What makes a difference? Supporting families in caring for children

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Introduction

This chapter will seek to address what makes a real difference in supporting families doing the work of bringing up children. I will argue that although the immediate family – the source of the primary attachment relationships – are where much of what is of significance in early development really takes place, a highly systemic approach to supporting attachment figures and providing treatment where necessary is congruent with the evidence for what works for children and young people facing mental health difficulties. It is also, as we will set out in the first section of this chapter, congruent with recent developments in our thinking in relation to mentalizing and epistemic trust. And at a very human level, it is in keeping with our basic sense – although one that has perhaps been undermined by aspects of modern life – that raising children is a collective effort, that 'it takes a village to raise a child.'

The first 1,000 days of life are a period of rapid and complex development, which most critically takes place in the context of the family environment. And families are doing this extraordinary work of building new minds in an ever-more complex and demanding environment. Entrenched social inequality, the cost of childcare, the cost of living, decreased social mobility, diminished access to local family and social support networks; these all form the very real backdrop against which families are operating, with very real effects. Increasing scientific knowledge – in the fields of neurobiology, developmental psychopathology, epidemiological outcomes studies – all indicate that social disadvantage and adversity have a direct

impact on child development (Center on the Developing Child at Harvard University, 2016; Cicchetti & Banny, 2014). The research consensus is overwhelming. And while there is no clear-cut research evidence about how to solve these wide social issues, there is a growing body of evidence on the kinds of interventions that can really make a difference to families. In the second half of this chapter we will discuss in more detail some of the interventions that the evidence shows to be effective for some of the most prevalent mental health difficulties that affect children. But we will begin by explaining how recent developments in our thinking on how the child's relationship with the social environment – in the first instance in the context of attachment relationships – relate to thinking about developmental psychopathology and the issue of resilience.

Creating a mentalizing system around the family

We still maintain a fundamentally attachment-informed perspective of how infants need responsive caregiving from primary attachment figures as a foundation stone for their happiness and wellbeing in the here and now, and for their ongoing emotional, cognitive and social development. But in a development from the traditional emphasis on the infant-caregiver dyad, we locate these earlier relationships in a much broader context, in terms of the social support that the dyad needs, and the wider social learning and meaning conveyed to the infant by experiencing those early relationships as supported. In recent years, the theory of mentalization has expanded to consider another important function of attachment relationships, namely their role in the development of epistemic trust – that is, trust in the authenticity and personal relevance of interpersonally transmitted knowledge (Fonagy, Luyten, & Allison, 2015). Epistemic trust enables social learning in a fluid and unpredictable social and

cultural context, and allows individuals to adapt to and benefit from their social environment – an essential component of resilience (Fonagy, Luyten, Allison, & Campbell, Forthcoming) .

As humans, given the social and practical complexity of our environment, much of the information we are presented with – and which we must convey – is complex and not immediately self-explanatory. Furthermore, as it can be harmful for us to accept all information indiscriminately we often approach new ideas or facts with a self-protective scepticism – the idea that children passively accept all information they are given has not been confirmed by recent research (Chen, Corriveau, & Harris, 2013; Corriveau, Meints, & Harris, 2009; Fusaro, Corriveau, & Harris, 2011; Harris & Corriveau, 2011). To accommodate the dilemma of needing to receive large amounts of complex social knowledge in order to function adaptively while also needing to discriminate when communicators are not reliable or well-meaning, Csibra and Gergely formulated the theory of natural pedagogy: this is the idea that humans have evolved a specialized form of social cognition which is highly sensitive to cues from the communicator, to open the channel for transmitting cultural knowledge (Csibra & Gergely, 2006, 2009, 2011). When the communicator provides the appropriate cues, the listener will respond with epistemic trust. The cues that stimulate epistemic trust in this way include eye contact, turn-taking, contingent reactivity and the use of a special tone of voice. These signals prepare the recipients of information, alerting them that the content being conveyed is relevant to them and should be incorporated as part of their general understanding of how their environment operates, i.e., it should be stored as part of their procedural and semantic rather than episodic memory.

We suggest that one of the benefits of secure attachment relationships is that they generate the conditions for a general opening of epistemic trust. More generally, responding to someone contingently (a key feature of secure attachment) is an indicator of a recognition of agency. The process of mentalizing that takes places in the contingent caregiving interactions of a secure attachment relationship in effect constitutes a powerful ostensive cue underpinning the relaxation of epistemic vigilance within that relationship (Fonagy et al., 2015). The child regards their caregiver as a reliable informant about the world; the social knowledge conveyed by the parent is accepted as part of their shared cultural currency that cumulatively builds up to enable the child to successfully navigate their shared social environment.

We suggest that many forms of psychopathology may be associated with a disruption of epistemic trust and the social learning process this trust normally enables (Fonagy, Luyten, & Allison, 2015). If a caregiver is unable to mentalize their infant effectively, not only will the child's own developing capacity to mentalize be compromised but (given the importance of mentalizing in providing ostensive cueing) the child's capacity for social learning will suffer. Many mental disorders have in common the feature of apparent rigidity and an incapacity to learn about the social world. Everybody seeks social knowledge, but without the reassurance and support of trusted caregivers, family or peers, the content of communication can be confusing and it may be rejected due to perceived hostile intent. In that sense, expressions of mental disorder might be considered manifestations of failings in social communication arising from epistemic mistrust, epistemic hypervigilance, or outright *epistemic freezing* (petrification) (Fonagy et al., 2015). Such disruptions of epistemic trust manifest as a reluctance to update beliefs, perceptions and expectations, regardless of the social experience that might indicate that such beliefs are

inappropriate or incorrect. Individuals who have experienced severe trauma and/or who are suffering from personality problems may be left with a complete inability to trust others as sources of knowledge about the world. An individual who has been traumatized in childhood, for instance, has little reason to trust others and will reject information that is inconsistent with their pre-existing beliefs. As therapists, we may consider such people "hard to reach", yet they are simply exhibiting an adaptation to a threatening social environment in which attachment figures were not regarded as reliable.

The concept of resilience is a dominant theme in discourses on child and adolescent mental health: many factors have been associated with it – from genes to parenting style to neighbourhood – but a definitive, integrative account of what single mechanism underpins the activation of these factors has been elusive. We have recently suggested (Fonagy, Luyten, Allison, & Campbell, Forthcoming) that the missing link in terms of understanding the mechanism for resilience may be disrupted epistemic trust, whether through genetic propensity, environmental influence or an interaction between the two. Epistemic hypervigilance or outright epistemic freezing limits an individual's capacity to benefit from, adapt to and responsively interact with their social environment. A lack of resilience, we suggest, emerges from the absence of flexibility in relation to the social environment that is associated with epistemic mistrust.

This is a perspective on the emergence of psychological vulnerability as an outcome of disruptions in relation to social cognition. It suggests that a lack of resilience/social flexibility is a by-product of an inability to respond to cues from the social environment in order to learn how best to adapt to it. This has powerful implications for thinking about how we approach supporting families in the first 1,000

days. It strongly confirms the idea that in order to be effective, interventions to support the developing mind of infancy have to be accompanied by a social environment that reinforces flexible social learning, i.e., a social environment which is supportive of mentalizing and does not generate chronic, overwhelming levels of stress. We cannot expect the primary attachment figure to maintain balanced mentalization in isolation. Particularly so if they are functioning in a non-mentalizing social environment, and/or if their infant – either for biological or experiential reasons – has a tendency to hide their mind from their parent, i.e. to be more resistant to mentalizing. If a child has this tendency, the parent may appear to be 'failing' to mentalize their child, with the consequent developmental implications for the child in terms of missing out on the full the experience of learning about themself through the feeling of being recognized and mirrored by the parent. The highly interactional and context-driven nature of mentalizing certainly challenges the tendency towards parent-blaming that has traditionally coloured some aspects of the therapeutic approach

This thinking, we argue, is congruent with the five key characteristics associated with positive outcomes across a range of interventions highlighted by the Harvard Centre on the Developing Child's (Center on the Developing Child at Harvard University, 2016) powerful and important new report, *From best practices to breakthrough impacts*:

1. Adults – parents, teachers, child care staff – need to strengthen their skills so they can support the healthy development of the children in their care
2. Interventions need to be tailored to address causes of major stress for families, such as homelessness, violence, children's special needs, parental depression.

3. The health and nutrition of children and mothers must be supported before during and after pregnancy
4. Improve the quality of the broader caregiving environment and increase economically disadvantaged families' access to higher-quality care
5. Establish clearly defined goals and implement a curriculum or intervention plan that is designed to achieve those goals. (Center on the Developing Child at Harvard University, 2016)

The report further argues compellingly that in order to really make a difference to children's lives in the early years, we have to implement some real shifts in the way we think about intervening to support young children, these are: 1) that early experiences affect physical and mental health, not just learning, 2) that healthy brain development requires protection from excessive stress, not just a stimulating environment, and 3), achieving breakthroughs in outcomes in relation to children experiencing adversity requires us to support the adults who care for them to transform their own lives (Center on the Developing Child at Harvard University, 2016). Maltreatment and social stressors form an allostatic load that place a cumulative burden (Rogosch, Dackis, & Cicchetti, 2011). Such non-optimal circumstances form a powerful cue, we argue, to the infant about the system in which they are functioning (one in which showing epistemic trust, for example, may not be advisable). If we are to make a real difference in the lives of children in the first 1,000 days, we have to think broadly about intervening to change what the child is learning about their social world.

Targeted support for particular needs

Attachment

We have compelling research evidence now indicating that attachment is malleable, and that interventions in childhood can result in children previously showing disorganised or organised/insecure styles attachment patterns coming to be measured as secure (Cicchetti, Rogosch, & Toth, 2006). A large meta-analysis of early preventive interventions (70 studies) aimed at parental sensitivity and infant attachment security found that such interventions did appear effective. The most effective interventions used a moderate number of sessions and a clear-cut behavioral focus in families with, as well as without, multiple problems (Bakermans-Kranenburg, van Ijzendoorn, & Juffer, 2003). The interventions which focused on sensitive maternal behaviour, were successful in improving insensitive parenting as well as infant attachment insecurity.

In accordance with such evidence, the NICE attachment guidelines suggest that when pre-school age children have or are at risk of attachment difficulties, and are on the edge of being taken into non parental care, intervention in the form of a video feedback programme should be provided for parents. This programme seeks to help them improve their nurturing of their infant, particularly when the infant is distressed; improve their understanding and interpretation of their child's behaviour; respond positively to cues and expressions of the child's feelings; behave in ways that are not frightening to the child; and improve self-regulation of their own feelings when nurturing the child. The NICE guidelines further recommend that this programme is delivered by a trained and experienced health or social care worker and consists of 10 sessions delivered over 3 to 4 months. Each session should include 10-20 minutes' filming of the parents interacting with the child, and then the worker

should watch the video with the parents and in this part of the process, highlight parental ‘sensitivity, responsiveness and communication’ as well as signs of parental strengths and improvements in behaviour (National Institute for Health and Clinical Excellence, 2015).

The guidelines further recommend that if the parents do not agree to take part in a video feedback programme, or if there is little improvement in parental sensitivity or child attachment, or there are other causes for concern, further interventions are indicated in the form of home-visiting programmes that take place over 18 months (National Institute for Health and Clinical Excellence, 2015).

Maltreatment

In cases of preschool aged children who have suffered or are at risk of maltreatment The NICE attachment guidelines recommend that parent-child psychotherapy be considered, while addressing safeguarding concerns (National Institute for Health and Clinical Excellence, 2015). This psychotherapy needs to address attachment concerns and should be based on the Cicchetti and Toth model (Cicchetti et al., 2006). It is recommended that this intervention takes place weekly and lasts over a year, is delivered in the home by a trained therapist, involves directly observing child-parent interactions, and explores parental understanding of the child’s behaviour and the relationship between the parents’ reaction to the child’s behaviour and perceptions of the child and the parents’ own childhood experiences. In the randomized preventive trial conducted by Cicchetti and colleagues to compare the effectiveness of an infant-parent psychotherapy programme and psychoeducational parent intervention for one-year-old infants in maltreating families, substantial increases in secure attachment were found in both the treatment groups at follow-up at 26 months (whereas increases

in secure attachment were not found in the community standard controls) (Cicchetti et al., 2006). However, a twelve-month follow up study found that the psychotherapy intervention had more sustained efficacy in terms of attachment security than the psychoeducational parenting intervention The children who had received child-parent psychotherapy had higher rates of secure attachment (55.6%) and lower rates of disorganized attachment (25.9%) at the 12-month follow-up assessment than children in the PPI (22.7% secure and 59.1% disorganized) and the community standard control (12.2% secure and 49% disorganized) conditions. Intriguingly, this suggests that the parenting psycho-educational interventions although promisingly efficacious by the end of treatment, did not demonstrate a sustained efficacy (Stronach, Toth, Rogosch, & Cicchetti, 2013).

Parental mental health

Parental mental health difficulties – in particular depression and anxiety – have been shown to be a risk factor for children, especially in particular behavioural problems, insecure attachment, depression and anxiety (S. L. Toth, Petrenko, Gravener-Davis, & Handley, 2016) (Halligan, Murray, Martins, & Cooper, 2007). There is clear evidence presented elsewhere in this book (Pawlby TBC; Barlow, J. TBC; Murry, TBC) of the risks associated with for example post-natal depression. A recent systematic review and meta-analysis of interventions to prevent mental disorders in the children of parents with mental illness found that interventions to protect such children appear to be effective (Siegenthaler, Munder, & Egger, 2012). A randomised preventive trial of child-parent psychotherapy (CPP) with 130 toddlers of mothers suffering with major depressive disorder found that the toddlers in the CPP treatment group had higher rates of secure attachment compared to those in depressed control group and the non-depressed comparison group (S. L. Toth, Rogosch, Manly, & Cicchetti, 2006). This

study was recently extended into a randomised clinical trial of the efficacy of interpersonal psychotherapy for economically disadvantaged mothers, which supported the efficacy of the intervention (S.L. Toth et al., 2013).

Parenting programmes

The most common reason for referring children to mental health services, and a major expenditure on health and social care and other professional resources, is conduct disorder (CD). Frequently comorbid with ADHD, and anxiety and depression, early onset CD is associated with slightly worse outcomes than adolescent-onset CD. CD is a risk factor for later substance misuse, and a risk factor for children with CD developing antisocial personality disorder as adults is the presence of callous and unemotional traits. Adaptive parenting practices, such as warm parent-child relationships – may well act as a buffer that provides protection against the biological risk factors – for example, temperamental fearlessness – for psychopathology. Parenting programmes might be helpful for families struggling with managing their young child's behaviours in ways that are of some preventive value. Intervening at the level of the family has been shown to be particularly relevant in cases of children with conduct difficulties: we have strong evidence that changing abnormalities in families' interaction patterns through parent training has the power to alter the child's behaviour (Sanders, TBC). There is very strong evidence (large number of RCTs) that parent training programs may be applied to a wide range of conduct problems and can be delivered effectively in various settings (Dretzke et al., 2009; Dretzke et al., 2005). On average, about two thirds of conduct-disordered children under 11 years of age whose parents participate in parent training improve. When it comes to research evidence on the efficacy of parenting programmes' among

younger children, a review, based on eight randomized and quasi-randomized studies has shown that group-based parent training was effective in preschool children (Barlow, Smailagic, Ferriter, Bennett, & Jones, 2010). The group-based interventions were brief (4–12 weeks) and were significantly effective in reducing children's problematic behavior and improving emotional and behavioral adjustments, as reported by parents (SMD = -0.25). However, the long-term benefits of group-based parent training are uncertain; three follow-up studies included in the meta-analysis showed the intervention to be effective when measured by parents but not to have a significant effect when measured by independent observations. The most well established of the parenting programmes are the Incredible Years Programme, the Triple-P Positive Parenting Program and the Oregon Social Learning Center Programs.

Conclusion

Helping children in the first 1000 days really means helping families. In our evolutionary past, each infant would probably have been surrounded by an extended family network of supportive adults; now parents are increasingly isolated in their caregiving. This is at one level deeply unnatural, and puts an unprecedented strain on parents. The importance of high-quality childcare provision, responsive and mental-health aware GPs, nurses and health visitors are critical ways in which families with young children can be helped and encouraged to access services (Lewing, TBC). Young children cannot ask for help: we need to create an environment in which their parents are able to access help on their behalf, or in which professionals are able to recognise family need and services can be accessed in a non-stigmatising way. Any parent with concerns about their child's mental health should feel able to seek help

without feeling judged. This work is about supporting families, and providing interventions where needed via families. We have the research evidence to show us what works, it is now a matter of creating mentalizing educational, health and social care systems that can reach out to parents, and to which parents are able to reach without shame or obstruction.

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