Assessment of Early Parent–Child Relationships

Roseanne Clark, Audrey Tluczek, Elizabeth C. Moore, and Amber L. Evenson
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Edited by Rebecca DelCarmen-Wiggins and Alice S. Carter

Abstract and Keywords

Using a relational approach to assessment integrates the theoretical application of developmental, psychological and psychiatric disciplines (Clark, Tluczek, & Gallagher, 2004; Sameroff & Emde, 1989; Sameroff, McDonough, & Rosenblum, 2004). Clark, Tluczek, Moore, and Evenson (2019, Chapter 2) presents a review of these perspectives. This chapter introduces best practices in the assessment of parent–child relationships and provides an in-depth description and illustration of the Parent–Child Early Relational Assessment, composed of both objective ratings and a subjective video replay interview used to engage the parent in assessing his or her relationship with his or her child. In addition, reliability, validity, research findings, and the clinical utility of a wide range of parent–child relationship assessment tools and procedures are provided. The importance of considering the individual contributions of the parent, the infant or young child, the family, and the cultural context in the assessment process is highlighted. Guidelines are also included on the use of relational assessments in research and to inform clinical practice.

Keywords: Parent-infant observation, parent–child observation, parent–child interaction, parent–child early relational assessment, relationship assessment, parent-child relationship assessment tools

Assessment of the Parent–Child Relationship: Best Practices

The American Academy of Child and Adolescent Psychiatry (Thomas et al., 1997) Practice Parameters for the Assessment of Infants and Toddlers and Zero to Three’s Diagnostic Task Force and Assessment Protocol Project (Weston et al., 2003; Zero to Three, 1994) have recommended that the psychiatric evaluation of children under 3 years of age, and more recently up to 5 years of age (Zeanah & Lieberman, 2016; Zero to Three, 2016), include an assessment of the parent–child relationship. The goal is to obtain a comprehensive picture of the parent–child relationship within its sociocultural context. The information learned from a relational assessment can assist the clinician in formulating an inter-
Assessment of Early Parent–Child Relationships

vention plan and in evaluating progress during the therapeutic process. Sources of information should include the parents and other caregivers, the child, the extended family when indicated, day-care providers, and the primary health care provider. If the family is involved in other services, such as social services, mental health services, or early intervention services, information should also be obtained from these collateral sources. Through an interview process with the parent, such as the ERA Video Replay Interview (Clark, 1985, 2010, 2015), the Working Model of the Child Interview (WMCI, Zeanah & Benoit, 1995), or the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996), identification of a parent’s internal working model of relationships, or “ghosts in the nursery” (Fraiberg, Adelson, & Shapiro, 1980), is better understood. Parental attitudes and perceptions of their infant or child, the meaning of the child’s behavior, and their internal working model (Bretherton, 1985) of what can be expected in a relationship develop within their own past experiences in early attachment relationships. Disturbed or adverse past relationship experiences may result in a parent misinterpreting and projecting negative attributions or feelings onto the infant; for example, the parent may misinterpret certain behaviors of the infant as demanding, negative, or attacking (Zero to Three, 1994).

The University of Wisconsin Parent–Infant and Early Childhood Program’s Relational Assessment Model uses a multimodal approach and actively involves the parents through interviews, observations, and parent report assessment instruments (Clark, Seidl, & Paulson, 1997; Clark, Burk, Hewitt, & Hipke, 2006). Observations of parent–child interactions are conducted across developmentally salient situations. Assessment procedures are structured to address particular domains appropriate to the child’s level of development. For example, infants need emotionally available parents who are capable of reading their cues and responding in a sensitive and timely fashion (Ainsworth, 1969; Stern, 2002), whereas toddlers need caregiving that is respectful of their emerging autonomy and provides cognitive and emotional scaffolding, clear expectations, consistent limit setting, and assistance in managing transitions, with affective and behavioral regulation. Note that an observation of interactions should be considered just one snapshot in time, whereas the parent–child relationship represents the child’s and parent’s “sense and quality of connectedness” over time and across settings (Clark, 1985, 2010, 2015). The parent’s mood and parenting capacities, the family’s stress, and the family’s access to and need for social supports and resources should also be assessed through the interview as part of the parent–child relationship assessment. Assessment approaches in this chapter include interview, self-report, and observational measures.

Interview With Parents

Developing a trusting relationship with the parents is critical to the assessment process. Taking a collaborative approach with parents throughout the assessment may build such an alliance. At the onset of the interview, parents should be asked about their concerns about their child and what they would like to get out of the assessment. By empathically listening to parents’ experiences of their child and their struggles in parenting, the clinician is providing a parallel process of attunement and responsiveness with the parents.
that they can then, with thoughtful exploration and support, provide for their child. Elements of the parent interview that are particularly salient to an assessment of the parent-child relationship include the following:

1. Demystify the assessment process by explaining the multimodal nature of the assessment procedures and the parents’ significant role in the assessment process.
2. Ask parents what their hope is regarding what they will receive from the evaluation process.
3. Provide a safe, comfortable, developmentally appropriate environment for the child/children and parents. Ideally, all members of the family household as defined by the parents should attend the initial evaluation. Having the whole family present provides the clinician information about family dynamics, including sibling relationships and cross-generational alliances.
4. Assess the parents’ optimal parenting capacities across several developmentally salient situations (e.g., routine tasks of daily living such as feeding, diapering, teaching and setting limits, play, separations/reunions).
5. Involve the parents in assessing their child’s regulatory capacities and behaviors and their capacity to see their child as a separate individual by observing the child together and discussing what you and they are observing.
6. Inquire about presenting problems and parents’ perspectives regarding the meaning of the child and his or her behaviors by asking parents to describe their child and their impressions about the source or cause of the concerns.
7. Include a perinatal history about the pregnancy, labor, and delivery. This time represents the critical beginnings of the child’s relationship with each parent. An unplanned or medically high-risk or stressful pregnancy or a complicated labor or delivery may have profound implications for the parent-child relationship. Ask open-ended questions (e.g., What was the pregnancy like for you?) to allow parents to share those aspects of the experience that are important to them.
8. Involve parents in assessing their relationship by reviewing a video recording of the parent and child interacting together. Help them focus on strengths, notice their child’s cues, and validate parents’ concerns. “Wonder along with” the parents about who their child reminds them of in general and when the problem behaviors are present. This information may help to elucidate parents’ projections of negative intentionality attributed to their child.
9. Assess the sociocultural context of the parent-child relationship, respecting and appreciating the family’s beliefs and values. Recognize the parents as the experts in their personal sociocultural environment and ask them to educate you about their life experiences and worldviews. Seek additional consultation from cultural experts to address the clinician’s cultural knowledge deficits or biases.
10. Provide parents with feedback about the assessment findings with a caring, non-judgmental attitude about the parents or their parenting style. This approach will facilitate a therapeutic joining with the parents vital to the development of a collaborative therapeutic relationship.
Observations of Parent-Child Interactions

When conducting an assessment of the quality of the parent-child relationship using observational methods, there are several key points to remember:

1. Note the intensity, frequency, and duration of the affect and behavior exchanged between parent and child. This information may differentiate normal interactions from disturbed interactions and assist the clinician in determining the seriousness of a relationship problem. For example, the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) Axis II uses this information to categorize caregiver-child relationships as levels of quality to distinguish well-adapted, at-risk, compromised, and disordered relationships (Zero to Three, 2016).

2. Assess the quality of interaction within the context of the situation. For example, differentiate parental directives or conversation related to structured tasks from play interactions in which the parent is following the child’s lead or engaging the child in a mutually enjoyable social interaction.

3. Consider parents’ responses relative to the child’s age and developmental level. Examples of reading cues and responding sensitively include a mother who adjusts the way she holds her infant after noticing the child’s discomfort in a particular position or the father who responds to his toddler tugging at his arm by a caring touch, talking to, or picking up his child.

4. When the child engages in behavior to seek the parent’s attention, negative testing or oppositional behavior, note whether the parent responds to the child verbally or behaviorally in a way that suggests he or she experiences the child’s behavior as resistant or “bad.”

5. Note whether the rapidity and regularity with which the parent responds to the child are contingent on the child’s cues, requests, or needs and helps the child feel that his or her actions are effective.

6. Differentiate a genuine sense of connectedness from “going through the motions.” An emotionally connected parent is aware of and involved with the child even when not actively interacting with the child. The parent is attentive to the child, subtly monitoring the child with an empathic awareness of the child’s emotional state. Connectedness may also include seeing the child as a separate individual.

7. Assess the parent’s capacity to reflect the child’s affect and/or behavior through echoing (with infants), gazing, confirmation of affect, behavior, approval, encouragement, and praise, as well as labeling the child’s internal feeling states. This process of mirroring represents the parent’s emotional availability and affective attunement to the infant or young child.

8. Assess the parent’s capacity for scaffolding by looking at the amount and way in which the parent gains, helps to focus, and sustains the child’s attention to the relevant aspects of the situation. Scaffolding is a process in which parents recognize their child’s developmental capacities and provide a physical and socioemotional environment that gives the child an opportunity to expand his or her capacities (Vygotsky, 1978). Just as a metal scaffold allows construction workers to build taller build-
ings, parents’ emotional and cognitive scaffolding helps their child reach higher levels of cognitive, social, and motor skills as well as emotional and behavioral regulation. Scaffolding with a younger infant may be manifested by protective caregiving. With an older child, this process may include assistance such as teaching, demonstrating, stating expectations clearly, and setting limits with a sensitivity to the child’s affective and cognitive functioning.

9. Note the parents’ consistency and predictability in their interactions with their child as well as the parents’ capacity to follow their child’s lead versus directive or intrusive behavior.

10. Observe from the child’s perspective as well. Ask the question, If I were this child, what would I see/experience when I look up at my mother or father?

11. Observe the child’s affect, mood, emotional lability, temperament, activity level, attentional capacities, persistence, quality of play, social initiative and responsiveness, compliance, communicative and motor competence, visual contact, and assertion or aggressivity.

12. After the observations, ask the parent(s) how typical the interaction was. If the parents indicate that it was different from usual, inquire about how it was different and what the parent(s) attributes this to. For example, parent(s) may state that the child was much more cooperative than usual and that they rarely have the opportunity to play with their child one on one. Such information informs the diagnostic process and the planning for therapeutic intervention.

13. Observe the dyadic organization and regulation in the interaction and parent’s capacity to pace and coordinate with the child’s needs and actions, as well as the affective tone of the dyad and capacity for mutual enjoyment, joint attention, reciprocity, and goodness of fit.

A structured and systematic approach to assessing parent–child interactions is central to identifying the areas of strength as well as areas of concern that may contribute to disturbances in the parent–child dyad. Researchers (e.g., Ainsworth, Blehar, & Waters, 1978; Barnard, 1979; Bromwich, 1976; Clark, 1985, 1999; Emde, 1992; Feldman, Dollberg, & Nadam, 2011; Lyons-Ruth, Bronfman, & Parsons, 1999) have identified specific characteristics of the parent, the infant or child, and the parent–child interaction that deserve attention during a relational assessment. The Parent–Child Early Relational Assessment (PCERA), a method that incorporates both an objective assessment of strengths and areas of concern across situations and a subjective component that involves parents in assessing their relationship with their infant or child and the meaning of their infant or child’s behavior through a video replay interview, is described in the next section. This is followed by descriptions of several other empirically validated methods for assessing the quality of the parent–child relationship. See Tables 3.1, 3.2, and 3.3 for overviews of these instruments.
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<tr>
<th>Instrument</th>
<th>Age</th>
<th>Domains</th>
<th>Reliability/validity</th>
<th>Description</th>
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<tr>
<td>Adult Attachment Interview (AAI;</td>
<td>Adult</td>
<td>Narrative/adjec-tives early attachment relationships rated:</td>
<td>Moderate interrater reliability ($k = .56-.63$), and low discriminant validity</td>
<td>Semistructured interview used for research and clinical purposes. 18 questions 1 hour to administer Highly established; however, it requires a lot of training (18 days) and time to code. Audiotape of interview is coded by raters trained to reliability. Reflective functioning can also be assessed.</td>
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<td>George et al., 1996)</td>
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<td>Secure/autonomous Dismissive Preoccupied Unresolved/disorganized</td>
<td>for memory, intelligence, and social desirability. AAI scores correspond with their infants’ attachment classification in the Strange Situation.</td>
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Table 3.1. Parent-Child Relationship Assessment Instruments: Parental Interview Measures
### Assessment of Early Parent-Child Relationships

| Insightfulness Assessment (IA; Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002; Oppenheim & Koren-Karie, 2002, 2009; Oppenheim, Koren-Karie, & Sagi, 2001) | Parents of toddlers and preschoolers | **Parent domains:** Insight into child’s motives
  - Openness
  - Complexity in description of child
  - Maintenance of focus on child
  - Richness of description of child
  - Coherence of thought
  - Acceptance
  - Anger
  - Worry
  - Separateness from child | Studies examining the utility of the IA reveal significant relationships between IA categories and child attachment classifications and child behavior. There is growing evidence of concurrent and predictive validity (e.g., Lausanne Trilogue Play procedure) with coordination and co-operation.
  - IA post-Circle of Security Intervention predicted child security of attachment at follow-up. | Well suited to research and clinical purposes. Promising utility in work with both low- and high-risk children and growing evidence that insightfulness may increase the impact of intervention.
  - Video replay procedure.
  - Interviews are transcribed and coded. |
### Assessment of Early Parent-Child Relationships

<table>
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<tr>
<th>Parent Development Interview (PDI)–R (Slade, Aber, Bresgi, Berger, &amp; Kaplan, 2003); Reflective functioning codes: Slade, Aber, Bresgi, Berger, &amp; Kaplan, 2004.</th>
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<td>Parents of infants and young children</td>
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| **Parental affective experiences**  
Degree, acknowledgment, and modulation of anger  
Neediness  
Degree, acknowledgment, and modulation of separation distress  
Degree and acknowledgment of guilt  
Experience of joy and pleasure  
Sense of competency and efficacy  
**Child affective experiences**  
Representation of child anger  
Child separation distress  
Child dependence–independence  
**State of mind**  
Coherence |
| High interrater reliability (intraclass correlation = .78 to .95).  
Construct validity with the AAI—Reflective functioning on the PDI was shown to be correlated with reflective functioning on the AAI (Slade, 2005; Slade et al., 2005). |
| 90-minute semi-structured interview with the parent (brief version is 45 minutes).  
Revised version assesses for reflective functioning.  
45 items |
### Assessment of Early Parent-Child Relationships

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<tr>
<th>Working Model of the Child Interview (WMCI; Zeanah &amp; Barton, 1989; Zeanah, Benoit, Barton, &amp; Hirshberg, 1996)</th>
<th>Parents of infants and toddlers</th>
<th>Richness of perception</th>
<th>WMCI has demonstrated strong inter-rater reliability for classification scoring ($k = .76-.79$). Strong concurrent validity with the Parent-Child Early Relational Assessment and predictive validity with the Strange Situation.</th>
<th>Grounded in attachment theory. Well suited to research and clinical purposes. Time intensive; requires training and coding from an audio recording. Structured interview 60 minutes to administer</th>
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<td>Richness of perception</td>
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<td>Openness to change</td>
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<td>Coherence</td>
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<td>Intensity of involvement</td>
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<td>Caregiving sensitivity</td>
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<td>Acceptance/rejection</td>
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<td>Infant difficulty</td>
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<td>Fear of loss</td>
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<td>Affective tone</td>
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<td>Narrative organization</td>
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## Assessment of Early Parent-Child Relationships

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<th>Instrument</th>
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<th>Reliability/validity</th>
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<tr>
<td>Atypical Maternal Behavior Instrument for Assessment and Classifica-</td>
<td>Infancy</td>
<td>Affective communication errors</td>
<td>Concurrent validity with the Strange Situation has been established (intraclass correlation [ICC] = .75–.84) and the Frightening, Frightened, Dissociated or Disorganized Behavior on the Part of the Parent Scale (total atypical behavior score, ICC = .67)</td>
<td>Useful for high-risk samples.</td>
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<td>tion (Bronfman, Madigan, &amp; Lyons-Ruth, 1992–2009)</td>
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<td>Role/boundary confusion</td>
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<td>Frightened/disoriented behavior and voices</td>
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<td>Intrusiveness/negativity</td>
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<td>Withdrawal</td>
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<td>Coding Interactive Behavior (CIB; Feld-</td>
<td>Newborns, infants, toddlers, preschool-</td>
<td>Parental sensitivity</td>
<td>Validated across a wide range of ages and cultures.</td>
<td>Utility in studies of both at-risk and healthy dyads.</td>
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<tr>
<td>man, 1998)</td>
<td>children, adolescents, and adults</td>
<td>Parental intrusiveness</td>
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<td>43 codes rated on a 5-point Likert scale Prerecorded video tape is coded.</td>
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<td></td>
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<td>Parental limit setting</td>
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<td>Child involvement</td>
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<td>Child withdrawal</td>
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<td>Child compliance</td>
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<td>Dyadic reciprocity</td>
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<td>Dyadic negative state</td>
<td>Shown sensitivity to differences in parent–child interactions related to family’s culture, sex of the parent, and social-emotional/behavioral risk factors, as well as changes in interactions resulting from intervention (internal consistency of maternal and infant scales $k = .83-.94$). Significant correlations between maternal sensitivity on the CIB and child intelligence and social engagement ($r = .25-.67$).</td>
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</table>
### Clinical Problem-Solving Procedure Rating Scale (Cowell & Feldman, 1988)

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<tr>
<th>24–54 months (with modifications as young as 12 months, see Zeanah, Larrieu, Heller, &amp; Valliere, 2000)</th>
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</thead>
</table>
| **Parent:** Emotional availability  
Nurturance/empathic responsiveness  
Protection  
Comforting/response to distress  
Teaching  
Play  
Discipline/limit setting  
Instrumental care/structure/routines |
| High internal consistency of items (Ω = .88 child items and .84 for caregiver items) and correlates with other measures of parent–child relationship quality (r = .51–.56, p = .001). |
| Nine episodes—range of activities is well suited for clinical observations. Parents’ interview would be helpful to establish ecological validity. |

**Infant:** Emotion regulation  
Security/trust/self-esteem  
Vigilance/self-protection/safety  
Comfort-seeking  
Learning/curiosity/mastery  
Play/imagination
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<th>Assessment of Early Parent-Child Relationships</th>
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<td><strong>Self-control/cooperation</strong>&lt;br&gt;Self-regulation/predictability</td>
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<td><strong>Emotional Availability Scales</strong> (Biringen, 2000, 2008; Biringen et al., 2005; Biringen, Robinson, &amp; Emde, 1998)</td>
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<td><strong>Nursing Child Assessment Satellite Training (NCAST)</strong></td>
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### Assessment of Early Parent-Child Relationships

| NCAST Parent–Child Interaction Feeding and Teaching Scales (Feeding Scale) (Teaching Scale) (Barnard, 1979; Sumner & Spietz, 1994a, 1994b) | Fostering cognitive growth  
*Infant or child:*  
Clarity of cues  
Responsiveness to caregiver | High concurrent validity with the Strange Situation has been established ($r = .19; p = .023$).  
Discriminates high-risk from normative dyads  
Parent total score has predictive validity for child IQ at 3-5 years. | Training is required. |
### Assessment of Early Parent-Child Relationships

| Parent-Child Early Relational Assessment (PCERA) (Clark, 1985, 2010, 2015) | Birth to 5 years old | Parental factors: Positive affective involvement and verbalization Negative affect and behavior Intrusiveness, insensitivity, and inconsistency Infant or child factors: Positive affect, communicative and social skills Quality of play, interest, and attentional skills Dysregulation and irritability Parent-child dyadic factors: Mutuality and reciprocity Disorganization and tension Video reply and interview: | High Interrater reliability (.85) and internal consistency (α = .78–.94). Discriminant validity has been established differentiating high-risk from normative dyads (parents with depression, other psychiatric and alcohol and other drug abuse disorders, premature infants and infants with other medical conditions) | Theoretically and empirically derived scales rated from video-recorded observations to identify areas of strength and concern. The PCERA includes a video replay interview to engage parent(s) in assessing their relationship with their child and for collaborative goal setting in clinical settings. Widely used for research and clinical purposes. 29 parental items, 28 infant or child items, and 8 dyadic items. |
Assessment of Early Parent-Child Relationships

| Meaning of child and child’s behavior | Construct, concurrent and predictive validity established with the AAI, security of attachment in the Strange Situation and the Attachment Q-Sort, the WCMI, and the Child Behavior Checklist (see review by Clark, 2010, 2015). Documents change in the quality of mother–child interactions following therapeutic intervention (Minde, Faucon, & Falkner, 1994). Cross-cultural validity established in use on six continents. |
| Parent's perception of self in parenting role | Four 5-minute segments of feeding/snack, structured task, free play, and separation/reunion episodes. Used internationally. Training is required. |
| Parent’s history of being parented | |

| Documents change in the quality of mother–child interactions following therapeutic intervention (Minde, Faucon, & Falkner, 1994). Cross-cultural validity established in use on six continents. | Four 5-minute segments of feeding/snack, structured task, free play, and separation/reunion episodes. Used internationally. Training is required. |
| Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (Roggman et al., 2013) | 10 to 47 months | Affection Responsiveness Encouragement Teaching | High interrater reliability ($k = .69-.80$), internal consistency ($\alpha = .68-.79$), and moderate to high confirmatory factory analysis ($r = .43-.86$). Content validity was strong (i.e., average rating of 2.6 of 3). Construct validity ranged from low to moderate at 14, 24, and 36 months of age ($r = .13-.65$). Predictive validity was strong for later child language, cognitive, and social-emotional outcomes. | For use with diverse ethnic groups, particularly for practitioners working with at-risk families. Checklist of 29 observable behaviors. |
### Table 3.3. Parent–Child Relationship Assessment Instruments—Parent Self-Report

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Age</th>
<th>Domains</th>
<th>Reliability/validity</th>
<th>Description</th>
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<tbody>
<tr>
<td>Parenting Stress Index (PSI; Abidin, 1986, 2012)</td>
<td>1 month to 12 years</td>
<td><em>Parent domains:</em> Competence</td>
<td>High internal consistency for the child ($\alpha = .78-.88$), parent ($\alpha = .75-.87$), and total score ($\alpha = .98$) domains. Test-retest reliability was moderate to high (.63, .91, and .96 for child, parent, and total stress scores, respectively).</td>
<td>Self-report paper-and-pencil instrument used clinically and in research. The fourth edition has been translated into other languages and used internationally. Approximately 20 minutes to administer. 120 items. The PSI Short Form is useful for clinicians because of its ease of use.</td>
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<td>Isolation</td>
<td>High internal consistency on PSI, fourth edition, Short Form ($\alpha = .88-.90$) for parent domain subscales and child domain subscales.</td>
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<td>Attachment</td>
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<td>Role restriction</td>
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<td>Depression</td>
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<td>Spouse</td>
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<td><em>Child domains:</em> Distractibility/hyperactivity</td>
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<td>Adaptability</td>
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<td>Reinforces parent</td>
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<td>Demandingness</td>
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<td>Acceptability</td>
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<td><em>Life Stress</em></td>
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Parent-Child Early Relational Assessment

The PCERA (Clark, 1985, 2010, 2015) is a widely used and well-established observational measure that has been validated across a wide range of ages from birth through age 5, with mothers and fathers, across cultures, and with normative and high-risk dyads (Clark, 1985, 2010, 2015; Dallay & Guedeney, 2016; Landorph & Clark, 2013). The PCERA captures the infant or child’s experience of the parent, the parent’s experience of the infant or child, the affective and behavioral characteristics that each bring to the interaction, and the quality or tone of the dyadic relationship. The quality of the parent-child relationship is assessed from video-recorded observations of the infant or child interacting with the parent during four 5-minute segments that include feeding, structured task, free play, and separation/reunion (Clark, 1985; Clark, 1999; Clark, 2010; Clark, 2015; Farran, Clark, & Ray, 1990). The rating scales are based on empirical developmental studies (e.g., Clarke-Stewart, 1973; Matas, Arend, & Sroufe, 1978; Sander, 1964) and attachment (Ainsworth, 1969), psychodynamic (Stern, 1985, 2002; Winnicott, 1965, 1970), and Soviet cognitive-linguistic theories (Vygotsky, 1978) and are informed by clinical observations of the domains of functioning seen as important for differentiating parents experiencing difficulties in parenting from well-functioning parents and aspects of infant temperament, affect, and behavior vulnerable to stress, medical vulnerability and family functioning (Clark, 1983; Musick, Clark, & Cohler, 1981). The PCERA identifies areas of strength and areas of concern in the parent, the infant or child, and the dyad. The PCERA may be used as part of an initial diagnostic evaluation to formulate relationship issues, develop a relational profile, collaborative goal setting with parent(s), focus intervention efforts, monitor progress in therapy, assess outcomes in treatment efficacy studies, and research with families at risk for early relational disturbances.

Ratings are made on a 5-point Likert scale for 29 domains of parental functioning, 30 domains of infant/child functioning, and 8 domains of dyadic functioning. The amount, duration, and intensity of affect and behavior exhibited by the parent, the infant or child, and the dyad are rated:

1. Items assessing aspects of parental behavior and affect include parental positive and negative affect, mood, sensitivity and contingent responsivity to the infant or child’s cues, flexibility/rigidity, capacity to structure and mediate the environment, genuine visual regard, connectedness, mirroring, and creativity/resourcefulness, etc.
2. Infant/child items include positive and negative affect, somber/serious mood, irritability, social initiative and responsiveness, interest/gaze aversion, assertion/aggressivity, persistence, impulsivity, emotional regulation, etc.
3. Dyadic items include mutual enjoyment, tension, reciprocity, joint attention, goodness of fit, etc.

The parent, infant/child, and dyadic scales were initially developed on a clinical intervention project funded by the National Institute of Mental Health studying maternal psychiatric disorders and the quality of the mother–
child relationship (Clark, 1983). The PCERA has been further developed for use with normative and other at-risk populations (Clark, 1999; Clark, Hyde, Essex, & Klein, 1997; Clark, Paulson, & Conlin, 1993; Clark, Tluczek, & Brown, 2008). Clark (1983) and Goodman and Brumley (1990) found that PCERA scores differentiated patterns of mothers with depression and mothers with schizophrenic disorders from the patterns of well-functioning mothers. In studies of mother–infant interaction with mothers with substance abuse problems, mothers with a range of psychiatric problems, and well-functioning mothers, Siqveland, Haabrekke, Wentzel-Larsen, and Moe (2014) found that mother–infant interaction quality as measured by the PCERA improved from 3 months to 12 months for the well-baby group and the group with psychiatric problems; however, the mother–infant interaction quality worsened across time for the group with maternal substance abuse problems. The PCERA has also been found to differentiate positive and less sensitive mother–infant interactions with babies in the neonatal intensive care unit (Gerstein, Poehlmann-Tynan, & Clark, 2015; Korja et al., 2008; Poehlmann, Burnson, & Weymouth, 2014; Weber & Harrison, 2014). When assessing babies with very low birth weights, Stolt et al. (2014) found that the PCERA factors of maternal positive affective involvement (at 6 months) and maternal communication (at 12 months) were associated with child language skills at 2 years. The PCERA has excellent internal consistency and concurrent and predictive validity (Clark, 1999) as well as concurrent validity, specifically with the WMCI (Korja et al., 2010). The PCERA ratings of early mother–infant interaction have been correlated with both concurrent measures of child temperament, behavior, and parenting stress and later quality of mother–child interactions and security of attachment behaviors at 12 months (Mothander, 1990; Teti, Nakagawa, Das, & Wirth, 1991) and has been found to document change following therapeutic intervention (Clark, 1999; Minde, Faucon, & Falkner, 1994; St. Petersburg–USA Orphanage Research Team, 2009). With clinical investigators choosing the PCERA for use in a variety of clinical programs and research projects internationally, studying high-risk and normative populations, the PCERA has become one of the most widely used clinical research measures.

Each of the four situations in the PCERA provides a window for understanding what has been shared in the early parent–child relationship. Each situation may be experienced differently by parents, with some eliciting conflictual feelings and others allowing for feelings of competence in the parenting role. After the interaction procedure has been explained to parents, written consent is obtained for video recording. The clinician explains that the video recording is for the family’s benefit so that the parent and clinician can view the video together in a reflective manner during a subsequent session. The following explanation is provided to parents: “We understand that this is a snapshot of one point in time. We’ll be interested in your sharing with us afterwards how the interaction is alike or different from how things usually go.” The video-recording procedure involves placing the camera at a 45-degree angle to the parent and infant or child, who are seated together, and using a medium shot to capture the facial expressions, behavior, and dyadic interactions of the parent and the child.
Assessment of Early Parent–Child Relationships

During the feeding situation, the parent and young child are provided a snack of juice and crackers and told, "We are interested in seeing [child’s name] and you during a feeding or a snack time together. Please be with [child’s name] as you usually would." If the mother is breastfeeding, she is asked whether she would be comfortable being video recorded during a feeding time with her baby. The feeding situation allows for an assessment of the parent’s capacity for nurturance and social interaction as well as sensitivity to the child’s cues and need for regulation. The child’s readability, affect regulation, social initiative, and responsivity during feeding may also be assessed. Comfort, tension, and regulation of the dyad in this situation are observed.

The instructions and nature of the structured task are determined by the age of the infant or child. For example, parents of infants under 7 months are asked to change their baby’s diaper and attempt to get the baby interested in shaking a rattle. Parents of children between 8 and 12 months are given two cups and a toy and asked to hide a toy under one cup and alternately hide it under the second cup within the child’s sight and have the child try to find it. It is also suggested that, if time permits, they may read a book together. For children 13 months and older, parents are asked to build a tower of three cubes and have the child do the same. With a child of 19 months and older, the task includes building a tower with more cubes, building a bridge of blocks, and having the child make a design with colored blocks that matches the increasingly challenging block design cards. This task is always a little too difficult for the child to complete on his or her own. The structured task situation allows for an assessment of the parents’ capacity to structure and mediate the environment according to the child’s developmental and individual needs. Some of the tasks tap the child’s emerging abilities and require adult cognitive scaffolding as well as emotional availability for the child to complete the task successfully. The child’s attentional skills, persistence, and interest in complying with parental expectations in a structured situation are observed. The dyad’s capacity for joint attention to an activity, reciprocity in negotiations, and mutuality may be assessed.

Instructions for the free play situation are as follows: “This is a free play time with your child. Please play with your child as you normally would.” For infants under 6 months, the instructions include: “Here are some toys you may use if you choose.” For children over 6 months, the instructions are: “You or [child’s name] may choose the toy(s) that you would like to play with together.” The standard toy list for the PCERA includes rattles, plastic keys, a busy box, two toy telephones, a ball, two puppets, a doll, a bottle, a blanket, small cars or trucks, bristle blocks, crayons and paper, and plastic animal and human family figures. The free play situation allows for an assessment of the parents’ capacity to be playful with and enjoy their child as well as to follow their child’s lead in play. The child’s capacity for exploratory and representational play and the dyad’s capacity for social interaction, mutuality, and reciprocity can be observed.

At the end of the instructions for the free play, parents are also given instructions for the separation/reunion episode. They are told, “We’d also like to see how things go for [child’s name] when you leave the room. After 5 minutes of play I’ll knock on the door but won’t come in. Let [infant/child’s name] know that you’re going to be leaving the room.
briefly to talk with the assessor. Then please come stand outside the room for a few minutes with me.” To ensure the child’s safety, this episode is only conducted when there is a one-way mirror or video camera or when another adult is in the room the child is in. This situation allows assessment of the parents’ ability and level of comfort in preparing the child for a brief separation. The child’s capacity for self-regulation and quality of mood and exploratory play during the parents’ absence are assessed. The dyad’s quality of affect and engagement at reunion may also be observed.

Confirmatory factor analyses of 12-month free play interactions revealed eight factors: Parent Factor I, Parental Positive Affective Involvement and Verbalization; Parent Factor II, Parental Negative Affect and Behavior; Parent Factor III, Parental Intrusiveness, Insensitivity, and Inconsistency; Infant Factor IV, Infant Positive Affect, Communicative and Social Skills; Infant Factor V, Infant Quality of Play, Interest, and Attentional Skills; Infant Factor VI, Infant Dysregulation and Irritability; Dyadic Factor VII, Dyadic Mutuality and Reciprocity; and Dyadic Factor VIII, Dyadic Disorganization and Tension. High internal consistency of factors at 4, 12, 24 months and 4.5 years has been determined, interrater reliability, and predictive and discriminant validity have been established for the PCERA (Clark, 1983, 1999; Clark, Hyde, et al., 1997; Clark et al., 1993) in numerous studies with normative and high-risk populations. Training is highly recommended and consists of 40 hours of didactic lectures, video ratings, and consensus discussion prior to rat­
ing of four standardized videos and achievement of exact interrater agreement at or above 0.85 and/or within one scale point agreement of 0.90 or above.

A video replay interview, in which brief segments of the video-recorded interactions are played back and reviewed with the parents, is an important part of the assessment process. In a semistructured interview, the parents’ perceptions, attitudes, and goals during the interactions with the infant or child are explored. Objective assessments often fail to answer questions about what parents are experiencing with their infant or child. The Video Replay Interview allows parents to share what they were seeing, doing, and feeling in relation to their infant or child as well as their perceptions of their infant or child and themselves in the parenting role. By wondering along with the parents about their perceptions, attitudes, and feelings about their infant or child, the clinician can gain insight about parents’ phenomenological experience of the parent–child relationship that influences their behavioral interactions with their infant or child. Before the video is reviewed, parents are asked, “How was this interaction like or different from how things usually go at home for [child’s name] and you together?”; “What was the most enjoyable part of this session for you?”; “What part was the most difficult or did you like the least?”; and “Do you have any questions or comments about the video recording?”

Video segments to review with parents are selected prior to the Video Replay interview. In the first segment, the video is paused at a point when the infant or child’s face can be seen clearly on the screen. The meaning of the infant or child to the parent is assessed with questions such as, “I wonder who [child’s name] looks like or reminds you of [physical features, temperament, behavior]?” “How did you select your child’s name?” and “How would you describe that person and your relationship with them?” The next seg-
Assessment of Early Parent–Child Relationships

ment shown is when the parent is not responding to the child’s cues. The parent’s capacity to read their infant or child’s cues may be assessed. In addition, parents’ capacity for reflective functioning is assessed, that is, the ability to reflect on the internal affective experience of their child and themselves (Fonagy & Target, 1998; Slade, 1999). The clinician asks parents, “How were you feeling during that interaction?” “What do you imagine was going on for your child?” and “What do you imagine your child may have been feeling then?” This process helps the clinician to assess the parents’ capacity to see the child as a separate individual and their ability to empathically read their child’s cues or misinterpret their child’s cues or attribute negative intentionality to their child’s behavior, making it difficult to respond empathically. In addition, the clinician can also help parents to expand their perceptions of their child and his or her behavior and increase their ways of being with their child by wondering with them about alternative explanations for the infant or child’s behavior.

To assess the reinforcement value of the infant or child and parents’ sense of competence in the parenting role, the clinician stops the video at a point when parent and child are experiencing a mutually satisfying interaction and wonders, “How do you imagine [child’s name] felt at that moment?” Then the clinician asks parents what they think they did to elicit this positive response from their child. The clinician offers additional observations that amplify parents’ strengths in reading their child’s needs and responding in a developmentally sensitive manner. Additional questions in the video replay interview inform the clinician about parents’ experience of parenting this child and include, “How would you describe yourself as a parent?” “In general, what have you found most difficult or frustrating about being a parent of [child’s name]?” “What have you found most enjoyable about being a parent of [child’s name]?” “When do you feel best, or that you have done well as a parent?” and “Did becoming a parent change you as a person in any way? If so, how?”

Finally, it is extremely valuable to obtain a relational history from each parent to better understand his or her own template of being parented or his or her internal working model of relationships. The following questions may be asked during the video replay interview or at a subsequent session: “How would you compare yourself to your own parents?” “What do you remember about being parented by your mother or father when you were young?” “What three words would you use to describe your mother or father? Please give specific examples that illustrate these adjectives.” “How was discipline (p. 59) handled in your family?” “Who was available/responsive to you?” and “Who kept you safe, physically and emotionally (or did not)?” (George et al., 1996).

The use of video replay in clinical interventions with parent–child dyads has been described as a powerful tool to enable therapeutic change in the client (Clark & Metcoff, 1983; Musick et al., 1981; Steele et al., 2014). Steele and colleagues (2014) described the use of video as a way to enhance the therapeutic alliance by watching and experiencing the interaction together. Steele et al. suggested that watching the video together can reduce distortions of the experience and requires the therapist to be sensitive to the caregiver’s experience while reviewing the footage and emphasized the importance of
empowering and supporting the caregiver during this time. Video review also allows the caregiver to reflect on the interaction, contributing to reflective functioning.

**Case Illustration of the Parent-Child Early Relational Assessment Relational Profile, Video Replay Interview, and Collaborative Development of the Parent-Infant Relationship Development Plan**

Josie, a young mother living on her own with her 12-month-old daughter, Kira, was referred for a relational assessment because of concerns of the home visitor working with them regarding the mother’s ambivalent feelings and negative verbalizations toward her infant, as well as her unpredictability in caring for her, often leaving Kira with relatives for days at a time. Josie was wary of meeting a new person but was intrigued by the video-recording of her and her daughter together. The psychologist and home visitor let Josie know that the video-recording was for her and that she would receive a DVD of their time together and that we would wonder with her what was alike or different from how things usually go with her to collaboratively develop goals for their time together in the mother–infant therapy group. Mother and daughter were video-recorded using the PCERA in a 5-minute feeding, a 5-minute structured task, and a 5-minute free play situation. An appointment was set for the Video Replay Interview to respectfully engage Josie in assessing her relationship with Kira as well as herself in the mothering role. Strengths, areas of some concern, and areas of concern were rated by reviewing the video prior to the next appointment. Selected items are illustrated in the Relational Profile in Table 3.4.
<table>
<thead>
<tr>
<th>Area of concern</th>
<th>Area of some concern</th>
<th>Area of strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental tone of voice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annoyed, angry, hostile</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Parental affect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressed positive affect</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Expressed negative affect</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Parental characteristic mood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irritable, frustrated, angry mood</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Anxious mood</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Parental expressed attitudes toward child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Displeasure, disapproval, criticism</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Enjoyment, pleasure</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Parental affective and behavioral involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality and amount of physical contact: positive</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Amount of verbalization</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Quality of verbalizations</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Contingent responsivity to child’s positive or age-appropriate behavior</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Contingent responsivity to child’s perceived negative and/or unresponsive behavior</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Parent reads child cues and responds sensitively and appropriately</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

**Parental style**

| Intrusiveness | X |
| Consistency/predictability | X |

**Child mood/affect**

| Apathetic/withdrawn/depressed mood | X |
| Anxious/tense/fearful mood | X |
| Irritable/frustrated/angry mood | X |
| Sober/serious mood | X |

**Child behavior/adaptive abilities**

<p>| Avoiding/averting/resistance | X |
| Compliance/noncompliance | X |</p>
<table>
<thead>
<tr>
<th>Assertion/aggressivity</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-regulation/organizational capacities</td>
<td>X</td>
</tr>
<tr>
<td>Consolability/soothability</td>
<td>X</td>
</tr>
<tr>
<td>Child communication</td>
<td></td>
</tr>
<tr>
<td>Visual contact</td>
<td>X</td>
</tr>
<tr>
<td>Communicative competence</td>
<td>X</td>
</tr>
<tr>
<td>Dyadic affective quality of interaction</td>
<td></td>
</tr>
<tr>
<td>Frustrated, angry, hostile</td>
<td>X</td>
</tr>
<tr>
<td>Flat, empty, constricted</td>
<td>X</td>
</tr>
<tr>
<td>Mutual enthusiasm, joyfulness, enjoyment, dyadic “joie de vivre”</td>
<td>X</td>
</tr>
<tr>
<td>Dyadic mutuality in interaction</td>
<td></td>
</tr>
<tr>
<td>Reciprocity</td>
<td>X</td>
</tr>
<tr>
<td>Organization/regulation of interactions</td>
<td>X</td>
</tr>
</tbody>
</table>

From Clark (1985, 2015).

To understand better the meaning of Josie’s ambivalent behavior and verbalizations with her daughter, the video was reviewed to select segments to replay with Josie, including a segment in which she could see Kira’s face large on the screen, one in which Josie missed or did not respond sensitively to Kira’s cues, and another of a positive interaction in which Kira responded to Josie. Josie shared that how they were together the week before was how they are usually, except that they do not play together very much because she
works nights and Kira stays with relatives, and when Josie picks Kira up, she herself is usually too tired to play.

In the part of the Video Replay that focused on her own experience of being parented, Josie shared that her father “wasn’t around at all” and that her mother was beaten and killed in a drug-related incident when Josie was a toddler. Josie was raised by her grandmother, who abused her both verbally and physically. She was also “beaten up” in middle school and sent to live with an aunt in another city. She described multiple losses and traumatic experiences and shared that her auntie had been there for her with love and consistency. Her sisters helped her but she could not count on them regularly because of their own struggles. Josie shared that she has struggled with anxiety, depression, and impulsive behavior that has gotten her in trouble with her siblings, who she was both close with and “at war with,” other family members, and at work, resulting in her being fired from two cashier jobs. This young woman expressed distrust of her own capabilities as well as what she could expect from others, which contributed to the unpredictability of her being home when her home visitor came. She seemed to have internalized the negative attitude and extreme frustration that her grandmother expressed toward her with her own child. When asked who Kira looks like or reminds her of, Josie responded that “She looks like her Daddy ... his mouth ... especially when she is angry.” She talked about Kira’s temperament by describing her as “a sweet, cuddly baby.” In a segment of her reading a board book to Kira, Josie taught her the sound that a cow makes and how to turn the pages of the book. She was effective in gaining and focusing her daughter’s attention on the book and she saw that Kira responded to her. This was reinforcing for Josie. In the next segment, Kira turned one of the pages quickly and the force of the board book page on her mother’s hand was responded to with Josie yelling, “Ouch! Why you hurting me?” Kira cried and her mother responded, “You look like a fish.” Kira looked away and at the (p. 60) other toys on the floor that were brought for the assessment and found some small cars. Kira expressed enthusiasm in seeing what she could make happen in pushing the cars across the floor and one of them hit her mother in the leg, to which her mother responded, “Why you have to be so mean?” She brought out a puppet and said, “Hey, what’s up?” “Do you like me?” (three times) and then she picked up a toy phone and said, “Hey girlfriend, where you at? You’re late ... you’re grounded!” She then took the pop-up toy and demonstrated to Kira how to play with it, saying “You do it!” There was some teasing with a rattle, at first not letting Kira reach it, and then Josie threw it at her. Then Josie ran a car (p. 61) over Kira’s foot and then apologized and kissed her daughter’s foot, saying “I’m sorry, little girl.” Kira cried again. When asked in the Video Replay what her daughter might be feeling, Josie laughed and said, “I threw the rattler at her ... she saw it so she wanted it so I threw it at her. Maybe ‘cause I ran over her foot with the car ... she hit my foot with it before!” With empathy and support, Josie evidenced insight and began to make some connections with how her reactions to Kira, such as attributing negative intentionality to developmentally appropriate behaviors, may be related to hurtful behaviors she experienced when she was young. When asked how she would describe her relationship with her grandma, who she called Ma, she exclaimed “either she didn’t pay any attention to me or she was Mean! ... She hit me with a belt,
broom, extension cord, switch and shoes.” This was noted compassionately by the interviewer as likely being very frightening and confusing for a child. When wondered with about how she compared herself to her Ma, she said “I see everything in myself.” Her concern about being like her Ma was reflected by the interviewer as she wondered with Josie whether she would appreciate some support in learning other ways of being with her child. Josie responded with a nod of her head and added, “As a mom I am still learning. The more they grow, the more you get more reactions. You don’t know what to expect ... she better not get into my hair stuff!” When wondered with about what she found most enjoyable about being a parent, Josie responded, “I miss being pregnant, I got a lot of attention.” When asked when she feels best or feels like she is doing well as a parent, she responded, “When I can provide for my baby.” Josie expressed some distrust and ambivalence, but also some motivation to participate in the mother-infant therapy group because she said she wanted to be a “good mom.” The PCERA Video Replay interview concludes with collaborative goal setting with the parent and the development of a Parent-Child Relationship Development Plan. Josie was engaged, with the support of her home visitor and the psychologist, in identifying relationship goals for their work together. Table 3.5 presents an example of a Parent-Child Relationship Development Plan.
### Table 3.5. Mother-Infant Relationship Development Plan

<table>
<thead>
<tr>
<th>Name of mother: Josie</th>
<th>Baby’s age: 12 months</th>
<th>Name of baby: Kira</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Areas of relationship to be addressed in dyadic sessions</strong></td>
<td><strong>Goals</strong></td>
<td><strong>Strategies/approaches</strong></td>
</tr>
</tbody>
</table>
| Kira being smart and learning to talk is important to her mother. | Kira will increase her language development. | • Encourage Josie to narrate Kira’s play  
• Encourage Josie to use puppets as well as telephones to have reciprocal dialogue with Kira  
• Support Josie in reading and book sharing with Kira |
| Josie expressed difficulty limiting reactivity and staying engaged in activities with Kira when Kira does not respond and she feels she is “being mean.” | Expanding Josie’s perceptions of Kira’s actions, moving past her projections of negative intentionality. | • Checking in with Josie about her emotional experience in interacting with Kira and reflect with her about how her perceptions of Kira may be influenced by her own history of early attachment relationships. |
| | | • Provide nonjudgmental developmental guidance regarding her 12-month-old’s emerging autonomy and interest in exploring her environment. |
Josie will bring Kira to group regularly and stay engaged with her even when she is experiencing frustration.

- Wondering with Josie about what Kira is feeling and needing in the moment.
- Speaking for Kira to amplify her cues and help convey her actual intentions.

There are limited experiences of shared joy between Josie and Kira.

Expand opportunities for and experiences of shared positive affect and joy through songs, games, and play.

- Encourage mother to use bright eyes and smile at Kira, with games like peek-a-boo and mirror play.
- Speak for the baby to amplify her responsiveness and shared dyadic enjoyment.

Josie would like to continue to grow in awareness of, and capacity to tolerate exploring, the loss and trauma that she experienced as a young child and how that may contribute to her experience of her daughter’s lack of responsiveness at times and age-appropriate physicality.

Josie will make initial phone call to set appointment for individual therapy.

- Josie will engage in individual and dyadic psychotherapy to address her own trauma and loss as well as dyadic support for her relationship with Kira.
### Review of Other Parent-Child Interaction Assessment Methods

#### Parent Interview Measures

**Adult Attachment Interview**

The AAI (George et al., 1996) is a semistructured, hour-long interview method consisting of 18 questions used to classify a parent’s state of mind with respect to attachment. Parents are asked to describe their salient early childhood relationship experiences and to give five adjectives that best describe their relationship with each parent, followed by specific memories to support each adjective. Hesse (1999) described the central task on this interview as “producing and reflecting upon memories related to attachment while simultaneously maintaining coherent discourse with the interviewer” (pp. 396–397). The narrative is classified as secure/autonomous, dismissive, preoccupied, or unresolved/disorganized. An early study of AAI psychometric properties found moderate test–retest reliability of AAI classifications (dismissing, autonomous, or preoccupied; $k = .63$), but reliability was lower when the unresolved classification was considered ($k = .56$) (Bakermans-Kranenburg & van IJzendoorn, 1993). When looked at with adverse childhood experiences and emotional support, Murphy and colleagues (2014) found that the more adverse childhood experiences and less emotional support the women experienced in childhood, the more likely they were to be categorized as unresolved regarding past trauma or unable to be classified on the AAI. Parents’ attachment classifications on the AAI have been found to be associated with their child’s attachment behavior with that parent (van IJzendoorn, 1995). Tests of discriminant validity indicated that AAI classifications were unrelated to non-attachment-related memory, verbal and performance intelligence, and social desirability (Bakermans-Kranenburg & van IJzendoorn, 1993). In a more recent examination of adult attachment measures, Ravitz and colleagues (Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2010) determined that the AAI “remains the most established instrument with excellent psychometric properties” (p. 428).
Assessment of Early Parent–Child Relationships

H. Steele and Steele (2008) suggested that beyond its use in research, the AAI is helpful in clinical work. For example, when this interview is conducted at the beginning of therapy, themes that emerge regarding the parents’ early attachment relationships can help establish treatment goals and a therapeutic alliance. Another important clinical use of the AAI is learning about a client’s experience of trauma and loss, defensive processes, representations of self and other, and ghosts and angels in the nursery. The AAI can also be used to observe the client’s reflective functioning (H. Steele & Steele, 2008).

The Insightfulness Assessment

The insightfulness assessment (IA; Koren-Karie, Oppenheim, Dolev, Sher, & Etzion-Carasso, 2002; Oppenheim & Koren-Karie, 2009; Oppenheim, Koren-Karie, & Sagi, 2001) evaluates parents’ capacity to empathically understand their infant, toddler, or preschooler’s internal experiences of the world. The IA involves video recording the child and parent during a play activity. Subsequently, the parent views segments of the video during an interview designed to assess his or her perspective about the child. The IA scales provide the basis for four classifications: positively insightful, one-sided, disengaged, and mixed. There is evidence to support underlying IA validity and reliability in differentiating securely attached from insecurely attached parent–child dyads. Mothers classified as positively insightful have been associated with securely attached children, mothers identified as one-sided tended to have insecure/ambivalent children, and mothers in the mixed classification had children with insecure/disorganized attachment patterns (Oppenheim & Koren-Karie, 2002). In a recent review of studies examining the underlying utility and validity of the IA, Oppenheim and Koren-Karie (2013) found that the disengaged classification is associated with emotional distance. They also found support for using the IA with fathers, highlighting the usefulness of examining insightfulness with other caregivers beyond the mother–infant dyadic context. Finally, change in parental classification from noninsightful to insightful has been associated with improvement in preschool children’s behavior following a therapeutic treatment program (Oppenheim, Goldsmith, & Koren-Karie, 2004). Gray, Forbes, Briggs-Gowan, and Carter (2015) found that 42% of this nonclinical, high-risk, low-income caregiver sample with violence-exposed children were considered insightful and that caregiver insightfulness was a protective factor for children exposed to violence because children whose caregivers were reflective and attuned on the IA were reported to have fewer behavioral problems and less negative affect.

Parent Development Interview

The Parent Development Interview–Revised (PDI-R; Slade, Aber, Bresgi, Berger, & Kaplan, 2003) is a 90-minute semistructured interview used to assess the parent’s reflective functioning by asking the caregiver questions about mental representations of oneself, his or her child, and their relationship (Slade, 2005; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). The PDI-R includes questions about the present and ongoing parent–child relationship that ask the parent to describe recent times when the parent and child got along, when they did not get along, when the parent felt angry or needy, or when the child needed attention (Slade et al., 2005). The interviewer records the parent’s response
to events as well as the child’s response to the interactions described by the parent. Reliability is measured using intraclass correlations, which range from .78 to .95 (Slade et al., 2005). The construct validity of the PDI is determined by looking at the association with the AAI. Reflective functioning on the PDI is correlated with reflective functioning in the AAI (Slade, 2005; Slade et al., 2005).

The PDI has been used in several clinical research studies, including with a population of substance-abusing mothers. Suchman and colleagues used the PDI to assess maternal reflective functioning before and after a 20-week mother–toddler therapy intervention and found that the intervention did produce more maternal reflective functioning (medium to large effect sizes) (Suchman, DeCoste, Castiglioni, Legow, & Mayes, 2008). Emotionally avoidant language (use of more positive and less frequent negative feeling words) was also analyzed in the PDI with substance-abusing mothers. Borelli, West, DeCoste, and Suchman (2012) found that use of positive, but not negative, feeling words during the PDI was correlated with lower reflective functioning, recent self-reported substance abuse, and poorer maternal sensitivity.

Working Model of the Child Interview

The WMCI (Zeanah & Barton, 1989; Zeanah, Benoit, Barton, & Hirshberg, 1996) systematically examines parental perceptions of their infant or toddler. Comprising an hour-long interview, the WMCI has been found to be correlated with the child’s behavior in the Strange Situation, classifications derived from the AAI, and mother–child interactive behavior (Benoit, Parker, & Zeanah, 1997; Dayton, Levendosky, Davidson, & Bogat, 2010; Zeanah & Barton, 1989; Zeanah, Benoit, Hirshberg, Barton, & Regan, 1994) and has been adapted for use in clinical settings (Zeanah & Benoit, 1995; Zeanah, Larrieu, Heller, & Valliere, 2000). Narrative features emerge that are considered clinical indices of the nature of the parents’ experience of the child. Concurrent validity with the PCERA (Korja et al., 2010) and high interrater reliability (Rosenblum, Zeanah, McDonough, & Muzik, 2004) have been established.

Parent-Child Observation Measures

Atypical Maternal Behavior Instrument for Assessment and Classification

The Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE; Bronfman, Parsons, & Lyons-Ruth, 1992–2004) is an expanded version of Main and Hess’s (1992) coding system of frightened/frightening behaviors to include a broader range of caregiving approaches presented in high-risk populations (Lyons-Ruth et al., 2013). The AMBIANCE examines contradictory communications, maternal withdrawal, and negative-intrusive and role-confused behaviors during the Strange Situation Procedure. More specifically, the AMBIANCE codes behaviors from an open-ended list that includes more than 140 items, and ratings are assigned on a 7-point scale. Together, caregivers can be given a qualitative score that reveals a global level of disrupted communication (Lyons-Ruth et al., 2013; Out, Bakermans-Kranenburg, & Van Ijzendoorn, 2009). It is also possible to assign a classification of either disrupted or nondisrupted communica-
tion. Role boundary confusion is defined as the extent to which a parent elicits affection from his or her baby or draws the baby’s attention to him-or herself rather than following the baby’s cues. In early studies of the AMBIANCE, maternal role boundary confusion in infancy was found to be highly correlated with negative intrusive behavior toward the infant, as evidenced by hostility or unnecessary involvement with the baby’s ongoing activity. Together, role confusion and negative intrusive behaviors were predictive of infant disorganized attachment behavior during the Strange Situation Procedure (Lyons-Ruth et al., 1999; Vulliez-Coady, Obsuth, Torreiro-Casal, Ellertsdottir, & Lyons-Ruth, 2013). Overall, as a measure, the AMBIANCE has demonstrated adequate construct and discriminant validity (Lyons-Ruth et al., 1999; Lyons-Ruth, Bureau, Holmes, Easterbrooks, & Brooks, 2012).

Coding Interactive Behavior

The Coding Interactive Behavior manual (CIB; Feldman, 1998) is a global rating system for coding parent–infant interactions using a set of observable behaviors. The CIB has demonstrated sensitivity to differences in parent–child interactions related to the family’s culture, sex of the parent, social-emotional risk factors as well as biological risk factors, and differences as a result of intervention (Feldman, Weller, Eidelman, & Sirota, 2003; Keren, Feldman, & Tyano, 2001). The CIB codes 43 behaviors using a 5-point scale, with 1 indicating a minimal level and 5 indicating a maximal level of the specified behavior. Twenty-two behavior codes pertain to the parent (e.g., intrusiveness, limit setting), 16 are child codes (e.g., withdrawal, compliance), and 5 are dyadic codes (e.g., reciprocity, negative state). The codes are averaged into several composite scores that are theoretically based and meant to touch on varied aspects of the mother–infant relationship (Feldman & Eidelman, 2009). The CIB is designed to code interactions with children ranging from birth through adolescence. As a coding system, the CIB has demonstrated adequate internal consistency and test–retest reliability and exhibited suitable predictive validity in numerous investigations with low- and high-risk samples (Feldman & Eidelman, 2009).

Clinical Problem-Solving Procedure

The clinical problem-solving procedure developed by Crowell and Feldman (1988) is based on the tool-use task developed by Matas et al. (1978). Although formal coding systems exist, the procedure can be used in clinical settings without regard to the research coding (Larrieu & Bellow, 2004). This assessment was originally developed for use with children ages 24 to 54 months old; however, it has been adapted for use with children 6 to 60 months. The Crowell procedure consists of nine episodes consisting of free play, clean-up, bubbles, four teaching tasks, separation, and reunion. In this procedure, the parent is given a variety of common toys and activities and instructed to play with the child. Sprang and Craig (2015) found the clinical problem-solving procedure child and adult scales to be internally consistent and appraised it for the thoroughly defined scales and items. They suggested that the high internal consistency for each scale provides support for use of the two separate scales measuring a child’s affective presentation and
Caregiver responsiveness or combined as a total score of relational functioning (Sprang & Craig, 2015).

**Emotional Availability Scales**

The Emotional Availability Scales (EAS), fourth edition (Biringen, 2008; Biringen, Robinson, & Emde, 1998), assess the emotional availability for both the parent and the child. Emotional availability emerged as a relationship construct, in which members of a dyadic interchange (e.g., parent and child) engage in reciprocal interactions, which, ideally, become smoother over time. The infancy and early childhood version of the EAS is used for children from birth to 5 years old. Parental sensitivity, structuring, nonintrusiveness, and nonhostility are assessed in the context of a parent-infant interaction. Children are observed for their responsiveness and involvement with parents. The EAS uses global ratings, taking the context into account, to make clinical judgments about the quality of behavioral interactions. As an example, when using the EAS with disadvantaged dyads across five age points in infancy and early childhood, Stack et al. (2012) found that maternal structuring was associated with responsiveness and maternal sensitivity was associated with child involvement. The EAS has been found to be associated with security of attachment (Biringen, 2000), and when used during observations that last 15 minutes or longer, the EAS demonstrated stronger predictive value of the attachment relationship (Biringen et al., 2005). When comparing EAS scores in a laboratory setting and a home setting, Bornstein et al. (2006) found strong cross-context reliability. In a large-scale review of the EAS, the measure demonstrated adequate to high interrater and test-retest reliability and validity and documented change in emotional availability in relation to therapeutic programming or intervention (Biringen, Derscheid, Vliegen, Closson, & Easterbrooks, 2014).

**Nursing Child Assessment Satellite Training Parent-Child Interaction Scales**

The Nursing Child Assessment Satellite Training (NCAST) Parent-Child Interaction Feeding and Teaching Scales are based on observations made in the home to assess mother and child behaviors on 149 variables: 76 in the Feeding Scale and 73 in the Teaching Scale (Barnard, 1979; Kelly & Barnard, 2000; Sumner & Spietz, 1994a, 1994b). Designed for use with infants and young children up to 36 months of age for the Teaching Scale and up to 12 months for the Feeding Scale, the NCAST scales have been widely used with infants at risk as a result of prematurity, failure to thrive, and maltreatment (Farran et al., 1990). The NCAST has measured the quality of mother and child interactions in samples of children with developmental delays and social-economic disadvantages (Barnard, 1994). During feeding and teaching activities, the absence or presence of behaviors is rated, indicating a mother’s sensitivity to her child’s cues, responsiveness to a child’s distress, and ability to foster social-emotional and cognitive growth. For example, through the use of the NCAST, Britton, Britton, and Gronwaldt (2006) found that mothers who chose to breastfeed were more sensitive to their babies’ cues during interactions and that sensitivity remained for mothers who continued to breastfeed beyond 3 months postpartum. Half of the items in each scale examine a dyad’s capacity for reciprocity and contin-
gent responsiveness, capacities considered important for learning and developmental
tasks. Children’s behaviors are rated on two subscales for clarity of cues and responsive­
to the caregiver. The teaching scales for young children 3 months and older are
more strongly correlated with cognitive development than the feeding scales and have
predictive validity when examining children’s language and cognitive outcomes at 3 and 5
years of age. Although the domains of parental functioning in the NCAST are central to
positive parent–child interactions and early childhood social-emotional development, use
of the NCAST scales in mental health settings may be limited by presence/absence rat­
ings, reducing the possibility of measuring incremental change with therapeutic interven­
tion. The NCAST is primarily used by home-visiting nurses and social workers (Dallay &
Guedeney, 2016). Training and certification are required by a certified NCAST instructor.

**Parenting Interactions With Children: Checklist of Observations Linked to
Outcomes**

The Parenting Interactions With Children: Checklist of Observations Linked With Out­
comes (PICCOLO; Roggman, Cook, Innocenti, Jump Norman, & Christiansen, 2013) is an
observational tool developed to measure parenting interactions. Specifically, the PICCO­
LO examines aspects of developmentally accommodating caregiving approaches that fall
into four behavioral domains: affection, responsiveness, encouragement, and teaching.
Roggman and colleagues (2013) indicated that the predictive value for each of these do­
mains may vary depending on the ethnicity and age of the child. The PICCOLO has exhib­
ited interrater reliability across scales and internal consistency across scales, and confir­
matory factory analysis demonstrated moderate to high factor loading across the four do­
mains. Content validity was determined by having practitioners rate each item in regard
to its significance in caregiving, with the average rating of importance being 2.6 of 3.
Construct validity for the PICCOLO domains ranged from low to moderate when compar­
ing it to another measure of parenting used in the Early Head Start Research and Evaluation
Project at 14, 24, and 36 months of age. Predictive validity of the PICCOLO was de­
termined based on significant correlations with later child language, cognitive, and
social-emotional outcomes (Roggman et al., 2013) and high correlations with other mea­
ures examining the strength of child-caregiver relationships in childcare settings (Nor­
man & Christiansen, 2013). The PICCOLO has shown promising utility for work with high-
risk families, particularly for practitioners working in home-based settings, because it
helps identify tangible recommendations and strategies and increases parenting self-effi­
cacy by identifying areas of strength (Wheeler et al., 2013).

**Parent Self-Report Measure**

**Parenting Stress Index**

The Parenting Stress Index–Fourth Edition (PSI-4) is a 120-item, self-report inventory
measuring the parent’s perception of specific areas of stress in the parent–child relation­
ship (Abidin, 1986, 2012). The PSI measures experience of stress within parent domains
(competence, isolation, attachment, health, role restriction, depression, spouse), within
child domains (distractibility/hyperactivity, adaptability, reinforces parent, demanding­
ness, mood, and acceptability), and on a Life Stress scale. Parent and child items are
scored on a 5-point scale (from 1 = strongly agree to 5 = strongly disagree). For the Life Stress items, the respondent simply indicates whether a specific life event (e.g., divorce, loss of job, and pregnancy) has occurred within the past 12 months. The PSI-4 has demonstrated high internal consistency and test-retest reliability and has maintained its factor structure, reliability, and validity across numerous translations (Abidin, 2012). The PSI-4 also comes in a short-form version, which was derived from the long version and takes approximately 10 minutes to complete (PSI-4-SF; Abidin, 2012). The PSI-4-SF contains three subscales, including Parental Distress, Parent–Child Dysfunctional Interaction, and Difficult Child, and the sum of these domains allows the examiner to obtain a Total Stress score. The PSI-4-SF has also demonstrated high internal consistency across items. The PSI-4 has been revised to improve cultural sensitivity of language, while also including fathers in the standardization sample. Additionally, the normative pool was updated to match the demographic composition of the 2007 U.S. Census (Abidin, 2012).

**Diagnosis of Relational Disorder**

Understanding the quality of the parent–infant relationship is an important part of developing a diagnostic profile for infants and young children. The primary relationships of infants and young children contribute not only to the development of children’s personality and structure of psychological defenses but also to young children’s beliefs about what is possible to expect in relationships with others.

**The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition**

The *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*; American Psychiatric Association, 2013), is a dimensional classification system developed to assist clinicians and researchers in the identification, study, and/or treatment of individuals with mental health problems. Several diagnoses address disturbances in the parent–child relationship. Reactive attachment disorder is defined as “a pattern of markedly disturbed and developmentally inappropriate attachment behaviors, in which a child rarely or minimally turns preferentially to an attachment figure for comfort, support, protecting, and nurturance” (p. 266). To receive this diagnosis, the child must have an underdeveloped attachment relationship with his or her caregiver and show related symptoms before age 5. Specifically, this diagnosis requires emotionally withdrawn behavior toward caregivers, social and emotional disturbances, and insufficient care of the child. Disinhibited social engagement disorder is another diagnosis in the *DSM-5* that describes a child’s response to insufficient care. Children with disinhibited social engagement disorder may have no or reduced inhibitions and approach and interact with unfamiliar adults in overly familiar verbal or physical ways. This may include the child leaving his or her caregiver in unfamiliar settings with no hesitation and rarely or never checking back with the caregiver. Insufficient care (i.e., neglect, repeated changes in caregivers, unusual rearing settings)
Assessment of Early Parent–Child Relationships

is a criterion for disinhibited social engagement disorder, and the insufficient care is thought to be the cause of the disinhibited behavior.

The DSM-5 also includes codes for psychosocial and environmental conditions that should be addressed by a clinician. The category of relational problems includes a code for parent–child relational problems: “the main focus of clinical attention is to address the quality of the parent–child relationship or when the quality of the parent–child relationship is affecting the course, prognosis, or treatment of a mental or other medical disorder” (p. 715). It is important to note that the parent in this definition is the primary caregiver of the child, not necessarily the biological parent. This parent–child relational problem is usually accompanied by behavioral, cognitive, or affective impaired functioning. Although not found in the DSM-5 system, the medical diagnosis of a nonorganic failure to thrive has been associated with a disturbance in the parent–child relationship. This disorder is usually recognized by the child’s pediatrician when a child who shows no other signs of illness demonstrates poor growth patterns that cannot be accounted for by parental growth patterns or further medical testing. Such patterns have been associated with caregiver deprivation and neglect. These children often manifest other signs of child neglect or maltreatment, such as poor hygiene and/or frequent accidental injuries (Tunnessen, 1999). Table 3.6 illustrates several classification systems used for describing attachment disorders. Although these systems vary in their classification, each system describes a disturbance in the balance between the child’s proximity-seeking and exploration of the environment.
<table>
<thead>
<tr>
<th>System of classification</th>
<th>Types</th>
<th>Manifestations</th>
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<tbody>
<tr>
<td>Strange Situation (Ainsworth, Blehar, &amp; Waters, 1978; Main &amp; Solomon, 1986)</td>
<td>Secure</td>
<td>Securely attached infants explore environment while intermittently making visual or physical contacts with parent; seek proximity of parent when distressed; reach for and seek comfort from parent following brief separation/reunion.</td>
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<td></td>
<td>Insecure-avoidant</td>
<td>Insecure-avoidant infants are upset when left with an unfamiliar person or in a strange setting. During the reunion, they may actively resist any attempts to be comforted by turning away and squirming to get down if picked up.</td>
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<td></td>
<td>Insecure-resistant</td>
<td>Insecure-resistant infants have difficulty feeling comfortable in a strange situation; are warier of strangers and tend to get more upset when the parent leaves the room; during separation/reunion they show ambivalence to the parent, first approaching and then pushing the parent away.</td>
</tr>
<tr>
<td></td>
<td>Disorganized/disoriented</td>
<td>Disorganized/disoriented infants show an inconsistent mix of approach and avoidance behavior when reunited with parents after a brief separation.</td>
</tr>
</tbody>
</table>
### Assessment of Early Parent–Child Relationships

<table>
<thead>
<tr>
<th><strong>Diagnostic and Statistical Manual of Mental Disorders, fifth edition (American Psychiatric Association, 2013)</strong></th>
<th><strong>Reactive attachment disorder</strong></th>
<th><strong>Disinhibited social engagement disorder</strong></th>
<th><strong>Parent–child relational problem</strong></th>
</tr>
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<tr>
<td></td>
<td>Children with reactive attachment disorder rarely show preference to an attachment figure during times of comfort, support, protection, and nurturance; are emotionally withdrawn from caregivers; have an impaired ability to form new relationships; are insufficiently cared for and commonly experience childhood neglect.</td>
<td>Children with disinhibited social engagement disorder interact with unfamiliar adults in overly familiar verbal or physical ways; do not or rarely check back with caregiver after leaving the caregiver in unfamiliar settings; lack hesitation when with unfamiliar adults; have experienced insufficient care (neglect, repeated changes of caregivers, or unusual rearing environments).</td>
<td>Children with parent–child relational problem are in treatment where the predominant focus of treatment is the parent–child relationship or when the parent–child relationship is affecting another medical or mental disorder. Children show cognitive, behavioral, or affective functioning impairment.</td>
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<tr>
<td>Children with parent–child conflicts show problems in their relationships. These terms are used to describe the necessity of treatment and used for billing and reimbursement.</td>
<td>Children with parent–child conflicts show problems in their relationships. These terms are used to describe the necessity of treatment and used for billing and reimbursement.</td>
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<tr>
<td>Parent–adopted child conflict</td>
<td>Parent–foster child conflict</td>
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<tr>
<td><strong>DC:0–5 (Zero to Three, 2016)</strong></td>
<td>Relationship-specific disorder</td>
<td></td>
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<tr>
<td>Reactive attachment disorder</td>
<td>Children with a relationship-specific disorder exhibit emotional or behavioral disturbances in one relationship with a caregiver; show aggression, fear, or self-endangering behaviors; refuse to comply with sleeping, eating, or toileting; are at risk for potential developmental harm; show signs of distress. Young children with reactive attachment disorder are emotionally withdrawn; have inhibited behaviors with adult caregivers; do not seek developmentally appropriate comfort when distressed; show minimal or no responses when comfort is given to them; rarely engage in social reciprocity with caregivers; have challenges with emotion regulation (i.e., little or no positive affect, fearlessness, and irritability).</td>
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<tr>
<td>Disinhibited social engagement disorder</td>
<td>Children with disinhibited social engagement disorder frequently engage unfamiliar adults by going with them, verbally or physically interacting with them, or being unaware of their own familiar caregivers’ whereabouts.</td>
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<tr>
<td>Axis II: Caregiver–infant relationship (Part A) and caregiving environment (Part B): Level 1: well-adapted to good-enough relationships; no clinical concern</td>
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<tr>
<td>Level 2: strained to concerning relationships; at risk; intervention not required but monitoring is suggested</td>
<td>(Part A) Caregivers in relationships must ensure physical safety; provide for basic needs; convey psychological commitment and emotional investment; establish routines and structure; recognize and respond to the child’s emotional needs and signals; provide comfort in distress; teach and socially stimulate; socialize, discipline, and engage in play; show interest in the child’s individual experiences and perspectives; engage in reflectiveness toward child’s developmental trajectory; incorporate child’s point of view; tolerate ambivalent feelings in the caregiver–child relationship.</td>
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<tr>
<td>Level 3: compromised to disturbed relationships; clinical concern; intervention required</td>
<td>Considerations of the infant contribution to the relationship include temperamental dispositions; sensory profile; physical appearance; physical health; developmental status; mental health; learning style.</td>
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<tr>
<td>Level 4: disordered to dangerous relationships; clinical concern; intervention required and urgent</td>
<td>(Part B) Caregiving environments are characterized by the people’s problem-solving; conflict resolution; caregiving role allocation; caregiving communication: instrumental; caregiving communication: emotional, emotional investment, behavior regulation, and coordination; sibling harmony.</td>
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**International Classification of Diseases-10, Clinical Modification, Parent-Child Conflict**

The *International Classification of Diseases-10, Clinical Modification (ICD-10-CM)*, is published and authorized by the World Health Organization and gives clinicians codes that are used to communicate necessity of treatment and for billing and reimbursement. In
Assessment of Early Parent–Child Relationships


Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood

The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (Zero to Three, 2016) is a multiaxial classification system designed to provide clinicians and researchers a diagnostic profile of an infant’s or young child’s functioning within the context of his or her caregiving environment. The DC:0–5 is intended to be used by infant mental health professionals in clinical settings who work with children through 5 years of age. The axes include Axis I, Clinical Disorders; Axis II, Relational Context; Axis III, Physical Health Conditions and Considerations; Axis IV, Psychosocial Stressors; and Axis V, Developmental Competence. The DC:0–5 is a recently revised and further developed diagnostic nosology expanding the age range and disorders in the DC:0–3 and DC:0–3R. Of relevance to this chapter, DC:0–5 has included the relationship specific disorder on Axis I and has expanded Axis II to include Caregiver–Infant/Young Child Relationship Adaptation and Caregiving Environment and Infant/Young Child Adaptation (Zero to Three, 2016).

The following relational disorders are on Axis I of DC:0–5.

Axis I: Relationship Specific Disorder

Relationship specific disorder focuses on the caregiver–infant/child relationship. A relationship specific disorder is determined when “the infant/child exhibits a persistent emotional or behavioral disturbance in the context of one particular relationship with a caregiver” (Zero to Three, 2016, p. 136). Zero to Three emphasizes the importance of these symptoms manifesting in the context of only one relationship in the child’s life, not presenting in more than one relationship. This disorder can be manifested in different ways, including aggression, fear, self-endangering behaviors, refusal to comply (i.e., sleeping, eating, toileting), or opposition. The diagnosis is only given when the functioning of the child or family is impaired. This impaired functioning may be seen as distress in the child, impaired relationships, limited participation in developmentally appropriate activities, limited family participation in daily routines and activities, or limited ability for the child to learn and develop appropriately (Zeanah & Lieberman, 2016; Zero to Three, 2016).

Axis I: Reactive Attachment Disorder

In DC:0–5, the original DC:0–3 reactive attachment disorder has been divided into two distinct diagnostic classifications: reactive attachment disorder and disinhibited social engagement disorder. To receive a diagnosis of reactive attachment disorder, the child must display “a pattern of emotionally withdrawn, inhibited behavior with adult caregivers” and “a pattern of emotion regulation difficulties characterized by reduced or absent positive affect and episodes of excessive or unexplained fearfulness or irritability/anger with
Assessment of Early Parent–Child Relationships

caregivers” (Zero to Three, 2016, p. 126). The child’s withdrawn and inhibited behavior must be characterized by no or minimal developmentally appropriate comfort-seeking and social engagement (Zero to Three, 2016). To receive this diagnosis, a child must have experienced insufficient care (neglect) and/or repeated change of caregivers (limiting the child’s ability to form secure attachments), and these experiences must be believed to have caused the child’s behaviors. Another criterion for this diagnosis is that the child’s symptoms or the caregiver’s response to these symptoms are impairing and significantly impact the child’s and/or family’s functioning (Zero to Three, 2016).

Axis I: Disinhibited Social Engagement Disorder
Disinhibited social engagement disorder describes a child with a history of neglect who regularly and indiscriminately interacts with unknown adults without hesitation. This can be manifested in willingness to go with unfamiliar adults, physically or verbally interacting with strangers, or lack of interest in following familiar caregivers’ whereabouts. As with relational specific disorder and reactive attachment disorder, the symptoms experienced by the child are significantly impairing (Zero to Three, 2016).

Axis II: Relational Context
In DC:0–5, Axis II is used to describe one or more of the infant or young child’s primary caregiver relationships, because the caregiving context is seen as central to every diagnostic evaluation (Zero to Three, 2016).

Part A—Caregiver–Infant/Young Child Relationship Adaptation
Both dimensions of caregiving and the infant’s contributions to the relationship are assessed. The assessment should include observations of caregiver–infant interactions as well as interviews with the caregiver to determine their attitudes toward and perceptions of the child. These assessment methods are meant to focus on the dynamics between the dyad, not the individuals themselves (Zeanah & Lieberman, 2016). The Parent–Infant Relationship Global Assessment Scale from DC:0–3 is no longer used to assess for Axis II. Instead DC:0–5 uses a four-level scale “with more detailed relational anchors designed to guide clinical intervention” (Zeanah & Lieberman, 2016, p. 518). Part A is composed of 14 Caregiver Dimensions (e.g., providing physical safety, structure and routines, discipline, recognition and response to emotional needs and signals, and comfort for distress, as well as reflective capacity and tolerance for ambivalent feelings in the caregiver–infant/young child’s relationship) and 7 Infant/Child Dimensions (i.e., temperament, sensory profile, physical health and appearance, mental health from Axis I, developmental status from Axes I and V, and learning style). Each of the Caregiver Dimensions and the infant contributions is marked as an area of strength, a concern, or not a concern. These ratings then assist in categorizing the relationship into one of four levels: well-adapted to good-enough relationships (Level 1; relationships that are not of clinical concern), strained to concerning relationships (Level 2; at risk and in need of monitoring and potentially intervention), compromised to disturbed relationships (Level 3; clinical level requiring intervention), or disordered to dangerous relationships (Level 4; clinical level requiring urgent intervention) (Zero to Three, 2016).
Part B—Caregiving Environment and Infant/Young Child Adaptation

Part B allows the assessor to attain a more holistic view of the nature of family, caregiving, and sibling relationships; communication quality, including collaboration and cooperation; and conflict resolution experienced by young children in their environment, and therefore, more than individual relationships with caregivers must be evaluated. Part B is composed of eight caregiving environment items to characterize the relationship network of the child (Zero to Three, 2016). These ratings of strength, not a concern, and concern contribute to the determination of levels of adaptive functioning of the caregiving environment. Similar to Part A, these levels include well-adapted to good-enough caregiving relationships (Level 1; environments that do not need clinical attention), strained to concerning caregiving relationships (Level 2; there is need for monitoring and potentially intervention), compromised to disturbed caregiving relationships (Level 3; clinical level requiring intervention), and disordered to dangerous caregiving relationships (Level 4; clinical level requiring urgent intervention because of severe impairments in the family that compromise the child’s development and safety) (Zeanah & Lieberman, 2016; Zero to Three, 2016).

Because relationships are central to a young child’s health and development, it is important to note that if a child’s relationships have been determined to have an Axis II rating of Level 2, 3, or 4 on Part A or B but the child is currently asymptomatic, that child may be considered at risk for psychopathologies described in Axis I in the future (Zeanah & Lieberman, 2016).

Integrating Culturally Sensitive Approaches

The integration of culturally sensitive and respectful approaches in the assessment of the parent–child relationship is critical to obtaining an accurate picture of the young child in the context of his or her family, community, and larger sociocultural environment. Parenting is inherently culture-bound. Each parent’s cultural worldview is influenced by a host of intersectional identities including, but not limited to race/ethnicity, gender, orientation, age, education, economic status, and religious beliefs (Lor, Crooks, & Tluczek, 2016). Culture forms the child’s identity and sense of self, which makes cultural awareness especially important in early childhood practice and research (Tamminen, 2006). The early parent–infant relationship is the child’s first introduction to culture. Around the world, early parent–infant interactions share similarities and differences at various levels. For example, mothers from different cultures may all be responsive to a baby’s cry, yet they might differ in how they choose to respond (i.e., touching the baby, feeding the baby, speaking to the baby). Although there are similarities, these unique differences are a result of culture (Tamis-LeMonda & Song, 2012). The meaning of the child and his or her behavior to the parents as well as the parents’ response to the child will be shaped by the parent’s cultural lens.
Additionally, interactions will look different depending on a family’s community and cultural context. For instance, parents in Western cultures tend to vocalize to their infant, gaze at their infant, and display objects to their child more frequently than parents in African, Middle Eastern, and Far Eastern cultures. However, parents from these Eastern cultures provide their infants with more physical contact than parents from Western cultures. Parents in Eastern cultures more commonly place their infants on their laps, inviting physical contact but no gaze, whereas parents in Western cultures are less likely to have their children on laps, which provides less physical contact but more opportunities for eye contact (Feldman, 2007). Even when comparing mothers of subcultures within the larger Western culture, different parenting beliefs arise, which lead to differing parenting practices (Senese, Bornstein, Haynes, Rossi, & Venuti, 2012). Some cultures value independence in the infant and toddler, while others value interdependence. Families in some cultures must focus on the survival of their infants, while others are able to focus on the achievements of their infants. The parents’ beliefs about infant development and the forces that support infant learning and development may also differ and result in various parenting styles across cultures (McCollum & McBride, 1997). Beliefs about successful infant adjustment, age of reaching various milestones in early childhood, and what and in what ways to care for the child depend on cultural beliefs and affect parenting strategies (Bornstein, 2012). For example, Japanese families tend to want their children to be emotionally mature, showing self-control, good manners, and interdependence, while American families tend to want their children to be independent, assertive, verbally competent, and self-actualized (Bornstein, 2012). When assessing parenting approaches across industrialized cultures, Bornstein (2012) saw that mothers who focused on the infant’s physical development had infants who became more motorically competent, and mothers who focused on social interaction with their infant had infants who were more interactive with their mothers.

Culturally congruent clinical assessments and interventions require continuous examination of one’s own cultural beliefs and biases, a desire to learn about the cultural other, cross-cultural engagement, knowledge of the family’s culture, and cross-cultural interpersonal skills (Campinha-Bacote, 2002; Day & Parlakian, 2003; Dudas, 2012; Gaskins, 2006). Assessments should either be standardized within the populations they are used in or revised to become conceptually, semantically, and operationally equivalent (Fisher et al., 2002). Together, observational methods and consultation with cultural brokers (individuals knowledgeable about the dominant culture as well as the particular underrepresented culture) can provide clinicians valuable insights and serve as liaisons between the assessment team and family (Day & Parlakian, 2003; Klotz & Canter, 2006). For observational relational measures, it is especially important to consider the infant’s entire caregiving network to determine who best to observe with the child. Discussing infant development and parenting beliefs with the caregiver(s) will also inform the assessors and aid them in their interpretations (Miron, Lewis, & Zeanah, 2009). Bernstein, Harris, Long, Iida, and Hans (2005) suggested that observational assessments provide a strength from a multicultural perspective and point to the importance of diversity in coders.
The Diversity-Informed Infant Mental Health Tenets were developed by the Irving Harris Foundation Professional Development Network (Irving Harris Foundation, 2012). These tenets include the importance of self-awareness in regard to personal values and beliefs, a diversity-informed stance toward infants and families (i.e., work to acknowledge privilege and combat discrimination, recognize and respect nondominant bodies of knowledge, honor diverse family structures), practice/research field participants (i.e., understand that language can be used to hurt or heal, support families in their preferred language, allocate resources to systems change, make space and open pathways for diverse professionals), and broader advocacy (i.e., advance policy that supports all families).

These diversity tenets are important in promotion of the professional’s self-reflection and sensitive and respectful consideration of family values when conducting parent–child relationship assessments.

Conclusion

In conclusion, assessment of the parent–child relationship and, when indicated, diagnosis of a relationship disturbance or disorder are important components, if not the centerpieces, of a clinical assessment of mental health in the infant or young child. Actively engaging parents in the assessment process is respectful and fosters a partnership between clinician and family in development of the therapeutic intervention. When parents take an active role in the assessment process and feel their concerns, strengths, and motivations have been heard and understood by the clinician, they are more likely to engage in the assessment and follow-through with therapeutic intervention. By conducting assessments of each member of the parent–child dyad as well as the dyadic and family unit, the clinician obtains information that is essential to developing treatment goals, ports of entry and intervention strategies. Goals should be developed collaboratively with parents for the child and each parent–child relationship. When assessing the infant or young child in the context of his or her caregiving environment, it is critical that the process include the acquisition of information from others such as day-care providers, pediatricians, mental health providers, early intervention and home visiting programs, social services, alcohol and other drug addiction treatment providers, and the court system. In our experience, the most successful interventions involve coordination of services across settings with regular communication. Empathically listening to the parents’ struggles and reflecting their feelings and concerns enhances the therapeutic relationship between clinician and parent. Finally, assessing the quality of the parent–child relationship should be an ongoing process because early childhood is a time of rapid change and parents are often faced with increased challenges as well as opportunities for growth and development in the parenting role, and the strengths and needs of the parent–child dyad will change as the relationship evolves.

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**Roseanne Clark**
Roseanne Clark, PhD, Department of Psychiatry, University of Wisconsin School of Medicine and Public Health, University of Wisconsin–Madison, Madison, WI, USA

**Audrey Tluczek**
Audrey Tluczek, PhD, RN, FAAN School of Nursing, University of Wisconsin–Madison, Madison, WI, USA

**Elizabeth C. Moore**
Elizabeth C. Moore, School of Education, University of Wisconsin–Madison, Madison, WI, USA

**Amber L. Evenson**
Amber L. Evenson, School of Medicine and Public Health, University of Wisconsin–Madison, Madison, WI, USA