C0-Parenting Items

0	Presence of appropriate co-parent support during pregnancy
1	Sporadic help from extended family, friends, or significant other. No practical, stable support.
2	Complete lack of co-parent support. *E.g.: No support from significant other, no extended family support, no friends.*
	Support after childbirth
0	Presence of appropriate co-parent support after childbirth
1	Intermittent, unreliable co-parent support after childbirth
2	Complete lack of co-parent support after childbirth *E.g.: No support from significant other, no extended family support, no friends.*
	Hostile and discrepant co-parenting practices*
0	Co-parent is present, is not hostile, and does not practice discrepant parenting.
1	Co-parent invests in the child, but practices discrepant parenting, and there is no inter-parental warmth. *E.g.: The co-parent who wants to monopolize the parenting responsibilities and who wants to "win" the child over by any means to prove they are the better parent. Evidence that both parents are competing with each other to prove who the better parent is.*
2	Presence of hostile co-parent. No inter-parental warmth and lack of co-parent investment in child *E.g.: Putting down and undermining the parenting style of the other parent even in the presence of the child.*

Social Networking Items:

	Social support network
0	Adequate informal and formal support.
1	Absence of either formal OR informal support. Must have presence of one or the other.
2	Absence of both formal and informal support.
	Neighbourhood
0	Living in a safe and friendly environment currently and at all points in the child's life.
1	Living in an anti-social neighbourhood during any point in the child's life
2	Currently residing in an antisocial neighbourhood for at least 3 months.

Parenting Supports	
0	Appropriate parenting supports.
1	Occasionally relying on inappropriate informal support. or devaluing existent informal supports
2	Relying on inappropriate informal parenting supports or being resistant or guarded to formal parenting supports.

Intrusiveness : Items

Child-led activities	
0	Caregiver is not controlling and allows child to lead. *E.g.: Caregiver allows child to decide what toy s/he will play with.*
1	Caregiver may allow child to lead certain appropriate activities, but caregiver will often interject and may sometimes take control of these situations.
2	Caregiver is controlling and does not allow child to lead. *E.g.: If child is playing with one toy, caregiver will take this toy away and make child play with another toy simply because this is what the caregiver wants. In the case of an infant, does not allow him/her to play with his body parts such as putting hands in mouth*
Scaffolding child	
0	Caregiver helps in an age-appropriate manner to teach child how to do certain tasks when child is having difficulties performing such task.
1	Caregiver may sometimes try to help guide the child when child is having difficulties, but caregiver will often become frustrated and end up doing the task herself.
2	Caregiver does not scaffold child. When child is having difficulties performing a task, caregiver takes over the situation and does it for the child.
Interruption of play*	
0	Caregiver does not interrupt play.
1	Caregiver will sometimes interrupt play either verbally or non-verbally. This is unintentional.
2	Caregiver very often interrupts play both verbally and non-verbally. This is intentional.

*This item can be rated in young infants. Play activity in infants is essentially dyadic in nature and may include exploratory activities with caregiver

---

Emotional Warmth: Items

Parental attentiveness	
0	Caregiver pays close attention to child and looks at child's face when communicating with them. Even cultures that do not promote direct eye contact or consider eye-to-eye contact as rude have their own internal codes about how a parent addresses a small child. Interpret mother's ability to hold eye-to-eye contact. This contact is to direct the child during

	instrumental parenting tasks as well as during times not demanding goal directed activity.
1	The parent makes eye contact but only during functional demands, such as during play observation. Caregiver holds eye contact through at least 50% time.
2	Caregiver does not look at child's face, but instead seems to be self absorbed or bored.
	Caregiver's facial expression (nonverbal)
0	Caregiver demonstrates warm interested facial expressions in response to child's positive gestures. *E.g.: If the child is happy and laughing, caregiver will match this reaction.*
1	Caregiver does not demonstrate warm interested facial expressions, but demonstrates flat affect and does not react positively even when the child is reacting positively.
2	Caregivers' facial expression suggests mocking or humiliating/shaming the child
	Words of praise
0	Caregiver uses words of praise during interaction with child when appropriate.
1	Caregiver sometimes uses words of praise during interaction with child when appropriate.
2	Caregiver never uses words of praise when appropriate, or discourse is full of critical comments during interaction with child.
	Congruency expressed in affect and words
0	Caregiver's affect matches what they say, all of the time. *E.g.: When child has done something well, the caregiver praises child with both words and appropriate facial expression.*
1	Caregiver's affect sometimes matches what they say to child, or the praise is not timely *E.g.: Child shows a number of happy face stickers earned at his daycare that the mother puts down on the table without comment. Later, when the father arrives, she praises the child profusely who has forgotten about the stickers.*
2	Caregiver's affect almost never matches what they are saying to child. This item has to happen during interaction, videotaping may be helpful. Presence of a colleague to corroborate situations such as these is recommended. *E.g.: Joey is hurt and demands mother's attention, but the mother does not believe that Joey is really hurt. She makes comments such as " My poor little boy, you must be hurt," a good statement and seemingly appropriate but not authentic if the mother is busy watching TV and not attending to him.*

Attachment Items :

	Discriminate attachment figure*
0	Child has established unshakable hierarchy of preference for a particular caregiver and is distressed by separation from this caregiver in all daily living contexts
1	Child's preference for attachment figures is complicated. E.g.: Child sharing joint custody arrangements, where two tiers of attachment figures might be happening.
2	Child has had multiple caregiving situations where there is no physical or psychological

	opportunity to establish proximity to attachment figures. *E.g.: This may happen due to situations such where children live in orphanages or children placed in multiple foster homes at a young age.*
	Physical and emotional availability of caregiver
0	Child has available stable primary attachment figure from an early age and access to secondary attachment figures/caregivers
1	Secondary attachment figures are relatively available, but infant has no access to primary attachment figure on an ongoing basis. There might be a situation where the child's parents separated and the child sees primary attachment figure only on summer holidays. Thus, complete absence of primary attachment figure or death of the primary attachment figure not necessary.
2	Child has multiple caregivers (three or more) from an early age or primary attachment figure has changed frequently throughout childhood.
	Child's inhibitions in social situations
0	Child does not show unusually exaggerated inhibitions in social situations familiar or unfamiliar
1	Child is shy and withdrawn in unfamiliar social situations, but does not stand out as being drastically different from other peers his/her age in situations that are routine or familiar.
2	Child shows extreme inhibitions in social situations to a degree that they stand out from peers. This includes children that are both emotionally and socially withdrawn in social settings. Do not rate normative stranger anxiety.
	Child's affection seeking
0	Child seeks affection from familiar adults. However, child does not seek indiscriminate affection from unfamiliar adults.
1	Child seeks familiar caregiver first but will also be soothed by unfamiliar adults if familiar adults are not available.
2	Child seeks unfamiliar adults for deriving soothing and social-emotional connections.
	Pseudo-parent behaviours in child
0	Child demonstrates behaviours consistent with developmental maturity
1	Child shows protective, quasi parent like behaviours toward younger siblings but only within immediate family context.
2	Child shows pseudo-parent behaviours or frank role reversal to adults and children. *E.g.: Child takes the role of a caretaker, tries to soothe and provide comfort for the caregiver.*
	Need to please/hypercompliance of child**
0	Child's interactions with caregivers are appropriately modulated with compliance, and assertive behaviour.
1	Child shows excessive need to please caregiver when demanded by caregiver
2	Child shows excessive need to please caregiver and is hypercompliant in unwarranted situations. *E.g.: Joe, age 4, is always vigilant and wants to please his mother as he does not want to see her upset, angry or sad. Although Joe was going to ride his bike with his sister at the playground, when he sees that his mom looks sad, he decides to stay indoors offering to sort laundry.*
	Child's comfort seeking

0	Child will almost always seek a preferred caregiver when hurt.
1	Child will seek comfort when hurt, however not exclusively with a preferred caregiver.
2	Child seldom seeks comfort from caregiver if hurt.
	Exploration opportunities
0	Caregiver regularly creates safe exploration opportunities *E.g. : A four year old collecting shells at the seaside within mother's eye sight; a seven year old allowed to go ahead of the parent on a familiar bike route.*
1	Caregiver creates inconsistent attempts to facilitate child's exploration opportunities.
2	Caregiver does not want the child to explore their environment, and very rarely creates safe exploration opportunities.
	Child's discourse regarding family events* **
0	Child often relates to her/his experiences as collective experiences involving attachment figures. This item is scored 0 if one gets impression that the child and attachment figure(s) are capable of forming a unique, safe and pleasurable interactive world of their own. *E.g.: "We like to have popcorn on Friday nights," referring to his mother and himself. This is a non-prompted, spontaneous description of what happens in the child's home on weekends.*
1	Child will narrate the event keeping actions of self and attachment figures separate but related to same goal. Child has availability or understanding of his attachment figures, but they are not always creating a shared loving experience, although they are engaged in the same goal at the same time. *E.g.: Joe says, "My parents like to watch western movies," or "They like to do their work and I watch my favourite TV channel."*
2	Child has no access to attachment figures even if they are potentially available. There is no unique opportunity to create positive attachment experiences based on daily life events. *E.g.: Joey is left with his babysitter on weekends.*
	Insecure/Disorganized attachment**
0	Insecure/disorganized attachment not suspected
2	Insecure/disorganized attachment suspected.

* Score only for infants over age eight months, those under the age of eight months are given a score 0

** For this item, you must take into account cultural parenting patterns and situational demands.

*** If child cannot speak, item is not applicable and subscale score should be pro-rated

**** See Appendix B for additional guidelines

Appendix B - Attachment Security

The following information is provided to screen for the possibility of a disorganized attachment pattern, and not to diagnose disorganized attachment. At least 15% of disorganized attachment is found in middle class non-clinical community sample (Main & Cassidy, 1988) As infants, these children have difficulty with physiological regulation of stress, as toddlers there are problems regarding aggressive, oppositional

behaviour and in school-aged children can either be punitive controlling or hypercompliant (Lyons-Ruth, Alpern & Repacholi, 1993). Mothers of these children show role confusion, intrusiveness/withdrawal, affective communication errors and disorientation (Hesse & Main, 2006).

Disorganized attachment status **suspected** (Main, & Solomon, 1990)

Only for infants 12-18 months of age

A) Sequential display of contradictory behaviour patterns

B) Simultaneous display of contradictory behaviour patterns

C) Undirected, misdirected, incomplete, and interrupted movements and expressions

D) Stereotypes, asymmetrical movements, mistimed movements, and anomalous postures

E) Freezing, stilling, and slowed movements and expressions

F) Direct expressions of apprehension regarding the parent

G) Direct indices of disorganization or disorientation

Disorganized attachment **suspected** (For older infants and preschoolers)

Child overly caregiving and nurturing toward caregivers, for instance, worries about caregivers, tries to demonstrate caring by engaging in developmentally inappropriate tasks (Critenden, 1992).

Secure attachment **suspected**

In secure attachment, the caregiver is attuned with the child at a primary effortless level in a contingent way. These shared moments are created by mutual eye contact, tone of voice and body gestures at the nonverbal level. This connection of two minds (mother and child) is facilitated by proportionate delivery of responses where intensity and timing of the response is respected. Some psychotic mothers may avoid such experiences actively and anxious mothers find it very difficult to find this level of attunement. Depressed mothers appear unresponsive if they are self absorbed and not attuned to infant's needs. One clinical task that has been used by many therapists is to suggest "silent nonverbal communication" (i.e. being with the infant rather than doing things with infants all the time).

Vignettes

Mercedes and Stella

This vignette is given to score Domain 1 Co-Parenting and Social networking items. If there are any questions arising ,please make a note.

Make sure that you make a distinct observation of preintervention and post intervention functioning.

VIGNETTE: MERCEDES & STELLA

Stella, a five and half year old kindergartner has been absent from school for twenty days this term. Her teacher is very concerned and tried to phone her mother, Mercedes. Their residential phone is not in service and other class parents do not seem to know about this mother or the child at all. Everyone agrees that Stella always seems well dressed and groomed. . Mercedes is seen as an aloof mother but always on time to pick up her daughter. One of the parents remarked on Stella's habit of wearing long sleeved blouses and tights even on hot humid days. However, the xonsensus was Stella and Mercedes seemed to be very happy together. As per school policy, a written letter of concern was sent and having received no reply, a ministry social worker was informed. By the time, the social worker visited the dyad at their home, three weeks had passed. When the social worker arrived, there was no response. She attempted to phone again and left a note to see her at her office. There was no communication following this. As a result, a protection concern for the child was raised and a social worker and a nurse visited the home. This community health nurse had previously visited them when Stella was born. She had not perceived anything out of ordinary with this single parent who seemed to be enjoying her baby and nursing her well. The nurse recalled that Mercedes attended most of her antenatal visits but was inconsistent with postnatal well baby clinic visits.She always came alone for the visits at the health centre and volunteered very little infomration about her family or supports. Fortunately, all of Stella's immunization records were in order.The apartment was in a busy assisted housing complex where the dyad lived since Stella was born. . Therefore it was unusual that none of the neighbours

had seen them. In the end, a financial worker was informed to contact the social worker when the mother would arrive to collect her financial assistance cheque. When Mercedes arrived at the financial worker's office, the social worker was informed who organized a meeting with the mother to find out what had happened to Stella.

Very next day, Mercedes and Stella were both in the social worker's office. They looked pale but not in obvious distress. Stella played with toys in the reception room while mother watched her. Mercedes told the social worker that she feared that harm might befall her child in the classroom. She had seen some of the signs of that happening. She claimed that on the first day of school, Stella had supposedly inhaled toxic fumes coming from the classroom and was very sick. Mercedes had decided to keep her home to keep her safe. Even today, Mercedes claimed that she would have to detoxify her daughter with a special bath routine. It became clear that Mercedes was deluded and needed mental health workers to assist her. Against her mother's wishes, the social worker decided to examine their home. To their surprise, the home was spotless but it was practically sealed all over. The social worker also found that the mother and daughter were sleeping in the corridor to avoid toxic fumes coming from one of the bedrooms. Stella did not perceive herself to be in danger but her mother seemed to be careful or too careful around her. There were only selective food items in the fridge and very few toys. An involuntary mental health assessment followed. Mercedes was diagnosed with schizophrenia with paranoid delusions. She was reluctant to be treated as an inpatient, and due to her non compliance, Stella was moved to a temporary foster home. Stella resisted this move and remained a handful for foster family. Due to their intermeshed existence so long, it was decided that upon the mother's discharge there would be a strict expectation of medication compliance, Stella's attendance at school and community events, as well as monitored home visits. After one year, Stella is in the first grade and loves her school and friends. Stella loves playing with toys and team sports. Mercedes asks her not to touch certain sports equipment in case she might get 'contaminated." However, Stella has found a new world now. She makes sure that her mother brings her to school. Mercedes although not too pleased with Stella's newly found love of friends , bows out to her daughter's wishes.Mercedes has not been very compliant with oral medications, therefore, a long acting medication that is injectable and given at monthly

intervals was recommended. These have made a remarkable difference in Mercedes; she is motivated and not too bothered about toxic fumes. Both of them attend a local church where they found supports and feel included.

Ayesha and Avi Vignette

For Practice, concentrate on Dimension 2 items on attachment security. You might be able to pick up some interesting facts on domain 1 as well.

Although most of the time , one would cover missing parts of history and observation on the second or subsequent interviews, with parents on this quadrant, one has to capture what one can during the single interview. There is much instability in the lives of parents with a personality disorder, and there is a likelihood that they might not attend the next meeting.

VIGNETTE: AYESHA & AVI

Ayesha is a pretty biracial woman who is twenty-three years old. She has never worked consistently, and she is always looked after by her friends. With no fixed abode, one would expect her to present as neglected and unkempt, but this is not the case. My first encounter with Ayesha was in the hospital emergency department when I was on night call. During that year, when Ayesha was eighteen years old, we admitted her four times for slashing her wrists, running away from a group home, and overdosing. Her past records had diagnosed her consistently as having personality disorder. The most recurring theme in previous diagnostic formulations was that of borderline tendencies as at that time she was a teenager. However, her most recent visit at the hospital emergency due to a suspected drug overdose confirmed the diagnosis of borderline personality disorder. Ayesha is presently being seen with her son Avi who is ten months old. Avi was found to have bruises on his buttocks and a questionable cigarette burn on his cheek. Additionally, this ten month old had the most outstanding hairstyle. His head was shaved in longitudinal strips similar to what one sees with some professional basketball players. Ayesha did not show any recognition of me. Her manner was abrupt and angry. She believed that her time was wasted in coming for this psychiatric evaluation. She had all

the answers for questions asked. I recalled in my mind, that as a teenager, she had undergone a psychological investigation and that her IQ was in a superior range.

This young mother came from a troubled family. Ayesha grew up in a large household with five younger siblings. Her father was not in picture. Her single parent mother minimally managed to feed the children. Ayesha's mother's boyfriend sexually abused Ayesha and her sister. Unfortunately, Ayesha and her sister were not believed by their mother who was emotionally dependent on her boyfriend. At age of fifteen and thirteen respectively, these siblings fled to the streets and were later placed in a group home. Ayesha did not attend school past grade 9 and was never gainfully employed. Ayesha managed to have relationships; some longer than others but all of them were intense. Whenever she felt rejected, her self-harming behaviour escalated. Ayesha conceived through one of these intense, stormy relationships. Her partner left her soon after he found out that she was pregnant. That set Ayesha on a revengeful vendetta. She threatened this ex-boyfriend, stalked him, and was aggressive toward him. In the end, he took out a restraining order against her. However, Ayesha's main pawn was Avi whom she believed had rights that she had to fight for.

Our psychiatric interview saw her as an angry, irrational woman. She was only concerned about how she was mistreated by Avi's father. She did not see any problem with living with different friends along with the baby. Avi was often babysat by friends who had no interest or experience in looking after babies. However, one of these friends had enough sense to alert the protection worker about Avi's bruises. Any questions regarding suspected abuse were shrugged off by her. She had explanations for everything. For example: the bruises were due to a fall and the baby was scooting around on his bum; the cigarette burn was actually not from a cigarette, but the baby had accidentally touched a candle; having a trendy hairstyle was not a criminal offense, etc. She refused to participate in a play interaction with her baby stating that she wanted her "Avi to act like a man" completly ignoring the fact that Avi was interested in colorful car and truck toys. We could not complete the interview as Ayesha gathered her son and his toys stating that it was a complete waste of her time and that she did not trust social workers, or psychologists. Her last words came off like a threat, telling me to smarten up and that she

had friends who would take care of anybody who intended to remove the child from her care.

Unfortunately, a cohesive treatment plan was not possible on that day. However, our team involved the social worker who decided to conduct random home based interview. A letter of expectation was given to Ayesha and she was encouraged to apply for a assisted housing. Ayesha was referred to a local community mental health team where she was expected to attend her weekly meetings. It also came to our attention that her mother might be moving to the city to help with Avi. I saw them again on a busy shopping area. Ayesha was walking with two of her friends and carrying Avi. She seemed happier. This time Avi was dressed as a little Elvis.
