Thinking about the next generation

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Thinking about the next generation: The case for a mentalization-informed approach to perinatal and intergenerational mental health

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Abstract

Background: There has been substantial progress made across multiple disciplines to emphasize the importance of perinatal mental health both for parents and offspring. This focuses on what has been termed the 'First 1000 Days' from conception to the child's second birthday. We argue that our understanding of this issue can go further to create an *intergenerational* approach to mental health. Despite the existence of theoretical frameworks and practical approaches to implementation, there are gaps in the understanding of perinatal and intergenerational mental health including which psychological mechanisms are implicated in the transmission of risk and resilience within the perinatal period; and how to leverage these into treatment approaches.

Aims and Methods: In this paper, we explore the potential for mentalization as a candidate psychological approach to intergenerational mental health.

Results: We contextualize this issue in terms of the points of contact between mentalization and broader theoretical models such as the social determinants of health and the Developmental Origins of Health and Disease (DoHaD) model. Further, we provide an overview of the existing evidence base for the relevance of mentalization to perinatal mental health.

Discussion: Finally, we sketch out an outline model for integrating mentalization into perinatal and intergenerational mental health, highlighting several areas of opportunity to develop research and practice from diverse geographies and demographics. Here, we suggest that integration of

mentalization with other conceptual frameworks such as DoHaD can mutually enrich the understanding of each model, pointing the way towards more effective early and preventative interventions.

KEYWORDS

DoHaD, intergenerational, mentalization, perinatal, psychotherapy, social determinants

Practitioner points

- Intergenerational mental health offers a theoretical framework to integrate multiple approaches including social determinants of mental health and the Developmental Origins of Disease model.
- Mentalization is a well-placed candidate psychological approach for informing intergenerational mental health.
- Integrating mentalization into perinatal and intergenerational mental health offers opportunities to develop research and practice across diverse geographies and demographics.

INTRODUCTION

There is substantial evidence that parents' mental health and well-being have a formative and long-lasting impact on developmental outcomes for infants and children. Parental mental health affects young children through its impact on parent-infant interaction and the family environment and this process begins as early as during pregnancy and is particularly important through what has been termed 'The First 1000 Days' from conception through to 2 years of age (also called the perinatal period). For individuals experiencing mental health difficulties, including but not limited to depression, anxiety and trauma, the perinatal period presents a time of profound change and challenges, but also of hope and opportunities for positive change (Howard & Khalifeh, 2020). However, these difficulties are often further nested within broader societal challenges such as discrimination, violence, migration and conflict and can be contextualized through the lens of social determinants of health (Lund et al., 2018).

In recent years there has been substantial progress across multiple disciplines to emphasize the importance of perinatal mental health both for parents and offspring. This is reflected in the positioning of mental health within the global priorities of child and maternal health (Patel et al., 2018). However, we can go further to make this into an *intergenerational* approach to mental health. There are gaps in this understanding, including (i) which psychological mechanisms are implicated in the transmission of risk and resilience within the perinatal period, (ii) which mechanisms are the best targets to leverage into focused and universal treatment approaches. Further, the emphasis on maternal mental health aspects has also obscured the importance of understanding the challenges facing fathers, LGBTQ populations and non-traditional parenting structures.

Herein, we will examine the evidence relating to mentalization as a candidate psychological approach for perinatal mental health, highlighting opportunities and challenges in the literature and also identifying where treatment approaches have been, or could be, developed. We broadly define treatments to denote any approach that could deliver benefit to parent (or caregiver) -infant dyads, from targeted interventions in the context of existing or indicated risk through to broad-based population strategies for enhancing awareness and skills for perinatal mental health and well-being. Our position throughout is that early intervention in the perinatal period, particularly through psychologically informed

approaches, such as mentalization, can be effective in reducing maternal mental health difficulties and improving child outcomes.

Mentalization (frequently operationalized as 'Reflective Functioning') denotes the capacity to understand and interpret one's own and other's mental states—be that from cognitive, affective or behavioural information and use that mental state information to guide actions or interactions. It is also related to, but not reducible to similar constructs such as empathy, metacognition, mind-mindedness and alexithymia; with mentalization constituting an umbrella theory combining self-other, affective-cognitive, state-context and automatic-controlled dimensions (Luyten, Campbell, Allison, & Fonagy, 2020).

THE INTERACTIONAL IMPORTANCE OF PERINATAL AND INTERGENERATIONAL MENTAL HEALTH

From a risk-based perspective, perinatal mental health (both antenatally and postnatally) is associated with greater adverse biological and social outcomes for both mother and baby. Common mental health difficulties such as depression and anxiety affect at least 10–15 out of every 100 women during pregnancy, with substantial variation in rates across the globe but with a consistently reported increase in prevalence across the post-pandemic world (Mateus et al., 2022). In maternal health, attention has rightly been focused on the most severe outcomes such as suicide, infanticide and self-harm in the perinatal period (Chin et al., 2022; Tanaka et al., 2017). However, there are also a plethora of developmental outcomes of concern for offspring including preterm birth, low birth weight, stunting, poor weight gain, greater risk of lifetime psychopathology with a childhood onset and intergenerational effects such as hypothalamic–pituitary–adrenal (HPA) axis dysregulation (Thomas et al., 2018). Antenatal depression is predictive of postnatal depression, and chronicity in maternal depression across more than one timepoints is associated with an elevated risk of multiple suboptimal developmental outcomes in children, such as elevated rates of externalizing and internalizing problems, lower prosocial behaviours and challenges in reaching overall developmental milestones in childhood (Morales, Girard, et al., 2023).

Further, persistent maternal depression in the first 12 months postpartum has long-range effects on behavioural, social, emotional and educational outcomes such as educational attainment at 16 years of age (Netsi et al., 2018; Psychogiou et al., 2020). Recent reviews have also highlighted associations between parental posttraumatic stress disorder (PTSD) and a reduction in parental satisfaction, as well as an increase in more negative parenting practices such as yelling or hitting (Christie et al., 2019; Creech & Misca, 2017). Further, research into the impact of parental trauma has emphasized the risk to the child due to their parent's poor mental health. Children of trauma-exposed parents may be at elevated risk for negative social, developmental and psychological outcomes in their own lives including externalizing problems, depression and multiple relationship difficulties (Enlow et al., 2014; Ensink, Bégin, et al., 2016; Mathews et al., 2013), including with parents (Scharf, 2007). This is broadly consistent with social-ecological and parenting models, which may suggest that in a family environment, post-trauma reactions are not experienced as isolated factors, but rather as interactions of multiple interconnecting and at times intergenerational risks (Bronfenbrenner, 1979; Ensink, Normandin, et al., 2016).

Similarly, evidence has accumulated that chronicity and symptom severity of parental depression (and potentially other mental health difficulties) are associated with offspring internalizing, externalizing and social competence outcomes, although even transient parental mental health problems may signal for future difficulties (Morales, Girard, et al., 2023). Importantly, the impact of these exposures on outcomes may be further located within interactions between maternal and paternal mental health difficulties such as depression (Psychogiou et al., 2020), and the interaction between these caregivers' presentations and the indirect impact on intergenerational relationships with their children be accounted for in models.

It is also likely that these associations are also relevant for offspring outcomes in the case of other common mental health difficulties such as anxiety and transdiagnostic issues such as stress (Tuovinen et al., 2021), as well as in the context of more complex mental health difficulties such as bipolar disorder

(Raouna et al., 2018), psychosis (Davidsen et al., 2015) and personality disorder (Steele et al., 2019). The literature on the long-range, potentially intergenerational impact of perinatal mental health can be contextualized within developmentally informed models. Before turning to the role of mentalization within these models, we will briefly introduce two candidate frameworks, the Social Determinants of Mental Health approach and the Developmental Origins of Health and Disease (DoHaD) model.

THE IMPORTANCE OF CONTEXT: SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are defined by the World Health Organization [WHO] as the circumstances in which people live and develop that can confer advantages or disadvantages from the antenatal period to old age (Organization, 2008). These circumstances are largely influenced by contextual and environmental forces (e.g. social policies, economic conditions, wealth distribution) that in turn, can shape individual and collective mental health status. In the specific case of perinatal mental health, social determinants can therefore be one of the mechanisms by which risk or resilience is intergenerationally transmitted. Therefore, taking into consideration social determinants gives new directions for promotion, prevention and intervention strategies for perinatal mental health, such as mentalization-based interventions, at the community and population levels (Compton & Shim, 2015; Lund et al., 2018). As we describe below, mentalization-based approaches are positioned between individual or dyadic targeted interventions and scalable universal interventions; whilst their focus on the promotion of resilience through a relational prism also speaks to the often interpersonal nature of these determinants (for a review of interventions see Izett et al., 2021).

The conceptual framework developed by Lund et al. (2018) foregrounds the importance of looking after proximal (i.e. immediately experienced by individuals) and distal (i.e. broader social or structural systems) social determinants of mental health. More precisely, they identified that proximal and distal determinants in the sociocultural (e.g. social support, cultural values), environmental (e.g. trauma, natural disasters, climate change), neighbourhood (e.g. safety, security, infrastructure), economic (e.g. deprivation, unemployment, economic inequalities) and demographic (e.g. ethnicity, gender, community diversity) domains have a direct impact on mental health outcomes. For example, women are frequently at increased risk for displaying mental health problems such as anxiety and depression (Yu, 2018), which set them at particular risk of developing mental health disorders in the perinatal period. From the social determinants framework, this vulnerability can also be interpreted as the result of exposure to social risk factors such as gender inequalities, which can interact with other adversities such as poverty, unemployment, domestic violence and sexual harassment (Patel et al., 2018). Consequently, the social determinants framework promotes the consideration of social factors that may trigger, maintain or cease the development of mental health problems in the perinatal period.

DEVELOPMENTAL ORIGINS OF DISEASE AS AN EXPLANATORY MODEL

A potential intergenerational pathway from parental risk, through the in-utero and postnatal environment to offspring outcomes can be articulated via the Developmental Origins of Disease (DoHaD) hypothesis (Barker, 1990; Seckl & Holmes, 2007). This theoretical framework has its origins in cardiovascular research, but recent efforts have been made to extend it to mental health outcomes (O'Donnell & Meaney, 2016; Van den Bergh et al., 2020). DoHaD offers a biologically informed model for understanding these mechanisms for risk and resilience, highlighting the importance of sensitive periods within early development for the epigenesis of positive and negative risk trajectories, whilst also speaking to biological mechanisms of risk such as neurodevelopmental, HPA axis and ANS correlates. DoHaD also provides a bridge to societally relevant environmental exposures such as the impact of

natural disasters (Graignic-Philippe et al., 2014), violence (Propper & Holochwost, 2013) and economic shocks (Bister et al., 2022) on developmental outcomes.

However, there are gaps in this model, particularly around the psychological mechanisms by which risk, and more importantly resilience, is transmitted within a DoHaD-informed approach. There are tantalizing glimpses that, at least for mothers, positive mental health characteristics such as positive emotions, curiosity and social support are associated with a lower risk of offspring mental and behavioural disorders, including in the context of existing maternal mental health difficulties (Lähdepuro et al., 2023). This immediately poses the question of how, and in what ways, can we bridge from developmental models such as DoHaD to lifespan developmental psychology-informed models which integrate aspects of attachment, interaction and mentalization?

SETTING THE STAGE FOR MENTALIZATION

Viewing the same question of identifying risk and resilience with a developmental psychology lens focuses us on the caregiving unit, particularly the caregiver-dyad, from which research has tended to privilege (although not always) the mother-infant relationship. Consequently, a key dyadic-psychological factor within the literature on perinatal mental health is the relationship between the caregiver and the infant, which has multiple, interchangeable components, variously termed as bonding, attachment or caregiver-infant interaction. These constructs exist both relationally but also dynamically across time, with a number of complex and nuanced bi-directional processes affecting the relationship between mother and infant, including concepts such as attunement, mutuality, reciprocity and synchrony (Golds et al., 2022; Provenzi et al., 2018).

In order to develop and maintain a healthy caregiver-infant relationship, crucial building blocks come in the form of a positive emotional connection between the caregiver and the infant in early life (Nelson III et al., 2019). Such a positive relationship is deemed to be achieved through infant and caregiver 'attachment' and 'bonding'. Whilst these terms are often used interchangeably, there are important differences between these two concepts. In this respect, 'bonding' in an attachment context is a descriptor of the close relationship between infant and caregiver, from which the attachment behaviour is the observable goal-directed action for gaining and maintaining the availability of an attachment figure when the attachment system is activated by a given situation.

Over time repetition of these attachment-activating interactions give rise to a pattern of attachment, which can be subjected to classification (Duschinsky et al., 2021; Verhage et al., 2022). Therefore, attachment forms a core aspect of how parents think about their child, both antenatally and postnatally and then direct their parenting actions accordingly. Contingent, responsive parental action in attachment-activating situations is linked to secure attachment, a flexible, responsive potentially lifespan psychological capacity to absorb and recover from stress. Whereas discontinuities or disruption of the attachment system is associated with 'insecure' adaptations or over- or under-activation of regulatory systems during attachment threats, with consequent risks for maladaptive behaviour and mental health challenges under certain stresses.

Where then do we situate mentalization in this framework for understanding perinatal mental health? The definition of mentalization has evolved over time since its conceptualization in the late 1980s by Peter Fonagy and colleagues (Duschinsky & Foster, 2021; Fonagy et al., 1991). Contemporary definitions of Mentalization and the process of mentalizing (frequently operationalized as 'Reflective Functioning') relate to an individual's awareness of how mental states occur, both within the individual and in other people, with specific reference to how these states can explain one's own and others' actions (Bateman & Fonagy, 2012). This can be derived from cognitive, affective or behavioural information, with that mental state information to guide actions or interactions. It has also been described as the balance between four dimensions: cognition and affect, self and other, inside and outside and reflective and intuitive modes (Duschinsky et al., 2019). Further, it is also related to, but not reducible to similar constructs such as empathy, metacognition, mind-mindedness and alexithymia; with mentalization

constituting an umbrella theory combining self-other, affective-cognitive, state-context and automatic-controlled dimensions (Luyten, Campbell, Allison, & Fonagy, 2020).

In contemporary models of mentalization, an infant's capacity to mentalize emerges from the cumulative build-up of interactions between caregiver and infant/child, but also family, peers and other social actors in an infant's life. These interactions, where the infant learns about their own mental states via sensitive and accurate mirroring by their caregivers, in turn, lead to the development of flexible and positive cognitive, interpersonal and regulatory capacities in the child, alongside the sense that the child is acknowledged and valued by the caregiver (Luyten, Campbell, Allison, & Fonagy, 2020). Disruptions to the continuity, and consistency of mentalization-related interactions between parent and infant, either due to stress, illness or lack of availability potentially may make the child more vulnerable to threats to their own psychological resilience. This in turn increases the risk of maladaptive coping strategies and ultimately potentially psychopathology, as in the absence of optimal mentalizing, and less optimal social supports the infant is more likely to use hyperactivating or deactivating attachment strategies to manage stress. This in turn precipitates dysregulated coping, which further over time may emerge as childhood internalizing, externalizing or harmful behaviours.

A further link between mentalization, attachment and perinatal mental health is the degree to which caregivers are able to mentalize about caregiving with their infant, or parental reflective functioning (PRF; Luyten et al., 2017). This is the reciprocal of the child's experience of mentalization-informed caregiving. Crucially, caregivers or parents with high levels of PRF offer sensitive, contingent caregiving which can be recognized by the infant or child as a mirror onto their own experience, enabling the ontogenetic development of the infant's own representation of their cognitive-affective experience. In this sense, a model of intergenerational risk and resilience would locate mentalization as a key mechanism for the child's psychological development. Indeed, the initial empirical evidence from the Anna Freud group for the mentalization construct used assessment of parental attachment representations and reflective function in pregnancy to predict childhood attachment (Fonagy et al., 1991), and although there have been numerous refinements to the model the core connections between early years, attachment and mentalization remain (Duschinsky & Foster, 2021).

Further, echoing the long-lasting links between perinatal mental health and offspring functioning, antenatal mentalization was also predictive of the reflective function of 16-year-old offspring (Steele et al., 2016). Recent review evidence also suggests modest associations between PRF and parenting quality (Stuhrmann et al., 2022); and in the context of maternal childhood sexual abuse (CSA), the capacity to reflect upon the experience of trauma or develop a secure attachment narrative in parenting was associated with greater positive parenting (Huth-Bocks et al., 2014) and lower risk of CSA in the offspring (Borelli et al., 2019). This accumulating evidence highlights the multi-factorial reach of a mentalization-informed approach.

MENTALIZATION, MODERATING FACTORS AND PERINATAL MENTAL HEALTH

Returning to the question of definitions, one of the ongoing conundrums of attachment research has been the transmission gap, by which parental attachment does not have a one-to-one match to child attachment. Work using individual participant meta-analyses suggests that there are substantial ecological constraints to attachment transmission, with transmission of the optimal 'secure' attachment representations from parent to child being weaker under conditions of environmental constraints such as parental (e.g. childhood abuse, parental psychopathology, adolescent parent status) and child risks (e.g. preterm birth), which could be further inferred to inhibit the parent's ability to access their own optimal attachment representations in the context of parenting interactions (Verhage et al., 2018).

Importantly, education did not moderate transmission, suggesting that intergenerational transmission cannot be reduced to broad-brush demographic predictors. A second meta-analysis on the role parental mentalizing plays in attachment security reported moderate effect size associations between

parental mentalization and offspring attachment security, but that sensitivity and mentalization together still only explained 12% of the variance in attachment security (Zeegers et al., 2017).

Taken together, these two meta-analyses have important implications for the role of mentalization in perinatal mental health. First, both underline the importance of understanding intergenerational determinants of mental health through the perinatal period. This spans from the antenatal representations of those about to become parents for the first, or subsequent time, to the early months of developing sensitive interactions between caregiver and newborn, through to the emergence of attachment behaviour in the infant.

Second, these findings perhaps unsurprisingly, also highlight the complexity of the system. It is relatively uncontroversial that parental sensitive caregiving, alongside the ability to integrate both self- and other related information, (whilst also drawing upon one's own representations of being parented and parenting) will confer optimal conditions for adaptive child development. However, the amount of unexplained variance suggests that there remain underexplored factors both between individuals and at the societal level, that could further help understand how transmission occurs. Indeed, returning to the intersection with models such as DoHaD and social determinants, it may be that environmental factors (such as early adversity, poverty and trauma) either directly or indirectly impact the individual's capacity to engage in mentalizing.

Third, as we argue later in the paper, the limits of attachment transmission create a niche for interventions (such as mentalization-based approaches that can support families, particularly those in adversity). This also presents a dilemma to policy makers and intervention developers as to whether approaches are targeted to directly support mentalizing in caregivers and children; or whether there is a need to create environmental conditions under which mentalizing can emerge naturally, as has already been implemented with adolescent samples (Twemlow et al., 2011).

Finally, and most importantly from a preventative and early intervention frame, there is consensus that risk factors, including parental mental health, but also potentially multiple adversity are disruptive to the prospects for optimal parenting. Therefore, there is a clear argument for the relevance of exploring how we can integrate mentalization into early intervention. This could be either directly, through mentalization-informed perinatal mental health programmes, but also indirectly, through initiatives that foster secure attachment. Indirect working could proceed in the knowledge that these will also support caregiver-infant dyads to develop mentalization capacity and interactions that promote the emergence of reflective function.

IMPLICATIONS FOR INTERVENTION AND SERVICES: INTERVENTIONS (ANTE AND POSTNATAL), PUBLIC HEALTH APPROACH

From a psychological intervention perspective, although the translation of mentalization-informed theory into treatment initially targeted personality disorder (Bateman & Fonagy, 2008), the developmental roots of mentalization ensure that an argument for its relevance to perinatal mental health can easily be made. Several resource-intensive parenting programmes have been developed that use mentalization-informed treatment, targeted at families at substantial risk of adverse developmental outcomes, such as 'Minding the Baby' for first-time mothers from urban communities experiencing multiple adversities (Sadler et al., 2013; Slade et al., 2020), and'Mothering from the Inside Out' for mothers receiving treatment for substance misuse (Suchman et al., 2010, 2017).

In both cases, RCT evidence (Slade et al., 2020; Suchman et al., 2017) suggested that intervention was associated with improvements in developmentally relevant outcomes such as maternal reflective function, sensitive parenting and infant attachment security. Delivery characteristics varied substantially between interventions, with Minding the Baby delivered from pregnancy through to the infant's second birthday, whereas Mothering from the Inside Out was delivered over a 12-week

period to mothers of children aged 11–60 months (therefore situated at the far end of the perinatal mental health distribution).

There are also short-term, mentalization-based parenting programmes for foster and adoptive families such as 'Family Minds' (Adkins et al., 2022) and the 'Reflective Fostering Programme' (Midgley et al., 2019). In both cases these approaches show improvements in carer stress levels, with evidence for improvements in parental mentalization (Adkins et al., 2022) and children's overall strengths and difficulties, and emotion lability (Midgley et al., 2019).

Therefore, although effective, the generalizability and scalability of these interventions remain a topic for debate. An alternative approach has been to deliver attachment-informed interventions, with an inbuilt focus on developing mentalization capacity. Examples of these have included Psychoanalytic Parent–Infant Psychotherapy for parents with mental health problems, experiencing high levels of social adversity and caring for a young infant (Fonagy et al., 2016), 'New Beginnings' for mothers and babies in prison (Sleed et al., 2013) and The Mothers and Toddlers programme for mothers being treated for substance misuse (Suchman et al., 2010).

Meta-analytic evidence from 6 studies, 4 of which relate to 'Minding the Baby' and 'Mothering from the Inside Out' (Barlow et al., 2021) suggests that although these types of programmes may reduce rates of attachment disorganization in infants, results do not suggest any benefit over comparison interventions with regard to secure attachment classification, quality of mother-infant interaction, maternal depression or maternal distress, although improvements in maternal reflective function trend towards significance. However, it should be noted that even pooling across studies overall sample sizes are small (depression, the largest comparison in the review was based on $n = 450$), and the heterogeneity of samples and underlying interventions urge caution in the interpretation of these results.

Alternative approaches to scaling up mentalization for perinatal and intergenerational mental health could also be investigated. For instance, there is now a substantial body of studies that span attachment, parental relationship, child well-being and maternal mental health using a broadly preventative focus (reviewed in Izett et al., 2021). These types of intervention either targeted or universal, deliver blended programmes in most cases including psychoeducation, modelling skills for practical parenting, but also multiple relational foci including parenting relationships, developing secure attachments and improving PRF.

However, although mentalizing can play a role in both more focused, selective early intervention programmes and more generally through scalable universal prevention initiatives, in both types of approach there are significant, specific, expectations of and demands upon the staff providing the interventions. Indeed, the more intensive, targeted interventions such as Minding the Baby and Mothering from the Inside Out have their origins in the classic MBT interventions that were designed for adults with complex mental health difficulties such as Borderline Personality Disorder (Bateman & Fonagy, 2013), sharing a focus on highly impaired mentalizing in hard-to-reach populations. Such groups are commonly present with significant social adversities outlined earlier in our paper. Therefore, to deliver the intervention there is an implicit requirement for in-depth training and ongoing continuous supervision.

However, from the perspective of universal delivery, both the mentalization and mental health aspects of these types of programmes can be subsumed within a broader public health approach and may also be delivered from within other therapeutic modalities (e.g. cognitive behavioural therapy). Therefore, the next step for the field is to better understand what works for whom from the perspective of transdiagnostic and cross-modality approaches to interventions. From an indirect perspective, there are also arguments for developing mentalization-informed staff training, as demonstrated by health visitors (Peacock-Chambers et al., 2023). This could have the advantage of enabling the delivery of techniques at scale, albeit with challenges around staff retention and fidelity to approach.

AN INTEGRATIVE MODEL FOR MENTALIZATION IN PERINATAL MENTAL HEALTH

Perinatal and intergenerational mental health offers a potential bridge between biologically informed (e.g. DoHaD) and psychologically informed developmental models. In doing so there are innovative opportunities to develop research that grounds mentalization within a contemporary developmental context through DoHaD, but also could enrich DoHaD research through the identification of a rich seam to investigate candidate psychological mechanisms implicated in First 1000 days mental health.

The parallels speak for themselves. First, from its inception, the mentalization school has eloquently argued that mentalization is evolutionarily grounded and underpinned by neuroscientific findings. There is substantial evidence that both attachment and mentalization can be rooted within a neurobiological tradition (Feldman, 2017), although in the case of attachment, the role of genetics seems to be as an interaction with attachment, rather than there being genetic markers for attachment per se (Golds et al., 2020). In this respect, the possibilities for research at a molecular and epigenetic level that DoHaD approaches to physical health have used could form fertile ground for collaboration. By their very nature, these require the focus of enquiry to be in the perinatal phase.

Our second point relates to the shift in focus in more recent writing on mentalization to a broader societal focus on epistemic trust, vis-a-vis the capacity of the child to recognize conveyors of social information as authoritative and trustworthy (Corriveau et al., 2009; Fonagy et al., 2017), as modelled by attachment figures. This broadens the scope of mentalization to take into account societal determinants of mental health. For instance, the mentalization-informed approach to borderline and anti-social personality disorders in adults already formulates the emergence of these disorders as responses to a social environment marked by abuse, violence and trauma, requiring fast, affectively-informed approaches to assessing trust, at the cost of a felt sense of safeness (Luyten, Campbell, & Fonagy, 2020). In the remaining sections of the paper, we highlight first where mentalization could help inform existing models of perinatal, infant and intergenerational mental health, and then offer thoughts on two aspects where mentalization theory may itself need development in order to more meaningfully contribute to our understanding intergenerational mental health.

Enriching social and biological developmental models

As the social determinants of mental health highlight that environments where adversity is high (such as exposure to trauma, population displacement and conflict) put vulnerable groups, which from a global perspective includes women and children, at substantial risk of mental health harm. The DoHaD literature has frequently focused on the impact of natural disasters and famine as underlying factors relating to mental health risk, but there is a broader parallel here with the societal disruption that these types of events cause such as population displacement, relational trauma such as abuse and mental health sequelae such as depression (Abubakar et al., 2018; Beaglehole et al., 2018), which creates a nexus of connections between DoHaD, social determinants and a developmentally informed theory such as mentalization.

Here, mentalization offers a framework to understand how social disruption wrought by trauma and displacement are experienced relationally, both by caregivers and children, but the biological substrates linked to mentalization also enable points of contact with DoHaD (Luyten & Fonagy, 2015). Focussing on the perinatal period gives a window of opportunity for framing risk and resilience, again informed by the concept of developmentally sensitive periods, but enriching this by introducing the relevance of the caregiver dyad. Therefore, there is a blending of the understanding that there are critical periods for emotional development (DoHaD informed) and that the caregiver dyad is the intergenerational vehicle for preventative or early intervention, which could be achieved through the promotion of mentalization.

Further, there are links to be drawn here between the success of mentalization-informed whole systems approaches, as have been modelled in Minding the Baby (Sadler et al., 2013; Slade et al., 2020), but

also in school-based prevention programmes (Byrne et al., 2020). A space exists here to establish scalable mentalization-informed public health interventions, focused on prevention and delivered within the perinatal period, even antenatally.

Incorporating the influence of social determinants of mental health in the perinatal field has several theoretical, research and practical implications. From the perspective of theory, social determinants can help to understand better the aetiology of mental disorders, particularly those emerging in the perinatal period. Additionally, it can help to clarify the potential mechanisms by which risk or resilience is intergenerationally transmitted (e.g. exposure of the mother and the baby to socioeconomic disadvantage). This relates to potential research implications. Social determinants largely depend on each country's specific contexts (e.g. cultural values), and therefore, it is important to study them in diverse populations or cultures to gain better clarity of their impact in different contexts, particularly in settings with more associated risk factors (i.e. low-middle income countries), or populations that have been understudied.

This directly highlights the need to increase research, particularly longitudinal designs exploring social determinants. For example, evidence from a longitudinal birth cohort study identified that caregiver mental health and parent-infant attachment in the perinatal period were protective factors against children's comorbid externalizing and peer problems from four to 10 years old, even after accounting for the role of social deprivation (Morales, MacBeth, et al., 2023). Thus, longitudinal studies can further asset the importance and permanent effect of perinatal mental health across childhood, including risk and resilience factors. Finally, social determinants have practical implications. From this social perspective, perinatal mental health is considered a public health concern, which is important to everyone in every country. Therefore, an increase in the promotion and prevention of mental health well-being during the perinatal period should be promoted instead of having a reactive strategy after a mental disorder presentation (Unicef, 2022). Consequently, mentalization promotion and prevention strategies could be scaled up worldwide through different solutions, such as digital technology.

Researching intergenerational mental health at a global level

Perinatal and intergenerational mental health is a global issue, but we also ignore context-dependent factors at our peril. Symptoms may manifest in diverse ways and are dependent on socio-cultural factors such as local rules, norms and conventions (Wyatt et al., 2017). What we know and understand about effective and widely used interventions are derived from predominantly white, HIC populations (Røren et al., 2019). This applies equally to our understanding of psychological mechanisms.

However, more Westernized approaches may be less effective or appropriate in different cultural settings, especially when there is a lack of incorporation of socio-cultural factors; such as the dismissal of positive effects of natural or indigenous healing (Ruane, 2010). Access to such interventions may not be readily available or accessible to parents and families in different cultural contexts. For example, in a Black South African population, treatment-seeking behaviours have been found to be hindered by a multitude of factors such as the need to resolve mental health concerns within the family, a lack of trust for psychological services and limited mental health literacy.

Mentalization is not immune from this challenge either. Although the concept of mentalization appears to be relatively universal across at least 45 cultures (Aival-Naveh et al., 2019), there are nuanced, contextual differences. These include the extent to which self, as opposed to other orientated mentalizing, is valued in individualistic and collectivist cultures; and differences in language, values, identities and parenting practices impact on the expression and measurement of mentalization (Aival-Naveh et al., 2019). Accordingly, we return to the importance of the interplay between developmental constructs and social determinants, but further building in cross-cultural aspects. If we acknowledge that there is still much to do to better understand intergenerational aspects of mentalization, then there is just as much need to understand the cultural component of this work.

Further, the stigma of mental illness is a significant barrier to mental health services, with people noting feelings of embarrassment and shame when attempting to access support. Lastly, the cost was

noted as a significant barrier to seeking mental health treatment (Ruane, 2010). Swartz (1998) argues for a more transcultural approach to mental health interventions whereby country-wide problems require country-specific solutions; with a move away from Westernized models and more towards more inclusive approaches that consider a multitude of social, environmental, cultural and contextual factors.

Expanding work with different parenting structures (fathers, LGBTQI+, marginalized groups)

In comparison to the maternal mental health literature, the role of the father's mental health and well-being in intergenerational mental health are still poorly understood and under-researched (Kotelchuck, 2022; Paulson & Bazemore, 2010). This warrants attention given factors such as marital dissatisfaction, financial strain, history of mental illness and partner depression, have all been shown to contribute to poor mental health in fathers post child-birth (Giallo et al., 2013). Although fathers and non-birth partners may not be directly susceptible to childbirth-related biochemical changes, they are equally subjected to psychosocial stressors that accompany the arrival of a new baby and may therefore experience distress uniquely tied to their new role which can contribute to the development of clinically diagnosable symptomatology (ca. 1%–25%; depending on the methodology used; Cameron et al., 2016; Da Costa et al., 2017). As with maternal mental health, there are long-term implications of paternal mental health. For example, untreated perinatal paternal depression, independent of maternal postnatal depression, may be associated with young children's behavioural and developmental difficulties, school-aged children's poor academic performance and adolescents' increased risk of psychiatric disorders (Gentile & Fusco, 2017). These findings emphasize that engaging fathers and promoting father involvement at the earliest contact with perinatal services is both a pathway to bolster access to support for mothers, and their children, but also impactful in its own right. Further work is needed to unpack the role of mentalization in this context. Optimizing the opportunities that lie in working with fathers with the aim of improving fathers' attachment with their newborn child, enhancing parents' support for each other, as well as addressing concerns with paternal mental health (Fletcher et al., 2017). We are also acutely aware that there is also a need to expand this work into other different parenting structures such as LGBTQ+ families and other marginalized groups. For instance, there is emergent work on the protective function of attachment and mentalization in gender-diverse young people and adults (Caldarera et al., 2022), but limited work on the experience of LGBTQ+ parenting.

CONCLUSION

We are at a junction point in the evolution of developmentally informed approaches to perinatal and intergenerational mental health. The evidence for the importance of perinatal mental health is robust. Arguments for the impact (often long-term) on multiple child developmental outcomes have been clearly evidenced. Developmental frameworks exist such as the social determinants approach or DoHaD that can benefit from the integration of psychological mechanisms.

Our contention is that mentalization offers a unique set of advantages here—it integrates cognitive, affective and interpersonal factors and has a clear intergenerational emphasis. It has an empirical evidence base for its psychological effects, but also for treatment protocols. Further, it has the potential for scalability, a focus on prevention or well-being development and it can cross diagnostic and demographic boundaries. Finally, focussing on the 'First 1000 days' creates a temporal framing device for both calibrating research and developing implementation. The opportunity to both mentalize and realize better intergenerational outcomes is in our grasp if we choose to reach for it.

AUTHOR CONTRIBUTIONS

Angus MacBeth was responsible for the initial conceptualization of the paper. All authors contributed to the initial draft and subsequent revisions.

CONFLICT OF INTEREST STATEMENT

No conflicts of interest to report.

DATA AVAILABILITY STATEMENT

None.

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