PSYCHOTERAPIA 1 (212) 2025
PAGES: 45–60
DOI: 10.12740/PT/201182

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INFANT MENTAL HEALTH. A DEVELOPMENTAL AND PSYCHOANALYTIC PERSPECTIVE

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mental health
infancy
mental health factor

Summary

This article is theoretical in nature. Its aim is to review selected determinants of infant mental health from the perspectives of human development psychology and psychoanalysis. The combination of both perspectives allows for a holistic view of the developmental needs of infancy and a look at the beginning of a person's life, emphasising mental health as the basis of the "true self". Recognising the developmental potential enshrined not only in the temperamental, neurobiological, cognitive, and motor dispositions but also in the emotional and social dispositions is possible through careful and sensitive observation of the delicate matrix of early bond formation in a supportive environment. The infancy period is a time of intense child development and the honing of many skills, including imitation and relationship formation. Research and observations to date indicate that depriving a child of proper and continuous care can negatively affect their development. It limits or inhibits the ability to form bonds, as well as to take further developmental steps in the areas of speech, motor, emotional and social development.

The article attempts to identify the vital importance of an infant's mental health, biological endowment, individual way of experiencing reality, one's own subjectivity, emotional regulation, communication of one's own emotions, exploration of the environment and bonding with the caregiver. The developmental part of the article focused on the formation of the infant's psychomotor skills, attachment and communication. In the psychoanalytic part, reference is made to the factors of object relations theory that foster the installation of a good internal object and enable the infant's mind and ego to develop. The dance of intimacy and interaction between mother and infant is also described, distinguishing between the functioning of the healthy and sick infant. Particular attention was paid to the conditions that provide an opportunity to build a matrix of understanding conducive to the infant's emotional development and development in general.

Introduction

Conceptualising the issue of mental health presents many problems. It is difficult to link 'mental health' with infancy. It is most often equated with security, emotional regulation, and the discovery of the immediate environment. Zeanah and Zeanah [1, p. 6] define

mental health as 'a young child's ability to experience, regulate and express emotions, form close and secure relationships, and explore the environment and learn'. All of the component skills associated with mental health are achievable with adequate recognition of the infant's individual needs and the opportunities for these to occur in the context of a caring environment (including mother, father, family, neighbourhood and cultural demands) [2]. Research to date on infant mental health at the level of psychiatry and developmental psychology has shown that the role of the caregiver, particularly secure attachment and sensitivity, is important for the mental health of the youngest [3]. Increasingly, emphasis is being placed on the 'maternal awareness' [4] and 'reflective function' [5] of the caregiver. Sameroff [6] pointed out that infant mental health and disorders are the result of 'interactional developmental changes occurring continuously between the child and the environment' [7, p. 238].

This article attempts to identify factors influencing children's mental health in infancy. Of particular importance is the analysis of the mother-child relationship and the recognition of the resources present in the child's environment.

Infant mental health and its selected determinants

Infant mental health is a field of research activity for many disciplines, encompassing theory and practice, as well as the search for methods of preventing suffering, treating it, and enhancing young children's competence. Because of the dependence of the infant's psyche, its dependence on parents and the extent to which they enhance or impede the child's development, infancy is sometimes considered the most developmentally fragile period. Exploring the issue of infant mental health includes taking a closer look at the intimacy of contact in primary relationships. Among other methods, psychoanalytic observation is used for this purpose. Attunement and knowledge of deep emotional reactions make it possible to recognise countertransference and the course of unconscious and latent emotional processes.

Research on brain development, the impact of stress and trauma and environmental difficulties has helped to identify risk factors that contribute to mental disorders in adulthood (depression, addictions, heart disease, cancer, obesity and diabetes). The earlier in development a difficulty existed, the more vulnerable an adult was to illness and psychological problems; hence, infancy is considered a critical period in brain development, which has been confirmed by research.

The infant mental health model involves recognising strengths in the child's functioning and how these help the child cope with current difficulties. It emphasises the child's subjectivity in experiencing internal and external realities and the importance of a stable relationship with the caregiver, which builds the infant's psyche over time. Consideration must also be given to the family system, the quality of the marital relationship and the level of parental and culturally conditioned beliefs about what is healthy and what needs to be changed or cared for.

Emotional regulation, ability to communicate emotions, and active exploration of the environment have been identified as behavioural indicators of strengths [1]. In older chil-

dren, mental health in infancy is evidenced by social competencies including resilience (the ability to pick oneself up after failures and cope with stressful situations), adequate adaptive behaviour and emotional and cognitive resources. The presence of a caring caregiver who recognises needs, is available and able to support the child's development over time is the most significant factor in building mental health resources in infancy [1]. Research by the National Institute of Child Health and Human Development (NICHD) [8, 1] lists several indicators of difficulties in children that require prevention of competencies involving early childhood mental health. These are: aggression (at 2 and 9 years of age, children show high reactivity and poor regulation); PTSD symptoms (studies have shown the validity of mother-child psychotherapy and its effectiveness); autism – identifiable as early as 2 years of age; separation anxiety at 2 years of age [1].

Specificity of the infant period

The infant period is an intensive stage in children's development, associated with the formation of bonds with caregivers, the development of walking and speaking skills and the acquisition of a sense of individuality [9]. Research by Naumova and colleagues [10] has shown that this stage is particularly important for children's development due to increased brain plasticity and the building of mother-child interactions, fostering the emotional and cognitive development of the youngest in later stages of life. Psychomotor development related to the interplay between perception, activity, memory and the maturation of the child's nervous system is intense during the first year of life.

Piaget [11] demonstrated the relationship between motor and cognitive development in children. He pointed out that 'constructive structuration' [11, p. 44] is important in cognitive development, in which 'the child constructs all the cognitive substructures that will be the starting point for his later perceptual and intellectual development' [11, 3]. In Piaget's theory [12], there are four stages of cognitive development: sensorimotor, pre-operational thinking, concrete and formal operations.

The sensorimotor stage (from birth to 24 months[1]) is characterised by the child's high sensitivity to sensory stimuli and the ability to react reflexively. These are important elements of developing intelligence. During this stage, the child's basic knowledge of himself and the world around him is formed, and the first patterns of a sensory-motor nature are created, which favour interaction with the environment. Practical intelligence develops and the ability to think situationally emerges, allowing the child to better adapt to functioning in the developmental environment. Object constancy is also formed during this time [13, 14].

Six sub-stages are distinguished in the first stage. The first is reflex training (from birth to 1 month of age) – here reflexes are modified, and cause and effect are linked through spontaneous reflex reactions. Children manifest reflex reactions to specific stimulation. The second sub-stage is the primary circular reactions (from 2 to 4 months of age) – during this time, the child repeats actions that are acquired adaptations that are limited to the child's

[1] Most of Piaget's works indicate the duration of this period as the first two years of life.

own body (e.g. sucking of the hands and feet, vocalisations, kicking). The third sub-stage consists of secondary circular reactions (from 4 to 8 months of age), at which time the child begins to grasp objects and perform specific movements with them, for example tapping or shaking. Children at this stage do not fully understand why the actions taken lead to certain outcomes [13, 14]. The fourth sub-stage is the coordination of secondary schemas (from 8 to 12 months of age). The child at this stage combines schemas and, through intentionality, is able to take goal-directed actions [13, 14]. The fifth sub-stage consists of tertiary circular reactions (from 12 to 18 months of age). The child, through his or her attempts to act with objects, begins to form knowledge about them. At this stage, the child's aim is to learn all the properties of the object through trial and error. The constancy of the object is also formed [13, 14]. In the sixth sub-stage – symbolic representations (insight; from 18 to 24 months of age) – mental schemas (cognitive representations of actions and objects) are formed, which enable the child to substitute real objects and actions. Some evidence of the existence of mental images are, for example, deferred imitation (imitating a behaviour some time after its exposure), symbolic play (also known as pretend play, in which the child replaces a specific object with a substitute one), speech or insight (an internal way of solving a problem). The child's thinking begins to become increasingly symbolic and internalised.

Stage two – pre-operational thinking – lasts from 2 to 7 years of age. It is characterised by the lack of a clear boundary between the external and internal worlds. During this time, the child develops five representational skills relevant to the mental manipulation of objects, including deferred imitation, mental imagery, symbolic play, symbolic drawing and language. Preoperational thinking is characterised by egocentrism, realism, animism and anthropomorphism. The youngest begin to reproduce behaviours noticed in the environment, using their own symbolism, and slowly begin to understand social rules [13, 14].

The stage of concrete operations (from 7 to 11 years of age) is characterised by the perception of cause-and-effect relationships and a better ability to solve problems with a clear connection to physical reality. Concepts of immutability, constancy, number, volume, and weight are formed at this stage.

The last stage – formal operations (from 11 to 16 years of age) – is characterised by the capacity for higher mental operations using abstract material and the refinement of logical reasoning [13, 14].

Cognitive, emotional, motor and communicative development foster the formation of factors responsible for mental health.

By coming into the world, children are equipped with the ability to imitate. Early forms of communication between child and caregiver are gestures, movements, eye contact and babbling. According to Hobson [15], emotions form the basis of the emerging relationship between child and parent. Around 8 months of age, triadic relationships (between child, caregiver and object or event) emerge. The infancy period is described as crucial for the development and formation of a secure bond with the parent [16]. Determinants of attachment development are the emotional and physical availability of the caregiver, the caregiver's sensitivity and readiness to respond to the child's signals

Development of attachment and communication

According to attachment theory [17], emotion regulation forms the basis of the caring relationship. During the first year of life, infants need closeness, which serves a protective function and helps them cope with stress and meet their needs [18]. Attachment represents a long-lasting, deep bond formed between individuals, whose function becomes to maintain closeness [19]. According to Bowlby [20], a child's attachment to a person involves the tendency to seek closeness and contact with that person in a variety of situations, especially difficult ones. An important element is the 'behavioural system of attachment', which involves a system of behaviours (related to proximity and the biological protection of children by their parents). According to Bowlby [18], this system consists of experience-based 'internal working models' of the self and the caring environment. These form 'the core of everyone's inner world, the essence of how we are inclined to perceive ourselves and others, how we understand relationships and what we expect from them – it is the matrix from which we form the subsequent bonds in our lives' [21, p. 187]. By postulating these cognitive components and their use by the attachment system, this theory enables an explanation of the mechanism by which the child's experience of attachment influences the formation of the attachment pattern.

In Bowlby's terms, 'no concept within attachment is more central to developmental psychiatry than the concept of a secure base' [22, pp. 163-164]. The term 'secure base' has two meanings. The first is related to the child's free exploration of the environment, while the second refers to a safe haven to which the child can return in situations of experienced distress. The sense of safety is based on the infant's confidence that the parent will respond appropriately to the signals the infant is sending, 'especially if they become tired or frightened' [22, p. 132].

Attachment behaviour is sometimes described as 'seeking and maintaining closeness with another individual' [19, p. 227]. From an early age, children try to interact with their caregivers through certain behaviours, for example crying, sucking or smiling. The parent-child relationship formed during infancy is of great importance for the social and emotional development of children [23]. The essence of healthy psychological maturation is that 'the infant and young child should experience a warm, intimate and continuous relationship with the mother (or permanent surrogate mother) in which both find satisfaction and joy' [24, p. 11].

Attachment style is a significant predictor of emotion regulation, coping strategies, and adjustment to stressors. It is also an indicator of vulnerability to mental health difficulties [25]. According to Bowlby [26], the development of attachment style occurs particularly in the infancy and post-infancy periods. During these periods, three phases occur: orienting and guided signals without distinguishing between persons; orienting and guided signals to one or more selected persons; maintaining proximity to a selected person by means of signals and locomotion. The first of the phases begins at birth and lasts from 8 to 12 weeks. During this time, caregiver activity dominates. The child uses some innate resources (such as crying and screaming) to maintain contact with the caregiver. The infant turns their head towards the caregiver, vocalises and smiles. Orientation and signals are directed to one

or more selected individuals. Over time, the child begins to orient the signals sent to one specific person (this is the second phase, which lasts from 2-3 months to 6 months of age). The primary attachment figure becomes the main recipient of the baby's signals. These are not just signals prompting playful activities. Children try to match their behaviour with the actions of the caregiver. In the third phase, the child establishes friendly relationships with a wider group of people with whom he or she is in contact. The mother at this time becomes the main attachment figure.

According to Rescorla [27], some socio-cognitive skills serve as social-cognitive components of language. Already at birth, infants start communicating with caregivers through the behavioural signals they send, such as crying, cooing or body movements. The goal of infant activity is to engage caregivers in meeting their needs [28]. During the first 3 months, infants express their needs by interacting with their environment and smiling [29]. Between 6 and 9 months they use symbolic gestures [30].

Secure attachment is associated with parents responding appropriately and consistently to children's needs [17]. Young children perceive caregivers as a secure base for exploring the environment and shaping their independence. During early and middle childhood, this is an important indicator of emotional and social adjustment [31]. It establishes key determinants of mental health, enabling the realisation of developmental potential. According to Czub [32], attachment and its resulting effects are important for children's emotional and social development in the future. Notably, children with secure attachment have the ability to regulate emotions even in the absence of the caregiver, which is another mental health competence [33].

Insecure attachment develops when the parent responds inadequately to the child's needs [20]. Infants then experience inconsistent, negative or rejecting responses from the caregiver, which are accompanied by anxiety, fear and confusion. This attachment style may also lead to difficulties in maternal care [34]. It leads to the infant not seeking the caregiver when stressed by contact with the caregiver, experiencing rejection, insensitivity and inconsistency from the significant other [35]. Trauma, difficulties in infancy and attachment instability are seen to increase vulnerability to psychiatric disorders in adulthood [36]. Non-secure attachment styles include avoidant, anxious-ambivalent and disorganised styles.

The first develops when the child experiences frustration at the caregiver's failure to meet basic needs, perceiving this as rejection and lack of acceptance [19, 37]. Avoidant attachment is associated with internalisation difficulties and social withdrawal, as well as difficulties in emotion regulation [38]. The youngest children try to regulate their emotions, but their attempts to adjust are often unsuccessful [39]. Children have difficulty identifying emotions, evaluate emotionally taxing situations negatively and use maladaptive coping strategies [40].

An anxious-ambivalent attachment style translates into the creation of inconsistent, unstable patterns of care towards children. At one time the parent reacts and at another time does not respond to the signals sent by the child. On the one hand, children naturally desire closeness with their caregiver, while on the other hand, they experience fear of closeness with them [37]. Anxious-ambivalent attachment is associated with increased

vulnerability to experiencing anxiety, a tendency to worry [41]. Children with anxious-ambivalent attachment try to regulate their emotions, but their attempts prove unsuccessful [39]. In addition, they have problems identifying emotions, evaluate emotionally taxing situations negatively and use less adaptive coping strategies [40]. A disorganised attachment style is characterised by bewilderment, confusion and anxiety. The child may move towards the mother while avoiding eye contact with her (mother a source of both comfort and stress). The child experiences severe anxiety and displays unusual behaviour, for example freezes, stares or assumes strange poses. In contact situations with the mother, the child feels confused.

The consequences of non-secure attachment styles include difficulties in terms of communication with other people, contributing to mental health disorders in the long term. Research to date indicates that children who build secure attachments with their parents or caregivers exhibit fewer internalising and externalising behaviours in the future [42]. They have better-developed social competences and build qualitatively meaningful friendships. Children who form non-secure attachments show an increased propensity for physical illness and function less well in terms of social and psychological competence [43]. Infants who experience insecurity from the caregiver do not seek the caregiver in situations of perceived discomfort. To them, the parent/carer appears incoherent, insensitive and rejecting [35]. Research by Ainsworth and colleagues [19] has shown that maternal sensitivity to the child's signals is positively related to the formation of attachment confidence. According to Ainsworth, the bond developed in early childhood depends on the caregiver's sensitivity to the child's signals and the child's temperament [44].

The research methods used in developmental psychology make it possible to perceive regularities and difficulties in children's development that may contribute to abnormalities in their mental functioning, while psychoanalytic theories allow for an in-depth analysis of the factors shaping the development of the youngest, taking into account processes that indicate competences contributing to the development of mental health skills.

Psychoanalytic theories – a way of understanding the factors shaping child development and mental health

The psychoanalytic understanding of child development involves the dynamics of unconscious processes, which, in object-relations theories, is linked to the process of gradual introjection of objects into the child's life and placing them inside the child's psyche. The ability to positively internalise an object creates the infant's resources in terms of the foundation of mental health.

When an infant experiences holding [45], it has a sense of being loved. This builds an inner world, enabling the infant's fantasies to develop. Holding initiates the establishment of contact and the learning of self-regulation, providing a prototype for the ability to play. Through this, the infant acquires the ability to modify and transform the anxiety experienced, one of the key competencies that create mental health. The mother, through holding, ordinary care and concern, shapes the infant's mind. The connection between

the minds of mother and infant lays the foundation for the other to learn and experience reality on the basis of resonance and intuition. A sufficiently good mother instinctively seeks to recognise the infant's needs, name them, and then gradually learns to anticipate and respond to the infant's actions, adequately decoding the meaning of gestures and reflecting them. By creating a structure of meaning, she supports the child's development in the preverbal period. She helps the infant gradually master internal chaos, thus enabling integration. She carries out instinct towards development and self-actualisation. She builds the foundation for a stable sense of self-worth and self-confidence. She enables the infant not to give up in the development process, adding strength and a sense of agency.

Thanks to this maternal function, the child has the opportunity to experience the 'thinking breast,' what Bion [46] calls the instinct to seek truth and distinguish it from fiction. In the process of maternal reverie[2], the mother keeps her own and the child's anxiety in her mind, thus transforming primal fears into bearable ones for the child. By giving him courage, she builds the capacity to take the next developmental steps. The lack of an active, reflective presence of the mother and her abilities described above leaves the infant at the mercy of primitive mental states, blocking the realisation of developmental steps.

In a classic still-face experiment, Tronick [47] recognised infants' reactions to a mother's unexpectedly frozen expression, when she suddenly failed to re-restablish contact after a period of previous interaction. He revealed that the infant, in the absence of contact with the mother, 'experiences a sudden sobering and begins to be distrustful and alert. It makes a number of attempts to return the interaction to a normal mutual rhythm. When these attempts fail, the infant withdraws and turns its face and body in the opposite direction from its mother. Desperation, a sense of helplessness and withdrawal can be seen on the face' [48, p. 452]. The mother's frozen face sends contradictory signals of 'hello' and 'goodbye' to the child at the same time, resulting in an emotionally trapped infant, who makes attempts to recognise the caregiver's mental state and engage her again for live 'face-to-face' contact, until the child gives up the initiative and feels helpless.

Trevarthen [49], citing the still-face experiment, points out the importance of intersubjectivity in terms of the fundamental processes of primary perception, emotion experience and recognition, forming a system for regulating tension and affect between mother and child [46]. The processes described in the experiment can be seen externally in the child's depressive reactions. Internally, they relate to the breakdown of maternal states of reverie. The child, being emotionally trapped, instead of learning to think, develops skills of excessive projective identification; it tries to recognise the mother's state at all costs. He 'forgets' about himself and his needs. Defending itself from the experienced excess of mutually unworked stimuli, it cuts itself off from experience, falls into a void and activates the need for defense mechanisms from the earliest moments. In the absence of a 'psychological skin,' as a result of insufficient emotional containment, it is forced to use

[2] Reverie — maternal reverie — 'enables the reception of sensations that the infant conveys through the method of realistic projective identification, and the attribution of meaning to them; through reverie, these sensations are transformed, and the infant receives them back as something bearable that can be integrated into their personality' [42, p. 108].

other forms of protection, for example by clinging to inanimate objects, forming a 'second skin' [50]. It copes with pain not by modifying the experience of the diadic relationship, but by evacuating impulses. If they miss the emotionally receptive person, they return to the child in the form of nameless terror, leading to states of fragmentation and depression.

These states were observed in a classic experiment on monkeys, the conclusions of which were later extrapolated to humans and their innate warmth- and affection-seeking behaviour. Harlow [51] demonstrated that monkeys preferred spending time with a soft, cloth surrogate mother over a wire mother who provided food. Harlow's experiment challenged the assumptions of drive-related theories, which posited that hunger and the satisfaction of hunger were the primary motivators of behaviour and skill development. It turned out that the monkeys were motivated by curiosity about the object and the need to get warmth and emotinal closeness from it. Harlow's experiment is considered a 'study of love,' inferring that the desire to seek warmth and affection is innate. The study suggests that love stems not from hunger for a particular food, but from a need for warmth and emotional connection [51].

The presence of the mother, her warmth, resonance and active participation in the processes of instinctive communication and evacuation gradually, in a latent way, transforms sensory experience. It enables the organisation of sensations and transforms them into symbols. Specific experiences, such as hunger and other needs, can not only be felt but also thought about. Symbolisation is the result of learning from experience. By recognising what is real and experiencing lack, the child can endure frustrations and gradually recognise the distinctiveness of the object. The newly formed cognitive developmental skill – object constancy – is followed by the emotional skills of experiencing loss and gratitude. These modify defense mechanisms, as well as envy and omnipotent control over the object. The infant reaches the next step in emotional development and begins to function, moving from schizoid-paranoid to depressive position experiences [52]. Originally connected to the mother, at this stage the child can already begin to build a separate space, to go towards individuation processes. Lacking the aforementioned competence and development of the mind, the child experiences internal and external reality as incomprehensible. It stops in the development process, relying on primitive defense mechanisms related to denial and projective identification. It operates on the principle of survival and creates a 'false self.' He acquires skills, but they do not go hand in hand with the development of emotional competence and regulating himself in bonds, which consequently blocks the possibility of transforming anxiety and further stages of development of the mind and development in general. The child lacks emotional competence crucial to mental health.

Mahler [53] noted that the early stages of life involve a series of developmental phases culminating in a second birth of a psychological nature, during which the child emerges as a distinct psychological entity endowed with its own Self and a separate identity. Arriving at the process of birth in the presence of a good enough mother, the child progresses through the phases of: normal autism (up to the first month of life), when the infant concentrates on his own processes and the external world does not exist for him; symbiosis (2-5 months of age) – in which an intrapsychic state of connection and emotional involvement with the

mother begins; separation-individuation, which is divided into the following sub-phases: differentiation (6-9 months of age) – when differentiation of self from mother begins and fear of strangers appears; experimentation with the mother's body and moderate frustration, practice (10-15 months of age) – when the child protests, marks his own separateness, wants contact with the world, and at the same time fears too much distance; re-approach (16-23 months of age) – when the child experiences a conflict between autonomy and dependence, wants re-approach, and at the same time fears being absorbed; consolidation (24-30 months of age) – when the child acquires the ability to recognise the constancy of the object, has a sense of the boundaries of the Self, recognises himself as someone separate, sees the parent multidimensionally and is able to defer gratification. Children with mental health difficulties are not competent in achieving the next developmental steps. Although they are growing physically and becoming older, they do not have the opportunity to develop a sense of self [54, p. 20].

Rhythms of mutual intimacy, communication and constancy as elements of the dance between mother and infant

In a healthy relationship with the mother, a mentally healthy infant learns by the age of 5 months to 'use the mother as a "beacon," a landmark. The mother is like a constant source of light that makes the child feel safe to explore the world and then safely return to port' [54, p. 20]. The mother's presence helps the child emerge from confusion, provides a sense of temporal and spatial orientation and installs a sense of the existence of an internalised mother, that is, an inner object, a caregiver present even when separated. A healthy child is able to trust her and build confidence in herself, her own competence and embark on a developmental journey because of this. A child experiencing emotinal disturbance carries an incompetent, disrupted and attention-demanding object that he cannot trust, hence he experiences states of terror in both symbiosis and separation situations. These oscillations ruin the next steps of development. His ego is fragile; he finds it difficult to contain impulses, to self-regulate and to engage with reality. The infant lacks emotional competence that is foundational to mental health.

The infant's early life shows that the human being needs the maternal object, its warmth, its ability to cling to, absorb and feel primal states, explore 'the potential for despair and disappointment' [54]. Through the mother's readiness to accept the infant's emotions, a dance of gestures, glances, touch and communication between them is established. It flows through the minds of the baby and mother. As a result of sensory-emotional processes [55], communication through fantasy becomes possible. A matrix of unconscious understanding is formed, the meanings of what is expressed are established, as well as ways of reading real gestures and recognising authentic intentions, needs and desires. Recognition of this matrix is contained in the parent's ability to reflect and mentalise [56]. Contact with the parent in ordinary care is the first experience of intimacy. It is made possible by emotional resonance, acquiring the ability to recognise, perceive the other person and flow in contact with them. This communication is a dialogue between connection and regression,

a longing to return to the earliest experiences in the mother's womb and the simultaneous desire to gain competence, separation and freedom. Thanks to its persistence in the child's development, there is a chance for reconciliation of aspirations – constancy [55]. Many times during development, especially during normal developmental crises, constancy is undermined, allowing the child to realistically exist and understand the separateness of the Self in relation to other people. The child begins to understand what it means to be mine or yours, to have or not to have, to give, to take, to be jealous and to have power. It is possible to develop the ego's sutures – the psychological home; the connection between body and mind, the stabilising Self, self-esteem, boundaries and separateness. The shape of constancy establishes the mental health potential of the infant and its caregiver.

Opening up the mother/parent to revive and relive the infant period creates an unconscious connection with the child. It activates skills stored in the mother and enables readiness for adaptive change.

The microanalysis of mother-child interactions introduced by Beebe [3] helps identify unconscious and latent processes of emotion regulation and activation of neural plasticity initiating learning abilities, as well as the mother's capacity to accept the child, experience delight and enthusiasm, as well as trauma and unconscious or hidden traces of disruptions that have occurred in families. The mother, her containing abilities and her mind become the developmental environment for the fragile infant's ego. The mother's environment, too, can be supportive, fostering relationships and repairing past disruptions, or hindering the establishment of intimacy. A supportive environment helps the mother replace the state of oneness experienced during pregnancy with closeness outside the womb, creating rhythms of care. It allows development by transforming exclusive dual relationships into a triadic structure, stabilising the Oedipal conflict. It provides an opportunity for group experiences and relating to cultural conventions. The child, immersed in his environment, is aware of its influences only when they require repair [56]. This occurs when his mental health is threatened and when he experiences emotional crises through environmental inadequacy.

Zeedyk [57] points out that adult-infant interactions are intimate and transformative for both. They build the experience of pleasure by modifying accumulated anxiety and regulating surprise. They help establish rhythms of contact and promote mutual stabilisation of physiology and emotions. Threvarten [58, p. 119] says that 'we are born to generate states of fluctuating self-awareness and to show them to other people, provoking interest and emotional involvement,' and a lively and intense emotional response from the mother is the best foundation for building mentally healthy functioning in the future. The process of the child falling in love with the mother and the mother with the child is supported by mutual affectionate gestures, exchanges during feeding and mutual contact. According to Kaplan [54, p. 54], 'In his love affair with his mother, the child is an artist (...)' and the child's love affair with the world is an authentic act of creation. By connecting with a parent, a child has the chance to find his place in a world full of human interaction.

A child experiencing deficits in the area of contact with the primary object experiences no support in dealing with emotional excess. His inner world is flooded with destruction and stripped of all tenderness. Emotional trauma in the primary relationship refers to the

'absence of the mental mother' despite the presence of the 'physical mother.' According to De Masi [55 p. 58], 'clinical experience confirms that the early distortion of emotional communication between the minds of children and parents has traumatic consequences (...) once identification with the sick parent has occurred, the patient senses the presence of an invasive object in his inner world and at the same time has the impression that some alien and incomprehensible object has taken possession of him. It is as if he absorbs the excited or psychotic part of the parent and identifies with it, perceiving it as a part of himself, and at the same time this part introduces confusion in his relations with other people.' In such a situation, the child grows without a sense of Self, and his functioning will be at risk of mental breakdown due to a lack of internal emotional competence and mental health resources.

Summary

The analysis of mental health and its components is important for a proper understanding of children's development and future functioning. It makes it possible to link the recognised developmental level of the child with unconscious factors relating to bonding and deep self-regulatory patterns, arising both from biological dispositions and from the child's psychological endowment and environment. The aim of infant mental health interventions is to reduce or eliminate suffering and to safeguard the adverse consequences of neglect, such as school failure, peer difficulties, isolation, conflict, developmental delays or disorders, and to promote health by enhancing social competence and resilience. Such interventions emphasise changes in the infant as well as in the behaviour of the parent and the functioning of the family as a whole, in order to enable development to be paved and to put the child on a safer and more developmentally beneficial trajectory. Parent-infant psychotherapy and recognition of patterns related to intergenerational trauma are also beneficial.

The specificity of infancy makes it possible to see the changing picture of the child's symptoms and difficulties in adapting and the persistence of rigid behavioural patterns over time. The peculiarities of the child's temperament and neurobiological endowment apparent during this period indicate the potential for the child to exist in the world. The complexity of interactions in the infant's external and internal world is also shown, as well as the infant's fragility and need for support. Early and appropriate identification of the family's needs helps to stop the negative transformation of early symptoms of deprivation and trauma and the formation of permanent character and personality disturbances. It also permits greater flexibility to act while the child is young and the parent is ready to acquire new experiences.

Infant mental health is an important and continuously analysed issue. It is particularly important to recognise the determinants of infant mental health and to strive to protect it effectively. Analyses from developmental and psychoanalytic psychology have recognised the importance of the relationship between mother and child, including the importance of attachment and emotion regulation, and the role of support and resources of the environment

in which the child develops and functions. Mental health implies flexibility and warmth of contact, as well as the possibility of repairing interrupted or inadequately mirrored contact through the installation of a good internal facility, which allows for the gradual occurrence of communication that takes into account individual differences between the child and his or her environment. Appropriate stimulation and meeting the child's needs promote development and effective functioning, thereby contributing to the maintenance of mental health.

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