

CHAPTER 16

Assessing the Relational Context of Infants and Young Children

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It is widely agreed in the field of infant mental health that young children develop within the context of important caregiving relationships. For clinicians, understanding a young child's functioning and development is predicated upon assessing the nature of the relationship between the child and the caregiver (Lieberman & Pawl, 1993; Zeanah, Larrieu, Heller, & Valliere, 2000). Increasing attention also has focused on the broader relational context for young children. Some of this interest is reflected in attempts to understand triadic, as well as dyadic, functioning. Other work has examined coparenting attitudes and behaviors, and their implications for the mental health of young children.

In this chapter, we begin by focusing on assessing dyadic relationships between a primary caregiving adult (referred to as "parent") and an infant or young child. This involves evaluating both patterns of behavioral interactions between parent and young child and the parent's narrative descriptions of the young child, as these represent targets of treatment or ports of entry into the parent-child relationship (Stern, 1995; Stern-Bruschweiler & Stern, 1989). Next, we broaden the focus from the parent-child relationship to consider family functioning, specifically, research on triadic interactions and coparenting as they affect the parent-young child relationship (Fivaz-Depeursinge & Corboz-Warnery, 1999; McHale, 2011; McHale

& Fivaz-Depeursinge, 2010; McHale, Fivaz-Depeursinge, Dickstein, Robertson, & Daley, 2008). Finally, we review an approach to characterizing the relational context of young children from DC:0-5 (Zero to Three, 2016). This approach includes rating both the adaptation of the young child's relationship with primary caregivers and the broader caregiving environment. This broad conceptualization of the relational context for infants and young children has important implications for infant mental health practitioners.

Assessing Parent-Young Child Relationships

A Model of Components of the Parent-Young Child Relationship

A luminary model that has guided our clinical assessments for three decades was originally proposed by Stern-Bruschweiler and Stern (1989). As shown in Figure 16.1, the model includes four components. In the middle are two components indicating the parent's and young child's interactive behaviors (IB_p and IB_{YC}). Recurrent patterns of interaction over time are the objective and observable components of the parent-child relationship. On the far left is the component indicating parents' representations of their child and relationship with the child (R_p). On the far right is the component indi-

cating the young child's representation of the parent and relationship with the parent (R_{YC}). Representations are believed to reflect the subjective components of the parent-child relationship, including the meaning of the child to the parent and vice versa. In our approach, each of these relationship components must be assessed in order to understand these relationships. Formal approaches to assessing interactions and parents' subjective experience are available for use in clinical assessments, whereas the child's representation of the parent must be inferred, based on observations gleaned from assessments of the other approaches.

Parents' Internal Representations of the Young Child

Internal representations may be considered memory "structures" that have been postulated as guiding perceptions, attitudes, attributions, and behaviors in parents' relationship with their child (Zeanah & Barton, 1989). Research has shown that parents develop specific and unique representations for each of their children, even during pregnancy (Ammaniti, 1991; Benoit, Parker, & Zeanah, 1997). Parents' representations of their infants have been shown to predict the quality of the infant-caregiver attachment relationship (Vreeswijk, Maas, & Van Bakel, 2012).

Several interviews with parents have been developed to assess representations of the infant or young child (Biringen, Matheny, Bretherton, Renouf, & Sherman, 2000; Slade, Belsky, Aber, & Phelps, 1999; Zeanah, Benoit, Hirshberg, Barton, & Regan, 1994). Using these measures, classifications and dimensions of parents' representations have been shown to predict parent and young child behavior, infant attachment classifications, and infant and young child symptomatic behavior (Benoit, Parker, et al., 1997;

Benoit, Zeanah, Parker, Nicholson, & Coolbear, 1997; Biringen et al., 2000; Slade et al., 1999, Zeanah et al., 1994). In this chapter, we focus on the Working Model of the Child Interview (WMCI; Zeanah et al., 1994), which has a growing empirical base and a track record of clinical use in diverse settings (Zeanah & Benoit, 1995).

The Working Model of the Child Interview

The WMCI assesses parents' specific internal representations of a particular child. The interview is semistructured and takes about an hour to complete, although an abbreviated, modified version is available. Probes include queries about parents' experiences of pregnancy and delivery, general and specific descriptors of the child's personality and their relationship with the child, the infant's difficult behaviors and the parents' responses to them, and hopes and fears parents have for their child later in life. Parental perceptions are elicited by interview probes, and based on their content, narrative features, and affective tones, the type of internal representation that organizes the parents' perceptions is inferred. A typology consisting of *balanced*, *disengaged*, and *distorted* was derived and corresponds with Strange Situation Procedure classifications of *secure*, *avoidant* and *resistant* (Ainsworth, Blehar, Waters, & Wall, 1978) and Adult Attachment Interview classifications of *autonomous-secure*, *dismissing*, and *preoccupied* (Main, Kaplan, & Cassidy, 1985). These types indicate how the parent experiences the child and internally organizes affects related to the child. Parents whose interviews are balanced describe both strengths and weaknesses in the child and convey understanding and empathy for the child's experience. They include rich and detailed memories and well-integrated affect in their descriptions of the child. Parents believe their relationship with their child has an

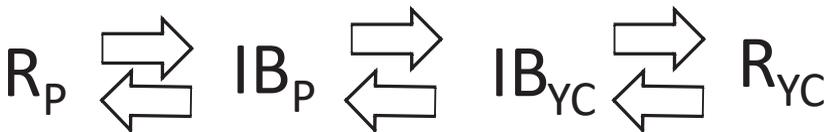


FIGURE 16.1. Components of the parent-child relationship. R_p , parent's representation of the young child; IB_p , interactive behavior of the parent (with the young child); IB_{YC} , interactive behavior of the young child (with the parent); R_{YC} , young child's representation of the parent. From Stern-Bruschweiler and Stern (1989). Copyright 1989 by John Wiley & Sons. Reprinted with permission.

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impact on the child's functioning and development. Parents whose interviews are disengaged lack emotional engrossment with the child and/or have a paucity of information about the child. There often is a lack of emotional connection to the child, and the child is described as "regular" or "normal," with no convincing appreciation of the child's unique or special qualities and characteristics. The parents do not recognize the impact of their relationship on the child's functioning or development. Parents whose interviews are distorted convey internal involvement with the child, but the involvement is unsatisfying. Narrative descriptions of the child are distorted, such as being unrealistic or incoherent, being confused and/or bewildered by the child, having an inappropriate expectation of the child's role, or being unable to focus on the child due to other concerns, such as preoccupation with the self, the other parent, or a single aspect of the child. The parents also demonstrate a lack of sensitivity to the child's experience (Zeanah et al., 1994).

In their review of numerous studies that used the WMCI, Vreeswijk and colleagues (2012) concluded that it is valid, demonstrating both concurrent and predictive validity. The three-way classifications are significantly related to Strange Situation classifications, Adult Attachment Interview classifications, maternal behavior, and infant-caregiver interactions. Furthermore, the WMCI distinguishes between clinical and nonclinical groups (Benoit, Zeanah, et al., 1997; Dayton, Levendosky, Davidson, & Bogat, 2010; Vreeswijk et al., 2012). Infants whose mothers had balanced representations of them prenatally were more likely to demonstrate secure attachment behavior with their mothers at 1 year of age (Benoit, Zeanah, et al., 1997). Mothers of infants seen in a clinical setting who reported higher levels of depression, hostility, and posttraumatic stress more often had non-balanced mental representations of their infants (Borghini et al., 2006; Korja et al., 2009; Rosenblum, McDonough, Muzik, Miller, & Sameroff, 2002; Sokolowski, Hans, Bernstein, & Cox, 2007; Wood, Hargreaves, & Marks, 2004). Of course, cultural considerations are important when using the WMCI with cultural groups that may not represent Western samples with which the WMCI was developed and has been studied (see Minde, Minde, & Vogel, 2006).

Adaptations to the WMCI coding system have been made in recent years. Following the development of the original classification of the

WMCI coding scheme involving the three categories of balanced, disengaged, and distorted, a fourth classification was proposed by Crawford and Benoit (2009). The *disrupted* classification corresponds with infant *disorganized* attachment in the Strange Situation Procedure, disrupted caregiver behaviors toward the infant using the Atypical Maternal Behavior Instrument for Assessment and Classification, or AMBIANCE (Lyons-Ruth, Bronfman, & Parsons, 1999), and Adult Attachment Interview representations of *unresolved mourning or trauma* (Main & Hesse, 1990).

Niccols, Smith, and Benoit (2015) administered the WMCI prenatally and when the infant was 6 months of age to women who participated in a home visitation program. They found significant concordance between WMCI—Disrupted classifications over the 8 months from pretest to follow-up, with 61% of mothers remaining classified as disrupted, 29% remaining classified as not disrupted, 8% becoming classified as disrupted, and 2% becoming classified as not disrupted. Mothers classified as disrupted on the WMCI reported being of lower socioeconomic status (SES) and having more parenting stress related to viewing their child as difficult, and their infants displayed less attachment security. Thus, having a method to capture disrupted representations of caregivers is a noteworthy addition to the WMCI classification scheme. Interventions to treat disrupted representations provide another potential avenue for treatment or prevention of disorganized attachment relationships.

Parent-Child Interactions

Assessing observable interactions between the parent and child is an essential component in developing an understanding of the nature of the young child-parent relationship. Many observational measures of infants, young children, and their caregivers that have a solid empirical base have been developed and are used in clinical settings (Miron, Lewis, & Zeanah, 2009). The interpretation of child and parent behaviors in these approaches generally does not involve using the same coding methods as those used for research, but by providing a standardized format, they do allow clinicians to compare children who are responding to similar situations in which they interact with their caregivers.

Another challenge of using research-derived paradigms in clinical settings is the large age

and developmental range of the young children being served. For clinical programs seeing infants as young as 2 or 3 months through 5-year-old preschool children, for example, there are no comprehensive methods that can be applied across that span of development. Our clinical approach is to apply different procedures—one for infants who are less than about 8 months of age, and another that we use with children from approximately 6 months through 5 years of age.

Face-to-Face Still-Face Procedure

The Face-to-Face Still-Face Procedure (FFSF) is an infant–parent assessment introduced in the 1970s by Tronick, Als, Adamson, Wise, and Brazelton (1978). The FFSF procedure has been widely used to examine a variety of infant and parent behaviors, as well as the synchronicity of infant–parent interactions (Mesman, van IJzendoorn, & Bakermans-Kranenburg, 2009).

During the procedure, the infant and parent are seated facing one another, and video cameras are focused on both the infant and the parent. The parent’s behavior is manipulated in order to assess the infant’s response. Although there have been several variations in the procedural instructions used for the FFSF since it was originally developed, there are generally three 2-minute episodes, including (1) the baseline episode, during which the parent is informed that he or she can interact with the infant normally; (2) the still-face episode, during which the parent is informed that he or she should be unresponsive and maintain a neutral facial expression while looking at the infant; and (3) the reunion episode, in which the parent is informed that he or she can resume normal interactions with the infant.

Sometimes intertrial intervals are used, in which the parent turns away from the infant between episodes (Weinberg & Tronick, 1996). Other variations have included allowing the parent to touch the infant during the baseline and reunion episodes (e.g., Stack & Arnold, 1998), adding additional still-face and reunion episodes in order to elicit a stronger physiological response in the infant (e.g., Haley, Handmaker, & Lowe, 2006), having two adults interact with the infant at the same time in order to examine the triadic interaction (e.g., Fivaz-Depeursinge, Favez, Lavanchy, de Noni, & Frascarolo, 2005), and having a stranger complete the procedure with the infant in order to examine the infant’s differential response to the parent versus the

stranger (e.g., Kisilevsky et al., 1998; Lamb, Morrison, & Malkin, 1987).

The baseline episode allows for the observation of typical interactions between the parent and the infant, and provides a point of comparison with the still-face and reunion episodes. The still-face episode is considered to be a stressor, as it marks a sudden loss of social interaction with the parent and produces a conflicting message for the infant as the parent is looking at him or her but not engaging socially. Tronick and colleagues (1978) describe the still-face episode as the mother “communicating ‘Hello’ and ‘Goodbye’ simultaneously” (p. 11). It is during this episode that infants typically demonstrate the classic “still-face effect,” which includes a significant reduction in positive affect and gaze toward the parent, and a significant increase in negative affect in comparison to the baseline episode (Adamson & Frick, 2003; Mesman et al., 2009; Provenzi, Borgatti, Menozzi, & Montiroso, 2015). The purpose of the third episode, or the reunion, is to examine how the infant and parent repair following the disruption in the parent’s responsiveness (Weinberg & Tronick, 1996). It is during this episode that infants typically demonstrate some recovery in positive affect and gaze toward the parent. In this reunion episode, infants typically exhibit less positive affect and more negative affect compared to the baseline episode, and this is considered to be a carryover effect from the still-face episode (Mesman et al., 2009).

Notably, the classic still-face effect is robust and has been found to withstand changes in procedural and sample variations (Mesman et al., 2009). For example, the classic still-face effect has been established across several diverse populations, including low- to middle-class African American dyads (Kogan & Carter, 1996; Segal et al., 1995) and Chinese and Canadian dyads of diverse SES backgrounds (Kisilevsky et al., 1998). Although there have been a few studies using the FFSF procedure across cultures (e.g., Grant, McMahon, Reilly, & Austin, 2010; Montiroso, Riccardi, Molteni, Borgatti, & Reni, 2010; Yato et al., 2008), there is a need for additional research from non-Western societies to increase cross-cultural generalizability of the still-face effect (Mesman et al., 2009).

There are several theoretical explanations for the occurrence of the classic still-face effect (Mesman et al., 2009). Tronick originally theorized that the still-face effect violates the infant’s expectations regarding the “rules that

govern the mutual regulation of social interactions” (Tronick, 2003, p. 477). Since then, Tronick (2005) has added to his original account, by emphasizing the dynamic process of the infant’s developing knowledge of and relationship to the world. Tronick (2003) noted that face-to-face interactions are “co-created by an ongoing moment-to-moment dynamic process that generates unique interactive exchanges and relationships” (p. 477). Although there are several models that differ slightly, each of the theoretical explanations emphasize the importance of the parents’ abilities to assist their infants in regulating their arousal; the infant is seen as an active contributor to the relationship with the parent (e.g., Field, 1994; Fogel, 1982; Gianino & Tronick, 1988; Tronick, 2005; Tronick et al., 1978; Tronick & Weinberg, 1997).

There is also a wide range of variables used to understand both the individual contributions that the infant and the parent bring to their interactions and the synchronicity of those interactions (e.g., Earls, Muzik, & Beeghly, 2009; Kogan & Carter, 1996; Mesman et al., 2009; Murray, Fiori-Cowley, Hooper, & Cooper, 1996; Pickens & Field, 1993), including individual infant behaviors (e.g., affect, soothability, solicitation of the parent, social engagement with the parent), individual parent behaviors (e.g., affect, sensitivity, engagement, flexibility, intrusiveness, and anxiety), and dyadic behaviors (e.g., infant–parent reciprocity and shared affect).

Of particular importance is the parent’s positive affect and sensitivity to the infant’s cues, which have been associated with infant positive affect and bids for the parent, more infant self-regulatory behaviors, less infant avoidant behavior, and less infant negative affect during the still-face and reunion episodes (Braungart-Rieker, Garwood, Powers, & Wang, 2001; Kogan & Carter, 1996; Mesman et al., 2009; Rosenblum et al., 2002; Tronick, Ricks, & Cohn, 1982). Other parent behaviors, including intrusiveness and anxiety, have been associated with less favorable infant behaviors, including less infant positive affect, less attention-seeking behaviors, and more negative affect and avoidant and resistant behaviors during reunion (Rosenblum et al., 2002).

In a longitudinal study, Braungart-Rieker and colleagues (2014) found that parental sensitivity was associated with increases in positive affect and self-soothing during episode transitions, and higher levels of gaze directed toward the parent during the still-face and reunion epi-

sodes, suggesting that infants of sensitive parents hold positive expectations regarding their parents’ abilities to assist them in regulating their arousal. Furthermore, lower parental sensitivity was associated with an insecure attachment classification at ages 12–14 months during the Strange Situation Procedure. Given both the concurrent and longitudinal implications of parental sensitivity, it is important to examine the parents’ ability to identify and respond sensitively to their infant. Optimally, the infant is observed to solicit the parent to assist him or her in regulating arousal produced by the still-face episode, and the parent is observed to accurately identify and respond sensitively to the infant’s cues. In turn, the infant is able to return to the approximate level of emotional functioning that was displayed during baseline.

In addition to attachment classifications, research has also examined the connection between FFSF behaviors and maternal mental representations, as assessed by the WMCI. Rosenblum and colleagues (2002) found that having a balanced representation was associated with more infant positive affect during the still-face and reunion episodes when compared to having disengaged or distorted representations. Furthermore, mothers with nonbalanced representations demonstrated more rejecting behavior of their infants. Given this connection, it is important to examine the parent’s representation of the infant, as it has implications for both parent and child behavior.

Overall, the FFSF procedure may valuably contribute to clinical interpretation of the infant–parent relationship, including how the dyad manages a temporary stressor or rupture in the relationship. From this clinical conceptualization, both prevention efforts and therapeutic intervention can be employed, as indicated.

Crowell Parent–Child Interaction Procedure

Our use of this semistructured interaction procedure involves a series of seven episodes including unstructured free play, clean-up, blowing bubbles, two developmentally graded teaching tasks, and a brief separation and reunion. The procedure assesses in a standardized manner several aspects of the parent–child relationship as reflected in interactions between parents and their infants (Crowell & Feldman, 1988, 1989; Heller et al., 1998). The procedure allows for the clinical assessment of the level of comfort of the parent and child with each other,

their familiarity and enjoyment in playing together, whether the play is task-oriented versus oriented toward the child's wishes, and whether the play connotes a partnership or whether each person plays separately. Child compliance is assessed, as well as whether the parent's expectations of the child are developmentally appropriate. The degree to which the two function as a team is also evaluated. An important variable is the manner in which the child handles transitions. The parent's ability to anticipate whether the child is going to have difficulty with the transition and to assist with future transitions is noted.

The developmental tasks are ordered, so that they increase in difficulty, such that the first task is near the child's developmental level and the second task is above it. The manner in which the dyad manages this increase in difficulty is assessed, including whether the parent offers assistance and whether the child makes use of the parent's help. Since the tasks become more challenging, the child's frustration level and tolerance can be measured. Is the parent able to defuse or anticipate any frustration that occurs?

Finally, a separation episode is included to introduce a potentially stressful situation that is designed to activate the child's attachment system. Does the parent prepare the child for the separation? How does the child respond to the separation? Upon reunion, whether the child seeks proximity—physically, visually, or verbally (e.g., greeting or inviting the parent to play)—or rejects or avoids the parent is documented. If the child seeks comfort, is he or she effectively soothed? Does the parent's response match the child's level of distress? Finally, is the child able to return to play by the end of the reunion and, if so, does the child's level of play match that of the play demonstrated prior to the separation? We observe the degree to which the child has resolved whatever distress the separation elicited, and if there was no obvious distress, whether the child and parent reengage positively. The interaction procedure provides rich material for use in preventive and clinical intervention (Larrieu & Bellow, 2004).

Crowell and Feldman originally developed a rating scale that included five caregiver items (behavioral responsiveness, emotional responsiveness, positive affect, withdrawn/depressed, and irritability/anger) and seven child items (positive affect, withdrawn/depressed, irritability/anger, noncompliance, aggression toward parent, enthusiasm, and task persistence)

(Crowell & Feldman, 1988, 1991; Crowell, Feldman, & Ginsberg, 1988).

Sprang and Craig (2015) used exploratory factor analysis to identify the latent constructs underlying the proposed variable items of the Crowell Problem-Solving Procedure rating scale. Their study involved a large clinical sample of mothers, fathers, and their children, referred due to involvement with the child welfare system. Both the child and caregiver scales were psychometrically defined by single factors (child affective presentation and caregiver responsiveness, respectively) that were internally consistent and well defined conceptually by the representative items. Each scale demonstrated high internal consistency, which suggests that the scores may be useful not only as two separate scales measuring child and caregiver interactions, but also collectively as a total score that assesses the functioning of the relationship.

Summary of Parent–Child Relationship Assessment

At the level of the parent–child relationship, both the internal, subjective representation of the child, held by the parent and assessed by the WMCI, and the external, observable interactions of the dyad, as measured by the FFSF or the Crowell Parent–Child Interaction Procedure, provide useful tools to assess the strengths and difficulties in the relationship of young children and their parents. These tools can be used clinically to guide treatment and optimize functioning of the parent–child dyad. We now move to the broader context of triadic and family functioning.

Coparenting and the Broader Relational Context

Although the dyadic relationship between mother and infant or father and infant has historically been at the center of infant mental health theory and practice, the larger caregiving system also needs to be included in the assessment of an infant or young child to capture the interpersonal context in which the child develops (Favez, Frascarolo, Keren, & Fivaz-Depeursinge, 2009; McHale, 2007b, 2011; McHale & Irace, 2011). Over the past 20 years, there has been an increasingly sharper focus on the importance of coparenting, the roots of which can be traced to Salvador Minuchin's (1974) structural family theory.

Coparenting is defined as two or more adults collaborating to care for and raise a child (McHale & Irace, 2011). At the core of coparenting is the understanding that children most often develop within a multiperson network of relationships (McHale & Lindahl, 2011). Although young children are parented by individuals, children also live in a larger system comprising several adults who care for them. We have modified Stern-Bruschweiler and Stern's (1989) original model in Figure 16.2. As the figure indicates, at a minimum, a coparenting system is triadic (Fivaz-Depeursinge & Corboz-Warnery, 1999; McHale, 2011; McHale & Fivaz-Depeursinge, 2010), but it often extends further to include many different adults. Traditionally, the triad has included father, mother, and child, but there is increasing research on other triads, including child, mother, and grandmother (McHale, Salman, Strozier, & Cecil, 2013).

Children as young as 3–4 months actively co-construct interactions within a triadic system (Fivaz-Depeursinge et al., 2005; McHale et al., 2008) and their development is interlaced with the functioning of the larger family context (McHale & Irace, 2011). Coparenting dynamics have been found to remain stable throughout early childhood in a nonrisk sample without clinical intervention (Favez et al., 2006, 2009; McHale & Rotman, 2007). Furthermore, several studies have indicated that prenatal interaction patterns between coparents have an influence

on the triadic interaction patterns once the child is born (Favez et al., 2006; McHale et al., 2004; Van Egeren, 2003). In order for coparenting to be successful, the adults involved need to form an alliance that allows them to put the child's best interest first, and to make decisions together in a constructive manner. Questions that need to be addressed include not only who makes decisions about the child and who lives with the child, but also to whom the child is connected and attached.

Coparenting dynamics have been linked to significant social and emotional factors in a child's development (McHale, 2007a). Specifically, high levels of coparenting discrepancy, negative affect, and hostility/competitiveness are linked to internalizing and externalizing behavior problems (McConnell & Kerig, 2002; McHale & Rasmussen, 1998; Schoppe, Mangelsdorf, & Frosch, 2001), and academic problems including attentional difficulties (Stright & Neitzel, 2003) and peer competency (Leary & Katz, 2004). Parent self-reports of coparenting alliances are also correlated with self-reported feelings of attachment toward the child (Abidin & Brunner, 1995), and hostility between coparents is linked to less secure attachment in preschoolers (Frosch, Mangelsdorf, & McHale, 2000). The effects of coparenting dynamics on the child's development have been found to remain in place even after variability in mother–child, father–child, and marital re-

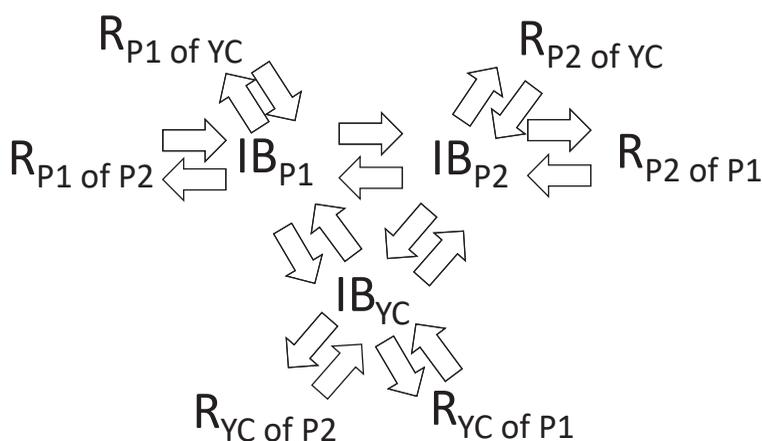


FIGURE 16.2. Components of coparenting relationships with two caregivers and one young child. R_{Pp} , parent's representation of the young child; IB_p , interactive behavior of the parent (with the young child); IB_{YC} , interactive behavior of the young child (with the parent); R_{YC} , young child's representation of the parent. From Stern-Bruschweiler and Stern (1989). Copyright 1989 by John Wiley & Sons. Reprinted with permission.

relationship functioning has been accounted for (McHale & Fivaz-Depeursinge, 2010). In addition, dyadic interventions may improve the relationship between the child and the mother or father, for example, but these changes do not necessarily transfer to the coparenting dynamic (McHale, 2007b).

Assessing Coparenting

A comprehensive coparenting assessment includes both individual interviews with coparents and direct observation of family interactions. Ideally, all coparents involved in a young child's life are interviewed individually to gather information about who the coparents are, their specific roles in the child's life, and the extent of their involvement with the child and with each other. Genograms and ecomaps can be helpful tools to gather this information. When using ecomaps, the coparents are asked to draw connections between the child and coparents from the child's perspective. This valuable tool ensures that all coparents are included, and allows the coparents to hold the child in mind as central to the coparenting system (McHale, 2011). Several self-report questionnaires are available to assist in gathering clinical information about coparenting strengths and weaknesses. The two most commonly used scales are the Parenting Alliance Inventory (Abidin & Brunner, 1995) and the Coparenting Scale (McHale, 1997).

An important goal in the assessment of coparenting is to understand the quality of the coparenting relationship. Mchale and Fivaz-Depeursinge (2010) and Mchale (2011) note the importance of assessing for the degree of (1) mutual involvement/engagement, (2) solidarity and collaboration, and (3) unresolved coparenting dissonance within family alliances. These three domains provide a useful framework and are relevant throughout the assessment process. When assessing for mutual involvement and engagement, the clinician notes how active each coparent is in the child's life, including decision making about the child. The clinician should also note whether any of the coparents are either absent or withdrawn, or overbearing and overinvolved. Solidarity and collaboration within the coparenting relationship refer to the levels of trust, cooperation, and support the adults involved in the child's life hold for each other. The clinician should note feelings of isolation, mistrust, or nonsupport expressed by any of the coparents.

Finally, coparenting dissonance includes the level of incompatibility of viewpoints between coparents with regard to the child in question, and how such incompatibility is navigated, including critical commentary about the other coparent and whether the child is caught in the middle of any discord. The level of dissonance can be noted as minimal, identifiable, or substantial (McHale, 2011; Mchale & Fivaz-Depeursinge, 2010).

Cultural factors play a significant role in coparenting dynamics and should always be considered throughout the assessment process. Thus far, coparenting research has focused primarily on European American families, often with the mother and father as the main coparents, although the focus of research has begun to expand to include other family constellations and cultural backgrounds (Forehand & Jones, 2003; Jones, Forehand, Dorsey, Foster, & Brody, 2005; Mchale & Coates, 2014; Naug, 2000). At a minimum, clinicians should always consider how the family's cultural background may influence observed interactions and beliefs, and be careful before pathologizing behaviors that are accepted within the family's culture. It is the clinician's responsibility to inform him- or herself about the family's cultural norms, which may include the frequency of gaze, the importance of verbal versus nonverbal cues, and the display of gender roles.

Formal Observations of Coparenting

In addition to clinical interviews and self-report questionnaires, a comprehensive coparenting assessment always includes direct observation of the coparenting dynamic (McHale, 2011). Clinicians may use semistructured observation of the child within the larger family dynamic, or they may choose a more structured observational approach such as the Lausanne Trilogue Play paradigm or the PicNic Game.

The Lausanne Trilogue Play Paradigm. The Lausanne Trilogue Play (LTP) paradigm was developed by Fivaz-Depeursinge and Corboz-Warnery in 1999 as a semistructured assessment tool to gather clinically relevant data on coparenting dynamics, as well as the child's contribution to these dynamics. The LTP consists of four phases:

1. One of the coparents plays with the baby, while the other is the third party and is instructed simply to be present.

2. The coparents switch roles.
3. All three family members interact.
4. The coparents interact, while the baby is placed in the “third-party” role.

During the introduction to the procedure, the coparents are told to “play together as a family” and are informed that they may choose who will be the first to interact with the child, how long each phase will last, and the positioning of the table. Throughout the procedure, the family members sit facing each other in a triangular format, and the infant sits in a car seat or reclining chair that can be moved to face either parent. Once the child has reached 12 months of age, the setting is adapted so that the parents and children are seated at a table, and three objects are provided for the family to use throughout the procedure. The interaction is videotaped and can be used for review with the family. Further modifications of the LTP include a prenatal adaptation (Carneiro, Corboz-Warnery, & Fivaz-Depeursinge, 2006) and the Lausanne Family Play procedure (LFP), which allows for more than one child to be included in the family interaction. The theme of the play can be adapted as the age of the child increases to include different activities and toys, or even discussion about family rules. The LTP can be used from infancy until adolescence; however, infants begin to actively co-construct interactions within a triadic system typically around 2–3 months of age, following the initial biobehavioral shift (see Rosenblum, Dayton, & Muzik, Chapter 6, this volume).

Throughout the procedure, the clinician notes the overarching level of warmth within the triad, as well as levels of cooperation, support, and mutual enjoyment. In addition, it is useful to note how the members of the triad repair if there is a misstep, such as one coparent becoming overly involved in interacting with the child when it is not his or her turn to do so. Transitions between phases provide valuable clinical information (i.e., Are they smooth? Do both adults agree that it is time to transition? Are there any preparatory steps taken?).

Fivaz-Depeursinge and Corboz-Warnery (1999) suggested classifying the qualities of the family alliance as cooperative (A), stressed (B), collusive (C), or disordered (D). In cooperative and stressed alliances, the family is working together as a team, leading to the classification of these alliances as “good enough.” Collusive and disordered alliances are termed “problematic,” as the coparents appear to be

working against each other rather than together. Here, the infant is either excluded or inappropriately included in a problematic interaction, which puts the infant’s social–affective development at risk (Fivaz-Depeursinge & Corboz-Warnery, 1999). Families with unresolved conflict are often classified as having “C” alliances. Collusive family alliances are further classified as either “overt” (C1) or “covert” (C2), based on how openly the conflict is shown. Families with “D” classifications often have significant parental psychopathology and strong negative affect. Disordered alliances are classified as either “chaotic” (D1) or “rigid” (D2).

Fivaz-Depeursinge and Corboz-Warnery (1999) noted four specific functions that correspond with these classifications and may be used to guide classification of family alliances. The first function is “participation,” which is the simplest function and requires everyone being included. When a member of the triad is not participating or is excluded from the interaction, the alliance is disordered (“D”). The next function is “organization,” which involves each member of the interaction remaining in his or her given role during the various phases of the assessment. If a family is not able to do so, but all members are participating, the family is described as having a collusive alliance (“C”). Next, “focal attention” is assessed, which involves all three participants focusing on the same thing at the same time. If a triad is able to participate and remain organized, but does not have focal attention, then the alliance is classified as stressed (“B”). Finally, the highest function is “affective contact,” which involves mutual enjoyment and emotional intimacy and connectedness. Triads that are able to fulfill all four functions in their interactions are classified as cooperative alliances (“A”). Nonverbal cues provide useful information in determining the various functions a triad is able to achieve, specifically in regards to the pelvises, torsos, gazes, and facial expressions of the participants.

Finally, the clinician may also assess for specific coalitions present during the LTP, which provides useful clinical information. Specifically, Favez and colleagues (Fivaz-Depeursinge, Lopes, Python, & Favez, 2009; Frasca-rolo, Fivaz, & Favez, 2011) describe “binding” (one coparent aligns with the child against the other coparent), “triangulation” (the child is caught between the coparents as they both bid for the child’s attention), and “detouring” (the

child becomes the scapegoat, and both coparents turn “against” the child).

To date, there is no single scoring system that is universally used with the LTP. However, several scales have emerged, including the Family Alliance Assessment Scale (FAAS; Favez, Scaiola, Tissot, Darwiche, & Frascarolo, 2011), the Evaluation Grid for Trilogue of the Centre for Family Study (GETCEF; Frascarolo, Favez, Carneiro, & Fivaz-Depeursinge, 2004), and the Coparenting and Family Rating System (CFRS; McHale, Kuersten-Hogan, & Lauretti, 2001), all of which have been used primarily in research settings. The GETCEF has good to very good interrater reliability (Favez, Frascarolo, Scaiola, & Corboz-Warnery, 2013) and the FAAS and the CFRS both have good interrater reliability and validity (Favez et al., 2011; McHale et al., 2004).

The PicNic Game. The PicNic Game (PNG; Frascarolo & Favez, 2005) is less structured than the LTP and allows for inclusion of other family members and coparents beyond the triad observed in the LTP, including siblings. Children (including infants) and family members of any age may participate in this procedure. The family members are asked to pretend that they are enjoying a picnic together. A carpeted space of 4 meters × 4 meters is provided to limit the available space, as well as a bench, chairs, toys, and a toy tea set. The family members are instructed to “play picnic” for approximately 15 minutes, and clean up when they are finished. This procedure allows the clinician to assess the family members’ ability to enjoy themselves and play together, as well as the adults’ ability to structure parts of the interaction, such as setting up the table, then cleaning up (McHale & Fivaz-Depeusinge, 2010). The PNG is recorded on video.

Important observations during this procedure include whether the coparents are working together, as opposed to working in parallel or against each other. Any conflict or competition is also noted, as well as levels of warmth throughout the procedure and the ability of the coparents to set appropriate limits. Favez, Frascarolo, and Grimard (2016) recently published the Revised-PicNic Assessment Scale (Re-PAS), a tool to evaluate observations of the PNG based on five dimensions: structure, coparenting, conjugal relationship, limit setting, and family warmth. Preliminary validity and reliability scores were found to be satisfactory.

The Relational Context of Infant Mental Health

An important question is how dyadic assessments and coparenting assessments may complement one another. Because dyadic assessments are fundamentally important in working with young children, we believe that coparenting assessments should not replace them; rather, conducting both dyadic and coparenting assessments allows the infant mental health practitioner to gain a more comprehensive picture of the infant’s functioning both within their primary relationships and within the larger context of which the infant is a part. Comparing the adult’s behavior with the child in the dyadic assessment to the adult’s behavior in a triadic or family observation can provide useful clinical information, especially with regard to any significant differences between the two assessments (McHale, 2007b, 2011). Indeed, parental behavior has been found to differ in dyadic and family settings (McHale, 2007b; McHale, Kuersten-Hogan, Lauretti, & Rasmussen, 2000).

The DC:0–5 Approach

A recent approach that attends to both the primary caregiving relationship and the broader relational context is that of DC:0–5 (Zero to Three, 2016). A number of important theoretical and empirical contributions over four decades led to this conceptualization. The most important conceptual breakthrough was made by Sameroff and Emde (1989), who argued that although young children might demonstrate serious emotional or behavioral disturbances, these were most commonly expressions of relationship disturbances with their primary caregivers. A fuller account of the background for the DC:0–5 (Zero to Three, 2016) characterization of the infant and young child’s relational context has been detailed elsewhere (Zeanah & Lieberman, 2016).

In this approach, the relationship between a young child and the child’s primary caregiver(s) is rated using an ordinal 4-point scale that rates the level of relationship adaptation for that specific relationship. Each level represents a range of relationship functioning (see Table 16.1). Level 1 relationships are those that function adaptively and are not of clinical concern. In most clinical settings, these will be rare, though in population studies, these would be expected to predominate. Level 2 relationships are those

that are clearly at risk of maladaptation that may or may not be the focus of intervention. Levels 3 and 4 represent relationship disturbances that are definitely within the clinical range, though it is noted that the disturbances may arise largely from within the child (e.g., because of a child's psychiatric disorder), from within the parent, or from the unique fit between parent and young child.

In completing ratings of the level of relationship adaptation—maladaptation, practitioners are encouraged to consider characteristics that primary caregivers bring to the relationship, or dimensions of caregiving (see Table 16.2) and characteristics that infants and young children bring to the relationship (see Table 16.3), and to note each as a “strength,” “not a concern” or a “concern.” This assessment helps to determine whether the specific dimensions are strengths that will be used in treatment to build on or concerns that will be a target of behavior change.

An additional rating, using the 4-point rating scales shown in Table 16.1, is also completed about the larger caregiving environment and

how it functions in relation to the infant or young child. Level 1 caregiving environments range from adequate to exemplary in terms of the coordination, collaboration, and compatibility that are generally evident. Caregiving environments are rated Level 2 when there are indicators of conflict and/or insufficient communication and coordination among the caregivers regarding the care and upbringing of the child. Level 3 caregiving environments are fraught with excessive risks to safety, significant conflicts, insufficient or irregular engagement, or significant imbalance as they affect the infant or young child. Finally, in Level 4, relationship pathology among caregivers is severe and pervasive, with significant harm to the child's well-being.

Clinicians are encouraged to think through each of the dimensions of the caregiving environment in Table 16.4 when completing the ratings and to indicate each of the dimensions as a “strength,” “not a concern” or a “concern.” As before, these dimensions are considered to focus treatment efforts, as well as

TABLE 16.1. Levels of Relationship Adaptation

	Primary caregiving relationship adaptation	Caregiving environment
<u>Level 1</u>	Well-adapted to good enough relationships Relationships are not of clinical concern. This level covers a broad range of relationships, from those that are functioning adequately for both partners to those that are exemplary.	Well adapted to good enough The caregiving environment ranges from those that are functioning adequately among caregivers in relationship to the child to those that are exemplary in their level of coordination, collaboration, and compatibility.
<u>Level 2</u>	Strained to concerning relationships Maladaptive qualities in the relationship are evident. Careful monitoring is definitely indicated, and intervention may be required.	Strained to concerning The caregiving environment includes indicators of conflict and/or insufficient communication and coordination among the caregivers regarding the care and upbringing of the child.
<u>Level 3</u>	Compromised to disturbed relationships Relationship disturbance at this level is clearly in the clinical range of concern, and intervention is indicated.	Compromised to disturbed Family relationships are fraught with inappropriate levels of risk to safety, significant conflict, insufficient or irregular engagement, or significant imbalance.
<u>Level 4</u>	Disordered to dangerous relationships At this level, not only are relationships in the clinical range of concern, but there is also an urgency about intervening due to the severity of the relationship impairment.	Disordered to dangerous Relationship pathology among caregivers is severe and pervasive, with significant impairments in the provision of adequate protection and responsive caregiving, age-appropriate socialization, and/or support for exploration and learning.

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TABLE 16.2. Dimensions of Caregiving

-
- Ensuring physical safety
 - Providing for basic needs (e.g., food, hygiene, clothing, housing, health care)
 - Conveying psychological commitment to and emotional investment in the infant/young child
 - Establishing structure and routines
 - Recognizing and responding to the infant's/young child's emotional needs and signals
 - Providing comfort for distress
 - Teaching and social stimulation
 - Socializing
 - Disciplining
 - Engaging in play and enjoyable activities
 - Showing interest in the infant's/young child's individual experiences and perspectives
 - Demonstrating reflective capacity regarding the infant's/young child's developmental trajectory
 - Incorporating the infant's/young child's point of view in developmentally appropriate ways
 - Tolerating ambivalent feelings in the caregiver–infant/young child relationship
-

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encourage systematic review of the caregiving environment.

The DC:0–5 ratings of the caregiving environment are intended to broaden consideration of the caregiving environment beyond coparenting. In this conceptualization, the environment in which the infant or young child develops includes other children or adults who are not involved in parenting but whose presence and behavior influence parenting. By considering both the primary caregiving relationship and the broader caregiving environment in which infants and young children develop, clinicians are better positioned to identify both sources of strength and areas of concern that should be targets of intervention. The specific assessment tools outlined in this chapter can provide information to assist in completing the ratings using the DC:0–5 system.

Concluding Comments

We have presented several models by which infants and young children and their relationships with their primary caregivers and broader caregiving environments may be considered. Assessments of these various aspects of the infant's or young child's relational context aid in understanding the child's development and functioning within his or her interpersonal world. For the measures outlined in this chapter, the empirical data to date demonstrate psychometric properties in the adequate to very good range. More work is needed to examine the use of these measures across a larger variety of cultural groups and family systems, including both normative and clinical samples. Nevertheless, clinical use of these methods and measures does not necessarily require fidelity to research coding methods.

TABLE 16.3. Infant/Young Child Characteristics

-
- Temperamental dispositions
 - Sensory profile
 - Physical appearance
 - Physical health
 - Developmental status
 - Mental health
 - Learning style
-

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TABLE 16.4. Dimensions of the Caregiving Environment

- Problem solving
- Conflict resolution
- Caregiving role allocation
- Caregiving communication: Instrumental
- Caregiving communication: Emotional
- Emotional investment
- Behavioral regulation and coordination
- Sibling harmony

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As more research and clinical data from their use with dyads, triads, and multiperson family systems are gathered, researchers and clinicians may have greater confidence in devising and implementing preventive and therapeutic interventions for infants, their caregivers, and their families who present with high-risk and challenging circumstances, including problematic relationships.

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