
November 27, 2015 by Essay Sauce

Introduction
Mentalization is the capacity to understand and interpret one’s own and others’ behaviour as an expression of mental states such as feelings, thoughts, fantasies, beliefs and desires (Katzenelson, 2014). In short: mentalization is the ability of seeing ourselves from the outside and others from the inside (Asen & Fonagy, 2012). Reflective functioning (RF) is an operationalization of mentalization (Katzenelson, 2014), so mentalization is the latent trait, which can be assessed by measuring RF. Reflective functioning is an adult’s quality of understanding his or her own and another’s intentions, motivations and emotions (Crowell, Fraley,
Parental reflective functioning is related to that, but focuses specifically on parents’ ability to mentalize in relation to their child (Katznelson, 2014). The way in which parents are able to do so is of influence on infant’s attachment (Fonagy, Steele, Steele, Moran, & Higgitt, 1991). Several studies have been performed to examine the relationship between adult attachment, reflective functioning and infant attachment (Fonagy, Steele, & Steele, 1991; Main, Goldwyn, & Hesse, 2003; Waters, Treboux, Fyffe, & Crowell, 2001 as described in Katznelson, 2014). In this research a moderate to strong relationship between RF and infant attachment has been found. The children of mothers with high reflective functioning capacities are more likely to be securely attached (Slade, 2008). This suggests that parents’ reflective capacities (assessed prior to the birth of their child) were highly predictive of the extent to which their children were securely attached at one year of age. The parent’s capacity to reflect upon the child’s internal experience is crucial to the development of secure attachment (Slade, 2005). A number of theories on mentalization give insight in the way in which parental RF influences children’s attachment. Examples include the social biofeedback theory (Gergely & Watson, 1996) and a theory of the development of psychic reality (Fonagy & Target, 1996). The first theory states that infants become sensitised through their categorical emotion-states through a natural social biofeedback process. This process is provided by the parents’ ‘marked’ reflections of the baby’s emotion display during affect-regulative interactions. A complex biosocial system regulates this process in which infants communicate dynamic affective change instinctively through their behaviour and the parents respond to this process by mirroring the infant’s affective state ‘markedly’. It is important that this affective state is ‘markedly’ mirrored, because it should communicate to the infant that the parent’s reaction is not representative of his or her own affective state (Gergely & Watson, 1996; Katznelson, 2014).

The second theory behind mentalization is the theory of psychic reality. This theory describes the changes in children’s perception of psychic reality and highlights a major shift in the child’s understanding of minds at a very young age (oedipal stage, around 3-6 years of age). The authors stated that a child in that age uses three stages of psychic reality: psychic equivalent, pretend mode and teleological mode. The first one refers to the young child’s experience of the world in which the internal world is equal to the outer reality. In this stage the world is how a child perceives it, the child has no understanding of thoughts and feelings as mental states. In the second stage, the pretend mode, the child can separate internal and external reality, but only when they are kept strictly apart, such as in play. In the third stage (teleological mode) the child experiences a world in mental states which are not represented and consequently must be expressed in action. In normal development, those three stages are integrated into a mentalizing capacity in which the child begins to understand thoughts and feelings as mental representations expressed through behavior. The capacity to mentalize is a developmental achievement and this depends, in part, on the quality of caregiving a child receives. The goal for parents is to treat their children as a psychological agent, which is someone who can reason about their own and other people’s explicit goals, intentions and beliefs (Sharp & Fonagy, 2008). In some cases parents are not able to reach this goal. Pathological development can interfere with the integration of the aforementioned three stages of thinking, which results in an inhibition of the mentalizing capacity (Fonagy & Target, 1996; Katznelson, 2014). So the capacity to mentalize is important in the development of young children. However the question is which developmental areas are influenced by mentalization.

Child mentalizing

As mentioned before mentalization involves both a self-reflective and an interpersonal component, is both implicit and explicit and concerns both feelings and cognitions (Lieberman, 2007). All humans are born with the ability to develop the capacity to mentalize. Early relationships create the opportunity for the young child to learn about mental states. In particular the mother plays an important role in allowing children to discover their own internal experience, because of her role as primary care-giver. Maternal capacities such as understanding that children have their own feelings, desires and intentions, observations of moment to moment changes in the child’s mental state and her representation of these in gestures, actions, words and play are important in the development of mentalizing capacities in children (Slade, 2005). However the maternal capacities to foster mentalization in the child may be disrupted by a variety of child characteristics such as temperament (Sharp & Fonagy, 2008).

A concept that is related to RF is Parental Meta-emotion Philosophy (PMEP). This includes two important components, namely emotion-processing and metacognition. PMEP refers to a ‘set of feelings and thoughts
about one's own emotions and one's children's emotions' (Sharp & Fonagy, 2008, p. 744). It differs from RF in the way that PMEP focusses on parent's and child's emotions. Gottman, Katz and Hooven (1996) demonstrated that children whose parents were more able in emotion-coaching show greater physiological regulatory abilities, less evidence of physiological stress, greater ability to focus attention, less physical illness, better peer relations and higher academic achievement. So the way in which parents can reflect on their child's emotions is of influence on children's (mental) development.

**Problem behavior**

Human beings are adapted to participate in collaborative activities which involve the capacity to have shared goals and socially coordinated action plans (Tomasello, Carpenter, Call, Behne, & Moll, 2005, as described in Sharp & Fonagy, 2008). Three prerequisites are necessary for this shared intentionality: the capacity to understand intentions, the motivation to share psychological states and the ability to communicate relevant information (Gergely et al., 2005 as described in Sharp and Fonagy, 2008). In the parent-child relationship shared intentionality is a product of the capacity of the parent to convey relevant information and the receptiveness on the part of the child to receive this relevant knowledge and the way in which parents are able to function reflectively is important for this process. In relation to this process, Sharp and Fonagy (2008) suggest that social-environmental factors such as reflective functioning play a crucial role in the way in which the child matures into a mentalizing agent. It could be that if parental reflective functioning does not work at an optimal level, this may have implications for child's psychosocial functioning. The link between maternal reflective function (or a related concept) and children's psychosocial functioning has been investigated several times.

Sharp and colleagues (2006) investigated the influence of maternal accuracy in mentalizing on child development. They measured maternal accuracy by asking mothers to guess the responses of their 7-11 year old children and found that this is related to child's psychopathology: mothers who had average or high scores on maternal accuracy had children with lower psychopathology scores than mothers who scored low on maternal accuracy. Gottman, Katz and Hoover (1996) investigated the relation between psychopathology and meta-emotion, which refers to parents' emotions about their own and children's emotions. This concept is closely linked to reflective functioning, but the latter is wider and involves also parent's intentions and motivations. They found that parental meta-emotion is related to child's regulatory physiology at age 5 which is in turn related to child's emotional down-regulation (children's ability to regulate their emotions) at age 8. Strassberg (1997) investigated mothers of aggressive vs. non-aggressive children (aged 4.5) and showed both of them vignettes of different forms of child noncompliance, varying in severity. They found that mothers of aggressive children are more inclined to ascribe hostile intent to children on all forms of noncompliance, while mothers of non-aggressive children ascribed hostile intent to their children only to the most severe vignettes.

Those three studies make clear that maternal attributions towards their child, maternal accuracy in guessing the responses of their child and the way in which mothers can reflect on the emotions of their child are of influence on child's psychopathology. Mothers who have a high ability to accurately reflect on their child's emotions, reactions and intentions have children with less psychopathology. Sharp and Fonagy (2008) described a testable model of factors which relate parental mentalizing to child psychopathology. They hypothesize that the relationship between parental mentalizing and child psychopathology goes through child mentalizing and emotion regulation. This means that parental reflective functioning influences child mentalizing capacities which in turn influences emotion regulation and child psychopathology. One of the bases of this model is that parental mentalization influences child mentalizing. Both parental reflective functioning and
child mentalizing are related to Theory of Mind, which could be described as a person's ability to attribute mental states to himself and others (Sher, Koenig, Rustichini, 2014). One central measure of ToM understanding involves knowledge that others can hold false beliefs about location or contents of an object, and that these beliefs produce undesired behavioral consequences. By the age of about 4 most typically developing children have an understanding of the consequences of holding false beliefs and thus have ToM understanding (Woolfe, Want, & Siegal, 2002). However early signs of ToM can be measured around the age of 2 (Hughes & Ensor, 2007), such as imitation (Sharp, 2006). Theory of Mind is preceded by a range of precursors to intentional understanding and those precursors emerge during the first year of life. An example of ToM precursor is a child’s innate capacity to imitate facial expressions (Sharp, 2006). ToM is strongly related to mentalization, because both involve the capacity to understand mental states of oneself and others (G?? rska & Marszal, 2014). So child’s mentalizing capacities can be measured by investigating their (precursors) of ToM. As described before, maternal RF is important in the development of mentalizing capacities in children (Slade, 2005). The question is whether the influence of maternal RF can be found in children’s precursors of ToM in a way that mothers with high reflective functioning capacities have children with more developed precursors of ToM.

Minding the baby

The theory described earlier makes clear that maternal reflective functioning influences the mother-child relationship (attachment) and this could have consequences later in the child’s life, for example with respect to problem behaviour. This emphasizes the importance of adequate reflective functioning capacities in mothers. The intervention ‘Minding the baby’ aims to enhance maternal reflective functioning to improve early health and relationship outcomes (Sadler et al., 2013). This intervention was first implemented in 2002 and is founded on two evidence-based early intervention models: Nurse home visiting and Infant-Parent Psychotherapy (IPP). The first mentioned Nurse home-visiting programme (in particular Nurse Family Partnership, NFP) has been developed for socially disadvantaged families and women were recruited who were either low income, unmarried or adolescents. The focus was particularly on women who had no previous live births, because those have legitimate concerns about their own health and the well-being of their baby. Mothers who had live birth before may give less reason for concerns, because of their experience with previous children (Olds, Hill, Robinson, Song, & Little, 2000). Public health nurses who were extensively trained in the programme visited mother weekly beginning in pregnancy until the child is 1 year old and a biweekly visit until the child’s second birthday. They educated the mother skills and provided information related to infant and maternal health (Sadler et al., 2013).

Three randomized clinical trials have been performed in three different areas in the USA: Elmira (Olds, Henderson, Tatelbaum, & Chamberlin, 1986; Olds et al., 1997), Memphis (Olds et al., 2010; Kitzman et al., 2010) and Denver (Olds et al., 2002; Olds et al., 2004). Those three randomized trials and the subsequent follow-up studies gave consistent evidence of positive health, public health, developmental, parenting and life-course outcomes (Sadler et al., 2013), such as less child abuse and neglect and greater intervals between the birth of first and second child in families participating in the Nurse Family Partnership (Olds, Sadler, & Kitzman, 2007).

The second model on which Minding the baby was founded is Infant-Parent Psychotherapy, which is now part of Child-Parent Psychotherapy (Lieberman, Van Horn, 2009). In this intervention at-risk mothers were visited by a mental health professional with experience in child development and family system approaches. Those visits were weekly at the end of pregnancy and first year of age and every other week in the second year of baby’s life (Heinicke et al., 1999) or took place between the baby’s first and second year of age (Lieberman, Weston, & Pawl, 1991). This program aims to enhance the mother’s skills on three different domains: communication and personal adaptation, alternate approaches to her relationship to her child and direct affirmation and support (Heinicke et al., 1999). So the affective obstacles in the mother-child relationship would be removed (Lieberman, Weston, & Pawl, 1991). Evidence for the efficacy of this intervention has been found in two studies by Lieberman and colleagues (1991) and Heinicke and colleagues (1999). They found mother ‘child dyads who followed the intervention more likely to be securely attached, mothers were higher in empathy and interactiveness towards the child. So mothers became more responsive to the needs of their children and the infants were more secure in their attachment to their mothers (Heinicke et al., 1999).
So both NFP and IPP are successful interventions for high risk families and emphasizes sensitive parenting and the development of a healthy parent-child relationship. However the focus in NFP is on both infant and maternal mental and physical health (by nurses), while IPP focuses on child development and family system (by mental health professionals). The program Minding the Baby (MTB) combines both approaches: nursing and infant mental health to meet families’ multiple layers of need (Sadler et al., 2013). The focus of MTB is on enhancing maternal reflective functioning (RF) for all mothers: both mothers with low maternal RF and mothers who are able to make sense of their children’s minds. Their sample consists of only high risk mothers, which were found to have more negative representations about themselves and their child (Pajulo, Savonlahti, Sourander, Piha, & Helenius, 2001).

Families who take part in MTB are visited weekly beginning in mother’s third trimester of pregnancy up through child’s first birthday. From this point visits take place biweekly up to the child’s second birthday. Visits are carried out by a team made up of a nurse practitioner and a social worker, which in turn visited the families. In times of crisis or when a family requires extra support or time, the home visits can be extended or increased in frequency. The nurse practitioner and the social worker confer regularly about each of their shared families. The role of the nurse practitioner includes reinforcing parental care and health education and supporting child’s health and development. The social worker’s role includes assessment of both mother and child, which includes diagnosing perinatal depression, anxiety and other forms of psychological distress and psychiatric illness and providing possible treatments, and helps mothers to negotiate issues involving the legal and court system. Both clinicians support maternal RF, promote the mother-infant attachment relationship and model and foster a range of parenting skills by modelling a reflective stance during home visits. This involves that they are curious with the mother about the child’s and parent’s thoughts and feelings. They often use ‘wondering’ questions and statements, such as ‘What do you imagine your child is feeling when he hears you crying?’ to make mothers able to explore their inner life as well as the child’s feelings, needs and wants (Sadler et al., 2013).

The first outcomes in a pilot-phase randomized control trial (Yale, Connecticut) revealed that families who participated in MTB were less likely to be referred to child protective services and had lower rates of subsequent childbearing. The intervention infants were more likely to be securely attached and less likely to be disorganized in relation to attachment at 1 year of age. And finally, mothers’ capacity to reflect on their own and their child experience improved over the course of the intervention in the most high risk mothers (Sadler et al., 2013). So overall those first results showed that MTB is effective in enhancing maternal RF and has positive family and child outcomes.

However those first promising results were found in the United States. The question is whether this intervention can also successfully be carried out in other countries such as The Netherlands. The Dutch situation is different from the American one in the care for mother and child. In The Netherlands all mothers have access to maternal health centre, which follows the development of the child. Mothers are standardly called to visit those mental health centres and certificated nurses and doctors examine the children. In case of developmental problems mothers are redirected to a medical specialist. So the ‘nurse-side’ of MTB is already arranged in the Netherlands for all mothers, as opposed to the USA. For that reason the program MTB was adapted to the Dutch situation so that mothers were visited weekly by social workers, who aim to enhance their reflective functioning capacities.

The current study focuses on maternal reflective functioning, prenatal and postnatal, and its possible influence on child’s aggressive behaviour. The child’s aggressive behaviour is studied when the child is 20 months old, by a questionnaire, filled in by mother. Based on the available literature, it is hypothesized that infants of mothers who have lower reflective functioning capacities have higher ratings of aggressive behaviour compared to mothers with average or high reflective functioning capacities. In addition, the current study aims to examine whether children’s precursors of ToM mediate the relationship between maternal reflective functioning and child aggressive behaviour. The child’s ToM is studied at an age of 20 months by means of a visual perspective task, an imitation task and a discrepant desires task. It is hypothesized that mothers with high reflective functioning capacities have children with more strongly...
developed ToM-capacities, which means higher scores on those three tasks. The third aim of this study is to investigate whether a MTB-like program (coaching program ‘A good start’) is effective in enhancing maternal reflective functioning and whether this is related to less aggressive behaviour in the coaching group. It is hypothesized that coaching enhances maternal reflective functioning, which in turn reduces child’s aggressive behaviour.

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