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ATTACHMENT AND MATERNAL DEPRESSION

Introduction: Parental Psychiatric Disorder and Childhood Disturbance

There is now extensive evidence that the children of psychiatrically disturbed parents are themselves at high risk of developing emotional or behavioral disturbance. In one major study it was shown that almost three times as many children attending a child psychiatric department had parents with a history of psychiatric disorder than a matched group of pediatric and dental patients (Rutter, 1966). Disturbance in the mother was shown to be more significant for the child's emotional state than disturbance in the father, and affective disturbance was a common diagnosis in the parents of psychiatrically disturbed children. Psychiatric disturbance was particularly likely in the parents of the youngest group of children referred to the department. Involvement in the parent's symptomatology was also shown to be particularly pathogenic, which led the author to conclude that the children of depressed parents were at particularly high risk since the symptoms so often included hostility to the child and sometimes overt violence. When followed up after treatment it was also clear that a significant proportion of the children of psychiatrically ill parents made less satisfactory progress than other children.

Rutter considers the possibility of a genetic basis to the association but rejects it on the grounds that there is no connection between the

type of parental disorder and childhood disorder. An environmental effect is more likely. A more extended discussion of the genetic question (Shields, 1976) concludes that there is considerable evidence of polygenic influences in the case of persistent criminality and psychopathy and in certain other disorders that come to psychiatric attention, such as dyslexia and enuresis. However, the inheritance of neurotic disturbance has been much less closely studied. The likelihood is that polygenic influences account for some part of the natural variance in temperament, and that what is inherited in neurosis is not the disorder as such but attributes such as poor adaptability or emotionality that are known to be associated with psychiatric disorder (Graham, Rutter, and George, 1973).

These findings have been confirmed and elaborated in more recent studies. The children of newly referred adult psychiatric patients have twice the rate of disorder of classroom controls, so that the association between child and parental disturbance holds in whatever direction it is studied (Rutter, Quinton, and Yule, in press). A similar study (Cooper et al., 1977) produced like results; the authors emphasize that it is not psychiatric disorder as such but the family turmoil it often produces that predisposes to disturbance in the child. They also point to the possibility that although some children in disturbed families may not show signs of overt disorder, they may grow up to repeat their parents' pattern of maladjustment, while the anxious children who show their distress may do better in later life: "The normal children who adjust well to the stress of parental illness may be more damaged through the defence mechanism of internalisation than others who react more vigorously and are judged to have psychiatric disorder in studies such as ours." In another study (Tonge, James, and Hillam, 1975, p. 521) a group of problem families was compared with control families living in the same housing estate. Not only was a high rate of psychiatric disorder found in the parents, particularly of neurosis in the mothers and personality disorder in the fathers, but a strong association between such disorder and disturbance in children was confirmed. In this and other studies marital conflict also emerges as a major variable associated with psychiatric disturbance in children. There is obviously a correlation between these two variables, but it is not clear from the reported data how much overlap there is between them.

Further evidence as to the importance of depression comes from the work of Brown and his colleagues, who have shown a high prevalence of depression in women with young children at home, especially if

they are working class and have little support from their husbands (Brown, Harris, and Copeland, 1977; Brown and Harris, 1978; and chapter 12 herein). The highest figure for depression was found in working-class women with a child under six (Brown, Bhrolchain, and Harris, 1975). Richman (1977) found a similarly high prevalence of depression in her community sample of mothers of preschool children (30 percent of the total sample) and confirmed the association with disturbance in the child. The reasons for the very high level of depression in this group are not yet clear. A small proportion may be ascribed to the persistence of postpartum depression (Pitt, 1968), but a large proportion seems to arise as a consequence of the isolation and demandingness of the maternal role, for which most women have had no realistic preparation or training (Ginsberg and Bolton, 1976). Economic problems and especially housing seem to be of major importance (Richman, 1974, 1976). However, it is not only the physical but also the psychological environment in which mothers carry out their task that affects their emotional well-being and especially the "esteem (or lack of it) ascribed to their child rearing activities" (Richman, Stevenson, and Graham, 1975 p. 285). In an increasingly mercantile society, unpaid work, no matter how skilled or necessary, can seem valueless. The loss of self-esteem involved in feeling undervalued may play an important part in the development of depression in such a large proportion of young mothers in the general population.

Maternal Depression and Child Psychiatric Disorder

There is thus considerable evidence that maternal depression is a serious hazard to a child's development during the early years. It is both alarmingly common among mothers of small children and also strongly associated with disturbance in the child. As yet there is little evidence as to the specific effects, although Cohler and associates (1977) showed deficits in cognitive development and in attention span in the children of psychotically depressed mothers compared not only with normal controls but also with the children of schizophrenic mothers. In their study of forty depressed women, Weissman and Paykel (1974) found that they were considerably impaired in their maternal role and most reported a high degree of friction between them and their children. In fact the children were more likely to be the recipients of the

hostility and irritability that is so common in depression than were the husbands or other relatives or associates. The depressed women with preschool children were particularly impaired in their maternal function, and thirteen of the sixteen children of this group showed signs of disturbance. The mother tended to be either "over-concerned, helpless and guilty" or overtly hostile. The children tended to respond either by tyrannical behavior or by inability to separate from mother and "poor ego boundaries." In general, the depressed mothers found difficulty in being involved in their children's lives, in communicating with them, and in showing affection to them. They also reported strong guilt feelings about the family and resentment and ambivalence about their family duties.

Maternal Depression and Attachment Theory

The high prevalence rate for depression in mothers with young children has clear implications for the study of attachment behavior. The emphasis in most attachment research to date has been on the effects of the physical separation of the child from the mother in the early years, although Bowlby himself has always emphasized the importance of the quality as well as the continuity in time of the mother-child relationship: "What is believed to be essential for mental health is that the infant and young child should experience a warm, intimate and continuous relationship with his mother (or permanent mother substitute), in which both find satisfaction and enjoyment" (Bowlby, 1953 p. 11). The mother's responsiveness and sensitivity to the baby's signals have already been shown to be associated with the security of attachment (Schaffer and Emerson, 1964; Ainsworth and Bell, 1970). Threats of abandonment or of suicide may be even more damaging to the child's sense of secure attachment than physical separation or may compound the effects of actual separation when it occurs (Bowlby, 1974). High degrees of anxiety and "over-dependence" have also been found in children who have been subject to parents' irritability or disparaging remarks (McCord, McCord, and Verden, 1962). Unresponsiveness, irritability, and suicidal threats are all commonly found in depressed patients and can be assumed to be behaviors to which the young child of a depressed mother is frequently exposed, and to result in insecure attachment.

As we have seen in chapters 1 and 2, mothers of babies who showed avoidant or ambivalent behavior in the strange-situation test (Groups A and C respectively) tended to be less responsive to the baby's signals, less accepting and warm toward him, and less cooperative and accessible than mothers of securely attached (Group B) infants. Mothers of A babies were more rejecting, unexpressive, and compulsive than were mothers of C babies, and they revealed a particular dislike of close bodily contact with the baby. Their lack of expression was seen as a means of keeping suppressed anger under control, but it appears that the baby is sensitive to the hostility implicit in the mother's unnatural behavior and withdraws from it accordingly.

Securely attached infants who are distressed by separation can be easily calmed by close contact with the mother at reunion, but the A infant has unsatisfactory experiences of close contact and cannot assume that he will be similarly soothed into a calm state. He is likely, therefore, to avoid his mother's gaze and continue playing, in an effort to reduce the painfully high arousal level produced by activation of the attachment system when there is no likelihood of its assuagement.

Similar mechanisms may be expected to occur when a mother is depressed and either withdrawn from her child or irritable and intrusive toward him. The children of some depressed mothers are also likely to be confused by the mother's rapid changes of mood from one state to the other; either they have to perceive their mother's current affective state very clearly or protect themselves from possible rebuff by avoidant behaviors. The child who cannot sustain the intense watchfulness necessary to detect maternal changes in mood and who retreats into avoidant behavior then faces a further problem, namely that the depressed mother experiences the avoidance as rejection, leading to a deepening of her depression. It is possible that at least a proportion of A and C mothers are or have been depressed, and the child's response makes them more so hence they both become trapped in a vicious circle of mutual disappointment and distress. On the other hand, a child who does not withdraw may institute a fourth variant, that of "role reversal." This behavior will be considered later.

CLINICAL EXAMPLES

Recent developments in observational techniques have opened up the possibility of investigating the quality of mother-child interaction with a precision and subtlety that has not hitherto been possible (Lyt-

ton, 1973; Schaffer, 1977). The value of such advances in methodology for the study of attachment is unquestionable. One study in which the author is involved (supported by a grant from the Medical Research Council), is investigating the effects of maternal depression on preschool children. Some of the observations discussed here derive from the pilot stage of the study. The measures used should be sufficiently sensitive to demonstrate not merely an association between maternal and child disturbance but to illuminate some of the mechanisms by which disturbance is transmitted from generation to generation.

We anticipate finding at least two subgroups among the mothers: a withdrawn, anergic group and an agitated, intrusive group, with corresponding differences among the children (Weissman and Paykel, 1974). The children of the first group are likely to be more vociferous and demanding in order to obtain a response from the mother, while the children of the second group are more likely to be watchful, tense, and withdrawn. The depressed mothers in general are expected to be less warm and responsive to the child, and to have less effective control stategies and ways of calming the child's distress. They would also probably stimulate the child less and engage in less varied play. The effects of depression on the quality of attachment are less obvious, especially if one considers the attachment relationship to consist not only of certain classes of behavior toward the attachment figure but also of certain kinds of internal representations of that figure. Some predictions can be made on the basis of what is already known of the psychopathology of depression. The depressed woman withdraws her interest from the outside world and becomes increasingly preoccupied with an inner world in which loved figures are lost or unsatisfactory and the self is abandoned and unloved (Abraham, 1927). Her mood is therefore both sad and angry. She may give up engaging with the world or try desperately to control it in order not to risk any further loss or rebuff. In either event she is less aware of the realities of her environment and less responsive to the needs of the people in it. Those most vulnerable to her negative mood and impaired capacity for relating are likely to be her young children, who depend on her for their survival and who cannot escape the field however distressing the situation becomes.

With these considerations in mind we may now proceed to consider some observations of children and their mothers, some of whom are currently depressed while some are known to have been severely depressed in the recent past.

PETER

Peter is now aged five and has just started school. Almost immediately he began to get into trouble because of fighting with other children. He is so provocative in the classroom that the staff considered the possibility of excluding him from school, but when interviewed the parents had no complaint about him and said he was a model child at home. It soon emerged that both parents were deprived people who had had unhappy and difficult childhoods. They tend to distrust the world at large, while clinging to each other for support. The father is a loyal husband but a stormy neighbor and workmate, and the mother has many neurotic symptoms. She was depressed for several years after Peter's birth, but, although she has many anxieties and psychosomatic complaints, she is not currently depressed. In the clinic Peter remains quiet and subdued but when seen at home a different picture of him emerges. Every time the parents' conversation turns toward topics that anger or distress them, Peter interrupts with a joke or comical routine, a funny drawing, or an amusing imitation. During a particularly difficult time in the family when they were beset by financial problems, both parents commented on how they would have "gone mad" if it had not been for Peter's liveliness and good humor.

LUKE[1]

Luke is a two-and-a-half-year-old boy with a deeply depressed, withdrawn mother, and he is sitting at her feet playing. Maternal grandmother is around in the background helping with some kitchen chores. Mother is sunk in her thoughts, her only activity a feverish chain smoking. Luke plays quietly but checks her face from time to time, and throughout his bare feet are pressed gently against hers. She asks for an ashtray, and he brings one with alacrity. She kisses and fondles him, pressing him against her. He goes to get another ashtray and another and another until she has five and suddenly lashes out in irritation at him. He returns to his quiet watchful play. Later Granny goes out to buy some sweets for him. He asks his mother why she is leaving and is told, "She's had enough of you, that's why."

ROWAN

Rowan is a girl of four, and she is playing with her mother. The mother was very deeply depressed for a year or so when Rowan was between two and three years old. They lived on the tenth floor of a high-rise block and the child became hyperactive and uncontrollable. The relationship deteriorated, and the mother sometimes had to lock Rowan in her room to prevent herself from harming the child. During this time the child developed a pattern of running away whenever they went out and would sometimes be found by the police several miles away. Rowan no longer runs away and the mother is no longer depressed, but has now become agoraphobic and

1. I am indebted to Christine Puckering of the Institute of Psychiatry, University of London, for this observation.

highly anxious. They kneel on either side of a small table in almost total silence. The child directs the play, which consists mainly of formal games with strict rules, like noughts and crosses or snakes and ladders.

It is still and tense; there is no laughter and no touching. We are filming them, but they are enacting a ritual that is played out every afternoon when the child returns from her special school. The mother usually talks nonstop to any willing listener, but the child has told her not to speak and she obeys. Later on Granny arrives. The child embraces her and kisses her hands and then slowly stomps over to the mother with a grannylike walk and kisses her. The mother asks, "What's that for?" and the child replies, "Because I love you."

MICHELLE

Michelle is a three-year-old girl, and she is playing with Lego blocks on the floor. Her mother sits nearby drinking coffee. She has recently recovered from a depressive illness. A year ago the child had seemed grossly retarded with no speech and little play, but when recently tested on the Merrill-Palmer she received an IQ score of 130. She is trying to build an hotel, but it is too tall and complicated in design and continually collapses. The child is clumsy; twice she falls down crying bitterly, once going to her mother for support but returning with extraordinary persistence to the task. There is a frantic, desperate quality to the activity—it seems like a life-and-death struggle rather than play. At one point the mother says, "I won't help you because I might destroy it." The child in any case expects no help and finally succeeds in her task, filling the hotel with little people and capping it with a roof.

DISCUSSION

There is indubitably a definite attachment between each of these children and their mothers, but it is of a very unusual kind. It is intimate, even intense, but not warm; continuous but also continuously threatened; and the only satisfaction seems to be that somehow the relationship is preserved intact. Some of the unusual features of the relationship can be seen as arising from reversals of the balance of power and resource that normally prevails between mother and child. Instead of the mother holding the child in her concerned attention, the child watches her, ready to respond to her need as it arises, though in his naïveté he is likely to get it wrong and imagine, for instance, that five ashtrays are better than one. While the healthy mother sees herself as responsible for the child's survival, in depression the child may feel responsible for the mother's. In some cases he may indeed keep his mother alive by his expressions of love when there seems nothing else for her to live for. Some children like Peter become

clowns to cheer the mother up and make her laugh—a different tactic with a similar aim.

The mother is usually the dominant partner of the mother-child pair. She may leave the child freedom to choose but within the boundaries of mealtimes, bedtimes, and other routines that she defines. Because of a depressed mother's helplessness and lack of contact with reality, her child may take control. Taking control serves several functions both for him and his mother, but it also creates further and sometimes intractable problems. It helps partly because by mastering the situation the child frees himself from identification with her hopeless state. A further reason is that both partners feel it is safer for the child to be in control. In the early relationship between Rowan and her mother, there had been a serious danger of the child being injured. The mother looks back on that time with intense guilt and pain and is terrified of ever harming her again. She is relieved that the responsibility has been taken from her hands, but the cost to the child is that she has to look after herself and her mother with the internal resources she already has. She is not able to listen and learn from adults, and she makes very slow progress at school. Her mother is also constantly reminded of her failure as a mother and cannot regain appropriate control, so that her depression is augmented by daily contact with her overpowerful child.

On the other hand, some children in this situation develop surprising capacities for constructive activity. They have survived by stretching all their capacities to the limit, by observing closely, inferring accurately, and creating their own sources of satisfaction and enjoyment. They do not look to the mother for instruction or advice; she may in fact depend more on them than they on her. However, they are likely, like Michelle, to be tense, anxious, and driven; the whole enterprise seems at any time likely to collapse, leaving them as helpless as their depressed mothers. In short, the child of a depressed mother is forced into a precocious maturity and has to become an attachment figure before he has had sufficient experience of being attached. Some children do not even attempt the task, of course, or if they do they fail to develop an adequate strategy for coping with such demands. The relationship often then deteriorates to the point of breakdown and the child is taken into residential or day care or the mother into a hospital.

In the children previously described, strategies for survival have been found and a relatively stable attachment system has been established, but at a high cost to the child's development. He is precipitated into what Winnicott (1958, p. 206) calls the "stage of concern" before

he has fully completed the earlier stage of using and sometimes misusing the attachment figure to establish his own sense of identity. In many adult patients in psychotherapy, the therapist can reconstruct just such a course of events in early life and also observe the long-term consequences in terms of chronic anxiety, guilt, and feelings of inadequacy. These patients' close relationships tend to resemble the first relationship or sometimes to reverse it, so that the partner is either indulgently mothered or clung to helplessly as the mother clung to him. The direct expression of need may be almost impossible, not just because no one is expected to respond but because the actual perception of need states is so rudimentary. At the stage when he should have learned to identify and label them, attention was fixed on the need state of the mother rather than the self. One could say that some of these patients present with a "false self." They are unaware of most of their own impulses and emotions and have to construct their behavior on the basis of conventional expectations, with a resulting sense of emptiness, frustration, and dissatisfaction.

Not all the unusual features of the relationship between the depressed mother and child can be subsumed under the rubric of role reversal. The heavy gloomy atmosphere, for example, created by the mother's posture, sighing, or weepiness cannot be included although it does involve a reversal of the usual (or perhaps ideal) atmosphere in a family with young children. As Weissman and Paykel (1974) have made clear, the child is also likely to be the chief recipient of the mother's hostility and invective (e.g., Luke's mother's explanation of Granny's leaving). There is also frequently an extreme discrepancy between the mother's verbal and nonverbal cues; for example, some depressed mothers cuddle the child a lot to comfort themselves while keeping up a stream of criticism of the child. The combined effect of these behaviors is likely to be a pessimistic outlook, poor self-esteem, and confusion about the meaning of interpersonal behaviors. The lack of basic security that they produce is likely to result in a state of "anxious attachment" in some individuals or a precocious "pseudo-independence" in others, depending on their temperament and on other factors in the environment, such as the availability of alternative attachment figures or the ordinal position in the family that the child occupies.

The discussion so far has concentrated for simplicity on the effect of the mother's behavior on the child as if the child were a *tabula rasa* who contributes nothing of himself to the interaction. A fuller description would take into account the dyadic system that they mutual-

ly create, as well as the larger family system of which the dyad is a part. The advent of children to a family introduces new sources of stress to which a childless couple is not exposed, and there is some evidence that childless couples are likely to have happier marriages (Slater and Woodside, 1951; Humphrey, 1975). Malmquist and Kaj (1971) also found more physical and psychiatric illness in a group of women who had borne children than in their childless twin sisters. If childbearing and child rearing are themselves sources of stress, some children are also more stressful than others. It is now clear there are marked temperamental differences between children that affect the ease with which they adapt to caretaking routines, their emotional lability, and predominant affective state (Thomas and Chess, 1977). Some children are simply harder to rear than others and require a higher degree of skill and tolerance on the part of the mother. A child who sleeps or eats poorly or who is excessively sensitive to change can undermine the confidence of a vulnerable mother and make her feel she is a "bad mother" who cannot make her child happy. The stage is then set for a downward spiral into increasing depression on her part and increasingly disturbed behavior on the part of the child. Much will also depend on the response of the father and other family members to the situation. As Hinde (1979, p. 51) has recently pointed out, "The complexity of the family system ensures that simple relations between particular influences in infancy and childhood and subsequent behaviour will be the exception rather than the rule."

Hinde considers the possibility that the demonstration of no effect from a particular variable (e.g., separation or parental death) may reflect a genuine negative finding, the insensitivity of the measures used, or the short time scale of the study. There may be long-term or "sleeper" effects of certain experiences that are not apparent until much later, perhaps when the subject is an adult and exposed to demands for mature and responsible behavior. Women who have suffered early loss, for example, are more likely to have problems during pregnancy and more likely to have difficulties in the early child-rearing period (Frommer and O'Shea, 1973; Wolkind, Kruk, and Chaves, 1976). There are many children in disturbed families who show no symptoms of severe disturbance, although the clinician may be concerned about their excessively serious or overresponsible behavior that is obviously inappropriate for their age. It is possible that a sleeper effect operates here too since we know that children with behavior disturbances are at high risk of becoming antisocial adults whereas neurotic children are no more than averagely likely to become neurotic adults. The question arises as to which children do become neurotic in later life. It seems likely, as Cooper has suggested, that it is the children who make an apparently good adjustment to a bad situation, like some of those described here, who are at high risk of later disturbance and we should be as concerned about them as for their more overtly disturbed siblings.

Conclusion

Depression in the mothers of young children has been shown to be a common disturbance and one that is highly associated with psychiatric disorder in the children. The effects on them are likely to be severe, but will vary according to the type of depression, the child's temperament, and the alternative sources of nurture in the family environment. Reversal of the normal mother-child roles is frequently observed, as is ambiguity in communication and maternal irritability and lack of responsiveness. Even in children who appear to make a good adaptation to the stress to which they are exposed, the long-term effects are likely to reflect lack of inner security and disturbed personal relationships. The implications for preventive psychiatry of such a widespread hazard to healthy child development cannot be underestimated. They are comparable to those of early loss or separation to which attachment theorists have long paid deserved attention.

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7

Beverley Raphael

THE YOUNG CHILD AND THE DEATH OF A PARENT

THE POWERFUL NATURE of the young child's ties to his parents and his dependence upon them for much of his nurturance and survival has led to many concerns about the effect upon him of the loss of these bonds. A childhood history of the death or loss of a parent is common in the fields of adult psychiatric and social morbidity. However, more specific and scientific assessments of the effects of the death of a parent upon a young child, both at the time of the loss and subsequently, have been difficult. The multiple variables operating, the many disruptions associated with the death of a parent, and the different time spans that may operate before effects are evident all make it difficult to draw definite conclusions as to the pathogenic potential of parental loss.

This complexity is reflected in the broad literature on childhood bereavement. Thus there are, for instance, a great many retrospective studies of psychiatrically disturbed populations (e.g., Gregory, 1966) suggesting that those who have suffered a childhood bereavement may be more likely to develop psychiatric disorders in adult life. Proneness to depression and suicidal tendencies have been the main areas of morbidity (Birtchnell, 1972), but even schizophrenia has been

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