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REVIEW ARTICLE

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# Framing the work: A coparenting model for guiding infant mental health engagement with families

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**Abstract**

When working with families of infants and toddlers, intentionally looking beyond dyadic child-parent relationship functioning to conceptualize the child's socioemotional adaptation within their broader family collective can enhance the likelihood that clinical gains will be supported and sustained. However, there has been little expert guidance regarding how best to frame infant-family mental health therapeutic encounters for the adults responsible for the child's care and upbringing in a manner that elevates their mindfulness about and their resolve to strengthen the impact of their coparenting collective. This article describes a new collaborative initiative organized by family-oriented infant mental health professionals across several different countries, all of whom bring expansive expertise assessing and working with coparenting and triangular family dynamics. The Collaborative's aims are to identify a means for framing initial infant mental health encounters and intakes with families with the goal of assessing and raising family consciousness about the relevance of coparenting. Initial points of convergence and growing points identified by the Collaborative for subsequent field study are addressed.

**KEYWORDS**

assessment, case conceptualization, clinical practice, coparenting, triangles

## 1 | INTRODUCTION

For the first time in the DC 0–5: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC 0–5: ZERO TO THREE, 2016), the relevance of the family's broader caregiving environment was formally recognized with a revised axis giving expanded attention to the caregiving context in the assessment of every infant and young child. With a dual emphasis on primary caregiving relationships and "the caregiving environment", DC 0–5 tacitly acknowledged the importance of family dynamics beyond dyadic attachment relationships as contributory to young children's development and psychopathology. Though partiality to focusing on dyads rather than larger family systems is still detectable in certain verbiage describing aims of this axis, for example, in allusions to the fit between the child and "the caregiver" (singular), the intent is incontrovertibly to capture both dyadic and system-level capacities and difficulties in case formulation.

  

While this shift marked a welcome advance, guidance for the completion of informed family assessments remains limited. With important exceptions (Keren et al., 2010; McHale & Phares, 2015; Philipp, 2012), coparenting and family assessments have yet to find their way into mainstream infant mental health practice. To help offer a bridge connecting the research-based understandings that helped inspire the Axis II revision with common clinical practice, a collaborative group of family scientists and practitioners gathered in Lausanne, Switzerland in March 2022 to reflect on how infant-family mental health efforts with families are customarily framed. The collaborative was comprised of family scholars from Switzerland, Israel, Italy, Sweden, Turkey, Canada, and the United States who collectively brought decades of expertise with evaluation of triangular dynamics in families with infants and young children. Reflecting on a generation of clinical and empirical research on coparenting and triangular dynamics during infancy, this International Coparenting Collaborative (ICC) developed and planned field testing of a research- and theory-based clinical approach to the framing of infant mental health encounters for families. The aim was to develop replicable, generalizable, and contextually valid intake guidelines that could be implemented by professionals in diverse practice settings, including guidance for (a) assessing coparental functioning and strength of family alliance, and (b) communicating with the coparents about how their unified and cooperative coparenting would be pivotally important in helping the family and child return to a healthier developmental trajectory.

This article summarizes the historical context and case for the undertaking and outlines the initial framework and planning that emanated from the Lausanne meetings. We underscore the value of approaching work with families of infants and toddlers from a family system frame from the earliest points of contact; outline a central set of coparenting constructs and dynamics that have been tied to healthy infant and toddler development in myriad empirical studies over the past 25 years; and detail the ICC's first steps toward field testing the framing and assessment blueprints in diverse clinical settings across six participating countries.

**KEY FINDINGS**

1. Practitioners evaluating young children's caregiving environments during infant mental health assessments have had little expert guidance about methods for assessing coparenting or for framing the significance of coparenting to family members.
2. A customized set of common methods, adaptable to a range of services and intake procedures and involving informant report and child-family observations may help practitioners aptly assess coparental participation, teamwork, conflict, and child focus.
3. Cross-national piloting of common methods and procedures by a team of family scholars well-versed in coparenting and triangular dynamics during infancy, engaging a broad range of families representing a diversity of family circumstances, will offer initial field-tested guidance and joint practice recommendations.

## 2 | BACKGROUND AND HISTORY

Although DC 0–5′s acknowledgment that coparenting dynamics play a vital and formative role in healthy adjustment and development of very young children marked an important turning point for the field, the family systems perspective is still relatively new. It was not until 2004 that a plenary at the World Association for Infant Mental Health Congress aptly entitled "When infants grow up in multi-person relational systems" (McHale, 2004, 2007a) drove home the reality that most of the world's infants did in fact spend their formative years in family systems and collectives where multiple adults contributed to their early care, socialization, acculturation, and core sense of safety and belonging. That analysis deliberately sidestepped dyadic frameworks and inspected new observational investigations of family triangles (Corboz-Warnery et al., 1993; Fivaz-Depeursinge & Corboz-Warnery, 1999) and coparenting dynamics in two-parent families (McHale & Cowan, 1996). It also drew connections to related scholarship highlighting the diversity of functional family constellations in which children are and always have been raised throughout history and throughout the world (McHale et al., 2002b). Studies of coparenting and family triangles, still new to the field in 2004, had begun marshaling evidence that family-level dynamics—levels of participation, teamwork, child-centeredness and conflict—could be reliably and validly assessed through observational means (Fivaz-Depeursinge & Corboz-Warnery, 1999; McHale & Fivaz-Depeursinge, 1999; McHale et al., 2000), and documenting that such dynamics uniquely and powerfully influenced infants' and young children's early psychological growth (Belsky et al., 1996; Fearnley Shapiro et al., 1997; Feinberg, 2002; Ingoldsby et al., 1999; McHale & Rasmussen, 1998; Schoppe et al., 2001).

This systemic lens was not itself new in 2004; 20 years prior, Patricia Minuchin (1985) had reproached developmental psychology's principal focus on child-parent dyadic relationships, noting that dyadic experience was not the child's significant communal reality, especially after infancy. P. Minuchin's exposition drew from several dozen seminal publications from the fields of family systems theory and therapy by Bowen, S. Minuchin, Satir and others, bringing fresh and needed perspective to child developmentalists; her treatise has been credited in over 2500 citations. However, despite its impact, contending with the venerable dyadic traditions that had served as the bedrock for the infant mental health field's development (Slade et al., 1999; Stern, 1985, Tronick, 1989), a family system conceptualization embracing the wisdom impacted in Minuchin's review never fully took hold. Indeed, it has at times even been cast as an inferior, competing frame for understanding early infant development, rather than as a parallel, necessary, complementary, and contextualizing perspective.

The preferential attention to mother-infant dyads in infant mental health practice reflects the reality that women take on the greatest share of caregiving and nurturing activities with young infants around the world. Equally, however, children's family collectives and circles of safety typically include both men and women, and in many cultural groups include both biological parents and extended blood and fictive kin (people not related by blood who may or may not live with the nuclear family but maintain familial ties—sometimes even given kinship titles, such as aunt or uncle; Chatters et al., 1994; Keefe, 1984; Stack, 1974; Sudarkasa, 1998). Coparenting adults are those who consensually invest in children and take on responsibility for their care and upbringing—some intensively, others gingerly and hesitantly—but each drawn to contribute their ongoing support to the secure and healthful development of the child. The roles these individuals play are sometimes overlapping and duplicative, in other cases complementary and distinctively growth-promoting in one particular realm or another (McHale & Irace, 2011). In each family, nonetheless, the child's sense of security, curiosity, joy, exploration, whimsy, courage, emotion regulation and self-concept are all built upon their recurring encounters with this collective of individuals.

As a collective, families can inspire in their members a sense of unity, camaraderie, and esprit de corps. However, in other family collectives there is fragmentation or conflict among the adults raising the children. Deficit collaboration, communication, and cooperation can lead to and amplify problems when children experience developmental challenges (Afifi et al., 2022; Lucarelli et al., 2012; Mazzoni et al., 2018; Minuchin et al., 1978). At a microlevel, disparate approaches by different adults in responding to crying, feeding, sleeping, toileting and other challenges can dysregulate children and aggravate problems (Fivaz-Depeursinge & Philipp, 2014; Hirshberg, 1990). At a broader level, if tension and conflict between adults is poorly contained and seeps over to impede bonds children are forming with other coparents, the risk of insecurity and attendant behavioral problems grows (Caldera & Lindsey, 2006). Since all children can, and typically do form, multiple attachments, their relationships with each adult can be either supported or opposed by the other adults within the family network (Brown et al., 2010; Liang et al., 2021).

This experience of the collective is not lost on young children. It becomes an important contributor to their own security, a context for their regulatory development and capabilities, and a support for their movement toward individuation (Byng-Hall, 1995; Greenspan & Lieberman, 1994; McHale et al., 1996, 1999). If adults in family systems where infants and toddlers are struggling can be helped to work more collaboratively together, children can benefit from the mutual, joint efforts of coparents working together as a team (Fivaz-Depeursinge & Philipp, 2014).

In summary, despite the expansive documentation that coparenting and family-level dynamics affect the emotional well-being of infants and young children, and initial consideration of ways existing research might inform family engagement and DC 0–5 Axis II evaluations (McHale & Dickstein et al., 2018), clinicians have thus far been left largely to their own devices determining strategies of approach. Coordinated guidance may hold value both in informing case conceptualization and in shaping conversations with parents about the child and their own parenting and coparenting.

## 2.1 | Coparenting within a family system framework: Initial efforts of the ICC

In March 2022, the ICC gathered in Lausanne, Switzerland for an initial set of strategic and planning meetings. The ICC's aim was to articulate a universal means of approaching, appraising, and communicating with families about the relevance of coparenting within the child's family system. An overview of the ICC initiative is provided in Table 1. The ICC limited its emphasis to case conceptualization, not appraising and delineating options for approaches to treatment. At present, multiple evidence-based interventions—including child-parent psychotherapy, coparenting consultations, marital counseling, parent training, reflective family play, and numerous other tested methods—all have potential for helping families with different circumstances. Rather, the ICC's explicit intent was on developing guidelines for framing infant-family mental health interventions for

**TABLE 1** ICC planning and implementation timeline.

| Activities | 2021–2022 Dec–Feb | 2022 March | 2022 March–Dec | 2023 Jan | 2023 Feb | 2023 Jan–June | 2023 July–Dec | 2024 Jan–June |
|---|---|---|---|---|---|---|---|---|
| Preliminary planning for collaborative, partner identification and agreements, literature, and concept review | X | | | | | | | |
| Weeklong in-person conference in Lausanne for consensus concept, measurement, and timeline development | | X | | | | | | |
| Monthly virtual meetings to develop training, protocols for intake procedures, data recording and reporting, data sharing and human subjects considerations | | | X | | | | | |
| All common written protocols and recording documents vetted and finalized | | | | X | | | | |
| All site material translations finalized, arrangement with collaborating regional professionals completed | | | | | X | | | |
| Pilot testing commences when sites are ready, monthly virtual procedural and data review meetings continue | | | | | | X | | |
| Ad-hoc minor revisions to protocols, documentation of coparenting conversations during interventions, follow through with families to obtain case closing perceptions of value of the coparenting frame | | | | | | | X | |
| Replication of initial programming and revised protocols with new sites | | | | | | | | X |

families, focusing on the assessment and conceptualization of coparenting within a family system framework.

Observations of the family are fundamental to building an understanding of coparental dynamics and functioning. The common denominator that brought ICC collaborators together was their wealth of expertise with a paradigm and procedure called the Lausanne Trilogue Play (LTP; Fivaz-Depeursinge & Corboz-Warnery, 1999) in their collective clinical and research efforts. The decision to center the LTP in the ICC initiative owed to the paradigm's extensive empirical research base with families of infants and toddlers. For over a quarter century, the LTP has been the subject of carefully controlled studies carried out by trained experts familiar with the implementation of the LTP assessment and the coding of the clinical data it yields. Moreover, over the past decade, the LTP has been creatively used in novel research and clinical contexts (McHale et al., 2018). There is hence a growing appreciation among those most conversant in its history and use that the LTP might serve as the important anchor needed by infant-family mental health professionals seeking to evaluate coparenting and family alliances at the point of clinical intake. While there was consensus among the ICC that LTP evaluations alone would be insufficient in yielding the depth of information practitioners would require to understand and communicate with families about family functioning, as a core evaluation tool used in combination with a small collection of other dyadic observation and parent-report measures, its merits as an observational procedure remain unparalleled.

In the LTP procedure, parents and child are asked to navigate in succession four distinctive parts: (a) First, one parent (the "Active Parent" or AP) plays with the baby or young child while the other parent (the "Third Party Parent" or TPP) is simply present; (b) Second, the parents switch roles—TPP becomes AP and AP takes the role of TPP; (c) All three family members play together, with no one in a Third Party role, and finally; and (d) both parents are Active and the baby is placed in the Third Party position. Parents are advised that they can decide when to transition from one part to the next and that sessions generally last about 10–15 min. Sessions are videotaped, and afterward the family is invited to receive video-feedback.

In the standard LTP program of work pioneered by Fivaz-Depeursinge and Corboz-Warnery, and explicated in dozens of published studies that followed (for review, see McHale et al., 2018), families are evaluated with respect to the following four levels:

1. Participation: holding in mind the ascribed role that was assigned to each family member in each part, the practitioner asks: was everyone participating? This level is formally assessed largely by attending to nonverbal signals exhibited by each family member signifying their readiness to interact (i.e., by observing their bodies, postures, and faces).
2. Organization: again, keeping in mind the ascribed role assigned to each family member in each part, the practitioner asks: did the family members keep to/respect the different roles they, and others, were assigned in each part of the LTP (e.g., what was visibly observed in their non-verbal signals as they enacted their ascribed roles? Were they able or unable to refrain from interference during the respective 2 + 1s)
3. Focalization: did the family members identify and share a common focus? Was everyone cooperating, and what was noticed in participants' non-verbal signals during games? Did the adults consider the child's initiative? Was there room made for, and engagement shown, in turn-taking?
4. Affect Sharing: to what extent did the parties share positive affect during play, and how did they respond to negative affect? What could be discerned by focusing on participants' affective signals across communication modalities (verbal, facial, gestural)?

In studies of family alliances, there is a focus on the degree of coordination that two parents and a baby or child reach when sharing a task together, sharing pleasure and being together (Fivaz-Depeursinge & Corboz-Warnery, 1999; Fivaz-Depeursinge & Philipp, 2014). Such studies examine not just the adults but also the infants' contributions, especially use of gaze and affect signals, and show that babies generally tend to privilege one parent during LTP Parts 1 and 2 and to address both parents more equally in Part 3. This concerted attention to the baby's contributions is a unique element in studies of family alliances; the prime focus in coparenting studies, by way of contrast, is usually on coordination, teamwork, and solidarity between parents while they are interacting with the child (McHale & Lindahl, 2011), As in family alliance studies, key indicators include observed balance of parental participation, interference and other signs of coparental conflict, coparental cooperation, and teamwork and affect sharing. Though infant contributions are not as carefully documented, coparental responsiveness to the baby's signals has been pivotal in coparenting studies. Constructs including competition, cooperation, verbal sparring, differential levels of parental involvement, family warmth, and child (vs. adult) centeredness have all been systematically investigated and tied to multiple important indicators of child and family functioning (e.g., McConnell & Kerig, 2002; McHale, 1995; McHale et al., 2000).

Synthetic review of the empirical literature during the Lausanne meetings led the ICC to establish engagement, teamwork, conflict, and child focus as prime higher-order considerations relevant to the assessment and framing of coparenting in infant-family mental health efforts. Levels of participation by different coparents, coparental cooperation and teamwork, coparental conflict and presence of child-centered focus in the family each meaningfully capture different features of coparental structure and function (Fivaz-Depeursinge & Corboz-Warnery, 1999; McHale & Dickstein, 2019; McHale & Fivaz-Depeursinge, 2010; McHale & Lindahl, 2011; Teubert & Pinquart, 2010). Although formal observational coding systems were discussed as one resource that might provide initial guidance to practitioners unfamiliar with the hundreds of studies of coparenting and family triangles during infancy, ICC members agreed that formal research-based coding or rating systems should not drive this initiative. Rather, the ICC set out to summarize concepts of engagement, teamwork, conflict, and child focus in enough detail to equip clinicians and lay providers with a sufficient grasp of these concepts. The following summaries emanated from these discussions.

1. *Engagement*: A fundamental aim in systematic observational studies of family triangles has always been to establish (a) whether all family members are engaged and (b) if not, how not. In observational contexts, the first question always precedes the second—disengagement, withdrawal, and exclusion are all terms that have been used to describe the phenomenon of one (or more) family member appearing to be less connected during triangular interactions than others. These terms do not all have the same meaning, and the determination of why one (or more) family members appear less engaged than others usually must be an ongoing question in the work. Ultimately, it is important to determine whether each person has the opportunity for equal interest, engagement, and access. Though for expedience's sake asking a single informant (most commonly, the mother) to describe engagement and access patterns of all others in the family has historically been commonplace in both research studies and in everyday clinical work prioritizing services to mothers, the view of any single person is typically biased and

insufficient and hence should not supplant systematic observations of the family group process.

2. *Teamwork*: For each family, cooperation (or lack thereof) between the coparenting adults is important to understand at both a surface and deeper level. Almost all observational coding systems include scales intended to rate cooperation from observations of support, turn-taking, and respect for the other coparent as an engaged partner with the child. One parent will frequently be observed to show more engagement or activity with the child in certain situations than the other, and this disparity is common—perhaps even normative. Symmetry and balance are less important in evaluating teamwork than is the regard with which members are held, and whether each coparent sees and endorses the other(s) as a fully participative and needed member of the team. This inclusivity of the stance by each coparent towards the other(s) is important to assess in determining whether coparents are on the same page, and whether disparate parenting aims are being or can be coordinated.
3. *Presence/absence of conflict*: The opposite of respect for the other is disrespect for the other, and such disrespect can be glimpsed in many different forms. Competition and verbal sparring during family interactions; conflict-like behaviors that recur, are sustained, or escalate; third party parent interruptions during the LTP; derogatory or disparaging comments made to the child in private about the absent coparent; and unrepaired dissonance during face-to-face interactions with the child can all be disorienting, confusing and harmful for the baby. Identifying such behaviors, so that they can be drawn to the attention of the coparents themselves, is an essential component of coparenting and family assessments. Greater mindfulness enables parents to better distinguish and intentionally limit or eliminate such behavior.
4. *Child focus*: One of the greatest delimiting factors in lay views of coparenting is a misconception that coparenting is a dyadic, couple-level construct. It is not. While couples coparent, so too do adults not in coupled relationships, and coparenting is always (at minimum) a triangular construct involving two adults and a focal child. The essence of growth-promoting coparenting is not just whether the adults are themselves agreeing and getting along with one another, but whether they are showing adequate attunement to the child and their needs. When observed in the LTP, quality of child focus can be estimated from adults' recognition and affirmation of the child's contributions during the interactions. Such attentiveness is significant even before a child is old enough to show intentionality of initiative. Particular attention in LTP coding has been given to adults' recognition and affirmation of child emotion (Hedenbro, 2006; Hedenbro & Lidén, 2002). Associated concepts that may be related to child focus include quality of parental scaffolding, child (as opposed to adult) centeredness of interactions, joint parental attunement, and over- or under-stimulation. In a family group where the coparenting team members are adequately meeting the child's developmental needs, each coparenting adult sees the child accurately, agrees on what the child needs, and collaboratively work in alliance to help to meet the most pressing of those needs.

With core concepts defined, the ICC discussed the importance of adequately sampling from different informational sources to build the most clinically useful perspective on the family and its coparenting structure and dynamics. ICC members recognized that the framework would need to include explicit guidance on engaging the family, strategies of assessment, and digestible guidelines for interpreting data for practitioners unfamiliar with the LTP- and coparenting-related empirical literature. The next section reviews preliminary guidelines for gathering and synthesizing relevant data, so that products of the evaluations can be used with diverse families to discuss the nature and impact of parenting and coparenting.

## 2.2 | Assessment: Standardizing an approach to evaluate coparenting

### 2.2.1 | Establishing who the family's coparents are

A first step to understanding the child within their family system involves accurately identifying who the child's most important coparents are (McHale & Irace, 2011). The answer to this question is best provided through the eyes of the child. In families led by two co-residential parents or parenting figures, who provide only limited and judicial access of children to others outside the household, identifying the child's main coparents is usually relatively straightforward. However, when children develop affectional and attachment bonds to one or more other regular caretakers, it is important to assess and determine the roles these individuals play in the family system and dynamic.

Moreover, different children within the same family can have different coparenting adults in their network and circle. This can be the case when one or more children differentially spend regular time in the care of blood or fictive kin, with a non-residential parent and their extended family network, or even with a caregiving neighbor or trusted

family ally during lengthy periods when the parent or parents are inaccessible (McHale & Irace, 2011). Also seldom considered—but extremely important—is the fact that two siblings in the same family who share the same pair or set of coparenting adults who have committed to them can nonetheless have quite different experiences of being coparented by those adults (McHale, 2007). Understanding who is coparenting the child and the intensity of their connection with that child is hence an indispensable first step to understanding the child's relational experiences in the world.

As part of their initial collaborative field testing of the common assessment framework, the ICC is obtaining a visual representation of who is in the child's relational network (a hand-drawn ecomap; McHale & Dickstein, 2019) from each coparent at the time of intake. Scripted guidelines and uniform instructions for administration are being used. Ecomaps can help visualize who the most appropriate coparents are to invite to take part in the LTP—as typically only two adults participate with a focal child. In orienting family members to ecomap completion, clinicians explain that children's coparents are not any adult who has ever met or taken interest in the child. Rather, they are the individuals who the child (if asked) would count as their most important "heart connections" (McHale & Dickstein, 2019).

It is not uncommon for different coparents to differentially estimate which adults are most important to the child; in cases where this happens, discrepancies in how the coparenting adults themselves understand their child can be of considerable clinical interest. Only after accurately conceptualizing the makeup of the child's coparenting system can the most useful determinations be made about who to involve in the work that follows, and in what ways. Understanding the coparenting collective also allows the work of documenting coparenting functioning and dynamics to have greater contextual validity and grounding.

### 2.2.2 | Conducting observations of engagement, teamwork, conflict, and child focus

To systematically observe the family's coparenting organization and dynamics, the ICC agreed that all collaborating sites would carry out a structured procedure honoring the four parts of the LTP—while also affording individual sites and practitioners with opportunities for adaptation to meet unique needs and configurations of families. This decision was made with due deliberation; adapting any existing research-based paradigm to suit clinical applications necessitates "second level change" (Watzlawick et al., 2011)—transferring known strategies and tactics to a novel context, and possibly expanding known rituals to explore unknown territory. Though outcomes of such adaptations cannot be known until the changes are accomplished, successful adaptations to the LTP procedure were earlier made in Israel and Toronto by two of the collaborative participants and contributing authors to this article (Keren et al., 2001; Philipp, 2012).

Participating sites will keep to the original 4-part LTP procedure for many to most families, with practitioners permitted to adjust as needed to honor different family constellations and configurations. For example, if a setting or practitioner found coparents unable to engage together in Part 4, the coparents might be redirected to retry Part 4 (for a relevant illustration, see Fivaz's "trial intervention" in Fivaz & Philipp, 2014). Creative ad-hoc additions to standard procedures can help establish whether coparenting capabilities exist even if they were not spontaneously displayed.

The ICC has also developed guidance for practitioners when evaluating LTP interactions. This guidance has been formalized as *"Guidelines for Observing Family Alliance Play" (FAP)* and accommodates the multiple different ways of interacting in a group. While there will always still be four Parts in the LTP's coparent-infant trilogue play, in larger groups, there may be many more additional ways of interacting. As the variety of ways will each hold importance, ICC protocols would allow a practitioner to consider adapting the LTP so that no pivotal family member would have to be excluded from participation in the assessment. One common circumstance may be adapting to include a second sibling (see also below), though there may also be circumstances involving more than two coparents (e.g., a co-residential couple and a live-in grandparent who assumes caregiving roles). To allow for the possibility that coparenting collectives caring for infants and young children may number more than two adults, the qualifier *infant/young child-coparenting constellation* (IYCCC) was adopted as a second moniker for the coding system being implemented by the ICC. For the remainder of this article, and in the initiative that follows, we will refer to the ICC's coding guidelines for evaluating adapted LTP procedures in the variety of practice settings as the Family Alliance Play-Infant/Young Child Coparenting Constellation (FAP-IYCCC).

There is another new procedural advance being tested out and evaluated across participating sites. Besides assessing family strengths and areas of challenge as coparents and children negotiate the LTP, participating sites will also attempt to informally observe and document noteworthy tendencies and themes exhibited spontaneously by the coparents and children twice—as they engage in the waiting area prior to completing the LTP procedure (i.e., during

an instructions/orientation stage when parents sit together with the child, but informally); and then again once the LTP ends (i.e., during a short wrap-up and debriefing with the family when coparents sit together with the child, engaging informally and naturally). The ICC has developed preliminary guidelines to help practitioners know what to cue into during these informal observations of coparenting tendencies, assets, and challenges.

While in most cases a three-person LTP will constitute the intake assessment of family functioning, and initial protocols the ICC will generate will begin with triangles, conceptual and logistical issues of circumstances where there are more than two coparents and/or two or more children will be more fully considered as the ICC initiative evolves. Several ICC members have had extensive experience with such circumstances and a variety of resolutions may be possible. For example, in one of the performance sites (Toronto, Canada), a Family Play rather than a trilogue play session modeled on LTP principles is frequently used if families have two or more children, as often major issues are best identified in the context of siblings (Philipp, 2012). When families have coparenting collectives involving more than two adults, coparents could be asked directly the most important people to include in an LTP assessment.

Alternately, as in one Turkish adaptation (Salman-Engin et al., 2018), families might be invited to complete dual LTPs (e.g., one with mother-father-baby, a second with mother-grandmother-baby). Salman-Engin and colleagues' adaptation respected a cultural norm wherein maternal or paternal grandmothers are often as or more engaged in coparenting and sharing caregiving with mothers during the baby's first year than children's fathers (whose involvement normatively intensifies post-infancy). In short, future guidance may speak to a wider variety of coparenting circumstances, though the initial set of guidelines being developed by the ICC involve standardizing intake guidance and protocols for a target referred child with two active caregivers.

### 2.2.3 | Obtaining self-reports of each coparent's personal contributions to coparenting teamwork and conflict

ICC members agreed that both insider (coparent) and outsider (clinician) views of the family would be important to obtain (McHale et al., 2002a), and concurred that parents' representations of and mindfulness about their own contributions to coparenting would be a pivotally important consideration in case conceptualization and treatment planning. Specifically, plans were made to evaluate what parents see and consciously know about how they coparent. While there have been research-based interviews developed to explore parents' representational models of coparenting (Kuersten-Hogan & McHale et al., 2021), most parsimonious for clinical settings is for practitioners to obtain individual adult self-reports of coparenting.

Different instruments exist, with different emphases. Some are focused on each coparents' experience of the other, the respect they feel and the teamwork they perceive between themselves and a primary coparent (Abidin & Brunner, 1995). Others are focused more directly on parents' own overt and covert coparenting actions in the presence of their children (e.g., McHale, 1997; Coparenting Scale-Revised for practitioners). But having the adults deliberatively reflect on what they themselves do to facilitate, or to hamper positive coparenting offers a major advantage.

In one of its more important decisions, ICC members agreed that each pilot site would follow up intake assessment sessions with at least one feedback meeting for the family. During that meeting, the practitioner reviews with the coparents what each of them learned about their own coparenting instincts from the coparenting instrument completion and the LTP assessment, toward a goal of elevating both mindfulness and intentionality. It is during this feedback meeting that the relevance of coparenting teamwork for the period of upcoming therapeutic work is made explicit and emphasized. Moreover, talking about coparenting in this deliberative way sets a stage allowing conversations about coparenting to be invoked episodically throughout the ensuing work. Because the initiative is making no attempt to influence the nature of the interventions families receive, the ICC expects the frequency and duration of coparenting conversations during the intervention phase to vary across sites. However, the uniform framing of the work makes the opportunity equally available to all.

### 2.2.4 | Obtaining and comparing coparents' perceptions of the child's behavioral strengths and concerns

Infants and young children typically find their way to infant mental health professionals because of some developmental, emotional, or behavioral concern, and a standard component of most intake procedures in clinics is an appraisal of the child's current symptomatology and parental concerns. Common practice is often for just one informant (most commonly the child's mother) to complete an intake questionnaire regarding her behavioral concerns; her report then serves as the family's consummate statement about the child. Far less common

in clinical practice is the obtaining of equivalent informant report data, separately, from multiple coparenting adults, with a review of the similarities and inconsistencies of each parent's perceptions afterward. This is unfortunate because parent perceptions can differ markedly. More pointedly, the degree of the difference between parental reports is greater when there is greater coparenting conflict in the family (McHale, 2007b).

The ICC hence agreed that each of the participating sites would adapt customary practice to obtain individually completed surveys from each coparenting adult. Subsequently, during the feedback meeting, the practitioner would identify which elements of their reports were similar and which differed between them to seed discussion of the child's emotional and behavioral needs. There was consensus that it would be important to obtain the initial reports independently, rather than questioning both adults together about the child. The dynamics of joint interviews are such that a coparent may see a concern differently from the other but remain silent and accede to the viewpoint presented by the other without ever voicing that they view the concern differently (c.f. Darwiche et al., 2022). By obtaining child reports separately and then providing coparents a chance to review areas in which they may genuinely disagree (e.g., presence of internalizing symptoms like depression or anxiety; context for a child's aggression), the practitioner is in a position to help coparents recognize how they may each perceive—and hence potentially respond differently to—different aptitudes and struggles. Again, discussing these differences in the penultimate feedback session helps frame the importance of coparenting accord and cooperation for the ensuing work ahead with the child.

In summary, the ICC agreed upon a small set of common approaches and measures that all participating sites will use to evaluate coparenting. Common across all sites at intake will be:

- An assessment of who's in the child's family circle (ecomaps)
- Completion and evaluation of three coparenting observations (i.e., informal coparenting exchanges in the waiting room/intake area, formal assessments as families complete the LTP procedure, and informal interactions again with their guard lowered during the immediate post-LTP debrief)
- Self-reports from all coparents (minimum two coparenting adults) regarding their perceptions of their own coparenting/coparenting behavior, and
- Reports from all coparents (again, minimum two) of how they see the child's strengths and problem areas using whichever standard instrument the service already employs for their intake (e.g., the Child Behavior Checklist 1 ½–5, The Infant and Toddler Social and Emotional Assessment (ITSEA), the Devereux Early Childhood Assessment (DECA) Infant and Toddler, or any other tool that is normally used).

## 2.3 | Initial rollout and implementation steps

With the groundwork agreed upon in Lausanne regarding core constructs and common measurement approaches to assess coparenting in clinical contexts, ICC members set about developing protocols in the winter of 2022–23 (see Table 1). These efforts included creating the common intake framework and assessment guidelines and drafting consensus scripts, protocols, and written guidance to be implemented across the participating sites. ICC sites began seeing families in early 2023 in Lausanne, Switzerland; Stockholm, Sweden; Rome and Pavia, Italy; Toronto, Canada; Safed, Israel; Georgetown, (D.C.) and St. Petersburg (FL), USA. During this startup phase, additional LTP expert contributors from Switzerland and Turkey continued to serve as advisors and team members.

The sites participating in the initial pilot implementation phase offer diverse clinical and professional settings serving families of infants, toddlers, and young children. ICC partners are each conducting a systematic intake and evaluation of the utility of the new framework with up to five families who are to be comparably assessed at each site. At all sites, assessments will be carried out in everyday professional and clinical settings and contexts. The work is not being relegated to experts or institutional settings that already have substantial expertise and familiarity with the LTP or with coparenting assessments in research labs. Since a primary goal of this initiative is to provide guidance for "novice" practitioners to help them carry out coparenting assessments that will be useful diagnostically, the ICC's pilot field testing is being conducted in naturalistic settings and is engaging actively practicing professionals. ICC members themselves (the authorship team for this article) will be providing necessary clinical oversight, consulting, and engaging in any ways that makes best sense for the various settings.

Of interest will be the feasibility of uptake, acceptability of protocols and procedures to practitioners and families, and experiences of sites as they adapt existing intake procedures to overlay the new family frame. Sites are relying on common customized protocols to guide the way they introduce family assessments to new clients, on shared written guidance for reviewing and synthesizing evaluation data, and on a standardized procedure for collating products of the evaluations to communicate with the coparents about

their family, parenting, and coparenting. The aim of the written guidance is to help novice practitioners develop a complete-enough picture of existing family assets and challenges to facilitate a fruitful feedback meeting with parents to talk about their coparenting alliance and its value to their child. Afterward, parents are providing brief ratings of how useful they found the family system framing for their child's situation, and practitioners are using evaluation forms to assess how successful they believed they were in raising parents' consciousness about the family's coparenting alliance and its impact on the child. Especially instructive will be the sites' and practitioners' distinctive experiences in utilizing the intake data to frame productive coparenting conversations with families. Preliminary written guidelines being used to standardize the intake procedures across sites and guide conversations with families will be updated in real time over the next year, as partnering sites collaboratively establish effective practices for engaging with families.

## 3 | CONCLUDING COMMENTS

The purpose of this article was to provide the context for, and a preliminary precis of, a new initiative being carried out by an International Coparenting Collaborative to develop a common, contextually valid initial "framing" of infant mental health encounters to accentuate the importance of coparenting. The ICC identified core constructs and accompanying common measures, and developed guidance regarding scripts and procedures to help professionals at eight participating sites across six different countries to:

- Ground themselves to help inculcate an understanding about coparenting and its impact on the child's emotional health and adjustment among all relevant caregiving family members in the child's caregiving system.
- Follow guidance for how to explain these concepts to family members upon intake.
- Follow guidance about how to obtain relevant self-report and observational data regarding the family's coparental dynamics as they are currently manifested.
- Follow guidance about how to effectively collate this information and use it to provide helpful feedback to the family in the service of elevating parents' own mindfulness about their coparenting process.

The ICC initiative is still in its infancy. It is not properly considered a "research study" in the traditional sense, tethered to immutable protocols or constraints to innovation. This is because the goal of the entire initiative is to explore and uncover viable ways for practitioners to successfully engage with adults around coparenting in infant mental health work. The LTP is serving as an anchor assessment that stands to have great meaning for families if they can be helped to recognize what the assessment reveals about their coparenting inclinations with their child. Among the ICC's development efforts will be issuing general guidance for practitioners in LTP reviews in the form of the FAP-IYCCC. However, while there will be shared guidance for framing, for common sets of instructions, and for approaching intake data reviews with families, there will be few precision protocols or scripts, as the effort will be an iterative process with ongoing reviews and input from ICC members (Table 1).

Of particular interest in the field-testing phase will be implementation successes and challenges, and practitioners' evaluations of initial successes in elevating family members' consciousness about coparenting in their family. As the initiative progresses, additional instruments will be developed offering guidance for how to document, in an ongoing way, the regularity with which coparenting issues are attended to (if at all) in the intervention work itself, and for how to close out the work with the family by circling back to have them reflect on any changes or progress they may have noted, or might hope to continue to make, in strengthening collaborative, child-centered coparenting.

During the initial pilot phase of implementation, however, the ICC's top priority will be in establishing the feasibility of conducting the assessments with diverse families across diverse settings. An important part of the initial effort will involve evaluating how well the common assessment spoke to families and helped to frame and guide the work with them—and those cases in which it was less successful—and why. This iterative process will allow the ICC to pull together initial determinations regarding where things could have been done better, and whether changes to the shared "protocol" might be advisable for different kinds of families or child disturbances. It is expected that the ICC may have unique opportunities to reflect on certain understudied populations at given sites. The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0–5) seeks to classify mental health and developmental disorders in children birth through five in relationship to their families, culture and communities. It is for this reason that the ICC includes various team members deeply experienced with and familiar with the cultural groups that their clinics and professional services most closely serve. The cultural diversity will permit relevant conversations, comparisons, and recommendations as the initiative progresses.

One explicit initiative planned across the two United States sites will involve detailed examination of the intake process and assessment procedures with a subset

of Black/African American families seen in community clinics in St. Petersburg and Georgetown, D.C. Pursuing coparental perspective and voice, case data will be reviewed by a collaborative team consisting exclusively of Black male and female infant-family mental health professionals working in concert with—but also independently from—the larger ICC collective. Because so much of the foundational research with triangular and coparenting assessments within the infant mental health field has followed from investigations of white, coresidential middle income European heritage families, the opportunity to incrementally expand the knowledge base to include more diverse families—at the same time as the ICC works to develop general guidelines for the international— community is a unique one that will afford beginning new glimpses into family structures and dynamics that have been understudied since the field's beginnings.

## CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest. The conceptual phase of the ICC initiative described in this report is Not Human Subjects Research; no human subjects approvals indicated.

## DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

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