Parent-Child Psychotherapeutic Interventions with Vulnerable Clients: Are They Within the Scope of Social Work Practitioners in Barbados?

Abstract

The predominant field of social work practice in Barbados is childcare and child protection (Ring & Carmichael, 2015), however few psychotherapeutic programmes and interventions are developed and implemented by social work practitioners. Sociological and structural perspectives have guided research examining macro issues such as health and poverty, children's rights and family structure (Shonkoff & Richter 2013) with very little emphasis placed on the examination of the beliefs and practices that shape the parent-child relationship (Williams Brown & Roopnarine 2006). With psychodynamic theories guiding their practice, social workers can explore the internal and external realities of the client's life (Bower, 2005) to understand the symbiotic relationship between these two inner and outer worlds.

This paper discusses the findings of a study that presents evidence of the way a social work led psychotherapeutic intervention can be an effective tool in social work practice.

Introduction

Social care provision has improved considerably in developing countries, however families of children with neurodevelopmental disabilities in Barbados continue to experience huge deficits in social provision, particularly with respect to parent-child intervention programmes. Parent psychotherapeutic intervention programmes for this vulnerable population are scarce in Barbados and non have been identified that are developed and/or led by social work practitioners. Vegas and Santibáñez (2010) stated that the majority of parent-child interventions in the Caribbean region are developed to address health and nutrition needs and poverty alleviation. Although these programmes have a positive impact on children's physical health, there is a lack of interventions that address the social and emotional aspects of the parent-child relationship that are social work led. In a review of parenting programmes in developing countries Mejia, Calam & Sanders (2012) found that the majority of programmes focused on physical health and well being of families and concluded that, "Even though efforts must be made toward eradicating poverty and its associated physical health outcomes, there is a need to integrate these efforts with psychological interventions to promote emotional and behavioral well-being of children and their carers" (p. 170). Globally, multidisciplinary psychotherapeutic programmes and interventions that aim to strengthen the parent-child relationship have shown success in enhancing the affective attunement of caregivers, helping them to read and respond contingently to their child's cues and consequently enhancing the parent-child attachment relationship, particularly with vulnerable, at-risk populations (Sadler, Slade & Mayes, 2006; McDonough, 2005; Beebe, 2003; Beebe, Friedman, Jaffe, Ross, & Triggs, 2010).

Intervention Programmes in the Caribbean

Early intervention programmes are on the increase in the Caribbean, however the majority of these are privately funded and are often out of the reach of many families due to disadvantaged economic circumstances (Janssens, Rosemberg and van Spijk 2009). In 1995 the Caribbean Association for the Mobilization of Resources and Opportunities for persons with Developmental Disabilities, (CAMRODD), initiated a programme throughout the Caribbean working with parents of children with intellectual disabilities. (Bean & Thorburn, 1995). This programme, now defunct, provided outreach education to parents with a focus on parent involvement and child rearing strategies and support and parent advocacy. In 1993 the Roving Caregivers Programme was initiated in Jamaica. It is one of the most widely known parent-child interventions in the region and has reached approximately 24,000 parents across five Caribbean islands. The intervention is a parent education initiative rather than a psychotherapeutic intervention and it is administered by paraprofessionals who do not require any social work training or experience (Janssens & Rosemberg 2014).

To address a gap in services for parents of children with disabilities in Barbados the author sourced private sector funding to implement an early intervention centre providing educational and therapeutic interventions for children with neurodevelopmental challenges and their families. The Centre employed the DIR/Floortime model to build and strengthen the parent-child affective relationship and the play-based strategies gave parents the skills and the confidence to engage and connect with their child. Supporting the parents to reflect on the play sessions stirred many emotions, with some parents commenting that this was the first time they felt a connection with their child. Schaefer and Drewes (2013) suggested that the therapeutic powers of play are not simply the medium by which change occurs in the client system but

actually produce the desired therapeutic change (p. 2). Schaefer and Drewes (2013) further state that play powers are not discrete techniques, rather they are less tangible constructs such as "insight" and "positive affect" that "transcend culture, language, age and gender" (p.1). Play powers act as change agents during therapy enhancing attachment relationships and clients' self-esteem, self-expression and emotional regulation. The success of these play powers relies on the establishment of a therapeutic alliance whereby the therapist builds an affective connection with the client nurturing a sense of trust, safety and security.

Evidence for DIR/Floortime

In a DIR/Floortime treatment intervention the therapist's goal is to create a safe space for the therapeutic work to take place by supporting the attunement of the parent and child through the development of specific factors such as empathy and insight that contributes to the parents' ability to accurately read the child's emotional signaling. Greenspan and Wieder (2006) stated that DIR/Floortime is a "parent-oriented developmental therapy" that places parents at the core of the intervention (p. 91). DIR therapy encourages parents' participation and values the parent as a partner unlike many clinical therapeutic interventions where the therapist is seen as the expert. According to Greenspan and Wieder (2006), the DIR clinician's role as coach is not to "demoralize the parents by taking over or lecture them on proper techniques of interaction" but to "empathize with their fears and anxieties, and to help them understand how their own histories contribute to the ways in which they interact with the child" (p. 92).

Evidence of the efficacy of the DIR/Floortime model of intervention was demonstrated in a randomized controlled study conducted by researchers at York University in Toronto, Canada. Fifty-one parents and their children with developmental disabilities received 2 hours of DIR/Floortime per week for one year (Casenhiser, Shanker and Stieben, 2011) and researchers

reported a significant gains in the social interaction and social communication skills of the children who received the DIR/Floortime intervention compared to a matched group receiving community services.

In a randomized controlled trial conducted by Pajareya and Nopmaneejumruslers (2011) parents received training in the DIR/Floortime model and implemented the model at home for an average of 15 hours per week over a three-month period. The researchers assessed the functional and emotional development of a group of children with Autism and found that the children who received the DIR/Floortime intervention made significant gains compared to a group of matched children who received their usual one-on-one behavioural intervention.

A pilot study by Solomon, Necheles, Ferch, & Bruckman (2007) incorporated the DIR/Floortime model in a parent-training program, The Play Project Home Consulting model, (PPHC). This study provided 15 hours per week of coaching for 68 parents of children with an Autism Spectrum Disorder and found that developmental progress was made by 45.5% of the children in the study. Following this pilot study, the National Institute of Mental Health (NIMH) in the United States awarded Solomon et al (2007) a US$1.85 million dollar grant to further investigate this model of intervention. A resulting three-year study found that 3 hours per month of the DIR/Floortime based treatment intervention, administered through home visitation, resulted in significant improvements in parent-child interaction, functional development, and autism symptomatology in the DIR group compared to a community group. (Solomon, Van Egeren, Mahoney, Quon Huber, & Zimmerman, 2014).

Parents of children with neurodevelopmental disabilities in the Caribbean

Along with limited parent-child interventions, the Caribbean literature suggests that families of children with disabilities in the Caribbean region continue to experience high levels of poverty that indirectly impacts the parent-child relationship. According to Williams, Brown and Roopnarine (2006), a longitudinal study of parenting found that Jamaican mothers experienced a higher level of parenting-related stress when compared with American parents. Forty-five percent of Jamaican mothers reported extreme stress compared to only eleven percent of mothers in the United States. Williams et al (2006) reported that the impact of poverty in the Caribbean region adversely affects the healthy development of parent-child relationships with fifteen to forty percent of Caribbean children living in conditions of poverty with poor social and educational services available to them. Barrow (2002) stated that in the Caribbean families exist in an "unsupportive social environment" where "there is no specific package of social policies to support families and households" (p. 196). With huge deficits in supportive services for families with children with developmental disabilities in Barbados it is reasonable to suggest that parents need support to strengthen the parent-child relationship.

In the Caribbean the medical model is the prevailing paradigm, a legacy of the Region's colonial cloak of the past where disabilities are viewed from an impairment perspective with the problem to be fixed by the medical professional (Scmid, Vézina & Ebbeson, 2008). Within this framework, parents of children with disabilities are not valued as partners and are expected to defer to the professional. According to Martin (2012) over the last three decades in developing countries there has been a shift towards a social model of disability. However, the linear, bio-medical model still prevails and many parents of children with developmental disabilities continue to have experiences with professionals that they consider unsupportive, where the professional is considered the skilled specialist who dispenses knowledge to the parent

(Jovanova & Radojichikj, 2013).

Clinical Social Work Practice in Barbados

According to Ring & Carmichael (2015) 84% of social workers in Barbados are employed with Government agencies with the majority employed within the area of welfare and family services and social workers in Barbados feel adequately prepared practitioners to meet the needs of the client system. According to Maxwell, (2002) social workers in the Caribbean are suitably prepared for generalist practice and acquire the necessary training and skills to work across all dimensions of the human services. Social workers are trained to challenge oppressive and discriminatory polices and practices that pose a threat to the health and welfare of clients and to intervene in the 'outer world' of the client system. However, the social worker also needs to be able to evaluate the 'inner' world of the parent to understand how complex emotional dynamics can impact the healthy functioning of the client system. According to Stevenson (2005) "The turmoil and disruption surrounding the past lives of children and adults with whom social workers work makes it inevitable that many of them will have little awareness of the interaction between experience and behaviour in their own lives. It is sometimes part of the social workers' task to facilitate such awareness" (p. 12). Whilst parent education programmes provide essential and valuable support to parents and families, many of the challenges that disrupt the parent-child relationship have their roots in deeper, psychological processes and require the professional clinician to have a greater understanding of the intergenerational nature of attachment security and to adopt a psychodynamic approach to their clinical practice.

Historical Nature of Psychodynamic Social Work

Historically, psychoanalytical and psychodynamic work with clients was embraced by early British social workers such as Clare Winnicott, a psychiatric social worker who along with psychoanalysts such as John Bowlby, Donald Winnicott, Melanie Klein and Anna Freud, significantly contributed to our understanding of the inner world of the child and how this impacts the parent-child relationship. In the 1950's and early 1960's psychoanalytical theory guided social work practice was washed away in the tide of sociological theories that flooded the social work field, (Bower, 2005). At this time an ideological shift occurred and by the 1970's social workers working from a psychodynamic perspective were accused of working from a deficit frame of reference and within a medical model. The social work profession embraced the systems perspective and macro theories of sociology and social policy theorists reigned. Unfortunately, the social work profession did not find a way to synergize these two perspectives and the psychoanalytical 'baby' was discarded with the bath water. Bower (2005) states that "Although emotional disturbance and the power of the unconscious internal world have been pushed to the edges of social work training, they are central aspects of our client's lives and make their presence powerfully felt in the relationships between clients and workers" (p. 3).

Reflective Practice with Parents and Families

With psychodynamic theories guiding their practice, social workers can engage parents in a reflective process where "observable interactions between the baby and the caregiver serve as the early therapeutic focus and, as such, serve as the therapeutic port of entry" (Sameroff, McDonough and Rosenblum 2005, p. 79). Bower (2005) has suggested that there is "a hole in the middle of social work where a comprehensive, coherent model of human personality and emotional development should be" (p. 3) and engaging parents to reflect on their interactions

with their children offers the opportunity to analyse the interaction from the inside out, focusing not only on the observed behaviours but also the mental states, the feelings, beliefs and intentions of the dyad. The parents' representational world can be vulnerable to assaults from the past where interactive experiences, lived or imagined, shape their internal representations. These form the parents' "schemas-of-being-with" (Stern, 1995, p. 107), and according to Siegel & Hartzell, (2004), understanding their own narratives from the past, present and future helps parents to understand their child's mental states and contributes to the development of a healthy the parent-child attachment relationship.

Methodology

In the current study 40 Barbadian parents with children with a neurodevelopmental disability were invited to participate and after meeting eligibility criteria were randomized to either a DIR/Floortime intervention group (n=20) or a psycho-educational (wait-list) group (n= 20). The study was guided by the following research questions: (1) Will there be an increase in the quality of the parent-child interaction after twelve weeks participation in a DIR/Floortime intervention as measured with the PICCOLO assessment? (2) Will the parents' perception of their relationship with their child change after participating in a twelve weeks DIR/Floortime intervention?

The Treatment Intervention

The DIR/Floortime approach is built on premise that affective interactions promote healthy social and emotional development in children through coaching in a clinical setting or at home. The social worker/clinician facilitates a natural play interaction while coaching parents on

how to affectively attune to their child to enrich the parent-child interaction. The DIR model looks at where the child is developmentally and also looks at each child's individual differences, i.e. the unique way each child takes in, regulates, responds to and understands sensations as well as the way the children plan and sequence their actions and ideas. The clinician supports the parent and child to advance along the following developmental stages: At Stage One the focus is on supporting the dyad to be emotionally regulated and available to each other for reciprocal interactions. At Stage Two the parent is supported to woo the child into a warm reciprocal relationship to maintain mutually joyful engagement. Stage Three relates to building and maintaining back and forth two-way purposeful communication. Here the dyad learns to read each other's communicative intent and respond sensitively. At Stage Four the children's interactions become more complex as they use a series of emotional signals and gestures to increase social cooperation. Stage Five is symbolic, representational and creative play and here the therapist encourages the dyad to expand their emotional range, introducing themes into the play and exploring feelings through this medium. At Stage Six the child and the parent begin to make logical connections leading to higher stages of 7,8 and 9 that focus on the development of abstract and reflective thinking. According to Davis, Isaacson & Harwell (2014), self-reflection is a critical component of the DIR/Floortime model of intervention and encouraging parents to reflect on their interactions with their child underpins the capacity for affectively attuned relationships.

The 'I' in DIR refers to the child and parents' individual differences, the unique biological characteristics that shape how they interact with their sensory world. The clinician may recognize that the parent and child have sensory processing capacities that disrupt the interaction. For example, the parent may use a loud, high affective tone while the child's

auditory processing is over-responsive to sound. In this regard the clinician's role is to help parents to develop an awareness of their own sensory profile along with their child's individual differences. The parents would be coached to modulate their affect, and to consider the rhythm, timing and pacing of their engagement with their child with the goal of facilitating a synchronized, affective, reciprocal interaction.

The 'R' in the DIR model emphasizes relationship building and places the development of warm, nurturing, emotionally secure relationships at the core of all interactions. The overarching goal is to encourage a dyadic intersubjective experience within a secure, trusting relationship (Greenspan & Wieder 2006b; Greenspan, Wieder, Hollander & Anagnostou, 2007). In the current study an emotionally safe space was created for the intervention to take place, and within this 'holding' environment the parents were coached to attune to their child's communicative intent and to respond sensitively and contingently. During and after the sessions the parents were encouraged to reflect on their interactions with their child whilst reviewing video recordings of the session. During this time the clinician would pause the video at a particular incident and encourage reflection by asking the parent questions such as, "When (child) did (action) what do you think he/she was feeling?" "What do you think he/she was trying to tell you here?" and "What were you feeling when (child) did (action)?" Parents were supported within a therapeutic alliance to try to understand their child's cues and communicative intent in order to better understand their child's behaviour. Fogel (2011) suggested that affective attunement between a parent and child relies on physiological and psychological awareness and supporting parents through the use of video feedback can enrich clinical practice by helping the parents to observe the mismatches in their communication with their child in a supportive, non-judgmental space.

Sample

Participants were drawn from the Barbadian population of parents with a child with a neurodevelopmental disability between the ages of 2 years and 6 years 11 months. Parent-child dyads consisted of the primary caregiver who was the child's mother or father, the child's informal or formal foster parent, or the legal guardian of the child who provides consistent care (see Table 1). Private and public medical and non-medical professionals referred parents to the study and the first 40 parent-child dyads that met the following criteria were enrolled in the study.

TABLE 1 HERE

Inclusion Criteria:

- Parents or primary caregivers of a child/children with a neurodevelopmental disability.
- Children were between the ages of 2 years and 6 years 11 months
- Children who attend a private or public facility that caters to children with developmental disabilities.
- Parents/caregivers who can commit the required time to the study.

Exclusion Criteria:

- Parents/caregivers who are not the child's primary caregiver.
- Parents/caregivers who have recently participated in, or who are presently participating in any type of parent-child intervention or research project other than scheduled therapy sessions.

- Children with comorbid conditions, such as medical illnesses and/or psychiatric conditions.
- Parents who declared a psychiatric or psychological disorder.
- Children who are younger than 2 years 0 months or older than 6 years 11 months.
- Parent-child dyads that have previously received, or who are currently receiving intensive DIR/FT™ intervention.

Measures

The Quality of the Relationship

The quality of the parent-child relationship was measured using the 'Parenting Interactions with Children: Checklist of Observations Linked to Outcomes' (PICCOLO™ Roggman, Innocenti, Cook, Jump & Akers 2007). The PICCOLO™ is a checklist of 29 parent behaviours within four domains, (a) Affection that looks for evidence of warmth by observing if the parent/caregiver speaks in a tone that conveys tenderness and does the parent smile at the child; and show physical closeness while being actively involved with child? (b) Responsiveness – this domain requires the parent to pay attention to what child is doing and respond to child's emotions. It also looks for flexibility in following the child's lead and ideas and changing pace to meet the child's needs or interests. (c) Encouragement – this domain examines how the parent supports the child in his/her choices while offering suggestions to help child; it also looks for evidence of enthusiasm about what the child is doing and relies on the parent to offer verbal encouragement. (d) Teaching – this area looks at shared conversation and play and expects the parent to offer cognitive stimulation by encouraging questions and back and forth dialogue. It looks for evidence of the parent encouraging symbolic play and sequencing.

The PICCOLO^{TM} is scored from observations of a five to seven-minute video recording of the caregiver and child involved in a natural play interaction and the scores are summed across the four domains. Low scores indicate that the caregiver and the child are demonstrating difficulty relating and engaging in a manner that supports the child's overall development. The measure has been tested on a subsample of 188 children with developmental disabilities and demonstrated good construct validity with statistically significant correlations averaging .57 (Roggman et al, 2007).

The Parents' Perception of the Relationship

The Parent Child Relationship Inventory (Gerard, 2005) is a self-report 75-item instrument that is used to assess parents' perceptions of their relationship with their child. It takes approximately 15 minutes to complete and requires only a fourth grade reading ability. The PCRI has a Likert-type four point response scale: strongly agree, agree, disagree, strongly-disagree. There is no composite score and the parent/caregiver reports on the following the seven domains of (a) Support, (b) Satisfaction (c) Involvement, (d) Communication, (e) Limit Setting, (f) Autonomy and (g) Role Orientation.

Each scale on the PCRI produces a standardized T score with a mean of 50 and a standard deviation of 10 with high scores indicating positive parental perceptions. The PCRI has a mean test-retest reliability of 0.81 (Gerard, 2005). Scores are calculated from the raw scores and a T score of less than 40 (i.e. more than one standard deviation below the mean) is considered low and is indicative of problems in the particular domain, a score below 30 suggests very serious problems in the specific domain. In the current study the domains of limit setting, autonomy and role orientation were not deemed relevant to the study goals and were therefore not included in the analyses. An examination of a correlation matrix revealed that the domain of 'support'

was poorly correlated with the domains of communication and involvement and was also eliminated. In the final analysis only the Communication, Involvement and Satisfaction domains were used and each of these domains showing good internal validity (alpha coefficients), (Communication .82, Satisfaction .85, and Involvement .76).

Limitations

One limitation of the current study is the small sample size and the specific sample population. Further research involving a larger sample of typically developing children would provide further evidence for the effectiveness of a brief, parent-child psychotherapeutic intervention. A limitation of the pretest-posttest experimental design is the lack of long-term follow up to observe whether the gains obtained during the study period are sustained over time. Additionally, the cultural relevance of measures used in research is often a source of concern for Caribbean researchers. Williams, Brown and Roopnarine (2006) argued that the appropriateness of many research measures has not been tested on Caribbean populations and future research is required to test the validity and reliability of these tools. Krishnakumar, Buehler and Barber (2004) argued that definitions of meanings and constructs ought to be examined within a cultural lens. For example, the Caribbean family and Caribbean relationships have specific cultural nuances that may not be captured in Eurocentric measures and models. Further research in the region is required to understand the culturally constructed ethnotheories that shape the parent-child relationship.

Results

All of the dependent variables were examined for accuracy of data entry no missing

values were found. To assess if groups were evenly matched, chi-square tests and one-way analyses of variances (ANOVAs) comparing the two groups were performed using an alpha level of .05. At the pre-test time point there were no significant differences between group allocation and age of parent, $F(1,38) = 2.99$, $p = .092$ or between group allocation and parents' level of education, $\chi^2 (3) = 4.49$, $p = .214$. There was also no difference in the age of the children in the treatment group, (M = 51.85, SD = 15.07), compared to the children in the waitlist group, (M = 53.15, SD = 17.45), $F(1,38) = .064$, $p = .802$ or in the type of children's NDRC diagnosis, $\chi^2 (3) = 1.83$, $p = .356$; or children's gender, $\chi^2 (1) = 2.84$, $p = .091$.

Preliminary analyses found no significant differences on any of the measures at pre intervention; PICCOLO: $F(1,38) = .057$, $p = .812$; PCRI Communication: $F = .000$, $p = .999$; PCRI Satisfaction: $F(1,38) = .029$, $p = .865$; PCRI Involvement: $F(1,38) = .080$, $p = .779$. Simply stated, before the intervention was administered the two groups were evenly matched on the scores of the tests and also on variables such as age of child, diagnosis, parental age and parental level of education.

The Quality of the Parent-Child Relationship

To examine the interaction between the intervention and time on the quality of the parent-child interaction a mixed Anova was conducted. The results of the test revealed statistically significant effect of time, $F(1,19) = 111.44$, $p = < .001$, indicating a significantly higher quality of parent-child interaction in the DIR/FT treatment group at post intervention when compared to the pre intervention time point, and a significant main effect for group, $F(1,38) = 26.98$, $p = < .001$, partial $\eta^2 = .415$. There was also a statistically significant interaction between time and group, $F(1,38) = 26.32$, $p = < .001$, partial $\eta^2 = .410$. All participants changed over time with the

participants in the DIR/FT treatment group showing significantly greater gains at post intervention than those participants in the wait list group.

TABLE 2 HERE

Parents' Perception of their Relationship

Upon examination the results of a MANOVA revealed no significant differences between the group on the combined dependent variables of the PCRI, Wilks' $\Lambda = .861$, $F(3,36) = 1.935$, $p = .141$, partial $\eta_p^2 = .139$. There was a large effect and a statistically significant effect of time, ($F(3,36) = 3.149$, $p = .037$, partial $\eta_p^2 = .208$), indicating that all parents' perception their relationship with their children increased from pretest to posttest. The test also revealed a significant effect of time by group, Wilks' $\Lambda = .735$, $F(3,36) = 4.339$, $p = .010$, partial $\eta_p^2 = .27$. Pairwise comparisons revealed a significant effect for communication and involvement, ($p = .007$ and $p = .003$ respectively), but not for the satisfaction domain.

These results revealed that the quality of the parent-child interaction increased significantly after the DIR/Floortime intervention compared to the group who did not receive DIR/Floortime. The parents' perception of their relationship with their child did not reach a level of significance when all domains of the PCRI were examined together. However, post hoc tests were conducted and revealed that when looked at individually, the parents' perception of the level of involvement they have in their child's life, and how they feel they can effectively communicate with their child significantly increased in the treatment group after the DIR/Floortime intervention when compared to the psycho-educational (waitlist group).

Discussion

Overall, this study provides evidence to support the implementation of psychotherapeutic interventions within social work practice with families. It can be said that any type of supportive parent intervention will have a positive impact on the parent-child relationship, however the results revealed that there was a significant difference and a high treatment effect, (see Table 1) indicating that the DIR intervention was particularly successful. In addition, the narratives of parents in the DIR group conveyed they felt more connected with their children after the intervention. A part of each session of the intervention was set-aside for the parent and clinician to watch a video recording of the parent-child interaction. During this time the clinician supported the parents' reflections on the interaction and it would appear that helped the parent to better read their child's cues and subsequently better understand and reflect on their behaviour. Disruptions in the reflective process within the attachment relationship can lead to a disordered sense of self and a distorted view of the world where the child develops internal schemas that reflect the self as unworthy and unlovable (Fonagy, Gergely & Target 2007). This can result in pathological adaptions that can derail development and disrupt healthy psychological functioning across the lifespan (Ainsworth, Blehar, Water, & Wall 1978; Bowlby 1969). Fonagy, Gergely and Target (2007) stated that when parents accurately reflect on their own and their child's mental states, particularly in early childhood, this nurtures the child's internal representations of the world and shapes the quality of the parent-child attachment relationship.

The parents' perception of the level of involvement and communication they have with their child increased significantly in the DIR intervention group. It is not surprising that parents in the DIR group felt more able to communicate with their child, as the nature of the DIR intervention is to strengthen engagement and two-way purposeful communication. It is also,

unsurprising that parents felt a higher level of involvement with their child, as the intervention required a commitment of two hours per week. Research suggests that higher levels of parental involvement results in positive outcomes in child development such as higher self-esteem (Amato & Afifi, 2006), decreased psychological stress levels of psychological distress (Fishman & Meyers, 2000), less externalizing behaviours (Nickerson & Nagle, 2004) and more securely attached children (Coyl-Shepherd and Newland 2013). The parents' perception of the level of satisfaction with the parent-child relationship increased but did not reach a level of significance. This was not a measure of the parents' satisfaction with the intervention, but rather an indication of their overall level of general satisfaction. With huge deficits in supportive services for families with children with developmental disabilities in Barbados it is reasonable to suggest that general life stressors may have impacted parents' perception of the satisfaction they are experiencing within the parent-child relationship and the nature and relatively short duration of the treatment intervention was unable to buffer this impact. Williams, Brown and Roopnarine (2006) suggested that the impact of poverty in the Caribbean region adversely affects the healthy development of parent-child relationships with fifteen to forty percent of Caribbean children living in conditions of poverty with poor social and educational services available to them. Barrow (2002) stated that in the Caribbean families exist in an "unsupportive social environment" where "there is no specific package of social policies to support families and households" (p. 196).

Conclusion

Whilst the literature on caregiver sensitivity and attachment reveals that there is cross-cultural variance in child-rearing environments the psychoanalytical literature on parent-infant psychotherapy provides overwhelming evidence that early adverse experiences can threaten an

infant's sense of safety and security. Baradon and Joyce (2005) stated that it is important to consider cultural practices when working with parents and children but it is also critical to be mindful of the infant's core developmental needs. Strengthening the parent-child interaction, by helping parents to accurately read their child's communicative intent and respond in a sensitive and contingent way, may mitigate the risk factors associated disruptions in the parent-child relationship.

The model utilized in the current study provides an effective and inexpensive intervention for social work practitioners to work with vulnerable and at-risk parent-child dyads and can be undertaken across disciplines in the areas of health, social care and education. Williams, Brown and Roopnarine (2006) stated, "Regrettably, much of the work on families and children in the Caribbean is loosely organized, with minimal discourse occurring across allied social science disciplines" (p.107). Social work practitioners globally are in the shadow of allied professionals, particularly the medical profession, when it comes to evidence based practice. According to Edmond, Megivern, Williams, Rochman, & Howard (2006), "Encouraging social work practitioners to rely on evidence to guide their practice is made difficult by the current paucity of scientific research underpinning many social work interventions" (p. 379). However, many universities are now integrating evidence-based practice into social work education curricula to prepare social work practitioners to play an integral part in shaping and delivering effective interventions. Heckman (2013) stated that a major shift is needed in social policy to promote early intervention programmes, particularly for disadvantaged populations, and further argued that, "The proper measure of disadvantage is not necessarily family poverty or parental education. The available evidence suggests that the quality of parenting is the important scarce resource" (p. 35). It is hoped that this paper inspires social worker practitioners to explore the

inner world of the parent-child to compliment interventions that address the macro level challenges facing parents of children with neurodevelopmental disabilities.

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Table 1 Parent Age, Level of Education and Occupation

Demographic Variable	N	%
Age of Parent		
18-30	7	17.5
31 - 43	23	57.5
Over 44	10	25.0
Total	40	100
Education Level Completed		
Primary	2	5.0
Secondary (high school)	18	45.0
College	7	17.5
University	13	32.5
Total	40	100
Occupation of Parent		
Housewife	5	12.5
Police Officer	1	2.5
Unemployed	9	22.5
Hairdresser	1	2.5
General Worker	5	12.5
Engineer	2	5.0
Mechanic	1	2.5
Nurse	1	2.5
Clerk/Administrative	4	10.0
Actuary	1	2.5
Banker	2	5.0
Veterinary Surgeon	1	2.5
Insurance Agent	2	5.0
Lecturer	2	5.0
Health/Spa worker	2	5.0
Marketing Executive	1	2.5
Total	40	100

Note: N = Number of participants, % = Percentage of parents.

Table 2 Estimated Means, Standard Error and confidence Intervals for Pre and Post Intervention Quality of Parent Interaction for the Treatment and Waitlist Groups.

Group	Time	M	SE	N	95% C.I.	
					LL	UL
Treatment	1	25.10	1.92	20	21.21	28.99
	2	47.50*	2.25	20	42.94	52.06
Waitlist	1	24.45	1.92	20	20.56	28.34
	2	30.95	2.25	20	26.39	35.51

Note: N = number of participants, M = Mean, SE = Standard Error, C.I. = Confidence Interval, LL = Lower Limit, UL = Upper Limit. Time 1 = pretest, Time 2 = posttest. Treatment = DIR/FT$^{(R)}$ Intervention Group, Waitlist Group = Psycho-educational. *p =< .001