



Parent-infant Psychotherapy for the Secondary and Tertiary Prevention of Infant Mental Health Problems: A Systematic Review

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Date Submitted to C2 SWG: Jan 2013

Approval Date C2 SWG: April 2013

TITLE OF THE REVIEW

Parent-infant Psychotherapy for the Secondary and Tertiary Prevention of Infant Mental Health Problems: A Systematic Review

BACKGROUND

Briefly describe the problem that the interventions under review are aiming to address, the relevance to policy and practice, and the objective(s) of the review.

Infant regulatory disturbances such as excessive crying, feeding or sleeping problems alongside bonding/attachment problems represent the main reasons for referral to infant mental health clinics (Keren et al., 2001). Increasing evidence has emerged from a range of disciplines during the last decade about the role of the parent-infant relationship in the aetiology of childhood psychiatric disorder. Recent research has shown that many infant problems of this nature are closely interlinked with the infant-caregiver relationship (Hofacker et al., 1998), and one three-year follow-up study showed that self-regulation disorders of infancy (such as eating and sleeping problems) were strongly associated with delays in motor, language and cognitive development at 3-years of age in addition to continuing parent-child relational problems (Degangi et al., 2000).

One of the key mediating mechanisms that have been identified is the child's attachment system, and their subsequent ability for affect regulation. Specifically, the evidence suggests that 'Disorganised' attachment is strongly associated with a range of childhood disorders that have continuity with later psychopathology (Green and Goldwyn 2002).

A number of forms of 'atypical' parent-infant interaction have been identified as being significant predictors of attachment disorganisation, including affective communication errors (e.g. mother positive while infant distressed), disorientation (frightened expression or sudden complete loss of affect), and negative-intrusive behaviours (mocking or pulling infants body) (Lyons-Ruth et al 2005). A systematic review (i.e. meta-analysis) of 12 studies found a strong association between disorganized attachment at 12-18 months and parenting behaviours characterized as 'anomalous' (i.e. Frightening, threatening, looming), dissociative (haunted voice; deferential/timid), or disrupted (failure to repair, lack of response, insensitive/communication error) (Madigan et al 2006).

Transactional models of mother-infant relations that recognise the 'bi-directionality' of the mother-baby relationship, and that a considerable amount of 'co-regulation' takes place between mother and baby (Beebe and Lackman, 2005; 1988), and suggests there is a need to work with both mother and infant to address both infant developmental problems and maternal mental health problems, by providing a range of secondary/tertiary level services for children presenting with problems that have their origins in the early parent-infant/child relationship.

Over the past two decades, a range of interventions have been developed to address developmental problems in the infant, and mental health problems in the parent with a view to promoting optimal infant development. The former typically comprise behavioural interventions that are directed at helping the parent to develop new parenting skills, such as for example, parent training programmes (e.g. Black 1997), and the latter, have typically focused on parent counselling (e.g. Cooper 2003). However, there is limited evidence of a positive benefit as regards the mother-child relationship or child outcomes (e.g. security of attachment, infant cognitive development etc.) (Murray 2003).

Parent-infant psychotherapy is increasingly being used to address a wide range of problems that can arise during the ante- and postnatal periods. Parent-infant psychotherapy is a dyadic intervention (i.e. is delivered concurrently to the parent and infant), and involves a parent-infant psychotherapist working directly with individual parent-infant dyads in the home/clinic/hospital. 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 (Cramer 1988).

More recently representational and behavioural approaches have been combined, and '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 (Cohen 1999).

In summary, parent-infant interaction is a significant factor for infant mental health (e.g. Fonagy 2002), and problems with the parent-infant relationship are common (Keren, Feldman and Tyano 2001). There is a growing body of evidence pointing to the effectiveness of parent-infant psychotherapy (Cohen 2002; Cohen 1999), and suggesting that different forms of the therapy may be differentially effective for parents with different types of attachment insecurity (Bakermans-Kranenburg 1998). However, there has to date been only one 'thematic' summary of the evidence about the effectiveness of parent-infant psychotherapy (Midgley 2004), and only one UK-based RCT which has not yet reported.

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OBJECTIVES

The objective(s) should be listed as questions which the review will aim to answer.

1. To synthesise data from rigorous studies to identify the benefits in terms of infant mental health; parental well-being and parent-infant interaction;

2. To assess the meditational role of parental well-being on infant outcomes.

EXISTING REVIEWS

List any existing systematic reviews on the topic, and justify the need for this review if existing reviews exist or are in progress.

None known

INTERVENTION

Describe the eligible intervention(s) and comparison(s) clearly in plain language. What is given, by whom, to whom, and for how long? What are the comparison conditions (what is usually provided to control/comparison groups who don't receive the intervention)?

Describe any similar interventions that will not be eligible and justify the exclusion.

Parent-infant psychotherapy programmes in which the intervention is delivered on a one-to-one basis in any setting (i.e. clinic, hospital or home) by a specialist parent-infant psychotherapist, and with the primary aim of improving parental internal working models, or parental representations of the infant.

Comparison: treatment as usual or waiting list control

POPULATION

Specify the types of populations to be included and excluded, with thought given to aspects such as demographic factors and settings.

Parent-infant dyads up to and including infants 24 months of age, in which the parent is experiencing mental health problems; domestic violence; substance misuse or child abuse, or the infant is showing signs of attachment and/or dysregulation problems.

OUTCOMES

List the primary and secondary outcomes for the review including all outcomes important to those who will be affected by and those who will make decisions about the intervention(s). Give thought to the inclusion of adverse and unintended effects, resource use, and outcomes along the causal chain.

Primary: The following outcomes will be extracted provided that they have been measured using a standardized (parent-report or independent observation) measure:

1. **parental**, including mental health and parenting stress (standardised assessments);
2. **infant**, including standardised assessments of physical and socio-emotional development; parent-infant relationship.

Studies will be included provided at least one of these outcomes is reported. Timing of outcome assessments will include post intervention and follow up times points. Any adverse effects of interventions will be included as an outcome measure.

Secondary: None

STUDY DESIGNS

List the types of study designs to be included and excluded (please describe eligible study designs). Where the review aims to include quantitative and qualitative evidence, specify which of the objectives noted above will be addressed using each type of evidence.

We will include randomised controlled trials (RCTs) and quasi-randomised controlled trials in which participants have been randomly allocated to an experimental or a control group, the latter being a waiting-list, no treatment, treatment as usual (normal service provision) or a placebo control group. Quasi-randomised controlled trials are defined as trials where allocation was done on the basis of a pseudo-random sequence, for example, odd or even hospital number, date of birth or alternation (Higgins 2009). We will also include studies comparing two different therapeutic modalities (that is, without a control group).

Subgroup analysis will be conducted to explore the impact of the age of the infant and the duration of the program.

Sensitivity analyses will be conducted to test if the findings of the meta analyses are robust, by examining the effect of variables between the studies, RCTs and quasi-RCTs, risk of bias.

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ROLES AND RESPONSIBILITIES

Please give a brief description of content and methodological expertise within the review team. It is recommended to have at least one person on the review team who has content expertise, at least one person who has methodological expertise and at least one person who has statistical expertise. It is also recommended to have one person with information

retrieval expertise. Please note that this is the **recommended optimal** review team composition.

- Content: **JB, NM**
- Systematic review methods: **All authors**
- Statistical analysis: **All authors**
- Information retrieval: **The TSC of the Cochrane DPLPG, working with all authors**

POTENTIAL CONFLICTS OF INTEREST

For example, have any of the authors been involved in the development of relevant interventions, primary research, or prior published reviews on the topic?

Dr Cathy Bennett is the proprietor of Systematic Research Ltd, a company which provides research activities in evidence based medicine. Dr Bennett will receive a consultancy fee for her work on this review. Dr Bennett is also paid for her work with other clients who have engaged her company's research services. We do not perceive this a conflict of interest but make this declaration in the interests of transparency.

PRELIMINARY TIMEFRAME

Note, if the protocol or review are not submitted within 6 months and 18 months of title registration, respectively, the review area is opened up for other authors.

We hope to complete the review by the end of June 2013.

**Form CONVERTED from Cochrane DPLPPG
version: April 2013**