Parent-infant relationships: Supporting parents to adopt a reflective stance

Abstract
This article draws on current research, highlighting the importance of parents being able to ‘mentalise’—to make sense of their own and their child’s mental state. Parents who ‘hold their child in mind’ are likely to be able to interpret behaviour in terms of his or her underlying feeling states. It is argued that health visitors and early years workers are ideally placed to explicitly ‘scaffold’ parents to adopt a reflective stance when trying to make sense of their infant’s behaviour. A range of interventions is discussed, beginning in the prenatal period. In conclusion, the opportunities for practitioners to reflect on and be affirmed in their own practice are highlighted.

Key words
Reflective stance  Mentalisation  Parent-infant relationships

A mother wryly commented as she ‘chased’ her distressed infant’s mouth with a spoon: ‘It’s a pity that babies don’t come with an instruction manual’. Every mealtime had become a battle and her comment was a plea to help establish more enjoyable routines. The regulation of emotional and behavioural states is rooted in early repeated patterns of interaction (Barton and Robins, 2000). The key task of developing regulatory function, relies on the caregivers’ and infants’ capacities to interpret communications and respond to one another. The infant is the instruction manual, if parents observe, interpret and respond to their infant’s cues and signals (Brazelton et al, 1974; Stern, 1985).

During the past decade there has been increasing recognition of the importance of infants receiving early sensitive care as a foundation for optimal development. Infants’ brains develop rapidly in response to early interactions and evidence from disciplines such as neuroscience, psychology, biology and psychoanalysis, which indicates that early caregiving relationships have a long term influence on the way individuals regulate their emotions and behaviour, and make relationships (Schore, 1994; Sroufe, 1995; Panksepp, 1998; Stern, 1998; Belsky, 2001; Fonagy et al, 2004). Evidence shows that the sensitivity of care directly affects the developing neuronal pathways, with significant consequences in terms of the infant’s developing sense of self, capacity for regulation and engagement with the environment (Schore, 1994; Fonagy et al, 2004; Glaser, 2000).

Increasing understanding about the sensitivity of interaction has extended the focus to the importance of parents treating their infants as ‘agents’ in their own right, with their own individual temperaments and underlying feeling states. This understanding enables parents to closely connect with their infant because they can reflect on his or her unique characteristics. This capacity to mentalise (to be able to interpret behaviour in terms of underlying feeling states) relies on parents adopting a reflective stance so that they can think about the meaning of their infant’s behaviour. Parents who can mentalise approach a confusing situation with curiosity and interest as they try to make connections between their child’s feelings and behaviour. One parent commented:

‘Sometime he fusses and feels it’s all too much. If I’m tired, he probably feels that I am tense; I know his bath will help him relax and then I will feel better too’.

This quotation conveys how a reflective mother was able to make connections between her own emotional state and her child’s behaviour and underlying feelings (Slade, 2005) and shows how reflections can guide actions and are central to sensitivity.

A parent’s capacity to mentalise
Mentalising is not a fixed attribute, and it can vary from one situation to another and be affected day to day by stress or tiredness. Some people will have developed more capacity to mentalise than others. Mentalisation is influenced by a range of factors including the parent’s capacity to reflect on their own feelings and behaviour,

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their experiences of being cared for, their mental and physical health, their socioeconomic status and circumstances such as bereavements, dysfunctional family processes or irritable and highly sensitive infants (Arnsten, 1998; Mayes, 2000; Sameroff and Fiese, 2000). Parents with low reflective function are less likely to make connections between the child’s feelings and behaviour or imagine what their child is feeling or how their own feelings affect the child. Parents with low reflective function may even misinterpret their baby’s behaviour and consider him to be naughty, manipulative or selfish for crying.

By the second trimester of pregnancy the woman’s imaginings of what she will be like as a mother develop alongside her representations of what her baby might be like (Zeanah et al, 1990; Slade et al, 2009). Expectant parents may begin to mentalise about their unborn baby and this reflective mother interpreted her baby’s behaviour in terms of what he might be like:

‘He is very active at night time when the comedy programmes are on, so we think he will be quite a cheeky little thing...’

Such prenatal mental representations are shaped not only by the biological changes taking place, but also by a range of psychic and social factors, such as the mother’s memories of her own early relationships, her family traditions, her hopes, her fears and her fantasies (Stern, 1998). A significant link has been found between the richness of prenatal maternal representations and the security of the infant’s attachment to the parents at 1 year of age (Benoit et al, 1997). However, women who had experienced domestic abuse had significantly more negative representations of their infants and themselves, and their babies were more likely to be insecurely attached (Huth-Bocks et al, 2004). Mothers who already had 2–3 children under the age of 7 years and an unplanned pregnancy, had more negative representations (Pajulo et al, 2001). Earlier pregnancy or perinatal loss, where grieving is unresolved, may impact on the mother’s capacity to engage with the new baby (Slade, 2005).

Although most mothers adjust quickly from their ‘imagined’ baby to the ‘real’ baby, this can be problematical if she is fearful about the unborn child or has unrealistic, idealised representations (Raphael-Leff, 2005).

**How can parents be supported to take a reflective stance?**

Increasing recognition of the importance of supporting women and men in building healthy relationships with their new babies and in negotiating relationship changes during the transition to parenthood has underpinned recent practice developments.

**Antenatal contacts**

Every contact that a health professional has with the parents should be an opportunity to support them to adopt a reflective stance. This can begin before birth by helping parents in the mid-trimester to imagine what their baby will be like. The Healthy Child Programme suggests that expectant parents should be offered a promotional narrative listening interview (Puura et al, 2005) that provides an opportunity to explore the parent’s perceptions about what their new baby will be like. Parents may have a special name for their baby and can be encouraged to engage by asking if their baby moves to the sound of music, and by suggesting they place their hands on their ‘bump’ and have a chat with their baby, noticing when their baby is most active. The Royal College of Midwives Good Practice Guide provides other good ideas (Underdown and Barlow, 2012). Classes to support women and their partners in the transition to parenthood also offer opportunities for expectant parents to build strong bonds with their unborn baby (Department of Health (DH), 2011). Baby Steps, a relationship-based perinatal programme comprising of nine sessions, has also shown to be useful for vulnerable families (Underdown, 2012).

**Postnatal contacts**

After birth, parents make the adjustment from the ‘imagined’ to the ‘real’ baby and can enjoy getting to know their baby through gazing and experiencing skin-to-skin contact (Puig and

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Sguassero, 2007). A reflective stance may entail ‘wondering’ and being curious about what their baby is feeling. One mother who was encouraged to wonder about her baby’s experience of being in close contact, spoke in the following way:

‘Holding her like this she feels incredibly safe and warm. It’s her favourite tree hug position as we call it. She can feel my heart beat and I can feel hers. I think it reminds her of when she was inside my tummy. Are you listening there? (addressed to baby)’.

The opportunity to learn about the sleep/wake states can be useful in helping parents interpret what their baby means. An APP which helps parents observe their baby’s states that can be downloaded onto parents’ and professionals’ mobile phones is currently being developed at Warwick University.

Postnatal promotional interviews by health visitors give opportunities for parents to develop their perceptions of what their baby is like as a person, for example, their likes, dislikes, strengths and sensitivities. As with the antenatal interview, it offers an opportunity for health visitors to identify parents needing extra support in getting to know their baby. Two examples of interventions that can support parents to take a reflective stance are infant massage and video interaction guidance.

**Infant massage**

Cues-based infant massage, such as the International Association of Infant Massage (IAIM) based programmes, encourage parents to ask for the babies’ permission before massaging and observe and interpret their behaviour (Underdown and Barlow, 2011). The following quotation was made by an IAIM trained infant massage instructor:

‘Remember this massage is all about asking permission. If you can try to pick up these cues your baby is giving you while you’re massaging. The massage is all about picking up the cues, the body language, the smell, the eye contact, all those things that your baby is telling you. If your baby doesn’t want to have a massage for any reason, they are pulling away from you, they are crying, fidgeting, just pick them up and cuddle them. It may not be the right time today to be massaged’.

Practitioners can also model reframing of the baby’s behaviour by wondering aloud with the parents. For example, in one class a mother felt rejected because her baby wouldn’t look at her and the massage instructor quickly reframed this in terms of the baby’s interest and curiosity about his surroundings.

**Video interaction guidance**

Video interaction guidance (VIG) is an intervention where individuals are guided to reflect and build on their successful interactions. The visual image is powerful and can be a helpful aid to enable parents to reflect on their baby’s experience. Interventions such as video interaction guidance can offer parents the opportunity to observe interaction on film and interpret this with the guider. A meta-analysis by Fukkink (2008) found that after video reviews, parents became more skilled at interacting with their child and gained more pleasure in their parenting role. Other meta-analyses have suggested increased maternal sensitivity after video interaction guidance (Juffer et al, 2008).

**Helping health professionals to take a reflective stance**

It is difficult for health professionals to help others become more reflective without being supported to reflect on their own practice. Reflecting on self may happen during supervision sessions or they could be offered some sessions of video enhanced reflective practice (VERP).

VERP involves the development of effective communication between professionals and their clients, and practitioners select video clips of themselves in a work situation to take to supervision. Similar to video interaction guidance, VERP uses a strengths-based approach, building on microanalysis of what is going well, and using the video to increase understanding about the impact of attuned interactions on parents. Self-modelling and video feedback stimulates confidence and creates reflective space for development.

VERP is based in theories of inter-subjectivity (Trevarthen, 1979) and promotes a culture of ‘no blame’ by focusing on strengths while jointly identifying working points. This approach enables practitioners to affirm their capacity to take a reflective stance and identify points of possible development for themselves. One health visitor colleague described her VERP supervision in the following way:

‘Before my session, I was a bit negative about the video clips, and very critical of how I looked on film! However I was surprised at how quickly I forgot about that. (Supervisor) was very skilled at enabling us to look closely at the details of my interaction with the mums and babies, and very much encouraged me to look positively at my skills. I wasn’t sure what to expect from the session, and was surprised at how much it encouraged me to really think about what I was seeing in front of me...it felt like a really rich learning...’
experience, and very affirming of the skills that I was rather reluctant to acknowledge’.

**Recommendations**

Mentalisation is a key element underpinning the development of optimal outcomes for young children. Helping parents to take a reflective stance in order to develop their capacity to mentalise about their infant is a key task for health visitors and should be an essential element of every contact with parents and infants. In parallel, health professionals will need opportunities to develop their own capacity for adopting a reflective stance, using supervision and techniques such as VERP.

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**References**


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PJ health visitors can be supported to take a reflective stance with self and others through supervision and interventions such as video enhanced reflective practice.

Key points

- Parents’ capacities to interpret baby’s behaviour in terms of their underlying feelings can have important implications for the baby’s subsequent emotional wellbeing
- Health visitors can support parents to take a reflective stance at every contact during the perinatal period
- Health visitors can be supported to take a reflective stance with self and others through supervision and interventions such as video enhanced reflective practice