

State of New Mexico  
Children, Youth and Families Department

**cyfd**



Children Youth & Families Department

**PULLTOGETHER**

# New Mexico Parent Infant Psychotherapy MANUAL

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**CYFD**  
**Behavioral Health Services**

**PARENT INFANT PSYCHOTHERAPY  
MANUAL**

*Dedicated to  
Alicia Lieberman, Chandra Ghosh Ippen, Julie Larrieu and Soledad Martinez  
Wise Mentors and Gentle Guides*

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## Preface

Healthy social and emotional development refers to a child’s capacity to experience, manage, and express a full range of positive and negative emotions; develop close, satisfying relationships with others; and actively explore environments and learn. Social and emotional development is an integral part of the foundation that helps guide a young child into adulthood and is firmly tied to every other area of development—physical growth and health, communication and language development, cognitive skills, and early relationships. Early childhood social and emotional development is influenced by biology, environment and relationships that exist between a small group of consistent caregivers and a child.

Professionals in the field of child development who focus on social and emotional development refer to their area of practice as “infant mental health” or “early childhood mental health.” Because the parent-child relationship is so critical for early development, the mental wellness of adults plays a critical role in how very young children develop. When an infant or toddler’s social and emotional development suffers significantly, they can, and do, experience mental health problems as well. But skilled providers can accurately screen, diagnose and treat mental health disorders in infancy and early childhood before they impact other areas of development.

—Zero to Three (National Center for Infants, Toddlers, and Families),  
*Laying the Foundation for Early Development*, 2009

## CHAPTER 1

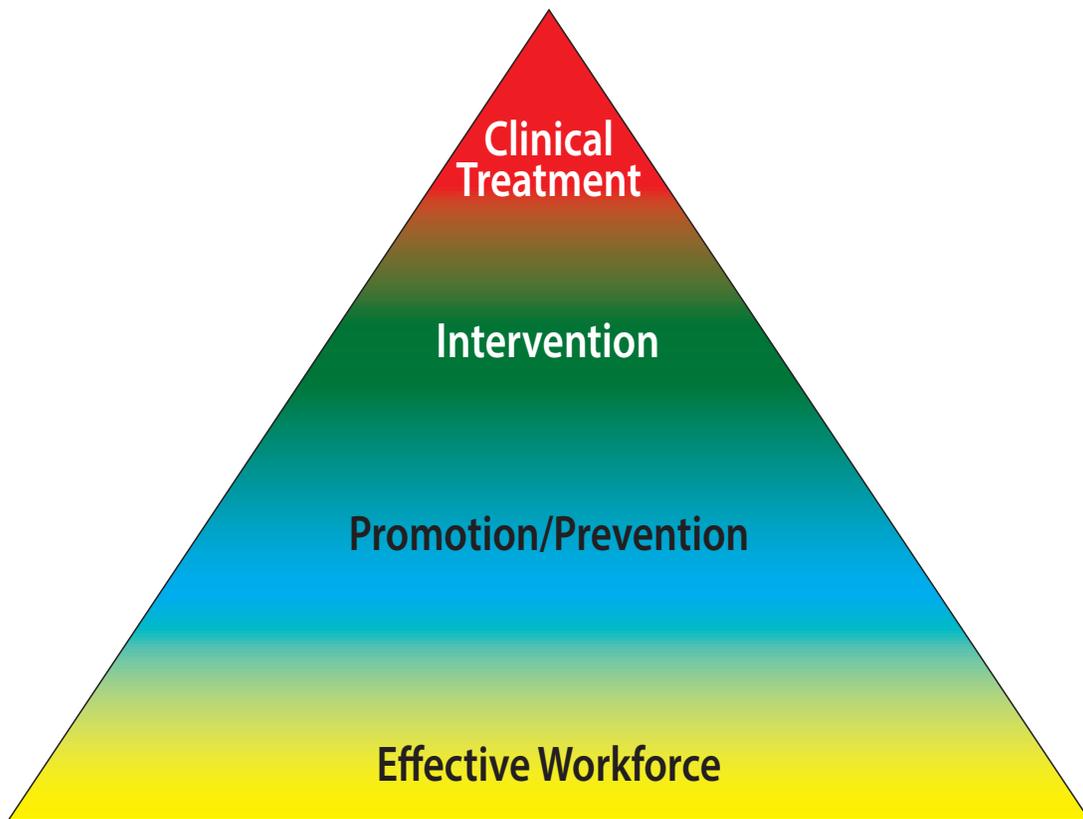
# Overview of Parent-Infant Psychotherapy (PIP) Role

### **A FRAMEWORK FOR SUPPORTING THE SOCIAL EMOTIONAL COMPETENCE OF INFANTS, YOUNG CHILDREN, AND FAMILIES**

#### **CYFD - BEHAVIORAL HEALTH, PULLTOGETHER AND PYRAMID PARTNERSHIP**

The NM Children, Youth and Families Department (CYFD) Behavioral Health Services - Infant and Early Childhood Mental Health (BHS-IECMH) along with the Pyramid Partnership anticipates an integrated and aligned system of early childhood and infant mental health programs, practitioners and families versed in the Pyramid Framework. CYFD Cabinet Secretary Monique Jacobson's PullTogether campaign envisions engaged communities helping families with infants and young children to access resources along the Pyramid to meet their needs. Together the BHS-IECMH along with the Pyramid framework and PullTogether effort, will build and integrate a system utilizing existing models to promote the social-emotional competence of children birth to age five in the context of nurturing relationships and quality learning environments.

The development of a competent community of behavioral health practitioners includes the CYFD funded Parent Infant Psychotherapy (PIP) Program in order to alleviate and remediate behavioral and social-emotional health issues interfering with normal developmental trajectories and healthy infant/young child and parent/caregiver relationships. The PIPs provide BHS-IECMH clinical treatment services that target the dyadic relationship between the child and the parent or primary caregiver. As part of an integrated statewide system of early childhood and infant mental health programs, the intention of the PIP services is to address the top tier of the Pyramid and align with other statewide system's building projects, efforts and resources.



### **INITIATIVES AND PYRAMID OFFERINGS**

The Early Childhood Home and Family Services (ECHFS) Division of the University of New Mexico - Center for Development and Disability (UNM-CDD) provides the training and consultation for the PIPs. The ECHFS of the UNM-CDD houses two important state-wide capacity building projects funded by BHS-IECMH: The Early Childhood Infrastructure Development (ECID) and the IMH-Community of Practice (IMH-COP) projects. In tandem, these projects seek to increase the capacity of targeted behavioral health providers throughout NM contracted by BH-IECMH to serve infants/young children who have significant behavioral and social-emotional issues that interfere with age-appropriate developmental functioning and affect the quality of their caregiver-child relationships.

The UNM-CDD and BHS-IECMH have developed an Infant and Early Childhood Mental Health Training Institute (IECTI) which offers different levels of CYFD funded trainings to support the ECID and IMH-COP projects, and to meet competency standards along the Pyramid continuum. The continuum from Effective Workforce to Treatment promotes the developmental and social-emotional wellbeing of all infants/young children and includes a unique leadership academy to build statewide capacity. The matrix below illustrates the BHS-IECMH continuum of training initiatives and supports according to the Pyramid Framework. The next table on page 10 illustrates the ECID and IMH-COP projects.



CYFD-Behavioral Health Continuum of Training Initiatives and Therapeutic Supports:

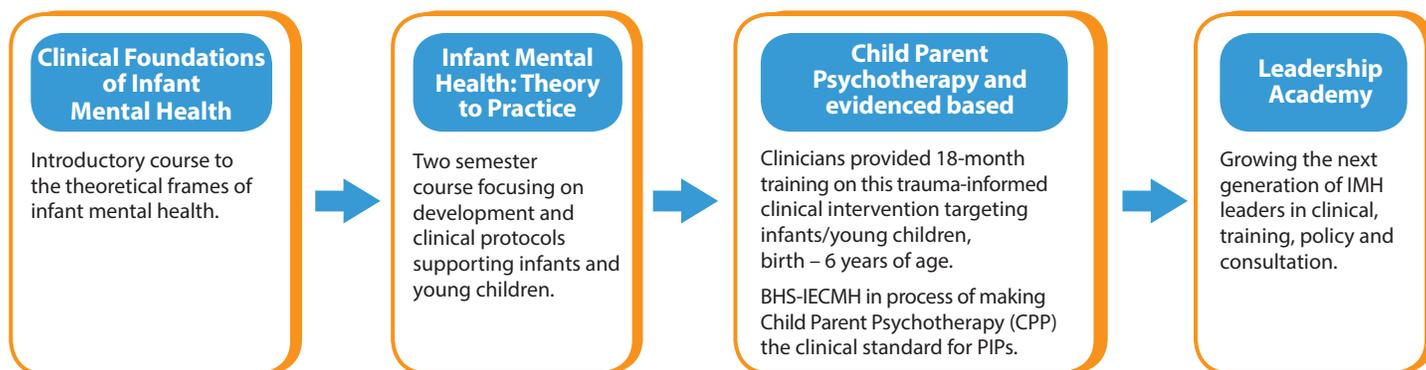
**Infant and Early Childhood Mental Health**

To Build a Statewide Capacity to Address Maltreatment and Foster the Social-Emotional Needs of Vulnerable Infants, Toddlers, Young Children and Families Using Best Practices and Evidence-Based Methods

STATEWIDE TRAINING/SERVICE	EFFECTIVE WORKFORCE/ PULL TOGETHER	PROMOTION/ PREVENTION	INTERVENTION	CLINICAL TREATMENT
PullTogether Campaign				
Foundations in Infant Mental Health				
Circle of Security – P (Parenting)				
Theory to Practice IMH Seminars				
UCSF-Child Parent Psychotherapy Cohort Trainings				
Circle of Security – T (Treatment)				
Infant Teams Collaborating with CPS				
Parent-Infant Psychotherapists				
UNM-ECHO Model Videoconference: IMH and Developmental Consultations for ITs and PIPs – 1x a month				
Ask the Manager Zoom Call for Improving Program Management – 1x a month				
ZOOM Call for Directors/ Supervisors – 1x a month				
ZOOM call for New Consultants – 1x a month				
Leadership Academy				
Legal Collaboration				
DC-0-5 Training				

## Infant Mental Health

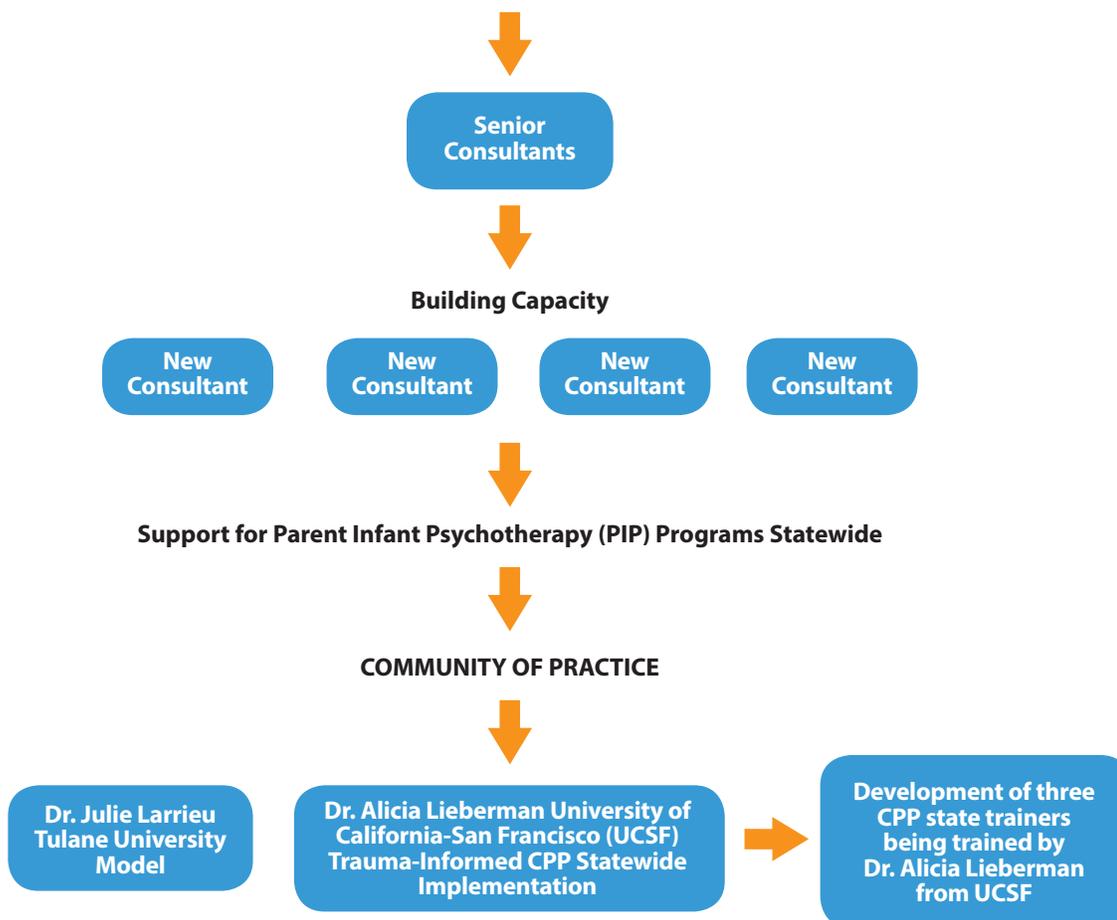
**Early Childhood Infrastructure Development (ECID) Project:**  
 Infant and Early Childhood Mental Health Institute at  
 UNM-CDD



CYFD contractors providing Infant Mental Health Services receive monthly case based clinical consultation and quarterly case based clinical consultation with internationally recognized infant mental experts.

### Infant Mental Health

BHS-IECMH in process of making Child Parent Psychotherapy (CPP) the clinical standard.



## PARENT-INFANT PSYCHOTHERAPY AND FIDELITY

The PIPs represent the upper part of the pyramid that encompasses clinical treatment. The goal is to provide PIP services in order to alleviate and remediate behavioral health issues interfering with healthy infant and parent/caregiver relationships. PIP programs funded by CYFD provide a continuum of clinical/behavioral health services to families based on the diagnostic, needs, strength and risk factors. Services provided by the PIPs are designed to meet the therapeutic needs at the local level and are responsive to the ethnic, cultural, racial, linguistic, and socioeconomic diversity of families.

The PIPs meet a fidelity criteria for the delivery of services that adheres to a program model and protocol. The protocol is based upon a theory of action that explains the mechanisms through which the program will achieve its desired outcomes. In order to maintain fidelity, PIPs receive not only their program or agency supervision, but also receive monthly case-based clinical consultation through the UNM ECHO Model, and quarterly case-based clinical consultation with internationally recognized infant mental experts.

This manual is developed to train PIPs and for monitoring program quality and performance to ensure fidelity to the PIP model and protocol. Fidelity is critical to provide assurances to policy-makers that services are being implemented as intended and that they reach the target audience. Fidelity then is defined as the adherence of assessment and treatment delivery to the PIP protocol described in this manual. Below is the PIP Logic Model from which the fidelity protocol is derived.



### Parent-Infant Psychotherapy Logic Model

#### Program Vision:

New Mexico Families involved in the Child Welfare System will be supported to raise children who are healthy, happy and successful.

#### Parent-Infant Psychotherapy

Infant and Early Childhood Mental Health offers a way of conceptualizing early disruptions in the attachment process, and of organizing interventions which include systems advocacy, developmental/parental guidance, supportive counseling and parent-infant psychotherapy. Parent-Infant Psychotherapy is a unique kind of treatment where the presence of the infant/child in the work is essential. Parent Infant Psychotherapists address the nature of the infant/child's progress or difficulties in development and the nature of the caregiving relationship(s).

#### Core Service Components:

- **Provide** trauma- and developmentally-informed, parent-infant psychotherapy (PIP) that includes a dyadic therapeutic process in order to identify, alleviate and remediate behavioral health issues that interfere with healthy infant/child and parent/caregiver relationships.
- **Promote** the biological foundation of affect regulation and interpersonal/social connection in the dyadic therapeutic process with a child who has been diagnosed as severely emotionally disturbed (SED) or at-risk of SED.
- **Utilize** state-of-the-art assessment procedures and evidence-based treatment modalities that address trauma and behavioral health concerns through strengthening caregiver-infant relationships, and providing new ways to understand an infant/child's needs and behaviors.
- **Support and Enhance** the social-emotional, developmental and behavioral health of infants/young children and families while including both top-down and bottom-up approaches that address nervous system imbalances.
- **Increase** parent/caregiver's ability to recognize and provide for infant/child's basic emotional needs for safety, comfort, affection and developmental stimulation.
- **Reduce** the need for foster care by prioritizing early childhood to lay the relational foundation for potential success and efficacy at a later age.
- **Improve** the parents/caregiver's ability to not only understand and help overcome his/her child's presenting problems within a dyadic therapeutic process but also to enable the infant/child to return to an adaptive developmental pathway.

New Mexico provides a coordinated continuum of high quality, community-driven, culturally and linguistically appropriate services that promotes strong parent-child relationships in addition to family, infant, and early childhood mental health, development, and safety.

The following are part of all Parent-Infant Psychotherapy Programs:

### Core Quality Components

- Trauma-informed and Developmentally Informed Team Expertise
- Culturally, Linguistically & Professionally Competent Service Providers
- Reflective Supervision and /or Consultation
- Data Management and Quality Improvement
- Best Practice Dyadic Assessment Procedures
- Evidence-Based Treatment Modalities
- Consistency across Community of Practice
- Community Collaboration
- Level 3 or 4 Endorsements to maintain IMH competencies



### Theoretical Framework

- Attachment Theory
- Theory to Practice Seminars
- Integration of IMH, Neurobiological and Developmental Concepts and Principles
- Reduction of Adverse Childhood Experiences (ACEs) and Cumulative Risks
- Relationship-Based Practice
- Transdisciplinary Teaming
- Self- and Co-Regulatory Systems

### Implementation

- Parent-Infant Psychotherapists (PIPs) address infant/child mental health disorders through relationship-based work with parents/caregivers to enhance key parenting variables and dyadic regulation.
- PIPs prioritize high risk families referred by Child Protective Services (CPS) in an effort to avoid an infant/child's placement in foster care or to reduce the length of foster care placement.
- PIPs promote developmentally appropriate and sensitive parent-infant/child interactions in order to facilitate developmental progress; to assist with the interpretation of an infant/child's behavior; and, to reinforce a parent/caregiver's appropriate actions and interactions.
- PIPs use an evidence-based intervention

### Goals

- Increase parent/caregiver's knowledge of the impact of trauma and stress on their child's development and how early caretaking experiences are a primary source of brain regulation, growth and health.
- Support the parent-infant relationship to ensure the safety and well-being of all children
- Enhance caregiver's positive parenting behaviors and promote child's healthy social-emotional outcomes through increased reflective functioning and targeted intervention strategies.
- Reduce adverse childhood experiences and the potential for recurrence.
- Provide integrated developmental and IMH services across environments and contexts to assure child well-being (physical and social-emotional).

### Therapeutic Benefits

- Provide PIP in order to alleviate and remediate behavioral health issues interfering with healthy parent infant relationships.
- Services target infants and young children (birth to 5 years) who have been comprehensively assessed by a licensed clinician and diagnosed with a Severe Emotional Disturbance (SED) or at-risk of SED. Children who are admitted for service before age 3 may be eligible to receive services up to age 5 (60 months) with an extension approved by the BHS-IECMH Program Director.
- Specialized treatment services by a fidelity trained clinician in Child-Parent Psychotherapy (CPP) which is an intervention model for children aged 0-5 who have experienced traumatic events and/or experiencing mental health, attachment, and/or behavioral problems.

### Outcomes

- Ensure the safety and well-being of vulnerable children
- Reduce the need for foster care
- Reduce recurrence and connect families with relevant, comprehensive services
- Ensure that children are nurtured by their caregivers.
- Increase prospect that children and families are safe.

## CHAPTER 2

# Why Parent-Infant Psychotherapy (PIP)?

### WHAT WE NEED TO KNOW

#### INTRODUCTION

Parent-Infant Psychotherapy (PIP) is intended for infants and young children who are evidencing or at risk for difficulties in social-emotional development. Infants and young children present with a range of emotional and behavioral difficulties including attachment complications, post-traumatic stress responses, failure to thrive and other feeding disorders, regulatory and sensory challenges, depression and anxiety, and disorders of relating and communicating.<sup>1</sup>

A PIP works directly with the parent and infant or young child to identify unconscious patterns of relating and behaving, and influences from the past that are impeding the parent-infant relationship. A broad range of parental mental health difficulties that can negatively impact the parent-child relationship are addressed. The aim of PIP services is to support an infant or young child's healthy age-appropriate functioning by enhancing the quality of caregiving relationships.

#### JUSTIFICATION

The early mental health of the infant/young child lays the groundwork for future relationships, mental health, and even physical health. Conversely, children exposed to early adversity, especially those related to personal relationships and interactions, can compromise development.

Indeed, the results of the Adverse Childhood Experiences (ACE) study demonstrated a strong, graded relationship between childhood trauma and level of traumatic stress with poor physical, mental, and behavioral outcomes later in life.<sup>2</sup> The key concept underlying the ACE study is that stressful or traumatic early childhood experiences can result in social-emotional and cognitive impairments. Fear-based childhoods disrupt neurodevelopment and can alter brain structure and function. For example, fear can result from familial violence or the chronic failure to receive responsive caregiving. The conclusion is that fear during infancy and childhood has a cumulative impact on childhood development.

When children experience maltreatment or toxic stress that manifest in social-emotional, behavioral, and relationship problems, they learn to modify their behavior to the environment and the caregiving they receive. An infant's or young child's adaptation to maltreatment or toxic stress can result in their cues and behaviors being difficult to understand. Although they develop coping strategies that help them survive in the face of adversity, the same strategies can interfere with many aspects of development. Deprivation of key developmental experiences will result in persistence of primitive, immature behavioral reactivity, and predispose a young child to flight, fright, or freeze responses which contribute to developmental disorganization.<sup>3</sup>

## **SAFETY AND MEMORY**

Safety is paramount to healthy social-emotional development; but when infants or young children do not feel safe in their relationships or environments, the memories become embedded in sensory and body-based neural connections in the brain. The memories and earliest mental representations that young children have of the parent/caregiver consist of the ways the parent/caregiver did things with the child. If the parent/caregiver leaves or dies, the child loses the feeling of security generated by those reassuring interactions —“hidden regulators”— that helped to organize the child physiologically as well as psychologically. When a young child loses a parent or caregiver, his or her sense of self is altered. Repeated disruptions of caring relationships continually interfere with the child's ability to form a clear sense of who he or she is in relationship to others.<sup>4</sup>

The paradox is that for many infants and young children growing up in high-risk environments, they may be bonded with their caregivers but they do not feel safe with them. The important point is that infants and young children do not just get over or forget early maltreatment or chronic stress; the experience is embedded in their brain and bodies.

Caregivers from high-social-risk populations, especially caregivers with their own traumatic histories, are vulnerable for the development of disturbed, dysregulating caregiver-child relationships and interactions.<sup>5</sup> Many caregivers with negative experiences during their critical upbringing bring their own early childhood maltreatment experiences forward implicitly into their parenting in the present. Some experiences become encoded in the brain in such a way that awareness is not readily available to the individual. The caregiver may in fact not know why they behaved in a certain manner. Realizing that caregivers may be operating from implicit memory and understanding how early childhood experiences affect adult behavior, including emotional regulation, help PIP service providers to better understand the caregivers that they are working with.

## **REFLECTIVE FUNCTIONING**

Parental reflective functioning is a key determinant of how, within the context of the child's early social relationships, an infant or young child learns to self-organize and self-regulate. Parental reflective functioning is a caregiver's capacity to understand the infant's behavior in terms of internal states and feelings.<sup>6</sup> Development of self-organization is dependent on the caregiver's ability to communicate an understanding of the child's intentional stance via “marked mirroring” of facial expressions, voice, or touch.<sup>7</sup> For example, an infant may become fussy and the mother, face-to-face with the infant, shows a concerned affect on her face and says, “You look like you are hungry, it must be time for your bottle.”

Being able to read a child's cues and anticipate their needs are important parts of parenting. In another example, a reflective caregiver can interpret her daughter's oppositional behavior as belying feelings of sadness or other feelings that are seemingly inconsistent with the behavior and help the child identify these feelings.<sup>8</sup> The caregiver is able to understand and reflect the “inner life of the child”. This ability allows the caregiver to respond accordingly to the child's behavior and to see the behavior as an expression of the inner state of the child. On the other hand, a caregiver with reflective deficits takes the child's behavior at face value; for example, aggression is viewed as an indication of the child's “badness.”<sup>9</sup>

The concept of parental reflective functioning provides a framework for PIPs to shift from a behavior “management” approach to a behavior “understanding” approach. This approach as articulated by Slade and colleagues (2014), moves away from identifying and labeling the behavior as a problem within the child and towards identifying the issue as a disruption within the parent-child relationship.<sup>10</sup>

### **TIMING OF SUPPORTS**

Because the early years are so crucial to development, supportive services should begin as soon as possible and include IMH principles and practices. IMH practitioners who are in regular contact with families of young children must share the responsibility of qualitatively supporting the caregiver-child relationship and early brain development.<sup>11</sup> The field of IMH trains practitioners to recognize the complexity of development in the early years and to organize the multiple influences underlying the meaning of behavior as informed by child-specific issues, relationship factors, and environmental conditions. In IMH, the key is to target developmental processes and utilize clinical interventions towards understanding and assisting fragile caregiver-infant or caregiver-child dyads as early as possible. PIP practitioners make an essential contribution to the early identification and remediation of dysfunctions in the caregiving relationship of those infants and young children who are evidencing or at risk for difficulties in social-emotional development.

### **PRINCIPLES OF IMH PRACTICE**

The IMH practice of the PIPs is guided by six principles, as articulated by Dr. Alicia Lieberman, an internationally renowned leader in the IMH field.

#### **1ST PRINCIPLE**

The most basic and widely accepted principle regarding the mental health of infants, toddlers and preschoolers is that their mental health unfolds in the context of their close emotional relationships and moment-to-moment interactions with parents and caregivers.<sup>12</sup> According to Dr. Kristie Brandt, every child must be provided with five essential ingredients for optimal mental health development: 1) a safe, healthy, and low-stress pregnancy; 2) the opportunity and ability to “fall in love” and “be in love” with a safe and nurturing adult; 3) support in learning to self-regulate; 4) support in learning to mutually regulate; and 5) nurturing, contingent, and developmentally appropriate care.<sup>12</sup>

#### **2ND PRINCIPLE**

The second principle is that constitutional characteristics, including temperamental predispositions, play a major role in how children register and process real life events and emotional experiences.<sup>14</sup> At the same time, because of the central importance of emotional relationships, the caregiver’s supportive response to the child can modulate and even transform constitutional vulnerabilities so that they do not derail the child’s developmental course.

#### **3RD PRINCIPLE**

The family’s cultural values and child-rearing customs form an indispensable matrix for understanding the child’s behavior and developmental course is the third Principle.<sup>15</sup> Each child and caregiver exists in a particular cultural context that deeply affects their individual functioning.

#### **4TH PRINCIPLE**

The 4th principle is that PIP practitioners make an effort to understand how behaviors feel from the inside, and not just how they look from the outside.<sup>16</sup> Within an IMH perspective, a PIP practitioner learns how moment-to-moment interactions are shaping and shaped by the ongoing meaning-making process of both child and caregiver.<sup>17</sup>

## 5TH PRINCIPLE

Central to PIP training is learning about empathizing with parents and infants in a dual process which includes practitioners learning about empathizing with and listening to themselves.<sup>18</sup> An intervener's own feelings and behaviors have a major impact on the intervention.

## 6TH PRINCIPLE

The next principle is to intervene as early as possible. Children's brains are organized and all aspects of learning are mediated by their relationships with caregivers. When those relationships are disrupted, brain development and learning are impacted. PIP practice then becomes supporting the child through the best possible relationships and interactions as soon as possible.

## 7TH PRINCIPLE

The next principle has to do with the importance of reflective supervision. Professionals who provide services to infants and young children and their families involved in child protective services face multiple daily challenges. Working with stressed and traumatized young children and their families, as well as the systems charged with providing services and oversight affects professionals on many levels. These early professionals (mental health providers, developmental specialists, early interventionists, home visitors, family educators, Head Start teachers, public health nurses, child welfare workers and others) in turn require support and ongoing professional development to provide perspective, increase their skills, and avoid burn-out. Reflective supervision, a practice that has evolved from the multi-disciplinary field of infant mental health provides the support needed by practitioners who are exposed to the intense emotional content and life experiences related to their work with families. An ongoing professional development process, reflective supervision provides a way for professionals working with very young children to reach greater understanding of their own responses, as well as the babies and adults they work with, and as a result, facilitating quality practice and intervention.

## 8TH PRINCIPLE

The last principle has to do with the importance of cultural considerations and formulation. It includes an approach to incorporating cultural perspectives in the mental health assessment and treatment of infant/young children (Sarche, Tsethlikai, Godoy, Emde, & Fleming (in press), *Cultural Perspectives for Assessing Infants and Young Children*). The goal is to help clinicians reflect on the different facets of cultural identity and their possible influence on the clinical presentation of the infant/young child and the family. The cultural formulation for use with infants/young children and their caregivers includes the following:

- Cultural identity of the Individual - Cultural Identity of Child and Caregivers
- Cultural Conceptualization of Distress - Cultural explanations of the child's presenting problem
- Psychosocial Stressors and Cultural Features of Vulnerability and Resilience – Cultural factors related to the child's psychosocial and caregiving environment
- Cultural Features of the Relationship Between the Individual and the Clinician – Cultural elements of the relationship between the parents/caregivers and the clinician
- Overall Cultural Assessment – Overall cultural assessment for child's diagnosis and care

For more on Cultural Formulation: read pp. 10-12 in DC:0-5 – Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Zero to Three; read pp. 26-27, Lieberman, Ghosh Ippen, and Van Horn, Don't Hit My Mommy.

These principles offer a roadmap of skills for PIP practitioners to develop a shared language and to be able to see the same baby and family. The PIP practitioner is not only viewed as a member of a particular discipline, but also as someone with a distinct set of IMH core beliefs, skills, training experiences, and clinical strategies who incorporates a comprehensive, intensive, and relationship-based approach to working with young children and families.<sup>19</sup>

## TREATMENT SERVICES

Services that target children in distress or with clear symptoms indicating a mental health disorder are considered treatment. The services address attachment and relationship disturbances and the interplay between the child, parent, and other significant caregivers that jeopardize achieving early mental health and social-emotional development. Specialized early mental health treatment services focus on the caregiver-child dyad and are designed to improve child and family functioning and the mental health of the child, the parents, and other primary caregivers.<sup>20</sup> This level of care must be provided by a PIPs who are licensed mental health therapists trained in IMH.

## WHEN TO MAKE A REFERRAL

Early neglect, trauma, and maltreatment have long-term pathogenic effects, including effects on brain dysfunction and related psychosocial difficulties. Problems in infant emotional development often involve parents' difficulties managing their own inner worlds—difficulties that impair their ability to care for their babies. These individuals' parenting difficulties can range from explicit repetition of early abuse to quite subtle distortions and deficits in parenting.<sup>21</sup> Priority referrals to PIP services come from CYFD's Protective Services Division in those cases where the caregiver-child dyad has significant difficulty in maintaining regulation, recovering from distress, or managing intense affect, and that these observed difficulties are hampering developmental success of the infant or young child.

Research clearly indicates that PIP services utilizing evidence-based, specialized treatment approaches such as Child-Parent Psychotherapy can have a positive impact on the trajectory of outcomes for infants and young children with serious disorders. "Those first few years are unprecedented in the life cycle for how rapidly the changes occur, as well as for the complexity of the changes," says Dr. Charles Zeanah, a professor of psychiatry at Tulane University, "The experiences that young children have are very important."

## KEY POINTS TO KNOW

### ATTACHMENT

1. Attachment is the enduring emotional relationship between the parent or caregiver and the infant that brings safety, comfort, security and pleasure. It is the foundation for love and provides the framework for all future relationships that the child will develop.
2. Attachment researchers emphasize the infant's proximity to the caregiver and include an emphasis on the parents' understanding and reflecting the infant's internal world.<sup>22</sup> Fonagy (2012) develops the concept of the mother's ability to know her baby's mind as she interacts with, responds to, and makes meaning for her baby.<sup>23</sup>
3. One of the saddest examples of this is when the primary caregiver – the source of food, warmth, comfort and love for the dependent infant or child – is also the source of episodic, unpredictable threat, rage and pain. The disorganized attachment relationship that results can impair healthy relational interactions for a lifetime. Again, much of the resulting dysfunctional relational interactions will be beyond the awareness and understanding of the developing child, youth or adult.
4. If the goal is to have a baby use the mother/father as a secure base, then interventions should focus on helping the mother/father serve as a secure base, even in the presence of maternal/paternal insensitivity. Important to identify positive maternal/paternal behaviors that may serve as a buffer against otherwise insensitive behavior.<sup>24</sup>

### STRESS AND TRAUMA

5. Attachment is a memory and a set of associations usually pleasurable and relational. The sequential acquisition of various memories is the primary task of development. Infants form template memories from early experiences.<sup>25</sup> Internal catalogs are created from early childhood.

6. For children who have a template of caregivers being unreliable and who will eventually yell and hit me, it takes a long time to lay down a new template for relationships.
7. A young child growing up in a home with a pervasive threat, for example, will create a set of associations –primarily pre-cortical and therefore out of his or her conscious awareness –between a host of neutral cues and threat. These neutral cues for the rest of the child’s life have the capacity to activate a fear response and therefore alter emotions, behaviors and physiology. When a child, youth or adult is in a high state of arousal–fearful – their brain will process and function differently.<sup>26</sup>
8. These fear inducing cues can range from expressions (e.g. eye-contact can become associated with impending threat), to scents (e.g. the abusive parent’s perfume or aftershave), to music, to styles of interpersonal interaction.
9. Selma Fraiberg (1975) writes about a system of caring that is transgenerationally transmitted. The “ghost in the nursery” might be an uninvited guest, the unfriendly intruder who interferes with mother and infant establishment of the mother-infant bond that encourages security and growth promoting development.<sup>27</sup>

## NEUROBIOLOGY

10. The most essential functions that the brain mediates – survival, procreation, protecting, and nurturing dependents – depend upon the capacity to form and maintain relationships.
11. Patterns that are novel cause arousal and focus attention – sometimes even alarm. Most of what we do is due to pre-cortical processing.
12. Chaotic and chronically stressful environments may affect the development of self-regulation processes by impairing temperamental adaptability and an aspect of self-regulation involving stress reactivity. Many of the frustrations that the children show is manifested in willful, difficult behavior and manifested in impulsivity.
13. A challenging environment is alright for a child who can self-regulate.<sup>28</sup>
14. Perry (2013) suggests that successful treatment with traumatized children must first regulate the brainstem’s sensitized and dysregulated stress response systems. Only after these systems are more regulated can a sequence of developmentally appropriate enrichment and therapeutic activities be successfully provided to help the children heal.<sup>29</sup>

## RISK FACTORS/ACE SCALE

15. Children’s prenatal exposure to “second-hand” smoke, alcohol, and drugs are implicated in a multitude of health concerns, including impaired growth and development.
16. Risk factors such as poverty, family violence, dysfunctional parenting, and inadequate access to health care, further influence a child’s developmental outcome.
17. Effects of poverty on a child’s educational outcomes are more pervasive when poverty is chronic or when it occurs early in the life of a child (birth to five) than when it is transitory, temporary poverty that occurs during adolescence. 53% of children in New Mexico are living in poverty.<sup>30</sup>
18. Prenatal drug exposure to any drug cannot reliably predict the outcome of an individual child and does not warrant a self-fulfilling prophecy, but such exposure is often a marker for a child with multiple risks.<sup>31</sup>
19. Children are more vulnerable to Post Traumatic Stress Disorder (PTSD) than adults. According to Dr. Perry, many children who have attachment disturbances and who view domestic violence or other trauma develop PTSD.<sup>32</sup>

20. Over 5 million children a year have traumatic events significant enough to cause PTSD. These children are often misdiagnosed as having an attention deficit disorder (ADD) or attachment disorder. Many do not get the help they need.<sup>33</sup>

## RESILIENCE AND PROTECTIVE FACTORS

21. Resilience is a universal capacity, which allows a person, group or community to prevent minimize or overcome the damaging effects of adversity.

22. Several factors distinguish resilient children from those overwhelmed by risk factors:

- a. A temperament that elicits positive responses from family member as well as strangers;
- b. A close bond with a caregiver during the first year of life;
- c. An active approach to problem solving;
- d. An optimistic view of their experiences even in the midst of suffering; and,
- e. An ability to be alert and autonomous.<sup>34</sup>

23. Caregiver emotionality may play a central role in moderating the relations between risk, family processes and child outcomes.<sup>35</sup>

24. The primary therapeutic implication is the need to increase the number and quality of buffering relationships and reparative opportunities for the high-risk child. Also need to recognize the developmental levels of children.

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## CHAPTER 3

# CYFD-003 and CYFD-004

### PARENT-INFANT PSYCHOTHERAPY SERVICE DESCRIPTIONS

Parent Infant Psychotherapy (PIP) “is designed to repair the behavioral and mental health problems of infants, toddlers, and preschoolers whose most intimate relationships are disrupted by experiences of maltreatment, violence, and other forms of trauma that shatter the child’s trust in the safety of attachments.”<sup>1</sup>

#### TARGETED POPULATIONS – CYFD-003/CYFD-004

PIP services funded by CYFD provide a continuum of clinical/behavioral health therapeutic interventions that are responsive to the ethnic, cultural, racial, linguistic, and socioeconomic diversity of families. A PIP contractor provides services according to established CYFD service descriptions titled as CYFD-003 and CYFD-004. CYFD expects that the PIP contractor will maximize *other available community funding sources* and relevant services in conjunction to these funds whenever possible.

#### 1. CYFD-003 – *PIP Services to Severely Emotionally Disturbed Children (see Appendix A for Service Description)*

- Services under this description include Severely Emotionally Disturbed (SED) infants/young children, birth to 3 years of age, who have had a comprehensive assessment by an independently licensed clinician, with Level III or IV endorsement for a culturally sensitive practice promoting Infant Mental Health (IMH-E®), to identify the need for PIP services.
- Infants/young children who are admitted for services before 3 years of age (36 months) may be eligible to received services to age 5 years (60 months) with an extension approved by the BHS-IECMH Program Director.
- A comprehensive assessment by an independently licensed clinician should include at a minimum, the Crowell Caregiver-Child Structured Interaction Procedure (Crowell), the Working Model of the Child Interview (WMCI), and the Adverse Childhood Events Screening (ACES), in addition to the DC:0-5 *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*.
- Services pertain to Severely Emotionally Disturbed (SED) Infants/young children who are diagnosed with a Behavioral/Emotional Disorder as indicated by the DC:0-5.

- Infants/young children who have been previously assessed with the DC: 0-3R, Axis II Parent-Infant Relationship Global Assessment Scale (PIR-GAS), should continue to be assessed with the PIR-GAS until discharged, while infants newly admitted for services beginning 7.1.17 will be assessed using the DC:0-5, Axis II Levels of Adaptive Functioning.
- Services target the dyadic relationship between the child and the parent (or primary caregiver).
- Services are provided according to the Fidelity Protocol outlined below. The protocol is designed to reduce both acute and chronic behavioral, social and emotional disorders and disruptions in the relationship between an infant/young child and parent (or primary caregiver) as a result of toxic stress and early childhood trauma.
- Services are provided to the targeted population regardless of Medicaid eligibility.

## **2. CYFD-004 – PIP Services to Children At-Risk of Severe Emotional Disturbance (see Appendix A for Service Description)**

- Services under this description include infants/young children, birth to 3 years of age who are At Risk of a Severe Emotional Disturbance (SED) who have had a comprehensive assessment by an independently licensed clinician, with Level III or IV endorsement for a culturally sensitive practice promoting Infant Mental Health (IMH-E®), to identify the need for PIP services.
- Infants/young children who are admitted for services before 3 years of age (36 months) may be eligible to receive services to age 5 years (60 months) with an extension approved by the BHS-IECMH Program Director.
- A comprehensive assessment by an independently licensed clinician should include at a minimum, the Crowell Caregiver-Child Structured Interaction Procedure (Crowell), the Working Model of the Child Interview (WMCI), and the Adverse Childhood Events Screening (ACES), in addition to the DC:0-5 *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*.
- Services under this description include infants and young children birth to 3 years of age who have been diagnosed with significant behavioral, emotional and/or mental health concerns that interfere with developmental skills and primary relationships but do not meet all of the criteria for Behavioral/Emotional Disorder as indicated by the DC: 0-5, *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*.
- Infants/young children who have been previously assessed with the DC: 0-3R, Axis II Parent-Infant Relationship Global Assessment Scale (PIR-GAS), should continue to be assessed with the PIR-GAS until discharged, while infants newly admitted for services beginning 7.1.17 will be assessed using the DC:0-5, Axis II Levels of Adaptive Functioning.
- Services target the dyadic relationship between the child and the parent (or primary caregiver).
- Services are provided according to the Fidelity Protocol outlined below. The protocol is designed to reduce both acute and chronic behavioral, social and emotional disorders and disruptions in the relationship between an infant/young child and parent (or primary caregiver) as a result of toxic stress and early childhood trauma.
- Services are provided to the targeted population regardless of Medicaid eligibility.

## **PIP CONTRACTOR REQUIREMENTS – CYFD-003 and CYFD-004**

PIP contractors meet the following qualifications:

1. Independently licensed Master's Level Clinician (LPCC, LMFT, LISW) or Licensed Clinical Psychologist, CNS or RN with a Master's or Certification in psychiatric nursing, or a Licensed or Board Eligible psychiatrist in good standing.
2. Endorsed by the New Mexico Association for Infant Mental Health (NMAIMH) as an Infant Mental Health Specialist - Level III or an Infant Mental Health Mentor - Level IV.
3. If not endorsed, a new PIP contractor obtains a provisional endorsement waiver from CYFD and completes the full NMAIMH endorsement process to achieve Level III or IV within (29) months of receiving the provisional endorsement waiver.
4. At least two years of supervised work experience providing relationship-based infant mental health services is preferred prior to becoming a PIP contractor.

5. Services are provided by an organization or independent licensed practitioner that meet the standards established by CYFD's Behavioral Health Services Division.
6. Contractors are legally recognized in the United States or a Sovereign Tribal Nation; are qualified to do business in the State; and, are located within the boundaries of the State of New Mexico.

## **PIP REFERRALS**

CYFD is committed to supporting psychotherapeutic clinical/behavioral health services leading to positive outcomes for infants, toddlers and their families in order to achieve optimal development and to alleviate and remediate behavioral health issues interfering with healthy infant/young child and parent/caregiver relationships. To this end, PIP services prioritize referrals from CYFD's Protective Services Division that include infants/young children and their families who are receiving In-Home Services or who have had an unsubstantiated investigation due to allegations of maltreatment. At least 25% of PIP monies are to be spent on non-custody infants/young children who are not part of New Mexico Infant Teams (NM-ITs). No more than 75% of PIP monies can then be used for infants/young children who are in state custody and part of NM-ITs.

## **FIDELITY PROTOCOL FOR PIP CONTRACTORS**

The fidelity protocol and performance outcomes of a Parent-Infant Psychotherapist (PIP) contractor include:

1. Knowledge base from which to understand infants or young children and the complexity of the early relationship development.
2. Ability to interpret classification and/or diagnose a young child from infancy to 3 years of age with a behavioral/emotional disorder as indicated by the \*DC-0-5, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.\* Or has plans to attend training in near future.
3. Ability to administer a Psychosocial Intake procedure such as the PIP Psychosocial Intake Assessment.
4. Knowledge of specific tools appropriate for the observation and assessment of the developmental capacities of the infant/young child, the parental/caregiver capacities (e.g., perceptions, reflective functioning), and the dyadic interaction. Tools include: Crowell Child-Caregiver Interaction Procedure (Crowell); Working Model of the Child Interview (WMCI) or Circle of Security Interview (COSI); Adverse Childhood Events Screening (ACES); \*Parent-Infant Relationship Global Assessment Scale (PIR-GAS); and, Developmental Competence (milestones and domains as articulated in the DC: 0-5 – Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood – see Appendix A and Chapter 6). \*PIR-GAS to be replaced with Axis II Relational Context – Dimensions of Caregiving and Relational Range of Functioning, from the new DC:0-5 manual by July 2017
5. Ability to administer the Traumatic Events Screening Inventory-Parent Report Revised (TESI-PRR) and the Life Stressor Checklist-Revised (LSC-R) when Child-Parent Psychotherapy is the clinical intervention model.
6. Provide at least 25% or more of weekly PIP services in vivo in the home or other settings natural to the infant/young child and family (or primary caregiver) except for infants/young children in custody which may prevent providing services in the home.
7. Knowledge of the evidence-based, clinical intervention model, Child-Parent Psychotherapy (CPP), designed for children aged 0-5 who have experienced traumatic events and/or are experiencing mental health, attachment, and/or behavioral problems.
8. Ability to design an Individualized Treatment Plan based upon assessment results that may include COS-P goals targeted helping parents or caregivers understand how secure parent-child relationships can be

supported and strengthened (child not present). COS-P goals may include: Work with parents and caregivers to help them to:

- Understand their child's emotional world by learning to read emotional needs
- Support their child's ability to successfully manage emotions
- Enhance the development of their child's self esteem
- Honor the innate wisdom and desire for their child to be secure<sup>5</sup>

9. Ability to design an Individualized Treatment Plan based upon assessment results that may include CPP goals targeted on aspects of the relationship as an intervention.<sup>6</sup> CPP goals include:

**Global CPP Goals:**

- Encourage normal development: adapt to infant or young child's developmental capacity
- Offer unstructured reflective developmental guidance
- Encourage and model appropriate protective behavior
- Maintain regular levels of affective arousal
- Interpret feelings and actions
- Establish awareness and trust in bodily sensations
- Achieve reciprocity in the caregiver-child relationship
- Provide emotional support/empathic communication
- Resolution of trauma-related symptomatology

**Trauma-Related Goals of CPP:**

- Increased capacity to respond realistically to threat
- Differentiation between reliving and remembering
- Normalization of the traumatic response
- Placing the traumatic experience in perspective
- Co-construction of a mutually meaningful trauma narrative
- Promote developmental progress through play, physical contact, and language

10. Knowledge of specific tools to measure progress: P-Progress in Treatment Assessment (P-PITA), the Caregiving Dimensions-Levels of Adaptive Functioning (DC:0-5), and Developmentally Informed Assessment Per Each Relationship (DIAPER).

11. Ability to meet Infant Mental Health database requirements and maintain fidelity to data entry procedures for each client file on a timely basis as designated by the UNM-Continuing Education, Early Childhood Services Center.

12. Ability to submit quarterly reports (October, January, April) and an annual summary report (June) according to the form titled, Infant Mental Health – Parent-infant Psychotherapy (see under Forms in Appendix A).

13. Ability to participate in monthly ECHO Model Consultations with the larger Community of Practice, in order to ask questions, for example, about infancy and early childhood, relationship risks and protective capacities, disorders of development, and strategies for effective work as well as to provide case write ups when requested.

14. Ability to participate in Community of Practice Quarterly meetings, attend trainings that are identified as required, and attend the Ask the Manager monthly ECHO calls.

15. Opportunities for reflective supervision or reflective consultation with a trained IMH supervisor, licensed and NMAIMH endorsed, who is knowledgeable about early development and relationships, and is able to maintain a consistent schedule.



## Parent-Infant Psychotherapy (PIP) Contracted Activities

PROCEDURE CODE	PROCEDURES	BILLABLE TO PIP	PROCEDURE TYPE	DEFINITION	PIP 003	PIP 004	COLLATERAL SERVICE FOR 003,004	COMMENTS
IMH00B	Intake and Screening	Yes	Direct	Meet client(s); gather initial information; conduct screenings as needed; and, may begin gathering Psychosocial Intake information.	Yes	Yes		
IMH00C	Comprehensive IMH Assessment	Yes	Direct	Crowell; WMCI or COS Interview; DC:0-3R or DC: 0-5; and, if doing CPP, the TESI and LSC-R	Yes	Yes		Biological Parents or Concurrent Foster Parents
IMH04	Dyadic Therapy – I	Yes	Direct	Therapeutic services focusing on the parent-child interaction. CPP with the dyad, and COS-P where the session may not involve the dyad, e.g., parent only	Yes			COS-P does not involve dyad directly but addresses how secure parent-child relationships can be supported and strengthened (Biological, Non-Biological or Relative)
IMH05	Collateral work to support Dyad and provide Developmental Guidance without child present	Yes - 12 hours per year per case	Direct	Therapeutic services focusing parent or caregiver on dyadic issues. Child not present. Use this when not doing CoS-P or CPP.	Yes		Yes	Primary Biological, Non- Biological or Relative Attachment Relationships
IMH14A	Family centered meeting with CYFD	Yes - 12 hours per year per case	Direct	Clinician meets with CYFD with family	Yes	Yes	Yes	

PROCEDURE CODE	PROCEDURES	BILLABLE TO PIP	PROCEDURE TYPE	DEFINITION	PIP 003	PIP 004	COLLATERAL SERVICE FOR 003,004	COMMENTS
IMH00D	Treatment Planning	Yes - 16 hours per year per case	Indirect	Drawing critical issues from assessments and identifying goals which will be presented to the client(s) or other relevant parties, developing assessments, treatment goals, status of case, including writing up assessments, completing the DF:0-3R, PITA, etc. Also includes report writing and discharge planning	Yes			
IMH07	Observe Supervised Visit/ Supervised Visit any location	No	Direct					
IMH00G	Observation / Assessment with Foster Parent	No	Direct	This is a direct service provided for individual(s) who regularly interact with client and are identified to have a role in the client's treatment				
IMH12	IFSP meeting (parent/child present)	No	Direct					
IMH14A	Meeting with CYFD (family not present)	No	Direct	Meeting with PPW, investigator, other individuals involved in the case to discuss and review status, etc.				
IMH10	Court Testimony (inside courtroom)	No	Direct					
IMH10A	Judicial Mediation meeting	No	Direct					
IMH61	Judicial Hearing/ no testimony	No	Indirect	Present in courtroom without testifying				

PROCEDURE CODE	PROCEDURES	BILLABLE TO PIP	PROCEDURE TYPE	DEFINITION	PIP 003	PIP 004	COLLATERAL SERVICE FOR 003,004	COMMENTS
S05	Phone Call	No	Indirect	Should not include calls regarding appointment changes, etc.				
S17	Text Messaging	No	Indirect	Should not include text messaging regarding appointment changes, etc.				
S16	Email	No	Indirect	Should not include emails regarding appointment changes, etc.				
S70	Chart Audits	No	Indirect	Case-specific. Enter record for specific cases audited.				
S09	Reflective supervision	No	Indirect or Non-client	Reflective supervision within the agency. If the activity involves cases or not specific to a case, can be recorded as a non-client activity.				
IMH13B	Clinical / Administrative supervision	No	Indirect or Non-client	If the activity involves cases or not specific to a case, can be recorded as a non-client activity.				
S80	Training (as trainee)	No	Non-client	Includes on-line courses as well				
S81	Training (as trainer)	No	Non-client	Provides IMH related training to community				
IMH13D	Clinical consultation with Deb and Jane	No	Non-client					
IMH71	COP Call	No	Non-client					
IMH70	IMH/PIP quarterly meeting	No	Non-client					
GL31	Travel for work with client	No	Travel					

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## CHAPTER 4

# Fidelity Protocol

### PARENT-INFANT PSYCHOTHERAPY (PIP) PROCEDURES

#### PIP REFERRALS

A. CYFD is committed to supporting psychotherapeutic clinical/behavioral health services leading to positive outcomes for infants, toddlers and their families in order to achieve optimal development and to alleviate and remediate behavioral health issues interfering with healthy infant/young child and parent/caregiver relationships. To this end, PIP services *prioritize referrals from CYFD's Protective Services Division* that include infants/young children and their families who are receiving In-Home Services or who have had an unsubstantiated investigation due to allegations of maltreatment.

Because very young children have a limited repertoire for expressing distress, the list of early childhood symptoms that may lead to a referral commonly includes a multitude of behaviors and concerns.<sup>1</sup> These symptoms typically have not remitted over time, are not better accounted for by a medical diagnosis, and are causing subjective distress to the infant or young child, primary caregiver(s), and often the family system as a whole.

- Dysregulation (sleeping/feeding/eliminating/behavior)
- Developmental regression
- Problems in toileting
- Inattention
- Hyperactivity
- Impulsivity
- Irritability
- Excessive or inconsolable crying
- Defiance
- Excessive or self-harming tantrums
- Aggression
- Hypervigilance
- Withdrawal
- Flattened affect
- Dissociation
- Somatization
- Fearfulness

B. In order for the child to be eligible for PIP services as was stated in Chapter 2, a child must be diagnosed as at risk of or having a behavioral/emotional disorder as indicated by the DC:0-5, *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*.<sup>2</sup> This classification needs to be made by a licensed and endorsed IMH therapist.

## PIP INTAKE, SCREENINGS, NEW DATA ENTRY

- A. The first step in beginning to develop a new relationship with an infant/young child and parent/caregiver is to begin the intake process. The PIP begins with an Intake Assessment such as the PIP Psychosocial Assessment to gather background information and history. This may take several meetings to complete intake assessment in addition to the Adverse Childhood Experiences Scoring Sheet (ACES) with the parent/caregiver.
- B. This would be a time to ask if the infant/young child has ever been referred and evaluated for Family Infant Toddler Program (FIT) Services. If the answer is 'yes,' they would request a copy to determine the developmental needs of the infant/young child you will be working with. If the answer is 'no,' determine during the IMH assessment process whether you think a referral to FIT-Part C would be warranted at a later date.
- C. If the PIP expects that CPP will be the treatment model to use with a new case based upon preliminary information, additional inventories to complete are the Life Skills Checklist-Revised (LSC-R) and the Traumatic Events Screening Inventory (TESI-R).
- D. Following the first meeting with a parent/caregiver and infant/young child, enter the case into the IMH database according to the Data Input Flow Chart in Appendix A and according to the TIP SHEET titled, Registering a New Case, which is available on the CYFD.org website.

## COMPREHENSIVE INFANT MENTAL HEALTH ASSESSMENT

- A. The PIP Comprehensive Infant Mental Health (IMH) assessment includes an assessment of the dyadic interaction, the parental/caregiver capacities (e.g., perceptions and reflective functioning), and the developmental capacities of the infant/young child. The ability to identify protective capacities and risks in the parent-child relationship is essential to Parent Infant Psychotherapy
- B. The videotaped assessment of the Dyadic Interaction is determined by the age of the infant/young child with the following observational methods:
  - Videotaped Observation (5-10 minutes) of Infant-Caregiver in Routine Activity (feeding, diapering, play) – for use with *birth to 6-7 months* (until infant can sit independently).
  - Videotaped Baby Crowell Caregiver-Infant Interaction Procedure – for use when infant can sit independently – approximately *6-7 months to 12 months*.
  - Videotaped Crowell Caregiver-Child Interaction Procedure – for use from *12 months – 60 months*.
  - Based upon observations of the dyad, complete the Parent-Infant Relationship: Global Assessment Scale (PIR-Gas–form in Appendix A) \*To be replaced with Axis II Relational Context - Levels of Adaptive Functioning (Caregiving Dimension, Infant's/Young Child's Contributions to the Relationship, and Dimensions of the Caregiving Environment) from the new DC: 0-5 manual by June 2017.
- C. To assess a Parent's/Caregiver's Perceptions and Reflective Functioning, choose between administering:
  - The Working Model of the Child Interview (WMCI) videotaped, or
  - The Circle of Security Interview (COSI) videotaped).
- D. To determine the infant/young child's developmental capacities choose from:
  - DC: 0-5, Developmental Milestones and Competency Ratings, or
  - Observation of Developmental Capacities and Milestones, or
  - Based upon a FIT evaluation of Developmental Levels if available.
- E. Information is entered into the IMH database reflecting the administration of these tools.

## INDIVIDUAL TREATMENT PLAN

- A. The PIP therapist determines specific goals and a treatment modality (COS-P or CPP) to begin with based upon the comprehensive assessment results targeting aspects of the relationship as an intervention.
- B. If the treatment modality the PIP determines to be most beneficial to begin with is the Circle of Security-Parenting DVD Program, then the goals would target helping parents/caregivers understand how secure parent-child relationships can be supported and strengthened.<sup>3</sup>  
Goals of COS-P are formulated to help parents/caregivers to:

- Understand their infant's/young child's emotional world by learning to read emotional needs
  - Support their infant's/young child's ability to successfully manage emotions
  - Enhance the development of their infant's/young child's self esteem
  - Honor the innate wisdom and desire for their infant/child to be secure
- C. If the parent/caregiver is ready for dyadic therapy, the unit of treatment is the relationship between the infant/child and parent. If the PIP determines that Child Parent Psychotherapy (CPP) is the best treatment modality CPP goals may include:

**Global CPP Goals-Objectives:**

- Encourage normal development: adapt to infant or young child's developmental capacity
- Offer unstructured reflective developmental guidance
- Encourage and model appropriate protective behavior
- Maintain regular levels of affective arousal
- Interpret feelings and actions
- Establish awareness and trust in bodily sensations
- Achieve reciprocity in the caregiver-child relationship
- Provide emotional support/empathic communication
- Resolution of trauma-related symptomatology

**Trauma-Related Goals-Objectives of CPP:**

- Increased capacity to respond realistically to threat
- Differentiation between reliving and remembering
- Normalization of the traumatic response
- Placing the traumatic experience in perspective
- Co-construction of a mutually meaningful trauma narrative
- Promote developmental progress through play, physical contact, and language <sup>4</sup>

- D. At least 25% of weekly PIP services are to be provided in vivo in the home or other settings natural to the infant/young child and parent/caregiver except for infants/young children in custody which may prevent providing services in the home.

**INTERVENTION/TREATMENT PROGRESS**

- A. A PIP has 4 ways to track progress: DAP Notes, PITA, DIAPER and CPP Fidelity Measures.
- B. The Data Assessment Plan (DAP) Progress Notes are completed after every session with the parent/caregiver or dyad and then entered into the IMH database. The DAP notes provide an ongoing record of interventions and treatment as well as document fidelity to the clinical treatment model.
- C. The P-Progress in Treatment Assessment (P-PITA) developed by Dr. Charlie Zeanah and Dr. Julie Larrieu from Tulane University, is a way to track treatment progress based upon the parent's/caregiver's behavior. The PITA is administered quarterly (4x a year) from the time the case is entered into the database.
- D. The Developmentally Informed Assessment Per Each Relationship (DIAPER) is a new tool that is administered quarterly and offers a way to monitor the parent/caregiver's interactions that support the infant/young child's developmental capacities and progress.
- E. CPP Fidelity Measures guide a PIP therapist through the different phases of CPP treatment and include: Reflective Practice Fidelity, Emotional Process Fidelity, Dyadic Relational Fidelity, Trauma Framework Fidelity, Procedural Fidelity and Content Fidelity.
- F. In addition, the Caregiving Dimensions – Levels of Adaptive Functioning (DC:0-5) is completed quarterly and entered into the IMH database for comparative review to determine progress.

## DATA COLLECTION AND PROGRAM EVALUATION

- A. The IMH database and program evaluations are necessary to track recurrence, permanency, treatment effectiveness and to provide assurances to policy-makers that services are being implemented as intended and that they reach the target audience.
- B. The UNM-Continuing Education, Early Childhood Services Center has designed a flow chart and tip sheets to allow PIP therapists to maintain fidelity to data entry procedures for each client file on a timely basis.
- C. CYFD Behavioral Health Evaluator provides a longitudinal assessment of PIP outcomes looking at data entered regarding the demographics of a case; the ACEs score from intake; and, the PIR-GAS (replaced for new cases beginning 7.1.17 with the DC: 0-5 Axis II, Relational Context – Dimensions of Caregiving and Relational Range of Functioning) and PITA scores, which are re-administered quarterly until the case is discharged.

## QUARTERLY/ANNUAL REPORTS

- A. The agency with a PIP contract or an individual PIP contractor is expected to complete Quarterly Reports (October, January, April) and an Annual Report (June) detailing cases served and the overall impact of the services provided.
- B. The reports are used to measure the PIP program efficacy and to support continued program funding.
- C. A form developed by the BHS-IECMH Program Director is used for report submission.
- D. At least 25% of PIP monies are to be spent on services to non-custody infants/young children who are not part of New Mexico Infant Teams (NM-ITs).
- E. No more than 75% of PIP monies can then be used for services to infants/young children who are in state custody and part of NM-ITs.

## SUPERVISION AND CONSULTATION

There are three types of supervision that are required to take place:

**Clinical:** must take place at least one hour every two weeks with each individual clinician. Group clinical supervision may be incorporated but not to supplant individual supervision.

**Reflective:** must take place at least one hour every two weeks with each individual clinician. Group clinical supervision may be incorporated as a support.

**Administrative:** includes the review of case documentation, completion of clinical protocols, goal reviews as well as session notes, data entry etc.

### A. Clinical Supervision

1. The goal of the clinical supervision process, is to enhance and support the best clinical skills that lead to improved outcomes for infants/young children and families by:

- Review case formulation and conceptualization
- If using CPP, addressing fidelity strands
- Reviewing comprehensive assessment protocols
- Goal formulation
- Strategies identified to address the goals
- DAP notes that accurately documents, progress in treatment
- Termination as clinical process discussion
- Reports to Protective Services
- Systems Issues and impact on clinical services

### B. Administrative Supervision

- Assure that IMH data entry is current and accurate
- Appropriate licensure level to practice
- Endorsement is completed
- Endorsement waiver requested and received
- Participation in all required functions such as quarterly meetings, ECHO calls, consultation and supervision calls.

- Quarterly reports and end of year reports are submitted on a timely basis
- No more than 75% of PIP monies can be used for services to infants/young children who are in state custody and part of NM-ITs
- Documentation of the completion of these administrative activities
- Staff evaluations
- Review three (3) case files per quarter for completeness

C. Reflective Consultation and Supervision (see 7th IMH principle, page 17)

1. In order to maintain protocol and program fidelity regular reflective supervision and consultation is critical to the PIP’s work. Reflective supervision is required for all PIP practitioners due to the evocative nature of working with young children and families.
2. It is recommended that PIP contractors receive regular Reflective Supervision and/or supervision by licensed and endorsed IMH specialist from their agency. For PIP independent contractors, it is recommended that they receive regular Reflective Supervision by an outside licensed and endorsed IMH Specialist.
3. A monthly ECHO Model Reflective Consultation Videoconference call with other PIPs in the state is required in order, for example, to ask questions about infancy and early childhood, relationship risks and protective capacities, disorders of development, and strategies for effective work as well as to provide case write ups when requested
4. Quarterly Reflective Consultation is often provided at the Community of Practice Meetings with Dr. Julie Larrieu, an international IMH expert, and all PIP contractors are required to attend.
5. PIP contractors receive monthly consultation from the BHS-IECMH Program Director on an Ask the Manager ECHO videoconference call.



**Parent-Infant Psychotherapy (PIP) Fidelity Protocol**

BIRTH – 5 YEARS	REFERRAL/ELIGIBILITY	TOOLS/RESOURCES	FORM	DESCRIPTION/PURPOSE
Referral for PIP Services	<ul style="list-style-type: none"> <li>• CYFD-003</li> <li>• CYFD-004</li> </ul>	<ul style="list-style-type: none"> <li>• CYFD Service Descriptions</li> </ul>	<ul style="list-style-type: none"> <li>• Agency or Individual PIP contractor Referral Form</li> </ul>	<ul style="list-style-type: none"> <li>• Priority referrals for PIP services come from CYFD's Protective Services Division</li> <li>• At least 25% of PIP monies are to be spent on services to non-custody infants/young children who are not part of New Mexico Infant Teams (NM-ITs).</li> <li>• No more than 75% of PIP monies can be used for services to infants/young children who are in state custody and part of NM-ITs.</li> <li>• CYFD-003 services include infants and young children birth to 3 years of age who have been assessed by a licensed clinician and diagnosed with a Behavioral/Emotional Disorder as indicated by the DC:0-5, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.</li> <li>• CYFD-004 services include infants and young children birth to 3 years of age who have been assessed by a licensed clinician and diagnosed with significant behavioral, emotional and/or mental health concerns that interfere with developmental skills and primary relationships but do not meet all of the criteria for Behavioral/Emotional Disorder as indicated by the DC:0-5.</li> <li>• CYFD-003 and CYFD-004 pertain to infants who are admitted for services before 3 years of age (36 months), and who may be eligible to receive services up to age 5 years (60 months) with an extension approved by the CYFD Infant/Early Childhood Program Director.</li> <li>• 25% or more of weekly PIP services in vivo in the home or other settings natural to the infant/young child and family (or primary caregiver) except for infants/young children in custody which may prevent providing services in the home.</li> </ul>

BIRTH – 5 YEARS	ASSESSMENT	TOOLS/RESOURCES	FORM	DESCRIPTION/PURPOSE
Child At-Risk of or Identified with Behavioral/Emotional Disorder	<ul style="list-style-type: none"> <li>• <i>Qualifications:</i> Licensed and Endorsed Infant Mental Health Specialist</li> </ul>	<ul style="list-style-type: none"> <li>• DC: 0-5 or Revised System</li> </ul>	<ul style="list-style-type: none"> <li>• Observation, Report and Interview, Diagnostic Criteria</li> </ul>	<ul style="list-style-type: none"> <li>• Child from infancy to 3 years of age with a behavioral/emotional disorder or at-risk for disorder as indicated by the DC-1-5, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.</li> <li>• Priority Referrals for PIP services from CPS</li> </ul>
Caregiver Circumstances, Risk and History	<ul style="list-style-type: none"> <li>• <i>Experience:</i> Family/Caregiving History, Current Circumstances, History of Trauma, Mental Illness, Domestic Violence, etc., Previous CPS involvement</li> </ul>	<p><b>CYFD Mandated</b></p> <ul style="list-style-type: none"> <li>• Psychosocial Intake</li> <li>• Adverse Childhood Events (ACES) Questionnaire</li> </ul> <p><i>Additional Information for Child</i></p> <ul style="list-style-type: none"> <li>• Get Birth/Medical Record (if possible)</li> <li>• Get Part-C Evaluations (if available)</li> </ul> <p><i>CPP Instruments/Tools</i></p> <ul style="list-style-type: none"> <li>• Life Stressor Checklist Revised (LSC-R)</li> <li>• Traumatic Events Screening Inventory-Revised (TESI-R)</li> </ul>	<ul style="list-style-type: none"> <li>• Caregiver Report/ Interview</li> <li>• Medical/ Developmental Records</li> </ul>	<ul style="list-style-type: none"> <li>• To determine level of risk regarding trauma, mental illness, substance abuse, domestic violence, etc.</li> <li>• To gather caregiver's and child's history</li> <li>• To determine household configuration, economic and social support systems</li> </ul>
Comprehensive Infant and Early Childhood Mental Health Assessment	<ul style="list-style-type: none"> <li>• Dyadic Relationship, Caregiver Risks and Protective Capacities, and Child Developmental Competence</li> </ul>	<p><b>CYFD Mandated</b></p> <p><i>Dyad</i></p> <ul style="list-style-type: none"> <li>• Crowell Caregiver-Child Interaction Procedure – 12 months – 60 months</li> <li>• Baby Crowell – When child can sit up independently - 7 months to 12 months</li> <li>• Observation of Infant-Caregiver in Routine Activity (feeding, diapering, play) – Birth to 6-7 months</li> <li>• Caregiving Dimensions-Levels of Adaptive Functioning (DC:0-5)</li> </ul> <p><i>Caregiver</i></p> <ul style="list-style-type: none"> <li>• Working Model of the Child Interview (WMCI) or Circle of Security Interview (COSI)</li> </ul> <p><i>Child</i></p> <ul style="list-style-type: none"> <li>• DC: 0-5 or Observation of Developmental Competence, Domains and Milestones</li> <li>• DIAPER</li> </ul>	<ul style="list-style-type: none"> <li>• Observation, Report, Interview, Videotaping, Diagnostic Criteria</li> <li>• Administration of Tools reflected in IMH database</li> </ul>	<ul style="list-style-type: none"> <li>• Look at multicausality by assessing what the child brings to an interaction; what the caregiver brings to an interaction; and, what is co-created in the quality of dyadic engagement and interaction.</li> <li>• Interactive or Co-regulation is dependent upon a contingent and reciprocal relationship.</li> <li>• Disorder interactions are bidirectional and mutually regulated, with each partner contributing to the exchange.</li> <li>• Example of questions to ask about Crowell: How did the dyad relate to one another? What was the overall emotional tone? How did the caregiver relate to the child? How did the child relate to the caregiver? Include any descriptive examples. What strengths could be built on? What areas need help?</li> <li>• Ongoing record of tools administered in IMH database.</li> </ul>

BIRTH – 5 YEARS	CLINICAL TREATMENT	MODEL/RESOURCES	FORM	DESCRIPTION/PURPOSE
Individualized Treatment, Goals and Strategies	<ul style="list-style-type: none"> <li>• <i>Therapeutic Intervention Targets the Caregiver-Child Relationship</i></li> </ul>	<p><b>CYFD Recommended</b></p> <ul style="list-style-type: none"> <li>• Child Parent Psychotherapy: A Relationship-Based, Trauma-Informed Treatment Model</li> <li>• Circle of Security - Parenting</li> </ul>	<ul style="list-style-type: none"> <li>• Relational Treatment of infants, toddlers, and preschoolers and their parents/caregivers using an integrated psychoanalytic, attachment, body-based, behavior-based, and developmental psychopathology perspective (1)</li> <li>• 8 session COS-P DVD Program</li> </ul>	<ul style="list-style-type: none"> <li>• An Individualized Treatment Plan based upon assessment results includes COS-P or CPP goals targeted on aspects of the relationship as an intervention.</li> <li>• <b>COS-P</b> helps parents or caregivers understand how secure parent-child relationships can be supported and strengthened (child not present)</li> <li>• <b>COS-P Goals:</b> Work with parents and caregivers to help them to: <ul style="list-style-type: none"> <li>• Understand their child's emotional world by learning to read emotional needs</li> <li>• Support their child's ability to successfully manage emotions</li> <li>• Enhance the development of their child's self esteem</li> <li>• Honor the innate wisdom and desire for their child to be secure</li> </ul> </li> <li>• <b>CPP</b> is the relational (dyadic) treatment of infants, toddlers, and preschoolers and their parents/caregivers using an integrated psychoanalytic, attachment, body-based, behavior-based, and developmental psychopathology perspective (1)</li> <li>• <b>Global CPP Goals:</b> <ul style="list-style-type: none"> <li>• Encourage normal development: adapt to infant or young child's developmental capacity</li> <li>• Offer unstructured reflective developmental guidance</li> <li>• Encourage and model appropriate protective behavior</li> <li>• Maintain regular levels of affective arousal</li> <li>• Interpret feelings and actions</li> <li>• Establish awareness and trust in bodily sensations</li> <li>• Achieve reciprocity in the caregiver-child relationship</li> <li>• Provide emotional support/empathic communication</li> <li>• Resolution of trauma-related symptomatology</li> </ul> </li> <li>• <b>Trauma-Related Goals of CPP:</b> <ul style="list-style-type: none"> <li>• Increased capacity to respond realistically to threat</li> <li>• Differentiation between reliving and remembering</li> <li>• Normalization of the traumatic response</li> <li>• Placing the traumatic experience in perspective</li> <li>• Co-construction of a mutually meaningful trauma narrative</li> <li>• Promote developmental progress through play, physical contact, and language</li> </ul> </li> </ul>

BIRTH – 5 YEARS	DOCUMENTATION/ DATA ENTRY	TOOLS/RESOURCES	FORM	DESCRIPTION/PURPOSE
Intervention/ Treatment Phases	<ul style="list-style-type: none"> <li>Track Progress and Services</li> </ul>	<ul style="list-style-type: none"> <li>Data Assessment Progress (DAP) Notes</li> <li>Progress in Treatment Assessment (PITA)</li> <li>Developmentally Informed Assessment Per Relationship (DIAPER)</li> <li>CPP Fidelity Measures</li> </ul>	<ul style="list-style-type: none"> <li>Rating Scales</li> <li>Checklists</li> </ul>	<ul style="list-style-type: none"> <li>Forms are in Appendix A and Data Entry information is in Appendix B.</li> <li>The DAP Notes are entered in the database after every session.</li> <li>The PITA from Tulane University is a way to track treatment progress based upon the parent's behavior. The PITA is administered quarterly (4x a year) from the time the case is entered into the database.</li> <li>The DIAPER is a way to track the parent/caregiver's progress in facilitating age appropriate developmental functioning.</li> <li>CPP Fidelity Measures guide a therapist through the different phases of treatment and include: Reflective Practice Fidelity, Emotional Process Fidelity, Dyadic Relational Fidelity, Trauma Framework Fidelity, Procedural Fidelity and Content Fidelity.</li> <li>DAP Notes entered into IMH Database after every session</li> <li>PITA and PIR-GAS completed quarterly and entered into IMH database for comparative review</li> </ul>
Data Collection and Program Evaluation	<ul style="list-style-type: none"> <li>Data Entry Per Case</li> </ul>	<ul style="list-style-type: none"> <li>IMH Flow Chart and Tip Sheets (available on CYFD.org website)</li> <li>ACES, Caregiving Dimensions-Levels of Adaptive Functioning (DC:0-5) and PITA</li> </ul>	<ul style="list-style-type: none"> <li>Specific guidelines and steps to follow to maintain Fidelity</li> <li>Caregiving Dimensions-Levels of Adaptive Functioning (DC:0-5) and PITA re-administered quarterly</li> </ul>	<ul style="list-style-type: none"> <li>The database and program evaluations are necessary to track recurrence, permanency, treatment effectiveness and to provide assurances to policy-makers that services are being implemented as intended and that they reach the target audience.</li> <li>Caregiving Dimensions-Levels of Adaptive Functioning (DC:0-5) and PITA reentered quarterly from time case is first entered into database.</li> <li>The UNM-Continuing Education, Early Childhood Services Center has designed a flow chart and tip sheets to allow PIP therapists maintain fidelity to data entry procedures for each client file on a timely basis.</li> </ul>
Report Writing and Documentation	<ul style="list-style-type: none"> <li>Quarterly and Annual Reports to PIP Contract Manager</li> </ul>	<ul style="list-style-type: none"> <li>Form developed by CYFD PIP Infant and Early Childhood Services Contract Manager</li> </ul>	<ul style="list-style-type: none"> <li>Quantitative and Qualitative Information</li> </ul>	<ul style="list-style-type: none"> <li>Each PIP agency or individual contractor submits quarterly reports as well as an annual report detailing cases served and benefit of the services provided.</li> <li>The reports are used to measure the PIP program efficacy and to support continued program funding.</li> </ul>

BIRTH – 5 YEARS	TYPE	SUPERVISION/ CONSULTATION SOURCE	FORM	DESCRIPTION/PURPOSE
Reflective Consultation/ Supervision	<ul style="list-style-type: none"> <li>Reflective Supervision</li> <li>Reflective Consultation</li> <li>Supervision</li> </ul>	<ul style="list-style-type: none"> <li>It is recommended that PIP contractors receive regular Reflective Supervision and/or supervision by licensed and endorsed IMH specialist from their agency</li> <li>It is recommended that PIP independent contractors receive Reflective Supervision by an outside licensed and endorsed IMH Specialist</li> <li>ECHO Model Reflective Consultation 1x a month</li> <li>Reflective Consultation at Community of Practice Quarterly Meeting with Dr. Julie Larriau</li> </ul>		<ul style="list-style-type: none"> <li>In order to maintain protocol and program fidelity regular reflective supervision and consultation is critical to the PIP's work.</li> <li>Reflective supervision is recommended for all IMH practitioners due to the evocative nature of working with young children and families.</li> <li>Providing PIP practitioners opportunities to recognize the potential stress of providing relationship-based practice and allowing time for adequate reflection is a component of the PIP program.</li> <li>With regular reflective consultation, the PIP practitioner uses internal knowledge and external knowledge to examine and advance practice in their clinical work.</li> </ul>

## REFERENCES

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- 2 ZERO TO THREE (2016). *DC: 0-5 – Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*. Washington, D.C.: Zero to Three.
- 3 Cooper, G., Hoffman, K. T., and Powell, B. (2009). *Circle of Security: COS-P Facilitator DVD Manual 5.0*. Spokane, WA: Marycliff Institute.
- 4 Lieberman, A. F., Ghosh Ippen, C., & Van Horn, P. (2015). *Don't hit my mommy! A manual for child-parent psychotherapy with young children exposed to violence and other trauma (2nd edition)*. Washington, D.C.: National Center for Clinical Infant Programs.

## CHAPTER 5

# Parent Infant Psychotherapy Services

### INFANT/CHILD-CAREGIVER DYADIC PSYCHOTHERAPY AND EMOTIONAL SUPPORT

#### A. PARENT INFANT PSYCHOTHERAPY AND CHILD PARENT PSYCHOTHERAPY (CPP) AS A TREATMENT APPROACH

##### 1. INTRODUCTION

Interactional capacities that occur between infants and caregivers in many families are often strained, impaired or absent when there are undue stressors and/or situations where there has been child maltreatment. In addition to identifiable abuse or neglect there can be emotional, behavioral, and engagement problems affecting the relationship.

In response to these dyadic relationship impairments, we bring a trauma informed and developmental lens to our work with the caregiver (which can be the biological parent(s), the foster parent(s), grand-parents, kinship or another primary caregiver for the infant). The Dyadic work focuses on and supports the relationship between the child and the adult and the interactions that take place when they are together. The caregiver's responsive, reflective and protective capacities are the target for enhancement as are the child's regulatory, developmental and interactive capacities. Therefore, in parent infant psychotherapy and Child Parent Psychotherapy (CPP), the relationship becomes our focus and the interactions between the dyad are the target for the therapeutic work. The therapeutic work is based on attachment theory and trauma theory, but also integrates developmental, psychodynamic, psychoeducational, social learning theories and executive functioning informed practices as well.

The focus of the work is to bring the parent's awareness to the infant's experience and needs in a way that is protective and supports the development of security and stability. This is done by addressing the caregiver's history including past and present trauma, their understanding of their child's experience and the impact of

trauma on their child's developmental and regulatory capacities as well as their reflective functioning, working models and behavioral interactions with the child.

In both PIP and CPP, the targets of treatment interventions include caregivers' and young child's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. (Lieberman, 2005)

The PIPs mental health goal is to:

#### **Have the adult:**

- Develop and maintain a therapeutic relationship with the infant mental health therapist. This involves developing a therapeutic alliance and often dealing with "institutional transference";
- Demonstrate capacity for reflective functioning to understand their own feelings and behaviors as well as their child's;
- Take responsibility for the impact of their behavior on their child and for assuring the child's safety;
- Understand the developmental and emotional needs of their child;
- Understand the experience of the child; and
- Understand the impact of trauma and past experiences as an influence on present functioning and behavior.

## **2. THE TULANE INFANT TEAM MODEL**

The PIPs often work with the New Mexico Infant Teams who utilize the Tulane Infant Team Model from the University of Tulane, School of Medicine, Department of Psychiatry and Behavioral Medicine. The Mental Health Assessment and Treatment Phase is articulated by following excerpts from the body of work by Charlie Zeanah, MD, Julie Larrieu, PhD, and Neil Boris, MD:

### **Clinical Context and Evaluation**

- Young children's development is powerfully affected by their relationships with important caregivers
- Developing an attachment relationship to caregivers is essential for young children
- Young children may have vastly different kinds of relationships with different caregivers
- Clinical Context: Attachment
- Infants are strongly biologically predisposed to form attachments to caregiving adults;
- Attachment develops gradually over the first several years of life, based upon relationship experiences with caregivers;
- Under usual rearing conditions, infants develop "focused" or "preferred" attachments in the second half of the first year of life seen by:
  - ~ Separation protest;
  - ~ Stranger wariness.

### **Importance of Attachment**

- Through experiences with caregivers, baby develops expectations about the dependability of attachment figures to provide comfort, support and nurturance in times of need;
- These expectations guide babies' behavior in intimate relationships; and
- Strongly predictive of child's subsequent social adaptation.

### **Attachment Disruptions**

- Disrupted attachments in early years have long been believed to be harmful;
- Increasing numbers of disruptions are associated with increased risk for clinical problems, including disorders of attachment;

- From child's perspective, disruptions are impossible to understand; and
- We work to minimize attachment disruptions.

### **Attachment Essentials**

- In order to protect young children adequately, foster parent must become primary caregiver and attachment figure for child;
  - ~ The young child cannot wait;
  - ~ The young child needs literal physical contact to sustain attachments; and
  - ~ Emotional availability and dependability are crucial.

### **3. SPECIAL FEATURES OF PIP SERVICES**

- Multimodal services;
- Relational, infant mental health perspective;
- Naturalistic and clinic settings and structured and unstructured assessments;
- Integrated treatment plans;
- High intensity, low volume case load;
- Addresses countertransference;
- Systems focus; and
- Program/funding partnerships.

The Initial Case Assessment Process is a comprehensive approach to gathering information from both structured and unstructured observational methods in multiple settings. This approach provides the clinician/team with information that is much more thorough and useful in treatment planning. In particular, when assessing infants and young children, observing them in multiple settings and with different caregivers yields the most helpful information regarding capacities. Observations and interviews may include the following:

- Home visits (Biological and foster parents);
- Clinic visits;
- Childcare Center visits; and
- Part C Developmental Assessment and Evaluation.

Following the initial assessment process, there may be collaborative activities, which will depend on the legal status of the case. They may include:

- Family/provider meetings;
- Case conferences;
- Parent conferences; and
- Collateral provider consultation.

Case and Treatments goals are defined and intervention and treatment approaches identified, including but not limited to:

- Individual psychotherapy;
- Dyadic psychotherapy;
- Infant-parent psychotherapy;
- Child-parent psychotherapy;
- Interaction guidance;
- Parent-child interaction therapy;
- Circle of Security®;
- Trauma informed treatment, including Part C developmental services;
- Therapeutic visitation;

- Visit coaching;
- Couples psychotherapy;
- Family psychotherapy;
- Sometimes includes extended family, kin, foster parents; and
- Other intervention and treatment approaches deemed appropriate.

### **Assessment of Relationship:**

Considerations for understanding the caregiver child relationship takes an observant and inquiring eye. Clinicians are trained to look at many aspects of the relationship between the child and adult which include:

- Identifying patterns of interaction between caregivers and infants to obtain information about healthy or disturbed aspects of the relationship;
- Caregivers response to teaching tasks, unstructured play, feeding and other caretaking activities;
- Caregiver’s ability to understand and respond to infant’s special needs;
- Caregivers’s capacity to consider objective and subjective experiences of infant and caregiver, which include caregivers’ history, culture, and community;
- Caregiver’s reflective capacity, theory of mind and executive functioning in regards to child’s developmental level and needs, state of mind and experience;
- Caregiver’s working model of the child(ren); and
- Identification of strengths and areas for growth in the relationship.

### **Essentials:**

- Experts who have seen caregiver and child together are best qualified to comment on the quality of their relationship; and
- Understanding that the quality of the relationship of the caregiver and child is an essential tool in making decisions regarding “best interest” of child in the placement decision of children in protective custody. Not all PIP cases will involve custody or placement decisions.

### **Interactive Behavior and Infant Development**

- High levels of warmth, synchrony and reciprocal responsiveness during infant parent interaction is associated with enhanced infant development across a number of domains; and
- Low levels of these same qualities dramatically increase risk for a variety of adverse outcomes.

## **4. PIP SERVICES**

### **What Do We Do with the Results?**

Our goal is to facilitate safe enough parenting that also supports security and optimal development for the child:

- Bringing benevolence and knowledge of theory and practice, the PIP will focus on identifying strengths as well as areas for growth. Specifically, behaviors that interfere with the caregiver’s capacity to parent productively and protectively;
- Remediate concerns (e.g., help parent address own issues which get in the way of seeing the child clearly, acknowledging the child’s experience and keeping the child safe both physically and emotionally); and
- Supporting the caregiver to support and engage with the child in a manner that promotes optimal growth and well- being.

### **How Do We Use Relationship Assessments?**

- To understand confusing/complex behaviors in a child;
- To understand child’s developmental and emotional needs;
- To understand caregiver’s state of mind;

- To understand caregiver's history and working models;
- For Treatment planning;
- To measure progress in treatment
  - For Custody cases;
- To address visitation issues; and
- To make permanency planning decisions.

## **What are Predictors of Recidivism in Protective Custody cases?**

### **Cumulative Risk Factors**

- Lack of Education
  - Untreated past or current;
- Substance Abuse;
- Psychiatric History;
- Arrest History;
- Childhood Maltreatment;
- Depressive Symptomatology;
- Partner Violence; and
- Multiple ACEs.

To address these risk factors here are Sample Treatment Goals (see more examples in Chapter 7):

Parent/caregiver will;

- Accept responsibility for child(ren)'s maltreatment and the need to change their own behavior;
- Acknowledge longstanding psychiatric, substance use and/or relationship difficulties;
- Place needs of child ahead of their own needs;
- Demonstrate a capacity for change and willingness to try different approaches within a reasonable time frame;
- Work constructively with involved professionals; and
- Make use of available community resources.

## **5. VISITATIONS AND PIP SERVICES FOR INFANTS/YOUNG CHILDREN IN PROTECTIVE CUSTODY**

### **Attachment and Visitation Considerations**

- Adults, but not young children, are capable of sustaining attachment relationships across time and space;
  - ~ Adults should bear the burden of difficulties, not young children, for example the adult should do the traveling, not the child, visitation frequency and duration should be scheduled according to child's capacity, perspective and tolerance;
- Who visits whom?
- Travel and familiarity of setting; and
- Biological relatedness does not trump stability (Zeanah, 2001).

### **Visitation with Biological Parents**

- Is it harmful to the child?
  - ~ Stress vs. harm.
- Is it helpful to child's attachment to biological parent?
  - ~ What is the goal?
- Is it helpful to biological parent's attachment to child?
  - ~ Need less contact than child (Zeanah, 2001).

### **Principles of Visitation**

- Child's well-being is primary concern;
- Recommended that an attachment figure is present if child is more than 6 months old;

- Child can sustain a relationship with parent without parent being an attachment figure;
- As parents progress towards reunification, frequency and length of visits should increase;
- Relationships with foster parents should continue after reunification whenever possible; and
- Attachment building efforts begin after parents:
  - ~ Have accepted responsibility for children’s maltreatment;
  - ~ Have begun recovery from mental health/substance abuse problems; and
  - ~ Are making progress towards reunification.

### **Considerations for Collaborative Visitation**

- Visiting without attachment figure (foster parent) causes undue stress on child (separation) by second half of first year;
- Presence of foster parent can improve quality of visit for biological parent:
  - ~ If biological parent understands rationale and can be supported;
  - ~ If foster parent can support child without undermining biological parent.
- Goal of visit with biological parents need not be developing attachment (especially initially) rather to increase pleasurable experiences and understanding of child’s capacities;
- Child’s best interest ought to be paramount in any visitation plan;
- Child must be able to tolerate stress of visit; otherwise, modify visitation schedule; and
- What is in the “child’s best interest” is a process of educating individuals and systems.

## **6. PIP INTERVENTIONS**

### **Interventions Aim to Change Systems**

- Infants and families are embedded within powerful and complex systems of care:
  - ~ Child Welfare
  - ~ Legal
  - ~ Mental Health, Substance Abuse, Developmental Disabilities
  - ~ Healthcare
  - ~ Education
  - ~ Other Community Resources

### **Goals of Systems Intervention**

- Change how the system understands and deals with young children;
- System is trauma informed and understands the impact of stress and trauma on the developing brain of the infant (neurobiology) including prenatally. System Recognizes:
  - ~ Developmental differences;
  - ~ Time frame differences; and
  - ~ Importance of caregiving relationships, culture, community.
- Enhance access to services; and
- Improve integration and coherence of services.

### **3 Levels of System Intervention**

- Proximal, immediate clinical context:
  - ~ Infant-parent relationship;
  - ~ Child care setting;
  - ~ Child protective services; and
  - ~ Community providers (Substance Abuse, Domestic Violence Treatment, medication management, individual adult treatment, etc.).
- Legal system:
  - ~ Juvenile or family court judge;
  - ~ Attorneys for protective services, children, parents; and
  - ~ CASA workers.

- Other, larger systems:
  - ~ Part C
  - ~ Educational
  - ~ Pediatrics
  - ~ Policy
  - ~ Legal

## 7. REFLECTIVE SUPERVISION/REFLECTIVE CONSULTATION

Professionals who provide services to infants and young children and their families involved in stressful situations, including involvement with child protective services, face multiple daily challenges. Working with stressed and traumatized young children and their families, as well as the systems charged with providing services and oversight affects professionals on many levels. These early professionals (mental health providers, developmental specialists, early interventionists, home visitors, family educators, Head Start teachers, public health nurses, child welfare workers and others) in turn require support and ongoing professional development to provide perspective, increase their skills, and avoid burn-out. Reflective supervision, a practice that has evolved from the multi-disciplinary field of infant mental health provides the support needed by practitioners who are exposed to the intense emotional content and life experiences related to their work with families. An ongoing professional development process, reflective supervision provides a way for professionals working with very young children to reach greater understanding of their own responses, as well as the babies and adults they work with, and as a result, facilitating quality practice and intervention.

*Ellen Munro states:*

Experience on its own is not enough. It needs to be allied to reflection – time and attention given to mulling over the experience and learning from it...The emotional dimension of working with children and families plays a significant part in how social workers reason and react. If it is not explicitly discussed and addressed then its impact can be harmful. It can lead to distortions in reasoning because of the unconscious influence it has on where attention is focused and how information is interpreted. (Munro, 2011)

The use of reflective supervision and/or consultation is an essential component of the New Mexico Infant Mental Health Community of Practice. The principles of RS/RC are that the process;

- a. Takes place with Regularity and Consistency in scheduling and format
- b. Is Collaborative between supervisor/supervisee
- c. Is Reflective and uses self-awareness and parallel process to produce transfer of knowledge to practice
- d. Is differentiated from administrative supervision, although can take place in the same setting with same acknowledgement from both parties
- e. Can take place individually or a group

When professionals who work with infants, young children and their families – as well as with multiple systems and providers- can participate in a supportive, engaged experience to explore their own reactions to their work in this field, they gain emotional stability, clarity of thinking and greater case understanding.

In addition to the resources listed below, please see the definition for on the [nmaimh.org](http://nmaimh.org) website for a lengthy description and further details.

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## CHAPTER 6

# Developmental Assessment and Intervention Considerations

### PRINCIPLES OF ASSESSMENT

Development occurs in the context of a caregiving relationship, and the parent/caregiver is vital in supporting the unfolding of the infant's and young child's developmental capacities. The parent/caregiver also exists within a network of relationships and culture, which can either enhance and support the parent's/caregiver's quality of life and relationships, or undermine them. Even if the infant or child is genetically and biologically programmed for development, certain environmental experiences are required at specific times – known as critical periods – in development.<sup>1</sup>

Risk factors such as premature birth, prenatal substance exposure, maltreatment, and maternal depression may undermine early development, self-regulation, and co-regulatory processes. These risk conditions may deplete the resources of the infant and the caregiver in ways that compromise their functioning in the present. If this compromised pattern of parent–child functioning persists, it may result in developmental and behavioral problems. For instance, higher levels of maternal depressive symptomatology (when chronic) may contribute to persistent infant dysregulation and compromised parent–infant relationships, which can lead to maladaptive child self-regulatory capacities as well as other developmental outcomes.<sup>2</sup>

PIP practitioners attend to these parental conditions in order to promote positive parent–child relationships and optimal child functioning, as well as to prevent or ameliorate developmental problems. In order to maximize the effectiveness of interventions and treatment the following principles of assessment should be kept in mind.<sup>3</sup>

#### **1. Parents Want the Best for their Children**

Almost always, parents want the best for their children and family. The PIP's role is to assist them in providing this. PIPs assess a parent/caregiver's strengths and protective capacities as well as the risks that can interfere with infant/young child's developmental functioning. Identifying vulnerabilities and strengths helps shape our interventions.

## 2. Developmental Context

The perinatal and early childhood period is a time of transition and enormous growth for infant and family. Emotional, behavioral and developmental problems presenting in infancy can have lifelong consequences but some are the manifestation of normal developmental transitions and can be addressed with adequate support.<sup>4</sup> It is important for the PIP practitioner to be aware of cumulative risk factors that can help distinguish between maladaptive and normal developmental trajectories.

## 3. A Relational Approach

Although individual factors in the child or parent may contribute to current difficulties, the interaction or “fit” between the needs and capabilities of each family member and the sources of stress and support in the family context, could determine developmental outcome.<sup>5</sup>

## 4. The Transactional Model of Development

The transactional model of development emphasizes the interaction between genetic and environmental factors over time and the development of the child is seen as a product of the continuous dynamic interactions of the child and the experience provided by his or her family and social context.<sup>6</sup>

## FACTORS THAT MAY COMPROMISE DEVELOPMENT

Here are possible Indicators that an infant/child is at risk for compromised development.

Infant/Young Child	Parents/Caregivers	Context
<ul style="list-style-type: none"> <li>• Failure to thrive</li> <li>• Failure to meet expected milestones</li> <li>• Hypervigilant or startling easily</li> <li>• Excessively quiet and withdrawn</li> <li>• Marked aggression in a toddler</li> <li>• Basic needs not met</li> <li>• Role reversal or caregiving behavior towards parent</li> <li>• Emotion regulation problems</li> <li>• Unexplained bruising or medical injury</li> </ul>	<ul style="list-style-type: none"> <li>• Inability to recognize or prioritize the child’s needs</li> <li>• Untreated or inadequately treated psychiatric illness or substance abuse</li> <li>• Lack of insight and lack of engagement with treatment services</li> <li>• Child incorporated in parental delusional system, including positive delusions</li> <li>• Insensitivity to child’s signals and needs (emotionally unavailable)</li> <li>• Thoughts of self-harm or fear of harming child</li> <li>• Scared of infant, ignores infants cries</li> <li>• Frightening or looming behavior, rough handling of infant</li> <li>• Hostile or negative attributions (“he is out to get me”)</li> <li>• Unrealistic developmental expectations</li> <li>• Lack of parenting skills</li> </ul>	<ul style="list-style-type: none"> <li>• No other available and protective adult</li> <li>• Significant cultural or social isolation</li> <li>• Minimal social supports</li> <li>• Domestic/family or community violence</li> <li>• Multiple social risks (e.g., homelessness, multiple moves, multiple partners)</li> <li>• Chronic stress</li> </ul>

**Developed by:** Nicholas Kowalenko, Sarah Mares, Louise Newman, Anne Sved Williams, Rosalind Powrie, and Karin van Doesum.

## IMPORTANCE OF SHARED ENGAGEMENT AND ATTENTION

Infants and young children learn about their family’s culture and ways of interacting and communicating through multiple episodes of shared attention. These episodes within a relational context occur during daily routines that happen in a consistent manner and are predictable. First they learn about facial expression, touch, prosodic features of the voice and rhythm of movement. At the same time, infants are typically able to share

attention to an object if the parent/caregiver scaffolds the interaction in ways that allow the infant to focus attention exclusively on the object during a period of supported joint engagement.<sup>7</sup>

Through these episodes of shared attention an infant/child learns how to engage in multiple circles of communication with his/her parent/caregiver. This is how the infant and child begins to learn language and words. Then through patterned repetitive stimulation and interaction, the topics to communicate about expand as the child develops new interests and new skills.

A pivotal period in the developmental course of shared attention occurs from 9 to 15 months of age as joint attention (the active coordination of engagement with a parent/caregiver and interest in shared objects and events) is consolidated and coordinated with shared affect, vocalizations, language, gestures and movement.

In conclusion, communication during periods of joint engagement and attention facilitates an infant's/young child's emerging understanding of words and language. A positive relation exists between joint attention, early word learning and language development. In addition joint attention provides a critical foundation for the subsequent development of the representational skills evident in the 3- to 4-year-old child's emerging theory of mind and growing narrative skills.<sup>8</sup> Having knowledge of how development unfolds enriches a PIP practitioner's ability to understand behaviors and to support the parent-child relationship.

## DYNAMIC APPROACH

Research tells us that affect along with shared engagement and joint attention are central to relating, learning and understanding, and that emotions drive early cognitive development. In this regard, it is best to observe developmental capacities from a dynamic vantage point within a relational context, moment-to-moment, rather than by looking at discrete skills.

The DIR® Functional Emotional Developmental Levels (FEDL) represent essential developmental capacities necessary in building the core foundation every child needs for optimum growth and development. The Functional Emotional Developmental Levels that were developed by Dr. Stanley Greenspan and Dr. Serena Wieder offer an integrative perspective on developmental domains, including health and well-being, social emotional, communication and language, regulation, sensory-motor, visual-spatial and ultimately cognitive functioning.<sup>9</sup>

## FUNCTIONAL EMOTIONAL DEVELOPMENTAL LEVELS (FEDL)

The first 6 FEDL levels are outlined below to serve as a guide for PIP practitioners to observe an infant's or young child's development while in relationship with his or her parent/caregiver. The **Top** indicates the skills needed to be competent at a particular level, and **Bottom** indicates that an infant or child is having difficulty with a level. The ages are when these levels typically occur.

### Level 1: Shared Attention/Regulation and Interest in the World (0-3 months)

The early regulation of arousal and physiological states is critical for successful adaptation to the environment. It is needed for mastery of sensory functions and for learning how to calm oneself and respond emotionally to one's environment. During this first level, the infant/child is learning to tolerate the intensity of arousal and to regulate his or her internal states so that he or she can maintain an interaction while gaining pleasure from it.

**Top:** The child is calm, organized and able to attend and interact with the parent/caregiver.

**Bottom:** The child is self-absorbed, engages in more self-stimulating behavior (possibly anxious), and/or unable to interact with others.

### Level 2: Engagement/Forming Relationships (2-7 months)

An infant's/child's experience of his or her parent/primary caregiver as a person who brings joy and comfort as well as a little annoyance and unhappiness furthers not only his/her emotional development but also his/her

cognitive development. The joy and pleasure an infant/child has in his/her parent/caregiver enable him/her to detect and decipher patterns in their voices. He/she begins to discriminate their emotional states and interpret their facial expressions.

**Top:** The child is able to engage with others through a range of emotions and activities (does not disengage when upset). The child displays a range of affect including, “the gleam in the eye.”

**Bottom:** The child has difficulty engaging with others, is self-absorbed or fixated on “things” (plays with objects without engaging parent in play), is easily distressed and/or displays a flat affect.

### **Level 3: Two-Way, Intentional Affective Signaling and Communication (3-10 months)**

At this level, the infant/child is able to enter into two-way purposeful communication. At its most basic level, this involves helping a child open and close circles of communication. This is a child’s ability to be intentional in interactions and activities (e.g., a child is able to initiate with another person and keep activities going, for desired objects or activities, etc.).

**Top:** The child is intentional, purposeful and persistent and can use gestures to convey intent.

**Bottom:** The child has no ability to be intentional with others except to maybe whine or grab for basic needs.

### **Level 4: Long Chains of Co-Regulated Emotional Signaling and Shared Social Problem Solving (9-18 months)**

This level involves the ability to string together many circles of communication, and problem solve into a larger pattern (ten – twenty circles). This is necessary for negotiating many of the most important emotional needs in life (being close to others, exploring and being assertive, limiting aggression, negotiating safety, etc.). This is the stage where the child begins to develop sense of self, self esteem, independence (“I did it!” or “Look what I did!” using affect, gestures and words if verbal).

**Top:** The child can sustain interactions for longer periods of time, uses motor planning to solve problems, is persistent in interactions and displays a strong sense of self.

**Bottom:** The child has no ability to sustain interactions for longer periods of time or when faced with stress or challenges.

### **Level 5: Elaborating Ideas/Representational Capacity and Elaboration of Symbolic Thinking (18-30 months)**

This level involves the child’s ability to create mental representations. The ability to do pretend play or use words, phrases or sentences to convey some emotional intention (“What is that?” “Look at this fish!, “ or “I’m angry!” etc.). The child begins to have their own ideas and share them with the people around them.

**Top:** The child begins to use language to express ideas, can have original ideas (not scripted), share them with other, elaborate on his/her ideas, connect emotions to ideas and replicate real life through play.

**Bottom:** The child has no ability to have original ideas or express their ideas, is often scripted or stresses when encouraged to “think”, has little understanding of emotions and/or the world around him/her.

### **Level 6: Building Bridges Between Ideas: Emotional and Logical Thinking (30-48 months)**

This level involves the child’s ability to make connections between different internal representations or emotional ideas (“I’m mad because you are mean”). This capacity is a foundation for higher level thinking, problem-solving and such capacities as separating fantasy from reality, modulating impulses and mood, and learning to concentrate and plan.

**Top:** The child can connect ideas logically, answer “why” questions and understand the underlying meaning behind ideas, give reasons behind their emotions, and display higher-level thinking abilities.

**Bottom:** The child can have ideas, but cannot connect them logically or give reasons behind them.<sup>10</sup>

## **DEVELOPMENTAL CAPACITIES AND DOMAINS**

The *Developmental Competency Rating Scale* from the DC:0-5<sup>11</sup> is included below and in Appendix A to begin to track an infant’s or young child’s development. The *Developmental Milestones and Competency Ratings* is also included in Appendix A.

# COMPETENCY DOMAIN RATING SUMMARY TABLE

On the basis of the review of this infant's/young child's developmental capacities, complete the table below to indicate the category that best describes the infant's/young child's functioning in each of the domains that comprise Axis V:

*To be completed for all infants/young children. Indicate competency domain rating scores by placing an "X" in the box for the appropriate score for each developmental domain.*

Competency Domain Rating	Emotional	Social-Relational	Language-Social Communication	Cognitive	Movement and Physical
Exceeds developmental expectations					
Functions at age-appropriate level					
Competencies are inconsistently present or emerging					
Not meeting developmental expectations (delay or deviance)					

**Overall impression.** Provide Axis V formulation as an overall impression on the basis of the ratings above. Indicate any unevenness of developmental competencies highlighting relative strengths and concerns. Also note whether there have been any recent changes in competencies in any developmental domain.

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## TABLE 2. INFANT’S/YOUNG CHILD’S CONTRIBUTIONS TO THE RELATIONSHIP

Indicate how each of the infant’s/young child’s characteristics contributes to relationship quality.

Indicate how each item contributes to relationship quality:	Contribution to Relationship Quality		
	Strength	Not a concern	Concern
Temperamental dispositions			
Sensory profile			
Physical appearance			
Physical health (from Axis III)			
Developmental status (from Axes I and V)			
Mental health (from Axis I)			
Learning style			

**Note:** Caregiving dimensions and the infant’s/young child’s characteristics that contribute to relationship quality are inherently culturally bound. Clinicians are encouraged to think carefully about family cultural values and practices that define the infant’s/young child’s characteristics and which parenting practices are endorsed or proscribed.

Specify/Describe Infant's/Young Child's Contributions to Relationship:

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## CHAPTER 7

# Treatment Goals, and Objectives

### TULANE'S PROGRESS IN TREATMENT ASSESSMENT (P-PITA)

#### EXAMPLES OF GOALS AND OBJECTIVES

1. Assess biological parent's/caregiver's capacity for engagement in services (see decision tree regarding challenges and barriers).
2. Provide appropriate level of intervention, i.e. COS-P, or Child Parent Psychotherapy to explore past and current trauma.
  - a. Help parent/caregiver to understand the reasons for the referral and parenting issues related to this such as inappropriate reversal of roles displayed in her/his relationship with infant/child, and change her actions that result in that behavior.
  - b. Support parent/caregiver to be able to carry the emotional responsibility for the relationship with infant/child.
  - c. Support and assist parent/caregiver in setting appropriate limits and boundaries with infant/child.
  - d. Support and strengthen parent/caregiver ability to be a safe and protective parent.
  - e. Assist both parent/caregiver and infant/child in integrating intervention strategies that increase feelings of safety, trust and competence.
3. Give parent/caregiver basic information about the critical role of attunement, affect-arousal regulation, security, exploration, and play in brain development.
  - a. Educate and expand parent/caregiver's awareness of concepts and interactions that support brain development and social-emotional well-being in vivo during moment-to-moment interactions.
  - b. Determine parent/caregiver's learning style and best way to impart information to help with generalization.

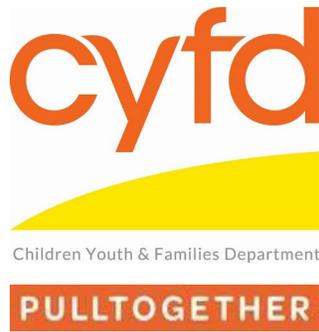
4. For parent/caregiver to become aware of the infant/child's arousal dysregulation and behavioral disorganization during specific situations or differing environments, and to reduce her/his own arousal in order to expand her/his ability to read infant/child's nonverbal communications.
  - a. Learn strategies for reading and anticipating infant/child's autonomic and behavioral cues that signal hypo- or hyperarousal and stress to modulate for social engagement.
  - b. Learn strategies for supporting and anticipating infant/child's nonverbal engagement cues, subtle and potent, to match affect through prosody, tone of voice, facial expressions, eye contact, gestures, touch, and rhythmic movements.
  - c. Learn strategies to support infant/child's vestibular, proprioceptive and tactile sensory processing to provide foundation for arousal regulation, contingency, and social-emotional engagement.
  - d. Learn strategies to support infant/child's ability to regulate behavior and enter into shared attention while being interested in a wide range of sensations (sounds, sights, smells, touch, own movement patterns and imposed, rhythmic movement patterns).
  - e. Become aware of and learn strategies to modulate caregiver's own arousal dysregulation and emotional states so that infant/child will not mirror dysregulation and be less available for social-emotional engagement.
  - f. Help support parent/caregiver as he/she attaches affective meanings to situations, and provides social expectations and values related to infant/child's specific emotional responses.
  
5. For parent/caregiver to recognize infant/child's disengagement and withdrawal behaviors as a cue to not increase but decrease her/his stimulation and give infant/child more interpersonal space.
  - a. Learn strategies for reading, responding to and anticipating infant/child states of behavior or states of consciousness, distress behaviors and subtle and potent disengagement cues.
  - b. Learn to recognize changes in motor tone and organization, eye contact, breathing, vocalizations, and color changes that communicate infant/child's inability to interact fully in the moment.
  - c. Help infant/child with managing and communicating strong emotions, distress or overstimulation, and allowing different comforting strategies by caregiver.
  - d. Help support parent/caregiver to manage stimulation within a comfortable range for infant/child and help alter her/his behavior if it is intrusive, aversive or insensitive to infant/child's coping behaviors.
  - e. Help support parent/caregiver to be able to pace their interactions within a comfortable range, give infant/child a break when "I've had enough" is communicated nonverbally, and pause to allow infant/child to respond to social overtures.
  - f. Help parent/caregiver be aware of her/his own unconscious cues that adults give when under some sort of stress, be it positive or negative.
  - g. Help support parent/caregiver understand how she/he attaches affective meanings to situations with infant/child, and provides social expectations and values related to infant/child's specific emotional responses that may indicate role reversals or unreasonable projections.
  
6. Help parent/caregiver engage in nonintrusive play by following infant/child's lead and amplifying infant/child's states of regulated positive arousal.
  - a. Learn play strategies and activities at infant/child's developmental level and be able to interact with appropriate developmental expectations and anticipate and support the next level of development.
  - b. Help parent/caregiver be able to support infant/child's ability to take turns in a reciprocal interaction and amplify infant/child's states of regulated positive arousal.
  - c. Support parent/caregiver to be emotionally available and an active participant in moment-to-moment interactions following the infant/child's lead.
  - d. Develop parent/caregiver's ability to interpret infant/child's experiences; develop action schemes; support infant/child's cognitive organization; support motivation, attentional skills and persistence; and, provide eternal support or co-regulation in the establishment of emotional and self-regulation.

7. Include ongoing assessment of child's capacities, progress and challenges and recommendations.
8. Include ongoing assessment of parental capacity to take responsibility, progress, challenges and recommendations.
9. For infant/child in custody, work with CYFD to determine visitation schedule and additional supports needed in the best interest of the infant/child; participate in provider and family-centered meetings; and, support visitations with biological parents and family.
10. Educate and guide the court when relevant based on infant/child evaluations and interventions in order to make informed placement decisions in the best interest of the infant/child.

\*\*Goals Adapted from: Allan Schore (2012), *The Science of the Art of Psychotherapy*, and Julie Larrieu, Ph.D., Tulane Infant/child Team

## CHAPTER 8

# Infant Mental Health, Child Protective Services Legal and FIT Early Intervention Glossary of Terms



## GLOSSARY OF TERMS

### A

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#### **Abuse:**

- **Physical:** Information indicates the existence of an injury that is unexplained; not consistent with the explanation given; or is non-accidental. The information may also only indicate a substantial risk of bodily harm.
- **Emotional:** Information indicates psychopathological or disturbed behavior in a child, which is documented by a psychiatrist, psychologist, or licensed mental health practitioner to be the result of continual scapegoating, rejection, or exposure to violence by the child's parent/caregiver.
- **Sexual:** Information indicates any sexually oriented act, practice, contact, or interaction in which the child is or has been used for the sexual stimulation of a parent, the child, or other person.

**Acculturation:** Cultural modification of an individual, group or people which involves adapting or borrowing traits from another culture; a merging of cultures as a result of prolonged contact.

**Adjudication and Disposition:** (also called the adjudicatory hearing) This hearing is held within 120 days of the initial custody hearing. The court will rule on whether the child has been abused or neglected and may order services for the family and continued custody.

**Adrenalin:** A hormone and neurotransmitter that increases heart rate, contracts blood vessels, dilates air passages and participates in the fight-or-flight response of the sympathetic nervous system.

**Affect:** Behavior that expresses a subjectively experienced feeling state (emotion); affect is responsive to changing emotional states, whereas mood refers to a pervasive and sustained emotion. Common affects are euphoria, anger, and sadness.

**Age Appropriate:** Experiences, a learning environment, and interactions with caregivers that match the infant's and/or toddler's age and/or stage of growth and development.

**Amygdala:** A part of the brain, considered part of the limbic system, located deep within the medial temporal lobes with a primary role in the processing and memory of emotional reactions.

**Anhedonia:** Inability to derive pleasure from previously pleasurable activities including eating, sex, hobbies, sports, social events, and family functions.

**Annual Review:** IFSP team meeting held each year to evaluate and, as appropriate, revise the child's IFSP.

**Apathy:** Lack of feeling, emotion, interest, or concern.

**Apraxia:** Inability to carry out motor activities despite intact comprehension and motor function.

**Assessment:** An ongoing process including the use of tests and tools to identify your child's or family's needs and strengths. A systematic procedure for obtaining information from observation, interviews, tests, and other sources that can be used to document behaviors and characteristics of infants/young children and their families that can be used for treatment planning. "Formative" **assessment** is measurement for the purpose of improving it. "Summative" **assessment** is what we normally call 'evaluation.' **Evaluation** is the process of observing and measuring a thing for the purpose of judging it and of determining its "value," either by comparison to similar things, or to a standard.

**Assessment:** The ongoing practice of informing decision-making by identifying, considering, and weighing factors that impact children, youth, and their families. Assessment occurs from the time children and families come to the attention of the child welfare system or PIP and continues until case closure.

**Assimilation:** To assume the cultural traditions of a given people or group.

**Attachment:** Child's connection to a parent or other caregiver that endures over time, establishes an interpersonal connection, and aids in the development of a sense of self. Refers to the quality of the emotional relationship between two people. Attachment styles are generally formed through early relationships between a caregiver and infant and evolves over time.

## B

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**BABYNET:** The statewide information and referral line (1-800-552-8195).

**Behavioral Health:** A state of mental/emotional being and/or choices and actions that affect wellness. Substance abuse and misuse, as well as serious psychological distress, suicide, and mental illness, are examples of some behavioral health problems that can be far-reaching and exact an enormous toll on individuals, their families and communities, and the broader society.

**Best interests of the Child:** The deliberation that courts undertake when deciding what type of services, actions, and orders will best serve a child as well as who is best suited to take care of a child. "Best interests" determinations are generally made by considering a number of factors related to the circumstances of the child and the circumstances and capacity of the child's potential caregiver(s), with the child's ultimate safety and well-being as the paramount concern.

**Bias:** Interpreting and judging phenomena in terms particular to one's own culture; judging people or phenomena associated with people based on the race/ethnicity, region of origin, or tribe of the people, rather than based on more objective criteria.

**Bio-social context:** For young children, the bio-social context includes the family culture and its influence on the values, beliefs, child rearing practices and expectations related to child development, and social-emotional health and well being. For those children in out-of-home care, this includes the experience of the culture, practices, and expectations of the program and those who provided care.

**Bonding:** The process of forming an emotional attachment. It involves a set of behaviors that will help lead to a close personal bond between the parent/caregiver and their child. It is seen as the first and primary developmental achievement of a human being and central to a person's ability to relate to others throughout life (Child Trauma Academy).

## C

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**Capacity building:** To improve or increase the ability of early childhood programs, providers, family members, and community partners to address the social and emotional needs of young children (adapted from Cohen Kaufmann, 2005)

**Caregiver:** One who provides for the physical, emotional, and social needs of a dependent person. The term most often applies to parents or parent surrogates, child care workers, health-care specialists, and relatives caring for children.

**CASA/ Court-appointed Special Advocates:** Legislatively mandated volunteer organization that operates in most New Mexico judicial districts. The court or other parties to the case may request a CASA be assigned to a child abuse case by order of the court. The CASA becomes an integral member of the case by advocating for what they believe are the best interests of the child and make recommendations to the court. CASAs are entitled to all information related to their cases.

**Case Closure or Discharge:** The process of ending the relationship between the caseworker and the family. This often involves a mutual assessment of progress and includes a review of the beginning, middle, and end of the helping relationship. Optimally, cases are closed when families have achieved their goals and the risk of maltreatment has been reduced or eliminated or the child has achieved his/her permanency goal.

**Central Register:** The central registry is a list of individuals identified as having been responsible for child abuse or neglect following an investigation either by law enforcement, CYFD, or both.

**Central Registry:** Data pertaining to child abuse or neglect.

**Child Abuse and Neglect:** Defined by the Child Abuse Prevention and Treatment Act (CAPTA), as, at a minimum, any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act that presents an imminent risk of serious harm. While CAPTA sets Federal minimum standards for States that accept CAPTA funding, each State provides its own definitions of maltreatment within civil and criminal statutes. (CAPTA Reauthorization Act of 2010)

**Child Maltreatment:** Sometimes referred to as child abuse and neglect, includes all forms of physical and emotional maltreatment, sexual abuse, neglect, and exploitation for infant/child birth to 17 years of age that results in actual or potential harm to the child's health, development, or dignity. Within this broad definition, five subtypes can be distinguished – physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse, and exploitation. (World Health Organization )

**Child Protective Services (CPS):** The social services agency designated (in most States) to receive reports, conduct investigations and assessments, and provide intervention and treatment services to children and families in which child maltreatment has occurred. Frequently, this agency is located within larger public social service agencies, such as departments of social services.

**Child's Record:** Is the file that includes evaluations, reports, progress notes and the child's IFSP, which is maintained by the service coordinator.

**Child Welfare:** A broad spectrum of services that starts with assessment of safety and risk to the child and provides needed intervention when indicated. It includes services that help to preserve families and enhance family strengths and functioning by actively engaging families decision making, assessing needs and linking with resources. It also includes services that children require when out of the home foster care, and different levels of group and therapeutic living arrangements. Finally, when children aren't able to return safely home, children are assisted to permanent living arrangements through services such as adoption, guardianship, or other long-term arrangements.

**Citizens Review Panel:** A panel of private citizen volunteers who review policies, procedures, and specific cases handled by State as well as local child protective services agencies to determine whether these agencies are effectively managing individual cases and/or child welfare systems.

**CRB/ Citizens' Review Board:** Legislatively mandated volunteer boards of child advocates are active in most counties in New Mexico. These boards hold meetings for parties to child abuse cases every six months and make independent recommendations to the court as to the status and direction of the case. CRB members are entitled to all information related to their cases.

**Community Partners:** Family, friends, neighbors, church organizations, health care systems, specialized childcare, social services, educational services, and other resources a family needs to care for an infant or toddler with a disability as close to home as possible.

**Complex trauma:** Also known as Developmental Trauma Disorder, complex trauma describes how children's exposure to multiple or prolonged traumatic events impacts their ongoing development. Typically, complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment and may include psychological maltreatment, neglect, physical and sexual abuse, and witnessing domestic violence.

**Concurrent Plan:** Children who enter foster care are screened for a potential concurrent permanency plan. A concurrent plan/ concurrent placement occurs when circumstances in the case indicate the child may not be able to safely return home. Foster parents who agree to a concurrent foster care placement make a commitment to adopt the child if they become available for adoption or become a permanent support for the child.

**Concurrent Planning:** A case planning approach that involves considering all reasonable options for permanency at the earliest possible point following a child's entry into foster care and simultaneously pursuing those that will best serve the child's needs. Typically, the primary plan is reunification with the child's family of origin. This primary plan and an alternative permanency goal are pursued at the same time, with full knowledge of all case participants. Concurrent planning seeks to eliminate delays in attaining permanency for children.

**Confidentiality:** The legally required process and ethical practice of not disclosing to the public or other unauthorized persons any private or identifying information regarding children, their parents, or other family members that may be collected while providing services in the home or community, including child protection, foster care, and adoption services.

**Consent:** The parent gives permission for the agency(ies) to evaluate the child, provide services, share information with other agencies.

**Continuity of Care:** Continuity of care is inclusive of what caregiving practices happen to a child at home and when he or she is under the care of another adult. In addition to daily routines familiar to the child, continuity of care includes the ability of the provider to understand, respect and build upon cultural and linguistic practices of the home.

**Coping resources:** Coping resources (or mechanisms) can be described as the sum total of ways in which we deal with minor to major stress and trauma. Some of these processes are unconscious ones, others are learned behavior, and still others are skills we consciously master in order to reduce stress, or other intense emotions like depression. Not all coping mechanisms are equally beneficial, and some can actually be very detrimental.

**Cortisol:** A steroid hormone produced by the adrenal gland in response to stress; sometimes referred to as the "stress hormone".

**Court-Appointed Special Advocate (CASA):** A person, usually a volunteer appointed by the court, who serves to ensure that the needs and interests of a child in child protection judicial proceedings are fully protected.

**Court Jurisdiction:** The legal authority of a court to hear and decide a certain type of case. It is also used as a synonym for venue, meaning the geographic area over which the court has territorial jurisdiction to decide cases. (Also see United States Courts.)

**CME:** A Comprehensive Multi-Disciplinary Evaluation is a group or team of persons responsible for evaluating the abilities and needs of an infant or toddler to determine whether or not the infant or toddler is eligible to receive early intervention and/or related services.

**Culture:** An integrated pattern of human behavior which includes thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, role, relationships and expected behaviors of a racial, ethnic, religious or social group and the ability to transmit this pattern to succeeding generations.

**Cultural Competence:** The ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, sexual orientations, and faiths or religions in a manner that recognizes, affirms, and values the worth of individuals, families, tribes, and communities, and protects and preserves the dignity of each. Cultural competence is a vehicle used to broaden our knowledge and understanding of individuals and communities through a continuous process of learning about the cultural strengths of others and integrating their unique abilities and perspectives into our lives. Adapted from the Child Welfare League of America .

**Cultural reciprocity:** In the context of early care and education, this term refers to the effort of staff to understand families' cultural beliefs, and to use this understanding as a way to help promote the healthy development of infants and toddlers; including the ability to respect families' beliefs and traditions, and look for ways to meet the families' unique needs while still upholding early care and education program objectives. (ZERO TO THREE, 2003)

**Custody (in child welfare):** Refers to the legal right to make decisions about children, including where they live. Parents have legal custody of their children unless they voluntarily give custody to someone else or a court takes this right away and gives it to someone else such as a relative or a child welfare agency. Whoever has legal custody can enroll the children in early intervention, childcare, school, give permission for medical care, and give other legal consents.

**Custody Hearing:** (Also called the 10-day or initial custody hearing). State law requires that a hearing be held in district court within 10 legal days of a child being placed in the custody of the state by ex parte custody. The state, children and parents are represented and/ or heard at this hearing in which the court determines if enough evidence is provided by the state for continued custody of up to 120 days. The court may order assessments to determine family needs requested by the state at this hearing.

**Custody Standard:** The federal laws regarding risk of child abuse/ neglect are interpreted liberally in New Mexico. Investigations regarding child abuse and neglect can be based on the perceived risk of potential abuse and do not require the abuse to have been perpetrated in order for the state to investigate. The safety and protection of the alleged child victim is always the overriding standard when assessing or determining custody.

## D

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**Decree of Adoption:** The document signed by a judge to finalize an adoption. It formally creates the parent-child relationship between the adoptive parents and the adopted child, as though the child were born as the biological child of its new parents. It places full responsibility for the child on the new parents.

**Defense Mechanism:** Automatic psychological process that protects the individual against anxiety and from awareness of internal or external stressors or dangers. Defense mechanisms mediate the individual's reaction to emotional conflicts and to external stressors. Some defense mechanism (e.g., projection, splitting, and acting out) are almost invariably maladaptive. Others, such as suppression and denial, may be either maladaptive or adaptive, depending on their severity, their inflexibility, and the context in which they occur.

**Development and Learning:** The process of change in which the infant or toddler comes to master more and more complex levels of moving, thinking, feeling and interacting with people and objects in the environment. Development involves both a gradual unfolding of biologically determined characteristics and the learning process. Learning is the process of acquiring knowledge, skills, habits and values through relationships, experience and experimentation, observation, reflection, and/or instruction. Neither takes place in isolation.

**Developmental Delay:** Any of the disability classifications or conditions which qualifies a child for early intervention services.

**Detachment:** A behavior pattern characterized by general aloofness in interpersonal contact; may include intellectualization, denial, and superficiality.

**Dispositional Hearing:** Hearings held by the juvenile and family court to determine the legal resolution of cases after adjudication. Dispositional hearings may determine where the children will live for the time being, who will have legal custody of them, and what services the children and family will need to reduce the risk and to address the effects of maltreatment.

**Domestic/Family Violence:** A pattern of assaultive and/or coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners. Intimate partners include spouses, sexual partners, parents, children, siblings, extended family members, and dating relationships.

**Due Process:** The principle that every person has the protection of a day in court, representation by an attorney, and the benefit of procedures that are speedy, fair, and impartial.

**Dyad:** A two-person relationship, such as the therapeutic relationship between doctor and patient in individual psychotherapy.

**Dyslexia:** Inability or difficulty in reading, including word-blindness and a tendency to reverse letters and words in reading and writing.

## E

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**Early Childhood Intervention:** A support system or collection of services for infants and children with developmental disabilities or delays and their families under the IDEA Part C program. The term is also used to describe services and supports that promote healthy development and a readiness to learn in children up to age 5 and that create safe, stable, and nurturing families and communities.

**Early Childhood Mental Health Consultation:** A problem-solving and capacity-building intervention implemented within a collaborative relationship between a professional consultant with mental health expertise and one or more caregivers, typically an early care and education provider and/or family member. Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat and reduce the impact of mental health problems among children from birth to age 5 and their families (adapted from Cohen Kaufmann, 2000).

**Early Childhood Mental Health:** The social, emotional and behavioral well-being of young children and their families, including the developing capacity of a child to experience, regulate and express emotional; form close secure relationships; and explore the environment and learn (adapted from ZERO TO THREE, [www.zerotothree.org](http://www.zerotothree.org))

**Early Intervention Program:** The point of entry to service coordination for eligible infants and toddlers as identified by each Early Intervention provider via the stat system contract.

**Early Intervention Services:** The early Intervention system contains entitled services and access to other available services designed to meet the developmental needs of each eligible infant or toddler with disabilities and the needs of the family related to enhancing the development of their infant or toddler.

**Emotional Development:** A component of early childhood mental health encompassing a child's ability to experience, regulate and express emotion.

**Endorsement:** Affirmation of specialized knowledge and competencies to provide services with a high level of quality and integrity based on formal education, in-service training, supervised practices, and testing or portfolio review. For example: Michigan Association for Infant Mental Health's endorsement in infant or early childhood mental health (Adapted from Michigan Association for Infant Mental Health (MI-AIMH), [www.mi-aimh.org](http://www.mi-aimh.org)).

**Entitlement:** Benefits of a program granted by law to persons who fit within the defined eligibility criteria. Entitlement through Early Intervention ACT includes services coordination and development of the (IFSP) Individual Family Services Plan.

**Entry:** The process of joining or “entering” a relationship, work place, or program and the essential elements that facilitate a smooth transition. In early childhood mental health consultation, this process includes an introduction, communicates collaboration, clarifies shared expectations, and provides time for relationship building.

**Ethnic or Culture Related Trauma:** Traumatic experiences and stress that are linked to or associated with ethnicity or culture, such as discrimination, violence, war, etc.; for example, refugees who have been exiled or sought asylum and safety in a different country.

**Ethnicity:** Ethnic quality or affiliation, of or relating to large groups of people classed according to common racial, tribal, religious, or linguistic, or cultural origin or background.

**Evaluation:** The measurement, comparison, and judgment of the infant’s/young child’s development and/or of their programs, schools, caregivers, teachers, or a specific educational program based upon valid evidence gathered through assessment.

**Evidence-Based Practice:** Involves approaches to prevention or treatment that are validated by some form of documented scientific evidence. This includes findings established through controlled clinical studies, but other methods of establishing evidence are valid as well.

**Evidence-Informed:** Use of the best available research and practice knowledge to guide program design and implementation within the context of the child, family and community characteristics, culture and preferences. (Guidelines for Community-Based Grants for the Prevention of Child Abuse and Neglect Programs - CBCAP) Also see evidence-based practice.

**Ex Parte Custody Hearing:** Occurs before a district court judge within 48 hours of a child being placed in the custody of the state by a law enforcement officer. The state can also request this hearing by providing an affidavit for ex parte custody as described above. Parents are not present at this hearing and the judge rules on the evidence presented by the state.

## F

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**Failure to Thrive:** Problem in pediatrics in which infants or young children show delayed physical growth, often with impaired social and motor development. Nonorganic [not caused by a medical problem] failure to thrive is thought to be associated with lack of adequate emotional nurturing (Edgerton & Campbell, 1994).

**Family Assessment:** An in-depth assessment of family issues where their contributing factors are identified. This assessment lays foundation for a family centered, child focused approach to case planning and service delivery.

**Family Court:** A family court is a court of limited jurisdiction that hears cases involving family law. For example, family courts typically hear cases involving divorce, child custody, and domestic abuse. Family courts are governed by State and local law. Depending on the jurisdiction, these courts might be called domestic courts. In some jurisdictions, family courts also handle guardianship and incompetence hearings. Other jurisdictions leave these matters to probate courts. (See Cornell University Law )

**Family Reunification:** Refers to the process of returning children in temporary out-of-home care to their families of origin. Reunification is both the primary goal for children in out-of-home care as well as the most common outcome. (See Family Reunification: What the Evidence Shows)

**Family Visiting (visitation):** Face-to-face contact between a child (or children) in out-of-home care and his or her biological family. Family visiting is considered a major feature of permanency planning for children in foster care (Adapted from (Information Packet: Visiting with Children in Foster Care ).

**Family Cultural Context:** The family cultural context refers to the values, beliefs, practices and customs that influence family life. This can include the influence of community as well as living circumstances such as poverty, refugee status, etc.

**Fictive Kin:** People not related by birth or marriage who have an emotionally significant relationship with an individual.

**Findings:** There are five categories of findings: Court substantiated, Petition to be filed, Inconclusive, Unable to locate, and Unfounded.

- **Court Substantiated:** A District Court, county Court, or Separate Juvenile Court has entered a judgment of guilty on a criminal complaint.
- **Petition to be filed:** a criminal complaint indictment or information or a juvenile petition that has been filed in District Court, county, court, or Separate Juvenile Court, and that allegations of the complaint, indictment, information, or juvenile petition relate or pertain to the same subject matter as the report of abuse or neglect.
- **Inconclusive:** The evidence indicates it is more likely than not (preponderance of evidence standard) that the child abuse or neglect occurred, and court adjudication did not occur.
- **Unable to Locate:** Subjects of the maltreatment report have not been located after a good-faith effort on the part of the CYFD/CPS.
- **Unfounded:** All reports not classified as court substantiated, petition to be filed, inconclusive or unable to locate, will be classified as unfounded.

**Foster Care:** A 24-hour substitute care for children placed away from their parents or guardians, and for whom the State agency has placement and care responsibility. This includes, but is not limited to, placements in foster family homes, foster homes of relatives, group homes, emergency shelters, residential facilities, child care institutions, and preadoptive homes (Adapted from the Code of Federal Regulations).

**Foster Care Adoption:** Adoption of children who are in the custody of their State or county's Department of Child and Family Services. These adoptions are usually handled by local public agencies and/or private agencies under contract with their State or county (Also see Adopting Children from Foster Care.).

**Full Disclosure:** Information provided to the family by the child welfare agency regarding the steps in the intervention process, the requirements of the case plan, the expectations of the family, the consequences if the family does not fulfill the expectations, and the rights of the parents to ensure that the family completely understands the process.

## G

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**Guardian Ad Litem (GAL):** A lawyer or layperson who represents a child in juvenile or family court. Usually this person considers the best interests of the child and may perform a variety of roles, including those of independent investigator, advocate, advisor, and guardian for the child. A layperson who serves in this role is sometimes known as a court-appointed special advocate (CASA). (See A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice)

**Guardianship:** A judicially created relationship between a child and caretaker that is intended to be permanent and self-sustaining as evidenced by the transfer to the caretaker of the following parental rights with respect to the child: protection, education, care and control of the person, custody of the person, and decision-making. (Adapted from the Code of Federal Regulations)

## H

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**Hippocampus:** A major component of the brain that is part of the limbic system and plays important roles in long-term memory and spatial navigation.

**Holding Environment:** The capacity of a family or other caregiving relationship that can both provide attention, nurturance, and safety that a child needs and can allow that child to grow, develop, and have appropriate independence.

**Home Study:** The process of gathering information, preparing, and evaluating the fitness of prospective foster, kinship, and adoptive parents. The primary purpose of a home study is to ensure that each child is placed with a family that can best meet his/her needs. Home study requirements vary greatly from agency to agency, State to State, and (in the case of intercountry adoption) by the child's country of origin.

**Identity:** A term used to describe a person's conception and expression of their individuality or group affiliation, such as national identity and cultural identity.

**Immunity:** Legal protection from civil or criminal liability for individuals making reports in good faith of suspected or known instances of child abuse or neglect. (Adapted from the Child Welfare Information Gateway State Statutes Series, Immunity for Reporters of Child Abuse and Neglect) Indian Child Welfare Act (ICWA)

**Individualized Education Program (IEP):** A written education plan for a child with special needs developed by a team of professionals and the child's parent(s); it is reviewed and updated yearly and describes how the child is presently doing, what the child's learning needs are, and what services the child will need.

**Individualized Family Service Plan (IFSP):** Refers both to a process and a written document required to plan appropriate activities and interventions that will help a child with special needs (birth through age 3) and his or her family progress toward desired outcomes. It is reviewed and updated yearly and describes how the child is presently doing, what the child's learning needs are, and what services the child will need. The written plan includes goals, outcomes, location duration and intensity of each service provided.

**IDEA - Individuals with Disabilities Education Act:** A federal law that provides funding and guidance to states to support the planning of service systems and the delivery of services, including evaluation and assessment, for young children who have or are at risk of developmental delays/disabilities. Funds are provided through the Infants and Toddlers Program known as Part C of IDEA for services to children birth through 3 years of age, and through the Preschool Program (known as Part B-Section 619 of IDEA) for services to children ages three to five.

**Informed Consent:** In medical jurisprudence, a physician must disclose to a patient sufficient information regarding a proposed procedure to enable the patient to make a knowing decision about whether to participate. In addition to sufficient information, any consent given must be voluntary and made by a person considered legally competent.

**In-Home Services:** Services provided to children and families who have been reported to child protective services (CPS) for possible child abuse or neglect and who are assessed as being able to benefit from services delivered in the home. Services are generally provided to families who have an "open case" with the child welfare agency and whose children remain at home or have returned home from out-of-home care. (Adapted from Child Welfare Information Gateway Issue Brief: In-Home Services in Child Welfare).

**Initial Permanency Hearing:** By the end of the 12th month of custody the state must provide evidence to the court at the initial permanency hearing that the causes and conditions that led to the abuse have not been alleviated and that the child's safety cannot be assured if returned to the home. Unless the permanency plan for the child has changed to something other than a return home prior to this hearing and approved by the court the state can also recommend an alternative permanency plan at this hearing.

**Intake:** The process of documenting all Child Welfare related contacts with CYFD/CPS. Intake includes the activities associated with the receipt of a referral, the assessment of screening, the decision to accept, and the referral of individuals or families to services. In New Mexico this occurs when reporters call Statewide Centralized Intake (SCI) located in Albuquerque and staffed 24 hours. SCI staff complete assessment and other structured decision making tools to determine how CYFD or other agencies will respond based on the information provided.

**Initial Investigation:** The gathering and analyzing of information in response to reports of suspected child abuse or neglect, to determine which families need further intervention. During this phase the CPS worker is primarily concerned with child safety. The CPS worker determines if child maltreatment did occur, determines the level of risk, and arranges services as necessary to protect the child (See Child Maltreatment 2013).

**"It Depends":** This statement is used widely in child welfare services. Just as all individuals and families are unique, circumstances and situations related to all child protective services cases are variable and differ widely. Each case presents its own unique set of issues, weaknesses, strengths and opportunities. Situations and circumstances are different in the case of every child we serve so we must respond to each child, family and case differently to preserve families, protect each child's best interests and achieve permanency for all children

## J

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**Judicial Review:** This hearing is held between the adjudicatory hearing and the initial permanency hearing for all parties to the case in order to review the progress in alleviating the causes and conditions that led to the court ordering the child into state custody.

## K

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**Kinship Adoption:** Adoption of a child by someone related by family ties or a prior relationship.

**Kinship Foster Care:** Kinship foster care refers to those arrangements that occur when child welfare agencies take custody of a child after an investigation of abuse and/or neglect and place the child with a kinship caregiver who is an approved placement based on the assessment standards developed by the agency. (See State Child Welfare Policy Database )

## L

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**Lead Agency:** The Department of Health, Family Infant Toddler Program is the lead agency appointed and responsible for planning, implementation, and administration of the federal early intervention program and the Early Intervention Act (Part C).

**Life Book:** Life books are created for children in foster care over 60 days. These books chronicle the child's activities while in foster care and may include photos and information about birth relatives, siblings, foster families, friends or anything important in the child's life. Life books remain permanently with the child as a historical reference of the child's time spent in foster care.

**Learning Disability (LD):** A neurological condition that interferes with an individual's ability to store, process, or produce information. Learning disabilities can affect one's ability to read, write, speak, spell, compute math, and reason, and can affect an individual's attention, memory, coordination, social skills, and emotional maturity. (Learning Disabilities Association of America )

**Legal Counsel:** Another term for a lawyer or attorney. A legal counsel advises clients about their legal rights and obligations and represents clients in legal proceedings.

**Legal Guardian:** An adult to whom the court has given parental responsibility and authority for a child. Appointment as guardian requires the filing of a petition and approval by the court and can be done without terminating the parental rights of the child's parents.

**Life Book or Life Story Book:** A journal or scrapbook that provides a chronicle of a child's life story and personal history. A social worker, therapist, foster parent, or adoptive parent can help a child to make a life book. It can then serve as a therapeutic tool to help facilitate the child's identity formation and understanding of adoption, and provides a way to share parts of the child's life not spent with their parents.

**Linguistic Competence:** The capacity to effectively communicate with persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. May include being bilingual/bicultural, using cultural brokers, using interpreters and translators, and easy to read or low literacy print materials.

**Locus Coeruleus:** A small area in the brain stem containing norepinephrine neurons that is considered to be a key brain center for anxiety and fear.

**Long-Term Memory:** The final phase of memory in which information storage may last from hours to a lifetime.

## M

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**Mediation:** A nonadversarial, voluntary process that allows the parties involved to agree on a permanency decision in the best interests of the child with the help of a trained, neutral, third party. Mediation generally avoids adversarial court hearings. Parties are more invested in the outcome because they participated in decision-making. Parties to mediation may include birth parents, foster/adoptive parents, relatives, the

child, the agency worker, attorneys, and others. Mediations can be court-based or may take place at other, more neutral locations. Mediation is a way to settle a conflict so that both sides win. For example, parents and other professionals discuss their differences and, with the help of a trained and independent mediator, reach a settlement that both sides accept.

**Medical Neglect:** Failure to provide or to allow needed care as recommended by a competent health care professional for a physical injury, illness, medical condition, or impairment, and/or the failure to seek timely and appropriate medical care for a serious health problem that any reasonable person would have recognized as needing professional medical attention.

**Mental Health Consultant:** A mental health professional providing early childhood mental health consultation services.

**Memory:** Episodic: Refers to memory for specific events; Implicit: refers to memory for automatic skills; Semantic: Refers to memory of facts; Short-term/Immediate memory: Recall of material within seconds to minutes; and, Long-term: Recall of events over the past few hours to years

**Mentoring:** A personal developmental relationship in which a more experienced or more knowledgeable person helps a less experienced or less knowledgeable person. Foremost, mentoring involves communication, is relationship based, and provides both knowledge and psychosocial support over a sustained period of time.

**Multidisciplinary Team:** A team established between agencies and professionals within the child protection system to discuss cases of child abuse and neglect and to aid in decisions at various stages of the child protective services' case process. These terms may also be designated by different names, including child protection teams, interdisciplinary teams, or case consultation teams. (See Child Protective Services: A guide for Caseworkers)

## N

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**Native Language:** Mode of communication normally used by the child's family.

**Natural Environments:** Settings that are natural or normal for the child's age and include the home, childcare and other community settings.

### **Neglect:**

- **Emotional neglect:** Information which indicates that the child is suffering or has suffered severe negative effects due to a parent's failure to provide the opportunities for normal experience which produce feelings of being loved, wanted, secure and worthy. Lack of such opportunities may impair the child's ability to form healthy relationships with others.
- **Physical neglect:** The failure of the parent to provide for the basic needs, or provide a safe and sanitary living environment for the child.
- **Medical Neglect:** the withholding of medically indicated treatment (appropriate nutrition, hydration, well-child care, and medication) from a special needs or disabled infant with life-threatening conditions or conditions that impede their developmental progress.

**Neonatal Abstinence Syndrome (NAS):** A group of problems that occur in a newborn who was exposed to addictive opiate drugs while in the mother's womb. (National Institute of Health)

**Neural Circuit:** A functional entity of interconnected neurons that influence each other, particularly in the brain.

**Neurobiological Chemicals:** Chemicals that support neurotransmission in the brain are responsible for regulating all physiological processes, including our ability to sense and respond to our environment, maintain consciousness, express emotions and display fluctuations in mood; these include those hormones that are organized in the limbic system of the brain, such as adrenalin and cortisol.

## O

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**Open Adoption:** A type of adoption in which birth and adoptive families have some form of initial and/or ongoing contact. Parents have several options available related to openness, including closed adoption, semi-open or mediated adoption, and open or fully disclosed adoption.

**Outcome:** The anticipated or actual effect of program activities and outputs. An outcome constitutes changes or improvements in the target populations being served or the target systems being affected. The Child and Family Services Reviews incorporate the following seven outcomes in evaluating State child welfare programs: (1) Children are, first and foremost, protected from abuse and neglect; (2) children are safely maintained in their homes whenever possible; (3) children have permanency and stability in their living situations; (4) the continuity of family relationships and connections is preserved for children; (5) families have enhanced capacity to provide for their children's needs; (6) children receive appropriate services to meet their educational needs; and (7) children receive adequate services to meet their physical and mental health needs. American Bar Association Center on Children and the Law In early intervention, outcomes are statements of changes wanted for a child and family that are documented in the IFSP.

## P

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**Parallel Process:** The perspective in relationship-based mental health consultation work that all relationships influence one another. For example, a positive experience in the relationship between the consultant and the early care and educator, positively influences the relationship between the early care and education provider and the children in his or her care and their families.

**Permanency:** Each child in care is assigned one of five potential permanency plans that will guide services to ensure the child achieves the goal of placement in a safe, loving and permanent family environment. Unless the state proves unusual circumstances in a case at the adjudicatory hearing a child's first permanency plan is always reunification, sometimes also referred to as return home. Other permanency plan options include: adoption, permanent guardianship, placement with a fit and willing relative or planned permanent living arrangement. Permanent plans are recommended by CYFD and approved by the court. A permanent plan for all children entering care is expected to be finalized within 24 months of entering care.

**Permanency Planning:** In child welfare work, permanency planning is a systematic effort to provide long-term continuity in a dependent child's care, as an alternative to temporary foster placements. This might be done by facilitating adoption, by establishing clear guidelines for remaining in foster care or by helping the child's family become capable of meeting the child's needs. (Adapted from Office of Children & Families in the Courts )

**Perpetrator:** The person who has been determined to have caused or knowingly allowed the maltreatment of a child. (U.S. Department of Health and Human Services)

**Physical Abuse:** Generally defined as "any nonaccidental physical injury to the child" and can include striking, kicking, burning, or biting the child, or any action that results in a physical impairment of the child. In approximately 38 States and certain territories, the definition of abuse also includes acts or circumstances that threaten the child with harm or create a substantial risk of harm to the child's health or welfare.

**Physical Neglect:** Failure to provide for a child's basic survival needs, such as nutrition, clothing, shelter, hygiene, and medical care. Physical neglect may also involve inadequate supervision of a child and other forms of reckless disregard of the child's safety and welfare.

**Post-Traumatic Stress Disorder:** A mental health diagnosis associated with symptoms following an exposure to any event that results in psychological trauma - involve a perceived or actual threat of death to oneself or to someone else, or to one's own or someone else's physical, sexual, or psychological integrity, overwhelming the individual's ability to cope.

**Prefrontal Cortex:** The anterior part of the frontal lobes of the brain that plays an important part in planning complex cognitive behaviors, decision making and moderating correct social behavior.

**Protective Custody:** A form of custody required to remove a child from his or her home and place in out-of-home care. Law enforcement may place a child in protective custody based on an independent determination that the child's health, safety, and welfare is jeopardized. A child can also be placed in protective custody via court order.

**Protective Factor:** A characteristic at the biological, psychological, family, or community (including peers and culture) level that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes. Protective/promotive factors include nurturing and attachment, parental resilience, knowledge of parenting, opportunities for engagement within school and the community, and individual coping skills. (Adapted from Youth.gov)

**Pruned Neural Synapses:** The cutting back or elimination of excess neurons and neural connections in the developing brain.

## R

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**Reasonable Efforts:** Efforts made by State social services agencies to provide the assistance and services needed to preserve and reunify families.

**Recovery:** The term recovery describes the process by which a person becomes more aware of the substance use, mental disorder, or co-occurring disorders as a problem and initiates and maintains a substance-free or symptom-managed life and, as a part of that process, generally achieves a stronger sense of balance and control over his or her life. Recovery is a lifelong process that takes place over time and often in specific stages.

**Referral:** When a parent or professional (with the parent's permission), for example, thinks that a child may benefit from early intervention services and makes contact with CMS (Children's Medical Services) or a local early intervention provider agency.

**Reflective Dialogue:** Describes interactive conversation used in the process of reflective supervision for identifying motivations, feelings, and insight toward self-awareness by associated with relationship-based work. See also Reflective Practices; Supervision.

**Reflective Practice:** A means of developing a greater level of self-awareness about and insight into the nature and impact of one's actions and interactions as an opportunity for personal and professional growth and development. In early care and education, reflective practice helps staff members understand their own reactions to the children and families with whom they work and help them to use this self-awareness to develop strategies to enrich their work.

**Reflective Supervision:** See Supervision.

**Relationship-Based:** The theoretical and developmental perspective that relationships and the interaction between caregiving adults and children have a primary role in the social/emotional development and mental health of young children. It also refers to the nature of the work between a mental health consultant and consultee, building on the collaborative relationship between the two.

**Relinquishment:** Voluntary termination or release of all parental rights and duties that legally frees a child to be adopted. This is sometimes referred to as a surrender or as making an adoption plan for one's child.

**Resilience:** The ability to adapt well to adversity, trauma, tragedy, threats, or even significant sources of stress. Parental resilience is considered a protective factor in child abuse and neglect prevention. Resilience in children enables them to thrive, mature, and increase competence in the midst of adverse circumstances. Resilience can be fostered and developed in children as it involves behaviors, thoughts, and actions that can be learned over time and is impacted by positive and healthy relationships with parents, caregivers, and other adults. (Adapted from the American Psychological Association )

**Respite Care Services:** Beneficial activities involving temporary care of the child(ren) to provide relief to the caretaker. It may involve care of the children outside of the caretaker's own home for a brief period of time, such as overnight or for a weekend. Not considered by the State to be foster care or other placement. (Children's Bureau)

**Retraumatize, Retraumatizing, Retraumatization:** These terms refer to an individual experiencing another traumatic event and the impact of that experience and or the experience of delayed onset or reactivated symptoms related to a past traumatic experience. For example, a child who suffered abuse and neglect that included sitting in a chair in isolation may be unintentionally "retraumatized" if placed in an isolating, time-out chair in the child-care setting.

**Review Hearing:** An opportunity to evaluate the progress that has been made toward completing the case plan and any court orders and to revise the plan as needed. (Children's Bureau)

**Risk:** In child welfare, the likelihood that a child will be maltreated in the future.

**Risk Assessment:** Collection and analysis of information to determine the degree to which key factors that increase the likelihood of future maltreatment to a child or adolescent are present in a family situation.

**Risk Factors:** A term to describe those individual aspects or circumstances that may be associated with potentially negative effects on healthy growth, development, and adaptation or resilience, such as premature birth, health problems, poverty, etc.

## S

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### **Safety Assessment:**

A part of the child protective services case process in which available information is analyzed to identify whether a child is in immediate danger of moderate or serious harm. Safety assessments also are conducted throughout the life of a case, including while in-home services are provided, when a child is in out-of-home care, preceding and during family visitation, and throughout the process of achieving permanency for the child. (Children's Bureau)

**Safety Plan:** A casework document developed when it is determined that a child is in imminent or potential risk of serious harm. In the safety plan, the caseworker targets the factors that are causing or contributing to the risk of imminent serious harm to the child and identifies, along with the family, the interventions that will control the safety factors and assure the child's protection. (Children's Bureau)

**Scaffolding:** A term used to describe the interactional support and the process by which adults mediate a child's attempts to take on new learning. Scaffolding represents the helpful interactions between adult and child that enable the child to do something beyond his or her independent efforts.

**Secondary trauma:** Secondary trauma (traumatic stress) or vicarious trauma, refers to the behavioral and emotional experience of those people who care for, or are involved with, those who have been directly traumatized. Those who work with traumatized people may experience intrusive thoughts, nightmares, feeling withdrawn and isolated, feel depressed, have difficulty concentrating, and feel helpless. For this reason, those who work with children and families impacted by trauma need an ongoing support system to deal with the intensity of their reactions in their relationship with the victim, or perpetrator.

**Sensitive periods:** A term to describe times in a child's development where the brain is most open to the influence of external experiences.

**Service Coordinator:** A person who works with your family to help coordinate the evaluation, the IFSP and early intervention services as well as other community support and resources for your child and family.

**Sexual Abuse:** According to the Child Abuse Prevention and Treatment Act (CAPTA), the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

**Shaken Baby Syndrome:** The collection of signs and symptoms resulting from the violent shaking of an infant or small child. The consequences of less severe cases may not be brought to the attention of medical professionals and may never be diagnosed. In severe cases that usually result in death or severe neurological consequences, the child usually becomes immediately unconscious and suffers rapidly escalating, life-threatening central nervous system dysfunction. Adapted from National Center on Shaken Baby Syndrome

**Socio-cultural context:** The physical, material, social and political aspects associated with a particular cultural group or community that influence family life.

**Social Support:** Formal and informal activities and relationships that provide for the needs of children and families in their efforts to live successfully in society. These needs include education, income security, health care, and, especially, a network of other individuals and groups who offer encouragement, access, empathy, role models, and social identity. (Adapted from Indiana University of Pennsylvania)

**Special Education:** Specially designed instruction and services to meet the education needs of children over the age of three. Provided by the local school district for children who are eligible in preschool or other settings.

**Special Needs Children:** Children in foster care available for adoption or adopted from foster care who meet a State's definition of "special needs." There is no Federal definition of special needs, and the guidelines for classifying a child as special needs vary by State. The term is used in State law to indicate eligibility for Federal financial assistance, and most frequently refer to children who are school-aged; part of a sibling group; children of color; or those with specific physical, emotional, or developmental needs. The phrase "special needs" can apply to almost any child or youth adopted from foster care. The preferred term is "children with special needs."

**Standardized assessment tool:** A testing instrument that is administered, scored, and interpreted in a standard manner. It may be either norm-referenced or criterion-referenced.

**State Custody:** Children can enter state custody in New Mexico by one of two methods. Children can be placed into CYFD custody in an emergency for a maximum of 48 hours by any law enforcement officer in New Mexico. During this period CYFD will assess the situation and either return the child home at 48 hours of filing a petition for continued custody with the district court. If the child is not returned home by CYFD within this time period an affidavit for continued or Ex Parte custody is provided to the court and the court will rule on the evidence of the affidavit within this 24 hour time period. The court can dismiss or place the child in continued Ex Parte custody for up to 10 days. Parents do not have a legal right to be present at the Ex Parte custody hearing but do have a legal right to be heard before the court within the initial 10 days of a child being placed in state custody.

Any person can also petition the district court to place a child in the custody of the state due to the perceived risk of abuse or neglect. The court will rule based on the preponderance of evidence submitted to the court and may place a child in the temporary custody of the state for no longer than 10 days.

A note on legal time: Once a child is placed into the custody of the state legal time overrides calendar time. Legal time is determined by the number of work (or court) days and do not include weekend days or holidays on which the court is closed. In the event a child is placed into 48 hour emergency custody on a Friday the 48 hour custody would expire by close of business in Tuesday. In this case if the following Monday were a national holiday the 48 hour emergency custody would expire by close of business on Wednesday.

**State Ward:** When a court of competent jurisdiction gives custody of a child under the age of 18 to the state, that child becomes a ward of the state. This is done to provide for safety and/or facilitate the provision of services. The state acts as the child's parent.

**Strategies:** The methods and activities developed to achieve outcomes. Strategies are written into the IFSP.

**Subsequent Permanency Hearing:** This hearing is held within three months of the initial permanency hearing to review the status of the case and review the plan for achieving permanency for children within 24 months of custody. Subsequent Judicial Reviews: In the event the child is not returned home within 18 months of custody these hearings are held every six months to review the status of the case until permanency is achieved.

**Substantiated:** An investigation disposition concluding that the allegation of child maltreatment or risk of maltreatment was supported or founded by State law or State policy. A child protective services determination means that credible evidence exists that child abuse or neglect has occurred. (Children's Bureau)

**Supervision:** The act of providing guidance, oversight, or shared responsibility in the work or tasks of another in a work, professional, or personal context. In early childhood mental health consultation, a mental health consultant may experience:

- **Administrative supervision:** Includes guidance on organizational structure and personnel/family interaction by an early childhood program director or supervisor,
- **Clinical supervision:** Includes guidance on diagnosis and intervention by a more senior or licensed clinician
- **Reflective supervision:** Includes reflective practices and guidance on identifying motivations, feelings, and insight toward self-awareness by a mental health professional trained in this type of supervision associated with relationship-based work

**Surrogate Parent:** Means the person appointed in accordance with these regulations to represent the eligible child in the IFSP Process when no parent can be identified or located or if the child is a ward of the state. A surrogate parent has all the rights and responsibilities afforded to a parent under Part C of IDEA.

**Synapses:** A synapse is a junction that permits a neuron to pass an electrical or chemical signal to another cell. Symbiosis A mutually reinforcing relationship between two persons who are dependent on each other; a normal characteristic of the relationship between the mother and infant child.

**System of Care:** System of care is an evidence-based approach to the care of children and adolescents with serious emotional disturbances and their families. It incorporates a broad array of services and supports that are organized into a coordinated network, integrate care planning and management across multiple levels, are culturally and linguistically competent, and build meaningful partnerships with families and youth at service delivery and policy levels. Guiding principles in a system of care specify that services should be • Comprehensive, incorporating a broad array of services and supports • Individualized • Provided in the least restrictive, appropriate setting • Coordinated at the system and service delivery levels • Involve families and youth as full partners • Emphasize early identification and intervention.

## T

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**Temperament:** Constitutional predisposition to react in a particular way to stimuli.

**Temporary Assistance for Needy Families(TANF):** A program that provides assistance and work opportunities to needy families by granting States the Federal funds and wide flexibility to develop and implement their own welfare programs. The focus of the program is to help move recipients into work and to turn welfare into a program of temporary assistance. (Adapted from Office of Family Assistance)

**TPR/ Termination of Parental Rights:** In some cases children are abandoned by their parents or cannot return to their care. In some of these cases the state may recommend the state pursue a termination of parental rights trial. During these trials the court will rule on evidence presented to the court as to whether a parent's legal rights to their children should be terminated. The courts may subsequently establish another legal parent-child relationship by means of adoption. Parents may appeal the district court's decision regarding termination of parental rights. There are currently no laws or regulations regarding time frames for higher court decisions. Appeals place children in legal-limbo until a decision by the appeals court is made.

**Therapeutic Foster Care:** Intensive care provided by foster parents who have received special training to care for a wide variety of children and adolescents, usually those with significant emotional, behavioral, or social problems or medical needs. Therapeutic foster parents typically receive additional supports and services.

**Transition:** The process of planning for support and services for when a child experiences a disruption in care or placement or will leave the Family Infant Toddler Program or if the family moves to a new community.

**Transitional Object:** An object, other than the mother, selected by an infant between 4 and 18 months of age for self-soothing and anxiety-reduction. Examples are a "security blanket" or a toy that helps the infant go to sleep. The transitional object provides an opportunity to master external objects and promotes the differentiation of self from outer world.

**Trauma trigger:** An experience that, for an individual, represents a troubling reminder of a traumatic event. The trigger need not be frightening or traumatic, but can prompt emotional or physical symptoms associated with the original trauma. The trigger can take many forms, such as a person, place, noise, image, smell, taste, scene, body sensation, etc. Also known as trauma reminders.

**Trauma:** A term to describe the unique individual experience of an event or enduring conditions in which the individual's ability to integrate his/her emotional experience is overwhelmed, and the individual experiences (either objectively or subjectively) a threat to his/her life, bodily integrity, or that of a caregiver or family.

**Traveling File:** A traveling file is created for children in foster care over 60 days which includes their medical, education, demographic and historical information. These files travel with the child in the event the child's placement changes.

**Treatment Plan:** A treatment plan is a plan of care that is designed especially for each child and family, based on individual strengths and needs. Ideally, mental health specialists and primary care clinicians collaborate with the child and family to develop the plan. The plan establishes goals and summarizes appropriate treatment and services to meet the special needs of the child and family, leading toward optimal function, self-sufficiency, and recovery.

## U & V

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**Unsubstantiated (not substantiated):** An investigation disposition that determines that there is not sufficient evidence under State law or policy to conclude that a child has been maltreated or is at risk of maltreatment. A child protective services determination means that credible evidence does not exist that child abuse or neglect has occurred. (Children's Bureau)

**Validity:** A term used to describe measures and instruments used in screening, assessment, and evaluation. If a measure is valid, this means that the measuring instrument accurately reflects what it is intended to measure.

**Visitation:** Scheduled contact among a child in out-of-home care and his or her family members. The purpose of visitation is to maintain family attachments, reduce the sense of abandonment that children may experience during placement, and prepare for permanency.

## W

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**Wraparound Services:** Wraparound services are a package of community services and natural supports that are flexible and tailored to meet the unique needs of children with serious emotional disturbances. Wraparound services are based on a definable planning process and are designed for children and their families to achieve a positive set of outcomes in the home setting. Services are provided by multidisciplinary teams that may include case managers, psychiatrists, nurses, social workers, vocational specialists, substance abuse specialists, community workers, peer specialists, and family members or caregivers.

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## APPENDIX A

# Service Definitions and Assessment Guidelines

### **PARENT INFANT PSYCHOTHERAPY FORMS AND INSTRUMENTS**

The Parent-Infant Psychotherapy program uses specific forms, assessment tools and instruments for intake, assessment, tracking progress, and quarterly reports.

**Parent Infant Psychotherapy  
Severe Emotional Disturbance  
Birth to three (3) years old  
CYFD-003**

**Effective date:** July 1st, 2017

**Service Description:**

Parent Infant Psychotherapy (PIP) treatment services target the dyadic relationship between the infant/young child and the parent/caregiver. They are grounded in attachment theory and the science of brain development; they are relationship-based, developmentally appropriate, and trauma-informed. PIP treatment services are an array of therapeutic and developmental services designed to reduce both the acute and chronic behavioral, social and emotional disorders and disruptions in the relationship between an infant/young child and their parent/caregiver, as a result of toxic stress and major trauma.

**Source of Funding:**

CYFD

**Admission/Service Criteria:**

Infants and young children, and their parent/caregiver, who are:

- Birth to three (3) years;
- Diagnosed with a Severe Emotional Disturbance (SED);and
- Experiencing disruptions in the relationship due to infant/young child and parent/caregiver vulnerabilities.

**Target Population:**

Infants and young children birth to three (3) years who:

1. Have had a Comprehensive Assessment by an independently licensed clinician, who is endorsed by the New Mexico's Association for Infant Mental Health (NMAIMH) as an Infant Mental Health Specialist Level III (Level III) or an Infant Mental Health Mentor Level IV (Level IV), identifying the need for this service, utilizing at a minimum:

A. DC: 0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5);

**B. Crowell Procedure;**

**C. Working Model of the Child;**

**D. Adverse Childhood Experiences (ACE);**

And,

2. Once enrolled in PIP treatment services, the following also apply:

- Infants/young children who are enrolled before three (3) years old, remain eligible to receive services up to their fifth (5th) birthday, with an extension approved by the Infant/Early Childhood Mental Health (IECMH) Program Director;
- Services shall be provided regardless of Medicaid eligibility, and;
- Infants/young children who have previously been assessed with the DC: 0-3 R Axis II Parent-Infant Relationship Global Assessment Scale (PIR: GAS), should continue to be assessed with the PIR: GAS until discharged.

**Program Requirements:**

1. Before engaging in PIP treatment services, the infant/young child must receive:
  - A. A Diagnostic Evaluation that has resulted in a diagnosis, and;
  - B. An individualized Treatment Plan that includes PIP treatment as an intervention;
2. When possible, safe, and clinically appropriate 25% of PIP services should be provided in the home or other settings natural to the infant/young child and parent/caregiver;
3. PIP treatment services must be provided by a NMAIMH Level III or Level IV endorsed infant mental health specialist;
  - A. See **Minimum Staff Qualifications** for a detailed definition;
4. Service delivery is focused on infant/young child and parent/caregiver interactions and the relationship needs of the infant/young child – on the dyadic relationship between the infant/young child and the parent/caregiver. The initial assessment identifies recommendations for service strategies;
5. Each PIP provider must address, at minimum:
  - A. Increasing the parent's(s')/caregiver's (s)' ability to consistently and appropriately provide for the infant's/young child's basic emotional needs for comfort, stimulation, affection, and safety;
  - B. Increasing the infant's/young child's ability to initiate and respond to most social interactions in a developmentally appropriate way;
  - C. Increasing the infant's/young child's ability to socially discriminate and be selective in choice of attachment figures;
  - D. Providing the parent/caregiver and infant/young child interaction in order to encourage language and play, interpretation of an infant's/young child's behavior and reinforcement of a parent's/ caregiver's appropriate actions and interactions;
6. Progress towards treatment goals will be assessed quarterly from date of intake and documented, including evidence of developmental goals. Some possible developmental goals include:
  - A. For Infants/Young Children:
    - Level 1: Regulation and Shared Attention 0-3 months;
    - Level 2: Mutual Engagement 2-5 month;
    - Level 3: Intentional 2-Way Purposeful Communication 4-10 month;
    - Level 4: Complex Problem-Solving, Sense of Self 10-18 month;
    - Level 5: Symbolic Thinking/Language/Emotions 18-30 month;
    - Level 6: Building Bridges/Abstract Thinking 30-42 month;
    - Level 7: Multi-causal and Triangular thinking;
  - B. For Parents:
    - Level 8: Comparative and Gray Area Thinking;
    - Level 9: Reflective Thinking/Growing Sense of self/Stable Internal Standard;
 (See PIP Manual glossary for description of levels)
7. Provider must also provide crisis intervention services as appropriate. See - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: (DC: 0-5) for related therapeutic issues.

**Performance Outcomes:**

The following outcomes shall be measured before, during and after the provision of services, by using the following tools: the PIR: GAS for the infants/young children presently being served and the DC: 0-5 for infants/young children enrolling in treatment on or after July 1, 2017, the Crowell, the Working Model of the Child, Circle of Security, ACE, Progress in Treatment Assessment (P-PITA), and Child Parent Psychotherapy (CPP) clinical intervention to:

1. Increase parent's/caregiver's ability to consistently and appropriately provide for the infant's/

young child's safety, social and emotional needs, and developmental progress;

2. Increase parent's/caregiver's ability to meet basic emotional needs for comfort, stimulation, affection, and safety of the infant/young child;
3. Increase infant's/young child's ability to initiate and respond to most social interactions in a developmentally appropriate way, and;
4. Increase developmentally appropriate and sensitive parent/caregiver and infant/young child interaction in order to encourage language and play, interpretation of an infant's/young child's behavior and reinforcement of a parent's/caregiver's appropriate actions and interactions.

**Provider Requirements:**

Services must be provided by a provider organization or independent licensed practitioner, meeting standards established by the Children, Youth and Families Department. Providers must be a legally recognized entity in the United States or a Sovereign Tribal Nation, qualified to do business in New Mexico or in a Sovereign Tribal Nation located within the state boundaries of New Mexico.

**Staffing Requirements:**

Anyone providing this direct service must do so in accordance with applicable NM licensing board standards for their level and type of credentialing.

**Minimum Staff Qualifications:**

1. Independently Licensed Master's Level Clinician (LPCC, LMFT, LISW) or Licensed Clinical Psychologist, CNS or RN with a Master's or Certification in psychiatric nursing, or a Licensed or Board Eligible psychiatrist in good standing, and;
2. Endorsed as a Level III or a Level IV by the NMAIMH;
  - A. If not endorsed, obtain provisional endorsement waiver from IECMH Program Director and complete the full process to achieve Level III or Level IV endorsement within 29 months of receiving the provisional endorsement waiver.

**Minimum Staff Experience:**

Two (2) years supervised work experience providing relationship-based infant mental health services.

**Minimum Supervision Requirements:**

1. Provide clinical, administrative and reflective supervision;
2. Document monthly clinical individual and/or group supervision/consultation, and;
3. Document monthly client records reviewed for:
  - A. Clinical supervision;
  - B. Data entry completeness (Administrative Supervision), and;
  - C. Reflective supervision.

**Minimum Supervisor Qualifications:**

1. Independently Licensed Master's Level Clinician (LPCC, LMFT, LISW) or Licensed Clinical Psychologist, CNS or RN with a Master's or Certification in psychiatric nursing, or a Licensed or Board Eligible psychiatrist in good standing, and;
2. Endorsed as a Level III or a Level IV by NMAIMH;
  - A. If not endorsed, obtain provisional endorsement waiver from IECMH Program Director and complete the full process to achieve Level III or Level IV

endorsement within 29 months of receiving the provisional endorsement waiver.

**Service Exclusions:**

This service may not be billed in conjunction with:

1. Multi-systemic Therapy;
2. Accredited Residential Treatment;
3. Residential Treatment Services;
4. Group Home services;
5. Inpatient Hospitalization;
6. Partial Hospitalization;
7. Recreational outings;
8. Travel time, report writing;
9. T1027, and;
10. CYFD-004.

**Continuing Service Criteria:**

Treatment goals and objectives are being met but symptoms are still present and there is still progress to be made. Once enrolled, children remain eligible for PIP treatment services until their fifth (5<sup>th</sup>) birthday, with an approval from the IECMH Program Director. The request for continuing services shall be made four (4) months prior to the infant's third (3<sup>rd</sup>) birthday.

**Discharge Criteria:**

1. Parent(s)/caregiver(s) completes treatment plan;
2. Parent(s)/caregiver(s) ends services;
3. Parent(s)/caregiver(s) moves out of provider coverage area;
4. No progress is achieved, a referral is indicated for further assessment regarding treatment, and;
5. Service Authorization Period Expires.

**Benefit Limits:**

Exhaust when the infant/young child reaches three (3) years, or their fifth (5th) birthday with an approved extension from the IECMH Program Director.

1. See **Continuing Service Criteria** for additional information.

**Documentation Requirements for the IMH Database:**

The Infant Mental database is supported by:

The University of New Mexico  
Continuing Education  
Early Childhood Services Center

Providers shall ensure that all documentation requirements are met and entered into the IMH database on a timely basis for each client file. Some examples of documentation required to be entered into the database are:

1. Diagnostic Evaluation, including diagnosis;
2. Individualized Treatment Plan;
3. P-PITA;

4. Progress Notes (DAP) that reflect the evidence of the treatment progress, and;
5. Discharge or transition plan that documents the need for any continuation or support services.

**Parent Infant Psychotherapy Manual:**

More inclusive and extensive programmatic information is provided in the Parent Infant Psychotherapy Manual (Manual). The Manual will be revised and updated as needed.

[https://cyfd.org/docs/Children,\\_Youth\\_and\\_Families\\_Parent\\_Infant\\_Psychotherapy\\_Manual.pdf](https://cyfd.org/docs/Children,_Youth_and_Families_Parent_Infant_Psychotherapy_Manual.pdf)

**Rate:**

- CYFD-003- PIP Services for SED infants and young children, birth to three (3) years, with a possible service extension to their fifth (5th) birthday, the billable amount is:
  - A. For services provided but not paid, all or in part, by Medicaid, other state funding source, private insurance, or grant during the contract period at a rate of \$34.00 per 15-minute unit, inclusive of all collateral activities. When possible, safe and clinically appropriate 25% of services should be provided in the home or other settings natural to the infant/young child and parent/caregiver.

**Parent Infant Psychotherapy**  
**At Risk for a Severe Emotional Disturbance**  
**Birth to three (3) years old**  
**CYFD-004**

**Effective date:** July 1st, 2017

**Service Description:**

Parent Infant Psychotherapy (PIP) treatment services target the dyadic relationship between the infant/young child and the parent/caregiver. They are grounded in attachment theory and the science of brain development; they are relationship-based, developmentally appropriate, and trauma-informed. PIP treatment services are an array of therapeutic and developmental services designed to reduce both the acute and chronic behavioral, social and emotional disorders and disruptions in the relationship between an infant/young child and their parent/caregiver, as a result of toxic stress and major trauma.

**Source of Funding:**

CYFD

**Admission/Service Criteria:**

Infants and young children, and their parent/caregiver, who are:

- Birth to three (3) years;
- Determined to be at risk of a Severe Emotional Disturbance (SED), and;
- Experiencing disruptions in the relationship due to infant/young child and parent/caregiver vulnerabilities.

**Target Population:**

Infants and young children birth to three (3) years, who:

1. Have had a Comprehensive Assessment by an independently licensed clinician, who is endorsed by the New Mexico's Association for Infant Mental Health (NMAIMH) as an Infant Mental Health Specialist Level III (Level III) or an Infant Mental Health Mentor Level IV (Level IV), identifying the need for this service utilizing at a minimum:

A. DC: 0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5);

**B. Crowell Procedure;**

**C. Working Model of the Child;**

**D. Adverse Childhood Experiences (ACE);**

**And,**

2. Once enrolled in PIP treatment services, the following also apply:

- Infants/young children who are enrolled before three (3) years, remain eligible to receive services up to their fifth (5<sup>th</sup>) birthday, with an extension approved by the Infant/Early Childhood Mental Health (IECMH) Program Director.
- Services shall be provided regardless of Medicaid eligibility, and;
- Infants/young children who have previously been assessed with the DC: 0-3 R Axis II Parent-Infant Relationship Global Assessment Scale (PIR: GAS), should continue to be assessed with the PIR: GAS until discharged.

## Program Requirements:

1. Before engaging in a treatment services, the infant/young child must receive:
  - A. A Diagnostic Evaluation that has resulted in a diagnosis, and;
  - B. An individualized Treatment Plan that includes PIP treatment as an intervention;
2. When possible, safe, and clinically appropriate 25% of PIP services should be provided in the home or other settings natural to the infant/young child and parent/caregiver;
3. PIP treatment services must be provided by a NMAIMH Level III or Level IV endorsed infant mental health specialist;
  - A. See **Minimum Staff Qualifications** for a detailed definition;
4. Service delivery is focused on infant/young child and parent/caregiver interactions and the relationship needs of the infant/young child – on the dyadic relationship between the infant/young child and the parent/caregiver. The initial assessment identifies recommendations for service strategies;
5. Each PIP provider must address, at minimum:
  - A. Increasing the parent's(s)/caregiver's (s)' ability to consistently and appropriately provide for the infant's/young child's basic emotional needs for comfort, stimulation, affection, and safety;
  - B. Increasing the infant's/young child's ability to initiate and respond to most social interactions in a developmentally appropriate way;
  - C. Increasing the infant's/young child's ability to socially discriminate and be selective in choice of attachment figures;
  - D. Providing the parent/caregiver and infant/young child interaction in order to encourage language and play, interpretation of an infant's/young child's behavior and reinforcement of a parent's/ caregiver's appropriate actions and interactions;
6. Progress towards treatment goals will be assessed quarterly from date of intake and documented, including evidence of developmental goals. Some possible developmental goals include:
  - A. For Infants/Young Children:
    - Level 1: Regulation and Shared Attention 0-3 months;
    - Level 2: Mutual Engagement 2-5 month;
    - Level 3: Intentional 2-Way Purposeful Communication 4-10 month;
    - Level 4: Complex Problem–Solving, Sense of Self 10-18 month;
    - Level 5: Symbolic Thinking/Language/Emotions 18-30 month;
    - Level 6: Building Bridges/Abstract Thinking 30-42 month;
    - Level 7: Multi-causal and Triangular thinking;
  - B. For Parents:
    - Level 8: Comparative and Gray Area Thinking;
    - Level 9: Reflective Thinking/Growing Sense of self/Stable Internal Standard;(See PIP Manual glossary for description of levels)
7. Provider must also provide crisis intervention services as appropriate. See - Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: (DC: 0-5) for related therapeutic issues.

**Performance Outcomes:**

The following outcomes shall be measured before, during and after the provision of services, by using the following tools: the PIR: GAS for the infants/young children presently being served and the DC: 0-5 for infants/young children enrolling in treatment on or after July 1, 2017, the Crowell, the Working Model of the Child, Circle of Security, ACE, Progress in Treatment Assessment (P-PITA), and Child Parent Psychotherapy (CPP) clinical intervention to:

1. Increase parent’s/caregiver’s ability to consistently and appropriately provide for the infant’s/young child’s safety, social and emotional needs, and developmental progress;
2. Increase parent’s/caregiver’s ability to meet basic emotional needs for comfort, stimulation, affection, and safety of the infant/young child;
3. Increase infant’s/young child’s ability to initiate and respond to most social interactions in a developmentally appropriate way, and;
4. Increase developmentally appropriate and sensitive parent/caregiver and infant/young child interaction in order to encourage language and play, interpretation of an infant’s/young child’s behavior and reinforcement of a parent’s/caregiver’s appropriate actions and interactions.

**Provider Requirements:**

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3. Residential Treatment Services;
4. Group Home services;
5. Inpatient Hospitalization;
6. Partial Hospitalization;
7. Recreational outings;
8. Travel time, report writing;
9. T1027, and;
10. CYFD-003.

**Continuing Service Criteria:**

Treatment goals and objectives are being met but symptoms are still present and there is still progress to be made. Once enrolled, children remain eligible for PIP treatment services until their fifth (5<sup>th</sup>) birthday, with an approval from the IECMH Program Director. The request for continuing services shall be made four (4) months prior to the infant's third (3<sup>rd</sup>) birthday.

**Discharge Criteria:**

1. Parent(s)/caregiver(s) completes treatment plan;
2. Parent(s)/caregiver(s) ends services;
3. Parent(s)/caregiver(s) moves out of provider coverage area;
4. No progress is achieved, a referral is indicated for further assessment regarding treatment, and;
5. Service Authorization Period Expires.

**Benefit Limits:**

Exhaust when the infant/young child reaches three (3) years old, or their fifth (5<sup>th</sup>) birthday with an approved extension from the IECMH Program Director.

1. See **Continuing Service Criteria** for additional information.

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More inclusive and extensive programmatic information is provided in the Parent Infant Psychotherapy

Manual (Manual). The Manual will be revised and updated as needed.

[https://cyfd.org/docs/Children,\\_Youth\\_and\\_Families\\_Parent\\_Infant\\_Psychotherapy\\_Manual.pdf](https://cyfd.org/docs/Children,_Youth_and_Families_Parent_Infant_Psychotherapy_Manual.pdf)

**Rate:**

CYFD-004-PIP Services for At-Risk SED infants and young children, birth to three (3) years old, with a possible service extension to their fifth (5th) birthday, the billable amount is:

- A. For services provided but not paid, all or in part, by Medicaid, other state funding source, private insurance or grant during the contract period at a rate of \$31.73 per 15-minute unit inclusive of all collateral activities. When possible, safe, and clinically appropriate 25% of services should be provided in the home or other settings natural to the infant/young child and parent/caregiver.

## FORMS, ASSESSMENT TOOLS AND INSTRUMENTS

### 1. INTAKE

- Psychosocial Intake Assessment
- Adverse Childhood Experiences Scoring (ACES) – for caregiver(s) and child.

#### For Child-Parent Psychotherapy Trained PIP Clinicians

- Life Stressor Checklist –Revised
- Traumatic Events Screening Inventory – Parent Report Revised (TESI)

### 2. INFANT MENTAL HEALTH ASSESSMENT

- Working Model of the Child Interview (WMCI) - full or modified versions
- Caregiver-Child Structured Interaction Procedure (Crowell) – full, modified or baby versions. \* At the end of Crowell administration, three questions from the Circle of Security Interview (COSI) are asked of parent/ caregiver.

### 3. DEVELOPMENTAL INFORMATION

- **DC:0-5:** Developmental Milestones and Competency Ratings (Axis V) - not required.
- **DC:0-5:** Infant's/Child's Contributions to the Relationship (Axis II) – not required.
- Developmentally Informed Assessment Per Each Relationship (DIAPER) – administered quarterly.

### 4. TRACKING TREATMENT PROGRESS AND PROGRAM EVALUATION

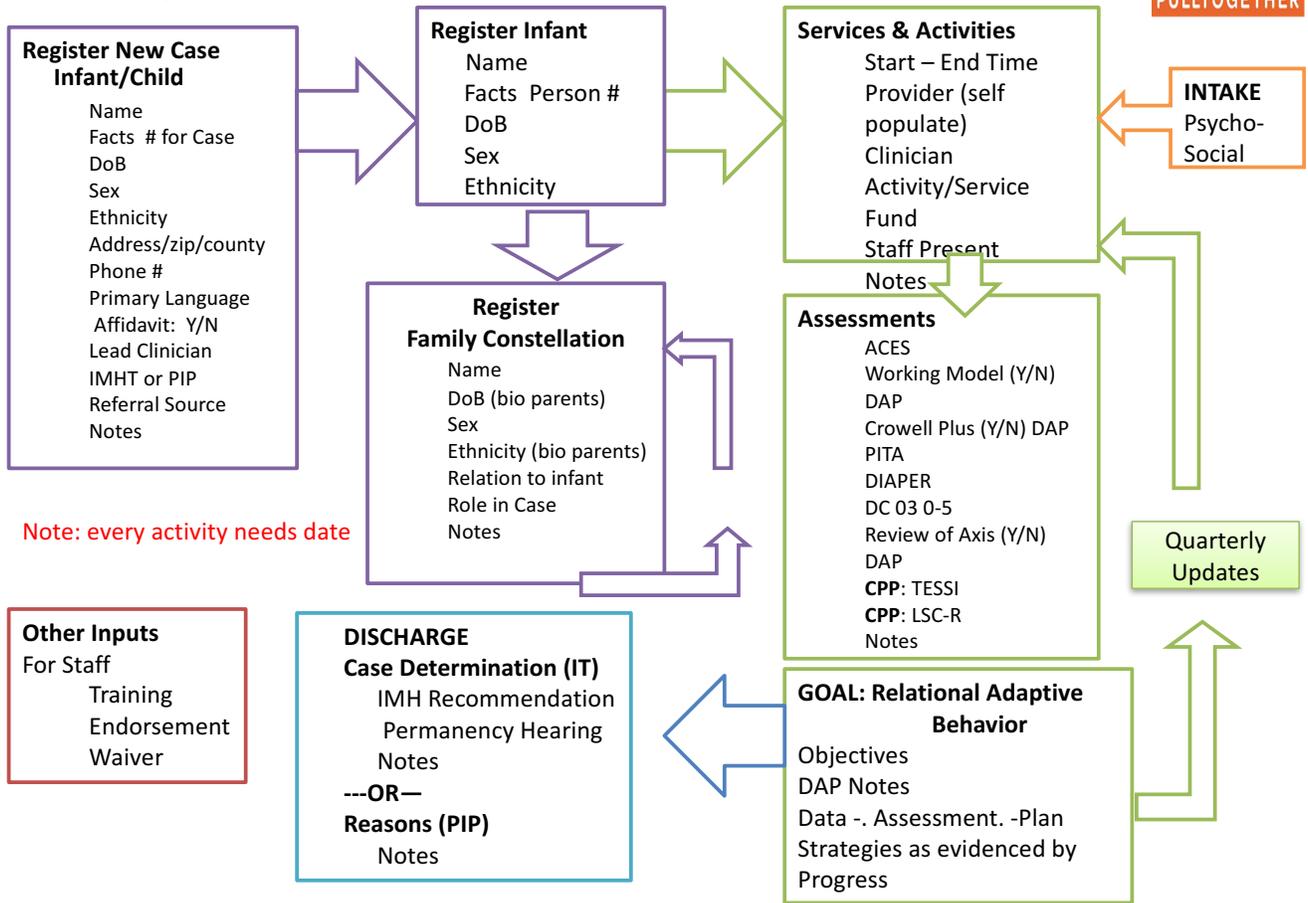
- Progress in Treatment Assessment (PITA) – administered quarterly
- **DC:0-5:** Dimensions of Caregiving and Relational Range of Functioning – Axis II Relational Context) – administered quarterly
- Developmentally Informed Assessment Per Each Relationship (DIAPER) – administered quarterly
- D.A.P. (Data, Assessment and Plan) Progress Note

### 6. QUARTERLY REPORTS

- PIP Quarterly Report Form

\* All forms, assessment tools and instruments are available in a Stand Alone file for PIP providers.

### Data Input Flow Chart



## Assessments

CYFD Required	Periodicity	Subjects++	TYPE OF INPUT
ACES	Once	Bio parents & infants	Data
Working Model *	Once	Bio parents	Yes/No
Crowell ** Plus	Once	Bio parents	Yes/No
DIAPER	Quarterly	Dyads with bio parents	Data
PITA	Quarterly	Dyads with bio parents	Data
DC 03 [0-5] ***	Quarterly	Dyads with bio parents	Data
Review of Axes 1, 2, 3	As Clinically Appropriate	Bio Parents	Yes/No

\*\* CROWELL. DAP summary notes

\*\*\* DC03 will be replaced and overlap with DC 0-5 (Axis II)

++ If >1 child, on each relationship

CPP Required	Periodicity	Subjects	Data Input
TESSI	Once	On bio parents	Yes/No
LSC-R	Once	On bio parents	Yes/No

## APPENDIX B

# Supporting Articles

### **PARENT INFANT PSYCHOTHERAPY SUPPORTING ARTICLES**

The following articles and documents support Parent-Infant Psychotherapy services.

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## DEFINING RELATIONAL PATHOLOGY IN EARLY CHILDHOOD: THE *DIAGNOSTIC CLASSIFICATION OF MENTAL HEALTH AND DEVELOPMENTAL DISORDERS OF INFANCY AND EARLY CHILDHOOD DC:0-5* APPROACH

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**ABSTRACT:** Infant mental health is explicitly relational in its focus, and therefore a diagnostic classification system for early childhood disorders should include attention not only to within-the-child psychopathology but also between child and caregiver psychopathology. In this article, we begin by providing a review of previous efforts to introduce this approach that date back more than 30 years. Next, we introduce changes proposed in the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood DC:0-5* (ZERO TO THREE, in press). In a major change from previous attempts, the *DC:0-5* includes an Axis I “Relationship Specific Disorder of Early Childhood.” This disorder intends to capture disordered behavior that is limited to one caregiver relationship rather than cross contextually. An axial characterization is continued from the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood DC:0-3R* (ZERO TO THREE, 2005), but two major changes are introduced. First, the *DC:0-5* proposes to simplify ratings of relationship adaptation/maladaptation, and to expand what is rated so that in addition to characterizing the child’s relationship with his or her primary caregiver, there also is a characterization of the network of family relationships in which the child develops. This includes coparenting relationships and the entire network of close relationships that impinge on the young child’s development and adaptation.

**Keywords:** parent–child relationship, relationship disorders, relationship psychopathology, infant mental health

**RESUMEN:** La salud mental infantil posee un ámbito relacional en cuanto a su enfoque y, por tanto, cualquier sistema de clasificación de diagnóstico de trastornos en la temprana niñez debe incluir no sólo la psicopatología interna del niño, sino también la psicopatología entre el niño y quien le cuida. En este ensayo, comenzamos revisando los esfuerzos previos para introducir este acercamiento que data de más de 30 años. Seguidamente introducimos los cambios propuestos en *DC:0-5*. En un significativo cambio con respecto a intentos previos, *DC:0-5* incluye un Eje I “Trastorno Específico de la Relación en la Temprana Niñez.” Este trastorno intenta captar la desordenada conducta que se limita a la relación con un cuidador en vez de la relación inter-contextualmente. Una caracterización axial continúa a partir de *DC:0-3R*, pero dos cambios significativos se introducen. Primero, *DC:0-5* propone simplificar los puntajes de adaptación y mal-adaptación en la relación, y expandir lo que se evalúa de manera que además de caracterizar la relación del niño con quien primariamente le cuida, se da también la caracterización del contorno de relaciones familiares dentro del que el niño se desarrolla. Esto incluye las relaciones de crianza compartida y el grupo entero de relaciones cercanas que tienen un efecto en el desarrollo y adaptación del pequeño niño.

**Palabras claves:** relación progenitor niño, trastornos en la relación, psicopatología de la relación, salud mental infantil

**RÉSUMÉ:** La santé mentale du nourrisson est explicitement relationnelle dans son orientation, et par conséquent un système de classification diagnostique pour les troubles de la petite enfance devrait prêter attention non seulement à la psychopathologie au-sein-de-l’enfant mais aussi à la psychopathologie entre l’enfant et la personne en prenant soin. Dans cet article nous commençons par passer en revue les efforts qui ont été déployés afin d’introduire cette approche qui date d’il y a plus de 30 ans. Ensuite, nous présentons les changements proposés dans le *DC:0-5*. Dans ce qui constitue l’un des

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grands changements par rapports aux versions précédentes, le DC:0-5 incorpore un Axe I "Trouble de la Petite Enfance Spécifique à une Relation". Ce trouble se donne pour but de capturer les comportements désordonnés qui sont limités à la relation avec une personne prenant soin de l'enfant, plutôt que trans-contextuel. Une caractérisation axiale s'inscrit dans la lignée du DC:0-3R, mais deux changements importants sont présentés. Tout d'abord, le DC:0-5 propose de simplifier les évaluations de l'adaptation/la maladaptation de la relation, et d'étendre ce qui y est évalué de telle façon qu'en plus de caractériser la relation de enfant avec la personne qui s'en occupe il existe aussi une caractérisation du réseau de relations familiales au sein desquelles l'enfant se développe. Ceci comprend les relations de co-parentage et le réseau entier de relations proches qui empiètent sur le développement et l'adaptation du jeune enfant.

**Mots clés:** relation parent enfant, trouble de la relation, psychopathologie de la relation, santé mentale du nourrisson

**ZUSAMMENFASSUNG:** Die psychische Gesundheit von Säuglingen hat einen deutlichen Beziehungsfokus und daher sollte ein diagnostisches Klassifikationssystem für Störungen der frühen Kindheit nicht nur die Psychopathologie des Kindes selbst, sondern auch die Psychopathologie zwischen Kind und Bezugsperson umfassen. Der Artikel beginnt mit einem Review der bisherigen Bemühungen, diesen bereits mehr als 30 Jahre alten Ansatz einzuführen. Nachfolgend stellen wir die in der DC: 0-5 vorgeschlagenen Änderungen vor. Eine wichtige Änderung früherer Versuche umfasst die Aufnahme der Achse I "Beziehungsspezifische Störungen der frühen Kindheit" in die DC:0-5. Diese Störung beabsichtigt gestörtes Verhalten zu erfassen, das sich auf die Beziehung zu einer Bezugsperson beschränkt und eher nicht kontextübergreifend ist. Eine axiale Charakterisierung wie bei der DC: 0-3R wird fortgesetzt, allerdings werden zwei wesentliche Änderungen eingeführt. Erstens, die DC:0-5 schlägt vor, Ratings der Beziehungsanpassung /-fehlanspassung zu vereinfachen und die Bewertung zu erweitern, sodass es zusätzlich zu einer Charakterisierung der Beziehung des Kindes zu seiner/ihrer Hauptbezugsperson auch eine Charakterisierung des familiären Beziehungsnetzwerks, in dem sich das Kind entwickelt, geben soll. Dazu gehört die Beziehung zwischen den Eltern und das gesamte Netzwerk enger Beziehungen, die auf die Entwicklung und Anpassung des Kleinkinds Einfluss nehmen.

**Stichwörter:** Eltern-Kind-Beziehung, Beziehungsstörungen, Beziehungspsychopathologie, psychische Gesundheit von Säuglingen

抄録: 乳幼児精神保健の焦点は、明白に関係的であり、そのために早期児童期の障害のための診断分類システムには、子ども自身の中within-the-childの精神病理ばかりでなく、子どもと養育者の間の精神病理も含まれるべきである。この論文では、私たちは、30年以上前にさかのぼるこのアプローチを導入するための努力のレビューを提供することから始める。次に、私たちはDC:0-5に提案した変更を紹介する。以前の試みからの主要な変更として、DC:0-5には第1軸「早期児童期の関係性に特異的な障害」が含まれる。この障害は、さまざまなコンテクストにまたがるのではなく、一人の養育者との関係性に限定されている障害のある行動を捉えることを目的とする。軸による特徴付けはDC:0-3から継続しているが、二つの主要な変更が導入されている。第一に、DC:0-5は関係性の適応/不適応という単純化した評価を提案しており、加えて子どもの主要な養育者との関係性を特徴付けられるように、評価した物を拡張することも提案している。また、その中で子どもが育つ家族の関係性のネットワークの特徴付けもある。これには、共同養育の関係性と、幼い子どもの発達と適応に影響を与える近い関係性のネットワーク全体が含まれる。

**キーワード:** 親子関係性, 関係性障害, 関係性精神病理, 乳幼児精神保健

摘要: 關係明確是幼兒心理健康的重點, 因此診斷幼兒疾病分類系統, 不僅應包括孩子精神病理學, 也須重視孩子和照顧者之間的精神病理學。在本文中, 我們首先審查以往的研究, 引進這種做法可以追溯到30年以上。接下來, 我們介紹DC:0-5的修改建議。DC:0-5包括“幼兒期的具體關係障礙”, 與以往建議相比, 有重要的改變。這種分類旨在捕捉僅限於一名護理人員關係的異常行為, 而非泛情境關係障礙。從DC:0-3R繼續一個軸向特徵, 但引入了兩個重大變化。首先, DC:0-5建議簡化關係適應/適應不良的評分, 並擴展評分的範圍, 除了描述孩子與他/她的主要照顧者的關係, 也描述在家庭網絡關係中孩子的發展。這包括共同撫養關係和衝擊幼兒發展和適應的密切關係網絡。

**關鍵詞:** 親子關係, 關係障礙, 關係病理學, 幼兒心理健康

**الهدف:** الصحة النفسية للرضيع علائقية بشكل جوهري ولذلك فإن أي نظام تصنيف تشخيصي لاضطرابات الطفولة المبكرة يجب أن يشمل الانتباه ليس فقط للتشخيص النفسي للطفل ولكن في ضوء العلاقة بين الطفل ومقدم الرعاية. في هذا البحث نبدأ بتقديم مراجعة للمجهودات السابقة التي أبرزت هذا الاتجاه الذي يعود لأكثر من 30 سنة مضت. ثم بعد ذلك نعرض للتغييرات المقترحة في تصنيف DC: 0-5. من التغييرات الأساسية عن الإصدارات السابقة يحتوي DC:0-5 على اضطراب في الطفولة المبكرة من نمط AXIS I ويختص بعلاقة معينة ويهدف تضمين هذا الاضطراب إلى وصف السلوك المرتبط بعلاقة معينة للطفل مع أحد مقدمي الرعاية وليس بوجه عام. ويستمر التوصيف المحوري من إصدار DC:0-3R ولكن مع تغييرين أساسيين. أولاً يقترح DC-05 تعديل تقييمات تكيف وعدم تكيف العلاقة وتوسيع ما يتم تقييمه بحيث يتم توصيف علاقة الطفل مع مقدم الرعاية وكذلك توصيف شبكة علاقات العائلة التي ينمو فيها الطفل. هذا يشمل علاقات الأبوّة المشتركة وكل شبكة العلاقات القريبة التي تطبع أثرها على نمو الطفل وتكيفه.

**كلمات مفتاحية:** علاقة الطفل والأب - اضطرابات العلاقة - الأمراض النفسية للعلاقة - الصحة النفسية للرضيع

\* \* \*

For many years, psychopathology in infancy and early childhood has been a controversial topic focused on the meaning of atypical infant behaviors, either as indicators of risk for subsequent psychopathology or as symptoms of present psychiatric disorders. Increasingly, however, manifestations of psychopathology in very young children are believed to reflect deviant developmental trajectories associated with significant distress and impaired functioning. Some surprising similarities between psychopathological conditions in younger and older children have been noted (Egger & Angold, 2006), but important differences also have been described (Sameroff & Emde, 1989).

Although few would dispute that relational processes are integrally involved with the mental health of individuals, and especially children, a thornier question is whether there are instances in which the relational processes rather than the individual may be “disordered.” Traditionally, psychopathology has been understood to exist *within* individuals rather than *between* individuals. A paradigm shift in clinical psychology and psychiatry was introduced by the conceptualization of family systems and family therapy approaches that evolved from this conceptualization (Keeney, 1982), but these approaches have remained peripheral to the dominant definitions of individual psychopathology.

The roots of the field of infant mental health are explicitly relational; that is, they are focused on understanding young children’s development and their manifestations of psychopathology within the context of their relationships with caregivers. Many major figures in our field have staked out explicitly relational frameworks. Winnicott’s (1960) oft-quoted declaration, “There is no such thing as an infant, meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant” (p. 585), was one of the first. Bowlby (1953) similarly asserted that “. . . essential for mental health is that an infant and young child should experience a warm, intimate and continuous relationship with his mother (or mother substitute . . .) in which both find satisfaction and enjoyment” (p. 13). More specifically, a clinical perspective on relational pathology was presented in Fraiberg and colleagues’s (1975) case studies of infant maladaptive behaviors associated with disturbances in the mother–infant relationship, which originated in turn in the mother’s conflicted relationships during childhood, or “ghosts in the nursery.” Each of these pioneers believed that a relational focus was necessary for understanding young children’s development and provided a path for ameliorating their pain.

In this article, we present a new conceptualization of disordered child–parent relationship disorders and a relational context for understanding psychiatric disorders in young children. The approach we outline has evolved from many discussions and reviews of the literature conducted by the ZERO TO THREE Task Force charged with revising the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood DC:0–3R* (ZERO TO THREE, 2005). We provide a review of previous efforts in this area and the rationale for our proposal, which includes a revised relational axis and a newly described “Relationship Specific Disorder of Early Childhood.”

## EMPIRICAL BACKGROUND

Infant mental health clinicians have consistently advocated for understanding young children’s emotional functioning in the context of their primary relationships. The most systematic research on parent–child relationships has come from the study of young children’s quality of attachment to their caregivers. This research has provided very strong empirical support for specificity in the emotional quality of relationships that infants establish with different caregivers. In this section, we highlight research underpinning this evidence.

The Strange Situation Procedure (SSP; Ainsworth, Blehar, Waters, & Wall, 1978) has long been considered the “gold standard” for assessing infant quality of attachment because the child’s behavior during reunion with the caregiver after a brief separation has been shown to predict concurrent and later behavioral patterns associated with adaptive or maladaptive socioemotional functioning. A major strength of the SSP is that the findings are firmly anchored in extensive home observations conducted over several hours twice a month and then analyzed in relation to the infant’s behavior in the laboratory (Ainsworth et al., 1978). Some studies have examined attachment to two different caregivers (e.g., mothers and fathers) and have found that the same child may have different patterns of attachment quality with different caregivers (Green & Goldwyn, 2002; van IJzendoorn & Wolff, 1997). This suggests that the dimension of security versus insecurity of attachment is not a child trait but rather a manifestation of how the child experiences each parent’s emotional availability and behavior.

Main, Kaplan, and Cassidy (1985) introduced the *Adult Attachment Interview* (AAI) as a measure of attachment quality in adults analogous to the SSP patterns of attachment in infants, providing a way to assess concordance/discordance in the patterns of attachment of the parent and the child. Adult attachment patterns are derived from individual differences in narrative discourse that are revealed in responses to systematic probes about adults’ recalled experiences with their own parents. Infant attachment patterns in the SSP, on the other hand, are derived from behavioral differences demonstrated by the young child toward the attachment figure, as compared to a stranger in response to separation distress. What links these two assessments, beyond a focus on attachment, is that each of them reveals the adult’s or child’s attempts to regulate negative emotions during a mild to moderate attachment salient stressor, including the flexibility/inflexibility of attention strategies associated with that emotion regulation.

For example, *securely attached* infants typically demonstrate distress during separation directly to their caregivers and use the attachment figure, but not the stranger, for comfort and resolution of their distress. Once reassured by contact with the caregiver, they generally resume exploration of the environment. Similarly, adults classified as *autonomous* (i.e., secure) report positive and negative experiences with their parents in a balanced way, neither avoiding nor overfocusing on challenging experiences with their parents. Infants with *avoidant* attachments, on the other hand, turn their attention away from their own internal distress and

focus externally on toys or the surrounding environment, much as adults classified as *dismissing* use their attention to avoid focusing on painful memories or insisting that they had no effect. Infants who are classified as *resistant* with their caregivers overfocus on caregivers at the expense of the surroundings, but they are unable to settle once distressed despite attempts by the caregiver to comfort them. Caregivers classified as *preoccupied* similarly describe relationship dissatisfaction with their parents, but seem so caught up by adverse experiences that they cannot seem to integrate their emotions and experiences. Thus, avoidant/dismissing, resistant/preoccupied, and secure/autonomous relationships involve reduced, exaggerated, and balanced activation of attachment needs and behaviors, respectively. Similarly, *disorganized* patterns of attachment in infants and *unresolved* in adults both involve lapses in strategies for obtaining closeness and comfort.

Based on attachment theory, we would predict that we could demonstrate a concordance between a parent's and a young child's patterns of attachment. In fact, several meta-analyses of studies of the AAI have confirmed the hypothesized substantial concordance between parents' attachment patterns in the AAI and their infants' attachment patterns in the SSP (van IJzendoorn, 1995; van IJzendoorn & Bakermans-Kranenberg, 1996, 2008).

Importantly, AAI patterns in parents can be used to predict their infants' attachments to them. For example, in a study of 100 first-time-pregnant couples, the AAI was administered prenatally to mothers and fathers, and SSPs were administered at 12 or 18 months (Steele, Steele, & Fonagy, 1996). Mothers' prenatal patterns, derived from narrative characteristics of their descriptions of the relationships with their own parents, predicted their infants' attachment patterns to them more than 1 year later. Fathers' attachment patterns, measured prenatally, predicted their infants' attachments to them more than 1 year later. Mothers' attachment patterns also showed a modest prediction of infants' attachment to that of their fathers more than 1 year later, but fathers' attachment patterns did not predict infants' attachments to their mothers. These findings provide support for relationship specificity. A meta-analysis of 14 studies comparing attachment of infants to mothers and to fathers found a significant, but modest, concordance and concluded that these relationships, as illustrated in the Steele et al. (1996) study, were largely independent (van IJzendoorn & Wolff, 1997).

Another line of research concerns parents' representations of their own infants. Using the *Working Model of the Child Interview* (WMCI; Zeanah, Benoit, Hirshberg, Barton, & Regan, 1994), investigators demonstrated concordance between parents' representations of their infants and infants' patterns of attachment in the SSP. The predicted patterns of concordance were that parents with *balanced* representations would have infants with secure attachments to them, parents with *disengaged* representations would have infants with avoidant attachments, and parents with *distorted* representations would have resistant classifications. Research has shown strong links between balanced/secure and disengaged/avoidant, with less consistent relations between distorted/resistant (Vreeswijk, Maas, & Van Bakel, 2012). Furthermore, in a recent

study, mothers' WMCI classifications fully mediated the relation between mothers' prenatal AAIs and infant SSPs at 12 months (Madigan, Hawkins, Plamondon, Moran, & Benoit, 2015).

These results speak to specificity in mother–infant relationships, especially because mothers' prenatal representations assessed with the WMCI predicted infant quality of attachment to mothers at infant age 12 months (Benoit, Parker, & Zeanah, 1997). Further, Crawford and Benoit (2009) showed that a disrupted scale applied to prenatal WMCI interviews predicted infant disorganized attachment at 12 months of age. In other words, these two studies have indicated that mothers who were interviewed about their child's personality and their relationship with their child before they had even met the child revealed narrative characteristics that were predictively related to the patterned organization of the child's attachment behaviors with them in the SSP more than 1 year later.

Note that the literature on early attachment has focused on individual differences in patterns of attachment, but has made no claim about these differences indicating disordered behavior. On average, approximately 40 to 45% of infants in low-risk samples are classified as being insecurely attached. Although insecure attachment is associated with higher likelihood of later psychopathology, the association is not strong enough to warrant the conclusion that insecure attachment is itself a form of relational psychopathology (Sroufe, 1997). Even disorganized attachment, which has the strongest concurrent and predictive relation to psychopathology—at least regarding externalizing and dissociative psychopathology (Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010; Groh, Roisman, van IJzendoorn, Bakermans-Kranenburg, & Fearon, 2012; van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999)—is not in and of itself evidence of a disorder. This is because, in part, disorganized attachment is tied to behavior in the SSP, and may be designated based on subtle behaviors during reunion, such as approaching a caregiver with closed eyes or interrupting an approach and stopping. To be a disorder, we expect to see a pattern of symptomatic behavior that is evident in naturalistic settings and associated with significant child distress and/or impaired functioning. By this standard, the single observation provided by an SSP would not by itself reflect a clinical disorder. On the other hand, many children whose classification with their caregivers is disorganized will have clinical disorders, but identifying those disorders will require more than observations from one standardized laboratory paradigm.

Thus, the literature on attachment patterns between young children and their caregivers has provided a template to identify relationship patterns that warrant clinical attention as well as clear evidence for the early specificity of the relationships that infants and young children establish with their different primary caregivers.

#### RELATIONSHIP DISTURBANCES: AN INITIAL TAXONOMY

A major impetus for considering parent–child relationship disorders was the publication of *Relationship Disturbances in Early Childhood* (Sameroff & Emde, 1989). This work derived from a



From Stern Bruschweiler and Stern (1989)

FIGURE 1. Model for conceptualizing components of the caregiver–child relationship. From “A Model for Conceptualizing the Role of the Mother’s Representational World in Various Mother-Infant Therapies,” by N. Stern-Bruschweiler and D.N. Stern 1989, *Infant Mental Health Journal*, 10, p. 142. Copyright 1989 by Michigan Association for Infant Mental Health.

year of collaboration at the Center for Advanced Studies in the Behavioral Sciences at Stanford University among a group of distinguished early childhood investigators. They developed a then-novel hypothesis, articulated by Sroufe (1989), that most psychiatric problems in children less than 3 years old, though poignantly expressed in child behavior, are best conceptualized as relational. Drawing upon several decades of developmental research, they argued that “If the individual is not a suitable level of analysis for infant development, neither is the individual a suitable level of analysis for understanding infant behavioral disorders” (Sameroff & Emde, 1989, p. 222).

The investigators then proposed a continuum of relationship disturbances organized around the regulatory function that caregivers serve for young children. They argued that the mutual regulation of parent–child relationships was necessary for healthy infant development and well-being and that regulatory disturbances would reflect disturbances in the relationship (Anders, 1989). They proposed five patterns of disturbances that could disrupt the parent–child relationships: overregulated, underregulated, inappropriately regulated, irregularly regulated, and chaotically regulated (Anders, 1989).

Finally, they also proposed a continuum of parent–child relationship disturbances. First, they described *relationship perturbations* that were transient disruptions caused by stressors, but which were time-limited because of the adequacy of supports or the mildness of the stressor. Next, they defined *relationship disturbances* that involved inappropriate or insensitive regulation in interactions leading to intermediate duration problems generally limited to one domain of interaction. At the most severe level, they defined *relationship disorders* as rigidly entrenched, of longer term duration, and associated with maladaptive interactions across several domains (Anders, 1989). Further, they declared that relationship disorders meant that the individual was symptomatic because of a relationship experience, that recurrent patterns of interactions of the partners were inflexible/insensitive, and that symptoms were impairing in daily life and inhibiting the expected developmental progress of both partners (Sameroff & Emde, 1989).

This groundbreaking work made explicit what had been implicit in the clinical work that had preceded it—that the parent–child relationship could be and should be the unit of focus in interventions for young children and their caregivers. But, if so, what about assessment? Here, they asserted that assessment of the relationship should include its regulatory pattern, affective tone, and developmental phase (Anders, 1989). They also emphasized the various contexts in which relationships are embedded: historical, social, and cultural.

This was the most systematic and well-articulated effort to integrate observations from infant developmental research into clinical work with young children and families that had ever been proposed. Their classification not only provided a means of focusing clinical efforts on the dyad rather than the young child alone but also attempted to do so in a way that would allow for systematic characterizations of relational problems.

Despite its considerable importance in advancing the field, the approach articulated by this group had two major interrelated problems. First, despite the compelling case they made for regulation as a core feature of the relationship, translating it into clinical practice proved daunting. Consider the following clinical scenario: An intrusive caregiver repeatedly overstimulates her infant. The caregiver appears to be overregulating, but the infant is actually underregulated. Assuming that this pattern reflects a consistent characteristic of the relationship, how should it be classified? It is overregulated from the perspective of caregiver behavior, but underregulated from the standpoint of infant adaptation. This relates to the second problem of the approach, which is that the descriptions of relationship problems were focused primarily on caregiver behavior. This adult focus has plagued most attempts to define relational disturbances. It seems that we lack the words to describe problems *between* rather than *within* individuals. Even the construct of relationship is unclear. Are we describing something in the mind of the parent, something in the mind of the young child, or something external to each of these? Most measures of interaction mostly focus on caregiver behavior or on infant behavior, and include scores for each. Interactive patterns of the dyad are less well-characterized, even though it is widely acknowledged that the behavior of each partner influences the other.

Another contribution of the Stanford group was to call attention to the importance of representations and behaviors in understanding relationships between young children and their caregivers. Inspired in part by this important distinction, Stern-Bruschweiler and Stern (1989) provided a model for conceptualizing parent–infant/child relationships (Figure 1). In their model, the observable components of the parent–child relationship, representing recurrent patterns of interaction over time, are in the center of the figure. Outside are the representations of parent and child, reflecting the subjective experiences and anticipations of each partner. They also emphasized that this model should be viewed as an open system, so that a change in one component would be expected to change other components. Although originally developed as a way of understanding the “ports of entry” or targets of various infant mental health interventions, the model also is useful for determining components of assessment of parent–child relationships. This

**TABLE 1.** Parent–Infant Relationship Global Assessment Scale

<i>DC:0–3</i> (1994)	<i>DC:0–3R</i> (2005)
90 Well Adapted	91–100 Well Adapted
80 Adapted	81–90 Adapted
70 Perturbed	71–80 Perturbed
60 Significantly Perturbed	61–70 Significantly Perturbed
50 Distressed	51–60 Distressed
40 Disturbed	41–50 Disturbed
30 Disordered	31–40 Disordered
20 Severely Disordered	21–30 Severely Disordered
10 Grossly Impaired	11–20 Grossly Impaired
	1–10 Documented Maltreatment

was another major breakthrough in providing a clinically useful frame of reference for infant mental health clinicians attempting to think relationally. Having a means of assessing relationships led to more intentional considerations of how to characterize and define relationship disorders between young children and their primary caregivers.

#### THE *DC:0–3*, AN INITIAL EFFORT AT RELATIONSHIP DIAGNOSIS

In 1994, a ZERO TO THREE task force, chaired by Stanley Greenspan and Serena Wieder, published a nosology of early childhood disorders, known as the *DC:0–3*. In this volume, a multiaxial system was introduced, with Axis II devoted to parent–child relationship disorders. Noting the importance of the parent–child relationship for young children’s development, and recognizing the potential for relationship-specific disturbances, *DC:0–3* was the first nosology that clearly articulated relationship disorders between parents and young children. Although the entire manual was an effort to create meaningful diagnostic categories for young children that were not available in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*; American Psychiatric Association, 1994) or International Classification of Diseases, 10th Revision (World Health Organization, 1992), the inclusion of relationship disorders was perhaps its most distinctive contribution.

In the *DC:0–3*, both a continuous and a categorical approach were used for relationship disturbances. The Parent–Infant Relationship Global Assessment Scale (PIRGAS; ) comprised a rating scale 10 (*grossly impaired*) to 90 (*well adapted*) of relationship adaptation (modeled after the Global Assessment Scale and the Child Global Assessment Scale that defined Axis V in the *DSM-IV*). This scale operationalized the continuum of parent–infant relationship disturbances originally described by Anders (1989). The anchored points on the scale, listed in Table 1, were to be used by clinicians at the completion of a clinical assessment to indicate the level of a dyad’s relationship adaptation. The idea was that a child’s relationship problems might co-occur with symptomatic behaviors, but that they could be distinct. The approach asserted

that “serious symptoms may be apparent in an infant without relationship pathology and relationships may be pathological without overt symptoms in the infant” (*DC:0–3*; ZERO TO THREE, p. 67).

The PIRGAS could be used to identify strengths as well as concerns, but for ratings of 40 and below (*disturbed* to *grossly impaired*), a classification of the type of relationship disorder was to be specified on Axis II. Ratings in this range designated severe and pervasive problems in the parent–child relationship that warranted a diagnosis.

To determine whether a relationship was disordered, clinicians were instructed to assess the behavioral quality of the interaction, the affective tone of the relationship, and the psychological involvement or the meaning of the child to the parent. The disordered relationship types defined in the *DC:0–3* included over-involved, underinvolved, anxious/tense, angry/hostile, mixed, and abusive (including verbally physically and/or sexually abusive). For each, a description of behavioral quality of the interaction, affective tone, and psychological involvement were provided.

The strengths of the *DC:0–3*’s approach were notable. First, there was an explicit acknowledgment that relationship disorders were specific to a relationship. This was the radical departure from traditional nosologies that had been advocated by Sameroff and Emde’s (1989) group. Different types of relationship disorders were not only specified in considerable detail but there also was an explicit recognition that relationship disturbances were arrayed along a continuum. PIRGAS ratings anticipated contemporary efforts in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*; American Psychiatric Association, 2013) and in the National Institute of Mental Health’s *Research Domain Criteria* (Insel et al., 2010) to move beyond a categorical taxonomy. There also was comprehensive attention to many aspects of relationships—including perceptions, emotions, and behaviors and their organization and integration by both partners—that are central to clinical formulations and interventions.

On the other hand, there also were significant weaknesses in the *DC:0–3* approach. Despite efforts to be balanced, there was an overemphasis throughout the classifications on parent behaviors, with descriptions of infant behaviors often framed as reactions to parent behaviors. Furthermore, the relationship classifications were simultaneously overly inclusive and underdetailed because they listed numbers of criteria for each type, without specifying how many were necessary to make a diagnosis. The types that were specified retained the same problems as the classification proposed by Anders (1989) in that they focused more on caregiver behavior—or at best, caregiver behaviors and infant behaviors—rather than on dyadic properties. In addition, substantial work has documented that coparenting (McHale & Lindhal, 2011), which involves adults cooperating in the care of children, has important effects on their development. Focusing only on the primary caregiving relationship in the *DC:0–3R* left this important consideration unaddressed.

The PIRGAS also was problematic in that it contained an internal inconsistency in its metric. In what was intended to be a continuous scale of relationship adaptation, perturbations and

significant perturbations were included as transient reactions to stressors. Thus, there was no way to use this scale to designate milder, but persistent, relationship disturbances. Given that the PIRGAS involved a 9-point scale, the anchors for each level of adaptation also were limited.

Most concerning about the entire Axis II of the *DC:0-3*, given its novelty and seeming centrality to the field of infant mental health, is how little research it inspired. A smattering of studies have examined reliability and validity of the PIRGAS as a scale (Aoki, Zeanah, Heller, & Bakshi, 2002; Muller et al., 2013; Salomonsson & Sandell, 2011a, 2011b), but there have been almost no attempts to assess the value of the typology of relationship disorders nor whether, for example, a rating of 40 on the PIRGAS is appropriate as a cutpoint for specifying relationship disorders.

For all of these problems, the introduction of the relationship as a central clinical focus in the *DC:0-3* was a vital contribution to the clinical enterprise of infant mental health.

### CONTRIBUTIONS OF THE REVISED *DC:0-3*

More than a decade after the original manual appeared, another ZERO TO THREE task force was charged with revising and updating the *DC:0-3*, and the result of their work culminated with the publication of the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R; ZERO TO THREE, 2005)*. This work maintained both the continuous ratings of parent-child relationship adaptation and the typology of relationship disorders that had been introduced by the *DC:0-3*.

There were only minor changes in Axis II in the *DC:0-3R*. First, the PIRGAS was expanded to a 10-point scale, by adding a “documented maltreatment” rating (see Table 1) to incorporate ratings that involved abuse or neglect. The anchors of the PIRGAS were expanded a bit as well. Second, a Relationship Problems Checklist was introduced. This provided a rating of 0 (*no evidence*), 1 (*some evidence*), or 2 (*substantial evidence*) for each type of relationship disorder classification.

The text also was updated, and clinicians were instructed to include five aspects of the “relationship dynamic” (p. 41) when conducting assessments. These included overall functioning of parent and child, level of distress in both partners, adaptive flexibility of parent and child, and level of conflict and resolution between parent and child. In addition, clinicians were to consider the effect of the quality of the relationship on the child’s developmental progress.

Thus, the revisions of Axis II in the *DC:0-3R* were helpful, but minor, and although some increased specification of details was provided, most of the same strengths and weaknesses evident in the *DC:0-3* were maintained.

### THE DIAGNOSTIC CLASSIFICATION OF MENTAL HEALTH AND DEVELOPMENTAL DISORDERS OF INFANCY AND EARLY CHILDHOOD *DC:0-5*, A PROPOSED REVISION

The ZERO TO THREE Diagnostic Classification Revision Task Force solicited feedback in a number of ways from clinicians about

**TABLE 2.** *Provisional Criteria Relationship-Specific Disorder of Early Childhood*

Diagnostic Algorithm: A-C criteria must be met.

A. The child exhibits a persistent emotional or behavioral disturbance in the context of one particular relationship with one primary caregiver but not with other caregivers. Examples include (but are not limited to) the following:

1. Oppositional behavior
2. Aggression
3. Fearfulness
4. Self-endangering behavior
5. Food refusal
6. Sleep refusal
7. Role-inappropriate behavior with caregiver (e.g., over-solicitous or controlling behavior)
8. Self-endangerment

B. The symptomatology in A is expressed exclusively in one caregiving relationship.

C. Symptoms of the disorder (or caregiver accommodations in response to the symptoms) impact significantly the child and/or family functioning in one or more of the following ways:

1. Cause distress to the child;
2. Cause distress to family;
3. Limit the child’s participation in developmentally-expected activities or routines;
4. Limit the family’s participation in everyday activities or routines;
5. Limit the child’s ability to learn and develop new skills, or interfere with developmental progress.

*Specify:* Caregiver(s) with whom symptomatology is manifest.

From *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-5)* by ZERO TO THREE (in press), Washington, DC. Copyright by ZERO TO THREE. Reprinted with permission of the author.

Axis II and the challenge of how best to characterize relational problems between young children and their parents. Criticisms of the *DC:0-3R* included those already noted as well as that the diagnostic labels were pejorative, that the PIRGAS was insufficiently operationalized and challenging to use, and that it included too many points and too few anchors to define them.

We recognized that the challenges of revising the approach of the *DC:0-3* and the *DC:0-3R* were considerable. In reflecting on these challenges, we concluded that there are two reasons why considering parent-child relationships and relationship disturbances are important. The first reason is that the primary caregiver/young child relationship is often the central focus of clinical assessment and intervention; thus, relationship-specific psychopathology ought to be captured. The second reason is that the network of family relationships in which the young child develops is of considerable importance to the child’s development and well-being. Based on these two principles, which we derived from clinical experience, research, and the work of many others reviewed herein, we have recommended modifying the *DC:0-3* and the *DC:0-3R* approach substantially in several major ways.

First, we introduced a major departure from previous approaches by defining an Axis I disorder of “Relationship-Specific Disorder of Early Childhood” (see Table 2). This is an explicit acknowledgment of the fact that clinical disturbances in young children’s behavior are often relationship-specific. Next, although

we maintained Axis II to characterize the caregiving context for the child, we introduced several changes in how that should be characterized. We did not retain the relationship disorder typology from previous editions; instead, we limited Axis II characterizations of the caregiving contexts to ratings on two continuous scales. The first is used to rate the parent–child relationship level of adaptation/maladaptation, and the second is used to rate the family–child relationship level of adaptation/maladaptation. We maintained the continuous rating method, but replaced the PIRGAS with a new scale.

### ***Relationship-Specific Disorder of Early Childhood***

Stern (2008) noted that although we acknowledge relational complexity in infant mental health, we do not always make sufficient use of our understanding in clinical endeavors. Given that so much clinical work in infant mental health concerns understanding relationship-specific symptomatology, and given the significant empirical base for relationship-specific behavior in young children that exists, we may ask why nosologies have not considered relationship disorders to be a primary and Axis I disorder?

One reason is that the challenge of defining a disorder between two individuals rather than within an individual has been daunting for the field. Nevertheless, we concluded that an Axis I Relationship-Specific Disorder of Early Childhood is warranted for the *DC:0–5*. Our approach to the dilemma of how to define such a disorder was guided by two decisions. First, we defined a relationship disorder as manifest in infant/young child symptoms, but symptoms that are apparent only in one relationship. Thus, the child who is oppositional with parents and siblings would not qualify for a relationship disorder because the symptoms occur in multiple relationships. Of course, this same child might qualify for another Axis I disorder. Nevertheless, the relationship disorder must manifest in infant/young child symptoms that are impairing to the child and/or the family's functioning. Second, we did not specify the nature of child symptoms required for relationship. That is, any significant symptoms that impair the child's adaptation and are specific to a relationship with a caregiver will qualify as a relationship disorder. The child might have food refusal, aggressive behavior, fearfulness, role-inappropriate caregiving behavior, or any other symptom picture as long as it is limited to one caregiving relationship. This is in obvious contrast with the *DC:0–3* and the *DC:0–3R* approaches that specify the nature of symptoms required by both caregiver and child and limit the relationship disturbances to one of a small number of types.

What this disorder will not capture is presymptomatic young children who are experiencing disturbed relationships with their caregivers. That is, if the infant/young child is experiencing a relationship disturbance without overt symptomatology (i.e., is at risk for rather than already manifesting psychopathology), then this disorder is not applicable. Nevertheless, relational disturbances that place the infant/young child at risk can be captured by Axis II in the *DC:0–5*.

### ***Axis II: Relational Context***

Axis II is based on the premise that young children usually establish emotionally salient relationships with a small number of primary caregivers that they identify as their attachment figures, and that the network of caregiving relationships that envelops the developing young child has important affects of the child's experiences and behaviors. Independent ratings are made of the overall adaptation of each the infant/young child's primary caregiving relationships (Part A of Axis II) and a separate rating for the infant/young child's caregiving environment (Part B of Axis II).

The emotional quality of the dyadic relationship that the child establishes with each of his or her primary caregivers is characterized by the specific contributions that the child and the caregiver make to their perceptions and interactions with each other. In addition, because relationships affect relationships, the coparenting patterns that the caregivers establish with each other in relation to the child and the dyadic relationships between the child and each caregiver create a web of relationships that comprise the caregiving environment and have a profound impact on the child's development. Axis II encompasses both the dyadic relationship between the child and the primary caregiver(s) and the totality of the caregiving environment using the scales described next.

*Part A: Caregiver–Child Relationship Adaptation.* This scale is used to rate the relationship as it exists *between* the primary caregiver(s) and the child rather than within each of these two individuals. Although disturbances in relationships between young children and their attachment figures may derive from within the caregiver, from within the child, or from the unique fit between the two, the key consideration in using the scale is that the caregiver–child relationship is affected regardless of the etiology of the disturbance.

Adequate caregiving is presumed to derive from three overarching characteristics: (a) the caregiver's knowing and valuing the child as a unique individual, (b) the caregiver's consistent emotional availability, and (c) the caregiver's capacity to take the lead in providing care for the child (being effectively and empathically in charge). These caregiver characteristics provide the scaffold that enables the child to develop age-appropriate trust in the caregiver's capacity to respond to his or her physical and psychological needs. Clinicians may base their ratings on observations of the caregiver–child interaction and other manifestations of the child–caregiver subjective experience of each other. Because children develop different relationship patterns with different caregivers, it is important to conduct direct assessments of all the primary caregiver/child relationships.

The caregiving dimensions listed in Table 3 (Dimensions of Caregiving for Primary Caregiver/Child Relationship) are intended to guide the clinician's assessment of the relationship by systematically reviewing a number of clinically relevant dimensions. Similarly, because we know that infants and young children are powerful elicitors of behaviors, feelings, and perceptions in adults, there also is a listing of clinically relevant infant/young child characteristics

**TABLE 3. Dimensions of Caregiving for Primary Caregiver/Child Relationship**

Indicate how each item contributes to relationship quality.			
	Strength	Not a Concern	Concern
Ensuring physical safety			
Providing for basic needs (e.g., food, hygiene, clothing, housing, health care)			
Conveying psychological commitment to and emotional investment in the child			
Establishing structure and routines			
Recognizing and responding to the 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 child's individual experiences and perspectives			
Engaging in reflectiveness regarding child's developmental trajectory			
Incorporating child's point of view in developmentally appropriate ways			
Tolerating ambivalent feelings in caregiver-child relationship			

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**TABLE 4. Infant/Young Child's Contribution to Relationship**

Indicate how each item contributes to relationship quality.			
	Strength	Concern/Strain?	Not a Strength/Concern
Temperamental dispositions			
Sensory profile			
Physical appearance			
Physical health (from Axis III)			
Developmental status (from Axes I and V)			
Mental health (from Axis I)			
Learning style			

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that the clinician is encouraged to use to inform the Axis II Part A rating of relationship adaptation (Table 4). The clinician is encouraged to consider for both caregiver and infant behaviors the degree to which they are culturally bound and to think carefully about family cultural values and practices that define young children's behaviors and endorse or proscribe specific parenting practices.

Four levels of adaptation are identified for a summary rating of the relationship. Level 1, *Well-Adapted to Good Enough Relationships*, describes relationships that are not of clinical concern. This level covers a broad range of relationships, from those that are functioning adequately for both partners on the caregiving dimensions to those that are exemplary. The "good enough" designation is worth emphasizing in that it is not necessary for the relationships to be exemplary at this level is not of clinical concern—only rarely will they be. Most will be characterized by typical ups and downs and struggles, but will be functionally adequate. At Level 2, *Strained to Concerning Relationships*, careful monitoring at least is definitely indicated, and intervention may be required. At Level 3, *Compromised to Disturbed Relationships*, the relationship disturbance is clearly in the clinical range, and intervention is indicated. Finally, at Level 4, *Disordered to Dangerous Relationships*, intervention is not only required but urgently needed due to the severity of the relationship impairment.

The levels are arrayed ordinally rather than continuously, meaning that each level becomes more problematic from 1 to 4, but the levels are not equidistant points in a continuum. In particular, Level 1 should contain most relationships in low-risk samples and should include a broad range of relationship adaptations.

The cultural values, practices, and beliefs of the family must be ascertained when deciding on a rating. In low-risk populations, Level 1 is expected to predominate, and the distribution of cases across different levels will be affected by the characteristics and circumstances of the children and caregivers being assessed. This scale should be used by trained infant mental health professionals in clinical settings, usually at the end of an assessment process.

The dimensions listed in Tables 3 and 4 are not formally connected to ratings but are intended as guides for clinicians to think through whether and which type of interventions might be recommended. There is no minimum number of dimensions that must be rated as concerning.

*Part B: Caregiving Environment and Child Adaptation.* Children construct different relationships with different caregivers, and the ratings of the caregiving environment are meant to specify the coordination, integration, and compatibility among the different caregiving relationships which the child experiences. The emotional quality of this web of caregiving relationships is an important predictor of the child's functioning, even when the caregivers do not live together. The caregiving dimensions listed in Table 5 are designed to guide the clinician's assessment of the caregiving environment. The clinician is encouraged to think carefully about family cultural values and practices. It is important to understand and accept cultural variations, but also to intervene to support the infant's/young child's development.

Just as with the primary caregiver/child relationship component of Axis II, the caregiving environment and child adaptation ratings including four levels of adaptation are identified for a summary rating of the network of caregiving relationships. Level 1, *Well-Adapted to Good Enough Relationships*, describes a

**TABLE 5.** *Dimensions of the Caregiving Environment*

Indicate how each contributes to the caregiving environment.			
	Strength	Not a Concern	Concern
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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caregiving environment in which the quality of coparenting relationships are not of clinical concern. This level is meant to cover a broad range of relationships, 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. At Level 2, Strained to Concerning Relationships, there are likely to be indicators of conflict and/or insufficient communication and coordination among the caregivers regarding the care and upbringing of the child. In addition, the child is likely experiencing distress, tension, or uncertainty about how to negotiate interactions with the different caregivers and may show preferences that spark conflict among them. The strain or concern places the child's social and emotional trajectory at risk for compromise. At Level 3, Compromised to Disturbed Relationships, the family relationships are fraught with inappropriate levels of risk to safety, significant conflict, insufficient or irregular engagement, or significant imbalance. The level of disturbance indicates that the child's social and emotional trajectory has been compromised. Finally, at Level 4, Disordered to Dangerous Relationships, there is a clear and immediate need for clinical intervention because the 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, to the extent that these disturbances are seriously compromising the young child's development and threaten the child's physical or psychological safety.

### INTEGRATING AXIS I AND II

Given that relational pathology may involve Axis I and/or Axis II, we consider briefly how the Axes are to be used in different situations. Relationship-specific disorder is to be used for a symptomatic child whose symptoms are limited to one particular relationship. When relationship-specific disorder is used, Axis II also should be coded. Part A of Axis II, caregiver-child relationship

adaptation, should be Level 3 or 4 when the child meets criteria for a relationship disorder on Axis I. Part B of Axis II may be at any level, although Levels 2 to 4 may be more likely than is Level 1 in the context of a relationship-specific disorder. A child may have an Axis I disorder other than relationship-specific disorder and also have an Axis II rating of any of the levels. In this instance, the child would be symptomatic cross-contextually, but the caregiving environment—either the primary caregiving relationship or the broader caregiving environment—could range from highly adaptive to highly maladaptive. A child who does not meet criteria for any Axis I disorder could have an Axis II rating that ranges from Level 1 to Level 4 on either Part A, the primary caregiving relationship, or Part B, the broader caregiving environment of relationships. A child with no Axis I diagnosis and an Axis II rating of Level 1 would be a child for whom there is no clinical concern. An asymptomatic child with an Axis II rating of Level 2, 3, or 4 on either the primary caregiving relationship or the broader caregiving environment relationship ratings would be a child considered “at risk” for subsequent psychopathology.

### SUMMARY AND THE WAY FORWARD

We detailed both the importance and the challenges of incorporating relational features into a diagnostic classification system. The *DC:0-5* represents the latest of several attempts that date back more than 30 years. In a major change from previous attempts, the *DC:0-5* includes an Axis I Relationship-Specific Disorder of Early Childhood. The diagnosis is made by focusing on symptomatic behavior in the child, but behavior that is expressed largely or exclusively in the context of one caregiving relationship. Much remains to be learned about the usefulness of this new disorder classification. Reliability and validity must be established, but the real test is whether it shapes treatment differently than would within-the-child disorders.

An axial characterization of young child/caregiver relationships is continued from the *DC:0-3R*, but also is different in two major ways. First, the PIRGAS has been replaced by a 4-point scale with more detailed relational anchors designed to guide clinical intervention. Second, in addition to characterizing the young child's relationship with his or her primary caregiver, there also is a characterization of the caregiving environment; that is, the network of family relationships in which the child develops. This includes coparenting relationships and the entire network of close relationships that impinge on the young child's development and adaptation. There already is considerable empirical evidence that family environments are powerful influences on young children's development. We hope that this contextualization of the young child's caregiving environment will receive the clinical attention that it warrants.

Our hope is that these new approaches to conceptualizing relationship psychopathology will receive careful empirical scrutiny and be revised as indicated. Careful evaluation of this approach represents an important challenge for researchers and a much-needed aid to practitioners.

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# Child-Parent Psychotherapy Research Fact Sheet

## ◇ OVERVIEW

Child-Parent Psychotherapy (CPP) is an intervention model for children aged 0-5 who have experienced traumatic events and/or are experiencing mental health, attachment, and/or behavioral problems. The treatment is based in attachment theory but also integrates psychodynamic, developmental, trauma, social learning, and cognitive behavioral theories. Therapeutic sessions include the child and parent or primary caregiver. A central goal is to support and strengthen the caregiver-child relationship as a vehicle for restoring and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (e.g. cultural norms and socioeconomic and immigration-related stressors). Targets of the intervention include caregivers' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. For children exposed to trauma, caregiver and child are guided over the course of treatment to create a joint narrative of the traumatic event and to identify and address traumatic triggers that generate dysregulated behaviors and affect. Treatment is generally conducted by a master's or doctoral-level therapist and involves weekly hour-long sessions.

Five randomized trials provide support for the efficacy of CPP. There is also a published study of CPP implemented within a wraparound foster care program in Illinois. These trials are summarized below.

## ◇ CPP with Preschoolers Exposed to Domestic Violence: Initial Findings

Lieberman, A.F., Van Horn, P.J., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 1241-1248.

### Sample Characteristics

#### Children

- Age: 3-5 years old ( $M = 4.06$ ;  $SD = 0.82$ )
- Gender: 36 boys and 39 girls
- Ethnicity: 37% mixed ethnicity (predominantly Latino/Caucasian), 28% Latino, 14.5% African American, 10.5% White, 7% Asian, and 2% of another ethnicity
- Trauma history:
  - All exposed to domestic violence
  - In addition, 49% experienced physical abuse, 46.7% community violence, and 14.4% sexual abuse

#### Caregivers (all biological mothers)

- Trauma history
  - All experienced domestic violence
  - Average number of stressful life events=12.36
  - As children, 48% witnessed domestic violence, 49% experienced physical abuse, 42% sexually molested, 44% experienced the sudden or traumatic death of someone close
- Education: average 12.51 years ( $SD=3.96$ )
- SES
  - Mean monthly income \$1,817 ( $SD = \$1,460$ )
  - 23% of families on public assistance
  - 41% had incomes below the federal poverty level

### Treatment Groups

Randomly assigned to either

- CPP ( $n = 42$ )
- Services in the community plus monthly case management ( $n = 33$ )
  - 73% of mothers and 55% of children received individual treatment

### Attrition and Attendance

- CPP Group
  - Attrition: 14.3%
  - Attendance: averaged 32.09 CPP sessions ( $SD=15.20$ )
- Comparison Group
  - Attrition: 12%
  - Attendance:
    - 50% of mothers and 65% of children who received treatment, received 20+ sessions
    - One child had <5 sessions
    - One mother attended 5-10 sessions
    - The remaining mothers and children attended between 11-20 sessions
- No difference between CPP and comparison group in terms of attrition

### Outcome Measures

- *Child*
  - Child Behavior Checklist (CBCL: Achenbach and Edelbrock, 1983, Achenbach, 1991)
  - Structured Interview for Diagnostic Classification DC: 0-3 for Clinicians (DC: 0-3; Scheeringa et al., 1995).
- *Mothers*
  - Symptoms Checklist-90 Revised (SCL-90-R; Derogatis, 1994)
  - Clinician Administered PTSD Scale (CAPS; Blake et al., 1990)

### Outcomes:

- CPP children showed greater reductions in total behavior problems ( $d = .24$ )
- CPP children showed greater reductions in traumatic stress symptoms ( $d = .64$ ).
- At posttest, significantly fewer children who received CPP met criteria for PTSD (6%) compared to comparison group children (36%); Rates of PTSD at intake were 50% for the CPP group and 39% for the comparison group.
- CPP mothers showed significantly greater reductions in avoidant symptomatology ( $d = .50$ ).

### ◆ CPP with Preschoolers Exposed to Domestic Violence: 6-month Follow-up

Lieberman, A.F., Ghosh Ippen, C., Van Horn, P.J. (2006). Child-Parent Psychotherapy: Six month follow-up of a randomized control trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45(8), 913-918.

### Sample Characteristics

Subset from sample described above (CPP with Preschoolers Exposed to Domestic Violence: Initial findings)

#### Children

- Age: 3-6 years old
- Gender: 22 boys and 28 girls
- Ethnicity: 38% mixed ethnicity (predominantly Latino/Caucasian), 28% Latino, 16% African American, 12% White, 4% Asian, and 2% of another ethnicity

### Attrition

- Dyads lost to attrition did not differ from those who completed follow-up assessment on 12-month outcome variables
- CPP group
  - 2 dropped
  - 7 were treated before the inclusion of follow-up (not included in the follow-up study)
- Comparison group
  - 4 dropped
  - 1 removed from dataset (received CPP at another clinic)
  - 1 data were invalid (mother had postpartum psychosis)

### Outcome Measures

- *Child*: Child Behavior Checklist (CBCL: Achenbach and Edelbrock, 1983, Achenbach, 1991)
- *Mothers*
  - Symptoms Checklist-90 Revised (SCL-90-R; Derogatis, 1994):Clinician Administered PTSD Scale (CAPS; Blake et al., 1990)

### Outcomes:

- CPP children showed greater reductions in total behavior problems ( $d = .41$ )
- CPP mothers showed significantly greater reductions in general distress ( $d=.38$ ).

### ◆ CPP with Preschoolers Exposed to Domestic Violence: Children with 4+ Traumatic and Stressful Life Events

Ghosh Ippen, C., Harris, W.W., Van Horn, P., & Lieberman, A.F. (2011). Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abuse and Neglect*, 35, 504-513.

### Sample Characteristics, Attrition, and Outcome Measures

Same as above: CPP with Preschoolers Exposed to Domestic Violence: Initial findings

**Description:**

Reanalysis of data from the randomized control trial to examine CPP treatment effectiveness by level of child exposure to traumatic and stressful life events (comparing those children with <4 traumatic stressful life events with those with four or more [4+] traumatic or stressful life events).

**Outcomes:**

- For children in the 4+ risk group, those who received CPP showed significantly greater improvements in PTSD and depression symptoms, PTSD diagnosis, number of co-occurring diagnoses, and behavior problems compared to those in the comparison group.
- CPP children with <4 risks showed greater improvements in symptoms of PTSD than those in the comparison group. Mothers of children with 4+ TSEs in the CPP group showed greater reductions in symptoms of PTSD and depression than those randomized to the comparison condition.
- Analyses of 6-month follow-up data suggest improvements were maintained for the high risk group.

## ◆ CPP with Maltreated Preschoolers

Toth S.L., Maughan A., Manly J.T., Spagnola M., Cicchetti D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Developmental Psychopathology*, 14, 877-908.

**Sample Characteristics***Children*

Demographics were provided on children who completed the study. Initially 155 dyads were randomly assigned (see below), and 122 completed treatment.

- Age at intake (**or baseline evaluation**): 4 years old ( $M = 48.18$  months,  $SD = 6.88$ )
- Gender: 68 boys and 54 girls
- Ethnicity: 76.2% ethnic minorities, predominantly African American (in the article, ethnicity is not specified)
- Trauma history:
  - All families in the maltreatment group had a documented history of maltreatment.
  - 60% of children experienced more than one form of maltreatment

*Caregivers (all biological mothers)*

- Trauma history – no data provided
- Education: by group CPP ( $M=11.32$ ,  $SD=1.91$ ); PHV ( $M=11.22$ ;  $SD=1.96$ ); CS ( $M=11.53$ ;  $SD=1.11$ ); NC ( $M=12.11$ ;  $SD=2.05$ )
- SES
  - Average group income ranged from \$16,700-\$19,930

**Treatment Groups**

Randomly assigned to either

- CPP ( $n = 31$ ) Note: In this study, CPP was called preschool-parent psychotherapy
- Psychoeducation home visitation; PHV ( $n=49$ )
- Community standard; CS ( $n=33$ )
- Also had a low-income normative comparison group; NC ( $n=43$ )

**Attrition**

- Dyads lost to attrition did not differ from those who completed treatment
- CPP
  - Attrition (25.8%)
  - Attendance: 11.63 months ( $SD=3.13$ ) and 32.39 sessions ( $SD=12.42$ )
- PVH
  - Attrition (29.2%)
  - Attendance: 13.32 months ( $SD=6.6$ ) and 31.09 sessions ( $SD=14.30$ )
- CS
  - Attrition (9%)
  - Attendance
    - 13% of children received individual therapy. Average length of treatment was 9.3 months.
    - Of mothers, 23% received individual therapy, 3% family or marital counseling, and 10% support group or day treatment. Additionally, 17% received some type of parenting service. Average length of treatment was 5.8 months.
- NC: Attrition (18.6%)

## Outcome Measures

MacArthur Story Stem Battery (MSSB; Bretherton, Oppenheim, Buchsbaum, Emde, & The MacArthur Narrative Group, 1990).

### Outcomes:

- Children who received CPP had significantly greater reductions in negative self-representations compared to children in the other three groups (PVH, CS, and NC).
- Children who received CPP showed significantly greater reductions in maladaptive maternal attributions compared to children in the NC group, with a trend for greater improvements compared to the CS group.
- Children who received CPP showed significantly greater improvement in relationship expectations compared with children in the NC group with a trend for greater improvement than the PHV group.

## ◆ CPP with Maltreated Infants

Cicchetti, D., Rogosch, F.A., & Toth, S.L. (2006). Fostering secure attachment in infant in maltreating families through preventive interventions. *Development and Psychopathology*, 18, 623-650.

### Sample Characteristics

#### Children

- Age: Infants ( $M = 13.31$  months,  $SD = .81$ )
- Gender:
  - 60 boys and 77 girls in maltreated sample
  - 28 boys and 24 girls in nonmaltreated sample
- Ethnicity: 60.3% African-American, 17.5% white, 5.8% Latino, 16.4% Biracial/Other
- Trauma history:
  - Recruited through a review of CPS records verifying infants were maltreated or living in maltreating families
    - 66.4% had directly experienced neglect or abuse
    - 33.6% living in families where their siblings had experienced abuse or neglect

#### Caregivers (all biological mothers)

- Age: 18-41 years ( $M=26.87$ ,  $SD=5.88$ )
- Ethnicity: 53.9% African-American, 25.4% white, 12.2% Latino, 8.5% Biracial/Other
- Trauma history: 90% of mothers reported at least one traumatic event; 34% met DSM-IV lifetime criteria for PTSD; Mothers in the maltreatment group reported significantly greater childhood history of physical, emotional, and sexual abuse than mothers in nonmaltreating families
- Education: 41.8% had a high school education or less
- SES: Average group income was \$17,151, including welfare benefits

### Treatment Groups

- 137 infants randomly assigned to:
  - CPP ( $n = 53$ ) Note: In this study, CPP was called infant-parent psychotherapy
  - Psychoeducation parenting intervention; PPI ( $n=49$ )
  - Community standard; CS ( $n=35$ )
- Also had a low-income, nonmaltreating families comparison group; NC ( $n=52$ )

### Attrition

- Dyads lost to attrition did not differ from those who completed treatment
- Attrition after initial randomization
  - 39.6% of CPP mothers
  - 51% of PPI mothers
  - Initial attrition was high perhaps due to fact that families were not seeking treatment
- Attrition following engagement
  - Overall attrition 21.7%
  - Greatest attrition in CS group: 42.9%
  - No difference in attrition between CPP and PPI groups
- Attendance
  - CPP: 46.4 weeks and 21.56 sessions
  - PPI: 49.4 weeks and 25.38 sessions
  - No difference in attendance between CPP and PPI groups

## Outcome Measures

- Strange Situation

## Outcomes:

- At intake, CPP, PPI, and CS groups did not differ in attachment classifications
- At intake CPP, PPI, and CS groups were more likely to have children classified as disorganized than the NC group.
- CPP and PPI both were significantly more effective than the CS group in altering children's attachment classifications, with no difference in efficacy between the CPP and PPI groups.
  - CPP group: rate of secure attachment changed from intake (3.1%) to post (60.7%)
  - PPI group: rate of secure attachment changed from intake (0%) to post (54.5%)
  - CS group: no change in secure attachment from intake (0%) to post (1.9%)
  - Similar results were found for rates of disorganized attachments, with greater improvements in the CPP and PPI groups compared to the CS group

## ◆ CPP with Anxiously Attached Latino Infants

Lieberman, Weston, & Pawl (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development*, 62, 199-209.

## Sample Characteristics

### Children

- Age: Infants aged 11-14 months ( $M = 13.31$  months,  $SD = .81$ )
- Gender: 44% male
- Ethnicity: not specified, but all had Latina immigrant mothers
- Trauma history: not specified

### Biological mothers

- Age: 21-39 years ( $M=25.08$ )
- Ethnicity: 100% Latina immigrants from Mexico or Central America who had been in the United States for less than five years ( $M=3.10$  years)
- Language: All Spanish-speaking
- Trauma history: not specified, but mothers averaged 11.34 stressful events on the Life Events Inventory
- Education: Average 9.42 years of education
- SES: 71.4% of mothers were unemployed (35.4% of fathers were unemployed)

## Treatment Groups

100 infants initially entered into study (7 dyads did not complete the initial assessment)

- Anxiously attached dyads ( $n=59$ ) were randomly assigned to intervention or comparison group
  - CPP ( $n=34$ ); Note: In this study, CPP was called infant-parent psychotherapy
  - Comparison group ( $n =25$ )
- Securely attached dyads formed a second control group ( $n=34$ )

## Attrition

- Overall attrition for the study was 18% (including all 100 dyads who entered the study)
- Overall attrition of the 93 dyads who completed the initial intake assessment was 9%
- No difference in attrition between CPP and comparison group
  - CPP attrition: 3%
  - Comparison group attrition: 8%
  - Securely attached comparison group attrition: 12%

## Outcome Measures

- Observational data gathered from coding of free play interactions

## Outcomes:

- At post, CPP toddlers scored lower than comparison group toddlers in avoidance, resistance, and anger and scored higher in partnership with mother
- At post, CPP mothers had higher scores in empathy and interactiveness with children
- At post, CPP group did not differ from securely attached comparison group on any outcome measures

## ◆ CPP with Toddlers of Depressed Mothers

- Cicchetti D., Toth S.L., Rogosch F.A. (1999). The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment and Human Development* 1, 34-66.
- Cicchetti, D., Rogosch, F.A., & Toth, S.L. (2000). The efficacy of Toddler-Parent Psychotherapy for fostering cognitive development in offspring. *Journal of Abnormal Child Psychology*, 28, 135-148.
- Toth, S. L., Rogosch, F. A., & Cicchetti, D. (2006). The efficacy of Toddler-Parent Psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. *Journal of Consulting and Clinical Psychology*, 74(6), 1006-1016.

**NOTE:** Similar procedures for all studies. Cicchetti, Toth & Rogosch (1999) and Cicchetti, Rogosch, & Toth (2000) are subsamples of the Toth, Rogosch, & Cicchetti (2006) study. Sample characteristics, treatment group, and attrition information are from Toth, Rogosch, & Cicchetti (2006).

### Children

- Age: Toddlers ( $M = 20.34$  months,  $SD = 2.50$ )
- Gender: 52.8% boys and 47.2% girls
- Ethnicity: not specified but most had Caucasian mothers
- Trauma history: not specified

### Biological mothers

- Age: 22-41 years ( $M = 31.68$ ,  $SD = 4.48$ )
- Ethnicity: predominantly Caucasian (92.9%)
- Trauma history: 25% of depressed mothers met DSM-IV lifetime criteria for PTSD
- Education: 54.5% were college graduates or had received advanced degrees
- Marital status: Majority married (87.9%)
- SES: 72.7% were ranked in the two highest socioeconomic status levels (IV and V) based on Hollingshead's four-factor index

### Treatment Groups

- Entry criteria
  - Child approximately 20 months of age
  - Mother met DSM-III-R criteria for major depressive disorder occurring during child's life (mothers meeting criteria for bipolar disorder were not retained)
- Originally recruited 130 depressed moms and 68 non-depressed moms
- Mothers with depression history randomly assigned to CPP ( $n=66$ ) and comparison ( $n=64$ )

### Attrition

- CPP: 30%
- Comparison group: 16%
- No maternal depression comparison group: 6%
- Final sample CPP ( $n=46$ ); comparison ( $n=54$ ); non-depressed control ( $n=63$ )

### Outcome Measures and Outcomes

#### *Cicchetti, Toth, & Rogosch, 1999*

- Sample note: Subsample of those described above, included 27 dyads assigned to CPP, 36 dyads in the no treatment comparison group, and 45 dyads where the mother had no current or past mental disorder.
- Outcome measure: Attachment Q-set
- At intake, CPP and comparison showed greater insecurity of attachment than nondepressed controls.
- At post, CPP children showed significant improvements in attachment security (74.1% CPP group rated secure compared to 52.8% of comparison group); no difference between CPP children and nondepressed controls in rate of insecure attachment

#### *Cicchetti, Rogosch, & Toth, 2000*

- Sample note: Subsample of those described above, included 43 dyads assigned to CPP, 54 dyads in the no treatment comparison group, and 61 dyads where the mother had no current or past mental disorder.
- Outcome measure: Bayley Mental Development Index
- At intake no difference between the three groups on cognitive scores
- At post, comparison group showed significantly lower scores than the intervention group and the non-depressed controls

- At post, no difference between CPP group and nondepressed controls in cognitive scores.

Toth, Rogosch, & Cicchetti, 2006

- Outcome measure: Strange Situation
- At intake, few children of depressed moms found to be securely attached (CPP=16.7% comparison=21.9%) compared to children of non-depressed mothers (55.9%)
- At post, rate of secure attachment in CPP group increased significantly in CPP group (67.4%) and declined slightly in comparison (16.7%).

### ◆ CPP Within a Wraparound Foster Care Program in Illinois

- Lyons, J. (2008). Evidence-based trauma interventions for foster children in Illinois. Presentation to funders and stakeholders, Chicago, IL.
- Weiner, D.A., Schneider, A., & Lyons, J.S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth : Treatment retention and outcomes. *Children and Youth Services Review*, 31, 1199-1205.

**NOTE:** This study examined the implementation of three evidence-based treatments addressing traumatic stress symptoms within a wraparound foster care program in Illinois. The study involved a racially diverse group of children approximately 46% of whom had experienced complex trauma. CPP was conducted with children under age 6. Trauma-focused cognitive behavioral therapy (TF-CBT) and Structured Psychotherapy for Adolescents Responding to Stress (SPARCS) were implemented with older children. Data are reported here for the CPP group.

#### Sample Characteristics

##### CPP Group

- Age:  $M = 3.7$ ;  $SD = 1.6$
- Gender: 33 boys and 32 girls
- Ethnicity: 43% African American, 25% White, 18% Hispanic, and 14% biracial
- Trauma history: All had experienced a moderate or severe traumatic experience

#### Attrition

- CPP Group: Attrition: 22.6%
- No difference between CPP, TF-CBT, and SPARCS groups in terms of attrition

#### Outcome Measures

- *Child*
  - Child and Adolescent Needs and Strengths (CANS: Lyons, 2004)

#### Outcomes for CPP Group:

- Compared to children in the traditional system of care (SOC), CPP resulted in greater improvements in all five domains assessed: traumatic stress symptoms, strengths, life domain functioning, behavioral emotional needs, and risk behaviors.
- CPP was found to be universally effective across racial/ethnic subgroups.
- "Among comparable youth in SOC (a program which improves stability) CPP significantly reduced all placement interruptions" (Lyons, 2008).

### ◆ REFERENCES

#### Randomized Trials Conducted at the Child Trauma Research Program, University of California San Francisco

- Lieberman, A.F., Ghosh Ippen, C., Van Horn, P.J. (2006). Child-Parent Psychotherapy: Six month follow-up of a randomized control trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 45(8), 913-918.
- Lieberman, A.F., Van Horn, P.J., & Ghosh Ippen, C. (2005). Toward evidence-based treatment: Child-Parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry*, 44(12), 1241-1248.
- Lieberman, Weston, & Pawl (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development*, 62, 199-209.

#### Research on Child-Parent Psychotherapy Conducted at Mt. Hope Family Center, University of Rochester

- Cicchetti, D., Rogosch, F.A., & Toth, S.L. (2000). The efficacy of Toddler-Parent Psychotherapy for fostering cognitive development in offspring. *Journal of Abnormal Child Psychology*, 28, 135-148.
- Cicchetti, D., Rogosch, F.A., & Toth, S.L. (2006). Fostering secure attachment in infant in maltreating families through preventive interventions. *Development and Psychopathology*, 18, 623-650.

- Cicchetti D., Toth S.L., Rogosch F.A. (1999). The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment and Human Development* 1, 34-66.
- Toth, S. L., Rogosch, F. A., & Cicchetti, D. (2006). The efficacy of Toddler-Parent Psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. *Journal of Consulting and Clinical Psychology*,74(6), 1006-1016.
- Toth S.L., Maughan A., Manly J.T., Spagnola M., Cicchetti D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: Implications for attachment theory. *Developmental Psychopathology*, 14, 877-908.

#### **Dissemination Study Conducted by**

- Lyons, J. (2008). Evidence-based trauma interventions for foster children in Illinois. Presentation to funders and stakeholders, Chicago, IL.
- Weiner, D.A., Schneider, A., & Lyons, J.S. (2009). Evidence-based treatments for trauma among culturally diverse foster care youth : Treatment retention and outcomes. *Children and Youth Services Review*, 31, 1199-1205.

#### **◆ EXTERNAL REVIEWS OF THE RESEARCH ON CPP**

The following organizations have conducted independent reviews of the research on CPP, have listed CPP as an evidence-based practice, and have posted summaries on their websites.

- The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices (NREPP): <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=194>
- The California Evidence-Based Clearinghouse for Child Welfare: <http://www.cebc4cw.org/program/child-parent-psychotherapy/>
- Oregon.gov Additions and Mental Health Approved Practices and Process: <http://www.oregon.gov/OHA/mentalhealth/ebp/practices.shtml>

Fact sheet last updated October, 2011

# THE CLINICAL ASSESSMENT OF INFANTS, PRESCHOOLERS AND THEIR FAMILIES

**Sarah Mares & Ana Soledade Graeff-Martins**



Photo: <http://www.dean.be>

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Health professionals encounter families with infants and young children in a broad variety of settings and circumstances. Consideration of mental health, social and emotional issues should be a necessary part of all health and welfare assessments. The extent to which mental health is the focus will be determined by the setting and the purpose of contact with the infant, toddler, preschooler and family.

This chapter outlines a framework for assessing infants, young children and their families and provides an approach to *understanding* and *formulating* their difficulties. No matter what the presenting problem, a comprehensive assessment always includes consideration of factors in the child, the parents and wider family, and the social and cultural context that contribute to vulnerability and resilience. These factors are used to inform and focus interventions. *Assessment of risk* (e.g., developmental risk, or risk of harm to the infant or the caregiver) is part of all infant and early childhood mental health assessments, which includes assessment of parenting capacity. This framework can be adapted to a range of clinical settings. The aim of this chapter is to enhance the interest and ability of health professionals to consider mental health and developmental issues in all their dealings with families who present during this period of rapid developmental change.

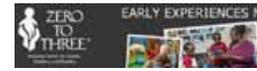
### The developmental importance of early relationships

There is increasing evidence of the infant's capacity and motivation to interact with the environment (people and objects), organising the self and learning from birth. Most accounts of early development stress the infant's move from dependency towards self-organisation alongside the development of identity.

Development does not occur in a vacuum but in the context of a caretaking relationship, and the carer is vital in supporting the unfolding of the infant's capacities. The family (infant, caregivers and siblings) also exists within a network of relationships and culture. This network includes the social and physical circumstances of the family, which can either enhance and support the family's quality of life and relationships, or undermine them. Even if the infant is genetically and biologically programmed for development, certain environmental experiences are required at specific times – known as *critical periods* – in development.

Infants are born ready to relate, not just to anyone but to specific caregiving individuals. They develop in the context of these relationships and the quality of parenting has a developmental impact. The human baby is born extremely vulnerable and remains dependent for longer than the young of any other species, and so the role of parent or caregiver is intense and prolonged. The family has a crucial part in facilitating and supporting infants' development throughout the early years and their capacity to do this affects the strengths and vulnerabilities infants will carry for their lifetime.

The *first year* involves the development of the basics for language and the establishment of attachment relationships. The *second year* of life involves two major achievements (i) language and symbolic play, and (ii) mobility. Mobility allows children to explore and develop cognitively and to develop independence from the caretaker. The toddler experiments with separation and develops a sense of identity and autonomy. During *the third and fourth years* of life children consolidate, refine and expand these abilities into a sense of self in relation to others and their place in the world (see Chapter A.2).



A series of podcasts, videos and print handouts about early development are available at the Zero to Three website. Click on the picture to view.

### A psychologically healthy infant is characterized by:

- The ability to form close and secure interpersonal relationships
- Drive to explore the environment and learn
- All within the context of family, community, and cultural expectations for the child
- Synonymous with healthy social and emotional development

A brief introduction to the science of early childhood development can be found at the *In Brief* series from Harvard University's Center on the Developing Child. Click on the picture to view.



## Attachment

The quality of attachments developed between a young child and their caregivers has a significant impact on social, emotional and cognitive development across the lifespan. Attachment can be defined as an enduring emotional bond characterised by a tendency to seek and maintain proximity to a specific figure(s), particularly when under stress. Attachment theory understands the nature of infants' attachment to their caregivers as a primarily biologically determined phenomenon upon which survival depends. The infant develops internal working models of relationships from the quality and nature of early experience with caregivers, and this influences ongoing social and emotional development. Evidence from longitudinal studies of attachment indicates that security of attachment during infancy is linked to the young child's developing capacity for self-regulation, reciprocity and collaborative social interactions (Sroufe et al, 2005).

## ATTACHMENT PATTERNS AND DISORDERS

Attachment theory describes three types of organised attachment and a pattern of disorganised or disoriented attachment. Attachment disorders (reactive attachment disorder) are also described (DSM-IV TR; American Psychiatric Association, 2000) but there is disagreement about the utility of current diagnostic categories and alternatives have been proposed (Boris et al, 2005; Chaffin et al, 2006; Newman & Mares, 2007; Zerotothree.org).

Organised attachment refers to strategies for managing oneself (and displays of affect) in relation to others that children develop in response to the relationship with their caregiver. These are classified as secure, insecure/ambivalent or insecure/avoidant. Disorganised attachment refers to the child who fails to develop coherent or effective strategies to deal with attachment anxiety, usually where the caregiver is simultaneously the source of comfort as well as the cause of distress or anxiety, for example in situations of child maltreatment (see Howe, 2005; Lyons-Ruth et al, 2005).

Attachment theory – developed initially by John Bowlby from a range of previously separate and diverse areas of knowledge – is an integrated body of theory and practice that enables links to be made between behaviour and inner representations of relationships, and between the experiences of one generation and the care they will provide to the next – that is, the transgenerational aspects of parenting. It provides explanations for the link between observed parenting behaviour, the quality of parent and infant relationships and the later functioning of the child, socially and emotionally. Attachment theorists and researchers have developed methods to elicit and evaluate aspects of the inner representational world of the infant, child and adult. Currently there are limitations to the application of these research-based approaches which cannot yet be easily utilised in the clinical situation.

## ASSESSMENT

A good knowledge of attachment theory allows clinicians to assess emotional and behavioural problems from a relationship perspective. This is not to say that all infant and early childhood mental health interventions require formal assessment



Click on the picture to access the NSW Institute of Psychiatry, which has a variety of training videos for sale.

### Attachment

An enduring emotional bond characterised by a tendency to seek and maintain proximity to a specific figure or figures, particularly when under stress.

Attachment can be:

- Organised
  - Secure
  - Insecure/ambivalent
  - Insecure/avoidant
- Disorganised



Click on the picture to view a brief introduction to John Bowlby, the development of attachment theory and transgenerational issues in attachment.

of attachment status. Research-based methods for assessing attachment such as the *Strange Situation Procedure* (Ainsworth et al, 1978) – are time consuming and require extensive training. A universally accepted clinical and diagnostic protocol for assessing attachment at different ages as well as for diagnosing disorders of attachment does not currently exist. This partially explains the limited research and inconsistent approaches to assessing attachment in clinical settings. Many clinicians when consulted about children's attachments are handicapped by having little formal training in and much uncertainty about assessing attachment clinically (Crittenden et al, 2007). For this reason, outside a research context, it is advisable to describe what is observed between child and carer rather than to use language that may imply an attachment classification or diagnosis when formal assessment has not been undertaken. Assessment of attachment in clinical settings requires a focus on problems and strengths in the relationship between caregiver and child, rather than a focus on strengths or difficulties as existing within the individual child alone (Zeanah et al, 2011). The principles of assessment are summarised in Table A.4.1.

#### Attachment-informed assessment

While a formal assessment of attachment is not usually conducted in clinical settings, an *attachment-informed* assessment can be undertaken. This includes:

- 1 *A history of the child's attachments.* It is important to focus on a chronological account of the significant attachment figures available to the child since birth, particularly disruptions in care, abandonment or losses, alternate caregivers, neglect of care and abuse. Availability of the current primary carer and contact with other caregivers should be noted, as well as the child's behaviour with each and response to changes of carer. In older children, relationships with peers and siblings should be described.
- 2 *Details and observations of the infant or child's current behaviour.* Of particular interest in relation to attachment quality and disruptions or disorder are:
  - Help or comfort-seeking behaviour, including response to pain or distress (e.g., who do they go to if they fall and hurt themselves; do they show distress; are they discriminating about who can comfort them? are they shy with strangers?)
  - Quality of interaction and ability to use caregiver or another adult for comfort, including ability to explore and play in a new setting, response to limit setting and the nature of the interaction with the clinician.

This needs to be understood within a developmental framework. A six-month-old is less likely to show shyness or fear of strangers than a 12-month-old. A three-year-old may be able to use verbal information from the carer (e.g., "I am going out for a minute, I will be back soon") to tolerate a separation while an 15-month-old is less able to do this.

There are a number of core principles and issues that need consideration in any assessment of a family with an infant or young child, independent of the setting in which the assessment occurs or the background of the clinician; these are summarised in Table A.4.1. These principles are drawn from clinical experience and are informed by research and theoretical understandings of infancy, early childhood and family processes. An approach informed by these core principles

The Circle of Security (COS) website contains useful information for parents and clinicians about the importance of attachment, attachment quality and approaches to parenting and interventions. It is based extensively upon attachment theory and current neuroscience. The COS is a user-friendly, visually based approach (with extensive use of both graphics and video clips) to helping parents better understand the needs of their children. Information about the core elements of this approach, as well as training opportunities can be accessed and downloaded by clicking the picture.



**Table A.4.1 Principles of Assessment**

<b>1</b>	<b>Assessment of risk</b>
	Assessment of the immediate and longer term safety or risks to the infant, young child, and other family members is a necessary and inevitable aspect of all assessments. This focus may or may not be clear to the family, but is a key component of clinicians' responsibilities and obligations.
<b>2</b>	<b>Parents want the best for their children</b>
	Almost always, parents want the best for their children and family. The clinician's role is to assist them in providing this.
<b>3</b>	<b>Biopsychosocial framework</b>
	A biopsychosocial approach ensures that physical, psychological, interpersonal, social and cultural factors that contribute to the presentation of the family and infant are examined. The physical and psychosocial wellbeing of the infant cannot be considered separately.
<b>4</b>	<b>Developmental context</b>
	The perinatal and early childhood period is a time of transition and enormous growth for infant and family, Children develop at differing rates across a range of normal parameters and difficulties need to be understood in a developmental context. Emotional, behavioural and developmental problems presenting in infancy can have lifelong consequences but some are the manifestation of normal developmental transitions: over time, with adequate support, they will resolve.
<b>5</b>	<b>A relational approach</b>
	Early development can only be understood within the caregiving context. As described above, this includes attachments and the quality of the infants' primary relationships. Although individual factors in the child or parent may contribute to current difficulties, the interaction or "fit" between the needs and capabilities of each family member and the sources of stress and support in the family context, could determine outcome.
<b>6</b>	<b>Vulnerabilities and strengths</b>
	Identifying vulnerabilities and strengths (also called risk and protective factors) helps shape and target interventions.
<b>7</b>	<b>The transactional model of development</b>
	The transactional model of development (Sameroff & MacKenzie, 2003) emphasises the interaction between genetic and environmental factors over time and 'the development of the child is seen as a product of the continuous dynamic interactions of the child and the experience provided by his or her family and social context' (Sameroff & Fiese, 2000, p10).

A thorough assessment is necessary:

- For accurate diagnosis and formulation
- To help the family maximise their child's developmental potential
- For appropriate, targeted intervention and management planning
- To collect data for research and statistical purposes.

enables the clinician to develop an understanding of the presenting problem, and where intervention and assistance are best targeted.

### **The Setting for the Assessment**

Assessment of infants and their families is undertaken in a number of ways and can occur in a wide range of settings and circumstances. Visiting a family at home provides very different information from that obtained in a clinic setting. Where a family is seen depends on the clinician's professional role, practice and the aims of the assessment. For example, a family may present only once to their local

emergency department late at night when the parents are concerned their baby is unwell and won't sleep. If seen at home, the practical and financial difficulties (for example, a one-room house and noisy neighbours) that affect their ability to focus on and settle their baby might become more evident. This would alter the focus of the assessment and require a very different use of the clinician's time. Assessment may occur in a mental health setting over two or three sessions because there is concern about parental depression. Alternatively, a family may be seen regularly in an early childhood clinic, allowing observation over time as their relationships develop and the infant grows. Concerns about abuse or neglect require evaluation and inevitably involve the clinician in the difficult task of establishing rapport and cooperation with parents who feel threatened, afraid or criticised. A developmental assessment or follow-up of a family with a child with medical or developmental problems may require a more direct medical or biological focus, but nonetheless needs to include consideration of the familial and social context. There are no clear right or wrong ways but every clinician needs to think about the advantages and limitations of the approach they take and how this may impact on the information they obtain.

#### **Aims of the assessment**

The essential aim of assessment, whatever the context or setting, is to identify and understand the problems facing the family, their strengths and vulnerabilities, in order to assist them in maximising their parenting capacity and the developmental potential of their child (assessing parenting capacity is discussed below). Information obtained during the assessment may also be used for other purposes, such as research into clinical or social conditions that affect parenting and child development.

#### **Sources of information**

During the assessment process a range of information is obtained from different sources, determined in part by the clinical setting and the purpose of the assessment. Direct sources of information include:

- Clinical history provided by the referring agent and the family
- Observations of family members and their interactions
- Medical and developmental tests and investigations
- Other sources (for example, the referring agency or other services involved with the family, the day care, the school).

Other information may include:

- Written documentation of past history and interventions
- Emotional or "affective" information – including the clinician's response to and feelings about the family and their presentation
- Information (knowledge, skills and attitudes) drawn from the clinician's professional experience.

#### **The Assessment Process**

Enabling parents and caregivers to explore the complex emotions related to parenting and identifying obstacles that may impede their best parenting efforts is an important part of the assessment. Non-judgemental listening and genuine curiosity about the problem, the family and the child are all essential. Effective assessment enables observation of more than what is spoken, through

A comprehensive assessment is based on an understanding of the developmental tasks of the period and observations of the child–carer relationship. It includes:

- The clinical assessment interview
- Observation of parent–child interaction and relationship
- Developmental assessment of the child.

The parents of a two year-old girl brought her to a mental health outpatient clinic complaining that she had been “very nervous and agitated since she was one year old”. Her parents said she often became aggressive, hit her head on the wall at home and scratched herself. She would wake up stressed, refusing the bottle and scratching her mother. Her behaviour worsened when in contact with other children, so parents kept her at home. She was aggressive with adults, throwing toys on the floor or at people. They reported that she was calm when near her maternal grandfather, who did everything she wanted including things the parents considered dangerous. With strangers she was very shy, keeping her head down and not talking. The parents could not identify a precipitant for the symptoms but the onset had coincided with the child learning to walk and therefore becoming more independent. She lived with her parents and her eight year old brother.

It was apparent that parents had very different approaches to managing her. The mother had difficulty setting limits, while the father, when he was at home, punished the girl physically (hitting her with slippers). The mother said she always wanted to have a daughter whom she could “dress like a princess” and this girl had not been what she expected. The brother was very calm and obedient and had never been a problem.

The psychologist assessed the family during four weeks, interviewing the parents, observing the child alone and the interaction between children and parents. She referred the parents to a parent training program. After a few sessions, the parents found better ways to set limits and parent more consistently and the girl's behaviour improved. The next step was to support parents in sending the child to daycare for a few days a week, giving her the opportunity to be with other children and adults.

an understanding of the rich and essential information conveyed in interactions between children and their caregivers. Advice and intervention should not precede a thorough understanding of the issues.

### ***The interview***

The goal of the interview process is not only to gather information and objective data, but also to form a therapeutic relationship within which the problem can be understood and progress made towards resolving it. Whether a family is seen only once or the initial meeting is the first in a series of ongoing contacts, the process of developing a *therapeutic alliance* runs parallel to and determines success in eliciting the *facts* of the history. Just as parenting is primarily about relationships so contact with distressed families needs to be understood as a professional relationship within which the family can feel heard and understood, and therefore better able to care for their child. Even when assessing concerns about child abuse or neglect or providing a medico-legal report, it is important to be aware of the importance of the therapeutic alliance while also being clear and direct about the purpose of the interview, professional role and responsibilities, and any limits to confidentiality. Equally central is the importance of listening to the family: Why have they come? What are their concerns? What do they want help with?

A unique aspect of assessing families with an infant or young child is that frequently the “patient” has no words to tell their side of the story. In this case, what is observed about the child, their behaviour, their responses and the interaction between family members is crucial in helping the clinician and family to understand the child's experience and their part in the current difficulties.

The process of assessment, of listening and observing, and of asking questions, allows clinicians and parents to begin to develop a clear and focused understanding of the core of the problem – or problems – underlying the family's presentation.

Information gained helps the clinician and parents together to organise and understand the experience of the family in order to construct a narrative or “story”, an account of the family's experience with the child. This is constantly updated and modified through the duration of assessment and intervention, as development

and change occur. During the interview there are opportunities to observe the infant or toddler and their interactions with the adults.

### ***The history***

During the interview – at which the child and, when possible, both parents and other significant caregivers are present – the clinician will explore with the family their hopes and fears, their expectations of themselves and this child, as well as their experience, if any, with medical and psychological services in the past. Using a bio-psycho-socio-cultural approach, information is obtained about:

1. The current problem
2. The background and developmental history of
  - a. Child
  - b. Parents and family
3. Current supports and stressors.

### ***The current problem***

- How do family members understand and describe what is concerning them?
- Has this happened before?
- Was there a precipitant?
- Why have they sought help now?
- What have they tried and what has been helpful?
- What made them decide to seek help from you and your service?
- What do they want help with? What are their priorities?

### ***The background history***

This includes information about:

- The individual parent's history of their own family and relationships
- Parents as a couple
- Conception, pregnancy and delivery
- Child's development since birth.

The information obtained will include risk and protective factors in the child, parent(s) and their relationship, social and cultural context. This material will include consideration of biological, psychological and socio-cultural factors.

### ***The bio-psycho-social framework***

The infant is born with a genetic endowment, including what is sometimes called temperament, and at birth has already been affected by their environment in utero (for example, the adequacy of nutrition, drug or alcohol exposure, prematurity or other medical illness) (see Chapter B.1). These are biological contributions to the presentation.

The quality of parenting may alleviate or exacerbate a child's constitutional difficulties. This is often described as *goodness of fit* between parental expectations and capabilities and infant aptitudes and needs. It includes psychosocial and interpersonal factors, as well as biological aspects of the parents' and infants' health that affect their ability to meet their baby's needs.

The place of the child in the family, including gender and birth order, the meaning of this child to these parents at this time in their lives and their place

- Assessment of infants or young children and their families will vary depending on the clinician's role, the purpose of the assessment, the setting and the professional relationship with the family
- All assessments are greatly enhanced when a biopsychosocial approach is taken, to enable the integration of information from a range of sources.
- Children's physical and mental health are not separable, just as infant well-being and safety cannot be considered outside the context of primary caregiving relationships and the family context
- The focus of an assessment will vary but the clinician's obligation is to keep in mind the bigger picture, in order to work with the family and other professionals to optimally facilitate infant or young child development and potential, and the quality of family life and relationships.

in the sociocultural context should also be considered. Information should be obtained about biological, psychological and social factors that have helped or hindered the family now and in the past.

**Biological factors.** These include genetic vulnerability, past and current health, and any significant family history of illness. In the young child this includes intra-uterine exposure to drugs or other toxins, and other factors affecting development and physical health.

**Psychological and relational factors.** *Intra-psychic factors*, such as current psychiatric illness, personality issues and attachment style and interpersonal factors, such as the history and quality of current relationships.

**Social, cultural and contextual factors.** Factors in the social context, the degree of cultural and social isolation or support, financial security and parental employment. Socioeconomic status is a powerful predictor of infant developmental outcome (Zeanah et al, 1997), but the family's ability and willingness to access and use support is crucial. Factors to be considered here, identified by Reder et al (2003), include:

- The context and the interaction between the family and the social environment
- Family functioning, for example, poverty, unemployment, responses to stress, social or cultural isolation
- Potential for stability in relationships and social circumstances
- Relationship with others and the ability to use interventions and community support.
- The extended networks that support or abandon the family at this time of rapid developmental change
- The social and cultural factors that impinge on the family
- Relationship quality and interactions
- Family violence
- Practical issues and circumstances; the practical reality of the family situation, including housing, poverty, employment, and educational opportunities.

#### ***What parents bring to parenting?***

- Their psychological and social strengths and resources
- Their phantasies of what and who the child will be for them
- The history that precedes conception and birth, including their experiences in their own family and their experiences of being parented
- Their expectations of themselves as parents, influenced by their own experiences of family life
- Their psychopathology – the parents' past and family psychiatric history and current difficulties including parental substance abuse
- Parental age and life stage

#### ***Transgenerational issues in parenting***

Having a baby to care for is a powerful trigger for feelings, thoughts and memories about the parents' own upbringing. Many aspects of parenting are determined by how we were parented ourselves, who held us, how we were

#### **Examples of risk and protective factors**

Tammy was born slightly premature and narcotic dependent as her mother had used heroin during pregnancy (biological risk). Her mother was thought to be unable to care for her because of ongoing substance use and Tammy was placed with her aunt and uncle when she was one month old (the quality of care she receives in this kinship placement will determine whether it is a developmental risk or a protective factor for Tammy). She was initially a very irritable and unsettled baby but then developed well and established an organised attachment to her aunt (psychologically protective).

When she was aged three, a severe tornado lashed the town where the family lived destroying the house (contextual risk). Although no one was hurt, the family had to live in a shelter for several months, the uncle lost his job and there were a lot of stressors, resulting in him becoming depressed (psychological/ relational risk). In order to find work they had to move from the area they had always lived in to another district where they were socially isolated (socio-cultural risk). They were a resourceful family and developed close relationships with other families who were also new to the town and who helped them settle in the new community (contextually protective).

**Table A.4.2 Rating scales and questionnaires**

Instrument	Comments
<i>Child Behavior Checklist (CBCL) for 1.5-5 yrs</i> (Achenbach & Rescorla, 2000)	<ul style="list-style-type: none"> <li>Two questionnaires to assess adaptive and maladaptive functioning of 1½-5 year-olds. Rated by parents, day care providers and teachers</li> <li>A recent international project using the CBCL identified consistencies in aggregations of emotional and behavioural problems in preschoolers across the 24 societies participating in the study (Ivanova et al, 2010; Rescorla et al, 2011).</li> <li>Proprietary</li> </ul>
<i>Strengths and Difficulties Questionnaire (SDQ)</i> (Goodman, 1997)	<ul style="list-style-type: none"> <li>It rates 25 attributes, some positive and other negative. The SDQ has an impact supplement that helps in the assessment of impairment related to behaviours the child is presenting with. Parent and teacher versions for three and four year-olds in several languages</li> <li>Free of charge</li> </ul>
<i>The Ages and Stages Questionnaire (ASQ-3)</i> (Squires & Bricker, 1999)	<ul style="list-style-type: none"> <li>Developed to identify infants and young children (0-5) with potential developmental problems. Five areas are screened: communication, gross motor, fine motor, problem solving, and personal-social. Completed by parents/carers</li> <li>Proprietary</li> </ul>
<i>The Ages and Stages Questionnaire: Social Emotional (ASQ:SE)</i> (Squires et al, 2003)	<ul style="list-style-type: none"> <li>A culturally versatile tool for clinicians to identify and monitor children at-risk for social, emotional and behavioural delays. The ASQ-SE rates a child's development in the behavioural areas of self-regulation, compliance, communication, adaptive, autonomy, affect and interaction with people</li> <li>Proprietary</li> </ul>
<i>Preschool Age Psychiatric Assessment (PAPA)</i> (Egger & Angold, 2004)	<ul style="list-style-type: none"> <li>A structured parent interview for diagnosing psychiatric disorders in preschool children (two to five years old). Used as a research tool, it can be used in also clinical work.</li> <li>Proprietary; formal training required. For more information</li> </ul>
<i>The Parenting Stress Index – Short Form (PSI-SF)</i> (Abidin, 1995)	<ul style="list-style-type: none"> <li>Screens for stress in the parent-child relationship, dysfunctional parenting, parental behaviour problems and child adjustment difficulties within the family.</li> <li>Available in several languages.</li> <li>Proprietary. More information at</li> </ul>

comforted, how our needs were met. This information is stored in procedural memory, memory for actions, not in verbal memory. The earliest experiences with our parents occurred long before we were able to put emotions in words. As Winnicott (1987) puts it: "... she was a baby once, and she has in her the memories of being a baby; she also has memories of being cared for, and these memories either help or hinder her in her own experience as a mother" (p 6).

Parents with a personal history of abuse or neglect enter parenthood at a disadvantage. This is because of the inadequate internal models they have to draw on, the effect of early neglect or abuse on their own capacity for self-regulation and reflection, and often limited current family and social support. Only about one third of children who have been abused go on to be abusive parents (Egeland et al, 2002), but this is clearly a risk factor for difficulties in parenting. Assessment of risk is discussed further below.

### Questionnaires and interviews

Besides the history and clinical observation of the child, questionnaires, rating scales and structured interviews can be used to help in the assessment

John Bowlby (1907 – 1990), a British psychiatrist, was the main theorist behind the concept of attachment.



process. Standardized instruments pose questions about the child's behaviour that can be easily rated. They are designed to be completed by parents, child-carers and teachers, giving information about the child's functioning in different contexts. These are summarised in Table A.4.2.

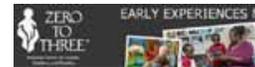
### ASSESSING INTERACTIONS BETWEEN PARENTS AND INFANTS OR YOUNG CHILDREN

Even in a brief interview with a family, many observations can be made that provide information about the *quality* of the interaction and relationships. Observation of the quality of the relationship with the child is also a central part of assessing risk. Interactions reflect the parents' nurturing capacity, their ability to respond sensitively and appropriately to their child's cues as well as the child's ability to accept and respond to parental care.

The daily routines of feeding, sleeping and changing are the setting for important social exchanges, and also times of increased risk for the child if the caregiving system is stressed or inadequate. What parents actually do is more important than what they say or think they do. Parents' sensitivity to the child's communications is central to the development of the relationship between them and is predictive of the kind of attachment relationship that is developing with each parent. Observation of the parents' responses to their child's emotional signals and communications, and the parents' capacity to interpret these and respond appropriately, is the basis of the assessment.

*Observation provides information about:*

- Parental sensitivity to the child
- Child responsiveness to parental care and attention
- The *fit* between them
- Child and parent safety



An extensive list of potential psychosocial and environmental stressors identified in the DC:0-3R: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, (Zero to Three Press; 2005) can be found and downloaded at the website (click on the picture).

- Parents' capacity to work together to care for the child and the quality of their relationship.

*The relationship and interaction with the child is affected by:*

- Immediate contextual factors
- Individual aspects and characteristics of the caregiver and child
- Events in the past, especially the parents' experience of being parented.

*The behaviour of the parents and child while they are with you is as important as what is said.* It is recommended that clinicians pay as much attention to what parents and infants are *doing* as to what they are *telling* you. With the infant in the room you will see how easily they settle, how responsive they are to parental voice and touch, how they indicate their needs and how these are responded to. With a toddler present, you will learn a great deal about how free he feels to explore the room, how much proximity he seeks from his parent and the behaviours that gain parental attention.

The language used by parents, the way they talk to and about their child also provides information. You may notice for example:

- Offhand remarks and nicknames
- Stories, when a parent may consciously or unconsciously be talking about other people or situations but is describing something about the child, or their interactions with the child
- Non-verbal communication between parents, and between parent and child, particularly facial expression and touch
- What parents say to the child, what they say about the child and how these compare.

*Ideally, communication between parent and infant or young child is:*

- *Contingent:* the parent is responsive to the child's cues, rather than intrusive and insensitive
- *Collaborative:* both parties are active participants in the interaction and build or *repair* their communication together to restore optimal and comfortable levels of arousal
- *Emotionally attuned:* the parent is able to identify and *tune into* the child's emotional state and to organise their response appropriately.

All this depends on the capacity of the caregiver to be empathic, and to be *attuned to the mind of the child*. It requires parents to reflect on their own experiences and inner state and to acknowledge their child as an *experiencing being*: to *be with* rather than *do things to* their child. This is known as *reflective* or *mentalising* capacity.

### **Reflective or mentalising capacity**

Mentalising or reflective capacity refers to the activity of understanding behaviour in relation to mental states, or "holding mind in mind" (Allen et al, 2008, p3). Mental states include thoughts, feelings and intentions; mentalising involves "the capacity to think about feeling and to feel about thinking" in oneself and in others (Slade, 2005; p271). Fonagy and colleagues (1991) propose

**Assessing interaction**

- A mother, who was having treatment for a postpartum psychosis, said proudly that she was breastfeeding her baby and it was going well. When the baby started moaning she picked him up and positioned him well to feel but did not open her shirt or give the baby access to her breast, just holding him against her shirt where the baby vainly attempted to latch onto the breast. The mother seemed unaware of his struggle until he grizzled loudly. She still did not open her shirt until the clinician suggested it.
- A two year old boy fell off the chair during the assessment and bumped his head quite hard. His mother had described him as “independent”. Instead of crying or going to his mother, he walked to the window and looked outside. It was striking to the interviewer that he did not seek parental comfort or show distress.
- A five year-old boy is brought by his mother to a consultation with a primary care psychologist. The boy was referred by his teacher because he was not able to do the activities proposed in class. He was always quiet and alone, refusing peers’ invitations to play. The mother could not understand his behaviour. In their second consultation, the psychologist invited the boy to play offering him some toys. The boy only could play when the mother came into the room and gave him verbal instructions about what to do. He only moved or changed toys after she gave him *permission*. After that, the psychologist enquired more about his habits and noticed that he was not allowed to do anything the mother had not planned.

that the parent’s capacity to hold the child’s experience in mind is linked to the intergenerational transmission of attachment security (Slade et al, 2005).

There are formal assessments of reflective capacity available, for example the *Parent Development Interview* or PDI (Slade, 2005). In relation to clinical assessment, the focus is on the parent’s capacity to take the child’s perspective to appreciate that the child has an experience separate from their own. Children are at higher risk of maltreatment if parents consistently misperceive or misinterpret their behaviour (Howe, 2005).

**Semi-structured play assessment**

Some services use a structured or semi-structured process for assessing the parent child relationship. An example is the *Modified Crowell Procedure* (Crowell & Feldman, 1988), which was developed for use with children aged 12-60 months and takes between 30 and 45 minutes to administer. The parent is asked to undertake a series of activities with the child. This usually includes: to play “as you would at home” (free play); to follow the child’s lead in the play; asking the child to clean up; playing with bubbles, a series of puzzles or problem-solving tasks and a brief separation/reunion. At the end, the carer is asked how representative these interactions were of what happens at home. The purpose of this assessment is to observe the carer and child interacting together in a series of slightly different tasks as a way of identifying strengths and weaknesses in their relationship. The focus is on problem solving, play and enjoyment and on an informal assessment of attachment. It gives an opportunity to observe the child’s persistence, their use of the carer for support, their ability and willingness to ask for help, their fine and gross motors skills, and the degree of enjoyment, ease and pleasure in the interactions. The quality and nature of each participant’s behaviour as well as of their interactions is important, as is the transition between tasks (e.g., do children have difficulty shifting from one activity to another? Is their attention span limited? Do they cooperate with the request to tidy up? How clearly do parents communicate with the child?). How children use the caregiver for support

A comprehensive assessment is based on an understanding of the developmental tasks of the period and observations of the child–carer relationship. It includes:

- The clinical assessment interview
- Observation of parent–child interaction and relationship
- Developmental assessment of the child

Parents of infants and toddlers frequently are worried about developmental delays and behaviours related to autism spectrum disorders (ASDs). It is important that clinicians keep this in mind to recognize the early signs of ASDs; children with ASD whose conditions are diagnosed early and who participate in appropriate intervention programs have better outcomes (Johnson et al, 2007). [The American Academy of Pediatrics](#) has resources to support paediatricians in the identification and care of children with ASD.

during transitions between activities and the separation and reunion is especially important because these changes represent mild stressors to young children. More discussion about the use of observational measures in assessment can be found in Aspland & Gardener, 2003, Crowell 2003; Crowell & Feldman, 1988; Miron et al, 2009.

## DEVELOPMENTAL ASSESSMENT

A developmental assessment can be included, when appropriate, as part of the therapeutic intervention. Many kinds of developmental assessment can be undertaken depending on the purpose of the assessment, the clinician's skill and the family's needs and concerns. Involving parents in the assessment process provides them with useful information about their child's abilities and needs and also allows the clinician to see what use parents make of this information. Advisability for a developmental assessment can arise from the history and observations of the child as well as from the results of rating scales or questionnaires such as the *Ages and Stages Questionnaire* mentioned above.

### Conducting a developmental assessment

#### General principles

- First, as in any assessment, ask what information the parents *want* to receive. This helps build rapport and indicates to the family that the process is for the benefit of the child and family. Respecting parents' requests at this stage may enable more sensitive or difficult information to be discussed at a later stage
- Provide a safe, comfortable environment for the child
- Assess infants' optimal level of functioning and what they can do with support
- Involve one or both parents (in the room for infants, or behind a one-way mirror for older children) in the process of assessing their child's skills, interests, behaviour and adaptive capacities.
- Be aware of and sensitive to cultural differences, respecting and appreciating these

Some of the instruments used for developmental assessments are:

- The *Neonatal Behavioural Assessment Scale (NBAS)* (Brazelton & Nugent, 1995). The NBAS was designed to capture the early behavioural responses of infants to their environment, before their behaviour is shaped by parental care. Brazelton and Nugent's assumption is that a baby is both competent and complexly organised and an active participant in the interaction with caregivers. The assessment seeks to help understand the infant's side of the interaction
- The *Bayley Scales of Infant Development (BSID)* (Bayley, 1993). Applicable to children 1-42 months of age, provides information about the child's language development, problem-solving skills, gross and fine motor development, attentional capacity, social engagement, affect and emotion, and the quality of the child's movement and motor control
- The *Wechsler Preschool and Primary Scale of Intelligence (WPPSI)* (Wechsler, 2002). Neuropsychological assessment that can be useful

#### The 4 Ps

The 4 Ps is a way of summarising the factors contributing to the problem as:

- *Predisposing*: what made this family vulnerable?
- *Precipitating*: why have they come now?
- *Perpetuating*: what makes it hard for things to get better?
- *Protective*: what strengths can we identify and build on in our intervention in the child, the family and the social and cultural context?

for children from 30 months of age onwards. It evaluates children's verbal comprehension, perception, organization and processing speed abilities, giving clinicians a developmental perspective of the child's intelligence.

- The *Vineland Adaptive Behavior Scales* (Sparrow et al, 1984). A parent interview that obtains information on children's adaptive functioning in real-life situations covering the domains of daily skills, communication, socialization, motor functioning and maladaptive behaviour.

## FORMULATION

The aim of assessment is to understand why *this family* is presenting with *this problem* at *this time*, and what are the impediments or obstacles that have prevented them from resolving their difficulties without professional help. This information forms the basis for what is called a *formulation*. Formulation is an integrative statement that provides an aetiological understanding of the problem and of the factors contributing to the presentation. It can take different forms, but ideally includes consideration of biopsychosocial factors. This summary informs the development of a comprehensive intervention plan. Another way of thinking about formulation is to identify or organise the information obtained in the assessment into what can be called the *4 Ps*.

Ideally, during the process of assessment, the family and clinician come over time to a new, shared understanding – a story – about the meaning and nature of the presenting difficulties and also the way forward. Developing an intervention and anticipating prognosis requires the clinician to think about and identify protective factors and resources that can be built on.

### The role of diagnosis

When possible, establishing a diagnosis contributes to a more complete formulation. For example, a diagnosis can help clinicians to decide which treatment is appropriate. It can also facilitate communication between the various professionals taking care of the child. With these purposes in mind, efforts have been made to elaborate a diagnostic classification for mental health problems in infants, toddlers and preschool children. The most important systems currently available are the *Diagnostic Classification of Mental Health Disorders of Infancy and Early Childhood* (DC: 0-3R) (Zero to Three, 2005) and the *Research Diagnostic Criteria-Preschool Age* (Task Force on Research Diagnostic Criteria: Infancy and Preschool, 2003).

## ASSESSING RISK IN INFANCY AND EARLY CHILDHOOD

Assessment of risk is an implicit – and sometimes explicit – aspect of every assessment of infants or young children and their caregivers. In many countries, health workers are required by law to report children who are at risk. Like all other assessments, risk assessment requires a detailed history, observation of relationships and information from a range of sources. Risk to the infant or to the relationship with the infant occurs whenever the caregiver's resources are overstretched. In considering risk in infancy and early childhood we are considering risk *within a relationship*. Infants can also be at risk developmentally or physically because of medical illness or prematurity, but the caregiving relationship and the social

### Symptoms of concern in young children

- Very frequent tantrums
- No tantrums at all, too quiet and compliant
- Role reversal:
  - Controlling and punitive
  - Compulsive caregiving
- Self-soothing, masturbating
- Self-harming, head banging
- Persistent regression, loss of toileting, more clingy
- Persistent precocity and over-maturity (little adult).

Toddler and preschool presentations are discussed further in Luby (2006) and Banaschewski (2010).

**Table A.4.2 Indicators that an infant/child is at possible physical, psychological or developmental risk.**

In the infant/child	In the parents	In the context
<ul style="list-style-type: none"> <li>• Failure to thrive</li> <li>• Failure to meet expected milestones</li> <li>• Hypervigilant or startling easily</li> <li>• Excessively quiet and withdrawn</li> <li>• Marked aggression in a toddler</li> <li>• Basic needs not met</li> <li>• Role reversal or caregiving behaviour towards parent</li> <li>• Emotion regulation problems</li> <li>• Unexplained bruising or medical injury</li> </ul>	<ul style="list-style-type: none"> <li>• Inability to recognise or prioritise the child's needs</li> <li>• Untreated or inadequately treated psychiatric illness or substance abuse</li> <li>• Lack of insight and lack of engagement with treatment services</li> <li>• Child incorporated in parental delusional system, including positive delusions</li> <li>• Insensitivity to child's signals and needs (emotionally unavailable)</li> <li>• Thoughts of self-harm or fear of harming child</li> <li>• Scared of infant, ignores infants cries</li> <li>• Frightening or looming behaviour, rough handling of infant</li> <li>• Hostile or negative attributions ("he is out to get me")</li> <li>• Unrealistic developmental expectations</li> <li>• Lack of parenting skills</li> </ul>	<ul style="list-style-type: none"> <li>• No other available and protective adult</li> <li>• Significant cultural or social isolation</li> <li>• Minimal social supports</li> <li>• Domestic/family or community violence</li> <li>• Multiple social risks (e.g., homelessness, itinerancy)</li> <li>• Chronic stress</li> </ul>

Developed in conjunction with Nicholas Kowalenko, Sarah Mares, Louise Newman, Anne Sved Williams, Rosalind Powrie, and Karin van Doesum.

context of that relationship are major determinants of the psychological outcome for the child.

There are various degrees and types of risk, which range from physical illness or disability in the infant, to those associated with child abuse and neglect. As well as prematurity and medical illness, factors that contribute to developmental risk include child temperament, problems with attachment, parental mental illness, exposure to violence, socioeconomic status, poverty and adolescent parenthood (Zeanah et al, 1997).

Here the focus is on the assessment of risk to the child within the caregiving relationship. When one or both parents have psychiatric illness, substance abuse histories or the domestic situation is unsafe, it is also necessary to assess the risk (of self-harm or violence) to the child's caregivers. When the caregiver is at risk, the child is also at indirect risk because of the centrality of the caregiving relationship to the child's wellbeing. Therefore domestic violence, even in the absence of violence directed towards the child, represents a significant developmental risk. The cumulative developmental impact of multiple risk factors must also be considered (Appleyard et al, 2005).

Rajni's parents both used drugs and alcohol regularly after her birth and possibly also during the pregnancy. She was neglected, physically abused and there was considerable violence between the parents. She was removed from her parents aged 11 months after an unexplained leg fracture. At that time her milestones were a little delayed and she was small for her age. She was placed with an older relative who cared well for her and her growth and development improved.

When she was 2½ years, her carer developed cancer and Rajni was returned to her parents. Another period of neglect and exposure to violence followed. Rajni was again placed with a foster family when she was 3½. They reported frequent tantrums, often scratching and hitting her head. She hoarded and stole food and was indiscriminate socially, attaching herself to relative strangers, climbing on their laps and holding their hands, and she would "go blank" when told off or reprimanded or if there was a loud noise, particularly shouting or arguing.

Rajni's difficulties could be understood as survival strategies she had developed in response to her early neglect and abuse. Her behaviour began to settle after a period in a safe and loving home environment but she remained sensitive to noise and had difficulties with sleeping, feeding and regulating her emotions.

### Risk

- Risks can be identified within the individual, the caregiving relationship and the social context
- Assessment involves weighing up risk and protective factors
- The greatest developmental impact is from cumulative risks, in particular those that operate long term
- Risk assessment requires history, observation of interactions and information from a range of sources

### Types of Risk

In general, risk can be defined as the probability of an event occurring, including consideration of the losses and gains associated with it. In this context (infant development and child protection) risk assessment is not free from cultural and moral judgements. There is a high degree of uncertainty when predicting risk in child-protection matters and inevitably this contributes to the anxiety felt by even very experienced clinicians working in this area.

In this context, different types of risk can be identified:

- Risk to the child's immediate physical or emotional safety
- Risk to the child's optimal development. This acknowledges the importance of early experience for later outcome. Genetic, in-utero and physical factors such as illness may be present
- Indirect risk, such as repeated separation from a parent hospitalised with a psychiatric or medical illness. Parental mental health problems are a significant risk factor.
- Cumulative risk occurs when a child and family are exposed to multiple risk factors. For example, a premature infant born to a young single mother with a narcotic addiction with little family support is clearly at greater risk than a premature infant with similar medical and biological risk factors, born to a couple with adequate financial and practical support.

The greatest developmental risks are those that operate long term, for example:

- Chronic neglect
- Chronic instability in the family's personal and social circumstances
- Exposure to parental personality disorder or dysfunction and ongoing mental health problems.
- Ongoing hostility towards the child

### Consequences of maltreatment

Children who have been abused or neglected may have physical, emotional and behavioural sequelae, which may then make caring for them more difficult. For example, traumatised children may continue to show avoidant or disruptive behaviour for some time after being placed in safe fostering environments. Abuse and neglect may have long-term effects on the child's understanding of feelings and relationships. A child with brain damage after head trauma may have long-term physical and emotional symptoms, meaning that caring for them is particularly difficult and challenging. This presents parents (including foster and adoptive parents) with challenges that they may not have anticipated, requiring them to demonstrate more patience or perseverance than with a less traumatised child.

Infants in high-risk situations are more likely to develop insecure or disorganised attachment relationships with their caregivers. There is evidence that disorganised attachment during infancy is linked to emotional and behavioural difficulties in childhood, adolescence and adult life. Therefore, although an infant may not be at an immediate physical risk, an erratic, neglectful or unstable caregiving environment is a threat to their social and emotional development. In child neglect, chronic unresponsiveness to the child's physical or emotional needs can have profound developmental consequences but may be harder to detect than physical abuse. Unfortunately, many infants at risk suffer both neglect and abuse, and neglect.

## PARENTING AND PARENTING CAPACITY

Many definitions of parenting and parenting capacity have been suggested over time (Jones, 2001; Reder et al, 2003). The core elements of parenting as defined by Hoghughli (1997) are:

- *Care*: meeting the child's needs for physical, emotional and social well-being, and protecting the child from avoidable illness, harm, accident or abuse
- *Control*: setting and enforcing appropriate boundaries; and
- *Development*: realising the child's potential in various domains.

Knowledge, motivation, resources and opportunity are necessary to be an effective parent.

### Parenting capacity

Parenting capacity can be described as the capacity to recognise and meet the child's changing physical, social and emotional needs in a developmentally appropriate way, and to accept responsibility for this. Parenting capacity is determined by:

- *Parental factors* (and the parent-child relationship), including the parent's models and understanding of their parenting role, and ability to understand their infant's emotional and psychological needs
- *Child factors* (and the child-parent relationship)
- *Contextual sources of stress and support* (and the family-context interaction) (Reder et al, 2003).

Recently, there has been consideration of the relative weight or emphasis to be given to each of the above factors in considering risk to infants and children.

### Risk in Infancy

- There are degrees of risk
- Risk factors may be cumulative—there is rarely a linear correlation between any one risk factor and later developmental outcome. There is a linear correlation between number of risk factors and developmental impact
- Risk may be direct or indirect
- Risk may be to immediate physical safety or to longer term psychosocial development.

Donald and Jureidini (2004) argue that parenting capacity assessment should centre primarily on the parent's ability or potential to provide empathic, child-focused parenting; in other words, on the "adequacy of the emotional relationship between parent and child", specifically "on the parental capacity for empathy" (p7). They describe factors in the child or the relational and social context as "modulating effects" upon the primary domain of parenting capacity. While their approach is untested in practice, it has the advantage of focusing the clinician on the quality of the relationship and the parents' potential for an adequate emotional relationship with their child, and links with the growing literature on parental reflective capacity as a core factor mediating risk. Farnfield (2008) proposes a theoretical model for assessment of parenting, identifying seven core dimensions and a number of modifying variables. This model uses an ecological framework informed by attachment theory and a systemic approach, identifying the parent's own history of being parented as the first of these core parenting dimensions.

### Capacity for change

Assessing the parents' capacity for change in situations where risk to the infant or caregiving system has been identified, or abuse or neglect has occurred is a necessary but difficult task.

For example, an adolescent mother has been unable to help her infant into organised patterns of sleeping, waking, eating and playing. The infant is failing to gain adequate weight and is fussy and restless. This parent may lack adequate information about infant development but is otherwise motivated and has just enough resources to meet the infant's needs. Support and education may reduce the risk to this infant, allowing her to get on with her development. However, if there is a lack of motivation from the parent, then provision of resources and information will not be enough to protect the infant from the consequences of neglect.

Repetition of abuse occurs in 25%–50% of families in the UK where children are returned to their parents after removal following abuse or neglect (Reder, 2003). Difficulty in identifying when it is appropriate to provide care or nurture, or when protection or control (limit setting) is required, are common for parents with histories of maltreatment. This can affect their capacity to parent adequately and to use available resources and support services.

Concerns about the immediate or long-term safety of an infant or a caregiver need to be addressed openly and directly with the caregivers and referral agency. Appropriate intervention must follow, and processes be put in place for monitoring the ongoing safety and wellbeing of all family members. Where possible, this involves establishing a network of support for vulnerable families and assessing their capacity to use services and relationships, to parent safely and effectively, to reflect on past experience, and to give priority to their child's needs for care and protection.

## CONCLUSION

Assessment of families with infants and young children occurs in a variety of contexts and for many different reasons. Nonetheless, a comprehensive assessment should always include a relational and developmental focus, with consideration of both strengths and vulnerabilities that parents' and child bring to their current

### Factors that promote resilience in the child (Ferguson & Horwood, 2003; Sameroff et al, 2003)

- A well-functioning parent or other involved adult
- Social supports
- Professional intervention when it is indicated
- Consistency in other relationships and activities
- Having a skill or talent.

circumstances, and attention to biopsychosocial factors that help or hinder the family at this time of rapid developmental change.

A working alliance between the family and the clinician supports any proposed interventions. Concerns about the immediate or long-term safety of the child or caregivers need to be addressed openly and directly with the caregivers and referring agency. Appropriate intervention must follow, and processes put in place for monitoring the ongoing safety and wellbeing of all family members.

All assessments of young children involve consideration of risk. The notion of risk in infancy and early childhood is complex and multifactorial. It includes consideration of immediate risks to child and parent safety, of the impact of single and cumulative risk factors, and the notion of developmental risk and psychopathology following early adversity. The vulnerability and dependence of young children on the availability of their caregivers means that risk is always considered within the caregiving context, and that threats to the safety of either or both parents inevitably impacts on the child's wellbeing.

Risk increases whenever the child's needs outweigh the capacity of the carers and their supports to meet these needs. As described, this can occur because of factors in the child, the caregiving system (parents), or the social context, and many at risk children and families have vulnerabilities in all three areas.

Situations of high risk are distressing for all concerned, particularly when the clinician is required to recommend the removal of an infant or young child from their home. A comprehensive assessment that includes a careful history, consideration of the coherence of the history provided, observation of interactions between child and caregiver(s), and corroborative history are central to an adequate assessment of risk. This ensures that decisions are based on sound information obtained from a variety of sources and are made in the best interests of the child and the family.

#### **Additional Resources**

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- Zeanah CH (ed) (2009). *Handbook of Infant Mental Health (3rd ed)*. Section III Assessment, Chapters 14–16 (pp231–280). New York: Guilford Press.

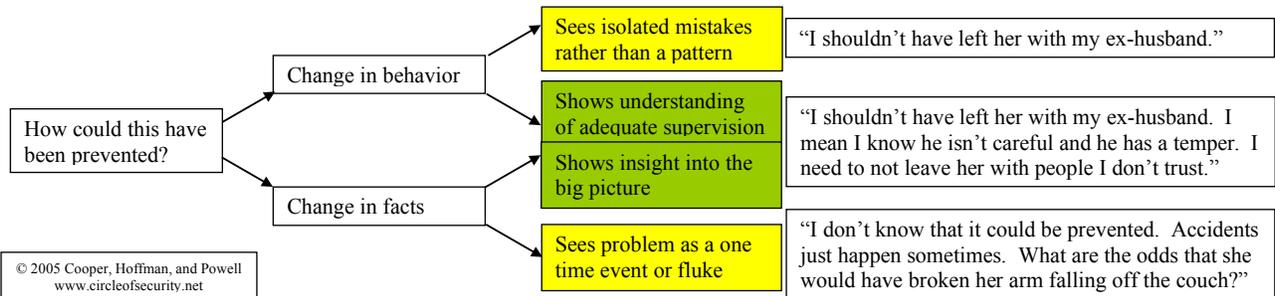
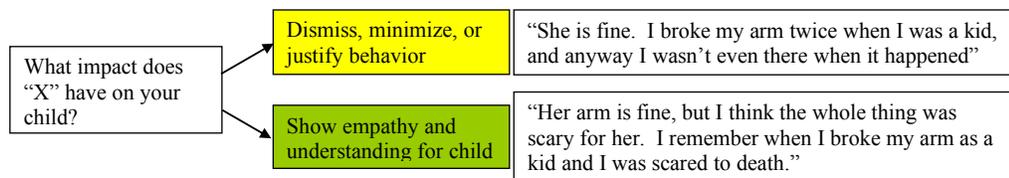
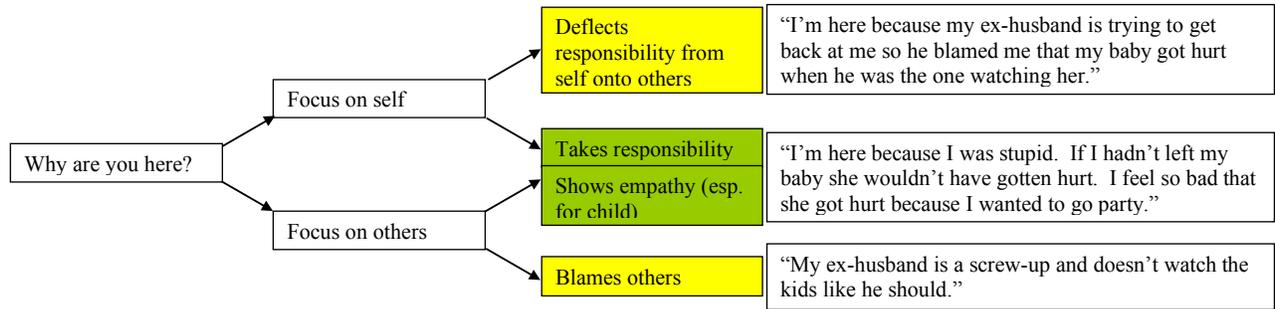
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## Questions for Parents

Taking responsibility for behavior, having empathy for children, and reflecting on the “big picture” are key indicators of parents’ ability to protect children from imminent harm. How a parent answers the following three questions gives clues to that parent’s capacity in the above areas. Answers in yellow boxes suggest a need for increased caution and answers in green boxes suggest greater potential for change. **Parents maybe coached so listening for coherence will be important.**



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## DC:0–5 CROSSWALK TO DSM AND ICD-10

DC:0–5™	DSM-5	ICD-10	
<i>Disorder Name</i>	<i>Disorder Name</i>	<i>Disorder Name</i>	<i>Code</i>
<b>Neurodevelopmental Disorders</b>			
Autism Spectrum Disorder	Autism Spectrum Disorder	Childhood Autism	F84.0
Early Atypical Autism Spectrum Disorder	Other Specified Neurodevelopmental Disorder	Pervasive Developmental Disorder, Unspecified	F84.9
Attention Deficit Hyperactivity Disorder	Attention Deficit/Hyperactivity Disorder	Disturbance of Activity and Attention	F90.1
Overactivity Disorder of Toddlerhood	Attention Deficit/Hyperactivity Disorder, predominantly hyperactive-impulsive presentation	Disturbance of Activity and Attention	F90.1
Global Developmental Delay	Global Developmental Delay	Other Disorders of Psychological Development, Global Developmental Delay	F88
Developmental Language Disorder	Language Disorder	Developmental Disorder of Speech and Language, Unspecified	F80.9
Developmental Coordination Disorder	Developmental Coordination Disorder	Specific Developmental Disorder of Motor Function (Developmental Coordination Disorder)	F82
Other Neurodevelopmental Disorder of Infancy/Early Childhood	Unspecified Neurodevelopmental Disorder	Unspecified Disorder of Psychological Development	F89
<b>Sensory Processing Disorders</b>			
Sensory Over-Responsivity Disorder	Other Specified Neurodevelopmental Disorder	Other Disorders of Psychological Development	F88
Sensory Under-Responsivity Disorder	Other Specified Neurodevelopmental Disorder	Other Disorders of Psychological Development	F88
Other Sensory Processing Disorder	Other Specified Neurodevelopmental Disorder	Other Disorders of Psychological Development	F88
<b>Anxiety Disorders</b>			
Separation Anxiety Disorder	Separation Anxiety Disorder	Separation Anxiety Disorder of Childhood	F93.0
Social Anxiety Disorder (Social Phobia)	Social Anxiety Disorder (Social Phobia)	Social Anxiety Disorder of Childhood	F93.2
Generalized Anxiety Disorder	Generalized Anxiety Disorder	Generalized Anxiety Disorder	F41.1
Selective Mutism	Selective Mutism	Selective Mutism	F94.0
Inhibition to Novelty Disorder	Other Specified Anxiety Disorder	Other Specified Anxiety Disorder	F41.8
Other Anxiety Disorder of Infancy/Early Childhood	Other Specified Anxiety Disorder	Other Specified Anxiety Disorder	F41.8
<b>Mood Disorders</b>			
Depressive Disorder of Early Childhood	Major Depressive Disorder	Depressive Episode	F32
Disorder of Dysregulated Anger and Aggression of Early Childhood	Disruptive Mood Dysregulation Disorder	Other Persistent Mood Disorders	F34.8
Other Mood Disorder of Early Childhood	Unspecified Depressive Disorder	Unspecified Mood Disorder	F39
<b>Obsessive-Compulsive and Related Disorders</b>			
Obsessive-Compulsive Disorder	Obsessive-Compulsive Disorder	Obsessive-Compulsive Disorder	F42.1
Tourette's Disorder	Tourette's Disorder	Tourette's Disorder	F95.2
Motor or Vocal Tic Disorder	Persistent (Chronic) Motor or Vocal Tic Disorder	Chronic Motor or Vocal Tic Disorder	F95.1
Trichotillomania	Trichotillomania	Trichotillomania	F63.3
Skin Picking Disorder of Infancy/Early Childhood	Excoriation (Skin-Picking) Disorder	Factitial Dermatitis, Neurotic Excoriation	L98.1
Other Obsessive Compulsive and Related Disorders	Unspecified Obsessive-Compulsive and Related Disorder	Obsessive-Compulsive Disorder, Unspecified	F42.9

## DC:0–5 CROSSWALK TO DSM AND ICD-10

DC:0–5™		DSM-5	ICD-10	
<i>Disorder Name</i>		<i>Disorder Name</i>	<i>Disorder Name</i>	<i>Code</i>
<b>Sleep, Eating, and Crying Disorders</b>				
Sleep Disorders	Sleep Onset Disorder	Insomnia Disorder	Nonorganic Insomnia	F51.0
	Night Waking Disorder	Insomnia Disorder	Nonorganic Insomnia	F51.0
	Partial Arousal Sleep Disorder	Non-Rapid Eye Movement Sleep Arousal Disorders—Sleep terror type	Sleep Terrors	F51.4
	Nightmare Disorder of Early Childhood	Nightmare Disorder	Nightmares	F51.5
Eating Disorders of Infancy/Early Childhood	Overeating Disorder	Unspecified Feeding or Eating Disorder	Overeating Associated with Other Psychological Disturbances	F50.4
	Undereating Disorder	Unspecified Feeding or Eating Disorder	Other Eating Disorders	F50.8
Atypical Eating Disorder	Hoarding	Other Specified Feeding and Eating Disorder	Feeding Disorders of Infancy and Early Childhood	F98.2
	Pica	Pica	Pica of Infancy and Childhood	F98.3
	Rumination	Rumination Disorder	Feeding Disorders of Infancy and Early Childhood / Rumination Disorder of Infancy	F98.21
Excessive Crying Disorder		None listed	Nonspecific Symptoms Peculiar to Infancy (Excessive Crying in Infants)	R68.1
Other Sleep, Eating, and Excessive Crying Disorder of Infancy/Early Childhood		Other Specified Feeding or Eating Disorder	Other Eating Disorders	F50.8
		Other Specified Sleep-Wake Disorder	Other Nonorganic Sleep Disorders	F51.8
			Nonspecific Symptoms Peculiar to Infancy (Excessive Crying in Infants)	R68.11
<b>Trauma, Stress, and Deprivation Disorders</b>				
Posttraumatic Stress Disorder		Posttraumatic Stress Disorder for Children 6 Years and Younger	Posttraumatic Stress Disorder	F43.10
Adjustment Disorder		Adjustment Disorder, Unspecified	Adjustment Disorder - Unspecified	F43.20
Complicated Grief Disorder of Infancy/Early Childhood		Other Specified Trauma- and Stressor-Related Disorder (Persistent Complex Bereavement Disorder)	Other Reactions to Severe Stress	F43.8
Reactive Attachment Disorder		Reactive Attachment Disorder	Reactive Attachment Disorder	F94.1
Disinhibited Social Engagement Disorder		Disinhibited Social Engagement Disorder	Disinhibited Attachment Disorder of Childhood	F94.2
Other Trauma, Stress, and Deprivation Disorder of Infancy/Early Childhood		Unspecified Trauma- and Stressor-Related Disorder	Reaction to Severe Stress, Unspecified	F43.9
<b>Relationship Disorder</b>				
Relationship Specific Disorder of Infancy/Early Childhood		Parent-Child Relational Problem	Other Specified Problems Related to Upbringing	Z62.820