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The impact of domestic violence and abuse on infant mental health

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Introduction

Infant Mental Health (IMH) is concerned with beginnings. First and foremost, beginning with the infant’s birth and early years. This includes understanding the parents/carers’ early beginnings, relationally and contextually, and how this has shaped who they are; and how the evolving infant-parents/carers’ relationship, with all the potential it holds, effects them in return. These threads then weave together to influence the developing infant and their caregiving world and intersect powerfully with multiple contextual factors such as race, culture, ideology, religion, gender and socio-economic considerations. Specific to this chapter is how domestic violence and abuse (DVA) within the primary caregiving relationship impacts the mental health of the infant.

Research has unequivocally demonstrated that DVA impacts the infant’s mental health and wellbeing (Schechter, Willheim, Suardi, & Serpa, 2019). The repetition of early relational trauma in the caregiving world lays the foundation for all subsequent development (Stern, 1985/2003). As yet without words, the preverbal infant communicates volumes about their world, psychosomatically, relationally and emotionally. Holding the infants’ experience of DVA in mind calls for adults to resist the impulse to minimise or disappear this trauma, as

fully engaging with an infant or young child’s psychological distress is often too confronting and too painful . . . if we are not prepared to go there, we leave the very small child alone to manage this by themselves, something they are neurologically, emotionally and physiologically ill-equipped to do.

(Bunston, 2017, p. 15)

Chapter overview

An overview of what is known about the developing infant begins this chapter. This will be followed by describing what IMH is and does, with prevailing research and thinking into the impacts of trauma on infants explained. The available research on the impacts of DVA on IMH will then be described in more detail and a critique of this research provided. Next will be a consideration of how to approach researching, as well as purposefully intervening with infants.
and mothers, and how fathers who use violence are included in this space. The final area explored involves hope, and the under-conceptualised, under-researched and underestimated hope infants hold for changing the future.

**The developing infant**

Infants demonstrate their ability for engaging with others, exploring their environment and demonstrating self-agency soon after birth (Zeanah Jr, 2009). The infant possesses a sense of self as separate to, but in relationship with others, and attempts to create connectedness, building their social and emotional competencies as they discover “ways-of-being-with-others” (Stern, 1985/2003, p. xii). This is “how communication begins and develops in infancy, how it influences the individual subject’s movement, perception, and learning, and how the infant’s biologically grounded self-regulation of internal state and self-conscious purposefulness is sustained through active engagement with sympathetic others” (Trevarthen & Aitken, 2001, p. 3).

The sensate, embodied and physiological processes experienced by the newborn are shaped by how their caregiving system responds to and/or initiates each relational exchange. Such exchanges have been described as a neural “mapping of the other onto the self” (Ammaniti & Gallese, 2014, p. 8). This exchange is reciprocal, particularly with the mother, who, as the likely primary caregiver (DESA, 2011), is most significantly impacted by the experience of giving birth (Stern, 1998), and most vulnerable to experiencing DVA at the hands of men (WHO, 2013).

Essentially, the infant is neurologically ‘wired to connect’ and will innately seek out proximity with others, occurring even when those others may also be a source of harm (Main, Hesse, & Hesse, 2011). A major developmental task for the first years of life is the infant beginning to emotionally and physically regulate, internalising the outside experience of being held ‘well enough’ physically, emotionally and relationally by their caregiving context (Winnicott, 2002). Emotional affect regulation, that of being able to manage internal feeling states, occurs in the context of safety and active reassurance, as does the capacity to experience relational repair when things do not immediately go well (Tronick, 2007). “Feeling felt” is an important validation of the emerging sense of self and throughout one’s lifetime, as “empathy soothes us and makes us feel safe” (Fishbane, 2007, p. 403).

It is the caregiving context enveloping the infant which directly shapes their attachment/s and “the functional origins of the bodily-based implicit self” (Schore & Schore, 2008, p. 10). Further, the quality of the attachment the infant develops in their primary caregiving relationships directly impacts the infant’s neurological, physiological, psychological and emotional development (Schore, 2016; Siegel, 2012). It is the reciprocity the infant is capable of which seems extraordinary to many adults: their demonstrated ability to show empathy for others, to initiate social engagement, and the evidence of implicit relational perceptiveness beginning in their first year of life (Liddle, Bradley, & McGrath, 2015).

**Infant mental health**

IMH focuses on the infant, their parent/s and the relational health of the caregiving system. Traditionally targeting the prenatal stage to age 3 (WAIMH, 2019), some now extend this to age 5. Zeanah Jr and Zeanah (2019, p. 6), quoting ZeroToThree (2001) explains that IMH is concerned with:

- the young child’s capacity to experience, regulate and express emotions, form close and secure relationships, and explore the environment and learn. All of these capacities
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will be best accomplished within the context of the caregiving environment that includes family, community and cultural expectations for young children.

In 2016 the World Association for Infant Mental Health (WAIMH) developed a “position paper on the rights of infants” (WAIMH, 2016, p. 4) declaring:

The infant’s status as a person is to include equal value for life regardless of gender or any individual characteristics such as those of disability . . . the right to be given nurturance that includes love, physical and emotional safety, adequate nutrition and sleep . . . the right to be protected from neglect, physical, sexual, and emotional abuse, including infant trafficking.

IMH is concerned with the overall welfare of infants, including adequate access to food, shelter and clothing as well as love, attention, protection and care (Weatherston, 2000). The infant is fully dependent on others for their survival and “cannot exist alone but is essentially part of a relationship” (Winnicott, 1964, p. 88).

As a field of enquiry, IMH began in the UK and US in the 1960s, drawing on developmental psychology and psychoanalysis (Harman, 2003; Zeanah Jr, 2019). Today, it is a large international, multidisciplinary, theoretically diverse, clinically based, scientific and research-informed field with most knowledge derived from research with infants from high-income countries (Bornstein, Putnick, Park, Suwalsky, & Haynes, 2017). As such, IMH knowledge has largely been formulated by white, Western, upper middle-class practitioners, researchers and academics, using a heteronormative lens and concerned with the influence of the early years across the lifespan. However, Western childrearing practices have been charged with being ethnocentric, posing challenges for differing cultural practices and what determines a beneficial start in life (Quinn & Mageo, 2013).

The mainstays of thinking within IMH includes attachment theory (Salter-Ainsworth & Bowlby, 1991), psychoanalytic and object relations concepts (Winnicott, 2002) and the transgenerational transmission of trauma (Fraiberg, Adelson, & Shapiro, 1975). Research into the brain throughout the 1990s laid the foundation for what is now a scientific agenda influencing IMH research and practice (Jones & Mendell, 1999), along with more recent explorations into epigenetics (Zeanah Jr, 2019). Current research into the cognitive and sensory-perceptual capacities of infants has definitively demonstrated that infants are not passive participants in the parent/infant relationship but competent and sentient beings in and of themselves, impacted by as well as impacting their caregiving environment (Ammaniti & Gallese, 2014).

Absent from IMH research and infant development generally, is a comprehensive examination of the effects of systemic racism, war, famine, ill-health, oppressive regimes and ideologies and the complexities facing low-income countries. The impacts of disease, poverty, malnutrition and lack of healthcare are conspicuous and measurable, receiving considerably more attention in the literature (Lu, Black, & Richter, 2016). Giving space to the experience of infants and their caregivers in low-income countries, their experience of violence and oppression, and the equally strong bonds and determination of mothers to protect and see their infants thrive, remains a challenge for this sector.

Impacts of relational, emotional, physical trauma and abuse on the infant

Infants are at the greatest risk of harm, neglect and death than any other time in childhood (UNICEF, 2015) with DVA identified as a significant associated factor (Menon, 2014). Within
high-income countries where DVA is present, infants and young children are at a heightened risk of being removed from families by state-based child protection services and placed in kinship or non-familial care (Alaggia, Gadalla, Shlonsky, Jenney, & Daciuk, 2015). Less common, poorly understood and responded to are incidences of filicide, murder-suicide and familicide, and the immediate and long-term impacts and consequences for surviving infants and siblings (Eyre, Milburn, & Bunston, 2020). Of concern for this chapter is what occurs for the infant when the caregiving environment is impacted by DVA such that the provision of ‘good enough parenting’ is thwarted or severely jeopardised.

Early childhood maltreatment has been linked to symptoms of anxiety and depression during adolescence (Harpur, Polek, & van Harmelen, 2015); increased risk of developing cancer, cardiovascular difficulties and immune system deficiencies (Cicchetti, Hetzel, Rogosch, Handley, & Toth, 2016); and reduced cerebral volume, verbal memory retrieval, attention and cognitive deficits (Carrion, Wong, & Kletter, 2013). The Adverse Childhood Experiences (ACE) study involving 17,337 adults, including some who reported experiences of DV (Anda et al., 2006, p. 174), found a correlation between ACEs and substance abuse, neuropsychiatric syndromes, numerous health problems and relational difficulties.

To some extent the impacts of exposure to early infant trauma are inferred (Schechter & Willheim, 2009). This is not to argue that they are not real, but that direct and time-specific correlates are hard to measure given much relational trauma impacting infants and young children occurs behind closed doors. Such trauma is infrequently reported, difficult to substantiate and too often minimised (Gilbert et al., 2009). Abuse may not be evident in infancy until a baby requires urgent medical attention, dies or impacts become apparent through longitudinal or retrospective studies (Enlow, Egeland, Blood, Wright, & Wright, 2012).

During pregnancy the foetal brain is vulnerable to acute maternal hormone expression resulting from trauma and stress and can leave enduring impacts (Beren & Nelson, 2019). Postnatally, the developing brain is ‘experience dependent’, shaped by their caregiving environment and with exposure to ongoing stress or trauma believed to significantly increase cortisol levels and the release of flight/fight hormones, epinephrine and norepinephrine, saturating the rapidly developing but immature brain. This is detrimental to cognitive development, affect regulation and optimal growth of the brain (Carpenter & Stacks, 2009). Ongoing and significant early relational trauma and maltreatment has been demonstrated to impinge hippocampal, cerebellar and corpus callosum volume; impair synaptic growth; and risk damage to the prefrontal cortex and limbic regions (Teicher & Samson, 2013). Such functional losses are consistent with the classification of paediatric posttraumatic stress disorder (Carrion et al., 2013).

Early implicit memories, particularly those created through trauma, are believed to remain operating throughout our lives, acting as the foundation upon, and intimately linked with later developing explicit memories and a sense of self (Van der Kolk, 2014). The right brain, responsible for the emotional, non-verbal self is dominant in the first 24 months of life and is highly vulnerable to cumulative, traumatic events “which are imprinted into the neurobiological structures that are maturing during the brain growth spurt of the first two years of life, and therefore have far-reaching effects” (Schore, 2001, p. 208).

Poor emotional development in the preverbal period impacts later developing, left hemisphere language, cognition and social capabilities (Schore, 2016; Van der Kolk, 2014). Teicher, Samson, Polcari and McGreenery (2006) in their research into the various effects of childhood maltreatment found that the “combined exposure to verbal abuse and witnessing of DV was associated with extraordinarily large adverse effects, particularly on dissociation” (p. 997), an outcome which has profound implications for future interpersonal relationships, skill acquisition and learning.
Research into the impacts of DVA in the early years

Infants born to mothers who were assaulted whilst pregnant are twice as likely to have lower birth weights, and more likely to suffer foetal death or die within the first year of life with infant mortality higher amongst females in some developing countries (Menon, 2014). Research specifically targeting DVA exposure in the early years points to difficulties in three substantive and intimately interconnected areas:

- Forming healthy attachments.
- Affect regulation.
- Developmental pathways.

Forming healthy attachments

The infant develops within the context of their caregiving environment, forming a significant attachment to a specific caregiver/s which largely endures across time (Van Ryzin, Carlson, & Sroufe, 2011). Four basic categories describe the type of attachment the infant develops through organising themselves in response to what they come to expect from each caregiver interaction (Crittenden & Ainsworth, 1989).

<table>
<thead>
<tr>
<th>Secure Attachment:</th>
<th>the infant is supported over time to develop a healthy and autonomous sense of self, engaging in play and discovery, experiencing their caregiver as a safe haven, finding continuity in this relationship and congruence in how to read and respond to the cues of others.</th>
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<tr>
<td>Anxious Ambivalent:</td>
<td>an infant or young child is excessively clingy and loath to separate from their caregiver, yet does not appear to gain sufficient comfort from their closeness.</td>
</tr>
<tr>
<td>Anxious Avoidant:</td>
<td>the infant appears to seldom use their caregiver as an emotional anchor yet will not stray too far. Proximity is desired but past experience has taught them that to express this need risks rejection.</td>
</tr>
<tr>
<td>Disorganised Attachment:</td>
<td>the infant does not find sanctuary in their relationship with their primary caregiver/s. They experience a paradox of wanting to seek safety with, but feel frightened of approaching their caregiver/s, exhibiting complex, contradictive, inexplicable and disorientated behaviours.</td>
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DVA reflects a ‘disorder of an attachment’ within a caregiving system according to (Bowlby, 1984). He believed violence, from male to female, or parent to child, tended to be transmitted across generations. The excessive and distorted use of anger was used to prevent the threat of abandonment, maintain proximity or assert control over another. Bowlby (1984) was appalled that “family violence as a casual factor in psychiatry should have been so neglected by clinicians” (p. 9). A comprehensive meta-analysis of the literature found attachment styles which are classified as insecure, strongly correlate with violent offending behaviours (Ogilvie, Newman, Todd, & Peck, 2014). Lieberman, Chu, Van Horn and Harris (2011) argue that, where children are exposed to DVA, it is the child 5 years and under who are most likely to experience DVA yet are least likely to be provided with a service response.
The infant in utero and DVA

The circumstances surrounding an infant's conception also has potential implications for their mental health. This includes, for example, where infants are conceived through rape or coercion, a mother experiences increasing violence targeted at herself and the unborn foetus, a mother is prevented from seeking an abortion or is accused of infidelity. Such circumstances impact a mother's feelings and ideas about the baby growing inside of her. “Maternal representations” describes how a mother comes to imagine what their baby is like, in character, temperament and personality, and the influence of her own current circumstances, and early experiences of being parented (Benoit, Zeanah, Parker, Nicholson, & Coolbear, 1997). For the infant to find security in their attachment with their caregiver, their caregiver requires a healthy “awareness of mental processes in the self and other” (Fonagy, Steele, Steele, Moran, & Higgitt, 1991, p. 203). Ongoing threat and/or presence of harm impinges the capacity for healthy awareness of others in favour of survival.

Envisioning the infant and the impact of their arrival becomes very potent during pregnancy, for the mother, father or co-parent, as their own implicit and explicit childhood experiences and memories of how they were parented are activated. “Caregivers who have unresolved mourning or trauma” (Crawford & Benoit, 2009, p. 132) and who themselves were exposed to DVA as infants and children risk carrying states of mind which may inhibit the infant forming a close and healthy attachment (Malone, Levendosky, Dayton, & Bogat, 2010).

Attachment difficulties

Exposure to DVA during pregnancy and in the early years has significant impacts on the infant’s ability to attach securely to their mother and father. The Michigan “Mother-Infant Study” with 150 pregnant women experiencing DV (Levendosky, Leahy, Bogat, Davidson, & von Eye, 2006) found the quality of the attachment of the infant with their mother was negatively impacted where mothers experienced DV during the pregnancy and their first years of life. In part, this was caused by the DV interrupting the maternal capacity to positively hold in mind a sense of themselves becoming a mother and their growing sense of their infant. However, where a mother had left a violent relationship post the birth and before age 1, the child by age 4 was more likely to be securely attached (Levendosky, Bogat, Huth-Bocks, Rosenblum, & Von Eye, 2011).

Research from the Lehigh Longitudinal Study recruited 457 toddlers from 18 months up to children aged 6 (average age 4) and their primary caregivers, from both child welfare services and community day care centres (Herrenkohl & Herrenkohl, 2007). Attempts to strengthen their attachments to parents post their early childhood experience of violence and abuse was hypothesised to be insufficient to ameliorate the impacts of this early trauma (Sousa et al., 2011).

Attachment behaviours

An infant’s attachment behaviour emerges from their relational exchange with their caregiver/s. Inherent in creating security is a reciprocity of engagement, with the mother and/or father/carer able to offer the infant responsive and attuned caregiving. This effectively provides the infant with external relational responses which help them to manage their own, overwhelming, internal emotional states; something they cannot do alone. If these states are co-managed with their mother’s, father’s or primary caregiver’s help, albeit not always perfectly but consistently enough; over time the infant internalises these neurophysiological competencies which allows
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The newborn, infant or very young child is reliant on their caregiver/s to manage their emotional wellbeing. “This process is internalized and over time builds the capacity for effective self-regulation” (Arvidson et al., 2011, p. 38). However, when a mother herself is overwhelmed...
by DVA, past traumatic memories and the struggle to survive; the capacity to manage her own dysregulation, let alone her infant’s is severely diminished. Levendosky, Bogat and Martinez-Torteya (2013) found that “in the youngest children, affective dysregulation is the most dominant response to witnessing IPV” (p. 196). Internalising (withdrawal, shutting down) and externalising (oppositional behaviour, settling problems) difficulties are the most reported symptoms resulting from exposure to DV in infancy. Children at age 3 who had experienced DV across their lifetime exhibited arousal and avoidance symptoms which by school age were more likely to measure within the subclinical range for disturbances in internalising and externalising difficulties (Briggs-Gowan, Carter, & Ford, 2012).

**Developmental pathways**

DVA impacts the infant’s ability to find a secure attachment and safe haven to help organise heightened emotional states, impeding development. Early experiences matter. In their small-scale study, Letourneau et al. (2013) found “effects of exposure to IPV even on children younger than 3 years of age”. Whilst their study suggested that infants counteracted the effects of Interpersonal Family Violence in their interactions with their mothers, “children in the sample scored significantly lower on the Ages and Stages Questionnaire (ASQ) Fine Motor and Problem Solving subscales and the means of the remaining ASQ subscales were lower (although not significantly) than the norm” (Letourneau et al., 2013, p. 582).

Levendosky et al. (2013) found that as children’s ages increased so too did their traumatic symptoms. Where infants struggle with affect regulation young children start to exhibit “more cognitive and behavioural dysregulation as a response to witnessing IPV” (p. 196). Kitzmann, Gaylord, Holt and Kenny (2003) in their meta-analytic review of 118 studies into child witnesses to DV suggested that pre-schoolers were at greater risk of problems in social competence and sensitivity to anticipated parental conflict. Osofsky (2003) reported on the ripple effect of children exposed to DV and child maltreatment, observing “disturbances in school behaviour, mixed feelings toward parents with positive affect being mingled with anger, and difficulties in forming later relationships” (p. 166).

A study of 206 children in the USA from infancy to early school years measured intelligence quotient, language and academic progress across three points with delays becoming increasingly evident as children grew older (Enlow et al., 2012). DVA was associated with decreased cognitive capacity, and most evident in the cohort exposed to family violence from birth to 2 years. Similarly, a study involving 47 children (7–16 years) used multiple standardised measures to assess their cognitive functioning concluded that family violence inhibited executive functioning, and increased impulsivity and distractibility (Samuelson, Krueger, & Wilson, 2012). DVA impacts IMH over generations, and shapes developmental trajectories as does “consideration of the ways in which historically informed systemic inequities intersect to create social conditions that increase risks for negative experiences such as IPV . . . and the compounded hardship that families face” (Grady, Hinshaw-Fuselier, & Friar, 2019, p. 634).

**Practice interventions which start with the infant’s inclusion**

Interventions targeting the impacts of DVA traditionally focus on children only, mothers only, or have used conjoint models, with separate concurrent groups for children and their mothers, and with some combined time (Graham-Bermann, Miller-Graff, Howell, & Grogan-Kaylor, 2015; McWhirter, 2011). Interventions have tended to include verbal children from 4 upwards, leaving mothers responsible for attending to the resulting impacts of the trauma.
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Approaches often emphasise education, behavioural change or enhancing maternal sensitivity (Letourneau et al., 2015).

However, the need to intervene earlier is clearly indicated. Interventions with the infant in mind, particularly in relation to DVA, have been scarce. This reflects a generalised belief that infants do not remember, are not impacted or are too young to understand what is happening. Furthermore, anxiety abounds in misguided attempts to ensure that the relational, emotional and psychological safety of infants is not further exacerbated by their inclusion in therapeutic interventions, resulting in infants being excluded from service responses. Unwittingly, this failure to actively involve the infant in therapeutic work risks disappearing their experience altogether.

The infant’s experience is relevant in dyadic and familial exchanges yet is made meaningless if they are not directly invited to participate and add their perspective to research, thinking and interventions which directly concern them (Bunston & Jones, 2020). Infants occupy the space where language has less meaning than action, participation, reciprocity and engagement. Infants are more than capable of letting others know their feeling states and to be active participants in therapeutic interventions should others take care to observe, reflect and intuitively listen to them.

Interventions which are ‘infant inclusive’ (Bunston, 2017) are likely to see rapid changes. Such work includes Child-Parent Psychotherapy (Bernstein, Timmons, & Lieberman, 2019; Lieberman & Van Horn, 2009) which undertakes comprehensive dyadic work with the infant and parent. The Peek a Boo Club offers an ‘infant-led’ approach for infants from birth to 4 years and their mothers within a group work setting (Bunston, 2015). Mothers in Mind uses a trauma informed, strengths-based group work intervention which caters for vulnerable infants under 4 and their mothers (Jenney, 2020).

Such work recognises the infant’s right to participate, and as the newest, least stuck and most receptive member of a family, the infant is often quickest to engage, ready to adapt and most amenable to change. The infant’s inclusion brings immediate interactional meaning into the research and treatment space as they bring their feeling states authentically to the fore. The infant’s interactions with their caregiver brings multifarious opportunities for intervention and reflection and presents evocative and immediate opportunities for revisiting parents’ own past experiences.

Involving fathers

Controversy surrounds developing interventions for fathers who use violence and evaluation of such programmes remain limited (Labarre, Bourassa, Holden, Turcotte, & Letourneau, 2016); however, there is increasing recognition that infants and young children often remain living with or remain in contact with fathers who use violence. For better or for worse, infants and young children form attachments with their fathers which are meaningful, often complex, may be different to what others experience, deserve to be acknowledged and allowed space to be safely recognised and made sense of (Jones & Bunston, 2012). “As the product of both parents, the infant needs something good to take from both, helping them to grow their sense of identity as connected to, but also separate from, both their mother and father” (Bunston, 2017, p. 156). However, working with fathers who have used violence should by no means place the infant at risk. To the contrary, it is imperative to make blatant the safety of infants and young children as the centrepiece in any work which concerns them.

Amongst the small number of programmes available approaches vary. For example, Caring Dads works solely with the fathers through what is largely a group-based motivational
intervention to enhance men’s capacity for child sensitive parenting (McConnell, Barnard, & Taylor, 2017). Fathers for Change piloted an intervention which combined attachment, systems and cognitive approaches, and provided individual treatment, co-parenting sessions and targeted interactional change through videotaped sessions of fathers engaged in free play (Stover, 2015). The Bubs on Board pilot programme worked with fathers post a men’s behaviour change programme, working directly with the infant/young child and their father in a group setting (Bunston, 2013). For Baby’s Sake commences their work with mothers and fathers during pregnancy, remains involved for the first two years and uses a ‘whole of family’ trauma and attachment-based approach (Domoney et al., 2019). Changing Futures tailored their work to flexibly meet the needs of the family and affect wider systems change (Stanley & Humphreys, 2017).

Labarre et al. (2016) argue that “it is vital to support fathers who wish to eliminate their violent behaviour and become positively engaged in their children’s lives” (p. 3). Analysing ten intervention programmes, Labarre et al. (2016) state that fathers need to take responsibility for their children, be accountable for their violence, need support to change and, as many remain involved in their children’s lives, use their motivation for wanting a relationship with their children as leverage for change.

**Hope**

Neuro-biologically, the birthing process “allows for mutual regulation of vital endocrine, autonomic, and central nervous systems of both mother and infant by elements of their interaction with each other” (Schore, 2005, p. 207). Oxytocin, associated with building trust and bonding can be activated during pregnancy and birth (Clark et al., 2013; Kimura, Tanizawa, Kensaku, J, & Hiroto, 1992) and a sensitivity to environmental impacts is heightened (Luijk et al., 2011). This early stage of infancy is their most vulnerable, but most expectant, with services, support, engagement and openness to possibilities ripe. Newborns actively seek and invite their parents to connect with them and can bring something new to the lives of their caregivers.

Young children exposed to DV have been shown to exhibit higher than usual sensitivity and clearer cues to their mothers than the norm, suggesting that the child actively participates in compensatory interactions with their mothers (Letourneau et al., 2013). Possibilities of change and wanting better for their children is a strong motivation for a mother to leave a violent relationship: “Infants and small children can represent hope for parents. This is in the form of repairing hurts from the past and creating something new. This is about capitalising on hope” (Bunston, 2017, p. 27).

**Conclusion**

This chapter has provided an overview of infant development, IMH and the deleterious impacts of DV on the infant’s ability to find security within their attachments, and subsequent developmental trajectories. How the DVA sector responds to the challenges of bringing the infants’ experiences of trauma and abuse into the forefront of this work will have implications for generations to come.

This chapter returns to where it began: with the evolving possibilities that the infant-parent relationship holds. The restorative hopefulness and receptivity of infants to change and healing, and the motivation many parents possess to grow a safe, different and healthy relationship with, and future for, their infants has yet to be fully recognised in DVA work. Not least because the infant and very young child is entitled, deserves and craves safe, respectful inclusion in all matters which concern them.
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Critical findings

- From birth the infant possesses subjectivity, demonstrates reciprocity and engages with their relational world.
- The infant’s mental health, general development and quality of attachment is adversely impacted by DVA.
- Keeping infants safe from harm does not prevent ‘infant inclusive practice’ nor their experiences of DVA to be kept in mind.
- Infants, as the newest members of families, can provide an entry point for engaging in change and hold hope for the future.

Implications for policy, practice, and research

- The infant’s experience can, and is entitled to be included in DVA practice, policies and research which concern them.
- The vulnerability of the infant to DVA calls for a greater service response.
- Recognition of wider social, gender and cultural inequalities for infants and their families experiencing DVA requires attention.
- The experience of the infant can bring something new to DVA research and service responses.

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