The Relational Foundations of Reflection

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TTAC
A COLLABORATION BETWEEN
NEW YORK CENTER FOR CHILD DEVELOPMENT
McSILVER INSTITUTE FOR POVERTY POLICY AND RESEARCH
NYU SILVER SCHOOL OF SOCIAL WORK

Who We Are

The New York City Early Childhood Mental Health Training and Technical Assistance Center (TTAC), is funded through **ThriveNYC**, in partnership with the **NYC Department of Health and Mental Hygiene (DOHMH)**

TTAC is a partnership between the New York Center for Child Development (NYCCD) and the McSilver Institute on Poverty Policy and Research

- **New York Center for Child Development** has been a major provider of early childhood mental health services in New York with expertise in informing policy and supporting the field of Early Childhood Mental Health through training and direct practice
- **NYU McSilver Institute for Poverty Policy and Research** houses the Community and the Managed Care Technical Assistance Centers (CTAC/MCTAC), which offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers

TTAC is tasked with building the capacity and competencies of mental health and early childhood professionals through ongoing training and technical assistance

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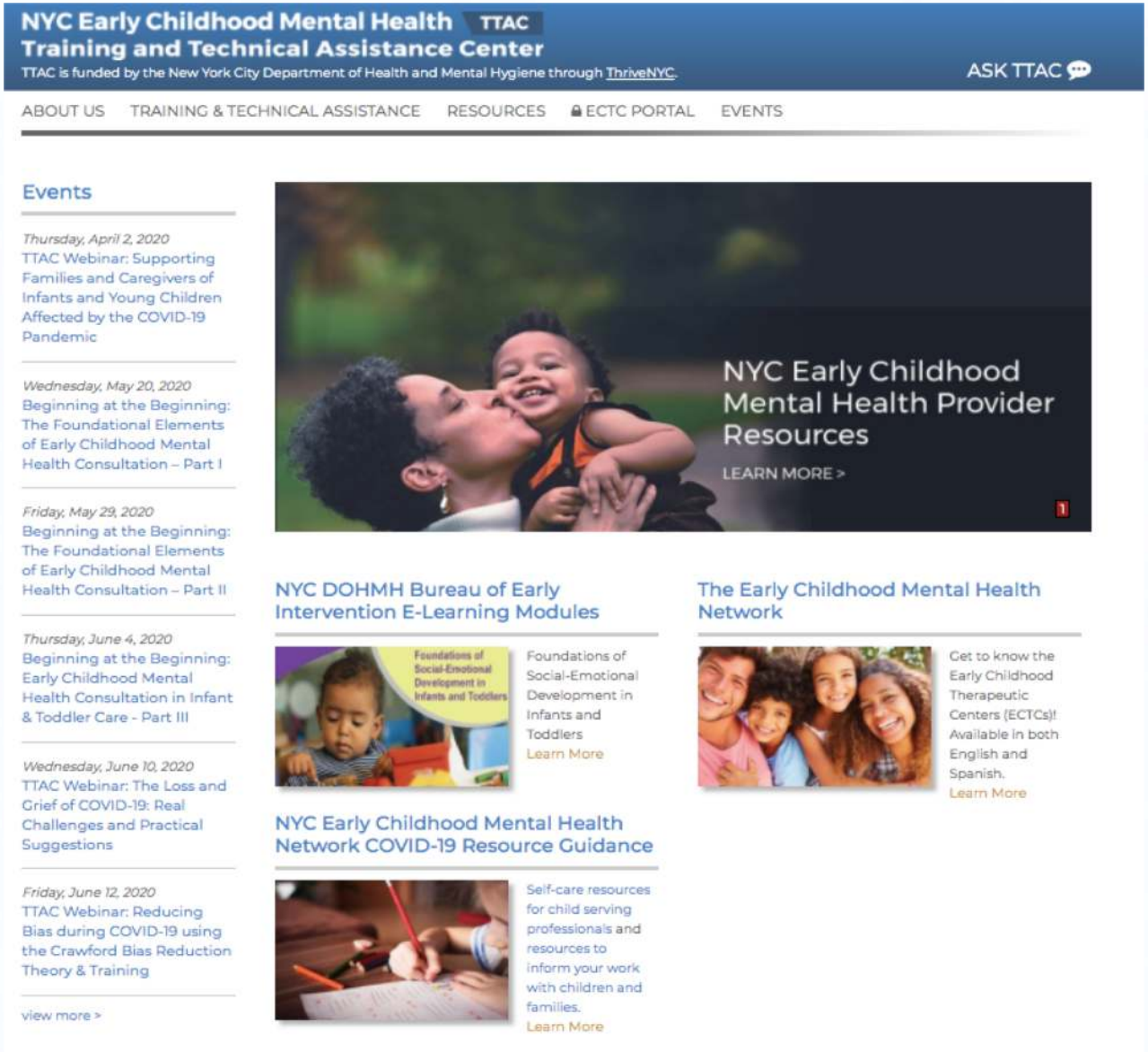


The plan for today

- The relational foundations of reflection (RFR)
  - Attachment, mentalization, and trauma: theory, research and clinical applications
  - The RFR Model: safety, regulation, and relationship
  - Disruptions in establishing safety, regulation, and relationship
  - Safety, regulation, and relationship in the clinician, parent, and child

THE RELATIONAL FOUNDATIONS OF REFLECTION

ATTACHMENT, MENTALIZATION, AND TRAUMA: THEORY, RESEARCH AND CLINICAL APPLICATIONS

ATTACHMENT

The core principles of attachment theory

- The child begins life ready for relationship
- Experiences with their nearest, and soon to be dearest, shape the kind of human being the child will become
- The child's basic needs:
  - Safety (*You will comfort me, protect me*)
  - Security (*You will support me, watch over me, delight in me*)
  - Regulation (*You will help me make sense of my feelings*)

The core principles of attachment theory

- The primary goal of all living things, including humans, is **survival (thank you, Darwin)**
- Infants are primed to seek safety, and diminish fearful arousal by seeking proximity to ***stronger and wiser attachment figures who can protect them***
- The *force* that insures the child's survival is the *attachment system:* Propels the frightened child to seek safety, ***and the caregiver/attachment figure to provide it***
- The child's primary relationships insure their survival and their humanity

The core principles of attachment theory

- Experiences with the caregiver largely account the "security" or "insecurity" of the child's attachment
- Child will adapt to the relational environment, for better or worse
- Biological imperative: *I can't do anything that will drive my caregiver (further) away*
- A range of defensive stances/postures take hold when the child (or adult) is fearful of loss, of harm, of being unheard – various manifestations of insecure attachment
- These are most dramatic when an individual has a significant trauma history

Insecure attachment classifications

- Increasingly problematic responses to the activation of the attachment system:
- Avoidant: The child avoids the parent on reunion, suppresses negative emotion (flight)
- Resistant: The child angrily clings to the parent on reunion; flooded with negative emotion (fight)
- Disorganized: The child is without a strategy for approach or avoidance, and looks dissociated, behavior is disorganized (freezing)

Factors influencing caregiver sensitivity

- Parent's own attachment organization
- Child/parent temperament, biology, or genetic make-up
- Differential susceptibility
- Ecological constraints:
  - Cultural differences
  - Parental psychopathology and other risks
  - Socioeconomic risk
  - Racism

Insecure attachment and threat

- Insecure attachment: graded responses to threat to primary attachments/survival
- The critical thing is not the classification, per se, but identifying the threat to the child/adult that is triggering defenses
- What are the dynamics that are underlying the child/adult's defensive responses?
- Most clinical interventions are aimed at softening defenses and promoting more flexible, open, and secure ways of responding and engaging

MENTALIZATION

The core principles of mentalization theory

- The parent's reflective capacities are key to the development of secure attachment in the child
- Parental reflective functioning (PRF) allows the parent to envision or imagine thoughts and feelings in the self or other
- Allows the parent to hold, regulate, and experience thoughts and feelings
- Profound impact on behavior toward and representation of the child

The reflective stance

- "Don't just *do* something. Stand there and pay attention. Your child is trying to tell you something."
- A "good enough" parent asks, enough of the time: *What is that **something**, and how can I address/ameliorate/regulate/understand it? Let me try to imagine what you are feeling so I can figure out what you need to help you feel better.*

The reflective stance

- It is a stance of curiosity, of wondering, both in action and in thinking, about the child's experience
- It is inherently *reflective,* as it allows the parent(s) to implicitly or explicitly ask the child: *Who are you, what happened, what do you feel, what do you need, and how can I help?*

Implicit/explicit mentalization

- Implicit: Conveyed non-verbally or in action (what the parent *does*)
  - Embodied mentalization (Shai & Belsky, 2017)
  - Reflective parenting in action (Ensink et al., 2017)
- Explicit: The parent's thoughts and feelings about the child, expressed in language
  - Parental reflective functioning (Fonagy et al., 1995; Slade, 2005; Slade et al., 2005)
- Both are critically important; implicit likely develops first over the course of intervention

Automatic/controlled mentalization

- Automatic: “Unconscious, parallel, fast processing of social information that is reflexive and requires little effort, focused attention, or intention . . . prone to bias and distortion, particularly in complex interpersonal interactions (i.e., when arousal is high)” (Luyten & Fonagy, 2015)

Automatic/controlled mentalizing

- Controlled: “Conscious, verbal, and reflective processing of social information that requires the capacity to reflect consciously and deliberately on and make accurate attributions about the emotions, thoughts, and intentions of self and others . . . relies heavily on effortful control and language” (Luyten & Fonagy, 2015)

Causes of impaired mentalizing

- History of trauma, vulnerability to affect dysregulation
- History of disrupted relationships
- Socioeconomic risk
- Systemic racism
- Parent's blunted or heightened stress reactivity
- Parent-child relationship - a "hot" relationship
  - Child's needs, emotions, become a threat
  - Child is a trigger or retraumatizing

COMPLEX, DEVELOPMENTAL TRAUMA

Complex trauma

- We are all working with very traumatized populations
- Until about 25 years ago, the only “diagnosis” that took trauma into account was PTSD
- A single incident or developmental phase concept that derived from work with veterans
- As clinicians began working with different types of trauma in more diverse populations (sexual abuse, physical abuse, domestic violence, etc.), limitations of this diagnosis became apparent
- Critical work of Judith Herman & Bessel van der Kolk

Complex trauma

- Multiple traumas over a number of developmental epochs
- Chronic threat and fearful arousal
- “Symptoms” like depression, anxiety, ADHD, BPD are symptoms of underlying *adaptations* to ongoing trauma
- Impairment across a range of domains: attachment, biology, affect regulation, states of consciousness, behavioral control, cognition, self-concept
- *These are adaptations to trauma, defenses* that protect against chronic threat

Complex trauma

- “Individuals exposed to trauma over a variety of time spans and developmental periods suffered from a variety of psychological problems not included in the diagnosis of PTSD, including depression, anxiety, self-hatred, dissociation, substance abuse, self-destructive and risk-taking behaviors, revictimization, problems with interpersonal and intimate relationships (**including parenting**), medical and somatic concerns, and despair.” (Courtois, 2004, p. 414)

Complex trauma: Posttraumatic adaptations

(Cook et al., 2005)

- **Attachment:** Distrust and suspiciousness, interpersonal difficulties, difficulty attuning to other peoples' states. Disorganized attachment.
- **Biology:** Somatization, increased medical problems.
- **Affect Regulation:** Difficulties labeling, expressing and regulating emotions, problems knowing and describing internal states.
- **Dissociation:** Alterations in states of consciousness, impaired memory for state-based events.

Complex trauma: Posttraumatic adaptations

(Cook et al., 2005)

- **Behavioral Control:** Aggressive/oppositional behavior, poor modulation of impulses.
- **Cognition:** Difficulties in attention regulation and executive function; lack of sustained curiosity; problems in planning, focusing on and completing tasks.
- **Self Concept:** Low self-esteem; shame and guilt.

Trauma and parenting

- Trauma has a dramatic impact on the capacity to regulate affect, particularly negative affect, and contain impulses
- Profound alterations in the sense of self, other, and the body
- Extremes of withdrawal or extreme lability, volatility
- Being frightening to the child, or frightened by the child
- **Parent cannot provide a secure base**

Trauma and parenting

- At these moments, the parent is unable to see the baby as separate from herself, to read his cues, or observe his fear – baby's subjectivity is lost
- Violence, frightening behavior become possible – the child is *unseen,* and hence alone and afraid
- Disabled caregiving system
- Non-mentalizing cycles of interaction

Impacts on the child

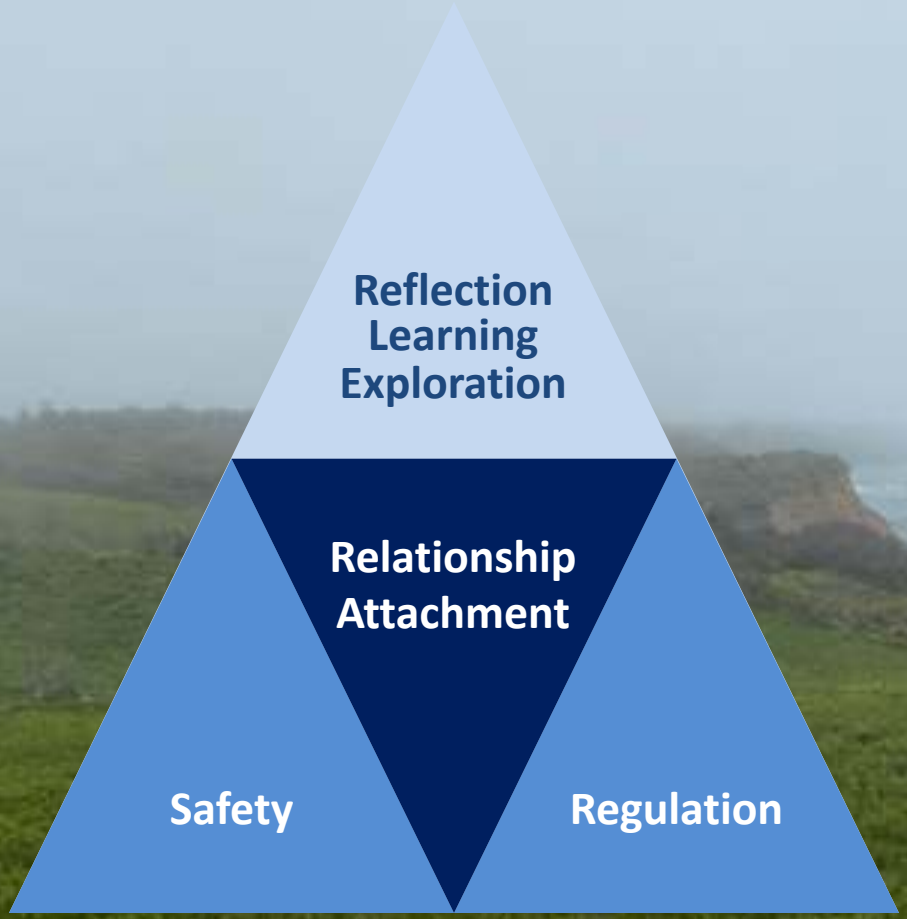
- *Adversity: chronic arousal of the fear system within context of relationships*
- Child feels controlled, afraid, and alone
- Thinking and exploring are curtailed
- Shuts down, or becomes overwhelmed, dysregulated
- Fight, flight, or freezing
- Anger, defiance, withdrawal, chaos, despair, confusion, disorientation, decompensation

THE RELATIONAL FOUNDATIONS OF REFLECTION

The relational foundations of reflection

- Through my work in *Minding the Baby®*, I developed a model to conceptualize infant mental health work that builds on affective neuroscience, attachment, mentalization, and trauma theories
- A model for understanding the complexities of the tasks facing infant mental health professionals, particularly in such threatening times
- A way of thinking about where we start when basic safety is threatened, and what we hope to achieve with the families we see

Relational Foundations of Reflection



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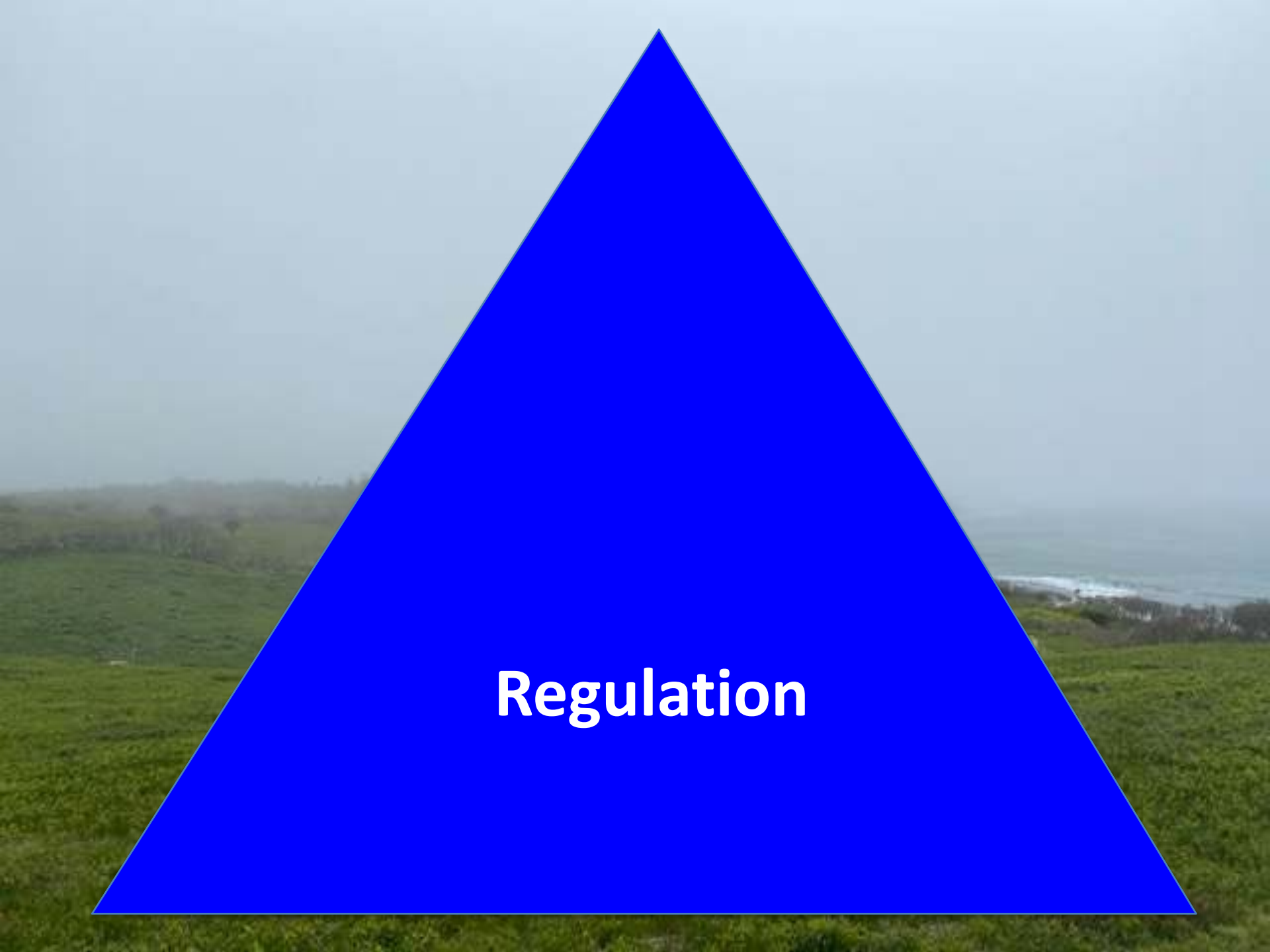
Threat and the Search for Safety

Essential survival mechanism:

Monitoring threat

Safety

- Threat is a normal part of human experience
- Particular parts of the brain are primed to detect threat (Porges, 2011): the limbic system, the amygdala, the emotional brain
- Chronic threat is enormously damaging (ACEs)
- Limbic system overdrive – a state of chronic, fearful arousal
- In traumatized children and adults, or those with significant relationship disruptions (i.e., forms of insecure attachment), 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
- Automatic mentalizing


Regulation

Regulation

- Ideally, the caregiver/therapist regulates:
  - Literal survival/safety
  - Internal survival/safety: Safety with feelings
  - Relational survival/safety: Safety with others
- Fearful arousal is regularly modulated
- When caregiver cannot/will not regulate certain experiences, adaptation/defense is necessary
- Flight, fight, freezing: Better safe than dead.
- Disruptions across a range of biological, cognitive, and relational systems

Relationships

Make living beings the humans they are

Balm against emptiness

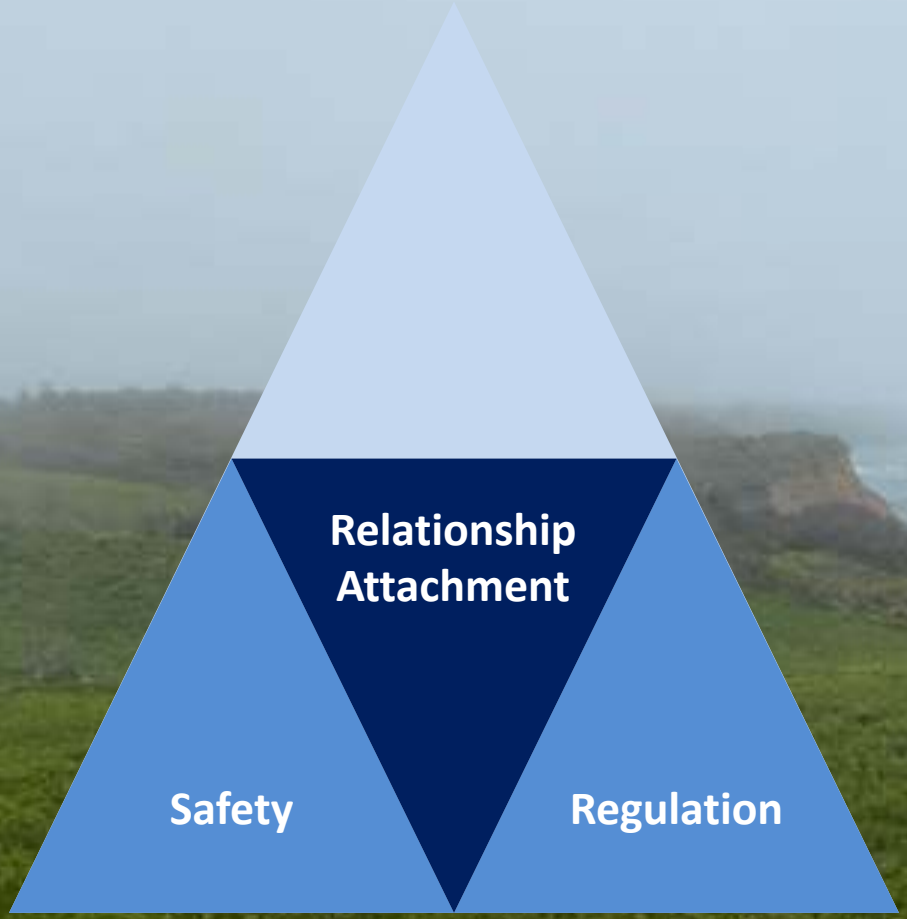
The birthplace of the symbol

Epistemic trust

Relationship

- Relationships are a basic remedy for fear—of loss, of annihilation, of psychic emptiness—and offer us the deepest expression of our humanity
- They are the foundations for relatedness, and for all of our relationships
- The quality of relationships is directly related to safety and regulation
- Insecure attachment: distortions, defenses, forced adaptation (false self) and thus disrupted relationships

Relational Foundations of Reflection



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Reflection

Meaning making

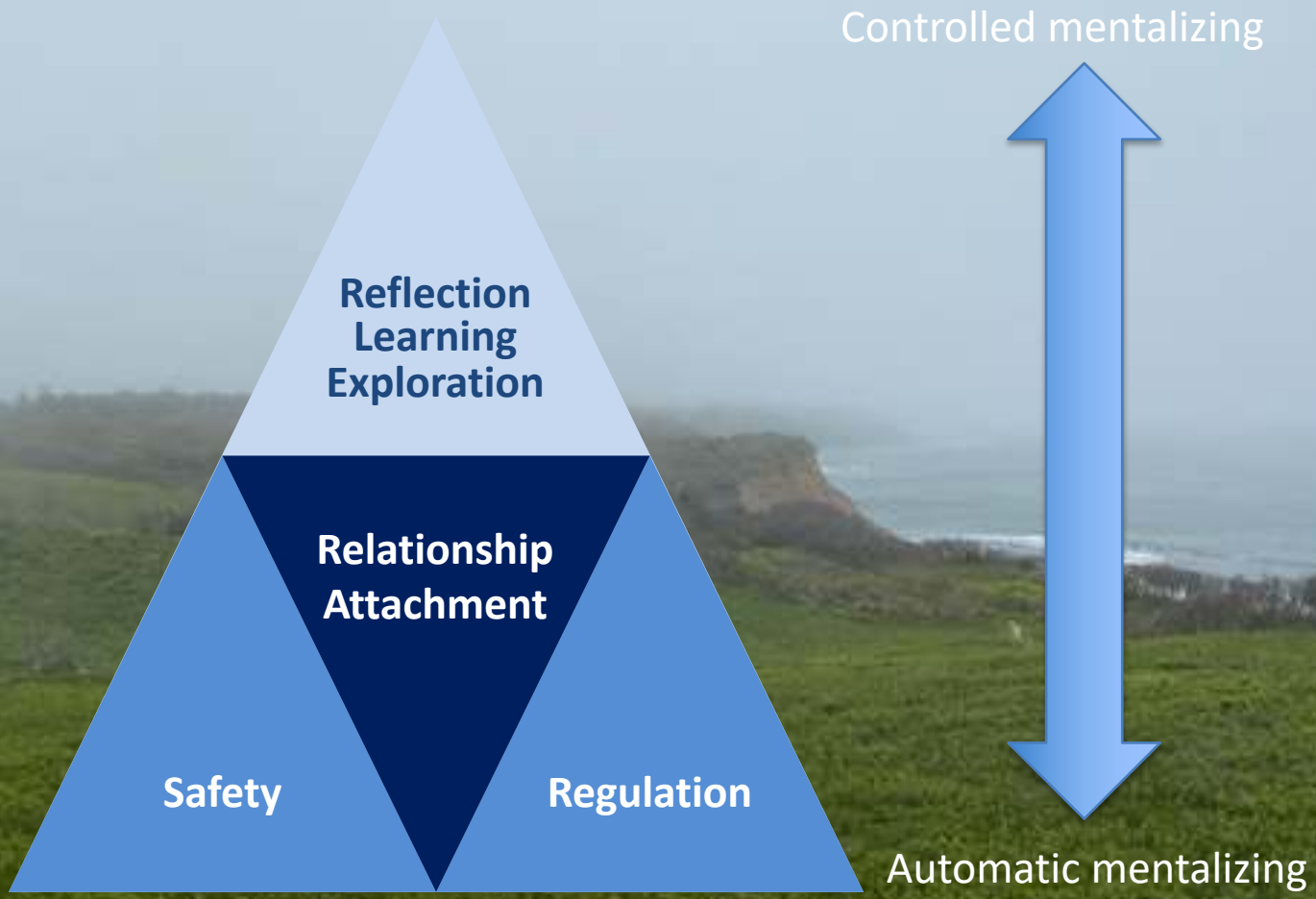
Mentalization

Insight

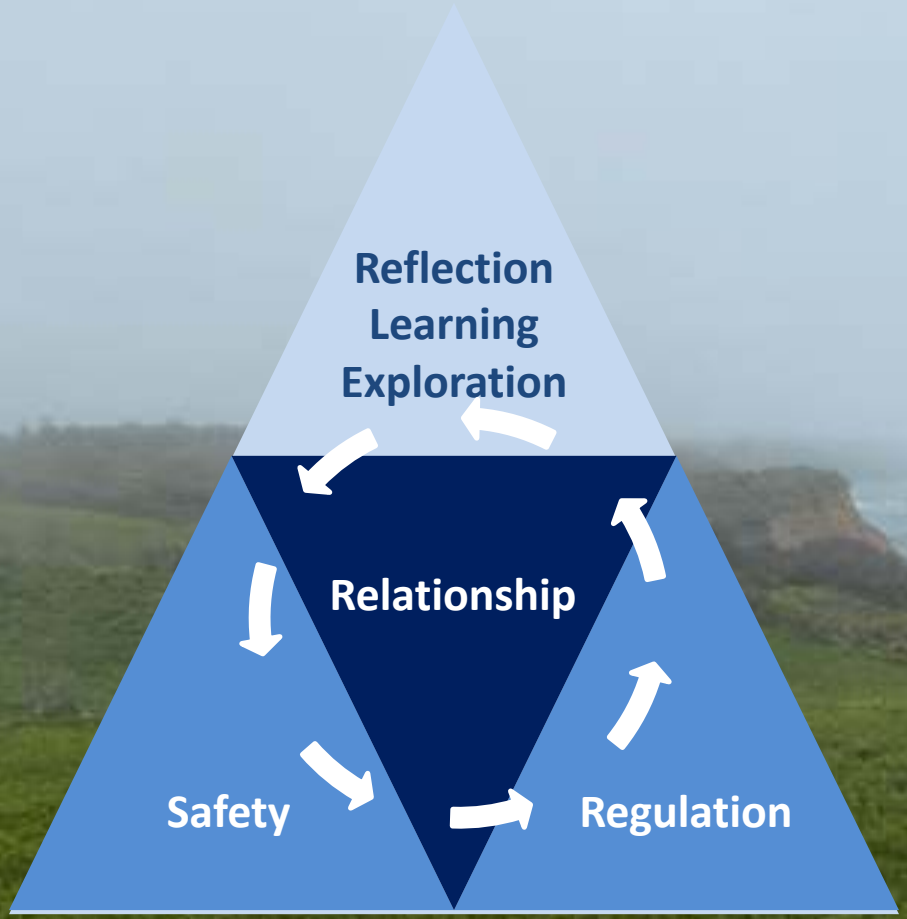
Play

Exploration

Relational Foundations of Reflection



Cycles of rupture and repair



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DISRUPTIONS IN THE RELATIONAL FOUNDATIONS OF REFLECTION

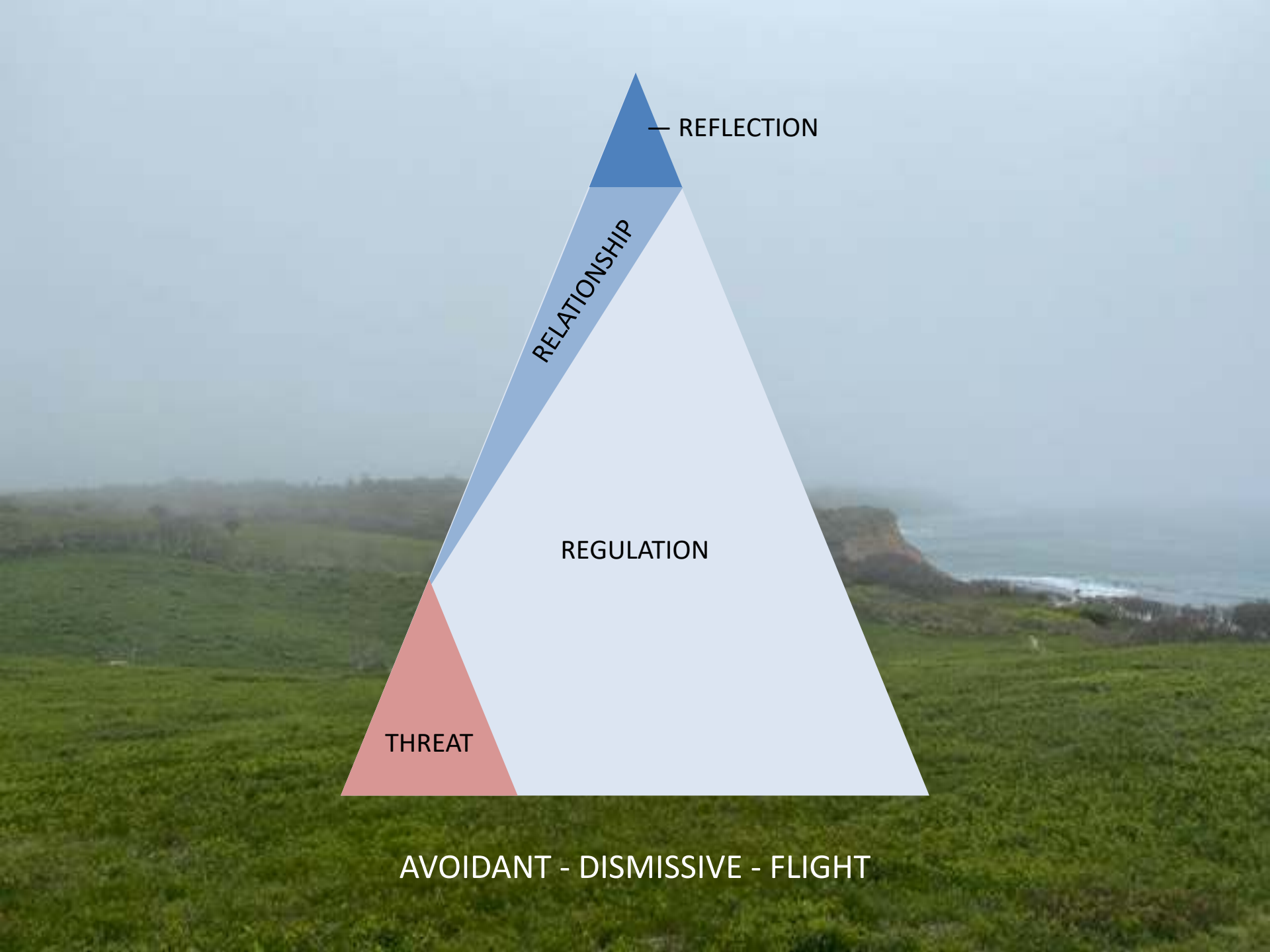
Arousal, Attachment, and Threat

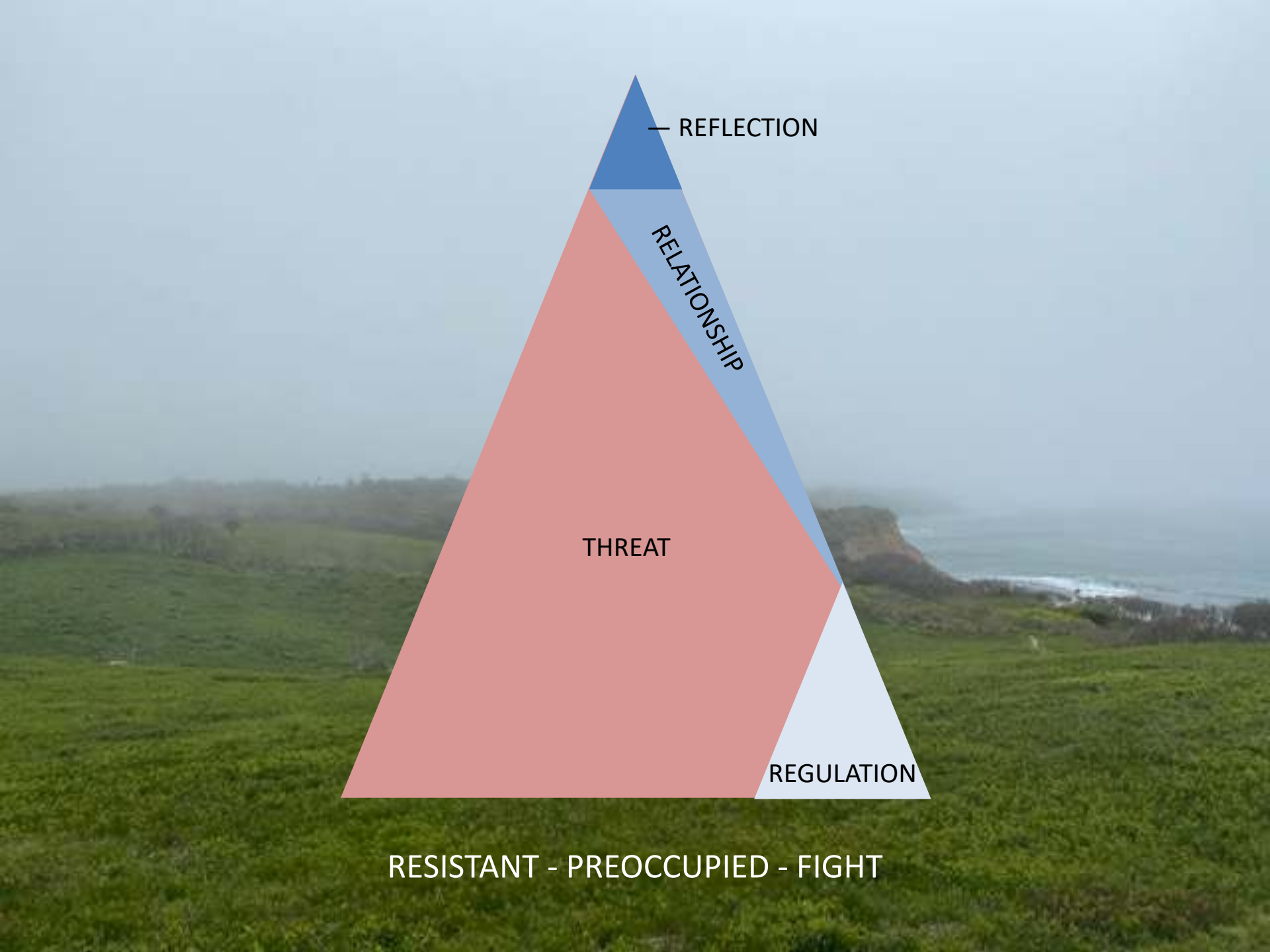
Arousal is modulated
Secure attachment

Low arousal
Hyper-regulated
Avoidant/Dismissive
Flight

High arousal
Under-regulated
Resistant/Preoccupied
Fight

Dysregulated
Disorganized/Unresolved/Hostile/Helpless
Freezing


REFLECTION
RELATIONSHIP
REGULATION
THREAT
AVOIDANT - DISMISSIVE - FLIGHT


REFLECTION
RELATIONSHIP
THREAT
REGULATION
RESISTANT - PREOCCUPIED - FIGHT


THREAT
DISORGANIZED - FREEZING

RELATIONAL FOUNDATIONS OF REFLECTION IN THE CLINICIAN, PARENT, AND CHILD

The Foundations of Reflection

- Safety, regulation, and relationship are the *foundations of reflection*
- There is no regulation without safety, no relationship without safety and regulation, and no reflection without a relationship
- If an individual is in survival mode, or dysregulated, thinking, feeling, and making meaning are impossible
- Reflection as a RESULT of the clinician's success in creating safety, regulation, and building a relationship

The Foundations of Reflection

The clinician feels safe, regulated, open to relationship and reflective

The clinician observes the parent and the degree to which they feel safe and are regulated

The clinician engages the parent and works to deepen the clinician-parent relationship

The Foundations of Reflection

- With the support of the clinician the parent can begin to understand their own experience, their own history, and their own inner life, and begin to reflect upon it

- They can now take a reflective stance toward the child, seeing, hearing, and understanding the child in a new way

The Foundations of Reflection

- Establishing these foundations can take months, even years
- The process begins with the clinician, who must feel safe, connected, regulated and reflective, and be able to establish a safe, connected, regulated relationship with the parent(s)


OBSERVE YOURSELF

It begins with you

- A graded, sequential process that begins with the clinician, who must feel safe, regulated, connected, and reflective
- This is necessary if you are to serve as a secure base, a transformative attachment figure, and a model for reflection
- This is a continuous, ongoing process, supported by supervision and self-awareness

Safety

- Do you feel physically safe with the family?
- Do you feel physically safe in your current location?
- Do you feel pressured by curricular expectations?
- Are there other sources of threat affecting you?
- Do you need to do something to establish your safety?

Regulation

- Are you physically reasonably calm and regulated? Or are you shut down or agitated?
- Are you in a state of fight, flight, or freezing?
- Are you able to attend and think clearly?
- Are you rushing *to do* out of your own anxiety*?* (Shifting to a behavioral stance?)
- What can you do to calm yourself and re-establish balance, if necessary?

Relationship

- Are you open to a relationship?
- This is the therapeutic port of entry
- Your humanity is the most important tool you have
- Safe relationships promote exploration and reflection
- As trust is established, the clinician becomes a trusted safe and secure base (epistemic trust)

Reflection

- Can you **observe** the parent and **listen** to them?
- Can you **mirror** their experiences?
- Can you be curious and open? **Wonder why?**
- Tolerate uncertainty and not direct?
- **Generate hypotheses?**
- **Repair ruptures?**

Layers of support for parental reflection

Clinician:

Do I feel safe?

Am I regulated?

Am I open to relationship?

Can I take a reflective stance?


OBSERVE THE PARENT AND CHILD


"Don't just do something. Stand there and pay attention. The **child/parent** is trying to tell you something!" – *Sally Provence*

Safety

- Does the child or parent feel safe with you?
- Are they physically open to you? (Head up, good eye contact, open chest, regular breathing, communicative speech?)
- Is there something you need to do to make the child or parent feel safe(r) (or less threatened)?

Safety

- They can feel threatened by you:
  - The expectation of a relationship
  - The suggestion that they describe their feelings or memories
  - The power differential (you have the power to have their child removed)
  - Race or class differences
- Any of these can lead to flight, fight, or freezing

Regulation

- Are they physically reasonably calm and regulated (or are they shut down or agitated or dissociated)?
- What is their body tone, tone of voice?
- Are they able to attend, to be present and think clearly?
- What can you do to calm them down or re-establish balance, if necessary?

Regulation

- “Limbic system therapy”: Calm the limbic system, regulate the fear response, emotional activation
- Quiet the level of arousal and the interference with thinking, regulating, reflecting
- Practice breathing, relaxation, mindfulness approaches
- Engage in pleasurable experiences (oxytocin!)
- Help the parent be present

Layers of support for parental reflection #2

Clinician:

Do I feel safe?

Am I regulated?

Am I open to relationship?

Can I take a reflective stance?

Parent:

Do they feel safe?

Are they regulated?


ENGAGE THE RELATIONSHIP

Relationship

- Relationships are a basic remedy for fear and offer us the deepest expression of our humanity
- We think about our families, we feel for them and with them
- We are a haven of safety, a secure base
- Our relationship with parents is the therapeutic agent of change

The clinician-parent relationship

- Build the relationship
  - Take the time necessary
  - Remain aware of parent's relationship history
  - Remain aware of parent's sensitivities around independence, connection, emotion regulation, and vulnerability and safety
  - Observe the parent's defenses

Establishing trust

- Clinician is:
  - Warm, emotionally available
  - Caring
  - Physically open
  - Consistent
  - Non-judgmental
  - Engaged and interested
  - Gently persistent
  - Supportive (including providing concrete support)

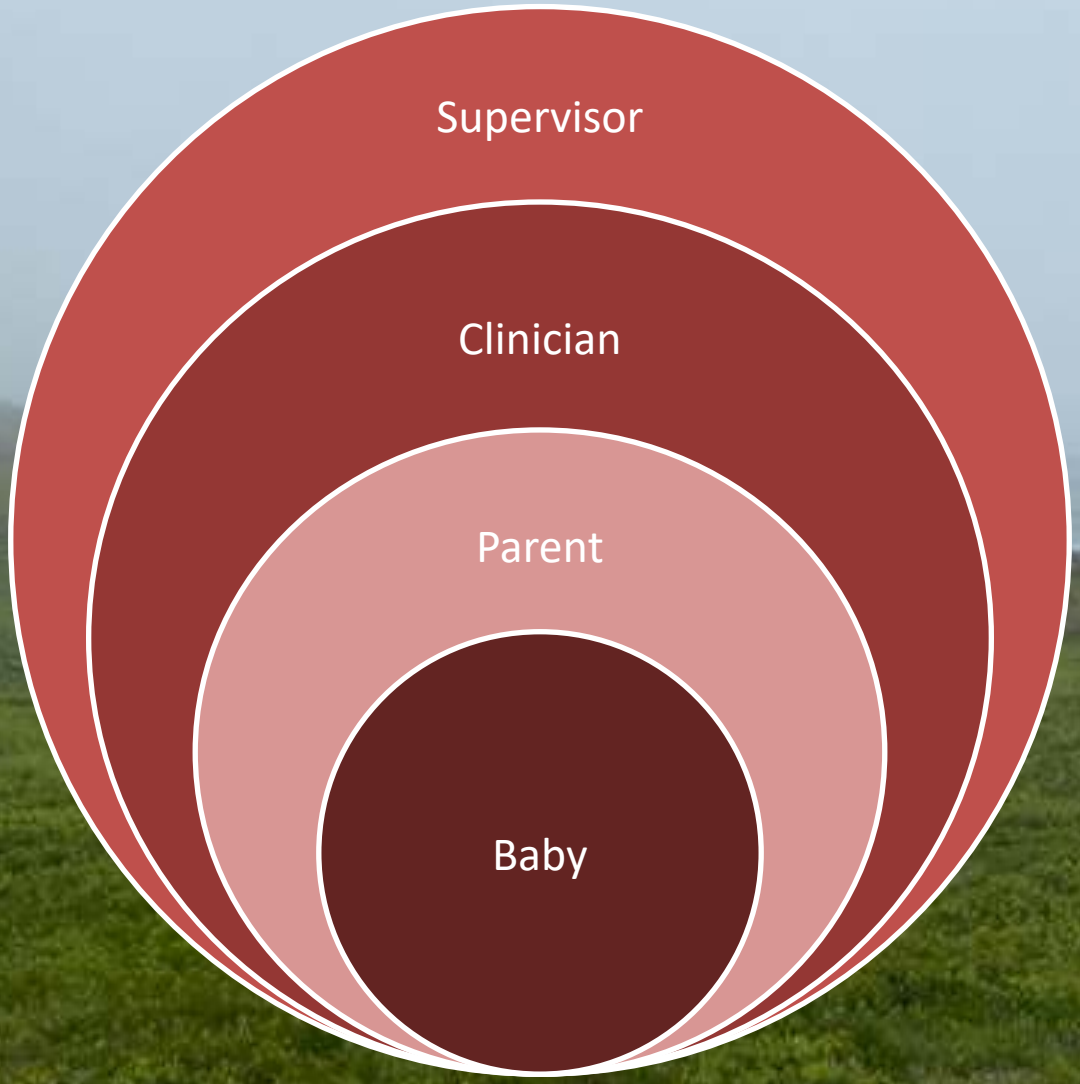
Relationship

- Training therapists (teachers, health professionals, etc.) to form relationships
  - Predictability
  - Follow the parent's/patient's lead
  - Basic helping orientation
- Also the crucial *human* element: caring, warmth, openness to connecting emotionally
- Saturating our clinical stance with *humanity* – they matter to us and we matter to them
- *NOT necessarily countertransference*

Reflection

- Can the parent **listen** to the child and to you and be curious about themselves and their behavior?
- Can they be curious and open? **Wonder why?**
- Tolerate uncertainty and not rush to action?
- **Generate hypotheses?**
- **Repair ruptures?**
- Do they physically respond in a synchronous, non-intrusive, engaged way?

Key Elements of a Reflective Parenting Approach




THANK YOU VERY MUCH