

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

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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.

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