A Community-Based Approach to Infant Mental Health Assessment: Infants and Parents at High Psychosocial Risk

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Abstract and Keywords

This chapter follows the establishment and operation of an infant mental health clinic in central Israel. It presents a general model of community-based assessment of infant mental health, which is based on the principle of expanding the context of infant assessment outside the clinician's office. The chapter then focuses on the unique challenges of mental health assessment of infants in multirisk families and in those placed out of home because of abuse and/or neglect. It describes the pretreatment and posttreatment evaluation battery for very high-risk infants and their parents who have agreed to enroll in a specially designed intensive treatment program that was developed at the unit during the past two years. Finally, this chapter presents a case study of high-risk infants that describes the process of assessment.

Keywords: infant mental health, high-risk infants, infant assessment, infant's symptoms, community-based evaluation, multirisk families, mental health assessment

(p. 419) Introduction

The process of assessment is the process that most closely reflects the mental health practitioner's philosophy on health and pathology because it requires a clear definition of deviant behavior from a range of related, more normative or transient behaviors. The setting in which the assessment takes place and the tools that are selected typically reflect the clinician's theoretical stance. In addition, assessment is influenced by the nature and severity of the reasons for referral, as well as by the ecological context where the infant or toddler grows. For instance, assessing infants reared within extremely high contextual risk or those removed from their biological parents and placed in foster homes often necessitates a unique diagnostic setting and specific strategies that may differ from those routinely used for infants reared in typical settings. In the following, we detail our own philosophy on health and pathology in infancy, demonstrate the specific tools we use for

assessment, and describe how such tools are implemented within a general community-based approach.

The current chapter reflects our experience in the establishment and operation of a community-based, free-of-charge, infant mental health clinic that has been open to the public since 1996 under the umbrella of the Tel Aviv University–affiliated Geha Mental Health Center in central Israel. Following the formation of long-term working relationships with multiple professionals in the community, including pediatricians, social workers, nurses, and government courts, we were also able to develop a special program for the most severe cases of infants and families. In this chapter, we begin by presenting our general model on community-based assessment of infant mental health, which is based on the principle of expanding the context of infant assessment outside the clinician's office. Next, we focus on the (p. 420) unique challenges of mental health assessment of infants in multirisk families and in those placed out of home because of abuse and/or neglect. We describe the pretreatment and posttreatment evaluation battery for very high-risk infants and their parents who have agreed to enroll in a specially designed intensive treatment program that was developed at the unit during the past 2 years. Overall, we suggest that expanding the scope of infant mental health assessment into a biopsychosocial integrative assessment is imperative in our field, particularly with the growing challenges and increasingly difficult conditions clinicians face daily. The final section will present a case study of a high-risk infant that describes the process of assessment as it unfolds at home and in the clinic. It also highlights the usefulness of a community-based evaluation and its utility in affording important insights into the infant's symptoms and in planning effective intervention. As we will demonstrate, the assessment process is not limited to the microsystem of the child's ecology but aims to affect the macro-system as well by increasing public awareness and changing social policies in the field of infant mental health.

Theoretical Rationale for Expanding the Scope of Infant Mental Health Assessment to the Community

Ecological perspectives (e.g., Rosenblaum, Dayton, & Musik, 2009) underscore the embedded nature of infant development in both health and pathology. Development, according to these models, draws on the child's biological dispositions, the parenting style, the family structure, and the cultural milieu. Therefore, not only should the level of infant biological and psychological adaptation be assessed, but also the special characteristics of the caregiving environment must be evaluated, both specifically and broadly. Specificity relates to the particular conditions under which a maladaptive pattern appears (e.g., only during feeding). Broad assessment refers to different manifestations of maladaptive patterns in different contexts (child noncompliance at home vs. at nursery school). In addition, the parents' strengths and weaknesses and the level of the co-parental alliance should be recorded. Viewed from such a broad perspective, our assessment aims to remove the field of infant mental health from its exclusive reliance on a medical categorical

model and affords a broader view of the entire range of maladaptive symptoms in the first 3 years of life.

The community-based approach requires the clinician to maintain working relationships with other professionals who are part of the infant's ecological system, such as the pediatrician, the community nurse, and the family's social worker. In multicultural contexts, a mediator from the local culture is often needed. Indeed, a behavior that constitutes a problem in the regulation of a basic function may, to an extent, be culturally defined. For example, direct eye contact in the community of Ethiopian immigrants to Israel is considered a socially unacceptable behavior. Eating habits and norms are also, to a great extent, culturally defined. Furthermore, some cultures tolerate more or less aggressive behavior between peers, more or less child defiance toward parents and other adults, or greater intrusion from parents (Feldman & Masalha, 2007). For instance, we found that among Israeli 3-year-olds, higher father controlling behavior undermined the development of social competence with peers in nursery school; however, the opposite pattern was observed among Arab families, where greater paternal control facilitated child social competence with peers (Feldman & Masalha, 2010). Similarly, the way differences are handled between family members, how parents negotiate a conflict with their child, and how co-parental arguments are handled are culture specific and directly impact young children's aggressive behavior with nonkin adults and peers in nonfamilial social settings (Feldman, Masalha, & Derdikman-Eiron, 2010). Cultural belief systems also dictate how parents perceive the referral, assessment, and proposed treatment in mental health clinics and should thus be considered prior to devising a treatment plan. The following vignette illustrates this point:

> A 2-year-old child who immigrated to Israel from Ethiopia was referred to us by Social Welfare Services following the murder of his mother by his father while the child was in his mother's arms. The referring social worker thought that the maternal grandparents needed guidance to cope with their own loss and with the child, who was now living with them. The first meeting was very difficult because the grandparents did not understand the need to talk to a professional about the event. They asked, "How can you help us? It is our loss and sorrow, this is God's will, this is it." Furthermore, they were extremely reluctant to talk with the child about the traumatic event. At first, they stated that "he is a young child, he can't understand what happened," and then, they said that in the Ethiopian culture one is not supposed to talk about bad things. Our psychological way of thinking about traumatic **(p. 421)** grief did not fit with Ethiopian beliefs and bereavement rituals. In light of this meeting, we invited an Ethiopian social worker to mediate the subsequent meetings with the family. This professional had gone through an acculturation process several years before and could be trusted by the grandparents as a member of their own community.

The Role of the Well-Baby Care System in Referral and Evaluation

To broaden the context of assessment to the entire community, one major research area that exists in some form in many countries involves the system of well-baby care. In Israel, the well-baby care system (Tipat Halav) is a community-based, nationwide infant care system that provides medical care and developmental follow-up to nearly all infants and their families in their immediate neighborhoods. One of the strongest assets of the well-baby care system is that contact between nurses and families is personalized. Each community nurse is assigned to a specific district and is responsible for developing long-term contact with the families there, often following families from their first to their last child. Under risk conditions, for instance, in the case of very young or unsupported mothers, nurses make home visits. Well-baby nurses often serve as the experienced women, such as can be found in any culture, who assume the role of training and counseling young mothers during the sensitive postbirth period (Olds et al., 2002).

According to our local experience in Israel, well-baby community nurses have developed considerable skill in detecting motor or cognitive delays but are typically unaware of social and emotional difficulties in the early years. In the past 15 years, because of a continuous working alliance between our unit and the well-baby community, nurses' awareness of social-emotional disturbances in infancy has greatly increased. As a result of the extensive training we provided to the nurses, they learned to pay close attention to specific signs of social-emotional risk and collect potentially useful information on infant, maternal, or relational problems. Currently, the well-baby nurses serve as the main referral source of infants and parents to our infant mental health units around the country. Nurses are instructed to attend to and ask directly about the infant's predominant mood, sleep and feeding patterns, aggressive behavior, relationships with different family members, sibling rivalry, stranger anxiety, and adaptability to new places, foods, or activities. Common emotional problems of new mothers, such as depression, anxiety, lack of social support, and high-risk situations of child abuse and neglect, are often first detected by these nurses. Furthermore, nurses learned to pay close attention to the postbirth period and detect disruptions in maternal–infant bonding, particularly among first-time mothers (Feldman et al., 2009; Weisman et al., 2010). Nurses were taught to detect signs of social-emotional distress and cases of maternal depression, to observe mothers in the toy-filled waiting room, when they are not "on their best behavior," and to assess whether and how the mother engages the infant or responds to his or her signals. We also instruct nurses to attend to the way parents undress and dress the child for a checkup, calm the infant after an injection, and divide her or his attention between the infant and nurse, because these actions are also important indicators of their parenting skills. Nurses are directed to listen for gross misperceptions in the parent's narrative (e.g., the mother of a 3-month-old boy who says, "Every time I change his diaper he dirties it. He does it on purpose to annoy me.").

The guidelines we provide to well-baby care nurses are summarized in Table 18.1.

Table 18.1. Observation of Caregiver–Infant Interaction at Community Well-Baby Centers

General guidelines for the observing nurse

1. *The observation* takes place during any routine visit of the infant to the station. One may observe the interaction in the waiting room or the office. Any routine caregiving activity, such as feeding, diaper changing, dressing, and holding, is a valuable opportunity for observation of caregiver–child interaction.

2. In addition to the observation, please *ask the caregiver* the following specific questions:

- What are the child's *sleep* habits (when, where, and how)?
- What are the child's *eating* habits (when, where, and how)?
- To what extent is the child's father routinely involved in caregiving?

3. Please *note the specific populations at risk* for a maladaptive parent–infant relationship:

a. Infant's risk factors:

- Low- and very-low-birthweight premature babies, with long hospitalization in the neonatal intensive care unit
- Infants with congenital malformations and/or chronic medical conditions
- Difficult temperament/regulatory problems

b. Mother's risk factors:

- High-risk pregnancy with difficult course
- Known emotional difficulties
- Known losses of significant figures in recent past
- Chronic physical illness

c. Environmental risk factors

- Poverty
- Chronic marital conflict with verbal/physical aggression
- Recent immigration
- Recent grief

4. *Guidelines for observation*:

	Indicators of at-risk development during first year of life	Indicators of at-risk development during second and third years of life
Infant	Persistent crying Lack of eye contact Lack of smile Lack of interest Lack of vocalizations Self-induced vomiting Breath-holding spells	Extreme stranger anxiety Extreme shyness Aggression toward self or others Lack of interest Sadness Irritability Lack of speech Lack of self-control Self-endangerment
Mother	Looks sad/anxious/tense Feeds baby every time it fusses or cries Isolates herself at home with baby Perceives baby as difficult/bad Poor quality of touch Poor quality of talk Lack of praising baby	Poor limit-setting Feelings of helplessness Looks angry/sad/tense Lack of praising
Dyad	Lack of mutual gaze Lack of mutual pleasure Lack of kisses/touch	Control struggle Aggressiveness Lack of mutual pleasure

In a previous study (Keren, Feldman, & Tyano, 2001), we found that well-baby care nurses are able to provide valid assessment of early relational difficulties. By comparing mother–infant dyads that were referred by the nurses to the infant mental health center with nonreferred dyads from the same stations and socioeconomic backgrounds, reliable differences in mother–child interaction patterns were found. Mothers of referred infants were less sensitive, warm, and consistent and provided less efficient limits and direction for their children. Referred dyads engaged in less reciprocal play, and referred children were more negative and withdrawn and showed less social involvement.

From Evaluation to Diagnostic Formulation

There is no value in assessment if it is not followed by planning for adequate and specific intervention. Categorical diagnostic evaluations are often necessary for practical purposes: They are typically required by health care agencies, serve as the basis for treatment, and sharpen the distinction between sets of maladaptive behaviors. Yet, giving psychiatric diagnoses to infants is controversial in many countries. Kagan (1989) suggested that the decision of whether to use a categorical or continuum approach to data collection is the scientist's choice, often reflecting the specific observer's theoretical framework. The complex task of evaluating a largely preverbal infant from a person-in-context perspective may benefit from the integration of these two traditions. Along the medical tradition, infant assessment can benefit from a differential, multiaxial diagnosis, from the epidemiological description of specific risk groups for various disorders, and from an attempt to devise treatment with measurable outcomes. Categorical assessment may be enhanced by multidimensional developmental information. Such information may include different levels of data collection (behaviors, representations), multiple (p. 422) (p. 423) informants, various contexts, and several settings that may provide convergent evidence on child adaptation and the caregiving context. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* reflects the shift from purely categorical to symptomatic dimensional approach.

The community-based model calls for integration of the medical and developmental approaches within a comprehensive framework. Most important, such integration implies the ability to view an infant's symptoms using two types of "lenses" concurrently. As we will illustrate with a clinical vignette, the evaluation at our infant mental health unit is formulated in nosological terms, based on the multiaxial *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised* (Zero to Three, 2005). Yet, we also formulate the infant's clinical condition in psychodynamic, dimensional terms, such as parental projections, defense mechanisms, and transgenerational transmission of conflictual issues.

Main Components of the Evaluation

The evaluation process includes three main components: the parent–child relationship, the child's developmental/emotional status and adaptive functioning, and parental functioning.

A summary of the three dimensions and the specific measures used in our assessment process is presented in Table 18.2. The assessment utilizes both well-known assessment tools and measures developed at our lab.

Table 18.2. The Community-Based Four-Dimension Model of Infant Mental Health Assessment

Parent–child relational profile	Child social-emotional adaptation profile	Correlates of child adaptation	Final diagnosis
A. Parent–child interactive behavior (setting: home) **1.** Home Observation for Measurement of the Environment (Caldwell & Bradley, 1978)	**A.** Child adaptation during social interactions (setting: home) **1.** Free play: child involvement and creativity, child withdrawal (CIB) **2.** Free play: micro-regulatory patterns of child proximity and touch **3.** Feeding: child acceptance, initiative, and withdrawal (CIB)	**A.** Family functioning (settings: home and clinic) **1.** Structured family interview: McMaster Model of Family Functioning: roles, system management, control of behavior, problem-solving, communication, affective responsiveness (Epstein, Bishop, & Levine, 1978)	**A.** Psychodynamic formulation **1.** Underlying conflict (maternal): precursors or indicators for child conflict

2. Free play: maternal sensitivity and responsiveness (Coding Interactive Behavior [CIB], Feldman, 1998) **3.** Free play: microregulatory patterns of maternal proximity and touch **4.** Feeding: maternal sensitivity, intrusiveness, and limit-setting (CIB)		**2.** Videotaped triadic interactions: Lausanne Triadic Play: disordered, collusive, stressed, and cooperative family alliance (Fivaz-Depeursinge & Corboz-Warnery, 1999)	**2.** Defense mechanisms (maternal): precursors or indicators for child defenses **3.** Maternal representations of the child (flexibility, anger management, acknowledgment of good and bad feelings)

			4. Nature of object relations (maternal provision of holding environment, dyadic acknowledgment of dependency needs) Issues related to the development of the self (providing boundaries, mirroring)

B. Parent–child interactive behavior (setting: clinic) **1.** Free play: maternal sensitivity and responsiveness **2.** Free play: maternal facilitation of child symbolic play **3.** Maternal support of child's exploratory skills **4.** Maternal disciplinary techniques Maternal regulation of child separation Distress	**B.** Child adaptation during social interactions (setting: clinic) **1.** Free play: child involvement and creativity, withdrawal (CIB) **2.** Free play: child symbolic play: level of symbolic complexity and topics expressed during free play **3.** Child persistence, motivation, and skill in exploring new toys	**B.** Maternal psychopathology **1.** Maternal clinical interview developed by the clinical team: maternal history of mental health, substance abuse, support system, bereavement, work functioning, conflict, current relations with parents **2.** Maternal self-report: Symptom Checklist–90–Revised (Derogatis, 1983)	**B.** Diagnostic classification **1.** Formal multiaxis diagnosis using the *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (Zero to Three, 1994): Axis I: child primary diagnosis

	4. Child self-regulated compliance **5.** Management of separation distress and reaction to reunion		Axis II: parent–child relational disorder Axis III: medical/developmental conditions Axis IV: environmental stressors Axis V: child adaptive functioning
C. Maternal representations of child and parent–child relationship Parent Developmental Interview (Slade, Belsky, Aber, & Phelps, 1999). Insightfulness Assessment (Koren-Karie, Oppenheim, & Dolev, 2002)	**C.** Child adaptation to daily living skills **1.** Interview of mother: Vineland Adaptive Behavior Scales (Sparrow, Balla, & Cicchetti, 1984)	**C.** Child developmental level and temperament Maternal report: Infant Behavior Questionnaire (Rothbart, 1981) Maternal report: Toddler Behavior Assessment Questionnaire (Goldsmith, 1996) Emotion regulation: coded from the feeding, separation/reunion, and toy pick-up situations Bayley Scale of Mental Development	
	D. Child adaptation to day care or nursery school		

	Observation of child in nursery school: Nursery Assessment Scale		

Parent–Child Relational Profile

Assessment of the parent–child relationship may be conducted in two contexts: home and clinic. Interactions are coded, and the level of analysis includes both global rating scales and microanalytic codes. Different interactive contexts that range from relaxed to emotionally taxing situations evoke different patterns of interaction: free play, teaching tasks, toy pick-up, and separation/reunion. Five aspects of the parental style are addressed: global sensitivity, facilitation of the child's symbolic play, skill in introducing new cognitive tasks, disciplinary techniques, and the parent's ability to manage the child's separation distress.

Observation of the Home Environment

The parent's sensitivity and discipline, environmental provision and organization, and opportunities for age-appropriate learning are assessed via the Home Assessment for Measurement of the Environment (Caldwell & Bradley, 1978). This hour-long observation of the child's natural environment is conducted by infant mental health clinicians and yields scores on six scales as well as a total score.

Parent–Child Free Play

Mothers and/or fathers and infants are videotaped in a 10-minute free play session. The session is coded using the Coding Interactive Behavior system (CIB; Feldman, 1998), a global coding scheme that includes 42 parent, infant, and dyadic codes summarized into six composites relating to maternal sensitivity, limit setting, and intrusiveness; dyadic engagement; and child involvement and withdrawal. Since our main aim is to detect disturbed early relationships, special attention is paid to the *maternal sensitivity* construct, considered a central element in children's social-emotional development (Sroufe, 1996; Sroufe, Egeland, Carlson, & Collins, 2005). The parental sensitivity composite includes codes relating to the parent's acknowledgment of the child's signals, adaptation to change in state, elaborating and expanding on child communications, and maintaining positive affect, warm vocal quality, consistent style, and synchronous interactions. The CIB system has been used in numerous studies across multiple cultures and has versions for newborns, infants, preschoolers, adolescents, and adults during social interactions. To date, about 70 publications present studies using CIB around the world, and the system has good psychometric properties, including construct and predictive validity, test–retest reliability, and concordance with other behavioral systems. A review of the CIB theoretical foundation, research, and psychometrics was presented by Feldman (2012). The CIB

has been used to describe differences in interaction patterns across cultures (Feldman & Masalha, 2010), in multiple biological and social-emotional risk conditions (Feldman & Eidelman, 2009; Feldman et al., 2009; Feldman, Keren, Gross-Rozval, & Tyano, 2004), and following psychotherapeutic intervention (Dollberg, Feldman, Tyano, & Keren, 2013). Several studies following children in repeated testing from infancy to adolescence using the CIB system demonstrate its long-term stability and predictability of social-emotional outcomes from infancy patterns of relatedness to adolescent social-emotional functioning and psychopathology as predicted from interactions with both mother and father (Feldman, 2010; Feldman, Bamberger, & Kanat-Maymon, 2013).

Within the parent–infant interaction, special attention is given to parent and infant patterns of (p. 424) (p. 425) *proximity and touch*. The mother's supportive physical presence—addressing the degree of physical closeness, touch, and proximity in the mother–infant dyad—not only is an important aspect of the mother–child relationship but also may be used as a diagnostic tool. In particular, because proximity and touch are often not under the mother's conscious control, these behaviors may provide a window into disruptions in mother–infant physical intimacy, the basis of attachment relationships (Field, 1996). Beyond a global, clinical evaluation of the quality of touch during the parent–infant play session, it may be coded in second-by-second frames. Coding addresses the degree of proximity, gaze, type of touch, maternal responsivity to the child's bids for closeness, appropriateness of the mother's touch, and degree of physical intrusiveness. We found, for instance, that infants with feeding disorders and their mothers engage in minimal affectionate touch and the mothers tend to place children out of arms' reach. This lack of touch was more severe not only in comparison with healthy controls but also in comparison with young children diagnosed with other Axis I disorders (Feldman, Keren, et al., 2004).

Facilitation of the infant's symbolic play by the parents is assessed by observing the parents offering play material, reframing the child's symbolic output, redirecting attention, and providing apprenticeship by expanding the child's symbolic level within the "zone of proximal development" (Keren, Feldman, Namdari-Weinbaum, Spitzer, & Tyano, 2005; Vygotsky, 1978). In both typical and high-risk infants, we found that early patterns of maternal and paternal sensitivity facilitate the development of children's symbolic play in the toddler years (Feldman, 2007a; Feldman, Eidelman, & Rotenberg, 2004) and that the capacity for symbolic play at 2–3 years predicts children's empathic development and social competence in later childhood and up to adolescence (Feldman, 2007b; Feldman et al., 2013).

Parents' support of the child's cognitive development is assessed during an easy task and a difficult one. The quality of parental assistance, ability to give the infant space for exploration, efficiency in offering help, and affective quality are assessed (Chase-Lansdale, Brooks-Gunn, & Zamsky, 1994). We recently found that clinic-referred mothers are less able to provide adequate assistance to their young children during a cognitive task (e.g., puzzle). Clinic mothers were more intrusive, less able to give the child room to resolve

the problem alone, and less able to structure the interaction for the child to reach the proper solution (Dollberg, Feldman, & Keren, 2010).

Parental disciplinary techniques can be easily assessed during the cleaning-up phase of the evaluation session. Patterns of harsh control, warm control, and no control can be observed. Parents' warm but firm style is considered optimal in facilitating socialization (Feldman & Klein, 2003). We found that more optimal disciplinary parenting repeatedly assessed at 2, 4, and 6 years predicted higher moral understanding and greater empathy during adolescence (Feldman, 2007b).

Attachment Behaviors and Mini-separation

At the end of the first session, we initiate a separation/reunion episode. This is especially relevant to severe psychosocial cases, where the infant has experienced very disturbed or disrupted attachment relationships, as illustrated at the end of this chapter. The infant's attachment behaviors include level of distress during the separation, greeting responses and proximity-seeking during reunion, and return to baseline level of his or her exploratory behavior level. The quality of the infant's attachment to the caregiver is then categorized into secure, avoidant, ambivalent, and/or disorganized types (Solomon & George, 2008). High-risk children who were better able to tolerate separation at 1 year showed lower internalizing and externalizing symptoms at 2 years (Feldman & Eidelman, 2004).

Feeding Interaction Quality

Parents and infants are observed during a feeding session. Feeding, an activity that requires the fulfillment of a basic need, has been shown to be an especially stressful situation for clinic-referred mothers and infants. During feeding, referred infants were found to show higher levels of withdrawal, negative emotionality, and resistance compared to the free play session, and the withdrawal was particularly high among infants with feeding problems (Keren et al., 2001). Chatoor et al. (1997) emphasized the parameters of dyadic contingency, affect sharing, control struggle, and autonomy as characterizing the quality of the feeding interaction. In our study of clinic-referred children, we found that feeding interactions are more stressed even in comparison to their play interactions, regardless of the reason for their referral (Keren et al., 2001). Among children at biological risk, such as premature infants, the quality of feeding interactions draws on both maternal characteristics and neurobiological risk (Silberstein, Feldman, et al., 2009), and maladaptive feeding patterns in the neonatal period predict feeding (p. 426) disorder at the end of the first year (Silberstein, Geva, et al., 2009). These findings lend support to the importance of observing mother–child interaction during feeding and attending to both the infant's and the parent's competencies.

The Psychological Level of the Parent–Infant Relationship

Parental Representations and Projections

Mental representations of intimate relationships are complex cognitive-affective schemata that are constructed on the basis of repeated experiences within the relationship and are colored by specific affective valance (Blatt, 1995; Bowlby, 1969). The parent's mental

representations of the child and the relationship may be assessed through the Parent Developmental Interview (PDI; Aber, Belsky, Slade, & Crnic, 1999). The PDI is an hour-long semistructured interview that assesses the mother's representations of the child and the relationship. Questions call for maternal descriptions of daily experiences, feelings, memories, sense of parenting, modes of handling positive and negative emotions, and management of guilt and separation distress. Analysis considers the parent's expressed feelings, such as anger, dependency, guilt, and joy; the parent's ability to acknowledge negative and positive feelings; and his or her capacity to self-regulate and modulate intense emotions. In line with the attachment literature, the quality of the narrative is considered, and its coherence, richness, and affective valance are assessed.

Although maternal behavior and mental representations form distinct aspects of dyadic relationships, mothers' responses on the PDI were found to be associated with observed maternal behavior toward the child and were related to the mother's attachment security to her own mother (Aber et al., 1999; Slade, Belsky, Aber, & Phelps, 1999). Still, this instrument, like the Adult Attachment Interview, is quite time-consuming and expensive and is used therefore mainly for research purposes. To our knowledge, the procedure is not used routinely at infant mental health clinics.

In contrast, parental projections onto their infant can be detected through verbal attributions as well as through nonverbal, body configurations that are observed during a routine, unstructured parent–infant session. Cramer and Palacio-Espasa (1993) defined three types of parental projections: *libidinal*, *conflictual*, and *narcissistic*. The basic difference between them is the extent to which the parent is able to see his or her child as a distinct entity from himself or herself. This distinction is very important in planning treatment intervention and evaluating the potential for change. For instance, identification of narcissistic projections signals a complicated parent–infant relationship where the parent does not see the child's needs as different from his or her own, and the clinician must plan for long-term parent–infant psychotherapy. We found links between the representative and behavioral levels of mothering and the disruption of both in our clinic-referred families. Among clinic-referred mothers, the PDI dimension or richness–coherence of narrative was disrupted and mothers showed a more rigid and fragmented narrative of attachment to both their parents and their child, which was associated with a higher level of intrusive behavior and reduced sensitivity assessed by the CIB during mother–child interaction (Dollberg et al., 2010).

In a recent intervention study conducted at our unit (Dollberg et al., 2013), we examined how relational behavior and maternal representations are manifested before and after parent–infant psychotherapy. Mothers' and children's interactive behaviors and maternal narratives were assessed in 45 clinic-referred dyads who participated in psychodynamically informed parent–infant psychotherapy. Pre- and posttreatment assessments included observations of mothers' and infants' behaviors using the CIB and assessment of maternal representations with the PDI. Parent–infant psychotherapy consisted of weekly child–mother, child–father, and two-parent sessions. We found that following parent–infant interactional guidance psychotherapy (McDonough, 2000), maternal sensitivity and child

social engagement, as expressed in child alertness, initiation of social bids, expression of positive affect toward mother, and greater competence in using symbolic play, increased substantially. An increase was also evidenced in the richness of maternal narratives regarding the mother–infant relations. During the pretreatment assessment, maternal intrusiveness was associated with restricted narratives and lack of joyful descriptions, and reduced coherence and child engagement were associated with maternal narratives characterized by incoherence and reduced joy. Maternal reports of high psychological distress were associated with lower maternal sensitivity and higher intrusiveness before treatment and with lower child engagement and lower maternal sensitivity after psychotherapy. This study has demonstrated that weekly mother–infant psychotherapy can alter both maternal narratives of attachment and her observed behavior.

In another recent study of typically developing toddlers (Feldman, Dollberg, & Nadam, 2011), we (p. 427) found that maternal representations were especially meaningful to toddlers' ability to regulate their anger. Mothers with less rigid and more coherent representations of the parental role were able to help their children regulate anger when encountering frustrating situations, highlighting the centrality of maternal representation for the infant's capacity to self-regulate negative emotions.

Parental Insightfulness

The Parental Insightfulness Assessment (Koren-Karie, Oppenheim, & Dolev, 2002) is a procedure designed to assess how parents apply their reflective capacities when they are asked to think about their children's inner experience and the motives underlying their children's behavior as they take place at the moment during interaction with the mother. In the Parental Insightfulness Assessment, mothers and infants are first videotaped in their interactional contexts. Mothers then watch 2 minutes of each segment and are interviewed with a semistructured interview regarding their children's and their own thoughts and feelings. The interviews are classified into one insightful and three noninsightful groups. The main characteristic of positively insightful mothers is their ability to see various experiences through their children's eyes, update their view of the child when necessary, and try to understand the motives underlying their children's behaviors, especially the negative ones. The validity of the Parental Insightfulness Assessment has been supported in two longitudinal studies (Koren-Karie et al., 2002; Oppenheim, Koren-Karie, & Sagi, 2001). In both studies, mothers classified as positively insightful were most likely to have a securely attached child and the others were more likely to have insecurely attached children. As we will describe later in this chapter, we are currently using the Parental Insightfulness Assessment at our unit, both as a pre- and posttreatment tool and as an intervention tool along the therapeutic sessions.

Infant's Developmental Level

During the intake period, the child's mental and psychomotor development are assessed with the Bayley Scale of Mental Development (2005). The Bayley scale is a developmental test that includes motor and mental scales, and it is the most widely used test for infant mental and motor skills around the world. In addition to information on the child's cogni-

tive and motor skills, the testing situation provides information on the child's cognitive style, such as persistence, motivation, relation to the examiner, and mode of problem-solving, because we found these aspects to be highly predictive of self-regulatory capacities and behavior problems in later childhood (Feldman, 2009). Particular attention is paid to the child's emotion regulation and behavior in the context of cognitive testing.

Infant Socioemotional Adaptation Profile

Three levels of child adaptation are examined to assess the child's adaptive functioning: adaptation to the demands of social interactions with the primary caretaker, adaptation to the requirements of daily tasks, and adaptation to the wider social system in the day-care center or nursery school.

Child adaptation during social interactions is coded from the same four interactive situations (free play, teaching task, pick-up, separation/reunion).

Infant Social Engagement and Withdrawal

During free play, two composites from the CIB are considered: the child's social engagement (including creativity in using toys, alertness, positive affect, enthusiasm, vocalization and vocal quality, initiative, and autonomy) and withdrawal (including negative affect, withdrawn behavior, gaze break, and labile or depressed mood). Infant-sustained social withdrawal is thought of as an early marker of an infant's later difficulties in relating to his or her environment and participating in interpersonal exchanges and, as such, is different from the normative, developmentally expected, brief withdrawal behaviors observed in normal parent–infant interactions as part of the infant's efforts of regulation (Beebe, Lachmann, & Jaffe, 1997; Weinberg & Tronick, 1994). Studies using the Baby Alarm Distress Scale (Guedeney & Fermanian, 2001), a scale designed to assess social withdrawal among 2- to 24-month-old infants, have shown that 3–27% of infants in the general population (e.g., Guedeney, Foucault, Bougen, Larroque, & Mentre, 2008; Puura et al., 2010) and about 31–39% of high-risk infants (HIV positive, mental health referrals) meet criteria for sustained social withdrawal (e.g., Dollberg, Feldman, Keren, & Guedeney, 2006; Hartley et al., 2010). Infants' sustained social withdrawal may be viewed as the end result of a combined interplay between constitutional/biological risk factors such as low birth weight, low gestational age, and intrauterine growth retardation (Guedeney & Fermanian, 2001; Guedeney, Marchand-Martin, Cote, & Larroque, 2012), inadequate caregiving environment characterized by parental depression and (p. 428) anxiety (Hartley et al., 2010; Mantymaa et al., 2008; Matthey, Guedeney, Starakis, & Barnett, 2005), and disturbed parent–infant relationships (Gerhold, Laucht, Texdorf, Schmidt, & Esser, 2002). Regardless of its etiology, an infant's social withdrawal behavior has its own dynamics and impact on the flow of parent–infant interaction. For instance, the caregiver may misinterpret the infant's withdrawal behavior as a sign of rejection or lack of interest toward him or her, which may lead to a vicious cycle of parental intrusiveness and insensitivity. This, in turn, may intensify and prolong the infant's withdrawal response, thus interfering with the normal dyadic regulation process and creating an overload on the mutual adaptation capacity of the infant–caregiver dyad (Mantymaa et al., 2008). Gradually,

if these negative transactions reoccur, the use of withdrawal as a coping mechanism may generalize to other contexts and may become the child's preferred defense strategy in dealing with the environment (Dollberg et al., 2006).

In a recent study on postinstitutionalized adopted infants (Dollberg & Keren, 2013), sustained social withdrawal was assessed 1 month postadoption and again 6 months later with the Baby Alarm Distress Scale. One month after adoption, 22.5% of infants scored within the clinical range for social withdrawal, whereas a significant decrease in social withdrawal was indicated 6 months later, with none of the infants scoring above the cut-off score. These results highlight the beneficial effect of adoption on the infant's social behavior.

Infant Adaptation to a Situation of Physical Intimacy

Microanalysis examines the child's adaptation in the domain of physical intimacy, including the capacity to flexibly approach and recede from physical contact, usage of the mother's proximity for comfort and refueling, and ability to give and receive affectionate touch. With regard to intimacy and touch, for instance, we found that mothers of infants with feeding disorders showed minimal amounts of touch and were the least able to maintain physical closeness with their young children, even in comparison with children diagnosed with other social-emotional disorders (Feldman, Keren, et al., 2004). Furthermore, we found that depressed mothers showed minimal affectionate touch of their infants (Feldman & Eidelman, 2003; Feldman et al., 2009). This pattern was related to lower tendencies to breastfeed, and longitudinal studies showed that the reduced maternal touch experienced in infancy was associated with higher propensity for psychopathology, lower empathy, and lower social competence when children were 6 years old (Apter-Levi, Feldman, Vakart, Ebstein, & Feldman, 2013). These findings indicate that patterns of physical proximity and touch may be specific indicators of psychopathology and may be associated with restricted prosocial development in early childhood.

Infant Temperament (Attention Regulation, Motivation, and Persistence)

In assessing child temperament—an important predictor of maladaptive social-emotional development—we are particularly interested in the child's emotion regulation capacities. Emotion regulation is assessed from the home visit, at kindergarten, at the clinic (particularly during the stressful pick-up and separation/reunion procedures), and at home. During the teaching task, adaptation refers to the child's skill in solving problems, working diligently and persistently, showing motivation, and using the mother for assistance (Feldman, 2009). In addition to the clinician's observation, we ask the caregiver to complete the Infant Behavior Questionnaire (Rothbart, 1981), which provides information on the child's reactivity and regulation.

Child Self-Regulated Compliance

During toy pick-up, the central assessment relates to whether the child's compliance is adaptive and is of the self-regulated, self-motivated type. Children who are less regulated

during compliance situations often show disrupted social-emotional development and higher psychopathology in adolescence (Feldman, 2007b).

Child Adaptation to the Demands of Daily Life and to Childcare

Child adaptation can be assessed with the Vineland Adaptive Behavior Scales (Sparrow, Balla, & Cicchetti, 1984), a caregiver interview that considers the child's daily behavior and communication. The instrument provides information on child adaptive functioning in the domains of daily skills, communication, socialization, motor functioning, and maladaptive behavior patterns in daily life, but as with every parent questionnaire, it may be very biased by the nature of parental projections. Therefore, in pathological relationships, the parent's answers may not be reliable enough. Observing the child outside the parent–infant relationship, with other adults (p. 429) and with peers, is therefore very important. One instrument we developed for assessing young children's behavior with nonkin adults and peers is the Nursery Assessment Scale (Feldman, Masalha, & Alony, 2006), a coding scheme for child socialization in the nursery or day-care setting. The instrument has been developed and validated at our laboratory on a sample of healthy Jewish and Arab toddlers in Israel. The assessment is conducted in a 45- to 60-minute visit to the kindergarten and includes observation during indoor activity and free outdoor play. The observer marks the setting and rates the child's appearance, activities, and interactions with the adults and children along 27 scales. These scales include the style of behavior (e.g., activity level, self-regulation), sociability (e.g., prefers being alone, functions as a social center), ego skills (e.g., persists, concentrates), relations with peers (e.g., approaches children, maintains eye contact, initiates, cooperates, aggressive), and relations with adults (e.g., relies on adults for help, independent, seeks contact). The observer also marks the areas where child behavior is most adaptive and maladaptive. Studies applying the Nursery Assessment Scale showed that aspects of the parent–child relationship in infancy predicted children's social competence in childcare (Feldman & Masalha, 2010), that self-regulation in nonfamily social settings is learned through co-regulatory processes within the family unit (Feldman et al., 2006), and that fathering may be especially important for children's modulation of aggression with peers in a childcare setting (Feldman et al., 2013).

Assessment at the Family Level

In accordance with the systems perspective (Minuchin, 1985), the family is viewed as a single functional unit, and interactive patterns, resources, integrative forces, and elements disruptive to the systems' functioning are evaluated. In a recent study we found that regardless of the reason for referral and independent of the quality of the dyadic relationships, clinic-referred infants and parents show maladaptive family relationships (Keren, Dollberg, Kosteff, Danino, & Feldman, 2010). In addition to the semistructured interview-based procedure we use in our clinic—the McMaster Model of Family Functioning (Epstein, Bishop, & Levine, 1978)—other models of family assessment may be used. An observational procedure of triadic relationships (two parents and the infant) that has been used extensively in clinical settings is the Lausanne Triadic Play model (Favez, Fras-

carolo, Keren, & Fivaz-Despeursinge, 2009; Fivaz-Despeursinge & Corboz-Warnery, 1999). Both instruments are described next.

The McMaster Model of Family Functioning is a semistructured family interview that draws on the family systems perspective and emphasizes that the child's social-emotional functioning is influenced by the general family atmosphere and by the specific alliances within the family system. The McMaster interview is conducted with the entire family. Areas of functioning include role definitions, allocation of resources, management, control of behavior, problem-solving skills, communication, and affective responsiveness within the family system. Specific areas of family function and dysfunction are delineated and serve as a basis for intervention. The family assessment is used to examine links between child symptoms, specific social-emotional problems, and areas of family dysfunction. Our study indicated that clinic-referred families show disrupted functioning in all six domains, independent of the quality of the dyadic parent–infant relationship quality and of the reason for referral (Keren et al., 2010).

The Lausanne Triadic Play is a structured paradigm that evaluates the mother–father–child communication and family alliances on the basis of videotaped interactions. The Lausanne Triadic Play consists of four episodes. There are three "two-plus-one" episodes, where two partners are interacting and the third person is a passive observer (mother–infant, father–infant, and mother–father). Finally, there is a triadic family play with all members. Each episode and the transitions between episodes are coded to evaluate four types of family alliance: the disordered alliance, collusive alliance, stressed alliance, and cooperative alliance.

Although the Lausanne Triadic Play procedure has mainly been used for research purposes, we found the paradigm clinically useful in the assessment process. For instance, when exclusion of a partner dominates or parents show difficulties in keeping to their role, as is often the case in families with parental psychopathology or severe marital conflict, intervention may be direct. In this case, the therapist may create a "holding environment" for the family and interact with the parents to activate intuitive parenting skills and the coordination between spouses. However, when the central problem is the sustaining of joint triadic play, intervention may be conducted during a video replay of the sessions, calling the parents' attention to the difficulties and pinpointing specific communicative tasks for parents to practice at home.

(p. 430) As part of the family functioning assessment, *the parent's psychopathological profile* is very relevant. Hence, in the second session of our routine evaluation, parents are interviewed with regard to their family history of mental health, areas of conflict in their life, past episodes of depression or mood disorder, previous losses of close people, anxiety and panic, substance abuse, accident proneness, functioning at work, social support networks and friendships, and current relations with their family of origin. The interview also relates to the psychological aspects of the pregnancy of the referred child. In parallel, we may use self-report questionnaires, such as the Symptom Checklist–90–Revised (Dero-

gatis, 1983). This instrument is widely used, with good reliability and validity, and provides information on nine subscales of psychopathology.

Formulation of the Diagnosis in Nosological and Psychodynamic Terms

The *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood*, revised (Zero to Three, 2005), has been suggested as a standardized way of summarizing all clinical information collected through the various assessment procedures. The formulation is multiaxial, based on the concept that the young child is influenced by and shapes his or her environment. The child's primary diagnosis (Axis I) reflects the main clinical symptoms of the child. The presence of a relational parent–child disorder, as reflected in the videotaped interactions, is marked as an Axis II diagnosis. Medical and/or developmental conditions are recorded as Axis III diagnoses. Environmental stressors, including parental psychopathology, parental conflict, and family dysfunction, are noted on Axis IV. Finally, the actual level of the child's adaptive functioning is recorded on Axis V.

As mentioned in the section "The Psychological Level of the Parent–Infant Relationship," in parallel to the nosological formulation, we use also a psychodynamic formulation of the infant's symptoms in terms of parental projections, parental defenses, infant defenses, and transgenerational conflictual themes.

Based on these formulations, a strategy for intervention is planned. Assessment, as the foundation for treatment, is continuously integrated with new information emerging from the intervention. During the treatment process, we continually evaluate the mother and child's propensity to change and note the areas that are resistant to change. The clinician pays continuous attention to change in the areas described during the evaluation process. Has the mother's narrative of the child become more coherent and positive during the treatment? Has her interactive style become more adaptive and reciprocal? Have family patterns become more functional? Finally, considering that a major treatment goal is to increase child adaptation, areas in which maladaptation have been successfully or unsuccessfully negotiated are continuously monitored.

When treatment is terminated, we mention whether the decision of termination was a mutual therapist–parent decision or a unilateral parental decision, and the clinician is asked to specify the level of change, that is, whether the change was at the infant's symptom level and/or at the parental projections level.

Adapting the Evaluation to Families at Very High Psychosocial Risk

The most vulnerable subgroup of the referred population is the group of infants referred by Social Welfare Services because of neglect or abuse and significant parental failure.

For this group, we devised a special intensive intervention program that we have implemented for the past 2 years. The evaluation process of this group is significantly impacted by the low level of motivation for change the parents display when they are referred by Social Welfare Services. For instance, initial home visits are often required as a first step for reaching out to these families. Monitoring the level of change is often crucial, since these infants are at severe developmental risk and may require removal from the home by authorities. Thus, our pretreatment evaluation not only is based on clinical judgment but also requires standardized procedures. We use videotaped parent–infant dyadic play and feeding interactions, Home Assessment for Measurement of the Environment observations, and the Parental Insightfulness Assessment (as described earlier) and all infants undergo cognitive testing with the Bayley Scale of Mental Development. In addition, parents complete standardized self-report questionnaires associated with the infant's symptoms, social competence, parental support system, parents' psychological profile, and a life-events questionnaire.

Recently, we extended our scope of clinical assessment to infants who experienced complete parental failure and who have been placed out of home on an emergency basis. Until a year ago, these infants were routinely evaluated by a pediatrician for their physical and developmental status, but no professional attention was paid to their psychological condition. Following the results of a pilot project (p. 431) we initiated, in coordination with government and nongovernmental organizations, a routine assessment battery is performed for all infants placed out of home 1 month after their out-of-home placement. Some of these infants continue to see their biological parents, but their final placement is determined in court. The following case will illustrate the evaluation process we have developed for these extremely high-risk infants.

Case Study

D., 2 years, 10 months old, was referred for evaluation at our Infant Mental Health Unit 1 month after he had been removed from his biological parents' home to a shelter family as a first step toward a permanent placement in a foster care family.

Background

D.'s mother is a drug-addicted young woman who is HIV positive and his father is an alcoholic and is homeless. Both parents were known to Social Welfare Services, and when D. was born he was immediately put under child protection surveillance. When D. was 3 months old, the police were alerted by neighbors following unusually loud shouting. Upon entering the house, the policemen saw the baby lying in mess and dirt, with traces of blood all around. Both parents were drunk and hitting each other. D. was immediately removed from the house and placed with a shelter family, but returned home within a month because his parents agreed to enter a rehabilitation program. At some point, the father left the program and went back to the street. When D. was 2 years, 8 months, passersby in the street reported to the police that D. was badly hit by his mother, who was under the influence of drugs. D. was removed again to a shelter family with three ad-

ditional infants and his mother lost her parental rights over him, with the exception of supervised visitations once a week.

History-Taking

The evaluation began with a session with the foster parents and aimed to obtain a description of D.'s general condition and behaviors since he arrived, 2 months prior to the assessment. The foster parents described that D. appeared dirty and neglected, cried most of the day and night, asked continuously for food, and refused to sleep alone in his bed; he would fall asleep only when the three other children in the shelter home joined him. Over 2 months, D. calmed down, agreed to be touched and held, and started to say a few words. Yet, he continued to eat large amounts of food, especially bread, and slept poorly, with frequent awakenings and crying. At kindergarten, which was completely unfamiliar to him, he would play alone and bite his own fingers. The foster parents also mentioned D.'s recurrent regression following every visit to his biological mother.

Clinical Status

The next session was dedicated to the child's mental status evaluation, which was performed by the unit's chief child psychiatrist (M. K.). D. came once with his foster father and once with his foster mother. D. presented as a thin and sad toddler, with no dysmorphic features and no abnormal movements. Both times, D. exhibited a disorganized pattern of attachment, observed even before the mini-separation procedure: He would stand "frozen" in the middle of the room and exhibited no attachment or exploratory behaviors. He never turned to the adults in the room for help and his affect was strikingly flat; only his eyes moved around ("gaze radar"). We were told that this behavior was typical of D. during visits with his biological mother. When the clinician said to the child, "Don't worry, you're not going to stay here, we'll play a bit, and then you'll go home with Y. and M. (foster parents' first names)," D. relaxed a bit and started to explore the room, yet his play involved only touching the toys rather than actual play. He never smiled.

Developmental Status

The Bailey test (third edition) was conducted by the unit's developmental psychologist. The test took three full sessions (an hour each) to complete because of D.'s extremely poor cooperation and lack of trust. His general level of functioning was 24 months (he was 2 years, 11 months at the time of testing), with reduced functioning in verbal compared to motor tasks.

Observation Beyond the Clinic Setting

The developmental psychologist, whom D. had encountered several times at the clinic, conducted the Home Assessment for Measurement of the Environment and kindergarten observations. In both contexts, D. looked less frightened than at the clinic, but his constricted affect and level of functioning were consistently low and he showed no play with peers (including with the other fostered children). We did not observe any attention-seeking behavior toward the foster parents or the kindergarten teacher and D. hardly spoke.

The adults' efforts to approach him remained ineffective, except when they offered him sweets.

(p. 432) Diagnostic Formulation

D.'s diagnoses of the revised Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood were as follows:

Axis I: Deprivation and maltreatment disorder
Axis II: No diagnosis was given on the axis of the parent relationship, since he had been at the shelter foster home only 2 months and the caregiving figures were temporary, by definition of the shelter foster care system in Israel.
Axis III: Global developmental delay, especially language delay
Axis IV: S/P disruptions of attachment relationships, deprived and abusive environment
Axis V: Did not reach level of socioemotional functioning expected at his chronological age

Formulation of the Case in Psychodynamic Terms

D.'s intrapsychic development was severely disrupted by the lack of maternal mirroring (impaired development of the child's primary narcissism and capacity of symbolization). Deprivation and maltreatment led to his striking lack of basic trust and, consequently, to impaired interpersonal relationships, in addition to global developmental delay. His insatiable hunger and craving for bread was understood as the metaphor for all that he needed and did not get from the adult world.

Treatment Plan

Following the intensive evaluations, our recommendations to Child Protection Services were informed by the aforementioned diagnostic formulations as follows:

1. Urgent placement in permanent home with less frequent visitations to biological mother, at least until some attachment is formed with the new caregivers.
2. Interactional guidance (McDonough, 2000) child–parent psychotherapy with the new parents and the child.
3. Hearing test and speech therapist evaluation.
4. Therapeutic kindergarten.

Conclusions

In this chapter, we elaborated on the fundamentals of assessing young children and their families in a specific context—the community-based infant mental health setting. We attempted to demonstrate the way in which the community-based setting offers the opportunity to expand the scope of assessment from the traditional mental health evaluation to the interactive engagement of multiple community health professionals in the field of infant mental health assessment. The clinical case illustrates the dynamic interplay be-

tween our multifaceted assessment paradigms and treatment planning, underscoring the benefits of a community-based approach to the field of infant mental health in general and for high-risk infants and parents in particular.

Given the constraints and limited resources of most clinics, we suggest using the research tools described above not necessarily for empirical purposes, which would involve tedious micro- and macro-level coding and empirical rigor, but as a framework for observations of behavior for specific clinical goals. The coding systems described here address various conceptual perspectives, each with a unique clinical utility, such as attention to parental representations and reflective functioning, the co-parenting level of functioning, the verbal and nonverbal quality of interactions, disciplinary techniques parents use, and the child's level of symbolization and internalization of attachment figures. Such use of empirical tools for clinical purposes may broaden the clinician's perspective on the infant's symptoms and their communicative meaning.

The goal of the community-based model is to provide a broad framework for the prevention, detection, and treatment of emotional difficulties in infants and their parents. Clinical work with multirisk families and parenting on the continuum of neglect and abuse requires the clinician's willingness and capacity to work within a network of community-based health and social services. It also requires that the clinician be prepared to adopt a much more flexible and open-minded approach compared to standard psychiatric outpatient clinics. Indeed, as we have shown through the clinical vignettes, "stubborn" reaching out, including being ready to make a home-based assessment, is the approach clinicians must adopt, rather than waiting for the parents to come to the clinic. The more at risk the family is, the higher the chance of having to deal with parents' mistrust toward health and social welfare providers as a result of their own deprived and chaotic histories. Although modern society has long neglected the notion that it takes a village to raise a child, when the concern for children's well-being is shared by the entire community, young infants may have a better opportunity for optimal social-emotional growth.

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