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# Attachment anxiety and avoidance predict postnatal partner support through impaired affective communication

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## Abstract

**Objective:** The purpose of the present study was to investigate perceived difficulties in affective communication as a key mechanism linking attachment anxiety and avoidance during pregnancy to the quality of postpartum support received by partners.

**Background:** During the postpartum period, partner support has the potential to promote family well-being by mitigating stress related to changes experienced during this transition. Attachment security is one of the most robust predictors of intimate relationship processes and impacts partner communication and support dynamics.

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**Method:** Heterosexual couples ( $N = 159$ ) completed surveys and semi-structured interviews to obtain measures of attachment security, perceived difficulties in affective communication, and quality of partner support quality during pregnancy. At 6 months postpartum, partners completed interviews to assess the quality of partner support received since childbirth.

**Results:** Greater attachment anxiety and avoidance predicted greater impairments in affective communication for men and women. Paternal difficulties with affective communication predicted the quality of support received by both mothers and fathers during the 6 months following childbirth controlling for prenatal support. The effects of attachment anxiety and avoidance on postpartum support were mediated by paternal perceptions of poor affective communication.

**Conclusion:** Findings demonstrate the utility of attachment theory for understanding adaptive and maladaptive prenatal couple dynamics and examining both parents in research on heterosexual couples navigating the pregnancy-postpartum transition. Results identify deficits in prenatal affective communication as a key factor explaining the link between attachment insecurity and postpartum partner support, warranting closer attention in interventions.

**Keywords:** attachment, communication, couples, parents, pregnancy, support

## Introduction

Social support provided by one's intimate partner is a vital resource for coping with stress (e.g., Brock et al., 2014; Cohen & Wills, 1985; Schwarzer & Knoll, 2007). Consistent with *family systems theory*, the transition from pregnancy to the postpartum period is associated with considerable adjustment and notable challenges (Cox & Paley, 2003); however, partner support has the potential to promote family health by mitigating the strains that are typical of this transition (Cowan & Cowan, 1995). Consequently, identifying factors that impact partner support during the months immediately following childbirth is an important research endeavor, especially given research consistently demonstrating the risk for declining intimate relationship satisfaction across the pregnancy-postpartum transition (e.g., Doss & Rhoades, 2017; Twenge et al., 2003). A key predictor of intimate relationship functioning is each partner's general attachment orientation

(Mikulincer & Shaver, 2016). Specifically, individuals who are lower in attachment security struggle in the domains of caregiving, proximity, and vulnerability (Bowlby, 1988; Feeney, 2004), hampering adaptive partner support processes. When one partner is inclined to either cling to or reject closeness and caregiving from a partner—two forms of attachment insecurity—both the skillful provision of support and openness to receiving support can suffer. This potential for impaired support during the postpartum period is concerning given it can interfere with caretaking of the infant (Green et al., 2007). Therefore, we aimed to investigate the role of partner attachment security in the quality of support received by each partner following childbirth, and to investigate difficulties in communication about emotion (i.e., affective communication) as a mechanism.

### ***The importance of high-quality partner support following childbirth***

The experience of pregnancy and childbirth is one of the most common shared stressors for intimate partners (Cowan & Cowan, 1995; Lawrence et al., 2008). During this transition, partners experience unique sources of strain such as navigating changes to the family, questioning their competencies as parents, and negotiating division of childcare decisions (Deave et al., 2008; Lawrence et al., 2010) which can threaten both individual health and relationship functioning. For example, rates of depression are elevated during pregnancy and the postpartum period which contributes to impaired bonding with infant and maladaptive parenting (O'Hara & McCabe, 2013). Furthermore, relationship satisfaction and quality often decline after childbirth for both first-time and experienced parents (Doss & Rhoades, 2017; Lawrence et al., 2008; Twenge et al., 2003; Volling et al., 2015) and, consistent with a spillover hypothesis, poor relationship quality negatively impacts the developing relationship between parent and child (e.g., less responsive parenting; Stroud et al., 2015). Yet, certain resources within the family system can serve to mitigate this risk. Social support received from intimate partners often serves as an essential resource for understanding, appraising, and coping with stressful experiences (e.g., perinatal role changes; Gebuza et al., 2016; Schwarzer & Knoll, 2007).

Nonetheless, it is important to acknowledge that receiving more frequent support does not universally serve an adaptive function in intimate relationships. For example, there is evidence suggesting that invisible support can be more effective under certain conditions than being aware of supportive behaviors enacted by one's partner (Girme et al., 2018). Additionally, overprovision of unwanted support can be detrimental (e.g., Brock & Lawrence, 2009). Therefore, researchers increasingly consider the function of support—above and beyond the form—by focusing on the degree to which support is perceived as adequate by the recipient (Gillis et al., 2019; Stapleton et al., 2012). Receiving more adequate support buffers against stressful experiences that contribute to individual psychopathology (e.g., Brock & Lawrence, 2010; Cohen & Wills, 1985; Cutrona & Russell, 2017), including during pregnancy and the postpartum period (Brock et al., 2014; Gebuza et al., 2016). Additionally, receiving adequate partner support serves as a protective factor for overall intimate relationship satisfaction, quality, and stability in relationships generally (Brock & Lawrence, 2008, 2010; Sullivan & Davila, 2010) and during pregnancy (Ramsdell et al., 2019). In sum, effective partner support is expected to promote the health of individuals and their relationships during the pregnancy-postpartum transition which, subsequently, results in healthier family dynamics surrounding the child.

### ***The importance of attachment security for promoting adaptive partner support processes***

*Attachment theory* has been applied to couples research for decades (Hazan & Shaver, 1987) and is one of the most robust predictors of intimate relationship outcomes such as partner support (Brock & Lawrence, 2014; Collins & Feeney, 2000, 2004). Attachment insecurity has been conceptualized as relatively stable with “the possibility of change” (Feeney, 2016, p. 443) and is characterized by difficulties with caregiving and vulnerability (Bowlby, 1988; Feeney, 2004). Thus, it is not surprising that attachment insecurity can interfere with both the provision and receipt of quality support by impairing one's ability to request support and undermining one's ability to provide adequate support when requested (Collins & Feeney, 2000).

Importantly, there are two specific dimensions of insecure attachment during adulthood that have been a focus of couples research: *anxiety* (i.e., apprehension about abandonment and preoccupation with relationships) and *avoidance* (i.e., fear of intimacy and mistrust; Kurdek, 2002). Both forms of attachment insecurity exist on continua and pose unique challenges for effective solicitation and receipt of support in intimate relationships. For example, when partners are high in attachment anxiety, they experience less comfort in exploration (e.g., they may be unwilling to take risks given the expectation that their partner may not be responsive or sensitive to signals of distress) and thus are less likely to seek support from their partner (Feeney, 2004). Alternatively, adults high in attachment avoidance experience a fear of closeness and lack of trust. They find it difficult to embrace helping behaviors and are more likely to report receiving too much support from their partners (Brock & Lawrence, 2014). Furthermore, partners who are high in attachment anxiety and avoidance are more likely to have negative interpretations of received support (Girme et al., 2015; McLeod et al., 2020).

As previously noted, the perinatal period is a high-risk time for stress and family dysfunction (Deave et al., 2008; Doss et al., 2009)—making this a key developmental period to examine attachment in couples. The attachment system is activated in times of distress (e.g., pregnancy) and these attachment related vulnerabilities can undermine social support as well as enhance perceptions of parenting strain (Alexander et al., 2001; Simpson & Rholes, 2019). There is ample evidence demonstrating that attachment insecurity undermines the couple's ability to adapt during this important family transition. Yet, the mechanisms that explain how general patterns of attachment avoidance and anxiety in one or both partners ultimately undermine the provision and receipt of postpartum support in couples warrant further research.

Given that attachment is conceptualized in part by one's willingness to express vulnerability in a relationship (Hazan & Shaver, 1987), communication is an important mechanism through which one's general attachment insecurity might impact partner support processes during the perinatal period. Furthermore, literature demonstrates that *couple* attachment (i.e., security with one's partner) shapes the communication dynamics unfolding in couple relationships more generally (e.g.,

Alexandrov et al., 2005; Feeney, 2016; Mikulincer & Shaver, 2012), and those general communication processes promote satisfaction with social support (Anders & Tucker, 2000). However, a more specific facet of communication that incorporates aspects of emotional intimacy (e.g., comfort, closeness, and willingness to engage vulnerably with one's partner; Lawrence et al., 2011), referred to as *affective communication*, has proven highly relevant for understanding couples' support processes (Brock & Lawrence, 2014; Cutrona & Russell, 2017). In accordance with Bodenmann's (2005) theory of *dyadic coping*, partners must effectively articulate and perceive distress signals during interactions with their partners as a part of the dyadic support process. These affective communication skills include the ability to openly express feelings, being willing to seek out comfort from one's partner when distressed, as well as perceiving responsiveness and understanding from one's partner in response to expressed emotion (Snyder et al., 1981). Consequently, if one or both partners are lower in attachment security, affective communication in the relationship can be compromised (Muetzelfeld et al., 2020). Indeed, attachment plays a central role in a couple's ability to build a close, trusting, emotional bond which is essential for vulnerable, affective disclosures (Constant et al., 2018) and builds a foundation for healthy support dynamics in the relationship.

***An integrated mediation model of postpartum partner support:  
The present study***

Taken together, past research and theory suggests that attachment insecurity in one or both partners might undermine effective communication about emotion in the couple relationship which, subsequently, compromises partner support processes (Mikulincer & Shaver, 2016). Although we contend that this pathway is likely to unfold in couple relationships more generally (e.g., Anders & Tucker, 2000), we believe it is particularly salient for couples navigating pregnancy and childbirth. As previously discussed, this family transition is an acutely stressful time and can strain the couple relationship prior to and following childbirth (Lawrence et al., 2010). During this period of elevated stress and adjustment, partners might be more inclined to draw on attachment-focused relationship expectations and behaviors

(e.g., withdrawal or reassurance seeking) as they anticipate and experience changing family dynamics early in parenthood (Simpson & Rholes, 2019). Furthermore, partners experience changes in family roles which contribute to deficits in communication and relationship satisfaction (Doss et al., 2009).

The overarching goal of the present study was to examine pathways linking attachment anxiety and avoidance to the overall adequacy and quality of partner support received by each partner during the 6 months following childbirth—an optimal period for intervention given the elevated stress and adjustment associated with early parenthood (Parker & Hunter, 2011; Sharma & Mazmanian, 2014). We hypothesized that impaired affective communication reported by each partner during pregnancy would emerge as a mediator through which attachment insecurity undermines partner support received by each partner during the postpartum period. Given research focused on the perinatal period has historically been limited to the experiences of pregnant women, overlooking partner contributions to overall family dynamics, the study aims were pursued within a dyadic framework with couples navigating the pregnancy-postpartum transition. Additionally, we used semi-structured interviews to obtain a robust and reliable score of the adequacy and quality of support received by each partner. Finally, a longitudinal design allowed us to examine whether attachment insecurity relates to affective communication during pregnancy, and whether deficits in affective communication during pregnancy precede subsequent support inadequacy after childbirth controlling for prenatal support.

## **Method**

### ***Participants***

Eligibility criteria for the present study included: (a) 19 years of age or older (legal age of adulthood where the research was conducted), (b) English speaking, (c) pregnant at the time of the initial appointment, (d) both partners were biological parents of the child, (e) singleton pregnancy (i.e., expecting only one child), and (f) in a committed intimate relationship and cohabiting (though couples did not have to be



married). Couples were recruited from an urban area in Nebraska; 162 couples enrolled. Three couples were excluded from the final sample due to revealed ineligibility or invalid data for a final sample of 159 couples for the pregnancy assessment (159 mothers and 159 fathers).

At the initial pregnancy assessment (completed for all couples between 2016 and 2017), couples had dated an average of 6.83 years ( $SD = 4.13$ ) and cohabited an average of 5.08 years ( $SD = 3.48$ ), indicating a relatively committed sample of couples. Most couples were married (84.9%). Over half (57.9%) reported that they were first-time parents (i.e., had no children living in the home). Most mothers were in the second (38.4%) or third (58.5%) trimester of pregnancy. Participants were primarily White (89.3% of mothers; 87.4% of fathers); 0.6% of mothers and 0.6% of fathers identified as American Indian or Alaskan Native; 2.5% of mothers and 2.5% of fathers identified as Asian; 0.6% of mothers and 3.8% of fathers identified as Black or African American; 6.9% of mothers and 5.7% of fathers identified as more than one race; 9.4% of mothers and 6.4% of fathers identified as Hispanic or Latino. On average, mothers were 28.67 years of age ( $SD = 4.27$ ), and fathers were 30.56 years of age ( $SD = 4.52$ ). The sample reported a median joint income of \$60,000 to \$69,999, and most participants were employed at least part-time (>16 hours per week; 74.2% of mothers; 91.8% of fathers). Furthermore, the modal education was a bachelor's degree (46.5% of mothers; 34.6% of fathers).

### **Procedures**

All procedures were approved by the University of Nebraska-Lincoln Institutional Review Board, some of which are part of a large-scale longitudinal study of child development that are outside the scope of the present study. Both partners attended a 3-hour laboratory appointment during pregnancy, completing a series of procedures to assess interparental relationship processes prior to childbirth. Procedures included each partner completing semi-structured clinical interviews and self-report questionnaires in separate rooms from one another. Partners did not interact until these procedures were complete. Participants were compensated with \$50 (for a total of \$100 per couple) for attending the appointment. Then, at approximately 6 months postpartum ( $M = 6.32$  months,  $SD = 0.36$ ), both parents completed

a semi-structured interview over the phone with a member of the research team. Participants were instructed to complete the phone interviews separately and privately. Participants were compensated with \$50 (\$100 total per couple) for the 6-month assessment. Approximately 89% of the couples in this sample participated in the 6-month assessment. During scheduling of the 6-month assessment, two couples revealed that they had separated and, therefore, their postpartum data were treated as missing.

## **Measures**

### *General attachment insecurity*

The *Relationship Styles Questionnaire* (RSQ; Griffin & Bartholomew, 1994) is a measure of individual attachment style. During the pregnancy assessment, participants responded to statements regarding their feelings about close relationships, both past and present, using a scale ranging from 1 (*not at all like me*) to 5 (*very much like me*). Though participants may consider their relationship with their partner in item responses, scores on the RSQ reflect a broader and more general internal working model about close relationships rather than attachment with their current partner. To extract scores of the two key dimensions of insecure attachment—*avoidance* (e.g., *I find it difficult to trust others completely*) and *anxiety* (e.g., *I often worry that romantic partners won't want to stay with me*)—we factor analyzed items as recommended by Kurdek (2002). Possible range of scores is 16–80 for the avoidance scale (16 items, Cronbach's  $\alpha = .86$ ) and 10–50 for anxious scale (10 items, Cronbach's  $\alpha = .86$ ).

### *Perceived difficulties in affective communication during pregnancy*

Participants completed a self-report measure of impaired affective communication (AFC) from the *Marital Satisfaction Inventory* (Snyder et al., 1981). This scale has been used as an indicator of deficits in felt closeness, discomfort with communication between partners and dissatisfaction with the mutual sharing of feelings (e.g., *my partner responds with understanding to my mood*) reported by an individual in a committed relationship (Snyder, 1997). Distinct from the RSQ, the

AFC scale asks participants to respond to items related to their current intimate relationship. Items were scored on a true/false response scale with a possible range of scores of 0–13. Internal consistency was adequate in the present study (Cronbach's  $\alpha = .77$ ).

*Quality of received partner support during pregnancy and 6 months postpartum*

The *Relationship Quality Interview* (RQI; Lawrence et al., 2011) is a 60–90 min interview that allows interviewers to conduct functional analyses of relationships across multiple domains over the past 6 months. One of these domains is the quality of partner support received when a person is feeling down or has a problem. Participants are asked to reflect on their experiences receiving support from their partners for each of several support types including emotional (i.e., validation of participant's feelings and expressed understanding of problem), tangible (i.e., offers to complete tasks, [in]directly solves participant's problem), informational (i.e., provides helpful information or advice to participant), esteem (i.e., expressing confidence in participant's ability to handle problems), and network (i.e., spending additional time with participant when distressed). Based on detailed accounts provided by participants throughout the discussion, the interviewer can assess (a) match between desired and received levels of support (i.e., the recipient's satisfaction with the amount and quality of support relative to their preferences) and (b) responsiveness and skillfulness of enacted support (e.g., partner is responsive to requests for support; support is not provided in a negative or condescending manner). Thus, this interview captures the *adequacy* of support that has been received over the past 6 months by factoring in both objective assessments of the overall skill in which support is enacted and subjective accounts of match between received and desired types and levels of support.

Parents completed the RQI with a member of the research team at approximately 6 months after childbirth and reported on the quality of partner support since the child was born. Participants had also completed the interview during pregnancy, which allowed us to include prenatal support scores as covariates in all analyses and isolate

change variance in support following childbirth. A team of trained clinical research assistants interviewed participants and coded the interview responses using established coding rules. Interrater reliability was excellent during pregnancy (intraclass correlation coefficient [ICC] = .91) and the 6-month postpartum assessment (ICC = .90). For the support section of the interview, a single objective global rating was made on a 9-point scale, and scores can range from 1 (*partner provided no support or partner provides some support but it was not what the participant wanted; partner almost always dismissed or ignored requests for support or responded with criticism*) to 5 (*some mismatch between type of support received and type of support desired [about half the time]; participant was neutral about received support*) to 9 (*high quality of support from partner; partner was excellent at providing support and always responded well to requests for support*). For example, someone receiving a relatively high score might endorse receiving support from their partner that meets their unique needs in response to a given problem, such as listening, understanding, and providing reassurance that they were not at fault for the problem. Alternatively, someone receiving a relatively low score might report receiving too little support (e.g., minimal validation or tangible assistance), or support from their partner that did not adequately address support needs, such as providing unwanted problem-solving that exacerbates distress. The RQI has demonstrated strong reliability, as well as convergent and divergent validity (Lawrence et al., 2009, 2011).

### ***Data analytic approach***

Data were analyzed using Mplus software (Muthén & Muthén, 2010). Missing data were addressed using full information maximum likelihood estimation (Enders, 2010). At the item-level for questionnaires (i.e., RSQ, AFC), missing data were addressed by first averaging across items on a scale and then multiplying by the number of items on the scale to convert to a sum-score metric; missing data at the item-level were minimal (>3%). Covariance coverage in the tested model (i.e., proportion of data available for a combination of any two variables) ranged from .70 to 1.00. We followed procedures outlined by Hayes (2009) to test mediation. A bootstrap approach (Shrout & Bolger,

2002) was implemented which provides an empirical approximation of sampling distributions of direct and indirect effects to produce confidence intervals (CIs) of estimates. If zero does not fall within the CI, one can conclude that an effect is present (i.e., different from zero). We performed a nonparametric resampling method (bias-corrected bootstrap) with 10,000 resamples drawn to derive the 95% CIs for the direct and indirect effects which addresses potential bias due to violations of normality (Shrout & Bolger, 2002).

We also implemented features of actor-partner interdependence modeling for distinguishable dyads (i.e., each couple was comprised of a pregnant mother and her partner; Kenny et al., 2006); in the present study, the couple was used as the unit of analysis. There were two dyad members, two variables ( $X$  and  $Y$ ) for each member, and two sets of effects: (a)  $X$  affects own  $Y$  (*actor effects*) and (b)  $X$  affects partner's  $Y$  (*partner effects*). In the case of distinguishable dyads, there are two actor effects (e.g., Father  $X_1 \rightarrow$  Father  $Y_1$ ; Mother  $X_2 \rightarrow$  Mother  $Y_2$ ) and two partner effects (e.g., Father  $X_1 \rightarrow$  Mother  $Y_2$ ; Mother  $X_2 \rightarrow$  Father  $Y_1$ ) to link any two variables together in the model (e.g., attachment avoidance  $\rightarrow$  impaired affective communication). Implementation of partner effects allows for the estimation of relational effects rather than focusing only on intrapersonal (actor) effects that can be overestimated when examined alone. There are also two types of correlations in the model between: (a) exogenous variables ( $X_1$  and  $X_2$ ), and (b) residuals of endogenous variables ( $M_1$  and  $M_2$  and  $Y_1$  and  $Y_2$ ). Furthermore, because the analyses were conducted with distinguishable dyads, we conducted a series of analyses to test for indistinguishability of paths across partners. This was accomplished by constraining any two parallel paths (e.g., mother anxiety  $\rightarrow$  mother communication; father anxiety  $\rightarrow$  father communication) to be equal across partners and comparing the fit of that model to a model with all paths free to be estimated. In the case of a nonsignificant chi-square difference test, we concluded that the fit was not improved by allowing paths to differ across partners and, instead, retained the equality constraint. This helped to promote parsimony in the model by reducing the number of estimated parameters.

## Results

Correlations and descriptive statistics are reported in **Table 1**. Notably, average scores of attachment anxiety and avoidance were relatively low, suggesting that individuals with more severe levels of attachment insecurity were not well-represented in this sample. However, these means are consistent with those reported in other community samples (e.g., Brock & Lawrence, 2014). A series of theoretically meaningful variables were screened for potential inclusion as controls in the hypothesized model, including: first-time parenthood status, length of intimate relationship, racial and ethnic minority status, and partner age (Becker et al., 2016). None of these variables were significantly associated with any of the endogenous variables in the model (i.e., impaired affective communication or postpartum partner support) and were not included in the final tested model. Given that couples entered the study at different points during pregnancy, week of pregnancy was also screened as a potential control but was not significantly correlated with any of the study variables. Therefore, the only control variable included in the tested model was support adequacy scores obtained by both partners during pregnancy to isolate change variance in support from pregnancy to 6 months postpartum.

To inform model specification, we first tested for indistinguishability of each path in the hypothesized model. Results are reported in **Table 2**. Introducing equality constraints across mothers and fathers was preferential for 9 out of the 14 paths as indicated by nonsignificant chi-square difference tests. For the proposed mediation mechanism (comprised of paths *a* and *b*), there were no gender differences in the association between attachment dimensions and affective communication; however, both actor and partner paths linking affective communication to postpartum received support differed across mothers and fathers.

Next, we proceeded to test the full hypothesized mediation model by implementing equality constraints as informed by preliminary analyses (summarized in Table 2). Results of the path model are reported in **Table 3** and **Figure 1**; Table 3 includes the 95% CIs from the bootstrap approach that was implemented for determining the significance of each path. Global fit of the model was excellent,  $\chi^2(9, N = 159) = 3.709, p = .930$ , comparative fit index (CFI) = 1.000, root mean square error of approximation (RMSEA) = .000, standardized root mean square residual (SRMR) = .016. The tested model explained 42%

**Table 1** Correlations and descriptive statistics

	1	2	3	4	5	6	7	8	9	10
1. M anxiety	-									
2. F anxiety	.34**	-								
3. M avoidance	.45**	.22**	-							
4. F avoidance	.22**	.52**	.17*	-						
5. M AFC	.32**	.13	.21**	.17*	-					
6. F AFC	.25**	.32**	.17*	.31**	.31**	-				
7. M 6M received support	-.25**	-.15	-.27**	-.16*	-.46**	-.42**	-			
8. F 6M received support	-.01	-.22**	-.08	-.15	-.19*	-.58**	.26**	-		
9. M prenatal received support	-.25**	-.03	-.15	-.03	-.60**	-.21**	.54**	.15	-	
10. F prenatal received support	-.18*	-.17*	-.08	-.18*	-.18*	-.45**	.24**	.35**	.11	-
Mean	20.49	18.99	38.48	40.53	2.38	1.53	6.52	6.80	6.56	6.83
SD	7.14	6.93	9.87	9.94	2.48	1.94	1.46	1.13	1.35	1.07
N	159	158	159	159	159	159	128	117	157	157

Abbreviations: AFC, poor affective communication; anxiety, attachment anxiety; avoidance, attachment avoidance; F, father; M, mother; prenatal, measured during pregnancy; 6M, measured at 6 months postpartum.

\* $p < .05$ , \*\* $p < .01$ .

**Table 2** Indistinguishability of specific paths in the model

	$\chi^2$ (1)	<i>p</i>	Indistinguishable
Path a – Anxiety → AFC			
<b>Actor</b>	<b>0.00</b>	<b>.978</b>	<b>Yes (fix)</b>
<b>Partner</b>	<b>0.10</b>	<b>.748</b>	<b>Yes (fix)</b>
Path a – Avoidance → AFC			
<b>Actor</b>	<b>0.42</b>	<b>.517</b>	<b>Yes (fix)</b>
<b>Partner</b>	<b>0.49</b>	<b>.486</b>	<b>Yes (fix)</b>
Path b – AFC → 6M received support			
Actor	10.46	.001	No (free)
Partner	5.60	.018	No (free)
Path c' – Anxiety → 6M received support			
<b>Actor</b>	<b>1.19</b>	<b>.275</b>	<b>Yes (fix)</b>
<b>Partner</b>	<b>1.83</b>	<b>.176</b>	<b>Yes (fix)</b>
Path c' – Avoidance → 6M received support			
Actor	4.00	.045	No (free)
<b>Partner</b>	<b>0.01</b>	<b>.912</b>	<b>Yes (fix)</b>
Covariate – Prenatal received support → 6M received support			
Actor	5.49	.019	No (free)
<b>Partner</b>	<b>0.03</b>	<b>.856</b>	<b>Yes (fix)</b>
Covariate – Prenatal received support → AFC			
Actor	3.99	.046	No (free)
<b>Partner</b>	<b>0.07</b>	<b>.792</b>	<b>Yes (fix)</b>

AFC: poor affective communication

Anxiety: attachment anxiety

Avoidance: attachment avoidance

(fix): paths were constrained to be equal across mothers and fathers based on a nonsignificant chi-square for nested model comparison suggesting indistinguishability (bolded)

Prenatal: measured during pregnancy

6M: measured at 6 months postpartum

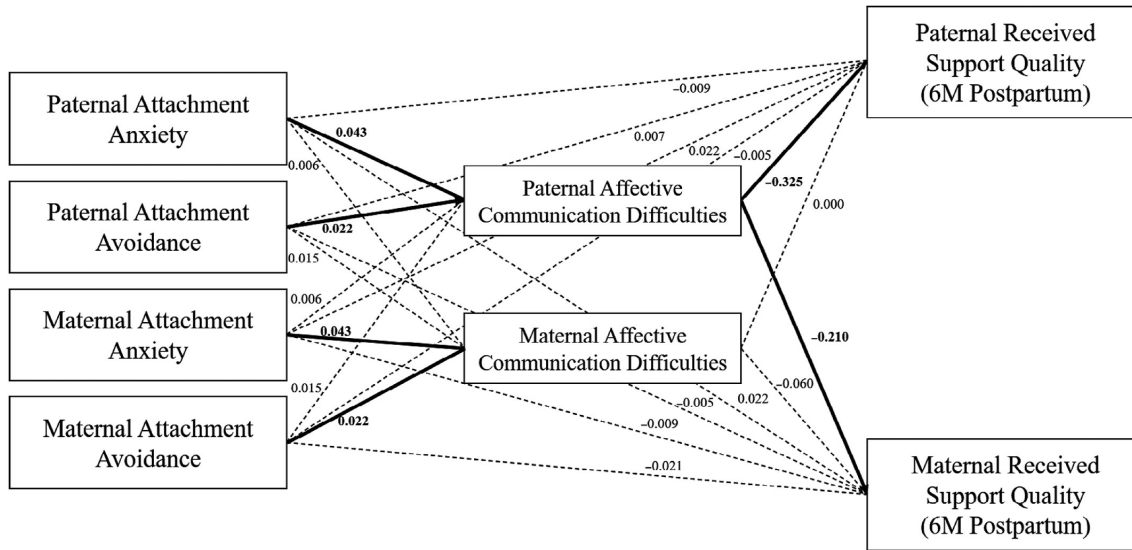
of the variance in maternal prenatal affective communication scores and 31% of paternal prenatal affective communication scores, as well as 42% of variance in maternal postpartum support scores and 37% of variance in paternal postpartum support scores. Regarding path *a*, only actor paths were significant (i.e., CIs did not contain zero) and, as previously established, were equivalent across partners. One's own anxiety and avoidance was associated with one's own perceptions of poor affective communication regardless of gender. Regarding path *b*, only paternal affective communication was uniquely associated with postpartum support; specifically, poorer communication reported by fathers predicted lower quality support received by both fathers (actor path) and mothers (partner path). Direct pathways from paternal and maternal attachment dimensions to support independent of affective communication (path *c'*) were not significant.



**Table 3** Final model results

Direct paths	Unstandardized estimate	95% CI	Standardized coefficient
Path a: Attachment insecurity → Communication difficulties			
<b>F anxiety → F AFC</b>	<b>0.043</b>	<b>[0.010, 0.078]</b>	<b>0.155</b>
<b>F avoidance → F AFC</b>	<b>0.022</b>	<b>[0.003, 0.043]</b>	<b>0.113</b>
F anxiety → M AFC	0.006	[-0.034, 0.044]	0.016
F avoidance → M AFC	0.015	[-0.009, 0.044]	0.062
M anxiety → F AFC	0.006	[-0.034, 0.044]	0.021
M avoidance → F AFC	0.015	[-0.009, 0.044]	0.079
<b>M anxiety → M AFC</b>	<b>0.043</b>	<b>[0.010, 0.078]</b>	<b>0.124</b>
<b>M avoidance → M AFC</b>	<b>0.022</b>	<b>[0.003, 0.043]</b>	<b>0.087</b>
Path b: Communication difficulties → Postpartum support			
<b>F AFC → M 6M received support</b>	<b>-0.210</b>	<b>[-0.342, -0.068]</b>	<b>-0.267</b>
<b>F AFC → F 6M received support</b>	<b>-0.325</b>	<b>[-0.444, -0.181]</b>	<b>-0.541</b>
M AFC → M 6M received support	-0.060	[-0.183, 0.078]	-0.099
M AFC → F 6M received support	0.000	[-0.104, 0.112]	0.000
Path c': Attachment insecurity → Postpartum support			
F anxiety → M 6M received support	0.022	[-0.002, 0.050]	0.100
F avoidance → M 6M received support	-0.005	[-0.022, 0.011]	-0.035
F anxiety → F 6M received support	-0.009	[-0.035, 0.015]	-0.053
F avoidance → F 6M received support	0.007	[-0.012, 0.025]	0.058
M anxiety → M 6M received support	-0.009	[-0.035, 0.015]	-0.042
M avoidance → M 6M received support	-0.021	[-0.044, 0.004]	-0.135
M anxiety → F 6M received support	0.022	[-0.002, 0.050]	0.135
M avoidance → F 6M received support	-0.005	[-0.022, 0.011]	-0.045
Covariances among exogenous variables			
<b>M anxiety - F anxiety</b>	<b>16.846</b>	<b>[9.855, 25.205]</b>	<b>0.341</b>
<b>M anxiety - M avoidance</b>	<b>31.763</b>	<b>[19.824, 45.006]</b>	<b>0.451</b>
<b>M anxiety - F avoidance</b>	<b>15.913</b>	<b>[4.702, 27.957]</b>	<b>0.224</b>
<b>F avoidance - M avoidance</b>	<b>16.373</b>	<b>[2.317, 30.335]</b>	<b>0.167</b>
<b>F avoidance - F anxiety</b>	<b>35.516</b>	<b>[23.78, 49.417]</b>	<b>0.515</b>
<b>F anxiety - M avoidance</b>	<b>15.024</b>	<b>[5.918, 25.566]</b>	<b>0.220</b>
Covariances among residuals of endogenous variables			
<b>M AFC - F AFC</b>	<b>0.446</b>	<b>[0.010, 0.981]</b>	<b>0.146</b>
M 6M received support - D 6M received support	0.009	[-0.193, 0.219]	0.008

Maternal and paternal support scores during pregnancy were included as covariates in the model (i.e., predictors of AFC and 6M received support scores) but are not reported here for ease of presentation. Significant findings are **bolded**. Bootstrapping was used to obtain 95% CIs of all effects; effects with CIs that did not contain zero were identified as significant. Abbreviations: AFC, poor affective communication; anxiety, attachment anxiety; avoidance, attachment avoidance; CIs, confidence interval; F, father; M, mother; 6M, measured at 6 months postpartum.



**Figure 1** Path model results. Unstandardized coefficients are reported. Full model results are reported in Table 1. Attachment anxiety and avoidance and perceived difficulties in affective communication were measured during pregnancy. Received support quality was measured at 6 months (6M) postpartum and prenatal support quality was included as a covariate (not depicted here for ease of presentation). Solid lines with bolded coefficients represent paths that were significant. Bootstrapping was used to obtain 95% confidence intervals (CIs) of all effects (see Tables 3 and 4); effects with CIs that did not contain zero were identified as significant. Residuals for maternal and paternal scores of affective communication and maternal and paternal scores of received support were covaried. Please refer to Table 3 for detailed results

Estimates of indirect effects for testing mediation hypotheses are reported in Table 4. Results support our hypothesis that poorer affective communication mediates the effect of attachment anxiety and avoidance on the quality of partner support received during the 6 months postpartum, controlling for prenatal support quality. However, consistent with findings that only *paternal* reports of affective communication uniquely predicted postpartum support, mediation effects were only present for pathways anchored in father attachment anxiety and avoidance through father's perceptions of poor affective communication. Specifically, higher scores of attachment anxiety, 95% CI [-0.030, -0.003], and avoidance, 95% CI [-0.017, -0.001], reported by fathers predicted lower quality support received by fathers during the 6 months following childbirth via paternal reports

of poorer affective communication during pregnancy. Paternal attachment anxiety, 95% CI [-0.022, -0.002], and avoidance, 95% CI [-0.012, -0.001], were also negatively associated with *maternal* received support through this pathway.

## Discussion

The experience of pregnancy and childbirth is a unique stressor shared by intimate partners as they navigate rapidly changing family dynamics and new caregiving roles (Deave et al., 2008; Lawrence et al., 2010). The quality of partner support available after childbirth is an important resource with the potential to protect the mental health of individual partners and promote intimate relationship stability during this time of heightened stress and adjustment. The primary goal of the present study was to apply an attachment framework to identify salient pathways present during pregnancy that predict individual differences in the quality of support available to parents during the first 6 months after childbirth. Results of the present study partially support our hypotheses that individuals who are higher in attachment anxiety and avoidance report greater discomfort with vulnerability and less disclosure of emotions during pregnancy (i.e., difficulties in affective communication) regardless of gender. However, it was only poor affective communication perceived by *fathers* that ultimately predicted postpartum support, a vulnerability that had a pervasive effect on the relationship such that both fathers and mothers received lower quality support. Taken together, results suggest that father attachment anxiety and avoidance undermine support available to both partners during the postpartum period to the extent that fathers perceived poorer affective communication with their partners.

Results are consistent with attachment theory and previous attachment-related findings for couples. Attachment anxiety and avoidance are expected to undermine a couple's ability to effectively communicate (Constant et al., 2018; Muetzelfeld et al., 2020). For example, adults high in attachment anxiety tend to be preoccupied with their own emotional experiences and insecurities (Mikulincer & Shaver, 2012) leading to discomfort when engaging in interactions that involve

disclosure or vulnerability (Simpson & Rholes, 2017). Furthermore, individuals high in attachment avoidance are more likely to reject vulnerable interactions and open expressions of affect (Brock et al., 2014; Simpson & Rholes, 2017). Despite some indication in past research that there are gender differences in how attachment security impacts relationships (e.g., that attachment anxiety is more salient and problematic for women; Kirkpatrick & Davis, 1994), recent perspectives suggest that attachment insecurity impacts relationship functioning regardless of gender (Feeney, 2016). Therefore, we are careful not to overstate gender differences in the present study. However, we highlight the importance of considering the contributions that fathers make to family dynamics during pregnancy and postpartum. In fact, our results converge with evidence that fathers undergoing the transition to parenthood exhibit lower relationship satisfaction and less responsiveness toward their partners to the extent that they are higher in attachment insecurity (Feeney et al., 2001).

Although no gender differences emerged regarding the impact of attachment on communication difficulties, it was only *paternal* perceptions of affective communication that were uniquely associated with postpartum support. This was surprising given perspectives that communication is central to dyadic coping efforts in couples (Bodenmann, 2005), leading us to expect perceptions of communication by both partners to be equally important for postpartum support. Ultimately, the hypothesized mediation pathway was only present through paternal perceptions of affective communication difficulties: to the extent that fathers were higher in attachment anxiety and avoidance, they perceived greater communication difficulties during pregnancy which resulted in both partners receiving lower quality postpartum support. Although we did not anticipate significant gender differences in this effect, research suggests that mothers and fathers experience the transition to postpartum differently such that fathers tend to struggle more with new childcare demands (Fillo et al., 2015). Additionally, men are more likely approach problems with an agentic orientation (i.e., concern with independence and self-competence), whereas women are often socialized to approach problems with a relational orientation (e.g., communal and unselfish; Eagly & Wood, 1988), which may prevent men from sharing emotional concerns during times of stress (e.g., major life transitions). If fathers avoid having difficult or

emotional conversations about upcoming role changes during pregnancy—perhaps due to perceived communication impairments in the relationship—the couple might have a more difficult time adapting to changes after childbirth, undermining their ability to support one another. Furthermore, if fathers perceive deficits in affective communication during pregnancy, they might be less inclined to express emotional needs or experiences during the postpartum period, further undermining support. However, these explanations are speculative, and future research is required to elucidate why fathers who perceive difficulties with affective communication in the relationship ultimately provide and receive lower quality partner support after childbirth. Results highlight that, for heterosexual couples navigating the pregnancy-postpartum transition, it is important to routinely examine both mothers and fathers given this salient pathway would have been overlooked if we had restricted our examination to mothers.

### ***Limitations***

There were several limitations to the present study to consider before discussing the implications of the results. First, support was measured with a semi-structured interview which largely captures the perceived adequacy of support that has been received. Because partner support is a multidimensional construct (Brock & Lawrence, 2010), other facets of support transactions unfolding between partners (e.g., observed help seeking behaviors or provision of support) might have been differentially impacted by the proposed mechanisms. Second, attachment avoidance and anxiety scores were relatively low and partner support was of relatively high quality on average, as is to be expected in a community sample; future research should be conducted with high-risk samples (e.g., low income) and clinical samples demonstrating more dysfunctional support processes during this transition. Third, it is important to highlight that participants were limited in ethnic and racial diversity, decreasing the overall generalizability of these findings to populations other than Midwest White families. Generalizability was further limited given that gender was measured as binary, and recruitment was limited to heterosexual couples experiencing the birth of their biological child. Importantly, future research should replicate the aims of this study in more diverse families (e.g.,

sexual and gender minority couples; adoptive parents; racially diverse couples), as well as extend examinations of support trajectories over time as family dynamics continue to develop. Fourth, the present study focused on communication and support patterns in couples across the pregnancy-postpartum transition. There is a robust literature demonstrating that global, subjective evaluations of the relationship (i.e., relationship satisfaction) also change. Future research might investigate how changes in relationship satisfaction coincide with changes in communication and support during this transition and explore whether a reciprocal association unfolds over time such that support also feeds back into affective communication. Finally, couples completed assessments of partner support processes during the first 6 months postpartum; however, it is important to note that additional change and adjustment occurs well beyond those first 6 months. Considering patterns of support at different time points—and perhaps later—during the transition to parenthood, as well as the potential for unique correlates of support processes, is important in future research.

### ***Implications and conclusions***

In sum, each individual partner's attachment security appears to play a salient role in relationship processes unfolding during pregnancy and after childbirth. Higher levels of attachment avoidance and anxiety predicted perceptions of affective communication difficulties during pregnancy for both partners regardless of gender (as paths were indistinguishable for mothers and fathers). However, quality of postpartum support was only undermined to the extent that *fathers* reported a lack of affection and comfort with vulnerability in the couple relationship during pregnancy. Results highlight the utility of applying attachment theory to understand couple relationship dynamics unfolding during the pregnancy-postpartum transition and identify a key mechanism linking attachment to partner support following childbirth— affective communication.

Taken together, results suggest that interventions aimed at promoting healthy expressions of affect, comfort with vulnerability, and emotional disclosure during pregnancy might be critical for overcoming susceptibilities arising from attachment insecurity. Although attachment insecurity is relatively stable in adulthood, it does have the

potential to change (Feeney, 2016), especially during the transition into parenthood (Simpson et al., 2003). Individuals who broadly struggle with responsiveness and caregiving—indicative of high levels of attachment avoidance or anxiety—during pregnancy might benefit from couples interventions that promote a relationship environment characterized by safe, open, and honest communication between partners, including disclosure of difficult-to-share information in the presence of stress (Stanley & Markman, 2020). Given perceived difficulties in affective communication reported by fathers undermined the quality of support available during the postpartum period in the present study, broader implementation of interventions with skill-building modules that specifically target affective communication within the couple relationship during pregnancy with *both parents* may address relationship vulnerabilities precipitated by attachment insecurity (e.g., Family Foundations; Feinberg & Kan, 2008). Ultimately, preventative interventions of this nature might help parents build critical skills that are foundational for the development of adaptive coparenting dynamics during early childhood (Feinberg et al., 2009).



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