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Attachment theory: A framework for understanding symptoms and interpersonal relationships in psychosis

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ABSTRACT

We investigated associations between adult attachment, symptoms and interpersonal functioning, including therapeutic relationships in 96 patients with psychosis. Using a prospective design, we also assessed changes in attachment in both psychiatrically unstable and stable groups. We measured attachment using the Psychosis Attachment Measure (PAM) and interpersonal problems and therapeutic relationships were assessed from both psychiatric staff and patient perspectives. Avoidant attachment was associated with positive symptoms, negative symptoms and paranoia. Attachment ratings were relatively stable over time, although changes in attachment anxiety were positively correlated with changes in symptoms. Predicted associations between high levels of attachment anxiety and avoidance and interpersonal problems were supported, and attachment avoidance was associated with difficulties in therapeutic relationships. Findings suggest that adult attachment style is a meaningful individual difference variable in people with psychosis and may be an important predictor of symptoms, interpersonal problems and difficulties in therapeutic relationships over and above severity of illness.

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Introduction

Attachment theory is a lifespan developmental theory that proposes that there is a universal need to form close affectional bonds and that attachment behaviour functions as a homeostatic mechanism for modulating distress in adulthood as well as in childhood (Bowlby, 1980). The theory postulates that earlier interpersonal experiences influence future interpersonal functioning and methods of regulating distress via 'working models', or representations about the self and others in relationships. If caregivers are responsive and sensitive to distress the individual develops a secure attachment style, which is associated with a positive self-image, a capacity to manage distress, comfort with autonomy and in forming relationships with others. Conversely, if caregivers are insensitive or unresponsive to distress, the individual either escalates levels of distress to get their attachment needs met (insecure anxious or ambivalent attachment) or deactivates their attachment system which is associated with low levels of affect and an avoidance of close relationships (insecure avoidant attachment) (Shaver & Mikulincer, 2002).

Although there are different ways of conceptualising adult attachment, Brennan, Clarke, and Shaver's (1998) factor analysis of more than 320 self-report measures administered to a large sample of respondents revealed two dimensions of attachment. Attachment anxiety is associated with a negative self-image and an overly demanding interpersonal style, coupled with a fear of rejection and high levels of negative affect. Attachment avoidance is associated with a negative image of others, defensive minimisation of affect, interpersonal hostility and social withdrawal (Bartholomew & Horowitz, 1991; Mikulincer, Shaver, & Pereg, 2003). Empirical research has also shown associations between insecure adult attachments and a wide range of psychiatric disorders (Dozier, Stovall, & Albus, 1999) and there is evidence from longitudinal research to suggest that insecure attachment styles predict the onset of psychiatric symptoms in high-risk samples (Bifulco et al., 2006).

Psychosis is a significant mental health problem and is characterised by high levels of interpersonal difficulties (Penn et al., 2004). The attachment system is likely to be particularly important in psychosis, as it is triggered by and determines individuals' approaches to seeking help during periods of psychological stress, and psychotic experiences are often highly distressing (Bendall, McGorry, & Krstev, 2006). There is increasing recognition of the role of interpersonal factors in predicting the course of psychosis as well as influencing vulnerability (Read, van Os, Morrison, & Ross, 2005). Cognitive models propose that for some individuals difficulties in earlier relationships with significant others and interpersonal traumas lead to the formation of negative beliefs about the self and others, such as 'I'm vulnerable' and 'other people are

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untrustworthy' which then facilitate the development and maintenance of symptoms (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001). In support of these models, there is a high incidence of negative interpersonal events and traumas in people with psychosis and some evidence from longitudinal studies to suggest adverse environmental experiences can predate the onset of psychosis (Read et al., 2005). There is also empirical evidence of associations between negative beliefs about the self and others and psychotic symptoms (Smith et al., 2006). Furthermore, insecure adult attachments, which are associated with negative beliefs about the self and others as well as maladaptive methods of regulating distress, may increase vulnerability to symptoms or have an adverse effect on the course of psychosis once symptoms are present (Berry, Barrowclough, & Wearden, 2007).

The majority of the work investigating attachment in samples with a diagnosis of psychosis has been carried out by one group of authors who have assessed attachment representations using the Adult Attachment Interview (AAI; Main & Goldwyn, 1984) in groups of patients with schizophrenia and other forms of severe mental health problems, including schizoaffective disorder, bipolar disorder and major depression (Dozier et al., 1999). These authors have found that individuals with a diagnosis of schizophrenia have higher levels of insecure attachment, in particular avoidant attachment, compared to those with affective diagnoses (Dozier, 1990; Dozier, Stevenson, Lee, & Valliant, 1991).

The AAI assesses attachment states of mind on the basis of the nature and form of the individual's discourse when describing parenting experiences during the interview. Questionnaire measures, on the other hand, assess adult attachment styles on the basis of self-reported feelings, thoughts and behaviours in close relationships in adulthood (Crowell, Fraley, & Shaver, 1999). The AAI therefore provides a measure of the person's current organisation of attachment memories elicited through narrative histories of childhood attachment relationships, whereas self-report measures provide more convenient surface indicators of attachment-related dynamics in adulthood. Both have unique value in the investigation of the function and operation of the attachment system (Roisman et al., 2007; Shaver & Mikulincer, 2002). Using a simple three-item, self-report instrument, Ponizovsky, Nechamkin, and Rosca (2007) found that avoidant attachment was associated with severity of both positive and negative symptoms, but the authors did not report associations between attachment and specific types of symptoms. Avoidant attachment may be a particularly important predictor of the positive symptom of paranoia, which is characterised by interpersonal distrust and social withdrawal (Freeman, Garety, Kuipers, Fowler, & Bebbington, 2002).

If attachment theory is to advance our knowledge of psychosis, it is also important to demonstrate, ideally using prospective designs spanning acute phases and remission, that measures of attachment styles in this group are not confounded by the presence of psychotic symptoms. It is possible that psychotic episodes lead to temporary increases in characteristics associated with both anxious and avoidant attachment, such as negative beliefs about the self and others and social withdrawal (Davila, Burge, & Hammen, 1997). Prospective studies comparing acute and stable populations would allow us to determine whether changes in attachment styles are influenced by changes in symptoms. Previous research with non-clinical samples has found changes in attachment styles over periods of time as short as six months (Fraley & Brumbaugh, 2005).

As well as informing our understanding of the symptoms of psychosis, attachment styles may provide useful ways of understanding interpersonal difficulties, particularly difficulties with psychiatric staff. Due to diminished social networks, psychiatric staff often play a number of different roles in the lives of people with psychosis, and some authors have even conceptualised staff as attachment figures with the potential to modify attachment working models (Adshead, 1998). The extreme and inflexible nature of anxious and avoidant response styles is problematic and is associated with both self- and informant-reports of interpersonal difficulties in non-clinical samples (Bartholomew & Horowitz, 1991). More specifically, we might expect that attachment anxiety would be associated with an overly demanding interpersonal style, whereas attachment avoidance would be associated with interpersonal hostility, and furthermore that these attachment-related interpersonal problems might impact on staff and patient relationships.

Tait, Birchwood, and Trower (2004) found associations between insecurity in self-reported adult attachment relationships and poorer engagement with services in a sample of people with psychosis. Dozier and colleagues found that avoidant attachment on the AAI was associated with clinician ratings of rejection of treatment (Dozier, 1990) and difficulties in engaging in therapeutic tasks as rated by independent observers (Dozier, Lomax, Tyrrell, & Lee, 2001). In non-psychosis samples, there is growing evidence of associations between attachment and the concept of 'working alliance' which is defined in terms of collaborative endorsement of tasks, mutual agreement of goals and degree of emotional bond (Bordin, 1979). This concept is relevant across a range of different clinical models (Howgego, Yellowlees, Owen, Meldrum, & Frances, 2003) and is a key determinant of outcome in psychosis (Neale & Rosenheck, 1995). However, it is important to assess alliance from both patient and staff perspectives, as the two are not necessarily related (Couture et al., 2006).

The present study aims to extend attachment and psychosis research in a number of important ways. Using a prospective design, we will assess associations between avoidant attachment and symptoms, including paranoia. The study will also assess associations between anxious and avoidant attachment and interpersonal difficulties; and avoidant attachment and therapeutic relationships, measured from both patient and staff perspectives. Firstly, we predict attachment avoidance will be associated with both positive and negative symptoms and that there will be a specific association between avoidance and paranoia. Secondly, assuming psychotic symptoms have a minimal influence on attachment styles, we predict that mean changes in attachment scores over time will be similar in both psychiatrically stable and unstable groups and changes in attachment scores will be unrelated to changes in symptoms. Thirdly, we predict associations between attachment and interpersonal problems, with specific associations between attachment anxiety and overly demanding behaviour and attachment avoidance and interpersonal hostility. Fourthly, we predict associations between attachment avoidance and both staff and patient perceptions of poorer therapeutic alliance. Finally, associations between attachment and interpersonal difficulties, and between attachment and therapeutic relationships will be maintained when the potential confound of illness severity is controlled.

Method

Participants and procedure

Ninety-six patients from psychiatric services across Greater Manchester were recruited to the study. Inclusion criteria were: documented diagnosis of schizophrenia, schizoaffective or non-affective psychosis; able to give informed consent; English speaking; and no history of organic factors implicated in the aetiology of psychotic symptoms. Psychiatric teams were informed about the study and staff were asked to provide potential participants with a study information sheet. With patient permission, the researcher then visited participants to answer any questions about the research and obtain informed consent. Sixteen (16.67%)

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