# VOLUME I: RESEARCH COMPONENT

# SUPPORTING FAMILIES TO STAY TOGETHER

**by**

**BRADLEY JAMES CROOK**

A thesis submitted in partial fulfilment to the University of Birmingham for the degree of

Doctorate in Clinical Psychology

Department of Clinical Psychology

School of Psychology

University of Birmingham

May 2015

## Thesis Overview

This thesis, comprised of a research volume and a clinical volume, is submitted as partial fulfilment of a Doctorate in Clinical Psychology at the University of Birmingham.

### Volume I: Research Component

Volume I, the research component, consists of a systematic literature review and an empirical paper. The literature review explores the effectiveness of attachment-based interventions when used with families in which the parents have committed child abuse. Specifically, the effect of the interventions on i) parental sensitivity; ii) the security and organisation of parent-child attachment and; iii) occurrences of future abuse is investigated in order to address gaps in the current evidence base.

The empirical paper explores the way in which social workers draw upon their personal and professional experiences when observing a video of parents with intellectual disabilities. Parents with intellectual disabilities are over-represented in child protection proceedings. Previous research suggests that additional processes that occur as part of these proceedings contribute to this. It has also been shown that health and social care professionals are influenced by their personal beliefs and past experiences when conducting assessments. In this paper social workers are interviewed about past experiences which inform their observations of parents with intellectual disabilities. Foucauldian Discourse Analysis (FDA) is used to explore the common discourse patterns used during interviews.

### Volume II: Clinical Component

Volume II, the clinical component of the thesis, presents 5 clinical practice reports. The first presents the assessment and formulation of a 23 year old female with mild to moderate intellectual disabilities, referred to a community learning disabilities team for

disordered eating. A small scale service evaluation is presented in the second report, which investigated the barriers preventing service users and staff from engaging in research projects in a learning disability service. The third is a single-case experimental design, reporting on the effectiveness of a dialectical behavioural therapy (DBT) informed intervention at reducing self-harm in a 13 year old British-Sikh female, seen in a community child and adolescent mental health (CAMHS) setting. Fourth, is a case study of a 19 year old female, referred to an adult community mental health team for low mood and anxiety, and the use of cognitive behavioural therapy in assessing, formulating and treating her difficulties. The final report is an abstract outlining a presentation based on work completed in a paediatric psychology setting with a 15-year old male experiencing chronic pain, using Acceptance and Commitment Therapy.

**Acknowledgements**

Firstly, I would like to thank all of the social workers who participated in the research. I would also like to thank the Head of Service for all her support during the recruitment stage and for making me feel so welcome.

Secondly, I would like to thank my research supervisors Dr Biza Stenfert Kroese and Dr Michael Larkin, for all of their guidance, support and containment throughout the research. I would also like to thank Laura Ogi for her inspiration and support in the early stages of the research and during my foundation placement.

Thirdly, I offer thanks to the supervisors who supported and guided me through my clinical placements and the development of the clinical practice reports.

Finally, I would like to thank my family and friends for supporting me throughout my three years of clinical training and the period leading up to it. In particular, I would like to thank my wife for all of her love, patience and for listening to me talk endlessly about my research. I would also like to thank my daughter for her 'help' highlighting papers. I truly could not have done it without them both.

## TABLE OF CONTENTS

**VOLUME I: RESEARCH COMPONENT**

## LIST OF TABLES AND FIGURES FOR VOLUME I

### CHAPTER ONE

**CHAPTER TWO**

# TABLE OF CONTENTS

## VOLUME II: CLINICAL COMPONENT

**LIST OF TABLES AND FIGURES FOR VOLUME II**

**CLINICAL PRACTICE REPORT ONE**



**CLINICAL PRACTICE REPORT TWO**



**CLINICAL PRACTICE REPORT THREE**

**CLINICAL PRACTICE REPORT FOUR**

# CHAPTER ONE

# LITERATURE REVIEW:

# EXPLORING THE EFFECTIVENESS OF ATTACHMENT-BASED INTERVENTIONS WHEN USED WITH FAMILIES IN WHICH THE PARENTS HAVE COMMITTED CHILD ABUSE

**by**

**BRADLEY JAMES CROOK**

Department of Clinical Psychology

School of Psychology

University of Birmingham

May 2015

## Abstract

This systematic review explores the effectiveness of attachment-based interventions when used with families in which the parents have committed child abuse. Of particular interest was the effect attachment-based interventions have on i) parental sensitivity, ii) parent-child attachment security and organisation and iii) rates of future abuse.

A search of four electronic databases was completed, identifying a total of eleven papers. The five different attachment-based interventions used in the studies are presented and briefly summarised. The results suggest that attachment-based interventions are effective at decreasing insensitive, frightening parent behaviours and increasing sensitive behaviours and responsiveness to child cues. The interventions were also shown to enhance attachment security and reduce rates of disorganised attachment. Rate of future abuse was found to be lower in families where an attachment-based intervention had been received. Generally, attachment-based interventions had significantly greater positive effects than the control interventions offered. Control groups delivering psycho-education were shown to have positive short-term effects, however these were not maintained as successfully as attachment-based interventions.

The results of the review are discussed in the context of previous research in this field. The strengths and weaknesses of the review are considered and the implications of the findings are presented, in addition to suggestions for future research.



**Keywords**: *Attachment, Intervention, Abuse, Maltreatment, Families, Parent, Mother, Child*

# Introduction

## Child abuse

The abuse of children remains a prevalent and persistent problem in society. Definitions of child abuse vary, however for this review the definition used by the National Society for the Prevention of Cruelty to Children (NSPCC) is adopted. This states that child abuse can occur "directly by inflicting harm [on a child], or indirectly, by failing to act to prevent harm [of a child]" (Radford et al. 2011). Within this definition "abuse" is an umbrella term which covers different forms, such as physical abuse, sexual abuse, emotional bullying and neglect.

## The scope of the problem

The true prevalence of child abuse is challenging to ascertain as cases may remain undetected or unreported. In 2002 the worldwide child mortality rate, through abuse and neglect, was reported to be 31,000 by the World Health Organisation (WHO, 2006), with the mortality rates of younger children (0-4 years old) double that of older children (5-15 years old), highlighting the vulnerability of this younger group in particular. However, death occurs only in the most severe cases and the number of children suffering abuse is much greater, believed to be between 25-50% of the worldwide child population (WHO, 2006).

In the United States it was estimated 1.25 million children were abused or neglected between 2005 and 2006 (Sedlak et al., 2010) and it is reported that 40,571 children were victims of substantiated abuse between 2012 and 2013 in Australia (Australian Institute of Health and Welfare, 2014). In the United Kingdom, Cawson (2000) estimated that around 16% of children are abused with varying rates across different types of abuse and Gilbert et al (2008) estimated that 4-16% of UK children are victims of physical, 10% emotional abuse

and up to 15% from neglect, with many children suffering multiple forms of abuse simultaneously (Finkelhor, Ormrod & Turner, 2007). The number of children believed to be victims of abuse, or potential abuse who are under a child protection plan, reached 42,900 in 2012, a number that had steadily increased from 26,400 in 2006 (Department for Education, 2012).

**Consequences of child abuse**

Child abuse has significant, deleterious consequences both on an individual level and on a broader, social-economic level (Toth et al., 2013). Gelles and Perlman (2012) reported an estimated financial cost of $80 billion dollars in the US for that year, with $33 billion of the cost being considered a direct result of child abuse (child welfare service, law enforcement, judicial system, medical care and psychological care). Indirect costs account for the remainder of the sum including the provision of specialist/emergency housing, special education, future services required by the child, juvenile delinquency and reduced work productivity. In the UK the financial cost of child sexual abuse alone was estimated at £3.2 billion in 2012/2013 (Saied-Tessier, 2014).

The cost of child abuse on a societal level reflects the longitudinal personal costs it has on the child, as the developmental, physical and psychological consequences manifest over time (Widom, 2000). These effects are well documented and include, poor emotion regulation, behaviour problems, cognitive deficits and increased risk of psychological difficulties, self-harm, suicide, delinquency, disrupted education, substance misuse, severe relationship difficulties and adolescent pregnancies (Bernard et al., 2010; Saied-Tessier, 2014; Salzinger et al., 1993; Silverman, Reinherz & Giaconia, 1996; Springer et al., 2003; Widom, 2000). Although these are not the outcomes for all abused children, as factors such as details of the abuse (e.g. type, chronicity, perpetrator) and characteristic of the child (e.g. resilience,

positive influences) mediate the outcomes (Cicchetti et al, 1993; Trickett & McBride-Chang, 1995), child abuse has the potential to set some children and adolescents on a trajectory of life-long struggle. Furthermore, a longitudinal study by Pears and Capaldi (2001) showed parents who experienced abuse as a child were more likely to act abusively towards their own children, thus resulting in 'inter-generational abuse' (Heyman & Smith Slep, 2002) that continues over time.

**Services for abused children**

Historically the role of Child Welfare Services (CWS) in the UK, and equivalent services in countries such as the US, Canada and Australia, has been to assess risk to children and take action to protect the child where necessary. This may include temporary removal of children from their families and placing them in foster or residential care or, in extreme cases, when the child cannot return, permanent removal from their family via adoption. Sadly, these attempts to provide safety for the child, although well intentioned, can result in further abuse (Uliando & Mellor, 2012). Hobbs, Hobbs & Wynne (1999) conducted a retrospective study in which the medical notes of 158 children who were believed have been abused whilst in foster or residential care, were reviewed. All reports of alleged physical and/or sexual abuse reported by paediatricians in Leeds, England between 1990 and 1995 were reviewed and the type of abuse and supporting evidence assessed. Sufficient evidence including injuries consistent with physical and sexual abuse, behavioural changes, disclosures of abuse and witness accounts led to the authors concluding that 133 of the children (84%) had been subject to abuse whilst in foster or residential care.

Recently there has been a greater emphasis within CWS on providing interventions to manage risk and keep the child with the family, or if the child is placed out-of-home, working

towards reuniting families. Most interventions focus on improving community-based support that is accessible to the family in order to reduce pressure and increase contact with services, and teaching parents practical skills that help them to manage their own difficulties. Although the benefits of such interventions have been evidenced, interventions that address parent-child interactions and enhance the parent-child attachment relationship, offer greater short and medium term benefits to the child (Tarabulsy et al, 2008) and reduce risk.

**Attachment and abuse**

Attachment theory (Bowlby, 1982) holds that the primary care givers (parents) provide the child with a secure base that is characterised by warm, supportive and predicable interactions that are able to meet the child's needs, alleviate distress and provide physical, emotional and psychological nourishment (Bowlby, 1988). When provided consistently, the child develops adaptive internal working models of relationships, the capacity to organise and regulate emotions, and the belief they are competent and can cope in times of distress. Bowlby (1982) emphasised the importance of parents demonstrating sensitive, responsive interactions in the development of a secure attachment. The benefits of developing a secure attachment have been well documented and include effective emotional and behavioural regulation, fewer behavioural difficulties and rates of delinquency, increased academic success and adaptive peer relationships (Sroufe, 2005).

Ainsworth et al. (1978) identified three distinct classifications of attachment patterns; secure (Type B), insecure-avoidant (Type A) and insecure-ambivalent (Type C). Main and Solomon (1990) identified a fourth classification, disorganised attachment (Type D), which accounts for behaviours observed in children that do not adhere to the classifications proposed

by Ainsworth et al. (1978). The types of behaviour associated with each of these classifications can be seen in Table 1.

**Table 1**. Typical behaviours observed in parents and children in each of the attachment classifications identified by Ainsworth et al (1978) and Main & Solomon (1990).

| Attachment Classification | Parent Behaviour | Child Behaviour |
|---|---|---|
| Type A- insecure-avoidant | Insensitive to child's needs or unable to meet the needs of the child and expects an unrealistic level of autonomy from the child. | Avoids the parent, both physically and emotionally and attempts to explore and manage distress autonomously. |
| Type B- secure | Aware of child's needs and respond sensitively to them. Allows child to explore autonomously but consistently provides care when the child requires it. | Will alternate between autonomous exploration and dependency on care giver. |
| Type C- insecure-ambivalent | Inconsistent care-giving and responses to child's needs. Parent may or may not sense what the child requires or may respond to the child differently at different times, i.e. only responding to heightened emotion. | Frequently conflicts with parent and demonstrates heightened emotions to retain parent's attention. |
| Type D- disorganised | Inconsistently responds the child's needs in frightening or threatening ways or becomes overly dependent on the child. Parent responses increase child's distress rather than contain it. | Alternating between avoidant and ambivalent responses to the parent, appearing confused or disoriented in presence of parent. Can adopt care giving role towards parent. |

It has been shown that abused children are more frequently classified as having an insecure disorganised attachment to their parents than non-abused children (Barnett, Ganiban & Cicchetti, 1999). This is a concern as early disorganised attachment has been shown to be a predictor (Sroufe et al., 1999) for the development of behaviour and socio-emotional difficulties (Moss et al, 2005). In addition, disorganised attachment has been shown to remain stable over time and resistant to change, even if abuse ceases.

## Attachment-based interventions for abuse

Interventions reducing parental abusive behaviours, even if successful, are not sufficient to improve attachment security and difficulties associated with disorganised attachment may continue to manifest. A number of interventions address this by helping the caregiver to adopt more sensitive care-giving practices, which has been shown improve parent-child attachment (Bakermans-Kranenburg, van Ijzendoorn & Juffer, 2003).

Research suggests that abusive parents may have difficulties associated with insecure attachments with their own parents that are activated when they interact with their children (Cicchetti, Rogosch & Toth, 2006). Attachment-based interventions may enable mothers to reinterpret their own experiences of being parented which may be impeding their ability to effectively parent their child (Moss et al., 2012). This function of attachment-based therapy has been thought to play an important role in breaking cycles of inter-generational abuse often identified in families with abusive parents.

## Aims of this review

To date there have been a small number of reviews conducted that summarise the effect of attachment-based interventions on parental sensitivity (van IJzendoorn, Juffer & Duyvesteyn, 1995) and parent-child attachment (Bakermans-Kranenburg, van IJzendoorn & Juffer, 2003). Bakermans-Kranenburg, van IJzendoorn and Juffer's (2003) meta-analysis of 88 attachment-based interventions concluded that these interventions are effective at increasing parent sensitivity and, to a lesser extent, enhancing parent-child attachment. The studies included in the meta-analysis feature families considered to be at risk of developing insecure, disorganised attachments (e.g. families with low social economic status, pervasive health and psychological problems), however, studies featuring families in which parents have

abused their child are absent. Additional reviews (Moss et al, 2012; Tarabulsy et al., 2008; Toth et al, 2013) have adopted a narrative approach to reviewing the impact these interventions have on parent sensitivity, attachment security and abuse and have concluded that families in which parents have committed abuse can benefit from attachment-based interventions. However, a systematic review has not been conducted to date. In addition, previous reviews have not assessed the effect of attachment-based interventions on rates of future abuse.

The current study aims to systematically review the research that reports the effectiveness of attachment-based interventions for families in which the child has been abused by the parent. The specific aim of this systematic review is to assess the effect interventions have on:

1) The levels of sensitivity and responsiveness parents demonstrate towards their child;

2) The level of attachment security and organisation in the parent-child relationship and;

3) The occurrence of future abuse.

# Method

## Scoping Exercise

A search of the Cochrane database for systematic reviews, the Centre for Reviews and Dissemination and Google Scholar indicated that no systematic reviews summarising the effects of attachment-based interventions with families in which parents have committed child abuse have been previously conducted.

## Definitions

In order to complete this review the following definitions were used:

Abuse was defined as action taken by parents that had the potential to cause harm to a child. This definition included neglect and physical, psychological and sexual abuse.

Intervention was defined as professionals introducing parents to new knowledge and/or skills.

## Search strategy

The search for relevant papers was completed between 8th January and 28th March 2015. Four electronic databases were searched; Medline, PsychInfo, Embase and Social Policy and Practices. The search terms used were derived from the following areas: 1) attachment, 2) intervention, 3) abuse, 4) family. Component words (e.g. mother as a component of family) and synonyms (e.g. maltreatment as a synonym for abuse) relating to each of these broad categories were considered and utilised in the search. The specific search terms and combinations used can be found in Table 2.

**Table 2**. The search terms and combinations used to identify relevant papers.

| Broad Category | Attachment | Intervention | Abuse | Family |
|---|---|---|---|---|
| Search terms used | Attachment ^<br>OR<br>Relationship<br>OR<br>Bond<br>OR<br>Parenting<br>OR<br>Affection<br>OR<br>Care<br>OR<br>Closeness<br>OR<br>Interaction ^<br>OR<br>Sensitiv* | Intervention<br>OR<br>Support<br>OR<br>Help<br>OR<br>Aid<br>OR<br>Improve<br>OR<br>Train*<br>OR<br>Teach*<br>OR<br>Develop<br>OR<br>Home-based | Neglect ^<br>OR<br>Abus* ^<br>OR<br>Maltreat*<br>OR<br>Court<br>OR<br>"At-Risk" | Family ^<br>OR<br>Parent ^<br>OR<br>Mother*<br>OR<br>Father*<br>OR<br>Child* |

Notes: ^ indicates that the search terms were used as "key-words" in the search.
* indicates the use of truncation to identify words beginning with search term e.g. "Maltreat*" would return "Maltreated", "Maltreating" and "Maltreatment".

**Inclusion/exclusion criteria**

Studies were selected if the sample included families where a parent was believed to have abused a child. Families that were included solely on the basis of being in a 'high-risk group' (i.e. due to parental mental health problems, domestic abuse, substance abuse or social deprivation) were excluded. Samples containing a combination of high-risk groups and families with abusive histories were included. Papers had to describe interventions that focussed on developing parent-child relationships in order to; increase parental sensitivity, improve attachment security, reduce the probability of future abuse or a combination of these. It was necessary for the paper to report quantitative pre- and post-intervention data in order to be selected for this review. Papers that failed to meet these criteria were excluded from the study.

**Search findings**

The search terms identified 2094 papers. The keyword ‘attachment’ was used as a ‘filter’ to identify papers that were relevant, which excluded 1,543 papers, leaving 551 papers. Duplicated papers were removed from the results (n=110), leaving 441 papers. Additional filters were applied which removed non-English language papers with no translation (n=20), papers not featured in peer reviewed journals (n=116) and published prior to 1995 (n=27), as previous reviews indicated no relevant studies prior to this time. Following the application of these filters 278 papers remained. The title of each paper was scrutinised to assess appropriateness to the current study. Those with titles that did not appear relevant to this review were rejected (n=196) and relevantly titled papers were retained.

In total, 82 papers were identified as having relevant titles. The abstract of each paper was examined and inappropriate papers were rejected because: the sample population in the study did not contain parents who were believed to have abused a child (n=19), the study was not based on an intervention (n=15) or the intervention described did not focus on improving the parent-child relationship in the ways outlined above (n=8), the paper did not report any quantitative pre-post data (n=4), the paper was a review (n=18) or the paper was a duplicate (n=10). In total the abstract review allowed for 74 papers to be excluded from the study, leaving 8 relevant papers. The reference lists of each of the included papers and of three relevant review papers identified during the search were scrutinised and 3 additional relevant papers were found, resulting in 11 papers in total.

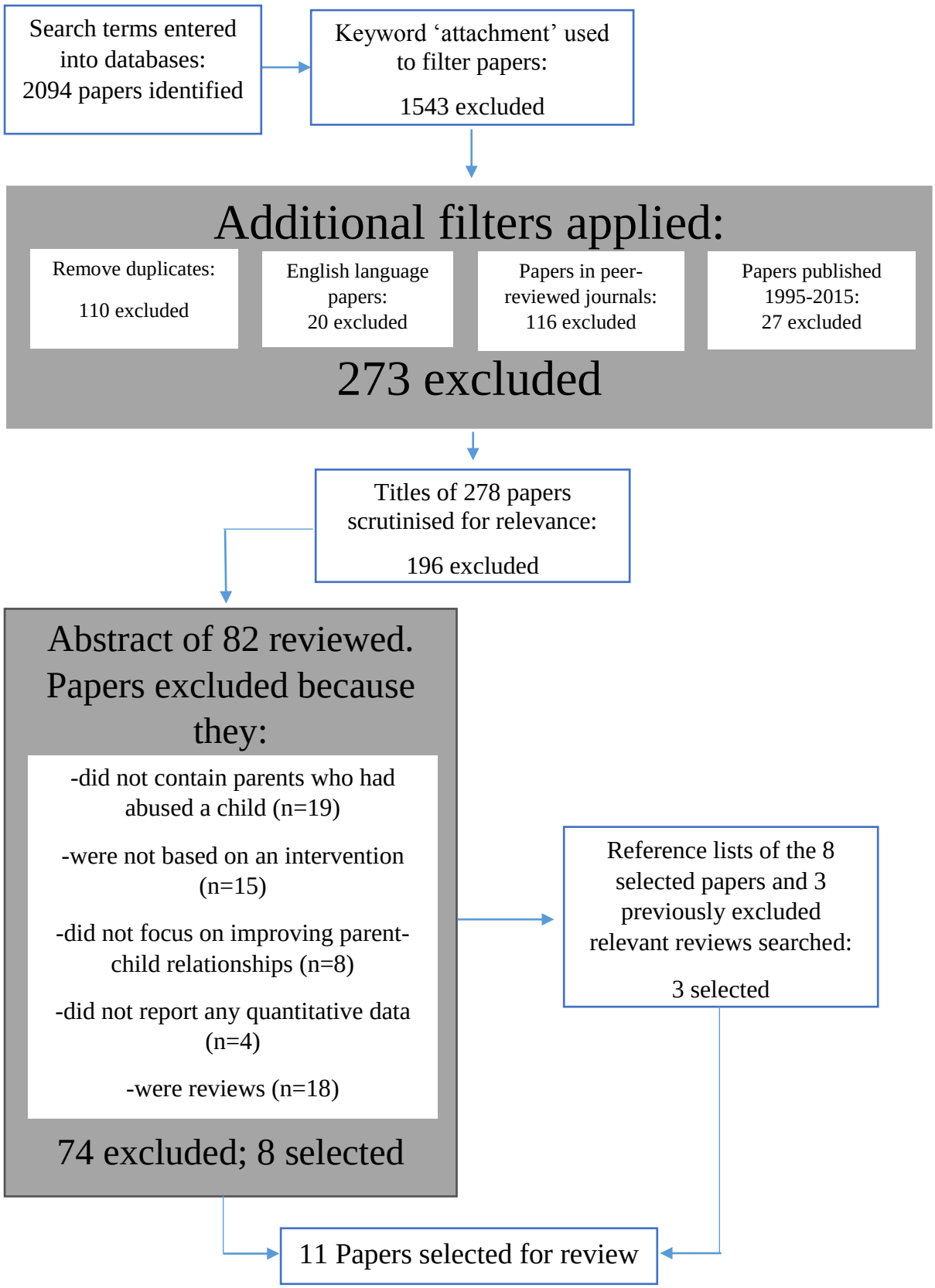



**Figure 1**: A flowchart illustrating the paper selection process.

## Data extraction

In order to extract relevant information from each paper a summary table (Appendix A) was created and populated. This allowed for a consistent approach when examining the papers, which reduced bias and allowed for easier identification of appropriate data.

## Quality assessment

In order to assess the quality of the evidence reviewed, each paper was subject to a quality assessment using the Quality Assessment Tool (QAT) (Appendix B) developed by the Effective Public Health Practice Project (EPHPP; 1998). This tool has demonstrated test-retest reliability and concurrent validity (Armijo-Olivio et al., 2012; Thomas et al., 2004). One advantage of the EPHPP Tool is that it provides quality ratings and comparisons for studies using different designs.

The QAT rates papers across eight 'sections'; 1) selection bias, 2) study design, 3) confounders, 4) blinding, 5) data collection, 6) withdrawals and dropout, 7) intervention integrity and 8) analysis. Sections 1-6 are assigned a rating of 'strong', 'moderate' or 'weak' based on how successfully they fulfil the specified criteria. The completion of each 'section' is guided by the QAT Reviewers Dictionary, which provides information to aid in the identification of the study designs and reduces bias when assessing their quality. Papers are assigned an overall quality rating. '*Strong*' papers are those with no '*weak*' sections, 'm*oderate*' papers have one '*weak*' section and '*weak*' papers have multiple '*weak*' sections. The quality scores obtained by each paper, and the sections considered to be '*strong*', '*moderate*' and '*weak*', can be seen in Table 3. A summary of the methodological strengths and weaknesses, according to the QAT, can be found in Appendix C.

**Table 3**. The 'sections' of each paper classified as strong, moderate and weak and overall quality of each paper, as measured by the QAT.

| Paper Number | Study Title | Author (s) & Date | Sections rated as 'strengths' | Sections rated as 'moderate' | Sections rated as 'weaknesses' | Overall rating |
|---|---|---|---|---|---|---|
| 1 | Accumulating evidence for parent-child interaction therapy in the prevention of child maltreatment | Thomas, R., & Zimmer-Gembeck, M. J. (2011) | • Study design (Controlled clinical trial)<br>• Data collection | | • Selection bias<br>• Confounders<br>• Blinding<br>• Withdrawals and drop-out | **WEAK** |
| 2 | Efficacy of a home-visiting intervention aimed at improving maternal sensitivity, child attachment, and behaviour outcomes for maltreated children: a randomised control trial | Moss, E., Dubois-Comtois, K., Cyr, C., Tarabulsy, G. M., St-Laurent, D., & Bernier, A. (2011) | • Study design (Randomised control trial)<br>• Confounders<br>• Data collection<br>• Withdrawals and drop-outs | • Sample bias<br>• Blinding | | **STRONG** |
| 3 | Enhancing attachment organisation among maltreated children: results of a randomised clinical trial | Bernard, K., Dozier, M., Bick, J., Lewis-Morrarty, E., Lindhiem, O., & Carlson, E. (2012) | • Study design (Controlled clinical trial)<br>• Confounders<br>• Data collection<br>• Withdrawals and drop-outs | • Sample bias<br>• Blinding | | **STRONG** |
| 4 | Fostering secure attachment in infants in maltreating families through preventative interventions | Cicchetti, D., Rogosch, F. A., & Toth, S. (2006) | • Study design (Controlled clinical trial)<br>• Confounders<br>• Data collection | • Selection bias<br>• Blinding | • Withdrawals and drop-outs | **MODERATE** |

| Paper Number | Study Title | Author (s) & Date | Sections rated as 'strengths' | Sections rated as 'moderate' | Sections rated as 'weaknesses' | Overall rating |
|---|---|---|---|---|---|---|
| 5 | Identifying therapeutic action in an attachment-centred intervention with high risk families | Steele, M., Murphy, A., & Steele, H. (2010) | • Data collection | | • Selection bias<br>• Study design (Cohort study & case study)<br>• Blinding<br>• Withdrawals and drop-outs | **WEAK** |
| 6 | Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports | Chaffin, M., Silovsky, J. F., Funderbunk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. L. (2004) | • Study design (Controlled clinical trial)<br>• Confounders.<br>• Data collection | • Blinding | • Selection bias<br>• Withdrawals and drop-outs | **WEAK** |
| 7 | Preventive interventions and sustained attachment security in maltreated children | Pickreign Stronach, E., Toth, S. L., Rogosch, F., & Cicchetti, D. (2013) | • Study design (Controlled clinical trial)<br>• Confounders<br>• Data collection | • Sample bias<br>• Blinding<br>• Withdrawals and drop-outs | | **STRONG** |
| 8 | The development and evaluation of the intervention model for the Florida infant mental health pilot program | Osofsky, J. D., Kronenberg, M., Hayes Hammer, J., Lederman, C., Katz, L., Adams, S., Graham, M., & Hogan, A. (2007) | | • Selection bias<br>• Study design (cohort study)<br>• Blinding<br>• Data collection | • Confounders (no comparison group)<br>• Withdrawals and drop-outs | **WEAK** |

| Paper Number | Study Title | Author (s) & Date | Sections rated as 'strengths' | Sections rated as 'moderate' | Sections rated as 'weaknesses' | Overall rating |
|---|---|---|---|---|---|---|
| 9 | The relative efficacy of two interventions in altering maltreated preschool children's representational models: implications for attachment theory | Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002) | • Study design (Controlled clinical trial)<br>• Confounders<br>• Data collection | • Selection bias<br>• Blinding<br>• Withdrawals and drop-outs | | **STRONG** |
| 10 | Using recidivism data to evaluate Project Safecare: teaching bonding, safety and healthcare skills to parents | Gershhater-Molko, R. M., Lutzker, J. R., & Wesch, D. (2002) | • Data collection | • Blinding | • Selection bias<br>• Study design (Cohort study)<br>• Confounders<br>• Withdrawals and drop-outs | **WEAK** |
| 11 | Video-feedback intervention with maltreating parents and their children: program implementation and case study | Moss, E., Tarabulsy, G., St-Georges, R., Dubois-Comtois, K., Cyr, C., Bernier, A., St-Laurent, D., Pascuzzo, K., & Lecompte, V. (2014) | | • Blinding<br>• Data collection<br>• Withdrawal and drop-out | • Selection bias<br>• Study design (case study)<br>• Confounders (no comparison group) | **WEAK** |

## Results

A brief description of the papers, their methodological characteristics and quality is presented, followed by a summary of the findings of the studies relevant to each research question (see page 8). Papers will be referred to in the text by the *paper number* they were assigned in Table 3.

### Description of included studies

Eight papers are based on studies completed in the USA, two originate from Canada and one from Australia. Seven studies are described as "randomised control trials" (RCTs). However, when the EPHPP QAT criteria for RCTs was applied only one (paper 2) was classified as a 'RCT'. As the remaining six studies (papers 1, 3, 4, 6, 7 and 9) failed to describe randomisation methods they were classified as "controlled clinical trials" (CCTs). This had no impact on the quality rating as both are considered "strong" designs. Two papers (8 and 10) were considered to be cohort studies, one paper (11) presented a case study and one paper (5) presented a cohort study and a case study.

Although eleven papers were included in the current review, of these two pairs were derived from the same studies. Paper 11 presents an in-depth description of the intervention provided in paper 2, along with a case study of one mother-child dyad the authors consider "typical" of the sample of their earlier paper. Paper 7 is a follow-up study conducted twelve months after the results in paper 4 were obtained. Therefore the papers included represent the findings of nine unique studies.

### Quality assessment ratings

As evident in Table 3, the quality of the papers is variable. Four papers (2, 3, 7 and 9) obtain a classification of 'strong' according to EPHPP QAT, one paper (4) is considered to be of 'moderate' quality and six studies (1, 5, 6, 8, 10 and 11) receive a 'weak' quality rating.

Common areas of weakness are ‘selection biases, ‘confounding variables’ and ‘participant withdrawal/drop-out’. In terms of selection bias, several papers do not report how the participants were recruited/selected (5, 10 and 11), and/or the number of individuals approached to participate given (1, 5 and 10). Due to these omissions it is not possible to ascertain how representative the sample is of the target population. Paper 6 does report on this, however only a minority (37%) of those approached took part in the study, making the sample unrepresentative. A couple of papers (1, 11) do not report whether any significant differences existed between intervention and control group and so it is unknown whether the results are affected by confounding variables. Most common weaknesses identified are either not reporting attrition rates and reasons (1, 6, 10), too many withdrawals from the study (1, 4, 6, 8) or both (1 and 6). High numbers withdrawing is common with this population and features in many studies on families in which parents commit child abuse (e.g. Kazdin, Holland & Crowley, 1997).

Despite weaknesses, all eleven studies are included as they fulfil the inclusion criteria and are thought to be relevant to the aims of this review. However, in light of their methodological weaknesses, it is important to exercise caution when interpreting the results of studies rated as ‘weak’ and remain mindful that findings may not be generalizable to the target population.

**Participant numbers**

As previously stated, the papers included in this review are based on nine studies. Table 4 (below) displays the number of participants (parents and children) recruited in each study, the number allocated into intervention and comparison groups, the number of participants who completed treatment and the number of participant withdrawals.

Eight studies (papers 1, 2, 3, 4, 5, 6, 8 and 9) recruited parent-child dyads. Paper 10 reports that 82 families received the interventions and, as no further information regarding the composition of these families is provided, it is not possible to report accurate participant numbers. However, it can be estimated that a minimum of one child and one parent were recruited for each family. Therefore it is possible that the minimum total number of participants across all studies is 2,099 comprised of 1,046 parents and 1053 children. The greater number of child participants is due to seven parents in paper 3 having two children included in the study. Therefore the sample consisted of 1039 parent-child dyads and 7 parent-child triads. As the triads are a very small minority the sample will be referred to as 1,046 parent-child dyads for brevity. The highest number of participants in one study is found in paper 1 (n=150) and the lowest in paper 5 (n=27).

A total of 890 parent-child dyads were allocated to intervention conditions. 10 dyads were excluded from paper 2 before being allocated to an intervention group. Papers 4 and 9 include comparison (NC) groups, comprised of non-abusive parents (n=95), and paper 1 allocated some abusive parents (N=51) to an "attention only wait-list" in order to provide a comparison. This group received intervention following an assessment at 12 weeks. Thirty-one of the 146 dyads in comparison and wait-list groups withdrew from the study prior to completion (21%). Interventions were completed by 662 of the parent-child dyads. From the data presented it was calculated that 201 dyads (22.6%) withdrew from intervention before completing. It is not possible to calculate how many of the 27 dyads completed or withdrew from the study presented in paper 5 due to unclear reporting, therefore these numbers have been omitted.

**Table 4**. Participant numbers reported in each of the studies.

| Study number | Number of parents at outset | Number of children at outset | Number of dyads excluded prior to group allocation | Number of parent-child dyads allocated to intervention groups | Number of dyads allocated to normal comparison or wait-list groups | Number of dyads that completed intervention | Number of dyads that withdrew before completing intervention | Number of dyads that withdrew from normal comparison and wait-list groups | Number of dyads that cannot be classified as completers or non-completers |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 150 | 150 | 0 | 99 | 51 | 42 | 57 | 15 | 0 |
| 2 | 89 | 89 | 10 | 79 | n/a | 67 | 12 | n/a | 0 |
| 3 | 113 | 120 | 0 | 113 | n/a | 113 | 0 | n/a | 0 |
| 4 | 189 | 189 | 0 | 137 | 52 | 104 | 33 | 8 | 0 |
| 5 | 27 | 27 | 0 | 27 | n/a | | | n/a | 27 |
| 6 | 112 | 112 | 0 | 112 | n/a | 110 | 2 | n/a | 0 |
| 7* | | | | | | | | | |
| 8 | 129 | 129 | 0 | 129 | n/a | 57 | 72 | n/a | 0 |
| 9 | 155 | 155 | 0 | 112 | 43 | 87 | 25 | 8 | 0 |
| 10^ | 82 | 82 | 0 | 82 | n/a | 82 | 0 | 0 | 0 |
| 11* | | | | | | | | | |
| Total | 1046 | 1053 | 10 | 890 | 146 | 662 | 201 | 31 | 27 |

Notes: *Data is not presented for paper 7 and paper 11 as these were based on the same sample recruited in papers 4 and 2
^ Data presented for paper 10 is a minimum possible number as paper described “families” in sample, not dyads

**Parent demographic data**

The degree to which parent participants' demographic information is reported varies between studies, however reported data can be found in Appendix D.

The youngest parent was 14 (paper 8) and the oldest 49 years old (paper 2). The mean age of parents ranged between 24.3 years (paper 8) to 33.5 years (paper 1) with the mean age of parents across the total sample, calculated from data reported in papers 1-6 and paper 8, was 28.8 years old. Five studies (papers 1, 4, 5, 8 and 9) used an all-female parent sample and male parent participants are only reported in two papers (3 and 6). Thus, female participants constitute 95% of the sample. Papers 2 and 10 may have had male participants included in the sample as they refer to "parents" and "families" and not "mothers", however the number of male participants in these studies is not reported. Data on ethnicity is reported in five papers (3, 4, 5, 6 and 8), with black and minority ethnic (BME) groups comprising 73.2% of the combined number of participants across these studies. Only papers 2, 4, 6, 8 and 9 report parents' marital status and these figures show that 63.21% of their combined samples were single. Finally, in terms of education, 45.1% of the combined samples of papers 2, 3, 6 and 8 had not completed secondary education.

**Child demographic data**

Few data regarding the child sample is reported (see Appendix E). The youngest child was 1 month old (paper 8) and the eldest child, in paper 1, was 5.7 years old. The mean age of the child sample, calculated from ages reported in papers 1-4, 8 and 9, was 38 months (3.2 years). The majority of studies (n=6) report child gender and therefore it can be calculated that the total sample of these studies (n= 785) is comprised of 448 boys (57%) and 337 girls (43%). Only three papers (3, 5 and 8) report child ethnicity. The samples were described as "diverse" in all three papers, with ethnic minority groups comprising 67.4% of the total sample of these papers.

**Recruitment**

The studies recruited via referrals into clinical services. The source of referral is stated for 997 of the 1,046 parent-child included in all studies. A total of 798 dyads (80.04%) were referred by child welfare or child protection services, 60 (6.02%) were referred by health services, 42 (4.21%) were recruited via referrals made by community services, 75 (7.52%) dyads were referred via the judicial system and 22 (2.21%) dyads were self-referred. It is unclear who referred the 27 participating dyads in paper 5 and 22 participants initially included in paper 2 withdrew from the study prior to these data being obtained.

**Abuse prevalence**

Three papers (2, 6 and 9) clearly report the number of children subjected to various types of abuse. The children in these papers (n=266) were victims of physical abuse (45.4%), neglect (24.8%), sexual abuse (0.8%), emotional abuse (4.5%) or a combination of these; physical/emotional/sexual abuse and neglect (0.4%), sexual/emotional abuse and neglect (0.4%), physical/emotional abuse and neglect (6.0%), physical abuse and neglect (5.6%), physical/emotional abuse (3.4%), emotional abuse and neglect (7.9%), sexual abuse and neglect (0.8%).

Across all studies, physical abuse and neglect were the most common reasons cited for referral. Emotional abuse is less commonly cited and very few papers include children who experienced sexual abuse, as this was grounds for exclusion in several studies. This may also be due to children who have been sexually abused being less likely to remain under the care of their parents or be returned to them following intervention.

## Study aims

Broadly speaking, the studies aim to demonstrate the effectiveness of attachment based-interventions at reducing child abuse in families. The aims and hypotheses of each paper, relevant to the aims of this review, can be found in Tables 6-8, below.

## Attachment-based interventions used

A total of five different attachment-based interventions were used across the papers; Parent-Child Interaction Therapy (PCIT), Attachment and Bio-behavioral Catch-up (ABC), Child-Parent Psychotherapy (CPP) (also referred to as Infant-Parent Psychotherapy (IPP) (paper 4) and Pre-schooler-Parent Psychotherapy (PPP) (paper 9) in the literature), SafeCare and a Video-Feedback Intervention Programme (VFIP). Some were adapted in order to meet the needs of the sample. A summary of each intervention can be seen in Table. 5 and additional information can be found in Appendix F.

**Table 5**. Summary of the attachment-based interventions delivered.

| Name of intervention | Used in paper(s) | Features of standard intervention | Deviation from standard intervention in studies |
|---|---|---|---|
| Child-Parent Psychotherapy (CPP) | 4, 5, 7, 8, 9 | • Home-based, manualised intervention<br>• Weekly sessions for one year<br>• Therapist provides feedback on parent-child interactions<br>• Aims to repair mother's maladaptive representations developed by her own experiences of being parented. | • Paper 9 completed majority of interventions in a clinic setting<br>• Paper 8 used additional approach, “speaking for baby” (Carter, Osofsky & Hann, 1997).<br>• Paper 5 delivered CPP as part of a group intervention. |

| Name of intervention | Used in paper(s) | Features of standard intervention | Deviation from standard intervention in studies |
|---|---|---|---|
| Parent-Child Interaction Therapy (PCIT) | 1, 6 | • Home-based intervention<br>• Aims to coach parents to effectively use non-coercive behavioural management strategies in response to 'difficult' child behaviour<br>• Consists of 2 phases lasting 7-10 sessions each; Child Directed Interaction (CDI) and Parent Directed Interaction (PDI), each preceded by a single one hour teaching session | • Paper 1 used *standard PCIT*, which requires parents to demonstrate mastery of skills learned in each phase before completing it (Hembree-Kigin &McNeil, 1995).<br>• Paper 6 delivered a PCIT intervention and an enhanced PCIT (EPCIT) intervention, which supported additional needs (e.g. depression, family violence and substance abuse).<br>• Paper 6 also included a six session orientation group, designed to increase parent motivation, delivered before PCIT and EPCIT interventions. |
| Attachment and Bio-behavioral Catch-up (ABC) | 3 | • Home-based intervention, manualised<br>• Aims to increase sensitive caregiving and reduce frightening parent behaviour through parent coaching<br>• Video feedback is used to reinforce times of positive interaction<br>• 10 Sessions delivered in total | |

| Name of intervention | Used in paper(s) | Features of standard intervention | Deviation from standard intervention in studies |
|---|---|---|---|
| SafeCare | 10 | • Aims to improve parent knowledge and skills in three main modules; child health care, parent-child interactions and home safety.<br>• Each module includes an assessment session, four to five training sessions to develop existing skills and teach new skills and a final assessment session.<br>• Parent-Child Interaction module teaches parents to communicate clearly with their child, provide positive feedback, offer choices, ignore minor misbehaviours and provide rewards and consequences | |
| Video-Feedback Intervention Programme (VFIP) | 2, 11 | • Home-based, manualised intervention<br>• Aims to increase parental sensitivity and consistent responses to child's emotional and behavioural signals, using video feedback<br>• Consists of 8 sessions<br>• Each session begins with 20 minute discussion, followed by 10-15 minute parent-child task which is video recorded. Video then played back to parents with emphasis on positive interactions. Final 15 minutes used to review progress/plan 'homework'. | |

## Measures used

The studies employed a wide variety of measures in order to assess the effectiveness of the interventions delivered. The majority of measures relevant to this review are either self-report measures completed by the parents or observations, completed by researchers. Papers 1, 6, 8 and 10 reviewed child protection case notes and child welfare databases to identify the reoccurrence of abuse. It is worth noting that nearly all papers report good levels of reliability and most measures are widely used, with established validity. A brief description of each measure relevant to the current review, how they were used in the studies and any reported reliability and validity data can be found in Appendix G.

## Control group interventions

Given the high level of risk present in the sample, it is unethical to withhold treatment in order to establish control groups. The majority of studies that include a control group (3, 4, 5, 6, 7, 8, 9 and 10) provided psycho-education to the family and risk was monitored. It is not clear what intervention the control groups received in papers 2 and 11, and no control group was used in paper 5. The control group in paper 1 was a "wait-list" group who were contacted on a weekly basis in order to monitor risk. Four of the papers (4, 6, 7 and 9) describe the use of "community standard" (CS) interventions being delivered to control groups, however these varied considerably.

## The effectiveness of attachment-based interventions

The aim of this review is to evaluate the effectiveness of interventions at improving i) parental sensitivity, attitudes and behaviours, ii) organisation and security of the child-parent attachment and, iii) child safety by reducing the future abuse. The results from the studies, relevant to each of these aims, are summarised below.

**Improving parental sensitivity, attitudes and behaviours**

A total of 6 papers (1, 2, 4, 6, 8 and 11) measured the effectiveness of attachment-based interventions at enhancing parent sensitivity as demonstrated by changes in their attitudes towards their children or the way in which they interacted with them. The findings of each paper can be found in Table 6.

The papers report that, at baseline, abusive parents interacted with their children insensitively with low rates of positive verbalisations, high rates of negative verbalisations, less responsiveness to their children and have different attitudes regarding their children.

There is evidence that attachment-based interventions had a positive effect on parent sensitivity, demonstrated through the use of observational measures (all papers) and self-report measures (papers 4 and 6). Papers 1, 2, 6, 8 and 11 report increases in parent sensitivity following intervention, with a reduction in negative verbalisations and vocalisations and an increase in positive behaviours, responsiveness and the use of positive discipline. Paper 6 reports that PCIT and EPCIT were more successful at reducing negative behaviours than the CS intervention. However, positive parent behaviours were high at post-intervention, regardless of intervention received.

Parent stress, as measured by the Parent Stress Index (PSI; Abidin, 1990) was thought to reflect parent attitudes towards their children, particularly the "child" domain, in which parents rate their stress caused by their children. Parent stress was measured at baseline in paper 4 and at baseline and post-intervention in paper 1. In paper 4 univariate contrasts revealed that parents who had abused their children scored significantly higher on the PSI at baseline than those that had not. In both papers parent stress was shown to be high at baseline, with 78.5% of the sample of paper 1 indicating clinical levels of stress in the "parent" domain of the PSI and 65.5% in the "child" domain. Those in the PCIT group in

paper 1 showed a greater reduction in PSI score than those in the control group. Paper 4 found that parents stress was not a mediator of intervention efficacy during post-intervention analyses.

**Table 6**. A summary of results demonstrating the effectiveness of attachment-based interventions on improving parent sensitivity, attitudes and behaviour.

| Paper number | Study aims/hypotheses relevant to this area of interest | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 1 | Aim: To demonstrate whether standard PCIT increased sensitivity of mothers who had abused, or were considered to be at high risk of abusing, their children. | Standard PCIT | •Parent Stress Index (PSI; Abidin, 1990)<br>•Emotional Availability Scales (EA; Biringen, Robinson, & Emde, 2000)<br>•The Dyadic Parent-Child Interaction Coding System-Third Edition (DPICS-III; Eyberg et al., 2004) | Following 12 weeks of intervention the PCIT group had a greater decrease in parental stress than control in parent ($p=.029$) and child ($p=.021$) domains. Those that completed PCIT had significant decrease in parental stress in both domains ($p<.001$).<br><br>At 12 weeks the PCIT group demonstrated improved praise ($p<.001$), descriptions and reflections ($p<.001$) and reduced questions ($p<.001$) and commands ($p<.001$) compared to the 'wait-list' group.<br><br>No difference seen between groups in overall sensitivity at 12 weeks. However, those that completed PCIT showed significant increase in positive sensitivity scores ($p<.001$) when compared to baseline. Improvements were maintained at a one month follow-up. | WEAK |

| Paper number | Study aims/hypotheses relevant to this area of interest | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 2 | Aim: To demonstrate the efficacy of an attachment-based video-feedback intervention program.<br><br>Hypothesis: The intervention group will show increased parental sensitivity at post-intervention assessment. | VFIP | •Maternal Behaviour Q-Set (MBQS; Pederson & Moran, 1995) | At baseline no differences in parental sensitivity observed between intervention and control group.<br><br>Parents in the intervention group demonstrated increased sensitivity following intervention when compared to the control group ($p<.05$). | STRONG |
| 4 | Aim: To test the effectiveness of CPP and Parent Psychoeducation Intervention (PP)I when compared to the community standard intervention and non-abused comparison group.<br><br>Hypothesis: Mothers in the abusive group would be subject to a greater number of factors associated with insecure mother-child attachment (including insensitive behaviour and stress) | CPP | •Maternal Behaviour Q-Set (MBQS; Pederson & Moran, 1995)<br>•Adult-Adolescent Parenting Inventory (AAPI; Bavolek, 1984)<br>•Parent Stress Index (PSI; Abidin, 1990) | Abusive mothers were shown be significantly less sensitive to their child than non-abusive mothers at baseline ($p=.001$) and they had higher expectations of the child ($p<.01$), less empathy ($p<.05$) and greater acceptance of physical punishment ($p<.05$).<br><br>Abusive mothers were shown to have higher levels of stress than non-abusive mothers.<br><br>Sensitivity post-intervention was not measured however, neither parent sensitivity nor parents stress were found to be mediators of intervention efficacy. | MODERATE |

| Paper number | Study aims/hypotheses relevant to this area of interest | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 6 | Aim: Investigate whether PCIT is more effective at reducing the reoccurrence of physical abuse in families in the child welfare system than standard group-based interventions.<br><br>Hypotheses: i) Changes in parent-child interaction would mediate intervention benefits; ii) enhanced PCIT would be more effective than standard PCIT. | PCIT & EPCIT | •Child Abuse Potential Inventory (CAP; Milner 1986)<br>•The Dyadic Parent-Child Interaction Coding System-Second Edition (DPICS-II; Eyberg et al., 1994)<br>•Beck Depression Inventory (BDI; Beck, Steer & Garbin, 1988)<br>•Behaviour Assessment System for Children (BASC; Reynolds & Kamphaus, 1992) | Parents in the EPCIT and PCIT groups showed a significant reduction in negative behaviours over time and when compared to the community standard intervention (both $p<.05$).<br><br>At post-intervention parent positive behaviours were high across all three intervention groups, with no significant difference found between groups.<br><br>Scores on CAP rigidity scale and BASC externalising behaviour scale decreased but no significant differences between groups was observed. | WEAK |
| 8 | Aim: To reduce the occurrences of abuse and neglect using the intervention. | CPP | •Modified Parent-Child Relationship Assessment (MP-CRA, Crowell & Fleishman, 1993) | Following CPP parents showed increased positive discipline ($p<.01$) and decreased intrusiveness ($p<.01$) compared to baseline.<br><br>Post-intervention, parents showed increased behavioural and emotional responsiveness ($p<.01$), to their children, especially when reuniting with them after a brief separation. | WEAK |

| Paper number | Study aims/hypotheses relevant to this area of interest | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 11 | Aim: To present an in-depth description of the video-feedback intervention used and the impact it had on the dyad in the case study. | VFIP | •Maternal Behaviour Q-Set (MBQS; Pederson & Moran, 1995) | The sensitivity of the mother in the case study significantly increased from 0.04 (dysfunctional level) at baseline to 0.55 (normal level) post-intervention. | WEAK |

Key:
Standard PCIT= Standard Parent-Child Interaction Therapy; VFIP= Video-Feedback Intervention Programme; CPP= Child-Parent Psychotherapy; PCIT= Parent-Child Interaction Therapy; EPCIT= Enhanced Parent-Child Interaction Therapy

**Improving attachment organisation and security in children**

Six studies (2, 3, 4, 5, 7 and 11) directly measured changes in attachment classification in the children as an outcome of attachment-based interventions. All of these papers used the Strange Situation Procedure (Ainsworth, 1978) in order to classify attachment style in children between the ages of 12-24 months and papers 2, 7 and 11 also used the Preschool Separation-Reunion Procedure (PS-RP; Cassidy, Marvin & the MacArthur Working Group on Attachment, 1992) to classify older children. Paper 9 measured changes in the child's internal representations of themselves, their mothers and the mother-child relationship as an outcome of the interventions. Detailed findings of each paper can be found in Table 7.

It was commonly found that, at baseline, abused children differed significantly from non-abused children in attachment security and organisation. However, paper 4 reports levels of secure attachment were still relatively low (32.7%) in the NC sample, when compared to the general population. The majority of the abused child sample in paper 4 was classified as disorganised in attachment style across the three intervention groups (CPP= 87.5%, Parent Psycho-educational Intervention; PPI= 83.83% and CS= 92.6%) at baseline. Disorganised attachment is also the dominant classification of insecurely attached children in paper 2 (68.6% at baseline). In paper 3, 75.7% of the insecurely attached children are classified as disorganised.

Generally, the attachment-based interventions improve attachment security and organisation. Paper 1 and Paper 3 report that the attachment–based interventions were more successful than controls at reducing disorganised attachment and improving attachment security and paper 5 reports "higher than expected" levels of attachment security following intervention. However, as the Strange Situation Procedure is not validated for children over

24 months old, paper 3 reports results with children older than 24 months omitted. In this study rates of disorganised attachments between the two groups remains significant with a medium effect size, however, no significant difference in rates of secure attachment is reported over time.

Papers comparing attachment classification pre- and post-intervention (papers 2 and 4) report improved attachment security and organisation over time. Paper 4 reports that the psychoeducational group produced similar effect as CPP, however the follow-up study (paper 7) reports that at 12-month follow-up these changes were only maintained in the CPP.

Paper 9 reports significant changes in internal representations in all intervention conditions. However, the greatest changes in representations were seen in the CPP group, and this was the only group to show a decrease in negative self-representations over time and in comparison to the other three groups CPP groups.

**Table 7**. A summary of results demonstrating the effectiveness of attachment-based interventions at improving attachment organisation and security in children.

| Paper Number | Study aims/hypotheses relevant to this area of interest | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 2 | Aim: To demonstrate the efficacy of an attachment-based video-feedback intervention program.<br><br>Hypothesis: The intervention group would show higher rates of secure attachment and decreased rates of disorganised attachment following intervention, than the control group. | VPIF | •The Strange Situation Procedure (Ainsworth et al., 1978)<br>• The Preschool Separation-Reunion Procedure (PS-RP; Cassidy, Marvin & the MacArthur Working Group on Attachment, 1992) | A greater proportion of children in the VPIF group developed secure attachments (42.9%) compared to the control group (15.6%) ($p<.05$).<br><br>A greater proportion of children (37.1%) moved from disorganised to organised attachment style in the VFIP intervention group than the control group (15.6%) ($p<.05$).<br><br>One child in the VFIP group became disorganised, compared to seven in the control group | Strong |
| 3 | Aim: To test the efficacy of the ABC intervention.<br><br>Hypothesis: Children and parents who received ABC would be more likely to develop organised attachment than the control group. | ABC | The Strange Situation Procedure (Ainsworth et al., 1978) | Following intervention significantly fewer children in the ABC group were classified as having disorganised attachment ($p<.01$) and more were classified as secure ($p<.05$).<br><br>ABC had a medium effect size on attachment organisation (Cohen's | STRONG |

| Paper Number | Study aims/hypotheses relevant to this area of interest | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| | | | | d=0.52) and security (Cohen's d=0.38). | |
| 4 | Aim: To test the effectiveness of CPP and PPI when compared to the CS intervention and NC group<br><br>Hypotheses: i) The rate of insecure attachment would be greater in abused group at 12 months old; ii) disorganised attachment would predominate the abused group; iii) higher rates of change would be seen in the active intervention groups; iv) secure attachment would be higher in CPP and PPI groups following intervention; vi) rates of stable attachment would be higher in CS and NC groups with insecure | CPP | •The Strange Situation Procedure (Ainsworth et al., 1978)<br>•Schneider-Rosen et al. (1985) coding system | At baseline no difference in attachment security were found between CPP, PPI CS group. The NC sample had lower insecure and disorganised attachment (p<.001).<br><br>Rates of secure attachments increased in CPP group (from 3.1% to 60.7%) and PPI group (from 0% to 54.5%), both significant increases from baseline (p<.001). No improvement was seen in the CS group.<br><br>Rates of disorganised attachments was significantly higher in CS group (77.8%) than the other three groups post intervention (p<.001), with decreases occurring in the CPP group (from 87.5% to 32.1%) and PPI group (from 83.3% to 45.5%).<br><br>CPP and PPI were significantly more effective at moving children | MODERATE |

| Paper Number | Study aims/hypotheses relevant to this area of interest | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| | being the dominant classification in the CS group. | | | from insecure to secure attachment than the CS intervention ($p<.005$), but did not significantly differ from each other. | |

| Paper Number | Study aims/hypotheses relevant to this area of interest | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 5 | Aim: To demonstrate the efficacy of Attachment-Centred Parent-Child Therapy Service when used with "high-risk" families.<br><br>Hypothesis: Children would show greater security and organisation in terms of attachment style. | CPP | The Strange Situation Procedure (Ainsworth et al., 1978) | Following 6-12 months of intervention 56% (n=7) of abused children were securely attached, higher proportions than would be expected for this population. 83% (n=5) of children classed as disorganised received forced alternative classification of "securely attached".<br><br>The child presented in the case study showed increased organisation in attachment style. | WEAK |

| Paper Number | Study aims/hypotheses relevant to this area of interest | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 7 | Aim: To investigate whether improvements observed in earlier study by Cicchetti et al. (2006) were maintained at 12 months later.<br><br>Hypotheses: i) Abused children receiving CPP or PPI would have higher rates of secure attachment 1 year post intervention when compared to children who received CS intervention. | CPP | •The Preschool Separation-Reunion Procedure (PS-RP; Cassidy, Marvin & the MacArthur Working Group on Attachment, 1992)<br>•The Strange Situation Procedure (Ainsworth et al., 1978)<br>•Schneider-Rosen et al. (1985) coding system | At 12 month follow up the CPP group had higher rates of secure attachment ($p<.001$) and lower rates of disorganised attachment ($p<.05$) compared to the CS group.<br><br>The CPP group were more likely to be classed as having secure attachments ($p=.02$) and less likely to be classed as having disorganised attachments ($p=.02$) at follow-up, than children who received the PPI intervention<br><br>No differences in disorganised attachment were seen between PPI and CS groups at follow up. | STRONG |

| Paper Number | Study aims/hypotheses relevant to this area of interest | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 9 | Aim: To demonstrate the effectiveness of CPP and PPI interventions at altering abused children's representation models when compare to each other CS intervention.<br><br>Hypotheses: i) children in CPP group would show greatest change in representation of self, self in relation to other and expectation of relationship compared to those in the CS intervention group at post intervention; ii) Children in CPP groups would show increased positive and reduced negative representations of self, mother and mother-child relationship and these levels would reach levels found in the NC group; iii) the PPI group would improve, but not to the same extent as the CPP group. | CPP | The MacArthur Story Stem Battery (MSSB; Bretherton et al., 1990); the Attachment Story Completion Task (ASCT; Bretherton, Ridgeway & Cassidy, 1990); the MacArthur Narrative Coding Manual- Rochester Revision (MNCMM-RR; Robinson et al., 1996) & the Global Relationship Expectations Scale (Bickham and Friese, 1999) | At baseline no difference in internal representation between abused and non-abused children was observed.<br><br>In all conditions adaptive maternal representation scores increased following intervention (<.001) and maladaptive maternal representations decreased over time (<.001).<br><br>In all conditions positive self-representations increased (<.001). Negative self-representations remained stable.<br><br>Mother-child relationship representations scores increased in all conditions over time (<.001) but CPP showed greater increase than other groups. (p<.001).<br><br>A highly significant decrease was seen in maladaptive maternal representation in CPP intervention group, whereas only a marginal decrease was observed in PPI group (p<.079). No change over time observed in NC and CS intervention groups.<br><br>CPP was the only intervention that significantly decreased children's negative self-representation over time (p<.001) | STRONG |

| Paper Number | Study aims/hypotheses relevant to this area of interest | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 11 | To present an in-depth description of the video-feedback intervention used and the impact it had on the dyad in the case study. | VPIF | •The Strange Situation Procedure (Ainsworth et al., 1978)<br>• The Preschool Separation-Reunion Procedure (PS-RP; Cassidy, Marvin & the MacArthur Working Group on Attachment, 1992) | The child's attachment style moved from "insecure-avoidant" at baseline to "secure" post-intervention.<br><br>Following intervention the child's score on the disorganised scale had reduced from 4 (atypical behaviours when caregiver present) to zero. | WEAK |

Key:
VFIP= Video-Feedback Intervention Programme; ABC= Attachment and Bio-behavioural Catch-up; CPP= Child-Parent Psychotherapy

**Reducing future abuse**

The reduction of future child abuse was the desired long-term outcome for all of the papers included in this review, however only four papers (1, 6, 8 and 10) directly measured this. Detailed findings of each study are stated in Table 8.

All papers used official reports by statutory government services (i.e. child protection services) in order to ascertain if parents had been reported for abuse of their children, post-intervention. Papers 1 and 6 also used a self-report questionnaire, the CAP, to demonstrate changes in parents' potential to perpetrate abuse following an intervention.

Generally, parents who received attachment-based interventions were the subjects of fewer future reports of abuse than control groups, and showed a greater decrease in abuse potential and abusive behaviours over time. Paper 6 reports that PCIT had a significantly greater length of treatment survival than CS intervention. Although no difference was seen between intervention groups at 12 weeks in paper 1, parents who completed PCIT were shown to be significantly less likely than non-completers to be suspected of future abuse.

A "major" reduction in reports of child abuse and neglect to Department of Children and Families was reported by paper 8. This contradicts the findings of paper 6, that none of the intervention groups had a significant effect on reducing future reports of neglect. However, paper 10 was shown to be the stronger study in terms of methodological quality and the findings should therefore be considered more valid.

**Table 8**. A summary of results demonstrating the effectiveness of attachment-based interventions at reducing future abuse.

| Paper Number | Study aims/hypotheses | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 1 | Aim: To investigate whether PCIT effectively reduced future reports of suspected abuse following intervention. | Standard PCIT | •Notifications received from Child Protection Services.<br>•Child Abuse Potential Inventory (CAP; Milner 1986) | At baseline 50.3% of parents in the sample scored above the signalling detection score for 'high probability' of committing child abuse.<br><br>Following 12 weeks of intervention, no differences in child abuse potential were observed between intervention and control groups.<br><br>After completing the intervention there was a significant reduction in child abuse potential, as measured by the CAP, in the PCIT group ($p<.001$), when compared to baseline assessment.<br><br>Parents who completed PCIT treatment were significantly less likely to be suspected of future abuse than non-completers ($p<.01$). 17% of completers were reported for abuse compared to 43% of non-completers.<br><br>Parents who were unknown to child protection prior to the study showed a greater reduction in child abuse potential and greater increase in sensitivity. | WEAK |

| Paper Number | Study aims/hypotheses | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 6 | Aim: To investigate whether PCIT is more effective at reducing the reoccurrence of physical abuse in families in the child welfare system than standard group-based interventions.<br><br>Hypotheses: i) PCIT would be more effective than CS interventions; ii) PCIT would have greater effect on physical abuse than neglect; iii) additional services in the EPCIT intervention group would enhance the intervention effect. | PCIT & EPCIT | •Child Welfare Administrative Database<br>•Child Abuse Potential Inventory (CAP; Milner 1986) | Re-reporting rates for neglect were not affected by intervention group.<br><br>The PCIT group had significantly ($p<.01$) lower percentage (19%) of parent re-reports of physical abuse than EPCIT (36%) and CS (49%) groups. Chi-square analysis revealed significant difference in re-reporting rate between groups ($p=.02$).<br><br>Kaplan-Meier survival analysis showed PCIT prevented re-reports of abuse for a significantly longer duration than CS intervention ($p<.02$). PCIT effects lasted longer than EPCIT effects but this was not significant.<br><br>Being part of the PCIT group was the only predictor of not abusing in the future ($p=.03$).<br><br>Cox regression showed parental negative behaviours were associated with physical abuse survival, suggesting that success of the PCIT intervention was due to a reduction in negative behaviours. | WEAK |

| Paper Number | Study aims/hypotheses | Attachment-based intervention delivered | Measures used | Results relevant to review | EPHPP Quality Rating |
|---|---|---|---|---|---|
| 8 | Aim: To reduce the occurrences of future abuse and neglect through intervention. | CPP | Court Database of Child Abuse and Neglect | Prior to intervention 97% of families were subject of child abuse reports. Over the course of the study (3 years) no reports were made regarding the parents in the intervention group.<br><br>All children residing 'out-of-home' prior to intervention were placed back in their parents care permanently following the intervention. | WEAK |
| 10 | Aim: To assess how effective SafeCare is at reducing future child abuse by examining recidivism rates following intervention. | SafeCare | Department of Child and Family Services case files | A higher percentage of parents in the SafeCare (85%) group were not reported for abuse 36 months following intervention when compared to the Family Preservation group (54%).<br><br>Parents in the SafeCare group refrained from abusing for longer durations following intervention than the control group ($p<.001$).<br><br>The number of reports made regarding parent abuse following intervention was significantly less for those from the SafeCare group than the Family Preservation group ($p<.05$).<br><br>Parents in the SafeCare group had fewer reports following the intervention that in the time period leading up to the intervention ($p<.01$). | WEAK |

Key:
Standard PCIT= Standard Parent-Child Interaction Therapy; PCIT= Parent-Child Interaction Therapy; EPCIT= Enhanced Parent-Child Interaction Therapy; CPP= Child-Parent Psychotherapy

## Discussion

The aim of this review was to identify research that measured effectiveness of attachment-based interventions when used with families in which the parent had abused the child and how attachment-based interventions impact on:

- The sensitivity parents demonstrate to their children (as measured by their behaviours and attitudes)
- The attachment organisation and security between child and parent
- Future child abuse

The nine studies included in this study test the effectiveness of a range of attachment-based interventions. Although these papers examine different aspects of the effectiveness of the interventions and varied in their methodological quality, they all report findings that address the aims of this review.

It was found that the different types of interventions were effective at enhancing parents' sensitivity, as evidenced by changes in parental attitudes towards and interactions with their children. This finding is consistent with Bakermans-Kranenburg, van IJzendoorn & Juffer's (2003) previous review, which found that the sensitivity of parents, from a range of backgrounds and with various presenting problems, increased as a result of attachment-based interventions.

The majority of studies report a significant decrease in the negative behaviours (physical and/or verbal) parents demonstrated towards their children, suggesting that attachment-based interventions are effective in reducing abusive parents' insensitive responses to their children. This change may be explained by shifts in parent attitude, as

demonstrated in changes to parent responses on the PSI and CAP in some studies. Parents who have unrealistic expectations of their child may attribute negative intentionality (Tarabulsy et al., 2003) and experience their children as being defiant and respond with negative or punishing behaviours (Whitman et al, 2001). Learning what can be reasonably expected of their children and what the child is trying to communicate through their behaviour may reduce the likelihood of parents responding negatively (i.e. they do not believe their child is acting defiantly so do not become as distressed and do not respond aggressively).

The interventions also effectively increased parent sensitivity. It is possible that prior to intervention parents lacked the knowledge and skills to respond to their children sensitively, due to receiving predominantly insensitive and frightening care from their own parents (Lyons-Ruth, 2005). The coaching and feedback provided during training may have supported parents to develop these skills successfully.

Consistent with previous literature, papers that report attachment classification at baseline found that abused child samples contained a higher proportion of children with disorganised attachments than non-abused samples (Barnett, Ganiban & Cicchetti, 1999. However, there was no significant difference in the internal representations held by these two groups as seen in paper 9. Both groups were characterised by high levels of social deprivation and low social-economic standing and the children in the control conditions were deemed to be "in need" but not abused. This may suggest that these social factors, which may prevent parents from providing consistent care, are more closely associated with the internal representations children develop than whether or not they are abused by their parents (Toth et al., 2002).

The findings of the papers reviewed suggest that children can experience an increase in attachment security and organisation as a result of attachment-based interventions. The two studies that compared pre- and post-intervention attachment styles demonstrate that VPIF and CPP are more effective at enhancing attachment than the interventions in the control conditions. However, in study 4 the group that received a non-attachment based intervention, PPI, also showed an improvement in attachment, which was an unexpected finding. The follow-up study conducted one year later found that rates of secure, organised attachment in the CPP group were higher than the PPI group and that no significant differences existed between the PPI and CS group. This suggests that the PPI intervention (parent skills training, education on child development and increased coping strategies and social support) can produce short-term changes but these are not maintained over time. Cicchetti, Rogosch and Toth (2006) suggest that this may be due to CPP creating a greater improvement of the mother's and child's internal representations than PPI to produce a more sustained effect. This is supported by the findings of paper 9 which found that representations, particularly maladaptive maternal representations, were subject to greater positive change in the CPP condition than in control conditions.

This contradicts Bakermans-Kranenburg, van IJzendoorn & Juffer's (2003) previous finding, that short-term interventions are more effective at increasing sensitivity and enhancing attachment security. However, as their study did not focus on families in which parents had abused their children but 'high risk groups', an explanation of this discrepancy in findings may be that severe cases of abuse require more intensive interventions, providing more than parent skills training, in order to create sustained change (Toth et al., 2013).

Significant enhancement of attachment was also reported due to VFIP and ABC. The authors of paper 3 suggest that the success of ABC may be due to the reduction of parents'

frightening behaviours. This is consistent with the theory that disorganisation occurs when the attachment figure is the source of both fear and reassurance (Main & Solomon, 1990). However, as this was a preliminary study and parent behaviour was not reported, it is not known if this was the mechanism for change.

Only four of the papers (1, 6, 8 and 10) measured rates of abuse following the intervention, despite this being the ultimate goal for all of the included studies. The findings are encouraging, with PCIT and SafeCare groups demonstrating lower rates of abuse reported post-intervention than the control groups. Maintenance of treatment effect was significantly better for the attachment-based interventions that is, parents that received these refrained from abusive behaviour for longer than those in the control groups. Interestingly, standard PCIT was shown to be more effective than EPCIT. The authors of paper 6 suggest this may be due to the additional services in EPCIT "diluting" the effectiveness of the PCIT component of the intervention. This assertion *is* supported by previous findings that the most successful interventions for increasing sensitivity and enhancing attachment are focussed interventions (Bakermans-Kranenburg, van IJzendoorn & Juffer, 2003). It may be that additional services meant less opportunity to develop the skills needed to improve sensitivity and enhance attachment which led to the EPCIT being less effective at reducing future risk than standard PCIT. The effectiveness of 'standard PCIT' was also demonstrated in paper 1 as parents in the PCIT group were shown to be significantly less likely to act abusively once they had completed the intervention and completers were less likely to be reported for abuse. This may indicate that standard PCIT is effective for abusive parents and that the motivational enhancement used in paper 6 is not necessary to achieve positive results, although it has been shown to significantly reduce attrition rates (Chaffin et al., 2009).

CPP was also shown to be effective at reducing re-reporting rates in parents that had been reported for abuse prior to intervention. Paper 8 was the only paper to report an improvement in neglect as well as the other forms of abuse. The authors of paper 6 state that they did not expect that PCIT would be effective at reducing neglect, as it is normally reported as a result of unsuitable environments, which would not be effected by the attachment-based intervention. The mechanism by which CPP may be more effective at reducing neglect was not explored. One possibility is that CPP helps the mother to address her own maladaptive attachment with her primary caregivers, which allows her to perceive her child and their relationship differently and be more attuned to the child's needs (Cicchetti, Rogosch & Toth, 2006).

When interpreting the findings of the included studies, several considerations must be taken into account. Firstly the methodological quality of the studies must be considered. Many of the studies were considered to be methodologically '*weak*' when the EPHPP QAT was applied, which indicates that their findings may not be reliable or generalisable. However, some of the criteria on which the studies scored poorly may be a reflection of the sampled population, rather than flaws in the study. For example, drop-out rates were consistently high. This has been shown to be a common difficulty when working with this population (e.g. Kazdin, Holland & Crowley, 1997). That is, parents who may have had little choice in participating (i.e. court mandated treatment), who may have poor relationships with services due to previous experiences, and who are living with high levels of social and economic deprivation. The quality scores may therefore be disproportionately reduced due to high attrition rates for papers 1 ('*weak'*), 4 ('moderate'), 6 (*'weak'*) and 8 (*'weak'*).

The attribution of a '*weak*' rating was more justifiable in other cases, such as a number of papers failing to report reasons for attrition, not reporting differences between intervention

and control groups or not stating how many of those approached actually participated in the study. However, all of the attachment-based intervention efficacy findings are supported by at least one methodologically '*strong*' study, which suggest that the findings can be generalised with caution.

One issue to consider is how representative the parents included in these studies are of abusive parents. Only 37% of the parents invited to take part in paper 6 agreed to participate and attrition was high in a number of studies. Abusive parents who a) agree to take part in an intervention and b) complete the intervention may constitute a minority of unusually motivated parents. It may be that these interventions are only successful with this subsection of the target population and generalising to the wider group is not justified. The majority (95%) of parent participants were female. This does not represent the gender ratio of abusive parents in the target population and therefore findings of these studies can only be applied to abusive mothers. Also, BME groups were disproportionately represented in abusive/abused samples. This could be due to cultural differences between the families and those assessing for risk. For example, differences in ethnicity, country of origin, social economic status, educational level, ability (or disability), religious beliefs or cultural beliefs may lead statutory services to perceive risk based on differential cultural attitudes to parenting or stereotyping (van Ryn & Fu, 2003).

Although the effectiveness of attachment-based interventions has been demonstrated in comparison to control groups it is not always clear what was offered in the control interventions. For example the "attention-only" wait-list group in study 1 received weekly telephone calls from a researcher to discuss any difficulties. This conversation may have had a therapeutic effect (Mozer, Franklin & Rose, 2008) that subsequently affected the results of the study. Providing adequate control interventions creates considerable ethical dilemmas

(Bakermans-Kranenburg, van IJzendoorn & Juffer, 2003). It is necessary to provide an intervention that reduces risk, as failure to protect children can have serious consequences, and is preferably evidence-based without reducing the validity of the study. This balance was most successfully negotiated in paper 3, where the education programme used in the control group had been adapted to ensure that it did not share any common features with the ABC intervention but was still helpful to the families.

The EPCIT group in paper 6 were offered individualised packages of care based on their needs. Although this is the preferred way of working in everyday practice, under research conditions it makes it challenging to identify what the underlying mechanism of change is and to replicate the intervention across the target population. Non-abusive parents and family members were encouraged to contribute to the PCIT intervention in paper 6, however details of who participated and the nature their involvement is not presented. This may have impacted on the success of the intervention as greater social support has been linked with lower parental stress and higher levels of parental sensitivity.

The reduction in reported abuse following intervention is encouraging. However, abuse is often hidden and because it has not been identified and reported, it does not mean it is absent (Cawson, 2000). The papers that measured post-intervention abuse tended to focus on physical abuse which is more 'visible' than emotional abuse and neglect.

Paper 6 used parent identifiers to establish whether those that had received interventions were subjects of future abuse reports. If the child was abused but by a different person, these data were not included in the study, making it more likely that subsequent family abuse was under-reported. In contrast, paper 1 used reports of child abuse that may not

have been substantiated, producing a possible underestimation of the effectiveness of the intervention.

**Clinical implications**

The reviewed evidence suggests that families with abusive histories can be supported to improve their relationships, learn new ways to interact, and break the cycle of inter-generational abuse. This is encouraging as removing children from their families has been shown to increase vulnerability of abuse and is associated with negative outcomes (Hobbs, Hobbs & Wynne, 1999; Rosenthal et al., 1991; Uliando & Mellor, 2012). If the interventions reviewed above can be developed further and delivered by those who work closest with families in which parents have committed abuse. This not only benefits the child and the family but also has economic benefits (Gelles & Perlman, 2012).

**Strengths and weaknesses of this review**

One strength of this review is the application of stringent inclusion/exclusion criteria which allowed papers with appropriate samples to be identified. Samples consisted of parents who had been found to abuse their children or suspected to, rather than parents in high-risk groups; the intervention effectiveness may differ for abusive parents and those believed to be high risk. This review explored the effect of attachment-based interventions on rates of future abuse, which has not featured in previous reviews.

The Quality Assessment Tool selected was a clear and appropriate tool to analyse the selected papers. It was developed for use in systematic reviews and has established validity (Thomas et al., 2004). However the rating system ('*strong*', '*moderate*' and '*weak*') does not allow the quality of papers with the same rating to be compared, even when some appear stronger than others. For example, paper 5 had multiple significant weaknesses; baseline

assessment was not conducted and no comparison group was included, authors do not report how participants were recruited and less than 60% of the sample completing outcome measures. This received the same methodological quality rating as paper 6, which had significantly fewer problems but was classed as *'weak'* because a minority of those invited into the study took part and reasons for attrition were not reported. Although these do effect the quality of the paper it appears to be stronger than paper 5. In future this could be remedied by ascribing a numerical score to each rating (i.e. *'strong'*=2, '*moderate'*=1 and *'weak'*= 0). This would allow scores to be compared between studies with the same overall rating and indicate which is of the strongest methodological quality.

Ideally, a meta-analysis would have been conducted, as this would be a more robust method of reviewing the effectiveness of the interventions and less vulnerable to researcher bias (Haidich, 2010). However this was not possible because the studies used a wide range of measures and, although they all included families where parents had committed child abuse, focussed on different outcomes. Meta-analysis may become appropriate in the future, as more studies in this area become available for review.

**Conclusions**

The selected papers provide some evidence that attachment-based interventions may show some promise when used with families in which the parents have committed child abuse. Attachment-based interventions can have significant positive effects on parent sensitivity, attachment security, some disorganised attachment characteristics and future abuse. This review has also identified some of the difficulties in providing interventions to these families and the ethical dilemmas that are raised.

**Future research**

Building on the research presented in this review could strengthen our understanding of the effectiveness of attachment-based interventions when used with families with abusive parents. None of the studies in this review that measured post-intervention abuse assessed whether changes in attachment security occurred, only changes in parental sensitivity. Addressing this could provide a clearer picture as to whether increased attachment organisation and security is associated with reduced abuse. The development of RCTs could also be instrumental in demonstrating the effectiveness of these interventions, although this must be balanced with ensuring that children are not put in further danger. Furthering our knowledge in this area may be employed to improve the ability of clinicians to break cycles of abuse and provide better outcomes abused children and their families.

## References


Abidin, R. R. (1990). *Parenting Stress Index (3rd ed.)*. Virginia: Paediatric Psychology Press.

Abidin, R. R. (1992). The determinants of parenting behaviour. *Journal of Clinical Child Psychology, 21*, 407-412. doi: 10.1207/s15374424jccp2104_12.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: a psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Armijo-Olivo, S., Stiles, C. R., Hagen, N. A., Biondo, P. D., & Cummings, G. G. (2012). Assessment of study quality for systematic reviews: A comparison of the Cochrane Collaboration Risk of Bias Tool and the Effective Public Health Practice Project Quality Assessment tool: methodological research. *Journal of Evaluation in Clinical Practice, 18(1*), 12-8. doi: 10.1111/j.1365-2753.2010.01516.x

Australian Institute of Health and Welfare. (2014). *Child protection Australia: 2012–13* (Child Welfare series no.58.) Canberra: AIHW. Retrieved from http://www.aihw.gov.au/publication-detail/?id=60129547965.

Bagner, D. M., & Eyberg, S. M. (2007). Parent-child interaction therapy for disruptive behaviour in children with mental retardation: A randomized control trial. *Journal of Clinical Child & Adolescent Psychology, 36*, 418-429. doi: 10.1080/15374410701448448.

Bakermans-Kranenburg, M., J., van IJzendoorn, M. H., & Juffer, F. (2003). Less Is More: Meta-Analyses of Sensitivity and Attachment Interventions in Early Childhood. *Psychological Bulletin, 129(2),* 295-215. DOI: 10.1037/0033-2909.129.2.195.

Bandura, A. (1977). *Social Learning Theory*. Englewood Cliffs, NJ: Prentice Hall.

Barnett, D., Ganiban, J., & Cicchetti, D. (1999). Maltreatment, negative expressivity, and the development of Type D attachments from 12 to 24 months of age. *Monographs of the Society for Research in Child Development, 64(3),* 97-118. doi: 10.1111/1540-5834.00035.

Bavolek, S. J. (Ed.). (1984). *Handbook for the Adult-Adolescent Parenting Inventory (AAPI).* Park City, UT: Family Developmental Resources, Inc.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory – Second Edition (BDI-II).* San Antonio, TX: The Psychological Corporation.

Bernard, K., Butzin-Dozier, Z., Rittenhouse, J., & Dozier, M. (2010). Cortisol production patterns in young children living with birth parents vs children placed in foster care following involvement of child protective services. *Archive of Paediatric and Adolescent Medicine, 164,* 438-443. doi:10.1001/archpediatrics.2010.54.

Bernard, K., Dozier, M., Bick, J., Lewis-Morrarty, E., Lindhiem, O., & Carlson, E. (2012). Enhancing attachment organisation among maltreated children: results of a randomised clinical trial. *Child Development, 83(2),* 623-636. doi: 10.1111/j.1467-8624.2011.01712.x.in

Bickham, N., & Friese, B. (1999). *Child narrative coding system*. Unpublished manual. Syracuse NY: Syracuse University.

Biringen, Z., Robinson, J., & Emde, R. N. (2000). The emotional availability scales (3rd ed.). *Attachment and Human Development, 2*, 257-270. doi: 10.1080/14616730050085626.

Bowlby, J. (1982). Attachment and loss: retrospect and prospect. *American Journal of Orthopsychiatry, 52 (4),* 664-678. doi: 10.1111/j.1939-0025.1982.tb01456.x.

Bowlby, J. (1988). *A secure base: parent-child attachment and healthy human development.* London: Routledge.

Bretherton, I., Oppenheim, D., Buchsbaum, H., Emde, R. N., & The MacArthur Narrative Group. (1990). MacArthur Story-Stem Battery. Unpublished Manual.

Bretherton, I., Ridgeway, D., & Cassidy, J. (1990). Assessing internal working models of the attachment relationship: An attachment story completion task for 3-year-olds. In M. Greenberg, D. Cicchetti, & E. M. Cummings (Eds.), *Attachment in the preschool years (pp. 273-308)*. Chicago: University of Chicago.

Carter, S., Osofsky, J. D., & Hann, D. M. (1991). Speaking for baby: A therapeutic intervention with adolescent mothers and their infants. *Infant Mental Health Journal, 12*, 291-301. doi: 10.1002/1097-0355(199124)12:4<291::AID-IMHJ2280120403>3.0.CO;2-3.

Cassidy, J., Marvin, R. S., & the MacArthur working Group on Attachment. (1992). *Attachment organization in 2 ½ to 4 ½ year olds: Coding manual*. Unpublished manuscript, University of Virginia.

Cawson, P., Wattam, C., Brooker, S., & Kelly, G. (2000). *Child Maltreatment in the United Kingdom: A Study of the Prevalence of Child Abuse and Neglect*. London: NSPCC.

Chaffin, M., Silovsky, J. F., Funderbunk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. L. (2004). Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72(3)*, 500-510. doi: 10.1037/0022-006X.72.3.500.

Chaffin, M., Valle, L. A., Funderburk, B., Gurwitch, R., Silovsky, J., Bard, D., McCoy, C., & Kees, M. (2009). A motivational intervention can improve retention in PCIT for chronic child welfare clients. *Child Maltreatment, 14(4)*, 356-368. doi: 10.1177/1077559509332263.

Cicchetti, D., Rogosch, F. A., Lynch, M., & Holt, K. D. (1993). Resilience in maltreated children: Processes leading to adaptive outcome. *Development and Psychopathology, 5*, 629-647.

Cicchetti, D., Rogosch, F. A., & Toth, S. L. (2006). Fostering secure attachment in infants in maltreating families through preventative interventions. *Development and Psychopathology, 18*, 623-649. doi: 10.1017/S0954579406060329.

Crowell, J. A., & Fleishman, M. A. (1993). Use of structured research procedures in clinical assessments of infants. In C. H. Zeanah (Ed.*), Handbook of Infant Mental Health (pp. 210-221).* New York: Guildford.

Department for Education. (2012). *Characteristics of children in need in England, 2011–12*. London: Department of Education. Retrieved from http://www.education.gov.uk/rsgateway/DB/SFR/s001095/index.shtml

Edwards-Gaura, A., Whitaker, D. J., Lutzker, J. R., Self-Brown, S., & Lewis, E. (2012). SafeCare: Application of and evidence-based program to prevent child maltreatment. In A. Rubin (Ed.), *Clinician's Guide to Best Practice: Programs and Interventions for Maltreated Children and Families at Risk (pp 259-272).*New Jersey: John Wiley & Sons.

Effective Public Health Practice Project. (1998). *Quality Assessment Tool for Quantitative Studies*. Hamilton, ON: Effective Public Health Practice Project. Retrieved from: http://www.ephpp.ca/index.html

Eyberg, S., Bessmer, J., Newcomb, K., Edwards, D., & Robinson, E. (1994*). Dyadic parent-child interaction coding system- II manual*. Unpublished manuscript. Gainesville: University of Florida.

Eyberg, S. M., Duke, M, McDiarmid, M., Boggs, S., Robinson E., & Washington, E. (2004). Dyadic parent-child interaction coding system: third edition. Unpublished manuscript. Gainesville: University of Florida.

Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Poly-victimization: a neglected component in child victimization. *Child Abuse and Neglect,* 31(1), 7-26. doi: 10.1016/j.chiabu.2006.06.008.

Gelles, R. J., & Perlman, S. (2012). *Estimated Annual Cost of Child Abuse and Neglect.* Chicago IL: Prevent Child Abuse America.

Gershater-Molko, R. M., Lutzker, J. R., & Wesch, D. (2002). Using recidivism data to evaluate Project Safecare: teaching bonding, safety and healthcare skills to parents. *Child Maltreatment, 7(3),* 277-285. doi: 10.1177/1077559502007003009.

Gilbert, R., Spatz Widom, C., Browne, K., Fergusson, D., Webb, E. & Janson, S. (2008). Burden and consequences of child maltreatment in high-income countries. *Lancet, 373,* 68-81. doi: 10.1016/S0140-6736(08)61706-7.

Haidich, A. B. (2010). Meta-analysis in medical research. *Hippokratia, 14(Suppl 1),* 29-36.

Hembree-Kigin, T. L., & McNeil, C. B. (1995). *Parent-child interaction therapy*. New York: Plenum.

Heyman, R. E., & Smith Slep, A. M. (2002). Do child abuse and interparental violence lead to adult family violence? *Journal of Marriage and Family, 64,* 864-870. doi: 10.1111/j.1741-3737.2002.00864.x.

Hobbs, G. F., Hobbs, C. J., & Wynne, J. M. (1999). Abuse of children in foster and residential care. *Child Abuse and Neglect, 23 (12*), 1239-1252. doi: 10.1016/S0145-2134(99)00096-4.

Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology, 65*, 453-463. doi.org/10.1037/0022-006X.65.3.453.

Lenze, S. N., Pautsch, J., & Luby, J. L. (2011). Parent-child interaction therapy emotion development: A novel treatment for depression in preschool children. *Depression & Anxiety, 28*, 153-159. doi 10.1002/da.20770.

Lutzker, J. R., Van Hasselt, V. B., Bigelow, K. M., Greene, B. F., & Kessler, M. L. (1998). Child abuse and neglect: Behavioural research, treatment and theory. *Aggression and Violent Behaviour, 3*, 181-196. doi: 10.1016/S1359-1789(97)00013-X.

Lyons-Ruth, K., Yellin, C., Melnick, S., & Atwood, G. (2005). Expanding the concept of unresolved mental states: Hostile/helpless states of mind on the Adult Attachment Interview are associated with disrupted mother-infant communication and infant disorganization. *Development and Psychopathology, 3*, 377-396. doi: 10.1017/S0954579405050017.

Main, M. & Solomon, J. (1990). Procedures for identifying infants as disorganised/disoriented during the Ainsworth Strange Situation. In M. T. Greenberg, D. Cicchetti & E. M. Cummings (Eds.), *Attachment in the pre-school years: Theory, research and intervention* (pp 121-160). Chicago: University of Chicago.

Milner, J. S. (1986). *The child abuse potential inventory manual (2nd ed.)*. DeKalb, IL: Psyctec.

Moss, E., Cyr, C., Bureau, J. F., Tarabulsy, G. M., & Dubois-Comtois, K. (2005). Stability of attachment between preschool and school-age. *Developmental Psychology, 41*, 773-783. doi: 10.1037/0012-1649.41.5.773.

Moss, E., Dubois-Comtois, K., Cyr, C., Tarabulsy, G. M., St-Laurent, D., & Bernier, A. (2011). Efficacy of a home-visiting intervention aimed at improving maternal sensitivity, child attachment, and behaviour outcomes for maltreated children: a randomised control trial. *Development and Psychopathology, 23,* 195-210. doi: 10.1017/S0954579410000738.

Moss, E., Lecompte, V., Pascuzzo, A., Dubois-Comtois, K., Cyr. C, Tarbulsy, G. M., St-Laurent, D., & Bernier, A. (2012). Evidence for the efficacy of attachment-based interventions for maltreating parents and their children. *Integrating Science and Practice, 2(1*), 5-8.

Moss, E., Tarabulsy, G., St-Georges, R., Dubois-Comtois, K., Cyr, C., Bernier, A., St-Laurent, D., Pascuzzo, K., & Lecompte, V. (2014). Video-feedback intervention with maltreating parents and their children: program implementation and case study. *Attachment & Human Development, 16(4),* 329-342. doi: 10.1080/14616734.2014.912486.

Mozer, E., Franklin, B., & Rose, J. (2008). Psychotherapeutic interventions by telephone. *Clinical Interventions and Aging, 3(2), 391-396.*

Ofofsky, J. D., Kronenberg, M. Hayes Hammer, J., Lederman, C., Katz, L., Adams, S., Graham, M., & Hogan, A. (2007). The development and evaluation of the intervention model for the Florida Infant Mental Health pilot program. *Infant Mental Health Journal, 28(3),* 259-280. doi: 10.1002/imhj.20135.

Patterson, G. R., & Reid, J. B. (1984). Social interaction processes within the family: The study of moment-to-moment transaction in which human development is embedded. *Journal of Applied Developmental Psychology, 5,* 237-262. doi: 10.1016/0193-3973(84)90021-2.

Pears, K. C., & Capaldi, D. M. (2001). Intergenerational transmission of abuse: a two-generational prospective study of an at-risk sample. *Child Abuse & Neglect, 25,* 1439-1461.

Pederson, D. R., & Moran, G. (1995). A categorical description of attachment relationships in the home and its relation to q-sort measures of infant-mother interaction. *Monographs for the Society for Research in Child Development, 60*, 247-254.

Pickreign Stronach, E., Toth, S. L., Rogosch, F., & Cicchetti, D. (2013). Preventive interventions and sustained attachment security in maltreated children. *Development and Psychopathology, 25*, 919-930. doi: 10.1017/S0954579413000278.

Radford, L., Corral, S., Bradley, C., Fisher, H., Collishaw, S., Bassett, C., & Howat, N. (2011). *Child abuse and Neglect in the UK today.* London: NSPCC.

Reynolds, C. R., & Kamphaus, R. W. (1992). *Manual for the coding assessment system for children. Circle Pines*, MN: American Guidance Service.

Robinson, J., Mantz-Simmons, L., Macfie, J, & The MacArthur Narrative Working Group. (1996). T*he narrative coding manual- Rochester Revision*. Unpublished manuscript.

Saied-Tessier, A. (2014). *Estimating the cost of child sexual abuse in the UK*. London: NSPCC. Retrieved from: *www.nspcc.org.uk/...reports/estimating-costs-child-sexual-abuse-uk.pdf.*

Salzinger, S., Feldman, R. R., Hammer, M., & Rosario, M. (1993). The effects of physical abuse on children's social relationships. *Journal of Child Development, 64*, 169-187. doi: 10.1111/j.1467-8624.1993.tb02902.x.

Schneider-Rosen, K., Braunwald, K., Carlson, V., & Cicchetti, D. (1985). Current perspectives in attachment theory: Illustrations from the study of maltreated infants. *Monographs of the Society for the Research in Child Development, 50*, 194-210.

Schuengel, C., Bakersman-Kranenburg, M. J., & van IJzendoorn, M. H. (1999). Frightening maternal behaviour linking unresolved loss and disorganised infant attachment. *Journal of Consulting and Clinical Psychology, 67,* 54-63.

Sedlak, A.J., Mettenberg, J., Basena, M., Petta, I., McPherson, K., Greene, A., & Spencer, L. (2010). *Fourth national incidence study of child abuse and neglect (NIS-4).* Washington, DC: U.S. Department of Health and Human Services.

Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long term sequelae of child and adolescent abuse: a longitudinal community study. *Child Abuse & Neglect, 20(8),* 709-723. doi: 10.1016/0145-2134(96)00059-2.

Springer, K., Sheridan, J., Kuo, D., & Carnes, M. (2003). The long-term health outcomes on childhood abuse. *Journal of General Internal Medicine, 18,* 864-870. doi:10.1016%2Fj.chiabu.2007.01.003.

Sroufe, L. A. (2005). Attachment and development: a prospective, longitudinal study form birth to adulthood. *Attachment & Human Development, 7(4),* 2349-367. doi: 10.1080/14616730500365928.

Sroufe, L. A., Carlson, E. A., Levy, A. K., & Egeland, B. (1999). Implications for attachment theory for developmental psychopathology. *Development and Psychopathology, 11,* 1-13.

Steele, M., Murphy, A., & Steele, H. (2010). Identifying therapeutic action in an attachment-centred intervention with high risk families. *Clinical Social Work Journal, 38,* 61-71. doi: 10.1007/s10615-009-0257-6.

Tarabulsy, G. M., Provost, M. A., Deslandes, J., St-Laurent, D., Moss, E., Lemelin, J. P., &_Dassylva, J. F. (2003). Individual differences in infant still-face response at 6 months. *Infant Behavior & Development, 26,* 421–438. doi: 10.1016/S0163-6383(03)00039-0.

Tarabulsy, G. M., St-Laurent, D., Cyr, C., Pascuzzo, K., Moss, E., Bernier, A., & Dubois-Comtois, K. (2008). Attachment-based intervention for maltreating families. *American Journal of Orthopsychiatry, 78(3),* 322-323. doi: 10.1037/a0014070.

Thomas, B. H., Ciliska, D., Dobbins, M., & Micucci, S. (2004). A process for systematically reviewing the literature: Providing the research evidence for public health nursing interventions. *Worldviews on Evidence Based Nursing, 1(3),* 176-184. doi: 10.1111/j.1524-475X.2004.04006.x.

Thomas, R., & Zimmer-Gembeck, M. J. (2011). Accumulating evidence for Parent-Child Interaction Therapy in the prevention of child maltreatment. *Child Development, 82(1),* 177-192. doi: 10.1111/l.1467-8624.2010.01548.x.

Timmer, S. G., Urquiza, A. J., Zebell, N. M., & McGrath, J. M. (2005). Parent-child interaction therapy: Application to maltreating parent-child dyads. *Child Abuse & Neglect, 29,* 825–842. doi: 10.1016/j.chiabu.2005.01.003.

Toth, S. L., Gravener-Davis, J. A., Guild, D. J., & Cicchetti, D. (2013). Relational interventions for child maltreatment: past, present, and future perspectives. Development and Psychopathology, 25, 1602-1617. doi: 10.1017/S0954579413000795.

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M., & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: implications for attachment theory. *Development and Psychopathology, 14,* 877-908. doi: 10.1017.s095457940200411X.

Trickett, P. K., & McBride-Chang, C. (1995). The developmental impact of different forms of child abuse and neglect. *Developmental Review, 15*, 311-337.

Uliando, A., & Mellor, D. (2012). Maltreatment of children in out-of-home care: A review of associated factors and outcomes. *Children and Youth Services Review, 34*, 2280-2286. doi: 10.1016/j.childyouth.2012.08.003.

Urquiza, A. J., & McNeil, C. B. (1996). Parent-child interaction therapy: An intensive dyadic intervention for physically abusive families. *Child Maltreatment, 1*, 132-141. doi: 10.1177/1077559596001002005.

van IJzendoorn, M. H, Juffer, F., & Duyvesteyn, M. G. C. (1995). Breaking the cycle of the intergenerational cycle of insecure attachment: a review of the effects of attachment-based interventions on maternal sensitivity and infant security. *Journal of Child Psychology and Psychiatry, 36(2)*, 225-248.

van Ryn, M., & Fu, S. S. (2003). Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health? *American Journal of Public Health, 93(2)*, 248-255.

Whitman, T. L., Borkowski, J. G., Keogh, D. A., & Weed, K. (2001). *Interwoven lives: Adolescent mothers and their children*. Mahwah, NJ: Erlbaum.

Widom, C. S. (2000). Understanding the consequences of childhood victimization. In R. M. Reese (Ed.), *Treatment of child abuse* (pp.339-361). Baltimore: John Hopkins University Press.

World Health Organisation. (2006). *Preventing child maltreatment: a guide to taking action and generating evidence*. Geneva: WHO/ISPCAN.

# CHAPTER TWO

# EMPIRICAL PAPER:

# EXPLORING THE INTERPLAY BETWEEN SOCIAL WORKERS' PERSONAL AND PROFESSIONAL EXPERIENCES WHEN DISCUSSING THE COMPETENCE OF PARENTS WITH INTELLECTUAL DISABILITIES

**by**

**BRADLEY JAMES CROOK**

Department of Clinical Psychology

School of Psychology

University of Birmingham

May 2015

## Abstract

Parents with intellectual disabilities have been shown to be over-represented in child care proceedings and previous research has suggested that underlying attitudinal processes may contribute to this. It has been shown that professionals working in health and social care are influenced by their personal beliefs and experiences when completing assessments, particularly around risk. The current study aimed to explore the way in which social workers draw upon their past personal and professional experiences when discussing the competencies of parents with intellectual disabilities.

An adapted version of the Burford Review Process was used. This required participants, ten practicing social workers from Child and Family Services, to view video clips of parents with intellectual disabilities and stop the video when they experienced a 'reaction' (e.g. a thought or feeling) in response to something they witnessed. After stopping the video participants were interviewed about what they were responding to and what experiences may have influenced their reaction. The interviews were audio recorded and later transcribed. The transcripts were analysed using Foucauldian Discourse Analysis.

Analysis revealed that social workers drew on their personal and professionals experiences when discussing the parents in the video. Personal experiences of parenting or being parented were commonly used to evaluate the competence of the parents in the video. Professional experiences were more commonly drawn upon by participants when considering the challenges the parents may encounter. Personal values also played an important role in informing participants' reactions. The strengths and limitations of the research are discussed. Clinical implications and future research are suggested and recommendations offered.



**Keywords:** *Parents, Intellectual Disabilities, Social Workers, Professional Conduct, Bias*

# Introduction

## Parents with intellectual disabilities

It is well documented that parents with intellectual disabilities are more likely to have their children removed from their care than parents without intellectual disabilities and parents considered to pose risk to their children, such as parents with substance abuse and mental health difficulties (McConnell & Llewellyn, 2000). Booth and Booth (2004) estimated that parents with intellectual disabilities are "over-represented in care proceedings by a factor up to 60 times more than would be expected on the basis of their numbers alone". The disproportionate number of parents with intellectual disabilities involved in care proceedings (Llewellyn, McConnell & Ferronato, 2003) may be indicative of additional processes which increase the likelihood of this occurring.

## Historical views of people with intellectual disabilities and sexuality

Brown (1994) reports that in early history people with intellectual disabilities were considered 'innocents' and in need of protection. During the industrial revolution this shifted and they were believed to pose a 'threat' to society. Heavily influenced by the eugenics movement (Barker, 1983) gender specific institutionalisation and coerced sterilisation procedures (Tilley et al, 2012) became widespread to prevent the intellectually disabled community from reproducing and thus to reduce the 'threat' of contaminating the gene pool.

Presently, people with intellectual disabilities live in the community with a greater degree of integration and, policy guidelines states, should be supported to achieve the same life goals as the rest of the population, including establishing sexual relationships and having families of their own (Department of Health, 2001; 2009). Despite an increasing acceptance of sexual behaviour in adults with an intellectual disability (Cuskelly & Bryde, 2004), evidence suggests that attitudes around parenting have not evolved to the same extent (Aunos

& Feldman, 2002) and subtle practices of preventing sexual relationships and pregnancy still occur today, such as the use of precautionary contraceptives (Carlson, Taylor & Wilson, 2000). These practices support Brown's (1994) suggestion that the historical views of people with intellectual influence society today and may play a role in the removal of children from intellectually disabled parents.

**Risk**

Previous research has established that there is a strong focus on the potential risks parents with intellectual disabilities pose to their children, with risk of neglect, failure to protect and environmental risks often the central concern (Azar et al, 2012; Booth & Booth, 2004; Feldman, 2002; Llewellyn et al., 2003; McConnell & Llewllyn, 2002; MacDonald, 2009; McGaw et al., 2010). The common concern amongst professionals is that parents with intellectual disabilities lack the skills required to care for their children and are considered to be unable to learn to do so adequately (McConnell & Llewellyn, 2000).

There is, however, an established evidence base suggesting that, with appropriate support, parents with intellectual disabilities are able to learn practical parenting skills and adequately care for and safeguard their children (Feldman & Case, 1997, 1999; Llewellyn et al, 2003; Tymchuk, Andron & Hagelstein, 1992; Tymchuk et al, 1990; Wade et al, 2008). It is possible that this evidence is not taken into consideration by professionals during child protection cases (Llewellyn, McConnell & Ferronato, 2003) or it is eclipsed by prejudicial assumptions (Goodinge, 2000) and stereotypes (McConnell & Llewellyn, 2000; Proctor & Azar, 2013) surrounding intellectual disabilities.

**Parent with intellectual disabilities and services**

The relationship between parents with intellectual disabilities and child protection/statutory services is fraught with complexities. Although able to recognise the need for support (Guinea, 2001; Tarleton & Ward, 2007) parents may be fearful to request it or mask the difficulties due to the fear of their children being removed (Bloomfield et al, 2010). Some parents have reported feeling disadvantaged in child protection procedures (Tarleton, 2007) and feel judge by, and are suspicious of, the services supporting them (Tarleton, Ward & Howarth, 2006). Some parents, whilst appreciative of support, have reported feeling that this does not always meet their emotional and practical needs (Guinea, 2001).

**Professional experiences of parents with intellectual disabilities**

In the UK, the professionals that become involved if there are concerns around parenting ability, are social workers. Social workers working with parents with intellectual disabilities have reported that they feel ill equipped to measure risk for this group of parents and lack the appropriate tools and training to do so (McGaw, 2010; Starke, 2011). It has been noted that professionals experience increased anxiety supporting these parents, especially when risk is involved, fuelled by the pressures of the scrutiny they come under when tragedies occur, such as the high profiles death of Victoria Climbie in 2000 (Lord Laming, 2003).

Starke (2011) conducted a focus group comprised mainly of social workers and found that they often felt uncertain as to what their role was when working with parents with intellectual disabilities. Although they felt they could provide the parents with support, they also had concerns about the child's safety which they felt they needed to act on, causing tension in their relationships with parents. Starke highlighted a change in the social worker's position depending on whether the child was in the care of their parents, indicating that

professionals' views on parents with intellectual disabilities are not fixed but context specific. This flexibility of attitude may suggest that other processes inform social workers' views on parent with intellectual disabilities.

**Effect of biases**

The judgements professionals make, particularly regarding risk, can be influenced by a number of variables, including case specific and professional factors (Hansen et al, 1997). Horwarth (2007) demonstrated that different professionals, even those from the same profession, have different perceptions of what constitutes child neglect and the thresholds at which they would feel concerned. This study showed that personal factors such as emotional reaction to the case, fear of making errors and organisational pressures influenced the likelihood of health professionals referring cases to social services. Doyle et al (2009) reported that social workers respond to ethical dilemmas using a combination of 'tangible' rationales such as following policy and procedures and more 'intangible' rationales such as acting on 'what feels right'.

**Research aims**

The existing literature suggests that there is a degree of subjectivity in the judgements made by professionals working with parents with intellectual disabilities and personal and professional factors may influence their judgements (Doyle et al, 2009; Hansen et al,1997; Horwarth, 2007) as well as cultural beliefs about intellectual disabilities prevalent in society (Brown, 1994). The current study aims to explore, through qualitative methods, the way in which past personal and professional experiences are drawn upon by social workers when observing parents with intellectual disabilities.

# Method

## Design

Foucauldian Discourse Analysis (FDA; Willig, 2001; 2003) was used to analyse the way in which social workers spoke about parents with intellectual disabilities. FDA examines the way in which the speaker uses language to construct the 'objects' they are discussing and how they position themselves and others in relation to the object. In doing so the speaker constructs a particular way of viewing and experiencing the world (Starks & Trinidad, 2007) which informs the way they behave in it.

Important to the current study, FDA also considers how discourses within wider society (i.e. the way in which a subject is viewed, understood and discussed in wider social processes) may influence how the speaker constructs their world through language. These discourses are a product of "social factors, powers and process" and not "an individual's set of ideas" (Holloway, 1983). This is particularly important when considering the role of discourses in establishing the distribution of power in society and the positions adopted by those involved.

FDA was selected over alternative methods, such as Thematic Analysis (TA; Braun & Clarke, 2006), as it allows for a 'deeper' level of analysis and was believed to be the most appropriate method for addressing the aims of the current study. For example, participants may not be overtly aware of how their past experiences inform their views and unable to express this, so the use TA may have been insufficient to explore this process. FDA is not reliant on the participant explicitly stating their views to elucidate the processes that may have informed them, as it focusses on how the subject has been talked about and how this reflects wider societal and historical discourses (Ussher & Perz, 2014). The consideration of these discourses on a 'macro' level is particularly relevant to this study and therefore FDA was

preferred over ‘micro’ level analyses, such as Conversation Analysis (Parker, 2013). FDA is also effective at identifying more discrete, well established, discourses that may be considered ‘common sense’ (Willig, 2003), or may not be expressed due to social desirability biases and would therefore be less likely to be identified via alternate methods.

**Ethical considerations**

Ethical approval was granted for the study by the Research Governance Advisory Committee (RGAC) of Birmingham City Council (Appendix H). Prior to participation all social workers who expressed an interest in being interviewed were given a participant information pack (Appendix I) which outlined the aims and methods of the research and were encouraged to ask any questions. Prior to interview participants signed a consent form (Appendix J) and their right to withdraw at any stage was explained. It was also explained that they were able to withdraw their data from the study up to two weeks following the interview, after which time their data would be analysed.

Participants were reassured that their anonymity would be maintained throughout the study, as fear of being identified may have resulted in them withholding relevant information regarding their experiences and beliefs. Participants were reassured that identifying would be omitted from reports resulting from the research. The limits of confidentiality were explained stating that disclosure of unethical professional practice would have to be shared with the research supervisor and further action may have been necessary to ensure the safety of the public.

It was recognised that inviting participants to share their experiences may result in disclosure of distressing experiences and/or evoke strong emotional reactions, which may impact on psychological wellbeing. All participants were urged to only discuss information

they were comfortable sharing to reduce the likelihood of them becoming overwhelmed or distressed. Information on sources of support were provided via the participant information pack. The interviewing researcher also had access to supervision if they experienced distress as a result of the experiences shared in the interview. These measures were not utilised by the participants or the researcher.

## Procedure

### Inclusion/Exclusion Criteria

Participants included in the study were qualified social workers, working primarily with children and employed by Birmingham City Council at the time of recruitment (November 2014). A participant group with a range of professional and personal experiences was deemed desirable in order to address the aims of the study and therefore exclusion criteria were limited. It was decided, however, that only qualified social workers would be included and trainee social workers and assistant social workers were excluded from the study. Through conversations with social service leads, and attending meetings, it became apparent that qualified social workers would be more likely to be the responsible practitioners working with families where the parents had a confirmed intellectual disability and assessing their parenting ability.

### Sampling method

The RGAC granted permission to complete the study at one research site, a social services office, in Birmingham. The study was publicised by a service lead during team meetings to increase the profile of the study at the research base and increase awareness amongst potential participants. Following this, the researcher attended meetings with the service lead and was introduced to available social workers. This process was repeated on five occasions during the recruitment phase, in order to access the majority of the sample

population. The researcher remained at the base for at least two hours during each visit to build rapport with the team and discuss the study with potential participants. Interested individuals were given participant information packs to review and were approached later in the visit to gauge interest. Preliminary dates and times were discussed and later confirmed via email to protect the anonymity of the participant. Despite attempts, not all were present or available during the researcher visits, and as participants were required to opt-in to the study, the sample selected for the study is best described as 'opportunist' and 'self-selected'.

**Participants**

Due to the depth of analysis required for FDA it was determined that between eight and ten participants would be sufficient to yield enough data to address the research questions. A total of fifteen individuals expressed an interest in participating in the study and provisional interview dates were agreed. Of the fifteen, one did not respond to the confirmation email, two cancelled on the day of the interview due to work demands and one did not attend the interview following email confirmation. One participant agreed to be interviewed but was an assistant social worker, not a qualified social worker, and was excluded from the study. Information on the remaining participants included in the study (n=10), ascertained from the demographic questionnaire, can be found in Table 1.

**Table 1**: Participant demographic details and previous experience relevant to the current study.

| Participant Number | Gender | Year Qualification obtained | Summary of Professional experiences of people with intellectual disabilities | Summary of Personal experiences of people with intellectual disabilities | Parent status |
|---|---|---|---|---|---|
| 1 | F | 2011 | Worked with children in care of local authority, some of whom had parents with ID. | Family member has ID | non parent |
| 2 | M | 2013 | Previous work as therapist in service for people with ID. | None | non parent |
| 3 | F | 2009 | Worked with young people with ID and a couple of parents with ID. | None | parent |
| 4 | F | 2009 | Previous role as support worker in residential service for people with ID | None | parent |
| 5 | F | 2013 | Supported mother with ID to develop skills and access services | None | non parent |
| 6 | F | 1994 | Assessed ability of mother with ID | Acted as advocate for young person with ID at school | parent |
| 7 | F | 2009 | Worked with a child with ID under care order and parents to provide support | None | non parent |

| | | | | | |
|---|---|---|---|---|---|
| 8 | F | 2013 | Previous work as a support worker with people with ID and mental health difficulties | None | non parent |
| 9 | M | 2008 | Worked with children with ID and supported their parents | Family member has an ID | non parent |
| 10 | M | 2011 | Worked with children and parents with ID | Family member has an ID | parent |

All participants reported that they had experienced working with parents with intellectual disabilities. Participants' ages were recorded and ranged from mid-twenties to early sixties.

**Data collection**

Prior to commencing the interview the participants completed the demographic questionnaire (Appendix K) and consent form. The format of the interview was adapted from the Burford Review Process (BRP; Burford, Kerr & Macleod, 2003), which utilises video in the interview. In previous studies this method had been shown to be an effective means of reviewing interpersonal processes occurring during therapy (Burford, Kerr & Macleod, 2003) and exploring early indicators of Rett disorder as observed by professionals (Burford & Jahoda, 2012). The method emphasises the development of a strong rapport between participant and interviewer and promotes a warm, engaging and open relationship in which the participant's views can be explored in order to collect in-depth qualitative data.

In previous studies (Burford & Jahoda, 2012; Burford, Kerr & Macleod, 2003) participants viewed a video relating to the topic of interest and were instructed to press a button when they observed or heard something in the video they found 'interesting', and the

time of each button press was recorded. Burford and Jahoda (2012) state that instructions are purposefully open-ended so as not to lead participants and capture a wide range of reactions to the footage observed, resulting in rich data; it is not only the where participants react that is of interest but where they do not react or where reactions differ. In these studies the time at which the participants pressed the button to indicate a reaction was recorded and once the video concluded participants were invited to discuss what had caused their reaction.

In the current study participants sat in front of a laptop with the researcher positioned at a right angle to them and slightly out of view, so as not to distract or influence them. Participants read task instructions (Appendix L) which informed them that they were to observe a fifteen minute video of a family in which both parents had intellectual disabilities. They were asked to imagine they were working with the family. They were instructed to press the 'spacebar' to pause the video when something they witnessed caused them to 'react'. Examples of different types reactions were given in the instructions, such as a 'thought' that what they were witnessing was 'good', 'bad' or 'noteworthy' or a 'feeling' such as 'happiness', 'sadness' or 'anxiety'. These examples were included to help participants understand what was meant by 'reaction', however, they were instructed to pause the video when they noticed any kind of response in order to retain the open-ended nature of BRP. Once the participant confirmed that they understood the instructions the audio recording device was activated and the video was played.

Once participants paused the video the researcher asked questions, following a semi-structured interview schedule (Appendix M), to ascertain what they reacted to and whether their previous experiences may have informed their reaction. The questions were asked immediately after the video was paused as the study was interested in exploring the participants' immediate reactions to the video footage, which may have been difficult to

capture if they were aware of the outcome of the video. Once both the researcher and participant the reaction had been fully explored the video was resumed. This continued until the end of the video, at which time the participant was asked how they experienced the family. The interview then concluded and the audio recording device switched off.

**The video**

The video used in the study was comprised of a selection of clips taken from a British television documentary, produced by RDF television. The rights to use the footage in the study was obtained from Zodiak Media. The original hour-long programme, made in 2002, presents the lives of a couple with intellectual disabilities as they raise their infant son. Clips of the programme were used to reduce interview duration, making participation more accessible.

Several measures were taken to ensure that the video clips used were suitable for the study. Firstly, the programme was discussed with the service lead. Sections of the documentary that most accurately represented the experiences of parents with intellectual disabilities accessing the service were selected. Clips that were seen to show extreme and unrepresentative behaviour, such as the father going missing overnight, were not included. Narration that may have biased participant reactions was removed. Each clip was given a title to provide the participants with context for the scene. A description of the clips included in the study can be seen in Table 2.

**Table 2.** A description of the clips included in the video observed by the participants during the interview.

| Clip number | Clip name | Duration (minutes) | Clip synopsis |
|---|---|---|---|
| 1 | [Names of family members] | 00:49 | The parents complete care tasks such as feeding, washing and playing with baby. The father can be seen doing household chores. |
| 2 | Shopping | 02:23 | The family attend the supermarket with their support worker. The support worker focusses on adhering to the set budget. The parents want to purchase items that the support worker states are not in keeping with the budget. The food the father wants is not purchased. The air freshener for the baby's bedroom that the mother wants is purchased. The cost of the shopping is three pounds and fifty pence over budget. |
| 3 | Testing baby alarm | 01:39 | The family test out the newly purchased baby alarms. Later, the parents sit on the sofa whilst the baby is crying and do not tend to him. The mother says "I' not giving into him, that what he wants". |
| 4 | [Baby's] hearing test | 01:40 | The family attend an appointment to test the baby's hearing. They are told by the health worker that the father is not allowed in the testing room as it may interfere with the test. The health worker and support worker explain the rationale but the mother does not accept this. They reach a compromise and the father is allowed in the room. |
| 5 | Speaking about [Baby] | 00:52 | The mother discusses the baby's future with the film maker and answers questions about the likelihood of the baby developing an intellectual disability. |
| 6 | Hiring new support | 02:33 | The mother reports that she has fired the support worker from the supermarket clip and hired her new neighbour, who is eight months pregnant, to support her. The neighbour comes to the family's home with her toddler and the neighbour and the mother are interviewed about the neighbour's role and care experience. |

| Clip number | Clip name | Duration (minutes) | Clip synopsis |
|---|---|---|---|
| 7 | Teleshopping | 01:28 | The parents shop for groceries using the television, without the new support worker. They have difficulty inputting the password and the father becomes frustrated. They resolve the problem and continue to shop. |
| 8 | Visiting the family planning clinic | 02:53 | The family attend the family planning clinic with a support worker and discuss having a second child with the medical professional. The professional highlights the health concerns for the mother in relation to this and some practical concerns in having two young children. The parents agree to wait two months to try for a baby, when the risk to the mother's health is reduced. |
| 9 | Bedtime | 00:41 | The father reads a story to the baby who is in his pyjamas. The mother puts the baby to bed, says "goodnight" and switches off the light. |

**Interview length and stop times**

The length of interview ranged from 29 minutes to 99 minutes with an average time of 58.6 minutes and median time of 57.5 minutes. The variation in length of interview was due to some participants stopping the video more frequently than others and therefore taking longer to complete the interview. In total the video was stopped 243 times, with an average of 24.3 stops for each participant.

**Data Analysis**

The audio recordings of the interviews were transcribed by verbatim. The researcher transcribed nine interviews and one interview was professionally transcribed. To ensure confidentiality was maintained the professional transcriber was not given any information regarding the individual being interviewed and signed a confidentiality agreement (Appendix N).

The method used to conduct FDA combined stages outlined by Willott and Griffin (1997) and Willig (2003). In order to address the research question, in-depth analysis focussed on times where participants drew specifically on their own experiences as an explanation for their reaction to the video. The process by which analysis occurred can be seen in Figure 1.

**Reflexivity statement**

It is important to consider how the researcher's own theoretical knowledge and biographical experiences contribute to the interpretation of the data (Lyons, 2007). Disclosure of these influences, via a reflexivity statement, allows for a greater understanding of the researcher's subjective position when interpreting and presenting the data.

I have clinical experience of working with people with intellectual disabilities in health services. Through this work I developed an appreciation of the challenges and oppression people with intellectual disabilities encounter and have previously researched the barriers preventing people with intellectual disabilities participating in research. I have also worked therapeutically with social workers in a primary care setting and have an appreciation for the level of complexity involved in their work and the pressures they experience. When commencing this research I had recently become a parent and often thought about what constitutes 'good enough' parenting.

When conducting the current study I remained aware of the impact these experiences have had on me and how this this may manifest. I was mindful not to let my own assumptions of what the data may show impact the analysis and accessed supervision and discussed my findings with peers. For transparency, I have included extracts of interviews to support the discourses identified and Appendix P contains pictures illustrating the analysis process.

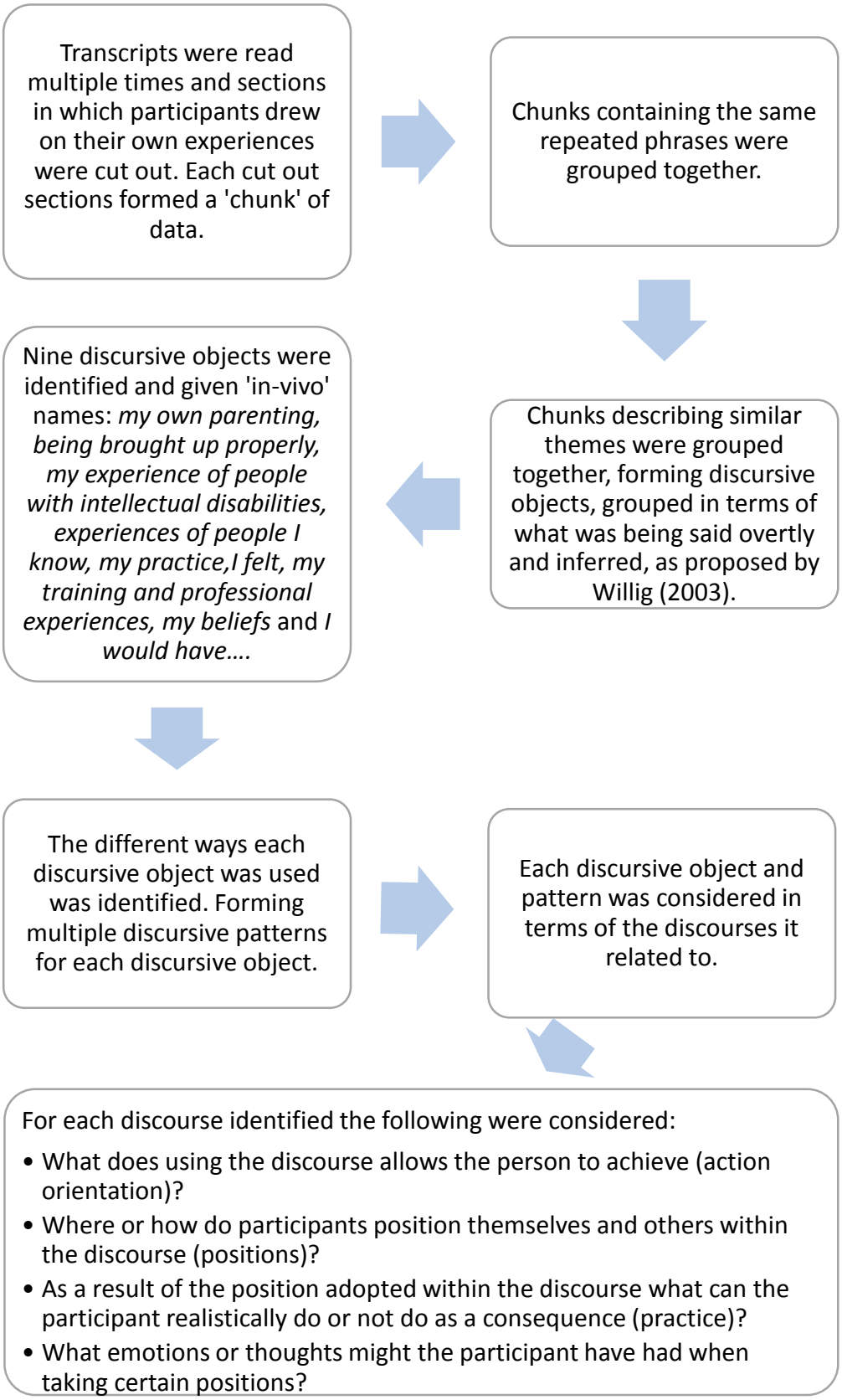



**Figure 1**. A diagram describing the process of FDA undertaken to analyse the data.

## Results

Analysis identified a number of prevalent discourses participants drew upon when discussing experiences that informed their reactions. They included *expertise and accountability, parenting the 'right' way, parenting is challenging, people with intellectual disabilities are challenging to work with, understanding is vital, people with intellectual disabilities are vulnerable, 'good' practitioner, people with intellectual disabilities are equal, people with intellectual disabilities are all the same* and *people with intellectual disabilities are individuals.* The different discourses identified in each discursive object can be seen in Table 3.

**Table 3.** The different discourses identified in each of the discursive objects.

| Discursive Objects | Discourses Identified | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Expertise and accountability | Parenting the 'right' way | Parenting is challenging | People with intellectual disabilities are challenging to work with | Understanding is vital | People with intellectual disabilities are vulnerable | 'Good' practitioner | People with intellectual disabilities as equals | People with intellectual disabilities are all the same | People with intellectual disabilities are individuals |
| **My own parenting** | ☑ | ☑ | ☑ | | | | ☑ | ☑ | | |
| **Being brought up properly** | | ☑ | | | | | | | | |
| **My experience of people with intellectual disabilities** | ☑ | | | | | | | | ☑ | ☑ |
| **Experiences of people I know** | ☑ | ☑ | | | | ☑ | | ☑ | | |
| **My practice** | | | | ☑ | | ☑ | ☑ | | | |
| **I felt** | ☑ | ☑ | | ☑ | ☑ | ☑ | | | | |
| **My training and professional experiences** | ☑ | | | ☑ | ☑ | | ☑ | | ☑ | |
| **My beliefs** | ☑ | | | | | ☑ | ☑ | ☑ | | |
| **I would have…** | ☑ | | | ☑ | ☑ | | | | ☑ | |

## How participants drew on their personal experiences

### Experiences of parenting

Throughout the video task, participants commonly reacted to practices adopted by the parents in the video and drew comparisons with their own experiences of parenting or being parented. These responses constructed two distinct discursive objects; *my own parenting* and *being brought up properly*. The consistent ways in which these objects were used allowed several discourses (wider ways of understanding and talking about something, which constructs a set of objects in reasonably predictable ways) to be identified.

Generally, when the practices of the parents in the video matched those of the participant there was a tendency to view these practices as being adequate and acceptable.

> *R: So what knowledge do you have that you're drawing upon there erm that tells you that that's a nice and good thing to do, that he's able to recognise voices and…*
>
> *P6: I think my own experience of of my own parenting and how I involved my children and then professionally we're assessing you know a couple parents with learning difficulties you know they are doing everything that I would do as well that's what I've noticed "oh I would do that". Erm (6.0)… It shows that you know they're coping at this stage yeah.*

(Extract 1 : Interview 6; Line 200)

Drawing on experiences of parenting her own children allows this participant to assess the practices observed and present a rationale as to why she believes the parents are "coping". A discourse of *expertise and accountability* is present in this extract, as using the phrases "my own experience", and "professionally" positions her as somebody who has the knowledge and expertise to be able to comment on parenting ability. Also, describing the parents as having

"learning difficulties" in need of "assessing", positions them as being in need of support and she is therefore accountable for doing this correctly.

This extract also draws upon the discourse of *parenting the 'right' way*. As the parents in the video are doing "everything she would do" she states they are "coping" and parenting in an acceptable way, indicating that there is a 'correct way' to parent. By drawing on her experiences in this way the participant creates a framework that allows her to assess the needs of the family. It can be speculated that the participant is relieved that the parents appear to be managing well and no further action is required at this point.

Disparities between participants' parenting style and that of the parents in the video tended to be viewed negatively. Clip 3, where the parents allow the baby to cry in bed, was commented on by many of the participants (7).

> *P3: So as a social worker I probably wouldn't view it in that way [risky]. I would kind of monitor it a bit further on to see how long it took them to respond to the child but from my personal parenting value base I don't leave my child to cry it out.*
>
> (Extract 2 : Interview 3; Line 73)

Here the difference between the participant's parenting and the parents observed would spur her to pay closer attention to how they respond to their child. Again this relates to *expertise and accountability*, as the participant is positioning herself as the "social worker" who will "monitor" the parents and intervene where necessary. There is an undertone of the discourse *parenting the 'right' way* as she states she would not "leave [her] child to cry it out" although she also states that she "wouldn't view it in that way [risky]". This statement seems to be used as a form of stake inoculation, a rhetoric device used by the speaker to "manage blame and responsibility in the process of accountability (being considered justifiable, rational, acceptable or believable" (Lee & Roth, 2003). Stating this at the beginning of extract

2 suggests that she recognises using her own beliefs to assess is inappropriate, and so minimises the impact this would have on her assessment. This fits with another wider discourse of being a *'good' practitioner* and working within appropriate parameters. This affords her the ability to state she does not agree with their parenting but maintain her integrity as a professional. Engaging in these discourses allows the participant to assess for risk to the child and identify where the parents may require support.

Interestingly, if the participants perceived the parents' behaviour to be inappropriate but something they had also engaged in, a different discursive pattern was adopted.

> *P3: It's hard when you are out and about with a child and stuff and you are focussed on things you need to get and remembering that even though they are in the push chair that they're still there you know and even as somebody with, someone with intellectual disabilities whatever, you know sometimes I might neglect to interact with my son when we are out…*
>
> (Extract 3: Interview 3; Line 19)

In this extract the participant engages in a discourse of *parenting is challenging* by citing "it's hard*"*, and reveals she has also "neglected to interact with [her] son" as observed in the video. This discourse allows the participant to excuse herself, and the parents in the video, for acting in this way, as they are all positioned as new parents learning how to manage. This allows her to take up a subject position of being morally justified- as parenting is difficult it is acceptable that she and the parents in the video behaved in this way.

This extract also touches upon another discourse, *people with intellectual disabilities as equals*, as the participant recognises commonalities between herself and the parents in the video. She positions herself as equal to them as she also finds it "hard" at times. Her tentative

mention of the parent's "intellectual disability" allows her to consider additional challenges they may contend with. Although it could be argued that this insinuates she views them in a worse position than herself, drawing on her own experiences of parenting allows her to identify with, and have greater empathy for them which may translate to greater levels of support in place of scrutiny.

**Experiences of being parented**

Participants who were not parents themselves tended to make comparisons between their own parents and the parents in the video. Practices concordant with their own upbringing were considered to be positive and those that were not, negative.

> *P1: …Erm just I just think it's I liked, this is a very personal thing, that I love parents read to their children. I think it's really important. I was always read to as a child I've always…and I've always loved book and I always buy books for my friends' children and family's children.*
>
> (Extract 4 : Interview 1; Line 388)

This draws heavily on the discourse of *parenting the 'right' way* by establishing that reading to children is "really important". Stating she "loves" it and describing how she promotes it to family and friends by "buying books". In doing so the participant is able to give approval to the parents in the video, as they fit with her own experiences of being parented successfully and are positioned as being able to provide the correct care.

Participants also drew on knowledge of parenting skills and child development learned through *training and professional experiences*, another of the discursive objects identified.

*P2: Umm, I'm just drawing from umm well I suppose things I've read things I've been told about and um child development um… care of a baby, watching foster carers do this day in day out ummm..*

(Extract 5: Interview 1; Line 63)

The participant in this extract qualifies their reaction to the parents in the video by presenting their professional experiences and training, thus engaging in the discourse of *expertise and accountability*. The use of "things I've read" and "day in day out" positions the participant as knowledgeable and allows them to speak with authority. However, the repeated "umm" may suggest that they are not entirely comfortable taking up this position and lack confidence in their knowledge. They may feel pressure to demonstrate expertise in order to present as a competent professional, thus engaging in the discourse *'good' professional.* It could be suggested that the participant feels vulnerable during this part of the conversation or may fear having their knowledge questioned further.

**Using personal beliefs**

Participants' reactions to the video appeared to be mediated, to some extent, by their own values creating the discursive object *my beliefs.* Generally, if they observed practices in line with their own beliefs, they were supportive.

*P6: So yeah there's an element of me understanding that personally and thinking "well that's definitely important, you pick who you want if you have that choice" erm and obviously they weren't getting on, for whatever reasons.*

(Extract 6 : Interview 6; Line 423)

The participant is reacting to the parents' decision to select a new support worker and, as she holds a belief about "hav[ing] that choice", she is able to approve of this. She appears

here to be drawing upon the discourse of *people with learning disabilities as equal*, and positions herself as an advocate for the parents' right choose. By establishing a difference between herself "personally" and the professional in the video who the parents "weren't getting on" with she presents herself as a *'good' practitioner*. Her use of the word "obviously" and by speaking as if addressing the parents in the video strengthens her apparent alignment with them. However, her use of "an element of me", a stake inoculation, allows her to have some reservations about the decision without overtly expressing this. The reservations may be due to potential risk, which draws on the discourse *people with intellectual disabilities are vulnerable*. In the extract she positions herself as both an understanding and moral practitioner and a knowledgeable expert aware of potential risks that may be revealed later. The parents are allocated conflicting attributes; as both capable of making choices and unable to make safe choices. This allows the participant to simultaneously advocate for their rights but also intervene when risk is identified and this may reflect feelings of empathy for the parents and concern for their future.

**Conflicts between personal and professional values**

Generally speaking the participants reported that their 'personal beliefs' were well matched to 'social worker values' and this allowed them to perform in their role. However at times during interview participants' expressed incongruence between their personal beliefs and the demands of the role.

> *P5: One, I don't think, even the job that I do where I'm removing babies which is extremely draconian and I'd much prefer not to remove them (quieter) but there are times where it is necessary.*
>
> (Extract 7 : Interview 5; Line 377)

Here a tension is caused by the mismatching of the participant's personal values and the job she has to perform. She refers to "removing babies" as "draconian" and states that she would "prefer not to" do it, demonstrating she is not at ease with her actions. Stating this acts as a stake inoculation as it protects her from any potential disapproval she might receive from others, and herself, for her actions; she does it but doesn't approve of it, therefore it is acceptable. Her final comment, "times where it is necessary", acts to reconcile the tension she experiences and takes up a subject position of being morally justified; despite going against her own values necessity dictates it must be done and is therefore morally acceptable. Her quiet delivery of this statement reinforces that she is not entirely comfortable with it. Her sensitivity and reflective nature may also draw on the discourse of being a *'good' practitioner*, as she is able to demonstrate an awareness of this tension but still carry out her role effectively. This allows the participant to fulfil her role without feeling guilty about compromising her personal values.

**How participants drew upon their professional experiences**

**Previous work with people with intellectual disabilities**

Participants commonly drew upon their previous professional experiences to better understand the challenges faced by the parents in the video and consider how they would best be supported and often made comparisons between their own practice and the professionals in the video.

> *P2: Umm, I suppose it's um my, my, placement with people with learning disabilities… Actually you've got to just keep it very simple, you know, one thing and I uhh, you know this is what it costs, do you want one or don't you want one.*
>
> (Extract 9 : Interview 2; Line 151)

The participant here demonstrates that his knowledge of people with intellectual disabilities comes from a valid source, his professional experiences obtained during his "placement with people with learning disabilities", engaging in the discourse *expertise and accountability*. He speaks generally about people with intellectual disabilities "you've got to just keep it very simple" which may present people with intellectual disabilities as a homogenous group, drawing on the discourse *people with intellectual disabilities are all the same.* Although a conflicting discourse, *people with intellectual are individuals* is also present in the data, this was the more predominant and was used by other participants, as shown in Table 11.

> *P10: …erm people with learning difficulties do find it difficult to understand what's been asked even a simple task like that, once they- onc-once they've got something in their- in their head erm it has to go forward, it has to go through with it and I think it causes more conflict, more drama when they're told no.*

(Extract 10 : Interview 10; Line 23)

The participant in this extract is suggesting that the professionals in the video should be more accommodating towards the parents. Here the use of "they've" presents people with intellectual disabilities as a homogenous group. In addition, by citing "conflict" and "drama when they're told no" he draws upon the discourse *people with intellectual disabilities are challenging to work with*. This participant also engages in the discourse *understanding is vital*, which suggests that in order to be successful as a parent one must have a certain level of understanding, which the parents in the video were frequently deemed to lack as they struggled with "simple tasks". People with learning disabilities are positioned as unreasonable and difficult and the professionals in the video as unaccommodating and dismissive. The

underlying emotional tone is speculated to be one of frustration, however it is unclear whether this is directed at the parents in the video or the professionals.

**Reflecting on previous professional practice**

Participants expressed emotional reactions to the practitioners in the video if they believed they were engaging in poor practices. This appeared to link closely with the discursive object *my practice* in which participants reflected on their previous work with people with intellectual disabilities.

> *P9: Yeah yeah it was it was quite a strong reaction only because I've I've I've I've probably er done it, been there, makes you ref- makes you reflect you know you see it and you think "Arr I don't like that" you know and knowing that I've probably…*
>
> (Extract 11 : Interview 9; Line 339)

The participant in this extract explains that the reason for their "strong reaction" is that they have acted in similar ways, although he attempts to minimise this by using "quite" and "probably" twice. This stake inoculation may be employed because admitting his past errors could make him vulnerable to criticism in the discourse *'good' practitioner* and his repetition of "I've" may demonstrate his anxiety about exposing himself in this way. It seems that there is a tension created between the ideal standards of being a *'good' practitioner* and the practices he has engaged in, which he consider to be poor. Being confronted with these in the video results in his strong reaction. The word "reflect" may be used by the participant to repair any damage to his professional reputation caused by his admission, as reflecting on one's practice is regarded positively, restoring his credibility within this discourse. Here the participant is positioned as being an acceptably flawed person and this allows him to

empathise with the professionals in the video, which may also draw on the discourse *people with intellectual disabilities are challenging to work with*.

## Discussion

Previous research identified that professionals' assessments are informed by a wide range of experiences and knowledge, some tangible (e.g. case specific factors, training, policy and guidance) and some intangible (e.g. emotional responses, 'gut feelings', organisational pressures)(Doyle et al, 2009; Hansen et al, 1997; Howarth, 2007). Furthermore, evidence suggests that professional's attitudes are not fixed and that variations in approach occur at individual (Starke, 2011) and organisational levels (Howarth, 2007; Ward & Tarleton, 2007). It has been suggested that when working with parents with intellectual disabilities professionals are more likely to perceive risk (Goodinge, 2000; McConnell & Llewellyn, 2000; Proctor & Azar, 2013), contributing to a disproportionate number of parents with intellectual disabilities involved in child protection proceedings (Llewelln, McConnell & Ferronato, 2003). The aim of this study was to explore how social worker's past personal and professional experiences were drawn upon when observing parent with intellectual disabilities, to gain a better understanding of how these processes inform their reactions.

The results showed that participants drew upon their past personal and professional experiences in multiple ways in order to account for their reactions to the video. Although these often intertwined there appeared to be some instances when personal experiences were used more predominantly in the participants' reaction, and some when professional experiences played a more significant role.

When commenting on the parenting practices observed it was common for participants who had children to draw upon their personal experiences of being a parent, in preference to their training and professional experiences. These participants often compared parents in the video with themselves, with a tendency to view discrepancies as an indication that the parents

required support. This occurred within the discourse *parenting in the right way* and although there is the acknowledgement that parents can and do adopt different practices, it suggests that the participants believe their practices to be the most effective. This could suggest that the participants, as social workers, may perceive risk when working with parents with intellectual disabilities where there may be simply be a difference in parenting style.

Conversely, there was also the tendency for participants to be more accepting of 'undesirable' parenting behaviour if they had also used it, which could lead to risks being overlooked. For example, participant 3 believed that the parents leaving their child to cry in bed warranted further monitoring as it may have been indicative of neglect whereas, participant 4, based on her own parenting experience, views this an important practice to help the baby "settle into a routine" and therefore would not intervene. This finding is consistent with previous studies which have found that parents with intellectual disabilities have been "praised and criticised by different workers" for the same action (Ward & Tarleton, 2007).

It is not the purpose of this paper to qualify the perspectives of the two participants as correct or incorrect as there are distinct advantages and disadvantages for both, and were both used with the best interests and of the family and child in mind. In a 'real-life situation' Participant 3 may be in a better position to identify risk, although her hypervigilance may be detrimental to her relationship with the parents as they may perceive her as 'waiting for them to fail', a barrier to effective working relationships between parents with intellectual disabilities and social workers (Tarleton et al, 2006). Participant 4 may be more successful at developing a successful relationship with parents she works with leading to increased engagement (Tarleton, 2007). However, she may be accepting of less desirable and potentially risky behaviours which could be detrimental to the child and family. Both of these

perspectives are within the wider discourse *parenting the right way* as the participants' perspectives are based on the belief that 'their way' is the most suitable method of parenting.

Interestingly, no participants suggested that the parents in the video were more successful in areas of parenting than they were. This may be because generally parents do not overtly criticise the choices they themselves make in terms of their child care. This may be because to do so would admit failing your children or putting them in jeopardy, which falls short of *parenting the right way*. This is a powerful discourse as there is a strong stigma attached to failing children in this way and the consequences, such as losing custody of your child, are experienced as shaming (Child Welfare Information Gateway, 2013). Even when participants did 'confess' to using undesirable practices they did not state this was due to inadequate parenting but by drawing on the discourse *parenting is challenging*, as this is more comfortable than admitting to engaging in practices that may be detrimental to your child. This is in-keeping with Howarth's (2007) finding that professionals are less likely to raise safeguarding concerns if they believe they would also struggle in the same situation.

Similarly, participants without children compared the parents in the video to their own parents and were more likely to approve of practices they recognised from their own childhoods. This could lead to a similar bias as they may be more likely to defend undesirable practices as to prevent them from casting aspersions on their own parents, highlighting a potential 'blind-spot'.

The tendency for participants to respond favourably to the parents in the video when they observed similarities with their own parenting, or the way they were parented, is consistent with Social Identity Theory (Tajfel & Turner, 1986) and showing preference to those with whom we share something in common. It has been demonstrated that cognitive

biases occur that cause us to appraise the actions and traits of those we perceive to be similar to ourselves (the 'in-group') more positively than of those we perceive to be different (the 'out-group'), even when the similarities and differences are small (Otten & Moskowitz, 2000). Research also suggests that when we perceive another to be similar to ourselves we tend to use the part of the brain that is activated when accessing our own experiences, the ventral region of the medial prefrontal cortex, to infer the beliefs and traits of the other person (Mitchell, Macrae & Banaji, 2006). Therefore, in the current study, similarities in parenting style may lead the participants to project their own attitudes onto the parents in the video and assume low risk or, conversely, perceive risk where parenting practices differ.

The use of personal experiences to assess parenting skills may also be due to the undefined nature of the term 'good enough parenting' which has been cited previously as causing confusion (Starke, 2011) due to being open to interpretation (Beth & Tarleton, 2007). In lieu of a structured definition to follow, social workers may draw upon their own experiences, which could result in inconsistent practice across services.

Brown (1994) suggested two prominent, conflicting societal views of people with intellectual disabilities; one, that they are vulnerable and need protection and two, that they pose a threat. The participants drew heavily on the first of these views, often using past professional experiences in which people with intellectual disabilities had placed themselves in risky situations, which was evident in the discourse *people with intellectual disabilities are vulnerable*. Participants also drew upon personal experiences of people in their life who had been vulnerable and exploited by others in order to identify potential risks. This meant that when viewing the video, particularly clip 6, participants tended to be concerned that the parents were exposing themselves, and their child, to risk.

This reaction is consistent with previous literature which suggests that parents with intellectual disabilities are perceived to be more likely to neglect their children or fail to protect them (MacDonald, 2009; McGaw et al, 2010). Rarely did participants view the parents as being threatening or dangerous. Instead, greater emphasis was placed on the parents' ability to understand what was required of them in order to successfully care for their child and where this was seen to be lacking participants reacted with concern. This engaged with the wider discourse *understanding is vital.* Difficulties understanding was viewed as a barrier and, as it is unlikely the parents have the knowledge of child development and attachment the social workers possess, there may be the perception that they lack the understanding and knowledge to provide appropriate care. This view is not consistent with research as intelligence is not a predictor of adequate care giving, providing IQ is above 50-60 (Tymchuk, Andron & Unger, 1987; Tymchuk, Andron & Hagelstein 1990).

An interplay between the participants' personal beliefs and their beliefs as a social worker was identified. Participants supported the rights of, and advocated for, people with intellectual disabilities, stating that this was based on personal beliefs such as 'equality' and 'the right to choose'. Many suggested that these values developed during childhood, formed part of their identity and were a likely contributing factor to their decision to become a social worker, as these values are congruent with social worker values (General Social Care Council; GSCC, 2010). Although there is no doubt they do hold these values they may have suspected their practice would be scrutinised during the interview and felt pressured to demonstrate that they operate in morally justifiable ways, thus responses may have been affected by social desirability bias (Phillips & Clancy, 1972).

When considering risk participants tended to draw more heavily upon their previous professional experiences of working with people with intellectual disabilities. Participants

generated examples of when their previous service users had struggled to accomplish tasks due to barriers to their understanding and this was projected onto the parents in the video (i.e. 'experience tells me people with intellectual disabilities struggle to understand and therefore these parents may struggle also'). Participants operated within the discourses *people with intellectual disabilities are vulnerable* and *people with intellectual disabilities are challenging to work with* to help to identify potential difficulties the parent may have and how this may translate to risk to the child. By drawing on past professional experiences the participants were able to use their expertise to consider what types of support may be of benefit to the parents in the video to minimise or manage risk. Although this is done in order to support the family it also drew on the wider discourse *people with intellectual disabilities are all the same*, which could be viewed as using stereotypes in order to judge parenting ability. It has been suggested in previous research (Goodinge, 2000; McConnell & Llewellyn, 2000) that the over-representation of parents with intellectual disabilities could be due in part to the effect of stereotypes on the assessment process. One possibility is that when these stereotypes are activated, particularly those around parents with intellectual disabilities posing a greater threat to their children (Proctor & Azar, 2013), anxiety is increased and an attentional bias is created that increases the likelihood of threat being identified, even in the absence of actual threat (Ford et al, 2010).

Although the participants frequently stated they did not agree with the discourse *people with intellectual disabilities are all the same* there remained a tendency to use generalisations when reacting to the parents in the video in order to identify risk. This may indicate that assessing and minimising risk takes priority over adhering to beliefs such as treating people as individuals. By 'putting the child first' it becomes acceptable to carry out practices that contravene their own personal beliefs as maintaining the child's safety

necessitates that these actions occur, drawing on discourses of being *'good' practitioner* and positioning themselves as being morally justified in their actions. This could explain previous findings by Starke et al. (2011) that professionals' attitudes to parents with intellectual disabilities changed depending on whether the child was placed with the parents or outside the home.

The emotional reactions participants displayed, especially those of anger and sadness, may be the result of a conflict between their personal values and the practices they engage in (Comartin & Gonzalez-Prendes, 2011). Participant 9 recognised that his angry response to the professionals in the video was due to identifying ways of working that he disagreed with but had engaged in. Participant 7 expressed "feeling sad" in response to the parents in the video, which she attributed to observing the parents' difficulties understanding. There was a recognition that the parents were trying to care for their child but struggled in some areas, resulting in feelings of sadness and at times frustration. Similar results were seen in Proctor and Azar's (2013) study, in which vignettes describing parents with intellectual disabilities neglecting their child were more likely to evoke feelings of pity in participants (Child Protection Services workers) than the same vignette with non-intellectual disabled parents. Participants also reported a greater willingness to help parents with intellectual disabilities who had neglected a child rather than non-intellectually disabled parents, who tended to evoke greater levels of anger and disgust in participants. For the participants in the current study the recognition that the parents in the video love their child and are not abusive but restricted by their difficulties created an uncomfortable tension that was difficult to resolve. The participants expressed a willingness to offer them support but also had to consider the risk to the child, resulting in a combination of strong emotions. This strong reaction which

may also feed into the discourse *people with intellectual disabilities are challenging to work with* and is consistent with previous research (Starke, 2011).

As Table 3 illustrates the most common discourse that the participants engaged in was that of *expertise and accountability* in which both professional and personal experience featured heavily. This was partly due to the task itself; participants were asked to consider why they experienced particular reactions, which may have led participants to present rationales for these. However, another possibility is that due to the scrutiny and pressure social workers are under from managers, the government and the public, they feel that they must demonstrate expertise to justify their actions. Although professional accountability is important to ensure safe practice (GSCC, 2010) there are risks in having to maintain this position, for example reduced reflective capacity. Participant 9 drew on his own professional experiences when observing undesirable professional practice in the video. His awareness of his own past practice, and his strong emotional reaction to this, allowed him position himself as a flawed human, rather than an expert, and learn from his past practice in order to improve. This drew on wider discourses of a *'good' practitioner* as reflective practice is encouraged. However if social workers feel they must maintain the expert position in order to justify their actions, in response to organisational pressures, the opportunity for honest reflection is narrowed (Ruch, 2007).

**Strengths and weaknesses of study**

In-keeping with the methodology of the BRP, participants were instructed to pause the video once they recognised they were reacting to what they observed or heard, specifically their 'thoughts and 'feelings'. This drew heavily on cognitive theories of emotional responses (Arnold, 1960; Smith & Lazarus, 1993) which hold that the way in which we think about (appraise) a situation or stimulus creates an emotional reaction. This theoretical approach

appeared an acceptable conceptualisation of 'internal responses'; participants frequently paused the video to explain their thought processes in response to the video, or were able to identify an initial emotional response, followed by the thoughts that generated it.

One possible limitation is that this narrowed the meaning of 'internal reaction' as it neglected other concepts. For example, it has been shown that different emotions are associated with changes in physiological states (Levenson, 1992); fear (anxiety) anger and sadness are associated with increased heart rate. It is possible that these physiological changes occurred in the participants as they viewed the video but as they were monitoring their thoughts and feelings they did not attend to this and respond accordingly. The cognitive theories of emotional response are also somewhat reliant on the participant being consciously aware of their thought processes in order to report their reactions. However, it is possible that participants' reactions to the parents in the video occurred unconsciously (Bargh & Morsella, 2008) and were therefore unreported.

Despite this possible limitation BRP appeared a successful method order to elicit participant reactions. This yielded a great deal of data and developing rapport with participants prior to the interview appeared helpful in achieving this. Presenting all participants with the same video allowed for comparisons to be made between their responses and consider the possible reasons for this. The use of FDA appears to have been an appropriate method of analysis, as it allowed for a deeper level of analysis that considered how participants responded and the implications of this, rather than focussing on the content of the conversation alone which may have been influenced by social desirability bias (Phillips & Clancy, 1972).

One limitation of the study was that all participants were recruited from a single research site. Therefore the participants may have been influenced by cultural attitudes specific to that location and generalising the findings to a wider population of social workers is not justified. Also, there was a large variation in the number of reactions between participants, which may suggest that some participants were not stopping the video when they experienced a reaction to the video. However, this variation may reflect the participants' styles of working, as those who responded fewer times tended to wait until the conclusion of a scene before expressing their reactions. Participants may have also felt pressured to demonstrate that they work in a reflective, measured way, and so were reluctant to respond to the video in haste. This is supported by the identification of the discourse *'good' practitioner*, in which participants, understandably, appeared to want to present themselves in a positive professional light.

**Conclusions**

This study showed that the participants' reactions to parents with intellectual disabilities whilst viewing the video drew heavily on their previous experiences, both from the personal and professional spheres. Participants drew upon their personal experiences of parenting and being parented which appeared to influence how competent they considered the parents in the video to be. Past professional experiences were drawn upon when considering the challenges the parents may encounter and when they had concerns regarding risk. Although many felt that there was a synchronicity between their personal values and the professional values at the core of social work, at times when these conflicted there was a tendency to be led by professional values, especially if it meant protecting a child. A number of different discourses were identified which were used by the participants to resolve the conflicts between their personal and professional beliefs. Professional experiences, were more

heavily drawn upon when participants discussed intellectual disabilities and although there was a tendency to make generalisations and use stereotypes this was primarily used to help participants consider potential risks and where support would be of greatest benefit. Despite the same video being shown to each participant a range of reactions to the parents' choices and practices were reported, suggesting that personal factors may play a part in this. However, issues surrounding risk received consistent responses across participants.

**Clinical implications**

The findings of this study suggest that social worker practice may vary due to individual variability and the influence of social workers' personal experiences on their assessments. Although no conclusion can be reached as to whether drawing upon personal experiences is an advantage or disadvantage, it remains important to maintain awareness of the role it plays in the way in which parents with intellectual disabilities are perceived by social workers. The video and interview drew out various, and at times conflicting, beliefs about parenting, intellectual disabilities, their personal values and the work they do. At times these beliefs were incongruent which appeared to result in a tension. This may explain some of the anxiety social workers have expressed regarding their work with parents with intellectual disabilities in previous research (Starke, 2011). Participants expressed an awareness of the importance of reflective practice to explore and resolve these tensions although most stated they preferred to do this informally with colleagues than in supervision with managers

**Recommendations**

Based on the findings of this study it can be suggested that services should continue to support social workers in recognising the impact their previous experiences have on their perceptions of parents with intellectual disabilities. It may be beneficial for services to

consider how social workers can draw upon these experiences to enhance their practice rather than attempt to minimise the influence personal experiences, such as personal beliefs and parenting style, may have on professional practice. As participants stated they feel more comfortable engaging in reflective practice with colleagues the use of reflective practice groups may provide an appropriate forum for this to occur. This could help embed reflective practice into the culture of the service and allow for transparent conversations regarding the interplay between personal and professional experiences and the impact this may have on practice.

**Further research**

As all participants were recruited from the same research site it would be beneficial for studies into the use of personal and professional experiences of this nature to be carried out across multiple sites and geographical locations. This would make it possible to see if the findings from this study are replicated over a larger population of social workers.

Despite feedback from participants that they found the video thought provoking the study may have lacked ecological validity, as the participants were not working with the parents in the video. It may be useful for similar studies to be carried out that explore social workers experiences as they work with 'real cases' to see the findings from this study are replicated. However, the ethical issues involved in this would warrant careful consideration i.e. would the research effect the decisions the participants make and what the consequences of this may be.

The current study also found that some participants appeared to find reflecting on their practice challenging, for reasons outlined above. Further research into the barriers that prevent

reflective practice may help services to support social workers to engage in reflective practice more frequently.

## References


Arnold, M. B. (1960). *Emotion and personality. Volume I: Psychological aspects*. New York: Columbia University Press.

Aunos, M., & Feldman, M. A. (2002). Attitudes towards sexuality, sterilization and parenting rights of persons with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities, 15,* 285–296. doi: 10.1046/j.1468-3148.2002.00135.x.

Azar, S. T., Robinson, L. R., & Proctor, S. N. (2012). Chronic neglect and services without borders: A guiding model for social service enhancement to address the needs of parents with intellectual disabilities. *Journal of Mental Health Research and Intellectual Disabilities, 5(2),* 130-156. doi: 10.1080/19315864.2011.592238.

Barker, D. (1983). How to curb the fertility of the unfit: The feeble-minded in Edwardian Britain. *Oxford Review of Education, 9(3),* 197-211. doi: 10.1080/0305498830090304.

Bloomfield, L., Kendall, S., & Fortuna, S. (2010). Supporting Parents: development of a tool to measure self-efficacy of parents with learning disabilities. *British Journal of Learning Disabilities, 38,* 303-309. doi: 10.1111/j.1468-3156.2009.00607.x.

Booth, T., & Booth, W. (2004). Brief research report: Findings from a court study of care proceedings involving parents with intellectual disabilities. *Journal of Policy and Practice in Intellectual Disabilities, 1,* 179-181. doi: 10.1111/j.1741-1130.2004.04032.x.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77-101. doi: 10.1191/1478088706qp063oa.

Brown, H. (1994). ‘‘An ordinary sexual life?’’: A review of the normalisation principle as it applies to sexual options of people with learning disabilities. *Disability & Society, 9,* 123–145. doi: 10.1080/09687599466780181.

Burford, B., & Jahoda, A. (2012). Do video reviews of therapy sessions help people with intellectual disabilities describe their perceptions of cognitive behavioural therapy? *Journal of Intellectual Disability Research, 56 (2),* 179-190. doi: 10.1111/j.1365-2788.2011.01450.x.

Burford, B., Kerr, A. M., & Macleod, H. A. (2003). Nurse recognition of early deviation in development in home videos of infants with Rett disorder. *Journal of Intellectual Disability Research, 47(8),* 588-596. doi: 10.1111/j. 1365-2788.2011.01450.x.

Carlson, G., Taylor, M., & Wilson, J. (2000). Sterilisation, drugs which suppress sexual drive, and young men who have intellectual disability. *Journal of Intellectual and Developmental Disability, 25(2),* 91-104. doi: 10.1080/13269780050033517.

Child Welfare Information Gateway. (2013). *Impact of adoption on birth parents*. Washington, DC: Children's Bureau. Retrieved from: https://www.childwelfare.gov/pubs/f-impact/?hasBeenRedirected=1.

Comartin, E. B., & Gonzalez-Prendes, A. A. (2011). Dissonance between personal and professional values: Resolution of an ethical dilemma. *Journal of Social Work Values and Ethics*, 8*(2),* 5-14.

Cuskelly, M., & Bryde, R. (2004). Attitudes towards the sexuality of adults with an intellectual disability: parents, support staff, and a community sample. *Journal of Intellectual and Developmental Disability, 29(3*), 255-264. doi: 10.1080/13668250412331285136.

Department of Health. (2001). V*aluing people: a new strategy for learning disability for the 21st century.* London: Department of Health.

Department of Health. (2009). *Valuing People Now: A new three-year strategy for people with learning disabilities.* London: The Stationery Office.

Doyle, O. Z., Miller, S. E., & Mirza, F. Y. (2009). Ethical Decision-Making in Social Work: Exploring Personal and Professional Values. *Journal of Social Work Values and Ethics, 6* (1).

Feldman, M. A., & Case, L. (1997). The effectiveness of audiovisual self-instructional materials in teaching child-care skills to parents with intellectual disabilities. *Journal of Behavioral Education, 7 (2),* 235-257. doi: 10.1023/A:1022897226255.

Feldman, M., & Case, L. (1999). Teaching child-care and safety skills to parents with intellectual disabilities through self-learning. *Journal of Intellectual & Developmental Disability, 24(1),* 27-44. doi: 10.1080/13668259900033861.

Ford, B. Q., Tamir, M., Brunye, T. T., Shirer, W. R., Mahoney, C. R. & Taylor, H. A. (2010). Keeping your eyes on the prize: Anger and visual attention to threat and rewards. *Psychological Science, 21,* 1098-1105.

General Social Care Council. (2010). *Codes of practice for social workers*. London: General Social Care Council. Retrieved from: http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCEQFjAA&url=http%3A%2F%2Fwww.scie.org.uk%2Fworkforce%2Ffiles%2FCodesofPracticeforSocialCareWorkers.pdf&ei=p45jVcToHoGasAGhloGoBg&usg=AFQjCNE_O_02_9BYZFp38WyVXjDIiz4BdQ&sig2=Wh28Nn5ujw63e6Qsd5o9Cw&bvm=bv.93990622,d.ZGU

Goodinge, S. (2000). *A jigsaw of services: Inspection of services to support disabled adults in their parenting role*. London: DH.

Guinea, S. M. (2001). Parents with a learning disability and their reviews on support received: A preliminary study. *Journal of Intellectual Disabilities, 5,* 43-56. doi: 10.1177/146900470100500106.

Hansen, D. J., Bumby, K. M., Lundquist, L. M., Chandler, R. M., Le, P. T., & Futa, K. T. (1997). The influence of case and professional variables on the identification and reporting of child

maltreatment: A study of licensed psychologists and certified masters social workers. *Journal of Family Violence, Vol 12 (3*), 313- 332. doi: 10.1023/A:1022852921883.

Holloway, W. (1983). Heterosexual sex: Power and the desire for the other. In S. Cartledge & J. Ryan (Eds.), *Sex and Love: New Thoughts on Old Contradictions* (pp.124-140), London: Women's Press.

Horwarth, J. (2007). The missing assessment domain: personal, professional and organisational factors influencing professional judgements when identifying and referring child neglect. *British Journal of Social Work, 37*, 1285-1303. doi: 10.1093/bjsw/bcl029.

Lee, Y.L., & Roth, W, M. (2003). Making a Scientist: Discursive "doing" of identity and self-presentation during research interviews. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 5(1), Art. 12. Retrieved from: http://nbn-resolving.de/urn:nbn:de:0114-fqs0401123.

Llewellyn, G., McConnell, D., & Ferronato, L. (2003). Prevalence and outcomes for parents with disabilities and their children in an Australian court sample. *Child Abuse & Neglect, 27(3)*, 235-251. doi: 10.1016/S0145-2134(03)00004-8.

Llewellyn, G., McConnell, D., Russo, D., Mayes, R., & Honey, A. (2003). Promoting health and home safety for children of parents with intellectual disability: a randomised controlled trial. *Research in Developmental Disabilities, 24*, 405- 431. doi: 10.1016/j.ridd.2003.06.001.

Lord Laming. (2003). *The Victoria Climbie Inquiry. Report of an Inquiry by Lord Laming*. London: The Stationary Office. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/.../5730.pdf

Lyons, E. (2007). Analysing qualitative data: comparative reflections. In E. Lyons, & A. Coyle (Eds.), *Analysing Qualitative Data in Psychology (pp. 158-173)*. London: Sage Publications.

MacDonald, L. (2009). Do parents with learning disabilities have adequate parenting skills to safeguard their children? *Journal of Neonatal Nursing, 15,* 212-217. doi: 10.1016/j.jnn.2009.07.013.

McConnell, D., & Llewellyn, G. (2000). Disability and discrimination in statutory child protection proceedings. *Disability & Society, 15(6),* 883-895. doi: 10.1080/713662015.

McGaw, S., Scully, T., & Pritchard, C. (2010). Predicting the unpredictable? Identifying high-risk versus low risk parents with intellectual disabilities. *Child Abuse & Neglect, 34,* 699-710. doi: 10.1016/j.chiabu. 2010.02.006.

Mitchell, J. P., Macrae, C. N., & Banaji, M. R. (2006). Dissociable medial prefrontal contributions to judgements of similar and dissimilar others. *Neuron, 50,* 655-663. doi: 10.1016/j.neuron.2006.03.040.

Otten, S., & Moskowitz, G. B. (2000). Evidence of evaluative in-group bias: Affect-biased spontaneous trait inference in a minimal group paradigm. *Journal of Experimental Social Psychology, 36,* 77-89. doi:10.1006/jesp.1999.1399.

Parker, I. (2013). Discourse Analysis: Dimensions of critique in psychology. *Qualitative Research in Psychology, 10,* 223-239. doi: 10.1080/14780887.2012.741509.

Phillips, D. L., & Clancy, K. J. (1972). Some Effects of 'Social Desirability' in Survey Studies. *American Journal of Sociology*, 77*(5)*, 921-940.

Proctor, S. N., & Azar, S. T. (2013). The effect of parental disability status on child protection service worker decision making. Journal of Intellectual Disability Research, 57 (12), 1104-1116. doi: 10.1111/j.1365-2788.2012.01623.x

Ruch, G. (2007). Reflective practice in contemporary child-care social work: The role of containment. *British Journal of Social Work, 37,* 659-680. doi: 10.1093/bjsw/bch277.

Smith, C. A., & Lazarus, R.S. (1993). Appraisal components, core relational themes and the emotions. *Cognition and Emotion, (7),* 233-269. doi: 10.1080/02699939308409189

Starke, M. (2011). Supporting families with parents with intellectual disabilities: views and experiences of professionals in the field. *Journal of Policy and Practice in Intellectual Disabilities, 8,* 163-171. doi: 10.1111/j.1741-1130.2011.00306.x.

Starks, H., & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380. doi:10.1177/1049732307307031.

Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behaviour. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations* (pp. 7-24). Chicago: Nelson-Hall.

Tarleton, B. (2007). Specialist advocacy services for parents with learning disabilities involved in child care proceeding. *British Journal of Learning Disabilities, 36*, 134-139. doi: 10.1111/j.1468-3156.2007.00479.x.

Tarleton, B., & Ward, L. (2007). "Parenting with support": the views and experiences of parent with intellectual disabilities. *Journal of Policy and Practice in Intellectual Disabilities, 4(3),* 194-202. doi: 10.1111/j.1741-1130.2007.00118.x.

Tarleton, B., Ward, L., & Howarth, J. (2006). *Finding the right support. A review of issues and a positive practice in supporting parents with learning difficulties and their children.* London, Baring Foundation.

Tilley, E., Earle, S., Walmsley, J., & Atkinson, D. (2012). 'The Silence is roaring': sterilization, reproductive rights and women with intellectual disabilities. Disability and Society, 27(3) pp. 413–426. doi: 10.1080/09687599.2012.654991.

Tymchuk, A., Andron, L., & Hagelstein, M. (1992). Training mothers with mental retardation to discuss home safety and emergencies with their children. *Journal of Developmental and Physical Disabilities, 4,* 151-165. doi: 10.1007/BF01046397.

Tymchuk, A.J., Andron, L., & Unger, O. (1987). Parents with mental handicaps and adequate childcare – a review. *Mental Handicap, 15,* 49–53. doi: 10.1111/j.1468-3156.1987.tb00393.x.

Tymchuk, A., Hamada, D., Andron, L., & Anderson, S. (1990). Home safety training with mothers who are mentally retarded. *Education and Training of the Mentally Retarded,* 25, 142-149.

Ussher, J. M., & Perz, J. (2014). Discourse analysis. In P. Rohleder & A. C. Lyons (Eds.), *Qualitative research in clinical and health psychology*. Basingstoke: Palgrave Macmillan.

Wade, C., Llewellyn, G., & Matthews, J. (2008). Review of parent training interventions for parents with intellectual disability. *Journal of Applied Research in Intellectual Disabilities, 21,* 351–366. doi: 10.1111/j.1468-3148.2008.00449.x.

Ward, L., & Tarleton, B. (2007). Sinking or swimming? Supporting parents with learning disabilities and their children. *Learning Disabilities Review, 12(2),* 22-32. doi: 10.1108/13595474200700014.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method.* Buckingham: Open University Press.

Willig, C. (2003). Discourse analysis. In J. A. Smith (Eds.*), Qualitative psychology: a practical guide to research methods* (pp. 159-183). London: SAGE Publications.

Willott, S., & Griffin, C. (1997). Wham bam, am I a man?': Unemployed men talk about masculinities. *Feminism & Psychology*, *7*(1), 107-128. doi: 10.1177/0959353597071012.

# CHAPTER THREE:

# EXECUTIVE SUMMARY

Department of Clinical Psychology

School of Psychology

University of Birmingham

May 2015

## Supporting Families to Stay Together

This document summarises two papers submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology at the University of Birmingham. Firstly, a systematic literature review exploring the effectiveness of attachment-based interventions when used with families in which parents have committed child abuse is presented. Secondly, an empirical paper exploring the way in which social workers draw upon their personal and professional experiences when assessing parents with intellectual disabilities is summarised.

**Literature Review:** *Exploring the effectiveness of attachment-based interventions when used with families in which the parents have committed child abuse*

**Background:** The number of children believed to be victims of abuse or potential abuse and under a child protection plan, reached 42,900 in 2012 (Department for Education, 2012). Child abuse is associated with developmental, physical and psychological difficulties, occurring throughout the child's life (Widom, 2000). Child Welfare Services intervene when abuse is suspected, and work with the family to reduce risk. Recently, interventions focussing on developing the relationship, or attachment (Bowlby, 1982), between the parent and child have been shown to have better short-medium term effects on abusive behaviour than parent skills training (Tarabulsy et al, 2008). A review found these interventions are effective (Bakermans-Kranenburg, van IJzendoorn & Juffer, 2003) at improving attachment when used with vulnerable families but a systematic review of their effectiveness with families in which parents have committed child abuse, has not previously been conducted.

**Aims:** The aim of this review was to explore whether attachment based intervention were effective when used with families in which parents had abused their child. Of particular

interest was the effect attachment-based interventions have on i) parental sensitivity, ii) parent-child attachment security and organisation and iii) rates of future abuse.

**Method:** A systematic search of four electronic databases was completed to identify papers in which attachment-based interventions were delivered to families in which parents had committed child abuse and outcomes were reported relating to the aims of the review. Eleven papers met inclusion criteria. The methodological quality of each paper was assessed and the data was extracted.

**Findings:** A decrease in parent's insensitive and frightening behaviours and an increase in sensitivity and responsiveness to their children was found. Enhanced parent-child attachment was also reported, with more children who received the attachment-based interventions developing healthier attachments to their parents than children who did not. Finally, attachment-based interventions were shown to reduce future abuse and had longer lasting effects than other interventions delivered.

**Conclusions:** The findings suggest that attachment-based interventions are effective when used with families in which parents have committed child abuse. However, methodological weaknesses were identified in the papers which suggests results should be generalised with caution. The implication of the findings is that these interventions could be used in services to manage risk and reduce future abuse, although more robust studies are required to develop knowledge around the most effective delivery.

**Empirical Paper:** *Exploring the interplay between social workers' personal and professional experiences when discussing the competence of parents with intellectual disabilities.*

**Background:** Parents with intellectual disabilities are over-represented in child care proceedings (Booth and Booth, 2004) and are more likely than other 'at-risk' groups to have

their children removed (McConnell & Llewellyn, 2000). This may be indicative of additional processes occurring, such as assumptions being made about their ability to parent (Goodinge, 2000) and the use of stereotypes (McConnell & Llewellyn, 2000). Research has shown that health and social care professional are not always certain about how to best support parents with intellectual disabilities (Starke, 2011) and that practitioners' assessments are influenced by personal factors. (Doyle, et al., 2009; Hansen et al., 1997; Horwarth, 2007).

**Aims:** The aim of the current study was to explore the way in which social workers draw upon their personal and professional experiences, in order to gain a better understanding of this process and consider how it might influence the way they think about parents with intellectual disabilities.

**Method:** Ten social workers viewed video clips of parents with intellectual disabilities and paused the video when they saw or heard something that caused a 'reaction' (a thought or feeling) in them (Burford, Kerr & Macleod, 2003). They were interviewed about their reaction and how it drew upon their previous experiences. The interviews were recorded and transcribed and the data analysed using Foucauldian Discourse Analysis as described by Willig (2001; 2003).

**Analysis**: It appeared that participants who were parents themselves used their own experiences of parenting as a framework when discussing the competencies of the parents in the video and participants without children tended to use the way in which they were parented in similar ways. Professional experiences were heavily drawn upon when considering the type of support the parents in the video may require. At times it appeared participant's personal beliefs conflicted with the demands of their role, leading to tensions.

**Discussion:** Participants' drew upon their previous professional and personal experiences in complex, and at times, conflicting ways. It was believed that this would have advantages and disadvantages in practice. It is recommended that supervision be used to manage this effectively, but barriers to reflective practice may need to be considered first.

**References**


Bakermans-Kranenburg, M. J., van IJzendoorn, M. H., & Juffer, F. (2003). Less Is More: Meta-Analyses of Sensitivity and Attachment Interventions in Early Childhood. *Psychological Bulletin, 129(2),* 295-215. DOI: 10.1037/0033-2909.129.2.195.

Booth, T., & Booth, W. (2004). Brief research report: Findings from a court study of care proceedings involving parents with intellectual disabilities. *Journal of Policy and Practice in Intellectual Disabilities, 1,* 179-181. doi: 10.1111/j.1741-1130.2004.04032.x.

Bowlby, J. (1982). Attachment and loss: retrospect and prospect. *American Journal of Orthopsychiatry, 52 (4),* 664-678. doi: 10.1111/j.1939-0025.1982.tb01456.x.

Department for Education. (2012). *Characteristics of children in need in England, 2011–12.* London: Department of Education. Retrieved from http://www.education.gov.uk/rsgateway/DB/SFR/s001095/index.shtml

Doyle, O. Z., Miller, S. E., & Mirza, F. Y. (2009). Ethical Decision-Making in Social Work: Exploring Personal and Professional Values. *Journal of Social Work Values and Ethics, 6* (1).

Goodinge, S. (2000). *A jigsaw of services: Inspection of services to support disabled adults in their parenting role*. London: DH.

Hansen, D. J., Bumby, K. M., Lundquist, L. M., Chandler, R. M., Le, P. T., & Futa, K. T. (1997). The influence of case and professional variables on the identification and reporting of child maltreatment: A study of licensed psychologists and certified masters social workers. *Journal of Family Violence, Vol 12 (3*), 313- 332. doi: 10.1023/A:1022852921883.

Horwarth, J. (2007). The missing assessment domain: personal, professional and organisational factors influencing professional judgements when identifying and referring child neglect .*British Journal of Social Work, 37*, 1285-1303. doi: 10.1093/bjsw/bcl029.

McConnell, D., & Llewellyn, G. (2000). Disability and discrimination in statutory child protection proceedings. *Disability & Society, 15(6)*, 883-895. doi: 10.1080/713662015.

Starke, M. (2011). Supporting families with parents with intellectual disabilities: views and experiences of professionals in the field. *Journal of Policy and Practice in Intellectual Disabilities, 8*, 163-171. doi: 10.1111/j.1741-1130.2011.00306.x.

Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behavior. In S. Worchel & W. G. Austin (Eds.), *Psychology of intergroup relations* (pp. 7–24). Chicago: Nelson–Hall.

Tarabulsy, G. M., St-Laurent, D., Cyr, C., Pascuzzo, K., Moss, E., Bernier, A., & Dubois-Comtois, K. (2008). Attachment-based intervention for maltreating families. *American Journal of Orthopsychiatry, 78(3),* 322-323. doi: 10.1037/a0014070.

Widom, C. S. (2000). Understanding the consequences of childhood victimization. In R. M. Reese (Ed.), *Treatment of child abuse* (pp.339-361). Baltimore: John Hopkins University Press.

# APPENDICES TO VOLUME I

# APPENDIX A

## Data Extraction Table

| Study information | | | EPHPP Quality Rating | Study Aims/Hypotheses | Study Design | Participants | | Intervention | Measures used | Statistical Analysis Used | Relevant Results | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Paper Number | Paper Title | Author (s), date & place of origin | | | | Sample | Types of abuse | | | | Parent Sensitivity | Attachment | Future Risk |
| 1 | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | |
| 11 | | | | | | | | | | | | | |

## APPENDIX B

## Quality Assessment Tool (QAT) developed by the Effective Public Health Practice Project (EPHPP; 1998)

# QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES


## COMPONENT RATINGS

### A) SELECTION BIAS

**(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?**

Very likely
Somewhat likely
Not likely
Can't tell

**(Q2) What percentage of selected individuals agreed to participate?**

80 - 100% agreement
60 – 79% agreement
less than 60% agreement
Not applicable
Can't tell

| RATE THIS SECTION | STRONG | MODERATE | WEAK |
|---|---|---|---|
| See dictionary | 1 | 2 | 3 |

### B) STUDY DESIGN

**Indicate the study design**

Randomized controlled trial
Controlled clinical trial
Cohort analytic (two group pre + post)
Case-control
Cohort (one group pre + post (before and after))
Interrupted time series
Other specify _____
Can't tell

**Was the study described as randomized? If NO, go to Component C.**

No Yes

**If Yes, was the method of randomization described? (See dictionary)**

No Yes

**If Yes, was the method appropriate? (See dictionary)**

No Yes

| RATE THIS SECTION | STRONG | MODERATE | WEAK |
|---|---|---|---|
| **See dictionary** | 1 | 2 | 3 |

## C) CONFOUNDERS

**(Q1) Were there important differences between groups prior to the intervention?**

Yes
No
Can't tell

**The following are examples of confounders:**

Race
Sex
Marital status/family
Age
SES (income or class)
Education
Health status
Pre-intervention score on outcome measure

**(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?**

80 – 100% (most)
60 – 79% (some)
Less than 60% (few or none)
Can't Tell

| RATE THIS SECTION | STRONG | MODERATE | WEAK |
|---|---|---|---|
| **See dictionary** | 1 | 2 | 3 |

## DATA COLLECTION METHODS

**(Q1) Were data collection tools shown to be valid?**

Yes
No
Can't tell

**(Q2) Were data collection tools shown to be reliable?**

Yes
No
Can't tell

| RATE THIS SECTION | STRONG | MODERATE | WEAK |
|---|---|---|---|
| **See dictionary** | 1 | 2 | 3 |

## F) WITHDRAWALS AND DROP-OUTS

**(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?**

Yes
No
Can't tell
Not Applicable (i.e. one time surveys or interviews)

**(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).**

80 -100%
60 - 79%
less than 60%
Can't tell
Not Applicable (i.e. Retrospective case-control)

| RATE THIS SECTION | STRONG | MODERATE | WEAK | |
|---|---|---|---|---|
| **See dictionary** | 1 | 2 | 3 | NA |

## G) INTERVENTION INTEGRITY

**(Q1) What percentage of participants received the allocated intervention or exposure of interest?**

80 -100%
60 - 79%
less than 60%
Can't tell

**(Q2) Was the consistency of the intervention measured?**

Yes
No
Can't tell

**(Q3) Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?**

Yes
No
Can't tell

## H) ANALYSES

**(Q1) Indicate the unit of allocation (circle one)**
community organization/institution practice/office individual

**(Q2) Indicate the unit of analysis (circle one)**
community organization/institution practice/office individual

**(Q3) Are the statistical methods appropriate for the study design?**

Yes
No
Can't tell

**(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?**

Yes
No
Can't tell

| | | | | | |
|---|---|---|---|---|---|
| **A** | **Selection Bias** | **STRONG** | **MODERATE** | **WEAK** | |
| | | 1 | 2 | 3 | |
| B | Study Design | **STRONG** | **MODERATE** | **WEAK** | |
| | | 1 | 2 | 3 | |
| **C** | **Confounders** | **STRONG** | **MODERATE** | **WEAK** | |
| | | 1 | 2 | 3 | |
| **D** | **Blinding** | **STRONG** | **MODERATE** | **WEAK** | |
| | | 1 | 2 | 3 | |
| **E** | **Data Collection Methods** | **STRONG** | **MODERATE** | **WEAK** | |
| | | 1 | 2 | 3 | |
| **F** | **Withdrawals and Dropouts** | **STRONG** | **MODERATE** | **WEAK** | |
| | | 1 | 2 | 3 | N/A |

**GLOBAL RATING**

**COMPONENT RATINGS**

Please transcribe the information from the grey boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

## GLOBAL RATING FOR THIS PAPER (circle one):

1 STRONG (no WEAK ratings)
2 MODERATE (one WEAK rating)
3 WEAK (two or more WEAK ratings)
With both reviewers discussing the ratings:
Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings?

No Yes
If yes, indicate the reason for the discrepancy

1 Oversight
2 Differences in interpretation of criteria
3 Differences in interpretation of study

**Final decision of both reviewers (circle one): 1 STRONG**
**2 MODERATE**
**3 WEAK**

## APPENDIX C

## A summary of the methodological strengths and weaknesses of each paper

| Paper Number and Quality Rating | Study Title | Author (s) & date | Strengths of Study | Moderate strengths of study | Weaknesses of study |
|---|---|---|---|---|---|
| 1<br><br>WEAK | Accumulating evidence for parent-child interaction therapy in the prevention of child maltreatment | Thomas, R. & Zimmer-Gembeck, M. J. (2011) | • Process of randomisation is unclear following QAT instructions the design and was therefore classed as a "controlled clinical trial".<br><br>• Valid and reliable data collection tools used. | | • It is not possible to tell what percentage of those referred participated.<br><br>• It is not stated whether there were any important differences between the intervention group and the "wait-list" control group prior to intervention.<br><br>• It is not reported whether independent assessors were blind to intervention group. It is not reported whether participants were aware of the research question.<br><br>• Reasons for withdrawal/drop-out were not reported and less than 60% of original sample completed intervention and follow up assessment (46%). |

| Paper Number and Quality Rating | Study Title | Author (s) & date | Strengths of Study | Moderate strengths of study | Weaknesses of study |
|---|---|---|---|---|---|
| 2<br>STRONG | Efficacy of a home-visiting intervention aimed at improving maternal sensitivity, child attachment, and behaviour outcomes for maltreated children: a randomised control trial | Moss, E., Dubois-Comtois, K., Cyr, C., Tarabulsy, G. M., St-Laurent, D. & Bernier, A. (2011) | • Randomised Control Trial (RCT) with suitable control group.<br><br>• No confounding differences between intervention and control group.<br><br>• Valid and reliable data collection tools<br><br>• Withdrawals and drop-outs are clearly reported and 60-79% of participants completed intervention. | • Sample is believed to be "somewhat" representative as was referred systematically by child welfare agency and community services.<br><br>• 60-79% of referrals participated in study.<br><br>• Outcome assessors were blind to participant intervention group but it was unclear whether participants were aware of research question. | |
| 3<br>STRONG | Enhancing attachment organisation among maltreated children: results of a randomised clinical trial | Bernard, K., Dozier, M., Bick, J., Lewis-Morrarty, E., Lindhiem, O. & Carlson, E. (2012) | • Process of randomisation is unclear following QAT instructions the design and is therefore classed as a "controlled clinical trial".<br><br>• No confounding differences between groups were found.<br><br>• Valid and reliable data collection tools were used.<br><br>• Reasons for withdrawal and drop out are not presented however over 80% of participants completed intervention. | • Sample is believed to be "somewhat" representative as was referred systematically by agencies working with child protection services. It was not possible to tell what percentage of those referred participated.<br><br>• Outcome assessors were blind to participant intervention group but it was unclear whether participants were aware of research question. | |

| Paper Number and Quality Rating | Study Title | Author (s) & date | Strengths of Study | Moderate strengths of study | Weaknesses of study |
|---|---|---|---|---|---|
| 4<br>MODERATE | Fostering secure attachment in infants in maltreating families through preventative interventions | Cicchetti, D., Rogosch, F. A. & Toth, S. (2006) | • Process of randomisation is unclear so following QAT instructions the design was classed as a "controlled clinical trial".<br><br>• No confounding differences between different intervention groups were found. Although the normal comparison group (no intervention received) had smaller family sizes and higher level of education in mothers.<br><br>• Valid and reliable data collection tools were used. | • Sample is believed to be "somewhat" representative as an employee of Department of Human services contacted all mothers eligible for the study. It is not possible to tell what percentage of those referred participated.<br><br>• Outcome assessors were blind to participant intervention group but it was unclear whether participants were aware of research question. | • Number of drop-outs are reported but reasons for doing so are not given. Overall attrition across groups was 21.7% however in the "community standard" intervention group only 57.1% completed treatment and returned for follow up. |

| Paper Number and Quality Rating | Study Title | Author (s) & date | Strengths of Study | Moderate strengths of study | Weaknesses of study |
|---|---|---|---|---|---|
| 5<br>WEAK | Identifying therapeutic action in an attachment-centred intervention with high risk families | Steele, M., Murphy, A. & Steele, H. (2010) | • Valid and reliable data collection tools were used. | | • It is not reported how the sample was recruited or how many of potential participant agreed to be included in the study.<br><br>• The paper reports pre and post data for a case study included. Data for the larger sample (not case study) is collected following a mean of 63 sessions and predictions are made to predict pre intervention data.<br><br>• No comparison group included.<br><br>• It appears that assessors of outcomes were not blind to participant condition and participants were aware of the research question.<br><br>• Not all participants completed outcome measures. Less than 60% completed measure of attachment security. Reasons for drop-out are not presented. |

| Paper Number and Quality Rating | Study Title | Author (s) & date | Strengths of Study | Moderate strengths of study | Weaknesses of study |
|---|---|---|---|---|---|
| 6<br>WEAK | Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports | Chaffin, M., Silovsky, J. F., Funderbunk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J. & Bonner, B. L. (2004) | • Process of randomisation is unclear so following QAT instructions the design was classed as a "controlled clinical trial".<br><br>• No confounding differences between different intervention groups were found.<br><br>• Valid and reliable data collection tools were used. | • Outcome assessors were unaware of which intervention group the participant belonged to. However, it is not known whether the participants were aware of the research question. | • Although all appropriate individuals entering into the child welfare system were referred to the study, indicating a "somewhat representative" sample, only 37% participated.<br><br>• Participant attrition patterns are broadly described but specific figures and reasons for drop-out/withdrawal are not presented. The number of participants completing intervention is not presented. |

| Paper Number and Quality Rating | Study Title | Author (s) & date | Strengths of Study | Moderate strengths of study | Weaknesses of study |
|---|---|---|---|---|---|
| 7<br>STRONG | Preventive interventions and sustained attachment security in maltreated children | Pickreign Stronach, E., Toth, S. L., Rogosch & Cicchetti, D. (2013) | • Process of randomisation is unclear so following QAT instructions the design was classed as a "controlled clinical trial".<br><br>• No confounding differences between different intervention groups were found. Although the normal comparison group (no intervention received) had smaller family sizes and higher level of education in mothers.<br><br>• Valid and reliable data collection tools were used. | • The sample was believed to be "somewhat representative" as all participants identified using records obtained from child protection service and abuse preventing services. All those who met inclusion criteria were contacted. It is not reported how many of those contacted agreed to participate.<br><br>• Outcome assessors were unaware of which intervention group the participant belonged to. However, it is not known whether the participants were aware of the research question.<br><br>• Reasons for drop-out/withdrawal are not presented however the number of participants completing study was 76.7% of original sample. | |

| Paper Number and Quality Rating | Study Title | Author (s) & date | Strengths of Study | Moderate strengths of study | Weaknesses of study |
|---|---|---|---|---|---|
| 8<br>WEAK | The development and evaluation of the intervention model for the Florida infant mental health pilot program | Osofsky, J. D., Kronenberg, M. Hayes Hammer, J., Lederman, C., Katz, L., Adams, S., Graham, M. & Hogan, A. (2007). | | • The sample is believed to be "somewhat representative" as all participants were court ordered to attend (not self-selected) or referred by child protection services. The percentage of referred individuals that actually participated is not reported.<br><br>• Based on the QAT criteria the study uses a cohort design.<br><br>• Outcome assessors were unaware of which intervention group the participant belonged to. However, it is not known whether the participants were aware of the research question.<br><br>• Data collection tools were shown to be valid however only self-report measures were used which may be impacted by biases. | • No comparison group was used.<br><br>• Participant drop-out and withdrawals are reported and their reasons for doing so, however only 44% of the participants recruited completed the study. |

| Paper Number and Quality Rating | Study Title | Author (s) & date | Strengths of Study | Moderate strengths of study | Weaknesses of study |
|---|---|---|---|---|---|
| 9<br>STRONG | The relative efficacy of two interventions in altering maltreated preschool children's representational models: implications for attachment theory | Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M. & Cicchetti, D. (2002) | • Process of randomisation is unclear so following QAT instructions the design was classed as a "controlled clinical trial".<br><br>• It was found that there was a significant difference in child IQ between groups at pre-intervention. However, IQ score was found to not be significantly correlated with any of the baseline narrative outcome variables (which the intervention aimed to change) therefore this was not considered a significant confounding variable. No other differences between groups were found.<br><br>• Valid and reliable data collection tools were used. | • Sample was believed to be "somewhat" representative as an employee of Department of Human services contacted all mothers eligible for the study. It is not possible to tell what percentage of those referred participated.<br><br>• Outcome assessors were unaware of which intervention group the participant belonged to. However, it is not known whether the participants were aware of the research question.<br><br>• The number of participants who did not complete the intervention are presented, as are their reasons and a total of 78% of participants completed the study. | |

| Paper Number and Quality Rating | Study Title | Author (s) & date | Strengths of Study | Moderate strengths of study | Weaknesses of study |
|---|---|---|---|---|---|
| 10<br>WEAK | Using recidivism data to evaluate Project Safecare: teaching bonding, safety and healthcare skills to parents | Gershhater-Molko, R. M., Lutzker, J. R. & Wesch, D. (2002) | • Data collection was shown to be valid and reliable with average inter-rater reliability at 98%. | • This is a cohort study with a constructed comparison group. According to the QAT dictionary this design is considered to be of 'moderate' strength.<br><br>•It is not reported whether those assessing the outcome (re-reports of abuse) were aware of whether the family were in the intervention or control group. It is not stated whether the participants were aware of the research question. | • The paper does not indicate how representative the sample is of the target population. It is not clear how many individuals approached agreed to participate.<br><br>• Families receiving intervention were matched with those in the control groups based on age and geographic location. However it is not reported whether any other significant confounding differences existed between groups.<br><br>• The number of participants who commenced, but did not complete the intervention, is not reported. The reasons given for participants leaving the study are not presented. It is not clear what percentage of the participants completed the study. |

| Paper Number and Quality Rating | Study Title | Author (s) & date | Strengths of Study | Moderate strengths of study | Weaknesses of study |
|---|---|---|---|---|---|
| 11<br>WEAK | Video-feedback intervention with maltreating parents and their children: program implementation and case study | Moss, E., Tarabulsy, G., St-Georges, R., Dubois-Comtois, K., Cyr, C., Bernier, A., St-Laurent, D., Pascuzzo, K. & Lecompte, V. (2014) | | • It is not reported whether those assessing the family pre- and post-intervention were blind to the aware of the aims of the study or if the family were aware of the research question.<br><br>• The primary outcome measure, the Strange Situation Procedure (Ainsworth et al., 1978) has well established validity, however, reliability is not reported.<br><br>• As this is case study it is not necessary or drop-out/withdrawal rate to be reported. | • This paper presents a detailed description of a video-feedback intervention and uses a case study to illustrate its effectiveness. According to the QAT dictionary a case study is considered a "weak" design.<br><br>• As it is a case study it is unlikely to be representative of the target population.<br><br>• No comparisons are made. |

# APPENDIX D

## Parent Demographic Data

| Study Number | Participant Total | Number of participants providing demographic data | Age | | Gender | | Ethnicity | | | | | | Marital Status | | Family Income | | Education | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Range (years) | Mean (years) | Female | Male | White /Hispanic | African/ American | Biracial White/ non-Hispanic | | Other ethnic minority group | | single in a relationship/ married | | <$15,000 | >$15,000 | number not completed high school | mean years |
| 1 | 150 | 150 | - | 33.5 | 150 | 0 | - | - | - | - | - | - | - | - | - | - | - | - |
| 2 | 89 | 67 | 18-49 | 27.8 | - | - | - | - | - | - | - | - | 35 | 32 | 36 | 31 | 36 | 10 |
| 3 | 113 | 113 | 15.7-47 | 28.4 | 111 | 2 | 17 | 69 | 10 | 17 | 0 | 96 | - | - | - | - | 77 | - |
| 4 | 189 | 189 | 18-41 | 26.87 | 189 | 0 | - | - | - | 47 | - | 142 | 133 | 56 | - | - | - | - |
| 5 | 27 | 27 | 20-41 | 28 | 27 | 0 | 14 | 8 | 0 | 5 | 0 | 22 | - | - | - | - | - | - |
| 6 | 112 | 110 | - | 32 | 72 | 38 | 4 | 44 | 0 | 57 | 5 | 53 | 37 | 73 | - | - | 29 | - |
| 7* | | | | | | | | | | | | | | | | | | |
| 8 | 129 | 129 | 14-42 | 24.33 | 129 | 0 | - | - | - | 21 | - | 88 | 67 | 43 | - | - | 47 | - |
| 9 | 155 | 122 | - | - | 122 | 0 | - | - | - | - | - | - | 106 | 16 | - | - | - | 11 |
| 10 | 82 | 82 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| 11* | | | | | | | | | | | | | | | | | | |
| Total | 1046 | 989 | | 200.9 | 800 | 40 | 35 | 121 | 10 | 147 | 5 | 401 | 378 | 220 | 36 | 31 | 189 | 21 |

‘-‘ signifies that this data was not reported in the paper

*Data is not presented for paper 7 and paper 11 as these were based on the same sample recruited in papers 4 and 2

## APPENDIX E

## Children Demographic Data

| Study Number | Participant Total | Number of participants providing demographic data | Age | | Gender | | Ethnicity | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Range (months) | Mean (months) | Male | Female | White /Hispanic | African/ American | Biracial | White/ non-Hispanic | Other | Total from ethnic minority group |
| 1 | 150 | 150 | 30-84 | 60 | 106 | 44 | - | - | - | - | - | - |
| 2 | 89 | 67 | 12-71 | 40.2 | 41 | 26 | - | - | - | - | - | - |
| 3 | 120 | 120 | 1.7-21.4 | 10.1 | 69 | 51 | 13 | 73 | 25 | 9 | - | 111 |
| 4 | 189 | 189 | - | 13.31 | 88 | 101 | - | - | - | - | - | - |
| 5 | 27 | 27 | 12-36 | - | 9 | 18 | 12 | 9 | 4 | 2 | - | 25 |
| 6 | 112 | 110 | - | - | - | - | - | - | - | - | - | - |
| 7* | - | - | - | - | - | - | - | - | - | - | - | - |
| 8 | 129 | 117 | 1-52 | 19-39 | 67 | 43 | 20 | 60 | 9 | 25 | 3 | 91 |
| 9 | 155 | 122 | - | 88.18 | 68 | 54 | - | - | - | - | - | - |
| 10 | 82 | 82 | - | - | - | - | - | - | - | - | - | - |
| 11* | | | | | | | | | | | | |
| Total | 1053 | 984 | 0 | 211.79 | 448 | 337 | 45 | 142 | 38 | 36 | 3 | 227 |

'-' signifies that this data was not reported in the paper

*Data is not presented for paper 7 and paper 11 as these were based on the same sample recruited in papers 4 and 2

## APPENDIX F

## Additional information regarding the attachment-based interventions delivered

**Child-Parent Psychotherapy (CPP)**

Previous research has highlighted that abusive mothers frequently have suffered adverse experiences in their own childhood (Lyons-Ruth et al., 1995; Steele, Murphy & Steele, 2010) and maladaptive relationships with their own parents. Through her experiences, often characterised by abandonment, criticism, rejection, abuse and ridicule, the mother develops a distorted maternal representation which influences the way she views herself, her child and their relationship. The mother's preoccupation with her own unresolved conflict associated with past experiences restricts her ability to provide sensitive, responsive care. This disrupts the relationship between herself and her child, reinforcing the maladaptive representation she holds. The aim of CPP is to provide the mother with a corrective experience that develops a more adaptive maternal representation, allowing her to view herself and child more positively and thus increase positive interaction.

CPP is normally delivered via weekly sessions, in the parent and child's home, over a twelve-month time period. The therapist observes interactions between mother and child and provides empathic feedback, offering unconditional positive regard, which develops the mother's insight into how her own maternal representations distort her perceptions of herself and her child. The mother can then begin to understand the extent to which her past experiences impact her present care-giving, for example she may perceive her child as "spoiled" due to having her own needs neglected as a child and therefore withhold food, drink, toys or affection from her 'undeserving' child. Developing this understanding allows her to respond more readily to her child, increasing the security of the mother-child relationship.

Of the papers included in this review, the intervention delivered in papers 4 and 7 adhere to the method outlined above. Paper 9 described delivering the intervention in a similar way except that the interventions were provided primarily at a treatment centre and only occasionally at the client's home. Paper 8 described conducting CPP with mother-child dyads with additional interventions. These included "speaking for baby" (Carter, Osofsky & Hann, 1991), in which the therapist speaks for the child, who may not be able to vocalise their feelings in order to help the mother empathise with the child, and provide a psycho-educational component to increase skills in providing nurturing and sensitive care.

The treatment delivered in paper 5 is a group intervention based on CPP, in which a group of mothers and children receive CPP from a therapy team for 15 minutes. Following this the children are taken to a separate room and engaged in age appropriate play activities with therapists. During the child group the therapists focus on supporting the children to express their thoughts and feelings and demonstrate understanding, reassuring the children that they will be reunited with their parents. Meanwhile the parents speak in a group about their experiences in order to increase their level of social support but also to allow them to reflect on their own parenting experiences through listening to others and offering advice. Following the groups the parents and children are reunited, which helps reinforce parent beliefs that their children need them and the authors draw comparisons between this and the Strange Situation Procedure (Ainsworth, 1978).

**Parent-Child Interaction Therapy (PCIT)**

PCIT was provided to families in two of the papers (1 and 6). Originally, PCIT was developed to support parents to manage child externalising (disruptive) behaviours and is based on principals of social learning theory (Bandura, 1977) and attachment theory. It has proven to be effective in treating children from different populations, such as those with developmental and neurological disorders (Bagner & Eyberg, 2007) and children with depression (Lenze, Pautsch & Luby, 2011).

Maladaptive parent-child interactions are associated with the development of serious child behaviour problems (Patterson & Reid, 1984), which can increase the risk of abuse occurring as part of an escalating negative relationship between the parent and child. The use of a coercive model of discipline establishes a cycle that reinforces the use of physical aggression in the parent-child relationship (Urquiza & McNeil, 1996). The child learns that they do not need to adhere to parent instruction until the threat of physical aggression is present, reinforcing the child's behaviour (i.e. "I can get away with it most of the time"). The parent learns that the threat of, or actual, aggression is effective at increasing child compliance, reinforcing parent behaviour. Over time this can escalate; the child becomes accustomed to the threat and externalising behaviours persist, which the parent perceives as defiant behaviour and becomes increasingly over reliant on the use of physical aggression to manage the child's behaviour (Chaffin et al., 2004), escalating the level of threat to maintain control over the child's behaviour.

PCIT aims to break the escalating coercive cycles established in negative parent-child relationships by teaching parents to maintain consistent boundaries and react consistently to disruptive child behaviour. It also teaches the parents how to effectively utilise non-coercive behavioural management strategies, increase positive reinforcement for preferred child behaviours and manage their own emotions during negative interactions. This has been shown to decrease the frequency and intensity of problematic child behaviours (Timmer et al, 2005), which in turn maintains an increase in positive parent-child interactions.

PCIT favours engaging both parent and child in therapy rather than working didactically with the parent only, the latter a method favoured by similar parent training programmes. In PCIT, didactic intervention is minimised to two sessions and the intervention focuses on live coaching to develop parent responses to the child behaviour during two phases, with each phase preceded by a one hour teaching session. During phase one, Child Directed Interaction (CDI), parents are coached via a "bug-in-the-ear" device to follow the child's lead and engage in positive communication to enhance the parent-child relationship (Timmer et al, 2005). This phase increases parents' awareness of the positive behaviours the child engages in and praise them accordingly. In phase two, Parent Directed Intervention (PDI), parents are taught to guide their children using clear communication and manage their child's behaviour through the use of appropriate methods of discipline such as" selective attention" and "time-out". Parents are also taught what they can reasonably expect from their child given their developmental stage and adapt communication in accordance with this. Both CDI and PDI phases can last between 7 and 10 sessions. However a protocol known as *standard PCIT* is commonly implemented which requires parents to demonstrate mastery of skills learned in phase one before moving onto phase two and consistent delivery of phase two skills before the intervention is completed (Hembree-Kigin & McNeil, 1995).

The PCIT intervention delivered to the participants in paper 1 was provided by psychologists with experience in working with parents and children prior to being trained to deliver PCIT. The intervention followed the standard PCIT protocol, outlined above, and participants who completed treatment (n=46) attended an average of 11.8 CDI sessions and 5.07 PDI sessions.

Paper 6 delivered an amended PCIT intervention across to condition groups; PCIT and enhanced PCIT (EPCIT). The PCIT intervention was consistent across both conditions,

however participants in the EPCIT group also received support for additional needs (e.g. depression, family violence and substance abuse) and were supported to implement new skills at home. Paper six also included a six session orientation group, designed to increase parent motivation, delivered before PCIT and EPCIT interventions. Parents were required to demonstrate motivation and willingness before moving onto the CDI phase. Additional amendments included increased use of role-plays to demonstrate appropriate interaction, the use of a wider range of discipline strategies for older children and the inclusion of non-violent alternative discipline strategies if children did not comply with the time-out protocol. Parents received between 12-14 sessions of PCIT.

**Attachment and Bio-behavioral Catch-up (ABC)**

Only one paper, paper 3, delivered ABC as the experimental intervention. ABC is a relatively brief (10 sessions), home-based, manualised intervention, developed to increase sensitive caregiving practices and attachment security. It also aims to reduce frightening behaviours displayed by parents as the presence of these is a predictor of disorganised attachment (Schuengel et al., 1999). The intervention is provided to parent-child dyads and the focus is to create change in the parent's behaviour via constructive feedback on parent-child interactions.

Sessions one and two of ABC focus on helping parents recognise the importance of nurturing their child, how to identify when this needs to be provided and how to overcome child behaviours that make this difficult, such as avoidance or resistance. In session three and four the parent learns to follow their child's lead during play activities and are supported to reduce interfering or controlling behaviour. Video feedback is used during the task and used to positively reinforce times when the parent is able to allow the child to lead the activity. Session five and six help parents to reduce their intrusive, overwhelming and frightening behaviours. Initially they are shown videos of parents behaving intrusively and the ways children respond to this. They then engage in play with their own children and comment on their behaviours and how the child responds to them. They also discuss different types of frightening behaviours (verbal, vocal, and physical) and are encouraged to consider what they found frightening as a child and the effect it had on them. The trainer provides video feedback of times during interactions when the parent has refrained from acting in frightening ways to reinforce this. During sessions seven and eight the trainer helps the parent reflect on their own

experiences of being parented and consider how this has impacted on the way they behave with their own child. The conversation is based on the strengths and weaknesses observed in previous sessions and is used to increase parental awareness of times they act in insensitive, uncaring or frightening ways and replace these with skills learned during the intervention. Sessions nine and ten are used to consolidate skills and to highlight progress made and provide positive reinforcement.

**SafeCare**

The experimental intervention provided in paper 10 was a home-based service named SafeCare. The intervention focuses on supporting parents to improve their knowledge and skills in three main modules; child health care, parent-child interactions and home safety. These modules domains are believed to be the most therapeutically effective and replicable domains that were originally part of a 12-part intervention, '12-ways' (Lutzker et al., 1998). Each module includes an assessment session, four to five training sessions to develop existing skills and teach new skills and a final assessment session. The pre and post training assessments are observation based and use tools with established validity (Edwards-Gaura et al., 2012).

The trainer explains what the skills are and why they are necessary, demonstrates the skills, and the parent practices the skills to develop mastery across different contexts. The trainer then provides feedback on their performance.

The goals of SafeCare's Parent-Child Interaction Module are to improve positive communication between parent and child using the Planned Activities Training Checklist (PAT Checklist). This provides the parent with a 10 step structure in which to engage their child in activities and focuses on clear communication, positively reinforcing feedback, offering choices, ignoring minor misbehaviours and providing rewards and consequences. Following the training sessions the parent must demonstrate mastery in these skills before progressing to the next module.

**Video-Feedback Intervention Program (VFIP)**

Papers 2 and 11 used a home-based, video-feedback intervention developed by Moss et al (2011). The purpose of the intervention is to increase parental sensitivity to the child's

emotional and behavioural signals and promote consistent responses to distress, in order to enhance attachment organisation and security.

The intervention is manual based and eight sessions were delivered over the course of treatment. A 20-minute discussion on a theme selected collaboratively by the parent and trainer occurs at the start of each session. Following the discussion a 10-15 minute interaction between parent and child, whilst engaged in an activity, is video recorded. The video is then viewed by the parent with the trainer placing emphasis on the positive sections and the impact sensitive parent behaviour has on the child. The final 15 minutes are used to highlight progress and plan similar activities in order for the parent to continue to develop their skills.

## APPENDIX G

## A summary of the measures used in studies

| Name of measure | Type of measure | Used by papers | Description of use in papers | Reported reliability (where available) and validity |
|---|---|---|---|---|
| Adult-Adolescent Parenting Inventory (AAPI; Bavolek, 1984) | Self-report questionnaire | 4 | The Adult-Adolescent Parenting Inventory (AAPI; Bavolek, 1984) consists of 32 items and using a 5-point Likert Scale. Parent attitudes are measures across four subscales; inappropriate expectations, lack of empathy, belief in corporal punishment and parent-child role reversal. | Internal consistency was shown to be good with Chronbach's α= .73 - .90. |
| Behaviour Assessment System for Children (BASC; Reynolds & Kamphaus, 1992) | Self-report questionnaire | 6 | The BASC requires parents to rate their child's behaviours, thoughts and emotions. It is used for children between the ages of 4 and 18 and measures internalising and externalising behaviours, both adaptive and maladaptive, and draws comparisons to age- and gender-based norms. Although multiple sources can be used to gather data (parent, teacher or self) paper 6 primarily sought responses from the abusive parent. If this was not possible the child's teacher completed the measure. | The paper reports the scales of the BASC have internal consistency and temporal stability ranging from "the mid .70's to the low .90's". Although a valid measure of child behaviours the BASC has been shown to have lower levels of validity for children of pre-school age (Sandoval & Echandia, 1994). As the age of the child sample in paper 6 is not reported it is difficult to comment on the validity of the BASC in this study. |
| Child Abuse Potential Inventory (CAP; Milner 1986) | Self-report questionnaire | 1, 6 | The CAP presents parents with 160 statements, across 10 subscales. Agreement and disagreement of statements produces a score indicating likelihood of future abuse. Paper 6 used the subscales of "parent distress", "rigidity" (of attitude) and "loneliness" as well as the global child abuse potential score to estimate the likelihood of future physical abuse. Paper 1 used six subscales, namely distress, rigidity, unhappiness, problems with child and self, problems with family and problems with others, only the global child abuse potential score was used as an outcome. | The CAP has been shown to have high internal consistency (KR-20= .92 to .95), a re-test stability of .83 (following one month) and "good" discriminant and predictive validity (Chaffin & Vale, 2003; Milner, 1986, 1994). Alpha levels for the CAP in paper 6 were reported to be .94 for the distress scale, .79 for the rigidity scale, .82 for the loneliness scale and .93 for the overall abuse scale. Paper 1 reported internal reliability for the global child abuse potential score was good (Chronbach's α= .94). |

| Name of measure | Type of measure | Used by papers | Description of use in papers | Reported reliability (where available) and validity |
|---|---|---|---|---|
| Child Neglect Index (CNI; Trocme, 1996); Abuse Dimension Inventory (ADI; Chaffin et al., 1997) | Case note review | 6 | The CNI and ADI were completed by research assistants using information obtained by reviewing child welfare case notes (CNI and ADI) and interviews with child welfare workers (ADI only). The CNI rates the severity of neglect on a global rating and across separate dimensions. The ADI rates the severity of both physical and sexual abuse over three dimensions- behavioural severity, duration and frequency. | Trocme (1996) repots "adequate" temporal stability for the CNI and good concurrent validity with similar measures. The ADI has been reported to have high levels of inter-rater reliability (Chaffin et al., 1997). The mean inter-rater reliability reported in paper 6 was .76 following the recording of 10% of the sample by an independent rater. |
| Department of Child and Family Services case files, the Child Welfare Administrative Database and the Court Database of Child Abuse and Neglect. | Case note review | 1, 6, 8, 10 | Paper 10 collected data regarding parent reoffending post- intervention by reviewing case files compiled by the Department of Child and Family Service every six months for a minimum of two years. Details of any abuse was recorded in (names and dates of births of the family members, type of abuse and outcome of the report). This was completed by one researcher and one observer independently of each other.<br>Paper 6 used the child welfare administrative database to identify re-reporting of abuse by the parents in their sample. Paper 1 used notifications from child protection services when suspected abuse occurred in participating families following intervention. Paper 8 used the court database of child abuse and neglect to measure rates of abuse following intervention. | The authors of paper 10 reported good inter-observer reliability (98%).<br>Paper 6 describes measures taken to ensure that re-reports were not duplicated.<br>The notifications of abuse in paper 1 were not substantiated and only related to the parent who had participated. Therefore the abuse may not have occurred or the child may have suffered abuse but not by the hands of the parent involved in the study, making this appear unreliable |
| Emotional Availability Scales (EA; Biringen, Robinson, & Emde, 2000) | Observation | 1 | Paper 1 also used an adapted version of one subscale of the EA to rate maternal sensitivity from 1 (highly insensitive) to 9 (highly sensitive) in terms of parent affect, responsiveness to child cues, flexibility and accessibility to the child. Each video segment is coded by two independent coders. | Good inter-rater reliability was reported ($\alpha$= .95) |

| Name of measure | Type of measure | Used by papers | Description of use in papers | Reported reliability (where available) and validity |
|---|---|---|---|---|
| Maternal Behaviour Q-Set (MBQS; Pederson & Moran, 1995) | Observation | 2, 4 | The MBQS is a tool consisting of 90 items. Each item presents a type of maternal behaviour which the observer sorts into nine piles, representing how characteristic or uncharacteristic the behaviour is of the mother's behaviour (i.e. pile 1 is the least characteristic, pile 9 is the most characteristic. The distribution of items is then correlated against an ideal distribution for prototypically sensitive and responsive maternal behaviour, producing a score between -1.0 (least sensitive) and 1.0 (most sensitive). | Intra-class correlations between pairs of observers in paper 2 averaged .84 at baseline and .81 following the intervention and paper 4 reported .72 at pre-test and .71 at follow-up. Paper 4 also reported that sensitivity scores demonstrated stability over a 4-month period (.71). |
| Modified Parent-Child Relationship Assessment (MP-CRA, Crowell & Fleishman, 1993) | Observation | 8 | In the MP-CRA parent behaviours are observed and coded during structured and unstructured play-based tasks and a brief separation. Parents and children are rated on a Likert Scale (1-5) for a range of observed behavioural and emotional responses. | Three independent coders scored videos of the task using the Parent-Child Relationship Scales (Osofsky et al., 2003), one of which was a master coder. When the two other coders matched their rating to the master on five videos, a third of the tapes were then coded by both these coders and paired r values indicated good inter-rater reliability (mean r= .96). |
| Parent Stress Index (PSI; Abidin, 1990) | Self-report questionnaire | 1, 4 and 5 | The Parent Stress Inventory (PSI; Abidin, 1990), a 101-item questionnaire, was completed by parents. This instrument measures parenting stress in relation to the child domain (adaptability, acceptability, demandingness, mood, distractibility/hyperactivity and reinforcing parent) and parent domain (depression, attachment, restrictions of role, social isolation, spousal relationship, health and sense of competence) and has good levels of construct, predictive and discriminant validity (Abidin, 1990). | Levels of internal consistency were not reported in paper 5. However, paper 1 reported mean Chronbach's α= .94 and .93 for the parent domain and child domain scores respectively and paper 4 reported an overall mean Chronbach's α= .95 for both domains. |

| Name of measure | Type of measure | Used by papers | Description of use in papers | Reported reliability (where available) and validity |
|---|---|---|---|---|
| Parent Stress Index- Short Form (PSI-SF; Abidin, 1990) | Self-report questionnaire | 8 | The Parenting Stress Index- Short Form (PSI-SF; Abidin, 1992) is comprised of 36 items and measures overall parent stress and three subscales; parent distress, parent-child dysfunctional interaction and difficult child, as well as a subscale for defensive responding which allows the validity of the parent responses to be reviewed. Changes observed in PSI following intervention were thought to represent a shift in the parent's beliefs about the child's behaviour. | No data is reported on the internal consistency of the measure, however it has been shown to be a valid measure of parent stress (Abidin, 1992). |
| Schneider-Rosen et al. (1985) coding system | Observation | 4, 7 | Following the intervention delivered in paper 4, and in the follow-up study presented in paper 7, the Schneider-Rosen et al. (1985) coding system was used to code behaviours displayed during the Strange Situation Procedure (Ainsworth et al., 1978), as this emphasises the "developmental reorganisations that occur within the attachment behaviour system". | Coders achieved 100% agreement with the Strange Situation training videos. Agreement between two blind coders on the classification of attachment style was 88% across the four attachment classifications, as reported by paper 4 and 7. |
| The Dyadic Parent-Child Interaction Coding System- Second Edition (DPICS-II; Eyberg et al., 1994) | Observation | 6 | The DPICS-II requires observers to code parent-child interaction in terms of the verbal behaviour, vocal behaviour and physical behaviour displayed by parents and children during a three-part task. During the task children and parents engage in a child-directed activity, a parent-directed activity and tidy up following the activity. | Past studies have demonstrated that this instrument has satisfactory test-retest reliability and discriminant validity (Aragona & Eyeberg, 1981; Bessmer, 1998; Foote, 2000; Webster-Stratton, 1985). |
| The Dyadic Parent-Child Interaction Coding System- Third Edition (DPICS-III; Eyberg et al., 2004) | Observation | 1 | The DPICS-III (Eyberg et al., 2004) codes parent-child interactions that occur in the first five minutes of a play task. According to the DPICS-III manual (Eyeberg et al., 2004) this is an appropriate use of the coding system and it can be applied flexibly to various tasks. Consistent with the DPICS-II, coding is based on observed parent verbal behaviour, vocal behaviour and physical behaviours. Each video segment is coded by two independent coders. | High intra-class correlations were reported between coders across the different observed behaviours ranging from .85 to .98. |

| Name of measure | Type of measure | Used by papers | Description of use in papers | Reported reliability (where available) and validity |
|---|---|---|---|---|
| The MacArthur Story Stem Battery (MSSB; Bretherton et al., 1990); the Attachment Story Completion Task (ASCT; Bretherton, Ridgeway & Cassidy, 1990); the MacArthur Narrative Coding Manual- Rochester Revision (MNCMM-RR; Robinson et al., 1996) & the Global Relationship Expectations Scale (Bickham and Fiese, 1999) | Observation | 9 | The authors of paper 9 use changes in children's representations of their mother, themselves and the mother-child relationship to illustrate the effectiveness of the intervention at improving parent-child relationships. Children completed story stems taken from the MSSB (Bretherton et al., 1990) and the ASCT (Bretherton, Ridgeway & Cassidy, 1990) relating to each representation. Representations of the mother were coded using the MNCMM-RR (Robinon et al., 1996) as being of the positive mother, negative mother, controlling mother, incongruent mother or disciplining mother. The MNCMM-RR was also used to code representations of self as either positive, negative or false. An adapted version of the Global Relationship Expectations Scale (Bickham and Fiese, 1999) was used to assess the child's representation of the parent-child relationship across five dimensions; predictable versus unpredictable, disappointing versus fulfilling, supportive/protective versus threatening, warm/close versus cold/distant and genuine and trustworthy versus artificial and deceptive. Global rating were attributed on a scale from 1 (dangerous, unpredictable, dissatisfying relati) to onship 5 (fulfilling, reliable and safe relationship). | Reliability for representations of mother and self, based on a reliability analysis of 20% of the sample, demonstrated "excellent" reliability, with Kappa coefficients for representation codes ranging from .86 to 1.0. Coding for the mother-child relationship was also shown to have good reliability, with intra-class correlation coefficient at .86. |
| The Preschool Separation-Reunion Procedure (PS-RP; Cassidy, Marvin & the MacArthur Working Group on Attachment, 1992) | Observation | 2, 7 | The PS-RP assesses attachment in children aged 2-6 years old. The procedure retains the separation and reuniting of parent and child and, as in Ainsworth et al.'s (1978) procedure, the child's verbal and physical behaviour is recorded and coded. However the PS-RP places greater significance on parent-child conversation than the Strange Situation Procedure as older children have a greater capacity for language. Also, the stranger does not feature in the procedure. The PS-RP was used for 83.6% of the sample in paper 2. As the study presented in paper 7 was a follow up to paper 4, and therefore featured an older sample making the Strange situation inappropriate, the authors also used the PS-RP. | The PS-RP has been shown to hold sufficient validity (Moss et al, 2004; NICHD Early Child care Research Network, 2001). Paper 2 reported good inter-judge reliability (k=.82). The authors of paper 7 reported good levels of inter-rater reliability (k= .7) across the four attachment styles. |

| Name of measure | Type of measure | Used by papers | Description of use in papers | Reported reliability (where available) and validity |
|---|---|---|---|---|
| The Strange Situation Procedure (Ainsworth et al., 1978) | Observation | 2, 3, 4, 5, 7, (11) | The Strange Situation Procedure (Ainsworth et al., 1978) is considered the "gold standard" measure of attachment and was used by the papers at baseline. During this 20-minute procedure the parent-child dyad are together in a laboratory setting, a stranger enters and speaks with the parent, after which the parent leaves the room. The stranger engages with the child and then the parent returns and interacts with the child according to their need (i.e. provide a distressed child with comfort), then the child is left alone before the parent returns once more. During the procedure the child's behaviour is coded in terms of the child's exploration of the room, the child's anxiety regarding the stranger, the child's reaction to the parent leaving and when they are reunited. In order to classify Disorganised attachment, Main and Solomon's (1990) criteria were used. | Papers 2, 3, 4 report coding was completed by two coders blind to the intervention condition of the participant and level of inter-rater agreement is 84% (paper 2), 85% (paper 3) and 88% (paper 4). Observations were coded by a single researcher in paper 5.<br>As the Strange Situation Procedure (Ainsworth et al., 1978) has only been validated for children aged 12-24 months paper 3 only included children of this age range in the analysis and paper 2 used an additional, but similar, measure for children over 24 months (see below). |

## APPENDIX H

## Letter of Approval from the Research Governance Advisory Committee (RGAC) of Birmingham City Council

# APPENDIX I

## Participant Information Pack

UNIVERSITY OF BIRMINGHAM

BradleyCrook
Trainee Clinical Psychologist

School of Psychology

The University of Birmingham

Edgbaston

Birmingham

B15 2TT

**PARTICIPANT INFORMATION SHEET**

*Title of Project:* Exploring the interplay between social workers' personal and professional experiences when discussing the competence of' parents with intellectual disabilities (ID).

*Researchers:* Bradley Crook & Dr Biza Stenfert Kroese

Thank you for expressing an interest in this research. My name is Bradley Crook and I am a Trainee Clinical Psychologist working in the NHS. I am currently studying at the University of Birmingham and completion of this research forms part of my Doctoral Qualification. My research supervisor on this project is Dr Biza Stenfert Kroese and my clinical supervisor is Laura Ogi, Clinical Psychologist.

Please read this information sheet carefully before deciding whether you would like to take part in my research. This sheet aims to answer any questions you may have about the project. If you still have questions after reading the information sheet please do not hesitate to contact me. My details can be found at the bottom of this sheet.

**What is the purpose of this research?**

It is well documented that social workers face many challenges when working with parents with intellectual disabilities (ID) and that it can be a difficult relationship, for both the social worker and the parent, to manage. My research will explore how child social workers draw upon their knowledge and experience, both personal and professional, when assessing parents with ID. By having a better understanding of this process it is hoped that recommendations can be made that will assist social workers in their work with parents with ID.

**Why have I been invited to take part?**

You have been asked to take part because you are a social worker who has worked, or could potentially be asked to work, with parents with ID. It is hoped that we will be able to interview between 8 and 12 social workers for this study. If a greater number of individuals express an interest than is required, participants will be selected at random to ensure fair and unbiased participant selection.

**What do you mean by an Intellectual Disability?**

An intellectual disability, also referred to as a learning disability, is a life-long condition which affects an individual's global intellectual ability. A person with an intellectual disability has an IQ of 70 or under and may experience difficulties in some aspects of their everyday life. It does not include people who have specific problems such as difficulty reading or writing (i.e. dyslexia), attention deficits or any other specific learning difficulty.

**What will happen to me if I agree to take part?**

Taking part in this research is completely voluntary. After you have read this sheet and voiced an interest in participating we will then arrange a time and place that is convenient for you to complete the interview. This can be at your workplace so that you do not have to travel.

You will be asked to watch a 15 minute video of a couple with intellectual disabilities, who are parents of a young child. Before watching the video you will be asked to sign a consent form, complete a short demographic questionnaire and read a short vignette that gives some information about the family and sets the scene for the video. You will be asked to pause the video when you find something you see or hear to be interesting. You can pause the video as many times as you wish. Once you have paused the video I will ask you some questions about what led you to pause the video, what you found interesting and why. The play time will be recorded each time you pause the video and your responses to the questions will be recorded on a digital recorder, providing you consent to this. At the end of the video you will be asked some general questions about what you have seen.

The interview will take approximately an hour to complete and you can ask to stop the task at any time if you wish.

**What will happen if I do not want to carry on with the study?**

You have the right to withdraw from the study at any point, even if you have already agreed to take part. You can withdraw from the study by contacting me using the details at the bottom of this sheet at any time before completing the interview task. You can withdraw from the study at any time during the interview task by stopping the interview. If you choose to leave the study you will not be asked why you have chosen to do so. It is completely up to you whether you decide to take part.

Following the interview you will have two weeks to reflect on whether you wish for your data to be part of the study. If you chose to withdraw your data you will not be asked why and all of your data will be destroyed. After this two week period you will no longer be able to withdraw your interview data from the study as analysis of the data will have commenced.

**Why does the interview task need to be recorded?**

In order to accurately analyse the data the interview does need to be recorded. This means that the responses given during the interview can be accurately analysed and important details will not be missed out. The audio recording will be transcribed in order for the data to be analysed. Only I (BC) will listen to the recording of the interview and it will be transferred to a computer and password protected so it will not be accessible to others. After it has been transferred it will be deleted from the recording device.

The transcripts will be viewed by myself and my supervisor, Biza Stenfert Kroese. Sections of some of the transcripts will also be viewed by a third person who will be checking that the data analysis is accurate and consistent, but your identity will remain anonymous. The transcripts will be stored in a secure cabinet at the University of Birmingham.

**Will my data remain confidential?**

Yes. The consent form you sign before completing the interview task will have a number on it and you will be known by this number throughout the study. Nobody will be able to link your name with this number as the signed consent forms will be kept away from the rest of the data (the completed demographic questionnaires and interview transcripts). The demographic questionnaire will require information such as your age, gender, when you qualified and some of your previous experience with people with ID. Although this information is recorded your name will not appear on the questionnaire in order to protect participant anonymity.

I will the participant numbers when discussing the research with my supervisors. When discussing the results of the research your name will not be used and there will be no way to identify you in the written report. You may be directly quoted in the written report and in presentations of the research but your name will not be used and any identifiable information such as age, gender, place of work etc. will be omitted so as to protect your anonymity. The anonymous data will be kept secure at the University of Birmingham for 10 years, as stipulated by University regulations.

If unsafe or unethical practices are disclosed during the interview I will have to report to my supervisor in order to ensure the safety of the population. In the event of such a disclosure your name will have to be shared in order for the appropriate safeguarding procedures to be followed.

**What benefits are there in taking part?**

Participants in the study will get a chance to consider their own practices and reflect on their personal feelings about the work they do. This experience could help practitioners consider and develop their current practice. The recommendations that come from the research could be used to help professionals working in statutory services to better understand and improve upon their relationships with parents with ID.

Unfortunately we are unable to award monetary compensation for your time.

**Will support be available to me following the study if I need it?**

It is hoped that you will find participating in the research to be an interesting and enjoyable experience. It is possible that some participants may choose to talk about difficult past experiences during the interview, which they may find upsetting. If you wish to stop the interview at any point then please let me know and the interview can be stopped. Following the interview task each participant will be debriefed to ensure that they feel happy with how the interview went. If for any reason you feel that you would like further support following the interview your details can be passed on to Dr Biza Stenfert Kroese, Clinical Psychologist, who will be able to discuss this with you further.

**What will happen to the results of the research study?**

The research will be written up and submitted to the University of Birmingham as a thesis for my doctoral qualification in Clinical Psychology. It will also be submitted to academic journals and could be published and therefore available to the public. As stated previously you will not be able to be identified by anything that is in the written report and will remain anonymous.

If you wish, you can request a copy of the final thesis by contacting me using the details below. I will also offer to give a short presentation of the general findings of the study to the teams that have taken part in the study. As there will be participants from different teams taking part it will not be possible to identify the contributions made by individual participants and your anonymity will be maintained at all times throughout the presentation.

**Who has reviewed this study?**

This study has been reviewed by the University of Birmingham and has been subject to ethical review by the University to ensure that it is ethically sound. It has been reviewed by the Clinical Psychology Doctorate course team and developed with my research supervisor, Dr Biza Stenfert Kroese.

**What happens if I have any further concerns?**

If you have any other concerns following the interview you can contact me using the details below or your details can be given to Dr Biza Stenfert Kroese as detailed above. Alternatively you could contact your GP or The Samaritans on 08457 90 90 90 (available 24hrs and day 365 days a year).

**What Happens Next?**

Please contact me using the details below to let me know if you wish to participate in the study or discuss it further. Please express your desire to participate before **30th June 2014** so participants can be selected, should the project become oversubscribed, and interviews can be scheduled.

**Contact Details**


| Lead Researcher: | Supervised by: |
| --- | --- |
| Bradley Crook | Dr Biza Stenfert Kroese |

Tel: Tel:

Email: Email:

## APPENDIX J

## Participant Consent Form

UNIVERSITY OF BIRMINGHAM

Research site:……

Study Number:……

Title: Exploring the interplay between social workers' personal and professional experiences when discussing the competence of' parents with intellectual disabilities (ID).

Researchers: Bradley Crook & Dr Biza Stenfert-Kroese

Participant Identification Number:.....

Please initial box

1. I confirm that I have understood the information sheet dated 10/12/13 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason, without my medical/social care or legal rights being affected. ☐
3. I understand that the research interview will be audio-recorded ☐
4. I understand that following the research interview I will have a two-week period for reflection. I may withdraw my interview entirely or in part, without giving any reason, without my medical/social care or legal rights being affected. ☐
5. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. ☐

6. I understand any disclosures made about unethical/unsafe practice will be reported to the lead researcher and investigated further, where appropriate. ☐

7. I understand that direct quotes from my interview may be published in any write-up of the data, but that my name will not be attributed to any such quotes and that I will not be identifiable by my comments. ☐

8. I agree to take part in the above study. ☐

| ..... | ..... | ..... |
|---|---|---|
| Name of participant | Date | Signature |

| ..... | ..... | ..... |
|---|---|---|
| Name of researcher | Date | Signature |

## APPENDIX K

## Demographic Questionnaire

UNIVERSITY OF BIRMINGHAM

Number:……

**Thank you for agreeing to take part in this research project. Before we start the interview task it would be helpful if you could answer the following questions (please complete both sides):**

- Date of Birth:…….

- Do you consider yourself to be male or female?
  **M / F** *(please circle as appropriate)*

- Year you qualified as a Social Worker:…….

- Do you work Full Time or Part Time?
  **FT / PT** *(please circle as appropriate)*
  If Part Time how many hours do you work per week? …….. **hours.**

- Have you ever worked with parents with intellectual disabilities since qualifying?
  **Yes / No** *(please circle as appropriate)*

- Have you had any experience of people with intellectual disabilities in your **professional** life, i.e. have you worked directly with a person with intellectual disabilities, worked with a family in which a person with an intellectual disability lived or attended training workshops on working with individuals with intellectual disabilities?
  **Yes / No** *(please circle as appropriate)*

  What is the nature of this experience? *(please provide below)*

- Have you had any experience of people with intellectual disabilities in your **personal** life, i.e. do you have any relatives or friends with intellectual disabilities or belong to any charities that support people with intellectual disabilities?
  **Yes / No** *(please circle as appropriate)*

  What is the nature of this experience? *(please provide below)*

- Are you a parent?
  **Yes / No** *(please circle as appropriate)*

  If you answered "yes" to the above how many children do you have and what are their ages? *(Please provide below)*

**Thank you for completing this questionnaire**

## APPENDIX L

## Participant Instructions

# Tracey, Mark and Lewis

For this interview you will be asked to watch video clips of a family in which the parents, Tracey and Mark, have a learning disability. The video clips present an insight into their lives as they parent their son, Lewis. Please imagine that this is a family that you are working with when watching the video clips.

We are interested in hearing your thoughts about what you are experiencing as you watch the video clips. Whilst watching, if there is something you see or hear that causes a reaction in you (i.e. you think that something is particularly good, bad, or noteworthy or you experience feeling such as happiness, sadness or anxiety) you are asked to pause the video and we will discuss your reaction to the video. To pause the video you will need to press the space bar of the computer. Please try and keep your finger on the space bar throughout the video to make pausing as easy as possible.

There is no limit on the number of times you can pause the video and it would be helpful if you pause the video as soon as you notice you are reacting to it. Some of the clips are quite short so please do not hesitate to discuss what you are thinking and feeling. Even if you are not sure what you are reacting to pause the video and we can discuss it together. Please only share what you are comfortable with, as some of the discussions may touch on sensitive themes i.e. your past experiences, some of which may have been difficult.

Once the video has finished we will discuss the video in general and your experience of watching it.

Thank you for your participation in this project.

## APPENDIX M

## Semi-Structured Interview Questions

Each time a participant pauses the video the following questions will be asked:

- What led you to stop the video?
- How did you feel about that?
- Why do you think you had that reaction?

If the participation identifies mixed feelings about what they have seen the following question will be asked:

- It sounds as though you are having a mixture of feelings about what you have seen. If this appeared at work which feeling would influence your working practice the most?
- Why?

Following the interview the participants will be asked:

- What would you recommend for this family from the information you have?
- Do you think that Tracey and Mark are “good enough” parents?
- What leads you to believe this?

## APPENDIX N

## Signed Confidentiality Agreement

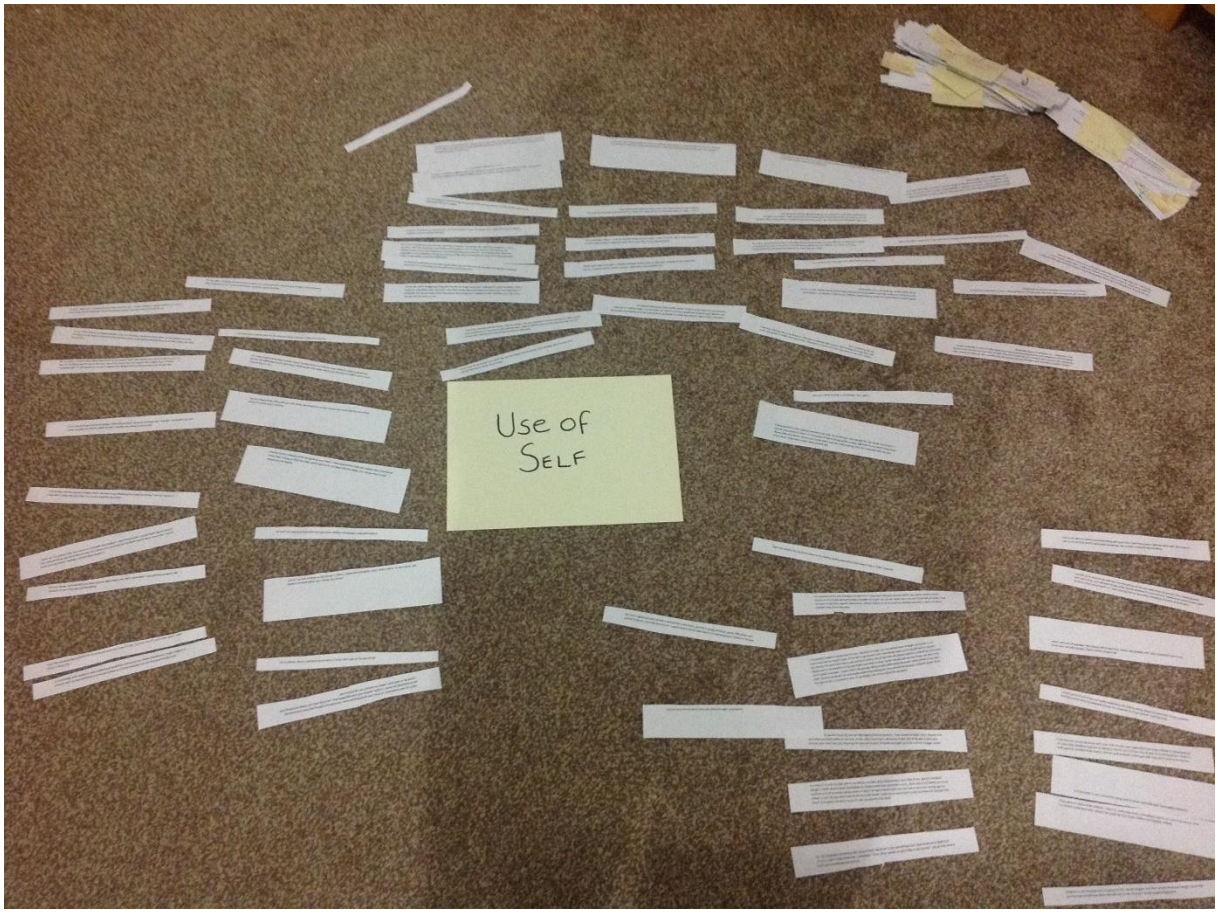
## APPENDIX O

**Pictures illustrating the analysis process**

Step 1:

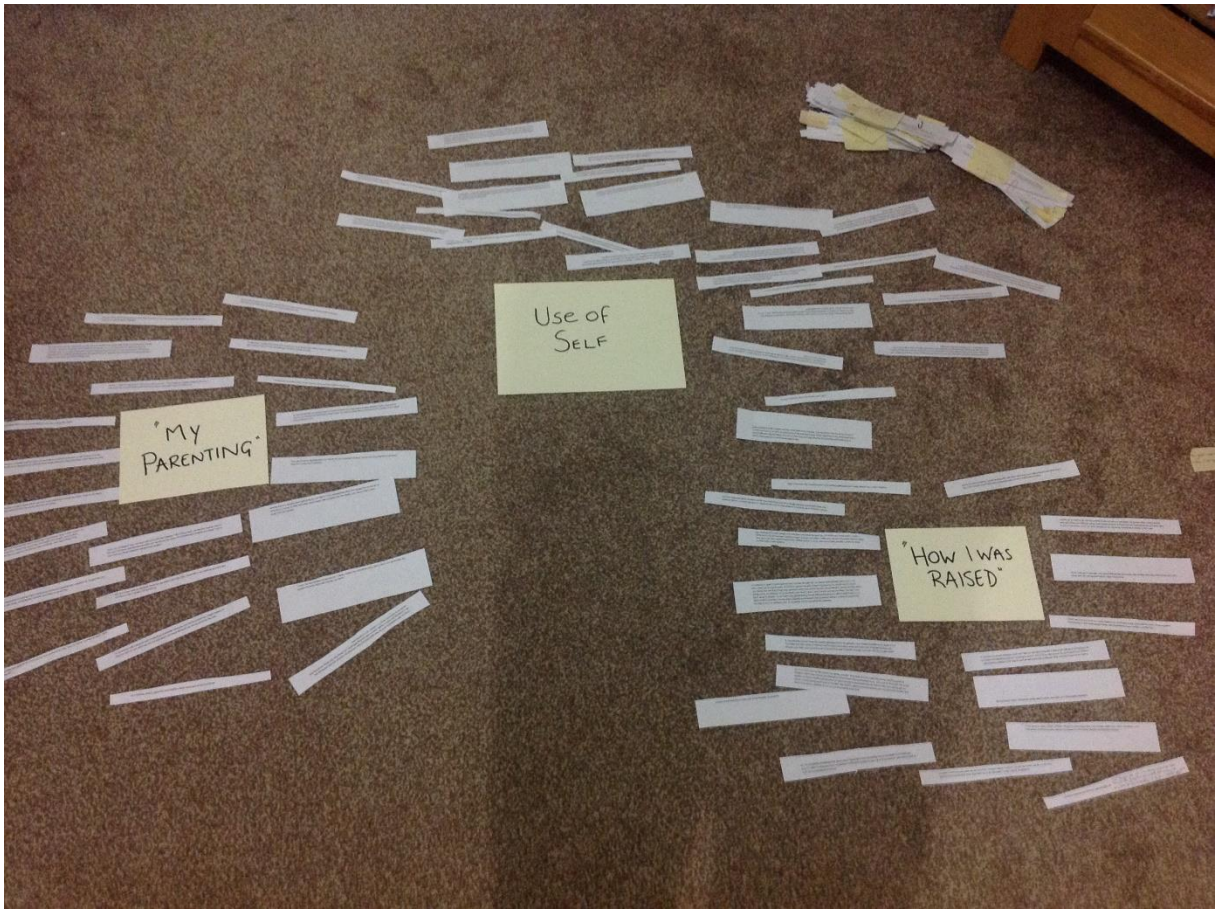
In order to address the research question all of the ‘chunks’ of data are laid out and references to ‘self’ are selected.

Step 2:



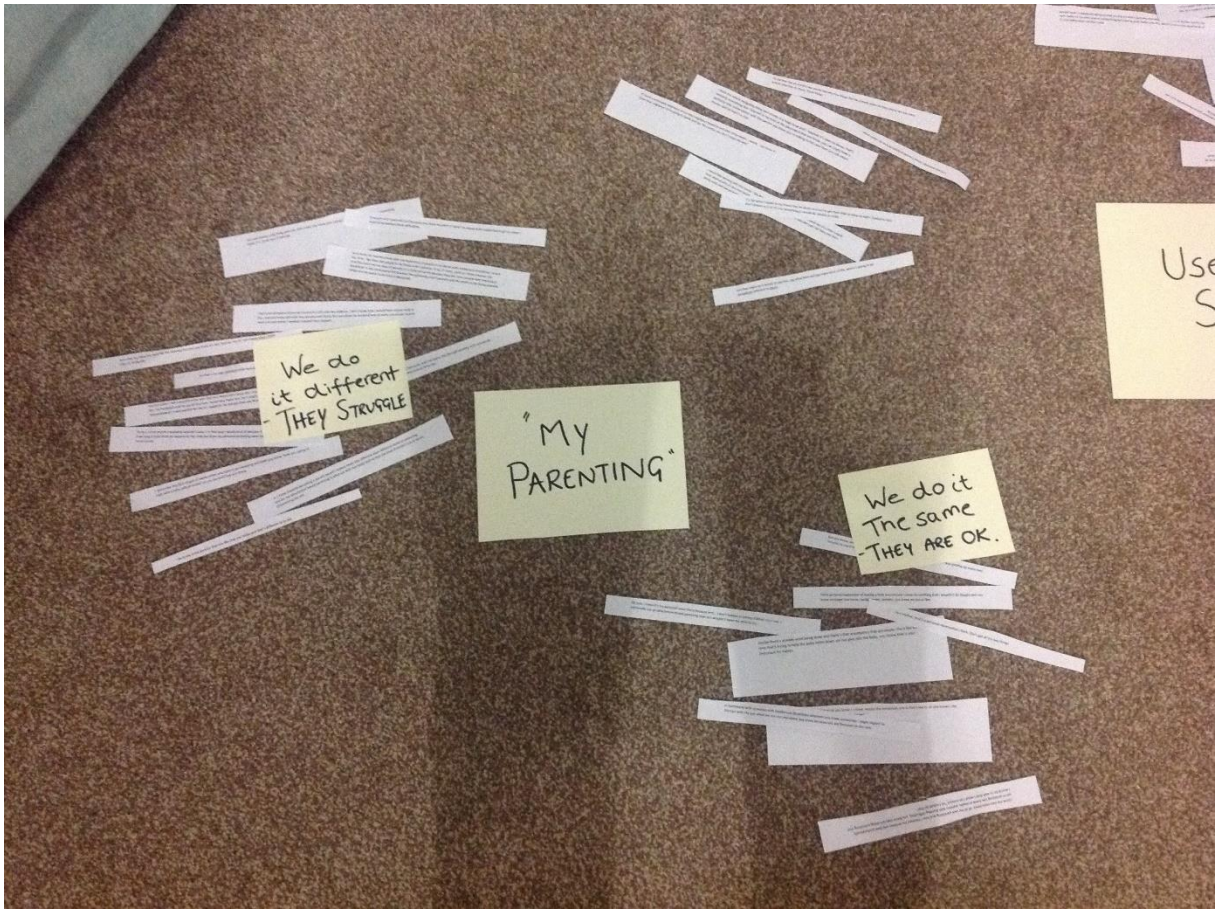

All the ‘chunks’ relating to ‘self’ are collected and laid out. They are all reviewed to see if there are any common words or phrases that are repeated.

Step 3:



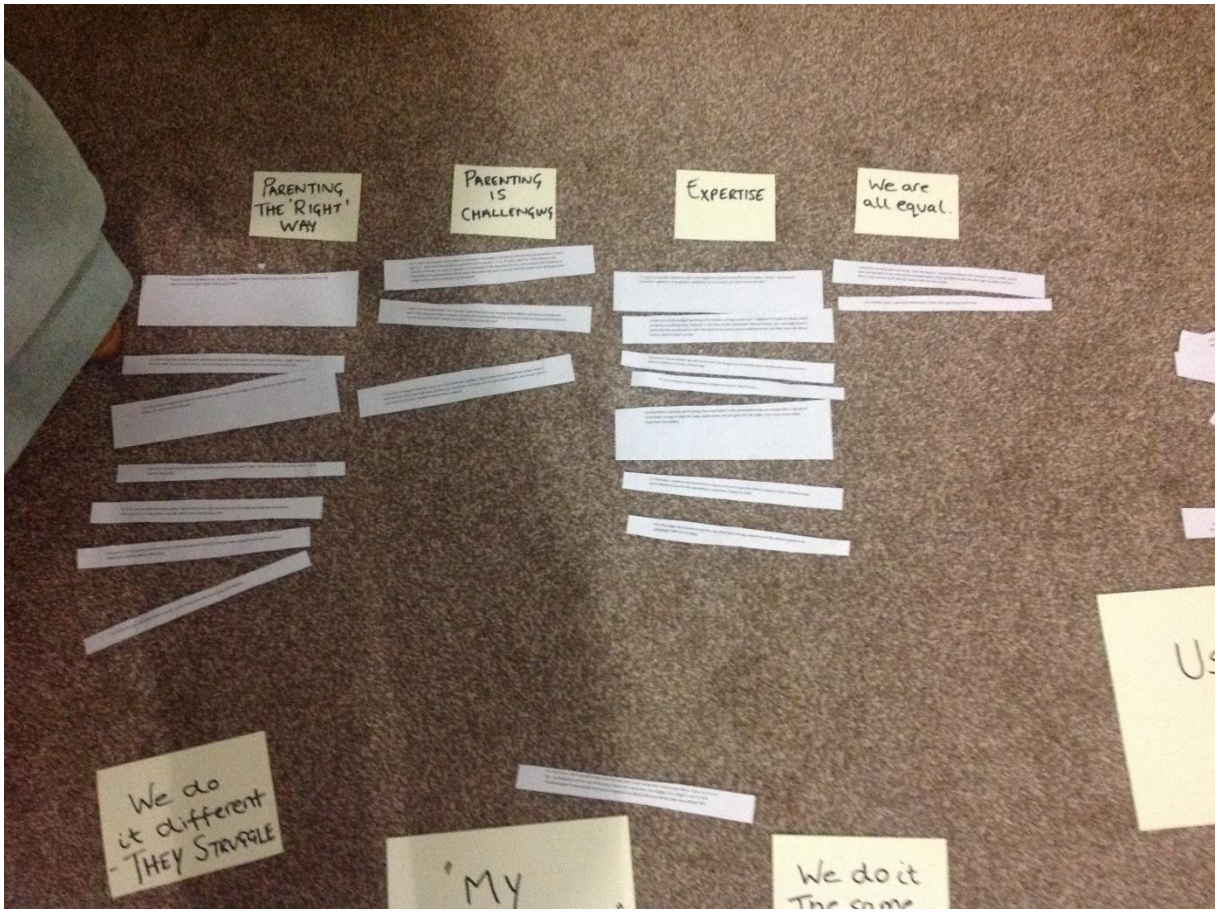

Grouping the ‘chunks’ allows discursive objects to be identified. Here ‘my parenting’ and ‘how I was raised’ begin to form.

Step 4:




The different ways the discursive objects are talked about and used (discursive patterns) are identified and grouped together. Here participants are using ‘my parenting’ to either infer that the parents in the video are coping or struggling.

Step 5:




The different patterns are reviewed and thought is given to which discourses might explain the use of the discursive objects on this way. Here the chunks are placed under the discourses that they fit best with.