# Pathways to Professional Development

Building Foundations in Infant and Early Childhood Mental Health

## Reflective Practice and Reflective Parenting

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# Pathways to Professional Development

**Pathways to Professional Development;  Building Foundations in Infant and Early Childhood Mental Health** was developed to build workforce competence and to prepare professionals working in the perinatal and birth to 5 periods

- 30  webinars focused on the foundations of Infant and Early Childhood Mental Health.
  - Provided live virtually
  - Recorded for viewing as LMS modules

- Diagnostic Classification of Mental Health And Developmental Disorders of Infancy and Early Childhood (DC:0-5) offered virtually.

  - View all offerings here→ https://www.mcsilverta.org/special-initiatives/pathways-to-professional-development/

The aim is to develop a well prepared and competent workforce trained to **identify** and address mental health concerns early, to **promote** awareness of mental health, to **prevent** long-term problems and to  **intervene** to help children stay on developmental track.

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# Who we are

These  trainings are funded by the New York State Office of Mental Health (OMH) and provided by the New York Center for Child Development (NYCCD)  in collaboration with CTAC.

- **New York Center for Child Development** (NYCCD) has been a major provider of early childhood mental health services in New York with a long history of providing system-level expertise to inform policy and support the field of Early Childhood Mental Health through training and direct practice.

- **NYU McSilver Institute for Poverty Policy and Research** houses the Community and Managed Care Technical Assistance Centers (CTAC & MCTAC), and the Center for Workforce Excellence (CWE). These TA centers offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers across NYS.

**NYCCD and McSilver** also run the **NYC Perinatal + Early Childhood Training and Technical Assistance Center (TTAC)** which offers ongoing training and technical assistance for those working during the perinatal period to age 5

https://ttacny.org/

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# Big thank you to:

- Susan Chinitz, PysD
- Evelyn Blank, LCSW
- Gil Foley, Ed.D.
- Gerard Costa, Ph.D.
- Nichole Aiello

- My colleagues at *Minding the Baby:*
  - *Lois S. Sadler, Ph.D., R.N.,*
  - *Nancy Close, Ph.D.*
  - *Denise Webb,* M.S.N, A.P.R.N., P.N.P.,
  - *Tanika Simpson, L.C.S.W., Ph.D.*
  - *Heather Bonitz-Moore,* A.T.R.-B.C., L.P.C.,
  - *Crista Marchesseault, M.A.T., M.A.*
  - *Andrea Miller, B.A.*
  - *Anna Kilbride, M.A.*

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# Reflective Functioning and Mentalizing – A Definition

- Researchers set out to discover the parental factors that contribute to a child's sense of security and safety.
- One powerful contributor:  The parent's capacity to imagine or envision the child's "mental states" (thoughts, feelings, desires, and intentions), and link these to behavior (Fonagy et al, 1995)
- Parents who are more curious about and interested in the child's experience are more likely to have secure children (Slade et al., 2005)
- Two important terms: Reflective functioning and mentalizing (Fonagy et al., 2002)
- Though they don't mean the same thing, they are often used interchangeably

# The Core Elements of RF/Mentalizing

- Awareness of the *nature* of mental states
- The explicit effort to tease out thoughts and feelings underlying behavior
- Recognizing the developmental aspects of mental states

# What Is Reflective Practice?

- The relevance of RF in clinical practice quickly became obvious (Gilkerson, 2004)
- An awareness of the self and the other in the therapeutic space
- A reflective or mentalizing stance – a stance of curiosity, interest, and not knowing (Gold, 2025)
- Being, wondering, discovering rather than doing
- The capacity to make sense of one's own internal experience and to link this to behavior and other responses in the clinical situation
- The capacity to imagine the internal experience of the parent and child, and to link these to behaviors
- Two brains in "conversation"

# Roadblocks to Reflective Practice

- Threat and trauma impede reflection or mentalizing
- Disruptions in clinician's capacity to remain open, curious, and "not knowing" – enormous impact on the work
- Threats from the past: traumatic memories, breakdowns in defenses, other triggers
- Threats in the present, including:
    - Implicit bias
    - Performance anxiety/supervisory conflict
    - Danger or threat in the clinical situation
    - Lack of knowledge or competence

# Reflective Practice Alone Is Not Enough

- In recent years, enormous focus on reflective practice and reflective supervision
- At the same time, important not to overlook other elements of good clinical practice. These are essential to clinical competence.
- The capacity to form a therapeutic relationship
- Thinking clinically – understanding relational dynamics, dyadic or family dynamics, psychological or developmental organization (for parent and child).
- Thinking diagnostically – are there psychiatric difficulties in the parent or child that need to be addressed?
- Knowledge

# What Is Reflective Parenting?

- A behavioral vs. reflective stance
- ”Don’t just do something. Stand there and pay attention.  Your child is trying to tell you something.” Sally Provence
- A reflective parent asks, in action and with language, enough of the time: *“What is that something, and I can I address/regulate/understand it?  Let me thy to imagine what you are feeling so I can figure out what you need to help you feel better?...What happened to you, how do you feel, what do you need, and how can I help?”*

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# Non-reflective parenting

- Threat and trauma impede mentalizing, and lead to non- or impaired mentalizing in parents
- What is non-mentalizing?
- Defenses interfering with capacity to see and hear the child
- Two kinds of non-mentalizing
    - Concrete, deficient
    - Intrusive/hostile

# Concrete/Deficient Nonmentalizing

- “Too little”
- The child’s experience is unavailable to the parent
- Little effort to make sense of the child, either at a bodily or emotional level
- No awareness of their internal, subjective experience.
- Equate what’s outside with what’s inside

# Concrete/Deficient Nonmentalizing

- ***Interviewer*: And how has having Letisha changed you?**
- ***Mother***: *Um, it's made me become a better person. Some, made me grow up more. And, um, yeah.*
- ***I*: And do you ever feel really angry as a parent?**
- ***M***: *No.*
- ***I*: Do you ever feel really guilty as a parent?**
- ***M***: *Mm-mm. [No]*
- **I: And, um, when Letisha's upset, what does she do?**
- ***M***: *Um, cries. [laughs].*
- **I: How does it make you feel?**
- **M:** *No way.*
- **I: And what do you do?**
- **M:** *I just, um, turn to her.*
- **I: And does she ever feel rejected?**
- **M:** *No.*

# How can we address this clinically?

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# Intrusive/Hostile Nonmentalizing

- "Too much"
- Relational intrusions that coopt and distort the child's experience
- Parent conveys to the child in one way or another that they *know* what is in the child's mind, without interest in the child's perspective, beyond what is probable.
- Malevolent projections

# Intrusive/Hostile Nonmentalizing

- ***I: And, so, can you describe a time in the last week when you and C really clicked?***
- *M: [Pause] In the last week…Probably that day, he had, in that one day, he got hurt probably five times, and he just kept falling, and kept tripping over his feet, and, bless his heart, he was just trying, he's just trying to do these funny silly things to make me laugh, and I love it, and, and I felt bad that he was getting hurt, but it was just, it was fun, we were having fun together, and sometimes, you know, that's the way life is, you get hurt, but you get up and you keep going, so, it was kind of cool for the both of us, I think.*
- ***I: Mhmm. And, how did you feel during that time?***
- *M: I felt, very motherly, very mother, I felt strong, I felt in control, to some sort, I felt empathetic for him, but I was glad that I was there, that he wasn't hurt while I was not there. Or, you know, I was glad that I was able to be there for him.*
- ***I: Mhmm. And how do you think C felt at that time?***
- *M: Being that he kept hurting himself, I don't think that he thought "Oh, if I'm gonna do this, I'm gonna get hurt", obviously. But, um, I think he felt comforted. I think he felt comforted.*

# How can we address this clinically?

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# An Approach to Enhancing Reflective Practice

## The Relational Foundations of Reflection

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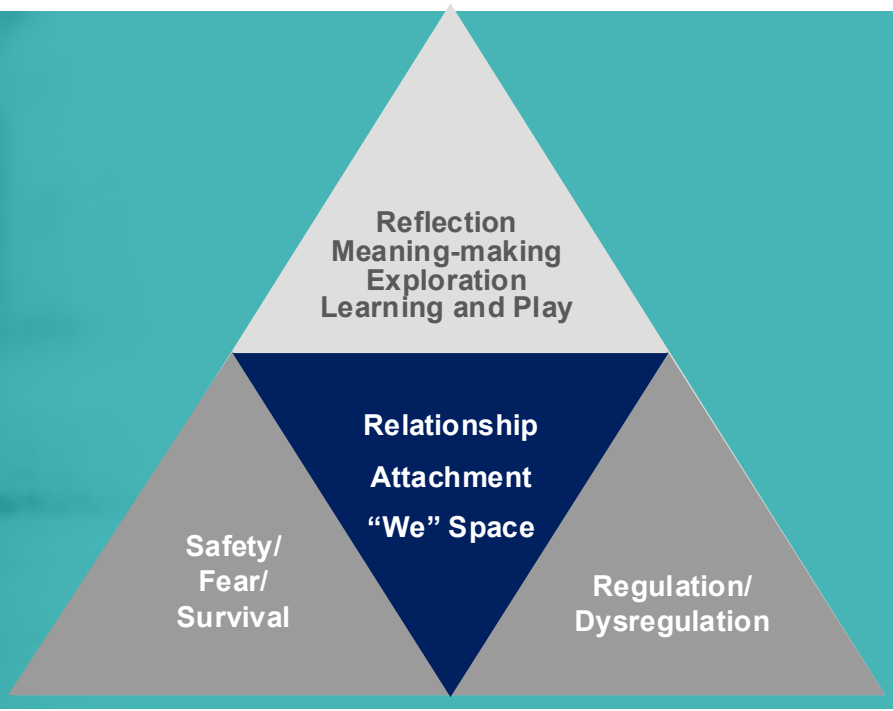
# The Relational Foundations of Reflection

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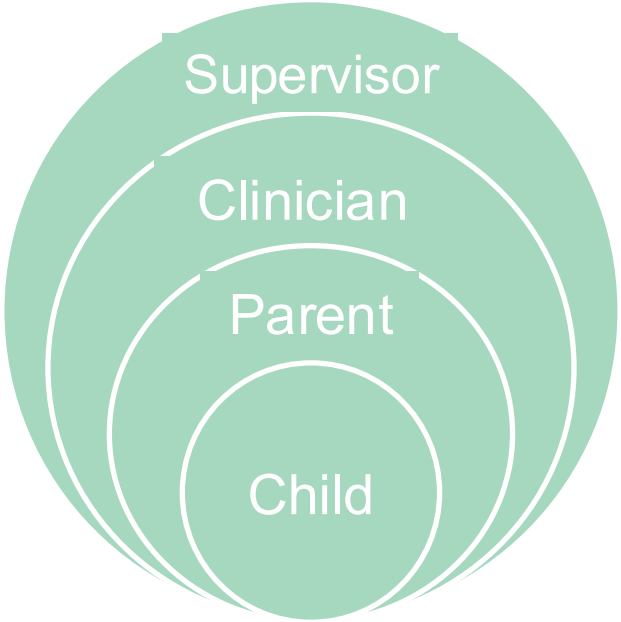
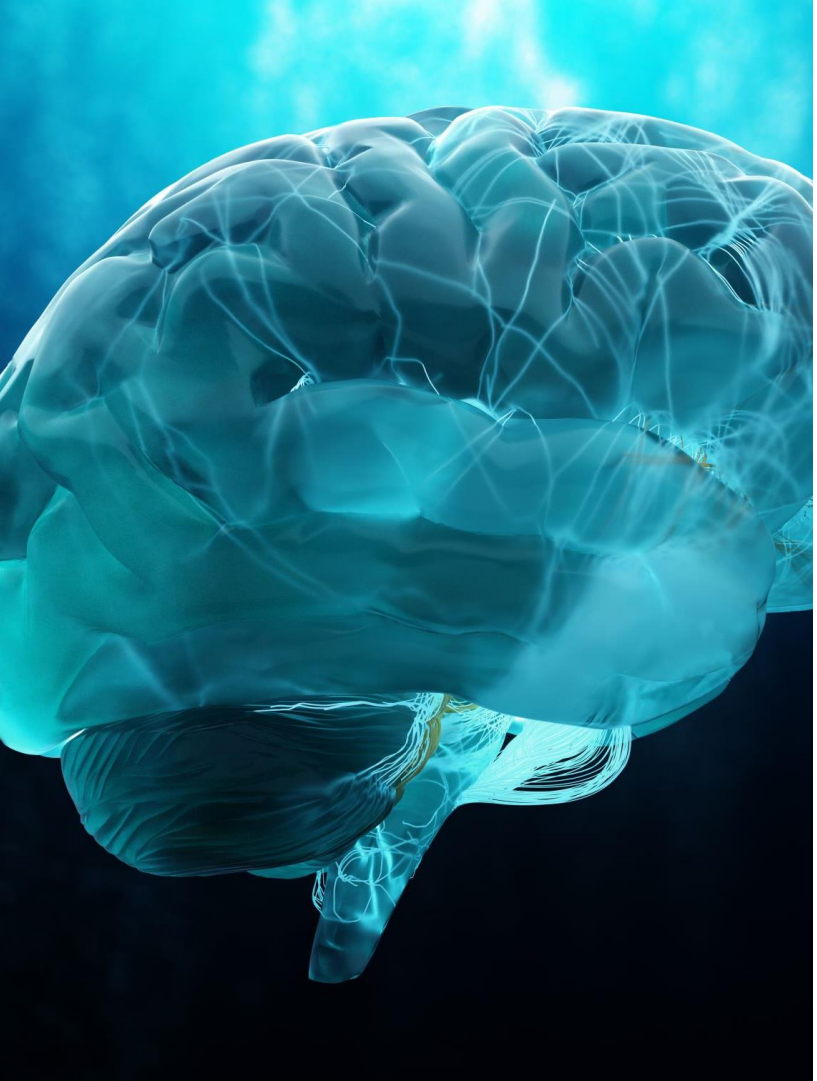
# It begins with you (and your supervisor)!



# The Clinician

# Safe or Threatened?

Essential survival mechanism: Monitoring threat



# Safety

- Threat is a normal part of human experience
- Monitoring threat is critical to survival
- Particular parts of the brain are primed to detect threat (Porges, 2011): the limbic system, the amygdala, the emotional brain
- Absence of threat: open to social communication
- Chronic threat and fear is enormously damaging (ACEs)
- Limbic system overdrive – a state of chronic, fearful arousal
- Significant relationship disruptions: these parts of the brain are active all the time, to the detriment of being able to mentalize, to recognize and identify feelings, to be able to plan, think, or use a range of executive functions

# Defended?

Fight, flight, or freezing?
Open to social communication?

# Regulation

- Threat leads to adaptations that insure survival
- Flight, fight, freezing: Better safe than dead.
- These are forms of self-defense, self-preservation
- These lead to disruptions across a range of biological, cognitive, and relational systems
- Signs of defense and dysregulation indicate that an individual is in survival mode

# Attachment, Threat, and Arousal

Arousal is modulated
Secure attachment
Mentalizing

Low arousal
Shut down
Over-regulated
Avoidant/Dismissive
***Flight***

High arousal
Inaccurate reading of the other
Under-regulated
Resistant/Preoccupied
***Fight***

**Dysregulated/Disorganized**
***Freezing***


Are you open to a relationship?

# Relationship

**Our humanity is the most important tool we have**
**Our capacity to form a relationship is the *therapeutic agent of change***

# Relationship

- *Relationship*-based practice
- Our “skill in being human” (Allen, 2013)
- The critical role of trust and care (Allen, 2022, 2024
- How do we establish epistemic trust? The “we” mode? (Fonagy & Allison, 2014; Fonagy et al., 2020)

# Relationship

Jon G. Allen, *Trusting in Psychotherapy* (American Psychiatric Association, 2022)

Rather than focus on method, - i.e., *what* we do - "we should shift the balance of our efforts from developing *therapies* to developing *therapists*" (p. xxvii). Developing the capacity to be trustworthy.

When parents whose capacity for trust has been savaged by attachment trauma, "the cultivation of trust and an intimate bond will not be the foundation for therapy or the vehicle for therapy; it will be *the work of therapy* and the ideal *outcome* of therapy" (Allen, p.22).

# Reflection

- Can I think? Can I feel? Can I wonder? Try to make sense?
- Can I imagine what's in my mind?
- In another's mind?
- Can I think about the past? Imagine and plan the future?
- Can I take in what is offered me?
- Can I play with possibilities? Explore?

# The Parent and Child

# Safe or Threatened?

Essential survival mechanism: Monitoring threat

# Regulated or Defended?

Fight, flight, or freezing?
Open to social communication?

# Attachment, Threat, and Arousal

Arousal is modulated
Secure attachment
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High arousal
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**Dysregulated/Disorganized**
***Freezing***

# The challenge of being defended *against*

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Open to a Relationship?
Emerging capacity to connect and trust
Openness to learning, accepting resources, etc.

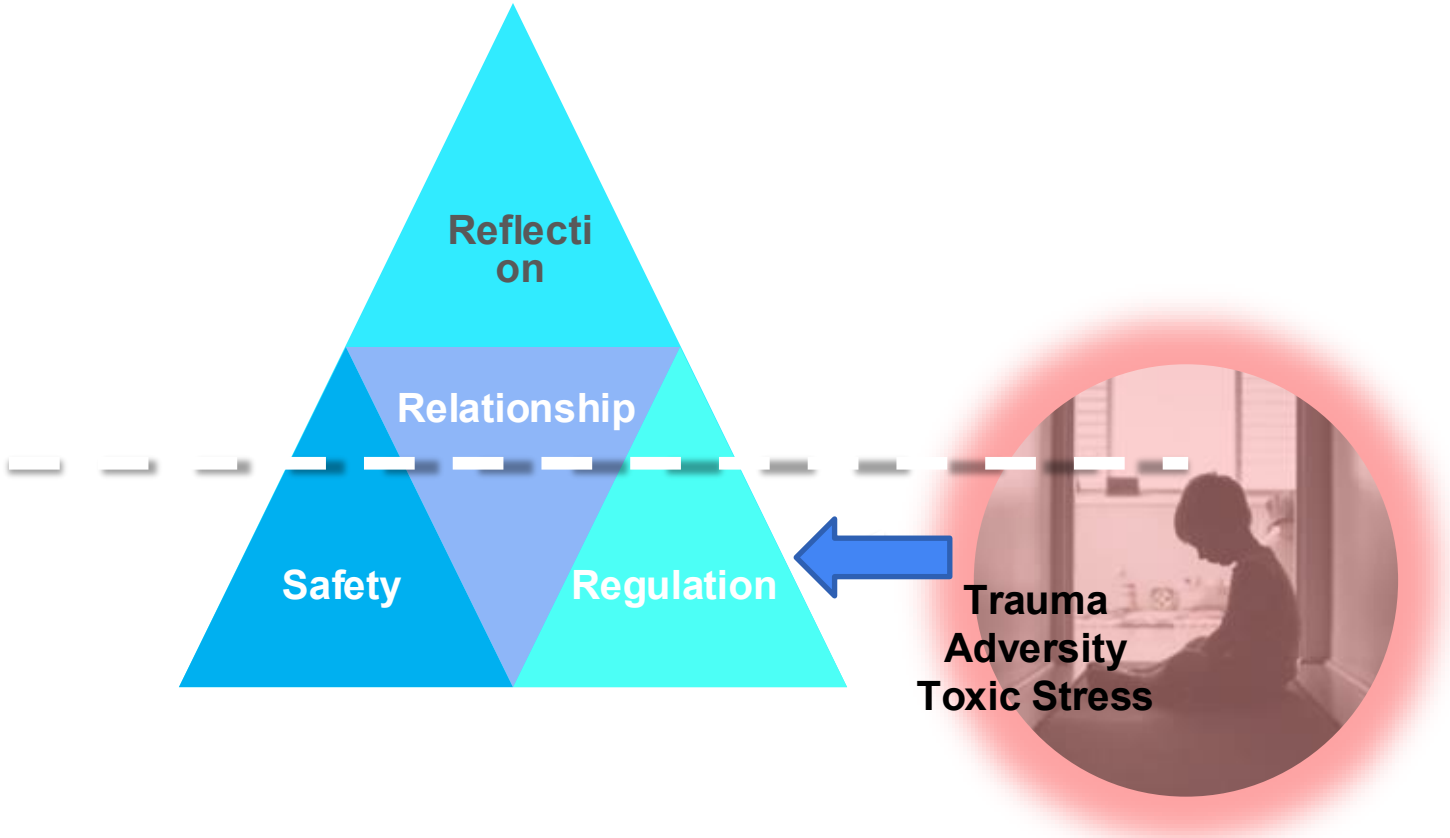
# Reflection

- Can they think? Can they feel? Can they wonder? Try to make sense?
- Can they imagine what's in their own mind?
- In another's mind?
- Think about the past? Imagine and plan the future?
- Enter a "we" space?
- Play with possibilities? Explore?
- In this state, they can begin to take in what you have to offer them: insights, psycho-education, developmental knowledge, and access to resources

# The Triangle in Clinical Practice

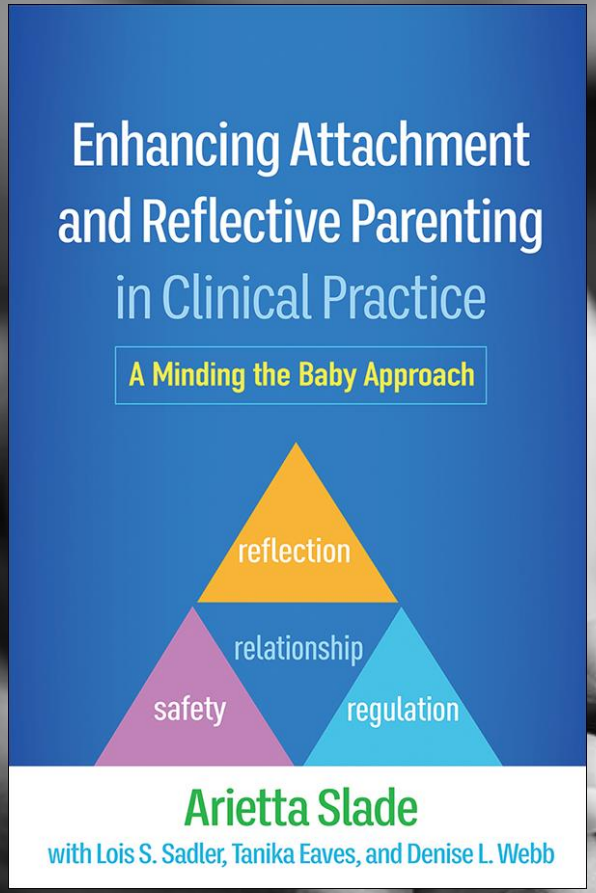
- Where are ***you***?
- Where are ***they***?

# Building the Relational Foundations of Reflection



# Larger Systems: Chronic Threat

Non-mentalizing environments

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# Thank you very much!

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