CHAPTER 21

Reflective and Mindful Parenting

A NEW RELATIONAL MODEL OF ASSESSMENT, PREVENTION, AND EARLY INTERVENTION

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> 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.
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> —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 child's state of mind 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,

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

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 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 by providing 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.

In this chapter, we 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 nondidactic. 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.

PSYCHODYNAMIC APPROACHES TO EARLY PREVENTION AND INTERVENTION

One goal of this 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 & 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 next 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 & 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 & Target, 1998). Fonagy, Gergely, Jurist, and Target (2002) have described this process as "marked mirroring," whereby the caregiver is able to contingently respond to the child's internal state 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 tone of voice to mirror the infant's gestures, or a facial expression to

mirror a child's words. This complex multimodal 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 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 parents' current relationships with their children (Grienenberger, Kelly, & Slade, 2005; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). These studies have utilized the Parent Development Interview (PDI; Aber, Slade, Berger, Bresgi, & Kaplan, 1985) to focus on the capacity of parents 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 (Sharp & Fonagy, 2008). 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 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 target parental mentalization directly 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 this point of interface between the mentalizing efforts of the caregiver and the heightened affective arousal that characterizes the activation of the attachment system with which 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). A number of approaches have evolved from the educational and behavioral world (e.g., Field, 1982; McDonough, 2004) 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 "Interaction Guidance" (2004), which 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, although 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 (Cassidy & Shaver, 1999; Sroufe, 2005). Thus, it could be argued that attachment security should be the primary early intervention target. Berlin et al. (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 bidirectional influence that occurs between representation and behavior (Grienenberger & Slade, 2002).

Since 2005, several attachment-based programs have demonstrated success in supporting children's early attachment security (for a review, see Berlin et al., 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. Furthermore, several authors have argued that shifting internal working models of attachment depends on parental reflective capacity. Thus, parental mentalization is perhaps the critical intervention target in and of itself (Grienenberger, 2007; Sadler, Slade, & Mayes, 2006; 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.

Other early intervention programs that specifically target parental mentalization include the Mothers and Toddlers Program (Suchman, DeCoste, Castiglioni, Legow, & Mayes, 2008), a 20-week individual therapy intervention for substance-abusing mothers, the Minding the Baby project (Sadler et al., 2006), an interdisciplinary home visiting program for high-risk mothers that combines nursing intervention with mental health support, and the Circle of Security Project (Hoffman, Marvin, Cooper, & Powell, 2006), a group treatment model that utilizes video feedback, parent education, and psychotherapy to target insecure and disorganized attachment

patterns. All three of these psychodynamic/attachment-based intervention programs have reported pilot data that include favorable outcomes. For example, the Mothers and Toddlers Program found that mothers who completed the program showed moderate improvement in maternal behavior and improved capacity to foster their children's socioemotional development. The Circle of Security project found significant within-subject shifts whereby the majority of children moved from disorganized to organized attachment classifications following the intervention. However, while these studies are promising, randomized control trials are an important next step in establishing the validity of mentalization-based models of early intervention. In addition, further replications at additional sites are needed to ensure that these models are transferable beyond work implemented under the direct involvement of the program developers.

The PDI 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 et al., 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., Powell, Cooper, Hoffman, & Marvin, 2002; Steele & Steele, 2008). The programs at the Center for Reflective Parenting are part of this next wave in the clinical application of attachment research. Both programs use the Reflective Functioning coding system (Slade et al., 2002) for use with the PDI (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 (Slade et al., 2002). An aggregate score is also provided for the interview as a whole. A score of –1 is indicative of antireflective, 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 majority of clinicians undergoing training at the Center for Reflective Communities do not receive formal training in the reflective functioning 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 we 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. 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, 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 (see also Mikulincer & Shaver, Chapter 2, Luythen & Blatt, Chapter 5, this volume).

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 21.1 illustrates an integration of the continuum of attachment states of mind with the role of parental mentalization within parent–child relationships.

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 reflective functioning in mothers of securely attached children, the lowest in mothers of children with disorganized attachment, and moderately low reflective functioning 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

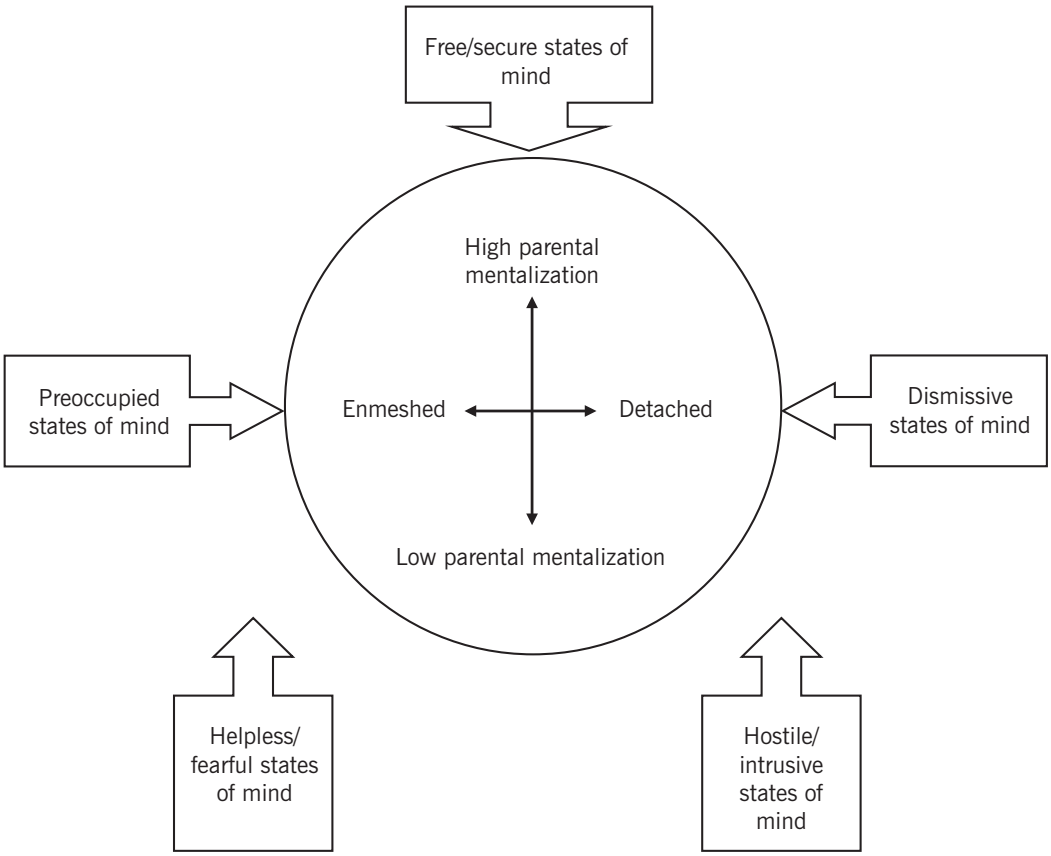

FIGURE 21.1. Parental mentalization and states of mind with respect to attachment.

of the parents within their groups. This approach to assessing states of mind with respect to attachment and the impact such states have on mentalization fits well within recent work that has increasingly seen mentalization as a multidimensional construct that requires the evaluation of a "mentalizing profile" in order to most effectively target areas of weakness and to formulate appropriate interventions (Luyten, Fonagy, Lowyck, & Vermonte, 2012).

PSYCHODYNAMIC APPROACHES TO EARLY INTERVENTION

The Center for Reflective Parenting 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. The Center is actively engaged in the empirical evaluation of these programs.

The Reflective Parenting Program is a manualized intervention. Preliminary outcome data indicate that after completing the program, parents reported significantly less stress, fewer depressive symptoms, and fewer behavior problems in their children (all *p*s <.001). More specifically, there was a 28% decrease in depressive symptoms on the Beck Depression Inventory with a medium effect size (.39) ($n = 89$), a 7% decrease in the Parenting Stress Index with a small effect size (.29), and a 12% decrease in Total Problems on the Achenbach Child Behavior Checklist, which represents a medium effect size (.45) ($n = 71$). Such findings suggest that interventions aimed at improving parental mentalization may be effective in improving both parental and child functioning, and thereby reduce some of the risks conferred upon children of parents who are compromised in some way, including those with mental health problems. A manual for Mindful Parenting Groups is currently under development. Both programs have been qualified as "Community Defined Evidence Based Treatments" by the California Institute of Mental Health. A large-scale randomized control trial study has recently been submitted for a federal grant that would include evaluation of the Reflective Parenting Program model with both Spanish- and English-speaking parents among families participating in community-based Head Start preschool.

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, nonverbal, 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 through which 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 in which 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 et al., 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 and 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 the 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 the Reflective Parenting Workshops and Mindful Parenting Groups foster the development of careful, detailed observation as the foundation for building reflective capacity. Infant observation was pioneered by Esther Bick (1964) at the Tavistock Clinic as a training tool for child psychotherapists to develop their ability to nonjudgmentally 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 to 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 the therapist's 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 bidirectional, 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 Reflective Parenting Program parent workshops and Mindful Parenting Groups include structured observational components as a way of developing parental mentalization. Reynolds 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 building reflective capacity and mindfulness.

The Reflective Parenting Program Workshop Structure

The Reflective Parenting Program parent workshops provide a developmentally scaled, 12-week workshop series for parents. These workshops are curriculum-based but process-focused. Multiple curricula are available, including workshop series

for expectant mothers and for 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, teenage 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 what arises inside 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 bidirectional, 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 are added. This provides opportunities for the 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 teenage mothers, Spanish-speaking parents, and parents adopting from foster care.

The next section provides two case examples, the first from a Mindful Parenting Group and the second from a Reflective Parenting Program workshop. The examples illustrate a theoretical model that is based in an understanding of states of mind with respect to attachment as contributing to the creation of case-specific profiles of mentalization. These profiles, in turn, allow for the highly individualized treatment planning that forms the foundation of these unique approaches to early intervention and prevention.

CLINICAL ILLUSTRATIONS

The following examples represent two parents who were struggling with states of mind at opposite ends of the attachment continuum. In both cases we describe some of the personal histories gathered at intake, and we use excerpts from the PDI, administered pre- and postintervention, 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 nontriggering 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, but these manifested themselves 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 and Billy: A Parent–Toddler Case Illustrating Dismissive/Hostile/Intrusive States of Mind

Billy, a 26-month-old toddler who had been prenatally substance exposed, was in the process of being adopted from the foster care system by Samantha, a single woman in her mid-40s, when they were referred to a Mindful Parenting Group. He had been placed with her 3 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 coherence. 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 began yelling when I was going to change the diaper and, and . . . I, um [long pause] grabbed him sort of, you know [pause] on the arm [laughs] [*uncontained hostility?*] and then I was like, OK, let's get this over with. But I was over it. I am a completely, a pretty calm sort of mom [*incoherent*]. Sometimes I grab him, but I decided not to yell at him, so I grab him by the arm instead. You know I wasn't pissed off, I was frustrated [*incoherent*]. Sometimes I have to be forceful, although usually he's already sobbing so I don't think it really matters what I do, as he is just going to cry it out on his own [*minimizing*].

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

"He is who he is, and I could do it four different ways and it isn't going to matter that much. I was expressing my annoyance nicely [*incongruent*] and he was fine with 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 Billy's internal experience. 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 track countertransference closely, 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

90-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 "isn't usually so emotional." She frequently described Billy as "a bruiser" and "rough."

During the fifth 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 him to be able to be tough." 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 handle this! I will not let him hurt other kids!" 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, and that she would be available during group to help her manage things. Samantha continued to struggle with the urge to punish Billy for his behavior, but she was able to take direction. 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, 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 sessions, facing her as he sat in her lap, looking into her eyes with a smile. He began to express more warmth, which Samantha was very responsive to. At times, Billy would cry, and Samantha would express concern and console him. During the observation period of the 15th group, Billy was struggling with another child over a toy when he hit the child. 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 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 on to 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 2 at the time of intake to 5 during the posttest, 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:

> "Yes, it was related to toilet training of course. He wet his pants again, and I was starting to get annoyed. So I made him sit on the toilet and I said very sternly, 'Billy, I want you to go potty on the toilet right now.' I think I was being harsh, and I knew it wasn't helpful to him. I started to feel guilty, and that I was being the critical mom again. He is not going to figure out toilet training if he is feeling pressured by me. [*Interviewer*: '*What kind of effect did these feelings have on Billy*?'] Well, I don't know if he was aware of my guilty feelings, but he definitely is aware of my anger. When he was first placed with me, I know I was not managing my anger well. I think I was too rough with him, you know, when I would grab him by the arm and walk him to where I wanted him to be. He is sensitive, and I remember the one time that it all began to change. It was when I could see by his expression that he was scared. It really changed my whole tone, I remember thinking, 'I don't want my kid to fear me.' I am working on all of that now, but it is hard. With the toilet training incident that I mentioned, I did feel pretty guilty, and I also realized I was making things worse, by causing him to feel pressure from me. The guilty feelings have actually been good to notice, and this has made me more sensitive to how my feelings, especially my anger, are impacting 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, she 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 4-year-old girl, joined a Reflective Parenting Program workshop offered at her daughter's Head Start preschool. During the intake, Joanne disclosed that her daughter had become gravely ill due to complications surrounding her birth. Joanne described the first year as very difficult but said that as a result of these experiences, she and her daughter "had become insanely close." The fear related to the possible loss of her daughter to illness seemed to have exacerbated already existing difficulties that Joanne had tolerating separation. The following excerpt is taken from the PDI administered at intake.

> "We don't have to talk for her to know what I am feeling. All I have to do is put it out there and she gets it. The same for her, I can always read her mind. And I am exactly like that with my mom. If I am having a bad day, she will turn up at my doorstep. It is a sixth sense. It is like we are always connected, me with my mom, and my daughter with me."

The PDI revealed that Joanne seemed to be struggling with, and fearful of, the growing evidence of her daughter's separate mind. She said she was motivated to join the Reflective Parenting Program group because in the past 18 months she had started to feel more helpless as her daughter began to test the limits and assert her independence. While this behavior may have been developmentally appropriate, Joanne described her daughter's desire to try to do things her own way as disturbing. Joanne's PDI responses further suggested that she often felt flooded with affect and that her daughter was playing an important regulatory function for these feelings. The following example illustrates the role reversal that was occurring in this parent–child dyad.

> "We are super tight. She has my back and I have hers. She also knows that I, I need [long pause] Papa. I don't want to feel scared or um, worried, and I don't think she feels like she's not safe, she helps me feel safe. Sometimes I fear things I don't want to have to hear, I mean fear. We can face my fears together, hers, you know, with Papa. You know honestly I've made it, we're a very tight family, nothing can hurt us."

This example illustrates the 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, containment, and integration of affect in order to facilitate thinking, particularly in regard to the separateness of others' mental states, often serve to assist the development of self-regulation and mentalization.

During the Reflective Parenting Program 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, with whom she was acquainted 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. First, 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, whom she'd been very close to as a child, had a mental breakdown when Joanne was 11. 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 think I have learned to see her more clearly through this group. [*Interviewer: 'How do you see that?'*] Well, just learning that it's important to slow it down and check out what she is feeling. Before, I believed that I always knew what she needed or felt, but I don't think I always did. I have slowed down and started to really pay attention to what she is saying to me, like when she wants to do something her way. I am realizing that she is trying to be her own person, and I don't feel so worried about that any more. Sometimes we can do things her way, and sometimes I have to say no, and she doesn't like that. But I am feeling calmer when I need to 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 4-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 interconnected yet separate.

CONCLUSIONS AND FUTURE DIRECTIONS

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 not only as representing stable patterns of relatedness, but also as capable of adaptation and change.

Mentalization-based programs such as the Reflective Parenting Program and Mindful Parenting Groups represent a depth approach to early intervention. Preliminary findings suggest that these models are effective in changing both parent and child outcomes. However, future research should include randomized control trials as well as additional replications to make sure that these models are transferable and therefore capable of wider dissemination for children and families facing the intergenerational and current risk factors that increase the likelihood of insecure and disorganized attachment styles in children. The Reflective Parenting Program is currently being evaluated in a federally funded randomized control trial promoting school readiness skills through parent workshops within Head Start preschools.

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