THE CLINICAL ASSESSMENT OF INFANTS, PRESCHOOLERS AND THEIR FAMILIES

Sarah Mares & Ana Soledade Graeff-Martins

Sarah Mares BMBS, FRANZCP, Cert Child Psych MMH (Infant)

Consultant Infant, Child and Family Psychiatrist; Senior Staff Specialist, Redbank House, Western Sydney LAHN, Sydney & Senior Research Fellow, Menzies School of Health Research, Darwin, Australia

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Ana Soledade Graeff-Martins MD, DSc

Child and Adolescent Psychiatrist; Postdoctoral Research Fellow, Department of Psychiatry, Universidade de São Paulo, São Paulo, Brazil

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

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

The developmental importance of early relationships

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

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

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

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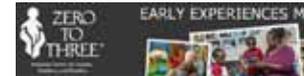
A series of podcasts, videos and print handouts about early development are available at the Zero to Three website. Click on the picture to view.

A psychologically healthy infant is characterized by:

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

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

Attachment

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

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

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.

Attachment

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

Attachment can be:

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

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

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

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

Table A.4.1 Principles of Assessment

1   Assessment of risk

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.

2   Parents want the best for their children

Almost always, parents want the best for their children and family. The clinician's role is to assist them in providing this.

3   Biopsychosocial framework

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.

4   Developmental context

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.

5   A relational approach

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.

6   Vulnerabilities and strengths

Identifying vulnerabilities and strengths (also called risk and protective factors) helps shape and target interventions.

7   The transactional model of development

The transactional model of development (Sameroff & MacKenzie, 2003) emphasises the interaction between genetic and environmental factors over time and 'the development of the child is seen as a product of the continuous dynamic interactions of the child and the experience provided by his or her family and social context' (Sameroff & Fiese, 2000, p10).

A thorough assessment is necessary:

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

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

The Setting for the Assessment

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

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

Aims of the assessment

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

Sources of information

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

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

Other information may include:

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

The Assessment Process

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

> A comprehensive assessment is based on an understanding of the developmental tasks of the period and observations of the child–carer relationship. It includes:
> - The clinical assessment interview
> - Observation of parent–child interaction and relationship
> - Developmental assessment of the child.

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

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

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

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

The interview

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

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

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

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

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

The history

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

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

The current problem

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

The background history

This includes information about:

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

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

The bio-psycho-social framework

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

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

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

- Assessment of infants or young children and their families will vary depending on the clinician's role, the purpose of the assessment, the setting and the professional relationship with the family

- All assessments are greatly enhanced when a biopsychosocial approach is taken, to enable the integration of information from a range of sources.

- Children's physical and mental health are not separable, just as infant well-being and safety cannot be considered outside the context of primary caregiving relationships and the family context

- The focus of an assessment will vary but the clinician's obligation is to keep in mind the bigger picture, in order to work with the family and other professionals to optimally facilitate infant or young child development and potential, and the quality of family life and relationships.

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

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

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

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

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

What parents bring to parenting?

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

Transgenerational issues in parenting

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

Examples of risk and protective factors

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

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

Table A.4.2 Rating scales and questionnaires

Instrument	Comments
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 behavioural delays. The ASQ-SE rates a child's development in the behavioural areas of self-regulation, compliance, communication, adaptive, autonomy, affect and interaction with people • 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 From (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

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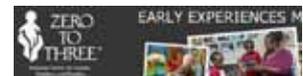
An extensive list of potential psychosocial and environmental stressors identified in the DC:0-3R: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, (Zero to Three Press; 2005) can be found and downloaded at the website (click on the picture).

- 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

> **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 confort 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.

> 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

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

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

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

DEVELOPMENTAL ASSESSMENT

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

Conducting a developmental assessment

General principles

- First, as in any assessment, ask what information the parents *want* to receive. This helps build rapport and indicates to the family that the process is for the benefit of the child and family. Respecting parents' requests at this stage may enable more sensitive or difficult information to be discussed at a later stage

- Provide a safe, comfortable environment for the child

- Assess infants' optimal level of functioning and what they can do with support

- Involve one or both parents (in the room for infants, or behind a one-way mirror for older children) in the process of assessing their child's skills, interests, behaviour and adaptive capacities.

- Be aware of and sensitive to cultural differences, respecting and appreciating these

Some of the instruments used for developmental assessments are:
- The *Neonatal Behavioural Assessment Scale (NBAS)* (Brazelton & Nugent, 1995). The NBAS was designed to capture the early behavioural responses of infants to their environment, before their behaviour is shaped by parental care. Brazelton and Nugent's assumption is that a baby is both competent and complexly organised and an active participant in the interaction with caregivers. The assessment seeks to help understand the infant's side of the interaction

- The *Bayley Scales of Infant Development (BSID)* (Bayley, 1993). Applicable to children 1-42 months of age, provides information about the child's language development, problem-solving skills, gross and fine motor development, attentional capacity, social engagement, affect and emotion, and the quality of the child's movement and motor control

- The *Wechsler Preschool and Primary Scale of Intelligence (WPPSI)* (Wechsler, 2002). Neuropsychological assessment that can be useful

The 4 Ps

The 4 Ps is a way of summarising the factors contributing to the problem as:
- *Predisposing*: what made this family vulnerable?
- *Precipitating*: why have they come now?
- *Perpetuating*: what makes it hard for things to get better?
- *Protective*: what strengths can we identify and build on in our intervention in the child, the family and the social and cultural context?

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

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

FORMULATION

The aim of assessment is to understand why *this family* is presenting with *this problem* at *this time*, and what are the impediments or obstacles that have prevented them from resolving their difficulties without professional help. This information forms the basis for what is called a *formulation*. Formulation is an integrative statement that provides an aetiological understanding of the problem and of the factors contributing to the presentation. It can take different forms, but ideally includes consideration of biopsychosocial factors. This summary informs the development of a comprehensive intervention plan. Another way of thinking about formulation is to identify or organise the information obtained in the assessment into what can be called the *4 Ps*.

Ideally, during the process of assessment, the family and clinician come over time to a new, shared understanding – a story – about the meaning and nature of the presenting difficulties and also the way forward. Developing an intervention and anticipating prognosis requires the clinician to think about and identify protective factors and resources that can be built on.

The role of diagnosis

When possible, establishing a diagnosis contributes to a more complete formulation. For example, a diagnosis can help clinicians to decide which treatment is appropriate. It can also facilitate communication between the various professionals taking care of the child. With these purposes in mind, efforts 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 A.4.2 Indicators that an infant/child is at possible physical, psychological or developmental risk.

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

Developed in conjunction with Nicholas Kowalenko, Sarah Mares, Louise Newman, Anne Sved Williams, Rosalind Powrie, and Karin van Doesum.

context of that relationship are major determinants of the psychological outcome for the child.

There are various degrees and types of risk, which range from physical illness or disability in the infant, to those associated with child abuse and neglect. As well as prematurity and medical illness, factors that contribute to developmental risk include child temperament, problems with attachment, parental mental illness, exposure to violence, socioeconomic status, poverty and adolescent parenthood (Zeanah et al, 1997).

Here the focus is on the assessment of risk to the child within the caregiving relationship. When one or both parents have psychiatric illness, substance abuse histories or the domestic situation is unsafe, it is also necessary to assess the risk (of self-harm or violence) to the child's caregivers. When the caregiver is at risk, the child is also at indirect risk because of the centrality of the caregiving relationship to the child's wellbeing. Therefore domestic violence, even in the absence of violence directed towards the child, represents a significant developmental risk. The cumulative developmental impact of multiple risk factors must also be considered (Appleyard et al, 2005).

Rajni's parents both used drugs and alcohol regularly after her birth and possibly also during the pregnancy. She was neglected, physically abused and there was considerable violence between the parents. She was removed from her parents aged 11 months after an unexplained leg fracture. At that time her milestones were a little delayed and she was small for her age. She was placed with an older relative who cared well for her and her growth and development improved.

When she was 2½ years, her carer developed cancer and Rajni was returned to her parents. Another period of neglect and exposure to violence followed. Rajni was again placed with a foster family when she was 3½. They reported frequent tantrums, often scratching and hitting her head. She hoarded and stole food and was indiscriminate socially, attaching herself to relative strangers, climbing on their laps and holding their hands, and she would "go blank" when told off or reprimanded or if there was a loud noise, particularly shouting or arguing.

Rajni's difficulties could be understood as survival strategies she had developed in response to her early neglect and abuse. Her behaviour began to settle after a period in a safe and loving home environment but she remained sensitive to noise and had difficulties with sleeping, feeding and regulating her emotions.

Risk

- Risks can be identified within the individual, the caregiving relationship and the social context
- Assessment involves weighing up risk and protective factors
- The greatest developmental impact is from cumulative risks, in particular those that operate long term
- Risk assessment requires history, observation of interactions and information from a range of sources

Types of Risk

In general, risk can be defined as the probability of an event occurring, including consideration of the losses and gains associated with it. In this context (infant development and child protection) risk assessment is not free from cultural and moral judgements. There is a high degree of uncertainty when predicting risk in child-protection matters and inevitably this contributes to the anxiety felt by even very experienced clinicians working in this area.

In this context, different types of risk can be identified:
- Risk to the child's immediate physical or emotional safety
- Risk to the child's optimal development. This acknowledges the importance of early experience for later outcome. Genetic, in-utero and physical factors such as illness may be present
- Indirect risk, such as repeated separation from a parent hospitalised with a psychiatric or medical illness. Parental mental health problems are a significant risk factor.
- Cumulative risk occurs when a child and family are exposed to multiple risk factors. For example, a premature infant born to a young single mother with a narcotic addiction with little family support is clearly at greater risk than a premature infant with similar medical and biological risk factors, born to a couple with adequate financial and practical support.

The greatest developmental risks are those that operate long term, for example:
- Chronic neglect
- Chronic instability in the family's personal and social circumstances
- Exposure to parental personality disorder or dysfunction and ongoing mental health problems.
- Ongoing hostility towards the child

Consequences of maltreatment

Children who have been abused or neglected may have physical, emotional and behavioural sequelae, which may then make caring for them more difficult. For example, traumatised children may continue to show avoidant or disruptive behaviour for some time after being placed in safe fostering environments. Abuse and neglect may have long-term effects on the child's understanding of feelings and relationships. A child with brain damage after head trauma may have long-term physical and emotional symptoms, meaning that caring for them is particularly difficult and challenging. This presents parents (including foster and adoptive parents) with challenges that they may not have anticipated, requiring them to demonstrate more patience or perseverance than with a less traumatised child.

Infants in high-risk situations are more likely to develop insecure or disorganised attachment relationships with their caregivers. There is evidence that disorganised attachment during infancy is linked to emotional and behavioural difficulties in childhood, adolescence and adult life. Therefore, although an infant may not be at an immediate physical risk, an erratic, neglectful or unstable caregiving environment is a threat to their social and emotional development. In child neglect, chronic unresponsiveness to the child's physical or emotional needs can have profound developmental consequences but may be harder to detect than physical abuse. Unfortunately, many infants at risk suffer both neglect and abuse, and neglect.

PARENTING AND PARENTING CAPACITY

Many definitions of parenting and parenting capacity have been suggested over time (Jones, 2001; Reder et al, 2003). The core elements of parenting as defined by 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.

Risk in Infancy

- There are degrees of risk

- Risk factors may be cumulative—there is rarely a linear correlation between any one risk factor and later developmental outcome. There is a linear correlation between number of risk factors and developmental impact

- Risk may be direct or indirect

- Risk may be to immediate physical safety or to longer term psychosocial development.

Donald and Jureidini (2004) argue that parenting capacity assessment should centre primarily on the parent's ability or potential to provide empathic, child-focused parenting; in other words, on the "adequacy of the emotional relationship between parent and child", specifically "on the parental capacity for empathy" (p7). They describe factors in the child or the relational and social context as "modulating effects" upon the primary domain of parenting capacity. While their approach is untested in practice, it has the advantage of focusing the clinician on the quality of the relationship and the parents' potential for an adequate emotional relationship with their child, and links with the growing literature on parental reflective capacity as a core factor mediating risk. Farnfield (2008) proposes a theoretical model for assessment of parenting, identifying seven core dimensions and a number of modifying variables. This model uses an ecological framework informed by attachment theory and a systemic approach, identifying the parent's own history of being parented as the first of these core parenting dimensions.

Capacity for change

Assessing the parents' capacity for change in situations where risk to the infant or caregiving system has been identified, or abuse or neglect has occurred is a necessary but difficult task.

For example, an adolescent mother has been unable to help her infant into organised patterns of sleeping, waking, eating and playing. The infant is failing to gain adequate weight and is fussy and restless. This parent may lack adequate information about infant development but is otherwise motivated and has just enough resources to meet the infant's needs. Support and education may reduce the risk to this infant, allowing her to get on with her development. However, if there is a lack of motivation from the parent, then provision of resources and information will not be enough to protect the infant from the consequences of neglect.

Repetition of abuse occurs in 25%–50% of families in the UK where children are returned to their parents after removal following abuse or neglect (Reder, 2003). Difficulty in identifying when it is appropriate to provide care or nurture, or when protection or control (limit setting) is required, are common for parents with histories of maltreatment. This can affect their capacity to parent adequately and to use available resources and support services.

Concerns about the immediate or long-term safety of an infant or a caregiver need to be addressed openly and directly with the caregivers and referral agency. Appropriate intervention must follow, and processes be put in place for monitoring the ongoing safety and wellbeing of all family members. Where possible, this involves establishing a network of support for vulnerable families and assessing their capacity to use services and relationships, to parent safely and effectively, to reflect on past experience, and to give priority to their child's needs for care and protection.

CONCLUSION

Assessment of families with infants and young children occurs in a variety of contexts and for many different reasons. Nonetheless, a comprehensive assessment should always include a relational and developmental focus, with consideration of both strengths and vulnerabilities that parents' and child bring to their current

Factors that promote resilience in the child (Ferguson & Horwood, 2003; Sameroff et al, 2003)
- A well-functioning parent or other involved adult
- Social supports
- Professional intervention when it is indicated
- Consistency in other relationships and activities
- Having a skill or talent.

circumstances, and attention to biopsychosocial factors that help or hinder the family at this time of rapid developmental change.

A working alliance between the family and the clinician supports any proposed interventions. Concerns about the immediate or long-term safety of the child or caregivers need to be addressed openly and directly with the caregivers and referring agency. Appropriate intervention must follow, and processes put in place for monitoring the ongoing safety and wellbeing of all family members.

All assessments of young children involve consideration of risk. The notion of risk in infancy and early childhood is complex and multifactorial. It includes consideration of immediate risks to child and parent safety, of the impact of single and cumulative risk factors, and the notion of developmental risk and psychopathology following early adversity. The vulnerability and dependence of young children on the availability of their caregivers means that risk is always considered within the caregiving context, and that threats to the safety of either or both parents inevitably impacts on the child's wellbeing.

Risk increases whenever the child's needs outweigh the capacity of the carers and their supports to meet these needs. As described, this can occur because of factors in the child, the caregiving system (parents), or the social context, and many at risk children and families have vulnerabilities in all three areas.

Situations of high risk are distressing for all concerned, particularly when the clinician is required to recommend the removal of an infant or young child from their home. A comprehensive assessment that includes a careful history, consideration of the coherence of the history provided, observation of interactions between child and caregiver(s), and corroborative history are central to an adequate assessment of risk. This ensures that decisions are based on sound information obtained from a variety of sources and are made in the best interests of the child and the family.

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