Chapter 10

Enhancing Parental Reflective Functioning

GENERAL CONSIDERATIONS

Jaycee, 16 months old, is sitting in her high chair with her dinner in front of her. After a few minutes, during which she has been happily eating and looking quite content, she starts to pitch her food off her high chair and grabs her bowl, with the obvious intention of flinging it down. It is the well-known toddler game of "watching things fall," combined with the other well-known toddler game of colluding with the dog, who is patiently waiting for morsels to fly his way. Jaycee's mom—who has seen this trick before—intervenes and moves the bowl out of her reach. She asks, "You done? You had enough?" looking to Jaycee for an explanation and tentatively offering her a piece of food. Mom is wondering, not assuming. Jaycee takes the proffered piece of carrot and chews happily. But soon she is again lobbing food off her high chair; the dog, sitting close by, is thrilled. Mom looks at her inquisitively and waves her hands slightly, their sign for "all done." "You're done?" Jaycee waves her hands animatedly. She is done. Mom clears off the high chair, gives Jaycee's face and hands a quick wipe, and puts her down on the floor to play.

Throughout this typical exchange, Jaycee's mother is focused on her child's intentions. Contrast this with a mother who—when the first bit of food is thrown to the floor—quickly responds: "No! That's enough. Don't do that. You're being bad. You're done." She removes the food. Her daughter fusses, and Mom lifts her wordlessly out of the high chair. The difference between these two very common scenarios is that, in the first, Mom sees her daughter as *having* intentions, as having desires. This is a mentalizing

interaction. In the second, Mom is not curious and takes over. She tells the child what she (the child) wants, which is really what she (the mother) wants. She thus misses a small opportunity to wonder why her daughter has suddenly moved from eating happily to recreating a scene from the iconic movie *Animal House* and to communicate with her daughter about her intentions. This is a nonmentalizing interaction.

For many parents, curiosity is second nature; for others, becoming curious marks a profound shift from *assuming* they know what the child is feeling or wants or what the child needs to do (and likely trying to change or control it) to *wondering:* "What are they trying to tell me?" Although it is a profound shift, it is also a very simple one, noticeable in the tiniest moments.

The important clinical question is, of course, how we help a parent move from assuming (controlling, directing, overlooking, projecting, ignoring) to asking and being curious? How do we enhance a parent's capacity to reflect upon and make meaning of the child's experience and to appreciate that the child has thoughts, feelings, desires, and intentions that are different from the parent's own? How do we create a reflective space for the parent so that they can eventually begin to wonder about and make sense of the baby, first with the clinician's help and eventually on their own? And how do we help parents describe *their own* thoughts and feelings and soften the defenses that protect them from strong and unmanageable emotions?

Maintain a Reflective Stance

This work starts and ends with the clinician, whose capacity to maintain a mentalizing stance is central to the reflective parenting approach and the primary mechanism of therapeutic change (Suchman et al., 2012). As we described in Chapter 4, reflective parenting programs clearly help parents develop the basic tools necessary to mentalize and move out of prementalizing modes. The clinicians' steady mentalizing, their effort to *wonder* and not *assume,* gets parents moving in the right direction, not necessarily to full reflective functioning but perhaps to recognizing their child's basic thoughts and feelings. Recall Sally Provence's wise words: "Don't just *do* something. Stand there and pay attention. The *parent and the child* are trying to tell you something." *What* are they trying to tell us? We understand that behaviors *mean* something, that they communicate something, and that our job is to make sense of what that might be. Rather than taking behaviors at face value (or trying to change them), we approach behavior as indicative of underlying feelings and thoughts that we have to *discover.* And the discovery is a mutual process, with us always checking our understanding against that of the parent. Maintaining a mentalizing stance is not a "separate" part of our work; it provides an approach that frames all of

what we do: drafting a labor plan, resolving a housing crisis, or responding to a parent's depression. It is a process we engage in as much as we can throughout the work.

In this chapter, we outline what we see as the stages of nurturing and supporting the parent's nascent mentalizing abilities: Engage the relationship, Observe/Listen, Mirror, Wonder, Hypothesize, and (when necessary) Repair. Whenever we initiate a clinical encounter, we begin at the beginning and engage the relationship with the parent. Then, we move sequentially, deciding when and whether the parent is ready for the next step. As the encounter proceeds, of course, we move back and forth across these various stances as is clinically appropriate. But we always begin with the relationship, and we repair whenever it is necessary. Once we have described each of these stages, we discuss some of the specific strategies for engaging the parent's reflective capacities and the means whereby the clinician can assess their success in staying reflective, even in the face of great challenges.

Throughout this chapter, we focus primarily on how we engage the parent, mirror their experience, and encourage them to wonder and hypothesize. But we never ignore the child. As should be evident in all of the following examples, we use the child's responses to guide us in our mirroring, affirming, wondering, and hypothesizing. And to return to a point we've made repeatedly in earlier chapters, we are trying to reach the child *through* the parent. Sometimes focusing on the parent may feel as if it is coming at the expense of the child's needs; one experienced clinician referred to this as the "MTB dilemma," the delicate balancing act of connecting with the parent while managing our concerns about the child. Doing so reflects our core belief that in order for the parent to attend to the child and become aware of and curious about the child's experience, the parent must themselves be held and nurtured by the relationship with the clinician. This may require the clinician to temporarily set aside concerns about the child while attending to the parent, with the ultimate intention of helping the caregiver quiet down enough to make room for the child.

This approach is quite different from a more child-centered approach, in which the primary clinical aim is to address the child's needs. One of our guiding principles is the belief that if clinicians skip the step of keeping the parents in mind and turn directly to the child (albeit for legitimate reasons), they will not have nurtured the parents' capacities to keep the baby in mind but have taken over their role for them. Naturally, there are instances in which the baby's needs are primary and imperative, notably when the child is in danger. That is, when the parent cannot fulfill their biological caregiving role to protect the child, we must step in. However, what we are ultimately trying to do is to create enough safety for the parent so that they can listen to the baby (Close, 2002). When parents can pay attention and listen, the child will flourish.

Engage the Relationship

As we emphasized throughout Part II, a trusting relationship with the parent is what supports reflection, exploration, and learning. As such, we—in any encounter—convey empathy, warmth, and support for the parent's strengths and capacities. We always highlight what they are doing well. Our care and the trust that develops between us and a parent not only gives the parent the secure base from which to mentalize but also gives us the foundation from which to address conflicts and challenges. We also always highlight the parent–baby connection. In this way, we are always underscoring not only the importance of their emotional bonds and connections but pointing to the specific ways in which these are maintained.

STRATEGIES FOR ENGAGING THE RELATIONSHIP

- Be emotionally present.
- Be supportive and empathic.
- Highlight and praise competencies in reflection and other areas.
- Validate the parent's experience.
- Highlight the parent–child connection.

Observe/Listen

We then try to join the parent *wherever they are*. To do this, we must first see and hear where that is. If we start anywhere else, we will lose them. And so we begin by observing and listening. Our goal in doing so is to have a sense of both the parent's experience *and* the baby's experience. What is it like to be *them* in that moment? How do they see and feel others in their lives? As Allen and his colleagues (2008) have noted, "patients' mentalizing capacities vary considerably within and across sessions; hence as a mentalizing therapist, you will be monitoring the patient's state of mind continually and intervening accordingly. A basic principle: the more fragile the patient's ability to mentalize, the simpler your interventions must be. This simple principle can be difficult for therapists to follow because most of us tend to become more complicated in our interventions as we understand less" (p. 185). Thus observing and listening as a means of monitoring *where the parent is at* is crucial.

As we described in Chapter 4, the capacity to reflect upon mental states can be conveyed *implicitly* in the way a person interacts with others or *explicitly* in language, namely, in the way an individual talks about

themselves and others. In populations where verbal expression or vocabulary may be limited as a function of trauma, educational opportunities, the way language is used in the family, or developmental/cognitive capacity, watching for *implicit* forms of mentalizing is particularly important. Thus, when we *observe* a parent and child, we are—among other things—looking for signs that the parent is implicitly mentalizing, namely, reading the baby's bodily cues and responding contingently. When we *listen* to a parent or child, we are listening for signs of a willingness to consider and imagine what is in the other's mind. In the Jaycee example earlier, the mother is both implicitly mentalizing (paying close attention to the baby's bodily cues and behaving in kind) and explicitly mentalizing (asking, with curiosity, "You done? You had enough?").

Observe

We observe the parent, the child, and their interaction, focusing on the physical body, the feeling tone of the interaction, and the quality of arousal.

The Body

What is the parent's body posture? What is their facial expression? How are they holding themselves? Is their stance open? Relaxed? Are there signs of contentment, pleasure? Are they crumpled, disengaged, not making eye contact? Are their movements sharp? Sluggish? Do they seem tense, angry, anxious, distracted? Do they seem frightening or frightened? What about the sound of their voice: Is it melodic? Flat? Pressured?

And what about the child? How do they hold themselves? What is the quality of their movement? Are they open and engaged? Or shut down and flat? Is the child physically relaxed or tense and edgy? Passive and floppy? Are their body movements calm and assured or timid? Is the child cooing or chatting, or is their voice flat? Are the child's eyes open and responsive, or do they avoid the parent's gaze? Does the child appear to feel safe with the parent, or are there subtle signs of threat and dysregulation? Does the child—as described by Main and Solomon (1990) and reviewed in Chapters 3 and 9—display contradictory behavior patterns, incomplete or interrupted movements, stereotypies, freezing, apprehension, disorientation, or confusion? These are all signs of fear and conflict.

And the parent and child together: How does the parent hold and handle the child? Do they seem comfortable being face to face? Can they establish a comfortable closeness, not too distant, not too close (gluey, sticky) but "just right"? Do we see signs of the capacity for "serve and return" (National Scientific Council on the Developing Child, 2012, 2020), for maintaining reciprocal, mutually regulating interactions? Is the child an

interactive *partner*? How does the child seek proximity and maintain contact? Is the parent interested in and reading the child's cues (following the infant's gaze, following the child's lead in play) with reasonable accuracy or overriding these in subtle or not-so-subtle ways? Is the parent making sense of the child's nonverbal signals?

OBSERVING PARENT AND CHILD

- Body posture
- Facial expression
- Physical stance
- Vocal tone
- Quality of eye contact
- Quality of the interaction
  - Ease of proximity seeking and contact maintenance
  - Reciprocity and mutual engagement
  - Parent's capacity to pick up on the child's lead and follow it
- Level of arousal in parent and child

Arousal Level

Returning to the arousal curve (see Figure 10.1), we observe the level of arousal in the parent and in the child. Where do they fall on the curve? What state are they in? Is the parent activated and highly aroused or shut down and remote? Or are they open and ready to engage? And what about the child? Are they excited, overexcited, or passive and withdrawn? Or are they engaged, focused, and regulated? As we described in Chapter 2, the arousal curve provides another way of describing an individual's state of consciousness. When a person is open and regulated, they are in a state to receive what we have to give; when they are shut down or overaroused, they cannot process their experiences and open themselves to change. To return to some of the material we reviewed in Chapter 9, when the parent is in a regulated state, the prefrontal cortex, or reasoning part of the brain, can be engaged to organize and make sense of emotional experience and thus allow for transformation. Note that parent and child can be in different states of arousal, a mismatch that can in and of itself be problematic. For instance, a child might respond to the parent's agitation by shutting down and withdrawing. Thus, as in the example of Sandy in Chapter 9, the mother is very distressed, yelling, pacing, and the child is wandering around looking apologetic. One clinical aim would be to help them get back in sync with each other. The home visitor attempted to do this by asking Sandy to take

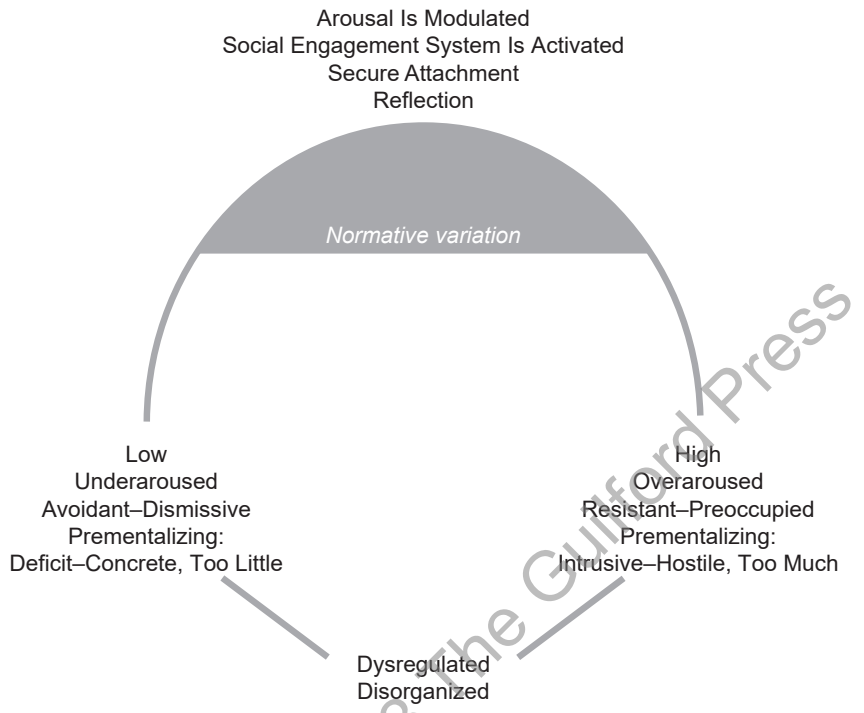

FIGURE 10.1 Arousal in the clinical situation.

note of her daughter, which might have calmed her down. Unfortunately, she was too agitated to pay attention to the home visitor's suggestion.

Listen

Anne Gearity, a social worker, infant mental health supervisor, and reflective practitioner in Minneapolis, Minnesota, regularly hands out cards to her supervisees that have only two words printed on them: "STOP TALKING." You can't listen with your mouth open. Making any sense of what is going on with a parent and/or child requires that we listen to what they are telling us. Silence is an open invitation to the parent to think and talk. This may seem like a simple and obvious point, but in fact it can be the hardest thing to do. We so often feel an urgency to do something, to solve a problem, to fill in the blanks, fill the silences, to get to *the work*. It may be uncomfortable, but this *is* the work. If we are going to join them, we have to know where they are.

Quality and Coherence of Narrative

Recall that in Chapter 2 we described Main's discovery of the importance of evaluating the quality of a parent's narrative, as this reveals the degree to which the parent has access to their thoughts and feelings (Main et al., 1985). We listen to the narrative for incoherence, contradictions, blocking, oscillations, incoherence, and vagueness. Can we follow the story? Does it make sense? When there are disruptions in the narrative, can we identify what triggered them? What is the parent talking about and why might there be a need to defend themselves, to get off track?

Quality of Representations

How does the parent represent or describe the child? How do they represent themselves and others important to them? In a positive way, inflected with humor and affection? Or in a negative way, with hostility or disengagement? What is the content of their stories? What kinds of things come to their mind when describing the child? Are their representations balanced, disengaged, or distorted (Vreeswijk et al., 2012; Zeanah et al., 1994).

Reflective Capacities

What do we hear in the way the parent is talking about the child's thoughts and feelings, and about their own? Where are they, more or less, along the continuum of reflective functioning?

Reflective Functioning Scale (RFS)

Prementalizing

– 1 Bizarre, hostile, or negative RF

1 Disavowed or absent mental states

The Foundations of Reflective Functioning

3 Identifying thoughts and feelings

Reflective Functioning

5 Average RF; reflecting on the nature and impact of thoughts and feelings

7 Complex or sophisticated RF

9 Exceptional RF

At the most basic level, is there evidence of the parent's mentalizing abilities? Are they, at any level, aware of their thoughts and feelings? Of others' thoughts and feelings (Level 3)? Or are they primarily stuck in prementalizing modes, either having little interest in or sense of what is going

on in the child, or projecting onto and distorting the child's experience (Level 1)? Do they think about mental states when trying to understand their own or others' behavior (Level 5)? Are they curious or do they make assumptions about others' mental states? Do they try to understand behavior in light of mental states? Can they be flexible and open in the way they think about internal experience? As we discuss more fully in Chapter 13, we do not expect clinicians to be expert coders or able to make precise assessments of the level of PRF, but we do hope that they can listen to the parent's speech with these distinctions in mind, as they will guide what the clinician says and does in working with the family.

LISTENING

- To the way language is used (to create closeness or distance)
- To the coherence of the parent's narrative
- To the ways the parent represents the child and others
- Does the parent assume they know what others are thinking or feeling?
- Is there evidence of projections or misattributions or an absence of interest in the child's mind?
- Can the parent acknowledge feelings?
- Can the parent be curious?
- Can the parent infer feelings and thoughts from behavior?
- Can the parent be flexible in imagining possibilities?

Mirror

Once we have a sense—by observing and listening—of where the parent is "at," we often begin by mirroring what the parent or child is saying. Recall Allen and his colleagues' (2008) reminder to start simple, especially when a parent is struggling to mentalize. Mirroring is a simple and powerful way to communicate interest in another's experience, to indicate that we are present and engaged. We saw this in the example of Sandy and Joni in Chapter 9. The clinician first says, "*You're mad, furious, in fact*"; Sandy agrees with and expands upon this. The clinician then mirrors, "*You are so mad you want to hurt her*," which is also right on target. However, when the clinician then asks Mom to think about her behavior or, later, to think about other ways to understand the situation or reactions, Sandy feels threatened, gets defensive, and slips into prementalizing. The clinician has asked her to do too much, and there is little

working with her in those moments; the clinician has to move back to curiosity and mirroring.

Mother–infant researchers noted long ago that the simple act of mirroring validates the child's affective experience, makes it more real, marks it, and acknowledges it (Stern, 1985). Mirroring a parent's stated experience can have the same effect. And it is always a good place to start, even when things are settled and calm. It can take many forms, in all of which the clinician stays *close to the feelings*. The first is simply repeating back what the parent has said, using the same words. The second, which is what the home visitor did in the example of Sandy, is to offer words to describe the parent's diffuse state or behavior. Another strategy is to clarify: "*So you're angry, and not scared?*"; "*Did I get that right?*"; and the like. In doing this, the clinician communicates in a variety of ways that they are open to and interested in understanding and knowing what the parent (or child) is feeling, rather than telling the parent or assuming that the parent knows. The clinician makes it clear that they hope to be accurate and in tune.

MIRRORING

- Stay in the moment and close to the parent's experience.
- Reflect the parent's feelings back to them, sometimes simply repeating what they said, at other times using other words, but staying close to the feelings. This can be regulating and containing.

  Example: "You are really mad. Furious, in fact."
- Ask a parent to clarify what they mean, so that you're sure you understand.

  Example: "You thought she was going around spreading stories about you? Is that it?"
- Ask the parent to tell you more, to elaborate on what they are saying.

  Example: "Can you say more about what you were feeling?"

Wonder

Here we come to the question of understanding the parent's state of mind. *What is going on* internally? Although we may well note denial, prementalizing, distortion, or projection, we take a stance of wondering, of trying to imagine what the child (or the parent's partner, family member, or the parent themselves) might be thinking or feeling. To discover this (and it *is* a

process of discovery), the clinician wonders and doesn't assume. They take a stance of *not-knowing*, of wanting to understand, tolerating uncertainty. The clinician acts—as it were—"like an alien" (Allen et al., 2008), trying to learn about a new culture. "*What's this like for you?*"; "*I want to know you. I want to understand.*" The clinician tries to remember, even when things get very hot (the parent is very upset), or very cool (the parent is shut down), that helping the parent cool down or warm up depends upon keeping the parent's thoughts, feelings, and mind in mind.

> The mentalizing, or not-knowing stance is not synonymous with having no knowledge. Not-knowing captures a sense that mental states are opaque and that you can have no *more* idea of what is in the patient's mind than the patient has and, in fact, you will probably have a lot less of an idea. Mentalizing, you demonstrate a willingness to find out about patients, what makes them tick, how they feel, and the reasons for their underlying problems. The mentalizing stance is respectful and devoid of assumptions. (Allen et al., 2008, p. 183)

Wondering can take many forms and can be conveyed nonverbally (a curious look, an open, interested look) or verbally: "*So, tell me what's going on. . . .* " "*What's that been like for you?*" "*How's that feeling?*" "*What do you think about his not wanting to let you go at school?*" "*What do you think made that feel so bad?*" "*Why do you think he had such a bad night?*" These statements not only convey curiosity, but they also convey that there are meanings, motivations, and causes to be discovered and understood.

Fearon and his colleagues (2006a) refer to mentalizing as an *attitude* rather than a skill. The word *attitude* conveys nicely that mentalizing is not something we are always doing *explicitly*, as in wondering out loud or asking a parent about their experience. It is an *internal* process, a way of approaching another human being. Oftentimes clinicians can interpret the word *wonder* rather concretely and begin statements that are veiled directives with it: "*I wonder why you didn't do such and such.*" Rather than being curious, the clinician is in this instance scolding the parent, which can easily be humiliating. Clinicians can ask too many questions, leaving the parent feeling badgered and—if they have no answer—shamed. For these reasons, we try to remain open-minded, interested, and engaged; we try to keep mentalizing, but not necessarily out loud. Parents (and older children) need time to process, to listen to and observe their own thoughts and feelings. This is how we hope they will approach their own children. And when we do wonder explicitly, we do so judiciously, respecting their tempo and level of engagement. To return, once again, to the question of threat, the mentalizing or reflective stance is inherently nonthreatening, in

that we invite the parent to share their experience in whatever way they are able; the clinician and parents are partners on a journey.

In the videotaped session described below, the clinician, Lisa, uses a variety of wondering approaches to help Belinda, age 17, become more curious about her 8-week-old baby, Carlos. We can well imagine, reading this passage, that the clinician wanted, first, to tell Belinda to pick up the baby and, second, to pick up the baby herself. But she is patient, and it pays off.

In the background is the sound of a television crime show, as well as rhythmic music. Infant and mother are seated on a double bed; the mother's younger sister is in the room, although not on camera. Belinda is holding Carlos loosely on her lap, facing away from her; she has a kind of half-smile on her face. She puts a pacifier in his mouth. He looks disoriented, floppy, kind of lost, fusses slightly, pushes back against her, refuses pacifier. She jiggles him and laughs nervously as he fusses. She continues to jiggle him and tries to get pacifier in his mouth. He continues to fuss.

She then picks him up and puts him face down on the bed (which is actually in line with pediatric guidelines for "tummy time" but implemented without apparent intention). He naturally tries to take a crawling position but does not have the muscle strength in his arms to do so; he fusses, moves his face from side to side to breathe. Belinda's sister notes twice that he is trying to get up, and Belinda remarks, "he's frustrated." He is obviously very uncomfortable and struggling. She is kind of laughing, not meanly, but anxiously. She pats his bottom, but otherwise there is no contact—she is observing impassively.

LISA: What do you think he wants? (*Lisa is inquiring.*)

BELINDA: He gets frustrated when he can't do what he wants to do. . . .

LISA: What do you think he wants to do? (*Her inquiries follow what Belinda has said.*)

BELINDA: Tryin' to crawl. . . . (*She rubs his bottom in a vigorous way while he fusses.*) You need help? (*She is speaking to the baby. She does not move, continues to passively observe.*)

We can well imagine that the clinician is likely itching to tell the mother to pick up the baby and hold him. But that would rob the mother of discovering the baby's needs on her own, albeit with the clinician's support. And it runs the risk of making the mother feel ever so slightly shamed for not recognizing the baby's needs on her own. And so the clinician proceeds slowly.

LISA: What do you think? Does he need help? (*Inviting Mom to explore her observation.*)

BELINDA: I don't know. . . . (*Shrugs.*)

LISA: How do you think he's feeling? (*Hoping Mom will pick up on what is apparent to the home visitor as well as Belinda's sister.*)

BELINDA: He feels frustrated. . . .

LISA: At?

BELINDA: Cuz he can't crawl?

LISA: You think he wants to crawl? (*She is affirming Mom's observation and encouraging her to keep observing.*)

BELINDA: I don't know. . . .

LISA: (*speaking for the baby*) Hey, Mom, it's kind of hard to hold my head up. . . . My arms aren't that strong yet. . . . (*Here she is imparting developmental information in hopes of getting Mom to imagine what it is like to be the baby.*)

BELINDA: (*Gazes at the baby with a little bit of curiosity.*)

LISA: (*to the baby*) You tryin' to find your mamma? You lookin' for her? (*Here, using a series of questions, she is highlighting the activation of the baby's attachment system as he signals that he needs help.*)

(*As if slightly roused, Belinda reaches over and pulls the baby into her lap. Gradually, she puts her arms around him and pats him vigorously, rocking him side to side. It's a little rough, but at the same time he calms and settles against her. She smiles slightly.*)

LISA: There, he likes that. . . . (*She is mirroring and thus marking baby's pleasure for Mom, thus reinforcing Mom's success.*)

In her next session, Belinda seemed much more attuned to the baby and was able to describe the infant's obvious pleasure in their feeding interaction. And when a loud noise in the room startled the baby, she readily and naturally moved in to protect and comfort him.

WONDERING

- Model and encourage curiosity and wondering ("not-knowing") about feelings and thoughts.
- Ask questions to promote exploration and clarity, rather than taking answers at face value or assuming you know the answer.
- Avoid certainty (you are not an expert on *them*).
- Ask parent to think about the feelings of all those involved (i.e., the parent, the baby, the grandmother).
- Work to identify and label hidden feeling states.

- Speak for the parent—sometimes parents have limited feeling vocabulary or little practice putting their own feelings into words.
- Speak for the baby—verbalize the baby's perspective, talk to the baby, describe the baby's world and experience to the dyad.
- Use humor judiciously when it feels right.

Hypothesize

Many of the parents we see really struggle to make sense of their own or their child's experience. Their parents, their friends, and their partners may all be quite mysterious to them; mentalizing is hard. And that is why we often need not only to wonder but also to *hypothesize* about what is going on in a way that offers the parent new ways of thinking and of being. Hypotheses are just that, *hypotheses*, and not certainties. They are not assumptions but a guide to considering alternatives and to developing a broader sense of why people do the things they do. Most important, they demonstrate that the clinician, too, is open to possibilities and to various ways of seeing a situation.

As clinicians, we know something about feelings, about people, about causes of trouble in relationships, and about what makes people unhappy and happy; we understand the role of unconscious dynamic processes in human relationships. And we know something about child development, about adult development, about learning. We don't have the answers, but we know something about the possibilities. And we can use this knowledge to speculate, to wonder "what if it's . . . ?" In training clinicians, we have noted many times that they can be reluctant to hypothesize and fall back on mirroring and wondering. At times, actively mentalizing for the parent or child is crucial, because this offers a new way of understanding a situation that is painful and confusing. We are knowledgeable about the impact of the past on the present, about relationships, and about development. And we can use this knowledge to inform the hypotheses we offer.

Note that we use the word *offer*; the parent can accept or reject them. It is so important that hypotheses not be presented as certainties. Nor are they "lessons" that a practitioner needs to teach the parent. We do not know for sure what the parent or child means to communicate, nor why they are doing one thing or the other. It is also important that we offer hypotheses in a way a parent can understand and make sense of. Language should be simple and clear; sentences should be short and coherent. And the "level" of the hypothesis should be close to the parent's level of understanding. Thus, for example, if a parent who had herself been abused as a child was describing a wish to hurt her son, we would not begin by linking this

to her childhood experience. We would first ask her to think about why she was so provoked and angry, what she imagined the child was feeling, and how she understood her own feelings. We might then hypothesize that she felt disrespected and helpless. Only once she was fully grounded in the present experience might we ask her to think about some of her own childhood experiences and how they might be triggered in the present.

In the following example, the clinician hypothesizes in a way that communicates developmental information. Marta, age 13 months, loves to hang on to the TV's remote control and to wave it around and press all the buttons. As a result, of course, the TV comes on and off randomly, and the volume fluctuates dramatically.

> Marta's mother, Lucia, is upset and frustrated. When the clinician asks her why she thinks Marta won't let go of the remote, Lucia resorts to relatively benign prementalizing: "Oh, she just wants to do whatever she wants!" The clinician might say, "Well, you're right that toddlers love to feel in charge . . . they love to press things and see what happens. Toddlers also like to copy their mommies, and . . . ? What if she's kind of enjoying being just like Mommy?"

What the clinician is doing here is first affirming Mom's efforts to understand her child and her observation about toddlers and their need for control. She then offers a couple of alternative explanations that are based on what she knows about toddlers and their development, and that also highlight the mother–child relationship. She is, in effect, saying, "Well, there might be some other ways to understand this. . . . How about this?" She is not saying, "*This* is what your child is doing," but rather, "Well, there could be all sorts of ways to think about Marta's behavior. . . . Can we think about them?" These subtle reframings, particularly the suggestion that Marta wants to be like her mommy, place the behavior in a positive light and hopefully will soften Mom's frustration. It may also help her find other, quieter ways for Marta to be like her mother.

The clinician's understanding of the parent's history can also often inform their understanding of what is going on with the child.

> A mother had recently separated from her abusive partner. Her son witnessed numerous fights between her and his father, and he has since been very aggressive toward his mother. When the clinician arrives, the mother is distraught and very upset with her child. "I can't take this anymore. He's hitting and biting me and I just want to smack him!" The clinician wonders to herself what this upsurge of aggression in the child is about. Does he miss his dad? Is he mad at his dad for leaving and taking it out on Mom? Is he copying his dad? And she wonders about the mom's wish to fight or flee. Is she frightened by the child? Is her rage at her partner being directed at the child? Is she feeling

that she wants to retaliate? Likely both the child and she are feeling a range of things, all understandable within the context of what's been happening in the family. The clinician offers some hypotheses. "Wow, you've been dealing with your partner's anger for so long. . . . This must not be what you expected. This sounds a little scary. . . ." Mom replies, "That is for sure. What if he turns out just like his dad, who is such a lowlife?" The clinician replies, "I can sure understand why you'd feel this way . . . but you know, maybe he's confused about why his dad left? And about why his dad was hitting you? Sometimes that's how kids act when they're feeling confused and lost."

The clinician is providing the parent with various ways to potentially understand what is going on with both her and her son; she is also trying to gently dislodge the negative attribution that the boy is going to grow up to be a loser like his dad. She is doing this using a relational and developmental framework, gently offering a range of possibilities that will hopefully allow the mother to see herself and her child in a different way. Such hypotheses will often be rejected by a parent who is still closed to reflection, usually because they are too shut down or agitated, as we saw in the case of Sandy. But even if the parent doesn't accept our hypotheses, our thinking about them may be helpful in the long run. And when there is a team of clinicians working with the family, the parent can hear different (though hopefully not contradictory) points of view from different clinicians. This directly conveys the idea that there are often multiple ways to view most situations.

In the following exchange between Leticia and the social worker she has been working with for more than 2 years, the clinician uses mirroring and wondering to support hypothesizing. Leticia is a full-time caregiver for her 4-year-old nephew, Marco, whose mother is unable to care for him. In this session, Leticia is able to use the clinician's hypotheses to expand her thinking about Marco and to understand some of the links between her own childhood experiences with her mother and her feelings about her nephew. It's important to note that—throughout the exchange—the clinician's efforts are working, in the sense that the mother doesn't become defensive, pull back, or resist. This allows the clinician to deepen her inquiries and gently push the mother toward more compassion toward her nephew and for herself.

Marco just returned from a trip to Disney World with his father, with whom he had little prior contact. The session took place outside, where Julia (Leticia's 18-month-old daughter) and Marco were playing. Julia got frustrated and grabbed a toy out of Marco's hand. Marco let out a woeful cry.

LETICIA: (*to Marco*) Why are you crying so bad? You're a big boy. Big boys don't cry! (*Marco cries even harder and goes over and tries to sit on Leticia's lap.*)

Go on, you don't need to sit here, go play with Julia, she wants to play with you, that's why she grabbed the toy. (*Marco puts his head down and cries harder.*)

LETICIA: (*to the clinician*) I don't understand. He just got back from this great vacation but he's been crying and clingy and whiney.

CLINICIAN: Seems like you knew from Julia's grabbing the toy that she wasn't "just being mean" or anything but just wanted to play. What do you think might be going on for Marco? (*Here the clinician is praising Leticia's accurate reading of her daughter's intention and inviting her to think about Marco's.*)

LETICIA: I have no idea, but it's really getting on my nerves.

CLINICIAN: It seems like it's hard for you to see him upset, especially when you think he should be "relaxed" from vacation. (*Here the clinician is offering a hypothesis [note: not with certainty!] about why Marco is getting on her nerves.*)

LETICIA: Yeah, I would love for someone to take me on vacation!

CLINICIAN: No doubt! It'd be nice for you or me. (*Here she empathizes with the mother.*) But I wonder, do you think it might feel the same for a 4-year-old? I was thinking it might feel a little different. He was traveling with a dad he doesn't know well and was away from all the family he does know well. (*Here she offers another way of thinking about Marco's behavior, an alternative perspective.*)

LETICIA: Yeah, I guess maybe he might feel kinda insecure or something. (*She softens and offers the possibility that Marco might not be feeling so great.*)

CLINICIAN: Yeah, that would make sense to me. Maybe being close to you, crying, wanting a hug or to sit on your lap is his way of saying, "I missed you and I feel kind of stressed. I want to be close to you because being close to you helps me feel better." (*The clinician praises Mom's recognition of the child's distress and then proceeds both to offer a possible explanation of Marco's need for Leticia and to speak for Marco directly.*)

LETICIA: Ugh! But sometimes I feel like, ugh, like just saying, "Get away! I need my space!"

CLINICIAN: Yeah, I can understand that. Sometimes he wants to be close to you and you don't like that. It makes you feel . . . "ugh." (*The clinician echoes the mother's feelings and supports them.*) It might be a silly question, but what is that feeling, "ugh"? . . . Can you describe it? (*Here she invites Mom to think more deeply about this feeling. This kind of inquiry will only work if the parent is open and receptive.*)

LETICIA: Stressed—like too much pressure. It just feels like too much to be with him, AND Julia, AND work, and everything I'm trying to juggle on my own.

And it's not like my sister ever even asked if I could take care of Marco, she just left him here one day. (*Mom's feelings come pouring out, clearly and coherently.*)

CLINICIAN: Yeah, it's very hard. You didn't sign up for this job taking care of him . . . and you already do so much on your own. (*The clinician empathizes with Mom and acknowledges the pain she is feeling.*)

LETICIA: And my mom—she was really my aunt, but I called her "Mom"—always encouraged that. She told me not to depend on anyone, that I didn't need a man or anything to get by. She really wanted me to be an independent strong woman. Needing someone or something wasn't something to be proud of! (*Here the mother has herself taken the conversation to a new level, spurred by the clinician's empathy and her invitation to deeper reflection.*)

CLINICIAN: Hmmm, I wonder if maybe that makes it hard for you to know what to do when Marco needs something from you. Do you remember what that was like for you—when you needed something from your mom or felt stressed and wanted to be close to her? (*Here the clinician is able to use what the mother has told her to begin to make links to the mother's own history and experience of feeling needy. Such moments are possible when the parent is not defensive or threatened and when she fully trusts the clinician. In this case, mother and clinician have known each other for 2 years.*)

LETICIA: Oh yeah, my mom usually pushed us away—if we cried she'd send us to our room and tell us not to come back until we could act like a big girl . . . or else she would really give us something to cry about—she never really wanted to hear why we were crying. (*The clinician notes but does not mention that Leticia has just described her interaction with Marco to a "T."*)

CLINICIAN: What do you remember about what that was like for you? (*The clinician is following the mother's lead, once again inviting Leticia to tell her more.*)

LETICIA: Well, on the one hand, when I could pull it together and stop crying, I felt proud. I believed her when she said that not crying meant I was acting like a big girl. On the other hand, I hated being pushed away. I always felt like I was being pushed out from under my mom's feet, like I was in the way and needed to learn how to be on my own faster so I wouldn't be a burden to her. (*Here Leticia describes her ambivalence clearly and coherently and makes clear why she is activated by Marco's neediness.*)

CLINICIAN: It makes me feel sad thinking about how that might have felt for you then—sad about you as a little girl wanting her mom and being pushed away. Do you think any of that ever influences any of the decisions you make about taking care of Marco? (*As we discuss below, here the clinician*

is using her own experience to imagine Marco's experience. She is also inviting her to reflect on how her past feelings influence her behavior with Marco.)

LETICIA: Well, I guess sometimes, especially when I'm stressed, I'm doing the same thing my mom did—I'm pushing him away when he needs something from me. (*Here she makes the link explicitly.*)

CLINICIAN: Sometimes it helps me to think about Marco's behaviors as his own kind of language, like he's saying, "I'm anxious, and it was hard for me to be away from you. I need to be close to you to feel better AND, Mommy, it will be hard for me to act better until I feel better." I think his being "clingy or whiney" might mean he needs to get close to you to feel more settled or safe. I wonder what it would be like when you are stressed and have those feelings, the ones that make you want to push him away, to do the opposite—to pull him close instead, stop and give him some attention, a hug or space on your lap for a few minutes? (*Now that Mom is open and reflective, and making complex connections across time, and between feelings, thoughts, and behaviors, she can take in the clinician's mentalizing for the child and potentially try out the clinician's suggestion.*)

LETICIA: It would probably feel awkward!

CLINICIAN: Awkward. Yup, I bet it would. Lots of times when we try something new it feels pretty awkward at first. (*The clinician is empathizing with and supporting Leticia.*)

LETICIA: I guess I could try. You mean if I try, it might help him feel better so he'll do what I want? (*Leticia uses humor, a good sign that she is feeling softer and more playful and considers alternatives.*)

CLINICIAN: Well, I do think it will help him feel better, but I wouldn't promise you it will always get him to do what you want in that moment! (*Clinician responds with humor and offers a little developmental guidance.*)

LETICIA: (*with laughter*) No, sometimes there is nothing that I can do to get him to do what I want. (*Continued humor and an apparent appreciation of Marco's complexity.*)

CLINICIAN: (*laughing, too*) That's true! Well, after all, he is his own little person with a mind of his own—and as hard as that can be on you sometimes, I think you do want him to keep using that mind! (*The clinician praises Leticia for her reflectiveness.*)

LETICIA: Yes, and I'd really like to figure out a way to keep letting him know that he can come to me when he's happy or stressed, trust me, and trust that I love him and won't push him away. (*Mom appears to have come to a new understanding and appreciation of Marco and her circumstances.*)

CLINICIAN: I think he'd really like that, too. (*The clinician again reinforces Mom's reflectiveness.*)

HYPOTHESIZING

- Think of this as expanding the parent's mentalizing capacities.
- Do so in moments when the parent seems receptive and open to reflecting.
- Elaborate possible alternatives when you have their attention.
- Validate the parent's experience before offering alternative perspectives or reframing.
- Use a "what if?" stance; encourage family members to play with new ideas.
- Generate multiple perspectives: "What else could be going on?"
- Use your knowledge and understanding of the parent, their history and way of regulating to reframe their perceptions of the child, themselves, or others.
- Gently challenge parent's beliefs about themselves or others.
- Use humor judiciously; be playful when it feels right.

Ideally, with mirroring, wondering, and hypothesizing, parents can begin to move out of prementalizing, nonreflective modes, name feelings, wonder about their own reactions and try to understand them, wonder about their child's reactions, focus less on behavior, respond more sensitively to the child, and have fewer disrupted interactions.

Repair Ruptures

Ruptures between interactive partners occur all the time (Tronick & Gold, 2020), including between parents and clinicians. We have noted throughout the book that cycles of rupture and repair are at the heart of all relationships. Thus clinicians should acknowledge mistakes when they arise, pay attention to ruptures in the relationship, and do what they can to repair them. The repairs can be subtle and swift, or—when there has been a painful rupture—they can take a long time and be very hard work. But they are so necessary. For this reason, clinicians must be very attuned to ruptures and not let them get too far along. Sometimes the repair can be made in the moment: "*Oh, I see, it works to keep her in bed with you until she falls asleep. I got that wrong. Sorry.*" In the Sandy transcript, the clinician's attempts to regroup and rewind are unsuccessful, but she tries. At the end of the session, she acknowledges the rupture. Mom has retreated to being defensive and shut down. This rupture will have to await another visit to be repaired. The clinician can begin the next session by acknowledging the rupture directly: "*You know, I think that somehow I really wasn't hearing*

you the other day when you were telling me about the woman who said you had crabs. . . . I've been thinking about that, and about you, and I realize just how hard that must have been. You try so hard to do what's right for your daughter and best for you. You must have been upset that I couldn't quite hear you." Or the clinician might send the mother a text in a few days to see how she's doing, implicitly trying to mend fences. Whether or not the mother responds is less important than that the clinician conveys to the mother that she's been thinking about her, that she (the mother) matters to the clinician, and that her voice is valued.

Use Your Own Experience

Throughout this book, we have discussed how important it is for practitioners to attend to their own reactions in clinical encounters. The way we feel in a situation, our gut reactions, our triggers, our impulses, our fantasies all tell us something about what the parent is experiencing. This can help us think about how to frame things, what hypotheses make sense, and when to back off and wait. Take, for example, the vignette described in Chapter 9, when the mother, Sandy, is in a rage at a woman who has insulted her. When the clinician could not move Sandy out of her angry state, she tried to elicit Mom's protectiveness by sharing her worries about Joni. Sandy could not hear the clinician, however, and eventually the clinician stepped back, acknowledged her uncertainty, and tried to step to the surface, pause, and rewind.

USING YOUR OWN EXPERIENCE

- Know yourself—pay attention to your own reactions and feelings.
- Make use of yourself as a clinician, your own feelings, and your experience.
- Share your feelings when therapeutically useful.
- Acknowledge when, as clinician, you do not know what to say or do.
- If overwhelmed with affect or content, step to the surface, pause, and rewind.
- Put your feelings and thoughts into words.

The Challenges of Working in a Reflective Way

We have found again and again that clinicians who adopt this approach, often after decades of working in a more behavioral, problem-focused

way, are quickly persuaded that the changes they see in families are deep and long-lasting. A nurse described it as "the gift of time" (Birgitte Bjerg, personal communication, April 2019). What this gift does, very simply, is greatly reduce the risk of the parent's feeling threatened, shamed, and disrespected. This allows them to discover the child and discover themselves. But such developments can be very hard won. Parents often come to intervention prone to being reactive, impulsive, and out of touch with their emotional lives. These defenses have been essential to their emotional survival. Such survival mechanisms are not going to yield quickly or easily, and, in fact, clinical progress often means that they shift just a little. We often remind clinicians to "cherish small shifts" because, although parents may, even after a course of treatment, be only fleetingly able to name feelings and contain their behavior, these are enormous steps forward for their own and their babies' development. Recall from Chapter 4 that simply being able to identify and recognize mental states can be quite therapeutic and an antidote to a position of threat, shame, and defense.

The main challenges in this way of working revolve around the clinician's very real struggle to balance reflecting on the one hand and taking a more active, directive stance on the other, to navigate what we call the "dance of reflecting and directing." There are, in fact, many times when parents need advice, guidance, and concrete resources. Typically, practitioners are able and willing to do this. They know a lot about how children develop and thrive; they have useful information and knowledge about parent and child health; they can link the parent to a range of resources. The key is doing this in a reflective and not directive way: *would,* not *should*. So, for example, a parent may ask: "*What's the best position to encourage her to nurse?" "Do you think my son is ready for day care?" "I just got an eviction notice—what do I do now?" "Can you show me how to meditate?*" In these situations, parents are *inviting* us to share our expertise, our thoughts. They are open, asking, curious. We offer advice within the framework of a mentalizing stance: "*What positions have you tried to encourage her nursing? Let me watch you . . . have you tried supporting her head?" "Well, what options are you considering for day care? How would you feel about sending him to the Park Lane Day Care? Shall we call them together and see whether they have openings?*" Our relationship with the parent makes us a trusted source of knowledge; as such, our expertise can be valued and not threatening. We try in every way not to threaten the parent or make them feel (consciously or unconsciously) that we are saying we know better than they do. That is—in any form—an invitation to resistance and defense. We never know for sure what is in another's mind, so it behooves us to find out!

It can be very difficult to keep listening and wondering. Even when concrete support or guidance is needed, it's important to maintain a slow

pace and try to help the parent(s) discover what they feel and/or what the child feels. The absorption of knowledge and the ability to make use of concrete advice and to modify behavior depends upon *experiential* understanding, and particularly the experience of getting to know oneself and one's child. By letting the parents come to a solution on their own, clinicians promote autonomy and sharpen the parents' awareness of their or the child's inner experience. And for many parents, the discovery that they *have* thoughts and feelings and that the baby also has thoughts and feelings can be utterly transforming.

Threat is often at the heart of therapeutic breakdowns, or what Fearon and his colleagues (2006a) have described as "nonmentalizing cycles of interaction." By this they mean interactions in which neither interactive partner is considering the thoughts and feelings of the other; as a result, both members—because they are unable to make any sense of the other—become more controlling and coercive, and reciprocity or attunement is impossible. These are forms of rupture that are perpetuated over time. In nonmentalizing interactions, the clinician has abandoned wondering and is imposing their assumptions and beliefs upon those of the parent. This is the essence of prementalizing; the clinician is *certain* of what is right. Let us return again to Sandy, first mentioned in Chapter 9. The clinician is able, at first, to remain curious about what it is that has so offended Sandy, staying close to Sandy's experience with her inquiries. But as her anxiety grows about the intensity of Sandy's rage and her repeated threats to go out and beat up her accuser, the home visitor moves too fast, and in effect tries to get Sandy to see how unreasonable she's being. This just sets Sandy off again. This is a nonmentalizing cycle of interaction, with both Sandy and the home visitor triggering more nonmentalizing in the other. Of course, there might well be moments when stopping Sandy might be the only possible course for the clinician (e.g., if she were storming out the door). In the moment, however, the home visitor might have had more success had she been able to fight her impulse to try to get Sandy to be reasonable, because it just led Sandy to be more unreasonable and allowed nonmentalizing cycles to continue.

Practitioners working with young families are almost always from the "helping" professions. Often their professional disciplines (social work, nursing, education) emphasize taking action to fix problems and restore health. As a result, the pace and subtlety of a reflective approach may leave them feeling that they are not "doing enough" and that not much is happening. Add to this that the "gift of time" may make clinicians very anxious. They've got to *do* something. Sometimes practitioners respond to this by *pushing* parents to reflect, peppering them with questions they cannot answer. Sometimes practitioners label, diagnose, or "other" the parent (Shapiro, 2008). "That's his ADD; I read about it in his chart." "She

is such a borderline, getting everyone all worked up and sowing chaos." They find themselves judging and critical: "Why would she see her boyfriend again after all we've talked about?" "Why didn't he give his son his medicine?" "He didn't show up at work *again*?" "*Why* would she leave the baby with her friend?" "Why couldn't he get himself to school?" Although these seem like questions, they're actually judgments, rather than attempts to imagine the parent or child's experiences. Practitioners can also resort to assuming, which is, in essence, disrespectful: "I know what you are *really* thinking." "I know what you want for your child/family." "I know the best way for you to behave." "I know what your behavior means." "I can see what is important in this situation." Once a clinician says, implicitly or explicitly, "I know what you feel. I know what you should do," they have created a power dynamic that—especially for young, disenfranchised, or marginalized parents—provokes defensiveness born of shame and threat. This dynamic is likely magnified when the clinician is White and inherently privileged.

Many early-intervention models offer guidance, education, and support without engaging the parent's reflective capacities. But knowledge that is offered without an opportunity to learn it *from the inside out* (Suchman et al., 2017) cannot be internalized in a meaningful way or used to support their agency and autonomy. To return to the central message of Part II, by attending to threat and dysregulation, by building on the relationship we have developed with parents, by being willing to repair when we've gotten it wrong or have threatened the parent, we create the foundation for increasingly complex reflection and the development of a sense of competency and confidence as a parent.

Self-Assessment: Maintaining a Mentalizing Stance

In an attempt to help clinicians keep track of how they're doing in maintaining a mentalizing stance, we recommend regular "self-assessment" checks. Adapted from Allen et al. (2008), these gentle self-correctives remind the clinician to step back and try to understand and listen. They can also help identify areas for improvement and potentially inform supervision. It is easy to step into a directing, educating, advice-giving mode or to make assumptions about the parent's internal experience, and these inquiries help reorient the clinician. Of course, to reiterate what we have said before and what we describe in more detail in subsequent chapters, there are times when giving advice and guidance, or directly intervening to curtail a behavior, is crucial.

CLINICIAN MENTALIZING SELF-ASSESSMENT

- I take a stance of not knowing what the parent's or the baby's experience is, and I am interested in finding out.

  Example: "Tell me more. I'd like to understand what that was like for you and what you were thinking."
- I ask questions to promote exploration and clarity, rather than taking answers at face value or not following up or assuming I understand.

  Example: "How do you understand it when she cries and falls to the floor? What do you make of that behavior?"
- I encourage curiosity.

  Example: "What do you think he made of that big crash?"
- I validate the parent's experience before I offer alternative perspectives or reframing.

  Example: "Wow! It sounds like reading her comments on Facebook made you furious."
- I always try to keep the baby in mind, even if they never enter our conversation in a given session. When I can, I try to bring the baby into the conversation. When I can't, I respect the fact that, for the moment, the parent needs my undivided attention.
- I highlight and praise competencies in reflection and other areas.

  Example: "You really figured out what she needed, and now she's smiling and relaxed!"
- I help the parent to imagine, "What if?"

  Example: "What if he's copying you, wanting to be more like you?"
- I ask the parent how they understand the motivations of the child or of family members.

  Example: "Why do you think Elsie did that? What do you think she's feeling when she does that?"
- When I can, I try to speak for the parent, putting a complicated experience into words.

  Example: "So when your mom said the baby was crying because he was hungry, and your aunt went to buy formula, it sounds like you were worried about your milk supply and the baby not eating, and things were happening so fast it was hard to think about what the baby really needed right then."
- I try to speak for the baby if the parent makes misattributions or isn't engaged.

  Example: "Oh, Mommy, I'm crying so hard because you left the room and I didn't know where you went!"

- I try to elaborate in moments when the parent can consider alternative perspectives.

  Example: "Ah . . . It seems as though you were wondering if his cry meant he really was hungry or if it meant that he was trying to tell you something else. What else did you think the crying meant right then?"
- I reflect the parent's feelings back to them in a modified form, that is, in a regulated, contained, and organized way.

  Example: "A toddler's crying can be so hard to handle! That cry just 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."
- I frequently highlight parent–child bond.

  Example: "Look! He is really looking into your eyes. When you look back at him he seems so loving and peaceful!"
- I use humor judiciously and I try to be playful when it feels right.

When parents are resistant or negative:

- When a parent can only see things in one way or in a negative way, I try to generate multiple perspectives.

  Example: "Can you think of other reasons why she's tantrumming?"
- I try to reframe the parent's perceptions of the baby or of herself.

  Example: "Do you suppose we can think about that in a different way? I wonder, when he makes that face and he looks like he is mad, I wonder if he might actually feeling sad."
- I gently challenge a parent's beliefs about me or herself or others.

  Example: "In your experience with other social workers, it seemed they just wanted to be in your business. Are you wondering if I will be the same way?"
- I stay in the moment and with the parent's current thoughts and feelings.

  Example: "You seem really angry"; "That sounds like it feels really scary to you."
- I stay away from complex explanations for her and her child's feelings. I tend not to bring up her past history as an explanation for her current reaction.

  Example: I avoid saying things like "Oh, the reason you are feeling so mad at your child is because your mom used to feel mad at you."
- When a parent is seeing things in black or white and with absolute certainty, I do not confront her but use techniques like exploration, considering alternatives together, and attending to current emotions.

  Example: Parent says, "My sister is a brat. She always gets what she wants and I hate her." I reply, "How does that happen? How does your sister get what she wants?"

- During an emotional outburst, I maintain our dialogue, and I don't comment on the reasons behind the outburst. I try to clarify what the parent is feeling without interpretation.
- I only consider underlying causes when the parent is no longer acutely upset.
- I try to identify triggers in recent interpersonal experience, including interactions with me.
- When things get too "hot," I try to stop, look, listen, rewind, and explore.

  Example: "You just got so upset. . . . Can we stop a minute and think about what happened there?"

In supporting myself as a clinician, I pay attention to my own experience:

- I pay attention to my own reactions and feelings and bring them to supervision, especially when I am upset during a home visit.
- I pay attention to ruptures in my interaction with the parent and try to sort out, from both of our sides, what led to the rupture.

  Example: "Perhaps you were trying to tell me that you didn't want to talk about that issue anymore, and I wasn't understanding what you were telling me."
- I use my own experience in the home visit to help me imagine what the parent or baby might be feeling.
- I share my feelings when it is therapeutically useful.

  Example: "I'm worried about you. If you decide to go beat up that girl who made you so angry, you could get hurt, or arrested, or even go to jail."
- I acknowledge when I do not know what to say or do.
- When I feel overwhelmed by affect or content, I put my feelings and thoughts into words.

  Example: "This is really hard to talk about. It brings up so many feelings. Let's take a breath and talk about what would help you feel supported."

Summary

Enhancing a parent's reflective capacities is best conceived of as a stepwise process, where we begin by engaging the relationship, observing and listening, gauging the parent's openness and capacity to be curious and open to the child's experience. This can be a painstaking, tentative process. As Allen and his colleagues (2008) suggest: "First, go slowly; second, when in doubt, be more supportive and less challenging of the patient's perspective" (p. 185). We use the relationship we have established with the parent to first support simply mirroring their experiences and then moving on

to wondering and hypothesizing or offering new and different frames for their experiences. We always keep an eye out for ruptures and the need for repair.

QUESTIONS FOR CLINICIANS

- Does the parent appear open and ready to reflect?
- Are you and the parent open to the relationship?
- Observe both parent and child behavior.
- Listen to the content, structure, and manner of the parent's speech.
- Note what happens when you simply mirror the parent's observations. Does this lead to their opening up and becoming more regulated?
- How do they respond to wondering, to your asking them to consider their experience, to describe it to you?
- Is the parent open to hypotheses offered in a respectful and curious way? Does this expand their understanding? Are they able to consider alternate perspectives?
- Have there been ruptures that need repair?
- Are you able to slow down and appreciate the gift of time?

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