Infant Behavior & Development 44 (2016) 148–158

Contents lists available at ScienceDirect

Infant Behavior and Development

Full length article

Postpartum depression and infant-mother attachment security at one year: The impact of co-morbid maternal personality disorders

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ARTICLE INFO

Article history:
Received 14 December 2015
Received in revised form 22 May 2016
Accepted 3 June 2016

Keywords:
Postpartum depression
Co-morbidity
Personality disorder
Infant-mother attachment

ABSTRACT

Previous studies on effects of postpartum depression (PPD) on infant-mother attachment have been divergent. This may be due to not taking into account the effects of stable difficulties not specific for depression, such as maternal personality disorder (PD).

Mothers ($N = 80$) were recruited for a longitudinal study either during pregnancy (comparison group) or eight weeks postpartum (clinical group). Infants of mothers with depressive symptoms only or in combination with a PD diagnosis were compared with infants of mothers with no psychopathology. Depression and PD were assessed using self-report and clinical interviews. Infant-mother attachment was assessed when infants were 13 months using Strange Situation Procedure (SSP). Attachment (in)security was calculated as a continuous score based on the four interactive behavioral scales of the SSP, and the conventional scale for attachment disorganization was used.

PPD was associated with attachment insecurity only if the mother also had a PD diagnosis. Infants of PPD mothers without co-morbid PD did not differ from infants of mothers with no psychopathology. These results suggest that co-existing PD may be crucial in understanding how PPD impacts on parenting and infant social-emotional development. Stable underlying factors may magnify or buffer effects of PPD on parenting and child outcomes.

1. Introduction

Infant-mother attachment as measured by the Strange Situation Procedure (SSP: Ainsworth, Blehar, Waters, & Wall, 1978; Main & Solomon, 1990), is one of the most well-established, reliable and valid measures (in the 2nd year of life) of how well or poorly toddlers are functioning in their primary attachment relationship (to mother) with long-term consequences for childrenís social and emotional adaptation throughout childhood and adolescence (for a review, see Thompson, 2008). The quality of the early attachment relationship has been found to be related to later externalizing, internalizing, and peer-related problems in diverse studies. In particular, attachment disorganization has been documented to be a major risk factor for the development of socio-emotional problems as well as for developing symptoms of psychiatric illness later in childhood

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http://dx.doi.org/10.1016/j.infbeh.2016.06.002
0163-6383/

(for three recent meta-analyses, see Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley, & Roisman, 2010; Groh et al., 2014; Groh, Roisman, van IJzendoorn, Bakermans-Kranenburg, & Fearon, 2012).

Maternal postpartum depression (PPD) has traditionally been considered as one of the most important risk factors for infant-mother attachment insecurity and disorganization within the field of perinatal and infant mental health (see for example, Goodman & Brand, 2009). However, recently, a discussion has begun to emerge regarding the effects of maternal postpartum depression (PPD) on infant-mother attachment and subsequent social-emotional problems in children: Whereas some previous studies have found long-term effects of PPD on infant-mother attachment insecurity independently of whether the mother still presented with depressive symptoms when infant-mother attachment quality was measured (Murray et al., 1996; Righetti-Veltema, Bousquet, & Manzano, 2003), such effects have not consistently been found. For example, two prominent large-scale studies (comprising in total 1704 mother-infant dyads) failed to find associations between PPD and attachment quality at one year (Tharner et al., 2012a) and at 36 months (Campbell et al., 2004). In the latter study, only children of mothers with late, intermittent, or chronic depressive symptoms who were also low in sensitivity had a heightened risk of insecure attachment.

Such inconsistencies between studies raise the question whether PPD *per se* puts at risk the developing mother-infant attachment relationship or whether it is rather a combination of risk-factors that often co-exist with PPD that explain the associations found in some studies. Indeed, the most consistent associations between depression and infant-mother attachment have been found in populations where the depressive symptoms occurred in combination with other severe psycho-social risk factors such as poverty (Lyons-Ruth, Lyubchik, Wolfe, & Bronfman, 2002, for a review, see Belsky & Fearon, 2008). However, in such samples it is difficult to disentangle the effects of depressive symptoms from other environmental risk factors (Goodman & Gotlib, 1999). Furthermore, it has been suggested that mothers with PPD are a very heterogeneous group with a substantial number of PPD-mothers presenting co-existent persistent psychological difficulties such as personality disorder or insecure attachment representations (Akman, Uguz, & Kaya, 2007; Apter, Devouche, Gratier, Valente, & Le Nestour, 2012; McMahon, Barnett, Kowalenko, & Tennant, 2006; Smith-Nielsen et al., 2015). For these mothers, it might be much more difficult to establish a secure attachment relationship with their child than for PPD-mothers who do not have such co-occurring difficulties.

Support for the idea that PPD mothers may be a far more heterogeneous population than has traditionally been assumed also comes from Lovejoy, Graczyk, O'Hare, & Neuman (2000)'s meta-analytic review on the effects of maternal depression on parenting. They suggest that the critical, intrusive, and coercive behaviors displayed by some depressed mothers may not be specific to depression, but are instead a consequence of other psychiatric conditions, such as chronic interpersonal problems or high levels of stress or anxiety, even in the absence of depressive symptoms. Along the same lines, it has recently been argued that maternal depression is too frequently considered as a unitary construct, ignoring the likely diversity among mothers with depression, in terms of their psychological disturbances (Goodman, 2014).

One important source of such diversity might be the presence of comorbid personality disorders (PD) that often, but not always, co-occur with depression in adults (Vilaplana, McKenney, Riesco, Autonell, & Cervilla, 2010; Viinamaki et al., 2006). For example, Gunderson et al. (2008) showed that having a comorbid PD confers very high risk for major depression, stressing the fact that depression is not a diagnosis that jusitfiably pushes the question of PD away. The importance of examining effects of PD on child outcomes was also underlined in a study showing that children of mothers suffering from Borderline PD exibihited significantly more emotional and behavioral problems than children of mothers with depression only, children of mothers with no psychiatric condition, or children of mothers with cluster C PDs (Barnow, Spitzer, Grabe, Kessler, & Freyberger, 2006). This means that when addressing the question of personality disorder in the context of PPD, we are both focusing on prevention of adverse child outcomes and on selecting groups for whom intervention might be more necessary than others.

DSM-IV and DSM-5 delineate 10 different PDs (American Psychiatric Association, 2000; American Psychiatric Association, 2013) grouped into three Clusters that are based on similarities among the specific PD diagnoses. Cluster A, includes paranoid, schizoid, and schizotypal PD, and individuals who qualify for a Cluster A diagnosis often appear odd, eccentric, or very socially withdrawn. Cluster B includes antisocial, borderline, histrionic, and narcissistic PD, and individuals who have a Cluster B disorder often appear dramatic, emotional, or erratic. Cluster C includes avoidant, dependent, and obsessive PD. Individuals with a Cluster C diagnosis often appear anxious, fearful or 'neurotic'. Moreover, DSM-IV/5 allows the diagnosis of "other personality disorder", which includes PDs that are not among the officially recognized diagnostic categories, e.g. depressive PD and passive-aggressive PD, as well as personality disorder not otherwise specified (PDNOS). PDNOS is among the most prevalent PD diagnoses in patient samples, with a relative prevalence in the range of 21–49%, dependent of the criteria used for diagnosing PDNOS and/or method of assessment (Verheul & Widiger, 2004; Verheul, Bartak, & Widiger, 2007).

Although individuals with PD thus appear differently across the three Clusters and specific PDs, essential commonalities also exist. Regardless of the specific diagnosis, PD (in definition) is characterized by having persistent and pervasive distorted perceptions of self and others, perspective-taking deficits, and importantly, a core feature of any PD is having persistent and pervasive interpersonal difficulties, particularly in close relationships (American Psychiatric Association, 2000; American Psychiatric Association, 2013). For example, while those with dependent PD are compliant and over-reliant in their relationships (Bornstein, 1992) individuals with schizoid PD lack interest in others (Sperry & Mosak, 1996). Moreover, those with borderline PD typically have relationships that are highly unstable and intense (Millon & Davis, 1996) whereas those with narcissistic PD typically are exploitative and do not regard for other people (Lyddon & Sherry, 2001; Sperry & Mosak, 1996). Support for the notion that commonalities with respect to relationship difficulties exist across the three PD clusters