

Spreading HOPE

HEALTHY OUTCOMES
FROM POSITIVE EXPERIENCES

Early Relational Health
David Willis, MD

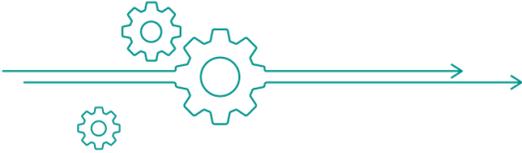
The First Annual HOPE Summit
April 9, 2021, Afternoon Breakouts



Early Relational Health

This materials packet includes:

- 1. Early Relational Health PowerPoint
- 2. Changing the Mindset: Foundational Relationships Counter Adversity with HOPE
- 3. Parenting and Child Development: A Relational Health Perspective



For more on HOPE, visit <https://positiveexperience.org/>

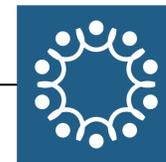




Early Relational Health Advancing HOPE

Spreading **HOPE**
HEALTHY OUTCOMES
FROM POSITIVE EXPERIENCES

HOPE Summit Breakouts
April 9, 2021



David W. Willis, MD FAAP
Senior Fellow, CSSP





Learning Objectives

- Describe **early relational health**
- Reflect on your **current mindset** about foundational relationships, early relational health and your current practices and understandings
- Apply concepts and practices of early relational health to your efforts of ***Spreading HOPE***



**A baby's future
starts now.**



The Core Story of Child Development

- Early experiences in life build “brain architecture”
- Children develop in an **environment of relationships**
- Genes and environments interact to shape the architecture of the brain
- Cognitive, emotional and social capacities are inextricably intertwined
- “Toxic stress” and adverse experiences derail healthy child development
- Brain plasticity and the ability to change behavior decrease over time

National Scientific Council on the Developing Child, 2015



Innocenti Report Card 16 2020

US ranks

- 36th of 38 countries overall
- 29th on policies supporting child wellbeing
- 28th for 15 yr. old reading and math proficiencies
- 33rd in child mortality rates for 5-14 yrs. old >1/1000



Figure 3: A league table of child well-being outcomes: mental well-being, physical health, and academic and social skills

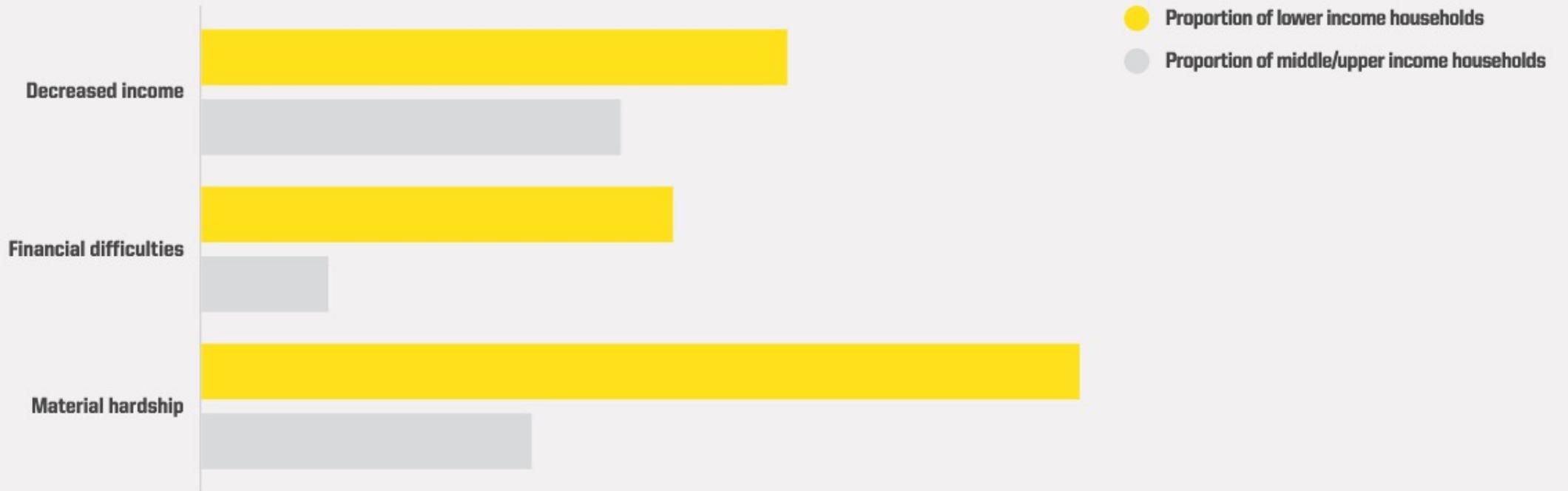
Overall ranking	Country	Mental well-being	Physical health	Skills
1	Netherlands	1	9	3
2	Denmark	5	4	7
3	Norway	11	8	1
4	Switzerland	13	3	12
5	Finland	12	6	9
6	Spain	3	23	4
7	France	7	18	5
8	Belgium	17	7	8
9	Slovenia	23	11	2
10	Sweden	22	5	14
11	Croatia	10	25	10
12	Ireland	26	17	6
13	Luxembourg	19	2	26
14	Germany	16	10	21
15	Hungary	15	21	13
16	Austria	21	12	17
17	Portugal	6	26	20
18	Cyprus	2	29	24
19	Italy	9	31	15
20	Japan	37	1	27
21	Republic of Korea	34	13	11
22	Czech Republic	24	14	22
23	Estonia	33	15	16
24	Iceland	20	16	34
25	Romania	4	34	30
26	Slovakia	14	27	36
27	United Kingdom	29	19	26
28	Latvia	25	24	29
29	Greece	8	35	31
30	Canada	31	30	18
31	Poland	30	22	25
32	Australia	35	28	19
33	Lithuania	36	20	33
34	Malta	28	32	35
35	New Zealand	38	33	23
36	United States	32	38	32
37	Bulgaria	18	37	37
38	Chile	27	36	38



The context of the moment: COVID-19 Pandemic

**LOWER INCOME HOUSEHOLDS ARE MORE LIKELY TO FACE MATERIAL
HARDSHIP, FINANCIAL DIFFICULTIES AND DECREASED INCOME**

R

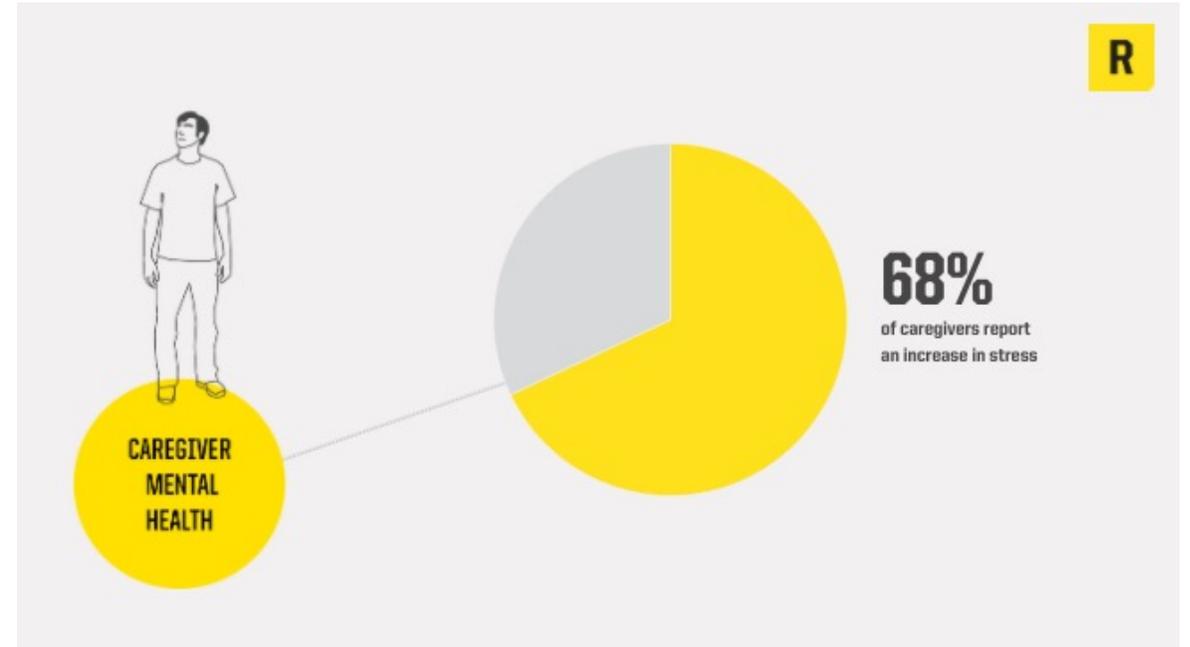
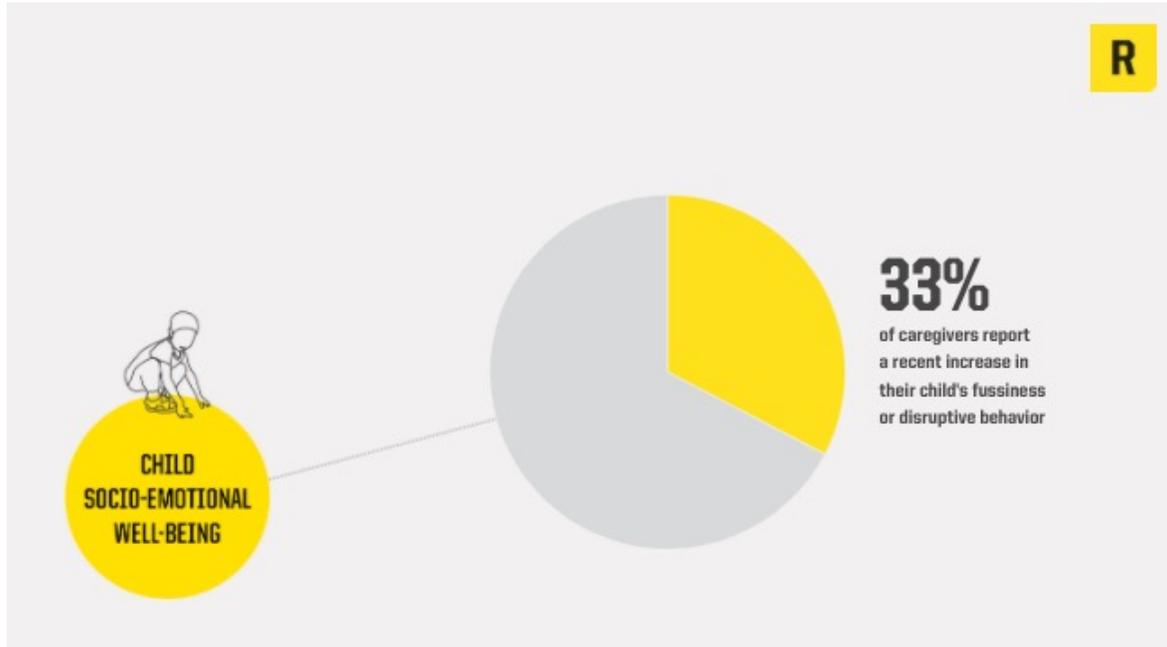




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RAPID-EC PROJECT

Fisher, P., Lombardi, J., Kendall-Taylor, N., 2020.





Build, Back, Better with *Hope*

“Never let a good crisis go to waste.”

Winston Churchill

Biden-Harris American Rescue Plan (1/5/21)

- Medicaid protections
- COBRA
- ACA premiums
- Diversify health and public health workforce
- Safety net provider investments
- Science-based COVID response
- Vaccine campaign
- Equity as a priority throughout

Protect health & health coverage



- Child tax credit
- Earned income tax credit (EITC)
- Child care tax credit
- Paid family leave
- Relief checks
- Unemployment benefits
- Minimum wage to \$15

Economic relief to families with children



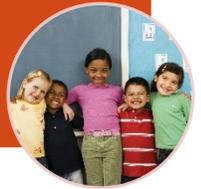
- TANF cash assistance
- Child care assistance
- Utilities assistance
- Food assistance (WIC & SNAP)
- Home visiting supports
- Eviction/ foreclosure protection

Assistance with basic needs



- \$ for schools
- “hardest hit” education fund
- Child care stabilization fund
- \$ for equity challenge
- Higher education emergency relief

Open education settings safely



<https://www.whitehouse.gov/briefing-room/legislation/2021/01/20/president-biden-announces-american-rescue-plan/>

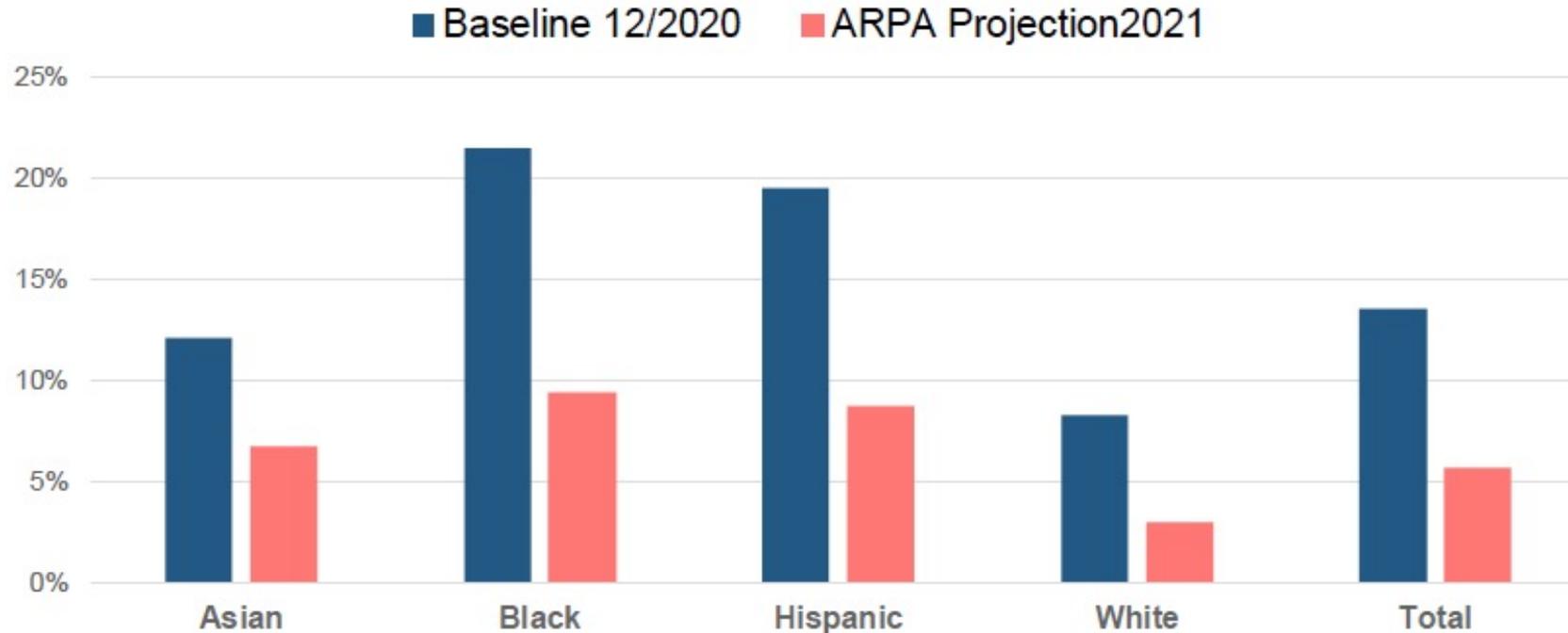
<https://waysandmeans.house.gov/media-center/press-releases/chairman-neal-announces-markup-covid-19-relief-measures>

<https://www.whitehouse.gov/wp-content/uploads/2021/01/National-Strategy-for-the-COVID-19-Response-and-Pandemic-Preparedness.pdf>





Impact of American Rescue Plan on Child Poverty, By Race/Ethnicity, US, December 2020* and 2021

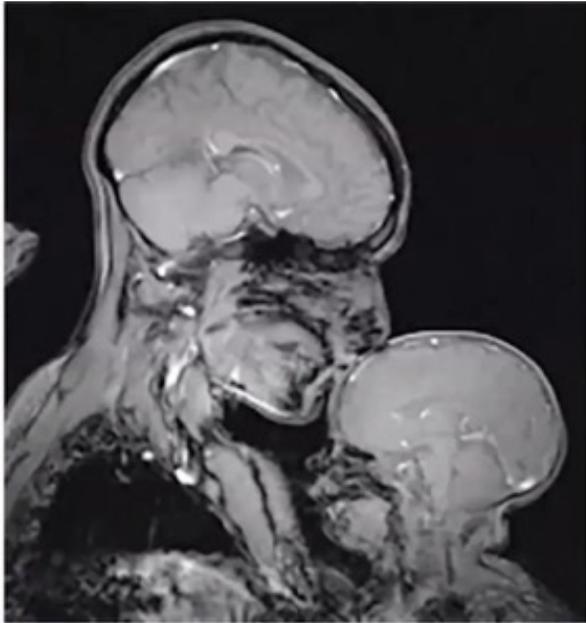


* Baseline includes December 2020 COVID 19 relief payments. Estimate assumes tax credits, relief checks, SNAP nutrition benefits, federal unemployment extensions, and minimum wage to \$9.50 per hour. The minimum wage provision in the President's proposed plan was not included in the American Rescue Plan Act as signed into law. Source: Parolin et al. *The Potential Poverty Reduction Effect of President Biden's Economic Relief Proposal*. (Factsheet). Center on Poverty and Social Policy. Columbia University. February, 2021. www.povertycenter.columbia.edu/news-internal/2021/presidential-policy/biden-economic-relief-proposal-poverty-impact





Early Relational Health (ERH)



R. Saxe, 2017

Early relational health: The capacity for, and ongoing engagement in, growth-fostering, empathic and empowering interpersonal interactions.

Frameworks Institute, 2020







Early Relational Health Development

Mutual Attention & Engagement 2-3mo



Mutual Responsiveness 2-4 mo.



Mutual Enjoyment 3-5mo



Mutual Initiation 7-10 mo.



Mutual Imitation 9-12mo



Shared Goal 15-18mo.





Bio-behavioral synchrony and dyadic neurodevelopment

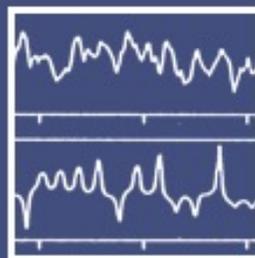
Bio-behavioral synchrony in human attachments



Behavioral Synchrony

Synchronized behavior in gaze, affect, vocal, and touch

Mother-specific
Father-specific



Heart Rate Coupling

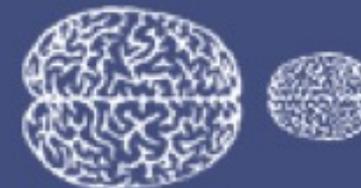
Synchronized HR during synchronized interactions



Endocrine Fit

Coordinated OT response following contact

Coordinated cortisol response to stress



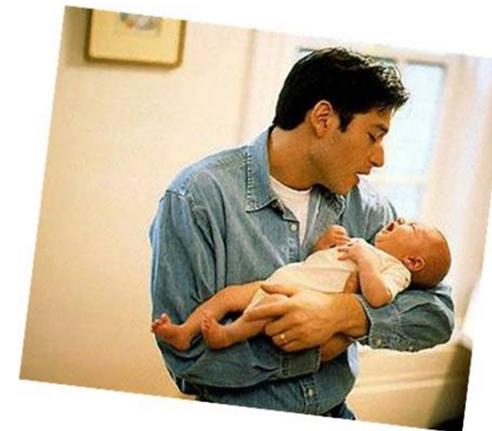
Brain to Brain Synchrony

Coordinated brain oscillations in alpha and gamma rhythms

Feldman, Ruth., The Neurobiology of Human Attachments, Trends in Cognitive Science, Feb 2017.



We are advancing a change in mindset that is.....



- Based on the importance of foundational relationships
- Arises from listening to families and communities
- About positive relationships, environments, and engagement that promote wellbeing
- Grounded in human dignity and opposition to systemic racism
- Science-based, strength-based, and family-centric
- Not a program or an intervention – it’s an “all-in approach” that partners with communities and with existing successful practices
- Changing what we need from public policies

Balancing ACEs with HOPE -- a paradigm shift for early childhood, society and our culture



Early Relational Health

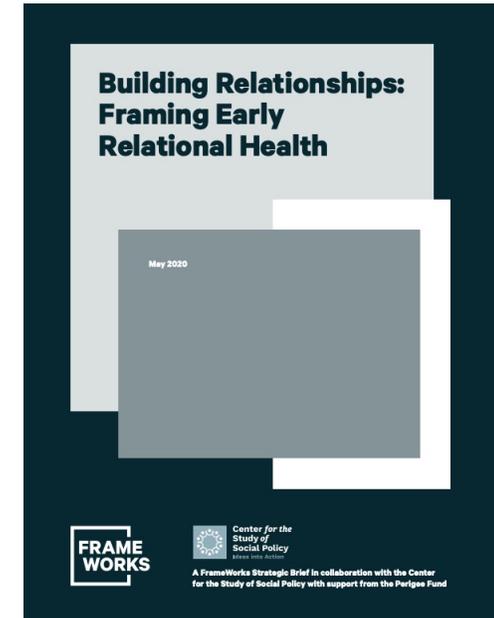
The Frameworks Institute Report

“Early relationships matter. How we talk about it matters as well.”

Early relationships shape the health and wellbeing of both the child and the caregiver and are a key driver for social-emotional development.

Early relational health:

- *A new term*
- *Does not designate a new field nor a series of new discoveries.*
- *Builds upon decades of research from the fields of :*
 - *child development*
 - *infant mental health*
 - *neurodevelopment*
- *Focuses on the centrality of relationships between caregivers and very young children for future health, development and social-emotional wellbeing*



Frameworks Institute, 2020



Early relationships matter..... how we talk about them matters too!

When do relationships matter?

Emphasize that early means early

Why do relationships matter?

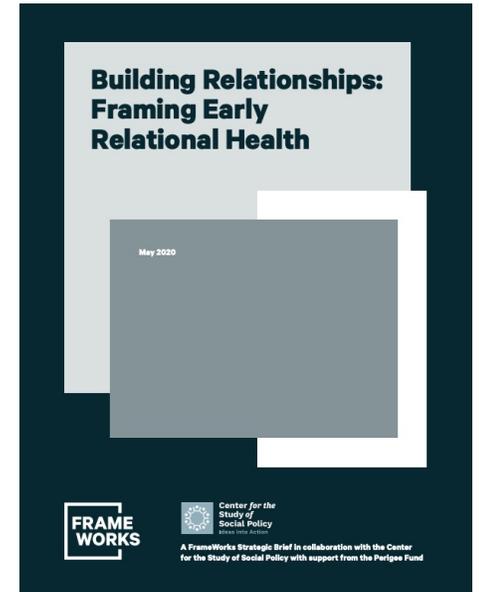
Use the term Foundational Relationships

Who do relationships matter for?

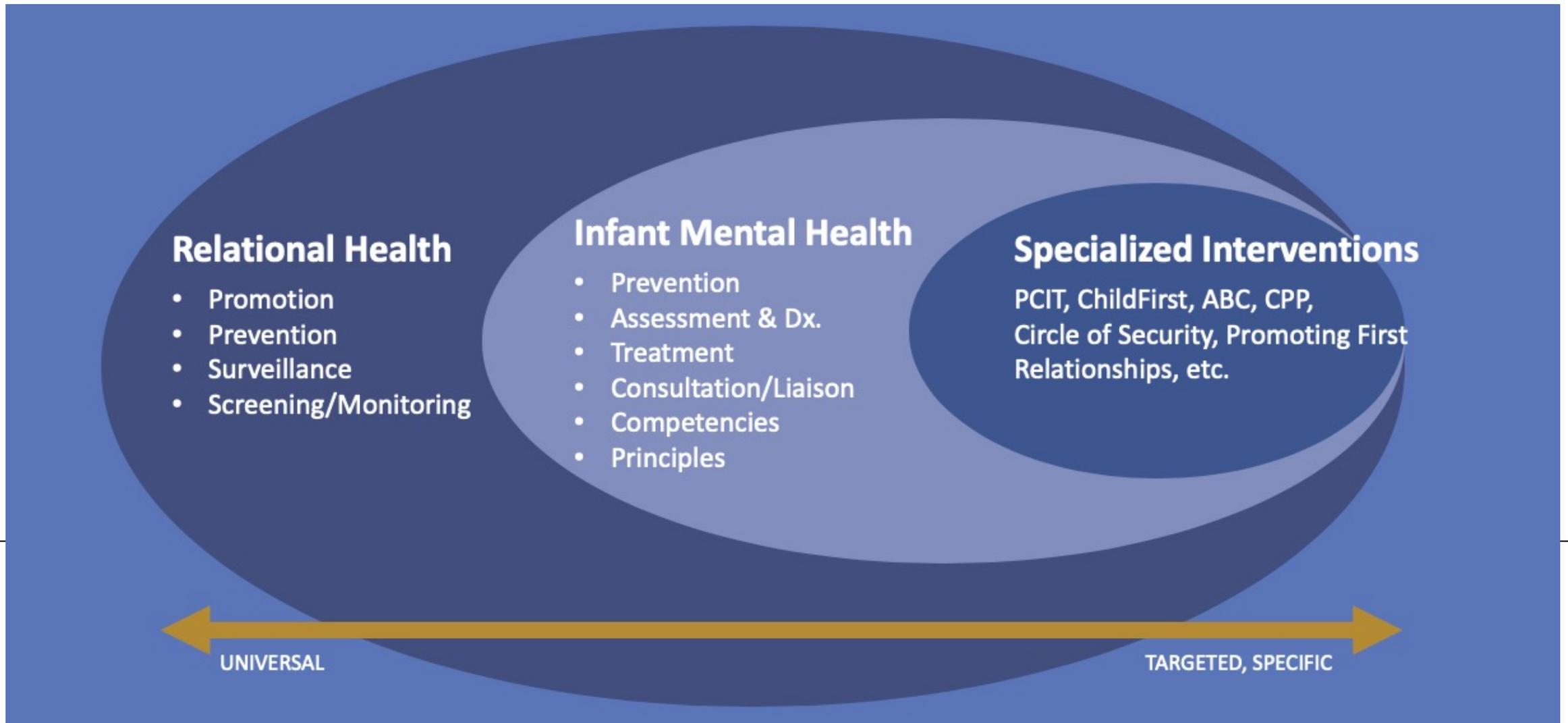
Always feature adult caregivers/bidirectional and dyadic benefits

Why are relationships important?

Show how they are joyful and gratifying, in the moment



Early Relational Health





Early Relational Health Definition

Early relational health: a foundational, culturally embedded and developing set of positive, responsive and reciprocal interactions from birth that nurture and build emotional connections between caregivers, infants and young children and results in the emerging confidence, competence and emotional well-being for all.

Natl ERH Advisory Panel, CSSP, 2020





Early Relational Health in Action: In child health systems

- **Promotion and Engagement**

- **Reach Out and Read (ROR): Next Chapter**
- Promoting First Relationships in Pediatrics (PFR)
- Well Visit Planner
- Key Stones of Child Development

- **High Performing Medical Home**

- **HealthySteps**
- Project DULCE

- **ERH measurements**

- Early Relational Health Screen (ERHS) and video feedback
- Welch Emotional Connection Scale (WECS)

- **ERH interventions**

- Filming Interactions to Nurture Development (FIND)
- Video Interaction Project (VIP)



Parenting Center



PEDIATRIC CARE • SUPPORTING • PARENTING



where great stories begin™



developmental understanding &

legal collaboration for everyone



play • read • grow • together



Early Relational Health in Action: In public health and communities

- **Positive parenting and relational programs**

- Triple P Positive Parenting Program
- Circle of Security- Parenting
- Power-of-Two



- **Home Visiting**

- Evidence-based home visiting



MIECHV Program

- **EC Community Initiatives**

- Bridgeport, CT
- Early Childhood Innovation Network, Washington DC
- EC-LINC ERH Action Learning Lab





Observing ERH

Autonomic Emotional Connection

Welch Emotional Connection Scale (WECS)

Nurturing Science Program at Columbia U.

- Attraction
- Vocal Communication
- Facial Expressiveness
- Sensitivity/Reciprocity





Early Relational Health Observation and Promotion Initiatives

- **Early Relational Health Screen and Video Feedback**
 - Kate Rosenblum, University of Michigan
 - Thrive with your baby Clinics - “Let’s make a movie”
- **Early Relational Health Conversations**
 - Early Childhood Innovation Network, Washington DC
 - Healthy Steps adaptations with equity and social justice in the lead



THRIVE WITH YOUR BABY CLINIC

Do you have a baby between 3-14 months of age?
Let's Make a Movie of You and Your Baby!

DAY, MONTH XX, YEAR at X:XX a/p.m.
At Briarwood Center for Women,
Children, and Young Adults

PLAY TOGETHER. WATCH TOGETHER. LEARN TOGETHER.

zero TO THRIVE
714.233.0547, perkins@regisumich.edu
zerotothrive.com

Get to know your baby.
Sign up at the front desk

The Next Chapter – *Shaping the future of pediatric healthcare*

Reach Out and Read
will maximize the potential of
pediatric primary care
to support the positive interactions
that foster healthy brain development
during the critical early years
of a child's life.







Developing and Testing an Early Relational Health (ERH) and Emotional Connection Training for Reach Out and Read (ROR) Providers

- A 9-month project funded by the Einhorn Collaborative that is a part of the Center for the Study of Social Policy strategy to incorporate promotion of ERH into pediatric primary care
- Uses a learning collaborative approach that brings the voice of both pediatric care providers and parents to an adaptation of the Welch Emotional Connection Screen (WECS) to support the promotion of ERH through delivery of ROR at routine pediatric healthcare visits
- Considers a training format that supports skill-building for providers in forming the relationships with patients that allow for productive discussion of parenting and associated issues



Goals

- #1 Adapt the WECS to create an emotional connection training for ROR clinicians
- #2 Test the acceptability and meaningful impact of the ROR emotional connection training



It's all about the relationship!

The Family “Moment”

*Creates Connection
Builds confidence
In the Moment
Mutual
Warm
Secure, safe
Loving
Joyful
Engaging
Hopeful
Togetherness
An Awakening
Magic
Impactful*



The Exam Room “Moment”

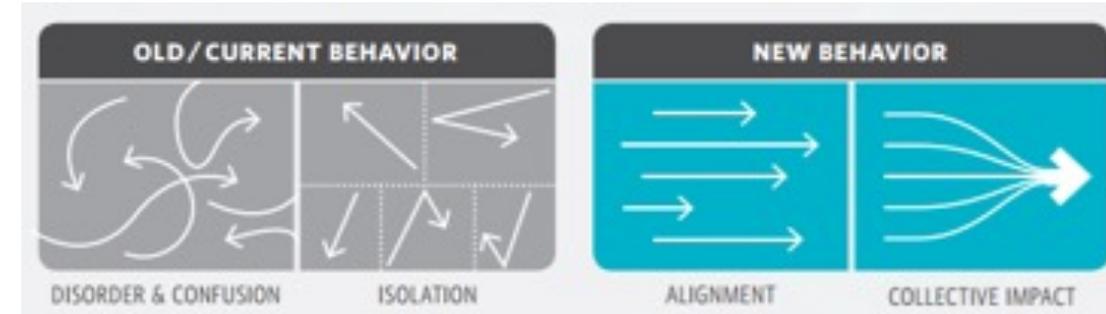
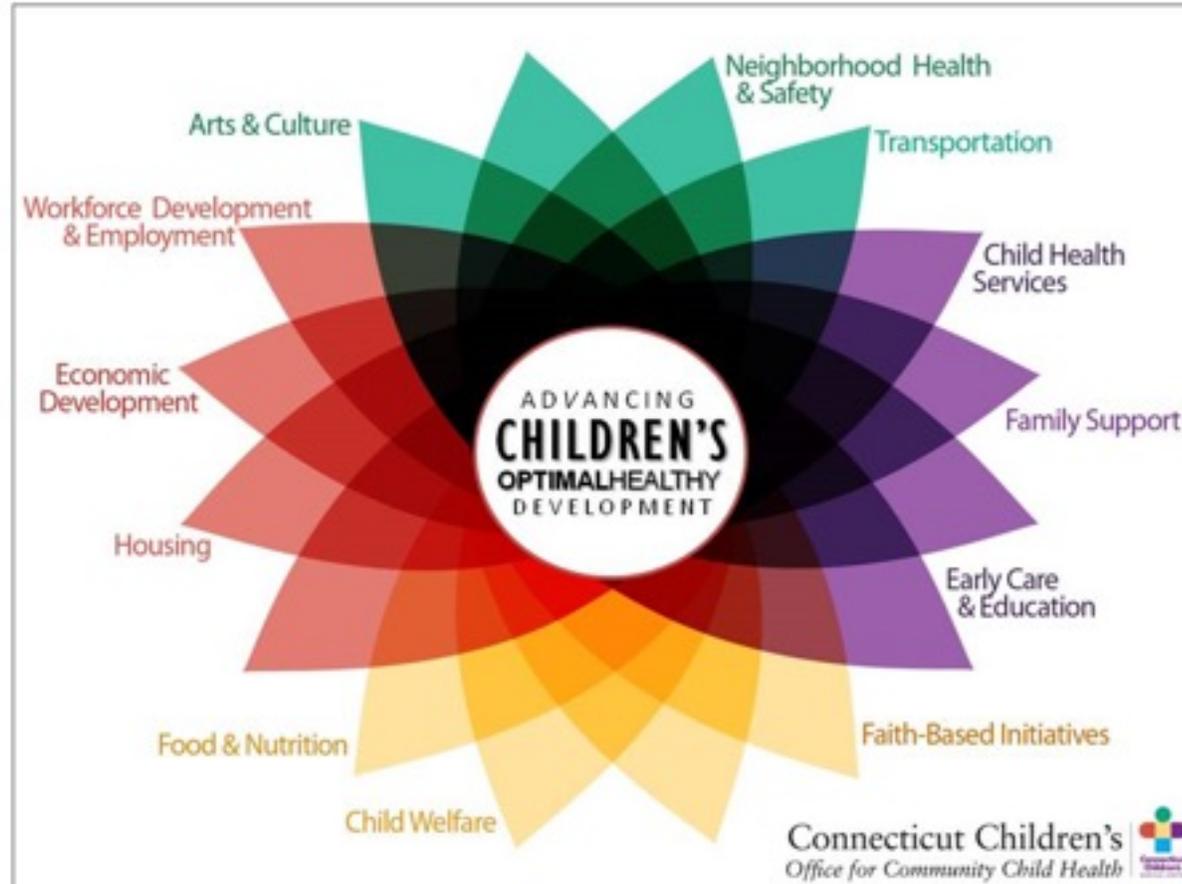
*Creates Connection
Strength-based
In the Moment
Mutual
Warm
Reassuring/Non-judgy
Empathetic
Genuine/Authentic
Caring/Compassionate
Conversational
Models the interaction*

The science says:

Focus on the babies, the people who care for them, and the places where they live and grow.



A place-based early childhood system building



Five Cohort and **Place-Based Strategies** from our Healthy and Ready by Three Playbook

Supported Care and Parenting

The Bridgeport Basics

*HV: Family Connects
Family Child Care
Early Literacy; Books, Blocks and Babies*

An Army of Helpers and Advocates

The Bridgeport Baby Brigade

*Faithful Parenting:
Leading from the Pulpit*

Bridgeport Baby Investment Bundle

*Universal HV: Family Connects
Universal Developmental Screening
Early Literacy: Reach Out and Read*

Innovation and Better Connections

*Elders Rock the Babies
Top to Bottom (linking food & diapers)
Leading from the Pulpit
Neighbor to Neighbor*

Track Change. Measure Impact

*Virtual Baby Data Coalition
2-1-1 Child Development Infoline
Medicaid admin data*



Relational Health Workforce

- Relational care coordinators
- Family development specialists
- Family service workers
- Community health workers
- Home visitors
- Family coaches
- Promotores
- Doulas
- Family navigators



Family voices and equity in the lead:

Parents' experiences of finding support from health providers?

- ◎ **Support comes from trusting relationships**
- ◎ **Experiences with health care providers have often significantly damaged trust**
 - Not being heard
 - Not being seen as experts in their own experiences
 - Being judged
- ◎ **Experiences often described explicitly as racist, traumatic**

<https://cssp.org/resource/my-baby-my-doctor-me-hearing-from-parents-about-foundational-relationships-and-the-role-of-the-health-care-system-in-promoting-early-relational-health/>

Family Voice in ERH, 2020



Family voices and equity in the lead

What Needs to Happen?

- **Health Care Professionals Need to:**
 - Pay attention to patients' emotional well-being;
 - Listen deeply and respond to patients' concerns and questions
 - Have a sustained practice of checking-in and providing reassurance
 - Seek and use authentic feedback from clients/patients
 - Take more time to develop relationships with patients
- **Health Care Systems Need to:**
 - Provide better **training and ongoing professional development** in:
 - Empathy and empathic listening
 - Specific culturally responsive practices and competencies;
 - **Recruit and retain** more medical providers of color

Family Voice in ERH, 2020



Early relational health is about advancing a framework that is.....

- A dyadic and two-generational focus
- A bidirectional perspective for parent-child development with the centrality of shared positive affect
- Foundational to equity, resiliency, recovery and protection
- Health, MEB health, early learning, and soc-emotional competencies are outcomes
- Science-based, strength-based and family-centric
- Recognizes cultural variability in parenting, but sees ERH as universal
- Is not one program, but an “all-in approach” across all place-based, community efforts
- Is not about teaching parenting, but about supporting the development of healthy relationships
- A paradigm shift for early childhood, society and out culture



Break Out Session #1: 10 minutes

Reflect on this concept of **early relational health** as it applies to your knowledge and your thoughts about early childhood





Early Relational Health and the Language of HOPE

- *Foundational relationships* build capacities
- HOPE (Healthy Outcomes from Positive Experiences) provides a common language beyond adversity
- Early relational health describes the positive and nurturing relationships that advance physical health and development, social well-being, and resilience.



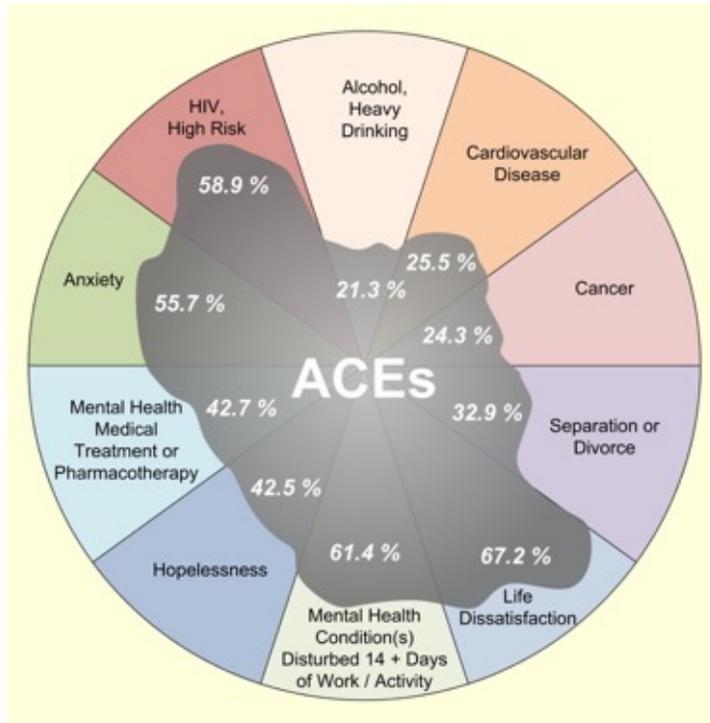
21st Century Perspective of Child Development

- Early experiences promotes brain development, and children develop in an environment of relationships. [National Scientific Council on the Developing Child, 2015](#)
- Safe, stable, nurturing relationships and environments are essential to preventing child abuse and neglect. [Centers for Disease Control and Prevention](#)
- Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential. [World Health Organization](#)
- Society benefits socially and economically from providing current and future generations of parents with the support they need to raise healthy and thriving children. [National Academies of Science, Engineering, and Medicine](#)
- We assert that health requires a healthy family and a healthy community, and we now have the science to support our belief. [American Academy of Pediatrics, Bright Futures](#)



From ACE's to HOPE

(Health outcomes of positive experiences)



Integration of HOPE into Trauma-Informed Care

Awareness:

- *Childhood memories*

Reassurance:

- *History is not destiny*

Healing:

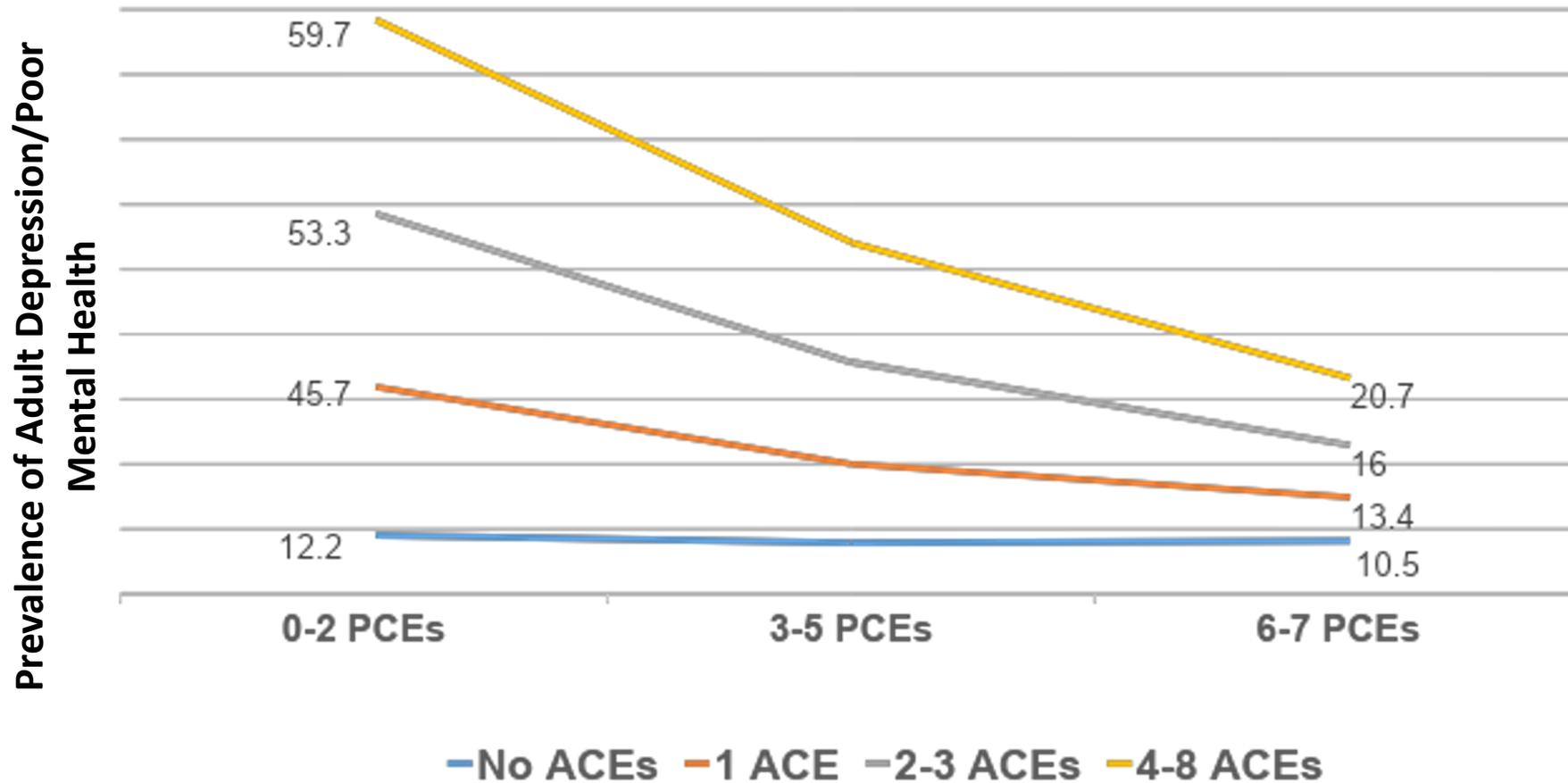
- *No shame in getting help*

Inventing:

- *Better ways to live*

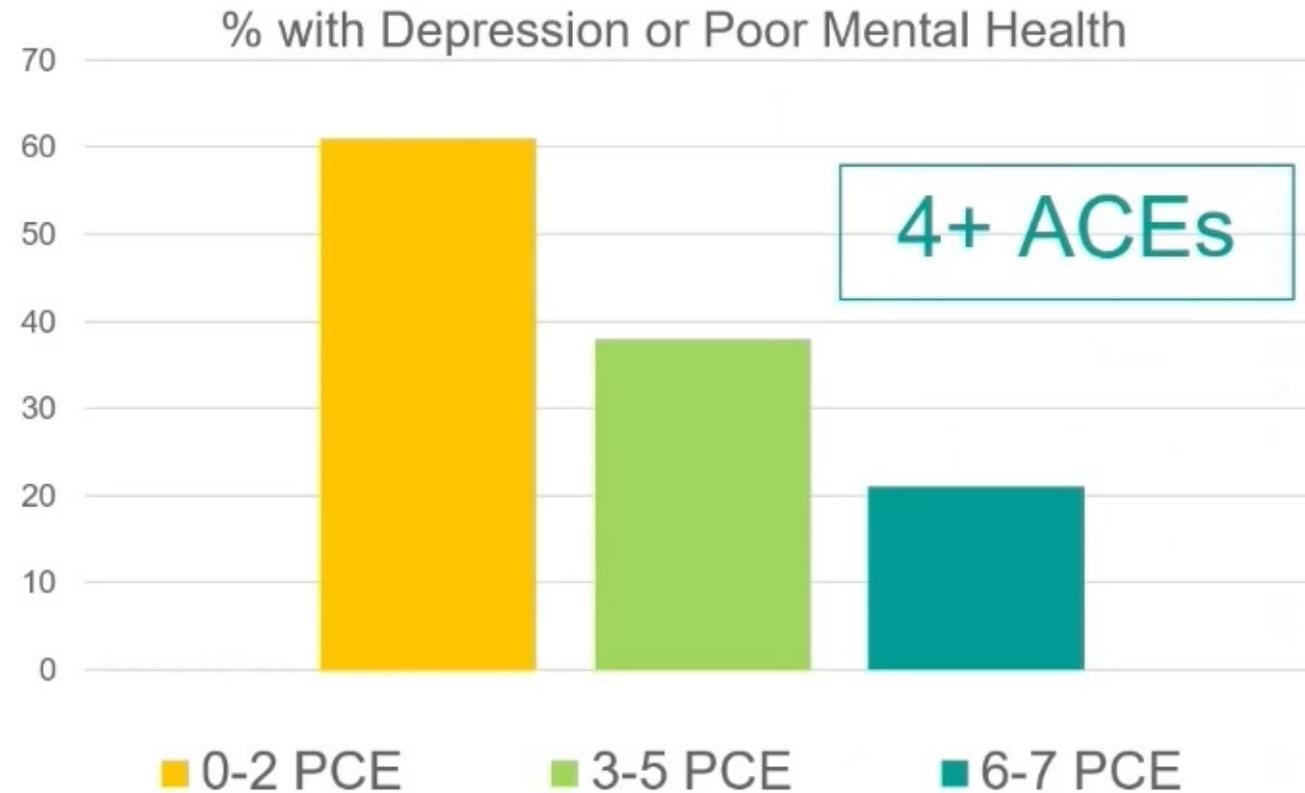


Positive Childhood Experiences Mitigate ACEs Effects





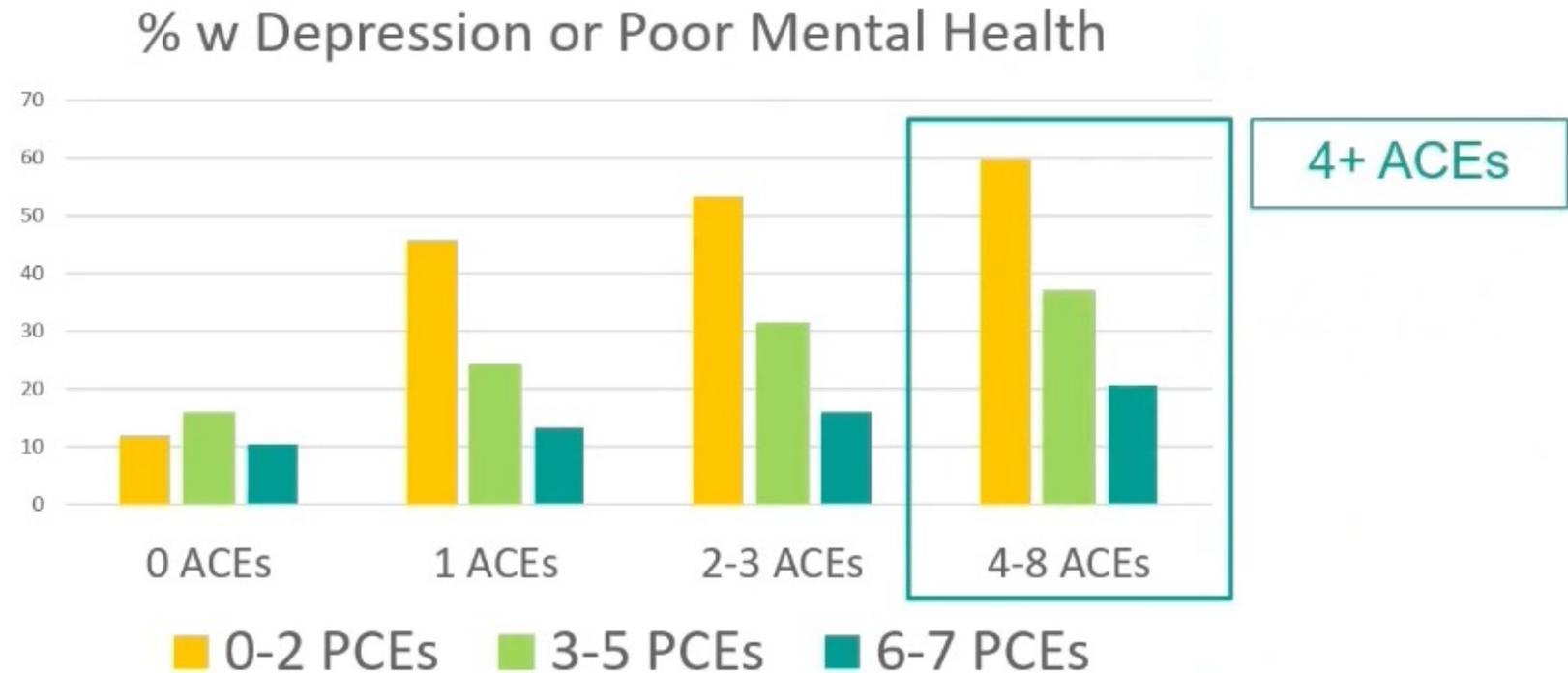
Positive Childhood Experiences Mitigate ACEs Effects



Bethell C, Jones J, Gombojav N, Linkenbach J, Sege R. Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample: Associations Across Adverse Childhood Experiences Levels. *JAMA Pediatr.* 2019:e193007.



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Leveraging the Biology of Adversity and Resilience to Transform Pediatric Practice

Jack P. Shonkoff, MD,^{ab,cd,e} W. Thomas Boyce, MD,^f Pat Levitt, PhD,^{g,h} Fernando D. Martinez, MD,ⁱ Bruce McEwen, PhD^{j†}

Genes, Environments, and Time: The Biology of Adversity and Resilience

W. Thomas Boyce, MD,^a Pat Levitt, PhD,^{b,c} Fernando D. Martinez, MD,^d Bruce S. McEwen, PhD,^{e†} Jack P. Shonkoff, MD^{f,g,h,i}



5 Facts about Health that are mis-understood

1. The experiences we have early in life are at least as important for the biological foundations of physical and mental health as the lifestyle choices we make as adults.
2. Poor health outcomes are not inevitable after experiencing adversity early in life, but they are more likely if we do not adequately support children and families experiencing persistent hardships or challenges.
3. When the developing brain and other biological systems adapt to what they experience in their environment, it may be positive in the short-term, but negative in the long-term.
4. The body's stress response is the same, no matter what causes it, but a pile-up of stressors over time means there's less time for recovery.
5. All policies and delivery systems serving young children and families across sectors can support both early learning and the foundations of lifelong health.

National Scientific Council on the Developing Child, 2021

The Four Building Blocks of HOPE

are composed of key positive childhood experiences (PCEs)—and the sources of those experiences and opportunities—that help children grow into healthy, resilient adults.



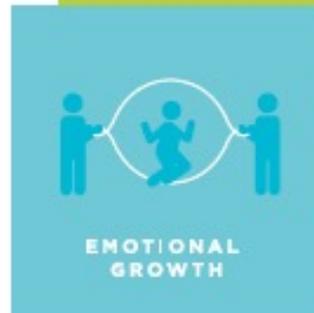
Relationships within the family and with other children and adults through interpersonal activities.



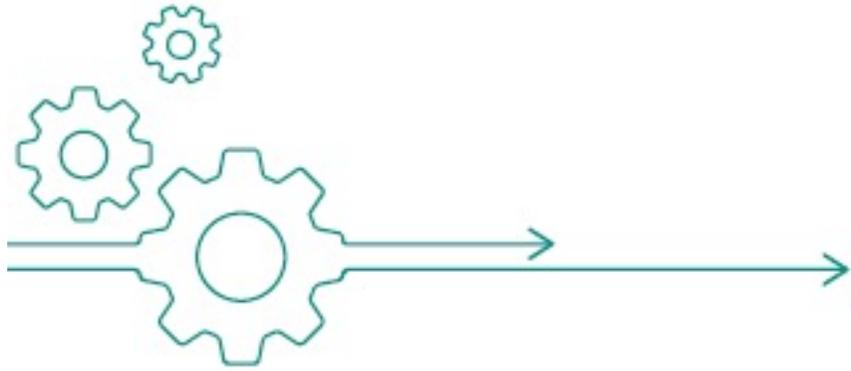
Safe, equitable, stable environments for living, playing, learning at home and in school.



Social and civic engagement to develop a sense of belonging and connectedness.



Emotional growth through playing and interacting with peers for self-awareness and self-regulation.



Putting HOPE into Action

Here are the approaches that provide the means for us to shift the paradigm in systems of care, education, research, and advocacy.



Education & Practice Transformation

Increase knowledge to support a paradigm shift at all levels in systems of care informed by the critical importance of positive experiences that foster the health and well-being of children, families, and communities



Advancing Research

Further our understanding of how experiences affect development and bring attention to the structural factors of racism to improve the effectiveness of care and create research-informed tools for practice and policy change.



Community Action & Advocacy

In collaboration with community partners, we will grow a HOPE-informed approach that identifies existing strengths and augments conditions that support the positive experiences children and families need to thrive.



Break Out Session #2: 10 minutes

Discuss how Early Relational Health and the **HOPE Building Blocks** are synergistic in early childhood.





Connection as a Social Determinant of Health

Research repeatedly demonstrates that social connection strongly influences health. Feeling connected to a community was one of the strengths identified in the community engagement data from this assessment.

“The work of creating health is the work of creating connection.”

- DIDI PERSHOUSE



The power of human connections

Even one human relationship can help us weather adversity and protect our youngest from harm

The power of human relationships comes from simple and ordinary interactions

We do not need to be perfect in every human interaction to be helpful

Winters, D., Li, J., Willis, D., Blog: 2020



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Changing the Mindset: Foundational Relationships Counter Adversity with HOPE

Posted on May 21, 2020 by [David Willis, MD](#) and [Robert Sege](#) | Kay Johnson



The three of us have been talking together for years, and have come to believe that it is important to articulate our common vision for the work we lead on behalf of children, families and communities. We are making a commitment to become allies in this important work, intentionally aligning the work on [foundational relationships](#) and [early relational health](#) led by David Willis; the work on [Healthy Outcomes from Positive Experiences](#) (HOPE) led by Bob Sege; and the leadership by Kay Johnson for maternal-child health, early childhood system building, and Medicaid policy.

Early childhood experiences, especially foundational relationships, are important drivers of healthy child development and future adult health. The contexts of those experiences, such as the protective factors articulated in [CSSP's Strengthening Families Protective Factors Framework](#) and other social determinants of health, also matter. While early relational health may be a new term, it builds upon decades of research from the fields of child development, infant mental health, and neurodevelopment, that has established the centrality of relationships between caregivers and very young children for future health, development, and social-emotional well-being.¹ Our work aims to galvanize the interest in foundational relationships among many more providers, stakeholders, and leaders in child health and early childhood systems—those concerned with supporting families, healthy development, and the social-emotional needs of infants and young children. In addition to supporting the community context, we are engaging with network partners to advance activities that support strong foundational relationships for all families with infants and toddlers, an age group that is often forgotten.

Positive Childhood Experiences (PCEs) have profound effects on development.^{2,3} While Adverse Childhood Experiences (ACEs) endanger mental and physical health in childhood and throughout the lifespan, emerging science helps us to understand how PCEs promote optimal health and well-being.⁴ Balancing knowledge of ACEs with Healthy Outcomes from Positive Experiences (HOPE) calls for the engagement with families in new way. Incorporating the HOPE framework into pediatric medical homes, early care and education, home visiting programs, child welfare services, and other child service systems, brings attention to the child, family, and community strengths and resilience. The building blocks of HOPE—relationships, environment, engagement, and opportunities for social-emotional development are accessible to all families and relevant in all communities and cultures. Recognizing, celebrating, and bolstering these strengths in all families and communities provides a bridge to issues of equity and the respect for human dignity within an anti-racist agenda.⁵

Based on current understandings of human development and factors that strengthen families, it is past time to shift child health and development services from its continued focus on risk and deficit to a holistic, strengths-based, family-centered and community context approach. Building momentum across systems of care for children and families can accelerate a changing mindset that offers better ways to serve children, their families, and their communities.

This 21st century perspective on fostering child development to promote lifelong health and well-being is grounded in research:

- Early childhood experiences promote brain development, and children develop in an environment of foundational relationships.⁶
- Safe, stable, and nurturing relationships and environments are essential to preventing child abuse and neglect.⁷
- Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential.^{8,9}
- Society benefits socially and economically from providing current and future generations of parents with the support they need to raise healthy and thriving children.¹⁰

Current knowledge supports approaches that implement a social ecological model, moving from a traditional focus on babies, to one which includes the people who care for them, the places where they live and grow and the public policies that impact their lives.

Strengths-based, family-centered, and anti-racist efforts aspire to transform pediatric care, early childhood systems, and social norms. We are witnessing an urgency for change that has spread through pediatric primary care, home visiting, and child welfare, as well as early childhood systems and community partnerships across the country. In addition to countless papers, editorials, and reports, numerous programs and providers have successfully implemented approaches in this vein, including, among others: [Strengthening Families](#), [Bright Futures Fourth Ed.](#), [Reach Out and Read](#), [DULCE](#), [HealthySteps](#), [Incredible Years](#), [Promoting First Relationships](#), and [Essentials For Childhood](#). While every model

program and newly funded initiative (including our own) strives to spread and protect its brand, transformation now requires the clarity of common terminology, alignment, partnering and networking.

We aim not to advance another model but to accelerate a **change in framing and mindset** and the alignment of efforts that are:

- Authentic partnerships with families and communities to advance equity;
- Based on the importance of early, foundational, and ongoing relationships;
- About positive relationships, environments, and local communities that promote well-being;
- Grounded in human dignity and therefore deeply opposed to systemic racism and xenophobia;
- Science-based, strengths-based, family-centric, and community-based;
- *All-in* approaches representing multiple partnerships among providers, parents, and communities with existing programs and practices all moving together; and
- Committed to changing practice, programs, and public policies.

Parents universally want the best for their children, and their passion and devotion to them drives many important adult decisions. However, a narrow focus on parenting skills or the parent-child relationship alone is too simplistic and risks reinforcing the “family bubble” model or “blaming the victim.” Strong communities, socioeconomic safety networks, and the corresponding public policies are critical to support foundational relationships and other positive childhood experiences.

Protecting the well-being of children and families necessarily includes addressing social determinants of health and social context. Societal factors such as racism, inadequate income, food, and housing often impact parents’ capacities to provide safe, stable, and nurturing environments for their children. Too many parents in the United States face substantial headwinds when raising their children, despite their own best intents. Improving their families’ lives begins with our nation’s commitment to all our children and their families.

Even before the COVID-19 crisis, one-third of young children faced physical, developmental, social, or emotional risks that could affect their health and well-being for a lifetime. Millions more families are in stressful situations that could disrupt the hopes and dreams for a better future for their children. Even if no one in a family gets sick or dies from COVID-19, parents feel the pressures of going to work on the front lines in jobs they worry about losing; of coping without income to pay the bills; managing without sufficient food; and fulfilling multiple roles as teacher, nurse, coach, and parent for their children. Thus, the COVID-19 crisis has dramatically raised the level of need, the urgency for action, and the importance of our opportunity to change the way we provide services to families. Building effective, comprehensive early childhood systems that prioritize foundational relationships, equity, and HOPE is our visible goal post.

We need an all-in approach: partners and networks, families, communities, government agencies, funders and, in fact, all of us. In our work, we want to do more than identifying, evaluating, and expanding successful practices—we want to be part of a networked movement that celebrates optimism and respect for families, that commits to trusted and authentic relationships with families and each other. To quote Hunkpapa Lakota religious leader and tribal chief, Sitting Bull: *“Let us put our minds together and see what kind of future we can create for our children.”*

We have committed to working towards this transformation. Will you?

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Parenting and Child Development: A Relational Health Perspective

Abstract: *A child's development is embedded within a complex system of relationships. Among the many relationships that influence children's growth and development, perhaps the most influential is the one that exists between parent and child. Recognition of the critical importance of early parent-child relationship quality for children's socioemotional, cognitive, neurobiological, and health outcomes has contributed to a shift in efforts to identify relational determinants of child outcomes. Recent efforts to extend models of relational health to the field of child development highlight the role that parent, child, and contextual factors play in supporting the development and maintenance of healthy parent-child relationships. This review presents a parent-child relational health perspective on development, with an emphasis on socioemotional outcomes in early childhood, along with brief attention to obesity and eating behavior as a relationally informed health outcome. Also emphasized here is the parent-health care provider relationship as a context for supporting healthy outcomes within families as well as screening and intervention efforts to support optimal relational health within families, with the goal of improving*

mental and physical health within our communities.

Keywords: parenting; relational health; parent-child relationships; health outcomes; child development

between a child and an adult, whereas Bowlby's observation underscores the responsibility of communities and practitioners in supporting healthy child development by supporting parents. The

 **Viewing development through the lens of relational health reflects recognition of the critical role that relationships play in children's social, emotional, health, and cognitive outcomes.** 

"In order to develop normally, a child requires progressively more complex joint activity with one or more adults who have an irrational emotional relationship with the child. Somebody's got to be crazy about that kid. That's number one. First, last and always."—Urie Bronfenbrenner

"If a community values its children it must cherish their parents."—John Bowlby

Introduction

Bronfenbrenner recognized the critical importance of the emotional relationship

belief that we can support children directly, without supporting their parents, overlooks the complex system of relationships within which children develop.¹ Together, Bronfenbrenner and Bowlby remind us that to support healthy development, we must focus on the emotional quality of the relationships within which the child participates—as well as consider how the larger community supports those relationships.

Yet parenting is a broad topic and an exhaustive review is beyond the scope of any one article. Informed by the field of infant mental health with its explicit

DOI:10.1177/1559827619849028. Manuscript received April 30, 2018; revised March 6, 2019; accepted April 17, 2019. From Department of Educational Psychology, University of North Texas, Denton, Texas (CAF); the Department of Psychology, Ohio State University, Columbus, Ohio (SJS-S); and the Department of Pediatrics, Emory University School of Medicine, Atlanta, Georgia (DDO) Address correspondence to: Cynthia A. Frosch, PhD, Department of Educational Psychology, University of North Texas, 1155 Union Circle #311335, Denton, TX 76203-5017; e-mail: cynthia.frosch@unt.edu.

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relational focus² and in an effort to contribute to our understanding of parenting as multiply determined,³ we focus our discussion here on the construct of relational health as a tool for promoting socioemotional and physical health among young children. Relational health reflects a sense of “connectedness” with attuned others, including caregivers, family members, and other individuals within the community.⁴ Such a focus is consistent with the field of lifestyle medicine—which considers the environment as a social determinant of health and well-being⁵—and research on health and social behavior, which highlights parents as significant influences on children’s health.⁶ Viewing development through the lens of relational health reflects recognition of the critical role that relationships play in children’s social, emotional, health, and cognitive outcomes.³ Accordingly, the revised Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC-05)⁷ considers how characteristics of the broader caregiving environment, such as coparenting quality and other close relationships, relate to developmental and mental health diagnoses.²

Relational Health Within Primary Care: The Parent-Provider Relationship

We suggest that the parent-provider relationship provides a potentially valuable, although far less emphasized, context for promoting relational health. We present a review of the literature surrounding relational health science and encourage the health care provider to view their patients through the relational health lens. When considered from this angle, for children and their caregivers, the *relationship* is the patient. As health care providers endeavor to encourage healthy lifestyle choices in the families they serve, each decision a family makes—whether to the benefit or detriment—will occur in the context of their relationships. The health care

provider must learn to consider and then acknowledge the family support relationships present in the exam room, the waiting room, and at home to best engage a family’s healthy choices. When caring for patients through this approach, the provider will consider the patient’s treatment choices in their realistic and relational context, rather than as compliant versus noncompliant. Moreover, by acknowledging the provider’s own relationship to the family, the provider can become a supportive member of the treatment decision team rather than an information broker, motivational interviewer, or reticent supplier of difficult-to-follow advice.

The relational health perspective considers the practitioner as a supportive (or unsupportive) “other” in navigating the sometimes difficult, uncertain, or fear-provoking experience of parenting a child from preconception through adulthood. An awareness of relational health in pediatric and adult medicine settings may increase positive outcomes in both parents and children through increased empathy. Specifically, during challenging situations, the practitioner should assess and address relationship quality rather than judging parenting or assigning sole credit or blame to either the parent or child. The focus lies in identifying strengths and opportunities in service to the relationship.⁴

Relational Health Within Families: The Parent-Child Relationship

A relational health perspective on development embodies a family systems perspective as well, which recognizes the interconnectedness of individuals and relationships within families⁸ and the bidirectional, transactional nature of relationships⁹; parents affect children and children affect parents.¹⁰ A relational health approach to understanding parent-child relationships emphasizes the dyadic connection between parent and child. Although a multitude of factors have been explored as correlates and predictors of parenting and child outcomes, we focus here on a subset of

the factors that may influence relational health, with the goal of increasing practitioners’ understanding of relationship-focused approaches to health promotion within families.

Parent-Child Attachment Relationships: Parental Sensitivity and Reflective Functioning

One of the most influential relationship-focused frameworks for understanding development is attachment theory. An extensive literature describes the early parent-child attachment relationship as an enduring, emotional bond that enables children to explore the environment,¹¹ yet maintain the proximity and contact necessary for healthy development. Parent-infant attachment relationships, therefore, provide the earliest contexts for children’s relational health. Secure attachment balances developmentally appropriate exploration of the world with seeking closeness and comfort from the caregiver when distressed. Secure parent-child attachment relationships are associated with a range of positive social and emotional outcomes in children.^{12,13} Conversely, disorganized attachment, a form of insecure attachment, is a risk factor for poorer developmental outcomes¹⁴ and has been linked to disturbed caregiving behavior.¹⁵⁻¹⁷ Efforts aimed at increasing security within these critical early relationships remain of interest to researchers and clinicians.¹⁸ Interventions including Attachment and Biobehavioral Catch-up (ABC),^{19,20} Circle of Security,²¹ and Video Intervention for Positive Parenting and Sensitive Discipline (VIPPSD)²² have been effective in promoting secure attachment and positive child outcomes (including fewer behavior problems) via creation of measurable, positive changes in parents’ sensitive and responsive behavior, a key factor in secure attachment.^{23,24} Yet these interventions are not widely available to the public, thus limiting the ability of clinicians to offer them to their patients and families.

Perhaps the most effective mediator toward creating change in parental

sensitivity and responsiveness is fostering growth in a parent's reflective functioning (RF). RF reflects the extent to which a parent can consider the mental states (ie, thoughts, feelings, intentions) that may motivate the behavior of self and other.²⁵ This capacity can be described in terms of both self-focused RF and child-focused RF.^{26,27} Interventions such as *Minding the Baby*^{28,29} and *Mothering from the Inside Out*^{30,31} appear effective in supporting healthy relational outcomes via a focus on growing RF. The concept of RF is also relevant for understanding how adults' own early relational experiences may affect their parenting.³²

Recommendations for Providers. These 2 elements of parenting—sensitive, responsive caregiving and RF—support the formation of secure parent-child relationships.²⁴ We suggest that health care providers use thoughtful questioning that may support parental RF, as recently suggested and detailed by Ordway et al.³³ Health care providers can also demonstrate and model RF and help build this capacity in families via routine care and also in medically intensive environments. In environments such as the neonatal intensive care unit (NICU), for example, barriers to parent-neonate relational health development are prominent because of parents coping with fears of infant death and infants experiencing frequent stressors.³⁴⁻³⁹ Although NICU staff recognize the critical role they play in supporting early parent-child relational health and promoting positive socioemotional outcomes among infants born prematurely,⁴⁰ this role may come secondary to the provision of direct medical support to neonates. Professionals' engagement in reflective practice, with its focus on awareness of the mental and feeling states of self and others,⁴¹ may be one pathway toward promoting positive infant outcomes via the provision of greater psychological support to parents of premature and medically fragile newborns. Building reflective capacity among a range of health care providers may further

strengthen the foundation of early relational health within families.³³

Mothering, Fathering, and Grandparenting

Although attachment perspectives historically have emphasized the mother-child relationship, attachment theory and research has been extended to a variety of other caregiver-child relationships, including father-child relationships.⁴²⁻⁴⁴ A family systems perspective⁸ on relational health suggests that to understand development, we must consider how mother-child and father-child relationships may independently or interactively contribute to developmental outcomes.

Rigorous recent research indicates that children benefit socially and emotionally when fathers are more involved in their lives.⁴⁵ Moreover, the benefits of father involvement hold for nonresident as well as resident fathers.⁴⁶ Yet fathers' engagement in parenting is multiply determined,⁴⁷ and individual, family, and institutional-level factors may all play important roles in predicting paternal involvement. At an individual level, a father's identity as a parent,^{48,49} as well as a father's attitudes and beliefs about his role in his child's life,^{50,51} matter for his engagement. At the family level, evidence highlights the quality of the father's relationship with a child's mother. For example, mothers are more likely to be gatekeepers within families, controlling fathers' access to children as well as the quantity and quality of fathers' interactions with their children.^{52,53} At a policy level, compared with countries such as Sweden where paternal leave is supported, the lack of paid paternal leave within the United States may also present barriers to fathers' involvement with their young children as well as erode fathers' sense of efficacy in the parental role.⁵⁴

Above and beyond these individual, family, and policy variables, mothers' and fathers' parenting may differ and uniquely predict developmental outcomes. For example, mothers may be the primary providers of emotional security for children via the establishment of early

parent-child attachment relationships, whereas for fathers, exploration of the world may be a primary emphasis in parenting.⁵⁵ Fathers' more stimulating play style—often involving rough-and-tumble play—may promote positive outcomes in children, including developmentally appropriate risk taking and establishment of autonomy.^{56,57} Mothers, by contrast, are more likely to engage in object-mediated teaching interactions as well as providing structure for their children.⁵⁸ However, though mothers and fathers may have interaction styles that differ, the fact remains that many children in the United States are raised in households headed by mothers and may experience wide variability in contact with their biological fathers.⁵⁹ This fact, coupled with increasing acceptance and prevalence of families headed by same-sex parents, cautions against a return to the belief that to develop optimally, children require both fathers and mothers (known as the “essential father” hypothesis).⁶⁰

We must also recognize that nonparental primary caregivers may play a central role in the care and raising of young children. For example, the increasing number of grandparent-headed households means that more grandparents—with their own sets of strengths and challenges—are making health and wellness decisions for children and may require a unique set of supports from health care providers.⁶¹ Even when not primary caregivers, many grandparents—especially maternal grandmothers—report being involved and influential in their grandchildren's lives.⁶² In fact, involvement of maternal grandmothers with grandchildren may buffer young children from the risks to their development posed by difficult temperament and harsh parenting by mothers.⁶³ A wider relational health perspective suggests that grandparents (both custodial and noncustodial) be considered as potential sources of support in children's health and well-being.

Recommendations for Providers. Shifting demographics suggest that fathers, nonparental caregivers, and grandparents play an active and involved role in the lives of children. As providers,

recognition of the range of relationships in which the child is embedded is critical. Examining potential biases around who is most knowledgeable or best equipped to care for children may help providers approach each adult who is involved in the child's life as a potential partner in health promotion.⁶⁴

Coparenting Relationships

The recognition that children develop within relationships between multiple caregivers, including mothers, fathers, grandparents, and others, makes it critical to also consider the health of the relationships among these adults (ie, coparents) who share responsibility for raising particular children.^{65,66} Whereas constructs such as marital quality or marital satisfaction focus on the intimate partner relationship, the coparenting relationship, although related, is separate and distinct. Coparenting reflects a wider range of relationship structures and processes specific to parenting.^{67,68} For example, coparenting relationships occur among a variety of individuals who share responsibility for parenting, whether romantically involved or not,^{65,69} such as same-sex parents, adoptive parents, divorced or never married parents, and mothers and maternal grandmothers.⁷⁰

Consistent with a family systems perspective,⁸ better coparenting relationship quality is associated with children's positive social and emotional development over and above the effects of both romantic relationship quality between parents (if present) and mothers' and fathers' parenting.⁷¹ Notably, coparenting relationship quality among same-sex parents shows similar associations with children's socioemotional development.⁷² If supportive, coparenting relationships may help caregivers, especially fathers, promote children's positive socioemotional development,⁷³ but undermining or conflictual coparenting relationships may have a detrimental effect on child development. For instance, although grandmother involvement may benefit children, conflict between mothers and grandmothers can be detrimental to children's socioemotional development.^{63,74} Thus, prevention and

intervention programs have been developed to support effective relationships between coparents.^{75,76} For example, Feinberg's Family Foundations program targets couples expecting their first child and focuses on building strong coparenting relationships across the transition to parenthood^{77,78}—a critical foundation for parent-child relational health.

Recommendations for

Providers. Coparenting research highlights the role of supportive versus undermining coparenting for children's development. Often, the extent to which coparents support or undermine one another stems from whether they share the same views on parenting goals and practices and have a similar perspective on the child's development. Thus, when interacting with patients, we suggest inquiring about the extent of agreement versus disagreement among the adults who make decisions regarding the child's health and development. For example, the primary custodial parent may emphasize healthy food choices and regular physical activity, whereas the nonresidential coparent may provide markedly different choices during visitation periods. Alternatively, one parent may have concerns about a child's language or motor development, whereas a grandparent may continually emphasize that the child is "just fine." These discrepancies in perceptions of typical versus atypical development may delay or interfere with prevention efforts, medical diagnosis, and treatment. Disagreements among multiple caregivers may create stress and tension within families, and challenges with coparenting can be addressed through prevention and intervention programs.

Parental Characteristics That Contribute to Parenting and Relational Health

Psychosocial Resources and Mental Health

Belsky's early model of parenting competence suggests that multiple factors

affect parenting and child outcomes, with parents' psychosocial resources playing a prominent role.³ Individual differences between parents in their personality characteristics affect the quality of their parenting.⁷⁹ In particular, higher openness, conscientiousness, extraversion, and agreeableness, and lower neuroticism has been related to more optimal parenting cognitions, practices, and behaviors, including parental warmth and support for autonomy.⁷⁹⁻⁸¹

For parents with common mental health issues such as anxiety and depression, the experience of parenting may be especially challenging. Maternal depression has been linked consistently with more negative and disengaged parenting behavior and lower engagement in healthy feeding and sleep practices.⁸² Less research has considered fathers' mental health in relation to their parenting,⁸³ although there has been a recent increase in attention to fathers' antenatal and postnatal depression,⁸⁴ and fathers who experience postpartum depression demonstrate lower levels of developmentally appropriate positive engagement with their infant children.⁸⁵ Anxiety disorders in fathers as well as mothers have been linked with more overinvolved parenting behavior that does not foster age-appropriate independence in children.⁸⁵

Although prevalence rates suggest the importance of considering parental anxiety and depression, other mental health disorders should be considered as well. For example, for mothers diagnosed with borderline personality disorder, higher levels of negative affectivity as well as lower rates of effortful control⁸⁶ and sensitivity, and support for child autonomy⁸⁷ have been reported. Less maternal sensitivity has also been reported among mothers with obsessive compulsive disorder.⁸⁸

Recommendations for

Providers. Screening for parental mental health concerns from pregnancy (or from pregnancy planning) throughout the child's development is consistent with a relational health approach. Beyond screening, health care providers can

become aware of evidence-based treatments that may support healthy outcomes in children by supporting maternal mental health and parenting skills.⁸⁹ For example, the attachment-based, group intervention Mom Power, which emphasizes parenting, self-care, and engagement in treatment, holds promise for supporting positive outcomes for children by supporting maternal mental health and parenting competence.⁹⁰ With increased knowledge of evidence-based treatments for fathers' mental health and parenting, we may be able to move beyond a focus on mothers to provide all parents with a stronger support system and resource base for effective parenting.

Parental Developmental History and Adverse Experiences in Childhood

According to Belsky's model of the determinants of parenting, a parent's psychosocial resources stem from their developmental history.³ The experience of adversity and toxic stress during development may affect *brain architecture*,⁹¹ a term used to convey how early experiences help build the structural foundation for healthy brain development. Under conditions of sustained, persistent stress such as maltreatment or neglect, the hypothalamic pituitary adrenal axis may be affected, contributing to atypical diurnal patterns of cortisol and increased risk over the course of development.⁹² As our understanding of the impact of toxic stress on children has grown, the focus on understanding patterns of intergenerational transmission of impaired parenting has grown as well. Experiences of adversity and toxic stress in one generation are linked to poorer parenting and developmental outcomes in the next generation.⁹³ Thus, improving the quality of the caregiving environment as early as possible may help improve stress responding in young children.⁹²

Foundational work on adverse childhood experiences (ACEs) as predictors of physical, relational, and behavioral health has contributed to a growing understanding of the

dose-response relation between experiences of adversity in early childhood (conceptualized as exposure to abuse and household dysfunction) and well-being in adulthood⁹⁴ as well as the experience of parenting.⁹⁵ Pregnant women reporting higher levels of ACEs in early childhood, for example, exhibit more hostile parenting toward their own infants; this pattern of hostile parenting then increases the child's risk for poorer developmental outcomes.⁹⁶

In response to growing recognition of the impact of adversity and toxic stress within families, in 2012, the American Academy of Pediatrics (AAP) released a policy statement recommending education for health professionals on ACEs along with 2-generational screening for ACEs within families.^{97,98} By screening for parental and child ACEs, health providers may be able to provide referrals to trauma-informed therapeutic supports within the community that can help build or rebuild relational health.

Yet, in the face of adversity, the presence of individuals who are connected to the child, such as family members, can help mitigate its negative effects.⁴ In addition to exploring multiple factors related to the experience of adversity, a relational health perspective suggests the importance of identifying and growing supportive connections. For example, the neurosequential model of therapeutics focuses on relational health and connectedness with others.⁹⁹ Results from recent work with this model highlight the importance of promoting the health, safety, and positivity of the parent-child relationship.

Recommendations for Providers. Although pediatric health care providers are aware of the impact of ACEs on parenting and developmental outcomes, additional research, education, and resources are necessary to support practitioners in identifying and addressing these impacts within families.¹⁰⁰ The limitations and potential cost-benefit analysis of screening for ACEs must also be considered because screening without provision of adequate referrals to evidence-based treatments

may undermine the possible value of the screen.¹⁰¹ Moreover, identification of appropriate screening tools for ACEs remains an important consideration. Focusing on the experiences of adversity as an ACE score that relates to poorer health outcomes may confuse correlation with causation; thus, to best inform policy and practice, factors such as timing of adversity, the overall pattern of stress, and the absence or availability of protective factors must be considered.⁴ Yet through increased awareness of ACEs (both the parent's and the child's) as well as other psychosocial risk factors for impaired relational health, professionals can widen their lens of assessment when interacting with parents and children during medical visits.

Child Characteristics That Contribute to Parenting and Parent-Child Relational Health

Another set of key factors in the quality of parenting and parent-child relationships involves characteristics of the child. Recognizing the bidirectional nature of relationships between parents and children, Bornstein noted that "caregiving is a two-way street."¹⁰² Although early literature emphasized the parents' impact on the child, a relational health approach to development suggests that we consider child contributions to parenting as well as to the overall parent-child relationship. Among a number of child characteristics that may affect parent-child relational health, research has focused on child temperament and age as well as children with special health care needs.

Temperament

Although early research on temperament emphasized the child's inborn characteristics (eg, rhythmicity, mood) and temperament types such as easy, difficult, and slow to warm up,¹⁰³ our current understanding of temperament reflects the interplay between biological and environmental factors over the course of an individual's development.¹⁰⁴ Definitions of

temperament typically include individual differences in activity, emotionality, attention, and self-regulation.¹⁰⁴ However, particularly relevant to the experience of parenting is the temperamental characteristic of reactivity, defined as the extent to which the child is predisposed to experiencing strong negative and/or positive emotions, which may reflect the sensitivity of the nervous system to environmental stimuli.¹⁰⁵

Although difficult child temperament has long been viewed as a risk factor for poorer parent-child relational health,¹⁰⁶ more recent theory and research on the concept of differential susceptibility suggest that children with difficult or highly reactive temperaments may be more susceptible to both the negative and positive effects of the parenting environment.^{105,107} For example, children with more difficult temperaments, reflecting higher levels of reactivity, may be particularly susceptible to the detrimental effects of negative parenting.¹⁰⁸ In contrast, for highly reactive children, the experience of more positive parenting is associated with fewer child behavior problems¹⁰⁹ and greater social competence.¹¹⁰ Parenting intervention studies have further shown that more reactive children appear to benefit more from experimentally induced positive changes in parenting.¹¹¹ Thus, it is important for practitioners to shift their perspectives on “difficult” children from vulnerability to opportunity and support parents in adopting a similar view. Indeed, to the extent that the biological parents of a highly reactive child may share similar underlying genetic sensitivities,¹¹² these parents may be especially responsive to practitioners’ efforts, just as their children are particularly responsive to their parenting.

Age

Because the demands and challenges of parenting change as a function of children’s age, parents must have opportunities to gain research-informed recommendations for supporting relational health with their children from birth throughout the life span. For

example, within early childhood, toddlers’ and preschoolers’ growing autonomy and self-awareness creates new demands and opportunities for both parent and child. Thus, supporting parents in reflecting on the thoughts, feelings, and beliefs regarding their child’s increasing autonomy could be one strategy for supporting relational health as children move through the early childhood years. Moreover, the roles of various parenting practices for supporting children’s self-regulatory capabilities may differ across early childhood, with responsiveness most critical in infancy and other forms of support becoming more critical during the preschool years.¹¹³ Research must, therefore, identify which practices are most relevant, at which age,¹¹³ and for which outcome of interest. Doing so will help practitioners provide targeted support to families, based on parents’ concerns regarding their child’s particular social and emotional strengths and challenges.

Special Health Care Needs

Children with special health care needs represent a growing demographic,¹¹⁴ and expert recommendations continue to promote early detection in primary care.^{115,116} Just as providers should consider the parent factors contributing to relational health, the child’s contribution to parent-child relationships is paramount. Within the family context, a child with a developmental disability and/or special health care needs may require disproportionate resources and time compared with neurotypical siblings.¹¹⁷ The child’s condition may translate into added health care costs and increased stress for parents along with decreased access to social support and leisure activities within the community.^{118,119} For example, a systematic review of parenting stress in the face of chronic child illness indicated that among parents who were parenting a child with chronic illness, significantly higher levels of parenting stress were found; in turn, this stress was related to lower levels of psychological adjustment among parents and children.¹²⁰ Among

parents of children with autism spectrum disorder (ASD), higher levels of parenting stress and psychological distress have also been reported.^{121,122} These higher levels of parental stress and distress may, in turn, affect parental availability and sensitivity, thus affecting relational health.

Recommendations for Providers. In light of the evidence on child contributions to parenting and developmental outcomes, it seems important to consider the “what” and “how” of child contributions to relational health. Identifying the ways in which child characteristics influence and interact with parenting behaviors and relational health may provide practitioners with the tools and questions necessary to shift from a focus on the effects of parenting on children to also consider how parenting has been influenced by the child and how the overall health of the relationship has been shaped by both relational partners.

Contextual and Process Variables That May Affect Relational Health

Although the bidirectional nature of parent-child relationships underscores the importance of considering parent and child contributions to relational health, a family systems approach, coupled with a bioecological approach, suggests that the social and contextual contexts in which parent-child relationships are embedded should be considered as well.

Parent-Child Feeding Practices

The promising protective role of healthy parent-child relationships in the development of obesity¹²³ in early childhood is also evident, perhaps via links with more optimal self-regulation in young children.^{124,125} For example, theoretical models¹²⁵ and research¹²⁶ on the development of appetite self-regulation and positive physical activity habits,^{127,128} which are critical to weight-related health throughout the life span, highlight the important role of parenting. Parental behaviors such as permissiveness or indulgence have been

associated with weight status and obesity in childhood. More specifically, allowing children too much freedom regarding food choices in society's obesogenic food environment can increase children's risk for obesity.¹²³ Similarly, unrestricted, unmonitored screen time has also been associated with unhealthy weight status.¹²⁹ Yet the question remains to what extent these cycles occur within families, whereby parents' lack of control over their own food choices and screen time contribute to unhealthy weight status for their children and the unhealthy weight status of children contributes to parents' continued struggles with their own food choices and activity levels. Thus, a family-level relational approach to understanding risks for obesity may be particularly advantageous.

Given that parents' attitudes and beliefs can shape a range of parenting behaviors related to health and wellness, including feeding practices, exploring relational correlates and predictors of feeding practices beginning in infancy seems prudent. Parents' feeding practices provide a unique window into parent-child relationship health, because from birth, feeding makes up a critical part of parents' daily interactions with young children. Decisions regarding breastfeeding and/or bottle-feeding can cause considerable stress for parents.¹³⁰ And although children's eating behavior emerges early and is relatively stable over time, eating is influenced more by external factors across development.¹³¹

Mothers who use food to soothe their distressed infants or toddlers have reported lower parenting self-efficacy and higher child negativity.¹³² Using food to soothe was also linked with higher weight status among children, particularly for children who were perceived as having more negative temperaments.¹³² Among preschoolers, parents' use of food for the purpose of emotion regulation was associated with children's increased intake of sweets when not hungry, a pattern that may reflect the early origins of children's emotional eating.¹³³

Recommendations for Providers. Eating behaviors and nutrition are important components of lifestyle medicine. In promoting healthy eating behavior and weight outcomes for children, health care professionals can consider how parents' attitudes may shape their feeding practices—above and beyond a child's weight status—and how dyadic and family-level interactions around food may support or undermine relational health. From birth, providers can recognize that decisions regarding feeding (eg, breast and/or formula; homemade meals versus fast food) may be multiply determined and best understood through a relational health lens, where parent and child factors are viewed as contributing to parenting practices, practices that may differ from recommended best practices for promoting child health outcomes.

The Household Environment: Family Chaos, Technology, and Social Media Use

The home environment represents an important context for parent-child relational health, including the quality of parenting as well as children's well-being and health.¹³⁴⁻¹³⁸ Recent research, focused on household chaos, has highlighted the role of disorder/disorganization¹³⁹ and instability/turbulence¹⁴⁰ for understanding parenting quality and family well-being. Lower levels of household chaos (evidenced by greater organization, stability, and predictability) are associated with higher-quality parenting behavior than home environments characterized as noisy, crowded, unpredictable, and disorganized.¹³⁸ Among preschoolers, recent evidence suggests that higher rates of household chaos are also associated with higher screen use.¹⁴¹

In fact, parents' and children's increasing engagement with, and reliance on, technology and social media suggest the need for providers to consider technology and social media as interactive partners. For example, Facebook may provide new parents with an important source of social capital,¹⁴² and parents report using the internet to

gain information about pediatric health.^{143,144} Yet parents (and grandparents) do not report universally positive effects of their technology use. For example, parents may experience a range of internal tensions surrounding their use of mobile technology, such as cognitive, emotional, and relationship tension.¹⁴⁵ Researchers are documenting how technology may interrupt the flow of interaction patterns between children and their parents—a concept known as technofence.¹⁴⁶ For example, higher levels of child internalizing and externalizing behavior problems have been reported by mothers who also reported higher levels of technofence in their interactions with their children.¹⁴⁶

Recommendations for

Providers. Supporting parents in identifying, reducing, or coping with household chaos, as well as technofence, may be promising avenues for supporting relational health. Because the experience of chaos in the home environment often co-occurs with poverty¹³⁹ as well as parental mental health symptoms,¹⁴⁷ screening and intervention approaches aimed at identifying and addressing the multiple co-occurring factors that relate to family chaos may be warranted. Moreover, gauging the perceived impact of technology and social media use on parent-child relational health may be an important area of inquiry for health practitioners.

Cultural Context and Relational Health

Understanding relational health requires us to also consider the impact of race, ethnicity, and culture on parent-child relationships; accordingly, consideration of diversity has moved to the forefront of our current research and practice efforts. Although broad parenting goals are remarkably similar across diverse cultures,¹⁰² the processes by which parents in varying cultural contexts seek to achieve these goals may differ. For example, some scholars have suggested that the concept of sensitivity, the primary determinant of secure

attachment according to attachment theorists, may be biased toward more individualistic cultures because it is focused on meeting the child's individual needs.¹⁴⁸ Moreover, the meaning of parenting constructs such as controlling behavior may vary across cultures. For example, Asian American parents may emphasize strict control of children as part of culturally embedded approaches to parenting, which are not equivalent to western notions of harsh/controlling parenting and do not appear to have negative effects on their children's development.^{149,150}

These debates can support practitioners in reflecting on how their own beliefs about what is the "best" kind of parenting to promote relational health and positive child outcomes may be shaping their messaging for parents. For example, among immigrant families, attention to acculturation—the process of adapting to a new culture—rather than parenting behavior, per se, may provide a window into relational health. For example, acculturation may happen at different rates for children and parents, and greater discrepancies in the level of acculturation may contribute to increased parent-child conflict.¹⁵¹

The roles of culture, race, and ethnicity in parenting practices are particularly apparent with respect to discipline practices. For example, higher rates of corporal punishment, including spanking, are generally reported by African American parents, in comparison to Hispanic or white parents,¹⁵² although recent evidence suggests similar endorsement of spanking by African American and Hispanic mothers, along with longitudinal associations between endorsement of spanking and children's later internalizing and externalizing behaviors.¹⁵³ Evidence continues to highlight the negative impact of corporal punishment on children¹⁵⁴ and the AAP's 2018 statement on effective discipline emphasizes the need for positive alternatives to corporal punishment and spanking.¹⁵⁵ And, although many parents report spanking their young children, these same parents may also be looking for nonphysical,

effective alternatives for guiding their children's behavior.¹⁵⁶

Recommendations for Providers. Understanding how cultural beliefs and practices shape parents' expectations and socialization goals may help us better define what relational health is, both within and across diverse families. Health care professionals can be a source of guidance and support for parents to choose discipline strategies that align with research and support parent-child relational health. When practitioners recognize the larger context in which parents' discipline decisions are embedded, they may more readily identify the beliefs, histories, and socialization goals that underlie families' discipline practices. Health providers can recognize parents' concerns regarding children's behavior and provide culturally responsive, research-informed, preventive recommendations for helping parents identify alternative strategies to the use of corporal punishment and physical discipline.

Reducing Risks to Relational Health: Screening and Referral

Given that the parent-child relationship is critical for healthy development, health providers must adopt a dyadic-level, family systemic, and culturally informed approach to screening, referring, and treating parent-child dyads to integrate research with practice. Equipping health professionals with knowledge of relational health may provide a solid foundation for supporting parent-child relational health from birth. For example, evidence from research with pediatric residents suggests that training in a parent-child relational framework was effective in supporting residents' observational skills and knowledge of child development.¹⁵⁷

An emphasis on transactional associations within families further underscores the importance of screening and early intervention to support child and parental well-being and use of positive parenting practices.¹⁰ Commonly

used assessments in parent-child attachment research, such as the Strange Situation Procedure¹⁵⁸ Attachment Q-Set,¹⁵⁹ are labor-intensive and were not developed as clinically relevant screening tools. Moreover, even when insecurity in the parent-child relationship is suspected, access to attachment-based interventions (ie, VIPP-SD, ABC) may be extremely limited.

Whereas much of the research literature on early parent-child relationships (typically mother-child relationships) has focused on attachment, recent work highlights the dyadic-level construct of *emotional connection* for understanding early parent-child relational health. The development of the Welch Emotional Connection Screen (WECS)¹⁶⁰ reflects an effort to provide practitioners with a rapid and valid screening tool for parent-child relational health from birth to 5 years. The WECS considers the presence or absence of 4 mutual behaviors that may serve to promote and maintain emotional connection within a parent-child dyad: attraction, facial responsiveness, vocal responsiveness, and sensitivity/reciprocity. Based on the overall interaction, a score of EC+ (connected) or EC- (not connected) is assigned to the dyad.

The WECS developed out of work with the Family Nurture Intervention, which seeks to support the development of emotional connection and coregulation via the provision of calming sessions that focus on the sensory experiences of touch, vocal soothing, and skin-to-skin contact.¹⁶¹⁻¹⁶³ Results from an RCT study indicated that mothers and infants participating in the Family Nurture Intervention showed improvements in face-to-face dyadic interaction, including increased frequency and quality of mothers' touch and for boys, infant's vocal affect and gaze.¹⁶⁴

Emotional connection, as assessed by the WECS in infancy, has been associated with healthier autonomic responding among infants born prematurely¹⁶⁵ as well as with fewer internalizing and externalizing behavior problems in a full-term, longitudinal sample.¹⁶⁶ Thus,

emerging evidence suggests that the WECS holds promise for screening, anticipatory guidance, and referral of early parent-child relationships that may benefit from support and intervention to promote healthy regulatory functioning and decrease risk for later child behavior problems. Efforts are under way to train a range of professionals—from pediatric residents to infant mental health practitioners and home visitors—to be reliable raters of parent-child relational health using the WECS.

In families with elevated risk for maltreatment, the automated self-report survey, the CARTS (Computerized Childhood Attachment and Relational Trauma Screen), reflects a relational approach to the assessment of trauma in childhood.^{167,168} The CARTS considers what trauma occurred and assesses caregivers' emotional availability, along with responses to the reported maltreatment. In contrast, the SEEK program (Safe Environment for Every Kid) focuses on risk factors related to child maltreatment, including parental depression, stress, and substance abuse.^{168,169} Thus, the SEEK program may benefit pediatric primary care professionals through its focus on psychosocial stress within families, which if addressed early, may prevent child maltreatment.

Notably, SEEK embodies a relational health perspective by acknowledging the parent's love for the child as a pathway to healthy outcomes for both parent and child as well as by acknowledging the relationships between health professionals and parents as protective factors for parents and children.^{169,170} For example, part of the SEEK program is the SEEK Parent Questionnaire, which begins by empathetically validating the sometimes challenging everyday experience of being a parent while simultaneously offering support to parents dealing with concerning circumstances. SEEK also aims to support relational health through the REAP approach, which encourages health care providers to Reflect-Empathize-Assess-and Plan with parents.

Intervention approaches that incorporate mindfulness practices, such as the 9-week Mindful Parenting course

tested in the Netherlands, also hold promise for supporting relational health within families. Mindful Parenting aims to increase awareness, decrease parental stress, and improve coparenting.¹⁷¹ Both parents participating in the program and their children report reductions in internalizing/externalizing symptomology. The interpersonal focus of mindfulness-based interventions supports healthy parent-child relationships through increased awareness of parent-child interactions as well as positive changes in both child and parent functioning.¹⁷²

Summary and Conclusions

Beyond attachment theory, which emphasizes parental sensitivity and responsivity as a primary determinant of attachment security, a relational health science approach offers a wider lens for understanding how parent-child relationships may affect children's development. A relational health approach recognizes both partners' contributions to the establishment and maintenance of relational processes and highlights the potential value of the health care provider as a relational partner for parents and children. Our focus here was on socioemotional development; future work will consider how a relational health framework can be applied to a range of parent-child health decisions from vaccinations and sleep behaviors, to physical activity, and medication use.

Although we view primary care as a valuable context for supporting relational health, continued development and validation of screening tools for relational health that are suitable for clinical and applied contexts remain an important goal along with more widespread availability of effective interventions. Moreover, given the existing demands on health care providers, we recognize that a relational health perspective on development may create additional demands on providers. Perhaps a necessary first step is a shift in perspective, more than a shift in practice.

By viewing the parent-child relationship as part of the "patient" and, therefore, part of health promotion, the long-term gains may be worth the initial investment.

By networking with community resources, health care providers can build a pipeline of referrals for parents as a component of pediatric and primary care. Offering parent-friendly pamphlets, information sheets, and face-to-face communication that reflects a relational health view on development may help parents see themselves as partners in relational health, rather than as the cause of their child's mental health, behavioral, or developmental problems. Such negative attributions may contribute to feelings of shame and guilt—feelings that may undermine parenting self-efficacy and parents' engagement in children's wellness and treatment. The AAP's recent call for pediatricians to partner with parents in supporting healthy outcomes through the sharing of information regarding child development and parenting¹⁵⁵ reflects the promise of a relational health approach.

Returning to the opening quote from Bowlby, we suggest that health care providers are in a strong position to serve children by valuing their parents and viewing child development through the lens of relational health. Perhaps by uncovering who *that* person is—the one who is "irrationally crazy" about the child, as Bronfenbrenner advised—professionals can help cultivate and reinforce that connection. And in its absence, we can seek to identify ways to build a web of relational health for the child and for the parent, a web that can support each partner in service to the relationship.

Acknowledgments

We are grateful to Ariana Shahinfar, Robert Ludwig, and Mark Lopez for feedback on an earlier version of this article.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Ethical Approval

Not applicable, because this article does not contain any studies with human or animal subjects.

Informed Consent

Not applicable, because this article does not contain any studies with human or animal subjects.

Trial Registration

Not applicable, because this article does not contain any clinical trials. **AJLM**

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