Review

Lighthouse Parenting Programme: Description and pilot evaluation of mentalization-based treatment to address child maltreatment

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Abstract

This article introduces an innovative mentalization-based treatment (MBT) parenting intervention for families where children are at risk of maltreatment. The Lighthouse MBT Parenting Programme aims to prevent child maltreatment by promoting sensitive caregiving in parents. The programme is designed to enhance parents' capacity for curiosity about their child's inner world, to help parents 'see' (understand) their children clearly, to make sense of misunderstandings in their relationship with their child and to help parents inhibit harmful responses in those moments of misunderstanding and to repair the relationship when harmed. The programme is an adaptation of MBT for borderline and antisocial personality disorders, with a particular focus on attachment and child development. Its strength is in engaging hard to reach parents, who typically do not benefit from parenting programmes. The findings of the pilot evaluation suggest that the programme may be effective in improving parenting confidence and sensitivity and that parents valued the programme and the changes it had helped them to bring about.

Keywords

Maltreatment, neglect, child abuse, mentalizing, mentalization-based treatment, disorganised attachment, parenting intervention, lighthouse parenting

Introduction

Maltreatment has profoundly negative and long-term impacts on a child's life. Maltreated children show elevated rates of reactive attachment disorder (Mulcahy, Badger, Wright, & Erskine, 2014; Zeanah et al., 2004) and are at increased risk of drug misuse, serious mental health difficulties,

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suicide attempts, risky sexual behaviour and physical ill-health throughout later life (Norman et al., 2012). In addition, they achieve poorer educational outcomes and are more likely to participate in crime and violence in adolescence and adulthood (Gilbert et al., 2009). In the United Kingdom, there has been a call for the development of effective attachment-based interventions for families where children are at risk of maltreatment (Centre for Social Justice, 2008). Yet, the availability of interventions for the most high-risk families remains limited (Barlow, Johnston, Kendrick, Polnay, & Stewart-Brown, 2006; Mulcahy et al., 2014).

Lighthouse MBT Parenting Programme

The Lighthouse MBT Parenting Programme has been developed specifically for high-risk parents. It is an adaptation of MBT for personality disorders (Bateman & Fonagy, 2016), with a particular focus on attachment and child development. The programme is designed to enhance *parental mentalizing*, that is, to foster in parents an active curiosity about the child's inner world and a readiness in parents to reflect on their own thoughts, feelings, and reactions. It supports parents to make sense of misunderstandings in their relationship with their child, including misunderstandings that arise from unresolved difficulties in the parent's own attachment history, it equips parents to inhibit harmful responses in those moments of misunderstanding and to repair ruptures arising from these misunderstandings in their relationship with their child.

The Lighthouse MBT Parenting Programme is a 20-week intervention. Parents attend a weekly Lighthouse MBT Parents' Group, facilitated by two MBT practitioners, and fortnightly one-to-one MBT-Parenting sessions with an individual therapist. In keeping with other MBT programmes, the Lighthouse Parenting Programme explores parents' own attachment styles, and the attachment styles of their children, but places more specific emphasis on explicitly working with attachment in each session. The central metaphor in the programme is of the parent as a lighthouse, providing a gentle attentive light for their child's journey and a homing beacon, guiding their child back to safe harbour/shore for support, help or comfort when needed. The programme helps parents approach their child with a curious, *wanting-to-know* mentalizing stance (*Illuminating Beam*), to recognise where their own mentalizing as a parent can fail and certainty about their child's inner world replaces curiousity (*Projecting Beam*), and, at such moments, to attempt to restore their own mentalizing to gain clearer sight of the child.

Why MBT for high-risk families?

Mentalizing is the capacity to imagine mental states and to be attuned to mental states in self and others, *holding minds in mind.* Mentalizing is a highly appropriate domain for therapeutic intervention in harmful parenting, because we can understand most instances of child abuse and neglect as arising from (a) deficits in mentalizing; (b) serious lapses in mentalizing; (c) mis-uses of mentalizing or (d) some combination of these factors.

Some parents' own experiences of maltreatment in childhood are likely to have disorganised their attachment system and thereby disrupted the acquisition of ordinary mentalizing (Fonagy & Allison, 2012). We suggest that deficits in mentalizing, in which a parent cannot see or imagine the child's needs, contribute to a pattern of consistent emotional or physical neglect. For instance, a parent who fails to recognise his baby as a person with wishes, desires and intentions and therefore does not provide opportunities for growth, curiosity, play or stimulation accordingly. Alternatively, in response to baby's cries of hunger, fear or loneliness, an avoidant/dismissive parent might not be roused into empathically responding, whereas a preoccupied/conflicted parent's own unmet needs might overwhelm them (Buisman et al., 2017). In either case, the baby is lost to view.

Mentalizing is an inherently imaginative mental activity, and as such, it is compromised in times of high emotional arousal. Parenting is stressful and therefore naturally leads to significant and frequent lapses in mentalizing for most people. Powerful feelings of guilt, protectiveness, humiliation, worry, love, frustration and anger are part of the ordinary parenting experience, and in high doses can leave parents with few mental resources for staying curious. Charged states lend themselves instead to snap judgements or hasty assumptions about a child's intentions. Parenting stress has also been shown to mediate the association between maternal history of maltreatment and parental sensitivity (Pereira et al., 2012) and can impinge on the capacity to mentalize (Nolte et al., 2013). The accuracy of reading and responding to the child's communications inherently requires the ability to mentalize and sensitivity may be seen as the behavioural manifestation of the mentalization process. Given their on-going life stressors, and often profound difficulties with emotion regulation, hard to reach parents are even more likely than the average parent to experience mentalizing lapses and when they do lapse, tend to show poorer parental sensitivity and have more difficulty in bringing curiosity and flexibility back online (Fishburn et al., 2017). Moments in which a parent makes a hostile misattribution about a child's intentions may result in non-accidental injury, physical chastisement or instances of emotional and psychological abuse (Richey, Brown, Fite, & Bortolato, 2016). For instance, when a parent is momentarily convinced that her crying or frustrated child is deliberately and maliciously provoking her.

Parents at risk of maltreating their children are often reluctant to engage in treatment or parenting interventions, refuse outright to do so or drop out. Neglect and emotional abuse in the parents' own histories often affect their development of epistemic trust, *that is, their 'trust in the authenticity and personal relevance of interpersonally transmitted knowledge about how the social environment works'* (Fonagy, Campbell, & Bateman, 2017, p. 177). In many cases, it can bring about a state of chronic *epistemic mistrust*, which manifests in parents' tendency to treat others with deep suspicion and results in a difficulty in internalising new knowledge (Bateman & Fonagy, 2016; Fonagy & Allison, 2012). An MBT approach has much to offer this population. MBT works directly with issues of trust, and there is robust evidence for its effectiveness at engaging hard-to-reach adults who have complex histories of attachment trauma or neglect, poor emotion regulation, and difficulties building stable trusting relationships (Bateman, Bolton, & Fonagy, 2013; Bateman & Fonagy, 2008; Bateman, O'Connell, Lorenzini, Gardner, & Fonagy, 2016)

Confidence in the parenting role can be severely undermined when families are referred to child protection services. This can further undermine the parent's ability to provide consistent nurturing for their children and may exacerbate their heightened levels of stress. A successful intervention for families where children have been identified as at risk of maltreatment should serve to improve parental sensitivity and confidence and alleviate the amount of stress that such parents are already under. The Lighthouse MBT Parenting Programme aims to promote parental sensitivity and confidence, reduce stress and tackles child maltreatment by attending to both parental deficits in mentalizing and lapses in mentalizing.

Aims

A number of reviews of the effectiveness of interventions to reduce child maltreatment have been conducted (Altafim & Linhares, 2016; Barlow et al., 2006; Chen et al, 2015; Mikton, & Butchart, 2009; Vlahovicova, Melendez-Torres, Leijten, Knerr, & Gardner, 2017) with some modest or promising evidence in high income countries (Desai, Reece, & Shakespeare-Pellington, 2016) of effectiveness of parenting programmes specific to this population (e.g. Vlahovicova et al., 2017) or to parents universally (Altafim & Linhares, 2016) in reducing child maltreatment

reports and enhanced protective factors while effects on reducing parental depression and stress were limited.

This study aims to assess the acceptability of the Lighthouse MBT Parenting Programme for hard to reach parents and to evaluate the effectiveness of the programme in reducing risk of harm to children by increasing parental protective factors and reducing parental risk factors.

In terms of protective factors, it was predicted that parental mentalizing, parental confidence and parental sensitivity would improve post-treatment. In terms of parental risk factors, we expected some improvement in parents' general wellbeing and mental health, but most importantly, we expected to see reduced stress and increased confidence specifically in their parenting role.

We expected the programme to have good face validity for parents, and to see some evidence that key concepts were understood and actively applied in their day-to-day parenting.

Method

Setting

The Lighthouse programme was developed in the Family Assessment and Safeguarding Service (FASS) (Oxfordshire) and ReConnect (Buckinghamshire). These services are highly specialised mental health teams working alongside the statutory safeguarding services and the family courts in reducing the harmful effects of maltreatment and keeping children safe in the care of their parents. This pilot evaluation was carried out in the ReConnect Service.

Participants

Participants were parents of children aged 0–2 years who were identified as at risk of disorganised attachment. Essential inclusion criteria were at least one of the following: history of severe parenting breakdown, including significant harm to a child and/or permanent removal of previous children; parental history of childhood trauma or neglect; parental mental health problems; history of domestic violence; and history of substance abuse. To participate in the programme, parents had to demonstrate at assessment some (even if only fleeting) acknowledgement of difficulties in their relationship with their child.

The current data represent the first 16 parents (across two 20-week groups) who met the criteria and gave consent for their data to be used in the evaluation. Table 1 shows demographic details of the participants; this sample represents a high-risk cohort, with high levels of unemployment, single parenting and previous removal of children into care. Several participants declined completing some of the measures. This was most pronounced for the assessment of maternal sensitivity, for which only six mothers consented. The analyses for each measure are therefore based on different sample sizes. As this was a pilot study and the sample size is small, methods for estimating missing data were not considered appropriate.

Measures

Parental mentalizing: Parent Development Interview. The Parent Development Interview (PDI) is a semi-structured clinical interview intended to examine parents' representations of their child, themselves as a parent and their relationship with their child (Slade, Aber, Bresgi, Berger, & Kaplan, 2004). Some parents were still pregnant at the start of treatment and in these cases the Pregnancy Interview (PI) was administered. Both interviews were blind coded on the Reflective Functioning (RF) scale. The RF scale, which results in scores ranging from −1 to 9, measures the parent's capacity for mentalizing in the parent–child relationship, with higher score indicative of better mentalizing.

Table 1. Demographic details of the parents participating in Lighthouse MBT Parenting Programme (*n* = 16).

	n	%
Parent ethnicity		
White-British	14	88
Other	2	12
Parent marital status		
Single	7	44
Cohabiting/married	9	56
Parents unemployed	13	81
Parents who have had other children taken into care	6	38
Parent highest level education		
Did not finish school	3	19
GCSE/higher education	11	69
Did not answer	2	12
Child gender		
Male	9	56
Female	7	44

Parental sensitivity: Observation Scales. Parental sensitivity was assessed via structured coding of video-recordings of the parent interacting with their child (NICHD Early Child Care Research Network, 1999). Parents were invited to participate in some ordinary tasks with their child: free play with and without toys, reading a picture book with their child, dividing their attention between monitoring their child and completing another task (filling in a questionnaire), and changing their child's clothes. These interactions were rated by a reliable rater who was blind to intervention status. For each task, sensitivity ratings are the sum of three four-point ratings for Sensitivity to Non-Distress, Intrusiveness (reversed) and Positive Regard. The potential range of scores is from 3 to 12, with higher scores indicating more sensitive responsiveness.

Parenting self-efficacy: Maternal Efficacy Questionnaire. A 20-item self-report scale assesses maternal self-efficacy in relation to specific caregiving activities (Teti & Gelfand, 1991). The potential range of scores is between 10 and 40, with higher scores indicating greater sense of self-efficacy in the parenting role.

Parenting stress: Parenting Stress Inventory–Short Form. A 36-item self-report measure captures stress levels within the parenting role (Abidin, 1995). In addition to a total stress score, the measure has three subscales: Difficult Child (DC, degree to which parents are bothered by behavioural characteristics of their child); Parent–Child Dysfunctional Interaction (P-CDI, degree to which parents are satisfied with their child's abilities to meet their expectations); and Parental Distress (PD, the distress parents feel as a function of personal factors related to parenting). Scores on each subscale have a potential range of 5–60, and total scores can range from 36 to 180. Higher scores on each scale are indicative of higher levels of difficulty.

Depression: Patient Health Questionnaire-9. A brief, valid and reliable measure of depression (Kroenke, Spitzer Robert, & Williams Janet, 2001). Higher scores indicate higher frequency of depressive symptoms, with a potential range from 0 to 27.

Anxiety: Generalised Anxiety Disorder-7. A reliable and valid 7-item measure for assessing generalised anxiety disorder (Spitzer, Kroenke, Williams, & Lowe, 2006). Higher scores indicate higher frequency of anxiety symptoms and scores can range from 0 to 21.

Global distress: Clinical Outcomes in Routine Evaluation Scale. A self-report measure of global distress which includes measures of subjective wellbeing, commonly experienced problems or symptoms, social/life functioning and risk to self and others (Evans et al., 2000). The potential range of scores is from 0 to 72, with higher scores on each subscale indicating poorer functioning.

Parental experience of the programme. All participants were contacted at the end of the programme and asked whether they would be willing to be interviewed about their experiences of the programme. Eight mothers agreed for their contact details to be passed on, and of these six mothers could be contacted by the researcher. All interviews were carried out over the telephone at the end of treatment. The semi-structured interviews consisted of six open-ended questions about how participants had experienced the intervention including questions about what was helpful/unhelpful, changes noted since taking part, anything that stood out for the parent and the infant and what changes they thought could be made to improve the service. These were audio-recorded and transcribed verbatim. A thematic analysis was carried out by the researcher who conducted the interviews. The analysis followed the method outlined by Braun and Clarke (2006). This involved an initial phase of transcription and immersion in the data, followed by a detailed coding of the data. The codes identified features of the transcripts that the researcher considered pertinent to the research question and that built on the initial notes and ideas generated from the data immersion phase. The next step involved searching for themes that combine similar codes and repeated patterns across the dataset. Thematic maps were used to conceptualise and refine patterns and relationships between themes. The final themes were named and described alongside relevant extracts of data.

Results

Effectiveness of the programme at reducing parental risk factors

Table 2 reports results of paired sample *t*-tests for pre- and post-treatment scores on quantitative outcome measures.

In the free-play task, parents were more sensitive to their child's cues post-treatment compared to pre-treatment ($t = -2.52$, $p = .045$), but this effect was not statistically significant after Bonferroni corrections were applied.

We saw non-significant trends for improvement in parental sensitivity even in the clothing change task (which is goal oriented), and the divided attention task (in which the parent's attention is, by definition, not focussed exclusively on their child). In the book reading task, parents were not more sensitive to their child's cues post-treatment.

There were significant reductions in self-reported parenting stress levels post-treatment, as measured by the Parenting Stress Inventory–Short Form (PSI-SF) ($t = 2.59$, $p = .025$). Again, this effect was not statistically significant after Bonferroni corrections were applied.

Parents reported higher levels of self-efficacy in their parenting role after the intervention than before ($t = -2.67$, $p = .018$).

Contrary to expectation, there was no significant improvement in parental mentalizing capacity over time, as measured by RF scale on the PDI-R. At both time points, parents were generally

Table 2. Parents' scores on parental sensitivity, mentalizing, parenting stress, parental self-efficacy, anxiety, depression and global distress before and after Lighthouse MBT Parenting Programme.

	(n)	Pre-treatment	Post-treatment	Paired sample *t*-test	Bonferroni corrected	Effect size (*d*)
		M (SD)	M (SD)	*p* value	*p* value[1]	
Parental sensitivity (NICHD)						
Free play	6	8.3 (1.8)	9.1 (1.8)	.045**	.585	−2.255
Divided attention	6	7.5 (1.4)	8.3 (1.6)	.185	1	−1.374
Book reading	6	8.5 (2.3)	8.0 (1.8)	.597	1	0.505
Clothes change	6	8.2 (1.7)	8.7 (2.2)	.646	1	−0.436
Parenting stress (PSI-SF)						
Parental Distress	12	38.2 (11.0)	27.9 (12.2)	.031**	.403	1.493
Dysfunctional Interaction	12	24.8 (11.1)	21.3 (9.1)	.067*	.871	1.227
Difficult Child	12	27.4 (11.9)	23.3 (9.4)	.092*	1	1.113
Total parenting stress	12	90.3 (29.0)	72.5 (27.8)	.025**	.325	1.561
Parental mentalizing (PDI)	11	3.3 (0.8)	3.5 (1.6)	.779	1	−1.828
Parental self-efficacy (MEQ)	12	25.8 (5.6)	31.2 (4.0)	.018**	.234	−1.675
Anxiety (GAD-7)	14	8.5 (6.4)	6.5 (6.0)	.222	1	0.711
Depression (PHQ)	14	9.4 (5.9)	7.4 (8.5)	.308	1	0.588
Global distress (CORE-18)	12	26.8 (17.6)	20.7 (19.9)	.266	1	0.707

PSI-SF: Parenting Stress Inventory–Short Form; PDI: Parent Development Interview; MEQ: Maternal Efficacy Questionnaire; GAD-7: Generalised Anxiety Disorder-7; PHQ: Patient Health Questionnaire; CORE-18: Clinical Outcomes in Routine Evaluation-18.
[1]Bonferroni corrected *p* values based on the critical value of .05 corrected for the number of tests (13), resulting in a corrected critical value of .0038.
**Statistically significant change (at $\alpha < .05$).
*Trend towards statistically significant change (at $\alpha < .10$).

scoring at the lower end of the scale, suggesting a fairly limited capacity for mentalizing about their child and themselves as parents.

Parents did not report significantly less general anxiety (as measured by the GAD-7) or depression symptoms (as measured by the PHQ-9) after the parenting programme. A large proportion of parents were not reporting high levels of anxiety or depression at baseline and there was only a small minority of parents for whom these symptoms were moderate or severe to begin with. Parents' global distress scores on the CORE-18 were also not significantly lower post-treatment. Unlike the scores for depression and anxiety, global distress scores were above the clinical cut off point at both baseline and follow-up, indicating high levels of global distress in these parents, even at the end of the programme.

Parental experience of the programme

Five out of six parents interviewed attributed very positive changes to the programme, with several of them referring to it as a 'life changing' experience:

> I feel like if I could have done it 6 months before, I think that I would have my other two children with me here as well. (Participant talking about older children in foster care)

There was one exception to the overwhelmingly positive experiences that the parents spoke of. One mother did not feel that the programme had been helpful to her When probed about the reasons she felt it was not helpful, this mother said that it was '*just once a week and you know, it was only for two hours. So it just wasn't enough*'.

Several parents commented that they felt more confident as a result of the programme. The improved self-confidence often resulted from the parents learning to not be so hard on themselves. They felt that this had a knock-on effect on their parenting. Most parents also talked about how the programme had helped them to be better attuned to their children and to make sense of their children's communications and emotions:

> It's made me realize that actually I did need the help. . . I started to realize that I was actually. . . missing all of his cues.

Some of the mothers talked about how they were now able to notice and understand their child's attachment behaviours, or that they saw noticeable changes in how the child responded to them over the course of the programme. Talking about seeing a video of her child greeting her, one parent said,

> And he came straight to me. Just the way we looked at each other and said how much we missed each other. . . Before he wouldn't even do that. He wouldn't be bothered if I walked back into the room, he wouldn't even notice I was gone. And he actually noticed. It was just amazing that, you know, just the feeling.

Five out of the six parents felt that they learnt how to trust through the relationship they developed with the MBT team. This trusting relationship with the MBT therapists was seen by many parents to be containing and even somewhat like another chance for them to be parented in a better way. Furthermore, the trust was important for engaging the parents in the group and with other supportive services:

> And, you know, it also gives me faith, a lot more faith in professionals, you know? I don't know why, I think it might just be a general non-trust for anyone. Like, I've always had a problem with trusting adults my whole life because it was adults that abused me and mistreated me throughout my life. . . . now that problem is breaking down and I'm able to work with professionals.

The combination of individual and group work was valued by most of the parents as serving different needs. The group sessions helped parents feel that they were not alone. The personal relationship that was built through the individual sessions was highly valued, and parents said it enabled them to build trust in the group as something that could be helpful. For the one parent who was less satisfied with the programme, she did find some of the small group exercises and the individual sessions with the psychologist helpful, but she felt she could not fully participate in the larger group setting.

The general consensus among parents interviewed, including the one mother who felt the programme was ineffective for her, was that even more input would have been good, although some of them also acknowledged that it was time to end and that the programme had equipped them to cope without the on-going support. 'It became such a safe place where we were really heard and where we could really sort of be open, that's what we wanted, as it were, but, yes, the course had to come to an end'.

All but one of the parents spontaneously said that this is a service that should be widely available to all parents, usually in response to the question about how the programme could be improved.

Discussion

This pilot evaluation gives some promising indication that the Lighthouse MBT Parenting Programme can reduce risk of harm to children by (a) increasing parental protective factors, including parents' behavioural sensitivity to their children's cues and parents' sense of self-efficacy in their parental role and (b) reducing parental risk factors, including parenting stress.

As stated above, in the free-play task, parents were more sensitive to their child's cues post-treatment compared to pre-treatment ($t=-2.52$, $p=.045$), but this effect was not statistically significant after Bonferroni corrections were applied. Because only a small number of participants completed the observed play assessment ($n=6$), there was very limited power to show statistically reliable change. The large effect sizes observed in this small pilot sample indicate that more robust improvements in parental sensitivity may be noted in a larger sample size in future.

Parental sensitivity, that is the capacity to recognise and respond appropriately to a child's communications, has been repeatedly shown in large studies to be a key predictor of secure attachment relationships (De Wolff & van IJzendoorn, 1997). Thus, improvements on this measure may indicate a shift for the children in this sample onto a more positive developmental trajectory. It should be emphasised that these findings, although potentially promising, are based on only six dyads who consented to the video-recorded assessment of maternal sensitivity. There may be a systematic bias in the type of parents who consented to this potentially intrusive assessment compared to those who did not consent. This also suggests that this measure may be difficult to implement on a wide scale in future large-scale studies with high-risk parenting groups such as these.

The reductions in self-reported parenting stress levels post-treatment, as measured by the PSI-SF ($t=2.59$, $p=.025$) was not statistically significant after Bonferroni corrections were applied, but the large effect size may indicate that further testing in a larger sample is warranted now. The most pronounced effect was in the PD subscale, indicating that parents had less negative feelings associated with parenting after treatment. There were also trends towards improvements in how parents perceived their child to be difficult, and in how positive they felt the interactions between them and their child were. Stress in the parental role represents a key risk factor for maltreatment in this population, given the link between high stress or arousal, and dangerous lapses in parental mentalizing described earlier that may leave a child vulnerable to hostile, violent or otherwise frightening reactions from a parent (Crouch & Behl, 2001; Reijneveld, van der Wal, Brugman, Hira Sing, & Verloove-Vanhorick, 2004). The findings here in relation to reduced parental stress may set the Lighthouse MBT Parenting Programme apart from other interventions; meta-analyses reveal that other parenting programmes have generally not noted change in parental stress, even when it is specifically targeted in treatment (Chen & Chan, 2015).

The reported higher levels of self-efficacy in their parenting role after the intervention than before ($t=-2.67$, $p=.018$) indicate that parents felt more confident in their capacity to care for children and effect change in their children's behaviour at the end of the programme than they did before the treatment started. It is interesting to note that the measures tapping more general emotional wellbeing in the parents (depression, anxiety, general distress) did not change significantly over time, and therefore the Lighthouse MBT Parenting Programme appears no more effective for parental mental health outcomes than other parenting programmes (Chen & Chan, 2015). We note, however, that our measures were all self-report and in future an additional clinical interview may yield more detailed and therefore more helpful information, as would an independent measure collected on therapists' examining how they feel parents have improved. It is worth noting that clinicians working with this population carry a considerable burden; it can be very challenging to work with parents who have harmed their children and who can present as really quite limited in their interactions and concrete in their perceptions of their children. However, while we have not collected the

data in this evaluation, anecdotally clinicians report greater optimism in their work throughout the programme, in part in response to progress made by parents, in part because of the support of working alongside other clinicians (two clinicians per group session) and perhaps also in part because the structure of the programme with an end in sight from the beginning creates a framework within which a clinician can feel confident that the parent has had a fair opportunity to improve parenting that will inform decisions regarding risk management and/or reunification/removal.

However, the two measures relating to their experience in the parental role did change (parental self-efficacy and parenting stress). Thus, the parents were clearly feeling more confident and relaxed in their ability to care for their child, even if they may have continued to have emotional difficulties themselves. The improved capacity to cope with the demands of parenting a young child may be an important protective factor for the children of these parents, many of whom have experienced a great deal of trauma in their past and for whom emotional difficulties are persistent.

In future, it will be important to consider more direct indices of reduction in maltreatment, such as changes in child abuse potential post-treatment (e.g. as measured by the Child Abuse Potential Inventory Milner, 1986), and where possible, an official substantiated child maltreatment rate over a follow-up period.

As noted, the treatment improvements described above were not statistically significant after Bonferroni corrections were applied. This modest result might be expected with a very small sample size. The effects sizes, however, were large and indicate a need now to extend this research with a larger group of parents. In addition, the qualitative interviews appear to add some strength to the quantitative findings in relation to parental self-efficacy, and sensitivity to a child's needs – parents gave descriptive examples of having improved confidence in their parenting role, increased attentiveness to their child's cues and a new understanding of attachment.

While parents clearly attributed these positive changes to the intervention, further research with a control group is needed now, to attribute with certainty any findings to the fact that these families took part in the programme.

We expected that improved parental sensitivity would be achieved by increasing *parental mentalizing*. In qualitative interviews, parents described having a better understanding of their child's communications, and this is at the heart of a mentalization-based approach, suggesting that this clinical aim was met at least for the participants interviewed, but this was not confirmed quantitatively by the RF coding on the PDI-R. The non-significant results may be that the coding system is not sensitive to treatment changes at the lower end of the scale. Several recent and larger studies have similarly not found improvements on this measure, despite treatment effects being found on other instruments (Fonagy, Sleed, & Baradon, 2016; Ordway et al., 2014).

Crucially, the Lighthouse MBT Parenting Programme appears to have been highly acceptable to parents in our service, who typically struggle to engage with parenting programmes. A number of the children were subject to family court proceedings (current or previous) and all were on Child Protection (CP) plans. All parents had histories featuring either childhood trauma or neglect or both. Court proceedings and CP plans place tremendous pressure on parents to attend, however, surprisingly, both in the histories of these parents and in parents in general referred to our services, CP plans and even court proceedings by no means guarantee attendance. The qualitative interviews revealed overwhelmingly positive experiences of the programme. For most parents, the intervention was described as 'life-changing', although for one the programme was not felt to have been helpful, and there were some aspects of the approach (e.g. the large-group activities) that she found uncomfortable to participate in.

The finding in relation to increased trust is theoretically and clinically important in this population for whom attachment difficulties are so pervasive. Recent thinking in attachment theory highlights the importance of epistemic trust in attachment relationships – a trust in the authenticity and personal

relevance of interpersonally transmitted knowledge (Fonagy & Allison, 2014). This suggests that the therapeutic relationship may have opened parents to new ways of thinking about themselves and the social world. This could have important implications in breaking the cycle of attachment difficulties for parents whose own childhood experiences have left them epistemically mistrustful of support from others. However, this needs to be robustly examined in any future research on the model.

The study highlighted a number of limitations to the programme. As noted above, the findings did not show significantly lower scores for anxiety or depression in the parents and while these were not targets of treatment we had expected some significant change here. While this is in keeping with other parenting programmes, nonetheless, it raises the question as to whether this should be addressed more directly in the programme.

A further limitation already alluded to is the duration of treatment. MBT treatment programmes for adults with personality disorders are effective when of 18-month duration with an initial psychoeducational group component of 12 sessions. Group session length is usually 75 minutes. In contrast, the Lighthouse MBT Parenting programme's sessions are 2 hours in duration with psychoeducation and group therapy together from the outset. Over time, the psychoeducation component reduces and the group process increases. The current programme length of 20 sessions is a serious constraint and we continue to discuss the merits of increasing the length of the intervention (in particular with the optional follow-up process group) and will continue to closely monitor its impact in future evaluations and research. Ideally, we would envisage this programme being made available alongside adult mental health interventions. The timing of the programme could either follow 18 months of MBT treatment or be offered alongside, perhaps when MBT treatment is well established (after 6–12 months for instance).

Conclusion

In summary, parents' reflections on the programme indicated a high level of acceptability and confirms that MBT is a potentially powerful approach for improving lives of hard to reach families who typically do not benefit from parenting programmes. The study found important indicators of a reduction in parental risk factors for child maltreatment (parenting stress), and enhancement in parental protective factors (parental sensitivity; parental self-efficacy), even in a very small sample size. These pilot data indicate that further research with a larger sample size, a control group and more direct indices of reduction in maltreatment is warranted now to verify these promising initial findings on the effectiveness of the Lighthouse MBT Parenting Programme.

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