New Mexico Parent Infant Psychotherapy
MANUAL

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Dedicated to
Alicia Lieberman, Chandra Ghosh Ippen, Julie Larrieu and Soledad Martinez
Wise Mentors and Gentle Guides
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“Every seven minutes a baby or toddler in America is removed from his parents’ care because of alleged abuse or neglect. At a time when these children are first exploring the world, when their lives as learners are just beginning, they are learning that the world is a dangerous and frightening place. Their brains are assaulted by stress hormones that can diminish their IQs and social interactions. Their need to find safe, trusting relationships overrides their curiosity. Their future and the future of their communities are compromised. These young children, a disproportionate percentage of whom are children of color, are often overlooked in the range of approaches designed to improve the early learning environments for poor children. Despite this grim forecast, research confirms that the early years present an unparalleled window of opportunity to effectively intervene with very young victims of maltreatment. Research-informed decision-making combined with developmentally appropriate services can change the odds for these babies and toddlers. Yet, the child welfare system is not guided by what science says babies need. As a result, what unfolds is a developmental disaster for babies.”

—Zero to Three (National Center for Infants, Toddlers, and Families),
Safe Babies, Strong Families, and Healthy Communities, 2014
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-IEMH) 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-IEMH 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-IEMH 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 PIP programs are part of the Early Childhood Home and Family Services (ECHFS) Division of the University of New Mexico - Center for Development and Disability (UNM-CDD). 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

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<th>STATEWIDE TRAINING/SERVICE</th>
<th>EFFECTIVE WORKFORCE/ PULL TOGETHER</th>
<th>PROMOTION/ PREVENTION</th>
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Clinical Foundations of Infant Mental Health
Introductory course to the theoretical frames of infant mental health.

Infant Mental Health: Theory to Practice
Two semester course focusing on development and clinical protocols supporting infants and young children.

Child Parent Psychotherapy and evidenced based
18 month training on trauma inform clinical intervention targeting infants and children age 6. BHS-IECMH in process of making Child Parent Psychotherapy (CPP) the clinical standard.

Leadership Academy
Growing the next generation of IMH leaders in clinical, training, policy and consultation.

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.

Senior Consultants

Building Capacity

New Consultant

New Consultant

New Consultant

New Consultant

Support for Parent Infant Psychotherapy (PIP) Programs Statewide

COMMUNITY OF PRACTICE

Dr. Julie Larrieu
Tulane University
Model

Dr. Alicia Lieberman
University of California-San Francisco (UCSF)
Trauma-Informed CPP Statewide Implementation

Development of three CPP state trainers being trained by Dr. Alicia Lieberman from UCSF
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.
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-ECMH 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.1

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.2 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.3

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.4

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.5 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.6 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.7 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.8 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.”9
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.10

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.11 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.12 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.12

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.14 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.15 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.16 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.17
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. An intervenor’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 last 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.

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.

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. 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. 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. 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.

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.

**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. 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.

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.

**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. 28

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. 29

**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. 30

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. 31

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. 32

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. 33

**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. 34

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

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.
REFERENCES
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.”

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
   • Services under this description include infants and young children birth to 3 years of age who have been comprehensively 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.
   • This service description pertains to infants who are admitted for services before 3 years of age (36 months), and who may be eligible to receive services to age 5 years with an extension approved by the BHS-IECMH Program Director.
   • Services must be 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 target the dyadic relationship between the child and the parent (or primary caregiver).
• Services are provided to the targeted population regardless of Medicaid eligibility.

2. CYFD-004 – PIP Services to Children At-Risk of Severe Emotional Disturbance

• Services under this description include infants and young children birth to 3 years of age who have been comprehensively 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, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. The service description pertains to infants who are admitted for services before 3 years of age (36 months), and who may be eligible to receive services to age 5 years with an extension approved by the BHS-IEMCH Program Director.
• Services must be provided according to the Fidelity Protocol outlined below designed to reduce both the 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 target the dyadic relationship between the child and the parent (or primary caregiver).
• 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. To this end, PIP services prioritize referrals from CYFD’s Protective Services Division.

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; Working Model of the Child Interview (WMCI) or Circle of Security Interview (COSI); Adverse Childhood Events (ACE); *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 the Psychosocial and Environmental Stressors Checklist (PESC) from the new DC: 0-5 manual by June 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

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. 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) 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

<table>
<thead>
<tr>
<th>PROCEDURE CODE</th>
<th>PROCEDURES</th>
<th>BILLABLE TO PIP</th>
<th>PROCEDURE TYPE</th>
<th>DEFINITION</th>
<th>PIP 003</th>
<th>PIP 004</th>
<th>COLLATERAL SERVICE FOR 003,004</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMH00B</td>
<td>Intake and Screening</td>
<td>Yes</td>
<td>Direct</td>
<td>Meet client(s); gather initial information; conduct screenings as needed; and, may begin gathering Psychosocial Intake information.</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
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<tr>
<td>IMH00C</td>
<td>Comprehensive IMH Assessment</td>
<td>Yes</td>
<td>Direct</td>
<td>Crowell; WMCI or COS Interview; DC:0-3R or DC:0-5; and, if doing CPP, the TESI and LSC-R</td>
<td>Yes</td>
<td>Yes</td>
<td>Biological Parents or Concurrent Foster Parents</td>
<td></td>
</tr>
<tr>
<td>IMH04</td>
<td>Dyadic Therapy – I</td>
<td>Yes</td>
<td>Direct</td>
<td>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</td>
<td>Yes</td>
<td></td>
<td>COS-P does not involve dyad directly but addresses how secure parent-child relationships can be supported and strengthened (Biological, Non-Biological or Relative)</td>
<td></td>
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<tr>
<td>IMH05</td>
<td>Collateral work to support Dyad and provide Developmental Guidance without child present</td>
<td>Yes - 12 hours per year per case</td>
<td>Direct</td>
<td>Therapeutic services focusing parent or caregiver on dyadic issues. Child not present. Use this when not doing CoS-P or CPP.</td>
<td>Yes</td>
<td></td>
<td>Primary Biological, Non-Biological or Relative Attachment Relationships</td>
<td></td>
</tr>
<tr>
<td>IMH14A</td>
<td>Family centered meeting with CYFD</td>
<td>Yes - 12 hours per year per case</td>
<td>Direct</td>
<td>Clinician meets with CYFD with family</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>IMH00D</td>
<td>Treatment Planning</td>
<td>Yes - 16 hours per year per case</td>
<td>Indirect</td>
<td>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</td>
<td>Yes</td>
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<tr>
<td>IMH07</td>
<td>Observe Supervised Visit/ Supervised Visit any location</td>
<td>No</td>
<td>Direct</td>
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<tr>
<td>IMH00G</td>
<td>Observation / Assessment with Foster Parent</td>
<td>No</td>
<td>Direct</td>
<td>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</td>
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<tr>
<td>IMH12</td>
<td>IFSP meeting (parent/child present)</td>
<td>No</td>
<td>Direct</td>
<td></td>
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<tr>
<td>IMH14A</td>
<td>Meeting with CYFD (family not present)</td>
<td>No</td>
<td>Direct</td>
<td>Meeting with PPW, investigator, other individuals involved in the case to discuss and review status, etc.</td>
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<tr>
<td>IMH10</td>
<td>Court Testimony (inside courtroom)</td>
<td>No</td>
<td>Direct</td>
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<tr>
<td>IMH10A</td>
<td>Judicial Mediation meeting</td>
<td>No</td>
<td>Direct</td>
<td></td>
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<tr>
<td>IMH61</td>
<td>Judicial Hearing/ no testimony</td>
<td>No</td>
<td>Indirect</td>
<td>Present in courtroom without testifying</td>
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<tr>
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<tr>
<td>S05</td>
<td>Phone Call</td>
<td>No</td>
<td>Indirect</td>
<td>Should not include calls regarding appointment changes, etc.</td>
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<tr>
<td>S17</td>
<td>Text Messaging</td>
<td>No</td>
<td>Indirect</td>
<td>Should not include text messaging regarding appointment changes, etc.</td>
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<tr>
<td>S16</td>
<td>Email</td>
<td>No</td>
<td>Indirect</td>
<td>Should not include emails regarding appointment changes, etc.</td>
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<tr>
<td>S70</td>
<td>Chart Audits</td>
<td>No</td>
<td>Indirect</td>
<td>Case-specific. Enter record for specific cases audited.</td>
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<tr>
<td>S09</td>
<td>Reflective supervision</td>
<td>No</td>
<td>Indirect or Non-client</td>
<td>Reflective supervision within the agency. If the activity involves cases or not specific to a case, can be recorded as a non-client activity.</td>
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<tr>
<td>IMH13B</td>
<td>Clinical / Administrative supervision</td>
<td>No</td>
<td>Indirect or Non-client</td>
<td>If the activity involves cases or not specific to a case, can be recorded as a non-client activity.</td>
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<tr>
<td>S80</td>
<td>Training (as trainee)</td>
<td>No</td>
<td>Non-client</td>
<td>Includes on-line courses as well</td>
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<tr>
<td>S81</td>
<td>Training (as trainer)</td>
<td>No</td>
<td>Non-client</td>
<td>Provides IMH related training to community</td>
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<tr>
<td>IMH13D</td>
<td>Clinical consultation with Deb and Jane</td>
<td>No</td>
<td>Non-client</td>
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<tr>
<td>IMH71</td>
<td>COP Call</td>
<td>No</td>
<td>Non-client</td>
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<tr>
<td>IMH70</td>
<td>IMH/PIP quarterly meeting</td>
<td>No</td>
<td>Non-client</td>
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<tr>
<td>GL31</td>
<td>Travel for work with client</td>
<td>No</td>
<td>Travel</td>
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</table>

REFERENCES
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. To this end, PIP services prioritize referrals from CYFD’s Protective Services Division.

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. 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. This classification needs to be made by a licensed and endorsed IMH therapist.

C. An example of a Referral Form is located in Appendix A.
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 (see form in Appendix A) 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 – form in Appendix A) 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) (both in Appendix A).

D. Following the first meeting with a parent/caregiver and infant/young child, enter the case into the IMH database according to the TIP SHEET titled, Entering a FACTS ID for a Case or Client along with the TIP SHEET titled, Registering a New Case which is available on the CYFD.org website and in Appendix B.

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 7 months to 12 months*.
- **Videotaped Crowell Caregiver-Child Interaction Procedure** – for use from *12 months – 60 months*.
- **Videotaped Crowell Caregiver-Child Interaction Procedure** – for use from *12 months – 60 months*.

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 (both interviews in Appendix A)

D. To determine the infant/young child’s developmental capacities choose from:

- **DC: 0-5, Developmental Milestones and Competency Ratings** (see Appendix A or Chapter 6), 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.³
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:**
• 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

D. At least 80% 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 required 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 PIR-GAS (replaced in June 2017 by DC:0-5 Psychosocial Stressors Checklist) is completed quarterly and entered into 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 maintain fidelity to data entry procedures for each client file on a timely basis (Flow Chart and Tip Sheets in Appendix B).
C. CYFD Behavioral Health Evaluator provides a longitudinal assessment of PIP outcomes looking at data entered regarding the demographics of a case; the ACE score from intake; and, the PIR-GAS insert (replaced in June 2017 by DC:0-5 Psychosocial Stressors Checklist) and PITA scores, which are re-administered quarterly until the case is discharged.

REPORT WRITING
A. The agency with a PIP contract or an individual PIP contractor is expected to complete Quarterly Reports (October, January, April) and 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-I ECMH Program Director is used for report submission and located in Appendix A.

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
   • Billing is accurately and submitted timely
Parent-Infant Psychotherapy (PIP) Fidelity Protocol

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 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.

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<thead>
<tr>
<th>BIRTH – 5 YEARS</th>
<th>REFERRAL/ELIGIBILITY</th>
<th>TOOLS/RESOURCES</th>
<th>FORM</th>
<th>DESCRIPTION/PURPOSE</th>
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| Referral for PIP Services | • CYFD-003 | • CYFD Service Descriptions | • Agency or Individual PIP contractor referral Form | • Priority referrals for PIP services come from CYFD’s Child Protective Division,  
• 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.  
• 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.  
• 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 to age 5 years with an extension approved by the CYFD Infant/Early Childhood Program Director.  
• At least 80% 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. |
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<tr>
<th>BIRTH – 5 YEARS</th>
<th>ASSESSMENT</th>
<th>TOOLS/RESOURCES</th>
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<tr>
<td><strong>Child At-Risk of or Identified with Behavioral/Emotional Disorder</strong></td>
<td>• <strong>Qualifications:</strong> Licensed and Endorsed Infant Mental Health Specialist</td>
<td>• DC: 0-5 or DC:0-3R until trained in Revised System</td>
<td>• Observation, Report and Interview, Diagnostic Criteria</td>
<td>• Child from infancy to 5 years of age with a behavioral/ emotional disorder or at-risk for disorder as indicated by the DC-0-5, Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. * or used DC:0-3R and has plans to attend training in near future. • Priority Referrals for PIP services based upon diagnosis from CPS</td>
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<td><strong>Caregiver Circumstances, Risk and History</strong></td>
<td>• <strong>Experience:</strong> Family/Caregiving History, Current Circumstances, History of Trauma, Mental Illness, Domestic Violence, etc., Previous CPS involvement</td>
<td><strong>CYFD Mandated</strong> • Psychosocial Intake • Adverse Childhood Events (ACES) Questionnaire <strong>Additional Information for Child</strong> • Get Birth/Medical Record (if possible) • Get Part-C Evaluations (if available) <strong>CPP Instruments/Tools</strong> • Life Stressor Checklist Revised (LSC-R) • Traumatic Events Screening Inventory-Revised (TESI-R)</td>
<td>• Caregiver Report/Interview • Medical/Developmental Records</td>
<td>• To determine level of risk regarding trauma, mental illness, substance abuse, domestic violence, etc. • To gather caregiver’s and child’s history • To determine household configuration, economic and social support systems</td>
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<td><strong>Comprehensive Infant and Early Childhood Mental Health Assessment</strong></td>
<td>• <strong>Dyadic Relationship, Caregiver Risks and Protective Capacities, and Child Developmental Competence</strong></td>
<td><strong>CYFD Mandated Dyad</strong> • Crowell Caregiver-Child Interaction Procedure – 12 months – 60 months • Baby Crowell – When child can sit up independently - 7 months to 12 months • Observation of Infant-Caregiver in Routine Activity (feeding, diapering, play) – Birth to 6-7 months • Parent-Infant Relationship: Global Assessment Scale (PIR-Gas) * (To be replaced by Psychosocial Stressors Scale in DC:0-5 at the end of June 2017) Caregiver • Working Model of the Child Interview (WMCI) or Circle of Security Interview (COSI) Child • DC: 0-5 or Observation of Developmental Competence, Domains and Milestones</td>
<td>• Observation, Report, Interview, Videotaping, Diagnostic Criteria • Administration of Tools reflected in IMH database</td>
<td>• 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. • Interactive or Co-regulation is dependent upon a contingent and reciprocal relationship. • Disorder interactions are bidirectional and mutually regulated, with each partner contributing to the exchange. • 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? • Ongoing record of tools administered in IMH database.</td>
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<td>BIRTH – 5 YEARS</td>
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<td>Individualized Treatment, Goals and Strategies</td>
<td>Therapeutic Intervention Targets the Caregiver-Child Relationship</td>
<td>CYFD Recommended</td>
<td>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)</td>
<td>An Individualized Treatment Plan based upon assessment results includes COS-P or CPP goals targeted on aspects of the relationship as an intervention.</td>
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<td>- Child Parent Psychotherapy: A Relationship-Based, Trauma-Informed Treatment Model</td>
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<td>COS-P helps parents or caregivers understand how secure parent-child relationships can be supported and strengthened (child not present)</td>
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### BIRTH – 5 YEARS

#### DOCUMENTATION/ DATA ENTRY

- Track Progress and Services

#### TOOLS/RESOURCES

- Data Assessment Progress (DAP) Notes
- Progress in Treatment Assessment (PITA)
- Developmentally Informed Assessment Per Relationship (DIAPER)
- CPP Fidelity Measures

#### FORM

- Rating Scales
- Checklists

#### DESCRIPTION/PURPOSE

- Forms are in Appendix A and Data Entry information is in Appendix B.
- The DAP Notes are entered in the database after every session.
- 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.
- The DIAPER is a way to track the parent/caregiver’s progress in facilitating age appropriate developmental functioning.
- 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.
- DAP Notes entered into IMH Database after every session
- PITA and PIR-GAS completed quarterly and entered into IMH database for comparative review
- 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.
- PIR-GAS and PITA reentered quarterly from time case is first entered into database.
- 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.
- Each PIP agency or individual contractor submits quarterly reports as well as an annual report detailing cases served and benefit of the services provided.
- The reports are used to measure the PIP program efficacy and to support continued program funding.

### Reflective Consultation/ Supervision

<table>
<thead>
<tr>
<th>TYPE</th>
<th>SUPERVISION/ CONSULTATION SOURCE</th>
<th>FORM</th>
<th>DESCRIPTION/PURPOSE</th>
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<tbody>
<tr>
<td>Reflective Supervision</td>
<td>- Reflective Supervision&lt;br&gt;- Reflective Consultation&lt;br&gt;- Supervision</td>
<td>- It is recommended that PIP contractors receive regular Reflective Supervision and/or supervision by licensed and endorsed IMH specialist from their agency&lt;br&gt;- It is recommended that PIP independent contractors receive Reflective Supervision by an outside licensed and endorsed IMH Specialist&lt;br&gt;- ECHO Model Reflective Consultation 1x a month&lt;br&gt;- Reflective Consultation at Community of Practice Quarterly Meeting with Dr. Julie Larrieu</td>
<td>- In order to maintain protocol and program fidelity regular reflective supervision and consultation is critical to the PIP’s work.&lt;br&gt;- Reflective supervision is recommended for all IMH practitioners due to the evocative nature of working with young children and families.&lt;br&gt;- 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.&lt;br&gt;- With regular reflective consultation, the PIP practitioner uses internal knowledge and external knowledge to examine and advance practice in their clinical work.</td>
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REFERENCES
A.. PARENT INFANT PSYCHOTHERAPY 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), grandparents, 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, 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, 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
- 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;
  - ~ 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;
- 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;
• 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;
  ~ 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;
- 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;
  - 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;
  - 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.
• 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;
• Caregiver’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).
• 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;
• 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.
• 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).
• 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
• Treatment planning;
• Measuring progress in treatment.
  For Custody cases;
• Visitation issues;
• 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
• 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;
• 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;
• 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.
• Attachment building efforts begin after parents:
  ~ Have accepted responsibility for children’s maltreatment;
  ~ Have begun recovery from mental health/substance abuse problems;
  ~ 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.
• 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.
  ~ Developmental differences;
  ~ Time frame differences;
  ~ Importance of caregiving relationships, culture, community;
• Enhance access to services;
• Improve integration and coherence of services.

3 Levels of System Intervention
• Proximal, immediate clinical context:
  ~ Infant-parent relationship;
  ~ Child care setting;
  ~ Child protective services;
  ~ 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;
  ~ CASA workers;
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 website for a lengthy description and further details.
REFERENCES
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.¹

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.²

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.³

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.

   ¹
   ²
   ³
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. 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.

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.

FACTORS THAT MAY COMPROMISE DEVELOPMENT
Here are possible Indicators that an infant/child is at risk for compromised development.

<table>
<thead>
<tr>
<th>Infant/Young Child</th>
<th>Parents/Caregivers</th>
<th>Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Failure to thrive</td>
<td>• Inability to recognize or prioritize the child’s needs</td>
<td>• No other available and protective adult</td>
</tr>
<tr>
<td>• Failure to meet expected milestones</td>
<td>• Untreated or inadequately treated psychiatric illness or substance abuse</td>
<td>• Significant cultural or social isolation</td>
</tr>
<tr>
<td>• Hypervigilant or startling easily</td>
<td>• Lack of insight and lack of engagement with treatment services</td>
<td>• Minimal social supports</td>
</tr>
<tr>
<td>• Excessively quiet and withdrawn</td>
<td>• Child incorporated in parental delusional system, including positive delusions</td>
<td>• Domestic/family or community violence</td>
</tr>
<tr>
<td>• Marked aggression in a toddler</td>
<td>• Insensitivity to child’s signals and needs (emotionally unavailable)</td>
<td>• Multiple social risks (e.g., homelessness, multiple moves, multiple partners)</td>
</tr>
<tr>
<td>• Basic needs not met</td>
<td>• Thoughts of self-harm or fear of harming child</td>
<td>• Chronic stress</td>
</tr>
<tr>
<td>• Role reversal or caregiving behavior towards parent</td>
<td>• Scared of infant, ignores infants cries</td>
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<tr>
<td>• Emotion regulation problems</td>
<td>• Frightening or looming behavior, rough handling of infant</td>
<td></td>
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<tr>
<td>• Unexplained bruising or medical injury</td>
<td>• Hostile or negative attributions (“he is out to get me”)</td>
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<tr>
<td></td>
<td>• Unrealistic developmental expectations</td>
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<tr>
<td></td>
<td>• Inability to recognize or prioritize the child’s needs</td>
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<td></td>
<td>• Untreated or inadequately treated psychiatric illness or substance abuse</td>
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<td></td>
<td>• Scared of infant, ignores infants cries</td>
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<td>• Hostile or negative attributions (“he is out to get me”)</td>
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<td></td>
<td>• Unrealistic developmental expectations</td>
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<td></td>
<td>• Lack of parenting skills</td>
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</table>

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.7

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.8 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.9

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 made 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.10

**DEVELOPMENTAL CAPACITIES AND DOMAINS**  
The Developmental Competency Rating Scale from the DC:0-511 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.*

<table>
<thead>
<tr>
<th>Competency Domain Rating</th>
<th>Emotional</th>
<th>Social-Relational</th>
<th>Language-Social Communication</th>
<th>Cognitive</th>
<th>Movement and Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exceeds developmental expectations</td>
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<tr>
<td>Functions at age-appropriate level</td>
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<tr>
<td>Competencies are inconsistently present or emerging</td>
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<td></td>
<td></td>
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<tr>
<td>Not meeting developmental expectations (delay or deviance)</td>
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</tbody>
</table>

**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.

Expression of overall impression here.

Expression of overall impression here.

Expression of overall impression here.

Expression of overall impression here.

Expression of overall impression here.

Expression of overall impression here.

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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.

<table>
<thead>
<tr>
<th>Indicate how each item contributes to relationship quality:</th>
<th>Contribution to Relationship Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strength</td>
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<tr>
<td>Temperamental dispositions</td>
<td></td>
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<tr>
<td>Sensory profile</td>
<td></td>
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<tr>
<td>Physical appearance</td>
<td></td>
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<tr>
<td>Physical health (from Axis III)</td>
<td></td>
</tr>
<tr>
<td>Developmental status (from Axes I and V)</td>
<td></td>
</tr>
<tr>
<td>Mental health (from Axis I)</td>
<td></td>
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<tr>
<td>Learning style</td>
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</tbody>
</table>

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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REFERENCES
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**
**P - Progress in Treatment Assessment (PITA)**

<table>
<thead>
<tr>
<th></th>
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<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Degree of responsibility parent assumes for state of child (the fact that the</td>
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<tr>
<td></td>
<td>child has been maltreated and/or has emotional, behavioral and relationship</td>
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<td></td>
<td>problems)*</td>
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<td>2.</td>
<td>Sustained awareness demonstrated by parent of the need to change his/her own</td>
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<tr>
<td></td>
<td>behavior</td>
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<td>3.</td>
<td>Evidence that parent can put the needs of their child ahead of their own needs</td>
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<td>4.</td>
<td>Does not blame the child for his/her maltreatment, emotional, behavioral, and</td>
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<tr>
<td></td>
<td>relationship problems*</td>
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<td>5.</td>
<td>Recognition by parent of need to address personal, marital, relationship</td>
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<tr>
<td></td>
<td>problems to improve parenting</td>
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<td>6.</td>
<td>Recognition by parent of need to address substance abuse issues to improve</td>
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<td>parenting</td>
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<td>7.</td>
<td>Recognition by parent of need to address psychiatric disorder in order to</td>
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<td>improve parenting</td>
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*Modification by Jane Clarke, PhD, of New Mexico Early Childhood Infrastructure Project

1. **Degree of responsibility parent assumes for state of child (the fact that the child has been maltreated and/or has emotional, behavioral, and relationship problems)**
   - 0 = parent accepts no responsibility for child’s condition (e.g., does not think neglect/abuse has occurred; does not feel child has been impacted; blames others (i.e., system, reporter, etc) for contact with system)
   - 1 = parent accepts limited responsibility for child’s condition (e.g., admits some problems may exist, does not feel child was impacted)
   - 2 = parent recognizes that child was impacted by behavior and begins to accept personal responsibility
   - 3 = parent accepts personal responsibility for child’s abuse/neglect and can provide convincing detail about ways in which child was impacted

2. **Sustained awareness demonstrated by parent of the need to change his/her own behavior**
   - 0 = parent demonstrates no awareness of need to change his/her own behavior (e.g., feels unjustly accused, ‘picked on’)
   - 1 = parent demonstrates limited awareness of need to change his/her own behavior (e.g., begins to voice awareness of problematic behavior)
2=parent demonstrates some progress in awareness of need to change his/her own behavior and actively works to alter behavior, demonstrates changes in behavior (e.g., can describe problematic behavior and its impact on life)

3=parent demonstrates significant progress in awareness of need to change his/her own behavior, consistently demonstrates change in behavior (e.g., parent reflects on impact of problematic behavior, details efforts made to alter behavior, awareness of impediments to changing problematic behavior)

3. **Evidence that parent can put the needs of their child ahead of their own needs**
   0=no evidence that parent can put needs of child ahead of their own (e.g., shows no ability to identify child’s needs; actively resists suggestion that child’s needs should be priority)
   1=limited evidence that parent can put child’s needs ahead of their own needs (e.g., agrees when child’s needs are pointed out; starting to identify child’s needs but may focus on instrumental needs only)
   2=increasing evidence that parent can put child’s needs ahead of their own, begins to identify and meet some basic emotional needs of child
   3=significant evidence that parent can put needs of child ahead of their own (e.g., parent actively identifies and quickly meets instrumental and emotional needs of child, even if parent’s wishes/needs may be sacrificed; parent values their ability to meet child’s needs)

4. **Parent does not blame the child for his/her maltreatment, emotional, behavioral, and/or relationship problems**
   0=parent actively and consistently blames child for his/her own maltreatment (e.g., cites child’s “bad” behavior; states that child left the house in disarray; blames other children in the home for maltreatment, failure to clean up, etc)
   1=parent sometimes or passively blames child for his/her own maltreatment
   2=parent rarely blames child for his/her own maltreatment
   3=parent does not blame child at all for his/her own maltreatment

5. **Recognition by parent of need to address personal, marital, relationship problems to improve parenting**
   0=parent has no recognition of need to address personal, marital, or relationship problems to improve parenting (e.g., parent does not feel that any changes are necessary to deal with family involvement in child welfare)
   1=parent has limited recognition of need to address personal, marital, relationship problems to improve parenting, just beginning to identify relationship issues that impact parenting
   2=parent has some recognition of need to address personal, marital, relationship problems to improve parenting, has begun to address problems (e.g., can identify several personal, marital, or relationship issues impacting parenting)
   3=parent has clear recognition of need to address personal, marital, relationship problems to improve parenting and continues process of addressing problems (e.g., actively participates with clinician in identification of issues and seeks ways to address issues)

6. **Recognition by parent of need to address substance abuse issues to improve parenting**
   0=parent has no recognition of need to address substance abuse issues (e.g., despite positive drug screens or being ‘high’ in visits, parent denies drug use and/or its impact on parenting “Everyone does it,” “Getting high doesn’t affect my parenting”; multiple excuses for failing to participate in treatment)
   1=parent has limited recognition of need to address substance abuse issues to improve parenting (e.g., occasional positive drug screens, may attend occasional meetings, attendance at drug treatment inconsistent)
2=parent has some recognition of need to address substance abuse issues to improve parenting (e.g., more consistent attendance at drug treatment, attends 12t step meetings, obtains a sponsor)
3=parent has significant recognition of need to address substance abuse issues to improve parenting (e.g., parent identifies effects of drug abuse on parenting, actively attends and values treatment, has obtained a sponsor and is actively, honestly working 12t Steps; can identify a ‘home meeting’) or parent does not have substance abuse issue.

7. Recognition by parent of need to address psychiatric disorder in order to improve parenting
0=parent has no recognition of need to address psychiatric disorder to improve parenting (e.g., parent does not feel that their mental state warrants intervention, shows active evidence of illness, e.g., psychosis, marked depression, significant dysregulation)
1=parent has limited recognition of need to address psychiatric disorder in order to improve parenting (e.g., somewhat able to identify psychological distress, unwilling to receive psychiatric evaluation to address issues)
2=parent has some recognition of need to address psychiatric disorder to improve parenting (e.g., parent has participated in psychiatric evaluation but has not followed up on recommended intervention)
3=parent has significant recognition of need to address psychiatric disorder to improve parenting (e.g., actively engaged in psychiatric treatment, can identify ways in which psychiatric illness impacts parenting) or parent does not have psychiatric disorder

8. Willingness and/or capacity to cooperate with involved professionals in process of treatment
0=parent shows no willingness and/or capacity to cooperate with involved professionals in process of treatment (e.g., parent cannot be reached to schedule appointments, parent refuses all evaluation/treatment)
1=parent shows limited willingness and/or capacity to cooperate with involved professionals in process of treatment (e.g., parent ‘not shows’ multiple appointments; parent refuses some interventions [eg.,DV, drug treatment], parent seems unable to understand/integrate treatment efforts; parent attends appointments but does not actively engage in treatment process)
2=parent shows some willingness and/or capacity to cooperate with involved professionals in process of treatment (e.g., parent misses occasional appointments, at times, but generally engages actively in treatment; parent appears open to treatment process and shows some overall ability to benefit from process of treatment)
3=parent shows significant willingness and/or capacity to cooperate with involved professionals in process of treatment (e.g., parent rarely misses appointments, thinks about treatment outside of session, actively brings issues to treatment for consideration, has incorporated information from treatment into dayt tot day parenting)

9. Potential for change, flexibility, and willingness to try different approaches within a time frame appropriate to child
0=parent shows no potential for change, flexibility or willingness to try different approaches within time frame appropriate to child (e.g., parent unwilling to think about different approaches to parenting)
1=parent shows limited potential for change, flexibility or willingness to try different approaches within time frame appropriate to child (e.g., parent shows beginning willingness to try different approaches, seems inflexible in approach to parenting child, not open to change)
2=parent shows some potential for change, flexibility or willingness to try different approaches within time frame appropriate to child (e.g., parent demonstrates flexibility, willingness to change in some areas)
3=parent has significant recognition of need to address psychiatric disorder to improve parenting (e.g., actively engaged in psychiatric treatment, can identify ways in which psychiatric illness impacts parenting) or parent does not have psychiatric disorder

8. Willingness and/or capacity to cooperate with involved professionals in process of treatment

0=parent shows no willingness and/or capacity to cooperate with involved professionals in process of treatment (e.g., parent cannot be reached to schedule appointments, parent refuses all evaluation/treatment)

1=parent shows limited willingness and/or capacity to cooperate with involved professionals in process of treatment (e.g., parent ‘not shows’ multiple appointments; parent refuses some interventions [e.g., DV, drug treatment], parent seems unable to understand/integrate treatment efforts; parent attends appointments but does not actively engage in treatment process)

2=parent shows some willingness and/or capacity to cooperate with involved professionals in process of treatment (e.g., parent misses occasional appointments, at times, but generally engages actively in treatment; parent appears open to treatment process and shows some overall ability to benefit from process of treatment)

3=parent shows significant willingness and/or capacity to cooperate with involved professionals in process of treatment (e.g., parent rarely misses appointments, thinks about treatment outside of session, actively brings issues to treatment for consideration, has incorporated information from treatment into day to day parenting)

9. Potential for change, flexibility, and willingness to try different approaches within a time frame appropriate to child

0=parent shows no potential for change, flexibility or willingness to try different approaches within time frame appropriate to child (e.g., parent unwilling to think about different approaches to parenting)

1=parent shows limited potential for change, flexibility or willingness to try different approaches within time frame appropriate to child (e.g., parent shows beginning willingness to try different approaches, seems inflexible in approach to parenting child, not open to change)

2=parent shows some potential for change, flexibility or willingness to try different approaches within time frame appropriate to child (e.g., parent demonstrates flexibility, willingness to change in some areas)

3=parent shows significant potential for change, flexibility or willingness to try different approaches within time frame appropriate to child and implements changes (e.g., shows flexibility, demonstrates change in most areas)

10. Makes use of available community resources needed to assist family

0=parent makes no use of available community resources needed to assist family (e.g., parent makes no attempt to follow up on suggestions re: housing, food stamps, other resources to assist family)

1=parent makes limited or inconsistent use of available community resources needed to assist family (e.g., even when parent is directed to community resources, makes little effort to pursue resources for family)

2=parent makes some use of available community resources needed to assist family (e.g., begins to independently seek, and make use of, community resources)

3= parent makes significant use of available community resources needed to assist family (e.g., independently seeks a variety of community resources, collaborates with agencies in meeting needs of family, makes good use of community resources)
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 Maltreatment: Maltreatment occurs whenever an infant/child, birth to 17 years of age, is physically, emotionally, or sexually harmed.

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.

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 of Handicapped Infant; the withholding of medically indicated treatment (appropriate nutrition, hydration and medication) from a disabled infant with life-threatening conditions. Exceptions include those situations in which the infant is chronically and irreversibly comatose; the provision of this treatment would merely prolong dying or not are effective in ameliorating or correcting all of the infant’s life-threatening conditions, and the provision of the treatment itself under these conditions would be inhumane.

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.

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.

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.

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.

**Perpetrator:** The person who was found to have committed an offense, as in abuse or neglect of a child.

**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.

**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.

**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 on 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.

**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.

**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.

**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.
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.

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.

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.

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.

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.

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.

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.

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.

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.
**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 courts 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.

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

Assessment: An ongoing process including the use of tests and tools to identify your child’s or family’s needs and strengths.

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

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.

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

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.

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

Cultural Competence: Respect for the beliefs, interpersonal styles, attitudes, and behaviors both of families who access or are referred to early intervention services and the staff who provide them. Early Intervention policy, administration and practices reflect this competency.

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

Due Process Hearing: A hearing involving a hearing officer who rules on evidence related to a disagreement between a parent and an early intervention provider’s professional judgment.

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.
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.

Family: Parent(s) guardian(s), and/or other person identified by the family.

IFSP: The Individual Family Service Plan is a process for providing early intervention services which results in a written plan for the provisions of those services that includes goals, outcomes, location duration and intensity of each service provided.

IDEA: The Individuals with Disabilities Education Act: A federal law that establishes the Part C Early Intervention Program for Infant and Toddlers with a disabilities.

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).

Mediation: A way to settle a conflict so that both sides win. Parents and other professionals discuss their differences and, with the help of a trained and independent mediator, reach a settlement that both sides accept.

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 peers, who have no disabilities and include the home, childcare and other community settings.

Outcomes: Statements of changes you want for your child and family that are documented in your IFSP.

Referral: When a parent or professional (with the parent’s permission) 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.

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.

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.

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

Transition: The process of planning for support and services for when your child will leave the Family Infant Toddler Program or if you move to a new community.

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 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.
PARENT INFANT PSYCHOTHERAPY FORMS AND INSTRUMENTS

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

PSYCHOSOCIAL ASSESSMENT

Child’s Name ____________________________________________________________

DOB __________________________ Record # __________________________

Source(s) of information ________________________________________________

Information recorded by __________________________ Interview Date(s) ________

Social Environment

Can you tell me the other family members and friends currently living in your home (names, ages, relationships)?

Are there other adults who have important relationships with your child (e.g., daycare providers, relatives, etc., list names and relationship to child)?

Do you have any worries about the other people who take care of your child? (alcohol/drug use, neglect/abuse, etc.)

Does your child have a regular opportunity to play with other children (describe, if in daycare ask name, number of children, child schedule)?

Prenatal and Perinatal Events, Developmental History, Significant early childhood events

Was the pregnancy planned? ☐ Yes ☐ No

Describe the pregnancy, labor, and delivery/ birth.
Did you have regular prenatal care with this child? ☐ Yes ☐ No

Did you have any health problems during the pregnancy? ☐ Yes ☐ No

Did you use drugs or alcohol during the pregnancy? ☐ Yes ☐ No

If yes, what substances were used, how often, and how long?

Did you have any problems during the birth? ☐ Yes ☐ No

Was the baby born with any of the following?

☐ Prematurity
☐ Low Birth Weight
☐ Small for Gestational Age
☐ Intrauterine Growth Retardation
☐ Birth Defects __________________
☐ Infections ____________________
☐ Feeding or Sucking Problems
☐ Neurobehavioral Abnormalities

Gestational Age: ________________  Birth Weight: ________________

Length: ________________  OFC: ________________ (Head Circumference)

If your child was adopted, what is the history of the adoption?

Medical History/Health Care

Where does your child currently receive health care? (Name and address, consider a release of information for health care provider at this point).

When was your child’s last physical exam?
Are your child’s immunizations up to date?

Do you have any questions or concerns about your child regarding the following:
Height?
Weight?
Hearing?
Vision?
Do you have any other concerns about your child’s health? If yes, please describe.

Does your child take any medications regularly?

Does your child have any ongoing medical needs or any past serious medical illnesses, injuries, or accidents? Please note approximate ages/dates and where treated.

Has your child ever been hospitalized since birth?

**Development//Behavioral**

Do you have any concerns about your child’s development? If yes, please describe.

Have you ever been concerned or worried about the way your child expresses his/her feelings?
Or the ways in which your child interacts with others?

Is your child overly sensitive to sounds, touch, or to the environment in general?

Describe your child’s sleep schedule (bedtime, naps, etc.)
Describe your child’s feeding routines.

Does your child have any special problems or developmental disabilities? Describe

Has your child had a developmental evaluation? (Note what and by whom, consider release of information).

Does your child have an IFSP with an early intervention program and/or an IEP from a school district?

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**Child Trauma History**

Children may experience stressful events that may affect their health and well-being. Please help us understand you and your child’s experience by answering the following questions to the best of your knowledge.

To your knowledge, has your child ever been directly threatened with physical harm?

☐ Yes  ☐ No

If yes, please describe:

Has anyone ever physically assaulted your child? (Hitting, pushing, choking, shaking, biting, or burning)

☐ Yes  ☐ No

If yes, please describe:

Has anyone ever punished your child and caused physical injury or bruises?
☐ Yes  ☐ No  If yes, please describe:

Has anyone ever touched your child in a sexual way?
☐ Yes  ☐ No  If yes, please describe:

To your knowledge, has your child ever seen, heard, or heard about, people in your family or surrounds physically fighting, hitting, slapping, kicking, or pushing each other?
☐ Yes  ☐ No  If yes, please describe:

Has your child seen that you or a family member was arrested, jailed, or taken away by the police?
☐ Yes  ☐ No  If yes, please describe:

Do you know what your child was told about the situation?

Has your child ever been yelled at in a scary way?
☐ Yes  ☐ No  If yes, please describe:

Has your child ever had someone threatened to leave or send him/her away?
☐ Yes  ☐ No  If yes, please describe:
Has your child ever gone through a period of time when she/he lacked appropriate care (e.g., not having enough to eat or drink, not having shelter, being left alone when too young to care for him/herself)?

☐ Yes      ☐ No

If yes, please describe:

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**Family History of Child's Parents**

Describe your household composition:

Do you have any other children? If yes, provide names and ages

Do you feel like you struggle providing basic needs to your child?

Where were you born?

Describe family of origin (include significant relationships, what was it like growing up in your home, etc.)

Describe your family's traditions (languages spoken, religious/spiritual practices or identification, community support, etc.)

Describe the ways in which these things impact your parenting.

Family history of developmental delays, emotional or social challenges, medical conditions?
Parent drug/alcohol use

History of family violence &/or trauma or other stressors

CPS involvement (include history of foster home placement)?

Legal Issues- (explore court cases, arrests, convictions, incarcerations, gangs, JPO involvement, DWI, CPS involvement (past investigations, current involvement, in-home services, custody, termination of parental rights, etc)

Education
What is the highest grade you have completed?
What were your difficulties in school? (Special Education, learning disabilities, etc)

Employment
Describe your history of employment:
What is your current job?
What is the source of income?

Physical Health
Describe your physical health (medical diagnosis, serious or contagious illness, hospitalization, major surgery, etc)

Mental Health
Have you ever received counseling or therapy before?
Have you ever been given a mental health diagnosis?

Have you ever been hospitalized due to mental health issues?

Have you ever engaged in self-harming behavior?

Have you ever struggled with suicidal feelings or attempted suicide?

**Substance Abuse**
Describe the use of substances in your family

Explore: Drugs, alcohol, age of first use, types of substances, frequency, blackouts, history of treatment:

**Family Violence**
Have you experienced violence in the family of origin, in romantic relationships, perpetrator, victim, anger issues, verbal/physical/sexual abuse?

Was your child present or has he/she witnessed violence?

**Outside Resources/Supports**
What outside supports do/can you rely on the most/are most supportive (family, friends, church)?

Other agencies/service providers (past & present; please note name, agency, phone # & address; include child’s pediatrician & any child care):
PARENT-CHILD RELATIONSHIP (to be EXCLUDED if already covered in parent perception interview/assessment)

How would you describe your child?

What are his /her strengths?

Describe any separations that have occurred between you and your child (length of time, effect on parent, effect on child, how this was explained to child, current impact on relationship, etc.)

What do you find most difficult about your child?

What do you most enjoy about your child?

How does your child handle transitions?

How does your child handle separations and reunions?

Have you or your family had any major problems or stressors in the past year? (Explore impact on family, parent, child, parent-child relationship)
What are some current difficulties that may be impacting your relationship with your child?

**Parenting Self-Assessment**

*It is helpful to spend some time thinking about your relationship to your child and how you are as a parent to this particular child. Please help us to better understand you and your child by answering the following questions.*

How would you best describe yourself as a parent?

What are your strengths as a parent?

What is challenging for you as a parent?

*How would you describe your relationship with your child? Can you choose one word to best describe your relationship? Please give an example.*

How are you doing? As a parent and any other ways that are important to you.
Do you have concerns about your own health or about being able to care for or manage your child?

Is there any other information you think is important for us to know about you or your child?
# PARENT INFANT PSYCHOTHERAPY PROGRAM

## ADVERSE CHILDHOOD EXPERIENCES SCORING SHEET (ACES)

|---------|---------|--------|---------|--------|---------|--------|---------|--------|-------------------|--------|-------------------|--------|

**While you were growing up, during your first 18 years of life:**

### 1. Recurrent Emotional Abuse

Did a parent or other adult in the household often or very often: Swear at you, insult you, put you down, or humiliate you? Or, act in a way that made you afraid that you might be physically hurt?

### 2. Recurrent Physical Abuse

Did a parent or other adult in the household often or very often... Push, grab, slap or throw something at you? Or, ever hit you so hard that you had marks or were injured?

### 3. Contact Sexual Abuse

Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? Or, attempt or actually have oral, anal, or vaginal intercourse with you?

### 4. Emotional Neglect

Did you often or very often feel that... No one in your family loved you or thought you were important or special? Or, your family didn’t look out for each other, feel close to each other, or support each other?

### 5. Physical Neglect

Did you often or very often feel that... You didn’t have enough to eat, had to wear dirty clothes, and had no one to protect you? Or, your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

### 6. One or No Parent

Were your parents ever separated or divorced?

### 7. Mother is Treated Violently

Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or, sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or, ever repeatedly hit at least a few minutes or threatened with a gun or knife?

### 8. An Alcoholic and/or Drug Abuser in the Household

Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

### 9. Someone who is Chronically Depressed, Mentally Ill, Institutionalized, or Suicidal

Was a household member depressed or mentally ill, or did a household member attempt suicide?

### 10. An Incarcerated Household Member

Did a household member go to prison?

---

**ACE Scores:**

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**CLINICIAN:** ____________________________  **DATE OF SCORING:** ________________
Life Stressor Checklist – Revised
ETTN 2010 Version – Revised September, 2010 by Chandra Ghosh Ippen

Jessica Wolfe, Rachel Kimerling, Pamela Brown,
Kelly Chrestman & Karen Levin

Women’s Health Sciences Division, National Center for PTSD

Note: While the form was originally developed to be a questionnaire, it has been revised to be administered as a clinical interview. Clinicians should ask the questions for each item and then ask follow-up questions as needed in order to be able to code the shaded items for each question.

For the question “how much does this continue to affect you?” please note that we are trying to capture negative impact. Most participants will answer in this way, but some may indicate that the event had a positive impact. If need be ask “how much does this continue to negatively affect you?” If the person indicates that the event affects them in a positive way and does not have a negative impact, mark “not at all.”

CTRP Introduction:
I am going to ask you about different stressful life events that you may have experienced, including being in a disaster like an earthquake or hurricane, witnessing an accident, and being physically assaulted. The reason we ask parents about these types of things is that as we work together to help your child, this may bring up memories about things you’ve been through. Although you have come here for help for your child, I want to be able to help and support you too, so it will help me if I understand a little bit about your life. If any of the questions I ask you make you feel uncomfortable, let me know. You can choose not to answer them or to take breaks.
1. Have you ever been in a serious disaster (for example, an earthquake, hurricane, tornado, large fire, or explosion)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>How old were you when this happened? (clinician mark all that apply)</td>
<td></td>
</tr>
<tr>
<td>[ ] Unknown (only check unknown if no estimate can be given)</td>
<td></td>
</tr>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24</td>
<td></td>
</tr>
<tr>
<td>25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49</td>
<td></td>
</tr>
<tr>
<td>50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 +</td>
<td></td>
</tr>
<tr>
<td>Clinician (write notes describing what happened)</td>
<td></td>
</tr>
<tr>
<td>How much does this continue to affect you?</td>
<td></td>
</tr>
<tr>
<td>1 (not at all)</td>
<td>2 (a little)</td>
</tr>
<tr>
<td>Clinician Code: Severity at time of disaster (what person experienced and/or disruption to life)</td>
<td></td>
</tr>
<tr>
<td>No real impact on person</td>
<td>Mild</td>
</tr>
</tbody>
</table>

2. Have you ever seen a serious accident (for example, a bad car wreck or an on-the-job accident)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>How old were you when this happened? (clinician mark all that apply)</td>
<td></td>
</tr>
<tr>
<td>[ ] Unknown (only check unknown if no estimate can be given)</td>
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<tr>
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<tr>
<td>50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 +</td>
<td></td>
</tr>
<tr>
<td>Clinician (write notes describing what happened)</td>
<td></td>
</tr>
<tr>
<td>How much does this continue to affect you?</td>
<td></td>
</tr>
<tr>
<td>1 (not at all)</td>
<td>2 (a little)</td>
</tr>
<tr>
<td>Clinician Code: Severity level (what person witnessed or knew about)</td>
<td></td>
</tr>
<tr>
<td>Level of severity unknown</td>
<td>None/Mild (saw accident but to person’s knowledge no medical treatment required)</td>
</tr>
</tbody>
</table>
3. Have you ever had a very serious accident or accident-related injury (for example, a bad car wreck or an on-the-job accident)?

<table>
<thead>
<tr>
<th>How old were you when this happened? (clinician mark all that apply)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Unknown (only check unknown if no estimate can be given)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Clinician (write notes describing what happened)

<table>
<thead>
<tr>
<th>How much does this continue to affect you?</th>
<th>1 (not at all)</th>
<th>2 (a little)</th>
<th>3 (somewhat)</th>
<th>4 (a lot)</th>
</tr>
</thead>
</table>

Clinician Code: Severity (harm to anyone involved in accident)

<table>
<thead>
<tr>
<th>No injuries</th>
<th>Mild injury or life threat</th>
<th>Moderate injury or life threat</th>
<th>Severe (requiring medical treatment) or great fear of threat to life</th>
<th>Someone died</th>
</tr>
</thead>
</table>

4. Was a close family member ever sent to jail?

<table>
<thead>
<tr>
<th>How old were you when this happened? (clinician mark all that apply)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Unknown (only check unknown if no estimate can be given)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Clinician (write notes describing what happened)

<table>
<thead>
<tr>
<th>How much does this continue to affect you?</th>
<th>1 (not at all)</th>
<th>2 (a little)</th>
<th>3 (somewhat)</th>
<th>4 (a lot)</th>
</tr>
</thead>
</table>

Clinician Code: Who was sent to jail (check all that apply)

- Bio mom
- Bio dad
- Other relative
- Child’s parent
- Other 1er caregiver
- Other partner before child’s parent
- Grandparents
- Other partner after child’s parent
- Sibling
- Other (specify in notes)

Clinician Code: What were they sent to jail for (check all that apply)

- Unknown
- Violent crime
- Drug related
- Weapon used

Did this result in a significant separation from a 1er caregiver?

- No
- <1 week
- <1 month
- <6 months
- <1 year
- ___ years
5. Have you ever been sent to jail?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How old were you when this happened?  (clinician mark all that apply)  

[ ] Unknown (only check unknown if no estimate can be given)  

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
|---|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

Clinician (write notes describing what happened)

<table>
<thead>
<tr>
<th>How much does this continue to affect you?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>(not at all)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a little)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(somewhat)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a lot)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinician Code: Did this happen during target child’s life?  

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

Clinician Code: Did this happen during another child’s life?  

<table>
<thead>
<tr>
<th>No</th>
<th>Yes →</th>
</tr>
</thead>
</table>

Clinician Code: What were they sent to jail for (check all that apply)  

<table>
<thead>
<tr>
<th>Unknown</th>
<th>Violent crime</th>
<th>Drug related</th>
<th>Weapon used</th>
</tr>
</thead>
</table>

Clinician Code: Did this result in a significant separation from child?  

<table>
<thead>
<tr>
<th>No</th>
<th>&lt;1 week</th>
<th>&lt;1 month</th>
<th>&lt;6 months</th>
<th>&lt;1 year</th>
<th>___ years</th>
</tr>
</thead>
</table>

6. Were you ever placed in foster care or adopted?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How old were you when this happened?  (clinician mark all that apply)  

[ ] Unknown (only check unknown if no estimate can be given)  

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
|---|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
|   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |    |    |    |    |

Clinician (write notes describing what happened)

<table>
<thead>
<tr>
<th>How much does this continue to affect you?</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>(only code negative impact)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(not at all)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a little)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(somewhat)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a lot)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinician Code: Number of placements? (include family of origin as 1, so minimum=2)  

Clinician Code: Type of placement (check all that apply)  

<table>
<thead>
<tr>
<th>Institutional care/group home</th>
<th>Foster care – relative or friend</th>
<th>Foster care – unrelated</th>
<th>Adoption</th>
<th>Other (explain in notes)</th>
</tr>
</thead>
</table>

Clinician Code: (total length of separation(s) from caregiver)  

<table>
<thead>
<tr>
<th>Adopted</th>
<th>&lt;1 week</th>
<th>&lt;1 month</th>
<th>&lt;6 months</th>
<th>&lt;1 year</th>
<th>Year+ or multiple significant separations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age_____</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. Did your parents ever separate or divorce while you were living with them?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How old were you when this happened? (clinician mark all that apply)

[ ] Unknown (only check unknown if no estimate can be given)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 |

Clinician (write notes describing what happened)

How much does this continue to affect you?

<table>
<thead>
<tr>
<th>1 (not at all)</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinician Code: Level of contact with parents following divorce (check one for mom and dad)

<table>
<thead>
<tr>
<th>Mom</th>
<th>Dad</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Have you ever been separated or divorced?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How old were you when this happened? (clinician mark all that apply)

[ ] Unknown (only check unknown if no estimate can be given)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 |

Clinician (write notes describing what happened)

How much does this continue to affect you?

<table>
<thead>
<tr>
<th>1 (not at all)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


9. Have you ever had serious money problems (for example, not enough money for food or a place to live)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>How old were you when this happened? (clinician mark all that apply)</td>
<td></td>
</tr>
<tr>
<td>[ ] Unknown (only check unknown if no estimate can be given)</td>
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<td></td>
</tr>
<tr>
<td>50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73</td>
<td>+</td>
</tr>
<tr>
<td>Clinician (write notes describing what happened)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How much does this continue to affect you?</th>
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<th>4 (a lot)</th>
</tr>
</thead>
</table>

10. Have you ever had a very serious physical or mental illness (for example, cancer, heart attack, serious operation, felt like killing yourself, hospitalized because of nerve problems)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>How old were you when this happened? (clinician mark all that apply)</td>
<td></td>
</tr>
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<td>+</td>
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<td>Clinician (write notes describing what happened)</td>
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<th>3 (somewhat)</th>
<th>4 (a lot)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Clinician Code (mark all that apply)</th>
<th>Physical illness</th>
<th>Mental illness</th>
<th>Hospitalization for mental illness</th>
<th>Suicidal ideation</th>
<th>Suicide attempt</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Clinician code (mark all that apply) Did illness affect care of child</th>
<th>No</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target child</td>
<td>Other child (not target)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11. Have you ever been emotionally abused or neglected (for example, being frequently shamed, embarrassed, ignored, or repeatedly told that you were “no good”)?

How old were you when this happened?  
[ ] Unknown (only check unknown if no estimate can be given)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
|---|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 |
| 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | + |

Clinician (write notes describing what happened)

<table>
<thead>
<tr>
<th>How much does this continue to affect you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (not at all)</td>
</tr>
<tr>
<td>□ Bio mom</td>
</tr>
<tr>
<td>□ Bio dad</td>
</tr>
<tr>
<td>□ Other 1st caregiver</td>
</tr>
<tr>
<td>□ Other relative</td>
</tr>
<tr>
<td>□ Siblings</td>
</tr>
<tr>
<td>□ Other: (specify)</td>
</tr>
</tbody>
</table>

Clinician Code: People who did this (check all that apply)

Clinician Code: Did target child see this?

| No | Yes | Unsure |

12. Have you ever been physically neglected (for example, not fed, not properly clothed, or left to take care of yourself when you were too young or ill)?

How old were you when this happened?  
[ ] Unknown (only check unknown if no estimate can be given)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
|---|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 |
| 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | + |

Clinician (write notes describing what happened)

<table>
<thead>
<tr>
<th>How much does this continue to affect you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (not at all)</td>
</tr>
<tr>
<td>□ Bio mom</td>
</tr>
<tr>
<td>□ Bio dad</td>
</tr>
<tr>
<td>□ Other 1st caregiver</td>
</tr>
<tr>
<td>□ Other relative</td>
</tr>
<tr>
<td>□ Siblings</td>
</tr>
<tr>
<td>□ Other: (specify)</td>
</tr>
</tbody>
</table>
### 13. WOMEN ONLY: Have you ever had an abortion or miscarriage (lost your baby)?

<table>
<thead>
<tr>
<th>How old were you when this happened?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>(clinician mark all that apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ]Unknown (only check unknown if no estimate can be given)</td>
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<td></td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>

**Clinician (write notes describing what happened)**

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<th>2 (a little)</th>
<th>3 (somewhat)</th>
<th>4 (a lot)</th>
</tr>
</thead>
</table>

### 14. Have you ever been separated from your child against your will (for example, the loss of custody or visitation, or kidnapping)?

<table>
<thead>
<tr>
<th>How old were you when this happened?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>(clinician mark all that apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ]Unknown (only check unknown if no estimate can be given)</td>
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<td></td>
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<th>3 (somewhat)</th>
<th>4 (a lot)</th>
</tr>
</thead>
</table>

**Clinician Code: Which child (check all that apply)**
- Target child
- Younger sibling of target
- Older sibling of target
- Other (specify in notes)

**Clinician code: Reason for separation (check all that apply)**
- Immigration
- Custody issues
- Foster care
- Kidnapping
- Other

**Clinician code: Length of separation (check all that apply)**
- Ongoing
- < 1 week
- < 1 month
- < 6 months
- < 1 year
- Year+ or multiple significant separations
15. Has a baby or child of yours ever had a severe physical or mental handicap (for example, mentally retarded, birth defects, can’t hear, see, walk)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How old were you when this happened? (clinician mark all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Unknown (only check unknown if no estimate can be given)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ]</td>
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Clinician (write notes describing what happened)

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<thead>
<tr>
<th>How much does this continue to affect you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (not at all)</td>
</tr>
<tr>
<td>Clinician Code: Which child (check all that apply)</td>
</tr>
<tr>
<td>Target child</td>
</tr>
<tr>
<td>Clinician Code: Does child live with target child?</td>
</tr>
<tr>
<td>Is target child</td>
</tr>
</tbody>
</table>

16. Have you ever been responsible for taking care of someone close to you (not your child) who had a severe physical or mental handicap (for example, cancer, stroke, Alzheimer’s disease, AIDS, nerve problems, can’t hear, see, walk)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How old were you when this happened? (clinician mark all that apply)

<table>
<thead>
<tr>
<th></th>
<th>Unknown (only check unknown if no estimate can be given)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[ ]</td>
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</tr>
</tbody>
</table>

Clinician (write notes describing what happened)

<table>
<thead>
<tr>
<th>How much does this continue to affect you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (not at all)</td>
</tr>
<tr>
<td>Clinician Code: People caregiver cared for (check all that apply)</td>
</tr>
<tr>
<td>□ Bio mom</td>
</tr>
<tr>
<td>□ Bio dad</td>
</tr>
<tr>
<td>□ Other 1st caregiver</td>
</tr>
<tr>
<td>□ Grandparents</td>
</tr>
<tr>
<td>□ Other relative</td>
</tr>
<tr>
<td>□ Other: (specify in notes)</td>
</tr>
</tbody>
</table>
17. Has someone close to you died suddenly or unexpectedly (for example, an accident, sudden heart attack, murder or suicide)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

How old were you when this happened? (clinician mark all that apply)

[ ] Unknown (only check unknown if no estimate can be given)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | + |

Clinician (write notes describing what happened)

<table>
<thead>
<tr>
<th>How much does this continue to affect you?</th>
<th>1 (not at all)</th>
<th>2 (a little)</th>
<th>3 (somewhat)</th>
<th>4 (a lot)</th>
</tr>
</thead>
</table>

Clinician Code:

How died:  
- a) violence
- b) illness/health related
- c) accident
- d) drugs
- e) other (specify)

<table>
<thead>
<tr>
<th>Person</th>
<th>How died (use letter codes)</th>
<th>Check if Witness Death?</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biological father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other 1st Caregiver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grandparents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other relative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling(s)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target child’s parent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other partner before target child’s parent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other partner after target child’s parent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify in notes)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinician Code: Number of people who died suddenly  # _______

Clinician Code: Did respondent lose a primary caregiver? IF YES -> Age

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Age:</th>
</tr>
</thead>
</table>
18. Has someone close to you died (do not include those who died suddenly or unexpectedly)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How old were you when this happened?  
(clinician mark all that apply)
[ ] Unknown (only check unknown if no estimate can be given)

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | + |

Clinician (write notes describing what happened)

How much does this continue to affect you?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>(not at all)</td>
<td>(a little)</td>
<td>(somewhat)</td>
<td>(a lot)</td>
</tr>
</tbody>
</table>

Clinician Code:

<table>
<thead>
<tr>
<th>Person</th>
<th>How died (if the way they died was sudden or unexpected code under item 17)</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Biological mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Biological father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other 1st Caregiver</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Grandparents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other relative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Sibling(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Friend</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ A child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Target child’s parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other partner before target child’s parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other partner after target child’s parent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other (specify in notes)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Clinician Code: Number of people who died # _______

Clinician Code: Did respondent lose a primary caregiver? IF YES -> Age

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Age</th>
</tr>
</thead>
</table>

T:\CTR\Studies\SAMHSA 2012\Measures\English\LSC-R.2010.doc
19. When you were young (before age 16) did you ever see violence between family members (for example, hitting, kicking, slapping, punching)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

How old were you when this happened? *(clinician mark all that apply)*

[ ] Unknown *(only check unknown if no estimate can be given)*

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
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_Clinician (write notes describing what happened)_

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</tr>
</thead>
<tbody>
<tr>
<td>People involved</td>
<td>Chronicity</td>
<td>Severity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Biological mother &amp; bio dad</td>
<td>(use codes below)</td>
<td>(use codes below)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Biological mom and partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Biological dad and partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other caregiver(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Biological parent and sibling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other caregiver and sibling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Siblings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other relatives in house</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Nonrelatives in house</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Other (specify in notes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

_Clinician Code: Who was involved in the violence (check all that apply)_

_Note: coding does not code for all possible variations_

_Clinician Code Overall: Chronicity_  
a) 1x  
b) Few times  
c) Occasional  
d) Frequent  
e) Other (specify in notes)

_Clinician Code Overall: Severity_  
a) Mild (no injuries)  
b) Moderate (mild injuries)  
c) Serious (significant injuries)  
d) Threat of death or actual death  
e) Other (specify in notes)
### 20. Have you ever seen a robbery, mugging, or attack taking place?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="#" alt="Table with options for age and description of event" /></td>
<td></td>
</tr>
</tbody>
</table>

**Clinician (write notes describing what happened)**

<table>
<thead>
<tr>
<th>How old were you when this happened? (clinician mark all that apply)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Unknown (only check unknown if no estimate can be given)</td>
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<td></td>
</tr>
</tbody>
</table>

**Clinician Code: Who was mugged**
- Stranger
- Friend
- Relative
- Other (specify in notes)

**Clinician Code: Severity (check all that apply)**
- Weapon used
- Person injured
- Person died
- Respondent threatened

### 21. Have you ever been robbed, mugged, or physically attacked (not sexually) by someone you did not know?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="#" alt="Table with options for age and description of event" /></td>
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<td></td>
</tr>
</tbody>
</table>

**Clinician Code: Severity (check all that apply)**
- Weapon used
- Mild injury
- Moderate injury (pain last more than a day)
- Serious injury (requiring medical treatment)

**Clinician Code: Person’s perception of danger**
- No serious danger
- Fear of mild injury
- Fear of serious injury
- Feared for life

---

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Page 13 of 22
22. Before age 16, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

How old were you when this happened? (clinician mark all that apply)

- [ ] Unknown (only check unknown if no estimate can be given)

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
</tr>
</thead>
</table>

Clinician (write notes describing what happened)

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<thead>
<tr>
<th>How much does this continue to affect you?</th>
<th>1 (not at all)</th>
<th>2 (a little)</th>
<th>3 (somewhat)</th>
<th>4 (a lot)</th>
</tr>
</thead>
</table>

**People involved**

- □ Bio mom
- □ Bio dad
- □ Other 1st caregiver
- □ Parent’s boyfriend/girlfriend
- □ Grandparent
- □ Sibling(s)
- □ Friend
- □ Target child’s parent
- □ Other boyfriend/girlfriend/partner
- □ Adult relative
- □ Child relative
- □ Teacher
- □ Other: (specify in notes)

**Clinician Code: People who did this (check all that apply but only one category per person)**

**Clinician Code Overall: Chronicity**

- a) 1x
- b) Few times
- c) Occasional
- d) Frequent
- e) Other (specify in notes)

**Clinician Code Overall: Severity**

- a) Mild (no injuries)
- b) Moderate (mild injuries)
- c) Serious (significant injuries)
- d) Threat of death or actual death
- e) Other (specify in notes)
23. **After age 16, were you ever abused or physically attacked (not sexually) by someone you knew (for example, a parent, boyfriend, or husband hit, slapped, choked, burned, or beat you up)?**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**How old were you when this happened? (clinician mark all that apply)**

- [ ] Unknown (only check unknown if no estimate can be given)
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25
- 26
- 27
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**Clinician (write notes describing what happened)**

<table>
<thead>
<tr>
<th>How much does this continue to affect you?</th>
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<th>2 (a little)</th>
<th>3 (somewhat)</th>
<th>4 (a lot)</th>
</tr>
</thead>
</table>

**People Involved**

- □ Bio mom
- □ Bio dad
- □ Other 1st caregiver
- □ Parent’s boyfriend/girlfriend
- □ Grandparent
- □ Sibling(s)
- □ Friend
- □ Target child’s parent
- □ Other boyfriend/girlfriend/partner before target child’s parent
- □ Other boyfriend/girlfriend/partner after target child’s parent
- □ Adult relative
- □ Child relative (under age 18)
- □ Teacher
- □ Other: (specify in notes)

**Clinician Code: People who did this (check all that apply but only one category per person)**

**Clinician Code Overall: Chronicity**

- a) 1x
- b) Few times
- c) Occasional
- d) Frequent
- e) Other (specify in notes)

**Clinician Code Overall: Severity**

- a) Mild (no injuries)
- b) Moderate (mild injuries)
- c) Serious (significant injuries)
- d) Threat of death or actual death
- e) Other (specify in notes)
24. Have you ever been bothered or harassed by sexual remarks, jokes, or demands for sexual favors by someone at work or school (for example, a co-worker, a boss, a customer, another student, a teacher)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
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</table>

How old were you when this happened? (clinician mark all that apply)

<table>
<thead>
<tr>
<th>[ ] Unknown (only check unknown if no estimate can be given)</th>
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</thead>
<tbody>
<tr>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24</td>
</tr>
<tr>
<td>25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49</td>
</tr>
<tr>
<td>50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 +</td>
</tr>
</tbody>
</table>

Clinician (write notes describing what happened)

<table>
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</thead>
<tbody>
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</tbody>
</table>
25. Before age 16, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn’t? | YES | NO

| How old were you when this happened? | [ ] Unknown (only check unknown if no estimate can be given) | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 |

Clinician (write notes describing what happened)

| How much does this continue to affect you? | 1 (not at all) | 2 (a little) | 3 (somewhat) | 4 (a lot) |

| People Involved | Chronicity (use codes below) |

- Bio mom
- Bio dad
- Other 1st caregiver
- Parent’s boyfriend/girlfriend
- Grandparent
- Sibling(s)
- Friend
- Target child’s parent
- Other boyfriend/girlfriend/partner before target child’s parent
- Other boyfriend/girlfriend/partner after target child’s parent
- Friend (child)
- Adult relative
- Child relative
- Another child
- Adult known to respondent
- Adult stranger
- Teacher
- Other: (specify in notes)

Clinician Code Overall: Chronicity
- a) 1x
- b) Few times
- c) Occasional
- d) Frequent
- e) Other (specify in notes)
26. **Before age 16, did you ever have sex (oral, anal, genital) when you didn’t want to because someone forced you in some way or threatened to harm you if you didn’t?**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

How old were you when this happened? *(clinician mark all that apply)*

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<th>6</th>
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</tbody>
</table>

*Unknown (only check unknown if no estimate can be given)*

Clinician (write notes describing what happened)

How much does this continue to affect you?

<table>
<thead>
<tr>
<th>1 (not at all)</th>
<th>2 (a little)</th>
<th>3 (somewhat)</th>
<th>4 (a lot)</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

**People Involved**

- Bio mom
- Bio dad
- Other 1er caregiver
- Parent’s boyfriend/girlfriend
- Grandparent
- Sibling(s)
- Friend
- Target child’s parent
- Other boyfriend/girlfriend/partner before target child’s parent
- Other boyfriend/girlfriend/partner after target child’s parent
- Friend (child)
- Adult relative
- Child relative
- Another child
- Adult known to respondent
- Adult stranger
- Teacher
- Other: *(specify in notes)*

**Clinician Code: People who did this (check all that apply but only one category per person)**

**Clinician Code Overall: Chronicity**

<table>
<thead>
<tr>
<th>a) 1x</th>
<th>b) Few times</th>
<th>c) Occasional</th>
<th>d) Frequent</th>
<th>e) Other <em>(specify in notes)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
27. After age 16, were you ever touched or made to touch someone else in a sexual way because he/she forced you in some way or threatened to harm you if you didn’t?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

How old were you when this happened?  *clinician mark all that apply*  

| Unknown (only check unknown if no estimate can be given) | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | + |

Clinician (write notes describing what happened)

<table>
<thead>
<tr>
<th>How much does this continue to affect you?</th>
<th>1 (not at all)</th>
<th>2 (a little)</th>
<th>3 (somewhat)</th>
<th>4 (a lot)</th>
</tr>
</thead>
</table>

People Involved

- ☐ Bio mom
- ☐ Bio dad
- ☐ Other 1er caregiver
- ☐ Parent’s boyfriend/girlfriend
- ☐ Grandparent
- ☐ Sibling(s)
- ☐ Friend
- ☐ Target child’s parent
- ☐ Other boyfriend/girlfriend/partner before target child’s parent
- ☐ Other boyfriend/girlfriend/partner after target child’s parent
- ☐ Friend (child)
- ☐ Adult relative
- ☐ Child relative (under age 18)
- ☐ Another child (under age 18)
- ☐ Adult known to respondent
- ☐ Adult stranger
- ☐ Teacher
- ☐ Other: *(specify in notes)*

Clinician Code Overall: Chronicty

- ☐ a) 1x
- ☐ b) Few times
- ☐ c) Occasional
- ☐ d) Frequent
- ☐ e) Other: *(specify in notes)*
28. After age 16, did you ever have sex (oral, anal, genital) when you didn’t want to because someone forced you in some way or threatened to harm you if you didn’t?  

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

**How old were you when this happened?**  
**clinician mark all that apply**  
[ ] Unknown (only check unknown if no estimate can be given)  

| 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | + |

**Clinician (write notes describing what happened)**

**How much does this continue to affect you?**  
1 (not at all)  
2 (a little)  
3 (somewhat)  
4 (a lot)  

<table>
<thead>
<tr>
<th>People Involved</th>
<th>Chronicity (use codes below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Bio mom</td>
<td>a) 1x</td>
</tr>
<tr>
<td>□ Bio dad</td>
<td>b) Few times</td>
</tr>
<tr>
<td>□ Other 1er caregiver</td>
<td>c) Occasional</td>
</tr>
<tr>
<td>□ Parent’s boyfriend/girlfriend</td>
<td>d) Frequent</td>
</tr>
<tr>
<td>□ Grandparent</td>
<td>e) Other (specify in notes)</td>
</tr>
<tr>
<td>□ Sibling(s)</td>
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</tr>
<tr>
<td>□ Friend</td>
<td></td>
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<tr>
<td>□ Target child’s parent</td>
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<tr>
<td>□ Other boyfriend/girlfriend/partner before target child’s parent</td>
<td></td>
</tr>
<tr>
<td>□ Other boyfriend/girlfriend/partner after target child’s parent</td>
<td></td>
</tr>
<tr>
<td>□ Friend (child)</td>
<td></td>
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<tr>
<td>□ Adult relative</td>
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<td>□ Child relative (under age 18)</td>
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<tr>
<td>□ Another child (under age 18)</td>
<td></td>
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<td></td>
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<td>□ Adult stranger</td>
<td></td>
</tr>
<tr>
<td>□ Teacher</td>
<td></td>
</tr>
<tr>
<td>□ Other: (specify in notes)</td>
<td></td>
</tr>
</tbody>
</table>

**Clinician Code: People who did this (check all that apply but only one category per person)**
29. Have you ever been directly exposed to war, armed conflict, or terrorism (were there soldiers or others fighting or hurting people near where you lived)?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

How old were you when this happened? (clinician mark all that apply)

- Unknown (only check unknown if no estimate can be given)
- [ ] Unknown

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
|---|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 |
| 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | + |

Clinician (write notes describing what happened)

How much does this continue to affect you?

1 (not at all) | 2 (a little) | 3 (somewhat) | 4 (a lot)

Clinician Code: Person’s own experience (check all that apply)

- Damage to own property
  - Injured
  - Threatened
  - Had to hide
  - Had to fight
  - Had to flee

Clinician Code: What person witnessed plus harm to others (mark all that apply)

- Family members injured
- Family members died
- Friends injured
- Friends died
- Saw people injured
- Saw people die
- Other specify in notes

30. Have you ever had to leave where you were living and move to another location (country, state, or city) because you could not pay for basic needs, like food clothing or shelter, or because you felt unsafe?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</thead>
</table>

How old were you when this happened? (clinician mark all that apply)

- Unknown (only check unknown if no estimate can be given)
- [ ] Unknown

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
|---|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 |
| 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | + |

Clinician (write notes describing what happened)

How much does this continue to affect you?

1 (not at all) | 2 (a little) | 3 (somewhat) | 4 (a lot)

Clinician Code: Reason for leaving (check all that apply)

- Economic
- Safety – related to DV
- Safety related to war/terrorism
- Safety Other (specify in notes)
### 31. Are there any events we did not include that you would like to mention?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
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</table>

**What was the event?** *(clinician write notes describing what happened)*

#### How old were you when this happened? *(clinician mark all that apply)*

|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|   | 0  | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
|   | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 |
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**How much does this continue to affect you?**

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<td>1</td>
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<td>4</td>
</tr>
<tr>
<td>(not at all)</td>
<td>(a little)</td>
<td>(somewhat)</td>
<td>(a lot)</td>
</tr>
</tbody>
</table>

#### Clinician Code: Number of events happening to others

- [x] Bio mom
- [x] Bio dad
- [x] Other 1st caregiver
- [x] Grandparent
- [x] Sibling(s)
- [x] Other relative
- [x] Other: *(specify under notes)*

- [x] Target child’s parent
- [x] Other partner before child’s parent
- [x] Other partner after child’s parent
- [x] Target child
- [x] Other child

### 32. Have any of the events mentioned above ever happened to someone close to you so that even though you didn’t experience the event yourself, you were seriously disturbed by it?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
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</table>

**What was the event?** *(clinician write notes describing what happened)*

#### How old were you when this happened? *(clinician mark all that apply)*

|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|   | 0  | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 |
|   | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 |
|   | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | + |

**How much does this continue to affect you?**

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<td>4</td>
</tr>
<tr>
<td>(not at all)</td>
<td>(a little)</td>
<td>(somewhat)</td>
<td>(a lot)</td>
</tr>
</tbody>
</table>
TRAUMATIC EVENTS SCREENING INVENTORY - PARENT REPORT REVISED

Children may experience stressful events, which may affect their health and well-being. Please indicate if your child has experienced any of these potentially stressful events by answering the shaded questions. If the answer is yes, please answer the follow-up questions. If it’s no, please go to the next shaded question.

If you have any questions or comments about any of the questions, we would be happy to talk to you about them.

<table>
<thead>
<tr>
<th>SAMPLE ITEM (instructions are in italics)</th>
</tr>
</thead>
</table>

### A. Has your child ever had a doctor’s visit? (Mark your answer in the next column. If yes answer the questions below.)

#### If YES
- **How old was your child?**
  - The first time: ______
  - The last time: ______
  - The most stressful: ______
- **Your child’s age the first time s/he saw a doctor (even if s/he would not have remembered it).**
  - Your child’s age during his/her most recent doctor’s visit.
  - Your child’s age during the most stressful visit for your child (in your opinion).

#### Was your child strongly affected by one or more of these experiences? [ ] yes [ ] no [ ] unsure

(By strongly affected we mean: did your child seem: a) to be extremely frightened; b) to be very confused or helpless; c) to be very shocked or horrified, d) to have difficulty getting back to her or his normal way of behaving or feeling when it was over, OR e) to behave differently in important ways after it was over.)

1. **Has your child ever been in a serious accident where someone could have been (or actually was) severely injured or died? (like a serious car or bicycle accident, a fall, an incident where s/he was burned, an actual or near drowning, or a severe sports injury)**
   - If YES
     - Identify the type of accident(s): ________________________________
     - Did anyone die? [ ] yes [ ] no [ ] unsure
     - How old was your child? The first time: ______
     - The last time: ______
     - The most stressful: ______
     - Was your child strongly affected by one or more of these experiences? [ ] yes [ ] no [ ] unsure

2. **Has your child ever seen a serious accident where someone could have been (or actually was) severely injured or died? (like a serious car or bicycle accident, a fall, an incident where someone was burned, an actual or near drowning, or a severe sports injury)**
   - If YES
     - Identify the type of accident(s): ________________________________
     - Victim’s relationship to your child: _____________________________
     - Did anyone die? [ ] yes [ ] no [ ] unsure
     - How old was your child? The first time: ______
     - The last time: ______
     - The most stressful: ______
     - Was your child strongly affected by one or more of these experiences? [ ] yes [ ] no [ ] unsure

3. **Has your child ever been in a serious natural disaster where someone could have been (or actually was) severely injured or died? (like a tornado, hurricane, fire, or earthquake)**
   - If YES
     - Type of disaster: ________________________________
     - Did anyone die? [ ] yes [ ] no [ ] unsure
     - How old was your child? The first time: ______
     - The last time: ______
     - The most stressful: ______
     - Was your child strongly affected by one or more of these experiences? [ ] yes [ ] no [ ] unsure

4. **Has your child ever experienced the severe illness or injury of someone close to him/her?**
   - If YES
     - What was this person’s relationship to your child?
     - How old was your child? The first time: ______
     - The last time: ______
     - The most stressful: ______
     - Was your child strongly affected by one or more of these experiences? [ ] yes [ ] no [ ] unsure

5. **Has your child ever experienced the death of someone close to him/her?**
   - If YES
     - What was this person’s relationship to your child?
     - How old was your child? The first time: ______
     - The last time: ______
     - The most stressful: ______
     - Was your child strongly affected by one or more of these experiences? [ ] yes [ ] no [ ] unsure

6. **Has your child ever undergone any serious medical procedures or had a life threatening illness? Or been treated by a paramedic, seen in an emergency room, or hospitalized overnight for a medical procedure?**
   - If YES
     - Describe__________________________
     - How old was your child? The first time: ______
     - The last time: ______
     - The most stressful: ______
     - Was your child strongly affected by one or more of these experiences? [ ] yes [ ] no [ ] unsure

7. **Has your child ever been separated from you or another person who your child depends on for love or security for more than a few days OR under very stressful circumstances? For example due to foster care, immigration, war, major illness, or hospitalization.**
   - If YES
     - Who was your child separated from: ____________________________
     - How old was your child? The first time: ______
     - The last time: ______
     - The most stressful: ______
     - Was your child strongly affected by one or more of these experiences? [ ] yes [ ] no [ ] unsure

8. **Has someone close to your child ever attempted suicide or harmed him or herself?**
   - If YES
     - What was this person’s relationship to your child?
     - How old was your child? The first time: ______
     - The last time: ______
     - The most stressful: ______
     - Was your child strongly affected by one or more of these experiences? [ ] yes [ ] no [ ] unsure
### 2.1 Has your child ever physically assaulted your child, like hitting, pushing, choking, shaking, biting, or burning? Or punished your child and caused physical injury or bruises. Or attacked your child with a gun, knife, or other weapon? (This could be done by someone in the family or by someone not in your child’s family.)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was this person’s relationship to your child?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Was a weapon used?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How old was your child? The first time:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The last time:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The most stressful:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was your child strongly affected by one or more of these experiences?</td>
<td></td>
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</tr>
</tbody>
</table>

### 2.2 Has someone ever directly threatened your child with serious physical harm?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was this person’s relationship to your child?</td>
<td></td>
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<tr>
<td>Did they threatened to use a weapon?</td>
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<tr>
<td>How old was your child? The first time:</td>
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<td>The last time:</td>
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<tr>
<td>The most stressful:</td>
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</tr>
<tr>
<td>Was your child strongly affected by one or more of these experiences?</td>
<td></td>
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</tbody>
</table>

### 2.3 Has someone ever mugged or tried to steal from your child? Or has your child been present when a family member, other caregiver, or friend was mugged?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who was mugged? (If not your child indicate the person’s relationship to your child.)</td>
<td></td>
<td></td>
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<tr>
<td>Was a weapon used?</td>
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<tr>
<td>How old was your child? The first time:</td>
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<td>The last time:</td>
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<td>The most stressful:</td>
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<tr>
<td>Was your child strongly affected by one or more of these experiences?</td>
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</tr>
</tbody>
</table>

### 2.4 Has anyone ever kidnapped your child? (including a parent or relative) Or has anyone ever kidnapped someone close to your child?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who was kidnapped? (If not your child indicate the person’s relationship to your child.)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>What was the kidnapper’s relationship to your child?</td>
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<tr>
<td>How old was your child? The first time:</td>
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<td>The last time:</td>
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<td>The most stressful:</td>
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<tr>
<td>Was your child strongly affected by one or more of these experiences?</td>
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</tbody>
</table>

### 2.5 Has your child ever been attacked by a dog or other animal?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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</thead>
<tbody>
<tr>
<td>How old was your child? The first time:</td>
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<td>The last time:</td>
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<tr>
<td>The most stressful:</td>
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<tr>
<td>Was your child seriously physically hurt as a result of the attack?</td>
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<tr>
<td>Was your child affected by one or more of these experiences?</td>
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</tbody>
</table>

### 3.1 Has your child ever seen, heard, or heard about people in your family physically fighting, hitting, slapping, kicking, or pushing each other. Or shooting with a gun or stabbing, or using any other kind of dangerous weapon?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>What were these people’s relationships to your child?</td>
<td></td>
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<tr>
<td>Was a weapon used?</td>
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<tr>
<td>How old was your child? The first time:</td>
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<td>The last time:</td>
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<tr>
<td>The most stressful:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Did your child see what happened?</td>
<td></td>
<td></td>
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<tr>
<td>Was your child strongly affected by one or more of these experiences?</td>
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</tbody>
</table>

### 3.2 Has your child ever seen or heard people in your family threaten to seriously harm each other?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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</thead>
<tbody>
<tr>
<td>What were these people’s relationships to your child?</td>
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<tr>
<td>Did they threatened to use a weapon?</td>
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<tr>
<td>How old was your child? The first time:</td>
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<td>The last time:</td>
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<tr>
<td>The most stressful:</td>
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<tr>
<td>Was your child present when the threat was made?</td>
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<tr>
<td>Was your child strongly affected by one or more of these experiences?</td>
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</tbody>
</table>

### 3.3 Has your child ever known or seen that a family member was arrested, jailed, imprisoned, or taken away (like by police, soldiers, or other authorities)?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was this person’s relationship to your child?</td>
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<tr>
<td>How old was your child? The first time:</td>
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<td>The last time:</td>
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<tr>
<td>The most stressful:</td>
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<tr>
<td>Was your child there when the police came?</td>
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<tr>
<td>Was your child strongly affected by one or more of these experiences?</td>
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</tbody>
</table>

### 4.1 Has your child ever seen or heard people outside your family fighting, hitting, pushing, or attacking each other? Or seen or heard about violence such as beatings, shootings, or muggings that occurred in settings that are important to your child, such as school, your neighborhood, or the neighborhood of someone important to your child?

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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</thead>
<tbody>
<tr>
<td>What were these people’s relationship to your child?</td>
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<tr>
<td>Was a weapon used?</td>
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<td>How old was your child? The first time:</td>
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<tr>
<td>Was your child strongly affected by one or more of these experiences?</td>
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</tbody>
</table>

### 4.2 Has your child ever been directly exposed to war, armed conflict, or terrorism?

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<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
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<tbody>
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<td>How old was your child? The first time:</td>
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<tr>
<td>Was your child strongly affected by one or more of these experiences?</td>
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</tbody>
</table>
4.3 Has your child ever seen or heard acts of war or terrorism on the television or radio?

IF YES

How old was your child? The first time:________ The last time:________ The most stressful:________

Was your child strongly affected by one or more of these experiences? □ yes □ no □ unsure

5.1 Has someone ever made your child see or do something sexual (like touching in a sexual way, exposing self or masturbating in front of the child, engaging in sexual intercourse)?

IF YES

What was this person’s relationship to your child? ____________________________

Was physical violence used? □ unsure □ no □ yes Was a weapon used? □ unsure □ no □ yes (type)________________________

How old was your child? The first time:________ The last time:________ The most stressful:________

Was your child strongly affected by one or more of these experiences? □ yes □ no □ unsure

5.2 Has your child ever been present when someone was being forced to engage in any sort of sexual activity?

IF YES

What were these people’s relationship to your child? Victim:__________________ Aggressor:___________________

Was physical violence used? □ unsure □ no □ yes    Was a weapon used? □ unsure □ no □ yes (type)________________________

How old was your child? The first time:________ The last time:________ The most stressful:________

Was your child strongly affected by one or more of these experiences? □ yes □ no □ unsure

6.1 Has your child ever repeatedly been told s/he was no good, yelled at in a scary way, or had someone threaten to abandon, leave or send him/her away?

IF YES

What was this person’s relationship to your child? ____________________________

How old was your child? The first time:________ The last time:________ The most stressful:________

Was your child strongly affected by one or more of these experiences? □ yes □ no □ unsure

6.2 Has your child ever gone through a period when s/he lacked appropriate care (like not having enough to eat or drink, lacking shelter, being left alone when s/he was too young to care for herself/himself, or being left with a caregiver who was abusing drugs)?

IF YES

How old was your child? The first time:________ The last time:________ The most stressful:________

Was your child strongly affected by one or more of these experiences? □ yes □ no □ unsure

7.1 Have there been other stressful things that have happened to your child?

IF YES

Briefly describe these things:_____________________________________________ ______________________________________
__________________________________________________________________________________________________________________

How old was your child? The first time:________ The last time:________ The most stressful:________

Was your child strongly affected by one or more of these experiences? □ yes □ no □ unsure
## Parent-Infant Relationship Global Assessment Scale (PIR-GAS)

<table>
<thead>
<tr>
<th>Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>91–100</td>
<td><strong>Well Adapted</strong> Parent–child relationships in this range are functioning exceptionally well. They are mutually enjoyable and without sustained distress. They evidence adaptation to new circumstances and are typically free of conflict as parent and child manage the stresses of everyday life. The relationship clearly promotes the growth of both partners.</td>
</tr>
<tr>
<td>81–90</td>
<td><strong>Adapted</strong> Relationships in this range are also functioning well, without evidence that the relationship is significantly stressful for either partner. Interactions within these relationships are frequently reciprocal and synchronous, without distress, and reasonably adaptive. At times parent and child may be in substantial conflict, but conflicts do not persist longer than a few days and are resolved with appropriate consideration of the child’s developmental status. The pattern of the relationship protects and promotes the developmental progress of both partners.</td>
</tr>
</tbody>
</table>
| 71–80   | **Perturbed** Some aspect of the overall functioning of relationships in this range is less than optimal; partners may experience transient distress lasting up to a few weeks. Nevertheless, the relationship remains characterized by adaptive flexibility. The disturbance is limited to one domain of functioning. Overall, the relationship still functions reasonably well and does not impede developmental progress.  
*Example: An infant with a minor physical illness sleeps poorly for several nights, exhausting his parents; or parents moving into a new house are less attentive to their infant, who is less able to self-regulate in the unfamiliar new surroundings.* |
| 61–70   | **Significantly Perturbed** Relationships in this range of functioning are strained but still largely adequate and satisfying to the partners. Conflicts are limited to one or two problematic areas. Partners may experience distress and difficulty for a month or more. The relationship maintains adaptive flexibility, as parent and child seem likely to negotiate the challenge to their relationship successfully. A parent may be stressed by the perturbation, but is not generally overconcerned about the changed relationship pattern, considering it within the range of expectable, relatively short-lived difficult periods in a lifelong relationship.  
*Example: Following the birth of a new sibling, a toddler develops new-onset food refusal and a sleep disturbance that lasts more than a month.* |
| 51–60   | **Distressed** Relationships in this range of functioning are more than transiently affected as one or both partners experience distress in the context of their relationship. Parent and child maintain some flexibility and adaptive qualities, but conflict may spread across multiple domains of functioning, and resolution is difficult. The developmental progress of the dyad seems likely to falter if the pattern does not improve. Caregivers may or may not be concerned about the disturbed relationship pattern. Neither parent nor child is likely to show overt symptoms resulting from the disturbance.  
*Example: A child expresses distress and oppositionality during toilet training and feeding. Her mother is increasingly worried about her ability to engage her daughter in these activities in growth-promoting ways.* |

*continued*
Disturbed

The adaptive qualities of a disturbed relationship are beginning to be overshadowed by problematic features. Although not deeply entrenched, dysfunctional patterns appear more than transient. Developmental progress can still proceed, but may be temporarily interrupted.

Example: A parent and child engage in excessive teasing and power struggles during, feeding, dressing, and bedtime. Although parent and child attempt pleasurable interactions, their teasing often goes too far, leaving one or both partners distressed.

Disordered

Rigidly maladaptive interactions, particularly if they involve distress in one or both partners, are the hallmark of disordered relationships. Most interactions between partners are conflicted; some relationships without overt conflicts may nevertheless be grossly inappropriate developmentally. Developmental progress of the child and the parent–child relationship is likely to be influenced adversely.

Example: A depressed parent repeatedly seeks comfort from her infant, actively recruiting caregiving behavior from the child. The child’s engagement in exploratory play is limited.

Severely Disordered

Relationships in this range of functioning are severely compromised. Both partners are significantly distressed by the relationship itself. Maladaptive interactive patterns are rigidly entrenched. To an observer, interactive patterns seem to have been in place for a long time, although the onset may have been insidious. In a severely disordered relationship, a significant proportion of interactions are likely to be conflicted. Developmental progress of the child and the relationship is clearly influenced adversely. Indeed, the child may lose previously acquired developmental skills.

Example: A father and his toddler frequently interact in a conflicted manner. The father sets no limits until he becomes enraged. Then he spanks the toddler vigorously. The toddler is provocative, and the father feels angry with him all the time.

Grossly Impaired

Relationships in this range of functioning are dangerously disorganized. Interactions are disturbed so frequently that the infant is in imminent danger of physical harm.

Documented Maltreatment

The relationship contains documented neglect and physical or sexual abuse that is adversely affecting the child’s physical and emotional development.

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THE PSYCHOSOCIAL AND ENVIRONMENTAL STRESSORS CHECKLIST FOR THE IDENTIFIED INFANT/YOUNG CHILD

This checklist provides the clinician with a framework for (1) identifying the multiple sources of stress experienced by an individual infant/young child and family and (2) noting their duration and severity.

To capture the cumulative severity of stressors, the clinician should identify all the sources of stress in an infant's/young child's circumstances. For example, an infant/young child who enters foster placement may be experiencing the impact of abuse, parental psychiatric illness, separation, and poverty. The greater the number of stressors involved, the greater the adverse impact on the infant/young child is presumed to be.

**Psychosocial and Environmental Stressor Checklist**

*(Complete information for all stressors that apply)*

<table>
<thead>
<tr>
<th>Stressors</th>
<th>Age of onset (in months)</th>
<th>Comments, including duration and severity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Challenges within the infant’s/young child’s family or primary support group</strong></td>
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<tr>
<td>Acculturation or language conflicts</td>
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<tr>
<td>Birth of a sibling</td>
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<tr>
<td>Change in primary caregiver</td>
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<tr>
<td>Criminal activity within the household</td>
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<tr>
<td>Death of a parent or important caregiver</td>
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<tr>
<td>Death of another important person</td>
<td></td>
<td></td>
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<tr>
<td>Death of other family member</td>
<td></td>
<td></td>
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<tr>
<td>Domestic violence</td>
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<tr>
<td>Emotional abuse</td>
<td></td>
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<tr>
<td>Family social isolation</td>
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<tr>
<td>Stressors</td>
<td>Age of onset (in months)</td>
<td>Comments, including duration and severity</td>
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<tr>
<td>-----------------------------------------------</td>
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<tr>
<td>Father or mother absence</td>
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<tr>
<td>Inadequate social support for the family</td>
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<tr>
<td>Incarceration of family member</td>
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<tr>
<td>Infant/young child has been adopted</td>
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<td></td>
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<tr>
<td>Infant/young child neglect</td>
<td></td>
<td></td>
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<tr>
<td>Infant/young child physical abuse</td>
<td></td>
<td></td>
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<tr>
<td>Infant/young child placed in foster care</td>
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<tr>
<td>Infant/young child placed in institutional care</td>
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<tr>
<td>Infant/young child reunification with parent after prolonged separation</td>
<td></td>
<td></td>
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<tr>
<td>Infant/young child sexual abuse</td>
<td></td>
<td></td>
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<tr>
<td>Medical illness of parent or caregiver (specify acute or chronic)</td>
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<td></td>
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<tr>
<td>Medical illness of sibling or other household member (specify acute or chronic)</td>
<td></td>
<td></td>
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<tr>
<td>Mental health problems of household member</td>
<td></td>
<td></td>
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<tr>
<td>New adult in household (e.g., romantic partner)</td>
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</tbody>
</table>
### Psychosocial and Environmental Stressor Checklist

<table>
<thead>
<tr>
<th>Stressors</th>
<th>Age of onset (in months)</th>
<th>Comments, including duration and severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>New infant/young child (not by birth) in home (e.g., adoption, stepsibling, foster child)</td>
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<tr>
<td>Other trauma to significant person in the infant/young child's life</td>
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<tr>
<td>Parent or caregiver discord or conflict (nonphysical)</td>
<td></td>
<td></td>
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<tr>
<td>Parent or caregiver divorce or separation</td>
<td></td>
<td></td>
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<tr>
<td>Parent or caregiver mental health problems</td>
<td></td>
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<tr>
<td>Parent or caregiver remarriage</td>
<td></td>
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<tr>
<td>Parent or caregiver separation from the infant/young child (e.g., out-of-town employment, hospitalization)</td>
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<tr>
<td>Parent or caregiver substance abuse</td>
<td></td>
<td></td>
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<tr>
<td>Removal of nonindex infant/young child from home</td>
<td></td>
<td></td>
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<tr>
<td>Severe discord or violence with sibling</td>
<td></td>
<td></td>
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<tr>
<td>Substance abuse by household member</td>
<td></td>
<td></td>
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<tr>
<td>Teenage parent</td>
<td></td>
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<tr>
<td>Unpredictable home environment</td>
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<tr>
<td>Unstable family constellation</td>
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</table>
Psychosocial and Environmental Stressor Checklist

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<th>Stressors</th>
<th>Age of onset (in months)</th>
<th>Comments, including duration and severity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Challenges in the social environment</strong></td>
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<tr>
<td>Discrimination or racism is experienced by family</td>
<td></td>
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<tr>
<td>Immigrant status</td>
<td></td>
<td></td>
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<tr>
<td>Inadequate access to health care</td>
<td></td>
<td></td>
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<tr>
<td>Infant/young child experiences bullying</td>
<td></td>
<td></td>
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<tr>
<td>Infant/young child is witness to community violence</td>
<td></td>
<td></td>
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<tr>
<td>Refugee status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsafe neighborhood</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Educational or child care challenges</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple changes in child care provider</td>
<td></td>
<td></td>
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<tr>
<td>Parent or caregiver low literacy</td>
<td></td>
<td></td>
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<tr>
<td>Poor quality early learning environment or out-of-home care (e.g., health and safety concerns, high infant/young child–staff ratios and large groups, inadequately trained staff, lack of attention to social and emotional development)</td>
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<tr>
<td><strong>Housing challenges</strong></td>
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<tr>
<td>Eviction from home or foreclosure</td>
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<tr>
<td>Homelessness</td>
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<tr>
<td>Inadequate, unsafe, or overcrowded housing</td>
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<td></td>
</tr>
<tr>
<td>Stressors</td>
<td>Age of onset (in months)</td>
<td>Comments, including duration and severity</td>
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<tr>
<td>Multiple moves</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Economic and employment challenges</strong></td>
<td></td>
<td></td>
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<tr>
<td>Dangerous or stressful parental work conditions</td>
<td></td>
<td></td>
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<tr>
<td>Food insecurity</td>
<td></td>
<td></td>
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<tr>
<td>Heavy indebtedness</td>
<td></td>
<td></td>
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<tr>
<td>Military deployment or reintegration</td>
<td></td>
<td></td>
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<tr>
<td>Parental unemployment or job instability</td>
<td></td>
<td></td>
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<tr>
<td>Poverty or near poverty</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Infant/young child health</strong></td>
<td></td>
<td></td>
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<tr>
<td>Infant/young child accident or injury</td>
<td></td>
<td></td>
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<tr>
<td>(e.g., animal bite, passenger in vehicular accident)</td>
<td></td>
<td></td>
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<tr>
<td>Infant/young child hospitalization</td>
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<td></td>
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<tr>
<td>Infant/young child medical illness</td>
<td></td>
<td></td>
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<tr>
<td>(acute or chronic)</td>
<td></td>
<td></td>
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<tr>
<td>Painful or frightening medical procedure(s)</td>
<td></td>
<td></td>
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<tr>
<td>Pregnancy-related stressors</td>
<td></td>
<td></td>
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<tr>
<td><strong>Legal or criminal justice challenges</strong></td>
<td></td>
<td></td>
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<tr>
<td>Child protective services involvement</td>
<td></td>
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</tr>
</tbody>
</table>
Psychosocial and Environmental Stressor Checklist

<table>
<thead>
<tr>
<th>Stressors</th>
<th>Age of onset (in months)</th>
<th>Comments, including duration and severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Custody dispute</td>
<td></td>
<td></td>
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<tr>
<td>Infant/young child is victim of crime</td>
<td></td>
<td></td>
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<tr>
<td>Parent is victim of crime</td>
<td></td>
<td></td>
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<tr>
<td>Parental arrest</td>
<td></td>
<td></td>
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<tr>
<td>Parental deportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental incarceration or return from incarceration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Undocumented immigration status</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
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<tr>
<td>Abduction (specify by family member or nonfamily member)</td>
<td></td>
<td></td>
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<tr>
<td>Disaster (e.g., fire, hurricane, earthquake)</td>
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<tr>
<td>Disease epidemic</td>
<td></td>
<td></td>
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<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terrorism</td>
<td></td>
<td></td>
</tr>
<tr>
<td>War</td>
<td></td>
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</tbody>
</table>

**Note:** “Parent” refers to parenting figure(s).
MODIFIED WORKING MODEL OF THE CHILD INTERVIEW

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email: czeanah@tulane.edu
The Modified Working Model of the Child Interview is a semi-structured interview to assess parents’ subjective experience of who their child is and what their relationship with the child is like for them. It is an abbreviated version of the Working Model of the Child Interview (Zeanah, Barton and Benoit, 1986).

The setting of the interview should be comfortable enough to allow for attention to the questions posed and a relaxed atmosphere that permits the opportunity for reflection. Ordinarily, this means the child is not present. The specific probes and questions are important but more important is that the interview be conducted in a conversational, non-stilted manner. Often, training is useful to learn proper administration and interpretation, though the interview may be used for clinical purposes without training.

The Modified WMCI (M-WMCI) includes several sections from the WMCI. We are evaluating its usefulness and validity at present and consider it to be under development. Do not use for research without permission of the author.
MODIFIED WORKING MODEL OF THE CHILD INTERVIEW

1a) Describe your impression of the child’s personality now.
Give the person enough time to respond to this before proceeding to the specific descriptors below. If parent is confused by the question, you can add something like – ‘Just describe his/her typical ‘ways’ or how s/he is in a nutshell.’

1b) Pick five words or adjectives to describe your child’s personality. After you have told me what they are, I will ask you about each one. For each one, what is it about him/her that makes you say that? I will ask you to tell one specific incident which illustrates (shows) what you mean by each word that you chose.
If the interviewee asks, you may say that it’s fine to use any of the descriptors s/he used in response to the general personality question above, but do not remind them about what those descriptors were. Phrases instead of words are fine (but do not make that part of the instructions). It is important not to rephrase what the interviewee says, but to use the words or phrases they stated. Some people have a hard time coming up with five words. Give them a “few more minutes” to think. If you feel they cannot come up with five, then move on. The numbers are less important than the descriptors. It does not matter if the words are synonyms. If the person cannot give five, you can say “That’s fine, if you think of another, we can come back to it.”

Write down the five words or phrases they give you, and when the interviewee is done, go back and get the specific example for each word or phrase.

(Probe each word for a specific incident/memory:
1. “The first (second, etc.) word (phrase) that you used to describe (your child’s) personality was _________. Tell me about a specific incident or memory that shows why you picked _________ to describe him/her.”
2. If the interviewee gives a non-specific example (e.g., “She always does that, or when we go to the park,” then say, “Tell me about one specific time that shows why you picked _____ to describe him/her; that stands out when child was _______.”
3. If you still don’t get a specific event, then ask, “When was the last time your child was_________.…Tell me about that time. If after those 3 requests you don’t get a specific example, move on to the next word.
You must use judgment about whether to do this for all 5 adjectives. If someone has only given generic examples rather than specific examples for the first 3 adjectives and is irritated about the probing, you may have to move on.

2a) At this point, who does your child remind you of?
- In what ways?
- When did you notice the first similarity?
If only one, or neither parent is mentioned, ask:
- In what ways does the child remind you of (the other parent)?
The following questions should be asked whether or not the parents have been mentioned.
- Which of his/her parents is your child most like now?
-In what ways is your child’s personality like yours? Not like yours? In what ways is his/her personality like his/her other parent’s (e.g., dad’s)? Not like his/her other parent’s personality?

2b) Are there any family characteristics on your side you see in your child’s personality?
   -What about (other parent’s) side?
   If the interview says s/he doesn’t know, move on.
   If s/he only mentions physical characteristics, probe again for personality.

2c) How did you decide on your child’s name?
   Find out about family names, etc.
   How well does the name seem to fit?

3) What do you feel is unique, different, or special about your child compared to what you know of other children?
   Give ample opportunities for the interview to respond—this is a question to linger on rather than move through quickly. So, if there is a very brief response (or no response) consider saying things like, “That’s ok, take your time,” or “Do you want to add anything else?”

4) What about your child’s behavior now is the most difficult for you to handle?
   Pause before moving to the next probe.
   Give a typical example.
   If the interviewee says “Nothing,” say, “Well, for most parents there’s at least one thing that’s challenging to deal with…what about for you?” If still nothing, try, “Ok, tell me something that’s just not as easy for you to handle.” If you still get no example of behavior, skip the following probes and go to question 5a).

   a) How often does this occur?
      -What do you feel like doing when your child reacts this way?
      -How do you feel on the inside when your child reacts this way?
      -What do you actually do?

   b) Does he/she know you don’t like it when she…?
      -Why do you think he/she does it?

   a) What do you imagine will happen to this behavior as your child grows older?
      -Why do you think so?

5a) How would you describe your relationship to your child now?
Give adequate time to respond before moving to the next probe.

5b) Pick five words (adjectives) to describe your relationship. Just like we did with personality, I’ll go back and ask you for a specific incident or memory for each word that illustrates what you mean. Again, accept whatever they say, then go through each word or phrase and use the same 3-probe approach used for the personality words as needed to get a specific memory.

6a) What pleases you most about your relationship with your baby?
   - What do you wish you could change about it?
   Some general probes that you can ask for either question include, “Tell me more.” “How so?” If interviewee says, “Nothing,” to the second question, probe “Is there anything that you wish were a little bit different? Only probe once here.

6b) How do you feel your relationship with your child has affected your child’s personality?
Be sure to give ample time to respond to this question. If the parent/caregiver says “Nothing,” probe [only] once “Are you sure?”

6c) Has your relationship to your child changed at all over time?
If the parent/caregiver says “No,” you can follow up with, “Not at all?” If the parent does not think the relationship has changed at all, move on to question 7.
   - In what ways?
   - What’s your feeling about the change?

7) Which parent/parent figure is your child closest to now?
   - How can you tell?
   - Has it always been that way?
   - Do you expect that to change (as the child gets older, for instance)?
   - How do you expect it to change?

8) Tell a favorite story about your child, perhaps one that you’ve told to family or friends. I’ll give you a minute to think about this one.
   If the person is struggling, you may tell them that this doesn’t have to be the favorite story, only a favorite, just one they really like. You want an answer!
   - What do you like about this story?

9) Think for a moment about your child as an adult. What hopes and fears do you have about that time?
WORKING MODEL OF THE CHILD INTERVIEW

Charles H. Zeanah
Diane Benoit
Marianne Barton

1986, rev. 1993

Introduction
This is a structured interview to assess parents’ internal representations or working model of their relationship to a particular child. The setting of the interview should be comfortable enough to allow for attention to the questions posed and a relaxed atmosphere that permits the opportunity for reflection.

The introductory section on developmental history is optional, depending upon the setting and purpose for which the interview is used. Otherwise, the interviewer should follow the outline. The interview allows for some follow-up probes, particularly those that encourage the individual to elaborate on responses. …the interviewer [should] not make interpretative comments, since we are interested in the degree to which individuals make these links on their own. Requests for clarification about contradictions may be made but only for the purpose of ascertaining whether the individual maintains contradictory views of the infant and only after allowing the individual an opportunity to recognize, acknowledge, and resolve the contradictions on his/her own. Essentially, the purpose of the interview is to have individuals reveal as much as possible in a narrative account of their perceptions, feelings, motives, and interpretations of a particular child and their relationship to that child.

Reference

Interview
We are interested in how parents think and feel about their children. This interview is a way for us to ask you about child's name and your relationship to him/her. The interview will take us about an hour to complete.

(1) I’d like you to begin by telling me about your child’s development.

(1a) Let’s start with your pregnancy. I’m interested in things like whether it was planned or unplanned, how you felt physically and emotionally, and what you were doing during the pregnancy (working, etc.). In a follow-up probe, find out how much the baby was wanted or not wanted. Had you ever been pregnant before? Why did you want to get pregnant at this time in your life? When did the pregnancy seem real to you? What were your impressions about the baby during pregnancy? What did you sense the baby might be like (including gender, temperament/personality)?
The idea is to put the subject at ease and to begin to obtain a chronological history of the pregnancy. Additional probes may be necessary to make sure that the individual is given a reasonable opportunity to convey the history of his/her reactions to and feelings about the pregnancy and the baby (which may or may not be the same).

(1b) Tell me about labor and delivery. Give some time to respond before proceeding. How did you feel and react at the time? What was your first reaction when you saw the baby? What was your reaction to having a boy/girl? How did your family react? Be sure to include husband/partner, other siblings.

(1c) Did the baby have any problems in the first few days after birth? How soon was the baby discharged from the hospital? Did you decide to breastfeed or bottlefeed? Why? What was the experience of breast-/bottle feeding like for you?

(1d) How would you describe the first few weeks at home in terms of feeding, sleeping, crying, etc. This is often a very important time because it may set the “emotional tone” of the baby’s entrance into the family, particularly if the delivery and perinatal period were routine.

(1e) Tell me about your baby’s developmental milestones such as sitting up, crawling, walking, smiling, and talking. Be sure to get a sense of the ways in which the baby was thought to be different, ahead or behind in motor, social, and language development. Did you have any sense of your baby’s intelligence early on? What did you think?

(1f) Did your baby seem to have a regular routine? What happened if you didn’t stay in the routine?

(1g) How has the baby reacted to separations from you? Try to get a sense of the baby’s reactions at various ages. Were there any separations of more than a day in the first or second year? How did the baby react? How was it for you? How did you feel? What did you do?

(1h) How and when did you choose your baby’s name? Find out about family names, etc. How well does your baby’s name fit him/her?

(2) Does your baby/child get upset often? Give some time to respond before proceeding to specific queries. What do you do at these times? What do you feel like doing when this happens? What do you feel like at these times?

(2a) What about when he/she becomes emotionally upset? Can you recall a specific example (or tell about a time when your child was emotionally upset [e.g., sad, frightened]). Make sure that subject describes incident(s) about the child being sad, frightened and not only angry. Also, indicate that you want an example by providing a reasonably long time to think of one. What did you do when that happened? What did you feel like doing? How did you feel or what was that like for you to see him/her upset like that? If the subject becomes extremely anxious and cannot recall an example, then proceed to part (2b).

(2b) Tell me about a time when he/she was physically hurt a little bit (e.g.,
a bump on head, scraping knees, cuts, bleeding) – in terms of what happened, what you did and what you felt. Be sure to find out what the subject felt like and did.

(2c) Tell me about a time when your baby/child was ill (e.g., ear infection, measles, flu/cold, etc), in terms of what happened, what you did and what you felt like. Again, include what this experience was like for the parent and how they responded to the child affectively and behaviorally.

(3) Describe your impression of your child’s personality now. Give the subject enough time to respond to this before proceeding to specific descriptors below.

(3a) Pick 5 words (adjectives) to describe your child’s personality. After you have told me what they are, I will ask you about each one. For each one. What is it about him/her that makes you say that? Then again for each one, tell at least one specific incident which illustrates what you mean by each word that you chose. You may tell the subject that it is fine to use any of the descriptors they used in response to the general probe above, but do not remind them what they said before you have given them time to recall themselves. Some subjects will have a hard time coming up with 5 descriptors. If you feel that they cannot come up with 5, then move on. The numbers are less important than the descriptions.

(4) At this point, whom does your child remind you of? In what ways? When did you first notice the similarity? If only one parent is mentioned ask. In what ways does the child remind you of (the other parent)? The following questions should be asked whether or not the parents have been mentioned. Which of his/her parents is your child most like now? In what ways is your child’s personality like and unlike each of his/her parents’?

(4a) Are there any family characteristics on your side you see in your child’s personality? What about (other parent)’s side?

(4b) How did you decide on your child’s name? How well does the name seem to fit?

(5) What do you feel is unique or different about your child compared to (what you know of) other children?

(6) What about your child’s behavior now is the most difficult to handle? Give a typical example.

(6a) How often does this occur? What do you feel like doing when your child reacts that way? How do you feel when your child reacts that way? What do you actually do?

(6b) Does he/she know you don’t like it? Why do you think he/she does it?

(6c) What does the child do after you respond to the difficult behavior in the way you described? How do you imagine the child feels when you respond this way?
(6d) What do you imagine will happen to this behavior as your child grows older? Why do you think so/what makes you feel that way?

(7) How would you describe your relationship to your child now? Give time to respond.

(7a) Pick 5 words (adjectives) to describe your relationship. For each word, describe an incident or memory that illustrates what you mean.

(8) What pleases you most about your relationship with your baby? What do you wish you could change about it?

(9) How do you feel your relationship with your child has affected your child’s personality? Give ample time to respond.

(10) Has your relationship to your child changed at all over time (since birth)? In what ways? What’s your own feeling about that change?

(11) Which parent is your child closest to now? How can you tell? Has it always been that way? Do you expect that to change (as the child gets older, for instance)? How do you expect it to change?

(12) Tell a favorite story about your child – perhaps one you’ve told to family or friends. I’ll give you a minute to think about this one. If the subject is struggling, you may tell them that this doesn’t have to be the favorite story, only a favorite. What do you like about this story?

(13) As you know, the first (age of child) months/years can be difficult at times – what is your worst memory of (child’s name)’s first (age of child) months/years of life?

(14) Are there any experiences which your child has had which you feel may have been a setback for him/her? Why do you think so? Indirectly, we’re trying to determine whether the parent feels responsible in any way for the setbacks. Therefore, be sure to give time to respond before moving on to the more direct questions which follow.

(14a) Do you have any regrets about the way you’ve raised your child so far?

(14b) If you could start all over again, knowing what you know now, what would you do differently?

(15) Do you ever worry about your child? What do you worry about? How worried do you get about (list each worry)?

(16) If your child could be the same age forever, let’s say you can freeze him/her in time – any age at all – what would you prefer that age to be? Why (what do you like about that age?).

(17) As you look ahead, what do you think will be the most difficult time in your child’s development? Why do you think so?
(18) What do you expect your child to be like as an adolescent? What makes you feel that way? What do you expect to be good and not so good about this period in your child’s life?

(19) Think for a moment of your child as an adult. What hopes and fears do you have about that time?
## Developmental Milestones and Competency Ratings

### By 3 months old

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional</strong></td>
<td>Briefly calms self (e.g., sucks on hand).</td>
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<td></td>
<td>Exhibits interest in the outside world when in an alert state (e.g., gazes at objects, people, or light; localizes to sound; adjusts breathing in response to sound of voices).</td>
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<td></td>
<td>Is comforted by proximity to caregiver and soothing motion.</td>
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<td></td>
<td>Remains in a calm, focused state for at least 2 minutes.</td>
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<td></td>
<td>Makes smooth state transitions (e.g., sleep to drowsy to awake).</td>
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<td></td>
<td>Expresses contentment or discomfort.</td>
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<tr>
<td><strong>Social-Relational</strong></td>
<td>Smiles responsively (i.e., social smile).</td>
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<tr>
<td></td>
<td>Looks at caregiver’s face.</td>
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<tr>
<td></td>
<td>Coos responsively.</td>
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<tr>
<td></td>
<td>Localizes to familiar voices and sounds.</td>
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<tr>
<td></td>
<td>Shows interest in facial expressions.</td>
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</tbody>
</table>
### Developmental Milestones and Competency Ratings

**By 3 months old**

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Language-Social Communication</strong></td>
<td>Follows sounds (e.g., turning head in response to sound).</td>
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<tr>
<td></td>
<td>Coos and gurgles.</td>
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<tr>
<td></td>
<td>Imitates simple facial expressions (e.g., smiling, sticking tongue out).</td>
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<tr>
<td><strong>Cognitive</strong></td>
<td>Follows people and objects with eyes.</td>
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<td></td>
<td>Loses interest or protests if activity does not change.</td>
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<tr>
<td><strong>Movement and Physical</strong></td>
<td>Pushes up trunk when lying on stomach.</td>
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<tr>
<td></td>
<td>Holds head up without support.</td>
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<td></td>
<td>Hands are often open (i.e., not in fists).</td>
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## Developmental Milestones and Competency Ratings

### By 6 months old

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional</strong></td>
<td>Responds to affection with smiling, cooing, or settling.</td>
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<td></td>
<td>Demonstrates a range of emotions that includes happiness, excitement, sadness, fear, distress, disgust, anger, joy, interest, and surprise.</td>
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<td></td>
<td>Expresses anger, frustration, or protest with distinct cries and facial expressions.</td>
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<td></td>
<td>Recovers from distress when comforted by caregiver.</td>
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<tr>
<td><strong>Social-Relational</strong></td>
<td>Imitates some movements and facial expressions (e.g., smiling or frowning).</td>
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<td></td>
<td>Engages in socially reciprocal interactions (e.g., playing simple back-and-forth games).</td>
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<td></td>
<td>Seeks social engagement with vocalizations, emotional expressions, or physical contact.</td>
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<tr>
<td></td>
<td>Watches faces closely.</td>
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<tr>
<td><strong>Language-Social Communication</strong></td>
<td>Copies sounds.</td>
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<tr>
<td></td>
<td>Babbles with p, b, and m sounds.</td>
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<tr>
<td></td>
<td>Vocalizes excitement and displeasure (e.g., laughs and coos).</td>
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<tr>
<td></td>
<td>Produces distinct cries to show hunger, pain, or being tired.</td>
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</tbody>
</table>

Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.
## Developmental Milestones and Competency Ratings

### By 6 months old

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>Tracks moving objects with eyes from side to side.</td>
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<td></td>
<td>Experiments with cause and effect (e.g., bangs spoon on table).</td>
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<td></td>
<td>Smiles and vocalizes in response to own face in mirror image.</td>
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<td></td>
<td>Recognizes familiar people and things at a distance.</td>
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<td></td>
<td>Demonstrates anticipation of certain routine activities (e.g., shows excitement in anticipation of being fed).</td>
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<tr>
<td>Movement and Physical</td>
<td>Swats at dangling objects.</td>
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<td></td>
<td>Pushes down on legs when feet are on a hard surface.</td>
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<td></td>
<td>Sits without support.</td>
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<td></td>
<td>Rolls over from tummy to back.</td>
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<td></td>
<td>Holds and shakes an object.</td>
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<td></td>
<td>Bangs two objects together.</td>
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<td></td>
<td>Brings hands to midline.</td>
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<tr>
<td></td>
<td>Reaches for object with one hand.</td>
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<tr>
<td>Competency Domain</td>
<td>Milestone</td>
<td>Milestone Rating</td>
<td>Comments</td>
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<tr>
<td><strong>Emotional</strong></td>
<td>Has strategies for self-soothing.</td>
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<td></td>
<td>Demonstrates preference for caregivers.</td>
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<td></td>
<td>Intentionally communicates feelings to others.</td>
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<tr>
<td><strong>Social-Relational</strong></td>
<td>Distinguishes between familiar and unfamiliar voices.</td>
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<td></td>
<td>Shows some stranger wariness.</td>
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<td></td>
<td>Protests separation from caregiver.</td>
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<td></td>
<td>Enjoys extended play with others, especially caregivers.</td>
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<td></td>
<td>Engages in back-and-forth, two-way communication using vocalizations and eye contact.</td>
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<td></td>
<td>Mimics other’s simple gestures.</td>
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<tr>
<td></td>
<td>Follows other’s gaze and pointing</td>
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</tbody>
</table>
### Developmental Milestones and Competency Ratings

**By 9 months old**

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.

<table>
<thead>
<tr>
<th>Competency Domain</th>
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<tbody>
<tr>
<td><strong>Language-Social Communication</strong></td>
<td>Responds to sounds by making sounds or moving body.</td>
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<td></td>
<td>Imitates speech sounds when prompted</td>
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<tr>
<td></td>
<td>Begins to use noncrying sounds (speech sounds) to get and keep attention</td>
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<td></td>
<td>String vowels together when babbling <em>(ah, eh, oh)</em>.</td>
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<td></td>
<td>Makes sounds to show joy or displeasure</td>
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<td></td>
<td>Begins to use gestures to communicate wants and needs <em>(e.g., reaches to be picked up)</em></td>
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<tr>
<td></td>
<td>Follows some routine commands when paired with gestures</td>
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<td></td>
<td>Shows understanding of commonly used words.</td>
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<tr>
<td><strong>Cognitive</strong></td>
<td>Mouths or bangs objects.</td>
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<td></td>
<td>Tries to get objects that are out of reach.</td>
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<td></td>
<td>Looks for things he or she sees others hide <em>(e.g., toy under blanket)</em>.</td>
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</table>
### Developmental Milestones and Competency Ratings

**By 9 months old**

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

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</thead>
<tbody>
<tr>
<td>Movement and Physical</td>
<td>Rolls over in both directions (front to back, back to front).</td>
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<td></td>
<td>Brings self to sitting position independently.</td>
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<td></td>
<td>Stands with support.</td>
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<td></td>
<td>Moves independently from one place to another (e.g., crawling, scooting).</td>
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<td></td>
<td>Turns pages of a book.</td>
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<td></td>
<td>Reaches for and grasps objects.</td>
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<tr>
<td></td>
<td>Passes objects from one hand to the other.</td>
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</tbody>
</table>
### Developmental Milestones and Competency Ratings

**By 12 months old**

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<table>
<thead>
<tr>
<th>Competency Domain</th>
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</thead>
<tbody>
<tr>
<td><strong>Emotional</strong></td>
<td>Looks to caregiver for information about new situations and environments.</td>
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<td></td>
<td>Looks to caregiver to share emotional experiences.</td>
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<td></td>
<td>Responds to other people’s emotions (e.g., displays sober, serious face in response to sadness in parent; smiles when parent laughs).</td>
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<td></td>
<td>Uses gestures to communicate feelings (e.g., clapping when excited).</td>
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<tr>
<td><strong>Social-Relational</strong></td>
<td>Offers object to initiate interaction (e.g., hands caregiver a book to hear a story).</td>
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<td></td>
<td>Plays interactive games (e.g., “peek-a-boo” and “pat-a-cake”).</td>
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<td></td>
<td>Looks at familiar people when they are named.</td>
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<td></td>
<td>Gives object to seek help (e.g., hands shoe to parent).</td>
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<td></td>
<td>Extends arm or leg to assist with dressing.</td>
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<tr>
<td><strong>Language-Social Communication</strong></td>
<td>Understands “no.”</td>
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<tr>
<td></td>
<td>Responds to own name.</td>
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<td></td>
<td>Looks in response to “where” questions (e.g., “Where is the doggie?”).</td>
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</tbody>
</table>
### By 12 months old

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<tr>
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<th>Comments</th>
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<tbody>
<tr>
<td><strong>Language-Social Communication (continued)</strong></td>
<td>Makes different consonant sounds such as <em>mamamam</em> and <em>babababa</em>.</td>
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<td></td>
<td>Points to nearby objects.</td>
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<td></td>
<td>Imitates conventional gestures (e.g., waving bye-bye, clapping).</td>
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<td></td>
<td>Responds to simple directives accompanied by gestures such as “come here.”</td>
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<td></td>
<td>Has a few words (e.g., “mama,” “dada,” “hi,” “bye-bye,” or “dog”).</td>
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<tr>
<td><strong>Cognitive</strong></td>
<td>Watches the path of something as it falls.</td>
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<td></td>
<td>Has favorite objects (e.g., toys, blanket).</td>
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<td></td>
<td>Explores objects and how they work in multiple ways (e.g., mouthing, touching, dropping).</td>
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<td></td>
<td>Fills and dumps containers.</td>
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<td></td>
<td>Plays with two objects at the same time.</td>
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</tbody>
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By 12 months old

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<tbody>
<tr>
<td>Movement and Physical</td>
<td>Takes a few steps without holding on.</td>
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<td></td>
<td>Walks holding onto furniture (i.e., cruises).</td>
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<td></td>
<td>Moves from sitting to standing position.</td>
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<tr>
<td></td>
<td>Stands alone.</td>
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<td></td>
<td>Picks up things between thumb and index finger (e.g., cereal).</td>
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<td></td>
<td>Crawls forward on belly, pulling with arms and pushing with legs.</td>
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<tr>
<td></td>
<td>Turns around while crawling.</td>
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<td></td>
<td>Crawls while holding an object.</td>
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</table>
## By 15 months old

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<table>
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<tr>
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</thead>
<tbody>
<tr>
<td><strong>Emotional</strong></td>
<td>Shows affection with kisses (without pursed lips).</td>
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<td></td>
<td>Demonstrates cautious or fearful behavior such as clinging to or hiding behind caregiver.</td>
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<tr>
<td><strong>Social-Relational</strong></td>
<td>Seeks and enjoys attention from others, especially caregivers.</td>
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<td></td>
<td>Engages in parallel play with peers.</td>
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<td></td>
<td>Presents a book or toy when he or she wants to hear a story or to play.</td>
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<td></td>
<td>Repeats sounds or actions to get attention.</td>
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<td></td>
<td>Enjoys looking at picture books with caregiver.</td>
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<tr>
<td></td>
<td>Engages in parallel play with peers.</td>
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</tr>
<tr>
<td><strong>Language-Social Communication</strong></td>
<td>Uses simple gestures such as shaking head “no” or waving “bye-bye.”</td>
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<tr>
<td></td>
<td>Responds to the gestures of others.</td>
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<tr>
<td></td>
<td>Enjoys looking at picture books with caregivers.</td>
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<td></td>
<td>Makes sounds with changes in tone (sounds more like speech).</td>
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### Developmental Milestones and Competency Ratings

**By 15 months old**

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</thead>
<tbody>
<tr>
<td><strong>Language-Social Communication (continued)</strong></td>
<td>Uses complex communication skills integrating gestures, vocalizations, and eye contact (e.g., looking to parent while taking his or her hand to bring him or her to a desired toy).</td>
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<td></td>
<td>Identifies correct picture or object when it is named.</td>
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<td></td>
<td>Follows simple requests (e.g., “pick up the toy”; “roll the ball”).</td>
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<tr>
<td><strong>Cognitive</strong></td>
<td>Initiates complex gestures (e.g., signing).</td>
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<td></td>
<td>Initiates joint attention (e.g., points to show others something interesting or to get others’ attention).</td>
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<td></td>
<td>Finds hidden objects easily.</td>
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<td></td>
<td>Uses objects for their intended purpose (e.g., drinks from a cup, smooths hair with brush).</td>
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<tr>
<td><strong>Movement and Physical</strong></td>
<td>Explores physical environment.</td>
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<td></td>
<td>Pushes objects (e.g., boxes, toy trucks, push toys).</td>
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<td></td>
<td>Walks independently.</td>
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### Developmental Milestones and Competency Ratings

#### By 18 months old

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<tbody>
<tr>
<td><strong>Emotional</strong></td>
<td>Demonstrates self-comforting strategies.</td>
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<tr>
<td></td>
<td>Shares humor with peers or adults (e.g., laughs at and makes funny faces or nonsense rhymes).</td>
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<tr>
<td><strong>Social-Relational</strong></td>
<td>Likes to hand things to others during play.</td>
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<td></td>
<td>Engages in reciprocal displays of affection (e.g., hugs or kisses with a pucker).</td>
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<td></td>
<td>Asserts autonomy (e.g., “me do”).</td>
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<td></td>
<td>Reacts with concern when someone appears hurt.</td>
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<td></td>
<td>Leaves caregiver’s side to explore nearby objects or setting.</td>
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<td></td>
<td>Engages in teasing behavior such as looking at parent and caregiver and doing something “forbidden.”</td>
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<tr>
<td><strong>Language-Social Communication</strong></td>
<td>Uses at least 20 words or word approximations such as <em>baba</em> for ball.</td>
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<td></td>
<td>Shows consistent increases in vocabulary each month.</td>
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<td></td>
<td>Says and shakes head “no.”</td>
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<td></td>
<td>Can follow one-step verbal commands without any gestures (e.g., sits when you say “sit down”).</td>
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</tbody>
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### By 18 months old

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<tbody>
<tr>
<td><strong>Language-Social Communication</strong> <em>(continued)</em></td>
<td>When pointing, looks back to caregiver to confirm joint attention.</td>
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<tr>
<td></td>
<td>Combines words, gestures, and eye contact to communicate feelings and requests.</td>
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<tr>
<td><strong>Cognitive</strong></td>
<td>Enacts play sequences with objects according to their intended use (e.g., pushing a toy dump truck and emptying its cargo).</td>
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<td></td>
<td>Shows interest in a doll or stuffed animal by giving a hug.</td>
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<tr>
<td></td>
<td>Points to at least one body part.</td>
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<tr>
<td></td>
<td>Points to self when asked.</td>
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<tr>
<td></td>
<td>Plays simple pretend games (e.g., feeding a doll).</td>
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<tr>
<td></td>
<td>Scribbles with crayon, marker, and so forth.</td>
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<tr>
<td></td>
<td>Turns pages of book.</td>
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<tr>
<td></td>
<td>Recognizes self in mirror.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Movement and Physical</strong></td>
<td>Stacks two blocks.</td>
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<tr>
<td></td>
<td>Walks up steps with help.</td>
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</tbody>
</table>

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*
## Developmental Milestones and Competency Ratings

### By 18 months old

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Movement and Physical (continued)</strong></td>
<td>Pulls toys while walking.</td>
<td></td>
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<tr>
<td></td>
<td>Helps undress him- or herself (e.g., pulls off hat, socks, mittens).</td>
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<tr>
<td></td>
<td>Eats with a spoon.</td>
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<tr>
<td></td>
<td>Drinks from open cup.</td>
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</tr>
</tbody>
</table>
### Developmental Milestones and Competency Ratings

**By 24 months old**

*Ratings key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional</strong></td>
<td>Exhibits embarrassment and pride.</td>
<td></td>
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<tr>
<td></td>
<td>Exhibits shame and guilt.</td>
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<tr>
<td></td>
<td>Exhibits empathy (e.g., offers comfort when someone is hurt).</td>
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<tr>
<td></td>
<td>Attempts to exert independence frequently.</td>
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<tr>
<td></td>
<td>Names or understands words for basic emotions.</td>
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</tr>
<tr>
<td><strong>Social-Relational</strong></td>
<td>Imitates others’ complex actions, especially adults and older children (e.g., putting plates on the table, posture, gestures).</td>
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<tr>
<td></td>
<td>Enjoys being with other young children.</td>
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<tr>
<td></td>
<td>Takes pride and pleasure in independent accomplishments.</td>
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<tr>
<td></td>
<td>Primarily plays in proximity to other young children but notices and imitates other young children’s play more frequently.</td>
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<tr>
<td></td>
<td>Responds to being corrected or praised.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Language-Social Communication</strong></td>
<td>Enjoys being read to.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Names actions.</td>
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</tr>
</tbody>
</table>
## Developmental Milestones and Competency Ratings

### By 24 months old

-Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.-

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Language-Social Communication</strong> (continued)</td>
<td>Knows names of familiar people and many body parts.</td>
<td></td>
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<tr>
<td></td>
<td>Uses two words together (e.g., “more cookie”; “Dada, bye-bye?”).</td>
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<tr>
<td></td>
<td>Repeats words overheard in conversation.</td>
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<tr>
<td></td>
<td>Names objects in picture books (e.g., cat, bird, ball, or dog).</td>
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<tr>
<td></td>
<td>Imitates animal sounds such as “meow,” “woof,” “baa,” and “moo.”</td>
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<tr>
<td></td>
<td>Uses some self-referential pronouns such as “mine.”</td>
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<td></td>
</tr>
<tr>
<td><strong>Cognitive</strong></td>
<td>Finds things even when hidden under two or three covers or when hidden in one place and moved to a second place (i.e., does not give up when the hidden object is not in the first location).</td>
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<tr>
<td></td>
<td>Begins to sort shapes and colors.</td>
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<tr>
<td></td>
<td>Completes sentences and rhymes from familiar books, stories, or songs.</td>
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<tr>
<td></td>
<td>Plays simple make-believe games (e.g., pretend meal).</td>
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<tr>
<td></td>
<td>Builds towers of four or more blocks.</td>
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<tr>
<td></td>
<td>Follows two-step instructions (e.g., “Pick up your shoes and put them in the closet”).</td>
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</tr>
</tbody>
</table>
## By 24 months old

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Movement and Physical</strong></td>
<td>Participates in dressing (e.g., putting arms into sleeves, pulling pants up or down, putting on hat).</td>
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<tr>
<td></td>
<td>Stands on tiptoes.</td>
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<tr>
<td></td>
<td>Kicks a ball.</td>
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<td></td>
<td>Runs.</td>
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<tr>
<td></td>
<td>Climbs onto and down from furniture without help.</td>
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<tr>
<td></td>
<td>Walks up and down stairs holding on.</td>
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<tr>
<td></td>
<td>Draws lines.</td>
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<tr>
<td></td>
<td>Drinks using a straw.</td>
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<tr>
<td></td>
<td>Opens cabinets, drawers, and boxes.</td>
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</tbody>
</table>

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## Developmental Milestones and Competency Ratings

### By 36 months old

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>Expresses full range of emotions, including pride, shame, guilt, and empathy.</td>
<td></td>
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<tr>
<td></td>
<td>Expresses distress or anger with words.</td>
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<tr>
<td></td>
<td>Shows pride in new learning and new experiences.</td>
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<td></td>
<td>Expresses affection openly and verbally.</td>
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<tr>
<td></td>
<td>Expresses feelings through pretend play and drama.</td>
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</tr>
<tr>
<td>Social-Relational</td>
<td>Shows affection to peers without prompting</td>
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<tr>
<td></td>
<td>Shares without prompts.</td>
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<tr>
<td></td>
<td>Can wait turn in playing games.</td>
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<tr>
<td></td>
<td>Shows concern for crying peer by taking action.</td>
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<td></td>
<td>Engages in associative play with peers (i.e., infants/young children participate in similar activities without formal organization but with some interaction).</td>
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<tr>
<td></td>
<td>Shares accomplishments with others.</td>
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<tr>
<td></td>
<td>Helps with simple household tasks.</td>
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</tbody>
</table>
By 36 months old

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language-Social Communication</td>
<td>Clearly uses ( k, g, f, t, d, ) and ( n ) sounds.</td>
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<tr>
<td></td>
<td>Builds logical bridges between ideas using words such as “but” and “because.”</td>
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<tr>
<td></td>
<td>Asks questions using words such as “why?” or “how?”</td>
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<td></td>
<td>Says first name when asked.</td>
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<tr>
<td></td>
<td>Names most familiar objects.</td>
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<tr>
<td></td>
<td>Understands words such as “in,” “on,” and “under.”</td>
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<tr>
<td></td>
<td>Knows own identifying information (e.g., name, age, gender).</td>
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<tr>
<td></td>
<td>Identifies peers by name.</td>
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<tr>
<td></td>
<td>Uses some plurals (e.g., “cars,” “dogs,” “cats”).</td>
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<tr>
<td></td>
<td>Uses labels “mine,” “I,” “you,” “me,” “their,” “his,” or “hers” accurately.</td>
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<tr>
<td></td>
<td>Speaks well enough for familiar listeners to understand most of the time.</td>
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<td></td>
<td>Carries on a conversation using two or three sentences.</td>
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<tr>
<td></td>
<td>Uses sentences that are at least three to four words.</td>
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</tbody>
</table>
## Developmental Milestones and Competency Ratings

### By 36 months old

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive</td>
<td>Labels some colors correctly.</td>
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<tr>
<td></td>
<td>Plays thematic make-believe with objects, animals, and people.</td>
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<tr>
<td></td>
<td>Answers simple “why” questions (e.g., “Why do we need a coat when it’s cold outside?”).</td>
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<tr>
<td></td>
<td>Shows awareness of skill limitations.</td>
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<tr>
<td></td>
<td>Understands “bigger” and “smaller.”</td>
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<td></td>
<td>Understands concept of “two.”</td>
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<td></td>
<td>Enacts complex behavioral routines observed in daily life of caregivers, siblings, or peers.</td>
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<tr>
<td></td>
<td>Solves simple problems (e.g., obtains a desired object by opening a container).</td>
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<tr>
<td></td>
<td>Attends to a story for 5 minutes.</td>
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<tr>
<td></td>
<td>Plays independently for 5 minutes.</td>
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</tr>
<tr>
<td>Movement and Physical</td>
<td>Manipulates some buttons, levers, and moving parts.</td>
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<tr>
<td></td>
<td>Climbs on high and low structures.</td>
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<tr>
<td></td>
<td>Runs fluidly.</td>
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</tbody>
</table>
### By 36 months old

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

<table>
<thead>
<tr>
<th>Competency Domain (continued)</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Copies a circle.</td>
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<tr>
<td></td>
<td>Builds tower of more than six blocks.</td>
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<tr>
<td></td>
<td>Pedals a tricycle (three-wheeled bicycle).</td>
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<tr>
<td></td>
<td>Catches and kicks big ball.</td>
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<tr>
<td></td>
<td>Walks up and down steps, alternating feet.</td>
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<td></td>
</tr>
<tr>
<td>Competency Domain</td>
<td>Milestone</td>
<td>Milestone Rating</td>
<td>Comments</td>
<td>Competency Domain Rating</td>
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<tr>
<td>-------------------</td>
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</tr>
<tr>
<td>Emotional</td>
<td>Expresses distress or anger with words.</td>
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<tr>
<td></td>
<td>Conveys emotional experiences in pretend play.</td>
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<tr>
<td></td>
<td>Complies with basic cultural rules for emotional expression.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Social-Relational</td>
<td>Pretends to play “Mom” and “Dad” (or other relevant caregivers).</td>
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<tr>
<td></td>
<td>Asks about or talks about parent and caregiver when separated (i.e., holds the other in mind).</td>
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<tr>
<td></td>
<td>Engages in cooperative play with other infants/young children.</td>
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<tr>
<td></td>
<td>Has a preferred friend.</td>
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<tr>
<td></td>
<td>Expresses interests, likes, and dislikes.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Language-Social Communication</td>
<td>Relates experiences from school or outside home.</td>
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<tr>
<td></td>
<td>Describes events or things using four or more sentences at a time.</td>
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<tr>
<td></td>
<td>Identifies rhyming words such as “cat–hat” or “ping–ring.”</td>
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<tr>
<td></td>
<td>Recognizes and understands basic rules of grammar (e.g., plurals, tense).</td>
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<tr>
<td></td>
<td>Sings a song or says a poem from memory (e.g., “Itsy Bitsy Spider” or the “Wheels on the Bus”).</td>
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</tbody>
</table>
### By 48 months old

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Language-Social Communication</strong></td>
<td>Tells stories.</td>
<td></td>
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<tr>
<td></td>
<td>Says first and last name when asked.</td>
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<tr>
<td></td>
<td>Uses words or adjectives to describe or talk about him- or herself.</td>
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<tr>
<td></td>
<td>Understands, uses, and responds to questions of “how” or “when.”</td>
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<td></td>
<td>Uses words that talk about time.</td>
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<tr>
<td></td>
<td>Speech is generally understood by nonfamily members.</td>
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</tr>
<tr>
<td><strong>Cognitive</strong></td>
<td>Names several colors and some numbers.</td>
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<tr>
<td></td>
<td>Counts to five.</td>
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<tr>
<td></td>
<td>Has rudimentary understanding of time.</td>
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<td></td>
<td>Shares past experiences.</td>
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<tr>
<td></td>
<td>Remembers parts of a story.</td>
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<tr>
<td></td>
<td>Engages in make-believe play with capacity to build and elaborate on play themes.</td>
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<tr>
<td></td>
<td>Connects actions and emotions.</td>
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</tr>
</tbody>
</table>
### Developmental Milestones and Competency Ratings

**By 48 months old**

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<table>
<thead>
<tr>
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<th>Milestone</th>
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<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive (continued)</td>
<td>Responds to questions that require understanding the idea of “same” and “different.”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Draws a person with two to four body parts.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Understands that actions can influence others’ emotions (e.g., tries to make others laugh by telling simple jokes).</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Waits for turn in simple games.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Elaborates on thematic make-believe play.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Plays board or card games with simple rules.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Describes what is going to happen next in a book.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Talks about right and wrong.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Movement and Physical</td>
<td>Skips, hops, and stands on one foot for up to 2 seconds.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Catches a large, bounced ball most of the time.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Copies “plus” sign.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uses toilet during the day with few accidents.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pours from one container to another, cuts with supervision, and mashes own food.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### By 60 months old

**Rating key:** 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional</strong></td>
<td>Expresses two or more emotions at the same time.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Shows awareness of and interest in personal success.</td>
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<tr>
<td></td>
<td>Shows increased confidence associated with greater independence and autonomy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Social-Relational</strong></td>
<td>Wants to please friends.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emulates role models, real or imaginary.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Values rules in social interactions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Participates in group activities that require assuming roles (e.g., Follow the Leader).</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Modulates or modifies voice correctly depending on situation or listener (e.g., outside voice, to adult, other infant/young child, or younger child).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Language-Social Communication</strong></td>
<td>Makes all speech sounds. May make mistakes on more difficult sounds such as ch, sh, th, l, v, and z (linguistically variable).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Understands words denoting order such as “first,” “second,” “third,” “next,” and “last.”</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Uses “today,” “yesterday,” “tomorrow,” “last week,” and “before” correctly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discriminates rhyming and nonrhyming words.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### By 60 months old

*Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent.*

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Language-Social Communication (continued)</strong></td>
<td>Recognizes words with same beginning sound.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identifies individual sounds within words (e.g., “dog”: d–o–g).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tells a simple story using full sentences.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uses future tense (e.g., “Grandma will be here”).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Says full name and address.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cognitive</strong></td>
<td>Counts 10 or more things.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tells stories with beginning, middle, and conclusion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Draws a person with at least six body parts.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Acknowledges own mistakes or misbehaviors and can apologize.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Distinguishes fantasy from reality most of the time.</td>
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</tr>
<tr>
<td></td>
<td>Names four colors correctly.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Follows rules in simple games.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Knows function of everyday household objects (e.g., money, cooking utensils, appliances).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## By 60 months old

_Rating key: 1 = Fully present; 2 = Inconsistently present or emerging; 3 = Absent._

<table>
<thead>
<tr>
<th>Competency Domain</th>
<th>Milestone</th>
<th>Milestone Rating</th>
<th>Comments</th>
<th>Competency Domain Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cognitive</strong></td>
<td>Attends to group activity for 15 minutes (e.g., circle time, storytelling).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(continued)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Movement and Physical</strong></td>
<td>Stands on one foot for 10 seconds or longer.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Copies a triangle and other geometric shapes.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Copies some letters or numbers.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hops on one foot.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Uses utensils to eat.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Uses the toilet independently (wipes, flushes, and washes hands).</td>
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</tr>
<tr>
<td></td>
<td>Swings independently on a swing.</td>
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<td></td>
</tr>
</tbody>
</table>
BABY CROWELL PROCEDURE

Tulane University

“Once you are in the room, please just make yourself and your baby comfortable. You can spend time with your child as you normally would.”

1) 2 minutes: Free play with caregiver/parent and baby

Stranger enters room and sits silently for 1 minute, talks to caregiver for 1 minute, then plays with baby for 3 minutes, as such:

2) 5 minutes: Interaction with stranger
   1 minute: stranger sits silently
   1 minute: stranger talks with caregiver/parent
   3 minutes: stranger plays with baby

Stranger asks parent to pick up the toys, put them in the bucket and push them over to the door. Stranger then leaves the room.

3) Parent puts the toys in the bucket and pushes them to the door.

On the phone: Ask caregiver/parent to take out the bubbles and blow them for the baby.

4) 2 minutes: caregiver/parent blows bubbles for the baby

On the phone: Ask caregiver to get out 1st task (see list of teaching tasks) and teach the baby the task.

5) 3 minutes: first teaching task

On the phone: Ask caregiver to get out 2nd task (see list of teaching tasks) and teach the baby the task.

6) 3 minutes: second teaching task

On the phone: “Please do whatever you feel is necessary to make your baby comfortable and then come out of the room. The baby will stay in the room for a couple of minutes.”

7) 2 minutes: separation (caregiver/parent leaves)

In the monitoring room: When time has elapsed (or if baby is distressed), walk caregiver/parent to the door. Instructions: “Please knock on the door, call the baby’s name, and then step all the way into the room. We would like you to spend some time with your baby doing what comes naturally. You will have several minutes alone with your baby.”

8) 3 minutes: reunion (caregiver/parent returns)
CROWELL PLAY PROCEDURE
GENERAL INSTRUCTIONS
For the Crowell Tool Task
Tulane Infant Team

INSTRUCTIONS given to the parent at the start of the session:

“I will call you between each task and remind you what to do, however, I will review everything with you now so that you will have an idea of what is going to happen. First I want you to play with (child’s name) and the toys here (indicate free play toys), then I will call you and ask you to have him/her clean up all of the toys. You can help him/her if you think he/she needs it, but see how much he/she can do on his/her own. I will then call and ask you to do each of the following tasks with him/her. One of these tasks may be fairly easy for him/her and one will be more difficult so you may help him/her if you think he/she needs it (review 2 tasks). After the second task I will call and ask you to leave the room. After leaving the room you may come back into the monitoring room with me and watch him/her. After a few minutes I will ask you to return to the room and the two of you will play for a few more minutes. If (child’s name) becomes upset we will end the separation early.”

**Individual episodes:**
- Free play: 5 mins
- Cleanup: no more than 5 mins
- Task 1: 2 to 4 mins
- Task 2: 2 to 4 mins
- Separation – no more than 5 mins
- Reunion: 3 mins

**Instruction given over the phone/during transitions:**
- Free play: *Play with the child as you would at home*
- Cleanup: *Have the child clean up, helping him/her if you feel he/she needs help.*
- Task 1: *(Specific task instructions.) Keep repeating the task until I give you a call.*
- Task 2: *(Specific task instructions.) Keep repeating the task until I give you a call.*
- Separation: *Open the cabinet door, so that the child can see the task toys, take the key and then leave the room as you would at home.*
- Reunion: *Knock on the door, call the child’s name, and step all the way into the room.*

--Parents are given basic instructions prior to the session and each task is demonstrated. During the session the clinician calls into the room to give specific instructions between each transition.

--Tasks 1 should be somewhat at the child’s developmental level, ideally the child should be able to do the task with little or no assistance. Tasks 2 should be above the child’s level so that they need the parent’s assistance to complete the task.

--The length of time allowed for each task varies. If the child finishes the task quickly allow time for the task to be done 1 or 2 more times. If time is up but the dyad is close to completing the task allow time for completion and joy sharing. If time is up, the child is getting frustrated and/or the task is far from complete, end the task.

© Tulane Infant Team – Training required to use procedure.
FREE PLAY TOYS

- Include toys that support pretend play.
- Currently included are the following toys:
  - 2 baby dolls with 2 bottles
  - puppets of a family
  - doctor kit
  - tool kit
  - 2 cellphones
  - play food/plates/cups

**If the child is younger (under 18 mos) include:
- stuffed animal
- farm house set
- some large trucks/cars

**If the child is older include:
- small dolls (doll house dolls)

Toys that should NOT be included:
- Do not include any toys that lend themselves to “teaching” type interactions, as that will occur with the Crowell tasks.
- Keep out any toys that make loud noises, as this makes scoring difficult.
- Do not use large toys (e.g., doll house, kitchen set) because this interferes with cleanup and if left in the room tend to act as a distracter. Large toys also inhibit videotaping as often the toy blocks the view of the child.

ROOM DESCRIPTION:
- The room never has more than 2 adult chairs during a Crowell.
- There is one cabinet in which the Crowell tasks are stored. This cabinet is locked and the parent is given the key.
- The free play toys are kept in a bucket and removed from the room after cleanup. If left in the room they tend to distract the child (and parent) from the tasks.
- We have 4 educubes in the room. These are the large plastic blocks, each block can be used as a table or if turned onto its side as a child size chair (available through J.L. Hammet, Lakeshore or Beckley Cardy).
- There is a phone in the room, which allows the clinician or researcher to call into the room and give instructions during the procedure. The procedure tends to run more smoothly when complete instructions are given before the Crowell starts and then again at each transition.
D.A.P. Progress Note Checklist

<table>
<thead>
<tr>
<th>Data</th>
<th>Check if addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Subjective data about the client—what are the client’s observations, thoughts, direct quotes?</td>
<td></td>
</tr>
<tr>
<td>2. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?</td>
<td></td>
</tr>
<tr>
<td>3. What was the general content and process of the session?</td>
<td></td>
</tr>
<tr>
<td>4. Was homework reviewed (if any)?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessment</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>5. What is the counselor’s understanding about the problem?</td>
<td></td>
</tr>
<tr>
<td>6. What are the counselors’ working hypotheses?</td>
<td></td>
</tr>
<tr>
<td>7. What are the results of any testing, screening, assessments?</td>
<td></td>
</tr>
<tr>
<td>8. What is the client’s current response to the treatment plan?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Based on client’s response to the treatment plan, what needs revision?</td>
<td></td>
</tr>
<tr>
<td>10. What goals, objectives were addressed this session?</td>
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</tr>
<tr>
<td>11. What is the counselor going to do next?</td>
<td></td>
</tr>
<tr>
<td>12. When is the next session date?</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>General Checklist</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Does this note connect to the client’s individualized treatment plan?</td>
<td></td>
</tr>
<tr>
<td>14. Is this note dated, signed, and legible?</td>
<td></td>
</tr>
<tr>
<td>15. Is the client name and identifier included on each page?</td>
<td></td>
</tr>
<tr>
<td>16. Has referral information been documented?</td>
<td></td>
</tr>
<tr>
<td>17. Are client strengths/limitations in achieving goals noted and considered?</td>
<td></td>
</tr>
<tr>
<td>18. Are any abbreviations used standardized and consistent?</td>
<td></td>
</tr>
<tr>
<td>19. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?</td>
<td></td>
</tr>
<tr>
<td>20. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?</td>
<td></td>
</tr>
</tbody>
</table>
INFANT AND EARLY CHILDHOOD MENTAL HEALTH SERVICES
Parent Infant Psychotherapy
QUARTERLY REPORT FORM

Reporting Period:
PPIP Provider:

Services Provided

• Number of Total Children Served:___________
• Number Served as CYFD-003_______________
• Number Served as CYFD-004_______________

CYFD-003

a. Before engaging in an IECMH treatment services, did infant(s) receive:
   • a diagnostic Evaluation that has resulted in a diagnosis _____________
   • an individualized Service Plan that includes IECMH treatment as an
     intervention _____________

b. Have services been:
   At least 80% of IECMH services must been provided in vivo at least weekly in
   the home or other settings natural to the infant and family (or primary
   caregiver). Please Describe:

c. Service delivery is focused on the dyadic relationship between the infant and
   parent (or primary caregiver) and the relationship needs of the infant or
toddler. The initial assessment results in intervention strategies and
   treatment recommendations for services.
   Describe recommendations below:

 d. Each Infant/Early Childhood Mental Health provider must address, at
    minimum:
   1. Increase parent’s(s’) adult caretaker’s(s’) ability to consistently and
      appropriately provide for the child’s safety, social and emotional needs,
      and developmental progress;
2. Increase parent’s(s’)/adult caretaker’s(s’) ability to meet basic emotional needs for comfort, stimulation, affection, and safety of the infant;
3. Increase child’s ability to initiate and respond to most social interactions in a developmentally appropriate way;
4. Increase developmentally appropriate and sensitive parent/child interaction in order to encourage language and play, interpretation of a child’s behavior and reinforcement of a parent’s (or primary caregiver’s) appropriate actions and interactions.

Describe Below:

**CYFD-004**

e. Before engaging in an IECMH treatment services, did infant(s) receive:
   - a diagnostic Evaluation that has resulted in a diagnosis
   - an individualized Service Plan that includes IECMH treatment as an intervention

f. Have services been:
   At least 80% of IECMH services must been provided in vivo at least weekly in the home or other settings natural to the infant and family (or primary caregiver). Please Describe:

g. Service delivery is focused on the dyadic relationship between the infant and parent (or primary caregiver) and the relationship needs of the infant or toddler. The initial assessment results in intervention strategies and treatment recommendations for services. Describe recommendations below:

h. Each Infant/Early Childhood Mental Health provider must address, at minimum:
   5. Increase parent’s(s’)/adult caretaker’s(s’) ability to consistently and appropriately provide for the child’s safety, social and emotional needs, and developmental progress;
   6. Increase parent’s(s’)/adult caretaker’s(s’) ability to meet basic emotional needs for comfort, stimulation, affection, and safety of the infant;
7. Increase child’s ability to initiate and respond to most social interactions in a developmentally appropriate way;
8. Increase developmentally appropriate and sensitive parent/child interaction in order to encourage language and play, interpretation of a child’s behavior and reinforcement of a parent’s (or primary caregiver’s) appropriate actions and interactions.

*Describe Below:*

**Descriptions of Children Served**

a. CYFD
   - Number of Substantiated/Previous Referrals
   - Number in Foster Care
   - Number with hx of current In-Home Services

b. Number in Child Care

c. Number in Head Start

d. Number in Early Head Start

e. Number in Home Visiting Program

f. Number in Pre-K program

g. Other

**Challenges and Successes this Quarter:**
APPENDIX B

Data Entry

PARENT INFANT PSYCHOTHERAPY DATA ENTRY

Data entry guidelines and Tip Sheets for documenting services are provided in Appendix B.
Database Buttons Key

- **Refresh** – updates the data grid with any new information since entering the screen.

- **Print Data Grid** – provides the ability to send the contents of the data grid to the printer.

- **Expand All** – records on the screen that appear with a plus symbol next to them will be expanded so the contents of underlying data can be seen.

- **Collapse All** - records on the screen that appear with a minus symbol next to them will be collapsed so the contents of underlying data will be suppressed.

- **Magnifying Glass** – Click the magnifying glass symbol to see a list of potential responses for the field. Double-Click an item from the list to select it.

- **Question Mark** – This is a look up function that may be used to display more comprehensive information related to the choices that appear in the dropdown.

- **Dropdown Box** - This is a selection function that may be used to display multiple options in a list.

- **Open Book** - Click the open book symbol to show all columns on a specified report grid.

- **Closed Book** – Click the closed book symbol to hide all columns on a specified report grid.

If you need further assistance please contact the ECSC Database Services Team:

- [ecscdata@unm.edu](mailto:ecscdata@unm.edu)
- Local: (505) 277-0469
- Toll Free: 855-663-2821
Quick Steps

- Open Firefox Internet Browser
- Enter https://ppp01.unm.edu in Browser’s Address Bar
- Enter Username and Password
- Click on your Database Icon

Detailed Steps to Login:

1. Look for this icon on your desktop and click on it to open the Firefox browser.

2. After Firefox launches, type in the website address: https://ppp01.unm.edu

3. The screen shown below launches when the website has been reached. Enter your Username and Password.

   **Note:** Passwords are assigned by the UNM Data Team. For any changes to your password, please contact ECSC database services using the information listed at the end of this training document.

4. Once you have typed in your username and password, the following screen appears displaying the name of your IMH program. Click on the icon to launch the Database.

   **Note:** If a message appears that your Java version is out of date, please contact ECSC database services using the information listed at the end of this training document.
Detailed Steps to Log Out:

1. From the menu bar choose **File**, then scroll down and click **Exit**.

   ![Menu Bar with Exit Option](image)

If you need further assistance please contact the ECSC Database Services Team:

- **ecscdata@unm.edu**
- Local: (505) 277-0469
- Toll Free: 855-663-2821
Quick Steps

- Click on the Cases Link
- Click on the Register New Case Button
- In Case/Client Registration Window, Complete all Registration Fields
- Click Next Button
- In Case/Client Registration Window, Complete all Address Fields
- Click Next Button
- In Case/Client Registration Window, Complete Provider/Staff Assignment Fields
- If Case File is Complete, Click Register Case/Client Button
- Click Yes to Create the Case
- Click OK to Complete Registration

Detailed Steps:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

2. Click on the Cases link (on the side menu bar) to get to your open case list.
3. Click on the **Register New Case** button at the bottom of the screen.

   ![Register New Case button](image)

   **Note**: If you do not have any open cases, you will get a screen like this. Click **OK**.

   ![OK button](image)

   Then, click **Register New Case** on this screen.

4. The **Case/Client Registration** window launches. In this process you will be completing information on each of the tabs, **Registration**, **Address**, and **Provider/Staff Assignment**.

5. **Registration Tab**

   ![Registration Tab](image)
Registering a New Case

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open Date</td>
<td>Type in the date the client started services.</td>
</tr>
<tr>
<td>Name</td>
<td>Type in the first name, middle initial and last name in the corresponding fields.</td>
</tr>
<tr>
<td>D.O.B</td>
<td>Type in the client’s date of birth.</td>
</tr>
<tr>
<td>Check Duplicate</td>
<td>After the client’s name and D.O.B is entered, click on the Check Duplicate button to check to see if the client is already registered in the database. The system will display any match or near matches. If the client is already in the database, choose Cancel Registration. To register as a new client, click Continue and Register New Client button.</td>
</tr>
<tr>
<td>Sex</td>
<td>Choose Male or Female</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Use the magnifying glass look up tool to view the ethnicity options, select, and click OK.</td>
</tr>
</tbody>
</table>

6. Click on the Next button to move to the Address tab.

**Address Tab**

- **Type**: Use the magnifying glass look up tool to view what kind of address is being entered (Home, Mailing, Other, etc.), select, and click OK.
- **Line 1**: Type in the first line of the address (example: 1313 Mockingbird Lane). Enter the information into the City, State, Zip and County fields.
- **Address Notes**: Type in specific information about the address (e.g., Beware of dog).
7. Click the **Next** button to move to the **Provider Status/Staff Assignment** tab.

**Provider Status/Staff Assignment tab**

![Provider Status/Staff Assignment tab](image)

- **Provider**: The field is automatically populated. If the provider listed is not correct, use the magnifying glass look up tool to select the correct option, select, and click **OK**.
- **Action**: Use the dropdown menu tool to select the correct option.
- **Referral Source**: Use the magnifying glass look to select the correct option, select, and click **OK**.
- **Referring Prv**: Use the magnifying glass look up tool to view the client provider options, select, and click **OK**.
- **Heard From**: Use the magnifying glass look up tool to view the sources list, select, and click **OK**.
- **Reason**: Use the magnifying glass look up tool to select a Client Provider Status Action Reason, select, and click **OK**.
- **Staff**: Use the magnifying glass look up tool to select a staff member, select, and click **OK**.
- **Role**: Use the magnifying glass look up tool to select the correct option to specify the role the staff member will play in the case, select, and click **OK**.
- **Activity Level**: Use the magnifying glass look up tool to view the sources list. Select and click **OK**.
8. When the required information has been completed, the **Register Case/Client** button will light up. Click on the button and a confirmation screen will appear.

9. Click **Yes** to create the case.

10. Click **OK** to complete the registration.

If you need further assistance please contact the ECSC Database Services Team:

- **ecscdata@unm.edu**
- Local: (505) 277-0469
- Toll Free: 855-663-2821
Registering a New Client

Quick Steps

- Open the Case List Screen (if you are not already in it)
- Click on the + Sign to the Left of the Case you are Adding a Client to
- Click on the Client Field
- Click the Register New Client Button
- Type in the Client Information (you can use the magnifying glass tool for drop down options)
- Click Save

Detailed Steps:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

2. Click on the Cases link (on the side menu bar) to get to your open case list.

3. From the Case List screen, click on the + sign to the left of the case that you want to work on.
4. Click into the client area under the case.

5. Click on the **Register New Client** button at the bottom of the window.

6. **Client Information** fields. Type in the client information for the fields indicated below.

   - **Name**: Type in the first name, middle initial and last name in the corresponding fields. (If a Prefix or Suffix are available, please use the drop down arrow for options).
   - **D.O.B**: Type in the client’s date of birth or use the dropdown tool to access calendar.
   - **Sex**: Type in Male or Female or use the magnifying glass look up tool to select sex, select, and click OK.
   - **Ethnicity**: Use the magnifying glass look up tool to select the correct ethnicity option, select, and click OK.
   - **Role in Case**: Use the magnifying glass look up tool to select the role in the case, select, and click OK.

   Once all of the fields are entered, click on the **Save** button to save the new client.

**Note**: If there is more than one client in the case, then add each new client (e.g., father, grandparents, foster care, etc.) by following these detailed steps.

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Local:
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Toll Free:
855-663-2821
Quick Steps

- Select the Case
- Select the Client
- Select Client Registration Link
- Enter Facts Person ID (7 Digit ID)
- Click Save

Detailed Steps:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

   ![Staff Window Screenshot]

2. Click on the Cases link (on the side menu bar) to get to your open case list.

   ![Cases Menu Screenshot]

3. From the Case List screen, click on the + sign to the left of the case that you want to work on.

   ![Case List Screenshot]
4. Under the case, click on the client you are entering the FACTS Person ID for.

5. On the right hand menu bar, click on the **Client Registration** link.

6. In the **Client Information** form, type in the client’s **FACTS Person ID** (7 digit ID).

7. Click **Save**.

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Toll Free:
855-663-2821
Quick Steps

- Open the Case List Screen (if you are not already in it)
- Click on the + Sign to the Left of the Case you are Working on
- Click on the Client Field you are Entering the Assessment for
- From the Right Hand Menu Bar, Click on the Client Assessments/ Screens Link
- Click the Add Button
- Complete the Information for Provider, Tool, Version, Eval Date, Rater, and Status
- Click Save/ Go to Responses
- Click the Close Button on the Evaluation/ Screening Responses Screen

Detailed Steps:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

2. Click on the Cases link (on the side menu bar) to get to your open case list.

3. From the Case List screen, click on the + sign to the left of the case that you want to work on.
4. Under the case, click on the client you are entering the assessment for.

5. On the right hand menu bar, click on the Client Assessments/Screens link.

6. To add a new assessment, click on the Add button.


   **Provider** Use the magnifying glass look up tool to view the provider options, select, and click OK.

   **Tool** Use the dropdown or magnifying glass tool to select the IMHI Infant Team Intake assessment, select, and click OK.

   **Version** Use the magnifying glass tool to locate the version of the screening tool you were using, select, and click OK.

   **Eval Date** Type in the date the evaluation was done or use the dropdown tool to access calendar.

   **Rater** Use the magnifying glass tool to identify the person who conducted the evaluation, select, and click OK.
Status  The database will default the status to C (closed). Use the magnifying glass tool to select another option when necessary, select and click **OK**.

When the **Evaluation/Screening Information** form is completed, click the **Save/Enter Responses**.

8. Click on the **Close** button after entering the responses to each question. The information is saved automatically and the assessment is complete.

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Quick Steps

- Open the Case List Screen (if you are not already in it)
- Click on the + Sign to the Left of the Case you are Working on
- Click on the Client Field you are Entering the Assessment for
- From the Right Hand Menu Bar, Click on the Client Services Link
- Click the Add Button
- Fill out the Staff/Services Activities Form (all 3 panes)
- Click Save/Add More Service
- If Another Service Entry is Needed, Fill out the Staff/Services Activities Form (all 3 panes)
- If There is Not Another Service to Enter, Click the Close Button

Detailed Steps:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

2. Click on the Cases link (on the side menu bar) to get to your open case list.

3. From the Case List screen, click on the + sign to the left of the case that you want to work on.
4. Under the case, click on the client you are entering the assessment for.

5. On the right hand menu bar, click on the Client Services link.

6. Click the Add button to add a new service.

7. The Staff Services/Activities window will open. 
   Please, note that there is no auto-save function. Save your information by clicking Save/Stay Open  
   often in case of a power outage or disconnection.

   The far left panel is logistical information related to the service.
Provider
Use the magnifying glass look up tool to select the provider, select, and click **OK**.

Staff
This field should automatically populate. Use the magnifying glass tool to select an option if necessary, select, and click **OK**.

Appointment Date/ Time
Type in the start and end times as well as the date of service (Service Date also has a dropdown tool to access a calendar).

Procedure
Use the magnifying glass tool to select the procedure, select, and click **OK**.

Appt. Status
The database will default the status. Use the magnifying glass tool to select another option when necessary, select, and click **OK**.

Place of Service
The database will default the place of service. Use the magnifying glass tool to select another option when necessary, select, and click **OK**.

Fund
Use the magnifying glass tool to select an option for fund information, select, and click **OK**.

The middle pane will have dropdown choices concerning who was present at the visit and what assessments were administered.

**Present At Session** Use the dropdown arrow tool to check an option or checkmark more than one option of who was present at the session.

**CoS Parenting DVD** Use the dropdown arrow tool to check an option or checkmark more than one option.

The right panel will have a notes section.
Notes. Clicking on the magnifying glass tool offers the choice between a free-form note field which can be used to copy and paste text from other documents. You also have the choice of using a DAP field for Data/Assessment/Plan style notes.

8. When the Staff Services/Activities window is complete, click on the Save/Add More Service button and the entry form will clear. If there are more services to enter, repeat step 7.

If there are no more services to enter for this client, click on the Close button to exit the form.

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Quick Steps

- Open the Case List Screen (if you are not already in it)
- Click on the + Sign to the Left of the Case you are Working on
- Click on the Client Field you are Entering the Assessment for
- From the Right Hand Menu Bar, Click on the Client Treatment Goals Link
- Click the Add Button
- Add the Goal/ Outcome Information
- Click Save
- Click Close to Exit this Screen

Detailed Steps:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

2. Click on the Cases link (on the side menu bar) to get to your open case list.

3. From the Case List screen, click on the + sign to the left of the case that you want to work on.
4. Under the case, click on the client you are entering the assessment for.

5. On the right hand menu bar, click on the Client Treatment Goals link.

6. Click the Add button to add a new treatment outcome.

7. The Goal/Outcome Information form will open.

   - **Outcome**: Click on the magnifying glass look up tool to the right of the Outcome field. The outcome list includes the four axes of the DC: 0-3R. Select the definition most closely related to the goal and click Ok.
   
   - **Treatment Goal Strategies**: Type in the goal in the Treatment Goal field. Enter the approach you use to achieve the goal in the Strategies field. This information may be copied and pasted from an outside document. Type in an Effective Date.
8. Click **Save** to add the Goal/Outcome Information.

9. Click **Close** to exit the Goal/Outcome Information screen.

If you need further assistance please contact the ECSC Database Services Team:

[ecsdata@unm.edu](mailto:ecsdata@unm.edu)
Local: (505) 277-0469
Toll Free: 855-663-2821
Quick Steps

- Open the Case List Screen (if you are not already in it)
- Click on the + Sign to the Left of the Case you are Working on
- Click on the Client Field you are Entering the Assessment for
- From the Right Hand Menu Bar, Click on the Client Assessments/Screens Link
- Enter the Evaluation/Screening Information
- Click the Save/Go to Responses Button
- Enter the Appropriate Evaluation Responses
- Click the Close Button

Detailed Steps:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

2. Click on the Cases link (on the side menu bar) to get to your open case list.

3. From the Case List screen, click on the + sign to the left of the case that you want to work on.
4. Under the case, click on the client you are entering the assessment for.

5. On the right hand menu bar, click on the Client Assessments/Screens link.

6. Click the Add button to add a new assessment.

7. The Evaluation/Screening Information form opens.

   **Provider**  Use the magnifying glass tool to locate the appropriate provider name, select, and click OK.

   **Tool**  Use the dropdown or magnifying glass tool to identify the name of the evaluation or screening you are entering the data for, select, and click OK.

   **Version**  Use the dropdown or magnifying glass tool to locate the version of the screening tool you were using, select, and click OK.

   **Eval Date**  Type in the date the evaluation was conducted or use the dropdown calendar.
Rater
Use the magnifying glass tool to identify the person who conducted the evaluation (e.g. Infant team member, PIP therapist, etc.), select, and click OK.

Staff ID
This field is optional for cases where more than staff may be assigned to the case. Use the magnifying glass tool to identify the person who is assigned to the case, select, and click OK.

Client ID
This field will only be applicable to the PITA (Progress in Treatment Assessment). If you are entering a PITA, enter the Client ID or use the magnifying glass search tool to identify the child client associated with the PITA (Progress in Treatment Assessment).

Status
The default status of the screening is closed. Use the magnifying glass tool to select another option when necessary, select, and click OK.

8. When the Evaluation/Screening Information form is complete, click the Save/Go to Responses button, and the assessment questions will appear.

Each question and response will follow your documentation of this screening.

Note: Responses in an evaluation responses can be narrative, multiple choice, check all that apply, or numbers/dates. In the narrative/text responses, two boxes are presented to allow text input. The Response Information box is intended for notes that will be displayed in reports. The Response Comments/Notes box is intended or personal notes and will not be displayed in reports.

9. Click on the Close button after entering the responses. The information is saved automatically and the assessment is complete.

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Toll Free:
855-663-2821
Quick Steps

- Open the Case List Screen (if you are not already in it)
- Click on the + Sign to the Left of the Case you are Working on
- Click on the Client Field you are Entering the Assessment for
- From the Right Hand Menu Bar, Click on the Client Assessments/Screens Link
- Enter the Evaluation/Screening Information
  - In Tools, choose IMHEN Discharge
  - In Version, Type IMHEN and Choose the Version
- Click the Save/Go to Responses Button
- Enter the Appropriate Evaluation Responses
- Click the Close Button

Detailed Steps:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

2. Click on the **Cases** link (on the side menu bar) to get to your open case list.

3. From the **Case List** screen, click on the + sign to the left of the case that you want to work on.
4. Under the case, click on the client you are entering the assessment for.

![Image of case list with client selected](image)

5. On the right hand menu bar, click on the **Client Assessments/Screens** link.

![Image of client assessment pane](image)

6. Click the **Add** button to add a new discharge assessment.

![Image of add button](image)

7. The **Evaluation/Screening Information** form opens.

![Image of evaluation form](image)

**Provider**

Use the magnifying glass tool to locate the appropriate provider name, select, and click **OK**.

**Tool**

Use the dropdown or magnifying glass tool to select the **IMHEN Infant Team Discharge Status** assessment, select, and click **OK**.
### Entering Discharge Assessment for Clients

<table>
<thead>
<tr>
<th><strong>Version</strong></th>
<th>Type in the version or use the dropdown or magnifying glass tool to locate the version of the screening tool you are using, select, and click <strong>OK</strong>.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eval Date</strong></td>
<td>Type in the date the evaluation was conducted or use the dropdown tool to access a calendar.</td>
</tr>
<tr>
<td><strong>Rater</strong></td>
<td>Use the magnifying glass tool to identify the person who conducted the evaluation, (e.g. Infant team member, PIP therapist, etc.), select, and click <strong>OK</strong>.</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td>The default status of the screening is closed. Use the magnifying glass tool to select another option when necessary, select, and click <strong>OK</strong>.</td>
</tr>
</tbody>
</table>

8. When the Evaluation/Screening Information form is complete, click the **Save/Go to Responses** button, and the assessment questions will appear.

   Each question and response will follow your documentation of this screening.

   **Note:** Responses in an evaluation responses can be narrative, multiple choice, check all that apply, or numbers/dates. In the narrative/text responses, two boxes are presented to allow text input. The **Response Information** box is intended for notes that will be displayed in reports. The **Response Comments/Notes** box is intended for personal notes and will not be displayed in reports.

9. Click on the **Close** button after entering the responses. The information is saved automatically and the assessment is complete.

If you need further assistance please contact the ECSC Database Services Team:

**ecscdata@unm.edu**

Local:
(505) 277-0469

Toll Free:
855-663-2821
Quick Steps

- Open the Case List Screen (if you are not already in it)
- Select the Case you Want to Close
- Click Close Case Button
- Enter the Close Date
- Select the Reason for Closure under the drop down menu next to Reason Field
- Click the Close Case/Members & Member Clients Button
- Click Yes to Save Closure
- Click OK

Detailed Steps:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

2. Click on the Cases link (on the side menu bar) to get to your open case list.

3. Under the case list, select the case you are wanting to close. Then click the Close Case button.
4. In the **Close Case Information** form, navigate to the **Close Date** field and enter the date the case was closed by either typing the information or using the drop down menu tool to access calendar.

5. In the same **Close Case Information** form, navigate to the **Reason** field and use the magnifying glass tool to select the reason you are closing the case, select, and click **OK**.

6. Click the **Close Case/Members & Member Clients** button at the bottom of the screen.

7. A confirmation screen will appear to close the case. Click **Yes** to save the closure.

8. Click **OK** on the final confirmation form.

If you need further assistance please contact the ECSC Database Services Team:

**ecscdata@unm.edu**  
Local:  
(505) 277-0469  
Toll Free:  
855-663-2821
Quick Steps

- Open the Case List Screen (if you are not already in it)
- Click on the + Sign to the Left of the Case you are Working on
- Click on the Client Field you are Looking at the Notes for
- From the Right Hand Menu Bar, Click on the Client Services Link
- Enlarge Service Notes by Left Clicking and Dragging the Double Line/Double Arrow Icon Up

Detailed Steps:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

2. Click on the Cases link (on the side menu bar) to get to your open case list.

3. From the Case List screen, click on the + sign to the left of the case that you want to work on.
4. Under the case, click on the client you are entering the assessment for.

5. On the right hand menu bar, click on the Client Services link.

6. In the Case Member Services form, you will be able to enlarge the Service Notes section. Click in the area below the Service Information and above the Service Notes. The cursor will change to indicate two lines with an arrow pointing up and an arrow pointing down. Hold down your left mouse key and drag the cursor up to expand the window.

The window will stay in the expanded view until you exit the Services menu. Don’t forget you can drag the lower left corner of the entire window to enlarge entire Service Information screen.

Note: These fancy little bars will expand and contract the bigger window depending on which way the arrow is pointing. Don’t be afraid to play with them.

If you need further assistance please contact the ECSC Database Services Team:

descdata@unm.edu
Local:
(505) 277-0469
Toll Free:
855-663-2821
Printing an IMH Note

Quick Steps

- Open the Case List Screen (if you are not already in it)
- Click on the + Sign to the Left of the Case you are Working on
- Click on the Client Field you are Printing a Note From
- From the Right Hand Menu Bar, Click on View Services Link
- Click Print
- Select IMH Note (Note 1)
- Click Print/Perform
- Click the Printer Icon Button Located in the Tool Bar on Top

It is not necessary to print a Services note because the details are stored in the database. However, if you would like a hard copy of the session information, there is an ability to print.

Detailed Steps From the Notes Page:

1. Finish entering a note.
2. Click Print Reports and skip to #8 below.

Detailed Steps From the Main Page:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

2. Click on the Cases link (on the side menu bar) to get to your open case list.
3. From the **Case List** screen, click on the + sign to the left of the case that you want to work on.

4. Under the case, click on the client you want to print notes for.

5. On the right hand menu bar, click on the **View Services** link.

6. From the **Case Member Service Information** form, Click **Print**.

7. Select **IMH Note** (1 Note) from the list and single-click **Print/Perform** (Double-clicking the Home Visit Note line item will do the same thing).
8. A status bar will appear indicating the report is being generated.

9. The Print Preview screen will appear with a thumbnail view of each page of the home visit note.

10. Click the printer button located in the tool bar at the top of the screen. Click Close to return to the previous screen.

If you need further assistance please contact the ECSC Database Services Team:

cscdata@unm.edu
Local:
(505) 277-0469
Toll Free:
855-663-2821
Quick Steps

- From the Main Menu, Click Reports and SELECT Print My Reports
- Select the Report “PIP Client Roster and Services Spreadsheet”
- Click the Print/Perform Button
- Enter the Beginning and Ending Reporting Dates and Click Select
- Select the Provider Contract and Click OK
- Click the Customer Report Layout Button
- Minimize Database
- Double Click HVReports shortcut on your Desktop
- Double Click Billing Workbook to Review

Detailed Steps for Running the Report:

1. Once logged into your database, from the main menu, select Reports and then select Print My Reports. This will open up your list of reports.

2. In the Outputs/Actions form, select the report titled “PIP Client Roster and Services Spreadsheet” and click the Print/Perform button. This will open the report options window.
3. In the **User Report Options** form, enter the **Beginning** and **Ending** dates for the month you are reporting or use the dropdown tool to access a calendar. Click the **Select** button.

4. In the **Search: R/Client Providers** form, select your provider contract and click **Ok**.

5. You should be back in the **User Report Options** form. Click the **Customize Report Layout** button. The report will run (you may see Excel open and close which is normal).

6. If you do not have a folder for the report to export into, you will receive this error:

   ![Image of a pop-up error message]

   **Note:** If this occurs, click **OK**, and close out. Please contact the ECSC Database Services Team.

**Detailed Steps for Reviewing the PIP Billing Workbook:**

1. After the above steps have been completed, minimize the database from the blue menu bar at the very top of the database window.

   ![Image of a minimized database window]

2. **Double click** on the **HVReports** shortcut on your desktop to open up the folder. This is where all Services Workbooks will be saved on your computer.

3. The Excel file will be named “**Services Workbook**”. Double click the file and review the report for accuracy.

If you need further assistance please contact the ECSC Database Services Team:

**ecscdata@unm.edu**

Local:
(505) 277-0469

Toll Free:
855-663-2821
Quick Steps:

- Open the Case List Screen (if you are not already in it)
- Click on the + Sign to the Left of the Case you are Working on
- Double Click on the Pink Client Field you are Entering the Assessment for
- Select Rel. to Client by Using the Magnifying Glass Look up Tool
- Click OK
- Click Next

Detailed Steps:

1. After logging into the database, the Staff window appears and the system identifies your name on the staff list.

2. Click on the Cases link (on the side menu bar) to get to your open case list.

3. From the Case List screen, click on the + sign to the left of the case that you want to work on.
4. Under the case, double click on the client name you are wanting to add a guardianship onto.

5. This will open a **Case Member Role Information** screen. Click on the magnifying glass look up tool to the right of the **Rel. to Client**.

   Select the most applicable relationship to the child and click **Ok**.

6. Click **Next** to complete the process.

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Supporting Articles

PARENT INFANT PSYCHOTHERAPY SUPPORTING ARTICLES

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


**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**
  - 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**


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

- **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**


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

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

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


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**


**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**


**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**

**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**

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

**Dissemination Study Conducted by**


**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:


Fact sheet last updated October, 2011
INTRODUCTION

Chapter A.4

THE CLINICAL ASSESSMENT OF INFANTS, PRESCHOOLERS AND THEIR FAMILIES

Sarah Mares & Ana Soledade Graeff-Martins

This publication is intended for professionals training or practising in mental health and not for the general public. The opinions expressed are those of the authors and do not necessarily represent the views of the Editor or IACAPAP. This publication seeks to describe the best treatments and practices based on the scientific evidence available at the time of writing as evaluated by the authors and may change as a result of new research. Readers need to apply this knowledge to patients in accordance with the guidelines and laws of their country of practice. Some medications may not be available in some countries and readers should consult the specific drug information since not all dosages and unwanted effects are mentioned. Organizations, publications and websites are cited or linked to illustrate issues or as a source of further information. This does not mean that authors, the Editor or IACAPAP endorse their content or recommendations, which should be critically assessed by the reader. Websites may also change or cease to exist.

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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).
**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 (Stroufe 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...
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 of 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...
### Table A.4.1 Principles of Assessment

<table>
<thead>
<tr>
<th>1</th>
<th>Assessment of risk</th>
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<tr>
<td>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.</td>
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<th>2</th>
<th>Parents want the best for their children</th>
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<tr>
<td>Almost always, parents want the best for their children and family. The clinician’s role is to assist them in providing this.</td>
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<tr>
<th>3</th>
<th>Biopsychosocial framework</th>
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<tr>
<td>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.</td>
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<th>4</th>
<th>Developmental context</th>
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<tr>
<td>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.</td>
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<th>5</th>
<th>A relational approach</th>
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<tr>
<td>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.</td>
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<th>6</th>
<th>Vulnerabilities and strengths</th>
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<td>Identifying vulnerabilities and strengths (also called risk and protective factors) helps shape and target interventions.</td>
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<th>7</th>
<th>The transactional model of development</th>
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<tr>
<td>The transactional model of development (Sameroff &amp; 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 &amp; Fiese, 2000, p10).</td>
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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
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.

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
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...
Table A.4.2 Rating scales and questionnaires

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Comments</th>
</tr>
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| **Child Behavior Checklist (CBCL) for 1.5-5 yrs** (Achenbach & Rescorla, 2000) | • Two questionnaires to assess adaptive and maladaptive functioning of 1½-5 year-olds. Rated by parents, day care providers and teachers  
• 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).  
• Proprietary |
| **Strengths and Difficulties Questionnaire (SDQ)** (Goodman, 1997) | • 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  
• Free of charge |
| **The Ages and Stages Questionnaire (ASQ-3)** (Squires & Bricker, 1999) | • 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  
• Proprietary |
| **The Ages and Stages Questionnaire: Social Emotional (ASQ:SE)** (Squires et al, 2003) | • A culturally versatile tool for clinicians to identify and monitor children at-risk for social, emotional and behavioral delays. The ASQ-SE rates a child's development in the behavioural areas of self-regulation, compliance, communication, adaptability, autonomy, affect and interaction with people  
• Proprietary |
| **Preschool Age Psychiatric Assessment (PAPA)** (Egger & Angold, 2004) | • 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.  
• Proprietary; formal training required. For more information |
| **The Parenting Stress Index – Short Form (PSI-SF)** (Abidin, 1995) | • Screens for stress in the parent-child relationship, dysfunctional parenting, parental behaviour problems and child adjustment difficulties within the family.  
• Available in several languages.  
• Proprietary. More information at |

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
Assessment of infants

A.4

IACAPAP Textbook of Child and Adolescent Mental Health

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 metalising 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
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

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**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.

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**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

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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.
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 are 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>
<thead>
<tr>
<th>In the infant/child</th>
<th>In the parents</th>
<th>In the context</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Failure to thrive</td>
<td>• Inability to recognise or prioritise the child’s needs</td>
<td>• No other available and protective adult</td>
</tr>
<tr>
<td>• Failure to meet expected milestones</td>
<td>• Untreated or inadequately treated psychiatric illness or substance abuse</td>
<td>• Significant cultural or social isolation</td>
</tr>
<tr>
<td>• Hypervigilant or startling easily</td>
<td>• Lack of insight and lack of engagement with treatment services</td>
<td>• Minimal social supports</td>
</tr>
<tr>
<td>• Excessively quiet and withdrawn</td>
<td>• Child incorporated in parental delusional system, including positive delusions</td>
<td>• Domestic/family or community violence</td>
</tr>
<tr>
<td>• Marked aggression in a toddler</td>
<td>• Insensitivity to child’s signals and needs (emotionally unavailable)</td>
<td>• Multiple social risks (e.g., homelessness, itinerancy)</td>
</tr>
<tr>
<td>• Basic needs not met</td>
<td>• Thoughts of self-harm or fear of harming child</td>
<td>• Chronic stress</td>
</tr>
<tr>
<td>• Role reversal or caregiving behaviour towards parent</td>
<td>• Scared of infant, ignores infants cries</td>
<td></td>
</tr>
<tr>
<td>• Emotion regulation problems</td>
<td>• Frightening or looming behaviour, rough handling of infant</td>
<td></td>
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<tr>
<td>• Unexplained bruising or medical injury</td>
<td>• Hostile or negative attributions (&quot;he is out to get me&quot;)</td>
<td></td>
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<tr>
<td></td>
<td>• Unrealistic developmental expectations</td>
<td></td>
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<td></td>
<td>• Lack of parenting skills</td>
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|                                                                 |                                                                                      |
| Developed in conjunction with Nicholas Kowalenko, Sarah Mares, Louise Newman, Anne Sved Williams, Rosalind Powie, and Karin van Doesum. |

The 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.

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

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
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 Hoghughi (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.
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
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**

- World Association for Infant Mental Health
REFERENCES


Assessment of infants


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.

**Why are you here?**

- **Focus on self**
  - Deflects responsibility from self onto others
    - “I’m here because my ex-husband is trying to get back at me so he blamed me that my baby got hurt when he was the one watching her.”
  - Takes responsibility
    - “I’m here because I was stupid. If I hadn’t left my baby she wouldn’t have gotten hurt. I feel so bad that she got hurt because I wanted to go party.”
  - Shows empathy (esp. for child)
    - “My ex-husband is a screw-up and doesn’t watch the kids like he should.”

- **Focus on others**
  - Blames others
    - “She is fine. I broke my arm twice when I was a kid, and anyway I wasn’t even there when it happened”
  - Dismiss, minimize, or justify behavior
    - “Her arm is fine, but I think the whole thing was scary for her. I remember when I broke my arm as a kid and I was scared to death.”

**What impact does “X” have on your child?**

- **Show empathy and understanding for child**
  - Sees isolated mistakes rather than a pattern
    - “I shouldn’t have left her with my ex-husband.”
  - Shows understanding of adequate supervision
    - “I shouldn’t have left her with my ex-husband. I mean I know he isn’t careful and he has a temper. I need to not leave her with people I don’t trust.”
  - Sees problem as a one time event or fluke
    - “I don’t know that it could be prevented. Accidents just happen sometimes. What are the odds that she would have broken her arm falling off the couch?”

**How could this have been prevented?**

- **Change in behavior**
  - Sees problem as a one time event or fluke
    - “I don’t know that it could be prevented. Accidents just happen sometimes. What are the odds that she would have broken her arm falling off the couch?”
  - Shows understanding of adequate supervision
    - “I shouldn’t have left her with my ex-husband. I mean I know he isn’t careful and he has a temper. I need to not leave her with people I don’t trust.”

- **Change in facts**
  - Sees isolated mistakes rather than a pattern
    - “I shouldn’t have left her with my ex-husband.”
  - Show empathy and understanding for child
    - “Her arm is fine, but I think the whole thing was scary for her. I remember when I broke my arm as a kid and I was scared to death.”

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