



Does reflective functioning mediate the relationship between attachment and personality?



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ABSTRACT

Mentalization, operationalized as reflective functioning (RF), can play a crucial role in the psychological mechanisms underlying personality functioning. This study aimed to: (a) study the association between RF, personality disorders (cluster level) and functioning; (b) investigate whether RF and personality functioning are influenced by (secure vs. insecure) attachment; and (c) explore the potential mediating effect of RF on the relationship between attachment and personality functioning. The Shedler-Westen Assessment Procedure (SWAP-200) was used to assess personality disorders and levels of psychological functioning in a clinical sample ($N = 88$). Attachment and RF were evaluated with the Adult Attachment Interview (AAI) and Reflective Functioning Scale (RFS). Findings showed that RF had significant negative associations with cluster A and B personality disorders, and a significant positive association with psychological functioning. Moreover, levels of RF and personality functioning were influenced by attachment patterns. Finally, RF completely mediated the relationship between (secure/insecure) attachment and adaptive psychological features, and thus accounted for differences in overall personality functioning. Lack of mentalization seemed strongly associated with vulnerabilities in personality functioning, especially in patients with cluster A and B personality disorders. These findings provide support for the development of therapeutic interventions to improve patients' RF.

1. Introduction

The clinical and empirical literature shares the view that mentalization can play a crucial role in the development of personality pathology (Bateman and Fonagy, 2016; Chiesa and Fonagy, 2013; Dimaggio and Brüne, 2016; Levy, 2005; Levy et al., 2015; Meyer and Pilkonis, 2005). Mentalizing capacity has been defined in different ways (Green and Horan, 2015; Premack and Woodruff, 1978; Semerari et al., 2003), but the term “mentalization,” as conceptualized by Fonagy and colleagues (Bateman and Fonagy, 2016; Fonagy et al., 2002, 1991), specifically refers to the ability to understand and interpret—both implicitly and explicitly—one's own and others' behaviors in terms of intentional mental states (e.g., needs, desires, feelings, beliefs, goals, intentions and motivations). This concept was developed within attachment research and operationalized as reflective functioning (RF). It is assessed by the Reflective Functioning Scale (RFS; Fonagy et al., 1998), which is typically applied to Adult Attachment Interview (AAI) transcripts (George et al., 1996).

Many authors who have contributed to the development of mentalization theory have emphasized that a deficit in the ability to make

sense of what occurs in one's own and others' minds is a core mechanism in patients with personality syndromes—particularly borderline personality disorder (Bateman and Fonagy, 2016; Dimaggio, 2016; Fonagy et al., 2002). Fonagy and Target (1996) found that borderline patients have significantly lower RF scores ($M = 2.7$) than those with other personality disorders; moreover, research suggested that a high RF value is a protective factor in individuals with a history of child abuse. Similar results have been confirmed in subsequent empirical investigations (e.g., Fischer-Kern et al., 2010; Gullestad et al., 2012; Ha et al., 2013; Levy et al., 2006; for a review, see Katznelson, 2014). However, studies that have examined RF in patients with borderline personality disorder have led to divergent findings. Diamond et al. (2014) found no significant differences in the mentalizing capacities of patients with borderline traits compared with patients with both borderline and narcissistic traits. Another study showed that borderline patients do not differ from those with other personality disorders, highlighting that both groups have low RF compared to non-psychiatric controls (Chiesa and Fonagy, 2013). Fonagy and Luyten (2009) suggested that borderline patients could present mentalizing impairments especially in interpersonal contexts, when the attachment system and

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high emotional arousal are activated. Considering another cluster B disorder using a wide battery of computerized mentalizing tests, Newbury-Helps et al. (2017) found more mentalizing impairments in a sample of offenders with antisocial personality disorder than in the control group.

Concerning the relationship between RF and other personality pathologies, one study suggested that patients with a *DSM-IV* cluster C personality disorder, such as an avoidant personality disorder, may have generalized poor access to their own and others' states of mind, partly due to scarce awareness and low tolerance of affect (Johansen et al., 2013). Another study found a low mean RF score in avoidant patients, but this sample also included borderline patients and a separate mean RF score was not reported for the two groups of patients (Gullestad et al., 2012). Finally, some authors have illustrated a mentalizing profile that is typical of paranoid patients, characterized by a lack of flexibility in understanding others' intentions and a rigid hypermentalization of their own mental states (Dimaggio et al., 2008; Nicolò and Nobile, 2007).

In some studies, RF has been studied as a mediator or moderator between different dimensions. For instance, Taubner et al. (2013b) found that RF moderates the relationship between psychopathic traits and proactive aggression. Other research has revealed the mediating role of mentalization between experiences of childhood abuse and the development of aggressive behavior (Taubner and Curth, 2013), between adverse childhood experiences and both psychiatric distress and personality disorders (Chiesa and Fonagy, 2013), and between attachment insecurity and antisocial traits (Beeney et al., 2015).

From a developmental perspective, RF is conceptually related to attachment theory (Fonagy et al., 1998). Overall, secure attachment relationships promote a fully developed reflective ability (Bartels and Zeki, 2004; Fonagy and Target, 1998; Meins et al., 1998). In fact, some empirical investigations have revealed that RF levels in adolescents and adults with secure attachment are higher than in those with insecure attachment (Bouchard et al., 2008; Fonagy et al., 1991; Fonagy and Target, 1997; Slade, 2005), and that parental RF seems to be involved in the intergenerational transmission of attachment (Slade et al., 2005; Stacks et al., 2014).

Several authors have also suggested that attachment disturbances can represent developmental risk factors for maladaptive personality functioning (e.g. Bowlby, 1988; Fonagy et al., 1998; Sroufe, 2005). Some studies have found that insecure attachment may create vulnerability to personality pathology (Barone, 2003; Carlson and Sroufe, 1995; Stovall-McClough and Dozier, 2016), whereas attachment security has been linked to better social adjustment, social support and a minor stress level (Atkinson et al., 2000; Crowell et al., 2016; Kobak and Sceery, 1988).

In summary, to our knowledge, no research has conjointly explored the association between RF, attachment and personality functioning, and the mechanisms by which their effects operate. In the current study, we attempted to explore these connections and extend the previous body of research.

The hypotheses tested were as follows: (a) there are significant negative associations of moderate magnitude (Cohen, 1988) between RF and cluster A, B and C personality disorders, as well as a significant positive association between RF and personality high-functioning (see the description of the SWAP-200 in Section 2.3, 'Measures'); (b) RF and personality functioning are significantly influenced by attachment, such that lower levels of RF and personality functioning are shown by patients with insecure attachment relative to those with secure attachment; and (c) RF mediates the relationship between attachment and overall personality functioning.

2. Methods

2.1. Sampling

A sample of patients was recruited from three national counselling centers, which had admitted the patients between 2013 and 2015. From the rosters of these centers, we contacted patients who fulfilled the following inclusion criteria according to their medical records: (a) they were at least 18 years old; (b) they presented no organic syndrome, psychotic disorder or syndrome with psychotic symptoms that could complicate the assessment of any variable in the study; and (c) they were not on drug therapy. Of the 266 patients contacted, 91 indicated their willingness to participate but three subjects showed non-compliance with assessment protocols. The final sample consisted of 88 patients, for an overall response rate of 33%. Comparing the available data between the responders and non-responders with the *t*-test, we did not detect statistically significant differences in patients' gender and age. All patients were currently in treatment, and their treating clinicians provided basic demographic and diagnostic data before we began the study protocol. All patients participated in this study on a volunteer basis and did not receive a fee. Written informed consent was obtained after a brief description was provided about the rationale of the project. The study protocol received ethics approval from the Research Ethics Committee of the local Department of Dynamic and Clinical Psychology.

2.2. Participants

The sample consisted of 88 Caucasians, of whom 49 were women; their mean age was 26 years ($SD = 5.46$, range = 18–40). Twenty-seven patients had only a *DSM-IV* axis I diagnosis, 8 had only an axis II diagnosis, 9 had comorbid axis I and axis II diagnoses, and 24 had a double axis II diagnosis, while 20 patients did not fulfill any psychiatric diagnosis and showed subclinical traits of personality pathology ($55 < T_{\text{SWAP-200}} < 60$; see the description of the SWAP-200 in Section 2.3, 'Measures'). Among the patients with personality pathology (alone and comorbid with psychiatric diagnoses), 2 had a cluster A diagnosis, 9 a cluster B diagnosis and 6 a cluster C diagnosis. Among the patients with two personality disorders, 4 had a double cluster A diagnosis, 14 a double cluster B diagnosis and 6 a double cluster C diagnosis. Concerning the AAI classifications distribution, the four-way distribution of states of mind with respect to attachment was as follows: 34 participants were Secure-Autonomous (F), 13 were Preoccupied (E) and 28 were Dismissing (Ds); the remaining 13 participants were Unresolved/disorganized (U/d). With regard to the AAI three-way distribution, our 13 U/d subjects were classified as Secure ($N = 3$), Preoccupied ($N = 8$) and Dismissing ($N = 2$). Table 1 shows other descriptive information.

2.3. Measures

2.3.1. Clinical questionnaire

We constructed an ad-hoc questionnaire for clinicians to report on patients' general demographic data (such as gender and age), education level and socioeconomic status. Clinicians were also asked to select, from a comprehensive list, which *DSM-5* (APA, 2013) clinical diagnoses the patients presented (see also Colli et al., 2014; Tanzilli et al., 2016, 2017).

2.3.2. Adult attachment interview

The Adult Attachment Interview (AAI; George et al., 1996) is a semi-structured interview used to assesses an individual's "state of mind" or internal working model with respect to attachment relationships. The AAI consists of 20 questions asked in a set order with standardized probes. Subjects are asked to describe the general quality of their childhood relationship with their parents as well as any experiences of early separation, loss, rejection, and maltreatment. The interview

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