to their child's demands indicated lower self-efficacy in managing discipline and routine. Similarly, parents expressed greater self-efficacy in managing discipline and routine, if they identified themselves as often 'feeling successful in their efforts as a parent'. Thus, parents had poorer self-belief in managing specific child rearing challenges when they were physically compromised by tiredness, or had, because of giving-up, rarely experienced positive mastery, whereas those experiencing mastery and success were more positive about their capabilities in the areas of discipline and routine. These results not only highlight important areas for attention by health visitors, but are consistent with Bandura's (1997) messages about the particularly powerful influence of being able to master a task and equally the damaging effects of the reverse; repeated exposure to non-mastery and giving-up.

Managing discipline appropriately, including establishing routines, is an important component of early child rearing patterns because through this practice parents can help their children develop self-control; a fundamental skill for later life (Moffitt *et al.* 2011). The challenge for parents is to be consistent with their positive discipline practices and to avoid 'giving-in' when they feel more stressed, as frequent inconsistencies in parenting practices (a lax style) have been associated with greater childhood behaviour difficulties (Ang 2008).

Factors Bandura (1997) identified as impacting on the ability to persist in mastering a new skill or means of managing a difficulty, such as child behaviour, include the individual's physical and psychological status, as well as feedback received from others. Here, parents' experiences of 'feeling tired' correlated positively with the belief that they often 'received negative comments' and often 'gave-in' to their child's demands. This reduced exposure to helpful sources perhaps explains why some of those who expressed 'feeling tired' were more inclined to have lower parenting self-efficacy scores.

Opportunities for strengthening parenting support

To strengthen support services for parents, practitioners, such as health visitors, face a fourfold challenge. This includes knowing individual families sufficiently to appropriately understand their requirements regarding the levels of self-efficacy experienced and concurrent exposure to sources of influence. Next, they need to be ready to provide guidance relevant to key aspects of parenting where parents express least self-belief; do this in a sensitive and balanced manner to avoid undermining any sense of general parenting self-efficacy; and use methods that can reverse exposure to negative and build on positive sources of influence. Achieving this, however, is likely to depend on the ability to have enough personal contact with each family. Contact as part of the universal component of a comprehensive child health

programme, such as the Healthy Child Programme in England (DH 2009), is important for two reasons. It offers a basis for determining need and identifying who might benefit from the more intensive modes of support and thereby provides data required for planning resource allocation from the care continuum.

The finding with respect to tiredness is one of the notes given that this can feature as part of the transition to parenthood (Barclay *et al.* 1997). In a survey of over 5000 mothers using online parenting support, 50% of respondents cited lack of sleep as one of their main day-to-day stressors (Netmums 2010b). Persistent tiredness can contribute to low mood and possible depressive illness (Sharpe & Wilks 2002), which can disrupt parental self-efficacy (Zayas *et al.* 2005, Weaver *et al.* 2008). Moreover, arguments for taking parental tiredness seriously are supported by evidence that poorer self-efficacy adversely affects maternal sensitivity (Donovan *et al.* 2005) whilst attentive sensitive parenting enables positive infant neurological development (Gerhardt 2004). Rather than minimising tiredness as an automatic parenting experience, parents' felt experiences can be acknowledged. This would create the opportunity to address the experience directly and introduce solution-focused approaches for managing parents' sleep/wakefulness difficulties. The intention was, to minimise threats that tiredness could be posing to parental self-efficacy and sensitive parenting practices.

If practitioners understand the areas where parents feel least self-efficacy, they can maximise exposure to positive sources of influence available through universal childhood services. This includes making the most of contact in the home, a support method valued by parents if they are able to establish firm relationships with health visitors (Hogg & Worth 2009). Kardamanidis *et al.*'s (2009) Australian study showed how the FPM (Davis & Day 2010), formerly known as 'parent advisor approach' (Davis *et al.* 2002), enables respectful relationships to develop, which can be used to facilitate a shared exploration of parental need and identity of tasks with which parents feel least self-efficacious. Part of the exploration would include identifying the different sources of support and influence in families and neighbourhoods (real or virtual), determining whether these have the potential to contribute positively or negatively to parenting self-efficacy experiences. By listening to parents' concerns, then guiding them in the process of identifying their own solutions, practitioners would enable investment in parents' own personal resources and thus psychological sources of influence on self-efficacy.

A broad-based preventive service, such as that described in the 'new service vision' for English health visitors (DH 2011), provides several opportunities for action directed at maximising exposure to positive sources of self-efficacy or active management of potential negative exposures. The universal service component might include home contact as described above, along with practitioner involvement in community parent–child groups. In community situations, practitioners have a role in facilitating respectful communication between participants, encouraging exposure to positive verbal persuasion messages and role modelling in community situations. Where parents have additional self-efficacy needs, parenting training programmes that incorporate role play and feedback would provide scope for task-specific role modelling and the chance to practice new parenting strategies in a safe situation. From this, an opportunity arises for exposure to positive verbal persuasion messages along with vicarious and mastery experiences. What is more, the increasing use of social networking internet sites and specifically the growth in those aimed at parents, would suggest that virtual communities are also environments where practitioners could have an important role to play in shaping exposure to self-efficacy sources. In this regard, the example of Netmums employing health visitors to support online clinics and parenting programmes might prove to be a useful model for practice capable of complementing other modes of universal service provision.

Limitations

The survey provided a one-off measure, a snapshot at a given period of time, of common parental self-efficacy experiences for users of any one of several parenting support facilities. This meant it would not have been appropriate, in this instance, to repeat the questionnaire to assess for change in outcome measure results. This was because the contextual situations for each questionnaire completion in a multi-component service were likely to vary between measurements. What is more, parents used several facilities simultaneously or at different times, so it was difficult to define a clear start and end point to use of formal parenting support. This meant that the survey data did not necessarily represent the true starting point of service use, so reliable measurement of changes to common parenting self-efficacy experiences was not feasible in this instance.

However, the outcome measures used in the study could be used elsewhere as valid and reliable indicators of parenting programme success, that is, in a study situation where greater assurances could be made about the intervention being measured and where a level of consistency in circumstances could be achieved for each questionnaire completion. The outcome measure Cronbach's alpha coefficients would, however, suggest that the SEPTI-TS and the SEPTI school subscales, with the exception of the nurturance subscale,

were more stable as measures of parental self-efficacy than the PSAM. These results and the fact that the PSAM was a general domain measure as opposed to a task-specific measure also provide some explanation for why only weak correlations were found between SEPTI-TS and the PSAM scale results.

Conclusion

The paper started by highlighting how support for parents has become a recognised feature of public services aimed at improving the life chances of children. The ways support can be organised have been outlined, drawing attention to the move in England to make services available as part of a broad-based preventive model whereby those with greater need have access to greater support (DH 2011). This background was presented as a basis for the discussion of findings from the first part of a realistic evaluation study; specifically survey evidence of parental self-efficacy experiences for those accessing universal support services. Survey findings indicated that parents generally experienced good levels of parental self-efficacy, although evidence from the task-specific scales would suggest that managing discipline was an area of parenting with which they felt least efficacious. There was also some suggestion of relationships existing between poorer self-efficacy and factors such as feeling tired, receiving negative comments and often 'giving-in' to a child's demands. These findings have implications for providers of universal child health programmes and in particular health visitors who are able to make contact with families in a wide range of community situations. Knowledge of social learning theory and understanding its application by managing exposure to sources of influence for self-efficacy development can provide practitioners with a valuable means of helping. Moreover, by developing an understanding of parental self-efficacy experiences in a community, practitioners have the opportunity to strengthen local parenting support through practices that are consistent with the development of environments rich in positive sources of self-efficacy. Practice of this kind could have implications for parent–child relationships and thereby the longer-term development of children and the communities in which they live.

Relevance to clinical practice

- Four sources of influence are known to be important to the strength of self-efficacy, which are mastery of experience, vicarious experience, verbal persuasion and physical/psychological state.
- Parents experience of 'feeling tired', 'receiving negative comments' and 'often giving-in to child's demands' are particularly associated with lower perceived parental self-efficacy – these are experiences that health visitors and colleagues should take seriously when delivering universal child health services
- Practitioners should be alert to the possibility that even when parents demonstrate good general levels of parental self-efficacy, they may be less sure of their capabilities in certain areas of parenting, such as discipline.

Contributions

Study design: KW, SC; data collection and analysis: KW and manuscript preparation: KW, SC.

Conflicts of interest

The authors have no conflict of interest.

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Once you have Acrobat Reader open on your computer, click on the Comment tab at the right of the toolbar:

Tools   Comment   Share
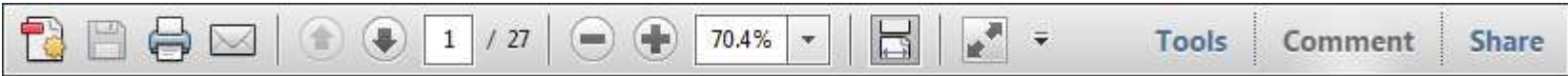
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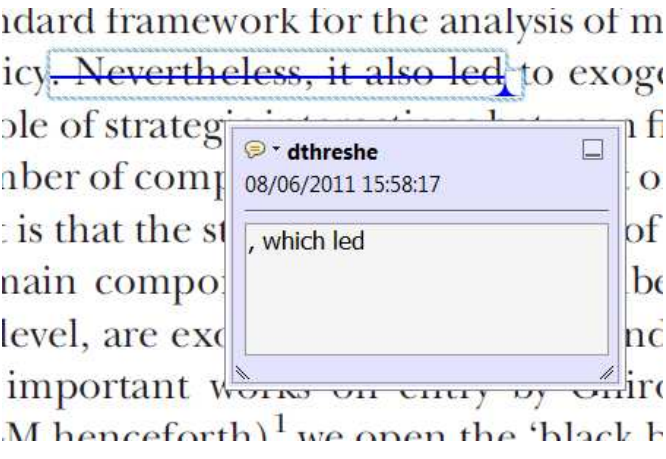
1. Replace (Ins) Tool – for replacing text.

Strikes a line through text and opens up a text box where replacement text can be entered.

How to use it

- Highlight a word or sentence.
- Click on the Replace (Ins) icon in the Annotations section.
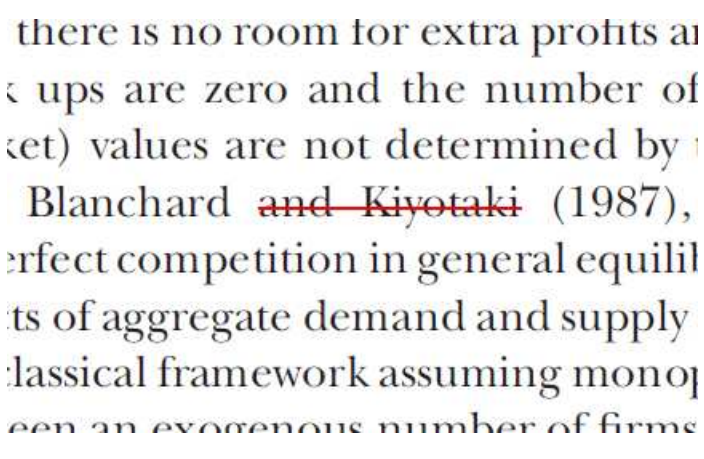- Type the replacement text into the blue box that appears.

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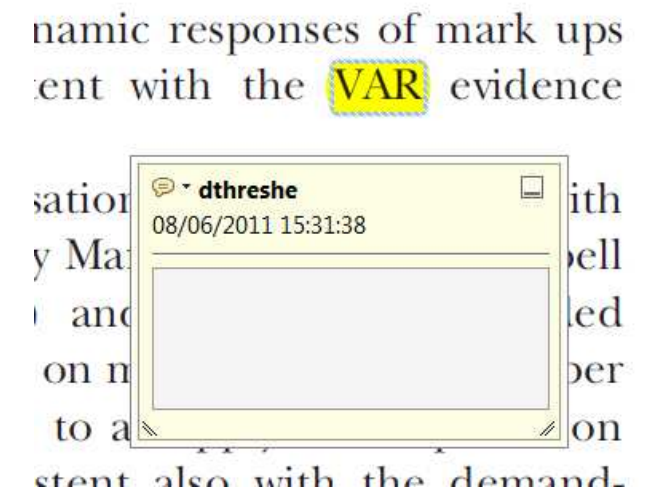### 3. Add note to text Tool – for highlighting a section to be changed to bold or italic.

Highlights text in yellow and opens up a text box where comments can be entered.

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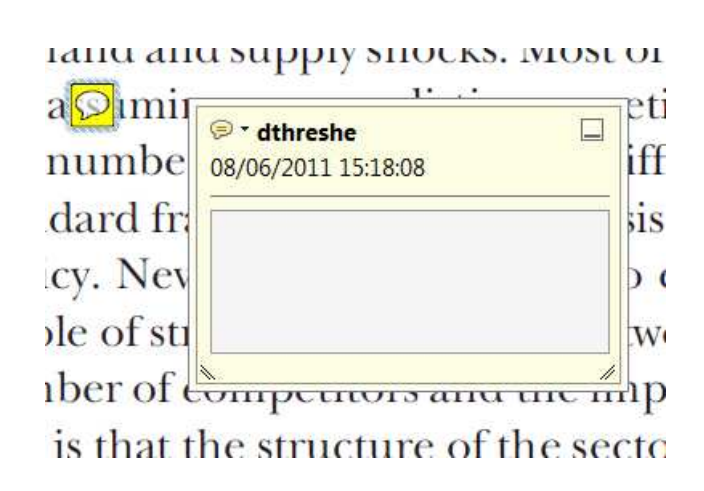- Type instruction on what should be changed regarding the text into the yellow box that appears.

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4. Add sticky note Tool – for making notes at specific points in the text.

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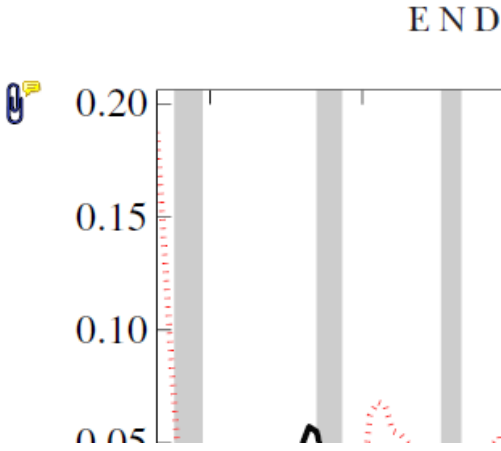- Type the comment into the yellow box that appears.

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5. Attach File Tool – for inserting large amounts of text or replacement figures.

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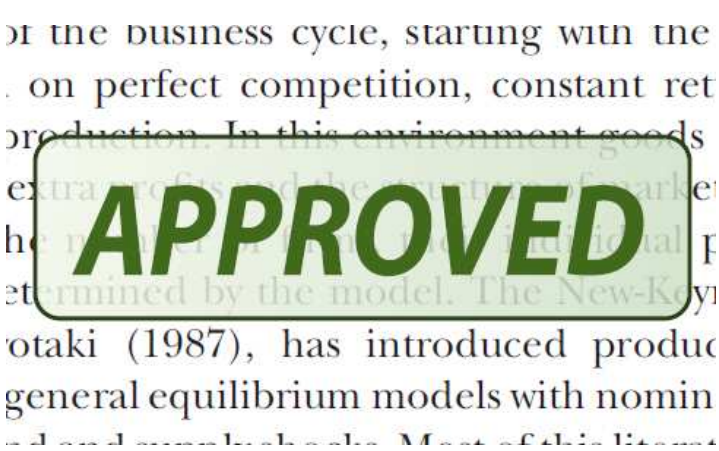- Select the colour and type of icon that will appear in the proof. Click OK.

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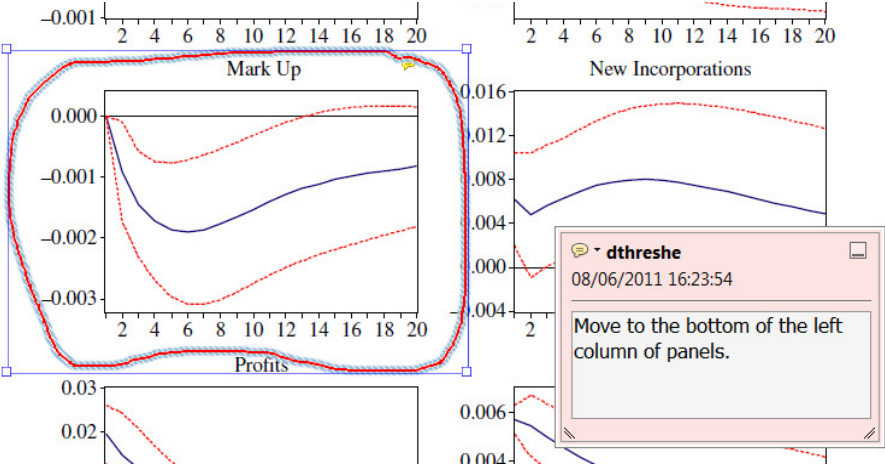**7. Drawing Markups Tools – for drawing shapes, lines and freeform annotations on proofs and commenting on these marks.**

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