
Does training in a systematic approach to emotional abuse improve the quality of children's services?

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Background

Child maltreatment in general and emotional abuse in particular are common and harmful, in many cases the harm extending into adulthood (Gilbert et al. 2009(a)). Emotional abuse is the second most common reason for children becoming the subject of a child protection plan in England (Department for Education, 2011). Moreover, some 80% of children who are physically abused and neglected also experience emotional abuse (Claussen & Crittenden, 1991; Glaser, Prior & Lynch, 2001). Emotional abuse is, therefore, arguably the most common form of child maltreatment, co-occurring with other forms as well as on its own.

Emotional abuse has posed a number of difficulties for professionals working in the field of child protection:

- **Different terms** used (Baker, 2009) including emotional abuse, psychological maltreatment (APSAC, 1995), psychological abuse (O'Hagan, 1995; Moran, Bifulco et al., 2002) and emotional neglect;
- Difficulties in **defining emotional abuse** (e.g. Brassard & Hardy, 1997); inconsistency in agreeing what aspects should be included e.g. exposure to domestic violence (Baker, 2009); lack of clarity about the difference between actual emotional abuse and neglect and parental risk factors – especially mental ill-health, drug and alcohol abuse, and domestic violence (Cleaver, Unell & Aldgate, 2011);
- Significant **under-recognition, under reporting** and therefore a **delay** in, or a lack of intervention in child maltreatment in general (Gilbert et al., 2009(b)) and emotional abuse in particular (Glaser, Prior & Lynch, 2001; Trickett, Mennem et al., 2009). The frequent co-occurrence of other forms of child maltreatment leads to an initial focus on more easily recognised forms such as physical abuse (Glaser, Prior & Lynch, 2001; Hart, Brassard, Davidson et al., 2010);
- Difficulties in determining **severity** and a **threshold** for intervention;
- Sparse literature on proven **interventions** (Hart, Brassard, Davidson et al., 2010; Barlow & Schrader McMillan, 2010). Some evaluated interventions are offered to families where there is emotional abuse, which is not, however, explicitly named or reported as such (e.g. Cicchetti, Rogosch & Toth, 2006; Skowron & Reinemann, 2005). Even very competent clinicians often do not evaluate the outcome of their work systematically.

A coherent conceptual framework encompassing the definition, recognition, assessment and management of emotional abuse, thus including elements of secondary and tertiary prevention, has been developed in the UK (Glaser, Prior and Lynch, 2001; Glaser, 2002; Glaser, 2011) and termed FRAMEA. It aims to

simplify the complex concerns about children and families which professionals encounter; increase their rate of recognition of emotional abuse within families of concern and; intervene more specifically when emotional abuse is recognised.

FRAMEA defines emotional abuse and neglect as the presence of non-physical, persistent, harmful parent-child interactions. The FRAMEA approach begins by encouraging professionals to observe and gather information about the child and family, followed by organising this information into tiers of concern, rather than seeking for the presence or absence of multiple single items according to a checklist.

The tiers of concern are:

- Tier 0 - Social and Environmental Factors
- Tier 1 - Caregiver risk factors – mental health problems, domestic violence, drug & alcohol misuse, significant unresolved history of childhood maltreatment
- Tier 2 - Caregiver-child interactions
- Tier 3 - Child's functioning

(For further details of the tiers please see appendix 1)

Although the framework has been taught and presented both nationally and internationally to many professional groups, and has also been implemented in practice (Boulton & Hindle, 2000), there has been no systematic testing of the utility of the framework. This study utilised FRAMEA to enhance professionals' definition, recognition, assessment and management of emotional abuse.

Aims of the study

The overall aim of this study was to investigate whether training and follow up consultation in FRAMEA would improve professional activity in terms of clarity of conceptualisation of concerns, recognition of emotional abuse and the nature of professional response and intervention in emotional abuse.

The research aimed to address the following research questions:

1. Is there greater clarity in presentation of concerns about families?
2. Is there a net increase in recognition of cases of emotional abuse in each of the professional settings?
3. Is there a reduction in the naming of emotional abuse based on parental risk factors?
4. Is there a reduction in the naming of emotional abuse based on harmful effects on the child?
5. Is there more appropriate service provision or referral to other agencies in cases of emotional abuse?

Methodology

The sample comprised professionals in four children's services settings.

Training

Training in FRAMEA was provided over one day by one trainer at four time points, at each of which four children's services teams were separately trained. The four children's services teams comprised: health visiting (n=51 trained); children's social care referral and assessment teams (n=106 trained); children's social care children in need teams (n=105 trained); and multidisciplinary child and adolescent mental health services (n=73 trained). The teams were from four ethnically diverse geographical areas, two in London and two in semi-rural areas. The decision to offer the training and consultation within services rather than in multi-agency/multi-disciplinary settings was based on the belief that what different professionals needed initially was to embed new thinking into their particular practice; the concerns, preoccupations and tasks of the respective services were different.

There were three month intervals between each of the training time points. Each of the 16 professional teams was randomly assigned to one of the four training time points, thereby staggering the intervention across the 16 teams. The day's training comprised a combination of elicited contributions from the participants (all of whom were experienced professionals), PowerPoint presentation, discussion and small group work as well as continuous opportunities for trainees to raise questions and seek clarifications. Participants were also requested to identify obstacles to implementing elements of FRAMEA into their practice and discuss ways of overcoming these obstacles. The training was accompanied by handouts, some laminated.

Training was followed by consultations to the professional teams, mostly offered by the trainer and some by other members of the research team. The first consultation, held within two months of the training, included a summary of the main points in FRAMEA and served to refresh professionals' memories. It was followed by two more consultations during which cases were discussed according to FRAMEA. Consultations were irregularly attended across the services. Overall, most trained child and adolescent mental health services (CAMHS) professionals attended consultations, while the attendance for the other services varied. Reasons given were pressure of work and staff shortages. Thirty seven professionals who had not been trained (either missed the training or joined the team after training) attended consultations.

Local inter-agency meetings were held at the completion of the study to discuss communication and respective thresholds for emotional abuse and neglect. These meetings had been planned and agreed with the various services at the beginning of the study.

Measures

The two main measures used to assess the effectiveness of the training on professional practice were designed specifically for this study. These were 1) Reasons for Family Referral Instrument (RFRI) and 2) Service Utilisation Inventory (SUI). These were completed by professionals and coded by the researchers.

For social workers and CAMHS, the measures were applied to the case files of 5 successive cohorts of children referred to these services. Some, but not all, would have been emotionally abused. Some of the analysis of the results applied only to the sub-sample of children who had been emotionally abused. Health

visitors were requested to complete the measures in respect of 5 cohorts of all the children and families where they considered emotional abuse to be present.

For both the RFRI and the SUI, coders were blinded as to the training status of the professionals completing the measures i.e. whether the professional was completing the measure before training, after training or after training and consultation. Inter-rater reliability measures across four coders were applied to the 79 variables in the RFRI and >200 variables (depending on the service) in the SUI. Agreement ranged from 100% to 45%, most being >70%. Where coders had any uncertainty about how to code an item, this was discussed at a panel meeting with at least 3 coders.

Reasons for Family Referral Instrument (total of 1645 collected)

This is a simple, narrative based questionnaire which asks open questions about the nature of the professional's concern with respect to a particular child or family. Versions were developed for each profession. Data were collected for 5 cohorts of children at three-monthly intervals. RFRI data collection thus spanned 15 months.

A coding system for the RFRI based on FRAMEA was developed by the research team. This included binary and 3-point scales, based on the professionals' description of the concerns in the RFRI. The contents of the descriptions were assigned into one of 4 tiers of concern. Within each tier, there were a number of possible variables which were marked as present or absent. Global scales, applied to the overall description were created for a number of specific aspects of the description: presence of tiers; separation of tiers; structure of the RFRI (i.e. way in which information is presented); level of description; coherence of RFRI (i.e. internal consistency, connectedness); and severity of both actual emotional abuse and actual impairment in the child.

Service Utilisation Inventory (total of 851 collected)

The SUI, for health visitors, social care children in need teams and CAMHS teams, is a semi-structured interview seeking information about current concerns, services offered and taken up by the families, presence of emotional abuse and the professional's current assessment of Tier 2 (parent-child interactions) concerns, including the five categories of emotional abuse (see appendix 1 for further details). Versions were developed for each service. As with the RFRI coding system, the companion SUI coding system seeks to collate information about children and families across a wide range of possible circumstances; thus, for individual children, many variables will be coded as not present. This however, is important information and requires a 'positive' judgment by the coder to code the item as absent.

SUIs were collected with respect to children and families reported in the RFRIs. For health visitors, there was one follow-up SUI interview at 6 months; professionals in children's social care children in need teams and CAMHS teams were followed-up with the SUI interview at 6 and 12 months; and for CAMHS the child wellbeing measures were also sought. According to this sequence, the last 12 month SUIs were completed 12 months after the final RFRI data collection, taking the duration of data collection to 27 months. The RFRIs and SUIs collected before training were termed baseline data.

The Service Decision Inventory (SDI) was used for social care referral and assessment teams only and attached to the RFRI (total of 306 collected). It comprises a set of written questions which seek to ascertain the service response to the difficulties and concerns described by the professional. Professionals are asked to provide 'Yes' or 'No' answers to questions concerning whether the family or any child was referred to another team in children's social care, to a child protection conference, to another service; whether the Referral & Assessment team was continuing to work with the family; whether the case was closed; and any

other action. Elaboration of each answer is requested.

Analysis

Chi square and regression analyses were conducted for various measures on the training variables. Results regarding the effect of training and consultation are reported only if significant at $p < 0.05$ or less, or if trends were considered important. For regressions each analysis was run three times (1) for all the professionals who had completed measures; (2) for only those professionals who had completed measures both before and after training and (3) for those professionals who had completed measures either before or after training.

Outcomes for children were to be collected by CAMHS teams, utilising the Strengths and Difficulties Questionnaire (SDQ) and Children's Global Assessment Scale (CGAS). In the event, SDQs were completed for too few children to be usable and there were only limited CGAS data. Thus, we were unable to measure outcomes for children.

Findings

Evaluation of training

Findings from the evaluation forms the professionals were requested to complete at the end of the training day showed that the training was viewed very positively. Three hundred and thirty five professionals were trained in 21 training sessions. Some participants failed to return the evaluation form or answer particular questions, thus the numbers of those who contributed to the evaluation is less than 335.

All participants enjoyed the course and would recommend it to others and most participants said the course met their expectations and was relevant to their day-to-day or future work.

The combined percentage for 'Excellent' and 'Very good' on the overall assessment of the training was 89%.

Outcomes

The findings from the coding of professionals' responses to the RFRI questionnaire and SUI interviews indicate several positive effects of training in FRAMEA at statistical significance $p < 0.05$ and some trends towards positive effects, not reaching this threshold. However, there were also some negative findings:

- There was significantly more reporting of harmful parent-child interactions, regarded as emotional abuse, following training;
- Using the RFRI measure there was a significant increase in separation of tiers of concern by both health visitors and CAMHS, but a significant decrease in separation of tiers for all social workers;
- Using both RFRI and SUI measures, professionals placed the descriptions of difficulties in more appropriate tiers of concern following training;

- Measures were collected at several time points after training, some before consultation and some later, after consultation. Some improvements which were found following training were not sustained in the longer term, despite follow-up consultations; there was a significantly increased frequency of reporting Tier 1 and Tier 2 concerns following training, and a significant increase in describing harmful parent child interactions. CAMHS reported provision of significantly more Tier 1 services and significantly more children's social care involvement for children who were being emotionally abused;
- Regarding professional response, for tier 1 (caregiver risk factors) and tier 2 (caregiver-child interactions) concerns, in some services there were already appropriate interventions being offered pre-training for at least 50% of cases. In those with lower rates of appropriate interventions pre-training, there was a significant increase in offering these following training;
- The picture for interventions for concerns in tier 3 (the child's functioning) was more complicated with CAMHS teams and children's social care children in need teams offering direct work with many emotionally abused children at similar rates pre- and post- training. For the CAMHS emotional abuse sub sample, there was a significant increase in children's social care involvement post training;
- There was a significant decrease in coherence following training across the sample;
- In SUI interviews, following training health visitors reported that emotional abuse was no longer continuing in more cases which they had previously identified as emotional abuse. Following training, CAMHS reported more improvement in children identified as emotionally abused. However, Children in Need social workers reported deterioration at follow-up in the emotional abuse and neglect cases.

Discussion and limitations of the study

- The training included aspects that were already being utilised in practice, for instance interventions appropriate to particular tiers of concern, so that no change following training would be expected for these aspects being measured.
- In effect, the study consisted of two studies. One was testing the utility of a conceptual framework in improving professional practice; the second was testing the possibility of bringing about change in thinking and practice through training and consultation. What transpired and may not have been sufficiently foreseen was that in the design of this study, testing the first became dependent on positive results from the second.
- The development of the RFRI as a measure was based on the assumption that the way information is organised should reflect clarity of thinking and should lead to clearer, more explicit and more rational decisions about how to intervene. However, that may not be the case and it might be that this logical sequence towards effective intervention is not, in practice, followed or, indeed, necessary.
- The SUI may have been insufficiently refined to capture detailed aspects of intervention.
- The decision to offer the training and consultation within services rather than in multi-agency/multi-disciplinary settings was based on the belief that what different professionals needed initially was to

embed new thinking into their particular practice. This appears to have been appropriate as the concerns, preoccupations and tasks of the respective services were different. In order to ensure functional and necessary cooperation between the respective services, mutual understanding of the roles, responsibilities, available services/treatment modalities, criteria and thresholds for acceptance of each of the services were, to some extent, included within the training but were not a main focus. They were revisited in the multi-agency meetings at the end of the study.

What are the implications for training FRAMEA in the future?

Given the high prevalence of emotional abuse and neglect and the very positive response to FRAMEA by all those who learn about it, it would seem worthwhile to encourage wider testing of the framework. Only a study in which FRAMEA was fully implemented would test the framework per se. The findings suggest that it is difficult to introduce new thinking into already established procedures and ways of working, especially with a relatively brief training, to professionals with a very heavy workload as was the experience of the health visitors and in settings where there is little time set aside for peer / team case discussions and in-depth, non procedure-driven case supervision or consultation, as was the case for social workers. Future more effective training in implementation of FRAMEA would therefore require more time spent with the teams following initial training and the involvement of supervisors as well as practitioners in the full process. Only thus would it be possible to extend the enquiry into testing the effects of FRAMEA on actual outcomes for children, in effect a treatment outcome study.

There is a need for greater clarity about respective agency responsibility for intervention specifically in emotional abuse.

What are the more general implications for child protection training?

Many aspects of FRAMEA extend beyond emotional abuse and neglect to other forms of child maltreatment, specifically the emphasis on obtaining and organising information in all four tiers of concern, describing what is observed instead of using more global terms such as emotional abuse or neglect, offering interventions according to tiers of concerns and regarding intervention as part of the assessment by testing the family capacity to change during a time limited trial, which is an integral part of FRAMEA but which was, however, not tested in this study.

Professionals spontaneously and repeatedly discussed difficulties in the use of the Common Assessment Framework; further clarification is therefore required in training professionals for its use.

Interagency training needs to address the issue of respective agencies' thresholds both for referral and acceptance of referrals of cases of emotional abuse.

Offering training is only likely to be effective if practitioners also have regular times for peer or supervised case discussions in which new thinking can be embedded.

References

- APSAC (1995). Psychosocial evaluation of suspected psychological maltreatment in children and adolescents. Practice Guidelines. *American Professional Society on the Abuse of Children*.
- Baker, A. (2009). Adult recall of childhood psychological maltreatment: Definitional strategies and challenges. *Children and Youth Services Review*, 31, 703–714.
- Barlow, J. & Schrader McMillan, A. (2010). *Safeguarding children from emotional maltreatment*. London: Jessica Kingsley Publishers.
- Boulton, S. & Hindle, D. (2000). Emotional Abuse: The work of a multidisciplinary consultation group in a child psychiatric service. *Clinical Child Psychology and Psychiatry*, 5, 439-452.
- Brassard, M., & Hardy, D. (1997). Psychological maltreatment. In M. Helfer, R. Kempe, & R. Krugman (Eds.), *The battered child*, pp. 392–412. Chicago: University of Chicago Press.
- Cicchetti, D., Rogosch, F. & Toth, S. (2006). Fostering secure attachment in infants in maltreating families through preventive interventions. *Development and Psychopathology*, 18, 623–649.
- Claussen, A., & Crittenden, P. (1991). Physical and psychological maltreatment: Relations among types of maltreatment. *Child Abuse & Neglect*, 15, 5-18.
- Cleaver, H., Unell, I. & Aldgate, J. (2011). *Children's needs – parenting capacity. Child abuse: Parental mental illness, learning disability, substance misuse, and domestic violence*. (2nd edition). London: The Stationery Office.
- Department for Education (2011) Characteristics of Children in Need in England.
<http://www.education.gov.uk/rsgateway/DB/STR/d001041/index.shtml>
- Gilbert, R., Spatz Widom, C., Browne, K. et al. (2009a). Burden and consequences of child maltreatment in high-income countries. *Lancet*, 373, 68–81.
- Gilbert R, Kemp A, Thoburn J et al. (2009b). Recognising and responding to child maltreatment. *Lancet*, 373,167–80.
- Glaser, D. (2002). Emotional abuse and neglect: A conceptual framework. *Child Abuse & Neglect*, 26, 697-714.
- Glaser D (2011) How to deal with emotional abuse and neglect - Further development of a conceptual framework (FRAMEA). *Child Abuse & Neglect* 35, 866–875
- Glaser D, Prior V & Lynch M (2001) *Emotional Abuse and Emotional Neglect: Antecedents, Operational Definitions and Consequences*. York: British Association for the Study and Prevention of Child Abuse and Neglect. (Peer reviewed).
- Hart, S. N., Brassard, M. R., Davidson, H. A., Rivelis, E., Diaz, V., & Binggeli, N. (2010). Psychological maltreatment. In J. E. B. Myers et al.(Eds.), *The APSAC handbook on child maltreatment* 3rd edition pp 125-144. Thousand Oaks, CA: Sage.

Moran, P, Bifulco, A, Ball, C, Jacobs, C & Benaim, K (2002). Exploring psychological abuse in childhood: I. Developing a new interview scale. *Bulletin of the Menninger Clinic*, 66, 213-240.

O'Hagan, K. (1995). Emotional and psychological abuse: Problems of definition. *Child Abuse & Neglect*, 19, 449-461.

Skowron, E. & Reinemann, D. (2005) Effectiveness of psychological interventions for child maltreatment: A meta-analysis. *Psychotherapy: Theory, Research, Practice, Training*, 42, 52–71.

Trickett, P., Mennen, F., Kim, K. et al. (2009). Emotional abuse in a sample of multiply maltreated, urban young adolescents: issues of definition and identification. *Child Abuse & Neglect*, 33, 27-35.

Appendix 1

The intervention - training and consultation

Description of FRAMEA

Emotional abuse and neglect is located in context of other forms of child maltreatment. Emotional abuse is now the second commonest form of maltreatment for children who are the subject of protection plans in England. Emotional abuse often co-occurs with other forms of maltreatment, specifically physical neglect and physical abuse, but can also exist on its own. Intention to harm the child is not a prerequisite for the recognition of emotional abuse. While there are often explanations for the emotional abuse, these do not absolve the parents of responsibility for the maltreatment, nor does an understanding of how the emotional abuse is brought about reduce the need for a professional response. Indeed, paradoxically, explanations and an understanding of how emotional abuse has come about may stand in the way of professional intervention in emotional abuse and neglect. FRAMEA defines emotional abuse and neglect as the presence of non-physical, persistent, harmful parent-child interactions. The FRAMEA approach, begins by encouraging professionals to observe and gather information about the child and family, followed by organising this information into tiers of concern, rather than seeking for the presence of absence of multiple single items according to a checklist.

The account of definitions, assessment and interventions developed within FRAMEA can be summarised in a stepwise pathway:

1. Initial observations and information about children and families of concern need to be separated into the appropriate tiers of concern. (These tiers are not dissimilar to the domains in the Assessment Framework Triangle):

Tier 0 - Social & Environmental Factors

Tier 1 - Caregiver risk factors – mental health problems, domestic violence, drug & alcohol misuse, significant unresolved history of childhood maltreatment

Tier 2 - Caregiver-child interactions

Tier 3 - Child's functioning

2. If information is lacking about one or more of the tiers, it needs to be gathered.
3. Tier 2 includes emotional abuse and neglect. These interactions need to be **described** and constitute the evidence for emotional abuse and neglect.

4. Unlike other forms of child maltreatment such as child sexual abuse where the question is whether the abuse has occurred, the argument in emotional abuse and neglect is the extent to which these interactions are harmful.
5. As there are many different forms of harmful parent-child interactions, it is helpful to assign them into the most appropriate categories:
 - I. Emotional unavailability, unresponsiveness and neglect.**
 - This category reflects the violation of the child's basic need and right to have her/his existence acknowledged.
 - II. Interacting with the child with hostility, blame, denigration, rejection or scapegoating, based on the belief that the child deserves this due to basic negative attributions to the child.**
 - This category reflects the violation of child's basic need and right to be valued and loved for what s/he is.
 - III. Developmentally inappropriate or inconsistent interactions with the child. These include expectations beyond or below the child's developmental capacity; harsh and inconsistent discipline; and exposure to confusing or traumatic events and interactions, in particular domestic violence.**
 - This category reflects the violation of the child's basic need and right to be considered at their particular age/developmental stage.
 - IV. Failure to recognise or acknowledge the child's individuality and the psychological boundary between the parent and the child. There is an inability to distinguish between the child's reality and the adult's belief & wishes; the child is used for the fulfilment of the parents' needs as a virtual extension of the parent.**
 - This category reflects the violation of the child's basic need and right to be recognised or acknowledged as a unique individual with their own feelings and perceptions.
 - V. Failure to promote the child's socialisation within the child's context, by either active mis-socialisation or corruption; by isolating the child or by failing to provide adequate stimulation and opportunities for learning.**
 - This category reflects the violation of the child's basic need and right to be able to function progressively outside the family.
6. The violation of the child's basic needs and rights transcend culture or ethnicity. When encountering harmful interactions in a family from a different culture, it is important to establish whether these interactions are actually culturally-based. This needs to be ascertained with members of that culture, as these interactions may be no more acceptable in that culture than in the host culture. However, if found to be culturally based, then skilled discussion needs to be undertaken with the parents on the basis that culture is not an acceptable reason for harming a child.
7. To satisfy the quantitative criterion, these harmful parent-child interactions need to be shown to be persistent.

8. There are many forms of harm to the child caused by emotional abuse and neglect (Tier 3):

Child's emotional state

The child may be

- unhappy or show low mood or low self-esteem
- frightened, distressed, anxious or show symptoms of post traumatic stress disorder (PTSD).

Child's behaviour

The child may be

- attention seeking
- oppositional, aggressive or antisocial
- age-inappropriately responsible.

Cognitive / educational opportunity, development and attainment

The child may show

- developmental or educational underachievement
- school non-attendance or persistent lateness.

Peer relationships

The child may be socially

- withdrawn or isolated
- aggressive.

Physical state

The child may have non-organic problems, for example.

- pains
- daytime wetting
- soiling without constipation
- eating difficulties
- sleeping difficulties
- faltering growth / failure to thrive.

9. It is important to establish which of the concerns about the child's functioning are actually attributable to emotional abuse and neglect.
10. The severity of the emotional abuse needs to be estimated. Severity is determined both by the intensity of the harmful parent-child interactions and the effect on the child. In practice, severity is one of the factors which will determine whether there are sufficient concerns about the child's welfare to initiate section 47 enquiries.
11. As emotional abuse and neglect are caused by the primary carers, immediate protection may be required, which may mean separating the child from their primary carers. It is therefore more appropriate for initial interventions to be regarded as a time-limited therapeutic trial of the family's capacity to change.

12. Intervention needs to address Tier 0 and Tier 1 concerns which will involve a number of different agencies.

13. Therapeutic interventions are offered according to the categories of emotional abuse (Tier 2) which are identified for a particular child:

Principles of intervention:

Category 1: Emotional unavailability

- Intervene in parental risk factors:
 - o Domestic violence – refer to DV service
 - o Drug & alcohol abuse – refer to D & A service
 - o Adult mental health issues – refer to AMHS
- Then work on parent-child interaction

Category 2: Negative attributions

- Refer to CAMHS for trial of change
 - o Explore with carer(s) what child's view of him/herself might be & how to alter it

Category 3: Inappropriate developmental expectations, inconsistent and/or harsh parenting (often present as children with behaviour problems (not due to ADHD or autism spectrum))

- Trial of Parenting Training (e.g. Webster Stratton)

Category 4: Using the child for parent's needs

- Look for maintaining factors for parent
- Refer to CAMHS for trial of intervention
 - o Explore child's perceptions with parent
 - o Look for ghosts from the past

Category 5: Not promoting child's socialisation

- Explore with parent, the child's experience within child's environment
- Parent skills training
- Explore cultural factors where applicable

14. Therapeutic intervention falls primarily to family services in the public or voluntary social care sector and mental health services (children and possibly also adults).

15. Intervention may lead to improvement and diminution of concerns. If the family do not engage, then referral to statutory children's social care services is required in order to encourage the family to participate. If the family still do not engage or if there is insufficient change, consideration may need to be given to initiating care proceedings in order to place the child in an alternative family.

16. Some children may be considered be too old to move, or removal may be deemed inappropriate or not possible. Direct therapeutic work is then offered to the child to enhance coping with the ongoing emotional abuse.

Additional Information

Further information about this research can be obtained from
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The views expressed in this report are the authors' and do not necessarily reflect those of the Department for Education.