A Systematic Review of Interventions for the secondary prevention and treatment of emotional abuse of children by primary carers

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EXECUTIVE SUMMARY

Background

Emotional abuse (or psychological maltreatment, as it is more commonly called in the US) is an inadequately researched and poorly understood concept, despite increasing awareness about the harm it can cause to children's lives. Although it unifies and underpins all types of maltreatment it also occurs alone and when it does, tends to elude detection and intervention. There have to date been no systematic reviews of the literature on the secondary prevention and treatment involving the parents or primary carers of emotionally abused children.

Objective

The objective of the review was to identify studies that evaluate the effectiveness of interventions in the secondary prevention and treatment of child emotional abuse involving the parents or primary carers of children aged 0 – 19 years.

Methods

Studies were included if they involved any intervention which was directed at emotionally abusive parenting and that measured change in (i) emotional unavailability (ii) negative attributions (i.e. that involve the parent attributing negative intentions, beliefs or attitudes toward the child); (iii) developmentally inappropriate interactions; (iv) lack of recognition of children's boundaries; (v) inconsistency of parenting role; (vi) missocialisation or consistent failure to promote the child's social adaptation. The primary outcomes evaluated involved proxy measures of a range of parent, family and child outcomes including parental psychopathology, parenting attitudes and practices, family functioning and/or child behaviour and the child's development and adaptation.

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A broad search strategy was developed in order to identify as many relevant studies as possible. An electronic search of a wide range of databases was carried about. No study type was excluded. The search was augmented by direct contact with academics and practitioners known in this field. The search included studies written in English, Spanish, French and German. Studies were included if the intervention was described, and the impact on at least one indicator of emotional abuse was assessed. Included

studies were critically appraised by two reviewers using standard criteria. Data were extracted using a standard proforma, and a qualitative synthesis of results was carried out.

Results

The initial search yielded 4248 publications of potential interest. Of these, 175 were obtained for possible inclusion or as background material. A total of 21 studies of 18 interventions, met all the inclusion criteria. A further 43 studies were relevant, but did not meet all of the inclusion criteria. Studies were organised according to the type of emotional abuse targeted: emotionally abusive parenting; parents of infants with faltering growth; missocialisation: parenting interventions with substance-abusing mothers. Twelve included studies had quantitative designs. Of these, 6 comprised randomised controlled trials; 1 comprised a follow-up of a randomised controlled trial; 2 were controlled studies; and 3 had one-group pre- and post-designs. The remaining 9 were case studies.

Included studies involved a wide range of interventions. The 8 studies for parents which address emotionally abusive parenting (rejection, misattribution, parent-child role reversal and anger management) involved evaluations of cognitive-behavioural training (CBT), behavioural training and parent-infant psychotherapy. Two further case studies involved cognitive-behavioural training, mentalisation and family-based therapy. The 9 interventions with parents of infants with faltering growth evaluated CBT, behavioural training, parent infant psychotherapy and interaction guidance; lay home visitors, and a range of therapeutic options based on the diagnostic condition of the parents. The 3 studies of interventions for substance abusing mothers evaluated a relational psychotherapy group for mothers, and a residential treatment for substance abuse with a parenting component. The sample sizes for quantitative studies were small and ranged from 17 to 98 participants. Ten interventions involved mothers alone, while a further 11 included fathers, either at the outset or at a later stage, and in 3 cases extended family members.

Interventions for emotionally abusing parents

The findings from the 8 included studies evaluating CBT, psychotherapy, and behavioural approaches suggest that group-based CBT may be an effective means of intervening with this group of parents, although it cannot currently be recommended with parents experiencing symptoms of severe psychopathology. While one comparative study showed a psychotherapeutic intervention to be more effective than a CBT focused intervention, the outcomes measured in this study (i.e. parent and child representations) favoured the former. Behavioural case work involving the use of problem-solving techniques may also have a role to play with some parents, although further research is still needed.

Interventions to enhance parental sensitivity

The findings from a systematic review of 81 interventions that aimed at enhancing parental sensitivity and / or infant attachment found strong evidence that short term (less than 16 sessions) interventions, with a behavioural focus and aimed exclusively at enhancing maternal sensitivity were also most effective in enhancing infant attachment security. This supports the notion of a causal role of sensitivity in shaping attachment. Interventions that included fathers as well as mothers showed higher effect sizes but results are tentative since they are based on a small number of small scale trials.

Parental behaviours associated with faltering growth

Nine studies evaluated a range of interventions with parents of babies with faltering growth including interaction guidance, home visiting; parent-child psychotherapy, behavioural casework and multi-component interventions. The findings show that interaction guidance and parent-infant psychotherapy may be potentially effective means of working with this group of clients along with behavioural casework, but that further research is needed before these can be recommended.

Missocialisation: Parenting interventions for substance-abusing parents

5 studies (one of which was a 6-month follow-up) evaluated interventions for substance abusing mothers, including a relational psychotherapy group and a residential treatment for substance abusing adults with a parenting component. The findings show that initial

gains made in the former were not sustained at 6-months and few benefits from residential intervention.

Conclusions

Emotional abuse is a complex issue resulting in part from learned behaviours, psychopathology and/or unmet emotional needs in the parents, and often compounded by factors in the families' immediate and wider social environment. As such, a 'one-approach-fits-all' is unlikely to lead to sustained change.

The evidence base is weak, but suggests that some caregivers respond well to cognitive behavioural therapy. However, the characteristics that define these parents are not clear. There is currently no evidence to support the use of this intervention alone in the treatment of severely emotionally abusive parents. Some of the evidence suggests that a certain form of emotional abuse (for example, highly negative parent affect, which may be expressed as frightened and frightening behaviours in the parent) stemming from unresolved trauma and loss, is less amenable to CBT. There is some evidence that interaction guidance and psychotherapeutic approaches can generate change in parents with more severe psychopathology.

Further research is urgently needed to evaluate the benefits of both psychotherapeutic and cognitive behavioural interventions, including those which take the form of family therapy, with parents at the more severe end of the spectrum, with fathers, and with older children. There is also a need to gain further understanding about which forms of emotional abuse respond best to different treatments.

1. BACKGROUND

1.1 Introduction

Emotional abuse is an inadequately researched and poorly understood concept, despite increasing awareness about its importance in children's lives.[1] [2] [3] Over the past decade, the number and percentage of children on the child protection register who were primarily referred for emotional abuse rose from 4,700 (13%) to 5,100 (20%).[4] [5] This equates to 4.7 per 10,000 children. As many as 80% of children registered for physical abuse and neglect have also experienced emotional abuse.[6]

Prevalence studies in the UK and elsewhere, suggest that this is just the tip of the iceberg, and that children who have been registered only represent a small proportion of the total number of children actually experiencing emotional abuse. In a large-scale population-based study (involving 2,869 adults) in the UK, 6% reported frequent and severe psychological control and domination; psycho/physical control and domination, humiliation, attacks on self-esteem, withdrawal of their primary carer's attention/affection, antipathy, terrorising or threatening behaviours and proxy attacks (p.70).[7] [8] These data strongly suggest that emotional abuse is likely to be common and therefore, that a central part of prevention and treatment should involve helping high-risk and vulnerable parents to develop healthier ways of relating to children instead of resorting to the use of child protection procedures (see below for further detail) once the harmful behaviour and interaction has become ingrained.

During the 1990s, research commissioned by the Department of Health showed that on the whole, the UK child protection system intervened too late and did not offer parents sufficient support or preventative services.[5] The Laming Report[9] made recommendations for major changes with regard to the ways in which services and professionals work together to reduce abuse in the UK, and a National Commission highlighted the need for more support to families including the teaching of parenting skills.[10] Some of these recommendations have been enshrined in recent policy documents, including 'Every Child Matters'[11], the National Service Framework for Children, Young People and Maternity Services,[12] and the Children Act 2004,[13] which created the legislative framework for whole system reform.

These changes represent an important shift in government policy on children's services, from a focus on child protection to family support and improved parenting.[14] They also recognise the need to locate targeted services within universal services, to intervene early and work 'in partnership' with parents.[15] They have resulted in extended early years provision, better integration of health, education and social care via Sure Start Children's Centres, 'parenting support embedded at each life stage', and 'multidisciplinary teams based in universal services such as clusters of schools or early years settings'.[13] Other changes aimed specifically at better protecting children have included the development of a shared database of children containing information relevant to their welfare, local authorities leading on multi-agency work via children's trusts, the development of statutory Local Safeguarding Children Boards (LSCBs) to replace non-statutory Area Child Protection Committees (ACPCs), and the development of an integrated inspection framework.[8] Most recently, 'Aiming high for children: Supporting families',[16] has pointed to the need to begin to focus on building resilience in children by promoting emotional skills and positive parenting and to provide more support to 'help parents play their critical role in supporting children's development' (ibid: 2).

However, despite these extensive policy developments considerable uncertainty remains about the best ways to intervene to prevent or reduce emotional abuse, due in part to issues related to definition and thereby to identification, and uncertainty about what works.

1.2 Definitional Issues

The lack of a universally agreed definition has made it very difficult to identify emotional abuse. Emotional abuse unifies and underpins all types of maltreatment; indeed, it has been suggested that the emotional or psychological dimension of maltreatment is central to an understanding of all abuse and neglect.[7] [17] [18] However, it also occurs alone,[14] and when it does, it tends to elude detection and intervention.[1] [2] [3]

> *Definitions of emotional or psychological abuse, although varying in emphasis, are consistently presented in the context of the family system. Each seems to call attention to a persistent, chronic pattern of maladaptive*

> *parental behaviour resulting in pervasive long-term damage to the psychological and emotional well-being of the child. Abuse can be passively (neglect) or actively [verbal assault] perpetrated and tends to involve either parental or caretaker skill deficiencies or maladaptive parental psychopathology.*[19] *(p.67)*

In this paper, the term emotional abuse is used interchangeably with 'psychological maltreatment' to refer to a constant, repeated pattern of parental behaviour, (unaccompanied by physical abuse, sexual abuse or necessarily by physical neglect) that is likely to be interpreted by a child that she or he is unloved, unwanted, serves only instrumental purposes, and/or which severely undermines children's development and socialisation. Emotional abuse therefore constitutes a form of habitual interaction rather than isolated events. Certain characteristics of the parent (such as addiction or some forms of mental illness) may increase the risk that parent-child relations will be characterised, for example, by a parent's habitual unavailability, active rejection, hostility, or the child's constant missocialisation. Similarly, some children (such as infants who are highly demanding) appear to be at greater risk of being rejected, treated with hostility, or simply being misunderstood, than others. It must be emphasised that characteristics of parents or children which put them at risk do not, in and of themselves, imply that children are being emotionally abused.

Glaser and Prior (2002)[20] propose five different categories of emotional abuse and neglect which integrate the work of theorists and practitioners in Europe, the US, UK and elsewhere (Table 1, below). Although in practice these behaviours often overlap, this framework can help practitioners who observe and think about situations that are often discordant and difficult to understand and manage.[21]

Table 1: Categories of emotional abuse and neglect (from Glaser and Prior, 2002: 703 – 704)

(i) Emotional unavailability, unresponsiveness and neglect. Primary carers are so preoccupied with their own difficulties (including mental illness) or practices (such substance abuse) or external commitments that they are unable or unwilling to respond to the child's emotional needs and make no provision for an alternative.

(ii) Negative attributions and misattributions to the child, including hostility towards, denigration and rejection of a child.

(iii) Developmentally inappropriate or inconsistent interactions with the child, including expectations of the child beyond his or her developmental capabilities; overprotection and limitation of exploration and learning and exposure to confusing or traumatic events and interactions (including witnessing violence towards a loved one, parental para-suicide and/or solvent abuse)

(iv) Failure to recognise the child's individuality and psychological boundary. This can involve using the child for the fulfilment of the parent's psychological needs and inability to distinguish between the child's reality and the adult's beliefs and wishes

(v) Failure to promote the child's social adaptation. This can include forms of missocialisation, such as exposing a child to corrupt, illegal or violent activities; failing to provide for a child's developmental needs for education, cognitive development and experiential learning.

This list draws attention to the ways in which children experience (consistent, habitual) emotional abuse.

1.3 Emotional neglect and parental mental health

As suggested above, emotional abuse includes acts of omission, and issues such as faltering growth and parental mental health problems/drug abuse/domestic violence, may all involve parenting behaviours that have implications for the emotional development of the child.

1.3.1 Parenting behaviours associated with infant faltering growth

Faltering growth (non-organic failure to thrive) is one example where acts of omission specifically in terms of a child's emotional needs, may result in an infant who falls into

the bottom 5% or lower on established growth charts.[22] The potential consequences of faltering growth to infants' long term physical and cognitive development are well-established.[23]

Infant faltering growth is defined as decelerated or arrested physical growth, in which height and weight measurements fall below the fifth percentile, which can have several causes that are sometimes difficult to unravel but are always inked to the child's feeding difficulties. An infant with a difficult temperament may exacerbate pressures on an already overladen caregiver (almost invariably the child's mother) and the combination can result in fraught and emotionally charged feeding. On the other hand, faltering growth may have purely or largely organic causes (such as an illness within the child). It can also be the symptom of emotional deprivation, as is the case when an infant's caregiver is preoccupied with her own emotional problems, with care for other children, is addicted and/or suffers from mental health problems.

1.3.2 Severe mental health problems

Two-thirds of adults who meet the criteria for psychiatric disorders - across all diagnostic conditions - are parents, but there is currently little attention paid to the consequences of such problems in terms of the ability of the parents to meet the emotional needs of their children. It is known that the effect of mental health problems on adults' parenting function varies according to the nature of the illness in question and that its consequences for the child are mediated by factors such as household financial stress, partner conflict, social and family support systems available and individual children's coping skills.[24] The nature of parenting for caregivers with mental health problems therefore varies and cannot be presumed to be 'emotionally abusive'. In an early study of the resilient children of psychotic parents, Kauffman et al. (1979)[25] drew attention to the mediating, protective role of parental warmth.

Nonetheless, some forms of parental mental health problems are associated with unpredictable and frightening behaviours, while others (particularly depression) are linked with parental withdrawal and neglect. The adverse effects of maternal caregiver depression on the well-being of children, and in particular the under-fives, is well-

documented.[26] The timing and severity of maternal depression is important, since it appears most harmful to children when it affects the first five years of life.[27]

A variety of anxiety disorders, including panic disorder and phobias, are one of the most widespread types of mental health problems.[28] Although there has been little research on the effects of anxiety on parenting, parents who do suffer from severe anxiety have been observed to be highly critical, express less affection, smile less, be more likely to over-react during interactions with their children and appear to be less likely to encourage psychological autonomy - for example, by soliciting their child's opinion or tolerating differences of opinion.[28]

Psychotic disorders (involving distortions of thought, perception and emotion, sometimes accompanied by significant restrictions in the range and/or changes in the intensity of emotional expression) are associated with greater difficulties in fulfilment of daily parenting roles, less positive affect, less responsiveness to children, more limited environmental stability and lower levels of sensory and motor stimulation.[27]. There is evidence that schizophrenia is a greater impairment to parenting than many other forms of mental health problems.[27] Nonetheless, practitioners are, perhaps understandably, reluctant to describe the often erratic, inconsistent and even frightening behaviour that result as a consequence of severe mental illness as 'emotional abuse' because adults with psychoses are less likely to be aware of the effects of their actions during periods of illness.

1.3.3 Substance abuse

In the US, around 80% of women who abuse drugs are of childbearing age (National Centre on Addiction and Substance Abuse, 1996) and have multiple, compounded psychopathology and histories of abuse and neglect.[29] [30] [31] Luthar et al (2004),[29] whose work has focused on mothers, have postulated that the factors that put women at risk of drug abuse (childhood abuse and poor social supports) also increase the risk of child maltreatment. However, the authors have observed that contrary to what is sometimes assumed, substance-abusing women often desire to be good mothers and are aware of what good parenting involves, but feel unable to fulfil this role.[32]

1.3.4 Domestic Violence

Over three decades of research on children who witness domestic violence has shown that it is one of the most serious factors undermining children's cognitive, emotional and even physical well-being.[33] [34] Attacks on a parent almost always frighten children even if the child is not the direct or indirect target, although a parent (most frequently, but not invariably, the male partner) will sometimes exploit a mother's or child's fears for each other and use threats or actual violence as part of a pattern of aggression.[35] [36] A study published in 1995 showed that 45% of a UK sample of adults across the social and age spectrum had witnessed domestic violence at least once; 10% had seen it 'constantly' or 'frequently'.[37] Although there is evidence to show high rates of co-occurrence of physical violence to (almost invariably female) partners and violence towards children, it is not always the case that men who assault women also physically abuse children.[197] Children who witness domestic violence, but who are not otherwise abused may elude detection, protection and support.

1.4 Consequences of emotional abuse

Apart from the contemporaneous harms from emotional abuse, a further, great risk posed by emotional abuse derives from the fact that the perpetrator is often the person responsible for enabling children to fulfill their developmental tasks (i.e. the primary carer).[19]. Six developmental periods and tasks (Table 2) have been identified.[38] For example, one of an infant's primary developmental tasks is to form a secure attachment with an adult caregiver, learning in the process to trust others to provide a stable environment and believe in his/her own ability to solicit that care. A caregiver who predominantly rejects a child's bid for attention will have a negative effect on the child's sense of self-worth and belief in the availability of others (Bowlby, 1951[39]; see section on attachment, below). Hart et al. (1986)[40] postulate that psychological maltreatment presents a direct attack on children's developmental needs for safely, love, belonging and esteem.

Table 2: Children's developmental periods (from Bingelli et al. 2001)

- Infancy (attachment, assistance in regulation of bodily states, emotional regulation);
- Toddlerhood (development of symbolic representation and further self-other differentiation, problem-solving, pride, mastery, motivation;
- Preschool (development of self-control, use of language to regulate impulses, emotions, store information, predict and make sense of the world; development of verbally mediated or semantic memory; gender identity; development or social relationships beyond immediate family and generalisation of expectations about relationships; moral reasoning);
- Latency age (peer relationships, adaptation to school environment, moral reasoning);
- Adolescence (renegotiation of family roles, identity issues – sexuality, future orientation, peer acceptance, ethnicity, moral reasoning);
- Young adults (continued differentiation from family, refinement and integration of identity with particular focus on occupational choice and intimate partners, moral reasoning).

Precisely because it interferes with a child's developmental trajectory, emotional abuse has been linked with disorders of attachment, developmental and educational problems, socialization and behaviour problems.[41] [42] Longitudinal studies have shown that it increases the risks of depression, self-harm, substance abuse and even suicide risk in adult life.[36] Psychological unavailability of primary caregivers in early childhood[42] and consistent rejection by a caregiver are associated, cross-culturally, with lower self-esteem, emotional instability and increased aggression.[43] Rejection, misattribution and parental hostility can affect children's physical health in early childhood and beyond.

Children's physical and psychological health can be harmed even if they are not physically injured or neglected. Children who witness domestic violence, for example, are at disproportionate risk of injury, eating disorders and self-harm[44] even when they are not themselves victims of physical violence**.** The profound distress caused by this under-studied form of child abuse is associated with girls' increased risk of eating disorders, self-mutilation and of becoming victims of domestic violence in later life[45] and

in both boys and girls to exposure to social violence and permanent impairment to cognitive and sensory growth.[46]

The presence of other loving caregivers and other supports can be protective against the effects of emotional abuse by a parent, as a child who is maltreated by many family members is at higher risk than one who has a range of alternative supports, including a non-abusing parent.[38] The effect on children is also mediated by the timing, chronicity and/or severity of abuse. An older child who has been emotionally abused from infancy is particularly vulnerable to multiple difficulties.[41] This has implications for policy and care decisions, since in the UK at least, the vast majority of emotionally abused young people stay with at least one birth parent into adulthood (ibid; see also Brougham, 1996).

As well as having profound effects on the individual, emotional abuse also carries a significant burden for society because of its impact on the health care and child protection services,[47] and the longer term cost to society of educational failure, crime and poor mental health.

1.5 Theoretical Perspectives

Theories of causation of child abuse generally fall into three main groups: (i) psychological theories, that focus on the personal history and characteristics of adults who abuse children; (ii) social psychological theories, that focus on the dynamics and interaction between abuser, child and immediate environment and; (iii) sociological perspectives, that emphasise the way in which social and cultural factors create the conditions for child maltreatment. Theoretical perspectives of emotional abuse recognise the role of social and environmental factors in influencing cultural mores – such as the belief that children are the 'property' of adults - or social/environmental stressors (such as the poverty or social isolation) that exacerbate the risk of maltreatment. However, far greater emphasis has been placed – in research and intervention development - on the parent (particularly the mother), the parent and child dyad, and the family unit.

Four main theoretical approaches have informed the development of interventions for the treatment of emotional abuse - psychodynamic theory (focusing on the way in which

parents re-enact with their own children, painful and unconscious experiences from their own childhood); attachment theory (focusing on the way in which the parent's attachment status influences their parenting behaviours and the impact of this on the child's attachment status); behavioural/cognitive perspectives (that focus on the ways in which aversive parenting behaviours are learned or how cognitive distortions lead to abusive parenting); and finally family systems theory (focusing on the way in which the boundaries between parents and children can become blurred resulting in abusive parenting behaviour). Each of these approaches has shaped the development of interventions to prevent, halt or address the effects of parental negative affect

(For a **brief introduction to** theoretical models see Appendix A).

1.6 Detection and treatment of emotional abuse

In spite of the dangers it poses, emotional abuse eludes detection and intervention.[1 2 3.] As Boulton and Hindle (p.4)[20] observed: *'We had become increasingly aware that children who were being emotionally abused were often the most vulnerable, but least likely to attract the attention of the child protection system, with workers feeling impotent in the face of problems which [unlike sexual abuse, physical violence or physical neglect] were difficult to tabulate.'* Problems of detection and treatment are compounded in the UK by child protection services' tendency to assess children for risk, rather than strengthen the capacity of families to care for children (Ibid.), and by an understandable concern to avoid false accusation of innocent parents. As a result, 'referrals framed in terms of neglectful behaviour or emotional abuse are likely at a very early stage to be steered away, not only from the formal child protection system but also, without an adequate assessment of need, from the provision of services' (Ibid: 353). Poorer families are also likely to be under greater surveillance than middle class or wealthy ones, in which problems may become evident only as a result of children's externalising behaviour.[48] A second problem - in the UK and elsewhere - is lack of collaboration, and sometimes actual conflict, between adult mental health and child protection/child mental health services.[20,49] There is, therefore, a gap between awareness of the risk posed by emotional abuse and the importance given to treating the parental behaviour that gives rise to it, although there is some evidence that early recognition and intervention can influence such interaction and improve outcomes for children.[50] However, interventions need to be underpinned by a sound theoretical framework and to have clear goals.

1.7 Aim of the review

The aim of this review is to identify studies that have evaluated the effectiveness of secondary preventive and treatment interventions on parenting that has been characterised using on of the forms of emotional abuse defined by Glaser and Prior (2002)[19]. The review covers interventions that involve parents alone, or parents and children, but not those that are directed solely at children. Henceforth the term parent will be used to cover parents and primary carers.

2. METHODOLOGY

The following search strategy was implemented aimed at identifying as many relevant studies as possible.

2.1 Search Strategy

2.1.1 Databases searched

A thorough search was undertaken of the following databases: Medline; EMBASE; Biological Abstracts; PsychINFO; Sociofile; Social Science Citation Index; CINAHL; Dissertation Abstracts; ERIC, Psychological Abstracts, and the Campbell Collaboration. The objective was to generate as comprehensive a list as possible of primary studies, both published and unpublished.

Unpublished studies were identified using the following sources: NSPCC library and database, Cochrane Library, Current Controlled Trials, National Research Register (NRR) and the Register of the Medical Editors Trial Amnesty. 25 leading researchers in the field were contacted as well as the major national and international child abuse and emergency medicine organisations. Reference lists of articles identified through database searches and bibliographies of systematic and non-systematic review articles were examined to identify further relevant studies. A hand search of the contents of the main child abuse journals (Child Abuse and Neglect; Child Abuse Review; Child Maltreatment; Journal of Emotional Abuse) was undertaken.

2.2 Inclusion criteria

The following inclusion criteria were used:

(a) Population

Studies were eligible for inclusion in the review if the intervention has been provided directly to parents of children aged 0 – 19 years, or to both parents and children within that age band. Programmes aimed solely at the treatment of children were not included in the review.

- Prevention programmes were eligible if a specific group at risk for emotional abuse was identified with specified criteria for identification and selection of those at risk.
- Treatment programmes were eligible if they included parents or children in whom emotional abuse has been identified according to any of the definitions outlined above.
- Interventions with parents of children with faltering growth, parents who are addicted to drugs or alcohol, and parents with severe mental illness were included if the intervention measured changes in parenting.

(b) Interventions

Studies evaluating any intervention that is directed at the secondary prevention or treatment of the following consistent parenting behaviours (Glaser and Prior, 2002):[19]

- Emotional unavailability, unresponsiveness and neglect
- Negative attributions and misattributions
- Developmentally inappropriate or inconsistent interactions with the child
- Failure to recognise the child's individuality and psychological boundaries
- Failure to promote the child's social adaptation.

(c) Outcomes

Only studies that had measured the following outcomes were included in the review: the impact of the intervention on emotionally abusive parenting using either parent- or child-report standardised measures or independent observations of the following: (i) parental attitudes and (ii) parental behaviour (iii) family functioning and/or (iv) the child's social, emotional, physical and developmental well-being and functioning. Diagnostic assessments by clinicians of emotional abuse, children's cognitive, motor, emotional and social development, and children's physical health were also included.

d) Language, time period

Studies that had been published in any of the following languages were included: English, German, French and Spanish. Searches covering the period 1980 to 2007 inclusive were undertaken.

The followings types of studies were excluded: universal primary prevention for vulnerable populations (e.g. poor, single, adolescent mothers) where there has been no clearly identified risk of emotional abuse; treatment in situations where emotional abuse has been enmeshed with physical violence or sexual abuse, or in which physical neglect is the primary presenting problem; interventions that involve identified emotional abuse of children but do not measure change in parent-child emotional interaction. Some, which approximate our inclusion criteria, have been listed with excluded studies (Appendix 2). Interventions that only measure change in risk factors, such as parental depression (see for example, Beardslee et al., 2003),[26] insensitivity and troubled attachment have been the subject of recent reviews (such as Bakermans-Kranenburg et al., 2003)[51] that are listed with other excluded studies. Studies of interventions with caregivers who have severe mental illness (SMI) could only be included if change in parenting practices was measured.

Titles and abstracts of studies identified through searches were reviewed to determine whether they met the inclusion criteria (Table 3). Abstracts that did not meet the inclusion criteria were rejected. Two independent reviewers assessed full copies of papers that appeared to meet the inclusion criteria. Uncertainties concerning the appropriateness of studies for inclusion in the review were resolved through consultation with a third reviewer.

2.2.1 Search terms

The search terms used to identify relevant studies were adapted for use in the different databases. The search terms used were developed using Glaser and Prior's (2002)[19] definition of emotional abuse (Table 3, below).

1) **Child/Infant/Adolescent**
   child$ or boy$ or girl$ or baby or babies or infant$ or teen$ or adolescen$ or pre school$ or pre-school$ or preschool$ or schoolchild$
2) **Parents**
   mother$ or father$ or parent$ or maternal or paternal or family or families
3) **Abuse**
   emotion$ or psychological or verbal$ adj3 abuse$ or maltreat$ or violen$ or neglect$ or unavailab$ or hostil$

reject$ or spurn$ or abandon$ or denigrate$ or degrade$ or terror$ or isolat$ or missattribute$ or scapegoat$ or hostage or threat$ or withdraw$ or abandon$
unrealistic$ adj3 expectation$ or developmental$ adj3 inconsist$ or developmental$ adj3 inappropriate$
failure to thrive or NOFTT or faltering growth

4) **Treatment**
intervention$ or prevent$ or treat$ or therap$ or counsel$ or program$ or manage$ or train$ or consult$ or conference$ or support or service$ or parent program$ or parent$ train$ or parent$ education$ or parent$ promotion or parent$-train$ or parent$-program$ or parent$-education$
cognitiv$ adj3 therap$ or train$
behavio#r adj3 therap$ or train$
parent$ adj3 train$
family therap$

No methodological terms were included to ensure that all relevant papers were retrieved. The final search strategies were developed by an iterative process that sought high sensitivity, and excluded no particular study type, since the initial scoping searches indicated that the total volume of relevant literature is limited.

2.3 Critical appraisal and data extraction

Data was extracted by the lead author (AS), using a data extraction form, and confirmed by the second author (JB). Where data were not available in the published study reports, authors were contacted to supply missing information.

Critical appraisal of the included studies was carried out independently by two authors. Disagreements were discussed and resolved by consensus among reviewers. Where disagreement was due to a lack of information, the authors of a study were contacted for clarification. The scientific rigour of published studies was evaluated according to established guidelines (Centre for Reviews and Dissemination 2001) to inform the interpretation of findings and recommendations for future research (Table 4).

Table 4 Data extraction criteria

Intervention	Evaluation
Aims Theoretical background Population and setting Intervention content and delivery	Design Identification, allocation and characteristics of subjects Outcomes measured and timing Measure content, reliability and validity Loss to follow-up Analysis and statistical tests used Results Cost information Author's conclusions Assessment of study quality Reviewer's comments

2.3.1 Data synthesis

The interventions and outcomes evaluated in the included studies were too diverse to allow for a quantitative synthesis of the study findings. A narrative synthesis is provided, and included studies were classified using the following criteria: aims and outcomes; content and delivery; and implementation.

Table 5: Quality assessment criteria

- Description of aims and outcomes
- Description and number of subjects
- Method of allocating subjects and comparability of groups
- Description of implementation and integrity of implementation
- Loss to follow-up and how accounted for
- Description of outcome measures, and data about their validity and reliability
- Clarity and precision of analysis and results

3. RESULTS

3.1 Results of the search

The search confirms that there is very little documented research on the treatment of child emotional abuse.[52] [53] The initial search strategies were broad and identified 4248 publications of potential interest. Of these 175 were obtained for possible inclusion or as background material. A total of 20 studies met all the inclusion criteria. Of these, 1[54] was a follow-up evaluation of an earlier study;[55] and Iwaniec et al. 1985a[56] and 1985b[57] and Fraiberg et al., 1981a[58] and 1981b[59] are two-part papers.

A further 42 studies were identified that were relevant to the treatment of parental behaviour associated with emotional abuse but did not meet the inclusion criteria. The most common reasons for exclusion were that (i) the intervention measured change in infant attachment (see meta-review by Bakermans Kranenburg et al., 2003); (ii) intervention was for parents considered to be at high risk because of their adverse life circumstances and personal history, rather than identified behaviours (e.g. Lieberman et al., 2006)[60]; (iii) because the study assessed the effect of interventions on attachment or maternal depression (Beardslee, 2003)**;** (iv) emotional abuse was indistinguishable from other forms of maltreatment (e.g. Gershater-Motlko et al. 2002a et al., 2002b); [61] or because interventions had no reported effect on children. This was the case with treatment of parent behaviour that causes children's missocialisation (male violence towards women, alcohol abuse) or factors that increase the risk of emotional harm to children (eg depression) but do not in themselves constitute emotional abuse. Results of systematic reviews on identification, prevention and treatment of domestic violence, antenatal and postnatal alcohol or drug abuse, and antenatal and postnatal depression, are included in Appendix 3.

Included studies were organised according to the type of emotional abuse targeted:

- Emotionally abusive parenting
- Enhancement of parental sensitivity
- Missocialisation: parenting interventions with substance-abusing parents

Although there is an emerging literature on prevention of domestic violence

Section 4.1 – 4.5 describe the interventions included, with further information in Appendix 3. The 55 excluded studies are listed in Appendix 3.

3.2 Characteristics of the included studies

The following section describes the characteristics of the included studies in terms of the methods used, the intervention, population and outcomes, and other relevant features of the studies such as the countries in which they were conducted. The results of this analysis are summarised in Table 3.1.

Table 3.1: Characteristics of included studies[1]

1. Emotionally abusive parenting						
Study ID	*Methods*	*Participants*	*Intervention*	*Outcomes Measured*	*Level of evaluation*	*Length of study*
RCTs						
Sanders et al. (2004)[62]	RCT with pre and post measures	98 parents with a child aged 2 – 7 years. Sample included parents referred by child protection services and parents who self-referred. Participants mean age 34 and of children 4.4 years. SES and ethnicity not specified.	Enhanced group-based cognitive-behavioural parent training with additional focus on attributional retraining and anger management (n=48) Standard cognitive-behavioural group-based parent training (n=50)	Parental blame and intentionality attributions Anger control, expression and intensity	A	8 - 12 week intervention Assessed at baseline, post treatment and at 6 months
Toth et al. (2002)[63]	RCT with pre and post measures	87 mothers and preschool infants. 1/3 of sample diagnosed as emotional abuse and neglect. 65% of minority ethnic groups, low SES and 87% unmarried.	Preschooler parent psychotherapy (PPP) (n=23) and home based psychoeducational home visitation (PHV) (n=34), community standard comparison group which received standard services through Department of Social Services (DSS) (n=30)	Parental emotionally abusive behaviours; parent-child interactions; parental anxiety and stress	A	12 month intervention Assessed at baseline and post-treatment
Two groups pre and post-test						
Iwaniec (1997)[64]	Controlled study with pre and post-intervention measures	34 mothers and fathers diagnosed as emotionally abusive (median age 26). 29 White, 5 Black. 6 single mothers, 10 intact families, 4 step-parent families. Most families low SES.	Group and individual home based behavioural parent training (n=17) Individual home based behavioural parent training alone (n=17)	Parental emotionally abusive behaviours Parent-child interactions; parental anxiety and stress	C	10 week intervention Assessed at baseline and post-treatment

[1] *Levels of evaluation*: A=Randomised controlled trial, B=Controlled trials with pre and post-test measures, C=Two of more groups with pre and post-test measures, D=One group with pre- and post-test measures, E=Case study.

Sample case studies						
Iwaniec (2007)[65]	Case studies	(I) Mother and infant with antagonistic interaction. Child age 3 ½. years. SES and ethnicity not stated. (ii) Father and mother and oldest of 7 children in a family with emotional violence and neglect. Children's ages ranged from infancy to 17. Low SES.	Application of parenting skills deficit model/cognitive-behavioural techniques in training of (i) emotionally unavailable mother (ii) verbally violent and neglectful parents and their older children	Cognitive re-structuring, anger management and problem-solving to change parent child interaction (example 1) and family interaction (example 2).	E	Length of treatment not stated
Slade et al. (2005)[66]	Case study	1 infant identified as high risk of abuse and neglect and her mother; later involvement of father; grandparents. Low SES; ethnicity not stated.	Mentalisation based multidisciplinary intervention complemented by health services	Development of mother's ability to mentalise infant	E	2 year intervention Assessed at intervals and post-treatment
Byng Hall (2002)[67]	Case study	1 family with parentified and triangulated 2 ½ year old child; father and mother, 1 grandparent, 7 mo baby. Middle class; ethnicity not stated.	Systemic family therapy grounded in an attachment perspective.	Reversal of child's parentified role	E	Length of treatment not stated; follow-up contact for 7 years
Boulton and Hindle (2000)[20]	Case studies	6 case studies involving families where children were affected by parental misattribution, role reversal, unavailability and missocialisation. SES not stated.	Psychodynamic family therapy.	To engage families, and to generate and sustain changes within parents.	E	Duration of interventions not stated
Dawson et al. (1986)[68]	Case study	3 emotionally neglectful mothers aged 20, 27 and 29. Ethnicity and SES not specified. All children aged 5 years or less.	Application of cognitive-behavioural techniques in one on one training of parents.	Cognitive training in problem solving which can be generalised to prevent emotional and physical neglect.	E	Duration of interventions not stated, assessed at baseline, 4 months and 15 months

2) Enhancing parental sensitivity and / or infant attachment						
Study ID	*Methods*	*Participants*	*Intervention*	*Outcomes Measured*	*Level of evaluation*	*Duration and follow-up*
Systematic review						
Bakermans-Kranenburg (2003)	81 studies, range of methods	Mothers only (78 interventions); mothers and fathers (3 interventions) during antenatal and/or postnatal period.	A range of interventions aimed at enhancing parental sensitivity or infant attachment.	Sensitivity outcome measures; infant attachment.	A	Duration range between <5 sessions to >16 sessions. Frequency not reported.
RCTs						
Black et al. (1995)[55]	RCT with pre and post measures	130 faltering growth infants median age <18 months, and their mothers. Mothers predominantly-low SES, 90% Black, median age 24. 83% single mothers. Low SES	64 mothers of faltering growth infants received home based visitor service combined urban paediatric care clinic services; 66 received clinic-only standard services	At 1 year: Maternal emotional and verbal responsiveness; Infants' physical and developmental gains Parent child behaviour during feeding; Home environment	A	1 year intervention assessed at baseline and post-treatment
Hutcheson et al. (1997)[54]	Follow-up to Black et al. (1995) above at 4 years.	76 faltering growth infants, median age 4 and mothers from original study (Black et al., 1995, below)	Follow up to Black et al (1995) above	At 4 years: Maternal psychological functioning; Children's physical and developmental gains	A	Follow up to Black et al. (1995) of infants at age 4
Controlled studies						
Benoit et al. (2001)[69]	2 comparison group, quasi experimental design	28 faltering growth infants and their mothers. Group 1 infants median age 18 mo., mothers 32. 47.9%, low SES. Ethnicity not specified.	14 mothers of faltering growth infants received Interaction Guidance (videotaped interaction followed by discussion, education and feedback) administered over 5 consecutive weeks. 14 received a behavioural feeding programme.	Maternal representations; mother-child interaction scores Infants' physical and developmental gains	B	5 weeks intervention (IG) or 7 weeks (behavioural, feeding programme) assessed 14 weeks after completion

Controlled studies	*Controlled studies*	*Controlled studies*	*Controlled studies*	*Controlled studies*	*Controlled studies*	*Controlled studies*
Haynes (1984)[70]	2 comparison group, quasi-experimental design.	50 faltering growth infants and their mothers. Infants age not specified. 44% Hispanic, 40% White, 14% Black. Mother median age 20.5. 20% single mothers. Low SES.	25 mothers of faltering growth infants received a combination of lay home visitor service (LHV) with standard services (hospital based treatment of child; hospital based parent training; parent training; follow-up support from paediatricians, social workers and a community nurse). 25 received standard services alone.	Infants growth and development Mother-infant interaction patterns	B	Length of intervention not stated. Assessed at baseline, at 6 months, 1 year and at three year follow-up

One group pre and post-test						
Study ID	*Methods*	*Participants*	*Intervention*	*Outcomes Measured*	*Level of evaluation*	*Duration and follow-up*
Dunitz et al (1996)[71]	One group pre-test and post-test design	76 parents (48 mothers and 28 fathers) and 50 firstborn infants. 94% White, 6% Black. Age and SES not specified. 42% single mothers, 2% single father.	Parents received a combination of training on child feeding in clinic, interaction guidance, and parents' choice of therapeutic and counselling services.	Parental psychological functioning Infants' physical and developmental gains	D	Length of intervention varied. Assessed at baseline, 3 months and 1 year
Iwaniec (1985a & b) [56 57]	One group pre-test and post-test design	17 faltering growth infants and their mothers; fathers involved 'where appropriate'. Ethnicity not stated. Mother median age 25, child median age 23.7, months predominantly low SES (58% unemployed).	Parent training grounded in behavioural social work.	Mother-infant interaction. Infants' physical and developmental gains	D	Length of intervention varied. Assessed post-treatment and at intervals for 5 years.
Fraiberg (1981a, 1981b)[58 59]	One group with pre and post measures	41 families with 50 infants (sample included siblings). 80% White, 20% Black. 20% single mothers.	Parent-infant psychotherapy, developmental guidance, individual psychotherapy with the parent(s) and support to parents in accessing social and economic resources.	Parenting, child health, child affective-social development, child adaptive modes, child cognitive-motor development.	D	Programme lasted 6 years. Length of intervention varied from less than 6 months to 2 years according to level of need. Length of time between 1st and 2nd assessment varied from 6 to 45 months.
Case studies						
Iwaniec (2004)[72]	Case study	1 mother-child dyad; support for father and siblings.	Holistic intervention including feeding/day care for infant and behavioural therapy for mother	Mother-infant interaction, family functioning, infant growth	E	Length of treatment not stated
Keren and Tyano (2001)[73]	Case study	1 mother-child dyad; later involvement of father. Age, ethnicity and SES not stated.	Dyadic mother-infant psychotherapy and interaction guidance	Maternal representation of her child; maternal care and nurture of the child.	E	4 years dyadic treatment; mother and child continued in individual therapy continued post-intervention

3) Missocialisation: interventions with drug and alcohol abusing parents						
Study ID	*Methods*	*Participants*	*Intervention*	*Outcomes Measured*	*Level of evaluation*	*Length of study*
RCTs						
Dawe and Hartnett (2007)	3 group RCT (1 treatment, 2 controls) Assessments pretreatment, posttreatment and at 6 month follow up.	64 families with at least 1 parent in methadone maintenance.	3 month PUP programme, which targets multiple domains of family functioning: psychological functioning of parent, parent-child relations and social contextual factors. Control groups received brief parent training (2 sessions) and standard care package offered by methadone clinic (including assistance with housing, employment etc)	Parenting Stress; child abuse potential; parental substance us	A	12 sessions over 3 months. Assessed at baseline, post treatment and at 6 months follow up.
Luthar et al. (2007)[29]	RCT measured at baseline, repeated intervals and 6 months post-test	127 opiate addicted mothers, low SES, 55% Caucasian, 31.7% African-American and 11.7% Hispanic 85% welfare (15% employed). 80% lone parents. Child age range 1 – 16 years average 9.23 years.	Group psychotherapy /parenting skills combined with standard methadone treatment Recovery training focused on processes of addiction and relapse preventions No-treatment control	Child maltreatment risk: Maternal aggression/hostility, neglect/indifference, undifferentiated rejection and low expressed warmth/acceptance Involvement and communication with children Limit setting and promotion of child autonomy/independence Maternal psychosocial adjustment Child psychosocial adjustment Maternal substance use Maternal sensation seeking Readiness for change	A	24 week intervention. Assessed at baseline post treatment and at 6 months

Study ID	*Methods*	*Participants*	*Intervention*	*Outcomes Measured*	*Level of evaluation*	*Length of study*
Luthar and Suchman (2000)[30]	RCT measured at baseline, repeated intervals and 6 months post-test	61 opiate addicted mothers, low SES, 78% Caucasian, 10% African-American and 12% Hispanic. All low SES. Mother median age 34, child age range 1-16, medina age 10.1.	Group psychotherapy/ parenting skills combined with standard drug counselling/ methadone treatment. Standard drug counselling/ methadone treatment control	Child maltreatment risk: Maternal aggression/hostility, neglect/indifference, undifferentiated rejection and low expressed warmth/acceptance Involvement and communication with children Limit setting and promotion of child autonomy/independence Maternal psychosocial adjustment Child psychosocial adjustment Maternal substance use	A	24 week intervention. Assessed at baseline, post treatment and at 6 months post treatment.
One group pre and post test						
Dawe et al (2003)	One group with pre and post-test measures	9 families with at least 1 parent in methadone maintenance.	3 month PUP programme, which targets multiple domains of family functioning: psychological functioning of parent, parent-child relations and social contextual factors. Control groups received brief parent training (2 sessions) and standard care package offered by methadone clinic (including assistance with housing, employment etc)	Parenting Stress; child abuse potential; practical and emotional support (significant other scale); parental opiate and sexual high risk behaviours; alcohol use. Child functioning (global: conducted, family, emotional, anger and anxiety)	A	12 sessions over 3 months. Assessed at baseline, post treatment and at 3 months follow up..
Conners et al. (2006)[31]	One group with repeated pre and post-test measures	305 substance abusing mothers. 64% Caucasian, 36% African-American or other. SES not specified. Mother median age 29.8, child age range specified as birth – 12 years.	Integrated services combining drug abuse treatment, individual, group and family counselling, parent education and support; medical services; case management, support to education and employment, Twelve-Step meetings and aftercare	*Adult-adolescent parenting:* Inappropriate expectations, empathy, role reversal, belief in corporal punishment, oppression of children's independence Maternal depression Post-traumatic stress Maternal risky sexual, drug-using and smoking behaviour.	D	Length of treatment 4 – 6 months, but 58% left earlier. Assessed at baseline and 3 times in year post treatment

3.2.1 Study designs

Of the 21 included studies 12 involved the use of quantitative designs. One two-part study involved one group pre- and post-intervention, but did nor report on significance levels.[58 59] The remaining were case studies of the treatment of emotionally abusive or emotionally neglectful parenting.[20 65 66 67 68 73]

Of the quantitative studies, six comprised randomised controlled trials [29 30 62 55 63 64 71;] one comprised a follow-up of a randomised controlled trial[54]; two were controlled studies [64 70]; and three comprised one-group pre- and post-designs.[31 56 57 71]

Of 3 included studies for substance abusing mothers, 2 evaluated participation in a relational psychotherapy group for mothers,[29 30] and 1 involved residential treatment for substance abuse with a parenting component.[31] The sample sizes for quantitative studies were small and ranged from 17 to 98 participants. 10 interventions involved mothers alone, while a further 11 included fathers, either at the outset or at a later stage, and in 3 cases extended family members.

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mothers alone, while a further 11 included fathers, either at the outset or at a later stage, and in 3 cases extended family members.

One systematic review is included.[75] This encompasses 70 studies with a range of quantitative designs. Since some of these studies focused on more than one intervention (eg by comparing two approaches) there are in fact a total of 81 interventions.

3.2.2 Interventions evaluated (summarised in Table 3.2)

Of the eight studies evaluating interventions for parents defined as emotionally abusive by child protection or mental health services, two quantitative studies evaluated standard cognitive-behavioural training (CBT) with an adjunctive component.[62] Sanders et al. (2004)[62] evaluated the effectiveness of Triple-P parent training (Standard Behavioural Family Intervention, SBFI) with an enhanced version of the same programme (Enhanced Behavioural Family Intervention, EBFI). The enhanced version incorporated additional sessions and support focused on attributional retraining and anger management. Iwaniec (1997) compared home- and group-based CBT with home based CBT alone. Neither intervention involved a no-treatment control. One quantitative study compared the effectiveness of attachment-based psychotherapy for mothers of preschoolers with a combined psychoeducational home intervention (parenting skills training) and standard, community-based behavioural training package.[63]

Both case studies reported on the effect of cognitive-behavioural interventions: one with a mutually antagonistic mother and infant and with their family[65], and the other with emotionally neglectful mothers.[68] One study examined a mentalisation-based parent training programme,[66] and two are accounts of family therapy.[20 67]

One systematic review compares outcomes for 81 interventions that aim at enhancing parental sensitivity and / or infant attachment in cases where poor early interaction patterns have been identified. These interventions aim at one or a combination of the following: (i) enhancing social support for parents (eg facilitating through provision of

information on infant development, modelling of touch and massage, vidoefeedback aiming a promotion of sensitive responsiveness (iii) changing parental representations: eg examination of internal working model; reexperiencing the past.

A further eight studies (and one follow up study) [54] aim at enhancing sensitivity of parents of infants with faltering growth that has been attributed to problematic parent-infant interaction. Two of these studies involved intensive psychotherapy[58 59 71]; one evaluated video interaction guidance[69]; three compared the effects of visits by lay home visitors with adjunctive community and clinic based services[70 54 55]; and one evaluated the effects of behavioural social work.[56 57] One case study focused on the benefits of standard cognitive behavioural interventions for parents of children with faltering growth[64] and one combined dyadic mother-infant psychotherapy and interaction guidance.[73]

Of the three studies focusing on emotionally abusive drug abusing mothers, one study compared a Relationship Psychotherapy Mother's Group (RPMG), i.e. a clinic-based, weekly form of group psychotherapy for mothers combined with standard methadone treatment, with standard methadone treatment alone[30]; a second compared RPMG to an adjunctive intervention, Recovery Training (RT)[29]; and a third examined the effectiveness of a residential substance abuse treatment programme which offered a comprehensive range of adjunctive treatments and forms of practical support for both mothers and children under 5 years of age.[31]

3.2.3 Populations (and nature of emotional abuse)

Five studies involved parents diagnosed as emotionally abusive by child protection services [20 62 64 65 69]; or diagnosed as parentified by child mental health services.[67] One also included parents who had self-referred because of concerns about anger management[62]; two further studies included parents of pre-school children who were emotionally abusive and neglectful[63] or considered to be at high risk of emotionally neglecting a child[66]. One systematic review focused on increasing parental sensitivity or enhancing child attachment in situations where parental insensitive or intrusive behaviours actually or potentially placed infants at risk. A further nine parents of infants diagnosed as having faltering growth with no identified organic causes[54 55 56 57 58 59 65 68 69]

[70 71]; one of which was a follow-up study[54]. Five studies focused on substance abusing parents [29 30 31].

Ten studies involved women alone[29 30 31 54 55 63 65 68 69 70]. In the 11 studies which specify ethnicity, 6 had predominantly white participants[29 30 31 58 59 64 71]. One involved a majority of African-American mothers[54/55], one Hispanic-American mothers[70] and one undifferentiated 'minority' participants.[63] Nine interventions involved a proportion of fathers from the outset[56 57 58 59 62 64 65 67 71] and 3 involved them at a later stage [20 66 74]. The one systematic review included both mothers and fathers, but in all cases included a far higher proportion of interventions that addressed women alone than both women and men.[75]

Although some interventions included a proportion of higher SES participants[69] and professionals[67], these were the exception.

3.2.4 Outcomes measured

3.2.4.1 Parents – A wide range of outcomes were measured across the included studies using standardised measures. Self-report outcomes included emotionally abusive behaviour; stress; blame and intentionality attributions; unrealistic expectations; potential for child abuse; anger; parenting satisfaction and efficacy; parental stress and conflict[62 74 76]; child abuse potential[74 76]; social supports/significant other support [76]; emotionally abusive behaviour[62 64] including rejection, unavailability and enmeshment[20]; anxiety[64]; verbal abuse[65]; skill acquisition and registration with child protection services[68]; parental psychopathology[71]; parental physical and emotional caregiving[58 59]; 'atypical' (frightening or frightened) behaviour[69]; parental expressed warmth;[55] parent-child interaction[56 57 70 71]; quality of parenting[31]; depression[29 30]; empathy[31;]; sensitivity[74]; instrumental aspects of parenting: limit-setting and promotion of children's autonomy[30]; parent-child role reversal[31]; psychosocial adjustment[29 30]; inappropriate expectations; post-traumatic stress; self-sufficiency; high-risk behaviours (e.g. needle use, sexual risk behaviour**)**[31 76]; and alcohol abuse[56 31 76].

Independent assessments of outcome included the following: risk of child maltreatment; substance abuse[29 30 31 74 76] and removal from parental care[56 57 70]; and child death.[70]

3.2.4.2 Children – Far fewer assessments were made of child outcomes. A majority of these were again parent self-report using standardised measures including the following: emotional and behavioural adjustment[62 64]; emotional and social development of infants.[58 59] Child reports of (their own) psychosocial adjustment and risk of being maltreated were used in two studies.[29] Change in children's positive, negative and false self-representations were measured by Toth (2002).[63]

Independent assessments of outcomes included the following: psychosocial functioning[74 76]; health and cognitive/motor development[54 55 56 57 58 59 70 71]; child emotional, social and behavioural problems [29 30 74 76]; children's representations of parents and children's self representations[63]; attachment[66 75]; depression[29]; feeding and play interactions[31.]

3.2.5 Countries where studies were conducted: 3 studies were conducted in Australia[6 74 76]**;** 1 in Canada[69]; 1 in Austria[71]; 6 in the UK [20 67 56 57 65 72]. The remaining studies were conducted in the USA. 1 systematic review includes studies from a range of industrialised country settings.[75]

Table 3.2: Content of included interventions

Study ID	Aim of intervention	Content and delivery
Emotionally abusive parenting		
RCTs		
Sanders et al. (2004)[62]	To compare the effect of standard and enhanced versions of group cognitive-behavioural training on parents' misattributions and anger management	The Triple-P Standard Behavioural Family Intervention (SBFI) was compared with an enhanced version of the same programme (Enhanced Behavioural Family Intervention (EBFI). The four-session SBFI teaches parents to increase positive interactions with children and reduce coercive and inconsistent parenting practices. The EBFI includes four additional sessions that address physical, cognitive and planning strategies to help parents manage anger and revert negative attributions.
Toth et al. (2002)[63]	To compare psychotherapy for mothers with a more didactic intervention that incorporated parent training	Preschool Parent Psychotherapy (PPP) focuses on the mother's interactional history and the effect this has on representations of her child. Therapy involves helping the mother recognise how her past history is re-enacted in the present, enabling her to change her representations. The outcomes of PPP were compared to those achieved through cognitive-behavioural parent training.
Two groups pre and post-test		
Iwaniec (1997)[64]	To compare the effect of group-based and individual cognitive-behavioural training with individual CBT alone on parents' misattributions and anger management	Programme comprised group based and individual (home based) cognitive-behavioural training (CBT). It included training on stress management skills and problem solving and offered a forum for mutual support and the establishment of social contacts. Programmes of home based parent training were tailored to requirements of individual families. It covered the following topics: developmental counselling, improvement of parent-child interactions and managing the problem behaviour of children and parents.

Case studies		
Iwaniec (2007)[65]	(i) Improved mother-infant interaction (ii) change in functioning of a family characterised by high levels of emotional abuse and neglect.	Behavioural social work aimed at changing aversive relationship in which mother felt rejected. Intervention focused on developing physical and emotional proximity during story-telling sessions. Problem-solving training was provided to two parents and older children in a large family in which children were registered for emotional abuse and neglect (1 infant showed signs of faltering growth). This involved eight intensive sessions in the family home, in which problems were identified and solutions worked out, and six follow-up/monitoring sessions. A practitioner coordinated sessions, modelled techniques and provided feedback to the family.
Slade et al. (2005)[66]	To enable a young mother to 'mentalise' her infant.	Minding the Baby is an interdisciplinary, relationship-based, home visiting program for young, at-risk new mothers. The intervention - delivered by a team that includes a nurse practitioner and clinical social worker- uses a mentalisation based approach; it involves working with mothers and babies in a variety of ways to develop mothers' reflective capacities. It aims at addressing relationship disruptions that stem from mothers' early trauma and derailed attachment history.
Byng Hall (2002)[67]	De-triangulation of a parentified child from the parent-child relationship.	The intervention involved systemic family therapy grounded in an attachment perspective in order to reduce the parentification of a 2 ½ year old girl. Work was done to resolve conflicts between parents, enabling them to recognise the ways in which their own histories shaped their expectations of each other and of the child. The intervention aimed at enabling them to provide each other with mutual support and de-triangulate the child.

Case studies		
Boulton and Hindle (2000)[20]	To enable parents to change distorted representations of children.	Interventions (delivered by a team of practitioners based at a Child and Adolescent Psychiatry Unit) involved family therapy. Interventions had psychodynamic orientation, and involved working with caregivers (and where possible and desirable, extended family members) to enable them to understand the way in which past trauma was being re-enacted with children and to create an undistorted representation of the child.
Dawson (1986)[68]	To prevent emotional and physical neglect through the provision of cognitive-behavioural training.	The intervention began with assessment of the childcare problem-solving competence of three physically and/or emotionally neglectful mothers aged 20 – 29. Initial assessment revealed substantial deficits in cognitive problem-solving skills related to childcare judgment. Treatment involved considering 'problem' childcare scenarios, modelling solutions and enabling mothers to generalise problem-solving approaches to their own lives. Independent caseworker ratings of each family's functioning provided external validation of the intervention's clinical impact.

Enhancing parental sensitivity / infant attachment		
Systematic reviews		
Bakermans-Kranenburg (2003)	Enhancement of maternal sensitivity and / or infant attachment.	A range of interventions aimed at enhancing parental sensitivity, increasing social support and / or changing parental representations of the child. Interventions focused on: - social support: eg facilitating access to community services providing clothes, food etc; - increasing sensitivity: et information on infant development, modelling of touch and massage, vidoefeedback aiming a promotion of sensitive responsiveness - changing parental representations: eg examination of internal working model; rexperiencing the past. Combination of any or all of the above. Interventions ranged from <5 sessions to >16 and started in the antenatal or postnatal period. Some interventions involved videofeedback. Interventions delivered by professionals and by nonprofessional intervenors, in the home or other (eg clinic) settings.

RCTs		
Study ID	**Aim of intervention**	**Content and delivery**
Black et al. (1995)[55]	To assess the effect of combined home visitation for mothers of faltering growth infants on mother-child interaction (including emotional and verbal responsiveness) and child development	All children received services in a multidisciplinary growth and nutrition clinic. A community-based agency provided the home intervention. Families in the HI group were scheduled to receive weekly home visits for one year by lay home visitors, supervised by a community health nurse. The intervention provided maternal support and promoted parenting, child development, use of informal and formal resources and parent advocacy. The Hawaii Early Learning Programme was used as a curriculum guide.
Hutcheson et al. (1997)[54]	Follow-up study examined the moderating effects of maternal psychological functioning and demographic risk status on the impact of home intervention four years later	As per Black et al. (above)
Controlled studies		
Benoit et al. (2001)[69]	To assess the effect of the play-focused interaction guidance on caregiver behaviours of mothers with faltering growth infants	Interaction Guidance consisted of 90 minute sessions (approximately 15 minutes of videotaped interaction followed by 75 minutes of discussion, education and feedback) administered over 5 consecutive weeks. The intervention included an individually tailored information component on specific issues exhibited by the infant.
Haynes et al (1984)[70]	To assess the effect of combined Lay Home Visitation (LHV) for mothers of faltering growth infants on maternal neglect, incoordination or hostility towards faltering growth infants	The intervention involved a lay hospital visitor services for six months, with follow-up by case workers, nurses and the referring paediatrician. Mothers received parenting classes. Children received physical therapy.

One group pre- and post-test		
Dunitz (1996)[71]	To assess the effect of combined parent training and psychotherapy on the Axis 1 and Axis 2 psychopathology of parents with faltering growth infants	The intervention combined training for parents in infant feeding with psychotherapy for parents. Parents' DSM-III status was evaluated by clinicians. Psychotherapy sessions took place weekly for the first 2 – 3 weeks, then less frequently. Team members were available to parents (by paging) in order to offer support and advice. Treatment of feeding behaviours aimed at training parents to feed infants if a hunger cue is shown and desist after any hint of refusal. Both aim at stimulating the child to break the vicious circle of opposition against feeding under pressure.
Iwaniec (1985a & b) [56/57]	To assess the effect of a behavioural social work intervention on children with faltering growth and their families	Intervention began with social work and behavioural assessment in the home. Short-term crisis intervention was followed by a longer-term intervention in three stages. The first six weeks consisted of bi-weekly visits to train parents on feeding routines. The second stage involved feeding and play sessions. The third stage involved two weeks of intensive interactions between mother, child, siblings and father where appropriate.
Fraiberg et al. (1981a; 1981b) [58/59]	To assess the effect of parent-child psychotherapy on infant development and parent functioning	The intervention involved child-parent psychotherapy (CPP) in an outpatient psychiatric unit. CPP integrates modalities derived from attachment, trauma, cognitive-behavioural and social learning theories. Mother and child are seen in joint sessions (approximately once a week) and collateral individual sessions were arranged with the mother when indicated. The intervention was conducted over approximately 50 weeks.
Case studies		
Iwaniec (2004)[72]	To assess the effect of a behavioural social work intervention on a child at high risk of faltering growth	Intervention involved behavioural social work with a mother and infant who had feeding difficulties and was at risk of faltering growth. Mother and infant had developed a mutually antagonistic relationship. In addition to cognitive work with the mother, the author used a variety of behavioural techniques to create greater physical and emotional proximity between mother and child.

Case studies (Parenting of infants with faltering growth, cont).		
Keren and Tyano (2001)[73]	To enable mother to create an undistorted representation of her child and ensure child's health and development	Intervention involved long-term (4 year) mother-infant psychodynamic psychotherapy and interactional guidance. Treatment combined Interactional Guidance, which focuses explicitly on strengths; and psychodynamic psychotherapy. The young child's presence at all the therapeutic sessions enabled simultaneous work on the mother's internal representations (shaped by traumatic events and an unresolved loss) and interactions.

Missocialisation: drug and alcohol abuse		
RCTs		
Study ID	**Aim of intervention**	**Content and delivery**
Dawe and Hartnett (2007)[75]	To compare the effect of the Parenting Under Pressure programme (PUP) on families in which at least one parent was in methadone treatment, with brief parent training and with standard care.	PUP involves 10 sessions that aim at improving parent functioning under pressure, parent child relations, partner relations, improve life skills and enhance social supports. Control groups were randomised into (i) a brief (2 session) parent training programme and (ii) a group which received standard care (including social support) from methadone clinic.
Luthar et al. (2007)[29]	To compare the effect of a relationship-based psychotherapy group with cognitive-behavioural training on parenting of opiate addicted mothers	RPMG involves 24 sessions of group psychotherapy (see Luthar and Suchman, 2000, below). This study compared outcomes with those of an adjunct intervention, Recovery Training (RT). RT was conducted by professional clinicians with expertise in standard drug abuse treatment. It focuses on processes of addiction and recovery and reinforces skills that prevent relapse into drug use.
Luthar and Suchman (2000)[30]	To evaluate the effectiveness of a relationship-based psychotherapy group combined with standard methadone treatment and drug counselling on the parenting behaviours of opiate-addicted mothers	The Relational Psychotherapy Mother's Group (RPMG) is a form of group psychotherapy aimed at facilitating optimal parenting among heroin-addicted mothers with children up to 16 years of age. The intervention has four defining characteristics: (i) a supportive therapist's stance which fosters the therapeutic alliance; (ii) an interpersonal, relational focus (iii) group treatment: to accommodate the chaotic schedules of many mothers, group membership is open or rotating; (iv) 'insight-oriented' parenting skill facilitation. In the first 12 of 24 weekly sessions, RPMG addresses mother's own psychological vulnerabilities. The second 12 sessions focus on specific parenting issues.

One group pre- and post-test		
Dawe et al (2003)	To evaluate the effectiveness of the Parenting Under Pressure programme (PUP) on families in which at least one parent was in methadone treatment.	PUP involves 10 sessions that aim at improving parent functioning under pressure, parent child relations, partner relations, improve life skills and enhance social supports.
Conners et al. (2006)[31]	To evaluate the effectiveness of a multi-modal programme for substance-addicted mothers on parenting behaviours	The Arkansas CARES residential programme combines parent education and support with individual, group and family counselling, substance abuse treatment, medical, educational and employment support and aftercare. Children receive educational and mental health services.

3.3 Critical appraisal of the included studies

Critical appraisal of the quantitative studies was undertaken using the CASP checklist for randomised controlled trials which is the gold standard for the evaluation of interventions. The results of the critical appraisal are summarised in table 3.3.

Size in groups: The size of the quantitative studies (not case studies) ranged from 17[57] to 305[31]. The six included RCTs had group sizes ranging from 24[30] to 64[55].

Random allocation: Only six of the included studies comprised randomised controlled trials [29 30 62 63 55] or compared two groups pre- and post-test[64]. Two studies compared interventions without randomisation[69 70]. The remaining studies were one-group or case studies.

Blinding to treatment: All of the six RCTs blinded follow-up assessors.

Attrition/dropout: Attrition and drop-out in the RCTs ranged from 22%[62 63] and 11%[55]. None of these studies confirmed in the paper that they undertook an intention-to-treat analysis.

Distribution of confounders: Two studies did not provide an assessment of the distribution of confounders or control for their impact in the analysis[30 55].

Generalisability: The generalisability of all of the included studies was limited due to the inclusion of volunteers[62]; highly focused populations, e.g. substance abusing mothers[29 30]; minority ethnic populations; [76] or because the form which emotional abuse took was not clear[65].

Table 3.3: Summary of the criteria for methodological quality

(a) Emotionally abusive parenting

Criteria for methodological quality	**Sanders et al (2004)[62]**	**Toth et al (2004)* [63]**	**Iwaniec (1997)[64]**
Size in groups **++ >25** **+ 15 – 25** **- <25**	++ (n=98; EBFI = 48, SBFU = 50)	++ (n=87; PPP = 23; PHV = 34, CS=30)	+ (n=34, Group 1 = 17, Group 2 = 17)
Random Assignment **+++ Randomised – allocation concealment** **++ Randomised – allocation not specified** **+ Quasi randomisation** - **No randomisation**	++	++	+
Attrition/drop-outs accounted for/percentage	12%	22%	none
Blinding to treatment/evaluation	+	+	-
Distribution of confounders	+	+	-
Generalisability **+++ Generalisable to whole population** **++ Generalisable to limited group** **+ Not generalisable /dk**	++	+	++

*** Non-maltreating controls not included**

(b) Parental sensitivity; infants with faltering growth

Criteria for methodological quality	**Hutcheson et al (1997)[54]**	**Black et al (1995)[55]**	**Haynes et al (1984)*[70]**	**Benoit et al (2001)[69]**
Size in groups **++ >25** **+ 15 – 25** **- <25**	++ (n=76; LHV = 36; clinic-only = 38)	++ (n=130; LHV = 64; clinic-only = 60)	+ (n=50; LHV=25; standard services=25)	+ (n=28; IG=14; feeding focused =14)
Random Assignment **+++ Randomised – allocation concealment** **++ Randomised – allocation not specified** **+ Quasi randomisation** - **No randomisation**	++	++	-	-
Attrition/drop-outs accounted for/percentage	43%	11%	30%	none
Blinding to treatment/evaluation	+	+	-	+
Distribution of confounders	-	-	-	+
Generalisability **+++ Generalisable to whole population** **++ Generalisable to limited group** **+ Not generalisable /dk**	+	++	++	++

*** Non-maltreating controls not included**

(b) Parental sensitivity; infants with faltering growth (cont.)

Criteria for methodological quality	**Dunitz et al (1996)[71]**	**Iwaniec et al (1985b)[56/57]**	**Fraiberg et al (1981)[58/59]**
Size in groups **++ >25** **+ 15 – 25** **- <25**	1 group (n=76 parents)	1 group (n=17)	1 group (n=41 parents, 50 infants)
Random Assignment **+++ Randomised – allocation concealment** **++ Randomised – allocation not specified** **+ Quasi randomisation** - **No randomisation**	-	-	-
Attrition/drop-outs accounted for/percentage	none	none	none
Blinding to treatment/evaluation	+	-	-
Distribution of confounders	-	-	-
Generalisability **+++ Generalisable to whole population** **++ Generalisable to limited group** **+ Not generalisable /dk**	++	+	++

c) Missocialisation: parenting interventions with substance-abusing parents

Criteria for methodological quality	**Dawe and Hartnett (2007)**	**Dawe et al (2003)**	**Luthar and Suchman (2000)[29]**	**Luthar et al (2007)[30]**	**Conners et al (2006)[31]**
Size in groups **++ >25** **+ 15 – 25** **- <25**	++ (n=64; PUP=22 Brief training=23; standard care=19)	- 1 group (n=9)	++ (n=61; RPMG=37; control=24)	++ (n=127; RPMG=67; RT=60)	- 1 group (n=305)
Random Assignment **+++ Randomised – allocation concealment** **++ Randomised – allocation not specified** **+ Quasi randomisation** - **No randomisation**	++	-	++	++	-
Attrition/drop-outs accounted for/percentage	11 / 64	All completed	14%	15%	57.4%
Blinding to treatment/evaluation	-	-	+	+	-
Distribution of confounders	**-**	**-**	+	-	-
Generalisability **+++ Generalisable to whole population** **++ Generalisable to limited group** **+ Not generalisable /dk**	++	++	++	++	++

3.4 RESULTS OF THE INCLUDED STUDIES

The results of the included studies have been organised according to the focus of the study in terms of the type of emotional abuse being targeted. Section 3.4.1 summarises the results of studies directed at emotionally abusive parents; section 3.4.2 summarises the results of studies directed at parents of infants with faltering growth; and section 3.4.3 summarises the results of studies focused on emotionally abusive drug abusing parents. Table 3.4 provides a summary of the results of the included studies.

3.4.1 EMOTIONALLY ABUSIVE PARENTING

A total of 8 studies focused on parents who had been diagnosed as emotionally abusive, although one of them included self-referrals[62]. Of these, two quantitative studies examined the effectiveness of cognitive behaviour therapy[62 64] as did two sets of case studies [65 68]; one compared the effectiveness of parent-infant psychotherapy and parent training[63] and one (a case study) the effect of parent-child mentalisation-based psychotherapy[66]. Two further case studies examined the role of family therapy[67] and a combination of psychodynamic and family therapy[20].

3.4.1.1 Cognitive behaviour interventions for the management of misattribution and anger

Two randomised controlled trials were identified that were designed to reduce anger and misattribution in parents reported for, or at self-reported risk of, emotional abuse.[62 64] Both involved standard cognitive-behavioural training (CBT) with an adjunctive component. Sanders et al. (2004)[62] evaluated the effect of Triple-P parent training (Standard Behavioural Family Intervention, SBFI) with an enhanced version of the same programme (Enhanced Behavioural Family Intervention, EBFI). The EBFI incorporated additional sessions and support focused on attributional retraining and anger management. Iwaniec (1997)[64] compared home- and group-based CBT with home based CBT alone.

A) Parent outcomes

A1) Global category of emotionally abusive parenting

In the study by Iwaniec (1997)[64] social workers who observed mother-child interactions in the home identified 22 forms of emotionally abusive behaviour (such as the child being ignored in the family circle, seldom being spoken to, socially isolated, not properly socialised and not permitted to show emotions). These behaviours were rated as occurring often, occasionally, or almost never. Ratings for all behavioural goals were collapsed into the global categories of satisfactory/improved, moderately improved and no improvement. Both the combined treatment group (which received a combination of home-based and group-based parent training) and the control group (which received home-based parent training alone) achieved statistically significant reductions in emotionally abusive behaviours. However, changes were more significant in the combined treatment group than in the home based intervention alone (p=<.01). Before the intervention 99% of participants in the combined treatment group said they were often emotionally abusive. By the end of the intervention, only 1% of participants who received home- and group-based treatment reported being emotionally abusive. In contrast, 88% of parents in group-based treatment said they were emotionally abusive at baseline and 12% continued to be post-intervention.

A2) Stress

Iwaniec (1997)[64] used a Likert scale, designed by the authors for this study, to measure parenting stress. The results showed a significant reduction in the stress levels of parents who received combined home- and group-based parent-training (p<.001) and those who received the home-based intervention alone (p<.001). There was no difference between the two groups.

A3) Anxiety

Iwaniec (1997)[64] used the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch and Lushene, 1970) to measure anxiety and found a significant reduction in state anxiety (p<.001) and in trait anxiety (p<.001) in parents who received combined home and group based parent training compared with the control group. There was no difference between the two groups.

Sanders et al. (2004)[62] found that parents who took part in an enhanced version of the Triple-P parenting programme (Enhanced Behavioural Family Intervention, EBFI) and those who participated in the standard Triple-P (Standard Behavioural Family Intervention, SBFI) reported a decrease in depression and anxiety (p=<.001) using the Depression-Anxiety Stress Scales (DASS).[76] There was no difference between the two groups.

A4) Blame and intentionality attributions

Sanders et al. (2004)[62] measured blame and intentionality using the Parents Attributions of Child's Behaviour measure (PABCM)[77] The results showed an improvement in parental blame and their attribution of children's intentions in both ambiguous (p=<.01) and intentional situations (p=<.001) for parents in both the SBFI and EBFI. While at post-treatment change was greatest for parents who had taken part in the enhanced version, by the six-month follow-up there was no significant difference between groups because parents who had taken part in standard Triple-P appeared to have 'caught up' with their counterparts in the enhanced intervention.

A5) Unrealistic expectations

Sanders et al. (2004) used the Parent Opinion Questionnaire (POQ)[78] to measure change in parents' unrealistic expectations. Although significant improvements were found in both SBFI and EBFI groups post-intervention (p=<.001), strongest effects were found for parents in the EBFI (p=<.01). At six month follow-up there was no difference between the two groups because of continued improvements by parents in the standard intervention.

A6) Potential for Child Abuse

Sanders et al. (2004) measured potential for child abuse with the Child Abuse Potential Inventory (CAPI).[79] A significant decrease (p=<.001) was found pre- to post-intervention in the potential for child abuse of participants in both the enhanced and the standard versions of Triple-P but effects were strongest for parents in the enhanced programme (p=<.01). Once again, there were no significant differences between the two groups at six months.

A7) Anger

Sanders et al. (2004)[62] measured parental anger using the Parental Anger Inventory (PAI)[80] and the State-Trait Anger Expression Inventory (STAXI).[81] The study found significant improvements (*p*=<.001) pre- to post-intervention in the reduction of anger associated with parenting (parental anger) and across life situations (global anger) for both standard (p<.001) and enhanced (p<.001) versions of the Triple P programme. Although no differences were observed between the two groups post-intervention, evaluation at six-month follow-up showed that parents who had taken part in the EBFI continued to improve at a greater rate than those who had taken part in the SBFI.

A8) Parenting efficacy and satisfaction

Sanders et al. (2004)[62] found significant improvements (*p*=<.001) pre- to post-intervention in the parenting style, parental satisfaction and efficacy of participants in both the enhanced and the standard versions of Triple-P using the Parenting Scale (PS)[82] and Parent Sense of Competence scale (PSOC).[83] There was no difference between the two groups at six months.

The Home and Community Problem-solving Checklist (HCPC)[84] measures specific situations in the home (e.g. bedtime, getting dressed) and in the community (shopping, visiting friends) in which parents experience difficulties in managing their child's behaviour. Significant improvements were found in the management of these situations by parents in both groups (*p*=<.001). There was no difference between groups at 6 months.

A9) Parental distress and parental conflict

Sanders et al. (2004)[62] found a significant decrease in both groups, pre- to post-intervention in parental distress and parental conflict (*p*=<.001), using the Parent Problem Checklist (PPC).[85] There was no difference between the two treatment groups.

A10) Participant satisfaction

Iwaniec's study (1997)[64] measured parents' perceptions of the parent-child relationship before and after the intervention by means of a participant satisfaction questionnaire. Ratings for nine behaviours were collapsed into global categories of

satisfactory/improved, moderately improved and no change. 47% in Group 1 and 77% in Group 2 reported strong change in their emotionally abusive behaviours. Results favoured participants in the combined intervention (*p*=<.001).

Sanders et al. (2004)[62] measured participant satisfaction using the Client Satisfaction Questionnaire (CSQ).[86] Although authors had hypothesised that participants in the EBFI group would show higher levels of satisfaction than the SBFI group, both showed similarly high levels of consumer satisfaction (*p*=<.001).

(B) Child outcomes

B1) Children's behaviour

Iwaniec (1997)[64] measured changes in children's behaviour using a rating scale designed by the authors for the purpose of the study.[56/57] A reduction was found in children's highly negative, aversive reactions ratings post-treatment, favouring the combined group- and home-based treatment (*p*=<.001). The author observes that these results are not wholly reliable as each child is affected in a different way by changes in their parents' behaviours.

Sanders et al. (2004)[62] used the Eyberg Child Behaviour Inventory (ECBI)[87] and the Parent Daily Report Checklist (PDRC)[88] to measure change in children's behaviour. Three different criteria were used to calculate reliable change post-intervention: (i) the Reliable Change Index (RCI)[89], (ii) a 30% reduction in observed child disruptive behaviour (Webster-Stratton et al., 1991) and (iii) a normative comparison approach which involved calculating the proportion of children whose behaviour was normalised after intervention.[90] Reliable improvements were found (on the PDRC scale) in children's positive behaviour (*p*=<.01) and reduction in the observed negative behaviour (*p*=<.01) of the children of participants in both groups, but there were no significant differences between the two groups in the number of children whose behaviour had improved or in the proportion of children in the non-clinic range. Parents in both groups reported a significant decrease (*p*=<.001) in the number of parenting and child care situations in which they experienced problem behaviour both in the home and in the community. There were no between-group differences.

Sanders et al. (2004)[62] hypothesised that parents who had had contact with the child protection services (Families, Youth and Community Care Queensland, FYCCQ) and took part in the enhanced programme (EBFI) would have significantly fewer notifications of child maltreatment at follow-up. However, both the enhanced and standard versions were associated with a decrease in reports for child maltreatment, and only one EBFI family had contact with the child protection services between the end of the intervention and six-month follow-up.

C) Case studies of the application of cognitive-behavioural approaches to individual parent-child dyads

C1) Cognitive re-structuring, relaxation techniques and early prevention of abusive episodes

The following are examples of the successful application of CBT techniques in work with a troubled dyad and in the second case, with both parents and their older children. Iwaniec (2007)[65] and Dawson (1986)[68] describe the application of a range of behavioural techniques in the treatment of parents of children with faltering growth. Cognitive treatment involves mapping thoughts - helping identify 'cognitive distortions that are linked to thinking, feeling and behaviour that undermines the parent-child relationship' (p. 263).[65] In successive sessions, the parent is encouraged to challenge maladaptive thoughts and reward themselves for more adaptive ones. Alternative ways of thinking and behaving are suggested. For example, parents can be taught to conceptualise anger as a state aggravated by self-presenting and often irrational thoughts, to identify 'triggers' and to 'interfere' with anger-provoking thoughts when these occur. 'Self-talk' (e.g. 'My baby is not refusing to eat to annoy me, but because he is nervous and I can care for him; This is not going to anger me') can help parents feel better and stall a potentially abusive episode. The author reports that potentially abusive episodes can be halted as parents learn relaxation techniques. For example, parents can listen to relaxation tapes, and learn to detect (and respond to) physical feelings of tension and agitation. The onset of abusive episodes can be halted when parents identify what events 'trigger' particular difficulties and thereby avoid the triggers.

The following case study illustrates the principles of interventions that address 'parenting skills deficits', in which practitioners train parents to use the behavioural management strategies that they need.[91] [92]

Case example 1: Reverting aversive mother-infant interaction (Iwaniec, 2007: 289)[65]

The author describes an intervention with a 3 ½ year old boy ('Jex') who had been born prematurely and spent two months in intensive care. Jex was a 'difficult' baby for whom feeding, sleeping and general responsiveness presented problems. Jex's mother found it difficult to enjoy her child and feel that he belonged to her, despite her desire to do so. As time went on her desire to love him disappeared as Jex became more demanding, attention-seeking and antagonistic. By the time he was 3 ½ years old they were mutually antagonistic. His mother's perception that Jex rejected her was exacerbated by the fact that Jex's four-and-a-half-year-old sister was a placid and easy child.

In addition to cognitive work, the author used a variety of techniques to create greater physical and emotional proximity between Jex and his mother. These included 'story telling'. Although it was difficult for both mother and child to engage with or sustain physical contact, this was initiated by the mother, who read from picture story books. As the child's interest in the stories increased, he became less tense and his mother less anxious. After ten weeks the child expressed a sense of security by embracing his mother, of his own accord, for the first time. From that point on, the relationship progressed rapidly and well.

C2) Motivational interviewing

Motivational interviewing (MI), which is also grounded in behavioural theory, is based on the premise that the possibility of change depends on a person's personal readiness to effect it. According to practitioners of MI, individuals move through a cycle of stages, before permanent change in behaviour occurs. These stages include: *pre-contemplation,* where a parent does not see any need for change; *contemplation,* when they may be ambivalent about making changes; *planning,* when they may have decided to make changes but not have done so yet; *action,* where active attempts have been made to change aversive behaviour; and *maintenance,* when changes have been made and need to be sustained. Motivational Interviewing functions differently in each of these five

stages. Parents at the pre-contemplation and contemplation stages need to be made aware of the problems their behaviour causes the child; those who are planning and engaged in action require support and help in problem-solving; while those who are at the maintenance phase need to develop new skills to avert difficulties.

C3) Problem-solving

Abusive parents are often more likely exhibit a general hyper-sensitivity to social and non-social stress, lack of skills to resolve multiple life problems and poorer cognitive problem-solving abilities.[93] The enhancement of problem-solving skills can help parents them tackle practical and emotional challenges. The following study illustrates the application of these principles to mothers who were adjudged, by child welfare services, to neglect their children; both cases illustrate the considerable overlap between neglect and emotional abuse.

Case example 2: Problem-solving training with emotionally neglectful parents (Dawson et al, 1986)[68]

Mothers living in poor and chaotic environments and defined as neglectful by child protection authorities were trained in problem-solving by the author. Parent 1 was a 27 year old mother who had left her child with an unwilling caretaker who had reported the mother to welfare agencies after 3 days. Parent 2 (aged 29) frequently abandoned her children because of alcohol abuse after she had been abandoned, in turn, by her former husband. At the time of the intervention, she had been abstinent for 2 years but showed inappropriate judgement in matters of child care. Parent 3 was 20 years old, had four children under the age of 5 years and was in extreme poverty. She was reported, among other things, for placing children in potentially dangerous situations.

The therapists, two predoctoral psychology residents, interviewed each parent's social caseworker and obtained all written records of past neglect incidents. Fifteen problem vignettes were constructed based on these reports and clients own descriptions, of past situations in which they failed to meet their children's needs. The 15 vignettes were randomly assigned: four as treatment scenes, four as generalisation scenes and the remaining seven as extended generalisation scenes. In one scene, the parent was to imagine being invited out by her boyfriend when she had no babysitter or money to pay

for one. She was then asked to define the problem fully, brainstorm solutions, describe the steps she would take to resolve the situation, describe the positive and negative aspects of each solution and choose the best one. Responses to each scene were audiotaped, transcribed and scored by an external rater.

Initial assessment showed substantial difficulties in identifying solutions to child care problems. Treatment involved teaching parents to recognise, evaluate and anticipate what solutions will lead to best outcomes in each situation. At 5 and 15 months after conclusion of treatment, there were no further reports of neglect about the first two mothers, and child welfare services considered the cases to have been successfully terminated. The case file of the third mother continued open; she was unable to secure employment and her children continued in foster care.

Iwaniec (1997: 277-278)[64] describes a 'decision tree' that helps identify and define the problem, generate alternatives, consider the advantages and disadvantages of different courses of action, implement a plan, and review progress and the success of the decision.

These techniques can be combined and taught not only to parents, but also to older children. Iwaniec (ibid.) illustrates the application of a problem-solving approach to help a family in which both older siblings and parents verbally abused younger children and each other.

Case example 3: Problem-solving training for parents and older children (Iwaniec, 2007: 276- 277)[64]

The 'Smith' family comprised of a father, mother and seven children. Children were registered under the categories of emotional abuse and neglect. Interaction in the 'Smith' family was characterised by degrading and abusive language, not only by adults, but also by the three older children, who bullied their younger siblings. One particular child had presented with chronic failure to thrive.

When faced with the possibility that Social Services might take the children into care, the older children and parents engaged in a problem-solving intervention to identify difficulties

of mutual concern, brainstorm and look for solutions. Four issues were prioritised: (i) to cease verbal abuse, (ii) to establish clear and fair rules and routines, (iii) to establish times when the older girls could see friends, and (iv) for the father to reduce his alcohol consumption. Parents were also helped to identify 'trigger events', i.e. *sequences of events that led to negative emotional states, and to avoid escalation of problems (e.g. by screaming at children). They learned to try and understand children's internal states and respond to the feeling in the child rather than screaming if, for example, a child destroyed a toy.*

The intervention took place over eight intensive sessions to work out problems and solutions (in the family home), and six follow-up/monitoring sessions. A practitioner co-ordinated the sessions, modelled techniques and provided feedback as the family tried out new behaviours. Parents were encouraged to use the decision tree (understanding the causes of the situation and children's internal states, defining their options, deciding on an appropriate course of action and evaluating the effect of the action). Outcomes were evaluated at baseline and at 1, 2 and 6 months and 1 year post-intervention. Cessation of verbal abuse and reduction in the father's drinking were somewhat improved, while considerable improvement was noted at 1 year in establishment of rules and routines and the older children's respect of agreements about the times when they could see friends.

The author notes that behavioural interventions (in this case, behavioural social work) enable parents (and children) to 'start over': focussing on the present and future may help parents who would be deterred from participating in programmes that they feel are 'blaming' them.

3.4.1.2 Parent-Child Psychotherapy

Since the 1990s, there have been an increasing number of studies that show the effectiveness of parent-child psychotherapy with parents who are abusive or at high risk (see Lieberman 2006, Cicchetti, 2000 in 'Excluded Studies'), however, this systematic review found only one RCT[63], and only 37% of the total study sample were parents referred for emotional abuse. Toth[63] compared the effect of psychotherapy for mothers of preschoolers (PPP), with a psychoeducational home visitation programme focused on

parenting skills training (HVP), a standard community services programme (CS) for maltreated preschoolers and their mothers and no treatment.

a) Children's representations of their mother

Toth et al. (2002)[63] used children's narratives to assess change in maternal representations pre- and post-intervention. The authors used eleven 'Story Stems' (selected from the MacArthur Story Stem Battery (MSSB)[94] and the Attachment Story Completion Task.[95] An abbreviated version of the Wechsler short form (WPPSI-R)[96] was used to measure intellectual functioning of children aged 3 – 7 years.

Although children in all four arms of the study exhibited more positive expectations of the mother-child relationship over the time of observation, the most dramatic improvements were found in preschoolers whose mothers were in the PPP group (p<.001). These dyads had received the lowest mother-child relationship score at baseline and the highest at post-intervention assessment. A significant post-intervention (p<.001) decrease in maladaptive maternal representations was noted in the PPP group. No significant post-intervention differences were found in the PHV or CS conditions.

b) Children's self-representations

Using the same measures (see above) Toth et al. (2002)[63] found a significant post-intervention difference in the positive self-representations of children in the PPP and CS groups (p<.001 in both cases). Only a marginal increase was found in the PHV group.

3.4.1.3 Mentalisation-based parent-child psychotherapy

Recent work has shown that a parents' capacity for mentalisation is linked to improved outcomes for children[97], and treatments whose focus is to improve the capacity of parents to mentalise are now being developed for patients with a diagnosis of borderline personality disorder,[98] and also with parents. It was only possible to identify one case study exploring the role of such therapy in the treatment of a mother and infant[66].

This study provides an example of an intervention oriented by emerging work on mentalisation (ibid.). Although the young mother in question was included in the

programme before her infant was born, the example is included because subsequent events show that the assessment of risk was accurate.

Case example 4: Mentalisation based treatment of mother and infant (Slade et al., 2004)[66]

The "Minding the Baby" programme is based in a community health centre that provides health care for people in a poor and ethnically diverse urban community. The programme was linked to health providers, but was administered by Masters Level trained clinicians who were trained to assess and manage complex clinical issues in a highly disadvantaged and often traumatised population.

Mia, a 17 year old girl 7 ½ months pregnant, who was taking part in a prenatal care group, was referred to a nurse and clinical social worker and began at 'Minding the Baby'. Mia, who lived with her boyfriend Jay in his parents' chaotic and dirty house, was doing everything she could to disavow the reality of the baby and of her own internal world and referred to the infant as 'that' or 'my belly'. This unwanted pregnancy interfered with Mia's own desire (and her mother's hope) that Mia would get an education. Mia had a remarkable ability to verbalise her feelings of pain, anxiety and confusion about the child, something which would be a valuable resource to the intervention team. Mia's own mother had lost interest in her when Mia was five years old. The two practitioners began by helping Mia 'make room' for her child by creating a physical space for the baby and helping her envision and plan for an infant's physical needs.

Before her baby was born, Mia began to make amends with her own mother. She gave birth to a healthy girl, 'Noni'. Mia suffered from post-partum depression which reached its peak a month after birth. As Mia rejected psychiatric treatment, it was agreed that in addition to nursing visits, a social worker would visit her weekly. Mia cared for Noni physically but did not willingly touch her and left Noni alone for extended periods.

At this point it was possible to start uncovering Mia's past. Mia's mother had been a drug addict (as Mia's father had been) who had 'come clean' and who, in her way, loved her daughter. Mia's mother's dreams for a better future for her daughter had been sabotaged by Mia's pregnancy.

Over the next few months, Mia forged a relationship with the social worker, in which she allowed herself to remember and describe moments and fears long forgotten, creating a narrative about her past that enabled her to make meaning of the present. The social worker validated Mia's care for the baby's physical, if not emotional, needs. Mia sometimes engaged in threatening behaviours, looming over the child, apparently delighting in the infants grimace and frozen expression and asserting that the infant was 'faking' hunger cues. Workers did not address these deficits directly, but instead helped Mia to understand the emotion that the baby's crying elicited and to trace a causal link between events in her past and her reaction to the child. As the intervention proceeded, Mia began to view the baby's intentions and affects with increasing accuracy and clarity, without needing to distort them in order to protect her fragile sense of self. Slowly, she became able to step outside her automatic reactions and observe her child's feelings. The baby began to express a more extended range of emotions to her now available mother. Although Mia continued her relationship with Jay, she decided to move back to her mother's cleaner, safer and child-friendly home. The intervention was complemented by practical support, as workers brought toys to help Mia learn to play with the baby, and offered advice on vocational planning, medical care and training in safety procedures.

When Noni was 14 months old (17 months after Mia had entered the programme) the social worker reviewed a videotape made when the baby was 4 months old. Mia was troubled by her own lack of sensitivity, noting signs of distress that she was now able to identify. At 20 months, the baby was thriving, showed signs of secure attachment and was clearly loved by her mother, father (who still lived with his own family but was involved with his daughter) and her extended family.

3.4.1.4 Family Therapy

In spite of the enormous contribution of Systems Theory to understanding phenomena such as 'scapegoating', 'hostage-taking', fusion and/or parent-child role reversal, no quantitative studies were identified about the effects of family therapy for cases in which emotional abuse is the primary cause for intervention – although there is an extensive literature on family therapy in cases of child sexual abuse and, to a lesser extent, parental violence[99] (see also Fraser, 1985[100], which is an example of short-term, intensive family

therapy with families in which emotional abuse is compounded by other forms of maltreatment). As Iwaniec. (2007)[65] has noted, in 'the rare studies which have explored the value of family therapy to parents and children where [psychological maltreatment and neglect] has occurred, significant improvement in the quality of parent child interaction and parental sensitivity… are observed' (see Brunk et. al., 1987[101]; Meegan and O'Keefe, 1998[102]).

One paper[20], included a number of brief cases studies based on the work of the authors (one a social worker and one a child psychotherapist) then working at a Child and Adolescent Psychiatry Unit. The authors concluded on the basis of treating such cases that the identification, assessment and treatment of emotional abuse demands a multidisciplinary approach because of the complexity and multi-factoral nature of the task (Ibid: 439). The child psychiatric service in which the authors were based created a consultation group which comprised at least one representative from four outpatient sector teams, one worker from the children's day unit (5-11 years) and one worker from the adolescent unit (a residential facility for young people 11- 17).

Three themes emerged from case-based discussion with the consultation group and helped to orient their work: first, 're-enactment', which purports that at least one parent had suffered considerable abuse or neglect in their family of origin and that, as a result of these childhood experiences remaining undigested, unresolved or unavailable for thought, abuse and neglect are re-enacted in the relationship with the child; second, unavailability, in which the parent is inaccessible to the child; and third, enmeshment, in which the boundaries between family members are diffuse. The more information the authors had about the family history of parents who emotionally abused children, the more easily they could formulate hypotheses about the effect of past events and aid 'recognition', i.e. help parents understand the effect of their history on their present behaviour. This approach can involve extended family members. Theoretically, this type of recognition and subsequent understanding enables families to move away from abusive behaviour.

Case examples 5, 6 and 7: Family therapy for a parental unavailability, rejection and/or inappropriate developmental expectations (Boulton and Hindle, 2000)[20]

Leah (9) was the second child of a mother whose first daughter, born with Down's Syndrome and an associated heart condition, had died aged 2 ½ years. The mother's preoccupation with the sick child had meant there had been little opportunity to develop a relationship with her second daughter. She rarely spoke to or engaged with her. Leah's father remained fairly peripheral to the family and was unable to provide the emotional availability and containment Leah needed. Leah was referred to a child and adolescent psychiatry unit by her paediatrician because of concerns about Leah's aggression and soiling and concerns about her mother's negative attitude towards Leah. On meeting the parents, the therapist recognised that they needed time to grieve the loss of their first child and to begin to reflect on their feelings toward Leah.

In this case, the therapist made herself available to the family for a long period, although she saw them infrequently. The focus shifted from complaints about the child to an understanding about her difficulties in establishing a place for herself in the family in the face of her sibling's illness and subsequent death. In time, the mother realised her need for help in her own right and sought referral to the adult mental health services. Her ability to 'own' the problems, rather than seeing them as being 'in' Leah, led to significant change.

Finally, in some of the most complicated cases, children are being emotionally abused by parents who deeply love them – something which is a major stumbling block for child protection services in considering the seriousness of the situation. The authors cite the example of John, a 12 year old child whose parent's preoccupation with his perceived illnesses meant they never let him go outside. The child's lack of self esteem and isolation led him to becoming agoraphobic. Recognition that John experienced inappropriate developmental expectations and considerations led to his being placed on the child protection register. Therapeutic work with the family involved creating the boundary that the parents needed to provide for John.

Elizabeth, aged 5, was considered difficult and triangulated in her parents' marriage. Elizabeth's mother's complaints were 'highly charged with emotion, words or deeds that

might have been appropriate in the context of the parent's relationship with their own parent or caregiver' (Ibid: 443). Elizabeth's mother had also been considered 'difficult' by her parents, and also, it transpired, triangulated in her parents marriage. One of the two authors (Hindle) worked with Elizabeth's mother and her maternal grandmother. This helped the grandmother take responsibility for family difficulties and relieve some of the guilt felt by Elizabeth's mother for her behaviour as a child. This enabled Elizabeth's mother to stop treating Elizabeth as the 'container' for the more difficult parts of herself, take appropriate responsibility for the problems in her present family and blame Elizabeth less for the struggles in her marriage.

The following case histories illustrate the value of involving extended family in the treatment of parent-child role reversal (parentification).

Case example 8: Family therapy: parent-child role reversal (Byng Hall, 2002)[67]

2 ¾-year Ann was referred to the author for sleeping and eating disorders. She was the eldest daughter of middle-class parents (Margaret and Bruce) and sister of Susan, a 7-month old baby. At bedtime, each parent took turns to try and get Ann to sleep, but when they left the room she would wake up and call for the other parent, and so on, late into the night.

Ann showed signs of parentification. The parents' relationship was conflicted and Margaret often threatened to leave Bruce. Ann appeared to take Margaret's threat at face value and call out at night to ensure that Margaret would stay. When the parents agreed to stop fighting in front of her, Ann's sleeping improved.

Therapy involved sessions with the parents and child, with Margaret and her own mother, and with Margaret and Bruce. The therapist invited Margaret's mother to two sessions. These helped Margaret recall her own experience of role reversal. Margaret's father had left when she was a child and Margaret was obliged to care for her own emotionally absent mother and grandparents. In therapy, Margaret began to recognise her own mother's inability to comfort her and Margaret's expectation that Ann would love her as her mother could not.

Bruce had been abandoned by his mother when he was ten, and like Ann (with whom he had forged a cross-generational coalition) he had expressed his anger at Margaret, who threatened to become like his mother and leave.

A central aim of therapy was to reduce the parents need to turn to a child for care. In work with the couple, the therapist helped the couple to address their own conflicts without involving Ann and to give and receive love and comfort from each other.

Ann's symptoms did not re-occur even when partner conflict re-surfaced, suggesting that she had been released from triangulation in her parents' relationship. After therapy ended, the couple was contacted yearly for seven years without further need for intervention.

3.4.2 INTERVENTIONS TO ENHANCE PARENTAL SENSITIVITY

3.4.2.1 Parental sensitivity and / or infant attachment

Bakermans Kranenburg et al (2003) contained 81 studies, involving 7,636 families and 88 outcomes.[103] Interventions were coded according to their focus: interventions that aimed to enhance sensitivity; sensitivity and maternal representations; social support; or any combination of the three. For example, video-feedback was used to enhance parental sensitivity; parent-infant psychotherapy was used to transform maternal representations; and interventions focused on support involved experienced mothers befriending and offering practical help to highly anxious mothers. Several interventions combined different strategies.

A) Parent outcomes

A1) Maternal sensitivity

Findings reporting on a core set of 51 randomised studies, showed a moderate but significant effect of attachment-based interventions on maternal sensitivity.

Interventions with a clear behavioural orientation and focused on enhancing maternal sensitivity were found to be more effective in increasing sensitivity and infant attachment than those with other orientations (i.e. that focused on support and/or changing maternal representations). It is suggested that although infant attachment is slower to respond to intervention, there may be a 'sleeper' effect involved in the use of sensitivity-focused interventions.

Short-term interventions (with fewer than five sessions) were found to be as effective as those with 5 – 16 sessions and more effective than interventions of more than 16 sessions.

The effect of interventions conducted at home was not significantly different from those conducted elsewhere (e.g. community mental heath centres).

Four studies that did not rely on personal contact with the client, but on the provision of infant carriers, kangaroo care, and a workbook on responsiveness to a videotape showed the largest effect size.

A2) Paternal sensitivity

Although only three studies involved fathers as well as mothers, these were significantly more effective than those involving mothers only.

A3) Infant attachment

29 intervention studies used infant attachment security as the primary outcome but a core of 23 randomised intervention studies, found that interventions aimed at enhancing maternal/parental sensitivity (without focusing on support and representation) were the only ones to show significant effect sizes. As with interventions to increase maternal

sensitivity, interventions focused on increasing infant attachment security were most effective if they had fewer than five sessions, started after the age of 6 months, and did *not* use video feedback.

Meta-analysis of the 15 randomised studies of families with multiple problems (low SES, adolescent parenthood, etc) showed an effect size comparable to that for families with fewer problems. Interventions aimed at sensitivity were most effective in improving infant attachment, and results once again favoured a reduced number of sessions, commencement postnatally, and behaviourally focused treatments.

3.4.3 Parental sensitivity: behaviours associated with infant faltering growth

Six studies were identified that involved parents and infants referred for faltering growth, and which measured change in parental psychopathology and/or negative affect. Two studies involved intensive psychotherapy.[58/59 71] Benoit (1996)[69] compared interaction guidance with training on feeding techniques for mothers with infants with faltering growth. Two studies compared the effects of visits by lay home visitors with adjunctive community and clinic-based services[55 70], one of which was a long-term follow-up study. One study involved behavioural social work[56/57.] Three case studies focused on parents of children with faltering growth were also identified; one of parent-child psychotherapy[58/59,] one of interaction guidance[73] and one of behavioural social work[72].

Black et al. (1995) used a randomised controlled trial to compare the combination of lay home visitation and clinic services with clinic services alone, assessing the effects at 1 year post-treatment. A 3-year follow-up study was conducted when the children were within six months of their 4th birthday.[54]

Benoit et al. (2001)[69] conducted a two-comparison group trial to compare the effect of a play-focused intervention and a feeding-focused intervention. Although not all children in the sample had fallen below the faltering growth threshold, all had been referred to a clinic for feeding difficulties.

Haynes (1984)[70] compared the effect of an intervention that combined home visits by lay health visitors with 'standard community support': parenting classes, physical therapy for children and medical treatment. A second group received standard community support alone.

Fraiberg (1981a; 1981b)[58 59] used one group with pre- and post-test measures to assess the effects of clinic based parent-child psychotherapy. The study involved infants with severe developmental delays, behavioural problems and failure-to-thrive attributed to malfunction in the relationship with their primary carers.

Iwaniec 1985(b)[57] assessed the effectiveness of an intervention grounded in behavioural social work using one group, with repeated pre- and post-test measures.

Dunitz (1996)[71] conducted a study with mothers and (where present) fathers of infants with faltering growth in which the parents had been assessed for Axis 1 and Axis 2 pathology using a German version of the DSM-III-R. Parents were then helped to select one of a range of therapeutic treatments best suited to their needs. In addition, they took part in an intervention to promote infant feeding. The effects of the intervention were assessed with repeated measures pre- and post-test study, the final assessment being one year after treatment completion. There was no control group.

A) Parent outcomes

A1) Parental psychopathology

Dunitz (1996)[71] assessed mothers and (where present) fathers of faltering growth infants, using a German version of the DSM-III-R for Axis 1 and Axis 2 pathology. 69.7% of all assessed caregivers (93% of mothers and 38% of fathers) had Axis 1 pathology, which included depressive disorders, brief reactive psychosis, dysthymia, somatoform disorders, eating disorders, adjustment disorders, reactive attachment disorder, alcohol dependence, impulse control, gender identity disorder and sedative dependent disorder. 27.3% had Axis 2 pathology (over-involvement, under-involvement, anxious/tense and mixed relationship diagnosis) at first assessment.

At the first evaluation (three months after the intervention began) there was a reduction of Axis 1 pathology in 38% of all caregivers (48% of mothers and 19% of fathers). By the third evaluation, at the end of the year, Axis 1 pathology was only was found in 11.8% of caregivers (14% of mothers and 7% of fathers). Axis 2 pathology showed a more consistent manifestation across all three assessments: 23.7% of all caregivers at the first and second assessments and 18.4% at the third.

A2) Parental physical and emotional caregiving

Fraiberg et al. (1981)[58 59] used a measure designed for the purpose of the study to assess outcomes and create a 'shorthand' summary of complex clinical judgements. Clinician's scores were allocated on a six-point scale pre- and post-assessment. On this scale, '1' represented a status that was 'adequate' (or above adequacy). 'Adequate' was defined as the absence of danger to the child, functioning commensurate to the child's age and no need for further professional support in this area. '2' signified 'marginally adequate', '3' moderately impaired, '4' seriously impaired, '5' severely impaired and '6' critically impaired. The following aspects of parenting were measured: physical care-giving, practical knowledge of and ability to read the infant's needs, emotional availability and modes of contact (empathy, conferring individuality to the child without projection or distortion). This category was assessed separately for fathers and for mothers. Assessors allocated scores from 1 (adequate) to 6 (critical).

In the case of mothers, 83.3% of the sample improved (gained one point on the scale) of whom 52.4% were rated as having 'adequate' parenting skills post-intervention There was no improvement in 16.7% cases but no cases in which a mother's quality of parenting declined over the intervention period. In the case of fathers, 83.3% of the sample improved (66.7% reached 'adequate' levels), there was no improvement for 8.3% and actual decline in a further 8.3%.

A3) 'Atypical' or 'Fr- Behaviour'

Benoit et al. (2001)[69] used the Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE)[104] to code atypical maternal behaviour during one minute of play interaction. These are: (a) affective communication errors; (b) role reversal; (c) frightening/disoriented behaviour; (d) intrusiveness and negative behaviour;

(e) withdrawal. A summary score can be obtained by adding up the scores for each of these five categories. This includes a qualitative score for level of disrupted communication and a bivariate classification for disrupted or not disrupted communication. Benoit's study focused primarily on global measures of change in parenting behaviour.

The authors found a significant decrease in atypical behaviours in the Interaction Guidance group from pre- to post-intervention (*p*=<.01) whereas atypical behaviours in the feeding-focused group remained stable (*p*=<.75).

Significant decrease of disrupted communication was found between mothers and infants from pre- to post-intervention in the Interaction Guidance group (*p*=<.002). In contrast, the feeding-focused group remained stable from pre- to post-intervention (*p*=<.21).

In the pre-intervention session, 85% of the mothers in the Interaction Guidance group and 43% of those in the feeding-focused group were classified as 'disrupted', while 15% of the mothers in the Interaction Guidance group and 57% of those in the feeding-focused group were 'non-disrupted'. Those in the Interaction Guidance group were significantly more likely to attain a classification of 'non-disrupted' by the end of the intervention than the feeding-focused group (*p*=<.05). Significant effects were found favouring the Interaction Guidance group (*p*=<.02).

A4) Parental expressed warmth

Black et al. (1995)[55] used the Parent-Child Early Relational Assessment (PERA)[105], (modified for African-American families) to assess the quality of parent-child interaction. Maternal psychological functioning was measured using a combination of three subscales of the Brief Symptom Index (BSI).[106] For the purposes of this study, a composite score of the depression, hostility and anxiety subscales was used. Mothers were divided into negative and non-negative groups using a median split. Demographic risk was assessed by calculating indicators on six risk categories, of which poverty was the most prevalent. No significant changes were found in parental

warmth and negative/non-negative status at the end of year 1. At the 4-year follow-up study of the intervention introduced by Black (ibid.), Hutcheson et al (1997)[54] found that baseline symptoms of maternal negative affectivity were inversely related to children's motor and cognitive development (described below).

A5) Parent-child interaction

Black et al. (1995)[55] found that at the end of year 1, parents showed more control in their interactions with children during feeding, regardless of intervention status or children's age at recruitment (p=<.01). However, HOME scores indicated that children whose parents had received the combined lay home visitor intervention and clinic services had higher levels of parent-child interaction, nurturance and lower negative control than those in the clinic-only control group (p=<.05).

Haynes (1984)[70] found a strong association between children's condition at three year follow-up and the assessment of maternal hostility and insensitivity at baseline. Mothers had been classified as 'actively hostile', 'incoordinated' or characterised by 'benign neglect' in the first year. Overtly hostile mothers caused active harm to infants and showed generalised difficulty in social relations. 'Incoordinated' mothers did not match action to babies' cues. For example, babies were fed according to a schedule. Mothers who behaved with 'benign neglect' were aware of infants needs but responded to infants, rather than initiating care. The authors concluded that mothers in the 'benign neglect' group improved somewhat through the lay home visitation programme but that those who were characterised by 'incoordination' or 'overt hostility' did not, with consequent effects on children's growth and development.

Iwaniec (1985)[56 57] assessed mother-child interaction with a rating form designed by the authors for the purposes of the study. This evaluated mothers' sense of control and resolution of feelings of anger, tension, resentment and anxiety. Change in mother-child interactions was satisfactory in 50% of cases, moderate in 33% and not achieved in 17%. Follow-up data suggest some loss of gains in maternal warmth but that feeding gains were maintained.

Dunitz (1996)[71] found that one year after treatment 23% of mothers and 7% of fathers still showed relationship pathology. While the nature of this pathology proved constant over the period of observation, its intensity diminished. Overall, the authors report a striking correlation between infants' degree of recovery and the simultaneous regression of parental psychopathology. Infantile growth data showed a normal distribution of height for weight over the course of one year.

B) Child outcomes

B1) Health and cognitive-motor development

Fraiberg et al. (1981a; 1981b)[58 59] created a rating scale (for the purposes of this study) that combined data from infants' medical records and clinician's observations to create scores for infants' health (see 'Parental physical and emotional caregiving', above). Authors found that post-intervention, the health of 76.9% of infants in the sample had improved (they were at least one point higher on the scale than they had been at baseline). 76.9% of infants had achieved 'adequate' status (they were in no danger, outcomes were appropriate for their age and no further clinical intervention was necessary at this point). There was no improvement in 7.7% and actual decline in 15.4% of cases.

The authors used the Bayley Scales of Infant Development[107] to measure change in children's cognitive-motor development. Post-treatment, the cognitive development of 66.7% of infants in the sample had improved and 55.6% had achieved 'adequate' status. There was no improvement in 22.2% of the cases and actual decline in 11.1%.

Black et al. (1995)[55] used the Bayley Scales[104] to assess cognitive and motor development. Significant *decline* was found in the cognitive development of all infants during the first year of the intervention (p=<.001). Some differences in the rate of decline were associated with the intervention and with children's age: although there was no difference in the rates of decline of older children in the treatment and control groups, the cognitive development of younger children in the intervention group declined less steeply than younger children in the control group (p=<.02).

Black et al. (1995)[55] assessed infant language development using Receptive-Expressive Language (REEL) scales.[108] Children also experienced a relative decline in their expressive and receptive language status over time (p=<.001). However, across both older and younger children, those in the home intervention group experienced less decline in receptive language than their age-matched peers in the control group (p=<.05).

Hutcheson (1997)[54] evaluated the effect of maternal affect (measured at baseline) in a 3-year follow-up of the study by Black (1995)[55], when the children were nearly four years of age. The intervention effects were mediated by the severity of mothers' negative affect at baseline. The children of mothers with lower levels of negative affect showed, at age four, improved cognitive development (p=<.05), motor development (p=<.01) and child negativity during play (p=<.05). In contrast, higher rates of maternal negativity at baseline were associated with poorer outcomes for children's cognitive development (p=<.03) and motor development (p=<.02) and were marginally associated with poorer outcomes in children's task engagement (p=<.09). Levels of demographic risk (such as poverty and low levels of parental education) had no effect on outcomes either at the end of year 1 (Black, 1995)[55] or by the time children were aged 4 (Hutcheson, 1997). In contrast, there was no difference in outcomes for children in the control group, irrespective of their mothers' affect at baseline.

Haynes (1984)[70] found that over half the faltering growth infants in the sample scored in the 'below average' or 'retarded' range on the Bayley Scale[104] at intake (62%) and six months into the intervention (59.5%). While all faltering growth infants gained weight during hospitalisation, catch-up growth of these infants was not taking place as expected by the end of the year. At year 1 only 7 of 37 children re-evaluated had improved in their developmental score category with no difference between treatment and control groups. A 3-year follow-up of 44 families for whom information was available found that 4.5% of children had died, 11.4% had been physically abused and 22.7% had been removed from parental care. A strong association was found between children's condition at follow-up and the severity of maternal hostility and insensitivity at baseline (see parent-child interactions, above). Authors concluded that the only advantage of the lay home visitation programme was that mothers visited were more

likely to remain in contact with services, which may have contributed to more effective screening and ensured minimal fulfilment of infants' nutritional needs.

Dunitz' (1996)[71] used the Cole Indices to measure growth and found a normal distribution for intervention children a year after referral. A significant difference was found between change in parental psychopathology and improved indices of infant weight/length and growth (*p*=<.00001).

Iwaniec (1985)[56 57] found that 64% of faltering growth infants had achieved satisfactory improvement in feeding, 29% had moderate improvement, while no improvement was identified in the case of 1 child (7%) who was readmitted to hospital. Follow-up data suggest some loss of gains in maternal warmth but that feeding gains were maintained. No significance given.

B2) Children's emotional and social development

Fraiberg (1981a; 1981b)[58 59] found that 80% of the infants improved at least one point on a six-point rating scale from pre- to post-intervention on affective-social indicators (indicators of attachment, characterisation of the baby's dominant mood and his/her range and intensity of affective expression); 53% had achieved adequate status. There was no improvement in 17% of cases and decline in 2.8%.

Fraiberg (1981a; 1981b)[58 59] used a six-point scale to create observational ratings of infants' adaptive modes: the regulatory functions of the sensimotor organisation (e.g. response to external stimuli, state regulation, development of imitations, responses to stress and novelty) and regulatory functions of the ego (including modulation of affect, use of play, organisation of self at a representational level). 79.4% of infants in the sample improved by at least one point on the scale, with 66.7% achieving 'adequate' status. There was no improvement in 14.7% of the cases and actual decline in a further 5.9%.

Black et al. (1995)[55] found significant improvements in children's interactive competence (*p*=<.001) at the end of year 1, showing children's achievement of higher interactive competence over time, but there was no difference between children in treatment and

control groups. Hutcheson (1997)[54] evaluated the effect of maternal affect (measured at baseline) in a 3-year follow-up of the study by Black (1995),[55] when the children were nearly four years of age. Higher rates of maternal negativity at baseline were marginally associated with poorer outcomes in terms of children's negative affect (p=<.09). There were no comparable differences between children in the non-intervention group, regardless of their mother's negative affect at baseline.

The following case studies illustrate the application of parent-child psychotherapy, interaction guidance and behavioural social work to the treatment of faltering growth children.

i) Parent-child psychotherapy

Essential to parent-child, or mother-child, psychotherapy is the idea that in the relationship there is a basic distortion of the parent's capacity to represent the child in a coherent and positive way.[66] A central goal of the therapist is to enable a shift in the parent's representations which will enable her to 'free' her child from her traumatic projections. The following case studies illustrate the way in which this change has been achieved. It should be noted that these interventions involve adjunctive practical support and guidance.

The following intervention combined psychotherapy with Interaction Guidance. The latter is an intervention designed to reach multiply-disadvantaged families who have been hard to engage and have resisted traditional psychotherapeutic measures (see Benoit et al., 2006,[69] above).

Case example 9: Interaction guidance

Keren and Tyano (2001)[73] present a case study involving 'S.', a one month old first-born child of two young parents referred by the community health nurse because of concerns about the mother's possible post-natal depression. At the first home visit, therapists observed the infant's feeding difficulties (although 'S' had not reached the faltering growth threshold) and noted the negative attributions of the mother ('A') of her baby's behaviour. A said, for example, that the infant 'is angry at me all the time, even when I feed her'.

A had a history of severe deprivation as the child of a drug-dependent mother, and had been sexually and emotionally abused. One particular traumatic loss appeared to influence A's feelings towards S. A had witnessed the death of her nine-year-old sister in an accident. A's loss was projected onto the child. She was filled with remorse at not having saved her sister's life, while at the same time believing that in some way, her sister had been reborn as S. The child's cries represented her (dead) sister's anger.

Therapists had three objectives: (i) to help A differentiate between her dead sister and the child (ii) to provide developmental guidance and (iii) to help create an emotional space for the child's true self, rather than the child imagined by her parent, by voicing the child's needs.

Two treatment modalities were combined: mother-infant psychodynamic therapy and interactional guidance, which is explicitly based on strengths (McDonough et al., 2000). Practitioners convey to parents that parents are doing the best they can, address what parents see as the problem, answer questions posed by the family, provide information when asked and jointly – with parents - define treatment goals and success.

The treatment stages focused on (i) provision of nurture for A, in order to help her become able to care for the child; (ii) enabling A to create a symbolic representation of the child. For example, the therapist sometimes spoke in lieu of the child, 'voicing' the child's feelings and desires. (iii) As S's cognitive and motor skills developed, and it became clear to A that S was not her dead sister, therapists helped A mourn her sister's death. Therapy ended when S was 18 months old, but resumed after S developed selective mutism after starting school. At this point (iv) the father, who had resisted treatment, became involved, enabling some resolution of partner conflict. Dyadic therapy ended when the child was 4, but both mother and child were referred to individual treatment.

The following intervention illustrates the principles of family support – the redirection of attention from the parent-child dyad to the wider family and community. It involves collaboration with parents. In this particular case, the intervention included therapy

grounded in cognitive-behavioural principles, for the mother of a child with faltering growth. The study also draws attention to the way in which a child was being harmed because of the problematic nature of interaction which was caused by the child's feeding difficulties and the parents' lack of skills with deal with these, rather than parental negative affect at the outset.

Case example 3: Family support, feeding intervention and behavioural therapy for the mother of an infant with faltering growth (Iwaniec, 2004: 192)[72]

Indira, a third child in the family, was born at full term and of adequate weight. Her parents and elder siblings were delighted with her arrival. However, Indira was difficult to feed, and this was exacerbated when she began to move to solids. In spite of intensive efforts to feed her, she did not grow adequately and from the age of 2 months to 1 year and 5 months she remained either just above or below the 2nd percentile. Additionally, she was prone to infections and illness.

As time went on her mother became more anxious and preoccupied, to the point of feeding the child at all costs. The two boys became attention-seeking and resentful as a result of their mother's preoccupation. The father became so concerned about the rapid changes in family life and functioning, as well as Indira's poor health, that he brought the child to the health centre.

Three major problems were identified: feeding difficulties due to mild oral-motor dysfunction; Indira's difficult temperamental attributes, which exacerbated feeding problems, and the mother's feeding style and interaction.

Daily attendance at the day nursery was ordered, so that Indira could be looked after by people who were calm and would feed her at a reasonable pace. While Indira was at the nursery – which she enjoyed – her mother was seen by a therapist to address her fears, anxiety, and perceived sense of inadequacy, low self-esteem and depressive moods. Relaxation training, cognitive counselling and restructuring brought about changes in the way she saw herself as a person, mother and wife. Indira's weight increased, family interaction improved and tension within the family reduced.

3.4.3 INTERVENTIONS WITH SUBSTANCE-ABUSING PARENTS

Three studies were identified that reported on change in emotional interaction and caregiving of women in treatment for substance abuse. Luthar and Suchman (2000),[30] conducted a randomised controlled trial to compare the effectiveness of two interventions for opiate-abusing women: a Relationship Psychotherapy Mother's Group (RPMG), i.e. a clinic-based, weekly form of group psychotherapy for mothers combined with standard methadone treatment, and standard methadone treatment alone. In a second study (which involved a new, and larger, sample) Luthar et al. (2007)[29] repeated the first study design, but added (and compared the RPMG to) an adjunctive intervention: Recovery Training (RT).

Conners et al. (2006)[31] undertook a one-group study with repeat measures, evaluating treatment outcomes of 305 women enrolled in a residential substance abuse treatment programme which offered a comprehensive range of adjunctive treatments and forms of practical support for both mothers and children under 5 years of age. All three studies[29, 30, 31] report on the affective quality of parenting.

A) Parent measures

A1) Overall quality of parenting

Conners et al. (2006)[31] used the Adult-Adolescent Parenting Inventory-2 (AAPI-2)[109] to assess parenting and child-rearing attitudes of adult and adolescent parents. The AAPI-2 contains five subscale scores which measure (i) inappropriate expectations (ii) lack of empathy toward children's needs (iii) belief in the use of corporal punishment (iv) reversal of parent/child responsibilities (v) oppressing children's power and independence. Significant improvements were noted on the total scale (p=<.001) pre- to post-intervention.

A2) Affective interactions (parental warmth and acceptance)

Luthar and Suchman (2000)[30] and Luthar et al. (2007)[29] used two of the six subscales of the Parent-Child Relationship Inventory (PCRI)[110]. These subscales measure maternal affective interactions (communication and involvement) and instrumental subscales that measure limit-setting and promotion of autonomy. The Parental

Acceptance-Rejection Questionnaire (PARQ)[42], a 60-item measure rated on a 4-point scale, was used to assess mother-child relationships. The PARQ yields a composite maltreatment score comprised of four subscales: aggression/hostility; neglect/indifference, undifferentiated rejection and very low expressed warmth/acceptance.

In the first study (Luthar and Suchman 2000)[30] reported robust improvements in the affective interactions of RPMG mothers and children. RPMG mothers fared significantly better than mothers in control group (who received standard counselling on addiction alone) on affective Interactions at both post-treatment (p=<.001) and follow-up (p=<.05).

In the second study, in which RPMG mothers were compared to mothers in a different intervention (RT) no significant differences were found in affective quality of parenting pre- and post-intervention.

A3) Empathy

Conners et al. (2006)[31] used the Adolescent Parenting Inventory-2 (AAPI-2)[106] to measure changes on empathy. No significant effect was found as a result of participation in the residential programme for drug-abusing mothers, regardless of length of stay.

A4) Instrumental aspects of parenting: limit-setting and promotion of children's autonomy

Luthar and Suchman (2000)[30] found no significant differences between treatment and control groups in the instrumental aspects of parenting (limit-setting and promotion of children's autonomy).

Conners et al. (2006)[31] found no significant effect for promotion of children's autonomy.

A5) Risk of child maltreatment

Dawe et al (2003) and Dawe and Hartnett (2007) used the Child Abuse Potential Inventory (CAPI) to measure risk of child maltreatment before and after the Parenting under Pressure (PUP) programme. In the first, one group pre- and post- intervention

study (Dawe et al, 2003) found a significant reduction in child abuse potential in 6 out of 8 (75%) participating families. In the second study, which involved a larger sample (64 participants) PUP participants showed significant reductions in child abuse potential (p=<.001) and rigidity (p=<.001). Of the two control groups in this study, the group which received brief parent training also reported a significant change in child abuse potential over time (p=<.001). However, the standard care group – which received a care package provided to methadone dependent adults – showed a significant increase in child abuse potential over time (p=<.001), indicating a significant worsening of this measure.

In the first study comparing the effect of the combined relationship psychotherapy (RPMG) and methadone treatment with methadone treatment alone, Luthar and Suchman (2000)[30] found that RPMG intervention mothers displayed significantly lower maltreatment risk scores than control mothers on reports by both mothers (p=<.05) and children (p=<.05) post-treatment. At six-month follow-up, there continued to be significant improvements on intervention mothers' self-reported maltreatment risk (p=<.05), when compared to controls, but children's reports of mothers' maltreatment risk were no longer significant.

In their second study, Luthar et al. (2007)[29] found marginal, but not significant, differences (p=<.10) favouring the RPMG, in mothers' reports of child maltreatment risk post-intervention. However, these gains were lost after six months, with a significant decline in clinician-reported maternal functioning (p=<.02). There were no other significant differences in rates of change between RPMG versus RT mothers.

Conners et al. (2006)[31] found no significant changes on belief in the use of corporal punishment.

A6) Parent-child role reversal

Conners et al. (2006)[31] used the Adult-Adolescent Parenting Inventory-2 (AAPI-2)[106] to assess parenting and child-rearing attitudes of adult and adolescent parents. Significant improvements were noted on Parent-Child Role Reversal (parentification) subscale (p=<.01), with more significant results for longer length of stay (p=<.001).

A7) Psychosocial adjustment

Luthar and Suchman (2000)[30] used (i) the Satisfaction subscale of the Parent-Child Relationship Inventory (PCRI)[106] and (ii) the Clinician Assessment of Functioning (CAF; Luthar and Suchman et al., 200b, which was designed for this study) to measure overall functioning (e.g. coping and life skills) and interpersonal efficacy (interpersonal functioning and affective style). Relational psychotherapy (RPMG) intervention group mothers showed greater satisfaction with their role as parents post-treatment than control mothers (*p*=<.05). Modest but non-significant advantages in the RPMG mothers' satisfaction with their parenting role continued at six-month follow-up.

Luthar et al. (2007)[29] used the same outcome measures for psychosocial adjustment in a study which compared the effects of RPMG with an alternative intervention, Recovery Training (RT). The results showed no significant improvement in maternal psychosocial adjustment as a result of participation in either intervention.

A8) Inappropriate expectations

Conners et al. (2006)[31] found significant improvements on the Inappropriate Expectations subscale (*p*=<.001) of the Adult-Adolescent Parenting Inventory-2 (AAPI)[106], which were marginally associated with length of stay (*p*=<.10)

A9) Self-sufficiency

Conners et al. (2006)[31] found a significant increase in clients' employment after treatment (*p*=<.0001), associated with longer length of stay (*p*=<.01). There was a small but significant increase in the number of clients living above the poverty line (*p*=<.0001) from intake to final assessment, also associated with length of stay (*p*=<.003). The number of clients living independently increased after discharge (*p*=<.001), but was not associated with length of stay.

A10) Depression

Luthar and Suchman (2000)[30] used the Beck Depression Inventory (BDI)[111] to measure improvements in maternal depression. There was a trend in favour of the RPMG relational psychotherapy group over those in the control group post-intervention

(*p*=<.10) in reduction of women's depressive symptoms. These effects were lost by 6-month follow-up.

Luthar et al. (2007)[29] reported similar findings in their second study comparing RPMG with Recovery Training (RT). Marginal differences in depressive symptoms were found that favoured the women in the RPMG relational psychotherapy group over the RT group post intervention, (*p*=<.10). These effects were also lost by 6-month follow-up.

Conners et al. (2006)[31] found a significant reduction in depressive symptoms (rated on BDI) from intake to follow-up (*p*=<.01), with better outcomes associated with longer length of stay in the residential treatment programme (*p*=<.04).

A11) Post-traumatic stress

Conners et al. (2006)[31] found significant improvements (*p*=<.01) in symptoms associated with post-traumatic stress (PTSD) measured on the PTSD Checklist (PCL-C)[112] from intake to follow-up. There was no association between length of stay and reduction of post-traumatic stress.

A12) Substance abuse

Luthar and Suchman (2000)[30] and Luthar et al. (2007)[29] measured change in substance use by using computerised toxicology records at methadone clinics. Separate analyses were conducted for opiates (the primary drug for which women were in treatment) and for cocaine, commonly used by patients in methadone maintenance.

Luthar and Suchman (2000)[30] found significant results for time and treatment group interaction, which indicate a significant probability that opiate use decreased over time in the RPMG group while it actually increased in the control group (which was receiving standard methadone treatment) over the same period (*p*=<.01). Cocaine use decreased over the course of the year (*p*=<.05), with no difference between groups.

Luthar et al. (2007)[29] found that the Relational Psychotherapy (RPMG) mothers' cocaine use decreased over the course of treatment (*p*=<.06) whereas that of Recovery Training

group mothers increased over the same period. These gains were lost at 6 month follow-up. No between-group differences were found in opiate use.

In Conners et al.'s (2006)[31] sample, 48.6% of participants reported being completely abstinent from alcohol or illicit drugs in the period between discharge and assessment, with longer stays associated with abstinence (*p*=<.006). A self-report tool (the Addiction Severity Index-Expanded, Self-Administered Version (ASI)[113] was used. There was a significant reduction in cigarette use (*p*=<.001) not associated with length of stay (*p*=<.003).

Dawe et al (2003) and Dawe and Hartnett (2007) used independent measures to assess the methadone dose of parents who participated in the PUP programme, In the first, small scale study (Dawe et al 2003) reduction in methadone use was reported for adults in 3 of 8 participating families. In the second, larger scale study (which involved 64 participants in treatment and control groups), statistically significant reduction was found for methadone use of treatment group parents (*p*=<.001) but no significant differences in the methadone does of either control group.

These two studies on the effects of the PUP programme also used the Alcohol Use Disorders Identification Test scores (AUDIT Saunders et al, 1993) to measure changes in parental alcohol use.[175] No changes were reported across time for either intervention or control groups in the second, larger scale trial (Dawe and Hartnett, 2007). However, significant reductions in alcohol use were reported for 6/7 families (data was missing for one family) in the earlier, smaller scale study. [2]

A13) High-risk behaviours

Conners et al. (2006)[31] found significant changes in intravenous drug use (*p*=<.001), lower rates of arrest (*p*=<.001) and marginal reductions in risky sexual behaviour (*p*=<.010). There was no relationship between length of stay and needle use, a strong association between length of stay and rates of arrest (*p*=<.002), and a marginal association between length of stay and risky sexual behaviour (*p*=<.010). Dawe et al

[2] Missing data on 1 family.

(2003) reported a reduction in the risky sexual behaviour of adults in 3 / 7 families who participated in the PUP programme in a small scale study.[3]

A14) Parenting stress

Dawe et al (2003) and Dawe and Hartnett (2007) used the Parenting Stress Index (short form) (Abidin, 1990)[79] to measure perceived stress in the parenting role. In the first, one group pre and post intervention study (Dawe et al, 2003) found a significant reduction in perceived stress of in 6 out of 8 (75%) participating families. The second study, which involved a larger sample (64 participants) showed significant reductions parental perceived stress in the PUP group (p=<.001) with no significant difference in either the brief parenting intervention or control groups.

B) Children's outcomes

B1) Children's psychosocial adjustment

Luthar and Suchman (2000)[30] and Luthar et al. (2007)[29] used the Behavioural Assessment System for Children (BASC)[114] in order to measure children's psychosocial adjustment. The BASC contains both a Parent Rating Scale (PRS) and a Self-Report Scale (SRP) for children aged 6 – 18 years. Separate PRS forms are available for different age groups of children (4-5, 6-11 and 12-18 years). The SRP Child and Adolescent forms have subscales for children aged 6 – 11 and 12 – 18 years. Both PRS and SRP yield composite scores that are intended to be used as measures of overall functioning. Specifically, the BSI contains subscales for behavioural and for emotional symptoms. Subscales for behavioural symptoms measure hyperactivity, aggression, anxiety, depression, atypical behaviour and attention problems, while the subscale for emotional symptoms provides indicators for emotional disturbance, particularly internalising disorders. It is composed of the following scales: social stress, anxiety, interpersonal relations, self-esteem, depression and sense of inadequacy.

[3] Missing data on 1 family.

The first study (Luthar and Suchman 2000) found marginal differences (p=<.10) in the self-reported personal psychosocial adjustment in the children of RPMG mothers immediately post-treatment, but no significant differences at six-month follow-up. No significant differences were found in mothers' reports of children's psychosocial adjustment either post-test or at follow-up.

In the first, small scale pre and post intervention study of the PUP programme (Dawe et al 2003), two measures were used to assess child functioning: the Difficult Child Subscale of the Parent Stress Index (Abidin, 1995)[174] and Connors Global Index of child functioning (measures of conduct, family, emotional, anger and anxiety problems). Statistically significant change, favouring the intervention, was reported on the PSI-DC measures for 7/8 families and on the CGI for 6 / 8 families.

In a second, larger scale RCT of PUP (Dawe and Hartnett 2007) the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997)[173] was used to measure changes in the following domains of children's functioning: emotional symptoms, hyperactivity-inattention, conduct problems, peer problems and prosocial behaviour. Significant increases were reported in the intervention group's child prosocial scores (p=<.001) as well as reductions in child behaviour problems (p=<.001). There was no significant change in child behaviour in either the brief intervention or standard care group.

B2) Children's depression

Luthar et al. (2007)[29] measured children's depression levels using the Children's Depression Inventory (CDI)[115]. Statistically significant reduction in depression (p=<.04) was found in the scores of children of RPMG mothers immediately post-treatment. Overall scores for psychosocial adjustment (p=<.02) also improved. These gains were lost six months post-treatment, when there were no longer any significant effects on RPMG children's depressive symptoms (p=<.12) and actual decline in the psychosocial adjustment of RPMG children (p=<.02).

Table 3.4 Study Results

1) Emotionally abusive parenting		
RCTs		
Study ID	*Measures*	*Statistical significance*
Sanders et al (2006) [63] Enhanced group-based cognitive-behavioural parent training with additional focus on attributional retraining and anger management (n=48) Standard cognitive-behavioural group-based parent training (n=50) Preschooler parent psychotherapy (PPP) (n=23) and home based psychoeducational home visitation (PHV) (n=34), community standard comparison group which received standard services through Department of Social Services (DSS) (n=30)	**Adult outcomes**	
		Group 1 (EBFI) vs. Group 2 (SBFI) interaction
	Blame and intentionality attributions	
	Ambiguous situations	*p*=<.01 favouring Group 1
	Intentional situations	*p*=<.001 favouring Group 1
	Global anger STAXI	
	Angry temperament	n/s
	Anger out	n/s
	Anger expression	n/s
	Parental anger	
	Problem	n/s
	Intensity	n/s
	Potential for abuse	*p*=<.01 favouring Group 1
	Parent Opinion Questionnaire (POQ), total score	*p*=<.001 favouring Group 1
	Child Abuse Potential Inventory (CAPI), abuse score	*p*=<.01 favouring Group 1
	Parental adjustment	
	Parent Problem Checklist(PPC)	n/s
	Depression Stress and Anxiety Scale (DASS) total score	n/s
	Parenting	
	PS	n/s
	Parenting Sense of Competency (PSOC)	
	Satisfaction	n/s
	Efficacy	n/s
	Child Outcomes	
	Child Behaviour ECBI	
	Intensity	n/s
	Problem	n/s
	Parenting Daily Record (PDR, Mean Problem Score)	
	Observed positive child behaviour %	n/s
	Observed negative child behaviour %	n/s
	Child behavioural settings	n/s
	Home and Community Problem Checklist (HCPC)	
	Home problems	n/s
	Community settings	n/s

Toth et al. (2002) [63] Preschooler parent psychotherapy (PPP) (n=23) and home based psychoeducational home visitation (PHV) (n=34), community standard comparison group which received standard services through Department of Social Services (DSS) (n=30)	**Child Outcomes**	
	Child's representations of mother Adaptive maternal representations	Marginal differences favouring PPP>CS No differences between PPP>PHV
	Maladaptive maternal representations	No sig. between-group differences
	Child self-representations Positive self-representations	PPP>CS (p<0.10)
	Negative self-representations	PPP>PHV (p<0.01) PPP>PHV (p<0.01)
	False self-representations	
	Mother-child relationship expectations	No sig. between-group differences PPP>PHV (p<0.10)
Controlled trials		
Study ID	*Measures*	*Statistical significance*
Iwaniec (1997)[64] Group and individual home based behavioural parent training (n=17) Individual home based behavioural parent training alone (n=17)	**Adult outcomes**	
	22 emotionally abusive behaviours Ratings for behavioural goals collapsed into global categories of satisfactory/improved, moderately improved and no improvement.	A relationship of p=<.001 found favouring combined intervention
	State-Trait anxiety: The Strait-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch and Lushene, 1970)	Sig. reduction of State anxiety (p=<.001) and Trait anxiety (p=<.001) favouring combined intervention
	Personal Parenting stress ratings: parents rated levels of personal stress on a Likert scale at the beginning and end of each session.	Sig. reduction of stress levels (p=<.001) favouring combined intervention
	Child outcomes	
	Child's Reactive and Proactive behaviours: Social worker's observations of mother-child interactions.	90% reduction of highly negative behaviour in children in home-only group, 100% in combined intervention

2a) Enhancing parental sensitivity and infant attachment		
Systematic review		
Study ID	***Measures***	***Statistical significance***
Bakermans-Kranenburg (2003)	**Adult outcomes**	
	Overall effect of interventions	Effect of interventions on maternal sensitivity in random studies was moderate but significant (d=0.33, p=0.001). The effect size for all studies was d=0.44. The effect for non-random studies was larger at d=0.61).
	Focus of interventions	Interventions that focused on sensitivity alone were more effective (*d*=0.45, p<0.001) than interventions that combined sensitivity and support (*d*=0.27, p<0.001).
	Timing of interventions	Interventions starting after the child was 6 months old (*d*=0.44) were more effective than prenatal sessions (*d*=0.32) or interventions during the child's first six months (*d*=0.28)
	Nature of intervention	Interventions with videofeedback (*d*=0.44) were more effective than those without (*d*=0.31). Four interventions that did not involve direct contact with the client, but that increased physical contact through the provision of baby carriers (the 'kangaroo') method), included a workbook on responsiveness or videotape showed the largest effect size (*d*=0.62). However, the difference was not significant.
	Number of sessions	Interventions with fewer than five sessions (*d*=0.42) were as effective as interventions with 5 to 16 sessions (*d*=0.38) and more effective than interventions with more than 16 sessions (*d*=0.21)
	Location of interventions	The effect of interventions conducted in the home (*d*=0.29) was not significantly different from those conducted in other settings (eg clinics) (*d*=0.48).
	Interventions involving mothers with multiple problems	A meta-analysis of the subset of samples showing multiple problems showed that interventions by non-professionals showed a larger effect size than those from professionals (*d*=0.42 and *d*=0.26 respectively).
	Interventions involving fathers vs mothers alone	Interventions involving fathers (n=81) significantly more effective (d=1.05) than those which involved mothers alone. (based on 3 non-randomised trials)
	What is the effect of interventions on infant attachment security (based on analysis of 23 RCTs):	Combined effect size for attachment security was small but significant (*d*=0.20, p<0.05)
	Interventions aimed at enhancing maternal sensitivity vs those that focused on social support or changing maternal representations of the infant	Interventions that aimed at enhancing sensitivity – without focusing on social support or changing mother's representations of the infant –were the only ones to show a significant effect size (*d*=0.39, p<0.01). Most sample characteristics (e.g. adolescent motherhood, SES) were not significant moderators.

	Maternal sensitivity: results of multiple regression analysis	A multiple regression analysis showed that sensitivity-focused interventions and later start of intervention produced higher effect sizes, even controlling for other factors, such as SES or adolescent motherhood.
	Infant outcomes	
	i) What is the effect of interventions on infant attachment security?	*A meta-analysis was conducted of 23 RCTs of interventions aimed at enhancing infant attachment security. Findings were:* Interventions that aimed at enhancing sensitivity – without focusing on social support or changing mother's representations of the infant – were the only ones to show a significant effect on infant attachment security (*d*=0.39, p<0.01). Interventions that started later – after the age of 6 months – showed a significant effect size (*d*=0.31) and significant difference with interventions that began in the pre- or immediately post-natal period. Interventions with fewer than five sessions showed a significant effect size on infant security (*d*=0.27. Interventions that did not use videofeedback showed a significant effect size (*d*=0.25) compared to other interventions. Most sample characteristics (e.g. adolescent motherhood, SES) were not significant moderators.
	ii) Are shorter, behaviourally focused interventions also effective for families with multiple risks?	*A meta-analysis was conducted of 15 RCTs involving families with multiple problems. Findings were*: Interventions focused on sensitivity alone were more effective than all other categories of intervention combined (d=25, p<0.02). The most effective interventions involved less than 16 sessions. Interventions with less than 5 sessions (d=.033) were as effective as interventions with 5 to 16 sessions (d=0.36) but both more effective than interventions with more than 16 sessions (d=0.20, p<0.007) Nonprofessional intervenors (d=0.42) were more successful than professionals (d = 0.26). Contrast was significant at p<0 .003). One study that involved videotape as a means of intervening was effective without further support (d=0.54).
	iii) Are interventions that succeed in enhancing sensitivity also more effective in enhancing infant security and attachment?	Studies with the largest effect sizes for sensitivity (*d*=0.40) were also the most effective in enhancing children's attachment security (*d*=0.45, *p*<0.001). The most effective sensitivity interventions (d = 0.40) were also the most effective in enhancing attachment security (d= 0.35).

2b) Parental insensitivity associated with faltering growth		
Controlled studies		
Study ID	***Measures***	***Statistical significance***
Hutcheson et al. (1997)[54] Nurse Home Visiting for multiply-deprived mothers with f.g. infants (follow-on of Black 1995, below)	**Adult outcomes**	
	Relationship of maternal negative affect to child outcomes at year 4 of study by Black et al. (1995, below) Parental warmth	Maternal negative affect at baseline inversely related to children's cognitive development (*p*=<.03) and motor development (*p*=<.02) at year 4. N/S
	Child outcomes	
	Motor development Cognitive development Behaviour during play Child negative behaviour during play	Sig. decline for all children (*p*=<.02) Sig. decline for all children (*p*=<.05) Sig. decline for all children (*p*=<.01) Sig decline for all children (*p*=<.05)
Study ID	*Measures*	*Statistical significance*
Black et al. (1995)[55] 64 mothers of faltering growth infants received home based visitor service combined urban paediatric care clinic services; 66 received clinic-only standard services	**Adult outcomes**	
	Parent-infant interaction at 1 year Parental warmth Parental control during feeding Home environment, including mother's emotional and verbal responsiveness at 1 year	No sig. between-group differences N/s No sig. between-group differences Improvement in overall home environment (p=<.05) of children in the intervention group
	Child outcomes	
	Infant weight for age Infant weight for height Infant height for weight Infant cognitive development	No sig. between-group differences No sig. between-group differences No sig. between-group differences Sig. decline for all children (p=<.001)
	Infant receptive language development Infant expressive language development	Sig. decline for all children (p=<.001) Sig. decline for all children (p=<.001)

Faltering growth (contd.)			
Controlled studies			
Study ID	***Measures***	***Statistical significance***	
Benoit et al. (2001)[69] 14 mothers of faltering growth infants received Interaction Guidance (videotaped interaction followed by discussion, education and feedback) administered over 5 consecutive weeks. 14 received a behavioural feeding programme.	**Adult outcomes**		
	Maternal 'atypical' behaviour: communication errors, role reversal, frightening/disoriented behaviour, intrusive and negative behaviour; withdrawal Levels of disruptive communication	Sig. interaction found favouring the Interaction Guidance group (p=<.02), primarily attributable to a sig. decrease in atypical behaviours from pre- to post-intervention (p=<.01). Atypical behaviours in the feeding-focused group remained stable (p=<.75). Sig. interaction between the intervention group and number of sessions, indicating that change took place over the period of the intervention (p=<.003). Sig. decrease in atypical behaviours in the Interaction Guidance group from pre- to post-intervention (p=<.002). Atypical behaviours continued in the feeding-focused group remained stable pre to post-intervention (p=<.21).	
Haynes et al. (1984)[70] 25 mothers of faltering growth infants received a combination of lay home visitor service (LHV) with standard services (hospital based treatment of child; hospital based parent training; parent training; follow-up support from paediatricians, social workers and a community nurse). 25 received standard services alone	**Child outcomes**		
		Post intervention	
	Infant weight	No sig. difference	
	Infant development	No sig. difference	
Dunitz (1996)71 Combination of training on child feeding in clinic, interaction guidance, combined with parents' choice of therapy.	**Adult outcomes**		
	Parental Axis 1 psychopathology (depressive disorders, brief reactive psychosis, dysthymnia, somatoform disorders, reactive attachment disorder, alcohol dependence, impulse control, gender identity disorder and sedative dependent disorder.	% of sample pre-intervention 38%	% of sample post-intervention 11.8%
	Parental Axis 2 psychopathology (over-involvement, under-involvement, anxious-tense and mixed relationship diagnosis).	23.7%	18.4%
	Child outcomes		

	Infant weight/length and growth	All infants achieved normal physical growth. Improvement Sig. associated with intervention p=<.00001

Controlled studies			
Iwaniec (1985b)[57] Parent training grounded in behavioural social work.	**Adult outcomes**		
	Mother-infant interactions (observed n=12) Improvement in feeding patterns (observed n=17)		Satisfactory level of change achieved in 50% of cases, moderate in 33% and not at all in 17%. Satisfactory level of change achieved in 64% of cases, moderate in 29% and not at all in 7%.
One group pre- and post-test			
Study ID	*Measures*		*Statistical significance*
Fraiberg (1981a, 1981b)[58 59] Parent-infant psychotherapy, developmental guidance, individual psychotherapy with the parent(s) and support to parents in accessing social and economic resources.	**Adult outcomes**		
	Parenting (physical care-giving, practical knowledge of and ability to recognise the infants' individuality without projection or distortion)		83.3% of mothers and fathers improved 1 point on a 6 point rating scale; 66.7% of fathers and 52.4% of mothers required no further clinical intervention. No improvement in 16.7% of mothers and 8.3% of fathers. No decline in any mothers but decline in 8.3% of fathers.
	Child outcomes		
	Infant's health		76.9% of infants improved 1 point on a 6 point rating scale; 76.9% required no further clinical intervention. No improvement in 7.7% and decline in 15% of cases.
	Infant's affective-social development		80% of infants improved 1 point on a 6 point rating scale; 53% required no further clinical intervention. No improvement in 17% and decline in 2.8% of cases
	Infant's adaptive modes (including response to external stimuli, state regulation, development of imitations, responses to stress and novelty) and regulatory functions of the ego (modulation of affect, use of play, organisation of self at a representational level) Infant's cognitive-motor development		80% of infants improved 1 point on a 6 point rating scale; 53% required no further clinical intervention. No improvement in 17% and decline in 2.8% of cases. 79.4% of infants improved 1 point on a 6 point rating scale; 66.7% required no further clinical intervention. No improvement in 14.7% and decline in 5.9% of cases.

3) Missocialisation: parenting interventions with substance-abusing parents		
Study ID	***Measures***	***Statistical significance***
RCTs		
	Adult outcomes	
Dawe and Hartnett (2007)	Parenting stress	PUP: (*p*=<.001) favouring intervention Standard care: *ns* Brief parent training: *ns*
	Child abuse potential	PUP: (*p*=<.001) favouring intervention Standard care(*p*=<.001) showing a significant increase in child abuse potential over time. Brief parent training: (*p*=<.001) favouring intervention
	CAP rigidity	PUP(*p*=<.001) favouring intervention Standard care: *ns* Brief parent training: *ns*
	Alcohol use	*Ns* across time for any group.
	Methadone dose	PUP (*p*=<.001) favouring intervention Standard care: *ns* Brief parent training: *ns*
	Child outcomes	
	Child behaviour problems	PUP: (*p*=<.001) favouring intervention Standard care: *ns* Brief parent training: *ns*
	Child prosocial scores	PUP: (*p*=<.001) favouring intervention Standard care: *ns* Brief parent training: *ns*

3) Missocialisation: parenting interventions with substance-abusing parents		
Study ID	*Measures*	*Statistical significance*
RCTs		
	Adult outcomes	
Luthar et al. (2007)[29] Group psychotherapy/parenting education Recovery training focused on processes of addiction and relapse preventions No-treatment control	*Child maltreatment risk: (maternal aggression/hostility, neglect/indifference, undifferentiated rejection and low expressed warmth/acceptance)* Mother's reports of maltreatment risk Children's reports of maltreatment risk *Affective quality of relationships:* (i) Involvement and communication with children (ii) Limit-setting and promotion of child autonomy/independence *Maternal psychosocial adjustment* Maternal depression Other aspects of psychosocial adjustment *Maternal substance use* Cocaine Opiates	 RPMG < RT (*p*=<.10) N/s RPMG < RT (*p*=<.01) N/s RPMG < RT (*p*=<.10) N/s RPMG < RT (*p*=<.05) No between-group differences
	Child outcomes	
	Child psychosocial adjustment Mothers' reports Children's reports	 RPMG < RT (*p*=<.10) RPMG < RT (*p*=<.10)

Missocialisation parenting interventions with substance-abusing mothers (cont)		
Study ID	*Measures*	*Statistical significance*
Luthar and Suchman (2000)[30] Group psychotherapy and parenting skill facilitation (RPMG) and standard drug methadone clinic treatment Standard methadone clinic treatment control	**Mother outcomes**	
	Child maltreatment risk: (maternal aggression/hostility, neglect/indifference, undifferentiated rejection and low expressed warmth/acceptance) Mother's reports of maltreatment risk Children's reports of maltreatment risk *Affective quality of relationships:* (i) Involvement and communication with children (ii) Limit-setting and promotion of child autonomy/independence *Maternal psychosocial adjustment* Depression *Maternal substance use* Cocaine Opiates	 RPMG < standard treatment *p*=<.05) RPMG < standard treatment (*p*=<.05) RPMG > standard treatment (*p*=<.001) N/s RPMG < standard treatment (*p*=<.10) RPMG < standard treatment (*p*=<.05) No between-group difference
	Child outcomes	
	Child psychosocial adjustment Mothers' reports Children's reports	 RPMG < standard treatment (*p*=<.10) RPMG < standard treatment (*p*=<.10)

3) Missocialisation: parenting interventions with substance-abusing parents		
Study ID	***Measures***	*Statistical significance*
One group pre- and post-test		
	Adult outcomes	
Dawe et al (2003)	Parenting stress	PUP: (*p*=<.001) favouring intervention Standard care: *ns* Brief parent training: *ns*
	Child abuse potential	PUP: (*p*=<.001) favouring intervention Standard care(*p*=<.001) showing a significant increase in child abuse potential over time. Brief parent training: (*p*=<.001) favouring intervention
	CAP rigidity	PUP(*p*=<.001) favouring intervention Standard care: *ns* Brief parent training: *ns*
	Alcohol use	*Ns* across time for any group.
	Methadone dose	PUP (*p*=<.001) favouring intervention Standard care: *ns* Brief parent training: *ns*
	Child outcomes	
	Child behaviour problems	PUP: (*p*=<.001) favouring intervention Standard care: *ns* Brief parent training: *ns*
	Child prosocial scores	PUP: (*p*=<.001) favouring intervention Standard care: *ns* Brief parent training: *ns*

Missocialisation: parenting interventions with substance-abusing parents (cont)		
One group pre- and post-test		
	Mother outcomes	
Conners et al. (2006)[31] Integrated services combining drug abuse treatment, individual, group and family counselling, parent education and support; medical services; case management, support to education and employment, Twelve-Step meetings and aftercare	*Maternal attitudes associated with child abuse and neglect.* Adult Adolescent Parenting inventory – total scale *Subscales:* Inappropriate expectations of children Empathy Strong belief in the use of corporal punishment Reversing parent-child responsibilities Oppressive power over child *Maternal social functioning, health and mental health* Arrest Independent housing Employment Cigarette smoking Depression Post-traumatic stress disorder Intravenous drug use scale Risky sexual behaviour scale *Drug use*	 Sig. improvements (p=<.001) favouring length of stay (p=<.03) Sig. improvements (p=<.001), marginally associated with length of stay (p=<.10) n/s n/s Sig. improvements (p=<.01) n/s Sig. reduction (p=<.001) Sig. increase (p=<.001) Sig. increase (p=<.01) Sig. reduction (p=<.01) Sig. reduction (p=<.01) Sig. reduction (p=<.01) Sig. reduction (p=<.001) Sig. reduction (p=<.01) 48.6% of mothers reported being completely abstinent from alcohol or drugs in the period between discharge and assessment. Sig. association between length of stay and relapse, with longer stays associated with abstinence p=<.006.

4. DISCUSSION

4.1 SCOPE AND TERMINOLOGY

To date, there has not been any overarching attempt to identify an evidence-based approach to the provision of treatment for parental emotional abuse. This report therefore represents one of the first attempts to synthesise the evidence on this topic, and all potentially relevant studies were included irrespective of the methods used to evaluate their effectiveness because we felt that it was important to identify the full range of interventions currently being used. We therefore also included the less rigorous case studies alongside the more rigorous randomised controlled trials.

This review was undertaken using Glaser and Prior's (2002) five categories of emotional abuse (emotional unavailability, unresponsiveness and neglect; negative attributions and misattributions to the child; developmentally inconsistent or inappropriate interactions with the child; failure to recognise the child's individuality and psychological boundaries; and failure to promote the child's social adaptation). Other classifications of atypical maternal behaviour, based on observations of mothers who had experienced childhood trauma, have identified a similar range of categories (e.g. affective communication errors; role/boundary confusion; fearful/disoriented behaviour; intrusiveness/negativity; and withdrawal).[116] This definition of emotional abuse is consistent with that developed by the World Health Organisation, which includes not only acts toward the child that have a high probability of causing harm to their health or to any aspect of their development (physical, cognitive, emotional or social), but also the failure to provide a developmentally appropriate and supportive environment in which the child can develop the full range of emotional and social competencies commensurate with his or her personal potential.[117]

Although the review was based on Glaser and Prior's (2002) five categories of emotional abuse, in the process of undertaking this review, we identified the need to have a broad search strategy. This was the result of variations in terminology, the wide range of harmful behaviours and interactions involved and the realisation that relevant studies may not have key words associated with 'abuse' even though interventions were being used with

parents, targeting emotionally harmful behaviours, in order to reduce harm or improve parenting or child outcomes.

We identified a number of studies involving parents that we felt were at risk of failing to provide a developmentally appropriate and supportive environment; those who had been explicitly identified as being emotionally abusive by child protection services; parents of infants whose faltering growth stemmed from feeding difficulties that had no organic cause; drug abusing parents; parents with mental health problems or perpetrators and survivors of domestic violence. However, we identified no studies of interventions for parents with severe mental health problems (other than substance misuse) that significantly jeopardised children's wellbeing. This is consistent with the findings of other reviews. Although parental mental health problems can have serious consequences for children's health and development, and despite the fact that improvement of parenting skills can improve wellbeing of children (and in the process, adults themselves) there appears to be no published empirical research on parenting programmes for adults with mental health problems at the time of writing.[118] No parenting programmes were identified that involved adult perpetrators of domestic violence.

Consequently, the results of this systematic review only included evaluations of a range of interventions for three groups of parents: parents identified as being emotionally abusive, parents of infants with faltering growth and substance-abusing mothers whose children were prone to missocialisation. Some had clearly identified mental health problems but others did not.

In light of the above, we suggest that there is a need to find an alternative concept to 'emotional abuse' – a term which reflects the fact that emotional harm can occur as a result of unintentional parental behaviour, or interaction between parent and child, which is not intended to be damaging. Such behaviours/interactions may be results of parental illness, the parent(s) own unmet emotional needs, a failure to have learnt positive parenting practices or parenting inabilities linked to socio-economic factors, (micro)cultural practices (including behaviours learned by adults in their own family 'culture') and other circumstances or experiences. A term such as "emotionally harmful behaviours", would capture a broader range of atypical and emotionally damaging

parenting behaviours, in a less stigmatising way. Parents described as exhibiting 'emotionally harmful interactions' with their child (as opposed to being emotionally abusive), would include a much broader group of parents, most of whom would be eligible for additional support to help them address these problems. This would help in the shift away from child protection toward a greater focus on support to the family as a whole and enabling better parenting.[119]

4.2 INTERVENING TO TREAT EMOTIONAL ABUSE

While each of the included studies explains emotional abuse in terms of different theoretical models underpinning the interventions, there appears to be a common hypothesis: the aetiology of abuse includes a parent's earlier experiences. This points to the importance of using behavioural or cognitive-behavioural approaches with parents who have learnt maladaptive ways of behaving/interacting (or who have not had the opportunity to learn adaptive ways) or attachment-based and psychotherapeutic approaches with parents whose own experiences of having been parented, or other traumatic life experiences, influence the way in which they interpret their child's behaviour or interact with that child. For example, one of the included studies adopted a behavioural casework approach which focused explicitly on changing parental behaviour, while one of the few RCTs adopted a cognitive-behavioural approach focused on changing parental behaviours by helping them to recognise and address distorted thinking/understanding of their child, and yet another used a psychotherapeutic approach aimed at helping parents to begin to address their own emotional needs. A majority of these approaches involved one-to-one work with a practitioner (mostly social worker, psychologist or therapist), and only two studies tested the effectiveness of a group-based intervention. So what does the evidence tell us in terms of what works?

Overall, the findings of this first attempt to summarise the literature has confirmed that there is a paucity of high-quality studies evaluating the effectiveness of interventions specifically designed for emotionally abusing parents. Only six of the 20 interventions that were evaluated in the included studies were randomised controlled trials[29 30 31 55 62 63 64] and while the quality of these was good, they were not directly comparable because they evaluated very different interventions, with diverse populations of emotionally abusing

parents, using a range of outcome measures. We will now present in more detail the results for each of the three groups of parents.

4.2.1 Emotionally abusive behaviour

Studies that focused explicitly on parents diagnosed as emotionally abusive, had on the whole evaluated the effectiveness of two approaches to working with emotionally abusing parents – cognitive-behavioural and attachment/psychotherapeutic-based approaches.

Cognitive Behavioural approaches

We identified two studies that explicitly examined the role of CBT with emotionally abusive parents. Sanders et al. (2004)[62] compared two group-based versions of CBT[62] (standard and enhanced versions of the Triple P parenting programme, the latter of which included additional components aimed at addressing parents misattributions and anger).. This study found that there were no differences between the two group-based programmes, with both treatment groups making substantial gains. There were three areas where the enhanced version appeared to have greater effects (anger management, misattribution and unrealistic expectations), although the observed differences had narrowed six months after the intervention ended. In other words, there was little difference in the long term effect of the standard and enhanced versions of Triple P. However, this study did not include a control group, and while the sample involved parents identified as emotionally abusive by child protection services, many had self-referred. This means that the intervention included a substantial proportion of participants who were aware of their difficulties in managing anger. Boulton and Hindle (2000) have observed, however, that parents who are severely abusive are less inclined to self-refer or to recognise the effect of their own behaviour on children's externalising behaviours. Thus, while a proportion of the parents in the study on standard and enhanced Triple P had been formally diagnosed as 'emotionally abusive', it seems unlikely that it included a majority of severely abusive parents, as in other studies.

The second study (Iwaniec (1997)[64]) compared a home delivered, one-to-one, CBT programme with a combined home and group-based programme[64]. It found that the

combined programme reduced emotionally abusive behaviour and decreased parental state anxiety and parenting stress. The study also found that participants valued group interaction as was predicted, and that lessons learned in the group and home intervention were applied not only to parenting, but to other aspects of their lives, enabling troubled adults to gain a greater sense of overall control. This study, once again, did not include a no-treatment control group, and as such, these results only indicate the benefit of combining group and individual treatment.

None of these studies included any assessment of costs and it seems likely that there should be a comparison of group CBT alone prior to the use of home-based programmes. Moreover, the nature and severity of the abuse involved in this study was not clear. Cognitive-behavioural interventions have been shown elsewhere to be effective with diverse groups of parents[120] but it has been noted that group-based CBT appears to be least effective with parents who are abusive or multiply disadvantaged (Morrison Dore and Lee, 1999). Further research is therefore needed to identify the profile of parents with whom this approach is effective.

Psychotherapeutic versus cognitive-behavioural approaches

One study[63] compared a psychotherapeutic intervention for parents of preschool children with a cognitive-behavioural (CBT) home visitation programme. The results suggest that the psychotherapeutic intervention produced a greater decline in children's negative representations of their mother and of themselves, and improved children's expectations of the mother-child relationship compared with the didactic CBT model. However, the outcomes in this study were limited to children's representations and as the authors note, no assessment was made of constructs that might have been expected to improve more dramatically following a cognitive-behavioural parenting programme such as for example, parenting skills and knowledge of child development.

One case study examined the effectiveness of a mentalisation-based intervention underpinned by both attachment and psychotherapeutic theory.[66] Mentalisation refers to the capacity of individuals to understand mental and emotional states in others. Work on the application of mentalisation theory is still in the early stages, but case studies suggest its value in improving a range of outcomes for extremely distressed parents.

While more in-depth work with parents has to date, tended to be undertaken using psychotherapeutic approaches that are delivered on a one-to-one basis, such approaches can be used effectively on a group-basis over an extended period of time. For example, NEWPIN[4] comprises a multidimensional group-based approach for very high-risk parents (i.e. who have children on the child protection register) (see Jenkins, 1996; Gurr and Hansen, 1997; Mondy and Mondy, 2004). This programme comprises an intensive 4-month intervention package including three elements: i) group based psychotherapy which aims to draw links between the mother's past and current relationships and present feelings; ii) supported activities with their children, and; iii) groupwork focused on parenting topics, and aims to support the development of problem-solving, and working with the mothers strengths. The intervention is based on a partnership model in which parental expertise about their child is encouraged. This intervention was evaluated with 21 mothers with severe parenting difficulties including 12 children on the child protection register. The results show that following this intervention ten out of twelve children had their names removed from the Child Protection Register, with both remaining children subsequently returning to the mother's care.[121] While this package has not been evaluated with mothers with a single label of emotional abuse, it seems likely that such comprehensive packages may be necessary to help parents who demonstrate seriously emotionally harmful behaviours.

Behavioural Case Work

One study suggested that behavioural case work involving the use of problem-solving techniques delivered over the course of eight intensive sessions in the home[65] could be effective in changing some aspects of family functioning. However, this was a case study only, and further rigorous evaluation is still needed.

[4] An evaluation of this intervention was not included in the current review because they have not focused to date on explicitly emotionally abusive parents. The approach used is, however, amenable to being adapted for emotionally abusive parents.

4.2.2 Enhancing sensitivity of hostile or intrusive parents of young infants

Interventions to enhance parental sensitivity and/or infant attachment security

The meta-analytic study by Bakermans-Kranenburg et al (2003) focused on improving the sensitivity or parents (primarily mothers) or improving the attachment security of infants. This involved parents who appeared to be at high risk of, or actually engaging in, neglectful or intrusive parenting. The most effective interventions were found to be brief, with a clear cut behavioural focus on enhancing parental sensitivity. Interventions that involve videofeedback (see interaction guidance, below) were found to be more effective in enhancing sensitivity than those that did not. Although only a small number of interventions (3 of 81) included fathers as well as mothers, the involvement of fathers was found to enhance sensitivity effects. Interventions that had a clear focus on enhancing parental sensitivity were also most effective in enhancing infant attachment security, which supports a the notion of a causal role of sensitivity in shaping attachment.

Interventions to enhance sensitivity of parents of infants with faltering growth

The emphasis of the interventions studied in this section was slightly different to the other groups due in part to the fact that all of the study samples involved parents of infants, and, interventions for parents of infants have on the whole been influenced by either a behavioural approach (i.e. mostly directly at changing problems with feeding and crying) or attachment and psychotherapeutic approaches (i.e. that focus more on the mother-child relationship). We did not identify any cognitive-behavioural interventions in this group.

Interaction Guidance

Interaction guidance is a behavioural strengths-based approach that focuses on changing the interactions taking place between a mother and baby. It involves videotaping mothers and infants at play, showing selected sections in order to highlight and review strengths, build competence and enhance motivation, and teach skills in detailed one-to-one coaching sessions. It is aimed at increasing maternal sensitivity and is a brief (6-7 week) intervention that can be used with families who have been hard to engage, or who have a limited capacity for introspection. There is a developing body of literature pointing to the effectiveness of interaction guidance with mother-infant dyads that are experiencing a

range of difficulties[122] but we were keen to examine its effectiveness in helping parents with a baby that has faltering growth.

We identified only one study that had evaluated the effectiveness of interaction guidance with this group of parents. [69] This compared the effect of a play-focused intervention form of Interaction Guidance, combined with training on feeding, with a feeding training intervention alone. The study measured not only sensitivity, but also reduction in mothers' 'atypical' (frightening and frightened) behaviours and in disrupted communications. Results showed that this modified version of Interaction Guidance was effective in decreasing atypical behaviours and disrupted communication. The authors conclude that their findings confirm those of other studies, which suggests that brief, focused interventions may be as effective as, or sometimes more effective than, longer-term programmes.

Home visiting by nurses or paraprofessional lay visitors

There is extensive evidence evaluating the effectiveness of different types of home visiting programmes. A recent review of reviews suggested that professionally delivered home visiting programmes can be effective in improving some outcomes in high risk parents and babies.[123] Studies that have compared professionally-delivered programmes with lay-delivered programmes, have on the whole favoured the former[124] particularly with high risk populations. We were once again keen to identify studies that had assessed their effectiveness with parents of infants with faltering growth but were only able to identify studies that had involved lay home visitors.[54/55 70] One of these studies showed delayed developmental and emotional decline of children in the intervention group at the four-year follow-up[54] and the second showed no evidence of effectiveness, particularly with mothers who have been defined at the outset as having severe negative affect (e.g. active hostility) in relation to their children.[70]

While the evidence on the effectiveness of home visiting programmes in reducing the incidence of abuse and neglect more generally is mixed,[116] this is due in part to the diversity of home visiting programmes that have been evaluated. One better quality programme has in fact demonstrated a role for home visiting programmes in reducing the

incidence of abuse and neglect in vulnerable parents[125], but did not include sufficient emotionally abusive parents to be included in the current review.

While the focus of this systematic review has been on secondary prevention and treatment, it should be noted that home visiting programmes have considerable potential in terms of the primary prevention of emotional abuse.

Parent-child psychotherapy

Fraiberg et al (1981) evaluated a child-parent psychotherapy (CPP) service provided in an outpatient psychiatric unit. The authors conclude that the intervention can bring about an improvement in a substantial proportion of extremely troubled parent-child relationships. The study, which provides information on each of the families treated and on the intervention, clearly involved families for whom this treatment was the last resort before children would be taken into care. However, this (rather early) trial did not include a control or comparison group, and did not include significance levels or the use of standardised instruments.

Fraiberg's pioneering study should, however, be set within the broader context of work on parent-infant/child psychotherapy, which suggests that it may be an effective means of improving parent-infant interaction.[126] There is a range of different types of parent-infant/child psychotherapy available, some based on more standard representational models of psychotherapy (i.e. that focus on changing aspects of the mothers internal world) and some incorporating behavioural components (e.g. Watch, Wait and Wonder[123]). However, research suggests that parents with particular types of attachment disorder (e.g. such as avoidant) are better suited to more behavioural than representational models of psychotherapy as a result of their inability to introspect about the role of earlier experiences on current parenting.[51] The attachment status of parents can be identified using the Adult Attachment Interview[127] or Parenting Bonding Instrument[128] and could be used to identify parents that would benefit from interventions, such as interaction guidance, that have a more behavioural orientation.

Behavioural casework

Iwaniec (1985a, 1985b),[56/57] explored the potential of behavioural social work for infants with faltering growth. The intervention was tailored to the needs of individual families and was highly flexible as a result. These studies suggested potential improvements in terms of the child's feeding and overall development, although the long-term effects on mother-child interaction were less clear, and the author points to the possible need for booster sessions. However, neither of these studies used a rigorous methodology (i.e. one group design and one case study), and as such, the premise of this intervention (i.e. that the building of more adaptive interaction during feeding and improved infant intake will result in improved parent-child relationship) requires further research.

While case studies suggest that behavioural social work can help some troubled parents and families, further research is needed to establish evidence and to see which groups of parents respond best to this treatment.

Multi-component interventions

The Austrian intervention discussed by Dunitz et al. (1996)[71]differs from the others presented here in several significant ways. First, unlike most studies of faltering growth which tend to focus on maternal-infant relations, this treatment involved both fathers and mothers and, in some cases aimed to involve extended family members, based on the premise that the syndrome may be affected by the father's attachment status, and by the relationship between the couple. Others have also pointed to the beneficial effect of the extended family in cases of faltering growth, and that grandparents and other relatives should be included when necessary.[129] Second, the psychological functioning of parents was evaluated by psychiatrists in the clinic where infants were being treated. This enabled clinicians to identify appropriate interventions and parents were also permitted to choose the treatment that they wanted. Different forms of psychotherapy, family therapy or counselling were available for the time they were needed and were paid for by the Austrian national health service. This study points to the value of diagnostic specificity - matching interventions to the needs of parents - and indeed, to the importance of taking the preferences of parents into account when planning treatment. No assessment of cost or cost-benefit was provided.

4.2.3 What works with substance-abusing parents?

Five studies[29, 30, 31] examined the effectiveness of intervening with drug-abusing mothers, and the findings of these point to the difficulties of intervening with this group of clients.

Two studies examined the effectiveness of the Parenting under Pressure programme.[74 76] Since drug addiction is almost invariably compounded by other problems) the programme also involves the promotion of social supports (helping socially isolated families access community resources and organisations), provides training in life skills and in improving quality of partner relationships. Two trials (one small scale pre and post intervention study and one larger scale RCT) found a reduction in child abuse potential, reduction in parental stress, improved child functioning and decrease in methadone dose of parents who participated in PUP. Results of the larger scale RCT were broadly consistent with findings in the earlier pre and post intervention study. Significant effects, favouring the intervention, were found in the parenting stress, child abuse potential and child behavioural indices of the PUP group. Independent reports of methadone consumption also found a reduction in the methadone dose of parents who participated in PUP. In contrast, parents who took part in brief parent training showed only a reduction in child abuse potential, with no change in parenting stress, child behaviour or parent methadone use. In the third group, which only received the standard care package provided by the methadone clinic, there was not only a lack of positive change, but an actual deterioration in adult functioning. These promising results suggest the need to address multiple domains of family life simultaneously, and to tailor interventions to the needs and desires of participating families. However, this study differs somewhat from those that follow in that participating parents were already on methadone maintenance.

Two studies examined the effect of attachment-based group psychotherapy for drug-dependent mothers of children aged 0 – 16 years. The authors argued for the benefits of an attachment-based intervention on the grounds that drug-abuse is likely to stem in part from unresolved attachment issues. Initial gains (in reducing risk of maltreatment and increasing the quality of maternal affect) reported for the Relational Psychotherapy Mother's Group (RPMG)[30] bore out the initial hypotheses of the authors. The RPMG capitalised on the desire of isolated, addicted women for affiliation. The follow-up at 6-

months of a second evaluation of this intervention, however, found no long-term benefits (Luthar et. al. et al., 2007)[29]. The authors concluded that women may have become more aware of what was missing in the deprived urban environment in which they conduct their everyday lives and experienced increased levels of distress as a result. As Steele (1968: 141) [130] observed: 'Termination of treatment can arouse once more the feelings of being deserted and rejected, and not rarely there will be a mild transient recurrence of tendencies to demand too much and be too aggressive toward the infant.' It is possible that support groups of this nature would be more effective if they were long-term and grounded in community-based, naturally occurring settings, in which new attachments could be created and sustained.

The Conners et al. (2006)[31] study showed limited benefits in terms of parenting, with limited improvements in either the drug-use of recipients or the well-being of their children, despite the use of a multimodal intervention that included a residential programme including methadone treatment, group counselling, parent training, educational and therapeutic activities for children and practical supports for housing and employment.

These findings suggest that while psychotherapeutic approaches appear promising in the short-term, more research is needed to identify whether and how changes can be sustained. It may be essential for adults to have achieved cessation of actual drug abuse before parenting behaviour and child outcomes.

4.3 ENGAGING AND RETAINING PARENTS IN TREATMENT

Crooks et al. (2006)[131] argued that parents who engage in any form of abuse need above all to appreciate their children's emotional and physical needs, and to begin to be able to prioritise their children's needs above their own. Only then 'will it be possible for them to benefit from more effective child management or broad-based parental support' (ibid: 72). A number of the case studies point to the importance of the parent's motivation to change, in terms of the overall value of the intervention, and that where motivation is low, it will not be possible to intervene successfully with parents. If motivation is low, there will

be many instances where children will need to be placed in the care of foster parents, or extended family members, because of the grave threat of parental abuse to the child.[72]

Where the level of abusive behaviour suggests the potential for intervention, the difficulties in engaging and retaining parents who emotionally abuse children in treatment cannot be underestimated.[20] Many parents in the case studies reported by the authors come to treatment because of the externalising problems (such as behaviour problems or feeding difficulties) of one particular identified child. Because the children are viewed by these families as being 'the problem', a shift in focus to the parents and family is often experienced by the parents as a profound threat. The need to note and monitor 'slipping back' and to make efforts to build professional links with other (sometimes competing) service providers was observed in some studies. Where the family has a tendency to leave treatment and start again with other agencies, it may be beneficial (with the parents' consent) to share information with other service providers. Teamwork also reduces the risk that individual staff can become enmeshed in the complex dynamics of families.

4.4 THE MISSING LITERATURE

A lack of coordination (in the UK and elsewhere) between adult mental health services, child and adolescent mental health and child protection services has been highlighted in several studies.[20 128] Partly because of this there is as yet no well-articulated evidence base on the effect on children, and on parent-child relations, of interventions for parents with severe mental health problems[132] although recent family-focused programmes – such as the Finnish Effective Family Programme - are moving towards a more integrated approach.[170 171 172] Craig (2004) undertook a systematic review of parenting interventions with adults with severe mental health problems but found only descriptive studies of interventions.[194] The majority of these studies involve integrated interventions that combine parent education (sometimes tailored for specific subgroups, such as mothers who have schizophrenia) with additional social and practical supports for vulnerable families. This review concludes that parenting programmes for mothers with mental health problems need to address the common problems faced by all parents as well as the challenges presented by specific forms of mental illness. The author cautions against the application of generic programmes that are successful with mainstream

populations, but equally urges the need for further research on what works with this population.

Recently**,** Hinden et al (2006[133] – see Appendix 2), undertook a qualitative study which involved 20 directors of targeted ('high specificity') programmes for parents with severe mental illness (SMI) and their families. These were selected from 53 such service providers in the USA that had been identified by the research team. Hinden et al. conclude from this work that future work with this group of clients should focus on the need for (i) intervening with the whole family; (ii) ensuring adequate housing for families; and (iii) parent education and support as a central feature of the treatment of mental health problems. The authors propose the need to adapt validated instruments that can measure intervention fidelity.

In spite of increasing awareness of the serious harm caused to children who witness domestic violence, little has been written on parent education for women who are being abused, or indeed, for men who are abusing their partners (see Peled et al., 2000).[134] There are clearly practical and ethical difficulties involved in parenting work with violent men but some interventions are emerging that have not yet been evaluated.[135] Two systematic reviews, included in Appendix 1, evaluate the effect of interventions to identify domestic violence in the antenatal or postnatal period and/or strategies to enhance protective behaviours of abused partners – almost invariably women – through, for example, access to shelters and community resources. One comprehensive study of individual trials and systematic reviews includes existing literature on programmes to change the behaviour of partner-battering men.

Similarly, the limited literature on the effect of interventions on the parenting of alcoholic parents did not meet our inclusion criteria because none were found that measured changes in the outcomes that were of interest to the current review. Again, some that most closely approximate our inclusion criteria are listed in Appendix 2.

4.5 IMPLICATIONS FOR PRACTICE

At present the evidence base relating to interventions to support parenting among parents who harm their children emotionally is very sparse. None of the studies we reviewed provide unequivocal evidence of the effectiveness of any of the evaluated interventions. However, the results are suggestive of the potential benefits of a number of methods of intervening. Because of the need to provide support to families in which children are emotionally abused, the following can be recommended:

- CBT including 'behavioural social work' delivered through a combination of individually tailored and group work;
- Interaction Guidance;
- Psychotherapeutic approaches including parent psychotherapy, parent infant psychotherapy and mentalisation training either on a one-to-one basis or in groups, and family therapy.

The psychological maltreatment of children has a variety of causes. It includes many forms of parenting behaviour and parent-child interaction, some of which are more satisfactorily classified as emotionally harmful, rather than abusive. This supports a shift in terminology from emotional abuse to 'emotionally harmful parenting', or 'emotionally harmful interactions'. The former would be commensurate with changes in policy which now emphasise family and parenting support rather than child protection. Such a shift in terminology may help health and social care practitioners to more readily identify the need for parenting- and child protection-related interventions when working with their adult clients or patients. Hopefully it would also help parents choose and engage with such interventions.

4.6 IMPLICATIONS FOR FUTURE RESEARCH

Emotional abuse is common and profoundly damaging to children. The paucity of research on the effectiveness of interventions is disquieting. There is an urgent need for research and development in this area and this should focus in particular on:

- Trials to establish the effectiveness and optimum method of delivery of CBT and psychotherapeutic approaches including:

  - Trials in which different interventions are provided on the basis of the parents' characteristics, such as attachment status, mental health diagnosis, experience of domestic violence or other current or previous forms of abuse, severity of emotionally harmful behaviours and interactions, and socio-demographic and economic variables;

    - Trials in which parents select their mode of therapy;

    - Trials using independent, reliable and validated assessment tools for a broad range of child, parent and parenting outcomes.

- evaluation of the long-term effectiveness of these interventions;

- evaluation of the effectiveness of interventions to support parenting in families where parents suffer mental health problems, abuse drugs or where domestic violence is present;

- methods of addressing emotional abuse in families with children over the age of five years;

- the development of diagnostic/outcome instruments that can be applied across different intervention types.

Appendices

Appendix 1

Theoretical Accounts underlying intervention studies

The following section introduces major theoretical accounts of emotional abuse: psychodynamic theory, attachment theory, behavioural/cognitive perspectives, family systems theory and ecological perspectives. Each of these has shaped the development of interventions to prevent, halt or address the effects of parental negative affect.

a) Psychoanalytic theory and socio-biological perspectives

In chronological terms, the earliest interpretations of child maltreatment emerge from psychodynamic theory. Steele and Pollock (1974)[136] postulated that abuse results from parents' unconscious anger towards themselves, and towards their own parents, vented onto children. Fraiberg et al. (1975)[137] introduced the metaphor of 'ghosts in the nursery' to describe the ways in which parents re-enact with their small children, their own unremembered but painfully influential childhood experiences of helplessness and fear. These 'ghosts' represent the repetition of the past in the present and express themselves as abusive or neglectful childrearing practices. Parents who have been traumatised find their children's needs and fears overwhelming and profoundly evocative, and as a result find it difficult to read the most basic cues without distortion or misattribution'.[138] Indeed, as a result of their own neediness and emotional immaturity, maltreating parents may feel that they are 'in competition with their children for care and attention' (Baumrind, 1994: 361).[139] They may simultaneously seek from their children the care they did not receive.[140] Intervention is difficult because parents who have projected their own fear and anguish onto children, may not recognise that there is a problem at all, or present themselves as angry or concerned about the child but seek assurance that the fault lies with the child.[20] As the recipient of the parent's negative attributions, the child comes to internalise a sense of self as unworthy and undeserving of love (Bowlby, 1951).[141]

One of the basic objectives of parent-child, or mother-infant psychotherapy is to help the parent understand how past experiences influence his/her feelings and beliefs about the child and enable him or her to begin to understand the child without distortion or

defence. The earliest approach, developed by Selma Fraiberg (1980) focused primarily on the mother's 'representational' world ('representation-focused' approach) or the way in which the mother's current view of her infant is affected by interfering representations from her own history, the aim of therapy being to help the mother to recognise the 'ghosts in the nursery' and to link them to her own past and current history, thereby facilitating new paths for growth and development for both mother and infant.[142] More recently representational and behavioural approaches have been combined.[123] 'Watch, Wait and Wonder' is an 'infant-led' parent-infant psychotherapy which involves the mother spending time observing her infant's self-initiated activity, accepting the infant's spontaneous and undirected behaviour, and being physically accessible to the infant. The mother then discusses her experiences of the infant-led play with the therapist with a view to examining the mother's internal working models of herself in relation to her infant (ibid).

There is a growing body of evidence pointing to the effectiveness of parent-infant psychotherapy[123] and suggesting that different forms of the therapy may be differentially effective for parents with different types of attachment status – including parents who are securely attached but who hurt their children for other reasons.[50]

b) Attachment theory

Building on psychoanalytic theory, Bowlby (1951)[138] developed the concept of attachment - an instinctual, two-way process by which infants use skills one is born with, such as smiling, grasping and crying, to initiate a bond with their mother that satisfies their need for protection, food and nurture. Depending on the availability and willingness of a primary carer to protect and provide for them, infants form an internal working model – a representation - of their own worthiness, other people and themselves in relation to other people; this in turn, affects behaviour, relationship style, social competence and engagement with the social world.[143]

Children then construct, 'at an early age, a model that best fits the reality that he or she experiences as the child grows older'(p. 366).[136] An infant who experiences a cold, detached response from a primary carer (for example, when crying for help) may develop an attachment style that shuns making demands or intimacy with others. As

the recipient of the parent's negative attributions, the child comes to internalise a sense of self as unworthy and undeserving of love.[138]

When the source of danger is the carer (typically a maltreating parent) 'children's attachment behaviour becomes increasingly incoherent and disorganised, showing a mixture of avoidance, anger, disorientation and inertia' (p.29).[144] In their observations of mothers and infants, Main and Hesse (1990)[137] identified a series of actively hostile, frightening and frightened behaviours by mothers that they called 'atypical' or 'Fr-behaviour'. These behaviours can be subtle (for example, periods of being dazed and unresponsive) or more overt (deliberately frightening children). Several instruments have been developed to measure parent's engagement in these behaviours. A coding system introduced by Main and Hesse (1992)[145] to assess 'Fr' behaviour has been developed by others, and has shown strong association between Fr-behaviour and maternal unresolved loss.[146] This research suggests that 'Fr' behaviours are distinct from neglect and express a distorted image of the child which is the consequence of the mothers' unresolved trauma and losses.

Not all emotionally abusive parenting involves negative affect.[20] Parents' unresolved trauma and loss can be expressed, for example, as fear for and over-protectiveness of a much loved child. Boulton and Hindle (2000) provide an example of a child who developed agoraphobia as a consequence of never being allowed out of the house. However, they conclude that this damaging over-protectiveness of a much-loved child also flows from unresolved trauma and loss.

The central aim of attachment-based interventions is to improve the sensitivity of the parent to the emotional needs of the child, and in particular to their need for a secure and reliable base. Attachment-based components can be integrated into a range of intervention strategies (see Bakermans, 1995 for example).[51]

Mentalisation theory, an emerging model of intervention, builds on both parent-infant psychotherapy and recent advances in advances in attachment theory. Applied to parenting, it involves enabling parents to come to understand their child as an intentional being.

c) Cognitive-behavioural perspectives

An influential framework for understanding child maltreatment emerges from social learning theory, which proposes that human behaviour is governed by a system of costs and rewards and virtually all learning occurs on a vicarious basis by observing other people's behaviour and evaluating whether this has desirable outcomes.[147] This purports that children are emotionally abused because parents have learned dysfunctional child-management practices.[65]

Numerous studies have shown that parents who maltreat often have unrealistically high expectations of their children's developmental capacities, the age-appropriateness of child behaviours and their own behaviour where interacting with children. Cognitive distortions can result in negative attributions of children's intentions and behaviour, as is the case when infants' crying is perceived as an attack on the parent, or when parents have unrealistically high expectations of their children's developmental capacities. When people believe that the ambiguous actions of others stem from malevolent intentions, they are much more likely to retaliate than if they can perceive other motives.[148]

These distortions are influenced by the immediate and wider social environment. Socially isolated parents are less likely to change their ideas about children since they do not benefit from the insight of others.

Parenting is clearly embedded in the mores and values of their immediate environment and those of wider society. Historical and cross-cultural accounts also show that what is now considered to be emotionally abusive may be understood in some contexts as responsible parenting aimed at toughening children up for adult life or even for serving the needs of the state.[149] [150] Childrearing strategies, and the cognitive framework that underpins them, are as such influenced by the mores and values of wider society, and to some extent by the wider context in which adults have been socialised.

Newberger and White (1989)[151] suggest parents perceive their children in one of three ways: as an extension of themselves (their property); as 'a child' to whom conventional roles are attributed; or an individual who has his/her own evolving identity and needs. Parents are most likely to maltreat children who they perceive as their 'property' – a belief which is to some extent influenced by the mores of their immediate and wider social context. In addition, parents can develop rigid expectations of their children which lead them to use high-power control strategies early.[50] In affluent societies, where the cost of raising a child is high, children may be emotionally maltreated for failing to meet their caregivers' social or personal aspirations.

The central theory underlying cognitive behaviour therapy is that our thoughts or attitudes mediate between external events or stimuli (perceptions) and our emotional responses and actions. Cognitive-behavioural approaches to child abuse focus on helping adults to change the way in which they perceive children, and the ways in which they interpret their own and their children's behaviour, by helping parents identify, confront and change their thinking and develop better child-management skills. While many practitioners with a cognitive-behavioural orientation recognise that cognition is shaped by attachment and that a parent's experience of secure or insecure attachment influences their ability to read children's signals or interpret them correctly[152] cognitive-behavioural parent training is primarily concerned with changing parents' thoughts, beliefs and behaviour in the present, rather than analysing the role of past influences.

d) Systems theory

Although family therapy is an eclectic discipline, it draws substantially from Minuchin's (1974)[153] work on family systems. Minuchin theorised that families have two principal subsystems – that of parents and that of children. Clear, but permeable boundaries are required between the two in order to ensure the healthy functioning and communication of family members. Boundaries are blurred when children are used for instrumental purposes, in order to act as parents to adult caretakers with profound unmet emotional, when they are deployed as 'hostages' in conflict between adults.[154] While short-term caretaking responsibilities may be necessary and actually beneficial to children, 'destructive parentification, where children internalise ongoing expectations to care for parents' practical and emotional needs, has been associated with a range of

psychological difficulties including depression, shame, anxiety and social isolation' (p.469).[155] Finally, attention has been drawn to the way in which a particular child becomes the scapegoat for conflict within the family. Children who are scapegoated may respond through externalising behaviour (by becoming 'difficult to control') and drawing further attacks.[151] Alternatively the boundaries between parents and children can be so rigid that adults are unavailable, cold and distant. Parents can fail to recognise a child's psychological boundaries 'when a parent's poor sense of self, extreme self-centeredness and preoccupation with their own emotional needs, which may include substance misuse, or a deep sense of identification with the child may all lead to the exploitation and detriment of the child' (p.76).[156]

Family therapy seeks to change maladaptive interactions rather than the behaviour or a single individual. Sessions may involve one or two members, parents and children, or even extended family members.

e) Ecological Theory

Early research on child maltreatment focused on individual psychopathology, but from the 1970s the shift moved from psychiatric profiles to a more social psychological approach that explored interactions between parents and children, between families and their immediate environment and (to a lesser degree) the culture and society in which they are embedded. Today, the most widely accepted model for understanding parental violence and neglect, and to some extent sexual abuse, has evolved from the ecological theory of human development.[157] This incorporates many single factor approaches in to a complex explanatory account and concludes that child maltreatment is a social-psychological phenomenon 'multiply- determined by forces at work in the individual, the family, as well as the community and the culture in which the individual and the family are embedded'.[158] [159]

The ecological model recognises that human beings operate within a series of connected or 'nested' environments, each of which contains cultural and environmental factors that exacerbate or diminish the risk of maltreatment.[160] [161] The overall likelihood of child maltreatment results from the combination and interaction of factors which enhance or diminish the potential for maltreatment.[162] Chronic stressors (such as social isolation/

lack of neighbourhood social capital, endemic poverty, poor quality housing) are associated with increased risk of physical and emotional abuse and neglect.[177] From a systemic perspective, unexpected crises (such as redundancy, housing repossession or exile) can affect the organisation of an otherwise functioning family and increase the risk of aggression towards children.[192] The likelihood that chronic or unexpected stress leads to child maltreatment is mediated by the characteristics of individual parents, by the supports available to them and by the values and attitudes towards children of immediate and wider society.

Risk is particularly high in poor areas with low levels of 'social capital' - formal or informal social organisation accessible to individuals and the shared values and trust that underpin it.[163] Empirical studies emphasise the detrimental effect of social isolation on parents, particularly on mothers.[164] Conversely, studies in the US suggest that risk factors appear to be reduced by high levels of social capital, church affiliation, the maternal caregiver's perception of personal social support and support within the neighbourhood.[165]

From the perspective of a critical community psychology, to identify abusive parents, without addressing the social conditions that undermine parenting, risks turning parents into the scapegoats for social dysfunction.[166] In the words of Marneff, it is necessary to offer 'services for abusive parents [that] we would like to use for ourselves' - services to which parents can turn to without fear of judgement and judicialisation.[167]

Interventions that work from an ecological perspective seek to address risk factors at several levels at the same time. This can include simultaneously addressing the parent's emotional needs (for example, through forms of therapy), providing practical support and advice, working with children and seeking to integrate the family into social supports and networks.[168] Interventions working from a cross-cultural perspective take into account the role of extended families and kin in the transmission of cultural norms that may support or undermine children. Such interventions generally respond to identified risk to the child (of physical violence and neglect or risk of sexual abuse) rather than emotionally abusive parenting.

Appendix 2: Summary of included studies

1.a Sanders et al. (2004)

Study design: Randomised controlled trial with 2 x 3 repeat measures. Assessment was made at baseline, post-intervention and at 6-month follow-up by 14 practitioners (1 clinical psychologist, 8 final year postgraduate psychology students, 2 psychologists, 2 social workers, 1 teacher). No allocation concealment; raters blinded.

Objectives: To evaluate the effect of a standard and an enhanced version of the Triple-P parent training programme on parents' negative attributions and anger management.

Participants: 98 parents, who were *either* identified as emotionally abusive by a paediatric assessment centre, outpatient clinics, or social workers *or* who self-referred following media outreach about the project (including newspaper articles and radio interviews), were randomised into standard (n=50) and enhanced treatment groups (n=48). Most participants were married women, average age 34, with a child aged 2 – 7 years. Half had completed secondary education.

Participants had to meet the following selection criteria (a) parent had received at least one notification to the child protection services for potential abuse or (b) parent expressed concern regarding difficulty in anger control and scored within an elevated range on three subscales of the State-trait Anxiety Inventory (STAXI; Spielberger, 1996). The group also included parents who self-referred because of concern about their anger or fear that they would harm their child.

Families who were receiving family therapy or psychodynamic intervention targeting parenting or child behaviour were excluded, as were families in which a child or parent had learning difficulties.

Loss to follow-on: Of 98 families that began the trial, 86 completed the intervention (12% dropped out). A further 2 (2%) were uncontactable at 6-month follow-up.

Theoretical foundation and content: The intervention compared the effect of the standard Triple-P parenting programme (Standard Behavioural Family Intervention, SBFI) with an enhanced version of the same programme, which incorporated attributional retraining and anger management (Enhanced Behavioural Family Intervention, EBFI). Parent training teaches parents to increase positive interactions with children and to reduce coercive and inconsistent parenting practices. Group-based interventions offer a way of reducing social isolation, increasing support and modelling positive behaviour.

Although there is much research on the effectiveness of Triple-P, findings suggest that standard CBT is not enough to create lasting change in the interactions of abusive families and suggest the need for attributional retraining and for regulation of anger and negative emotion (Whiteman et al. 1987). Parental anger has been associated with poor adjustment and control; when combined with hostile attributions, parents' deficits in anger control are positively correlated with an increased potential for child abuse.

The standard version of Triple P (SBFI) involves teaching parents 17 core child management techniques over four 2 hour sessions and four telephone conversations with trainers, which last between 15 – 30 minutes. Ten child management strategies involve promoting children's competence and development (e.g. praise, engaging activities, incidental training) and seven are designed to help parents manage misbehaviour (setting rules, logical consequences, quiet time and time out). In addition, parents were taught a planned activities routine to introduce and maintain parenting skills. This included anticipating and preparing for high-risk situations. The SBFI involved four sessions, once a fortnight, over 8 weeks.

EBFI consisted of the SBFI, with four additional 2-hour sessions addressing risk factors associated with child abuse and neglect and four telephone conversations. The EBFI usually lasted 12 weeks. Parents were taught physical, cognitive and planning strategies to manage their anger, as well as to anticipate and prepare for it.

Measurement of outcomes:

- *Family background interview:* Observation of child behaviour, using a 30 minute video recorded home intervention. Observations were coded in consecutive 10 minute intervals using the Revised Family Observation Schedule (FOS-R; Sanders, Waugh, Tully & Hynes)
- *Measures of risks of maltreatment:* Parents Attributions of Child's Behaviour (PABCM; Pidgeon and Sanders et al., 2002); State-Trait Anger Expression Inventory (STAXI, Spielberger, 1996); Parental Anger Inventory (PAI; Hansen and Sedlar, 1998); Child Abuse Potential Inventory (CAPI; Milner, 1986); Parent Opinion Questionnaire (POQ; Azar and Rohrbeck, 1986)
- *Parenting measures:* Parenting Scale (PS; Arnold, O'Leary, Wolff and Acker, 1993); Parent Sense of Competence (PSOC; Gibaud-Wallston and Wandersman, 1978).
- *Parental Adjustment Measures:* Depression-Anxiety Stress Scales (DASS; Lovibond and Lovibond, 1995); Parent Problem Checklist (PPC; Dadds & Powell, 1991)
- *Measures of Child Behaviour:* Eyberg Child Behaviour Inventory (ECBI; Eyberg & Pincus, 1999); Parent Daily Report Checklist (PDRC; Chamberlain & Reid, 1987).
- *Measures of Parenting Contexts for Child Behaviour Problems:* Home and Community Problem-solving Checklist (HCPC; Sanders and Dadds, 1993); Client Satisfaction Questionnaire(CSQ): Evaluated the quality of service provided by the programme.

Limitations of the study: The majority of the participants had not been formally notified for child maltreatment. Although formal notification is a very crude indicator of abusive parenting, results need to be treated with caution. The most severely emotionally abusive parents are unlikely to recognise that they have a problem at all (Main and Hesse, 1990) and are unlikely to enrol because of their own concerns. The study did not include a no-treatment control which reduces the capacity to rule out maturational effects or regression to the mean as an explanation for improvements.

1.b Toth et al. (2002)

Study type: Quasi-experimental design with 2 x 2 measures which compared two interventions for maltreated preschoolers and their mothers. No allocation concealment; raters blinded.

Aim: To compare the effects of two interventions (psychodynamic and behavioural) that involved mothers and children on children's representations of self and self in relation to others.

Sample: 122 mothers and their pre-school children (87 maltreated and 35 non-maltreated) served as participants. Of these, 38% were referred for emotional abuse alone or emotional abuse and neglect. Maltreating parents were randomly assigned to either preschooler parent psychotherapy (PPP, n=23), psychoeducational home visitation (PVH, n = 34), or community standard (CS, n=30); and non-maltreating parents were assigned to a no intervention control group (NC=35) and their families served as comparisons.

Drop-out/loss: 8 of 31 in PPP, 14 of 48 in PVH, 2 of 30 in CS and 8 of 43 in control. Total of 122 of 155 recruited at baseline completed treatment.

Theoretical foundation and content:

Preschool Parent Psychotherapy (PPP)

This model (which is a form of parent-infant psychotherapy) aims at fostering attachment in order to promote positive child development, improve parent-child interaction and reduce all forms of child maltreatment. It is grounded in the belief that cognitive behavioural focus alone is insufficient to alter the complex maladaptive behaviours that lead to child maltreatment.

The core of the PPP model focuses on the mother's interactional history and its effect on the representation of her relationship with the child. This model links the maternal past with current perceptions and responses and focuses on transforming the relationship.

Therapists see mothers (in the clinic) for weekly 1 hour sessions. Instead of modifying parental behaviour or giving instructions, the therapist assists the mother in recognising how her representations are enacted in her representations of the child.

Psychoeducational home intervention (PVH)

The second form of intervention is grounded in an ecological-transactional developmental model of child maltreatment together with psychoeducational and cognitive-behavioural techniques for addressing parent skills training, maternal self-care and the development of adaptive competences in children. The intervention involves home based, weekly, 60-minute sessions with a clinical therapist. The initial goal is to conduct an assessment of the risk and protective factors present in the environment. Sessions focused on parent education regarding child development, parenting skills and self-care skills. Therapeutic sessions were grounded in the present and involved teaching mothers specific skills and practices.

Community Standard (CS):

The CS was a comparison group receiving standard services available through the Department of Social Services (DSS). These varied according to an assessment of the needs of individual mothers and children. Some mothers were receiving individual psychotherapy, counselling, parenting assistance and practical help in securing accommodation.

Methods/measures:

- *Child Measures:* Eleven 'Story Stems' were selected from the MacArthur Story Stem Battery (MSSB, Bretherton et al., 1990b) and the Attachment Story Completion Task (Bretherton et al., 1990a). All children were administered the set of Story Stems pre and post intervention. Codings of maternal representations were derived from children's narratives. These included positive mother, negative mother, controlling mother, incongruent mother and disciplining mother.
- An abbreviated version of the WPPSI-R was used to test children's intelligence.

Limitations of the study: Only 37% of participants reported for emotional abuse and emotional neglect alone. No follow-on evaluation.

1.c Iwaniec (1997)

Design: A 2 (Treatment Groups) x 2 (Time periods) model evaluated pre- and post-test. No allocation concealment and no blinding.

Aim: The study compared the effect of home based, individual cognitive-behavioural parent training (CBT) with the combination of individual and group based CBT on parents' negative attributions of children's behaviour and their anger management. Children's outcomes were also assessed.

Participants: 34 parents (20 women and 14 men) referred by paediatric assessment centre, outpatient clinics and social workers for emotional abuse and neglect. Participants were randomised into two groups of men, women, single parents, stepparents and couples. Parents' mean age 26 in Group 1 and 27 in Group 2. Age of children is not specified. Allocation concealment was not possible. No drop-out/loss reported. Parents in both groups had high rates of trait and strait stress and anxiety. Fathers attributed this to worries about money and employment, mothers to inability to manage children's behaviour, and both to fear that children would be placed on the Child Protection Registry. No loss to follow-on is mentioned.

Theoretical foundation and content: The intervention involved two forms of cognitive-behavioural parent training (CBT) premised on the belief that emotional abuse and neglect can arise from a lack of knowledge of the physical and psychosocial needs of children, as well as from a lack of parenting skills and support systems that might help parents achieve a more positive, less stressful experience of child rearing. Moreover, children's behaviour can reinforce parents' negative attributions of the child, creating a cycle of mutually damaging interactions. CBT aims at helping parents develop childrearing skills and helps parents understand children's developmental needs.

The author hypothesised that the combination of group-based and individual CBT would be most effective in modifying parents' perceptions of children and their anger management. Since emotionally abusive and neglectful parents are often socially isolated, group-based parent education offers an antidote to this. However, since abusive parents may be reluctant to expose themselves to strangers, the author argues that individual parent training is necessary to prepare them for learning in public and engage in shared, group-based problem-solving.

The intervention consisted of (i) home based, individually-tailored parent training or (ii) a combination of home-based and group-based training. Both home-based and group-based training were offered weekly over a ten-week period. Each session of group-based training lasted around two hours.

Individual parent training:

Trainers agreed content and expectations with parents prior to starting, but home based training covered the following topics:

Developmental counselling: in order to create realistic expectations of children's evolving capacities; trainers presented developmental charts and discussed these with parents. Parents were given literature to read between sessions.

Improvement of parent-child interactions: parents and trainers discussed parents' attitudes and feelings, and show how behaviour is learned and maintained.

Managing children's and parents problem behaviour: the third aspect showed parents how to set and maintain rules and boundaries. Videotaped vignettes were used to show positive reinforcements and techniques to deal with difficult behaviour.

Each session was mutually evaluated and outcomes recorded. Educators telephoned parent between sessions to assess their progress, offer advice and provide positive reinforcement.

Group-based parent training:

Parents were consulted in advance on the content and methods of the group training. Each session lasted two hours. A play group for children was provided, as was transport for parents who needed it.

The major objective of the training was to provide: (a) stress-management skills (b) self-control training (c) problem-solving abilities and (d) a forum for mutual support and establishment of social contacts. Each workshop has three sections: feedback on work between sessions; role-playing and exercises on new skills; and discussion of difficult issues (scenarios) and problem-solving.

Outcome measures: The following outcome measures were used

- *Goal attainment setting:* Degree of improvement in nine targeted areas were defined in terms of goals achieved, rated on a Likert scale. Final ratings were expressed as +2 all goals achieved and high level of satisfaction; +1 some goals achieved; 0=no change; -1 slight deterioration; -2=definite and sustained deterioration.
- *Parental emotionally abusive behaviour***:** Social worker's observations of mother-child interactions. 22 forms of emotionally abusive behaviour (such as active maltreatment, neglect and mis-socialisation) were identified. Behaviours were rated as occurring often, occasionally, and almost never during training sessions.
- *Child's reactive and proactive behaviours*: Social worker's observations of mother-child interactions.
- *State-Trait anxiety:* The Strait-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch and Lushene, 1970)
- *Personal parenting stress ratings:* parents rated levels of personal stress on a Likert scale at the beginning and end of each session.
- *Post-treatment parental questionnaire:* established comparison of parent-child relationship before and after the intervention. The questionnaire involved a Likert scale ranging from positive to negative, anchored to operational criteria.

Limitations of the study: The sample is small and no information is provided on the nature of parents' emotional abuse. Assessment of parental emotionally abusive behaviour and child's reactive and proactive behaviours was made on a rating form designed by the authors for the purposes of this study. Although definitions of emotionally abusive behaviour were strictly observed when recorded, no reliability checks were made. No validated instruments were used for parents' post-treatment self-report.

2. Interventions to enhance parental sensitivity

Bakermans-Kranenburg et al (2003)

Study type: Meta-analysis of seventy published studies (which included 81 interventions), that present the effects of 88 interventions on enhancing sensitivity (n=7,636) and/or attachment (n=1,503).

Aim of the study: create a quantitative synthesis, and measure the effect of, interventions that aim at enhancing mother-infant sensitivity and attachment in infancy.

These studies do not address attachment disorganisation, prevent disorganisation or aim at preventing and changing parents hostile, frightening and/or frightened behaviour. Promotion of maternal sensitivity and measurement of infants attachment security act as proxy measures for change of parental behaviours.

Sample: Mothers (78 interventions) and mothers and fathers (3 interventions) from a wide range of SES, racial and age characteristics.

Coding system:

A detailed coding system was used to rate every intervention study on design, sample and intervention characteristics. Design characteristics included sample size, randomisation, absence or presence of a control group, and the study's attrition ate. To test the effectiveness of the interventions for specific populations, features of both involved parents were coded. This included for example, their SES, adolescence, clinical reference, or a high sociodemographic risk; characteristics of children (eg prematurity, irritability, international adoption). When reported the percentage of insecurely attached children was included as indicator of the risk for attachment related problems in the sample. Intervention characteristics were the number of sessions, the age of the child at the start of the intervention and the status of the intervener (professional or nonprofessional). In addition, studies were coded according to whether

they took place in the family home and whether video feedback was used as an intervention tool. Finally, the intervention was coded according to whether it aimed at enhancing parental sensitivity, affecting parents' mental representations, providing social support, or any possible combination of these approaches.

Design characteristics: Sample size, randomisation, absence or presence of a control group and attrition rate.

Characteristics of parent and children: SES, adolescent parenthood, clinical history and high risk factors such as poverty, social isolation and single parenthood. Characteristics of children included prematurity, irritability and international adoption.

Focus of the intervention:

Interventions that aimed at enhancing parental sensitivity: e.g.

- Affecting parent's mental representations
- Providing social support
- Any combination of the above

Intervention characteristics: the number of sessions, child's age at the beginning of the intervention, status of the person carrying out the intervention (professional or non-professional), whether the intervention took place in the family home or a clinic, whether videofeedback was used.

Results:

Maternal sensitivity: A core set of 51 randomised control studies was established. These involved 6,282 mothers with their children. The effect of interventions on maternal sensitivity in random studies was moderate but significant (d=0.33, p=0.001). The effect size for all studies was d=0.44. The effect for non-random studies was larger at d=0.61). Since this suggested inflated effects for the non-random studies, most findings reported concerned the 51 RCTs.

Randomised studies:

- Contrary to expectations, it was found that interventions that focused on sensitivity alone were more effective (*d*=0.45, p<0.001) than interventions that combined sensitivity and support (*d*=0.27, p<0.001).

- Effect of interventions on maternal sensitivity in random studies was moderate but significant (d=0.33, p=0.001). The effect size for all studies was d=0.44. The effect for non-random studies was larger at d=0.61).

- Interventions that focused on sensitivity alone were more effective (*d*=0.45, p<0.001) than interventions that combined sensitivity and support (*d*=0.27, p<0.001).

- Interventions starting after the child was 6 months old (*d*=0.44) were more effective than prenatal sessions (*d*=0.32) or interventions during the child's first six months (*d*=0.28)

- Interventions with videofeedback (*d*=0.44) were more effective than those without (*d*=0.31).

- Four interventions that did not involve direct contact with the client, but that increased physical contact through the provision of baby carriers (the 'kangaroo') method), included a workbook on responsiveness or videotape showed the largest effect size (*d*=0.62). However, the difference was not significant.

- Interventions with fewer than five sessions (*d*=0.42) were as effective as interventions with 5 to 16 sessions (*d*=0.38) and more effective than interventions with more than 16 sessions (*d*=0.21)

- The effect of interventions conducted in the home (*d*=0.29) was not significantly different from those conducted in other settings (eg clinics) (*d*=0.48).

- A meta-analysis of the subset of samples showing multiple problems showed that interventions by non-professionals showed a larger effect size than those from professionals (*d*=0.42 and *d*=0.26 respectively).

- Interventions involving fathers (n=81) significantly more effective (d=1.05) than those which involved mothers alone. (based on 3 non-randomised trials)

- Combined effect size for attachment security was small but significant (*d*=0.20, p<0.05)

- Interventions that aimed at enhancing sensitivity – without focusing on social support or changing mother's representations of the infant –were the only ones to show a significant effect size (*d*=0.39, p<0.01).

- Most sample characteristics (e.g. adolescent motherhood, SES) were not significant moderators.

- A multiple regression analysis showed that sensitivity-focused interventions and later start of intervention produced higher effect sizes, even controlling for other factors, such as SES or adolescent motherhood.

Attachment:

Twenty-nine intervention studies (involving 1,503 participants) and which used attachment security as an outcome measure were analysed. The effect size for attachment security was, again, small but significant (*d*=9.19, p<0.05) for all studies; for 23 randomised controlled trials, *d*=0.20, *p*=0.05. The authors addressed three specific questions:

1) What is the effect of interventions on infant attachment security (based on analysis of 23 RCTs):

- *A meta-analysis was conducted of 23 RCTs of interventions aimed at enhancing infant attachment security. Findings were:*

- Interventions that aimed at enhancing sensitivity – without focusing on social support or changing mother's representations of the infant – were the only ones to show a significant effect on infant attachment security (*d*=0.39, p<0.01).

- Interventions that started later – after the age of 6 months – showed a significant effect size (*d*=0.31) and significant difference with interventions that began in the pre- or immediately post-natal period. Interventions with fewer than five sessions showed a significant effect size on infant security (*d*=0.27.

- Interventions that did not use videofeedback showed a significant effect size (*d*=0.25) compared to other interventions.

- Most sample characteristics (e.g. adolescent motherhood, SES) were not significant moderators.

2) What is the effect of short, behaviourally focused attachment interventions compared to more intensive treatment of multiply-troubled families?

A meta-analysis was conducted of 15 RCTs involving families with multiple problems. Findings were:

- *A meta-analysis was conducted of 15 RCTs involving families with multiple problems. Findings were*:

- Interventions focused on sensitivity alone were more effective than all other categories of intervention combined (d=25, p<0.02). The most effective interventions involved less than 16 sessions. Interventions with less than 5 sessions (d=.033) were as effective as interventions with 5 to 16 sessions (d=0.36) but both more effective than interventions with more than 16 sessions (d=0.20, p<0.007)

- Nonprofessional intervenors (d=0.42) were more successful than professionals (d = 0.26). Contrast was significant at p<0 .003). One study that involved videotape as a means of intervening was effective without further support (d=0.54).

3) Are interventions that succeed in enhancing sensitivity also more effective in enhancing infant security and attachment?

- Studies with the largest effect sizes for sensitivity (*d*=0.40) were also the most effective in enhancing children's attachment security (*d*=0.45, *p*<0.001). The most effective sensitivity interventions (d = 0.40) were also the most effective in enhancing attachment security (d= 0.35).

Conclusion:

Interventions that focus exclusively on enhancing maternal sensitivity appear to be most effective not only in achieving greater maternal sensitivity but also in promoting children's attachment security. Short term interventions are as likely or more likely to be effective as those of longer duration.

2.1 & 4.2.2. Black M et al. (1995); Hutcheson et al. (1997)

This study took place in two phases. The first study assessed the effect of home intervention for faltering growth infants one year after completion (Black et al., 1995). The second study focused on the effects of demographic risk factors and parenting style/maternal negative affect on children's development four years from baseline (Hutcheson et al., 1997). Parenting styles of faltering growth mothers had been identified and defined in an earlier study (Black et al., 1994).

Study type: Randomised controlled trial evaluated at baseline followed by repeated ANCOVA over the intervention period, at 12 and 18-month follow-up (Black et al., 1985)

and four years from baseline (Hutcheson et al., 1997). Data collection at 12 and 18 and 4 years post-intervention. No allocation concealment; raters blinded.

Aim of the study: To evaluate the efficacy of a home-based intervention on the growth and development of children with non-organic failure to thrive. The follow-on study (Hutcheson et al., 1997) examined the moderating effects of maternal psychological functioning and demographic risk status on the impact of home intervention four years after the original intervention began.

Participants: At baseline, the study consisted of 130 children (mean age 12.7 months) of predominantly African-American, low-income single mothers with an average of 10.8 years schooling. Mothers and infants were referred by urban paediatric primary care clinics. They were randomised into two groups: infant feeding programme at a multidisciplinary growth and nutrition clinic plus home intervention (n=64) or clinic only (n=60) (Black et al., 1995). At the follow-up phase (Hucheson et al.1997), four years later, the infants were within six months of their 4th birthday. Apart from age, there was no change in the profile of participating mothers.

Loss to follow-up: Data available was for 116/130 children at the end of 12 month intervention (Black et al., 1995). 76/130 children were available for the follow-up evaluation four years after the intervention began (Hutcheson et al., 1997)

Theoretical foundation and content: The intervention was grounded in an ecological model. It involved a therapeutic alliance between home visitor and parent, and support for the mother's personal, family and environmental needs. The intervention group received a combination of services in a growth and nutrition clinic and home visiting by lay home visitors, who were supervised by a community health nurse. The control group received treatment at the growth and nutrition clinic alone.

The aim of the home based intervention was to support mothers, promote better parenting, and foster child development through a combination of parent training, and helping parents access informal and formal resources providing advocacy on parents

behalf. Families received an average of 19.2 (SD, 11.5) visits a year, each of which lasted 1 hour.

The Hawaii Early Learning programme was delivered by lay home visitors using a curriculum guide for parent-child interaction and child development phases. An individualised service was created to meet the family's needs. Mothers were encouraged to keep a logbook, personalised notebooks and photographs of children. Home visitors provided toys and mats to model play and the creation of toys out of household materials.

Methods/measures:

Phase 1 (Black et al. 1985).

- *Infant growth:* Delecto-Medic Scales (Brooklyn, NY).
- *Infant cognitive and motor development*: Bayley Scales of Infant Development (Bayley, 1969)
- *Infant language development: receptive/expressive language scale:* (REEL; Bzoch & League, 1991).
- *Parent-child behaviour during feeding:* Parent-child Early Relational Assessment (Clark et al., 2004), modified for African-American families.
- *Home environment:* Home Observation for Measurement of the Environment (HOME) Scale. This involves six scales, and includes measurement of mothers' emotional and verbal responsiveness.

Phase 2 (Hutcheson, 1997)

- *Maternal psychological functioning* was measured at baseline using a combination of the Brief Symptom Index (BSI, Derogatis and Spencer, 1982). Subsets measuring depression, hostility and anxiety were used. Questionnaires were administered orally to control for literacy levels. Data collection measures were repeated one year after recruitment and again when children turned four.
- *Demographic risk* was calculated by summing positive indicators on six categories: maternal age under 18 at the index child's birth, maternal education less than high school, high household density, poverty status, presence of only

one adult in the household, and adult's never having had a job. At baseline 5% of families were identified as having no risk factors and 49% had at least three. Poverty was the most common risk factors. Maternal psychological and demographic risk indices were similar across the home intervention and clinic-only groups.

- *Children's height for weight* was measured pre-intervention using Delcto-Medic (Brooklyn) scales; gender specific charts from the National Center for Health Statistics**.**
- *Children's interactive behaviour* was measured using a modification of the Parent-Child Early Relational Assessment (PCERA; Clark, 1985) validated on low-income African-American children and families.
- *Children's behaviour during play* was coded using global ratings of preschool children's behaviour with their parents. Three scales were identified (task engagement, negative affect and warmth) (Cohn, Cowan, Cowan and Pearson, 1992).
- *Child developmental outcomes* were measured using the Bayley Scales of Infant Development at the end of the intervention period (Bayley, 1969); the Battelle Developmental Inventory at age 4.

At baseline and following the intervention, children and parents were videotaped during a meal. At the 4-year follow-on year visit parent and child were seated at a table, asked to work on several puzzles and parents were asked to behave as they did at home. Observations were coded using measures drawn from the PCERA (Clark, 1985). Three scales have been identified (task engagement, negative affect and warmth) which enable individual items to represent a global rating for continuous parent-child interaction over a 10-minute observation period.

The impact of demographic and maternal psychosocial risk factors on changes in children's cognitive and motor development and behaviour from baseline to the close of intervention were examined by eight multiple regression analyses.

Limitations of the study: This study demonstrates that maternal negative affectivity moderates the effect of this intervention but does not show how that process works or

why the moderating effects of negative affectivity were not evidence at the close of the intervention.

Enhancing sensitivity of parents of infants with faltering growth (FTT)

2.1 & 4.2.2. Black M et al. (1995); Hutcheson et al. (1997)

This study took place in two phases. The first study assessed the effect of home intervention for faltering growth infants one year after completion (Black et al., 1995). The second study focused on the effects of demographic risk factors and parenting style/maternal negative affect on children's development four years from baseline (Hutcheson et al., 1997). Parenting styles of faltering growth mothers had been identified and defined in an earlier study (Black et al., 1994).

Study type: Randomised controlled trial evaluated at baseline followed by repeated ANCOVA over the intervention period, at 12 and 18-month follow-up (Black et al., 1985) and four years from baseline (Hutcheson et al., 1997). Data collection at 12 and 18 and 4 years post-intervention. No allocation concealment; raters blinded.

Aim of the study: To evaluate the efficacy of a home-based intervention on the growth and development of children with non-organic failure to thrive. The follow-on study (Hutcheson et al., 1997) examined the moderating effects of maternal psychological functioning and demographic risk status on the impact of home intervention four years after the original intervention began.

Participants: At baseline, the study consisted of 130 children (mean age 12.7 months) of predominantly African-American, low-income single mothers with an average of 10.8 years schooling. Mothers and infants were referred by urban paediatric primary care clinics. They were randomised into two groups: infant feeding programme at a multidisciplinary growth and nutrition clinic plus home intervention (n=64) or clinic only (n=60) (Black et al., 1995). At the follow-up phase (Hucheson et al.1997), four years

later, the infants were within six months of their 4th birthday. Apart from age, there was no change in the profile of participating mothers.

Loss to follow-up: Data available was for 116/130 children at the end of 12 month intervention (Black et al., 1995). 76/130 children were available for the follow-up evaluation four years after the intervention began (Hutcheson et al., 1997)

Theoretical foundation and content: The intervention was grounded in an ecological model. It involved a therapeutic alliance between home visitor and parent, and support for the mother's personal, family and environmental needs. The intervention group received a combination of services in a growth and nutrition clinic and home visiting by lay home visitors, who were supervised by a community health nurse. The control group received treatment at the growth and nutrition clinic alone.

The aim of the home based intervention was to support mothers, promote better parenting, and foster child development through a combination of parent training, and helping parents access informal and formal resources providing advocacy on parents behalf. Families received an average of 19.2 (SD, 11.5) visits a year, each of which lasted 1 hour.

The Hawaii Early Learning programme was delivered by lay home visitors using a curriculum guide for parent-child interaction and child development phases. An individualised service was created to meet the family's needs. Mothers were encouraged to keep a logbook, personalised notebooks and photographs of children. Home visitors provided toys and mats to model play and the creation of toys out of household materials.

Methods/measures:

Phase 1 (Black et al. 1985).

- *Infant growth:* Delecto-Medic Scales (Brooklyn, NY).
- *Infant cognitive and motor development*: Bayley Scales of Infant Development (Bayley, 1969)

- *Infant language development: receptive/expressive language scale:* (REEL; Bzoch & League, 1991).
- *Parent-child behaviour during feeding:* Parent-child Early Relational Assessment (Clark et al., 2004), modified for African-American families.
- *Home environment:* Home Observation for Measurement of the Environment (HOME) Scale. This involves six scales, and includes measurement of mothers' emotional and verbal responsiveness.

Phase 2 (Hutcheson, 1997)

- *Maternal psychological functioning* was measured at baseline using a combination of the Brief Symptom Index (BSI, Derogatis and Spencer, 1982). Subsets measuring depression, hostility and anxiety were used. Questionnaires were administered orally to control for literacy levels. Data collection measures were repeated one year after recruitment and again when children turned four.
- *Demographic risk* was calculated by summing positive indicators on six categories: maternal age under 18 at the index child's birth, maternal education less than high school, high household density, poverty status, presence of only one adult in the household, and adult's never having had a job. At baseline 5% of families were identified as having no risk factors and 49% had at least three. Poverty was the most common risk factors. Maternal psychological and demographic risk indices were similar across the home intervention and clinic-only groups.
- *Children's height for weight* was measured pre-intervention using Delcto-Medic (Brooklyn) scales; gender specific charts from the National Center for Health Statistics**.**
- *Children's interactive behaviour* was measured using a modification of the Parent-Child Early Relational Assessment (PCERA; Clark, 1985) validated on low-income African-American children and families.
- *Children's behaviour during play* was coded using global ratings of preschool children's behaviour with their parents. Three scales were identified (task engagement, negative affect and warmth) (Cohn, Cowan, Cowan and Pearson, 1992).

- *Child developmental outcomes* were measured using the Bayley Scales of Infant Development at the end of the intervention period (Bayley, 1969); the Battelle Developmental Inventory at age 4.

At baseline and following the intervention, children and parents were videotaped during a meal. At the 4-year follow-on year visit parent and child were seated at a table, asked to work on several puzzles and parents were asked to behave as they did at home. Observations were coded using measures drawn from the PCERA (Clark, 1985). Three scales have been identified (task engagement, negative affect and warmth) which enable individual items to represent a global rating for continuous parent-child interaction over a 10-minute observation period.

The impact of demographic and maternal psychosocial risk factors on changes in children's cognitive and motor development and behaviour from baseline to the close of intervention were examined by eight multiple regression analyses.

Limitations of the study: This study demonstrates that maternal negative affectivity moderates the effect of this intervention but does not show how that process works or why the moderating effects of negative affectivity were not evidence at the close of the intervention.

2.c Benoit et al. (2001)

Study type: Randomised controlled trial with 2 x 2 repeat measures ANOVA. Assessments made at baseline and 14 weeks after the 7-week intervention. No allocation concealment; assessors blinded.

Aim: to determine whether inappropriate caregiver behaviours measured by the AMBIANCE (Atypical Maternal Behavior Instrument for Assessment and Classification) would decline as a result of a play-focused intervention, but not a feeding-focused intervention. The AMBIANCE behaviours are defined as: (a) affective communication

errors (b) role reversal (c) frightening/disoriented behaviour (d) intrusiveness and negative behaviour (e) withdrawal.

Participants: 28 mothers (14 in play focused group, 14 in feeding focused group) referred to an infant psychiatry clinic in a tertiary care paediatric hospital in Canada. All infants presented feeding disorders and non-organic failure to thrive, which was attributed to parent-child interaction.

Loss to follow-up: Results from one participating mother-infant pair in the play focused group omitted, leaving 13 pairs.

Theoretical foundation and content:
This study draws on the concept of maternal 'atypical behaviour' (Fr-behaviours), a form of overtly hostile emotional maltreatment thought to disrupt the formation of parent-infant relationships elaborated by Main and Hesse (1990).

However, the authors argue that the dyadic therapies developed by Fraiberg (1981a; 1981b) and other psychodynamic psychotherapists to address these behaviours require considerable commitment from participating parents. Authors found that caregivers in high-risk categories were least likely to benefit from such interventions, since they lack the cognitive sophistication, commitment and resources to engage in exploration of past experiences. Since short-term interventions have been shown to be effective in addressing attachment disorders (see for example, Bakermans-Kranenburg et al., 2003: Prior and Glaser, 2006) the authors test the effect of a short-term intervention on Fr-behaviours measured on the AMBIANCE scale.

Play-focused intervention (modified Interaction Guidance)
A modified version of Interaction Guidance (McDonough 1993 et al., 2000) was used. Interaction Guidance is an intervention designed to reach multiply-disadvantaged families who have been hard to engage and have resisted traditional psychotherapeutic measures. The intervention included an individually tailored information component on specific issues exhibited by the infant. It consisted of 90 minute sessions

(approximately 15 minutes of videotaped interaction followed by 75 minutes of discussion, education and feedback) administered over 5 consecutive weeks.

Feeding-focused intervention (behaviour modification). For seven consecutive weeks, infants and their primary feeders attended a weekly clinic with one dietician trained in the use of behaviour therapy. During each 90 min. visit, feeders received training on behavioural techniques to eliminate specific problem behaviours in a predetermined sequence. At each visit, 3 – 5 behaviours were targeted.

Methods/measures:

- *Atypical maternal behaviour.* The AMBIANCE measure (Bronfman et al., 1999) was used to code (a) affective communication errors (b) role reversal (c) frightening/disoriented behaviour (d) intrusiveness and negative behaviour (e) withdrawal during one minute of play interaction. A summary score can be obtained by adding scores for each of the five dimensions; a qualitative score for level of disrupted communication; and a bivariate classification for disrupted or not disrupted communication. In this study, because hypotheses focus on global changes in parental behaviour, the focus was primarily on global measures.

Limitations of the study: This study involves a small convenience sample, with some differences between the two groups at baseline. Since both training and assessment occurred in the context of play, this may have enhanced the likelihood of observing change in the play-focused group. It is not clear whether change persisted beyond treatment and whether they were generalised to other situations. A longer follow-up period is necessary to document whether treatment effects are sustained.

2.d Haynes et al. (1984)

Study type: Non-randomised, quasi-experimental design. Assessments made at baseline, six months after intake, and at one to three year follow-up.

Aim of the study: To evaluate the effect of a short-term lay health visitor intervention in cases of faltering growth.

Sample: 50 infants hospitalised for failure to thrive and 25 thriving children and their mothers. 80% of children were less than 6 months old. Assessment of mothers of faltering growth and thriving infants showed no differences in SES, education, ethnicity and household size or congestion, but clear differences in childhood history of the two groups. While 72% of the thriving group reported a happy childhood, none of the faltering growth group did. Difficulties were therefore identified as the disturbed mother-child relationship, which stemmed in turn from faltering growth mothers' inadequate experience of nurture in childhood.

Loss to follow-up: Three years after intake, information was available on 44 of 75 participating families.

Theoretical foundation and content: 25 mother-child dyads were offered 6 months of home visits by lay health visitors (LHV) as well as a protective case social worker, a visiting nurse, parenting classes, physical therapy for children and medical treatment from the referring paediatrician. 25 dyads were offered community and medical resources but no LHV. A further 25 thriving infants were selected from birth records in the same hospital and matched with the LHV faltering growth pairs on the basis of child's age at intake, sex, birth weight and the mother's age, ethnicity and number of children.

While the infant was in hospital, an initial assessment was made. This involved a videotape of mother-child interaction during feeding and play and an informal interview with the mother while she was attending to the child. Mothers and infants were left alone for 5 minutes of both the feeding and play sessions. During the remainder of the session she was interviewed about her experience with her child, perception of the child, own upbringing and current life situation. The process was replicated with thriving mother-child dyads.

Following discharge from the hospital both faltering growth groups received follow-up by case workers, nurses and referring paediatrician. Psychiatric evaluations were made of parents who were obviously disturbed and counselling provided for one or both parents who reported unresolved conflicts or problems in their relationship.

Methods/measures:

- Infants' weight and development: Bayley scales of infant development (Bayley, 1969).
- Videotaped observations of mother-infant interaction patterns.

Limitations of the study: High rate of loss to follow-up (26 of 75 participating dyads) reduces reliability of findings.

2.e Dunitz et al. (1996)

Study design: The study conformed to a three-time quasi experimental design. The intervention was evaluated over two to three sessions in the first week of admission. The second assessment took place three months later, and the third after a year. All were undertaken by three raters whose training in psychiatry and psychotherapy included courses on baby observation. All had been assessed for inter-rater reliability. No allocation concealment; assessors blinded.

Aim of the study: To evaluate the effect of a feeding programme for infants with faltering growth combined with a range of therapeutic interventions for parents with Axis 1 and Axis 2 psychopathology.

Sample: The study consisted of 76 parents (48 mothers and 28 fathers) and 50 firstborn infants – 23 boys and 27 girls aged 6 to 18 months. 47% Caucasian, 1 African, 2 mixed race. No drop-out/loss reported.

Parents and infants were referred by the Division of General Paediatrics and Gastroenterology after infants had undergone a standard check-up by paediatricians in private practice or in paediatric hospitals. Allocation concealment was not possible.

Faltering growth was diagnosed if infants showed weight loss or stagnation in a Cole Index of <85%. Within the organic scale defined by Woolston for rating the proportion of organicity in faltering growth infants, 34 infants showed no definable organic factor and only mild secondary complications for malnutrition; 16 infants showed malnutrition-based developmental delay. At referral 16 infants were being tube-fed, 9 intermittently and 2 constantly over a period of 2 weeks. All infants were non-handicapped, term-born and organically healthy; their birth weight was within the normal range.

Caregivers were assessed using DSM-III-R for Axis 1 and Axis 2 pathology. 69.7% of all assessed caregivers (93% of mothers and 38% of fathers) showed Axis 1 pathology, which includes depressive disorders, brief reactive psychosis, dysthymia, somatoform disorders, eating disorders, adjustment disorders, reactive attachment disorder, alcohol dependence, impulse control, gender identity disorder and sedative dependent disorder. 27.3% showed Axis 2 pathology (over-involvement, under-involvement, anxious/tense and mixed relationship diagnosis) at first assessment.

Theoretical foundation and content: Psychopathological traits such as severe attachment behaviour problems and primary bonding difficulties may have been latent in parents and only become manifest due to the task of nurturing an infant for the first time. Infants' failure to thrive is profoundly linked to parental disorders. One of the aims of this study is to investigate the course of parental psychiatric disorder during the treatment of affected infants.

When the psychodynamic problems of the parents of infants with faltering growth are not addressed, infants' chronicity and secondary complications are frequent. A central objective of the intervention is to transform 'internal representations' – the thoughts and feelings a mother experiences before and after childbirth, which are in turn influenced by the woman's interaction with her own mother. This forms the starting point for

psychotherapy. (Detailed information on the theoretical background, diagnostic terms and therapeutic methods presented in Duntiz & Scheer, 1991).

Content: The intervention combined psychotherapy for parents and training in infant feeding. Therapy was offered to parents as part of in-hospital treatment. Parents who wanted additional therapy outside the hospital setting were referred to practitioners.

Psychotherapy sessions took place weekly for the first 2 – 3 weeks, then less frequently. Team members available to parents (by paging) in order to offer support and advice. This provided parents with a sense of security.
*Treatment of feeding behaviours***:** Treatment hinged on two rules: providing infants with food if a hunger cue is shown; ceasing feeding after any hint of refusal. Both aim at stimulating the child to break the vicious circle of opposition against feeding under pressure.

Measures:

- *Parental psychological functioning:* A semi-structured clinical psychiatric interview (30 mins) in a *German adaptation of the DSM-III-R Non-patient Version* for evaluation and assignment of psychiatric diagnosis. *A psychiatric interview (approx. 20 mins) evaluating DSM-III-R Personality Disorders* (adapted after SCID-II) with the parents. Two standardised *Behaviour Observation Scales* rating a 15 min play and a 15 min feeding situation recorded on video during the first 2 days after admission. The *Working Model of the Child Interview (WMCI)* evaluates the internal representations of the parents. The interview is performed separately for each parent in the absence of the infants and provides and impression of the affective quality of the parent-infant relationship with 14 sub-items.
- *Infant physical development:* Height for weight charts

Limitations of the study: Conclusions may be influenced by hospital-based design (infants and parents contacted only after clinical referral) and by inclusion only of firstborn infants. Given the need to meet the emotional needs of as many family members as possible, it was impossible to adhere to strictly standardised treatment, which makes it difficult to compare the effect of different elements of treatment.

2.f Iwaniec (1985b)

This study - which contrasts the effect of two behavioural interventions for faltering growth - appeared in two parts. Part 1 (Iwaniec, 1985a) contrasted the psycho-social features of the intervention and control groups. Part 2 (1985b) covers the intervention itself.

Study type: Quasi-experimental design with repeated pre- and post-test measures. No allocation concealment and no blinding.

Aim of intervention: To assess the effect of the intervention on feeding, mother-child relations and child behaviour problems.

Sample: 17 children with faltering growth and their families, referred by hospital paediatricians to a paediatric social worker. Mothers in the treatment group had had higher levels of depression and anxiety and lower self esteem than mothers in the control group. Families in the treatment group were often financially stressed (although not necessarily low SES). Mothers' average age was 25 and that of children 27 months**.**

Loss to follow-up: None reported.

Theoretical framework and content: The intervention was grounded in behavioural social work. Social workers trained parents in the skills they needed in order to manage their own children's behaviour.

Since the antecedent feeding problems were believed to vary from one family to another, contributory causes have implications for treatment and prevention. As others have noted, children's initial feeding difficulties can trigger panic-stricken force feeding which exacerbated already hostile attitudes in mothers who have in any case experienced faulty learning processes.

Initial social work and behavioural assessments were made in the hospital and the home, and followed by a short-term crisis intervention. This included a day nursery for children, which provided them with a stimulating environment while reducing stress on parents.

The longer-term intervention took place in three stages. Each involved instructional and behavioural techniques such as modelling adaptive interactions and providing personal and developmental counselling. Stage 1 consisted of 6 weeks of meetings, twice a week, for structured feeding routines. Stage 2 involved longer feeding and play sessions. Stage 3 involved 2 weeks of intensive interactions between mother, child and siblings. Fathers were involved where appropriate. The intervention lasted approximately 13 months.

Measures: Parent's assessment of child behaviours, staff checklist of child and parent behaviours, records of child weight gains, agency records of re-admission of children to hospitals.

Limitations of the study: Small sample; absence of standardised instruments; lack of control group.

2.g Fraiberg et al. (1981)

Aims: To examine the effect of child-parent psychotherapy (CPP) on infants showing signs of developmental disturbance primarily related to impairment in parent-child attachment. The study lasted six years.

Sample: 41 families with 50 infants with faltering growth (the group included four siblings of index babies and two infants born while parents and older siblings were in treatment). 24 infants referred before 12 months old, 20 between 12 and 23 months (group 2) and 6 between 24 and 36 months (group 3). 28 children were boys and 22 girls. Two thirds of infants were first-born. 80% of sample Caucasian, 20% Black,

Asian or mixed race. More than half the cases involved serious perinatal problems. Six children suffered from long-term disabilities (cleft lip, tracheostomy or blindness). SES evenly distributed in the group, with 21 families beneath the poverty line and the remaining 20 distributed evenly among the higher levels. 20% of parents in the sample were teenagers, 27% consisted of unmarried women and 75% of the mothers in the group had marked depression. Majority of cases involved withdrawn, emotionally neglectful parents. Two adoptive parents.

Theoretical framework and content: CPP integrates modalities derived from psychodynamic, attachment, trauma, cognitive-behavioural and social learning theories. The parent-child relationship is used as a vehicle for improving the child's emotional, social and cognitive functioning through a focus on safety, affect regulation, the joint construction of a trauma narrative and engagement in developmentally appropriate goals and activities. CPP therapists are guided by a treatment manual that describes treatment strategies and provides clinical examples to address various domains of functioning, including fearfulness and self-endangering behaviour, and relationship with the maltreating parent. Mother and child are seen in joint sessions, and collateral individual sessions are arranged with the mother when indicated. Weekly CPP meetings, which took place in a psychiatric outpatient unit, lasted approximately 1 hour and were conducted over 50 weeks.

Measures:

Data analysis was conducted on 38 children whose functioning could be assessed at baseline (i.e. they did not have a biological impairment, nor were unborn). Pre- and post-treatment assessments were conducted by a 3 member team comprised of a paediatrician, a psychiatrist and a paediatric nurse who used narrative case records, videotape records and medical records. Assessment was made over several sessions. Team raters rated each assessment twice: first privately and then after a two-hour meeting in which raters compared findings. Inter-rater agreement was resolved by consultation with senior staff members. Four external judges rated a sample of cases in order to determine whether in-house bias operated. Scores from 6 (critical) to 1 (adequate) given to each participating child, mother and father.

- *Health:* Medical records
- *Affective-social:* Indicators of attachment, characterisation of the baby's dominant mood and his/her range and intensity of affective expression.
- *Adaptive modes:* Indicators of the regulatory functions of the sensimotor organisation (such as response to external stimuli, state regulation, development of imitations, responses to stress and novelty) and regulatory functions of the ego (including modulation of affect, use of play, organisation of self at a representational level)
- *Cognitive-motor:* Bayley Scales of Infant Development (Bayley, 1969)
- *Parenting:* physical care-giving, practical knowledge of and ability to read the infants' needs, emotional availability and modes of contact (empathy, recognition of the individuality of the child without projection or distortion). This category was assessed separately for fathers and for mothers.

Author's conclusions: The findings provide evidence of the efficacy of infant-parent psychotherapy in improving parents' ability to nurture a child, and the positive effect on the infant who is at risk because of attachment, affectivity and adapting functioning.

Limitations of the study: The significance of findings was not determined, and while the study measured change within the mother and within the infant, differences in mother-infant interactions were not determined.

3. Missocialisation: interventions with drug and alcohol abusing parents

3.a Dawe and Hartnett (2007)

Study design: Randomised controlled trial.

Aim of intervention: Building on an earlier trial by Dawe et al (2003), to ascertain the effectiveness of the 10 session Parenting Under Pressure (PUP) programme, a brief

parent training (based on the same materials as the PUP programme) and standard care provided by standard methadone treatment programmes.

Sample: 64 families, with a greater number of mothers (86%) than fathers. Mean age of primary carer 30 years (sd = 6.4). Child age ranged from 2 – 8 years.

Drop-out/loss: All parents completed treatment, but of 22 randomised to treatment, 20 remained in the study through the follow-up phase 6 months later. Of the 23 assigned to the brief parenting intervention, 20 were assessed at follow-up and of the 19 assigned to standard care, 13 were available at 6 months. There were no differences between those who were followed up and those who were not on any intake variables.

Theoretical foundation and content: The PUP programme aims to improve family functioning and child outcomes by addressing risk factors both within the family and in the wider social systems around the family. The individual treatment focus is designed to decrease parental psychopathology. This in turn enables parents to put into practice parenting skills (which address the parent child relationship as such) and relapse prevention techniques. Finally, difficulties that occur between individuals and their social environment are addressed. The programme is primarily cognitive behavioural in focus and draws from the literature on regulation of affect, decreasing negative mood states and preventing lapse and relapse into substance misuses and improving parenting practices using behavioural family therapy approaches. An individual treatment plan is created. The programme consists of 10 units delivered over 12 sessions, but tailored to the needs of each family. Treatment was delivered by two clinicians.

Measurement of outcomes: Outcomes were measured by two clinicians with experience in treating complex families.

- The Parenting Stress Index (short form) (Abidin, 1990)[79] was used to measure perceived stress in the parenting role.

- The Child Abuse Potential Inventory (CAPI)[79] was used to measure risk of child maltreatment before and after the Parenting under Pressure (PUP) programme

- Alcohol Use Disorders Identification Test scores (AUDIT Saunders et al, 1993) to measure changes in parental alcohol use.[1]

- Methadone dose was independently confirmed by case records.

Limitations of the study: Three limitations are noted. First, the period in which the families were followed up was only 6 months post treatment and enduring change cannot be assumed. The nature and value of booster sessions needs to be ascertained. Secondly, the measures, although well validated, were all self report measures with the exception of independent, clinical assessment of methadone use. Finally, the PUP programme was delivered through home visits by professionals. Although there is evidence that home visiting alone is not associated with reduced child abuse potential, it is possible that the way in which it was delivered, rather than the content, may have affected outcomes.

3.b Luthar et al. (2007)

Study design: Randomised controlled trial using URN procedures to balance groups for maternal characteristics including age, ethnicity, IQ, SES, recent drug use, level of motivation for change, sensation seeking and child age and gender. No allocation concealment**.** Some assessors (clinicians in methadone clinics) blinded. Methadone treatment clinics in New Haven, Connecticut.

Aim of intervention: Building on an earlier trial by Luthar and Suchman (2000), to ascertain the effectiveness of the Relationship Psychotherapy Mothers' Group (RPMG) on substance-abusing mothers' parenting and on drug use.

Sample: 127 opiate-addicted mothers and 91 children aged 7 – 16. Mean age of mothers 36, children aged 1 – 16, average 9.23. Participants were referred by counsellors, identified through visits made by research assistants to counselling groups and medication lines, and were mothers who had already participated in the earlier study. Exclusion criteria included cognitive deficits, psychotic thought processes, suicidal and homicidal tendencies.

Drop-out/loss: Of 127 mothers randomised to treatment, 108 (85%) remained in the study through the follow-up phase. Of the 60 mothers assigned to RPMG, 50, (75%) remained through to follow-up. Of the 67 in RT, 58 (87%) remained.

Theoretical foundation and content: As for Luthar and Suchman (2000) above. This experimental study differed from the earlier pilot project in four critical ways. First, comparisons between RPMG treatment groups were made, not with women receiving treatment in a methadone clinic, but with RT as an adjunct intervention. Like RPMG, RT was conducted by professional clinicians with expertise in standard drug abuse treatment. RT focuses on processes of addiction and recovery and reinforces skills that prevent relapse into drug use. Secondly, the effectiveness of both RPMG and RT was evaluated in terms of the intention-to-treat sample and the sample who received treatment. Third, in addition to reports of mothers' functioning and children's reports, ratings of mothers' functioning were also received from clinicians in methadone clinics. Finally, while the first study involved evaluation at baseline, post-treatment and at six-month follow-up, this one incorporated assessment at 8-week intervals.

- *Emotional interaction outcome measures:* Major variables assessed were similar to those in the first study: measures of parenting, maternal depression, children's functioning and toxicology reports (see above). However, four further domains were assessed:
- *Maternal sensation seeking:* the Sensation Seeking Scale, Form V (SSS-V, Zuckerman, 1984) was used to measure maternal levels of stimulation and arousal.
- *Maternal intelligence:* the Kaufman Brief Intelligence Test (K-BIT, Kaufman and Kaufman, 1990) is a brief measure of verbal and nonverbal intelligence.

- *Readiness for change:* The University of Rhode Island Change Assessment Scale (URIA; McConnaughty, DiClemente, Prochaska, & Velicer, 1989) assessed an individual's stage of readiness to address a particular problem.

Limitations of the study: The study does not include information on children under the age of 6 and lacks observational data on interactions between participating children and their mothers (recommended, although rarely used in assessing parenting interventions). The study relies on self-report measures which could not be verified with data from child protection agencies.

3.c Luthar and Suchman (2000)

Study design: Randomised controlled trial using URN procedures to balance groups for maternal age, ethnicity, IQ, SES, recent drug use, level of motivation for change, sensation-seeking and child age and gender. No allocation concealment. No allocation concealment; some assessors blinded.

Aim of intervention: To evaluate the effectiveness of the Relationship Psychotherapy Mother's Group (RPMG), a parenting group intervention for opiate abusing women, on child maltreatment and on drug use. Randomised controlled trial.

Sample: The study involved 61 opiate addicted mothers, median age 34, of children aged 1 – 16, median age 10.1. Mothers who were enrolled in three methadone clinics in New Haven, Connecticut. Mothers were randomised into the Relational Psychotherapy Mothers' Group (RPMG) (n=37), a form of group psychotherapy, in addition to standard methadone treatment and counselling. Control mothers (n=24) received methadone treatment and drug counselling alone. The majority were on the second-to-lowest class in Hollingshead's five class hierarchy of social status. 78% of mothers were Caucasian, 10% African-American and 12% Hispanic. Exclusion criteria included cognitive deficits, psychotic thought processes and suicidal tendencies.

Drop-out/loss: Of 37 mothers randomised to treatment, 32 completed, yielding an 86% retention rate. Of 24 mothers in the control group, 20 completed, yielding an 83% retention rate. 47 women were traced six months later. These included 28 of the 32 RPMG group and 19 of the 20 control group completers.

Theoretical foundation and content: RPMG is a form of group psychotherapy aimed at facilitating optimal parenting among heroin-addicted mothers with children up to 16 years of age. It is grounded in the belief that (a) drug abuse in women is one of a constellation of problems. Drug-abusing mothers usually report high levels of childhood abuse, past and present traumatic events and high levels of depression and anxiety. (b) These underlying problems undermine mothers' emotional relationships with children and their parenting practices. (c) Mothers' psychiatric and interpersonal difficulties warrant at least as much attention as promotion of abstinence.

RPMG is based in a multivariable risk and protective model derived from the literature on resilience in developmental psychopathology. It has four defining characteristics: (i) a supportive therapists' stance, which fosters therapeutic alliance; (ii) an interpersonal, relational focus with group treatment; (iii) open or rotating group membership, in order to accommodate the chaotic schedules of many mothers; (iv) 'insight-oriented' parenting skill facilitation. Instead of instructing mothers about appropriate parenting, therapists encourage women to explore the strengths and limitations of their own experience and reflect (through discussion, brainstorming and role-plays) how these could be improved.

RPMG takes place weekly over 24 weeks. Treatment completers were considered those who had missed no more than 2 consecutive sessions and who attended at least half of all group meetings.

RPMG strives to reduce risk and increase resilience within the individual, family and community. Since the individual needs of substance-abusing mothers need to be addressed before attempting to effect change in the parent-child relationship, 12 of 24 sessions address the mother's psychological vulnerabilities. RPMG therapists foster mother's negotiation of fundamental developmental tasks that have been undermined by women's negative childhood experiences. The second 12 sessions turn to specific

parenting issues, using guided discussions grounded in women's actual experience, as substance-abusing women often interpret parent training as a focus on their parenting 'deficits'. Finally, RPMG is a form of group psychotherapy that capitalises on substance-abusing women's desire for affiliation and social ties. Substance-abusing women are often socially isolated and/or involved in potentially damaging relationships with men.

Women in both treatment and control groups received methadone treatment and were offered participation in weekly drug counselling groups. They had periodic meetings with case managers to ensure basic rights such as housing, benefits and legal aid.

Measurement of outcomes: Outcomes were measured by two psychologists and five drug counsellors.

Child maltreatment risk:

- Parental Acceptance-Rejection Questionnaire (PARQ; Rohner, 1991), a 60 item measure rated on a 4 point scale, used to assess mother-child relationship. PARQ yields a composite maltreatment score comprised of four subscales: aggression/hostility; neglect/indifference, undifferentiated rejection and very low expressed warmth/acceptance.
- *Affective quality of parenting:* Parent-Child Relationship Inventory (PCRI, Gerard, 1994). This contains six subscales. Two of these subscales were used to measure maternal affective interactions (Communication and Involvement). Instrumental interactions were assessed on the Limit Setting and Autonomy subscales.

Mother's psychosocial adjustment:

- Three measures were used (i) The Satisfaction subscale of the Parent-Child Relationship Inventory (PCRI, Gerard, 1994) and (ii) the Clinician Assessment of Functioning (CAF; Luthar and Suchman et al., 200b), which was designed for this study to measure overall functioning (e.g. coping and life skills) and interpersonal efficacy (interpersonal functioning and affective style). Finally, the Beck Depression Inventory (BDI, Beck and Beck, 1972) was used as in the pilot.

Child's psychosocial adjustment:

- Behavioural Assessment System for Children (BASC; Reynolds and Kamphaus, 1992), using both the Parent Rating Scale (PRS) and the Self-Report Scale (SRS) for children. Children's depression levels were assessed with the Children's Depression Inventory (CDI, Kovacs, 1992).
- *Maternal substance abuse***:** computerised toxicology records at methadone clinics.

Limitations of the study: The RPMG therapists' manual went through several revisions throughout the 3 year study, so that interventions received by mothers over this period were similar but not identical. Little is known about the degree of variability in the treatment received by women in the comparison groups, because drug counselling groups (unlike RPMG) could not be videotaped. Third, the sample is not necessarily representative of methadone clinic populations in general (as suggested by the relatively high number of Caucasian participants). Finally, results may in part reflect varying 'doses' of treatment across conditions, as mothers in the RPMG group received this intervention in addition to standard treatment.

3.d Dawe et al (2003)

Study design: Quasi-experimental design with repeat measures, pre and post intervention with follow-up at 3 months.

Aim of intervention: To evaluate the effectiveness of the 10 session Parenting Under Pressure (PUP) programme on parenting stress, child abuse potential, substance abuse as well as child outcomes.

Sample: 9 families with at least one parent in methadone treatment.

Drop-out/loss: 8 of 9 participating families were available at follow-up. Data was incomplete for 1 of the 8 families.

Theoretical foundation and content: The PUP programme aims to improve family functioning and child outcomes by addressing risk factors both within the family and in

the wider social systems around the family. The individual treatment focus is designed to decrease parental psychopathology. This in turn enables parents to put into practice parenting skills (which address the parent child relationship as such) and relapse prevention techniques. Finally, difficulties that occur between individuals and their social environment are addresses. A strong therapeutic alliance is considered critical and is achieve by ensuring that immediate, short and medium turn goals are set by both the therapist and the client. The programme is primarily cognitive behavioural in focus and draws from the literature on regulation of affect, decreasing negative mood states and preventing lapse and relapse into substance misuses and improving parenting practices using behavioural family therapy approaches. An individual treatment plan is created. The programme consists of 10 units delivered over 12 sessions, but tailored to the needs of each family.

Measurement of outcomes: Outcomes were measured by two clinicians with experience in treating complex families.

- The Parenting Stress Index (short form) (Abidin, 1990)[79] was used to measure perceived stress in the parenting role.
- The Significant Other Scale (SOS) was used to assess levels of practical and emotional support available to the parent.

- The Child Abuse Potential Inventory (CAPI)[79] was used to measure risk of child maltreatment before and after the Parenting under Pressure (PUP) programme

- The Opiate Treatment Index (OTI): HIV Risk Taking Behaviour (11 items focusing on injecting practices and sexual behaviour) was used to determine high risk behaviours.

- The Alcohol Use Disorders Identification Test scores (AUDIT Saunders et al, 1993) to measure changes in parental alcohol use.

- Methadone dose was independently confirmed by case records.

- Connors rating Scales-revised is a measure of child functioning, including conduct, emotional, family, anger and anxiety problems.

Limitations of the study: Small scale study with no control group.

3.e Conners et al. (2006)

Study type: Quasi-experimental design with repeat measures. Assessments made at intake, every three months during residential stay, and six and 12 months post discharge. Data analysed by two members of an independent evaluation team. No blinding.

Sample: 305 of 340 drug using mothers who attended the Arkansas Centre for Addiction, Education and Services (Arkansas CARES) treatment programme between 2000 and 2004. 64% were Caucasian, 81.4% single, average of 2.1 children of pre-school and school age. 27% pregnant at the time of admission. 35.8% at risk of severe depression, 51.2% of PTSD and 87.2% with previous history of arrest.

Aim of intervention: To examine treatment outcomes of 305 women enrolled in a comprehensive, residential substance abuse treatment programme. Analysis focused on length of treatment and on outcomes, including inappropriate expectations of children, lack of empathy towards children's needs, reversal of parent-child responsibilities and oppressing children's power and independence.

Drop-out/loss: 57.4%.

Theoretical foundation and content:
Arkansas CARES provides integrated services. It provides daily substance abuse treatment; individual, group and family counselling and Twelve-Step meetings; parenting education and support; medical services; case management; support to

education and employment, and aftercare. Children in treatment with their mothers receive a variety of educational and mental health services.

Emotional interaction outcome measures:

- *Parenting and child-rearing attitudes:* Adult-Adolescent Parenting Inventory-2 (AAPI-2, Bavolek & Keane, 1999). This is designed to assess parenting and child-rearing attitudes of adult and adolescent parents. It contains five subscale scores designed to measure (i) inappropriate expectations (ii) lack of empathy toward children's needs (iii) belief in the use of corporal punishment (iv) reversal of parent/child responsibilities (v) oppressing children's power and independence.
- *Addiction:* Addiction Severity Index-Expanded, Self-Administered Version (ASI), (McLellan et al., 1990)
- *Depression:* Beck Depression Inventory II (BDI-II, Beck, Brown & Steer, 1996)
- *Post-traumatic stress:* PTSD Checklist (PCL-C, Weathers, Litz, Herman, Huska & Keane, 1993)
- *Measures of risky behaviours:* questionnaire devised by Kalling-Knight, Chatham and Simpson (2005) to gage risk of HIV, infected needle use and smoking
- *Smoking beliefs and behaviours:* Questionnaire designed for this study by the research team.

Results analysed through paired *t* test for continuous variables and McNemar change test for dichotomous variables.

Limitations of the study: Without a comparison group, it is difficult to know whether positive outcomes were actually the consequence of treatment. However, intervention effect can be measured by comparing length of participation with indicators of participant functioning.

Appendix 3

Risk factors associated with missocialisation and emotional harm to children

Domestic violence

As noted above, in the section on missing literature, in spite of increasing awareness of the serious harm caused to children who witness domestic violence, little has been written on parent education for women who are being abused, or indeed, for men who are abusing their partners (see Peled et al., 2000) although some new forms of intervention are emerging that have not yet been adequately evaluated (see Appendix 4, 'Excluded studies).

Identification of domestic abuse in the antenatal period

Three systematic reviews have evaluated the effectiveness of antenatal identification of domestic abuse.[169] A number of validated assessment tools for use by health workers were identified. Overall, the findings suggest that assessment using 1 - 3 questions is as reliable as more complex measures. However, there is no adequate evidence about the potential harm associated with the assessment process.

Prevention/treatment of domestic abuse

Ramsay et al (2002) reviewed interventions in primary health care settings, designed to prevent and treat violence against women, identified four types of intervention for abused women: shelters, post-shelter advocacy counselling, personal and vocational counselling and prenatal counselling.[60] Six studies found that screening/assessment detected higher levels of domestic abuse than no screening/assessment. However, little evidence exists for changes in important outcomes (e.g. decreased exposure to violence) as a result of screening/assessment. No studies measured quality of life, mental health outcomes or potential harm to women from screening/assessment programmes. No differences in detection sensitivity found for assessment with or without significant additional staff training. No difference found between use of single questions and more complex measures.

Two studies measured effect of interventions in healthcare settings on further exposure to domestic abuse. These found mixed results, with some evidence of the effect of combined counselling and advocacy. Five studies of referral to other agencies found limited evidence that battered women continued to use community resources. One RCT which found that women who had spent at least one night in a shelter reported a decreased rate of re-abuse and improved quality of life during the subsequent two years. However, there is insufficient rigorous evidence on the effect of screening, advocacy or counselling on women's exposure to domestic violence, and therefore of preventing children from suffering the significant emotional harm associated with witnessing violence.

MacMillan et al (2001) reviewed interventions to prevent and treat violence against women identified 10 studies of interventions that targeted male perpetrators alone or with their partners[170]. Only one of the ten studies was of sufficient methodological rigour to be reported. This study is of limited generalisability because the sample consisted entirely of US Navy staff. There is insufficient evidence to recommend for or against screening/assessment for violence against women in the antenatal or postnatal period. There is insufficient evidence to recommend for or against any specific interventions for women exposed to violence, other than referral to post-shelter advocacy counselling. The effectiveness of shelters in preventing violence against women is unknown. There is limited evidence on the effectiveness of any intervention that aims to reduce male violence towards female partners and an urgent need to pilot and test a range of approaches.

Summary and recommendations:

Simple questions should be used as part of the routine assessment of women presenting during pregnancy and the postnatal period, to identify women who are being exposed to domestic abuse.

There is, however, limited evidence concerning i) effective methods of supporting women who are exposed to domestic abuse, both in terms of the immediate safety

and long-term well being of themselves and their children; ii) interventions with men who are and who are not mandated to treatment; and iii) to gauge the effectiveness of interventions beyond the healthcare setting (e.g. public awareness campaigns, community support initiatives, including those for women in ethnic minorities.

Further guidelines on treatment of domestic violene are provided by the Department of Health (2000).[198]

Alcohol dependency

Identification and treatment of alcohol abuse in the antenatal period

One systematic review of motivational interviewing interventions in prenatal clinics included 9 RCTs of motivational interventions aimed at the cessation of any form of alcohol consumption during pregnancy. None of the studies included women enrolled in formal alcohol treatment, although four trials included participants with combined alcohol/drug dependence.[171] As health practitioners are likely to see women who are ambivalent about abstinence (either unaware that their level of consumption harms the infants, or uncertain as to how to change) motivational interviewing (MI) aims to increase their readiness for change. Interventions ranged from brief education, advice and self-help manuals, to more intensive programmes. A variety of brief motivational interventions (ranging from one to four sessions), delivered in the home or in clinical settings, were found to be effective in all but one study. Evidence of effect was reported for both 'lighter' and heavy drinkers. One study found that the provision of written information without an interview was enough to galvanise change in women in the sample, and that effects were not enhanced by the provision of a video and face to face advice.

In contrast, a Cochrane review of interventions for drug and alcohol addicted women which included 3 studies on MI, found no significant effects for MI on obstetric or neonatal outcomes[172]. The findings from this study had limited generalisability, however, due to the fact that they all involved poor, African-American women with low levels of education.

MI appears therefore to have some value in precipitating change in terms of addictive behaviour, but further research is needed to identify which factors (i.e. such as level of alcohol consumption or gestational age upon enrolment) are associated with treatment effectiveness.

One systematic review of Motivational Interviewing (involving 72 randomised trials not exclusively during pregnancy/the postnatal period) was included on expert advice.[173] This found a significant effect for MI on alcohol use abuse, drug addiction, smoking cessation, weight loss and increase of physical activity.

One Cochrane review of home visiting (HV) during and after birth for women with drug and alcohol problems (6 studies) included no interventions with a significant antenatal component, but found some evidence that postnatal home visits increased engagement in drug treatment services. However, the studies do not provide evidence to indicate that treatment adherence improved health outcomes for infant or mother.[174]

Alcohol consumption/addiction

There is some evidence that brief motivational interviewing can be effective in motivating mothers who are light to moderate drinkers to cease drinking during pregnancy.

There is good evidence that the treatment of alcohol abuse (as opposed to light to moderate drinking) should be tailored to the specific needs of the client and should involve a psychosocial component in addition to standard treatment. Treatment options include brief motivational interventions/motivational interviewing, behavioural couples-therapy (where there is a drug-free partner), family therapy, mutual aid (self-help) approaches, including community reinforcement approaches and/or network therapy (exploration and development of network support). There is some evidence that treatment may be more effective if it includes the provision of rewards and incentives (contingency management). Information leaflets should include material for other family members.

Further research is required about the effectiveness of individual treatment enhanced by multimodal, community-based paraprofessional support, similar to the extended Doula model for teenage mothers in recovery from alcohol or drug dependence. Further research is also needed regarding the benefits of family counselling (which has been shown to increase engagement and retention of resistant problem drinkers and drug users) in the antenatal/postnatal period.

The Department of Health (2006) provides full guidelines on treatment of alcohol misuse through the life course.

Drug misuse

In addition to interventions that directly address parenting of addicted/methadone dependent parents several studies have evaluated the effectiveness of interventions to treat drug addiction in the antenatal and early postnatal period.

Four systematic reviews have evaluated the effectiveness of interventions to treat drug addicted women. [175] Two studies are included on expert advice.[176]

Methadone drug treatments

One Cochrane review was identified evaluating the effectiveness of attendance in methadone drug treatment in pregnancy. Results showed an increase in birth weight, increase in one minute APGAR score, and overall lower costs.[177]

Contingency Management and Motivational Interviewing

One systematic review of Motivational Interviewing (involving 72 randomised trials not exclusively during pregnancy/the postnatal period) was included on expert advice.[178] This found a significant effect for MI on alcohol abuse, drug addiction, smoking cessation, weight loss and increase of physical activity. In contrast, a Cochrane review of interventions for drug and alcohol addicted women which included 3 studies on MI, found no significant effects for MI on obstetric or neonatal outcomes[179]. Generalisability of this study was limited to poor, African-American

women with low levels of education. Interventions of this nature may also be less effective among people who have been coerced into treatment.

MI therefore has value in motivating change, but further research is needed to establish which factors (such as level of drug consumption or gestational age upon enrolment) are associated with treatment effectiveness.

Home visiting

A Cochrane review of 6 home visiting programmes for drug or alcohol dependent women found no interventions with a significant antenatal component.[180]

Doula programmes

Two studies of enhanced Doula programmes were included on expert advice. These evaluated the effectiveness of a service delivered by local paraprofessional women to young mothers who met 3 of 8 risk factors (including addictions and poverty). The enhanced Doula programme consists of psychosocial support, training, and liaison with community networks, work with families and case management in the pre- and post-natal period and during childbirth where necessary. Findings showed that this service was effective in increasing the sensitivity of mothers in the postnatal period, and was associated with enhanced breastfeeding initiation and reduced caesarean birth rates.[181]

Parenting programmes

One systematic review of parenting interventions with drug-using mothers included 6 RCTs (see Postnatal period – Parenting Programmes, below).

Summary and recommendations: drug use in the antenatal period and pregnancy

As in the case of alcohol addiction (with which it frequently co-occurs) there is good evidence showing that the treatment of drug use should be tailored to the specific

needs of the client but should involve a psychosocial component in addition to standard care (e.g. methadone and counselling). Treatment may be more effective if it includes the provision of rewards and incentives (contingency management). Information leaflets should include material for other family members.

As in the case of alcohol abuse, further research is required about the effectiveness of multimodal, community-based paraprofessional support, similar to the extended Doula model for teenage mothers in recovery from alcohol or drug dependence. Further research is also needed regarding the benefits of family counselling (which has been shown to increase engagement and retention of resistant problem drinkers and drug users) in the antenatal/postnatal period.

For full guidelines on treatment of drug misuse throughout the life course see Department of Health (England) and the devolved administrations (2007).

Identification, prevention and treatment of depression in the antenatal and postnatal period

The following section summarises findings on identification and treatment of maternal depression in the antenatal and postnatal period. Depression is associated with increase risk to the parent-child relationship and of emotional unavailability. Early detection and treatment of depression is therefore of critical importance.

Prevention of depression – antenatal and postnatal period

16 studies (RCTs) of interventions aimed at preventing the development of mental disorders in populations with specific risk factors in both the antenatal and postnatal period were identified in the NICE review.[182] Risk factors included childhood abuse and relationship difficulties or factors related to delivery. Providing treatments for women with risk factors for depression particularly existing sub- threshold symptoms was found to have some benefit. No evidence was found for any intervention that aimed at preventing depression in low-risk populations.

Sixteen studies evaluated the effect of psychosocial interventions such as group psychoeducation designed to prevent the onset of mental health disorders among women at low risk. Treatments aimed at preventing depression in the postnatal period that are not directly targeted at populations at high risk were not found to have any effect on future depression.

Identification of antenatal depression

The NICE review of standard postnatal care included 8 studies that measured the predictive value of the 10-item Edinburgh Postnatal Depression Scale (EPDS).[183] The EPDS has been found to accurately predict which women would not become depressed, but was relatively poor at predicting those who would experience depression at a later date.

A brief (and less expensive) identification strategy is for practitioners to ask women two questions (whether they have experienced low mood, or have felt a decline in interest and pleasure in life over the previous month). A third question has been proposed: whether the respondent would like help. These too, have relatively low predictive value.

Although neither the EPDS nor the '3 questions' have robust predictive value, NICE guidelines favour the use of 3 questions over the EPDS as women themselves have been found to dislike the EPDS, and because the 3 questions can be asked in both the antenatal and postnatal periods.

Prevention of ante-natal depression

Two systematic reviews evaluated the effectiveness of psychosocial interventions (e.g. psychoeducation) to prevent onset of depression during the ante-natal period (See also section on prevention of postnatal depression).[184] There is no evidence that these interventions prevent the onset of depression during the ante-natal period, and as per NICE guidelines the routine, universal provision of these is not currently recommended.

Identification of antenatal depression

The NICE review of standard postnatal care included 8 studies that measured the predictive value of the 10-item Edinburgh Postnatal Depression Scale (EPDS).[185] The EPDS has been found to accurately predict which women would not become depressed, but was relatively poor at predicting those who would experience depression at a later date.

A brief (and less expensive) identification strategy is for practitioners to ask women two questions (whether they have experienced low mood, or have felt a decline in interest and pleasure in life over the previous month). A third question has been proposed: whether the respondent would like help. These too, have relatively low predictive value.

Although neither the EPDS nor the '3 questions' have robust predictive value, NICE guidelines favour the use of 3 questions over the EPDS as women themselves have been found to dislike the EPDS, and because the 3 questions can be asked in both the antenatal and postnatal periods.

Treatment of antenatal depression and anxiety

One Cochrane review evaluated the effectiveness of psychological support to treat antenatal depression, and this included only one trial comprising 38 women who met Diagnostic and Statistical Manual for Mental Disorders-IV criteria for major depression.[186] The results showed that compared with a parenting education program, interpersonal psychotherapy was associated with a reduction in the risk of depressive symptomatology immediately post-treatment using the Clinical Global Impression Scale (one trial, n = 38; relative risk (RR) 0.46, 95% confidence interval (CI) 0.26 to 0.83) and the Hamilton Rating Scale for Depression (one trial, n = 38; RR 0.82, 95% CI 0.65 to 1.03).

A comprehensive review of the identification and treatment of depression (as well as other mental health problems including panic disorders, eating problems and post-traumatic stress) in the antenatal and postnatal period is presented in NICE

guidelines.[187] This provides rigorous evidence of the effectiveness of psychological treatments for women who have symptoms of depression and anxiety in the antenatal period. Brief (4 – 6 sessions) inter-personal psychotherapy and cognitive behavioural therapy are effective for pregnant women who have had a previous episode of depression or anxiety and who have developed symptoms that do not meet diagnostic criteria but that significantly interfere with social and personal functioning.

Social support (individual, including support through antenatal home visiting, or group-based interventions) is effective for women who have not had a previous episode of depression or anxiety.

Postnatal treatment:

15 studies of treatment of depression in the postnatal period were included in the NICE review. Eight compared standard care or waiting-list control with psychodynamic psychotherapy, non-directive counselling and social support. Treatments with at least moderate quality evidence, that showed an effect, included cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT), psychodynamic psychotherapy and non-directive counselling. Very little evidence was found of differential effectiveness.

Four studies included in the NICE review compared psychosocial and psychological interventions with other treatments. IPT was found to be more effective than psychoeducation; six sessions of counselling more effective than one session; group exercise was more effective than social support alone; psychoeducation with women's partners more effective than psychoeducation with women alone; and individual counselling more effective than group counselling.

Three studies compared physical non-psychological treatment (infant massage, exercise, acupuncture). The evidence is not of high quality, but one study supports the view that exercise may be of some benefit for depression. No evidence was

found to support the use of infant massage or acupuncture to treat postnatal depression.

There is some evidence (from six RCTs included in NICE review on postnatal mental health) that dyadic interventions which involve depressed mothers, and which are designed to improve mother-infant interactions, can alleviate or prevent depressive symptoms even if the intervention was not designed specifically to target this.[188]

Two further systematic reviews also assessed the effectiveness of interventions to treat postnatal depression and reached consistent findings.[189] A Cochrane review, which comprised nine trials and reported outcomes for 956 women found that any psychosocial or psychological intervention, compared to usual postpartum care, was associated with a reduction in the likelihood of continued depression, at the final assessment within the first year postpartum. Trials selecting participants based on a clinical diagnosis of depression were just as effective in decreasing depressive symptomatology as those that enrolled women who met inclusion criteria based on self-reported depressive symptomatology.

A third systematic review (Craig 2004) searched for parenting interventions for women with mental health problems (e.g. schizophrenia, mood disorders, postnatal depression, psychosis) who have young children, but identified only descriptions of programmes.[190]

Guidelines on the management and treatment of depression throughout the life course are available from several sources, including a recent review by NICE (2008). [196]

Recommendation:

Prevention of postnatal depression:

There are currently no effective interventions to prevent postnatal depression in low risk populations.

Identification of postnatal depression:

The use of simple questions to identify women with postnatal depression appear to have similarly low predictive validity to screening tools such as the EPDS, but appear to be more acceptable to women.

Treatment of postnatal depression:

Inter-personal psychotherapy, cognitive behavioural therapy or listening visits in the home are effective for women who have developed symptoms of depression. One-to-one therapy appears to be more effective than group work. Treatments should be combined with patient education about the illness, the treatment selected, and other mechanisms for promoting health such as social support and a healthy lifestyle.

Women requiring psychological treatment should be seen for treatment normally within 1 month of initial assessment, and no longer than 3 months afterwards.

Social support (individual, including home visiting, or group-based interventions) is recommended for women who have subthreshold symptoms and who have not had a previous episode of depression or anxiety.

Dyadic treatment is recommended to improve parent-child interaction in women experiencing depression in the postnatal period.

Appendix 4: Sample interventions from some excluded studies

Emotional abuse general	
Author	**Review**
Trowell et al. (1999)	Examined the characteristics of 156 abusive families and the effect of treatment in a family centre.. Characteristics included parent care/abuse history, mental health difficulties, substance abuse, death of previous children, and premature births. A therapeutic assessment which used standardised checklists is reported. Parents rated their children as very disturbed with little change pre- and post-attendance at weekly treatment in a family centre. However, they did rate themselves as significantly improved in negative symptomatology post-attendance. When children were school age, their teachers rated them as far less disturbed than the parents had rated them. Parents rated the children's behaviour as improving post-attendance. Reasons for these differences are discussed. The study included families in whom emotional abuse was compounded with other expressions of child maltreatment.
Fraser et al (1995)	The Eastfield Ming Quong Child-Adolescent In-Home Program (CAIHP) provides structured family therapy that involves structural and strategic family systems approaches as well as marital, individual and play modalities. The first phase of treatment includes an orientation session, multiple-impact and initial weekly sessions in which a three-member therapeutic team aims at engaging the family, developing an initial hypothesis of family system operation, assessing alliances and hierarchical structure and testing the hypotheses. By slowly building to the presenting problem, the team lays the groundwork for presenting the issues as a family problem rather than those of an individual identified patient (IP) – a child or young person. A primary therapist meets the parents, an adolescent specialist with the IP and the secondary therapist with the remaining family members. In the middle phase, therapeutic work focuses on effecting change that is fundamental and structural in nature. Each family member grapples with identifying what they need from each other and how to enact these changes. During the final phase of the treatment (the last 3 to 4 weeks) the family may recognise a sense of loss and abandonment which can help access underlying loss and abandonment issues. If change has not been effected according to plan, the CAIHP created linkage to other resources including a referral to family therapy in a more traditional setting. The CAIHP works with the family and the new therapist to bring them into treatment and the work the family has achieved so far. The application of the 90-day treatment is exemplified by Fraser (1995) in three case studies in which different forms of abuse have co-occurred and brought children to the attention of mental health services.

Sample interventions that promote infant attachment and caregiver sensitivity	
Bakermans Kranenburg et al. (2003)	A comprehensive meta-review of interventions that aim to enhance parental sensitivity and infant attachment security. Seventy studies were traced, producing 88 intervention effects on sensitivity (n = 7,636) and/or attachment (n = 1,503). Randomized interventions appeared quite effective in changing insensitive parenting (d = 0.33) and improving infant attachment insecurity (d = 0.20). The most effective interventions used a moderate number of sessions and had a clear-cut behavioural focus in families with, as well as without, multiple problems. Interventions that were more effective in enhancing parental sensitivity were also more effective in enhancing attachment security, which supports the notion of a causal role of sensitivity in shaping attachment.
Ciccetti (1999)	The efficacy of toddler-parent psychotherapy (TPP) as a preventive intervention for promoting secure attachment in the offspring of depressed mothers was evaluated, 63 mothers with major depressive disorder being randomly assigned to TPP (n = 27) or to a no treatment group (n = 36) and compared with a control group (n = 45) of women with no current or past mental disorder. At baseline, comparable and higher rates of attachment insecurity were found in the two groups of the offspring of depressed mothers as compared with the non-depressed mother control group. At the post-treatment follow-up, offspring in the intervention group attained rates of secure attachment that were comparable with those of youngsters in the non-depressed mother control group. In contrast, the children in the depressed mother control group continued to demonstrate a greater rate of attachment insecurity than children in the non-depressed mother control group. The findings support the efficacy of an attachment-theory based model of intervention for fostering developmental competence in the offspring of depressed mothers.
Lieberman (1991)	Anxiously attached 12-month-olds and their mothers as assessed in the Strange Situation were randomly assigned to an intervention and a control group to test the hypothesis that infant-parent psychotherapy can improve quality of attachment and social-emotional functioning. Securely attached dyads comprised a second control group. Intervention lasted 1 year and ended when the child was 24 months. ANOVAs were used to compare the research groups at outcome. Intervention group toddlers were significantly lower than anxious controls in avoidance, resistance, and anger. They were significantly higher than anxious controls in partnership with mother. Intervention

	mothers had higher scores than anxious controls in empathy and interactive exchange with their children. There were no differences on the outcome measures between the intervention and the secure control groups. The groups did not differ in maternal child-rearing attitudes. Within the intervention group, level of therapeutic process was positively correlated with adaptive scores in child and mother outcome measures.
Marvin et al. (2002)	The Circle of Security represents a circle around which the child moves away from the secure base provided by the caregiver and back to the caregiver when s/he needs comfort or reassurance. The secure base is drawn as a safe pair of hands. During the intervention, parents are alerted to their children's needs for support, oversight, help, welcome, protection, comfort, praise and organisation of the child's feelings. Some of children's states evoke a sense of threat in parents, and this can set up a defensive strategy by miscuing the child about the child's needs, which leads children to miscue their needs in turn. Therapists help parents understand the sources and triggers of their defensive strategy, and enable parents to manage them. Individualised intervention goals are developed on the basis of classification, ratings and clinical observations. Preliminary data on 75 dyads that have completed the protocol have resulted in a significant shift from disordered to ordered attachment patterns (55% to 20%), increase in the number of children classified as secure (32% to 40%) and decrease in the number of caregivers classified as disordered (60% to 15%).
Muir (1992) & Cohen et al. (1999)	(a) Muir (2002) The 'WWW' technique is a community-based mental health service and is based on the idea that the child initiates infant-parent psychotherapy. The conceptual basis for WWW is described, and a case illustration of a 5.5-month old boy and his mother is presented, focusing on assessment and the clinical process. In this process, the infant facilitates the mother's self-analysis, while the mother facilitates the resumption of the infant's potential self-development. (b) Cohen et al. (1999) Mothers are instructed to interact when the infant initiates activity. This fosters an observational reflective stance in the mother and enables the infant to negotiate the therapeutic relationship with the mother. The therapist provides a supportive environment, but does not instruct. Evaluation involved comparison of WWW with another form of psychodynamic psychotherapy. There was no difference in attachment classification prior to treatment. Infants in the WWW groups were significantly more likely to shift to secure or organised attachment than infants in the control group (p=<.03) but no difference was found in maternal sensitivity.

Toth et al. (2006)	The development of insecure attachment relationships in the offspring of mothers with major depressive disorder (MDD) may initiate a negative trajectory leading to future psychopathology. Therefore, the provision of theoretically guided interventions designed to promote secure attachment is of paramount importance. Mothers who had experienced MDD since their child's birth were recruited (n = 130) and randomized to toddler-parent psychotherapy (DI) or to a control group (DC). Nondepressed mothers with no current or history of major mental disorder and their toddlers also were recruited for a nondepressed comparison group (NC; n = 68). Children averaged 20.34 months of age at the initial assessment. Higher rates of insecure attachment were present in both DI and DC groups at baseline, relative to the NC group. At postintervention, at age 36 months, insecure attachment continued to predominate in the DC group. In contrast, the rate of secure attachment had increased substantially in the DI group and was higher than that for the DC and the NC groups. These results demonstrate the efficacy of toddler-parent psychotherapy in fostering secure attachment relationships in young children of depressed mothers.
Sample interventions with parents with severe mental health problems	
Bassett & Lloyd (2001)	Describes the development and implementation of a parenting program for parents with a major mental illness. Occupational therapists working in an Australian mental health service developed "Living with Under-fives", a 2-stream program which aimed to consolidate the parent/child relationship and enable parents to develop effective parenting skills. This program has a parents' educational stream and a stream with developmentally appropriate activities for the children. 34 parents were referred to this program over a two year period. Outcome assessment was based on staff observation, client self-report, readmission rates, and community access. Observed outcomes have included the parents becoming more responsive to their children, increased treatment compliance, improved community access, and a decrease in the number of children in temporary foster care.
Beardslee et al. (2003)	The authors conducted a large-scale efficacy trial of 2 manual-based preventive intervention programs that were designed to be used widely in public health settings. These interventions target the relatively healthy children (ages 8-15) of parents with mood disorder. Both interventions were specified in manuals. The lecture condition consisted of 2 separate meetings delivered in a group format without children present. The clinician-facilitated condition consisted of 6 to 11 sessions, including separate meetings with parents and children, and a family meeting in which the parents led a discussion of the illness and of positive steps that can be taken to promote healthy functioning in the children. In addition, telephone contacts or refresher meetings were conducted at 6- to 9-month intervals. In both conditions, psychoeducational material about mood disorders, risk, and resilience

	was presented and efforts were made to decrease feelings of guilt and blame in children. Parents were helped to build resilience in their children through encouraging their friendships, their success outside of the home, and their understanding of parental illness and of themselves. In the clinician-facilitated condition, efforts were made to link the psychoeducational material presented to the family's own unique illness experience. All family members in both conditions were assessed for psychopathology and for overall functioning at intake, and for psychopathology, functioning, and response to intervention immediately postintervention, approximately 1 year postintervention, and again approximately 2.5 years postintervention. The outcomes of child understanding and internalizing symptomatology were examined, and a number of predictor variables, using repeated measures, analysed with generalized estimating equations. Parents in both conditions reported significant change in child-related behaviour.
Brunette et al. (2002)	Women with SMI are involved in childbearing and childrearing, but may have problems with parenting related to symptoms, lack of knowledge and skills, or lack of environmental supports. They may need intensive services to manage their mental illness and to parent to the best of their abilities. Preliminary research suggests that mental health interventions can improve family functioning, but that these services are not widely available in community mental health systems. This paper describes services to help clients who are parents, which includes integration of adult's and children's services, long-term, home-based parent training, and linkage with community supports.
Brunette & Dean (2004)	This paper reports a case series of families participating in Integrated Family Treatment, a home-based parent training and family support program for parents with severe psychiatric disabilities. All 8 families who entered the program over 6 months were followed for 1 year. Seven families remained in treatment for more than 10 months and rated the program highly. Six of the seven parents (85.7%) remaining in treatment improved on one or more measure of parent skills.
Cohler et al. (1996)	Authors report on an outpatient service for women with severe mental illness. The 'Mothers Project' is a nursery programme for women who have been discharged from public psychiatric hospitals. The programme provides day care for young children, enabling mothers to attend classes and to work and complete education. Because mothers typically came from poor parts of the city at some distance from the agency, a pick up service was provided. Mothers could continue to use this facility even after they had completed their programme of work and social rehabilitation. Intervention with children aimed at helping children function in the social world outside the family, since their mothers' mental state often interfered with their ability to do this. An RCT comparing mothers involved in the Thresholds programme, and those who only received weekly home visits, was conducted by a doctoral student. At 6 and 12 months post-intervention there was little evidence to support the presumed benefits

	of this intensive treatment compared with the less intense home visitation programme. While the Thresholds group reported lower rates of rehospitalisation (35% versus 50% in the control group) as well as greater 'consumer satisfaction', there were otherwise no differences between treatment and control groups. Ratings of mother-child interactions did not show greater maternal sensitivity. The lower rates of rehospitalisation of Thresholds women were related to adherence to anti-psychotic medication. A decade later, as the value of medication has been widely recognised, greater effort is placed on medication compliance. Psychiatric illnesses were only one of many problems confronting these women and their children. The authors conclude that the Thresholds intervention simply did not last long enough or go deep enough to impact on women's wider social environment.
Do Prado Lima et al (1996)	Authors report on a woman with borderline personality disorder and a history of childhood trauma who showed significant clinical response with low dosage of topiramate. Outcomes included a decrease in emotional abuse of children. Authors propose that topiramate changed some of the main features of this disorder, such as catastrophic reaction to real or imaginary abandonment or rejection, improving adaptive functioning. Authors hypothesize that topiramate might facilitate memory extinction, therefore decreasing emotional and behavioural reactivity.
Gelfand (1996)	Studied demographically matched groups of 38 nondepressed and 73 clinically depressed mothers (aged 18-45 yrs) of 3-13-month old infants in a home visit intervention (37 depressed mothers) or in usual care (36 depressed mothers). More children of depressed mothers were insecurely attached, and children of intervention Ss were less avoidant/inhibited and more resistant/coercive than were children of usual care mothers. Intervention mothers improved more in reported depression and daily hassles than did the usual care mothers and nondepressed mothers. Better maternal and child adjustment accompanied decreased depression. Maternal punitiveness significantly increased in usual care mothers but not in the other groups, yielding a marginal Time x Group interaction. Social support decreased among usual care mothers only.
Grunebaum (1982)	The authors reported on the joint admission a mother with schizo-affective disorder and her infant into a psychiatric ward when no alternative childcare was available. The presence of the baby in the ward focused attention of therapist and mother on her fears and anxieties about motherhood, her past history and her relationship with her husband. The four-month hospitalisation was followed by a lengthy period of psychotherapy. Mother recovered and infant thrived. Subsequent experience of joint admission showed the need for intensive after-care services (usually weekly visits) to deal with the effects of mothers' hospitalisation on other children and family members, and to help families integrate into other community support services.

Gurr et al (1997)	Discusses the NEWPIN program. Pioneered in the London Borough of Southwark in 1982, it was influenced by the rising child abuse figures, and low take-up of ante- and postnatal services in the district. The original aims of NEWPIN were to improve the mental health and self-esteem of mothers and thus to reduce child abuse. After 13 years, NEWPIN now focuses upon the minimization of emotional damage to children and their parents since it is argued that this is the likely prelude to emotional, physical, and sexual harm. The personal experience of one woman is presented to describe what mechanisms NEWPIN offered to facilitate change.
Hinden, et al. (2006)	This study involves interviews with directors of programs that serve parents with mental illness, and their families. Qualitative analyses revealed noteworthy similarities in the target population; source of funding; community context; agency context; mission, theoretical orientation, and assumptions; locus of care and essential services; desired outcomes; and moderators. Program similarities were identified to provide parameters for research, and to contribute to the development of testable hypotheses. All 20 programme directors emphasise the need for (i) a focus on the whole family,(ii) ensuring adequate housing for families and (iii) parent education and support as central features of treatment of mental health problems. Case management was also reported to be desirable and necessary for most families. The authors propose the need to adapt validated instruments that can measure intervention fidelity.
Lyons Ruth (1984)	Authors examine professional services and community-based support provided for troubled, socially disadvantaged mothers and their infants living in disorganized families and suggest that each form of assistance may be useful in fostering the parent-child relationship and improving parenting skills. Two clinical service models used in a family support project are outlined, along with the types of services offered, the project's rationale, and evaluative data.
Jenkins (1996)	Describes the philosophy and program of NEWPIN, an independent voluntary organization in London, working with parents who are experiencing depression, social isolation or mental distress and disturbed relationships with their children. NEWPIN's main thrust is the prevention of child abuse and it is targeted toward families who have no support in the community / it aims to help parents to become aware of the role they have in the relationships they have with their children, and to work with the effects of their own childhood experiences on current relationships.
Malphurs (1996)	Interaction coaching was given to 44 depressed (as measured by the Beck Depression Inventory) teenage mothers (mean age 17.6 yrs) who had either a withdrawn or intrusive interaction style with their 3-6 mo old infants. The mothers were given instructions either to imitate their infants' behaviour or to keep their infants' attention and were videotaped for later coding and analysis. Results suggest that the specific type of interaction coaching for the

	specific type of depressed mother (imitation for the intrusive mothers and attention-getting for the withdrawn mothers) significantly improved their interaction with their infants.
Mondy and Mondy (2004)	This paper suggests that child protection programmes are themselves a valuable source of inspiration for communities, and examine how a centre-based child protection programme, NEWPIN, has set out to engage its national community. Some of the practical and ethical issues involved in this task are discussed in the light of the NEWPIN experience in Australia. NEWPIN is a centre-based intensive child protection and parent education intervention for children under five and their parents. Briefly, however, NEWPIN offers group therapy, play therapy, parenting information, a 24-hour peer support network and direct vocational skill training to 20-25 families who are vulnerable and need guidance and support to improve their parenting skills. NEWPIN has a high proportion of both indigenous parents and parents from culturally and linguistically diverse backgrounds.
Phelan, et al. (2006)	The Parenting and Mental Illness Group Program is a 6- week group programme that is followed by four weekly, individual home visits. Data from the Eyberg Child Behaviour Inventory and Parenting Scale suggest the programme produced positive outcomes in children's behaviour and parenting practices; the programme was also viewed favourably by participants. While encouraging, these findings require replication, using larger numbers and evaluation of the programme in other sites. Supported by an evidence base, programmes such as this will be important to implement if mental health services are to improve outcomes for parents with mental health problems and their children.

Rubovits (1996)	The author describes Project CHILD, a model demonstration programme serving mothers who have chronic psychosis and their children under five. Most participating mothers live alone with children and have troubled relationships with families and children's fathers. As in the case of the thresholds or PACE programmes, mothers take part in a range of activities designed to foster healthy parent-child relationships and stimulate age-appropriate development in children. The focus of Project CHILD is on developing parenting skills (often the 'healthiest' part of a psychotic woman). A psychiatrist or psychiatric nurse provides supportive therapy and medication. Programme components include home visits, mother-baby school, social activities, and community liaison. Baby school has three variations, depending on the age of the child. The first variation is for infants who do not yet walk. This focuses on helping the mother read her baby's cues and respond to them. The second variation involves children in the 12 – 18 age range. The focus at this stage is to enable mothers and toddlers to tolerate limited separation. Finally, the variation for infants aged 18 months and more is to enable children to engage in play groups while mothers meet together without their children. Mothers are also coached during meal times, when tension with children frequently surfaces.
Solantanus & Toika (2006)	The Effective Family Programme was initiated in Finland in 2001 to provide methods for health and social services to support families and children of mentally ill parents. The methods are implemented and clinicians are trained in psychiatric services and primary health care. The methods include the Beardslee Preventive Family Intervention, a parent-focused Let's Talk about Children Discussion and the Network Meeting. The Effective Family Programme represents large-scale implementation of a promotive and preventative child-centred approach in adult psychiatry. The first five years have been successful. Two thirds of health districts have initiated training. However, big challenges lie ahead. While the work was initiated in psychiatric services, it needs to be extended to primary health care and social services as well. Institutionalisation of the methods is still in progress, as well as incorporation of the work into the basic training of all mental health professionals.
Toika & Solantanus (2006)	Mental health clinicians were trained to master interventions and to become trainers for promotion of development and prevention of mental health problems in children with mentally ill parents, as part of the Effective Family Programme. The trainees' experiences of the impact of the training on their professional skills and work satisfaction, on one hand, and implementation of the methods, on the other, were examined. The data was collected by a questionnaire. The 30 respondents (response rate 83%) reported an increase in their professional skills as well as in work-related joy and motivation. Most of them had trained others, and implementation of the new working methods had started. The success factors of the Effective Family training for first phase of the implementation are discussed.

Van Doesum et al (2005)	Many studies have reported on the adverse effects of maternal depression on offspring. Infants of depressed mothers are found to be more likely at risk to develop mental and socioemotional problems. In this study, an early intervention program is presented that aims to improve the interaction between depressed mothers and their infants to prevent developmental problems in the children. The program has recently been introduced in the Dutch Community Mental Health Centres as part of a national multicomponent program to reduce the risk of psychiatric and social problems in the offspring of parents with a mental disorder. The intervention for depressed mothers with babies is based on a transactional model in which the mother-child interaction plays a key role in explaining the development of socioemotional problems in the children. The model as discussed in the first part of this article addresses a range of evidenced-based parental, child, and contextual risk factors that effect the quality of the interactions between depressed mothers and their infants and that contribute to both vulnerability and resilience of the children during later childhood and adolescence.
Anger management	
Fetsch et al. (1999)	Presents the preliminary results of the RETHINK Parenting and Anger Management programmes on participants' mean anger and conflict levels. A pretest-posttest design was applied to a sample of 75 parents (aged 18-70+ years) of infants, toddlers, preschoolers, school age children and adolescents participating in the 6-week series of skill-enhancing workshops. Results indicated that the participants' group mean anger control levels increased and family conflict levels fell. Their overall anger levels and verbal aggression levels fell (p=<.000 and (p=<.002 respectively). Participants reported increased knowledge levels, improved attitudes, improved behaviours, and decreased unrealistic expectations of their children.

Child neglect	
Allin et al (2005)	A systematic review of the available evidence regarding the effectiveness of child neglect treatment programs, including those focused on victims of childhood neglect and (or) their caregivers. Fourteen articles met design criteria. Evidence was found that 2 specific types of play therapy and a therapeutic day treatment program had beneficial effects for children. Further, parents and children in families where neglect had occurred showed improvement with multisystemic therapy. Rigorous studies of treatments for neglected children and their families are lacking. Well-designed and well-conducted evaluations are urgently required to identify effective treatments, which should then be made available to children and their caregivers.
DePanfilis (1996)	Child neglect is the most common form of child maltreatment reported to public Child Protective Services in the US. The author presents evidence that families who are socially isolated, experience loneliness, and lack social support in both rural and urban settings may be more prone to neglect than matched comparison groups. The article reviews the relationship between neglect and these factors and contrasts models for assessing and intervening with neglectful families. Results suggest that modest improvements in the parenting behaviour of neglectful parents can be achieved through the following: (a) differential assessment; (b) a multi-service approach; (c) intense social contacts with a volunteer, lay therapist, or parent aide; (d) use of modelling, coaching, rehearsing, and feedback to improve social interaction skills; (e) development of personal networks; and (f) structured parenting and support groups for socialization, support, and social and parenting skill building.
Lutzker and Rice (1984)	Describes Project 12-Ways, an ecobehavioural approach to the treatment and prevention of child abuse and neglect. Multifaceted in-home services are provided to clients, and in-home data are collected on as many variables related to these services as possible. Four levels of research, data collection, and assessment are used to evaluate these services: (a) data collected for clinical purposes; (b) data from single-case experiments; (c) research through the use of single-subject design logic applied to several subjects or groups of subjects, or by group statistical research designs; and (d) program evaluation. Program evaluation data are presented from a comparison of incidents of abuse and neglect during and after treatment between 50 families served by Project 12-Ways and 47 comparison protective service families. Data show significantly fewer combined abuse and neglect incidents among the families served by Project 12-Ways.
Lutzker et al. (1998)	Project SafeCare is an ecobehavioral research and treatment project conducted with 116 families either reported or at risk for child abuse or neglect. Project SafeCare focuses on 3 areas of intervention: (1) home safety, (2) infant and child health care, and (3) bonding and stimulation (parent-child training). Each service component is conducted over 5

	wks. Two groups of families are served: a nonabuse, at-risk group is referred from a local hospital maternity centre, and an abuse/neglect group is referred from the Department of Children and Family Services. Preliminary demographic data are reviewed along with indirect assessment data and measures including the Child Abuse Potential Inventory, the Parenting Stress Index, and the Eyberg Child Behavior Inventory. Four case studies are described to exemplify the effects of training provided to families. The implications for the current assessment data, treatment and outcome are also discussed.
Sample interventions for faltering growth (failure to thrive)	
Booth (1998)	The Theraplay model aims to develop parents' empathy with children who have failed to attach by helping children and parents experience the pleasure that comes from interacting with each other. During the early, more difficult process of treatment, the Theraplay therapist is available and skilled in providing parents with support and training. The therapist serves as a model-parent, thus ensuring that parents of Failure-to-Attach children know, firsthand, what it feels like to be taken care of. As the parents develop increased skill and empathy, they become more available to their children and understanding of their needs.
Daly and Fritsch (1995)	Presents the case report of a male infant who was admitted twice during his second month of life for failure to thrive. An extensive organic workup was unremarkable. During the second admission, the paediatric inpatient psychiatry team was consulted. Evaluation led to the diagnosis of residual attention deficit disorder (RADD) in the mother. Inattention and impulsivity hampered the mother's ability to feed the child. Successful treatment of the mother's RADD with methylphenidate led to significant improvement in the infant's feeding, subsequent weight gain, and observed maternal-child interaction.
Drotar and Sturm (1988)	Discusses the origins of maladaptive communication between practitioners and parents of nonorganic failure to thrive (NOFT) infants and recommends ways to improve parent-physician interaction. It is suggested that communication with parents of NOFT infants can be enhanced by concerted efforts to understand parental explanations of their child's condition and to involve parents and family members in treatment planning and conflict resolution. Case examples illustrate the utility of eliciting family members' concepts of NOFT, informing parents about the child's diagnosis and treatment, and dealing with conflicts with parents.
Feldman et al. (1997)	The authors evaluated the effects of parent training in conjunction with ongoing medical involvement on the weight gain of 2 children with NOFT (7 and 11.5 mo old). The mothers of these children were considered to have intellectual disabilities. Parent training consisted of weekly home visits in which nutrition and feeding skills were taught via discussions, self-record charts, pictorial prompts, modelling, feedback, and reinforcement. Nutrition training involved shopping, planning, and preparing three balanced meals each day using the four food groups.

	Training in proper feeding techniques revolved around introducing new foods to the child and positive coaxing strategies to encourage the child to eat. Authors found that parent training, combined with ongoing medical advice and supervision, increased the children's weights to the point where they were no longer considered failure to thrive. The results suggest that parent education can serve as an important supplement to outpatient medical care for children at risk for neglect.
Hanks et al. (1988)	Assessed the effect of a focused intervention on an unselected sample of nonorganic failure-to-thrive (faltering growth) children in a community setting, using paediatric, health visiting, and psychotherapeutic assessments and interventions. The intervention was applied to 6 mothers (aged 20-29 years) whose children (aged 11-18 months) were faltering growth children. The once weekly, 6 month intervention was designed to enable the mothers to provide their children with adequate nutrition and resulted in a significant improvement on all weight gain and growth measures. It was concluded that it is possible to produce a substantial and rapid improvement in weight using a scale of intervention that is realistic in terms of community resources. Two case reports are appended. Parents kept a dietary record. This and parents' accounts of management of children's behavioural problems and other parenting issues were the main themes of the sessions. Significant increases in all growth measures were reported post intervention.
Hobbs and Hanks (1996)	Describes a multidisciplinary clinic (involving paediatrics, psychology, dietetics, health visiting, and social work) established in 1993 to provide help for children with failure to thrive (faltering growth). The first 18 months of the clinic's operation are described. The clinic's use of videotaping the children and families eating a main meal and the analysis of the tapes are discussed. A case history of a 8-year-old boy referred to the clinic is given. The children referred to the clinic are described, and their attendance, hospitalization, severity of faltering growth, and improvements while attending the clinic are discussed. It is concluded that the high attendance rates suggest that the clinic is providing a service which is needed, and improvements in the children's growth hopefully reflect real changes in their parent's ability to cope with this difficult problem.
Loewald (1985)	Presents clinical findings obtained in a psychotherapy programme involving 8 mothers with 4 month to three year old children who failed to thrive (i.e., had height and weight below the 3rd percentile of normal for their age and sex). It is suggested that failure to thrive is not a single disease but a syndrome of common outcome. Thinking of its aetiology as a spectrum seems to fit the clinical facts. The project involved two social workers, three paediatric nurses, a clinical psychologist, and a psychiatrist. Offered to parents were information and counselling, periodic developmental testing of the child, play therapy for depressed or disturbed children, coordination of work with social and educational agencies, and regular consultation with the paediatrician. An individualised approach was taken.
Moore (1982)	The article describes Project Thrive, a multicomponent method of

	intervention with families of failure-to-thrive infants that employs supervised social work students who serve as nurturing models and provide support services to mothers
Sample interventions with alcohol-abusing parents	
Burdzovic Andreas et al. (2006)	Psychosocial adjustment in children of alcoholics (COAs; N = 125) was examined before and at 3 follow-ups in the 15 months after their fathers entered alcoholism treatment. Before their fathers' treatment, COAs exhibited greater overall and clinical-level symptomatology than children from the demographically matched comparison sample, but they improved significantly following their fathers' treatment. Children of stably remitted fathers were similar to their demographic counterparts from the comparison sample and had fewer adjustment problems than children of relapsed fathers after accounting for children's baseline adjustment. Thus, COAs' adjustment improved when their fathers received treatment for alcoholism, and fathers' recovery from alcoholism was associated with clinically significant reductions in child problems.
Dumaret and Constantin-Kuntz (2005)	This research has evaluated the impact of a group support designed to help parents to face social isolation, to be responsible for their health and to enhance parental competencies. Twenty-two families from high-risk backgrounds with a prevalent history of transgenerational family alcoholism were assessed through psychological and comprehensive approaches. Families participated in the group support with their infants or toddlers for more than one year; this included professionals and paraprofessionals, too. Evaluation took place seven years on average after receiving such a support: all the mothers and eight spouses were interviewed. This paper focuses on the current situation of the parents, their social relationship competencies and their parenthood. The verbal competencies of the mother were also assessed. Three family profiles were drawn from this analysis, based on their level of autonomy and depending on whether they were raising their child or not. The impact of such an early intervention is notable among these families: intra-family violence has largely diminished, severe neglect and abuse has disappeared, nine mothers out of eleven became alcohol-abstinent. An increased level of autonomy in half of the families also was observed. However, some situations remain precarious and support from social workers is absolutely necessary for very disabled families from high-risk environments.

Moos and Billings (1982)	51 children (mean age 12.4 yrs) of relapsed and recovered alcoholic patients were compared with children from socio-demographically matched control families on a set of indices of emotional and physical status. Parents completed the Health and Daily Living Form and the Family Environment Scale. Children of relapsed alcoholics evidenced more symptoms of emotional disturbance than did control children. In contrast, the children of recovered alcoholics were functioning as well as controls. Additional analyses showed that the emotional status of children was related to the emotional, physical, and occupational functioning shown by their alcoholic and their non-alcoholic parent, as well as to family life stressors.
Feder et al. (2005)	This study is a systematic review of the extant research on court-mandated batterer intervention programs. Experimental and quasi-experimental studies that used matching or statistical controls were included. Results were mixed. The mean effect for official reports of domestic violence from experimental studies showed modest benefit, whereas the mean effect for victim-reported outcomes was zero. Quasi-experimental studies using a no-treatment comparison had inconsistent findings indicating an overall small harmful effect. In contract, quasi-experimental studies using a treatment dropout design showed a large, positive mean effect on domestic violence outcomes. The findings raise doubts about the effectiveness of court-mandated batterer intervention programs.
Fuhrman et al (1999)	Parent education programs are proliferating rapidly throughout North America and elsewhere. A number of new programs address targeted populations such as violent or high conflict families. Specialized programs for violent or high conflict parents have inherent difficulties in screening and availability. The authors urge parent educators not to assume that generic or "mainstream" programs will not have victims or perpetrators of violence in attendance. The authors provide specific advice for making all mainstream programs safe and appropriate for violent families.
Peled (2000)	Enabling children of abused women to maintain a positive relationship with the perpetrator is extremely complex in the light of the potential danger for women and children and the conflicting needs, interests, and rights of different family members. Nevertheless, one cannot ignore the role of abusive men as fathers. Holding such men accountable for their children's well-being may, under certain conditions, contribute to the healthier emotional development of their children. This article critically discusses this controversial issue by examining available literature on (a) children's perceptions of their violent fathers, (b) abusive men as parents, (c) qualifications for abusive men's access to their children, and (d) intervention with children of abusive men and their fathers.

Sample interventions with drug-dependent mothers	
Black et al. (1994)	The paper discusses a home-based intervention for drug and alcohol abusing mothers. It combined case management for personal needs; cognitive behavioural parent skills training; psychoeducation about child development; drug treatment encouraged but not required The intervention took place over fortnightly home visits from pregnancy to 18 months. At 18 months post-enrolment, the intervention group scored higher on two subscales, (i) maternal emotional and verbal responsiveness and (ii) opportunity for variety in children's daily stimulation.
Camp and Finkelstein (1997)	This study reports the effect of incorporating a parenting component in two urban residential treatment programmes for pregnant and parenting drug dependent women. The parenting component consisted of multiple services for both women and their infants while they were in residential treatment as well as aftercare services after discharge from treatment. Participants in both programmes reported gains.
Catalano et al. (1999)	Experimental intervention combined methadone treatment with 33 sessions of parent training. The intervention adapted Focus on Families (FOF), a form of behavioural parent training, for parents in methadone treatment This intervention involves home based management with a dual focus on addiction and parenting. Controls received parent training alone. At 12 months post enrolment, the intervention group showed significant improvements in parent skills and family management and reduction of drug use and deviant peers. Few changes noted in children's behaviour or attitudes.
Grant et al. (1999) & Ernst et al. (1999)	Experimental intervention combines home visitation based, individually tailored parent training and advocacy to ensure families' access to, and incorporation in, wider social support networks for low SES drug or alcohol abusing mothers. Outcome measures involved composite variable drug/alcohol consumption, use of drug/alcohol treatment, family planning, child health care and connection with community services. At 18 months follow-up, results favoured intervention over no-treatment control.
Huebner et al. (2002)	The purpose of this study was to evaluate whether a relatively brief and inexpensive clinic-based education program could benefit parents of infants and toddlers by alleviating parental stress and improving parent-child interaction. Participants were 199 parents of children 1 through 36 months of age who were at risk for parenting problems and child maltreatment due to serious life stress including poverty, low social support, personal histories of childhood maltreatment, and substance abuse. Program effects were evaluated in terms of improvement in self-reported parenting stress and observed parent-child interaction. Positive effects were documented for the group as a whole and within each of three subgroups: two community samples and a group of mothers and children in residential drug treatment.

	Additional analyses illustrated a dose-response relationship between program attendance and magnitude of gain in observed parenting skills.
Kern et al. (2004)	The study examines how the New Connections parent education and support programme for drug-involved parents act on parental stress and symptoms of depression, factors that impact on the psychosocial development of children. Seven domains of parenting stress were measured pre- and post-intervention. Changes in four domains of parenting stress (demandingness, competence, isolation and role restriction) showed significant reduction post intervention. There was significant reduction in depressive symptoms.
McComish et al. (2003)	This article presents findings from a three-year evaluation of a family-focused residential treatment program for women and their children. Longitudinal assessment of the mothers indicated that their psychosocial status and parenting attitudes improved over time. Additionally, the mothers remained in treatment longer. At intake, as a group, the children who were birth to three years of age and did not exhibit developmental delay. However, developmental concerns were identified for some children in the areas of motor and/or language development. The results reported here provide beginning evidence that family-focused treatment improves retention, psychosocial functioning, and parenting attitudes of pregnant and parenting women. It also provides a mechanism for early identification and intervention for children.
Schuler et al. (2002)	This prospective study examined the effects of ongoing maternal drug use, parenting attitudes, and a home-based intervention on mother-child interaction among drug-using women and their children. At 2 weeks postpartum, mothers and infants were randomly assigned to either an Intervention (n = 67) or Control (n = 64) Group. Intervention families received weekly visits until 6 months postpartum and biweekly visits from 6 to 18 months by trained lay visitors. The home intervention was designed to increase maternal empowerment and promote child development. Control families received brief monthly tracking visits. Mother-child interaction was evaluated at 18 months through observation of play. Mothers who continued to use cocaine and/or heroin had lower competence scores ($p < .05$); poor parenting attitude was also associated with lower competence scores during mother-child interaction ($p < .05$). Although the intervention had no measured effect, ongoing maternal drug use and poor parenting attitudes were associated with less optimal maternal behaviour during mother-child interaction.

Appendix 5: Included and excluded studies in alphabetical order

Included Studies

Bakermans-Kranenburg MJ, van IJzendoorn MH, Juffer F (2003) Less is more: meta-analyses of sensitivity and attachment interventions in early childhood. Psychol Bull 129:195-215

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