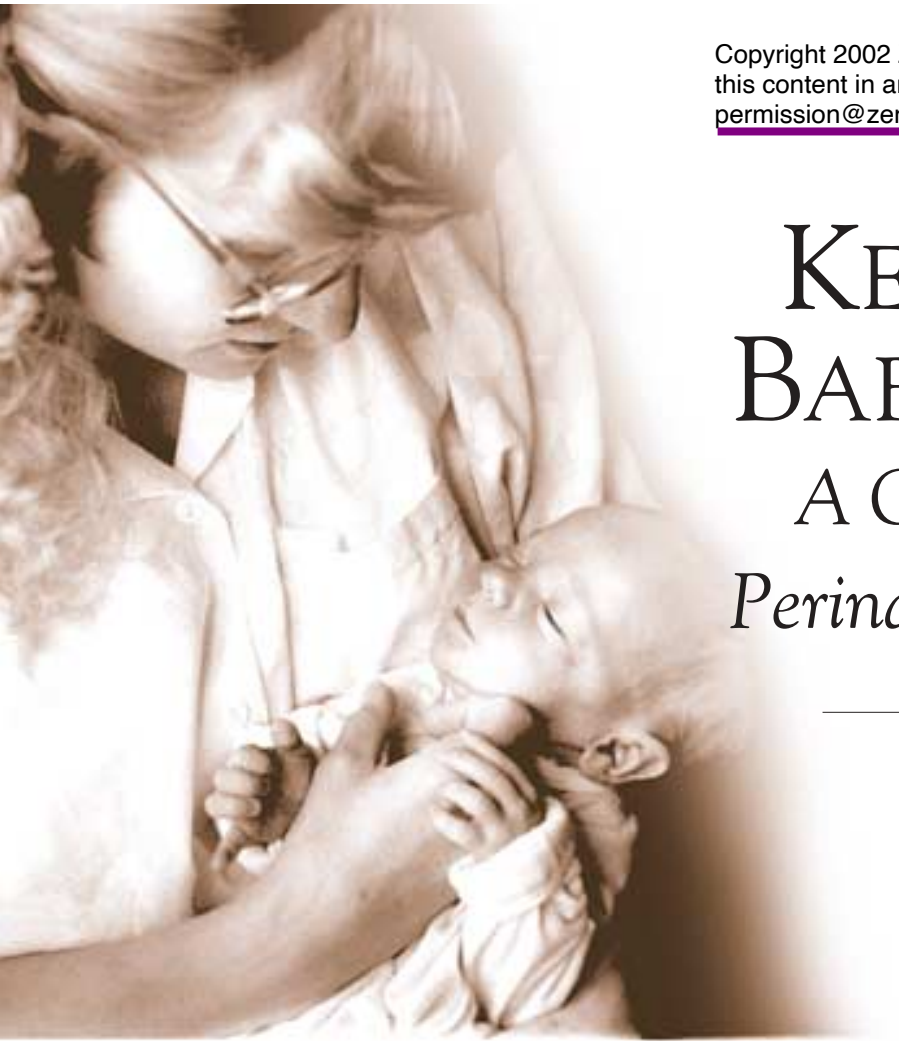

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KEEPING THE BABY IN MIND:

A Critical Factor in Perinatal Mental Health

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The time between a woman's discovery that she is pregnant and the baby's first smile is one of great crisis and opportunity. It is a time of enormous change and upheaval: for the individual woman, whose body and identity shift in concert, and who begins almost instantly to form a psychological relationship with her unborn child; for family members, who must reconfigure to make room for a new voice; and for the community, which must rally to care for the new mother, her new baby, and the family. Most important, it is the beginning of life for the baby, the beginning of a long and complex journey whose contours are established during the first months and years in the world. It is the time when babies learn their very first lessons about people, about feelings, and about relationships.

The perinatal period, thus, is a highly vulnerable time, filled with the potential for transformation, and with the even greater potential for repeating old patterns of relatedness and intimacy. For mental health providers, the rate and complexity of developmental reorganization across so many physical and psychological domains make this a moment ripe for intervention and ripe for change. The mother is just developing a sense of herself as parent to *this baby*; the child's mind, in all its aspects, is just beginning. However, also inherent in such change processes are dangers: The psychological and hormonal changes of pregnancy can trigger or potentiate severe psychopathology in the mother, and thus contribute to the establishment of disrupted, troubled mother-child relationships, the effects of which can continue to be felt across generations.

There are many ways to think about intervention and prevention during the perinatal period, about the spectrum of disturbances that require the attention of mental health providers, and about the spectrum of approaches that can and must be used to insure maternal and infant mental health. As I will describe here, and as is described elsewhere in this issue, staff members at the Yale Child Study Center are developing a range of prevention and intervention programs for the promotion of perinatal and infant mental health. Central to these various programs are our efforts to develop maternal reflective capacities. That is, we seek to enhance, from pregnancy on, the mother's capacity to keep the baby in mind.

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Keeping the Baby in Mind: The Reflective Function

For decades, infant and attachment researchers have emphasized the critical role of maternal sensitivity in promoting a range of positive biological, cognitive, and relational outcomes in the child. And indeed, much of the work of early intervention programs has focused upon enhancing maternal sensitivity and responsiveness. However, the recent work of a group of British psychoanalysts and child developmentalists — Peter Fonagy, Mary Target, Miriam Steele, and Howard Steele — has turned our attention to the internal qualities that allow mothers to be sensitive. They have focused upon an individual's capacity for "reflective functioning" (RF), her capacity to understand that her own or another's behaviors are linked in meaningful, predictable ways to underlying mental states, to feelings, wishes, thoughts, and desires. In other words, RF refers to the awareness that an individual's behavior is a reflection of underlying, likely unobservable, changing, dynamic intentions and emotions. Human beings naturally try to understand each other in terms of mental states, in order to make sense of and even more importantly, to anticipate, each other's actions (Fonagy & Target, 1998). Fonagy considers the reflective function to be a crucial aspect of what he calls the Interpersonal Interpretive Mechanism, the "uniquely human capacity" to process interpersonal experience and make sense of each other (Fonagy, Gergely, Jurist, & Target, 2001).

In their original work, Fonagy and his colleagues (Fonagy et al, 1995) examined parents' capacity to reflect upon their childhood experiences with their own parents. Parents high in RF had the capacity to see their parents' experience as separate and distinct from their own. For example, an adult might understand that his mother's harsh treatment was the result not of his own intrinsic badness, but of his mother's depression and anger at her own mother's physical abuse. Children develop the reflective capacity as a function of interpersonal experience. A mother's capacity to hold in her own mind the notion of her child as having feelings, desires, and intentions allows the child to discover his own internal experience via his mother's experience of them. In essence, the mother provides a secure base for his discovery of his own feelings and thoughts, and for his developing a sense of himself as both connected to and separate from her.

Reflective abilities are inherently linked to affect regulation: A mother's recognition of a link between her infant's mental states and behavior will make it possible for her to develop a mental model of his experience, and thus aid in the his developing capacities for self-regulation. Likewise, her capacity to appreciate the dynamics of her own affective experience is regulating as well. Fonagy suggests, in fact, that the Interpersonal Interpretive Mechanism is further related to stress and attention regulation. Indeed, there is now a growing literature supporting the notion that disrupted relationships — and, implicitly, caregivers' inability to hold their children's experiences in mind — contribute significantly to elevated stress hormones and fragmented attentional processes. Over the past 5 years, Fonagy and his colleagues have documented strong links between a mother's reflective capacity and her own attachment security, as well as that of her child. This is particularly the case for traumatized mothers, because RF appears to mediate the effects of trauma upon caregiving. Thus, deprived and traumatized mothers with high reflective capacity were highly likely to have secure children, whereas deprived mothers with low reflective capacity almost invariably had insecure children (Fonagy et al., 1995). A mother's RF has also been linked to social cognition, particularly to the theory of mind reasoning in children (Fonagy, 1996).

The term "reflective functioning" refers, in part, to a cognitive process, namely an individual's *understanding*. In this sense, it refers to metacognitive processes such as perspective taking and monitoring one's attention and experience. At the same time, however, it refers to an *emotional* process, namely the capacity to hold, regulate, and fully experience emotion. It refers to a nondefensive willingness to engage emotionally, to make meaning of feelings and internal experiences without becoming overwhelmed or shutting down. The complex processing and integrating that is inherent in high RF bespeaks emotional richness and depth, and a capacity to appreciate and experience the dynamics of an internal and interpersonal emotional life.

Maternal RF and Her Relationship With Her Child

In recent work, we have begun to apply this construct to mothers' understanding of their children's internal experience. That is, we have begun to study maternal RF as it pertains to the developing relationship with the child. We have asked – in a series of research investigations – how maternal RF contributes to positive outcomes in the child. Central to

at a glance

- Reflective functioning is a cognitive and an emotional process that indicates a capacity to understand the dynamics of an internal and interpersonal emotional life.
- High maternal RF makes it possible for a mother to accurately read a child's intentions and feelings and to respond sensitively.
- An intervention model has been developed that focuses on a mother's capacity to identify her own affective experience and to recognize and respond to her child's experience, but not, per se, on the *meaning* underlying her feelings.
- The Parents First intervention program emphasizes taking a fresh look at the meaning behind a child's behavior or feeling, rather than strategies or specific solutions.
- The Keeping the Baby in Mind project trains home visitors to continuously model reflective awareness in everyday caregiving and nurturing.

our work is the Parent Development Interview (Aber, Slade, Berger, Bresgi, & Kaplan, 1985), a 45-item clinical interview designed to examine a parent's experience of his or her relationship with the child. Our preliminary studies indicate that a mother's capacity to understand her own or her child's behavior in terms of mental states is significantly related to her own attachment status, her child's attachment status, and to disrupted affective communication in the dyad. Even more important, maternal reflectiveness appears to mediate the relation between adult and child attachment; thus, a mother's capacity to reflect upon and understand her child's internal experience is what accounts for the relation between attachment status and her child's sense of security and safety (Grienenberger, Kelly, & Slade, 2001; Slade, Grienenberger, Bernbach, Levy, & Locker, 2001). In a third study of the relation between drug dependence and RF, mothers who abused cocaine during their pregnancies were significantly less reflective than their equally disadvantaged, but cocaine free counterparts (Levy, Truman, Slade, & Mayes, 2001). Maternal RF also has been found to predict child attention, withdrawal, social skills, and adaptability to parent distress and parent-child dysfunction, and to mediate the link between drug use, child social skills, parent distress, and parent-child dysfunction (Levy & Truman, 2002). Schechter and his colleagues (Schechter et al., 2002) have documented changes in maternal RF following a single videofeedback session in traumatized mothers and their babies. These results linking maternal RF to both child and parent outcomes strongly suggest that these are qualities we need to target for intervention.

"A mother's capacity to reflect upon and understand her child's internal experience is what accounts for the relation between attachment status and her child's sense of security and safety."

What does maternal RF look like? An essential aspect of RF is the mother's capacity to recognize that the infant or toddler has mental states – that he has feelings, thoughts, and intentions of his own: "He's *sad*." "She's *angry*." "He *likes* bananas." "She *knows* I'm gonna' feed her." " He *wants* to go outside." But it is her capacity to *link* this awareness of her child's or her own internal state to behavior or to other internal states that is the hallmark of true reflectiveness: "He threw a tantrum in the store (behavior) *because* he was *tired* and *hungry* (physical state), and I'd been dragging him around all day and he was *sick of it* (mental state)." "I was just so *sad* and *frightened* (mental state) by the fight I had with my husband. I wasn't *myself* at all (behavior) and this was *so disorienting to my baby* (implies effect upon baby's mental state)."

Finally, an example of a highly reflective mother, who makes sophisticated links between her own and her child's mental state and behavior throughout: "Sometimes she gets *frustrated* and *angry* (child mental state) in ways that *I'm not sure I understand* (link to mother's mental state). She points to one thing and I hand it to her, but it turns out *that's not really what she wanted* (child mental state). It *feels very confusing to me* (mother mental state) when *I'm not sure how she's feeling* (link to child mental state), especially when she's upset (child behavior). Sometimes *she'll want to do something* (child mental state) and I won't let her because it's dangerous, and so *she'll get angry* (child mental state). I may try to pick her up and she obviously didn't want to be picked up because she's in *the middle of being angry* (appreciation of the process of child's mental state) and I interrupted her. In those moments it's *me who has the need to pick her up and make her feel better, so I'll put her back down* (distinguishes own needs from those of child)."

These examples of high RF vividly convey how a reflective mother grasps the complex interplay between her own mental state and that of her child, between her internal experience and her behavior, and between her child's internal experience and behavior. Highly reflective mothers understand that mental states can be ambiguous, that they change and de-intensify over time, and that they can be hidden or disguised. These are mothers with a keen sense of how emotions *work*, what makes them and their child "tick". These are mothers who are – to use the Robert Emde's term – emotionally available to their children. As suggested by the research described above, a mother's capacity to make sense of her child's mental states, as well as of her own, is intrinsic to sensitive parenting. The mother who understands that her child is fussing *because* he is hungry or frightened, that her child's distress has both a meaning and a trajectory of its own, or simply that he is having a feeling that she doesn't share or understand is by definition keeping her baby – his needs, his desires, and his feelings – in mind. And in so doing, she can respond to her child in ways that are sensitive, containing, and regulating. From an intervention standpoint, this is the critical issue. Contingent, sensitive responding *depends* upon an accurate reading of the child's intentions and feelings, upon the mother's emotional availability. The reflective function is what makes this possible.

Low maternal RF takes many forms. On the one hand are mothers who seem to have little notion of their baby's internal experience. These mothers may simply seem oblivious to the fact that their child has feelings or thoughts that are particular and personal to him. When asked, for instance about their child's reaction to separation, they may respond: "I don't know," "Nothing," or "Fine." Others focus, instead, on personality and behavior: "He's cute," "He's pig-headed," or "She's pushes me around." Other mothers may describe but not reflect their child's distress or anxiety: "She clings to me, but she's fine." "She wakes up in the night screaming, screaming, but nothing really bothers her." Of course there are the more malevolent reflections: "He's a devil, just like

his father, and I have to keep a close watch on him." " She's just bad, bad, bad, and there's nothing can be done about it." Finally, mothers often deny their own internal experience in relation to parenting; for instance, responding "No" to questions about the most common feelings of parenting, namely guilt, anger, and joy. The range of responses briefly described here are characteristic of mothers who simply will not or cannot enter their child's experience as a means of understanding them, and who do not use their own internal experience as a guide to sensitive responsiveness. In clinical terms, they are highly defended, and resort to primitive means of blocking out or distorting their child's internal life.

A mother's reflective capacity is different from, but related to, her attachment organization, although the research briefly described above suggests that RF is critical to the intergenerational transmission of attachment. Inherent in the notion of adult attachment security is a mother's capacity to attend to and make coherent meaning of her own and her parents' internal experience; RF is thus a critical aspect of a secure attachment organization. Inherent in the notion of a parent's insecurity, however, is the distortion, denial, or misreading of the child's mental state; that is, low or distorted reflectiveness. These disruptions are central to the development of disturbed and dysfunctional mother-child relationships. Indeed, they are often of most concern to early interventionists: the misattribution of mental state, the obliteration of the infant's intention, the obliviousness to the child's basic rhythms and cycles of arousal.

"[Research] results linking maternal RF to both child and parent outcomes strongly suggest that these are qualities we need to target for intervention."

Selma Fraiberg, whose work set the course and the gold standard for all subsequent work in early intervention, did not use the term "reflective functioning," but her papers provide us with wonderful examples of the power of a mother's discovery of her own and her baby's internal states, and the *link between these experiences*. Fraiberg and her colleagues used remarkably straightforward techniques to bring the baby's experience into the mother's consciousness, to begin to help mothers accurately read their babies' signals and *underlying intentions*. She was the first to "speak for the baby." But this was not sufficient to provoke demonstrable change in mothers' sensitivity and responsiveness to their babies. Her therapeutic successes evolved from the development of the mother's capacity to *link* her baby's experiences to her own. It was through this process that the mother could see her baby as separate from her, needing a mother who would know and take care of him, just as she herself had needed mothering so long ago. From Fraiberg's perspective, developed within the framework of psychoanalytic, dynamic psychology, it is the link between the present and the past that is crucial to change. From the point of view of developing maternal reflective capacities, however, it is the link between mental states, and between mental states and behavior, that is at the heart of healthy mother-child relatedness. At times, these connections develop through an examination of past-present links; at others, they may more simply arise through the process of reflection as it pertains to daily, relational experience.

Within the early intervention and infant mental health literature, our understanding of the parental side of attachment and of healthy parent-child relationships has been greatly enhanced by Alicia Lieberman's work on parental attributions and Charley Zeanah's work on the quality and coherence of parental representations of the child. Lieberman has written beautifully about the complex task of untangling distorted, negative, and malevolent representations of the child within the course of infant-parent psychotherapy, the slow and painstaking separating out of the mother's own fears and aggression from her representation of the child. Likewise, Zeanah has written about the development of balanced, disengaged, and entangled representations of the child. Secure and coherent models of the complexity of the child's internal experience contrast sharply with those that deny the child's internal experience, or — even more disturbingly — distort such experience in self-serving and chaotic ways. These latter models invariably lead to poor developmental and relational outcomes. The work of Lieberman and Zeanah gives us a way of thinking about the dimensions of low reflectiveness within the context of disturbed mother-child relationships. Distorted or unelaborated representations of the child are a direct manifestation of the mother's inability to hold in mind or reflect upon her child's experience. Indeed, change in infant-parent psychotherapy is a direct outgrowth of the therapist's implicit focus on the mother or caregiver's reflective capacities. Because the reflective function allows for the representation of dynamic and complex internal experiences, it is intrinsic to the development of coherent, affectively vital, and organized representations of the self and of the baby. It is for this reason that we have begun developing treatment and intervention models that specifically target the development of RF.

Keeping the Baby in Mind: A Critical Factor in Perinatal Mental Health

Optimally, the process of keeping the baby in mind begins early in pregnancy, and at all levels of experience. It takes place on a cultural and familial level, as the broader community prepares the mother for her journey. Every culture has a way of embracing the woman's new identity and welcoming the child, and of holding the complexity of the joyful, arduous, and sometimes dark moments of pregnancy, childbirth, and new motherhood. Making room takes place at the physical level, as anatomical, biological, hormonal, and neurological changes literally make room for the baby

(Mayes & Cohen, 2001). Finally, and most important from the point of view of perinatal mental health, the mother begins to make emotional room for the child. This first takes place at the level of imagining: She begins to imagine her baby, and herself as a mother (or if not a first pregnancy, herself as mother to *this* child). As her body changes and delivery approaches, imagining slowly becomes reality. Myths abound about the bliss of pregnancy. And yet, it has often been observed that – even under the best of circumstances – this can be a time of great anxiety, mood dysregulation, and general emotional turmoil. Given all the ways in which the woman is making room for the baby, and for herself as mother, this hardly seems surprising.

The derailment of the caregiver-child relationship that is the focus of infant-parent psychotherapy almost always begins in pregnancy. Indeed, this is why intervention before the birth of the baby is so critical. The degree of psychological reorganization necessary for a healthy adaptation to parenthood is enormous (Cohen & Slade, 1999). It is for this reason, of course, that the process of a mother's imaginings becoming reality, of developing representations of the self as parent and caregiver, of the child, and of the relationship is so vulnerable to distortion and disruption. We can begin to observe the degree to which a mother is making room for her baby early in the pregnancy, and – as the pregnancy progresses – we can begin to understand the shape and dynamics of her psychological readiness for motherhood (Slade & Cohen, 1996). During pregnancy women high in reflectiveness will begin to acknowledge their own complex and fluctuating emotions. And they begin to consider the baby as someone who already has physical needs, and who will someday have emotional needs as well. The baby is not simply a projection of the mother's fantasies and dreams, but a living, vital, and,in some sense, already separate human being.

"Helping parents to observe their child and learn to "read" their actions and words are at the heart of the reflective model."

The idea of the baby's separate mind can be denied or frightening to some mothers; thus, it cannot be contemplated. Consider, for instance, Ruth, who was having a great deal of difficulty acknowledging the intensity of her own responses to being pregnant. In particular, she was struggling mightily with the idea of her child's separateness. In response to being asked if she could imagine her baby when she was 7 months pregnant: "I imagine that it's going to be very willful because I can't make it move. . . . The baby will be very active and definitely has a mind of its own, you know. But that's a good thing because it's preparing me that this is another human being. It's not me. It's not an extension of me. So that's one of the first things I learned about the baby was like when I saw my stomach move and everything, you know. I can't make the baby do that. And I'm never going to be able to make the baby, and child, and teenager, and adult do what I want them to do." Ruth indeed imagined that her baby would be separate from her; however, this realization was not a comfortable one. She was already angry at the child for his imagined willfulness, layering the child's natural activity in the womb with meaning and with distortion. Ruth's struggle with the idea of separateness makes it easy to imagine the potential for clashes of desire once the baby was born. Indeed, these struggles erupted in full force by the time baby was 3 months old.

For Ruth, her child's separate mind was threatening because it insures conflict; there could be no meeting or sharing of minds. Ruth's reflections on her own feelings regarding her pregnancy and impending motherhood were fragmented and contradictory. Her ambivalence and rage were intense and palpable, and yet she had no capacity to hold such complexity or to regulate and contain her feelings. A reflective approach to working with Ruth would involve helping her hold her own intense feelings in mind, thereby freeing her to imagine the child as both separate but connected. This would allow her to prepare for the arrival of a "good" baby in need of a mother, rather than organize herself around polishing her armor for full battle with the arriving warlord.

Keeping the baby in mind during pregnancy is largely a psychological process, aided, of course, by all the ways mothers-to-be and their families tangibly prepare for the new arrival. Once the baby is born, however, the mother's capacity to hold him in mind is critical to her helping him regulate and maintain basic biological and social rhythms that will form the basis for his evolving sense of self. The baby's establishment of homeostasis, the first achievement of postnatal life, is vitally dependent upon the mother's capacity to first recognize, and then organize and contain his most fundamental experiences: hunger, tiredness, the need for and pleasure in contact, the displeasure in dysregulation and disorganization. In order to do this, she must be able to make meaning of his experience; this will bring vital order and consistency to his earliest awareness of his interior life.

As documented by many of the pieces in this issue, the reasons behind disruptions in the caregiver's capacity to hold the baby in mind during the perinatal period are complex and multifaceted. They include — often in some dire combination — the re-emergence of early childhood disruptions and traumas, the eruption or worsening of biologically based psychiatric disorders (triggered, in part by the hormonal changes in pregnancy), and the devastating effects of disadvantage and poverty upon basic mental and emotional processes and the regulation of stress. The complex and often interrelated nature of such causes requires flexible approaches to treatment and intervention.

The Reflective Model

RF is basic human capacity – it is what allows us to make sense of the people in our world. For some, reflection is too painful and overwhelming, and thus becomes obliterated; for others, whose intentions have never been recognized, they remain foreign and unacknowledged in experience. Over the course of the past year, we have begun developing programs that are aimed at enhancing RF in parents across a range of settings. This effort grew out of our conviction that RF is key to sensitive caregiving, and, thus, is critical to establishing security and confidence in the child. Clinicians' success in helping parents attend to the baby's cues, to follow the baby's lead, and to respond in a contingent fashion *depends* upon helping mothers develop the capacity to make sense of the child's mental states. Without an emotional understanding of the child, parenting skills are of little use, and remain empty recipes that bear little relation to the child's internal experience and needs. While the development of this understanding has often been central to early intervention and infant mental health programs nationwide, recent advances in theory and research make it possible to target reflective capacities quite explicitly. It is our belief, borne out by early assessments of outcomes in our Parents First program, that working explicitly on RF can directly impact both parent and child behavior, and contribute to the diminution of parent-child difficulties.

Key to the reflective model are three interrelated aims:

1. helping the mother to reflect upon the emotional, internal life of her baby, (even before it is born);
2. helping the mother to reflect upon her own internal affective experience of parenting, as early as pregnancy; and
3. helping the mother to understand the dynamics of her own and her baby's affects — as they exist internally and interpersonally — as a means to problem solving and the development of sensitive, responsive caregiving.

The model is beautifully captured by Sally Provence's wonderful directive to parents: "Don't just do something. Stand there and pay attention. Your child is trying to tell you something." Helping parents to observe their child and learn to "read" their actions and words are at the heart of the reflective model.

While this model is inherently psychodynamic, it is not explicitly an interpretive model. We are interested in a mother's capacity to identify her own affective experience, and to recognize and respond to her child's experience, but not, per se, in the *meaning* underlying a particular set of feelings a mother might have. Thus, we would be very concerned, in working with Ruth, for instance, about her capacity to imagine how her need for control might be affecting her capacity to make room for the baby, and – after he is born – to see him through a broader lens, and appreciate the preciousness and pleasure in autonomy. We would be less, interested, however, in *why* this mother has such a need for control; i.e., how her relationship with her own parents might have left her feeling powerless and helpless (which indeed it did). While such understanding might naturally flow from the process of reflecting upon her own and her child's experience, the intervention model directs mother first to deepen her appreciation of her own and her child's experiences, and not upon the *meaning* of her struggle as they pertain to her own history.

The Parents First Program

The first program we developed is called Parents First (Goyette-Ewing et al., 2002). This is a mental health consultation service for parents that has been implemented at day care and preschool programs in the New Haven area. The group intervention curriculum includes various components: handouts for parents, journaling exercises, suggestions for playful activities, and group meetings. The Parents First groups are the central aspect of this intervention. These are organized in 12-week cycles, and have been piloted with middle- and working-class parents of children between 1 and 5 years of age. These groups are organized around a single aim: helping parents consider their children's internal experience as it relates to their behavior. Each group is organized around a reflective activity; for instance, "Try to think of a time when you and your child had very different feelings about something. . . . What were you feeling? What do you think he was feeling?" or "Try to think of a time when your strong feelings had an impact on your child. . . . What were you feeling? What kind of effect did it have on your child?"

The groups are conducted in an atmosphere of contemplation, and the emphasis within each group is rethinking or taking a fresh look at the meaning behind a child's behavior or feeling, rather than upon strategies or specific solutions. We find that the process of the group indeed encourages reflection, and that upon completion of the program, parents spontaneously note that problems (sleep, transition, etc.) have resolved. More important, they seem much more able to make sense of their children: "Now I realize that he really needs time to transition; it's too hard for him otherwise. Everything's fine if I give him the time." Or, "I just find myself much more aware, and, like, I'll stop myself and reflect on what he might be feeling." These preliminary results have been quite encouraging, and suggest to us that RF may be a parenting skill that can – with the help of an experienced, trained clinician – be enhanced within a group setting. We are now preparing a curriculum for mothers and fathers during the pregnancy and perinatal periods.

The Minding the Baby Project

We have also developed a home intervention study with disadvantaged mothers and their babies, again with the reflective model at the core of the intervention. This program – which will begin during the second trimester of pregnancy and continue through the child's second birthday — is aimed at helping the mother "keep the baby in mind" in a variety of ways, physically, emotionally, and

relationally. Mothers will be visited in the home beginning during the second trimester of pregnancy, continuing through the first year of life. We have named this project Minding the Baby (Slade et al., 2002). The model is based upon the flexible implementation of an integrated nursing/mental health model, and will be delivered by a team that includes a clinical social worker with infant mental health training and an advanced practice pediatric nurse who also is trained in early relational development and attachment. One member of the clinical team will form a primary relationship with the mother; as has been demonstrated time and again in home visiting studies, the mother's relationship to the home visitor is of vital importance in predicting outcomes.

This relationship-based team approach ensures that the mother and baby receive the nursing care that Olds and his colleagues have found so critical to early home visiting. At the same time, it allows for specific attention to the attachment and mental health needs of mother and baby, as are central to the attachment interventions pioneered by Fraiberg, Lieberman and Pawl, Heinicke, and Zeanah. We use this combined model because we believe that the capacity to keep in mind multiple aspects of the baby's experience – physical needs, emotional needs, and affiliative needs — is critical to sensitive parenting. Equally central is helping the mother keep herself and her own feelings in mind as she negotiates the complex transition to parenthood and the development of a new, complex, and lifelong relationship.

Central to the training of home visitors, and to the organization of home visits is the implementation of the reflective model: training the home visitors to keep the baby's mental and physical states alive for the mother, and to continuously model reflective awareness in everyday caregiving and nurturing. This approach will bring a coherence and focus to the intervention, and will be essential in helping mothers develop the capacities that are intrinsic to raising healthy, well-adapted children. The women and families we will be working with are struggling with the severe and complex effects of urban poverty and disadvantage. Many of these women have had significant trauma histories, and many continue to be exposed to a range of ongoing traumas. For these women, reflective capacities have been deadened by life's circumstances; it is often too painful to acknowledge emotions that feel unmanageable and terrifying. In order to help women tolerate and regulate their self-experience, there will be an emphasis throughout pregnancy and the perinatal period on using the techniques of mindfulness meditation as an adjunct to enhancing RF. Many of the mothers in our sample are quite defended against their own internal experience, and these skills can be quite helpful in simply helping them hold their own feelings in mind.

The two pilot programs just described mark the beginning of testing out a range of hypotheses regarding the enhancement of maternal reflective capacities in normal and therapeutic settings. These programs reflect our first efforts to translate research and theory on maternal reflectiveness into practice, in hopes of ultimately improving the effectiveness of early intervention for parents and their children.

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