Reflective and Mindful Parenting: An application of parental mentalization theory toward a new relational model of assessment, prevention, and early intervention

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INTRODUCTION

"Collaborative and flexible parent-infant dialogues have been termed *open communication* in the developmental attachment literature but this term is subject to misinterpretation. Coherent, or "open" dialogue is characterized not by parental "openness" in the sense of unmonitored parental self-disclosure, but by parental "openness" to the state of mind of the child, including an entire array of the child's communications, so that particular affective or motive states of the child (anger, passion, distress) are not foreclosed from intersubjective sharing and regulation…Collaborative dialogue, then, is about getting to know another's mind and taking it into account in constructing and regulating interactions…Another's mind is a terrain that can never be fully known…Thus, empathy should not be viewed as a simple apprehension of one person's state by another but as a complex outcome of a number of skilled communicative procedures for querying and decoding another's subjective reality" (Lyons-Ruth, 1999, pp. 583-584).

These statements highlight some of the most significant implications that have emerged

from developmental theory and research aimed at uncovering the intersubjective foundations

of early cognitive and emotional development. Recent theories emphasize the importance of

the parental capacity to comprehend the developing mind of the child and to respond in a

manner that gives the child a sense of his own mind.[1] Lyons-Ruth has tied parental "openness"

to the state of mind of the child to the quality of the regulatory functions provided by the

parent. Thus, the parent must rely on an emerging understanding of the child's mind in order to

engage effectively with the child at the level of behavior.

This involves great challenges to the parent, including both the attempt to understand

the child and in terms of self-reflection or mindful awareness. For many parents, the birth of a

child can lead to the healthy reorganization of previously established beliefs, defenses, and

definitions of self. However, parents are not equally prepared to meet the psychological

burdens of parenthood. Thus, there is a great range in the degree to which the parent-child

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[1] In the pages that follow, for purposes of clarity, we have chosen to refer to the child as "he" and to the parent/caregiver or group leader as "she."

relationship is dominated by the emotions or defenses of the parent versus the developmental needs of the child.

The majority of parenting and early intervention programs have sought to help caregivers through the provision of both specific behavioral techniques and general information about child development. These models often fail to influence the deeper dynamics and intergenerational patterns of relatedness that powerfully impact the overall quality of parent-child interactions. Therefore, it is important to address each parent-child dyad as a unique entity, characterized by particular strengths and vulnerabilities at the level of intersubjective relatedness. The provision of proscriptive behavioral techniques often fails to take such factors into consideration. It may also serve to undermine a parent's development of an emergent capacity to reflect on her child's developing mind, as she attempts to fit a given child or child rearing situation into a general behavioral approach. By telling parents what to do, rather than helping them tolerate the experience of "not knowing," we may be undermining the reflective and regulatory processes that can emerge as caregivers attempt to make sense of the confusing, chaotic, and distressing interactions that are an inevitable part of parenthood.

We will describe a model of early intervention and prevention that seeks to minimize such pitfalls. This model emphasizes the cultivation of the emotional and cognitive processing mechanisms that underlie affect regulation and form the basis for attachment security in children. It utilizes interventions derived from the assessment of the reflective capacities and attachment dynamics of each caregiver on a case-by-case basis. It is a strength building approach that allows space for differences in cultural and familial values while enhancing the

reflective processes that can be extended into a wide range of parenting issues or relational dynamics.

This approach is explicitly non-didactic. Instead it engages parents in a process of exploration, curiosity, imagination, and mindfulness. Parents attempt to sort through and become more sensitive to the internal states within their children and themselves, then begin to make links between these "inside stories" and the behaviors being expressed externally. We call this approach "reflective and mindful parenting." It is rooted in contemporary psychodynamic theory, attachment research, and mindfulness practice, with a particular emphasis on the role of parental mentalization as it contributes to the emotional development of young children.

THEORETICAL BACKGROUND

One of the goals of the present volume is to examine the disease mechanisms that underlie a range of psychological disorders across the developmental spectrum, with the hope of contributing to the emergence of treatment models that can address the underlying causes of psychological suffering. It is a timely volume, as evaluation researchers (e.g. Kazdin and Nock 2003) have increasingly demanded that treatment approaches be based on clearly defined models of psychopathology that include consideration for underlying change mechanisms (Fonagy & Target, 2005). The two early intervention models described below meet these criteria, as they utilize case specific assessment of the strengths and limitations of a given caregiver's capacity for mentalization as it relates to her ability to respond in developmentally appropriate ways to her child's attachment cues. In utilizing a nuanced assessment of parental mentalization, clinicians are afforded the opportunity to develop interventions that specifically

target the blind spots or areas of vulnerability that the parent is experiencing in relation to her child, while also highlighting and consolidating any inherent parenting strength that may exist.

Mentalization

Mentalization is a construct with roots in multiple disciplines, including cognitive psychology (Baron-Cohen, 1995; Dennett, 1987), attachment theory (Main, 1991), and psychoanalytic theory (Bion, 1962; Winnicott, 1960). In the present context, we are most concerned with the seminal ideas introduced by Peter Fonagy and his colleagues (Fonagy, Steele, Steele, Moran, & Higgitt, 1991) that have been expanded in recent years and extended to a wide range of clinical applications (e.g. Allen & Fonagy, 2006). Fonagy and Target (2008, p. 17) define mentalization as "a form of mostly preconscious *imaginative* mental activity, namely, interpreting people's actions in terms of 'intentional' mental states." Fonagy and his colleagues have elaborated on Main's concept of metacognitive monitoring to include not only the capacity to observe one's own representational processes, but also the ability to reflect on the mental states of one's attachment objects. Their research considers the developmental achievement of the capacity for mentalization as involving an awareness of the nature of complex mental states including attitudes, feelings, beliefs, intentions, desires, and plans (Fonagy and Target, 1998). Mentalization is first developed within the context of early attachment relationships, as the parent relates to the child as an intentional being. As children internalize this process, they begin to see other people's behavior as predictable. Mentalization underlies affect regulation, impulse control, and self-agency. Individuals lacking in this capacity struggle to step back from their experience to consider the symbolic aspects of other people's thoughts and feelings.

Mentalization theory also considers the concept of containment (Bion, 1962); the idea that the parent not only reflects the infant's internal state but also represents it as a manageable experience. In doing so, the parent demonstrates that she understands the child's feelings and communicates this in a way that indicates that the child can have a similar experience of mastery (Fonagy and Target, 1998). Fonagy and his colleagues (Fonagy, Gergely, Jurist, & Target, 2002) have described this process as marked mirroring, whereby the caregiver is able to contingently respond to the internal state of the child while adding something that makes it clear to the child that her internal state is not a direct equivalent of his own. This "re-presentation" of the child's state of mind may involve a softening or heightening of affect, or a cross modal response in which the caregiver uses voice tone to mirror the infants gestures or a facial expression to mirror a child's words. This complex multi-modal dialogue operates largely outside the conscious awareness of the caregiver; however it is crucial to the child's emerging capacity for symbolic representation and his developing sense of self. It also forms the basis of the child's representations of attachment.

In fact, Fonagy has suggested that secure attachment is the direct outcome of successful containment, while insecure attachment evidences failures of containment that differ in terms of the defensive compromises adopted by the caregiver (Fonagy, 1996). In the case of dismissing attachment, there is a failure of affect mirroring but there is some evidence of stability and mastery. In the case of preoccupied attachment, there is an abundance of affect mirroring but a dearth of calmness and confidence on the part of the caregiver.

The caregiver's capacity for mentalization is particularly critical in cases of deprivation, loss, or abuse, as it provides a protective measure against the intergenerational transmission of

trauma (Fonagy, 1996). However, if the parent is lacking in mentalization, she will not be able to accurately attend to the child's painful reactions to stressful situations, and will thereby misrepresent the child's affect and intentions. For these children, it is too painful to consider the apparently malevolent intentions of one's caregivers. As a result, the developmental acquisition of mentalization within the child may become severely impaired.

Parental Mentalization

The original reflective functioning measure (Fonagy, Target, Steele, & Steele, 1998) was designed for application to the Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1985); thus it referred to the parent's capacity to reflect on her childhood experiences with her own parents. More recently, Slade and her colleagues have extended mentalization research into the context of parent's current relationships with their children (Grienenberger, Kelly, & Slade, 2005; Slade, Grienenberger, Bernbach, Levy and Locker, 2005). These studies have utilized the Parent Development Interview (PDI) (Aber, Slade, Berger, Bresgi, & Kaplan, 1985) to focus on the parental capacity to reflect upon their children's internal experiences and upon their own experiences as parents. Unlike the AAI, which assesses representations of past experiences, the PDI elicits representations derived from a current, ongoing relationship with one's child. Thus, child development, and the caregiver's capacity to reflect upon the child's ever-changing abilities and upon the constantly evolving parent-child relationship, all provide the backdrop to the assessment of parental mentalization.

The PDI studies, as well as others using related measures (e.g. Meins, Ferryhough, Fradley, & Tuckey, 2001; Oppenheim & Koren-Karie, 2002) have shown that parental mentalization is strongly predictive of child attachment. Parental mentalization has also been

demonstrated to be inversely related to disruptions in mother-infant affective communication in response to infant distress (Grienenberger et al., 2005). More specifically, reflective mothers were found to have fewer and less severe behaviors that evidenced affective communication errors, role or boundary confusion, fearful, disoriented or dissociated behavior, withdrawal, or intrusiveness and negativity.

The Transmission Gap and Implications for Early Intervention

Attachment theorists have long emphasized the role of "maternal sensitivity" in the intergenerational transmission of attachment from caregivers to their children. They have hypothesized that caregivers who are themselves secure in their attachment will be more able to respond to their children in ways that are warm, sensitive, and responsive. However, a meta-analytic review of the attachment literature (van IJzendoorn, 1995) has identified a "transmission gap," as behavioral measures of maternal sensitivity failed to account adequately for the strong link between adult attachment and infant attachment.

The studies by Slade and her colleagues (Grienenberger et al., 2005; Slade et al, 2005) have helped to close this gap, and suggest that maternal mentalization, rather than maternal sensitivity per se, may be the critical mediator between the parent's attachment style, parental behavior in response to infant distress, and child attachment. These findings provide further support for the need to directly target parental mentalization in order to have a significant impact on child attachment security. They also suggest that more sensitive, positive, or warm parental behavior in general, in the absence of a reflective stance in relation to the child, is likely to have a limited impact on child outcomes.

In fact, the maternal behaviors likely to be the most salient in terms of child attachment security are those occurring during times of distress within the child, the parent, or both. It is also during such moments of heightened affective and physiological arousal that mentalizing efforts are the most difficult to sustain. Fonagy (2008) has reviewed a growing body of research on the neurobiology of attachment and mentalization that "suggests that being in an emotionally attached state inhibits or suppresses aspects of social cognition, including mentalizing and the capacity to accurately see the attachment figure as a person" (p.12). One of the most useful aspects of the PDI as an assessment measure is that it requires parents to reflect on some of the painful, distressing, and uncomfortable mental states occurring within themselves and within their children, and to make links between these states and what is being expressed behaviorally. It is at this point of interface between the mentalizing efforts of the caregiver and the heightened affective arousal that characterizes the activation of the attachment system that we are most concerned. Following from the PDI, our early intervention model is focused on helping parents identify and navigate elements of the parent-child relationship that involve conflict, distress, anger, and other uncomfortable feelings. As parents begin to see such experiences as inevitable, ordinary aspects of parenting, they often shift toward a more reflective stance and are better able to regulate emotions within themselves and within their children.

Current Models of Early Intervention

Current models of early intervention primarily target the parent-child relationship utilizing parental representations, or parental behavior, as ports of entry, due in large part to the theoretical or contextual environments from which they have emerged (Stern, 1995). There

are a number of approaches that have evolved from the educational and behavioral world (e.g. Field, 1982; McDonough, 2005) that target parent-child interactive behavior using mothers' behavior as the overt port-of-entry. In contrast, a core concept guiding psychodynamic models of early intervention is that change in the child depends on change in caregiver representations of the child and of the caregiver-child relationship (Lieberman, Silverman, & Pawl, 2000).

Models such as McDonough's 'Interactive Guidance' (2005) that begin with the observable parent-infant behaviors as the therapeutic focus, also understand caregiver interactions as a reflection of the caregiver's and infant's representational world, though this is not the therapeutic port of entry. Other popular group approaches such as "The Incredible Years" (Webster-Stratton, 2005) utilize stricter behavioral models that provide parents with behavioral tools as well as child development information, but do not consider parental representations.

Literally hundreds of studies have shown attachment to be a critical variable that has been linked to multiple measures of social and emotional functioning, psychopathology, and resiliency across the lifespan (for a review see Cassidy & Shaver, 1999) and thus it could be argued that attachment security should be the primary early intervention target. Berlin and colleagues (2008) propose that the main focus of attachment based early intervention should include both parents' internal working models and parenting behaviors, specifically in relation to how they respond to their children's desire for contact, along with their desire for autonomy. It is clear that models of early intervention need to account for the reciprocal and bi-directional influence that occurs between representation and behavior (Grienenberger, 2003).

Since 2005 several attachment-based programs have demonstrated success in supporting children's early attachment security (for a review see Berlin, Zeanah, & Lieberman, 2008). These programs start from the premise that while behavioral tools may be helpful in managing interactive behaviors, the underlying intentions that drive and motivate behavior need to be addressed in order to most effectively target the quality of parent-child attachment and child developmental outcomes. Further, Slade and others have argued that shifting internal working models of attachment depends on parental reflective capacity and thus parental mentalization is perhaps the critical intervention target in and of itself (Grienenberger, 2007; Slade, Sadler & Mayes, 2005; Suchman, McMahon, Slade, & Luthar, 2005). When therapists give voice to the intentions behind children's behavior, it can allow for shifts within parents' internal working models (Berlin et al., 2008). As parents acknowledge their children's intentions, it also has the effect of reducing the frequency and duration of children's dysregulated or disruptive behavior.

Mentalization Based Early Intervention Programs at the Center for Reflective Communities

The Center for Reflective Communities (CRP) is a non-profit organization established in Los Angeles in 2009, whose mission is to 1) promote the development of secure parent-child attachment through increasing parental mentalization and 2) provide training to clinicians in the facilitation and development of parental mentalization through the use of the Reflective Parenting Program Parent Workshops and Mindful Parenting Group models. CRP is actively engaged in the empirical evaluation of both programs, and preliminary data suggests significant improvement in parental mentalization as well as a number of other outcome measures. Both

programs have been qualified as "Community Defined Evidence Based Treatments" by the

California Institute of Mental Health.

Certification training is available for both programs that includes the following: 1)

training in the building blocks of parental mentalization; 2) training in group dynamics and ways

of interacting with parents and infants that attend to both verbal and also the more subtle,

non-verbal, procedural level of communications; 3) engaging facilitators-in-training through an

experiential learning process that involves holding and containing complex, difficult,

emotionally charged case examples; and 4) group supervision experiences where trainees learn

to develop dynamic case formulations of the parents they are working with. These formulations

include an integration of attachment dynamics with an understanding of parental

mentalization.

The training is heavily experiential, actively facilitating the development of the reflective

capacities of facilitators in training. The Mindful Parenting Group Facilitator Training includes a

demonstration group led by a senior trainer where trainees are supervised as they sit in a

"participant-observer" role; the Reflective Parenting Program utilizes role-playing and review of

videotaped groups to facilitate the trainee's development of a reflective stance in relation to

parents with a wide range of mentalizing strengths and limitations. Watching experienced

senior trainers make interventions from a mentalizing perspective, and then having the

opportunity to practice through role-playing, or through the experience of being supervised

while leading groups, maximizes procedural learning. Our training model is consistent with

other mentalization-based programs that have noted the importance of using exercises that

immerse trainees in the challenges of mentalizing in the face of intensely emotional dynamics (Williams, Fonagy, Target, Fearon, Sargent, Bleiberg, & McGregor, 2006).

Recent research into attachment-based programs supports the idea that the parent's relationship with the therapist or intervener is a major facilitator of change (Berlin et al, 2008). We believe that it is the observational and reflective stance of *both* the therapist *and* the other group members that is the agent of change. Thomson-Salo & Pawl (2001) suggest that the benefits of a group experience may include a lessening of mothers' feelings of blame and persecution as they listen to each other weather struggles with their children. Furthermore, other group members provide rich sources of material for therapeutic identification. Reynolds (2003) refers to the meaningful and regulating social contact that groups can provide for parents and infants. Grienenberger (2007) describes how the group process creates a secure-base and a holding environment that is containing and facilitative of mentalization, as well as accelerating the therapeutic process by providing parents with a chance to observe the strengths and limitations of a range of parenting styles seen among various group members.

Both programs foster the development of careful, detailed observation as the foundation for building reflective capacity. Infant observation was pioneered by Esther Bick (2002) at the Tavistock Clinic as a training tool for child psychotherapists to develop their ability to non-judgmentally attend to the minute details of infant experience, and bear witness, rather than react to, intense affects. Formal infant observation traditionally consists of weekly visits with a family during the first year of the baby's life. During these visits, the therapist maintains an observational stance, tracking the moment to moment experience of the infant's and mother's states and behaviors, alongside her own emotional experience.

The training builds on Bion's (1962) notion of 'reverie', emphasizing the willingness of the therapist to be permeated by the infant's state as much as possible, allowing the infant to "find a place inside us" (Sternberg, 2005, p.49). The ability to experience and observe simultaneously develops the internal flexibility of the observer, along with the ability to think and feel at the same time (Sternberg, 2005). While intervention is not the focus of this method, the observer's mind may provide the family an unseen digestive function, what Bion described as "alpha function". Reynolds (2003) built on the idea of formal infant observation in introducing Child-Centered Observation in Mindful Parenting Groups. She describes a "profound bi-directional, relational, and regulatory utility in strengthening a parent's capacity to come as close as possible to a child's subjective, affective experiences" (p. 362). Both RPP parent workshops and MP groups include structured observational components as a way of developing parental mentalization. Reynolds (2003) describes this process as "the accumulated practice of directing quieted, patient, curious, alive attention to both child and self, through learning to respect and follow the child's lead in contact-seeking and exploratory behaviors" (p. 362). This slowed down focus on moment-to-moment experience helps to develop parents' curiosity and wonder, their ability to think and feel at the same time, and their ability to sit with the uncertainty that is a fundamental part of the building of reflective capacity and mindfulness.

The Reflective Parenting Program Workshop Structure

The Reflective Parenting Program Parent Workshops provide a developmentally scaled, twelve-week workshop series for parents. RPP Workshops are curriculum-based but process focused. Multiple curricula are available, including workshop series for expectant mothers,

parents of 0 to 2-year-olds, 3 to 6-year-olds, and elementary school-aged children. A curriculum

for parents of adolescents is currently under development. The workshops have also been

applied to specific, diverse populations, including Spanish-speaking parents, teen mothers, and

parents adopting children from the foster care system.

Each curriculum focuses on specific topics that are used as the context within which to

explore parents' capacity to reflect on their children and their experiences as parents. Topics

include areas such as temperament, responding to children's emotions, rupture and repair, and

limit setting. Each workshop begins with a structured mindfulness exercise that engages

parents in an experience of observation and provides a transition into the reflective space of

the group experience. Exercises such as role-playing are utilized in order to stimulate parents'

engagement in making sense of children's feelings and behavior and to help parents examine

their characteristic, often automatic ways of responding. "Take home reflections" are employed

as a way for parents to practice observational, mindful ways of relating to their children. The

workshops are led by co-facilitators who model a collaborative, reflective approach for parents,

offering containment and support, as well as boundaries and limit-setting. Facilitators help

group members expand and explore by asking questions that elicit reflection, and they

reinforce reflective comments by explicitly noting when links are made. Interventions are

tailored to each parent's mentalizing capacity and parenting style.

Mindful Parenting Group Structure

Mindful Parenting Groups are experiential, observation-based, development-driven

groups for infants or toddlers and their parents. Each group consists of three primary

components: Child-Centered Observation of the children at play, modeling of respectful

parenting practices through Facilitation of Social Interactions, and Parent-Centered Reflection on what is observed, as well as time for questions and discussion (Reynolds, 2003). During Child-Centered Observation, parents' are asked to sit back quietly while they follow their children's lead and pay attention to both their children's feelings and behaviors and to what arises inside of themselves. The facilitator then poses an open question to the group about their observations to facilitate a process of inquiry and wonder (Reynolds, 2003). At times facilitators actively draw the attention of the group back to an affect-laden moment, such as one between two toddlers, to explore both the parents' experiences and what they imagined about the nature of the toddlers mental states and behaviors. The inquiries are bi-directional, looking always at the flow of mental states and behaviors between the parents and children. Facilitators work to enhance mentalization about affect-laden moments in the here and now between parents and their children, as well as making links between the present and past family histories.

Parents commonly inquire about practical concerns around behavioral and emotional issues, such as sleeping, eating, fears, tantrums, and other challenges typical of infants and toddlers. Facilitators hold these questions in a lively way and the group is challenged to wrestle with uncertainty and complexity, as all group members are invited to share their unique perspectives. For older toddlers, a group snack and a circle time with songs and games is added. This provides opportunities for children to participate in a school-readiness activity at their own pace, experiencing the joys and challenges of navigating structure and turn-taking (Reynolds, 2003). The groups have been facilitated with a number of diverse populations, including teen mothers, Spanish speaking parents, and parents adopting from foster care.

The Parent Development Interview as Assessment Tool and Outcome Measure

During the past two decades, there has been a significant growth in clinical applications of attachment theory to a variety of treatment contexts including adult psychotherapy (Wallin, 2007), child therapy (Slade, 2004), and family therapy (Fearon, Target, Sargent, Williams, McGregor, Bleiberg, & Fonagy, 2006). Even more recently, research tools such as the Strange Situation and the AAI, are being directly integrated into clinical interventions across a range of treatment modalities (e.g. Marvin, Cooper, Hoffman, & Powell, 2002; Steele & Steele, 2008). The programs at the Center for Reflective Communities are part of this next wave in the clinical application of attachment research. Both programs use the Reflective Functioning (RF) coding system (Slade et al., 2004) for use with the Parent Development Interview (Aber et al., 1985) as both an outcome measure and a tool for case formulation. A key element of the intake process is that the PDI is administered by one of the clinicians facilitating the group. This allows for a one-on-one meeting that engages the parent in the therapeutic process and facilitates the development of a therapeutic relationship with the clinician. It also affords the group leader an opportunity to begin to develop a working formulation of the parent's attachment dynamics in terms of her capacity to mentalize around various issues.

More specifically, the PDI asks questions about a range of mental states and behaviors with an emphasis on the challenging emotions and interactions that are central to issues of affect regulation within parent-child attachment. For example, there are questions that ask the caregiver to speak about her own pain, anger, guilt, or neediness in her parenting role and the impact of these feelings on her child. Other questions focus on the child's negative affects, such as times when he may feel upset, rejected, or distressed about separation, as well as the impact

that the child's affective experience may have on the parent. There are also questions that ask

about the role of the parent-child relationship in the child's emerging personality or

development and the impact of the parent's own early history on her current experience as a

parent.

Parental reflective functioning is scored for several passages on the PDI on a scale

ranging from -1 to 9. An aggregate score is also provided for the interview as a whole. A score

of -1 is indicative of anti-reflective, unintegrated, bizarre, distorted, or self-serving responses. A

rating of 5 indicates ordinary reflective functioning, such as a response that links affect to

behavior or to another mental state. A score of 9 indicates exceptional mentalizing capacity.

The Building Blocks of Parental Mentalization

The majority of clinicians undergoing training at the Center for Reflective Communities

do not receive formal training in the RF coding system for the PDI, however they are all trained

to administer the interview. They also learn to recognize the range of mentalization within

parents' speech as it exists along a continuum from low to high. This allows group leaders to

utilize the PDI as an assessment tool even if they will not be scoring it as an outcome measure.

Trainees learn to listen for mental state language within parents' communications and to notice

when parents are able to link mental states to behaviors and to other mental states in

themselves and their children. They are trained to listen for the following "building blocks of

reflective functioning," which can be understood as indicating increasingly complex or

sophisticated indications of parental mentalization: 1) recognizing and labeling basic mental

states (e.g. sad, angry, worried, afraid, etc.) in self, child, or other family members; 2) enhancing

the understanding that one's overt behavior or that of others is motivated by underlying mental

states (e.g. "I feel guilty because I have to work so much, so sometimes I think I have trouble

saying no to my daughter"; 3) fostering links between mental states (e.g. "I feel guilty because I

have to work so much, and sometimes I think she picks up on that and is confused); and 4) an

awareness of the interconnectedness of minds – the notion that one's own mental states and

behaviors impact and are impacted by the mental states and behaviors of one's child (e.g. " I

feel guilty because I have to work so much, and sometimes I think she picks up on that and is

confused. She may even play off of my guilt a bit and try and push limits with me, knowing that

I may have a hard time saying no after I have been traveling for work"). We have found that

clinicians can be trained, in a relatively short amount of time, to identify these building blocks,

to evaluate the range of parental mentalization, and to listen for those areas where a parent

may be more or less able to reflect on their children's attachment needs.

States of Mind with Respect to Attachment

The intervention models we have developed integrate traditional attachment theory,

with its focus on internal working models of attachment or attachment categories and

mentalization theory. Mentalization theory has tended to emphasize the range of mentalizing

capacities, from low to high, rather than focusing on particular patterns of representation, as

was the focus of Main's original coding system for the AAI (Main & Goldwyn, 1998). We view

attachment organization as representative of various positions existing upon a continuum

(Slade, 2004). These positions are seen as indications of the dominant mode of affect regulation

and defense for a parent at a particular time and in relation to a specific child. In other words,

we focus on "states of mind" with respect to attachment, and see these states as somewhat

fluid as they develop in relationship to a range of parenting issues and parent-child interactions.

In translating the findings of attachment research to clinical intervention, we concur with Slade (2004) who argues that it is more important to sensitize clinicians to identify attachment phenomena within their patients' behavior and narratives than to try to assign them to attachment categories. By focusing on states of mind within a specific parent-child context, rather than seeing each parent or child in a categorical way, clinicians are freed from the limitations that have sometimes been associated with the application of attachment theory to clinical work.

We have found that it is useful to think of dismissing states of mind and preoccupied states of mind as simply opposite ways of defending against the same experience: the challenge of managing strong affect within the context of intimate relationships. However, we do find it helpful to consider the contributions of the adult attachment literature as a means of understanding the various ways caregivers might navigate issues of separation and autonomy versus connection and intimacy in relation to their children. On the Preoccupied side of the continuum are states of mind characterized by feelings of enmeshment, dependency, and uncontained affect. Moving further in this direction are states of mind influenced by unresolved loss or trauma, leading to the development of a "helpless/fearful" parenting style, as child distress re-stimulates dissociated memories or affect (Lyons-Ruth, Bronfman & Atwood, 1999).

On the Dismissing side of the continuum, are states of mind that may be intellectualized or concrete, minimizing of emotions, and characterized by detachment from others. At the extreme of this end of the continuum are states of mind that are unresolved with respect to loss or trauma in which the caregiver may have developed a "hostile-intrusive" parenting style, as her child's vulnerability stimulates an identification with past aggressors as a means of

warding off dissociated feelings of vulnerability (Lyons-Ruth et al., 1999). In contrast to the two ends of the continuum described above, free or secure states of mind can be understood as existing in the middle of the attachment continuum. These states involve a balance between thinking and feeling, autonomy and intimacy, separateness and connection with others.

As we consider this continuum, it is helpful to examine the implications that are posed regarding the impact of states of mind on a given caregiver's ability to mentalize. For example, mentalization is often more limited within dismissing states of mind around issues of dependency, intimacy, and the experience of distress, shame, or uncertainty. The caregiver may be able to think of her child as having a separate mind; however she may fail to see the impact of her thoughts, feelings, and behaviors on her child's emotions. By contrast, preoccupied states of mind are often characterized by breakdowns in mentalization fueled by feelings of anxiety, insecurity, or fear of loss. The primary challenge to the caregiver involves seeing her child as having a separate mind that is not the equivalent of her own.

Figure 1 illustrates an integration of the continuum of attachment states of mind with the role of parental mentalization within parent-child relationships.

(Insert Figure 1 About Here)

In this model, secure states of mind are thought of as evidencing the highest levels of mentalization, both hostile/intrusive and helpless/fearful states are seen as being the least reflective, and preoccupied and dismissive states fall somewhere in the middle to low range. [This model has preliminary empirical support from a study that found the highest level of RF in mothers of securely attached children, the lowest in mothers of children with disorganized attachment, and moderately low RF in mothers of children with insecure/organized attachment

(i.e. the anxious-resistant and avoidant groups) (Grienenberger et al., 2005)]. It is often helpful for clinicians to consider this continuum as they attempt to formulate interventions that target the specific areas of strength and vulnerability of the parents within their groups. The next section will provide two case examples, the first from a Mindful Parenting Group and the second from a Reflective Parenting Workshop. The examples illustrate these concepts and the utility of a mentalization-based approach to early intervention.

EMPIRICAL FINDINGS

The following examples represent two parents who were struggling with states of mind on opposite ends of the attachment continuum. In both cases we describe some of the personal histories gathered at intake, and use excerpts from the PDI, administered pre and post intervention, to illustrate changes in each parent's mentalizing capacity and states of mind in relation to specific attachment-related contexts. Interventions based on our case formulations are also presented. These examples can be understood as cases in which there were breakdowns in parental mentalization triggered by histories of unresolved loss or trauma. Both parents, however, exhibited average reflective capacity in the context of non-triggering attachment-related affects. The mentalizing deficits that were observed related to out-of-control feelings involving fear, anger, intense need, loss, or vulnerability in relation to their children, however these manifested in two very different parenting styles: a dismissive/hostile/intrusive parenting style in the first example and an enmeshed/helpless/fearful style in the second.

Samantha & Billy: A parent-toddler case illustrating dismissive/hostile/intrusive states of mind

Billy, a 26-month-old, prenatally substance exposed toddler, was in the process of being adopted from the foster care system by Samantha, a single woman in her mid-forties, when they were referred to a Mindful Parenting Group. He had been placed with her three months before the start of the group after experiencing a disrupted and chaotic foster care environment from which he had been precipitously removed. During the PDI at intake, Samantha demonstrated an intermittent capacity for reflection, however questions inquiring about more challenging affect states and difficult interactions revealed moments of uncontained hostility, distortion of its impact on Billy, and lapses of narrative coherency. An example is her response to the question, "can you tell me about a time in the last week when you felt really angry as a parent?"

> "He started screaming hysterically when I told him to go potty and I got angry and, and...
> I, I, I, (long pause) snatched him up a little (pause) roughly (laughs) (*uncontained
> hostility?*) and then I was like, OK, just go put him in bed. But I calmed down right away.
> I am a completely even-tempered person (*incoherent*). Sometimes I just snatch him up.
> We decided not to yell at him, so I snatch him up. You know I wasn't angry, I was
> frustrated (*incoherent*). I tell people when I don't like it, it's just how I am (*self-serving*).
> Sometimes I grab him with real force, although usually he's crying about as hard as he
> ever could cry so I don't think it gets worse for him whatever I do really *(minimizing).*

> The interviewer then asked a follow-up question about the impact of her anger on Billy
> and Samantha responded:

> "He tries to find the best in everything, I was expressing my frustration but in a nice way
> (*incongruent*) and he was happy about it *(self-serving, minimizing impact on child)."*

This example illustrates the role of uncontained, unmentalized hostility within Samantha's narrative that is likely related to unresolved trauma from her own early history. Parents with unresolved/intrusive attachment strategies often pose some of the greatest challenges to group leaders because of their inherent difficulties with self-regulation. There is often a tendency to externalize affect, and parental behavior may be characterized by criticism,

detachment, and rejection of the child. It is clear that Samantha is finding the experience of parenting to be highly provocative, and she is having great difficulty seeing the ways in which her own mental states (in particular anger) are impacting her behavior and subsequently the internal experience of Billy. Samantha's narrative in the PDI foreshadows some of the disrupted behavioral interactions that would later be observed during the Mindful Parenting Groups.

Armed with this kind of information, group leaders are able to develop interventions for working with parents who struggle with dismissive or hostile/intrusive states of mind by helping them to slow down and begin to make links between their mental states and their behavior in relation to their children. Parents may benefit from interventions that help to clarify misperceptions of their children and the impact of their responses to their children's behavior. It is also important to closely track countertransference, as feelings of annoyance, rejection, rage, helplessness, and even dissociation may be felt by the therapist. Group leaders should seek to avoid overreaction to such feelings, which can manifest as intrusiveness, boundary violations, or power struggles. Interventions should seek to stop the action and allow for the gradual integration of difficult material. It is also important to help parents struggling with dismissive or hostile states of mind to become more aware of and sensitive to their children's needs for comfort and contact. These parents often fail to see that their child's apparently provocative or disruptive behavior may in fact be his way of seeking proximity and connection (Slade, 2004).

Samantha and Billy joined a Mindful Parenting Group for families with toddlers being adopted from foster care. Billy typically entered the group independently of Samantha and initially he rarely made eye contact or returned to her during the ninety minute group

experience. If something happened that upset him, he would stand or sit alone in the room and cry. At these times, Samantha would not respond, commenting frequently to the facilitator that he "cried more here than anywhere else." She frequently described Billy as "a bully" and "aggressive".

During the 5th group, Samantha disclosed that Billy had frequently hit her during the previous week. When asked for her thoughts about this, she said she believed it was "good for children to stand up for themselves." The facilitator gently inquired as to whether she knew anything about that from her own history. Samantha then shared that she was the youngest of four, that her eldest sister had been physically abusive, and that her parents had done nothing to protect her. While she was speaking, Billy initiated several conflicts with other toddlers. Suddenly, Samantha stood up and lurched across the room saying, "that's it! I can't take it anymore! I can't sit there and watch! Especially when he is hurting other children!" She grabbed Billy roughly by the arms and pushed him hard toward the facilitator, saying angrily, "I want you to pay attention". The facilitator, a trainee, later reported in supervision that she had felt frightened by Samantha's behavior, as well as significant dread as to how Samantha might respond to any intervention. She noted that during the group, she was unclear whether Samantha was speaking to her or to Billy when she said, "I want you to pay attention", and she reported a countertransference reaction in which she had felt criticized for having "allowed" Billy's aggression. This led to a deeper understanding of the confusion that existed between Samantha and Billy in terms of the ownership and source of anger and aggressive impulses.

During the group, the facilitator had recognized the need to slow things down. She told Samantha that she could see that she was very upset by Billy's behavior, that she could manage

things from here, and that it might be easier to talk about what was happening if Samantha

were sitting down. Samantha took her seat, however she continued to struggle with the urge to

punish Billy for his behavior. During Parent-Centered Reflection, the facilitator commented that

Samantha had been talking about something important and relevant from her personal history

when she had responded to Billy's behavior. Samantha, who had become very quiet, said that

she realized she had been aggressive with Billy. She had worried that if she was too focused on

trying to understand the meaning behind Billy's behavior, it meant that she would not be able

to set limits on his aggressiveness. This led to a discussion of how difficult it is to "hold the

feeling" while also "holding the line" in relation to children's aggression.

Over the course of the next several weeks, Billy began to occasionally check in with his

mother during group, facing her as he sat in her lap, looking into her eyes with a smile. He

began to say "I love you" to which Samantha would respond with a warm smile. At times, Billy

would cry and Samantha would express concern and console him. During the observation

period of the 16th group, Billy was struggling with another child over a toy when he hit the child

in the head. It was unclear whether this had been intentional. The facilitator moved in close and

narrated for both the children. Billy was obviously curious about what was going on with the

other little boy, who was crying, and he continued to look at the child's face with curiosity.

When the incident had been resolved, the facilitators asked the group for their thoughts and

feelings about what had happened. Samantha, who had been observing relatively calmly during

the entire incident, stated that she didn't believe that Billy had intended to seriously hurt the

child, and she wondered whether a child his age had the ability to anticipate the outcome of his

actions. A turning point seemed to have been Samantha's experience of reflecting on her

unresolved traumatic history with her sister, which had been projected onto her relationship

with Billy.

Samantha's ability to mentalize had grown through the course of the group, with her

overall reflective functioning score improving from a 2 at the time of intake to a 5 during the

post-test, a significant increase. This enhanced reflective capacity was also evident in her

improved ability to regulate her anger and feelings of helplessness, to accurately identify Billy's

intentions, and to recognize both her own aggressive impulses and feelings and their impact on

Billy. As an example, in answer to the question "can you tell me about a time in the last week

that you felt really guilty as a parent?" Samantha responded:

> "Yeah, it was in the potty training, he went in his pants for the third time. Then I got him
> to sit on the potty and I said 'Billy, I want you to go on the potty'. I felt that I was being
> negative, and I don't think that is a good way of doing it. So I felt guilty about that, I felt
> my tone of voice was saying 'I don't like you'. I was using that tone of voice you save for
> people you don't like and I felt pretty guilty about that."

> Interviewer: "What kind of effect did these feelings have on Billy?"

> "Well, the guilty feelings I don't think he is aware of, but the anger he is pretty sensitive
> to. When I first got him, I wasn't handling my anger very well. Sometimes I would get
> too rough with him, like I said, I would grab him. He is very responsive and I remember a
> turning point for me was when he saw my face one time and I could see that he was
> scared. It diffused me just like that, the idea that he was afraid of me. Now I am working
> on my tone of voice, but sometimes I am not so successful. I wasn't sure about the potty
> incident, but I did feel guilty about it. I think he may have looked a little hurt. I imagine
> he probably was hurt by it. So I think that my guilty feelings have helped me to work on
> managing my anger, because I see the impact of my angry feelings on Billy."

This example highlights the way in which targeted assessment tools such as the PDI can

aid clinicians in their attempts to facilitate parental mentalization precisely in those areas

where the parent is most challenged. Samantha entered the adoption process with Billy with a

history of relational trauma that was manifesting in her current experience around issues of

aggression and uncontained anger. She was not conflicted about setting limits, but rather had a tendency to do so in ways that were aggressive, controlling, and punitive. The group facilitators were able to intervene in this dynamic through a careful process of slowing down and attending to Samantha's mental states, and to Billy's, in a manner that helped her to begin to form a more contained and containing way of responding to Billy's behavior that was grounded in an increased awareness of his underlying intentions and motivations.

Joanne: A case study illustrating preoccupied/helpless/fearful/enmeshed states of mind

Joanne, the mother of a four-year-old girl, joined a Reflective Parenting Workshop offered at her daughter's school. During the intake, she disclosed that she had nearly died from heart failure during childbirth, and that her daughter had also become gravely ill with viral meningitis in the days following her birth. Joanne described the first year as very difficult but said that as a result of these experiences, she and her daughter had "bonded like crazy." The fear related to the possible loss of her daughter seemed to have exacerbated already existing difficulties that Joanne had tolerating separation. The following excerpt is taken from the PDI administered at intake, where Joanne described an intergenerational history of "mindreading".

> "We don't need to necessarily talk for her to understand what Mommy's saying to her. All I have to do is just send her a message and she just gets it. I always know how she feels. And so yeah, um, it's just a special thing that my, I even had when I was little with my mom. I still have it now too, she lives thousands of miles away but when I'm upset, I know my mom will call, and she always does".

The PDI revealed that Joanne seemed to be struggling with, and fearful of, growing evidence of her daughter's separate mind. She said she was motivated to join the RPP group because in the last eighteen months, she had started to feel more helpless as her daughter began to "test the limits and change the rules." While this behavior may have been

developmentally appropriate, Joanne described as disturbing her daughter's desire to try to do

things her own way. Her PDI responses further suggested that Joanne often felt flooded with

affect and that her daughter was playing an important regulatory function for these feelings.

The example below illustrates the role-reversal that was occurring in this parent-child dyad.

> "She sees that it's a good thing that I need her a lot, as much as she needs me, you know, that I'm not Wonder Woman. She also knows that I, I need (*long pause*) Daddy. I don't want to feel uncomfortable or um, frightened, in any way, and I don't think she feels like she's not safe, she helps me feel safe. And um, we do, we do, you know go over that a lot you know. Like dreams, we have dream catchers, I have one over my bed and we throw away the bad scary things every night, and sometimes I fear things I don't want to have to hear, I mean fear. You know honestly I've made it, we're a very open, very open family."

This example illustrates the tremendous fear that Joanne was living with, and the

confusion she sometimes has between her own experience and her daughter's. The

incoherence in her response makes it difficult to know whose fear she is speaking about. This

kind of response alerts the interviewer to the possibility of unresolved loss or trauma, as her

narrative reads as if she were a young girl needing containment and regulation, rather than a

mother responsible for providing these functions for her child. Parents presenting with

unresolved trauma sometimes exhibit more helpless or fearful ways of interacting within

groups. They may pose a challenge to group leaders as they become flooded with uncontained

affect or dissociated memories, and may often demand much of the time and resources from

the group by their overt needs and their intense search for solutions. Paradoxically, solution-

focused interventions are often not particularly helpful, due to the "leaky bucket" nature of

their internal psychic structure. Instead, interventions that promote slowing down and

containment and integration of affect in order to facilitate thinking, particularly in regards to

the separateness of others' mental states, often serve to assist the development of self-regulation and mentalization.

During the Reflective Parenting Workshops, Joanne repeatedly demonstrated her difficulty tolerating and being sensitive to separate states of mind in others. For example, during the first group, she made several intrusive comments about some of the other parents, whom she was acquainted with from school. This included the assertion that "she was intuitive" and therefore "knew" the reasons they had joined the group. She proceeded to provide these specific reasons, however her explanations were unrelated to anything the other parents had said. The group facilitators felt ambushed, and described in supervision experiencing feelings of helplessness related to containing Joanne's hijacking of the group process. Joanne did not respond well to the group leaders' attempts to redirect her during the initial sessions, and often interrupted the group process with emotional pleas for help, along with contradictory statements saying that there was nothing that could help her, as she already understood her daughter so well.

During supervision, the facilitators worked with the trainers to devise several intervention strategies. Firstly, they would seek to model their own separate states of mind and their ability to provide boundaries, by letting Joanne know, if she interrupted, that she would need to wait until later in the group when there would be time for her to share. They also sought to address her feelings of helplessness by facilitating the development of more structured narratives as they slowed her down and provided containment of the feelings that seemed to interfere with her ability to think. The facilitators spoke directly to her ambivalence about taking a strong authoritative role in relation to her daughter. They were able to link this

ambivalence to the fear of loss that she had associated with her daughter's increasing

autonomy.

In the workshop focused on "Responding to Children's Distress", the facilitators asked

the group what they knew about this topic from their own experiences of being parented.

Joanne disclosed that her mother, who she'd been very close to as a child, had a mental

breakdown when Joanne was twelve. The group leaders gently facilitated a reflective process

about how this had impacted her, and she was able to state that without her mother's

presence, she had felt completely adrift, with no emotional anchor. The facilitators helped

Joanne to differentiate this experience from what was happening currently with her daughter.

They helped her to see that her daughter was developing not just a mind that was connected to

her mother's, but one that was most definitely her own, as evidenced by the behaviors that

were leaving Joanne feeling worried and unsettled. This reframed the benefits of having a

separate mind and opened the door for Joanne to be less threatened by her daughter's

autonomy. In her post-group PDI, Joanne stated,

> "I've actually learned to enjoy her a lot more through this group. (*Why do you think?*). Well, just learning that it's more important to stop and see how she feels about things. I always thought that I knew how she felt, but I don't think I did as much as I thought I did. So this was a really good reminder. I have slowed down in that respect and stopped and listened to what she's trying to tell me, like when she's trying to change the rules. I am realizing that she is trying to assert herself, and I don't feel so threatened by that anymore. We have changed some of the rules when that makes sense. Some of the rules we haven't, and she doesn't like that. But I am also feeling more sure of myself when I do need to stick to something or say no to her and she is handling it better when I do."

This example illustrates the decrease in anxiety that Joanne began to feel in relation to

her daughter's autonomy. Rather than experiencing these behaviors as merely confrontational,

she began to internalize a model that more accurately linked her daughter's behavior to the

normal developmental strivings of a four-year-old child. This reflective stance had helped her to become less influenced by her own early trauma and more grounded in her current relationship with her daughter. Also evidenced was a growing capacity to set limits, as she viewed her daughter's upset feelings as not necessarily destructive to their connection, but as the normal conflict experienced between two people whose minds are both interconnected yet separate.
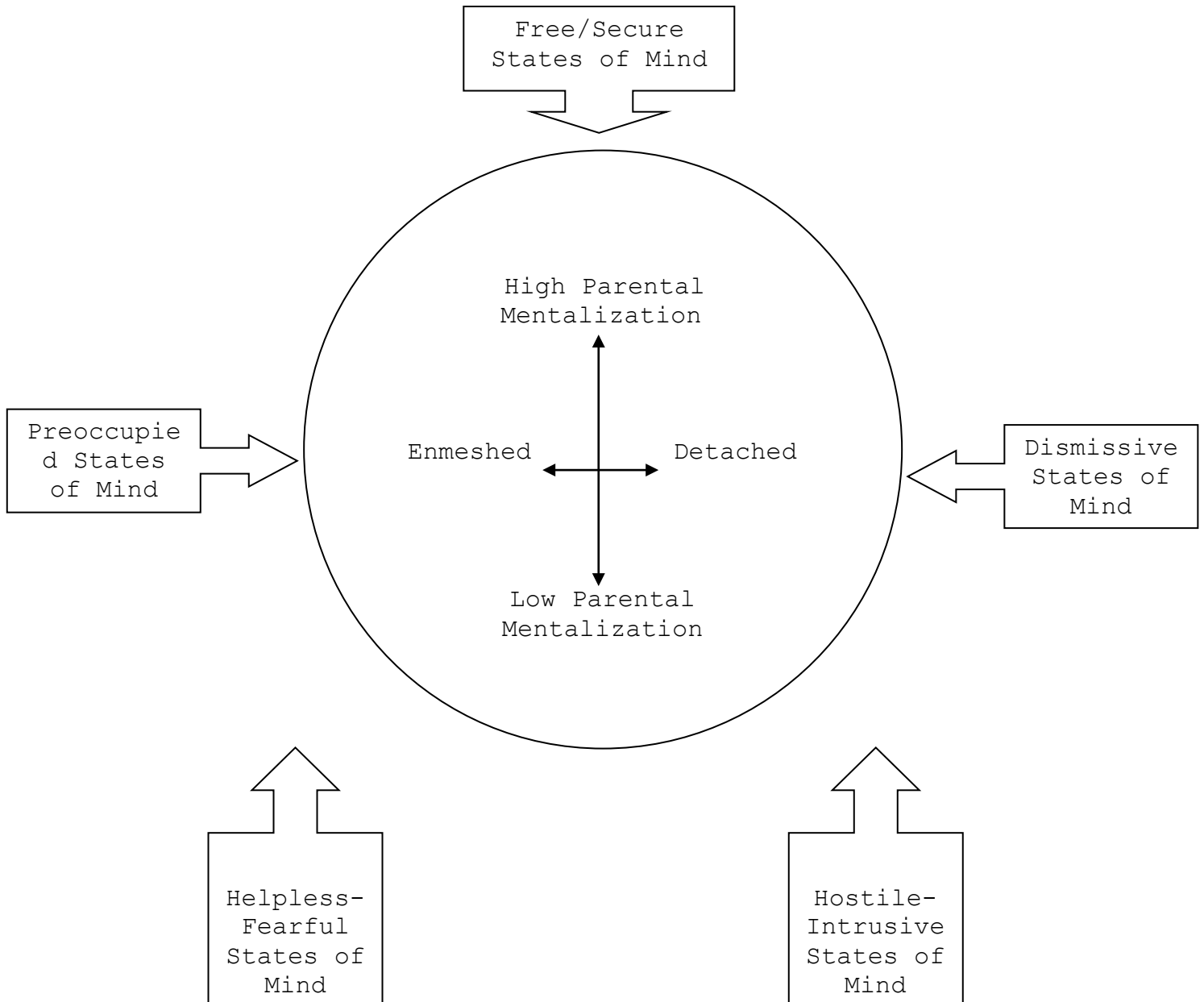
DISCUSSION AND CONCLUSIONS

The PDI was originally designed to help researchers better understand the processes involved in the intergenerational transmission of attachment. The programs at the Center for Reflective Communities have extended the use of this measure and are part of a new wave of treatment approaches that utilize attachment measures for the purposes of assessment and intervention. We have found that clinicians can be effectively trained to use the PDI during the intake process to informally assess a given parent's capacity for reflective functioning by evaluating "the building blocks of mentalization."

The PDI is also an ideal tool for understanding attachment dynamics because it has many questions that require parents to reflect on negative affect or times of relational strain, which we know to be central to the issues of affect regulation that are involved when the attachment system is activated. By focusing on "states of mind with respect to attachment," clinicians are able to evaluate areas of strength and vulnerability within the parent's narrative that may be linked to key parenting issues. This integration of mentalization with attachment patterns provides a rich source of information that can be used for case formulation and intervention planning. It also helps group facilitators to use attachment concepts in a manner that is flexible and nimble.

This fluid way of conceptualizing parenting allows clinicians to track moments of reflection and moments where parents become reactive and concrete. By focusing on the waxing and waning of mentalization within a given parent or within the group, facilitators are able to engage parents in a manner that can be understood as a parallel process to the dynamics that occur in the parent-child relationship. By creating a safe holding experience, parents are more likely to be reflective during the day to day interactions that occur with their children.

All caregivers, regardless of what attachment category might be assigned to them in a formal research study, are nonetheless capable of moments that might be characterized as exhibiting dismissing, hostile, preoccupied, helpless, or secure states of mind. By moving away from attachment categories and toward attachment processes, group leaders are able to engage with parents in a manner that is empathic, flexible, and hopeful. In this model, attachment patterns and mentalization are viewed as representing not only stable patterns of relatedness, but also as capable of adaptation and change.

Figure 1: Parental Mentalization & States of Mind with Respect to Attachment

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                    ┌─────────────────┐
                    │   Free/Secure   │
                    │  States of Mind │
                    └───────┬─────────┘
                            ▼

                     High Parental
                      Mentalization
                            ▲
                            │
┌──────────────┐           │
│ Preoccupie   │   Enmeshed   ◄──┼──►   Detached      Dismissive
│ d States     │              │                       States of
│  of Mind     │              │                       Mind
└──────────────┘           │
                            ▼
                     Low Parental
                      Mentalization


   Helpless-                        Hostile-
   Fearful                          Intrusive
   States of                        States of
   Mind                             Mind
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