



Enhancing coparenting using video feedback: Consensus guidelines for infant and preschool families

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Abstract

Objective: An International Coparenting Collaborative (ICC) was formed to develop consensus guidelines for incorporating a coparenting frame into clinical practice with families of infants and preschoolers.

Background: Historically, early childhood mental health practice has primarily focused on mother–child dyads. With growing evidence highlighting the impact of coparenting quality on infants' and preschoolers' mental health, practice innovations involving coparents and whole families have emerged.

Method: Lausanne Trilogue Play (LTP), a well-established observational tool, can be used to assess coparenting and family interactions in very young families. Four evidence-based coparenting dimensions—coparental engagement, teamwork, conflict, and child focus—are observable during an LTP and selected vignettes can be used to provide video feedback to coparents.

Results: Overarching principles to frame the filming of families playing in the LTP and to provide coparents with video feedback are outlined. A case example is included to illustrate the potential of this method.

Conclusions: This report contributes helpful guidelines for using LTP video feedback to enhance coparenting across diverse practice settings serving the infant and preschool population.

Implications: Consensus guidelines on observational methods that include coparents and other family members

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in early childhood mental health practice can help advance both clinical practice and research.

KEYWORDS

coparenting, family dynamics, infant and preschool mental health, video feedback intervention

In recent years the field of infant and preschool mental health has seen heightened interest and recognition of the importance of coparenting in families and its impact on the well-being of children. In 2022, a multinational collective of leading coparenting and family scholars, all well-versed in the Lausanne Trilogue Play (LTP) observational method for assessing family triangles during infancy and the toddler years, began meeting together to address existing gaps in the infant–family mental health field.

OBJECTIVE

The International Coparenting Collaborative (ICC), comprised of family clinicians and scholars from seven different countries, examined the existing coparenting literature, with an eye on coparenting dynamics observable in families across cultures. One of their main objectives was to provide big-picture guidance for practitioners interested in using observations of families of infants, toddlers, and young children in their initial intake evaluations and case formulations. ICC members, each of whom brought extensive clinical and research expertise using the LTP observational method to understand and strengthen infant–family mental health, sought to identify a common framework that included core observational components, had applicability in diverse clinical contexts, and would be useful to infant mental health practitioners, regardless of theoretical orientation. From this collaborative effort came an initial set of consensus guidelines specifically for clinical use of the LTP (McHale et al., 2025; McHale, Tissot, et al., 2024).

BACKGROUND

Historically, the role of the mother–baby dyad has been central to our understanding of infant development (Ainsworth, 1969). However, the past 30 years have seen a major shift in focus to the role of the whole family as a distinctive and dynamic force uniquely shaping infant and preschool mental health (McHale & Cowan, 1996; McHale & Fivaz-Depeursinge, 1999). In particular, the impact of the coparenting relationship within the family has received substantial attention (McHale et al., 2023; ZERO TO THREE, 2016).

Coparenting

Coparenting is defined as the mutual, shared efforts by the two or more adults who assume responsibility for children’s socialization, care, and upbringing (Feinberg, 2003; McHale et al., 2002). This broad definition is an inclusive one that honors a wide variety of family constellations and encompasses the efforts of most families worldwide, in which children have bonds with multiple caregiving adults—regardless of those adults’ marital status. Indeed, any adult who assumes a protective role and is regularly and meaningfully involved in the enterprise of coraising a child can rightfully be considered the child’s coparent (McHale & Jones, 2021). Of note, although our definition of coparents is quite broad, the primary focus of work to date

on coparenting has been on biological, adoptive, step, and separated parents, as well as biological parents who were never together but nonetheless coparent. Though the focus of this paper is on parents as the coparenting definition, the ICC model is flexible enough to include multigenerational and other functional coparent and family constellations.

The concept encompasses both the positive aspects of collaborating to raise a child or children, characterized by support and coordination, as well as the challenges that child-related conflict and competition can bring (Nunes et al., 2021; Teubert & Pinquart, 2010). Although in many families features of the coparenting relationship overlap with similar elements of a marital relationship, and these two family subsystems impact one another reciprocally in both positive and negative ways (Christopher et al., 2015; Favez & Frascarolo-Moutinot, 2013; Talbot & McHale, 2004), the two are also distinct (Feinberg et al., 2012). For example, couples who are no longer married or living together, as well as couples who were never married or coresidential, nonetheless forge coparenting alliances that can vary in quality and sometimes even be quite strong (McHale, 2009; Til Ogut et al., 2021). The converse can also be true; those in a strong couple relationship can and sometimes do struggle as coparents (Darwiche et al., 2022; Fivaz-Depeursinge & Philipp, 2014). Further, couples do not necessarily coparent each of their children the same way, and the emotional system in different coparent-child triads can be different in the same family (McHale, 2007). Finally, coparenting has been established as an independent predictor of child adjustment, even after controlling for the quality of the couple relationship (Teubert & Pinquart, 2010).

Since the seminal observational studies of coparenting in the family system in the mid-1990s, there has grown a large body of research documenting the impact of coparenting and whole family dynamics on young children's development (Cowan & McHale, 1996; Feinberg, 2003; McHale & Lindahl, 2011; Parkes et al., 2019; Schoppe-Sullivan et al., 2023; Teubert & Pinquart, 2010). In a meta-analysis of more than 50 studies, most of which examined families of infants and preschoolers, Teubert and Pinquart (2010) established that coparenting was an independent predictor of numerous key indicators of child psychological well-being, including social functioning and security of attachment. Coparental conflict was reliably correlated with externalizing behavioral problems and symptoms in children. Later, Parkes et al. (2019) combined results from the UK Millennium Cohort Study ($N = 5,779$) and the U.S. Fragile Families and Child Wellbeing Study ($N = 2,069$) to also explore this question. Coparenting measures were obtained during early infancy and between 2 and 5 years of age. They then looked at child behaviors at age 8–10 (using both parent and teacher reports) and consistent with the analyses completed by Teubert and Pinquart (2010), found that elevated child externalizing behaviors were correlated with problematic coparenting relationships earlier in childhood. From these longitudinal analyses they concluded that helping parents work on their coparenting early on may be one way to mitigate the emergence of childhood behavioral problems. Other studies exploring the impact of coparenting on older child and adolescent adaptation have likewise consistently found that cooperative coparenting promotes better outcomes at older ages, as well (for reviews, see Abraham et al., 2017; Teubert & Pinquart, 2010).

This longitudinal work has been particularly important in this evolving field with several studies demonstrating that without intervention, families' coparenting trajectories tend to remain stable across time (Favez et al., 2012; Feinberg et al., 2012; Hedenbro, 2015; Le et al., 2016; McHale, 2007; Schoppe-Sullivan et al., 2004). Clinical interventions have thus been designed to support whole families—that is, coparents together with their infants and preschoolers—with the aim of improving child outcomes in families that are struggling (for a review, see Fivaz-Depeursinge & Philipp, 2014). However, these interventions continued to take a back seat to infant mental health interventions that focused principally on one parent and child—most commonly, the mother-child dyadic relationship (Lieberman et al., 2000; Philipp, 2012). Although Fabiano and Caserta (2018), in a systematic review of 64 studies, found that fathers were now more often included in programs that targeted improving

parenting, there still remained relatively fewer studies examining more systemic determinants of family outcomes, such as coparenting.

To summarize studies that had focused on intervening to improve coparenting, Nunes et al. (2021) carried out a meta-analysis of interventions specifically targeting coparenting, including some families with infants and preschoolers. Programs were characterized as largely psycho-educational in nature (Doherty et al., 2006; Shapiro & Gottman, 2005), with some offering skills training around communication and conflict resolution (Faircloth & Cummings, 2008; Feinberg & Kan, 2008; Halford et al., 2010; Miller-Graff et al., 2016) and/or brokering coparenting plans around disputed issues, such as division of labor (Doherty et al., 2006; Gjerdingen & Center, 2002; Halford et al., 2010). Although overall there were improvements on self-report measures of coparenting support, romantic satisfaction, parents' stress, and positive parenting, no changes were seen in child outcomes (Nunes et al., 2021). The authors have proposed that this unexpected absence of benefits for children might have been due in part to the focus on child behavioral outcomes in most of the studies, rather than on emotional ones. Furthermore, they noted that only nine of the 16 studies selected for the meta-analysis had even included child outcomes at all. We would add that although the authors underscored the central role of child symptom improvement for these interventions, in none of the studies reviewed were the children themselves included in the intervention. Moreover, all of the measures of coparenting were obtained via self-report, with no studies obtaining observations of family interactions.

Though the early childhood field saw heightened interest and recognition of the importance of coparenting in families in the 2010s and 2020s, at present it is probably safest to conclude that early attempts to improve child behavior problems by enhancing coparenting have achieved only mixed success. In part this may be because research and clinical interventions that never see coparents together with their child, or that rely excessively on parent report measures, miss out on the essential impact of multiperson family dynamics, particularly impactful when children are very young. In 2022, a multinational collective of leading coparenting and family scholars, all well-versed in the LTP observational method for assessing family triangles during infancy and the toddler years, began meeting together to address existing gaps in the infant–family mental health field. This International Coparenting Collaborative (ICC), comprised of family clinicians and scholars from seven different countries, examined the existing coparenting literature, with an eye on core coparenting dynamics observable in families across cultures. One of their main objectives was to provide big-picture guidance for practitioners interested in using observations of families of infants, toddlers, and young children in their initial intake evaluations and case formulations, regardless of their theoretical orientation. From this collaborative effort came an initial set of consensus guidelines specifically for clinical use of the LTP and to identify several relevant coparenting dynamics of particular interest to infant mental health clinicians (McHale et al., 2025; McHale, Tissot, et al., 2024).

The ICC identified four readily observable core components or dimensions of coparenting that can be seen during any LTP interaction. These four dimensions—engagement, coparenting teamwork, coparenting conflict, and degree of child focus—are also higher-order concepts that have broad applicability and clear traditions in many observational systems inspired by family process theory (Broderick, 1993). Whereas certain transactional aspects of coparenting—such as the pursuit of greater egalitarianism in the division of childcare responsibilities—may carry more weight in some cultural contexts than others (see Feinberg, 2003; Van Egeren & Hawkins, 2004), and more abstract, clinically derived constructs—like family boundaries—often require significant interpretation and may differ in meaning across cultures (see Margolin et al., 1998), patterns of engagement, teamwork, conflict, and child focus tend to be clearly recognizable and readily understood across diverse cultural settings (McHale, Coates, et al., 2024). In outlining the common framework developed for infant–family mental health intakes, the ICC contends that if infant–family mental health

assessments are framed for the coparenting adults as a way to better understand the family's distinctive patterns of engagement, coparenting teamwork, coparenting conflict, and degree of child focus, parents intuitively understand the premise and find the assessments meaningful (below, in the Framing section, we provide further details on how to approach such framing). Having a coparenting frame can help guide not only preliminary assessments but also case conceptualization, case planning, and sometimes even the character of the intervention with families. Further, when intentionally incorporating a coparenting focus, practitioners can begin to help parents understand how strengthening cooperative coparenting can support the child's development and mental health. The guidance provided by the ICC (McHale et al., 2023, 2025; McHale, Tissot, et al., 2024) is meant to add incremental value to best practices for practitioners already working with this very young population.

The importance of a focus on family observations in families with infants and preschoolers cannot be overstated. Family observations themselves do have a long well-established history (Kerig & Lindahl, 2000; McHale & Grolnick, 2002; Walsh, 1982, 2012), but observational systems have relied heavily on language and communication among family members. Inclusion of the infant in most of the major observational approaches was largely nonexistent. Similarly contributions from the preverbal infant or child have been overlooked or largely ignored by most family therapists, with many suggesting they be excluded, or simply provided toys to play with while the family talks (Philipp & Hayos, 2015). More surprisingly, given the research documenting healthy family functioning and collaborative coparenting as major contributors to infant mental health across a broad range of family constellations (McHale et al., 2025), most infant mental health clinicians have remained primarily focused on infant–parent dyads (Opie et al., 2023; Philipp & Hayos, 2015).

Given these disconnects, the ICC's main recommendation has been to include observations of the whole family interacting as a key part of our clinical assessments. Doing so routinely would reflect a major paradigmatic shift from how clinical assessments for referred young children are customarily conducted. Though dyadic observations of children with parents typically occur, rarely do clinicians also observe coparent–coparent–child triads or larger family groups. Toward this end, the ICC saw the value of expanding upon previous guidance about using Fivaz-Depeursinge and Corboz-Warnery's (1999) LTP to provide guidelines about how best to use this tool to provide video feedback to coparents about their shared interactions with their child.

Lausanne Trilogue Play (LTP)

The ICC's recommendation of the LTP paradigm is based on years of research on its acceptability and ecological validity in assessing family dynamics in the very young (Favez et al., 2019; Fivaz-Depeursinge & Corboz-Warnery, 1999; Fivaz-Depeursinge & Philipp, 2014; McHale et al., 2018; Philipp, 2025). The procedure itself is straightforward. Families are seated at appropriate social distance, in a triangle formation, with the child between the two parents and in an infant seat if very young, or later on in a high chair. Typically there is no table or toys for very young infants, but by the toddler stage there are a few small toys provided and the family is seated, again equally spaced from one another around a small round table. The interaction is video recorded as they play together following a four-part structure. The family is given the following instructions:

I'm going to ask you to play together as a family today. The play is going to take place in four parts. First, one parent will interact with your child while the other parent remains seated in the grouping and is simply present. Next, when it feels right, you will trade roles, so whoever was simply present first will become the

active parent, while whoever was active first will now become simply present. In the third part, again, when it feels right, the family is to interact as a whole, trying to find a game or activity that you can all participate in together. Finally, in the fourth part, you, the parents, will interact with one another, while your child is left to manage on their own, as best they can. The entire play should take between 8-10 minutes (10-12 minutes after 18 months of age). We ask that you not use your phones to time it, but let it flow as organically as possible. When you've finished all four parts, signal me that you are done, and we can discuss how it went. Do you have any questions? (Fivaz-Depeursinge & Corboz-Warnery, 1999, p. 201).

The parents may ask if they will be told who should go first and when to move from part to part. These decisions are left to the family to sort out on their own as there is rich clinical material in how a family will navigate all of these transition moments (Philipp, 2025) as well as how they cooperate throughout the task in general. As such, if asked directly about who should play when or how they should play, the clinician might then respond, "I'll leave that to you to decide." This structure mirrors common scenarios in two-coparent families: sometimes one parent takes the initiative while the other is an "active" observer, sometimes parents work together, and other times parents talk with one another and children must learn to respect a generational boundary (Minuchin, 1974).

The LTP has now been studied in a variety of contexts, including European families from all socioeconomic levels (Cairo et al., 2012; D'Amore et al., 2022; Favez et al., 2012; Hedenbro, 2006; Mazzoni et al., 2018; Mensi et al., 2020; Tissot et al., 2017), African American family systems (Coates & McHale, 2018; McHale & Coates, 2014), Middle Eastern families (Keren et al., 2001; Oppenheim et al., 2023; Witte et al., 2020), Turkish families (Salman-Engin et al., 2018), families in China (Liang et al., 2021), families living in South America (Olhaberry et al., 2017; Pérez Cortés et al., 2023), same sex couples (D'Amore et al., 2013), and couples who have gone through medically assisted conception as well as adoption (Cairo et al., 2012; Darwiche et al., 2013). Clinically the LTP has also been used with Canadian families of South Asian and East Asian descent. By moving away from the historical bias of engaging only mothers in the evaluation of the child when serving the infant and preschool population, the ICC's guidance and recommendations for involving the whole family set an expectation that ensuing feedback will not only target the child's symptoms and parenting responses, but also coparenting and family dynamics.

Video feedback

Although video feedback for coparenting and whole family interactions is a comparatively new intervention (Hedenbro, 2019; Iles et al., 2017; Kemenoff et al., 1995; Olhaberry et al., 2017; Philipp et al., 2023), it has a compelling foundation grounded in research demonstrating its effective use with parent-child dyads (Aarts, 2000; Hedenbro, 1997; Juffer et al., 2008; McDonough, 1995; Rusconi-Serpa et al., 2009; Yagmur et al., 2014). There are now several evidence supported methods used primarily with mothers and their infants or toddlers, including Interaction Guidance (McDonough, 1995; Rusconi-Serpa et al., 2009), the Marte Meo Method (Aarts, 2000), and Video Intervention to Promote Positive Parenting (VIPP; Juffer et al., 2008).

Video feedback for dyads, regardless of theoretical approach, starts with a period of video-recorded play. The clinician then chooses segments or vignettes from the play to show to the parent. Some may choose to only focus on areas of strength (Hedenbro, 1997). Other models begin with strengths but then bring the parent's attention to areas of concern or opportunities for growth. In all instances, the video allows the parent to see themselves in action, to view their impact on the child, and to consider the relationship. A meta-analysis including 29 studies using

video feedback for dyads documented the efficacy of this approach in improving parent–child interactions, increasing parental sensitivity, enhancing satisfaction in parenting (decreasing stress, improving confidence), and reducing symptoms (Fukkink, 2008).

Because the LTP is by definition a period of recorded observation of the two caregivers and their child at play, it was a natural fit for a video feedback model. When incorporated with additional feedback around the child and family, video feedback about coparenting can be a powerful tool for helping struggling families recognize possibilities for change and move back onto a more positive trajectory (Fivaz-Depeursinge & Philipp, 2014).

Several members of the ICC have been using video feedback in their work with families for many years as a means of helping them to become more aware of their coparenting behavior. LTPs with video feedback are not a replacement for other forms of assessment and intervention currently being used by clinicians working with infants and preschoolers. Rather, the intent of the ICC's recommendations and guidance is to include and integrate the LTP as an additional useful element in child and family evaluations. Effective use of LTP observations offers the clinician a powerful tool for highlighting and integrating coparenting into the family's shared understanding of the factors affecting their child's mental health.

EXPERIENCE

In this next section, we outline key principles that have been articulated by the ICC for effective use of video feedback with parents around their coparenting.

Framing

Within the ICC protocol (McHale, Tissot, et al., 2024), an important “stage setting” phase involves introducing the clinical assessment to families, stressing the importance of coparenting. In so doing, clinicians are able to give families a clear rationale for using the LTP. Because this part of the assessment is typically filmed, this framing is also an integral part of the consent process. (Depending on the practice jurisdiction, the formal process of obtaining consent to videotape, as well as how and for how long recordings can be stored will vary.) More specifically, clinicians can explain that:

The goal of this next exercise is for us to get a window into your family in action, not only what each of you might tell us about your family in words but also what happens when you and your children share in an experience together. It's not the only way we will try to get to know your child and family; we use questionnaires and/or clinical interviews as well.

ICC guidelines emphasize the importance of helping the adults understand ahead of time how the information will be used: “Later, with the help of video clips we will have the opportunity to reflect on moments from this exercise, together with you the parents.”

Clip selection

After the session in which the LTP is recorded and before the next session, the clinician must set aside time to review the LTP recording and identify and carefully prepare short video clips for the video feedback session. Selection of footage is based on a combination of factors including the referral question, what the clinician thinks would be helpful for the family, and as much as

possible capturing examples illustrating each of the four main coparenting dimensions—engagement, teamwork, conflict, and child focus (detailed further below). The clinician should also keep in mind that a primary aim will be to highlight the family’s resources. Deciding whether to also show clips of problematic interactions depends on clinical judgment and comfort level. Observing and reflecting on moments of challenge can be an opportunity to inspire change, if the family can tolerate it. However, exploring challenges should be undertaken with caution, as there is the potential to shame parents and undermine our growth-oriented approach.

The brief excerpts chosen for review are intended to evoke and stimulate conversation about coparenting. The main indices to focus on are the four core dimensions of coparenting (McHale et al., 2023) that have been explained to the family: engagement, the extent to which all family members are interested, engaged, and participating during the interaction; teamwork, the extent to which the adults cooperate together and work as a team; conflict, the presence or absence of criticism, negative comments, or competition between the coparents; and child focus, the extent to which the coparents respond appropriately to the child’s signals and contributions.

Although parents’ roles in different parts of the LTP vary, these indices of coparenting can be observed in all parts of the play. For example, in Parts 1 and 2, a parent successfully interacting with the infant is an example of successful child focus in parenting and could happen even if they were alone in the room playing with their child. But simultaneously, the “simply present” parent’s ability to leave space and enjoy the interaction between their partner and child is a sign of teamwork in coparenting. The opposite can also be true; in some clinical families, the “simply present” parent may instead intrude, offering unsolicited suggestions or correcting the active parent (conflict). In still others, the “simply present” parent may look away and disengage from the interaction between their coparent and child (lack of engagement). In Part 3, if they all come together in play, even just briefly (e.g., 30 seconds), we can highlight the engagement as a resource. The ability of the couple to turn to one another to talk in Part 4 (teamwork) might also be shown as a strength. In other words, in this form of teamwork the coparents are able to create a clear but flexible boundary (Minuchin, 1974) around their couple—aware of the infant should they be needed, but also helping the child learn what it means to not be included in an interaction, even if only briefly.

Video feedback session

Just as the LTP needs to be adequately framed, so too does the video feedback meeting:

The goal of the play assessment was for us to get a window into your family in action; to see how you are when you are all together. Today we’re going to reflect on some of the moments from your family play, with the help of video clips.

The video feedback meeting is framed as an opportunity to find resources and possibly “opportunities for change” in the parenting and coparenting. The clinician helps the parents make connections between what they see in the video and their day-to-day life, drawing attention to the four important elements of positive coparenting:

- Promoting engagement for all
- Teamwork and supporting one another
- Containing and minimizing conflict about child-related or parenting matters
- Child focus—assuring the child is seen and heard

Sharing video clips helps parents to see themselves in action within the family context and can help parents become more aware of their child’s experience and communications

(enhancing child focus), and their communication with one another (promoting teamwork, managing conflict). We aim to create a space for coparents to talk about the observed interactions, and elaborate on meanings we may have missed. To foster reflection, understanding, and mentalizing of themselves and their child, parents are asked about their experience both while in the LTP situation, and again now, watching themselves on video. These conversations can be important steps in improving parents' awareness of their coparenting behavior. To help illustrate the process, we present a case example.

Case illustration

Alfredo and Clarissa (names changed to protect patient confidentiality) were referred for consultation by their couple's therapist as they were struggling with their 3-year-old son, Matteo. He was not responding well to limits and was becoming easily dysregulated when not allowed to do what he wanted. Mornings and evenings were particularly challenging, with Matteo defying his parents at these times. Clarissa described Alfredo as always taking their child's side when she tried to set limits. Based on a thorough history and standard child measures, no major psychopathology was diagnosed and Matteo seemed to be developing normally. The Coparenting Scale (McHale, 1997), completed independently by Alfredo and Clarissa, revealed that both parents regularly took part in activities that helped build a sense of family integrity for Matteo, but also engaged in conflict in the boy's presence. We begin with an overview of the family's strengths in the LTP.

The family's LTP was collaborative overall, with no overt competition or criticism. Each parent was open to the other's initiatives, playing along with what the other proposed. The family decided to build a "doctor's office" from the toys provided. During Parts 1 and 2 each parent engaged well as the active parent and remained simply present when that was their role. In Part 3, when they all played together, there was a stretch where they played together quite collaboratively. During the fourth part, the parents talked at length about the day's plans and Matteo played quietly on his own.

In the video feedback session, excerpts from these successes were shared to encourage continued cooperation but also to show the coparents the extent to which they were already capable of teamwork. Of course there were also some challenges during the LTP, and the clinician opted to show the conflict as an opportunity to explore ways in which the family could consider change.

Right from the beginning, there was considerable negotiation between each parent and Matteo on how to build the roof for the office. Matteo was assertive and his parents struggled between supporting his initiatives (child focus), while at the same time accomplishing the task using their adult knowhow. Communication between the parents was limited. Instead, they addressed Matteo and did not check in with each other directly. Here we pick up the interaction in Part 3 as they work together to build the roof of the office.

Matteo: Don't put it that way!!!

Mother: Oh ... otherwise ... if we want it to work ... are there other pieces like this one?

Father [holding up some other appropriate pieces]: These?

The parents work together. Matteo watches without reacting. With Alfredo's help, Clarissa comes close to finishing the roof, but Matteo objects again, pulling his mother's Lego piece away.

Matteo: It's not right!! It goes here ... have you seen our doctor's office? That's right!! [having placed the piece once again in a precarious position].

Mother [removing the piece Matteo just placed]: Ah, but if we put it like that and ...

Father: But in my opinion he was putting it another way ... can you see?

Mother [Clarissa gives the piece to her son]: Ah okay, but it won't stay in place that way ...

Father: But either way it has to cover the roof, right?

She makes a disappointed face. Matteo nods his head and seems happy. Everyone is still for a moment. The room feels tense. Alfredo then suggests moving on to the fourth part.

Father: Hey Matteo, Mama and I are going to talk now, so how about you finish building the office on your own?

At first Clarissa looks withdrawn, but then she reinforces Alfredo's suggestion.

Mother [pointing to some of the figurines]: Yeah, Matteo maybe pretend those guys are going to the doctor's office.

Clarissa does not say anything further, but still seems frustrated.

Father [picking up a figurine]: Oh look, a pig! Oink oink!

All three recover as they all make pig sounds and laugh together. Matteo begins to play on his own, but the parents hesitate to start the fourth part.

Father: Listen, before Mama and Papa talk to each other, can we try something? If you like it, keep it, otherwise take it down.

Alfredo picks up the piece of roof Matteo had previously rejected when Clarissa tried to place it.

Father: In my opinion, Mama was right. You can put it here, see?

Mother: Ahhhhhhhh [Matteo looks directly at his mother].

Dad [taking another piece of roof]: ... and then like this.

Mother: Look at the roof Matteo!!!! [taking another piece]

Father [taking one last piece that connects the two parts of the roof]: ... and there you go!!!

The parents' hands briefly touch as they put in the two last pieces. Clarissa smiles widely. Matteo watches intently.

Mother [clapping her hands]: Well ... we deserve a degree in engineering!

Father: We did it Matteo!!

Matteo looks serious, but he does not resist, and he immediately begins to play with the office which finally has a roof. Clarissa now suggests they move on to Part 4.

This vignette offers much to work with—child autonomy, which for some might be interpreted as oppositionality; different parenting approaches, one tending toward leading, one following; moments of dissonance and uncertainty; efforts at collaboration and repair. Vignettes like these provide opportunities for coparents to discuss the communication between them about their different beliefs and feelings about child-rearing. In the absence of any such communication, challenges can crop up in the family leading to symptoms shown by the child, even when each individual is a competent parent on their own. Children can hear different messages from their two parents; however, in distressed families, these differences and the lack of communication about them can lead to parents often behaving differently when alone with their child than when they are together as a family (Lauretti & McHale, 2009). In other words, the parents, caught up in some unspoken conflict, can appear less competent, less sensitive, and less attuned to their child when they are together as a family than when each of them is alone with their child. The conversation during video feedback can help parents begin to understand and openly discuss their coparenting dynamics—as they relate to engagement, teamwork, conflict, and child focus—in a way that helps the whole family.

Having already viewed and reflected on the strengths described earlier, the coparents were now open to discussing the challenging segment with the clinician. Even before watching the sequence, Clarissa recalled that she “bit her tongue” to keep from intervening when Matteo resisted guidance in building the roof. Alfredo shared that he appreciated not being undermined by her. On viewing the video recording, the parents could see that they did resolve the impasse eventually. Although Alfredo did side with Matteo early in the conflict, he later led Matteo towards Clarissa’s plan. In discussing the interaction, the therapist helped the parents redefine the problem: Whereas Clarissa faces conflict straight on, which sometimes results in clashes, Alfredo tries to avoid conflict. Their “problem” was then reframed as “complementarity” in the couple, and a way they could work together in managing Matteo’s behavior when it crossed a line into him becoming oppositional.

CONCLUSION

Video feedback is a well-established approach with parent–child dyads, but it is also a promising tool for promoting insight into coparent functioning and whole family dynamics in the infant and preschool population. By adding the LTP to traditional assessment protocols, parents and other caregivers can be provided with an additional mirror into their family functioning. When parents become more mindful of their coparenting, improvements can be found not only in the coparenting and marital relationship but also in parenting strategies and dyadic parent–child interactions (DiMarzio et al., 2022). That is, by targeting coparenting there is also added value as the conversations inevitably focus not only on coparenting but also parenting strategies—strengths and areas of concern, as well as similarities and differences between the coparents. During video feedback sessions, coparents can learn to more mindfully talk about their coparenting, as well as any parenting differences, and support one another as they apply tools they have learned together in both domains (Nunes et al., 2021).

This is a model that can be flexible to the needs of different family constellations, including parent–grandparent coparents, other forms of kin coparents, coparents that reside together, and those who were never married or are separated or divorced. It can even extend beyond coparenting dyads to include multiple coparents working together to raise a child or children, as is often the case in separation or divorce as well as multigenerational families. In the context of an appropriately framed clinical intake, this more inclusive focus can set a positive stage for fostering a family’s openness to strengthening coparental engagement and teamwork, mitigating the impact of coparental conflict, and sharpening the family’s focus on the child’s signals and needs.

In terms of challenges or limitations of this model, many families, including many in which a parent suffers from serious mental illness, may initially express trepidation about being filmed (Barnicot et al., 2023). As has been reported by others, once parents understand the aims of the assessment and how the information can be used to help their child and family, most are able to proceed. In a recent systematic review of 17 studies exploring parents’ experiences with video feedback interventions, Wan et al. (2025) found that most parents did initially express concerns about being filmed and worried about appearing “good enough.” Ultimately, however, most found the interventions highly useful once they understood the aims of the assessment and how the information could be used to help their child and family.

Clinicians must also be well briefed in the privacy regulations within their jurisdiction as well as their particular setting (hospital, clinic, private practice). Some sites may not allow or may have more stringent guidelines for filming clinical material. Moreover, some cultures and religions may impose certain restrictions such as refusal to be photographed or videotaped. In these instances, the LTP can still be done and the clinician notes the strengths and weaknesses in real time to be discussed at the feedback session. The loss of video footage is a significant

one, however, particularly given what a powerful adjunct it can be to clinical work (Fukink, 2008). In most situations, we have found that these challenges can be resolved by taking the time with the family or with one's organization to address concerns and discuss the substantial benefits of video feedback. Finally, clinicians should exercise caution when dealing with divorced or separated parents, holding in mind as much as possible that data collected could be introduced as evidence in a custody battle by either parent. Having clear guidelines for storage and destruction of video recordings from clinical encounters is crucial for these families in particular, but are of course necessary in all cases, in order to best insure the privacy of clients. Despite these hurdles, the clinical value added from the unparalleled information about family dynamics captured from this 8–12 minute observational tool typically far outweighs any challenges.

IMPLICATIONS

As with any new tool, training and supervision are key, and a comprehensive manual for clinicians exploring multiple facets of video feedback using Lausanne play tools, including the LTP, is now available (Philipp, 2025). Readers are encouraged to explore learning opportunities for this work. We also emphasize that the video feedback procedures detailed in this report are but one element of the ICC's guidance to increase mindfulness about coparenting. The ICC's objectives have been to articulate clinical- and research-informed guidelines that enable practitioners to more fully incorporate a coparenting lens into infant mental health assessments and case formulations. The ICC is unique in having deliberately engaged multinational practitioners representing diverse clinical and practice settings and contexts, and in having created latitude for culturally informed and grounded adaptations so as to maximize comfort and familiarity for families of different backgrounds. Since its inception, the ICC has expanded to include South American collaborators, and each ICC site spanning Europe, the Middle East, South America, and North America has implemented practice models uniquely and independently, but adhered to the ICC's shared guidance.

For nearly 3 decades, the LTP has guided research and clinical investigations in studies of families with infants and preschoolers. Experts in use of the LTP regularly incorporate video feedback in their work with families; however, for the most part such practices have been confined to those most experienced in use of the technique. The ICC brought together coparenting clinicians and researchers with expertise in using the LTP in clinical and research settings to help stimulate greater awareness and understanding of how what has been learned about family dynamics can advance clinical research and practice.

The ICC's guidance is outlined in an open-access site with overviews of both the initiative and the consensus guidelines (McHale et al., 2025). This rich resource will help provide additional guidance for both individual and multisite research collaborations through its common procedures, protocols, and instruments. Bringing together clinical innovations and evidence-based coparenting conceptualizations is a launching pad for additional scholarship on the impact of systematically incorporating a coparenting frame into infant and preschool mental health assessments and interventions.

DATA AVAILABILITY STATEMENT

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

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