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PRINCIPLES & PRACTICE

A Cycles-Breaking Framework to Disrupt Intergenerational Patterns of Maltreatment and Vulnerability During the Childbearing Year

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ABSTRACT

We propose a cycles-breaking conceptual framework to guide perinatal research, interventions, and clinical innovations that can prevent or disrupt intergenerational cycles of childhood maltreatment and psychiatric vulnerability. The framework is grounded in literature, clinical observations, team science collaboration, and empirical research from numerous disciplines and is specific to the childbearing year. Adoption of the framework has the potential to speed the progress of research on the social problems of intergenerational childhood maltreatment and psychiatric vulnerability.

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The importance of maternal mental health and the early mother–infant relationship for child health, development, and welfare outcomes has long been established. More recently, unresolved maternal trauma, especially in the form of posttraumatic stress disorder (PTSD), has been designated as a risk factor for poor maternal experience of childbearing, poor postnatal mental health, and difficulties in early parenting (Seng et al., 2013; Slade, 2006). The childbearing year is a point of intersection between generations and an optimal time to provide trauma-informed care (a framework for service delivery based on knowledge of how trauma affects people's lives and their needs) and PTSD-specific interventions (M. Harris & Fallot, 2001; Sperlich, 2015; U.S. Department of Health and Human Services, 2014). Nurses and midwives are ideally positioned to provide such care and intervention, but interprofessional collaboration is the gold standard. Research on interventions to address the phenomena of intergenerational cycles of maltreatment and psychiatric vulnerability also will require participation of diverse disciplines, necessitating a team science approach that capitalizes on the cross-disciplinary expertise of its members (Stokols et al., 2008). The different professions and disciplines taking part in research teams working on this topic may view it from diverse perspectives. The "science of team science" is still emerging (Stokols et al., 2008), but an early step toward success for such teams is the adoption of a transdisciplinary conceptual framework that adequately delineates key components and propositions about the phenomenon of interest (Falk-Krzesinski et al., 2011). Crucial to the approach is to first determine the key concepts and assumptions that all members of a team can embrace (Hall et al., 2008). The purpose of this article is to explicate such a conceptual framework that our team is using that might be useful to others. Q2

Background

The consequences of childhood abuse and neglect can be persistent and long term, with devastating effects that can be manifested in physical or mental ill health or disorders in adulthood (Shonkoff et al., 2012). Early experiences of maltreatment are associated with greatly increased risk of childhood mental health problems, such as conduct disorder and other

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Pregnancy is a crucial point of intersection between generations during which cycles of childhood maltreatment and psychiatric vulnerability are transmitted.

disruptive behavioral disorders, and a range of mental disorders, drug use, suicide attempts, and risky behavior into adulthood (Norman et al., 2012; Twardosz & Lutzker, 2010). Adverse childhood experiences have been associated with morbidity and mortality beyond those effects that could be explained by behaviors alone, including lung cancer, autoimmune disorders, prescription drug use, chronic obstructive airway disease, and poorer health-related quality of life (Anda et al., 2007; Anda et al., 2008; Brown et al., 2010; Corso et al., 2008; Dube et al., 2009; Felitti et al., 1998; Hetzel & McCanne, 2005).

The burden of physical and mental health diseases caused by early maltreatment experience exerts lifelong pressure on health and social services, criminal justice and law enforcement systems, housing, and community safety (Jordan & Sketchley, 2009; Lynch & Cicchetti, 1998; Shonkoff et al., 2010; Stein, Leslie, & Nyamathi, 2002; Widom, 1989). In response to this burden, there is a growing emphasis in pediatric research on maltreatment, parental mental illness, and substance use as forms of toxic stress; this is informing research and policy agendas across the world and reflects a growing recognition of the cumulative burden and costs of maltreatment (Shonkoff et al., 2012).

The symbiotic relationship between brain development and environmental stimuli means that although inherited genetic potential predisposes children to certain characteristics and abilities, environmental influences and contexts determine the ultimate expression of these potentials (Jordan & Sketchley, 2009). This has broadly been described as the *gene by environment interaction*, which proposes that phenotypic variation is the result of the interaction of nature and nurture (Rutter, 2006). Early exposure to stress and trauma causes physical effects on neurodevelopment, which, combined with environmental risk factors, may lead to changes in an individual's long-term response to stress and vulnerability to psychiatric disorders (Glaser, 2000, 2014; Lubit et al., 2003). The attachment relationship between an infant and primary caregiver has a profound effect on child functioning and future development (Fearon et al., 2010; Siegel, 2001). Exposure to trauma, including abuse, neglect, and violence, affects every dimension of an infant's psychological functioning (Lubit et al., 2003; Perry, 2002). Caring for an infant may be challenging for any parent, especially for infants who experience incessant crying, an inability to be soothed, and feeding and sleep problems. Women with unresolved trauma, especially those with PTSD, may be triggered by such behaviors and less able to cope in ways that regulate rather than disorganize the infant (Swain et al., 2012).

Thus, although recent years have seen increased sophistication in integrating trauma theory and attachment theory, there has not yet been an organizing framework produced that can be used to guide studies by collaborators who occupy various professional roles or bring diverse expertise (Twardosz & Lutzker, 2010). The need for such a framework is suggested by noting that the authors of the 34 references just cited come from 35 different academic disciplines or clinical professions as diverse as economics, educational psychology, epidemiology, immunology, infant mental health, internal medicine, kinesiology, microbiology, nuclear medicine, nursing, psychology, psychiatry, public health, pediatrics, public policy, social work, and sociology. Although extant theories (e.g., trauma theory, attachment theory) will inform such studies, a conceptual framework to inform longitudinal measurement and analyses that is very practical could be helpful within these team science collaborations. Practitioners at the cutting edge of care delivery can draw on this framework to inform clinical innovation, and we will end the article by offering some examples of clinical utility.

Perinatal PTSD and Depression

Focus on PTSD as a common perinatal mental health concern fuels a paradigm shift (Sperlich, 2015). Until recently, most attention has been pointed toward perinatal depression. Although *stressful* life events have been linked to depression onset, depression per se has not been seen as a *trauma*-related disorder (Heim & Binder, 2012). Addressing perinatal depression is considered important because maternal depression is associated with impaired parenting and adverse developmental and mental health outcomes in the child, that is, perinatal depression contributes to the cycle of psychiatric vulnerability. Addressing PTSD is important for the same

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