

Parental Reflective Functioning: An Approach to Enhancing Parent-child Relationships in Pediatric Primary Care

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Abstract and Introduction

Abstract

The current state of science suggests that safe, responsive, and nurturing parent-child relationships early in children's lives promotes healthy brain and child development and protection against lifelong disease by reducing toxic stress and promoting foundational social-emotional health. Pediatric health care providers (HCPs) have a unique opportunity to foster these relationships. However, such a role requires a shift in pediatric health care from a focus only on children to one that includes families and communities, as well as the inclusion of children's social and emotional health with their physical health. To foster healthy parent-child relationships, HCPs must develop the expertise to integrate approaches that support the family's socioemotional health into pediatric primary care. This article suggests ways in which pediatric HCPs can integrate a focus on parental reflective functioning into their clinical work, helping parents to understand some of the thoughts and feelings that underlie their children's behavior.

Introduction

There has been an important paradigm shift in the field of pediatrics away from the traditional biomedical approach and toward an ecological health approach that focuses on the broad array of environmental influences—family, society, and social policy. This paradigm shift was highlighted in the January 2012 policy statement and accompanying technical report by the American Academy of Pediatrics (AAP) that discussed the importance of mitigating the effects of toxic stress on the health and development of persons across their life span (Garner et al., 2012, Shonkoff et al., 2012). Toxic stress is defined as the experience of a prolonged stress response in children in the absence of safe responsive caregiving and is considered to be an important risk factor in the development of lifelong disease (Shonkoff et al., 2012). Because negative physiological effects of toxic stress are so extensive and complex, the earlier the stressor/issue is identified and remedied, the better (Shonkoff, 2010). Knowing that a key modifier to the experience of toxic stress is the provision of safe, responsive caregiving to children, pediatric health care providers (HCPs) have been called upon to develop effective strategies to enhance parent-child relationships (Garner et al., 2012). Here, we suggest ways in which pediatric HCPs can enhance parents' capacity for reflective functioning, or the capacity to envision their own and their child's mental states (Fonagy et al., 2002; Slade, 2005). We will first define parental reflective functioning (RF) and describe its role in the parent-child relationship and then provide an overview of the potential use of parental RF in pediatric primary care practice. This approach can be used by HCPs to promote secure relationships and better socioemotional health in routine well-child office visits by helping parents respond sensitively and reflectively to their children.

Parental Reflective Functioning

Parent-child attachment research conducted during the past 40 years has shown that interpersonal and emotional aspects of the parent-child relationship are important predictors of children's development (Bowlby, 1969, Bowlby, 1988, Cassidy and Shaver, 2008). A healthy parent-child relationship is essential to socioemotional health, and one outcome of a nurturing and safe early relationship is the "security" of the infant-parent attachment. Security refers to the child's sense that he can seek and obtain safety and comfort from his caregiver when he needs it, and that—with this safety in mind—he can explore the world freely and comfortably. Without this sense of safety, his ability to grow emotionally, develop healthy relationships, and feel confident in his explorations is diminished. Secure parent-child relationships are strongly related to numerous positive child outcomes (Goldberg, 2000, Sroufe et al., 2009). In contrast, insecure parent-child relationships leave infants and young children less able to regulate stress and vulnerable to other adverse child behavioral and emotional outcomes (Bakermans-Kranenburg, Van Ijzendoorn, & Juffer, 2005).

Contingent parent-child interactions are key to the development of secure attachment. When children's emotional cues are addressed in a safe, responsive manner, the parent becomes a "secure base" from which children can learn through exploration of their environment with the knowledge that their parents are close by and will welcome them back with interest, support, and curiosity about their children's experience (Bowlby, 1988). Contingent interactions help children develop a capacity for self-regulation and exploration, which in turn results in better psychosocial adjustment and a sense of empathy in their school-aged and adolescent years (Egeland, Weinfield, Bosquet, & Cheng, 2000). Children are more likely to have behavior problems and relationship difficulties in their school-age and adolescent years if their caregivers have limited capacity to recognize and respond to their early emotional cues (Egeland et al., 2000, Sroufe et al., 1999). In contrast, children of caregivers who are able to respond to them sensitively are less likely to have behavioral problems (McClain et al., 2010; Ordway et al., 2014a).

Parents are most likely to respond sensitively when they can understand the meaning and intention of children's signals and see their children as separate from themselves. Peter Fonagy and his colleagues (Fonagy et al., 1991, Fonagy and Target, 1997) refer to this capacity—to keep the child in mind—as reflective functioning (RF), or the ability to understand oneself and others in light of mental states (thoughts, feelings, and intentions). A reflective parent is able to make sense of her child's behaviors *in light of* mental states, which is to understand, for example, that he is crying because he is angry, or clinging to her because he is afraid, or banging his spoon on his high chair because he wants more food. Mature RF reflects a complex understanding of "how the mind, and particularly mental states, work" (Slade, 2005, p. 274), that feelings can intensify and then diminish over time (her child will not continue to be sad all day), that they can be opaque and hard to discern (the caregiver cannot be certain what her child is feeling, so she will have to figure it out), that they can trigger other mental states (if he gets scared, he may then get angry), and—most important—that they can trigger behavior, both in oneself and the other. Thus, within the context of the parent-child relationship, for example, a reflective parent might understand her child's temper tantrum in light of his anger at having to stop at the grocery store after a long day at day care, or her own shortness with him as a function of frustrations left over from a hard day at work. In both of these instances, the mother is able to understand her own and her child's behavior in light of thoughts and feelings and to understand how feelings "work," namely, that they can carry over from one situation to another. This capacity has been linked to both maternal sensitivity (Grienemberger, Kelly, & Slade, 2005) and secure infant-mother attachment (Fonagy and Target, 2005, Slade et al., 2005), and its absence is linked to disrupted interactions and both insecure and disorganized attachment (Grienemberger et al., 2005, Slade et al., 2005).

A parent's capacity for parental RF is also characterized by his or her understanding of the unique perspective that the parent and child have—even if their experience was shared. That is, effective parental RF is manifest in parents' capacity to recognize their own mental states as separate from their children's mental states and how their mental states affect another's behavior. For parents to become more sensitive and responsive to their child's emotional cues, they must be aware of (a) their child's and own mental states, (b) that mental states underlie behavior, and (c) how both a and b unfold in a developmental context. For example, for a mother to understand why her 2-year old son, who is happily playing with his favorite toy, does not want to be picked up upon her arrival home, she must have the capacity to recognize her child's mental state (preoccupation) as well as her own mental state (rejection). The next step is for the mother to link her son's mental state (preoccupation) with his behavior (resistance to her touch). Her capacity to make this connection will lead to understanding rather than a feeling of rejection. In this example, it is important for the mother to recognize her own mental state (e.g., feeling rejected, hurt, disappointed, and/or frustrated) and the influence of her emotions on her behavior (intrusiveness) in order to distinguish between her own and her son's emotional experience.

When parents do not recognize their own and their children's individual and separate emotional states and subsequent effects on behavior, there is a risk for miscuing one another, resulting in miscommunication that can lead to poor emotion regulation and an elevated stress response. In the previous example, if the mother was to insist on picking up her son despite his resistance, they would both likely become increasingly frustrated. However, if the mother is able to recognize her son's emotional cue and respond to him by saying, "It looks like you are having a great time playing with your blocks. I missed you today and I wonder if I could play along with you," it is likely that the result would be more pleasurable for both.

RF-based Parent-child Interventions

In light of the link between parental RF and child attachment, a number of interventions have recently been developed that are aimed at enhancing parental RF and thus promoting secure parent-child attachment and other positive health and mental health outcomes. The program we have developed, Minding the Baby (MTB), is a home visiting program that aims to help parents become more reflective in their interactions with their children and learn to manage the multiple demands in their lives (Sadler et

al., 2013, Slade and Sadler, 2005, Slade and Mayes, 2005). The MTB program provides intensive interdisciplinary home visits over the course of 2 years, beginning during the third trimester of pregnancy, to first-time young mothers ages 14 to 25 years. Mothers who participated in the MTB program had better life course outcomes, such as lower rates of rapid subsequent childbearing, and were less likely to have a child referred to child protective services during their 2-year involvement with the program. Additionally, the intervention infants were more likely to be securely attached to their mothers, and the teen mother-infant interactions were less likely to be disrupted at 4 months in the intervention group (Sadler et al., 2013). In a small follow-up study of intervention and control group mothers, the mothers reported significantly fewer behavioral problems among their 3- to 5-year-old children (1 to 3 years after the intervention; Ordway et al., 2014a). Our intervention has been critical to thinking about the expansion of RF approaches to primary pediatric health care practice.

Among other programs that aim to enhance parental RF, the Short Term Mentalization and Relational Therapy (SMART) is an emerging method of family therapy for families with children and adolescents (Fearon et al., 2006). This program has been used with children ranging in age from 7 years to late adolescence. The mentalization-based therapy lasts for 6 to 12 sessions and focuses on relationship problems within families and "mentalizing solutions" (Fearon et al., 2006). Another set of programs include Mindful Parenting and Reflective Parenting Groups developed for parents of young children (Grienenberger et al., in press, Reynolds, 2003). SMART, Mindful Parenting, and Reflective Parenting Groups emphasize that the development of parental RF is crucial to promoting healthy parenting.

RF is also at the core of two treatment programs for substance-using mothers to promote abstinence and improve maternal and child relationships (Pajulo et al., 2006, Suchman et al., 2012). Mothers with addictive disorders commonly have histories of negative childhood experiences, as well as neurobiological changes caused by the substance use. This combination of risk factors in the parents, together with pre-verbal infants' fluctuating mental states (e.g., crying 3 hours a day, on average), can set the stage for dyadic disruptions and a lack of emotion regulation strategies (Pajulo et al., 2006).

Reflective Stance

The previously described interventions focus on clinicians' ability to adopt a "reflective stance" as crucial to the enhancement of RF in parents. What is typical across these programs is that every effort is made to help parents take a reflective stance in relation to their children and their behavior. A reflective stance is one of curiosity and wonder—for example, "I wonder why he seems so withdrawn today" or "I can't really make sense of why she's been so unhappy about going to school"—in which the parent is encouraged not to focus only on changing behavior but on understanding the feelings and thoughts that underlie behaviors. It is by acknowledging the underlying mental states and addressing them that behaviors are likely to shift. This approach stands in sharp contrast to a behavioral approach, in which the parent is encouraged to try to change behavior rather than make sense of underlying causes (mental states) leading to the behavior. In all of these RF interventions, the clinician is encouraged to herself take a reflective stance of curiosity (as opposed to an assumptive stance common in a behavioral approach) of trying to imagine what might be going on for the parent and the child, as a way of modeling this for the parent, who may be too stressed and distressed to keep the child in mind. The goal is to support the development of the parent's capacity for parental RF.

We argue that, similar to the approach used with families in the previously described programs, HCPs can adopt a reflective stance in order to help parents explore the reasons behind their children's behaviors. In addition, HCPs can support parents' capacity for RF by facilitating parents' exploration of their own and their children's cognitive and emotional experiences. As we will describe later in this article, there are numerous ways and contexts in which HCPs can model a reflective stance for parents. We suggest that clinicians use such reflective phrases as "I wonder what (s)he was thinking," or "How did that make you feel?" as the basis for intervening and providing an example of sensitive, responsive caregiving by the pediatric HCP to the family. This approach is consistent with the call by the AAP for more narrative interview assessments in pediatric primary care visits (Hagan et al., 2001) and incorporation of mental health expertise (Committee on Psychosocial Aspects of Child Family Health & Task Force on Mental Health, 2009).

Parental RF in Pediatric Primary Care

What we would like to suggest is that, by adapting the techniques developed in therapeutic or home visiting settings, the same basic principles can also be applied to primary pediatric health care where the visits are of relatively short duration—15 minutes or less—but occur frequently over the first 3 years of life. The AAP recommends 14 well-child visits in the first 36 months of a

child's life (AAP Committee on Practice and Ambulatory Medicine Bright Futures Periodicity Schedule Workgroup, 2014), thereby providing an ideal opportunity for clinicians to model and enhance parental RF at regular intervals. Pediatric HCPs must examine effective ways that go beyond the traditional biomedical approach to care for families at risk for experiencing toxic stress. Because, by definition, the experience of toxic stress can be mitigated by the buffering effects of responsive, supportive caregiving (Garner et al., 2012, Shonkoff et al., 2012), the focus during each of the frequent pediatric office visits should be on enhancing parent-child interactions using a reflective parenting approach.

RF Integrated With Bright Futures Guidelines

Effective health supervision in pediatric primary care settings is best provided through a partnership between health care professionals and families as described in the AAP publication, *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd edition (Hagan, Shaw, & Duncan, 2008). Understanding that children's health is contextually viewed within their families and communities, *Bright Futures* highlights the importance of HCP's reflective health supervision that includes listening and considering family perspectives (Hagan et al., 2008). To guide clinicians in using this ecological approach clinically, the AAP Early Brain and Child Development (ECBD) Leadership Workgroup (see www.aap.org/ebcd) has developed an evidence-informed grid to proactively address supportive, responsive caregiving and child development within pediatric primary care settings using the Bright Futures guidelines (grid available at http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/EBCD/Documents/EBCD_Well_Child_Grid.pdf#search=bright%20futures%20grid) (AAP, 2014). In following the actions suggested in the ECBD Well Child grid, we developed practical examples of a reflective stance that that can be used during office visits to enhance parental RF (see the).

Table. Reflective stance examples to coincide with the Early Brain and Child Development grid^a

Pediatric visit	Example of application of reflective stance
Prenatal/newborn/week 1	"They say that your face is the precursor to the mirror for your baby. Your baby will use your face to learn about understand emotions. You have great impact in the teaching of emotion regulation to your baby. This begins at the earliest stage of life."
2–4 weeks	"How are you all sleeping?" "What's that like for you?/What's it like to meet the baby's needs?" "Sometimes mothers stay awake just watching their child and listening to his/her breathing. Sometimes babies sputter or even sound like they are choking when they drink/nurse. Do you ever wonder about those kinds of things?" "During these first few weeks, it is common to experience sleep deprivation, which can cloud our judgment. When we are tired, we may feel overwhelmed or depressed. It can be difficult to not overthink things—for example, sometimes when babies cry, they just want to be held. If you have just fed him/her and the diaper is clean, then some quiet time in your arms may be the ticket."
2 months	"I wonder what it has been like for you to return to work." "Your baby has likely become much more social and begun cooing. What has that been like for you?" "Sometimes it's hard to know why a baby is crying—to know when s/he is hungry or tired or lonely. When they are a little older their cries sound different when they are telling you different things. How is that going for you?" "How does your baby tell you when s/he is tired? Hungry? Lonely? Happy? Needs a rest?" "Are there things your baby does that are hard to understand? How do you try to figure out what s/he is communicating?"
4 months	"I imagine that your baby is making more and more vocalizations. Do you ever wonder what (s)he is thinking or trying to express during those times?" "Often babies are very sensitive to the moods of their parents. Have you noticed your baby's reaction to you when you are upset? What does s/he do?" "What do you do that changes your baby's mood? Why do you think that happens?" (Prompt for using books, music, outside time, bath time, cuddling)

6 months	"As your baby begins to take solid foods, I wonder what that is like for you?" "How do you think about establishing feeding routines, and how they might help you to bond with your baby?" "What kinds of feelings do you have when the baby is crying? Frustrated? Tired? Do you notice your body gets tense? Do you sometimes think you and your baby have similar feelings? Why do you think that is?"
9 months	"Just as we discussed when your baby was a newborn, your facial expressions teach him/her a great deal. Babies often experience some stranger anxiety and will look to you to acknowledge the person as someone they should know or is a stranger. How is it for you to help you baby to label their emotions or feelings?" "I wonder if you've noticed your baby watching your face when s/he is meeting someone s/he hasn't met or seen for a longtime. What do you think the baby is looking for in your face? Why do you think your baby looks at you in that situation?" "What is it like for you when the baby wants to explore and touch everything?" "When you say 'no' to the baby, what happens? Why do you think the baby has that reaction? What does it feel like to you to have to say 'no?' What do you imagine it will feel like when your baby is able to say 'no?'"
12 months	"This is often a time when your baby may experience some separation anxiety. How have you experienced this? Sometimes babies will cry as if to say, 'Oh mommy, I'm crying so hard because you left the room and I didn't know where you went!'" "What's it like for your child when you have to leave (the room, to go to work, etc.)? What kinds of things does your child do? What do you imagine s/he is feeling? How is that for you? Are there things that make saying goodbye easier? Harder? Why do you imagine that is?" "How does your child tell you what s/he wants? Doesn't like? Sometimes it's hard to know what children want. What's that like for you? What do you do when that happens—when you and your child don't understand each other?"
15 months	"As your child becomes more curious about the world and begins to explore his/her surroundings, what is that like for you?" "What's it like for your child when you have to leave (the room, to go to work, etc.)? What kinds of things does your child do? What do you imagine s/he is feeling? How is that for you? Are there things that make saying goodbye easier? Harder? Why do you imagine that is?" "How does your child tell you what s/he wants? Doesn't like? Sometimes it's hard to know what children want. What's that like for you? What do you do when that happens—when you and your child don't understand each other?" "Sometimes children this age don't want to stop what they are doing. How do you help your child 'change gears'? Why do you think that works/doesn't work?"
18 months	"Children's emotions at this stage can sometimes be overwhelming and difficult to handle. It sometimes gets to you and you get worried, frustrated, and upset all at the same time. It's hard to know what to do when you have so many feelings at one time." "Sometimes toddlers get frustrated and 'fall out.' Does that happen with your child? What kinds of things make her/him frustrated? What do you imagine your child is feeling/wishing s/he could do? What do you do when that happens? Why? What is your child's reaction to you?" "What kinds of things do you feel when your child has a tantrum?" (Probe: Some parents feel incompetent or worry that other people will judge them. Sometimes parents just want their child to feel better and try to help the child—and the child just gets angrier. Sometimes parents worry that their child is spoiled.)
24 months	"Tell me about your thoughts on toilet training." "Some children at this age suddenly don't want to eat certain foods. Sometimes they want to eat the same foods every day. They might close their mouths and shake their heads 'no' and run from the table." (These same sorts of statements can be used regarding clothing and dressing or diaper changing, going to bed, reading the same story, etc.)

	"Toddlers can have really strong feelings. What kinds of feelings does your child have during the day? What is that like for you? What do you do when that happens? Why? What is your child's reaction to you?"
30 months	"I imagine that your child is having some strong opinions about what (s)he wants and doesn't want. Tell me what it is like for you to set limits and offer choices." "What are the hardest times of the day for you and your child? Why do you think that is?"
36 months	"I am curious about your thoughts on preschool for your child."

^aThe Early Brain and Child Development grid can be found at American Academy of Pediatrics, 2014.

When HCPs use a reflective approach during health supervision visits, they are providing an important office-based intervention to help parents prevent or buffer the effects of toxic stress on young children (Garner et al., 2012, Shonkoff et al., 2012). When HCPs take a reflective stance and remain curious while discussing age-appropriate domains of development, parents are encouraged to share triumphs and challenges they have experienced during their parenting. This shared information presents an opportunity for the HCP to assist parents in strategizing about how to best address behavioral or developmental issues in the future by reflecting on the underlying mental states. A reflective and curious stance helps HCPs avoid a dogmatic approach to patient-centered health care. Adopting a reflective stance involves using statements like, "I wonder...." or "How did you feel when...." or "What do you think was going through your child's mind when....". The use of empathy and reflective listening by HCPs increases patients' reported satisfaction and a sense of feeling understood and having options that support autonomy (Pollak et al., 2011).

As mentioned earlier, an important element of the RF approach is the understanding that human minds are opaque (Fonagy et al., 1998, Ordway and Slade, 2014b). The concept of opacity may be challenging for HCPs who have been trained to "know what to do" when parents come to them with their concerns. By being comfortable with the state of "unknowing" what is in another's mind, one can adopt a reflective stance through wonder and curiosity. It is only when an HCP is able to assist parents to "engage in wondering that developmental guidance and knowledge takes on real meaning and vitality" (Busch, 2008, p. 225). A clinical example of this approach during routine pediatric health supervision is provided by *Bright Futures* (Hagan et al., 2008) in describing the 9-month visit as a good time to assess parents' attitudes and coping mechanisms with regard to their children's separation anxiety. Using a reflective stance, the HCP would begin by asking questions and engaging the parent in a state of wondering about his or her child's experience of separation, as in following example:

HCP: Tell me about how your daughter responds to being separated from you.

Parent: It has become very difficult for me to go to work in the mornings. My spouse is home with her in the mornings and he is no help. She just cries and has a fit. I get so frustrated and annoyed and I am often late to work because of her.

HCP: I wonder what could be going on for her.

Parent: I have no idea. She never used to be like this.

HCP: It sounds like the mornings have become very upsetting for you. I wonder what your daughter could be feeling.

Parent: I'm not sure. Maybe she's worried that I won't come back—I'm not sure why she would feel that way, because I come home at the same time EVERY day.

HCP: You're right, we can never really know what our children—or others for that matter—are thinking [opacity], but it is interesting to know that children at this age have begun to understand a concept we refer to as "object permanence." This means that while your daughter now understands that things, including you, exist even when they are not visible to her, she is not yet confident about them—or you—reappearing, which can lead to fear.

Parent: Wow, I had not thought about that before; it makes sense. What do you suggest that I do the next time she gets upset when I am leaving?

HCP-parent-child Relationship

Unlike acute care settings, primary care settings allow for the development of a HCP-parent-child relationship, and building rapport with the families over time results in a sense of respect and trust. Whether the relationship is between the HCP and family or the parent and child or all three, it is important to avoid overthinking or hyper-reflecting, which can feel intrusive. Effective parental RF requires that parents provide a "secure base" that allows children to go off and explore the environment and return back to their parents, knowing that their parents will welcome them back to the secure base and will comfort, protect, and help them with emotion regulation. It is important to assist parents in avoiding "helicopter parenting" (Padilla-Walker & Nelson, 2012)—that is, the sense of compulsive contemplation combined with excessive worry that some parents feel as a result of their overwhelming parental concerns and need for control. This state may indicate a struggle for parents in recognizing their mental state as separate from their child's mental state. Parents must learn the art of "being with" their children during healthy exploration of their environment while also remaining flexible to their children's unique experience and separate perspective in order to create a goodness-of-fit environment (Chess & Thomas, 1984). The ability of parents to "be with" rather than hover over (helicopter) their children helps provide early support for their children's emotion regulation resulting from the memory of their parent offering strength, care, and support.

HCPs can help parents to view their parent-child interactions from multiple perspectives. While taking care to validate the parent's perspective, the HCP may also offer alternative perspectives—perhaps the assumed perspective of the child. This approach is commonly referred to as "speaking for the baby" and involves providing a verbal description of what the parent (or HCP if the parent cannot) understands the child's physical or emotional cues to mean (Carter, Osofsky, & Hann, 1991). When the HCP attempts to "speak for the baby" in an effort to convey the connection between the child's mental state and behavior, the use of the first person may feel less formal or threatening to the parent. For example, when the HCP says, "Mommy, I may look big, but I am still little and I need your help getting dressed in the morning," the parent feels a sense of confidence and understanding as compared to being *told* what to do: "Your child is still very young and needs your help getting ready in the morning."

While considering alternative perspectives, one must be aware of misinterpretations and look for opportunities to correct any misinterpretations or "disconnects" in relationships, thereby promoting repair in the relationship as needed. This may happen in relationships between parents and children and parents and their children's HCP. When there is a disconnect or disruption in the parent-clinician relationship, the process of working on repair within the clinical setting (as in the example below featuring a pediatric nurse practitioner [PNP]) will serve as a model for the parents when relating to their children. Using a reflective stance involves, among other things, taking time to "pause and rewind" when a disruption in the relationship occurs. The pause acknowledges the disruption or change in behavior, and the rewind works to identify the emotional triggers that resulted in the behavior. This disruption in the provider-parent relationship should be identified and repaired, as in the following example of a new mother who became frustrated by the conflicting information she received about feeding her newborn:

Discussion After a PNP has Counseled a New Mother on Breastfeeding

PNP: Does the information we just talked about feel helpful to you?

Mother: I guess, but it makes me think that the lactation consultants in the hospital did not know what they were talking about. Every day, I heard different information from the nurses on each shift and the lactation consultants, and now you have said different things. It is all a bit confusing [sign of disrupted relationship between the PNP and mother].

PNP: It sounds like you felt frustrated by the varied advice you received [recognition that repair is needed].

Mother: Yes, I did.

PNP: [Attempt to repair] I can't speak to what the clinicians in the hospital were thinking, but I can share with you that my experience has been that the first few weeks of breastfeeding can be extremely varied between mothers and changes from day to day. All of these changes can sometimes feel overwhelming in the midst of trying to figure out your new role as a mother. These changes may also result in advice that seems to be inconsistent. Throughout your transition to becoming a mother, it will be important for me to listen to you and watch your baby's cues to gather information about how the experience is progressing. The experience is likely to change often over time. We talked about a lot of information today based on the experiences you have had with your daughter to date; however, you may call me in another day or two and share a new set of "data" that may result in me suggesting something completely different than what I suggested today. Please continue to let me know if you feel

frustrated or have any concerns about the advice if it seems contradictory, but I hope you feel reassured that my advice will be based on my reflective listening of your concerns today.

RF Approach With Anxious/Depressed Mothers

By using an RF approach, HCPs can help anxious and/or depressed parents recognize their impact on their children. The literature contains much information about the tendency of depressed mothers to report increased behavior problems concerning their children (Feng et al., 2008, Fihrer et al., 2009, Goodman, 2007, Ordway, 2011). In the pediatric health care setting, HCPs must recognize signs and symptoms of maternal anxiety and depression, because these are known to affect children in negative ways (Earls & The Committee on Psychosocial Aspects of Child Family Health, 2010). For example, in the case of a 4-month-old baby who was on the examination table awaiting four vaccines, the PNP noticed that the new parent was sitting off to the side of the examination table far from the baby. Recognizing the need for the baby to have her parent's face reflect or mirror her emotions, the PNP asked the parent to come over to the table. She gave an uplifting description of how a parent's face is the precursor to the mirror (Bowlby, 1982), meaning that a parent's face can serve as a teaching tool for emotion understanding and regulation. In the following example, the PNP talked to the mother about how to use her facial expression to facilitate her baby's capacity for emotion regulation at a very young age during the administration of four immunizations:

PNP: I was hoping that you could help me while I give your daughter these immunizations. I have four to give to her and she is going to be uncomfortable. While we cannot know what she is thinking, it is common for babies to cry when they receive their shots. I imagine them thinking "Ouch, ouch, ouch—what is going on here?" [speaking for the baby] I think it would be great if you could stand here and look down at her while I give the immunizations. That way she will be able to look at your face and use it as her mirror into her own feelings. Perhaps you can use a slightly exaggerated expression like, "Oh dear, I bet that hurt, I am here, sweetheart. The nurse practitioner will be done soon." This will help your daughter learn how to manage her emotions by modeling the emotion. The slight exaggeration in your facial expression will help your daughter to see her mind as separate from your mind."

The RF approach assists parents in "meaning making" through the use of narrative as described in the previous examples. Many other opportunities arise to use narrative throughout pediatric visits from the prenatal period through adolescence. As a final example, consider an infant looking up at his mother during a feeding. The provider may comment in a reflective, narrative, and marked manner: "I wonder what he is thinking. My guess is that he is thinking, 'Wow, I was hungry a few minutes ago and now this familiar person is feeding me and I am no longer hungry...this person is very important in my life!'" This type of encouragement of and emphasis on the importance of positive parent-child interaction by the HCP can ultimately help parents become supportive, responsive caregivers.

Conclusion

Leading organizations concerned with child health and development, such as the AAP and the Committee on Integrating the Science of Early Child Development, recognize that child health and development are both influenced by the effects of early caregiving relationships (Shonkoff, 2003). Children's growth, well-being, and healthy brain development is contingent upon the experience of nurturing, stable, and predictable relationships early in life (Shonkoff, 2011). Positive, nurturing and reciprocal experiences during the first few years of life create the foundation for healthy brain development (Coe & Lubach, 2005) and secure attachment relationships. Therefore, programs aimed at supporting the many factors that contribute to the development of a healthy brain early in a child's life should include approaches that support the development of secure parent-infant attachment. HCPs can play a critical role in fostering these healthy relationships. Such a role requires a shift in pediatric health care focus to include families and communities, as well as a shift to include children's social and emotional health. HCPs must therefore develop effective approaches, such as those described in this article, to be used while providing pediatric primary care.

Enhancement of parental RF by using a reflective stance during well-baby visits and pediatric care is ideal for ensuring child health and development in many ways, including providing opportunities for prevention, early problem identification and intervention, counseling, anticipatory guidance, care coordination, and identifying personal and community resources. The use of an RF approach described in this article can be very helpful to HCPs as they work with parents to care for their children's health, development, and behavior at all ages, thus supporting a healthy brain and child development by reducing toxic stress and promoting foundational social-emotional health. Child development is a major component of all pediatric health supervision

visits, and it is one of the critical elements that differentiates the care of children from care of adults (Hagan et al., 2008). By using a reflective stance, HCPs can better communicate with parents about their thoughts, concerns, and observations of their child's development and behavior to elicit important clinical information about the child. Subsequently, providers may better identify the potential need for intervention early on, resulting in healthier outcomes (Glascoe & Dworkin, 1995). What remains to be done is the development of programs to train pediatric HCPs how to incorporate approaches, such as adopting a reflective stance, into their very busy practices. Future work includes the development and implementation of such programs while evaluating important biological and psychosocial outcomes related to toxic stress.

Training Opportunities

The following Web sites are available for clinicians who are interested in receiving training on the concept of parental reflective functioning and application to practice:

- <http://mtb.yale.edu/training/index.aspx>
- <http://reflectiveparenting.org/programs-services-for-professionals/>
- <http://www.annafreud.org/pages/mentalization-based-treatment-training-programme.html>

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