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Research paper

Investigation of associations between attachment, parenting and schizotypy during the postnatal period

Melanie Hugill[a], Ian Fletcher[a], Katherine Berry[b,*]

[a] Department of Health Research, Lancaster University, United Kingdom
[b] Division of Psychology and Mental Health, School of Health Sciences, University of Manchester, United Kingdom

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ABSTRACT

Background: Parenting can be a stressful experience particularly for people with mental health problems or people who experienced abuse or attachment difficulties in their own childhoods. This study examined the relationships between earlier trauma, attachment, parenting and schizotypy in a non-clinical sample, with the specific hypothesis that parenting stress and competence would mediate any association between trauma, attachment and schizotypy.

Methods: One hundred and thirty-four first time parents with a child under 12 months old completed the following questionnaires online: the Experiences of Close Relationships Scale – Short Form (ECR-S), the Schizotypal Personality Questionnaire – Brief, Revised (SPQ-BR) the Parenting Stress Scale, the Parenting Sense of Competence Scale (PSOC) and the Adverse Childhood Experiences (ACE) Questionnaire.

Results: Parenting stress mediated the association between attachment and schizotypy, though parenting competence did not have a significant effect as a mediator in a parallel model. Childhood trauma was associated with attachment and schizotypy but did not correlate with the parenting variables.

Limitations: The study utilised a cross-sectional design and self-report measures which limits the ability to make causal inferences from the results. However, findings warrant replication in clinical samples with psychosis.

Conclusions: The study adds to the understanding of what may exacerbate schizotypal symptoms in the first 12 months postpartum as parental attachment insecurity and parental stress together predicted elevated self-reported experiences of schizotypal symptoms.

1. Introduction

Recent literature conceptualises psychosis as on a continuum, with disorder level psychosis at one extreme and experiences of psychosis that are transitory and sub-clinical at the other, namely schizotypy (Barrantes-Vidal et al., 2015; Nelson et al., 2013). Schizotypy and psychosis share many characteristics, with a factor analysis suggesting conceptual models of three factors for both schizotypy and psychosis: positive, negative and disorganised aspects (Wuthrich and Bates, 2006). Barrantes-Vidal et al. (2013) advocate the study of schizotypy to facilitate understanding of the development of clinical level psychosis. Investigating schizotypy may also contribute to the identification of protective factors, as the presence of schizotypy does not necessarily lead to the development of clinical symptoms (Debbane et al., 2015). Furthermore, research into schizotypy may facilitate a clearer understanding of the aetiology and trajectory of psychosis without debilitating extraneous variables being present, such as distress, hospitalisation and medication effects (Lenzenweger, 2015) which may be present in clinical level psychosis.

The aetiology of psychosis and schizotypy is multifaceted and includes possible genetic factors (Linney et al., 2003), early-life characteristics (e.g. low birth weight; Lahti et al., 2009) and environmental factors (Van Os et al., 2010). It is now well established that early relational trauma, such as sexual, physical and emotional abuse has a significant role in the development of psychosis and schizotypy (Velikonja et al., 2015). More recently, an increasing number of studies are looking at how subtler relational traumas, such as attachment difficulties and neglect in the context of earlier caregiving relationships may be associated with psychosis. Attachment theory was introduced by Bowlby (1969) who posited that children develop internal working models of the self and others through early relationships with caregivers. These internal working models persist throughout adulthood. Infants form secure attachments when their caregiver is consistently sensitive and appropriately responsive to their needs and the attachment figure represents a secure base for children to begin to explore the world around them. Problems arise when these conditions are not met

* Correspondence to: Division of Psychology and Mental Health, University of Manchester, 2nd Floor, Zochonis Building, Brunswick Street, Manchester M13 9PL, United Kingdom.
E-mail address: Katherine.berry@manchester.ac.uk (K. Berry).

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and the care received in childhood is suboptimal (Fraley et al., 2013). Attachment styles are relevant throughout the lifespan (Hazan and Shaver, 1987) and attachment in adulthood is conceptualised along two dimensions of anxiety and avoidance (Mikulincer and Shaver, 2003). Individuals who score highly on anxiety and/or avoidance on self-reported measures of attachment are considered to have insecure attachment styles.

Attachment anxiety refers to the desire for close relationships but an inability to be content, consistently seeking reassurance of care and a hypersensitivity to perceived rejection. In contrast, attachment avoidance is the tendency towards self-reliance and defensiveness, and individuals may resist becoming too close to others as this causes discomfort (Shaver and Mikulincer, 2007). Insecure attachment is considered to have potentially wide-ranging effects with studies linking insecure attachment with mental health outcomes (Morley and Moran, 2011) and personality difficulties (Fossati et al., 2003). Specifically, associations have been found between insecure attachment styles and the later development of psychosis, for example Korver-Nieberg et al. (2014) systematically reviewed studies of attachment and psychotic phenomenology and found that high levels of attachment anxiety and attachment avoidance were associated with increased reports of psychotic phenomenology in both clinical and non-clinical samples.

Research is now beginning to explore the underlying mechanisms that explain the association between insecure attachment and schizotypy/psychosis. One possibility is that insecure attachment is associated with difficulties in regulating affect and possibly negative beliefs about others and the self in relation to others (Mikulincer and Shaver, 2005), which are both key triggers for psychosis (Harder and Folke, 2012). One life event that can be highly stressful and may be particularly pertinent for those with attachment difficulties and earlier trauma/neglect is becoming a parent for the first time. The transition to parenthood activates the caregiving system (Jones et al., 2015a) which coexists with the parent's attachment system. However, parents with insecure attachment styles may be more susceptible to activation of their attachment system, for example from perceived threats or stress, resulting in reduced activation of their caregiving system and thus their abilities to care for their children. For example, a new mother with an anxious attachment style may be overly concerned with seeking care from her attachment figure (her partner) to attempt to assuage her insecurity. This may affect her ability to respond to her infant's attachment seeking behaviours and result in negative beliefs about herself as a parent. Jones et al. (2015b) conducted a thorough review of research regarding self-reported attachment styles and parenting and their findings indicate that insecure attachment is associated with more negative parenting behaviours, emotions and cognitions. For instance, lower parental responsiveness and support, more punitive approaches to discipline and an increase in parenting stress.

The postpartum period is acknowledged to be a vulnerable period for new mothers to develop mental health difficulties (Murray et al., 2003) and research has consistently demonstrated that parental mental health difficulties may compromise effective parenting. For instance, a systematic review by Davidsen et al. (2015) concluded that mothers with schizophrenia differed in their maternal behaviour compared to controls, for example in reduced contact with their child and increased tension. They noted that most studies regarding the effects of mothers with psychosis take place within the first 12 months after the birth of their child. Ammerman et al. (2013) suggest that parenting stress is especially likely during the first year for parents as they adjust to the unfamiliar demands of raising an infant and increased stress has been shown to decrease parenting self-efficacy and perceived competence (Leahy-Warren and McCarthy, 2011).

Schizotypal experiences in a non-clinical population may also be experienced as stressful and as parenting stress is linked to poorer parent-child relationships and outcomes for the child (Neece et al., 2012), the current study is a worthy investigation The conceptualisation of psychosis on a continuum means that analogue samples can provide a convenient preliminary test of models which may subsequently be tested in a clinical population, for example women with postpartum psychosis (PPP) or individuals with established psychosis who become parents, but these populations are notoriously difficult to recruit. Therefore, a non-clinical sample was utilised for the current study.

The specific aim of the current study is to explore associations between earlier trauma, attachment, parenting and schizotypy in first time parents with a child under 12 months. The specific hypotheses to be tested are grouped into three sets: (Set H1) there will be a positive association between schizotypy and attachment anxiety, attachment avoidance and childhood trauma, (Set H2) there will be a positive association between parenting stress and attachment anxiety, attachment avoidance and trauma, but a negative association between parenting competence, attachment anxiety/avoidance and trauma, (Set H3) there will be a positive association between parenting stress and schizotypy and a negative association between parenting competence and schizotypy. Finally, exploratory analyses will test whether parenting variables mediate any associations between schizotypy and earlier relational experiences (trauma and attachment).

2. Method

2.1. Design

The current study is an online survey utilising a cross-sectional design which recruited participants between 15 February 2016 and 15 May 2016.

2.2. Ethics

Ethical approval for the study was obtained from Lancaster University Research Ethics Committee. All participants completed a consent form before gaining access to the study.

2.3. Measures

2.3.1. Demographics questionnaire

Participants were asked to report their: age, gender, age and gender of their child, nationality and any prior mental health conditions.

2.3.2. Schizotypal Personality Questionnaire – Brief Revised (SPQ-BR)

(Cohen et al., 2010): The SPQ-BR is a 32-item scale used to assess schizotypal traits organised into seven trait subscales: 1) odd beliefs or magical thinking, 2) unusual perceptual experiences, 3) excessive social anxiety, 4) odd or eccentric behaviour, 5) odd speech, 6) no close friends and constricted affect, and 7) ideas of reference and suspiciousness. Participants are asked to indicate their level of agreement with each item on a five-point scale from 0: strongly disagree to 4: strongly agree. Internal reliability is previously reported to be ‘robust’ with a mean alpha coefficient of .91 (Callaway et al., 2014). In the present study Cronbach's Alpha was .94.

2.3.3. Adverse Childhood Experiences Questionnaire (ACE) (Felitti et al., 1998)

This 10-item screening questionnaire was initially developed within the Felitti et al. (1998) study to ascertain presence of trauma before the age of 18 years. The World Health Organisation have recently developed a lengthier version intended to measure ACE's in all countries and explore associations with subsequent risk behaviours. Participants can score between 0 and 10 depending on how many traumas they indicate they have experienced.

2.3.4. Experiences of Close Relationships Scale-Short Form (ECR-S) (Wei et al., 2007)

The ECR-S is a 12-item scale used to measure adult attachment, with