Independent Social Work Matters Ltd

Contents

The CARE-Index (Infant version)

The CARE-Index assesses parent-infant interaction (C-I, Crittenden, 1981, 2007). It is videotaped 3-5 minute free play observation in which the adult is asked 'to play with your child as you usually would'. Unlike the Strange Situation, it highlights parental behavior, but because the procedure does not contain any threat, it tends to show parents at their best. Moreover, adults do what they think is the right thing to do with children, thus, giving an assessment of the best of their potential interaction at times of low stress. It should be noted, however, that in the context of court assessment, all assessments are threatening.

The infant CARE-Index is unique because it can be used from birth to 15 months (after which the Toddler version should be used) and with adults who are not the child's parents. It is also flexible in where it can be carried out, e.g., home, office, laboratory. The videotapes are coded by reliable coders who are blind to the facts of the case.

Based on directions in the manual, adults are evaluated in terms of sensitivity, control, and unresponsiveness; children in terms of cooperation, compulsivity, difficultness, and passivity. The outcome includes a rating of dyadic synchrony. This is tied to the degree of risk to the child's future development. The CARE-Index was designed as a screening tool and should always be considered in the light of other evidence.

There are more than 40 publications supporting the validity of the CARE-Index, including those addressing its use in situations of maltreatment and maternal psychiatric disorder (cf., Farnfield at al., 2010.)

Limitations: Unpublished data from a thesis (Olrick, 1992) indicate that fathers are generally more sensitive in play than mothers, but that their sensitivity is not related to the child's development; it is likely that this is because the fathers in this study were not the child's primary caregiver. The CARE-Index was designed as a screening tool and should always be considered in the light of other evidence, that is, it is <u>not</u> a stand-alone assessment. In addition, the CARE-Index is <u>not</u> an assessment of attachment. Further, play episodes cannot provide evidence of how the parent will behave when children are distressed and need comfort (Goldsmith, et al., 2004).

References

Farnfield, S., Hautamäki, A., Nørbech, P., & Sahhar, N. Dynamic-Maturational Model methods for assessing attachment. *Clinical Child Psychology and Psychiatry*,*15*, 313-328.
Crittenden, P.M. (2007). *CARE-Index: Infant Coding Manual*. Unpublished manuscript, Miami, FL.
Crittenden, P.M. (1981). Abusing, neglecting, problematic, and adequate dyads: Differentiating by patterns of interaction. *Merrill-Palmer Quarterly*, *27*, 1-18.
Goldsmith, D., Oppenheimer, D. & Wanlass, J. (2004). Separation and reunification: Using attachment theory to inform decisions affecting the placements of children in foster care. *Juvenile and Family Court Journal*, *Spring*, 1-13.
Olrick, J. (unpublished thesis, 1992). Maltreating fathers' internal representational models of attachment relationships, Senior Honors Thesis, University of Miami, Miami, FL.

KEY POINTS FOR CLIP ANALYSIS

SENSITIVITY
No lows or extremes at the upper end-gentle positive interaction

AFFECT
Is there an appropriate match of arousal (infant crying-mother should empathise and respond but not cry with the baby). How does the affect match each other? When there is a discrepancy of arousal, we normally go with the child's arousal. So low arousal in baby with high arousal in mother would indicate Ua pattern in mother; high arousal in baby with low arousal in mother would indicate a covertly controlling pattern in mother.

TEMPORAL ORDER
Can you predict what is going to happen next? Can the baby predict what the mother is going to do? What happens regarding control of what they do? What is the sequence?

CONTINGENCIES
1. **Sensitive** contingency in turn-taking is adult responses to infant behaviour that increase infant comfort and attention (leading to infant Type B). Contingent in positive ways.
2. **Controlling** contingency in turn-taking is adult responses to infant behaviour that either increase the infant's distress (leading to infant Type C in less consistent and predictable cases) or increase infant passivity/withdrawal (leading to infant Type A in more consistent and predictable cases). Contingent in negative ways.
3. **Unresponsive** contingency is the relative absence of adult responses to infant behaviour that either increase the infant's distress (leading to infant Type C in less consistent and predictable cases) or increase infant passivity/withdrawal (leading to infant Type A in more consistent and predictable cases).
   - UA-un-contingent responses. Pleasantly unconnected
   - UB-conspicuous lack of connection

You are looking for adult responses to infant behaviour (not the reverse). Some adults intermittently and unpredictably give positive responses to infant behaviour; that increases infant distress but is not controlling (it is confusing to the infant!). (It is the basis for some Type C organisations and it heightens infants' negative, i.e., 'difficult behaviour,)

REPAIR OF BREACHES
Will complement the global synchrony scale. If you have a discrepancy between your global synchrony and item by item, review the clip looking for repairs which may help resolve discrepancy. Repair of a breach will increase sensitivity.

COMPULSIVE VERSUS PASSIVE
Difference shown in body position. Passive babies are floppy even though there may be some compulsive items. Compulsive babies are stiff/jerky/delayed/inhibited movements/still.

INEPT
The problem shows the way it is. Nothing is hidden.
(often C's, whereas risk more likely to be A's)

CARE-Index

Useful questions to guide your reasoning, but not to replace thinking

Cognition

Is mother contingent to child? Does she notice and then respond to the child's signal or what the child has done?

- yes in a positive way=sensitive;
- doesn't notice=unresponsive; notices but no response= unresponsive. So the failure to respond as important than the not-noticing. It is that that makes the unresponsive mother unresponsive;
- notices & carries on anyway=controlling or maybe UA. CA will repeat the aversive behaviour, or increase the behaviour (i.e. a punitive contingency) in response to the signal from the child; the UA may carry on with non-child relevant behaviour and the child may not even notice

What does the mother want? Is it easy for you, and therefore the baby to work out?

- Is it in or out of her baby's zone of proximal development?
- How does she respond if she doesn't get what she wants?
- Changes the activity= sensitive
- Disappointment and withdrawal=Unresponsive
- Punitive contingency=Controlling

Is what the child is doing in response to what the mother has done? Does the baby notice/experience the efforts of the mother?

- In a positive way=cooperative;
- in a negative way=difficult or compulsive (is the negative affect displayed or inhibited);
- no response=passive

Affect

How aroused are mother and child?

- Low arousal=UB & passive
- High arousal displayed= difficult
- High arousal hidden=compulsive
- High arousal in mother=OTT or FPA

- Is the valence (chemistry) positive or negative?
- How does the baby feel?
- Does the baby like what the mother does?
- How does the baby feel when its close to the mother?

Do they have any moments of togetherness?

- Yes, both temporally and affectively=sensitive cooperative
- No, not at all= risk
- Sort of but not really=inept
- Sometimes but other times not=adequate

Is the displayed feeling true or false or slightly over the top?

- OTT but not FPA (transformation of negative affect)=not likely to be in bottom of scale
- FPA in the mother=UA or CA;
- FPA in the child = compulsive
- Is the feeling displayed by the mother and child congruent?
- How synchronic are the dyad?

What is the direction of the engagement?

- Does the mother learn what the child likes and change her behaviour = increased sensitivity;
- Does the child learn to inhibit what the mother doesn't like =compulsive;
- If it get worse over the film=decrease synchrony score
- If it gets better=increase the synchrony score?
- Increased or decreased over the interaction?

- How is any behaviour I see in the mother and child functioning dyadically?
- Can the baby turn away from the mother and not do what she wants?
- Who repairs the breach and how?
- If you think the baby is compulsive, which one and how is it functioning?
- Who's leading the play?
- Who's doing all the work?

Achieving Reliability

Developmental Stage

Counter transference

Dyadic Synchrony Scale

Interactional Patterns

RELIABILITY

Differentiating Infant Patterns

Exemplars

Micro analysis

Signifier Behaviours

Reliability Standards - 2019

Level I: Authorization to record person-specific case data or report to court, etc.
This level of agreement is suitable for all purposes <u>except</u> teaching the assessment to others.

Test: Clinical/Forensic Reliability Test
Additional work: Facilitating, 2 Advanced Clinical Courses, 3 Family Functional Formulations
Duration: 2 years at first tested reliability, 3 years thereafter.

Level II+: Authorization to code research, group-level data.
This level of agreement is suitable for all purposes <u>except</u> person-specific records and teaching the assessment to others.

Test: Clinical/Forensic Reliability Test
Additional work: Facilitating, Advanced Clinical Course, 2 Family Functional Formulations
Duration: 1 year at first tested reliability, 2 years at second, then 3 years thereafter.

Level II: Authorization to code research, group-level data.
This level of agreement is suitable for all purposes except person-specific records and teaching the assessment to others.

Test: Clinical/Forensic Reliability Test
Additional work: Facilitating, Advanced Clinical Course, 1 Family Functional Formulation
Duration: 1 year at first tested reliability, 2 years at second, then three years thereafter.

Levels II-, III+, III, III-: Authorization to code for personal clinical use
This level of agreement is suitable only for personal clinical use, but <u>not suitable for written case records</u>, court reports, or research data.

Test: Normative Reliability Test
Duration: 1 year.

Levels IV+, IV, IV-: Authorization to screen dichotomously for "risk" or "not risk"
This level of agreement is <u>not</u> suitable for any clinical use (including guidance of one's own cases); it can only be used in conjunction with a coder with Level I, II+, or II reliability.

Test: Normative Reliability Test
Duration: 9 months.

	Infant CARE-Index (ICI) Dyadic Synchrony
	Sensitive
14-13	Mutual Delight in a shared activity, a dance; a synchronous exchange that gives both parent and infant comfortable pleasure (without extreme highs or lows) with exploration that expands the infant's ZPD intellectually, linguistically, or socially. Little or no frustration and any frustration is easily repaired.
12-11	Smooth, pleasing interaction; playful, shared positive affect, but lacks some component of 13-14. Disruptions yield clear negative affect, without an enduring bad mood and are repaired easily.
	Adequate
10-9	Quite satisfactory play; no problems, but no dance either. The relationship stays positive albeit with less comfort (displayed as less synchronous and moderated change in arousal) as compared more synchronous dyads.
8-7	Adequate play, but noticeable periods of dysynchrony (either controlling or unresponsive), with repair. An on-going coolness or mild struggle.
	Inept
6-5	Clear unresolved problems; limited playfulness, but no evidence of hostility (control) or lack of empathy (unresponsiveness). Arousal is high or low or alternating. Compliance or frustration seem part of the mood of the interaction, rather than a breach.
	Risk
4-3	Clear lack of empathy, nevertheless, some feeble (insufficient or unsuccessful) attempt is made to respond to infant; lack of playful quality (false cheerfulness, unresponsiveness, or mocking and teasing of child etc.)
2-1	Pervasive failure to perceive or attempt to sooth infant's distressed state; no play or joint engagement.
0	Substitution of maternal isolation, sexualisation, seductiveness or taunting of the infant for affectionate closeness.

0-3 months: Physiological Regulation (maintaining moderate arousal)
The central issue is regulation of infants' somatic state. In play, arousal should be in an awake and alert state. The threat is falling asleep or becoming distressed; adults need to observe arousal changes a respond so as to moderate them. The central question is:
Can the adult enable the infant to remain in an alert and relaxed state for increasingly long periods of time?

3-6 months: Turn-Taking
The central issue is learning to take turns. In play, the adult should time their acts to create contingent responses to infant behavior. The threat is too much variation or too rapid adult responding; the adult needs to wait for the infant to organize a response and repeat the identical sequence until it is clear that the infant anticipates the sequence. Laughter or excitement usually indicate such anticipation. The central question is:
Can the adult help the infant to find and expect repetitive dyadic sequences in which they each have a part?

6-9 months: Playing the Game
With attachment figures, the form of interaction is becoming more complex with longer and more varied sequences. The variations will both extend the infant's interest and also teach him to attend to the components of the sequence and treat them as interchangeable units in a pattern. The threat is too much (or too little) variation; repair depends upon finding and responding contingently to infant signals. The central question is:
Can adult and infant establish a dyadic pattern and then play with (vary) the components of the pattern?

9 - 12 months:
Reciprocal Communication Around Objects of Joint Attention
The central issue is sharing an object of joint attention about which the dyad communicates, often without looking at one another. That is, sounds and pointing free the dyad to look at objects while maintaining interpersonal connection. A particular threat is disagreement, with dyadic repair strategies becoming important. The central question is:
Can the adult and baby turn their attention away from each other and toward an object that both enjoy?

12-15 months:
Incorporating Language in Play
With the onset of language, interaction should combine action, words, and response to vocalization. Threats are misunderstanding language and interruption, with adults needing to clarify infant communications in a simple form (but without 'correcting' them). Accuracy of affect is also an issue, with both adults and infants sometimes expressing false happiness; adults should guide children to express all feelings accurately and moderately. The central question is:
Can the adult use language in simple ways that enable the baby to regulate play without exclusive reliance on non-verbal forms of communication?

Differentiating Infant's Patterns

Cooperative	Compulsive	Difficult	Passive
Moderate relaxed arousal	High arousal with stillness	High arousal with action	Low arousal with stillness
Interested attention	Vigilance	Avoidance	Low Awareness
Signals for continued involvement	Active acceptance with FPA or fear	Active refusal or protest	Inactive tolerance
Relaxed body	Tense still body	Tense reactive body	Floppy hypotonic body

Differentiating Compulsive Patterns

Compulsive Pattern	Function	Behaviour	Where commonly seen
Attention	To elicit positive attention by gratifying the parent	Steady attention to the adult. Adult plays child watches	"needy parents"
Caregiving	To elicit engagement from psychologically withdraw/unavailable parent	Acting in very bright ways to keep parent engaged	Child neglect/parent depression
Performance	To elicit approval from controlling parent	Performing skills to earn love (lack of spontaneity, joy)	Middle class aspiring families
Compliance	To prevent adult hostility/ intrusiveness	Fear, inhibition, lack of spontaneity, vigilance	Child abuse

Signifier Behaviors – Infancy

	COOPERATIVE	COMPULSIVE	DIFFICULT	PASSIVE
Facial Expression	Slowly developing smile that lingers after its peak, even after the infant turns away from the adult; Shared eye contact at moments of mutual importance (points of uncertainty and points of shared affect).	Ambiguous half smiles Sudden beginning and ending of smiles Asymmetrical expressions Hands or objects held in front of face when facing the adult Lifeless face - like a mask that hides expression Facial changes when looking away (mostly sad) Negative affect not shown to mother, but displayed when mother presumably can't see it Frozen watchfulness Gaze aversion - avoidance of gaze Hypnotic gaze Hand in front of face Stress (yawns, tongue protrusion)	Avoidant gaze Turning head away Refusing eye contact Tongue protrusion Grimacing Blocking with toy Scowling	No eye contact (but no active avoidance either) No smiles (but also no refusal to smile) No response to offers (but also no active refusal) Still, expressionless face Brief glances without sustained looking Wide, unfocussed eyes

Signifier Behaviors – Infancy

	COOPERATIVE	COMPULSIVE	DIFFICULT	PASSIVE
Vocal Expression	Relaxed voice tones, neither strained, nor flat, with smooth variation in tone that fits both activity and adult's voice tone.	Silence, hand in or in front of mouth Strained positive voice Stress (hiccups, coughing)	Vocal protests Vocal growling	Few vocalizations Low tone Unchanging vocal quality Low volume Not initiate speech Failure to respond (but not active refusal) Incomprehensible speech (through lack of articulation)
Position/ Body Contact	Fluid motoric movement, ease with physical closeness;	Uncomfortable positioning - stiff body, still body Body parts kept still Jerky body movementsStress (scratching)	Squirmy Pushing away Resistant Hitting Kicking Resisting touches Arching back Twisting away	Low muscle tone, floppy Not well coordinated Still (but not rigidly still) Floppy

Signifier Behaviors – Infancy

	COOPERATIVE	COMPULSIVE	DIFFICULT	PASSIVE
Arousal and Affection	Moderate and comfortable arousal; Shared peaks of joy that rise smoothly, fade away lingeringly, and fit the activity.	Behaviors have sharp beginnings and endings Bright, happy behaviors (e.g., singing, dancing) appear without prior stimulus Lack of joy High arousal combined with stillness Giddy, OTT extreme excitement Incomplete "packages" of behavior, e.g., open, excited mouth without sound	Defensive sleeping Restlessness Irritability Highly aroused Tense body Pinching Biting Refusal to engage Refusal to be comforted Spitting out food Vomiting	Low arousal Low mood No expression of emotion No response to expressed emotion (from adult) Flat Seems half asleep Not responses to changes in adult Unconnected to adult Hard to arouse No clear positive or negative affect
Turn-Taking	Alternation of turns that contains some uncertainty or variability of action within a context of certainty of turn (i.e., not rote responses and not an uncertainty of there being any response);	Lack of initiative Avoidance of intimacy Temporal gaps in behavior, both within and between people	Refusal to respond Not responding to contingencies	Not initiate interpersonal turns Not resist Not express intention Lifeless play No engagement (neither positively, nor resisting) Slow response to turns

Signifier Behaviors – Infancy

	COOPERATIVE	COMPULSIVE	DIFFICULT	PASSIVE
Control	Infant's initiation of contact with the adult or signaling for the adult to repeat a pleasing action; Adult's modification of their behavior in response to infant signals; Effort to restart a failed moment of interaction (as opposed to withdrawal without change);	Immediate switches of adult's interest	Throwing toys offered by the adult Ignoring M	Permits manipulation of self and toys Shows no initiation for activities Decides by self what to do – and usually this is very little No active seeking of control Little play, tends to watch inattentively
Choice of Activity	Developmentally challenging and satisfying activity that is shaped by both adult and infant input; adult modifies their behavior to work in the infant's zone of proximal development.	Toleration without complaint of aversive adult behavior	Frustration with play or task Refusal of all adult initiatives	Accepts difficult or dull activities without protest or reaction No activity Not initiate activity Overall: not initiate, not give clear negative response: Hard to read!

The Item by Item Method
Function statements

I. Facial Expression

1 Responsive

Functions to attract or maintain the infant's attention either to the adult or to the activity.

2a Incongruous

Functions to make the interaction appear happy and congenial when, in fact, the baby is not pleased with, and may even be in opposition to, the adult.

2b Hostile or Angry

Functions to acknowledge openly the adult's disappointment in, or anger at, the child to either the infant or the viewer.

3a Self-animated

3b Impassive

Functions to reduce the infant's interest in the adult and the activity while concurrently signalling the adult's lack of involvement in the interaction.

II. Vocal Expression

4 Warm

Functions to attract or maintain the baby's attention.

5a Strained

Functions to create a discrepancy between the apparent pleasantness of the adult's behavior and the resistance or distress of the infant.

5b Angry

Functions to inhibit the child or express adult displeasure.

6a Cheerfully unresponsive

6b Flat

Functions to reduce infant involvement with the activity and, especially, with the adult.

III. Position and Body Contact

7 Comfortable and Accessible

Functions to facilitate involvement with the toys and with each other.

8a Intense

Functions to create a general physical wariness to the adult's behavior either because the infant is being made to comply physically with adult demands or because the infant is not able to predict and prepare for sudden instances of adult closeness;

8b Intrusive

Functions to create instances of infant distress or discomfort in reaction to the adult's behavior by startling or overwhelming the infant;

9a Intrusively unaware

9b Awkward

Functions to reduce activity, especially interaction, or contact between the adult and child.

IV. Expression of Affection

10 Affectionate

Functions to express the adult's pleasure in the infant in a way that the infant could perceive.

11a Covertly angry

Functions to permit the adult to irritate the infant or take pleasure in his/her distress without overtly appearing to do so.

11b Overtly hostile

Functions to express the adult's displeasure in the baby in a way that both baby and observers can recognize.

12a Unconnected

12b Uncaring or child-dependent

Functions to inhibit infant overtures to the adult.

V. Turn-taking contingencies (within bouts of play)

13 Positively contingent

Functions to keep the adult and infant in an interaction with smoothly alternating turns, each related to the other's behavior.

14a Distorted positive contingencies

Functions to increase, over the course of the interaction, the positively reinforced behavior, i.e., the inhibition or disruptive behavior.

14b Negatively/punitively contingent

Functions to decrease, over the course of the interaction, the punished or negatively reinforced behavior. This causes disruptions in infant activity and prevents smooth turn-taking.

15a Self-focused turn-taking

15b Contingently uninvolved/passively attentive

Functions to prevent turns of adult and child interaction.

VI. Control (between bouts of play)

16 Joint

Functions such that no obvious use of control is apparent, so that the wishes of both partners affect the process of the play.

17 Adult a) when control is subtle, but relentless or covertly punitive; b) when it is harsh and overtly punitive

Functions to impose the adult's will upon the child.

18a Pseudo-infant

18b Infant

Functions to give the infant full choice over the activity, but only because the adult does not choose to be involved.

VII Choice of Activity

19 Developmentally Appropriate

Functions to maximize the acceptance of the activity by the infant the (all activities are deemed to be the adult's choice because the adult could change an inappropriate activity).

20 Too demanding a) if this is done "playfully" and b) if intrusively

Functions to frustrate the infant.

21a Pseudo-adapted

21b Understimulating

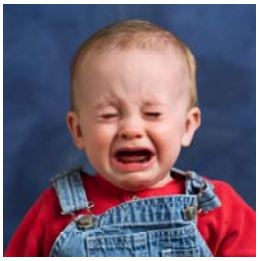
Functions to leave the infant on his own to amuse himself.

Child Communication Cue Listing

Here is a complete list of engagement and disengagement cues both potent and subtle. It is interesting to note that the number of disengaging cues far exceed the number of engaging cues we in our behavioural repertoire.

Engagement Cues		***Disengagement Cues***	
Potent	**Subtle**	**Potent**	**Subtle**
Babbling Facing Gaze Feeding sounds Giggling Mutual gaze Mutual smiling Reaching toward caregiver Smiling Smooth cyclic movements Talking Turning head to caregiver	Brow raising Eyes wide and bright Facial brightening Feeding posture Hands open, fingers slightly flexed Head raisin Hunger posture Immobility	Back arching Choking Coughing Crawling away Cry face Crying Fussing Halt hand Lateral head shake Maximal lateral gaze aversion Overhand beating movement of arms Pale/red skin Pulling away Pushing away Saying “no” Spitting Spitting up Tray pounding Vomiting Walking away Whining Withdraw from alert to sleep state	Arms straightened along sides Cling posture Diffuse body movement Dull-looking face/eyes Eye blink Eyes clinched Facial grimace Fast breathing Finger extension Frown, brow lowering Gaze aversion Hand-behind-head Hand-to-back-of-neckHand-to-ear Hand-to-eye Hand-to-mouth Hand-to-stomach Head lowering Hiccups Hunger posture Immobility Increase in sucking noise Increased feet movement Increased sucking movements Join hands Leg kicking Legs straightened with tension Lip compression Lip grimace Looking away Pout Pucker face Rapid wrist rotation Self clasp Shoulder “shrug” Sobering Tongue show Turning head Ugh face Whimpers Wing Palm Wrinkles forehead Yawn

Infant States



Crying
- Tears
- Jerky movements
- Color changes
- Muscle tension
- Rapid breathing
- Generally doesn't respond quickly

Intensity

Irritable (Active Alert)
- Lots of movement
- Irregular breathing
- Eyes open, but not focused
- Sometimes fussy
- Sensitive to body and surroundings
- Common before feeding

Intensity

Quiet Alert
- Little body movement
- Eyes open and wide
- Steady, regular breathing
- Very responsive
- Wants to play and interact
- Requires energy and can make babies tired

Intensity

Drowsy
- Variable movement
- Irregular breathing
- Opens and closes eyes
- Tired eyes
- Delayed reaction time
- Easily awakened and startled

Intensity

Active Sleep
- Some movement
- Irregular breathing
- Facial movement
- Rapid eye movement (REM)
- Easy to wake up
- Easily awakened and startled

Quiet Sleep
- No body movement
- Regular breathing
- Bursts of sucking
- Not easily wake up

Changing States

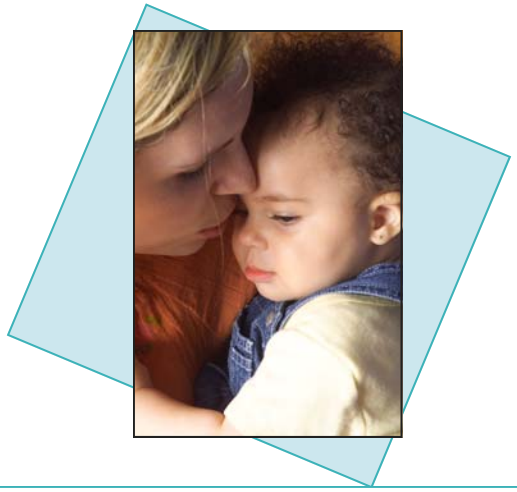
Babies can move through states very quickly, making it hard for parents to know why their baby is behaving the way she is. Being aware of cues and paying attention to the baby's surroundings can help caregivers understand why their babies might be upset or overly sleepy.

Repetition to Soothe:

Whenever a baby is crying, caregivers should be encouraged to try to identify why the baby is crying. Once the baby's needs are met, he may still be fussy. Fussy babies will calm down when caregivers remain calm and use soothing sounds and motions over and over again. Remember, it may take a few minutes or more to calm a baby who is very upset.

Examples (repeat over and over):

- Sing a song softly
- Hold the baby close and rock gently back and forth
- Rub the baby's back
- Say the baby's name in a calm voice



Variety to awaken:

Sometimes babies are very sleepy and may be hard to wake for feeds. Newborns of mothers who had medication during labor may be particularly sleepy. Fortunately, babies brains are made to react to varied stimulation. When a sleepy baby needs to wake up, it is best to use different touches, sounds, and positions to stimulate the baby's brain.

Examples:

- Change the baby's position
- Remove the baby's clothes and/or change her diaper
- Touch the baby gently in several different places (toes, hands, tummy)
- Call the baby by name several times

Although all healthy babies are different, most move through the states in similar ways. If babies are very sleepy or very upset, it may take some time for them to respond. If a baby does not respond at all to the suggestions above (after several minutes), she may need to be referred to a doctor.

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Risk assessed by CARE Index & History	Needs	Types of Intervention required
Borderline 6/7 Some de-synchrony but some sensitivity	Developmental Guidance	Familiarizing the caregiver with the relevant knowledge on infant development • Focus on state transitions and active alertness (NBAS) • Temperament; easy, slow to warm up, difficult • Stimulation thresholds/hypersensitivity • Developmental progression
Dyadic Synchrony Scale 4/5/6 Motivated to change. Able to work with Health Visitor but not able to understand baby's communication	Interactive guidance (video feedback) and Developmental guidance	Enabling carer to perceive and respond appropriately to the infant's cues To help: • the intrusive caregivers to sit back • the unresponsive caregivers engage • inconsistent caregivers develop consistency
Dyadic Synchrony Scale 2/3/4 Clear problems in family system (unresolved trauma, depression, anxiety)	Parent-Infant Psychotherapy	Intervention that link parental history
Dyadic Synchrony Scale 0-2 Substantial, complex problems (maybe in/on edge of child protection arena)	Safety for children Support for mother (adult psychotherapy)	Social Services Adult mental health Multi-agency working

DMM Self-Protective Strategies in Adulthood

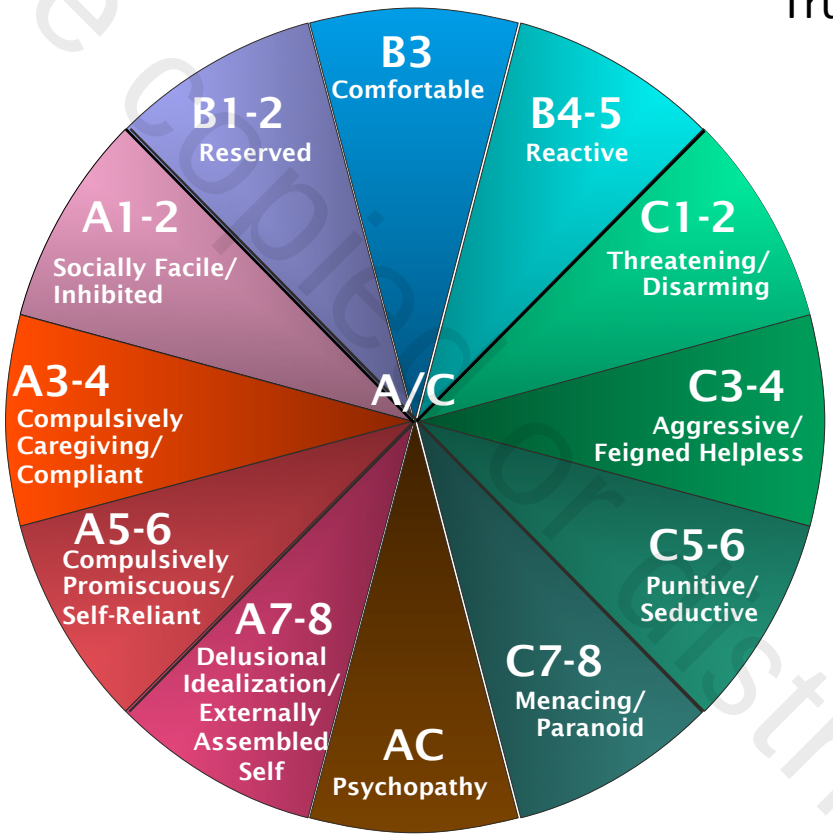
Integrated True Information

True Cognition

True Negative Affect

Distorted Cognition & Omitted Negative Affect

Distorted Negative Affect & Omitted Cognition



False Positive Affect

False Cognition

Denied Negative Affect

Denied True Cognition

Delusional Cognition

Delusional Affect

Integrated Transformed Information

Dynamic-Maturational Model Self-Protective Strategies

Patricia M.Crittenden, Ph.D.

The descriptions below accompany and elaborate the circular model of self-protective strategies found on www.patcrittenden.com and www.iasa-dmm.org

Type B strategies integrate cognitive and affective information in a balanced and flexible manner.

B3: The Type B strategy involves a balanced integration of temporal prediction with affect. Individuals using the Type B strategy show all kinds of behaviour, but are alike in being able to adapt to a wide variety of situations in ways that are self-protective, partner-protective, and progeny-protective. As often as possible, they cause others no harm. They communicate directly, negotiate differences and find mutually beneficial compromises. They distort information very little, especially not to themselves. They display a wider range of individual variation than people using other strategies-who must constrain their functioning to employ their strategy. This strategy functions in infancy. By adulthood, two sorts of Type B strategies can be differentiated. Naïve B's simply had the good fortune to grow up safe and secure. Mature B's, on the other hand, 1) have reached neurological maturity (in the mid-30's), 2) function in life's major roles, e.g., child, spouse, parent, and 3) carry out an on-going process of psychological integration across relationships, roles and contexts. Where naïve B's tend to be simplistic, mature B's grapple with life's complexities.

B1-2: Individuals assigned to B1-2 are a bit more inhibited with regard to negative affect than B3s, but are inherently balanced.

B4-5: Individuals assigned to a B4-5 exaggerate negative affect a bit, being sentimental (B4) or irritated (B5), but are inherently balanced.

Type A strategies emphasise cognitive contingencies while inhibiting display and awareness of feelings.

A1-2: The A1-2 strategy uses cognitive prediction in the context of very little real threat. Attachment figures are idealised by over-looking their negative qualities (A1) or the self is put down a bit (A2). Most A1-2s are predictable, responsible people who are just a bit cool and business like. Type A strategies all rely on inhibition of feelings and set danger at a psychological distance from the self. This strategy is first used in infancy.

A3: Individuals using the A3 strategy (compulsive caregiving, cf., Bowlby, 1973) rely on predictable contingencies, inhibit negative affect and protect themselves by protecting their attachment figure. In childhood, they try to cheer up or care for sad, withdrawn and vulnerable attachment figures. In adulthood, they often find employment where they rescue or care for others, especially those who appear weak and needy. The precursors of A3 and A4 can be seen in infancy (using the DMM method for the Strange Situation) but the strategy only functions fully in the preschool years and thereafter.

A4: Compulsively compliant individuals (Crittenden & DiLalla, 1988) try to prevent danger, inhibit negative affect and protect themselves by doing what attachment figures want them to do, especially angry and threatening figures. They tend to be excessively vigilant, quick to anticipate and meet others' wishes, and generally agitated and anxious.

The anxiety, however, is ignored and downplayed by the individual and often appears as somatic symptoms that are brushed aside as being unimportant.

A5: A5 individuals use a compulsively promiscuous strategy (Crittenden, 1995) to avoid genuine intimacy while maintaining human contact and, in some cases satisfying sexual desires. They show false positive affect, including sexual desire, to little known people, and protect themselves from rejection by engaging with many people superficially and not getting deeply involved with anyone. This strategy develops in adolescence when past intimate relationships have been treacherous and strangers appear to offer the only hope of closeness and sexual satisfaction. It may be displayed in a socially promiscuous manner (that doesn't involve sexuality) or, in more serious cases, a sexual promiscuity.

A6: Individuals using a compulsive self-reliant strategy (Bowlby, 1980) do not trust others to be predictable in their demands, find themselves inadequate in meeting the demands or both. They inhibit negative affect and protect themselves by relying on no one other than themselves. This protects the self from others, but at the cost of lost assistance and comfort. Usually this strategy develops in adolescence after individuals have discovered that they cannot regulate the behaviour of important, but dangerous or non-protective caregivers. They withdraw from close relationships as soon as they are old enough to care for themselves. There is a social form of the strategy in which individuals function adaptively in social and work contexts, but are distant when intimacy is expected, and an isolated form in which individuals cannot manage any interpersonal relationship and withdraw as much as possible from others.

A7: Delusionally idealising individuals (Crittenden, 2000) have had repeated experience with severe danger that they cannot predict or control, display brittle false positive affect and protect themselves by imagining that their powerless or hostile attachment figures will protect them. This is a very desperate strategy of believing falsely in safety when no efforts are likely to reduce the danger (cf., the "hostage syndrome"). Paradoxically, the appearance is rather generally pleasing, giving little hint of the fear and trauma that lie behind the nice exterior until circumstances produce a break in functioning. This pattern only develops in adulthood.

A8: Individuals using an A8 strategy (externally assembled self, Crittenden, 2000) do as others require, have few genuine feelings of their own, and try to protect themselves by absolute reliance on others, usually professionals who replace their absent or endangering attachment figures. Both A7 and A8 are associated with pervasive and sadistic early abuse and neglect.

Type C strategies emphasise feeling states in contexts where contingencies are complex of information is ambiguous or incomplete.

C 1-2: The C 1-2 (threatening-disarming) strategy involves both relying on ones own feelings to guide behaviour and also using somewhat exaggerated and changing displaying negative affect to influence other people's behaviour. Specifically, the strategy consists of splitting, exaggerating, and alternating the display of mixed negative feelings to attract attention and manipulate the feelings and responses of others. The alternation is between presentation of a strong, angry invulnerable self who blames others for the problem (C1, 3, 5, 7) with the appearance of a fearful, weak, and vulnerable self who entices others to give succorance (C2, 4, 6, 8). C1-2 is a very normal strategy found in

people with low risk for mental health problems and a great zest for life. Infants display the C1-2 strategy.

C3-4: The C3-4 (aggressive-feigned helpless) strategy involves alternating aggression with apparent helplessness to cause others to comply out of fear of attack or assist out of fear that one cannot care for oneself.

Individuals using a C3 (aggressive) strategy emphasise their anger in order to demand caregivers' compliance. Those using the C4 (feigned helpless) strategy give signals of incompetence and submission. The angry presentation elicits compliance and guilt in others, whereas vulnerability elicits rescue. The precursors of this strategy can be seen in infancy (using the DMM method for the Strange Situation), but the strategy only functions fully in the preschool years and thereafter.

C5-6: The C5-6 strategy (punitively obsessed with revenge and/or seductively obsessed with rescue) is a more extreme form of C3-4 that involves active deception to carry out the revenge or elicit rescue. Individuals using this strategy distort information substantially, particularly in blaming others for their predicament and heightening their own negative affect; the outcome is a more enduring and less resolvable struggle.

Those using a C5 (punitive) strategy are colder, more distant and self-controlled, and deceptive than people using C3. They appear invulnerable and dismiss other people's perspectives while forcing others to attend to them while misleading others regarding their inner feeling of helplessness and desire for comfort. Individuals using the C6 (seductive) strategy give the appearance of needing rescue from dangerous circumstances that are, in fact, self induces. C6 individuals mislead others regarding their anger.

This alternating pattern is often seen in bully-victim pairs, within gangs, and in violent couples where the hidden half of the pattern is usually forgotten or forgiven-until the presentation reverses. This strategy develops during the school years, but does not fully function fully until adolescence.

C7-8: C7-8 (menacing-paranoid) is the most extreme of the Type C strategies and involves a willingness to attack anyone combined with fear of everyone. Type C strategies all involve distrust of consequences and an excessive reliance on ones own feelings. At the extreme, this pattern becomes delusional with delusions of infinite revenge over ubiquitous enemies (a menacing strategy, C7) or the reverse, paranoia regarding the enemies (C8). These two strategies do not become organised before early adulthood.

Type A/C strategies alternate or blend Type A and Type C strategies.
A/C: A/C strategies combine any sub-patterns. In practice, most A/C's consist of the more distorted patters, i.e., A3-4 or higher and C3-4 or higher. Individuals using these strategies display either very sudden shifts in behaviour (A/C) or, in the case of the blended strategies (AC), they show very subtle mixing of distortion and deception. The extreme of the blended form is psychopathy.

STRATEGIES FOR CHANGING PARENTAL BEHAVIOR by Patricia M. Crittenden

Teaching parents new skills is a difficult task. Program evaluation, which identifies programs that work, rarely indicates which aspects of those programs were most effective. This article will focus on five commonly-used strategies for helping mothers change aspects of their parenting behaviour. The strategies evaluated were (1) positive reinforcement, (2) demonstration/modelling, (3) self-rating, (4) role-playing, and (5) instructional booklets. Surprisingly, some of these were not only ineffective but also counterproductive.

The setting for testing the effectiveness of these instructional strategies was a parent group. Over a period of three years, 107 mothers, most of whom abused and/or neglected their children, participated in the parent group. Data on their behaviour with their children were used to evaluate the effectiveness of each strategy. Before each parent group meeting, each mother was videotaped briefly playing with her child. During the subsequent meeting, she viewed her tape along with those of the other mothers; the group leader using the viewing to carry out a teaching strategy.

The tapes were later coded for maternal and child behaviour by research assistants who were blind to the identity and maltreatment status of the mothers, the date and order of the tapes, the intervention used, and the hypotheses tested, The code focused on discrete behaviours, coded sequentially, such as smile, speak, demand, correct, comply, etc.

Positive reinforcement The first strategy used and tested was direct and modelled positive reinforcement. For thirteen weeks, the mothers were reinforced for behaviour which was sensitively responsive to their child's signals. Insensitive behaviour was ignored. Mothers not only received reinforcement for their own behaviour, they also observed other mothers being reinforced for similar behaviour.

At the end of three months, the tapes were coded and early tapes compared with later tapes. There was absolutely no evidence of change in any maternal behaviour across the three month period of intervention. It was concluded that sensitive responsiveness was too complex and variable a behaviour to be identified by the mothers as the focus of reinforcement.

Demonstration/modelling More powerful procedures were clearly needed. A series of test of intervention strategies were begun. On several occasions, the group leader, taking a more instructional role, demonstrated a positive, skill building activity with a child, and using a videotape of her performance, discussed the interaction with the mothers.

Comparisons of the mothers' video-taped behaviour with their children before the demonstration revealed that the mothers had become more demanding, intrusive, and punitive and less gentle and pleasant. Apparently, the mothers tried to duplicate the demonstrator's skilled performance without recognising that the demonstrator's skill depended upon sensitive reading of, and response to, the child's signals.

Self-rating Another strategy was tried and tested. Before viewing their tapes, mothers were given a set of two or three questions, such as: Did you face your baby? Did you smile at him/her? Did you talk to him/her? The mothers were asked to answer these questions privately as they viewed their own tape. Discussion was kept briefer than usual in order to facilitate observation. The mothers were reminded several times to rate their own tapes. After just one week, before and after comparison showed that the follow-up tapes were much improved with respect to the behaviours on the self-rating sheet. In addition, sometimes unrelated behaviours improved simultaneously: for example, mothers who faced their babies also talked and smiled more (Crittenden and Snell, 1983).

Role-playing In other attempts to change mother's parenting behaviour, the group leader and one parent role modelled an activity. First the group leaded pretended to be a mother. The group member pretended to be her child. After they had enacted a sequence (e.g., playing ball, bringing a toy to mommy), the leader asked the "child" how what the "mommy" had done had made the "child" feel. then the former "child" became the "mommy" and a new "child" was selected from the group. As "children" the mothers revelled in obstreperous; with discussion, they easily recognised what in the "mother's" behaviour had irritated them and given them license to be difficult.

Again after just one week, pre-post test of mothers' videotaped behaviour with their children showed consistent increases in positive behaviour and reductions in undesirable behaviour. Moreover, their children were more cooperative in the tapes taken after role playing.

Instructional booklets Finally, the effectiveness of instructional booklets about parent-child relationships was assessed in two ways. One was the videotaping procedure. The tapes made one and two weeks after the distribution of the booklets were compared to those made before the distribution. There were no differences in maternal and child behaviour. This was true even thought the booklets were written in simple language, illustrated, and discussed in the group meeting.

On the other hand, more informal analysis of the booklet alone suggested some detrimental effects. Several protective service workers noted that some abusive mothers were citing the information in the booklet (which was given by the hospital to all new mothers) as evidence that their behaviour was correct. For example, one mother and her husband engaged in a dispute over the mother's overfeeding of the baby. The mother asserted, "You should always feed a baby when it cries. The booklet says so!" A number of instances highlighted the rigid mothers' search for prescriptives regarding the "right" way to rear children and their propensity for applying advice which is generally correct to the wrong specific situation. The problem was not the advice but rather the mothers' lack of judgement regarding its use. This suggested a danger in offering educational services to abusive mothers who lack judgement regarding its application. Therapeutic services or services focused on helping mothers interpret child behaviour and evaluate conflictual situations may be more appropriate. Neglectful mothers did not misapply instructional information, as abusive mothers did; rather, they seemed unable to benefit from it at all.

Conclusions What do these findings say about how to change maternal behaviour> First, approaches in which parents are passive recipients of the technique (e.g. positive reinforcement, demonstration/modelling, and instructional materials) were both ineffective and sometimes counterproductive. These techniques are, however, generally the least difficult for professionals to implement, the least expensive to deliver, and the most easily used with large groups.

Second, effective strategies involved direct work with each parent and the opportunity for each to exercise judgement and receive feedback in a non-threatening context. The evidence suggested that even the models and examples provided should be only a little better than the mothers' own behaviour. Expert models were too complex and intimidating for the mothers; in trying to match such models, the mothers became coercive with their children and insensitive to their cues. Using other, slightly more competent mothers as models, was more effective.
These findings emphasise the importance of small groups with individualised intervention to abusing and neglectful mothers and suggest the inappropriateness of offering maltreating mothers simple parent education and large group interventions.

References

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10 Ways to Help Parents to Protect their Children

Patricia M. Crittenden, Ph.D.

1. **Assess parents' danger:**
   Consider dangers to parents before trying to change parents. (Drugs, abandonment by their parents, couple violence, poverty, our threat to remove their child). Reduce the danger.

2. **Assess parents' needs & readiness to change:**
   Evaluate parents' needs and readiness to learn. No matter what the child needs, professionals must begin with what the parents need and are ready to learn. Everyone is ready to change something; begin there. (You can't teach division to someone that can't add!)

3. **Understand each parent's perspective empathetically:**
   Professionals need to set aside their own perspective and the child's perspective (temporarily) to step fully into each parent's perspective. This is the basis for empathy.

4. **Communicate this to each parent & correct your misunderstandings:**
   Articulate your appreciation of their experience to the parent and accept their corrections. To work with professionals, the parent must recognize themselves in our description of them.

5. **Integrate:**
   ONLY THEN can the professional consider the multiple perspectives: parent, child, and professional. Parents must do this all the time. We can too.

6. **Identify the gap:**
   Usually there is a gap between what the parent needs and is ready to learn and what the child needs from the parent.

7. **<u>This gap is where innovative services are needed</u>**
   This is what specialized training and experience are meant to accomplish. Think outside the box. Off the menu. Demonstrate creative problem solving. After all, that is what we want parents to do with their children! Let's show parents how to:
   a. Be empathic
   b. Be flexible
   c. Be creative
   d. Be exploratory as we seek an individualized plan for each family and person
   e. Attend to multiple perspectives at once
   f. Use feedback from our initial efforts to change and improve our approach
   g. Articulate this process to parents.

8. **Keep safety in mind:**
   Parent and child safety is crucial. So is our own. Professionals need to balance their own, parents' and child safety. If we are not explicit about this, we might not protect anyone.

9. **Prioritise!**
   Don't get caught up on trivial problems. Keep the BIG PICTURE in mind. Winning skirmishes (clean rooms, compliance with professionals etc.) can cost the child the battle. Be empathic!

10. **Apply the Golden Rule:**
    Let's treat parents the way we want them to treat their children. Let's describe that process, with humility for what we don't know and didn't accomplish. The Golden Rule can't be improved.

Directions for Making Videotapes of Play Interactions Suitable for Coding Using the CARE-Index

Location: The video-recording can be done in the subject's home, in a laboratory, or in a clinic setting.

Equipment: It is best to use video-cameras, but tablets and phones can also be used.

Preparing the setting: Before beginning the video-recording, select a spot on the floor (or seating for a neonate) that has lighting from behind the camera so that the light will fall on the mother and baby. Do not have bright light behind the subjects and facing the camera. Open window curtains or blinds and turn on room lights.

Listen. Reduce sounds as much as possible by turning off radios, televisions, stereos, etc. Listen for background noises such as open windows, refrigerators, air conditioners, and fans, which will drown out infants' sounds. Avoid these. Ask family members to be as quiet as possible while you are filming. (These sounds are easily excluded by the human ear but, when recorded, cause considerable problems.)

Toys: Bring a small box of toys suitable for a wide range of development. Have the toys varied, but not overwhelming in quantity. The following toys are suitable: 1 or 2 rattles, stuffed animal, bell, blocks that stack, cups and dishes, a big cup or bowl that will hold a few blocks, cars, small dolls, books. Avoid noise-making toys.

Procedure: Place a baby blanket on the floor with the toys in the front center. (This will encourage the mother to place herself and the baby behind the box, facing the camera.) Ask the mother to "Play with your baby as you usually would. You can use the toys, or not, as you choose. Sit so you are comfortable and don't worry about the camera." Do not tell her where to sit or how to position her baby. As the mother sits down, begin filming.

Film 3-3.5 minutes of their play. Longer interactions inappropriate because such intense bouts of interaction are unnatural and stressful to both mothers and babies: consequently, the end of all long interactions will become insensitive.

After video-recording, turn off the camera, thank the mother, and let her ease out of the play with her child at her own speed.

Directions for Filming Toddler CARE-Index Videos with Frustration and Repair Task

In advance: Choose a location (home, clinic, preschool, park, etc.) where there is space to play and enough light and quiet for the dyad to be seen and heard. Be sure the light is on the child and adult's faces (and not behind their heads).

When meeting a dyad:

1. Before beginning, instruct the adult (mother, father, etc.) in private, without the child overhearing. Tell the adult:

   In these 5 minutes, we want to see how you child plays and handles the ordinary frustrations of daily life. Before we start, can you tell me a bit about what kind of things frustrate your child? [Hold a short discussion.]
   You should begin by playing with your child as you usually would. Then when you hear me cough, try to frustrate your child. If he is interested in a toy, you might take it away. You might say that the play is over, but not offer anything else to do. If you are playing a game, you might break the rules. If he needs help, you might refuse to give it. You should do something that is uncooperative and frustrates him. After a minute, I will signal again and you can return to play in a way that makes your child comfortable again. You can return to play sooner if you want to. So to summarize, it is play, frustrate, repair and play.

2. Show the dyad into a room that has toys with a wide developmental range (from infancy to early school-age) and that require both interpersonal engagement (telephones, board or card games) and caregiving (cooking-and-eating, doctor kit). Let parent and child decide what toys to use.

Carrying out the procedure:

1. The camera can be visible.
2. Film 3 minutes of play without interfering.
3. Then at 3 minutes, signal with a sound to the adult (clear your throat, click your fingers, etc.)
4. Watch the child to gauge their distress; it should not exceed mild-moderate (2-3 on a scale of 5) and should not become self-maintaining (where the child's arousal engenders greater arousal). Look for silent children who are devastated (depressed), not just screaming children.
5. End the frustration episode in 1 minute or earlier (when the child is distressed.) Signs that the frustration should be ended early include: excessive distress, especially when (1) the child cannot self-soothe, (2) the adult cannot soothe the child, and (3) the camera person expects that the child's distress cannot be contained. Look for somatic evidence of stress to guide this decision.
6. Continue to film for 1 minute after the end of the frustration task to capture the process of repair.
7. Close the procedure pleasantly with both parent and child.