Attachment and psychosis
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Introduction
Attachment and psychosis

This thesis focuses on the concept of ‘attachment’ in order to increase our understanding of current psychosocial models of psychosis and schizophrenia. Schizophrenia is considered the most severe of psychiatric disorders, affecting about 1% of the world population and is amongst the top 10 causes of long term disability (Mueser & McGurk, 2004). To date, the exact cause of schizophrenia remains unknown, although research has suggested an interaction between genetic and environmental factors such as early adverse events, urbanisation level, cannabis use and social isolation, which are thought to affect the development of the ‘social brain’ (van Os, 2010).

A relatively understudied environmental factor within psychosis research is the impact of ‘insecure attachment’ patterns. This is surprising as there is well established prospective evidence of attachment predicting other psychiatric disorders such as borderline personality disorders (Fonagy et al., 1996), dissociative disorders (Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997) and anxiety disorders (Warren, Huston, Egeland, & Sroufe, 1997). A core characteristic of the ‘Attachment Theory’ is that people are biologically driven to form attachment bonds with others (Fraley & Shaver, 2000; Rholes & Simpson, 2004). Individual differences in attachment relationships are a result of different experiences, expectations and beliefs regarding these relationships. The formed ‘attachment style’ is considered a guide through social life. In psychosis, social life is often disrupted and therefore studying attachment could contribute to the identification of possible underlying mechanisms involved in the development, course and outcome of psychosis.

In this thesis, attachment is studied from two perspectives. The first being the role of attachment in the development of interpersonal functioning in psychosis. Several studies, investigating pathways to psychosis, identified childhood trauma or adverse events in early life as a risk factor for developing psychosis (Varese et al., 2012). Attachment has been proposed a potential mediator of this process, as childhood trauma negatively affects the development of secure attachment patterns which in turn increases the risk of both interpersonal difficulties and the development of psychosis (Read & Gumley, 2008).

Another factor closely related to interpersonal dysfunctioning is the development of impaired social cognition. Social cognition skills enable individuals to accurately interpret and process interpersonal relationships and the social world in general. Secure attachment bonds provide optimal conditions for the development of these skills and can be disrupted by negative interpersonal experiences, including difficulties in early attachment relationships (Fonagy et al., 2012). Impaired social cognition skills were found to be related to paranoid ideation, social functioning, help-seeking behaviour and the quality of the therapeutic alliance between patient and therapist (Davis, Eicher et al. 2011, Garety, Kuipers et al. 2001, Lysaker, Carcione et al. 2005, Lysaker, Gumley et al. 2013). In this light, attachment will be studied in relation to both childhood adversities and social cognition.

The second perspective is the role attachment plays in the process of adaptation and recovery from psychosis. After psychosis has established itself, poor interpersonal functioning, as a result of the previously described factors, may have become a key issue in daily life of patients. Difficulties with interpersonal relationships and diminished social
networks, in combination with psychotic symptomatology, increase the negative impact on the quality of life of many patients with psychosis. As attachment is believed to play an important underlying role in social dysfunctioning in psychosis, this underlines the importance of further studying the concept, in order to understand what influences quality of life of patients with psychosis.

In order to cope with the stressful experience of psychotic symptoms and related (social) problems, treatment often plays a major part in the recovery process. Treatment adherence and the relationship with therapists are therefore of utmost importance and are important predictors of therapy outcome (Horvath & Symonds, 1991). As interpersonal relationships include those with therapists, attachment may also influence treatment relations. In this light, quality of life and the therapeutic alliance in patients with psychosis will be studied.

In the following paragraphs these concepts will be briefly introduced.

**Attachment Theory**

A developmental model that captures interpersonal functioning, is the ‘Attachment Theory’ (Bowlby, 1973). This theory is based on the assumption that early experiences lead to the formation of ‘internal working models’ or ‘mental representations’ of self, others and relationships with others, which help individuals guide and interpret social experiences throughout life (Berry, Barrowclough & Wearden, 2007; Collins & Allard, 2004). It proposes that early affectionate bonds with significant others have great impact on later interpersonal and psychological functioning, personal resilience and affect regulation (Gumley et al., 2013). Thoughts, feelings and behaviours in social context derived from internal working models are conceptualized in so called ‘attachment styles’, which are activated in times of distress (for a detailed description of the attachment styles see chapter 1).

Support for this theory are the reported associations between early experiences and close relationships in later life, as well as associations between adult attachment style and social functioning, interpersonal difficulties and psychopathology (Bartholomew & Horowitz, 1991; Berry, Wearden, Barrowclough, & Liversidge, 2006; Platts,Tyson, & Mason, 2002, Crowell, Fraley, & Shaver, 1999, van Ijzendoorn & Bakermans-Kranenburg, 2008).

Specifically in psychosis, interpersonal difficulties and diminished social networks often occur (Bellack et al., 1990; Berry et al., 2007b; Berry et al., 2007c). As attachment theory is by its very nature a theory about interpersonal relationships, it might provide insight into these interpersonal difficulties experienced in psychosis and help further develop existing models and conceptualizations of psychosis.

**Assessment of attachment**

Several instruments have been developed to measure attachment (Mikulincer and Shaver 2007). Narrative and self-report approaches are the most commonly used in research assessing and conceptualizing attachment. The theoretical background of both these approaches is similar; early childhood experiences lead to the formation of attachment patterns which in turn influence later interpersonal functioning. Self-report measures are the least time consuming and easy to administer and are therefore used in this thesis. Self-report attachment measures with an underlying two factor structure distinguishing attachment
anxiety and attachment avoidance have repeatedly been found to be the valid (Brennan et al. 1998; Kurdek 2002; Stein et al. 2002). Attachment anxiety represents tendencies to have a strong desire for closeness and a need to feel loved, combined with intense worry about whether others are available (Berry et al. 2007; Howe 2011; Mikulincer and Shaver 2007). Individuals with high levels of attachment anxiety need approval from others for their well-being and may present themselves as helpless and vulnerable when distressed. In contrast, attachment avoidance represents tendencies to prefer emotional distance and being uncomfortable with closeness to others. Individuals with high levels of attachment avoidance value independence and autonomy, may even be compulsively self-reliant and prefer doing things alone (Berry et al. 2007; Mikulincer and Shaver 2007). Secure attachment is operationalized by low levels of both anxiety and avoidance dimensions whereas high levels of one or both dimensions demonstrates insecure attachment.

A detailed description of attachment assessment and related issues is provided in chapters 1 and 4.

**Psychosis**

Psychosis is an abnormal state of mind with distortions in perception, thought and reality testing. A first psychosis usually occurs in late adolescence and is often very disruptive with regard to personal and social functioning. Psychotic syndromes have therefore been described as disorders of social context adaptation (Van Os et al., 2010).

According to the DSM-5 (APA, 2013) psychotic disorders are characterised by the following five features: (1) delusions, (2) hallucinations, (3) disorganized thinking and speech, (4) grossly disorganized or abnormal motor behaviour (including catatonia) and (5) negative symptoms (such as the inability to experience pleasure and lack of motivation, affective flattening, social withdrawal and poverty of speech). To extend the categorical (absent/present) approach of the DSM IV (APA, 2000), the DSM-5 adopted a dimensional approach to assess severity in psychotic disorders. In addition to these symptom dimensions, scales for depression, mania and cognitive impairment were included. These are used for distinguishing within schizophrenia and between schizophrenia spectrum disorders and other psychotic disorders. Of those, schizophrenia is often considered as the most severe psychosis spectrum disorder, with a lifetime prevalence between 0.30-0.66% (MacGrath et al., 2008). Schizophrenia is characterised by significant impairment in social and interpersonal functioning. The DSM states ‘for a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved before onset’.

**Social and Interpersonal Functioning**

Even though a first psychosis often occurs in late adolescence, deficits in social functioning are frequently evident long before onset of psychotic symptoms. Problems in social functioning have also been reported in individuals at an increased genetic risk of developing psychosis, such as patient’s siblings, and in individuals at an ultra-high risk of developing psychosis (Shapiro et al., 2009; Addington et al., 2008). Social deficits were associated with course of illness and quality of life (Couture et al., 2006). Taken together, social dysfunction is an...
important feature of psychosis that is associated with its development, course and outcome and has therefore been studied intensively.

In unravelling the possible mechanisms that underlie social deficits in psychosis, it is important to determine which aspects of social functioning are of interest, as it is a broad concept with different components that might relate differentially to outcome (Collip et al., 2010). According to Birchwood and colleagues (1990), the following domains of social functioning in schizophrenia should be considered; social engagement or withdrawal; interpersonal behaviour; engagement in social activities and recreation; independence competence and performance; and employment or occupation. Couture et al. (2006) propose to distinguish between these domains as they may be differentially related to outcome.

In relation to psychosis, specifically the ‘quality of social relations’ or ‘interpersonal functioning’ was found to be related to (subclinical) psychotic symptoms, transition risk and age of onset of psychosis (Cornblatt et al., 2003; Velthorst et al., 2010; Collip et al., 2010).

In a longitudinal study, poor interpersonal functioning predicted psychotic phenomena, but not the other way around, suggesting that poor interpersonal functioning in adolescence may precede psychosis (Collip et al., 2010). These findings suggest a potential role for interpersonal functioning in relation to the formation of specific symptoms, such as persecution ideation and paranoid experiences. The authors suggest that interpersonal functioning in later life is affected by family interactions early in life when schemes or working models about self and others are formed. For example, important concepts such as ‘trust’ are developed in early life and may be related to an increased vulnerability to paranoid ideation later in life.

**Social Cognition and attachment**

A concept closely related to interpersonal difficulties is social cognition, defined as the mental processes underlying social interactions (Couture et al., 2006; Fett et al., 2011). A domain particularly of interest in this regard is ‘Theory of Mind’ (ToM), the ability to understand mental states such as beliefs, emotions and intentions of self and others (Bailey and Henry, 2010; Dumontheil et al., 2010a). ToM impairments have repeatedly been described in patients with psychosis (Corcoran et al., 1995; Sprong et al., 2007; Versmissen et al., 2008). To understand underlying or associated factors of ToM impairment in psychosis, insights derived from attachment theory may be helpful (Berry et al., 2007a), as both are based on mental representations about self and others. Insecure attachment and impaired ToM were found to co-occur especially in patients with paranoid symptoms and are considered possible underlying mechanisms of interpersonal difficulties (Randall et al., 2003; Sprong et al., 2007; Taylor and Kinderman, 2002). Increasing our knowledge of factors underlying social cognitive impairment may offer handles for treatment interventions.

**Adverse childhood experiences and attachment**

Adverse childhood experiences increase the risk of psychosis (Varese et al., 2012) and may precede specific symptoms of psychosis such as paranoid thinking (van Os & Kapur, 2009). Cognitive models of psychosis suggest that early childhood trauma (Morrison, 2009) and/or environmental adversities (Bentall & Fernyhough, 2008) may result in cognitive deficits,
such as impaired ToM skills, which in turn may increase vulnerability for developing specific psychotic symptoms such as paranoia (Garety et al., 2001). Read and Gumley (2008) proposed attachment style as a potential mediating mechanism between childhood adversities and psychosis. When childhood adversities occur early in life, they may interfere with the potential to develop a healthy, secure attachment style (Baer & Martinez, 2006; Morton & Browne, 1998), which may result in problems in interpersonal functioning (Davila & Bradbury, 2001; Weinfield, Sroufe, & Egeland, 2000). These difficulties and their associated distress may in turn affect vulnerability and course of psychosis (Read, van, Morrison, & Ross, 2005).

**Quality of life and attachment**
Illness characteristics of psychosis and their consequences on functioning often impact on the quality of life of patients (Caron et al., 2005, Couture et al. 2007). Social support, social networks and cognitive schemas related to self and others play an important role in the experience of quality of life of people in general, including patients with psychosis. Since working models of attachment are frameworks for social life, studying its predictive value in quality of life is of interest.

**Therapeutic relationships and attachment**
Individuals with psychosis often experience difficulties with interpersonal relationships, including those with therapists. The quality of the therapeutic relationship is an important predictor of therapy outcome (Horvath & Symonds, 1991). Bowlby suggested that the patient-therapist relationship is influenced by attachment style (Mikulincer & Shaver, 2007). In patients with psychosis the quality of the therapeutic relationship was found to predict symptomatology, quality of life, treatment adherence and outcome of rehabilitation (Davis & Lysaker, 2007; Lysaker, Davis, Buck, Outcalt, & Ringer, 2011). In light of this, attachment style of both patients and therapists might provide insight into factors underlying the quality of therapeutic relationships which in turn is related to important outcome.

**Aims and outline of this thesis**

**Aims**
The main aim of this thesis is to further our understanding of current psychosocial models of psychosis by studying the concept of attachment as developmental mechanism of interpersonal functioning and psychopathology and its relation to clinical outcome.

**Thesis outline**

*Part 1 Attachment and psychosis research*
Chapter 2: An integrative overview of research on attachment and psychosis (up until 2011).
Chapter 3: A detailed description of the samples used for the majority of studies in this thesis, which were derived from the Genetic Risk and Outcome of Psychosis project.
Chapter 4: Complementing the description of the patient sample with regard to the validity of subtypes in schizophrenia.
Chapter 5: The validation of the Dutch ‘Psychosis Attachment Measure’, used in the majority of studies.

Part 2 The role of attachment in the development of interpersonal functioning and psychopathology

Chapter 6: Theory of mind, insecure attachment and paranoia in adolescents with early onset of psychosis and healthy controls.
Chapter 7: Theory of Mind and insecure attachment in people with psychotic disorders, their siblings, and controls.
Chapter 8: The mediating role of attachment between childhood adversities and psychosis.

Part 3 Effect of attachment on clinical outcome in psychosis

Chapter 9: The impact of attachment and personality traits to the quality of life of patients with psychosis.
Chapter 10: The impact of attachment styles of both patients and psychiatric staff on the quality of the therapeutic relationship.

Summary key findings & General discussion

Chapter 11: The general discussion will highlight the important findings, their clinical implications, limitations, strengths and suggestions for further research.

References Introduction


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