In an Idealized World: Can Discrepancies Across Self-Reported Parental Care and High Betrayal Trauma During Childhood Predict Infant Attachment Avoidance in the Next Generation?

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In an Idealized World: Can Discrepancies Across Self-Reported Parental Care and High Betrayal Trauma During Childhood Predict Infant Attachment Avoidance in the Next Generation?

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Adult caregivers’ idealization of their parents as assessed by the Adult Attachment Interview is a risk factor for the intergenerational transmission of the insecure-avoidant attachment style. This study evaluated a briefer screening approach for identifying parental idealization, testing the utility of prenatal maternal self-report measures of recalled betrayal trauma and parental care in childhood to predict observationally assessed infant attachment avoidance with 58 mother–infant dyads 18 months postpartum. In a logistic regression that controlled for maternal demographics, prenatal psychopathology, and postnatal sensitivity, the interaction...
between women's self-reported childhood high betrayal trauma and the level of care provided to them by their parents was the only significant predictor of 18-month infant security versus avoidance. Results suggest that betrayal trauma and recalled parental care in childhood can provide a means of identifying caregivers whose infant children are at risk for avoidant attachment, potentially providing an efficient means for scientific studies and clinical intervention aimed at preventing the intergenerational transmission of attachment problems.

**KEYWORDS** attachment, assessment, methodology, betrayal trauma, childhood abuse, cognitive processes

Bowlby (1969/1982) conceptualized internal working models of attachment as dynamic mental schemas that influence individuals' affect; behavior; and perceptions of the self, others, and interpersonal relationships. Beginning in infancy, these working models are expressed in the form of attachment styles (i.e., secure, avoidant, anxious-resistant, and disorganized; for full descriptions, see Hesse & Main, 2000; Main, 2000), which are characterized by distinct patterns of behavior designed to maintain proximity with an attachment figure. These styles, and the working models they represent, are thought to be stable within individuals over time and also across generations—a phenomenon known as the intergenerational transmission of attachment. Indeed, a large number of studies (prospective, retrospective, and concurrent) have documented striking 66%–82% correspondences between parents' representations of their own attachment experiences in childhood as reflected by the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) and their infants' attachment as assessed by the Strange Situation (SS; Ainsworth & Bell, 1970), with the most robust correspondences existing between (a) adult Autonomy and infant security and (b) adult Dismissingness and infant avoidance (e.g., Ainsworth & Eichberg, 1991; Bretherton, Lambert, & Golby, 2006; Fonagy, Steele, & Steele, 1991; van IJzendoorn, 1995; Ward & Carlson, 1995; Zeanah et al., 1993). In fact, several studies have found attachment styles to be stable across three generations (Benoit & Parker, 1994; Hautamäki, Hautamäki, Neuvonen, & Maliniemi-Piispanen, 2010).

Despite this trend for intergenerational stability, clinical studies have revealed that, fortunately, attachment insecurity remains sensitive to early intervention (see Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003). To disrupt intergenerational transmissions of insecure attachment effectively and efficiently, preventionists' first task is to predict which children are at risk. Though the AAI has been found to be the most reliable predictor of infant attachment (in one study accounting for an impressive 22% of its variance; Steele & Steele, 2008), because of cost and time demands using
this method is not always feasible, and alternative ways of predicting child attachment insecurity and identifying families who may benefit from treatment are needed. Without intervention, insecurely attached infants remain prone to emotional and behavioral problems in childhood and beyond (e.g., Main, Hesse, & Kaplan, 2005; Thompson, 2008). Avoidant infants in particular tend to adapt less readily to day care settings (Blanchard & Main, 1979), demonstrate less prosociality and more aggression and hostility (Kennedy & Kennedy, 2004; Rydell, Bohlin, & Thorell, 2005), exhibit less perseverance in social interactions and greater emotional reactivity to threat (Sroufe, 2005), and become dismissing of attachment in adulthood (Main et al., 2005).

CONSTRAINTS TO USING THE AAI AS AN INTERVENTION TOOL

Though the AAI is a reliable and valid measure of parent attachment and is useful in predicting child classification, it is cost and time intensive. Administering and scoring the AAI requires that interviews be recorded, transcribed, redacted of all identifying information, and then thoroughly analyzed by a certified reliable coder. Interviewers, transcribers, and coders receive extensive training, and those without the training must hire personnel with these qualifications. As a result, the AAI is not a practical screening tool for use in clinical settings, where resources needed to prepare and code the interview are likely unavailable. Nevertheless, while extant attachment-based interventions often target women with more global risk factors such as poverty (e.g., Cooper, Hoffman, Powell, & Marvin, 2005; Spieker, Nelson, DeKlyen, & Staerkel, 2005), it would be more efficient to target specific risk factors more closely related to parents’ state of mind (SoM) with regard to attachment—the maternal feature most salient to the development of offspring attachment.

Brief self-report questionnaires (which cost little and are expedient to administer) are typically the most useful screening tools for widespread use. Although scholars have developed a number of self-report measures to assess adult romantic attachment (e.g., Bartholomew & Horowitz, 1991; Fraley, Waller, & Brennan, 2000; Hazan & Shaver, 1987), no self-report measure has emerged to assess what the AAI does—that is, adults’ attachment styles relative to their childhood caregivers. Perhaps this is because the AAI is thought to address subconscious representations not easily accessible via self-report measures (Jacobvitz, Curran, & Moller, 2002)—representations that, on the AAI, are captured via multiple SoM scales. Indeed, most AAI SoM scales (e.g., the Passivity scale, which is closely associated with the Preoccupied classification; and the Unresolved scale, which determines placement into the Unresolved SoM) are concerned with structural and stylistic aspects of the attachment narrative—characteristics that are unlikely to be captured
via self-report questionnaire. However, one—the Idealization scale, which is closely associated with the AAI Dismissing classification, is more concerned with narrative content—something that is more likely measurable via questionnaires. More specifically, idealization represents a moderate to marked lack of unity between adults’ retrospective reports of (a) childhood experiences of unloving or abusive parenting and (b) how favorable or warm their relationships with their parent(s) had been (Hesse, 2008).

Important to the present study’s guiding hypothesis is the fact that research has shown that parents’ Idealizing SoM scores directly relate to their infants’ avoidance during the SS. In one analysis, infants’ avoidance of their mothers during the task’s two reunion episodes (as measured using Ainsworth, Blehar, Waters, & Wall’s, 1978, 7-point scale) correlated with maternal idealization of their own mothers ($r = .47$) and fathers ($r = .43$) on the AAI (Hesse, 2008). This is perhaps unsurprising given that parental idealization is such a principal feature of the Dismissing classification. Using an adult’s Idealizing SoM score would not be substantially more efficient for predicting infant avoidance, however, as it still requires all of the time and resources needed to administer and code the AAI. In contrast, measuring analogous discrepancies across a pair of self-report surveys assessing childhood parental abuse and parental care (PC) may allow clinicians to more effectively and efficiently determine which children and families are at risk.

A NOTE ON UNDERLYING MECHANISMS

Though AAI SoM classifications and their corresponding SS infant attachment classifications share several key features (i.e., attentional flexibility vs. inflexibility toward or away from a real or remembered an attachment figure), the AAI coding scheme was developed via an iterative process whereby developers continued to modify classification criteria through sequential examination and unblinding to infant SS classifications of speakers’ children. Because SoMs were developed via this data-driven, rather than theory-driven, method, there remains much that is not understood about the relations between these narrative features, the psychological processes underlying them, and intergenerational transmissions of attachment. Though a thorough exploration of possible processes by which parental idealization impacts child attachment is beyond the scope of this article, thematic similarities between parental idealization and the dissociative defensive strategies proposed by Betrayal Trauma theory (Freyd, 1996) are worth mentioning.

Betrayal Trauma theory holds that when people are violated by a depended other, it may be adaptive in the short term for them to forget or reinterpret the violation(s) so as to maintain that relationship (see Freyd, 2008). Over the long term, however, the systematic suppression or minimization of traumatic experiences often has negative interpersonal
and psychological consequences. According to this framework, parental idealization may represent a gratuitously favorable interpretive bias for abusive parental behaviors—a bias that, when maintained into adulthood, is associated with intergenerational transmissions of attachment insecurity. During childhood, however, it served as an adaptive way to maintain proximity to a primary attachment figure. Indeed, attachment theory holds that infant attachment avoidance is an adaptation to insensitive and contact-averse parenting (e.g., Main & Stadtman, 1981) that functions to reduce the chance that a child’s bids will be rejected (e.g., Kouolomzin et al., 2002).

OTHER PREDICTORS OF INFANT ATTACHMENT

In addition to parental SoM, research has identified several other variables as predictive of infant attachment, including maternal psychopathology (e.g., Atkinson et al., 2000) and sensitivity (e.g., Bakermans-Kranenburg, van IJzendoorn, & Kroonenberg, 2004), particularly in response to infant distress (McElwain & Booth-LaForce, 2006). Thus, the present study was designed to determine whether maternal parental idealization is prospectively associated with infant avoidance independent of the effects of maternal psychopathology and sensitivity.

THE CURRENT STUDY

The current investigation examined whether discrepancies between (a) participants’ endorsements of childhood high betrayal trauma (CHBT; i.e., maltreatment perpetrated by a close other on whom the participant was dependent—usually a caregiver) and (b) participants’ reports of childhood parental care (PC; i.e., the warmth and care provided to them by their parents during their childhood) would predict their infants’ SS attachment classification. Because idealization of one’s parents and the parent–child relationship is a central feature of dismissive AAI transcripts, and because dismissive parents tend to have insecure-avoidantly attached infants, we hypothesized that women who described their parents as being very caring on one self-report measure but also endorsed high levels of CHBT experience on another would be more likely to have avoidantly attached children. We predicted that those women who described a more congruent set of experiences across self-report measures, on the other hand (i.e., high PC scores and low CHBT, or low PC scores and elevated CHBT), would be less likely to have avoidantly attached infants. In the current analyses, the interaction of self-reported PC and CHBT was used to represent parental idealization (i.e., if higher PC ratings predicted infant avoidance only when CHBT experience was high, parental
idealization could be inferred). Lastly, we hypothesized that the influence of parental idealization would remain significant when we controlled for maternal psychopathology and postnatal sensitivity.

METHOD

Participants

The present investigation utilized data from a longitudinal effort to identify psychological and psychobiological markers of risk for insensitive parenting in a high-risk population. Participants \((n = 105)\) were selected for dual risk factors of economic disadvantage and elevated depressive symptoms and/or problematic parenting risk and were recruited during their third trimester of pregnancy from local childbirth education classes, hospitals, and public assistance organizations. Women were eligible to participate if they were fluent in English and pregnant with a single fetus they intended to carry to term. Those with high-risk pregnancies, severe psychopathology, or plans to give the baby up for adoption or relocate within the year were excluded from the study. Written informed consent was obtained from participants at each wave of data collection, and all protocols were approved by the host university’s Office for the Protection of Human Subjects.

At the time of their prenatal assessment, participants ranged in age from 18 to 38 years \((M = 24.5, SD = 4.7)\). Participants were demographically representative of the county in which they resided (80% Caucasian, 3% African American, 7% Latina, 4% Native American, 1% Asian, and 5% other). Nearly one third (31%) of women were on government assistance, with 21% reporting a yearly household income <$10,000 and 91% reporting <$40,000. A minority (21%) of the women had a college degree, whereas 43% had attended some college and 36% had a high school degree or less. Most indicated that they were married (41%) or unmarried but living with a partner (42%).

Procedures

Participants returned to the laboratory for postnatal visits when their infants were 5 months \((n = 96; 57\% \text{ female})\) and 18 months \((n = 88; 59\% \text{ female})\) of age. All three time points involved a laboratory assessment and completion of questionnaires. Women who did not return for the 18-month visit were no different from those who did on any variables used in this study.

PC. The Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979) is a 25-item self-report scale that assesses participants’ recollections of their parents’ caregiving behaviors during their first 16 years of life. In this study, participants were asked to rate their parents together. The measure contains care (12 items) and control (13 items) subscales. High scores on the
care dimension represent parental affection, emotional warmth, and closeness, whereas low scores indicate coldness, indifference, and rejection. For control, low scores represent a detached promotion of autonomy, whereas high scores indicate parental intrusion, infantilization, and excessive contact. Each item is rated on a 4-point scale, with the summed scores ranging from 0 to 36 for care and 0 to 39 for control. In the current sample, internal consistency reliability using Cronbach’s alpha was .94 for PC and .87 for parental control.

**CHBT.** The Brief Betrayal Trauma Survey (BBTS; Goldberg & Freyd, 2006) is a short questionnaire used to assess the experience of 12 different traumas before and after 18 years of age. The instrument begins with a multiple-choice section wherein participants report on whether they have experienced each of 12 traumas “never,” “one or two times,” or “more than that.” After this section, respondents are asked to provide information about the perpetrator for all endorsed events (gender and relation to the participant). Traumas on the BBTS vary from those that are low in betrayal (e.g., a natural disaster) to those that are very high in betrayal (i.e., being physically, sexually, or emotionally abused by someone with whom the respondent is very close). Questions avoid using labels for the events and instead describe them (i.e., read “made to have sexual contact” rather than “sexually abused”), and items from the three betrayal levels (high, medium, and low) are interwoven throughout the measure. Participants’ levels of low, medium, and high betrayal trauma experiences in both adulthood (≥18 years of age) and childhood (≥18 years of age) were calculated as the sum of responses within each level of betrayal trauma. The BBTS has been found have high test–retest reliability over a period of three years (Goldberg & Freyd, 2006).

In the current sample, internal consistency reliability according to Cronbach’s alpha was .61 for CHBT, .56 for adulthood high betrayal trauma, and −.01 for childhood low betrayal trauma. Because this scale represents a count of events (much like life events scales) and not repeated measures of one construct, we would not expect alphas in the range found for typical unidimensional construct scales. In this case, higher alphas instead represent a tendency for high betrayal traumas to co-occur.

**Infant attachment security.** At 18 months postnatal, infant–mother attachment was measured using Ainsworth and Bell’s (1970) SS, a 21-min task designed to assess children’s reliance on their caregivers for comfort when distressed. During the task, infant and caregiver are twice separated and reunited, and the infant’s attachment behaviors during the reunion episodes are coded in terms of proximity seeking, contact maintenance, resistance, and avoidance (Ainsworth & Bell, 1970). Based on these codes, dyads are assigned to one of four classifications: secure (B), avoidant (A), resistant (C), or disorganized (D). Upon reunion, B infants seek out contact from their caregivers and calm easily in their presence. C infants, in contrast, show angry resistance to their caregiver’s attempts to calm them, and A babies
turn away from their caregivers, showing few overt indications of an emotional response. Lastly, D infants appear to lack a strategy for coping with distress in the caregiver’s presence or show a breakdown in their strategies. Infants coded as D also receive an alternate classification of either A, B, or C. For the purposes of this study, analyses included infant–mother dyads classified as either secure (B) or insecure-avoidant (A or D alternate A [D/A]). SS videotapes were sent for expert classification and attachment behavior coding by Elizabeth Carlson, PhD, at the University of Minnesota.

RESULTS

Descriptive Statistics

Variable descriptive statistics and intercorrelations are displayed in Table 1. Of the 88 children in our sample with coded SS tapes, 59 (67%) were classified as secure (B), 7 (8%) as avoidant (A), 4 (5%) as resistant (C), and 18 (20%) as disorganized (D; of which 6 had an alternate classification of B; 6 of A; and 6 of C). Of the 73 mother–child dyads with a B, A, or D infant attachment classification, 58 had complete data for all other variables. This group (47 B, 11 A or D) made up our final sample. Given the elevated risk of our sample, fewer infants were classified as organized-insecure (i.e., avoidant or resistant) than we had expected.

**TABLE 1** Correlations and Descriptive Statistics

<table>
<thead>
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<td>6. Parental care</td>
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<td>7. Childhood high betrayal trauma</td>
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*aMaternal ethnicity: 0 = other, 1 = Caucasian. bMaternal education: 0 = no high school, 1 = some high school, 2 = high school diploma/general equivalency diploma, 3 = some college, 4 = 4-year college, 5 = some schooling beyond college, 6 = graduate/professional degree. cMaternal depression (Center for Epidemiologic Studies–Depression scale; Radloff, 1977). dMaternal anxiety (Beck Anxiety Inventory; Beck & Steer, 1993). eMaternal sensitivity to infant distress at 5 months postnatal was assessed using the Global Ratings of Mother–Infant Interaction Scales (Murray et al., 1996), coded during the reunion episode of Lewinsohn’s (1996) modified version of the Still Face Paradigm (Tronick et al., 1978).

*p < .05.

**p < .01.
Typically, 62%–65% of children from middle-class, nonclinical samples are found to be secure (Prior & Glaser, 2006), with another 15% classified as avoidant, 9% as resistant, and 15% as disorganized (van IJzendoorn, Schuengel, & Bakermans-Kranenburg, 1999). In samples of children of mothers with depression or of a low socioeconomic status, the proportion of disorganized infants tends to increase (21% and 25%, respectively; van IJzendoorn et al., 1999). Thus, compared to similar samples, ours had slightly higher rates of secure attachment, slightly lower rates of disorganization, and considerably lower rates of attachment avoidance and resistance. This may be due to the fact that women in our sample had higher levels of education (64% had at least some college) than other at-risk samples with elevated depressive symptoms and low household income levels. For example, one recent study of low-income pregnant women reported that just 33% had any postsecondary education (Canning, Frizzell, & Courage, 2010).

More closely in line with what is typical of high-risk samples, we found that a substantial proportion of participants had experienced CHBT. More specifically, 24 women endorsed being physically abused, 19 reported being sexually abused, and 46 reported being emotionally abused by a very close other. Where it was possible to isolate the identity of the childhood perpetrator (when the abuse occurred in childhood only \( n = 15 \) for physical abuse, \( n = 10 \) for sexual abuse, \( n = 23 \) for emotional abuse), the majority (73% for physical abuse, 60% for sexual abuse, 75% for emotional abuse) were identified as parents/legal guardians.

## Hypothesis Testing

A logistic regression analysis was performed to determine whether, after we controlled for a number of possible demographic and attachment-relevant variables (including maternal age, ethnicity, education, prenatal anxiety and depression, and postnatal sensitivity), infant attachment classification (secure vs. avoidant) could be predicted by mothers’ CHBT (mean centered), childhood PC ratings (mean centered), and the interaction between the two. A test of the full model against a control-only model was significant, \( \chi^2(3) = 10.99, n = 58, p = .01 \). Whereas a control-only model (i.e., a model that included only the aforementioned six control variables) explained 45% of the variance in attachment classification (secure vs. avoidant), the full model (also including CHBT, PC, and their interaction) accounted for 65% of the variance. This full model correctly classified 93.9% (46 of 49) of secure cases and 72.7% (8 of 11) of avoidant cases (up from 45.5% in the control-only model), for a total correct classification rate of 90%. Among the control variables, postnatal maternal sensitivity trended toward significance (\( B = 1.55, \text{ Wald } [1] = 3.65, p = .06, \text{ ns} \)), but only maternal ethnicity (Caucasian vs. non-Caucasian) reached significance (\( B = 4.68, \text{ Wald } [1] = 5.15, p < .05; \text{ Exp}[B] = 107.56 \)), such that the infants of Caucasian mothers were significantly more
likely to belong to the secure group. Examination of the focal parameter estimates (see Table 2) indicated that only the interaction variable was significant ($B = -0.2$, Wald [1] = 5.51, $p = .02$), whereas main effects of CHBT and PC were nonsignificant. The difference between the variance explained by the full model (Nagelkerke $R^2 = .65$) and a modified model with only the main effects of CHBT and PC and not the interaction (Nagelkerke $R^2 = .49$) revealed that PC × CHBT accounted for a unique 15.6% of the variance in infant classification.

To better interpret the PC × CHBT interaction, we calculated and plotted the regions of significance (Bauer & Curran, 2005) for the effect of PC (see Figure 1). These regions represent the range of (mean-centered) CHBT scores at which PC significantly predicts the likelihood of infant attachment security versus avoidance. The upper bound was 3.09, indicating that for people with CHBT scores at or above the 95th percentile (indicating multiple experiences of several forms of abuse by a close other), higher PC

### TABLE 2 Summary of Logistic Regression Analysis for Variables Predicting Infant Attachment Classification (Secure-Avoidant), Controlling for Maternal Control Variables

<table>
<thead>
<tr>
<th>Predictor</th>
<th>$B$</th>
<th>$SE$</th>
<th>Wald</th>
<th>$e^B$</th>
</tr>
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<tbody>
<tr>
<td>Childhood parental care (PC)</td>
<td>-0.00</td>
<td>0.09</td>
<td>0.00</td>
<td>1.00</td>
</tr>
<tr>
<td>Childhood high betrayal trauma (CHBT)</td>
<td>-0.29</td>
<td>0.43</td>
<td>0.46</td>
<td>0.75</td>
</tr>
<tr>
<td>PC × CHBT</td>
<td>-0.20*</td>
<td>0.08</td>
<td>5.51</td>
<td>0.82</td>
</tr>
<tr>
<td>Constant</td>
<td>-1.50</td>
<td>1.19</td>
<td>1.58</td>
<td>0.22</td>
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Notes: Controls are maternal ethnicity, age, education, 5-month sensitivity, and prenatal depression and anxiety (omitted from the table). $e^B =$ exponentiated $B$.

* $p < .05$.  

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**FIGURE 1** Region of significance of the relation between attachment security vs. avoidance and parental care as a function of childhood high betrayal trauma. Note: CHBT = childhood high betrayal trauma. This region of significance defines the specific values of CHBT at which the regression of attachment on PBI Care moves from non-significance to significance. The regression of attachment on Care is significant at values of CHBT that are less than the lower bound and greater than the upper bound, and is non-significant at values of CHBT falling between these bounds.
ratings related to a lower likelihood of having a securely attached child. The lower bound was -0.95, indicating that for those with scores at or below the 50th percentile (indicating no reported abuse by a close other), higher PC ratings related to a greater likelihood of having a securely attached child. Additional post hoc analyses tested whether our findings would hold when we compared discrete groups of women who (congruently) reported high CHBT (i.e., scores >1) and low PC (i.e., scores < the median [26]) with those who (incongruously) reported high CHBT and high PC (i.e., scores >26), and also when we compared those who reported low CHBT (i.e., score = 0) and low PC with those who reported low CHBT and high PC. Crossing these two variables, we classified women into one of four groups: (a) high CHBT/low PC (n = 16, of whom 1 had an A- and 15 had B-classified infants), (b) high CHBT/high PC (n = 7; 4 A, 3 B), (c) low CHBT/low PC (n = 12; 4 A, 8 B), or (d) low CHBT/high PC (n = 19; 1 A, 18 B). Chi-square tests revealed that when CHBT was low, the high PC group showed a greater likelihood of B versus A classification, \( \chi^2(1) = 4.28, n = 58, p = .04 \). Consistent with our hypothesis, this relationship was even stronger and in the opposite direction when CHBT was high, \( \chi^2(1) = 7.09, n = 58, p = .01 \).

By testing alternative models, we were able to establish that these effects were specific to the interaction between PC (vs. control) and CHBT (vs. child low or adult high betrayal trauma). Not only were these three modified interaction terms nonsignificant, but the correct classification and variance explained by each of the altered models was less than in the original model. Next, because our ultimate objective was to find an efficient way to predict future infant classification, the model was again tested with self-report variables only (i.e., without maternal sensitivity). This abridged model remained significant, \( \chi^2(8) = 25.69, n = 58, p = .001 \), and correctly categorized a comparable number of cases as the full model. Examination of the individual parameter estimates indicated that, as in the original model, only the interaction variable was significant (\( B = -0.20, \text{Wald}[1] = 5.35, p = .02 \)). Lastly, when primary study variables (i.e., CHBT, PC, and CHBT \( \times \) PC) were modeled without control variables, both the overall model, \( \chi^2(3) = 15.04, n = 58, p = .002 \), and interaction term (\( B = -0.16, \text{Wald}[1] = 7.31, p = .007 \)) remained significant.

Finally, in an attempt to better understand the significance of maternal ethnicity, we tested whether it would remain significant if we also controlled for prenatal household income, a frequent confound of ethnicity. Results of this additional logistic regression revealed that the PC \( \times \) CHBT interaction (\( B = -0.20, \text{Wald}[1] = 5.68, p = .02 \)) and maternal ethnicity (\( B = 4.41, \text{Wald}[1] = 5.33, p = .02 \)) remained the only significant predictors, whereas income level (\( B = 0.16, \text{Wald}[1] = .07, p = .79, \text{ns} \)) and postnatal maternal sensitivity (\( B = -1.58, \text{Wald}[1] = 3.70, p = .06, \text{ns} \)) remained nonsignificant. Thus, neither income level nor maternal sensitivity could explain the found association between maternal ethnicity and infant attachment.
DISCUSSION

In the current study, we examined whether the interaction between women’s retrospective reports of CHBT and PC could, like AAI-measured parental idealization, predict infant insecure-avoidant attachment in the next generation. Reasoning that incongruent depictions of the early caregiving environment as represented across these two self-report measures might be analogous to processes captured in the AAI’s idealizing SoM scale, we hypothesized that this interaction term would predict later infant security versus avoidance. Our analyses revealed that this interaction term was indeed the sole significant predictor of infant secure versus avoidant attachment classification 18 months later, accounting for a unique 15.6% of the variance in classification. Main effects of CHBT and PC, in contrast, were not significant predictors of infant classification, indicating that it is the interplay between these two measures that predicts future infant attachment classification and not either one in isolation. Likewise, maternal prenatal psychopathology and sensitivity to her infant 5 months postpartum did not predict 18-month infant attachment classification, indicating that the PC × CHBT interaction may be a better predictor of infant secure versus avoidant classification than other maternal characteristics known to impact parent–infant relationships.

The regions of significance of the interaction confirmed our hypothesis that for those women with the highest levels of CHBT, higher ratings of childhood PC (a discrepancy denoting idealization) were associated with offspring attachment avoidance. These calculations also revealed that for those endorsing no CHBT, higher PC ratings were associated with offspring attachment security. This latter finding illustrates an intuitive relation between higher levels of care in mothers’ own childhoods and their ability to form secure bonds with their infants. Lastly, these findings confirmed that at intermediate ranges of CHBT, where we expected no association between care ratings and child attachment, the effect of PC was indeed nonsignificant.

Because parental idealization has until now only been measured with the AAI, the current findings may act to (a) further validate caregiver parental idealization as a latent construct closely linked to infant avoidance and (b) introduce a more expedient way to measure it that is better suited to clinical purposes. Several methodological strengths of this study help to underline these conclusions. Because data for the current analyses came from both self-reports and observer-coded dyadic interactions, with self-report data predicting subsequent behavioral interactions, we can be fairly confident that the effect of the CHBT × PC interaction does not simply reflect shared method variance. In addition, the study’s prospective design increases the confidence with which our findings can be interpreted as predictive and not merely correlational.

Aside from predicted found effects, maternal ethnicity emerged as an unexpected predictor of infant attachment. Though this finding is not
unprecedented (see Bakermans-Kranenburg et al., 2004), it does not seem to be explained (as in previous studies) by differences in maternal sensitivity and/or income, as ethnicity remained significant in models including these covariates. Unfortunately, our ability to interpret these findings is limited by constricted sample variance in socioeconomic status and a relatively small number of non-Caucasian mothers in the sample ($n = 20$, of which only 12 had a B baby [$n = 6$] or an A or D/A baby [$n = 6$]). Thus, further study with larger, more diverse samples will be necessary to better understand this finding.

Limitations and Future Directions

Given the limited sample size available in the current study, it is critical that these findings be replicated in a larger sample so that the separate and interactive effects of parents’ self-reported CHBT and PC on infant attachment avoidance in the next generation can be confirmed and more thoroughly examined. In addition, because AAI classifications were not available for these participants, it was not possible to determine to what extent the PC $\times$ CHBT interaction overlapped with the AAI parental idealization subscale—only that it appeared to carry similar predictive power for infant attachment. Likewise, without this information we cannot see how congruent reports of elevated CHBT and low PC relate to AAI “earned secure” classification. A critical next step in this work involves directly comparing AAI and self-report measures as predictors of infant attachment. In addition, future work in this area should also pursue ways to use easily administered and scored measures to more efficiently predict dyads at risk for forms of insecure attachment other than avoidance (i.e., Anxious-resistant and Disorganized).

Two additional limitations stem from design features of the PBI and the BBTS. Because the version of the PBI used in the present study posed a single set of questions regarding the plural referent “parents,” we were unable to consider participants’ representations of their childhood relationship with each parent separately. Given that individuals can idealize one parent but not the other, subsequent studies should use a version of the PBI that asks about primary caregivers individually. Similarly, though the BBTS solicits supplemental information about the perpetrator(s) of each endorsed high and medium betrayal trauma, these queries do not distinguish between traumatization before and after age 18. Thus, for those who were victimized in childhood and adulthood and by more than one abuser (e.g., a parent and a romantic partner), it was impossible to disambiguate who victimized them and when. To confirm that the effects found here are indeed a product of idealization, it is imperative that participants in future studies specify the relationship they had with their abuser(s) for each victimization and rate the level
of each parent’s care separately. Without this information, it remains possible that high reporting of both CHBT and PC signifies an accurate reflection of warm parenting despite betrayal trauma (or by a different close other) rather than genuine parental idealization.

Next, although the model including only self-report measures correctly classified a substantial 63.6% of avoidant infants and only incorrectly classified 4.1% of secure infants, it remains an imperfect predictive tool for identifying mother–infant dyads at risk. Because we found that higher PC ratings predicted infant avoidance only when CHBT was high, it appears that the PC × CHBT interaction captures only marked, and not moderate, forms of idealization. More moderate forms manifest in the AAI as the speaker’s failure to substantiate claims of a happy or normal childhood. For example, a caregiver described as very caring may appear to have been only instrumentally supportive, but not abusive. An important future step in this work involves creating an assessment battery that can more sensitively identify milder forms of idealization.

Finally, moving beyond the practical objective of creating a screening tool to identify mothers and children at risk for perpetuating attachment avoidance, future research should delve more deeply into the mechanisms underlying this phenomenon. Additional prospective research that assesses child betrayal trauma and PC more proximately (hence circumventing confounds due to retrospective report methods) may be helpful toward this end.

Implications

These limitations notwithstanding, the potential clinical implications of these findings are substantial. Although parental AAI classification is a powerful predictor of infant attachment classification, use of the AAI is prohibitively time and resource intensive for many clinical settings. Given the well-documented facts that (a) attachment insecurity tends to be transmitted across generations (e.g., Hautamäki et al., 2010), particularly for the dismissing/avoidant cluster (van IJzendoorn, 1995), and (b) relatively brief behaviorally focused attachment-based interventions can change infant attachment insecurity (Bakermans-Kranenburg et al., 2003), the need for more readily accessible screening tools is pronounced. The current findings suggest that simple self-report measures may be able to help identify children at risk for developing an avoidant attachment. Used as a screener, this assessment method may be readily implemented in a wide variety of clinical and early intervention settings, including obstetric and early pediatric health care settings as well as early prevention programs that conduct home visits for mother-infant dyads at risk. By way of widespread screening, in turn, care providers may have a better chance of interrupting intergenerational cascades of insecurity.
REFERENCES


