

Infant and Parent Mental Health: developmental Trajectory as a Communal Concern

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Abstract. This article covers recent research in the field in the context of lifelong growth and mastering developmental milestones. It denotes intrinsic connection between parental and child's psychological well-being, including patterns of early attachment. There is also well documented connection between deviations in early attachment and consequent adult functioning. "The bigger picture" approach based on the DIR method is proposed as one of the crucial components of mitigating early trauma. It includes comprehensive multidisciplinary diagnosis, parent education and play interventions based on immediate interests, needs and resources of the family. It targets all areas of development and builds foundation for the emergence and maintenance of healthy attachment. Other successful approaches, implications for clinical work and social organization of early intervention services are also discussed.

Keywords: mental health, informational warfare, mass media, information, consciousness, influence, protection, text classification.

Literature Review. A substantial body of recent research proves that mental health of infants directly correlates with maternal mental health. When the mother has been traumatized, whether by loss of a loved one, catastrophic/traumatic events ranging from war to natural disasters or an assault; when economic and societal pressures or personal and interpersonal history of violence or abuse (Cyr et al., 2010) start to outweigh “primary maternal preoccupation” (Winnicott, 1959), her response to the baby and baby’s needs becomes less than optimal. There are situations when unfavorable events shift her locus of control deeming her helpless. In other words, relinquishing control over the unpredictable and erratic world that the mother faces are inevitably coupled with losing control over her infant and compromising their unique bond. Traumatized mothers exhibit emotional unavailability, rigid parenting styles, heightened expectations, mood disorders as predictors of sleep disturbance (O’Connor et.al., 2000), flat affect and frequent gaze aversion from the infant during daily routines. Princeton’s 2017 study demonstrated that infants’ own communicative attempts were positively associated with adults’ neural synchronization to them, indicating mutual regulation of synchronization within infant–adult dyads. Thus, interpersonal neural synchronization may provide a mechanism by which infants construct their own earliest social networks. Disruption of this up-regulating mechanism is detrimental to early development.

As per neuroscientists researching intergenerational attachment patterns, mothers’ attachment-related trauma, when unresolved, undermines her optimal brain response to her infant’s distress. Mother’s unresolved trauma blunts amygdala response to infant distress (Kim, Fonagy, Allen & Strathearn, 2014). Researchers note that mothers with no trauma demonstrated greater amygdala responses to the sad faces of their own infant as compared to their happy faces, while mothers who were classified as having unresolved trauma in the Adult Attachment Interview (Kim et. al., 2014; Dynamic Maturational Model) displayed blunted amygdala responses when cued by their own infants’ sadness as compared to happiness.

Attachment patterns are grossly affected by maternal attachment system and history of attachment to significant figures. Even in the beginning of pregnancy the woman’s attachment system and her own representations based on her relationship with her parents gets activated (Ammaniti, M. et.al,2013). Renata, T. et al. (2015) notes that mothers with early traumatic experiences had significantly more maladaptive interactions during the feeding of their children, both at 3 months and 6 months of age, when compared to mothers who had not experienced traumas. Additionally, fathers with prior traumatic experiences elicited high anxiety in their infants during feeding. It is important to note that even in the absence of overt maltreatment, the intersection of multiple social and economic risks experienced by a family consistently results in considerably elevated rates of infant disorganized attachment.

Therefore, trauma is unfolding into cross-generational affair that casts a shadow on further development of babies born to mothers who fell victims to direct trauma or those with history of exposure to traumatic material. For instance, research which focused on babies born after 9/11 WTC attacks shows that reduced cortisol levels were observed in infants, suggesting a larger role for very early environmental, genetic, or genetic-environmental interactions than previously thought (R.Yehuda, 2005). Where the well baby who comes into direct contact with the traumatized parent is concerned, his/her social and cognitive outcomes during infancy and toddlerhood are in danger of being poor, suggesting impaired psychological functioning in adolescence, compromised ability to empathize, weak school performance and/or school anxiety, inadequate self-regulatory capacities, and attachment insecurity.

Disruptions of attachment become especially prominent when it comes to disorganized

attachment that is commonly associated with horror and unresolved fright. It is important to note that disorganized infant grows into an adult who is either hostile or helpless (Lyons-Ruth, Jacobitz, 2008), and continues to misinterpret intimacy as danger throughout his/her lifetime. "The innate drive to move towards the attachment figure for soothing only to find that it is this parent who is the source of distress yields a disorganized response" (Siegel, 2003). For the children of war and military aggression, negative consequences are innumerable. V. Felitti (1998) notes high prevalence of disability, mental health problems, medical conditions and premature death. In the case of the prolonged exposure to danger or chronic trauma, odds of building safe attachment decrease even further.

Clinical implications. Pathways to wellness include maternal psychoeducation starting with the understanding of the brain's works and proceeding to the skills of distinguishing between different mental states; teaching parents the value of physical and emotional contact with their babies, using gestures, facial expressions and touch to reactivate triune ANS (Porges, 2011); reflective listening aimed to strengthen reflective capacity (see successful experimental work of A. Slade, proving that parental reflective capacity can be developed); and playing with purpose (see Developmental individual-difference, relationship-based Floortime as formulated by S. Greenspan & S. Weider).

Learning about neurological mechanisms underlying trauma, as well as complexities of the impact of early vicarious traumatization (via the traumatized parent), can increase parents' ability to relate and attend to their young children. However, the first step should be assessing parental trauma and attachment history. There are assessment tools that can be also used in the course of such treatment. Adult Attachment Interview (AAI; George, Kaplan, & Main, 1984) where adult reflective functioning assessed on the basis of an adult's capacity to reflect upon memorized childhood relationships with their parents; Parent Development Interview (PDI; Aber, Slade, Berger, Bresgi, & Kaplan, 1985; PDI-R; Slade, Aber, Bresgi, Berger, & Kaplan, 2004) examining parent's capacity to specifically reflect upon her child's emotional experience or upon her own experience as a parent; Emotional Availability (EA) Scales (Biringen, 2008); and Multiaxial diagnosis of infant disorders as a part of PDM-2 (S. Greenspan, 1999, 2016) can offer opportunities for the parent to reflect, remember, and apply "in vivo" theory of mind (realization that babies have their own mind and posing simple but powerful questions like, "What does my baby think?"). Mentalization can pave the way to developing mindsight (D. Siegel, 2004) and becoming observant of the meta-processes in parent's own brain, in addition to their child's.

As the DIRFloortime practitioner, I would like to offer a quick overview of the approach. DIRFloortime®, also known as the Greenspan approach, offers comprehensive approach to has become more and more popular as a successful treatment approach of working with children with the Autistic Spectrum Disorders, sensory dysregulation, language and processing delays, inattention and behavioral problems. DIRFloortime® is a dynamic, child driven, developmentally based model that takes into account normative functional emotional development and builds on the existing strengths of the child. It takes into account unique capacities of their emotional and functional profile as superimposed on the individual sensory, biological, communicative and proprioceptive characteristics. DIRFloortime® as a parent oriented program partners with parents and equips them with highly individual skills set for dealing with their particular baby. Model incorporates biologically based individual differences, child's functional developmental capacities and familial, cultural and community systems as they influence the child. There is strong research based evidence that proves the effectiveness of this approach. Most importantly, systematically using strategies of nondirective play ("Floortime"), it approaches development of language, cognition and motor skills in a comprehensive and fun way.

Another important component of DIRFloortime® program is developing parental self-reflective capacity. Mentalization is a crucial human capacity that is intrinsic to affect regulation and productive social relationships. This skill of understanding one's own behavior, as well as behavior of others, in terms of underlying mental states and intentions is unique to humans (P. Fonagy et. al., 2002). Mentalization can pave the way to developing mindsight (D. Siegel, 2004).

All these activities, although not directly addressing maternal trauma, help to reduce impact on the infant. Studies suggest that those mothers with unresolved trauma who were reorganizing toward secure attachment eventually had infants with secure attachment (Iyengar, U. et.al., 2014). Therefore, healing power of relationship helps mitigate the damage and reverse the course of detrimental neurological and psychological events in the future generations. Use of available diagnostic instruments can become a platform for future treatment and determine positive outcomes: recognizing the need to understand child's emotional world, identifying strategies for effective reading of infant's emotional signals, supporting child's ability to self-soothe and accept soothing from the meaningful adult figure, and developing ability to honor the child's innate wisdom and desire for emotional security.

Discussion. This paper examined parent-infant relationship in the light of the developmental trajectory and lifelong consequences. Because of the direness of need to protect those mothers and children who have been exposed to unresolved or chronic trauma (i.e., residing in the occupied zone, mourning losses or just experiencing uncertainty and environmental stress), it is pertinent that protecting mothers and infants should become a matter of national emergency. Future research is needed to assess the need and establish evaluation and treatment procedures, as well as prophylactics for the 0 to 3 population. Current state of affairs in Ukraine calls for systematic child-centered approach that is outcome focused and evidence based. Establishment of such program can initiate promising directions towards healthy parents and happy infants.

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