



ELSEVIER

Contents lists available at ScienceDirect

Psychiatry Research

journal homepage: www.elsevier.com/locate/psychres

Childhood adversity and social functioning in psychosis: Exploring clinical and cognitive mediators



Jasper Palmier-Claus^{a,b,*}, Katherine Berry^c, Hannah Darrell-Berry^c, Richard Emsley^d, Sophie Parker^a, Richard Drake^b, Sandra Bucci^c

^a Psychosis Research Unit, Greater Manchester West Mental Health NHS Foundation Trust, Manchester, UK

^b Institute of Brain, Behaviour and Mental Health, University of Manchester, Manchester, UK

^c Section for Clinical & Health Psychology, School of Psychological Sciences, University of Manchester, Manchester, UK

^d Centre for Biostatistics, Institute of Population Health, University of Manchester, Manchester, UK

ARTICLE INFO

Article history:

Received 23 September 2015

Received in revised form

31 January 2016

Accepted 3 February 2016

Available online 9 February 2016

Keywords:

Psychosis

Trauma

Adversity

Social functioning

ABSTRACT

Childhood adversity may increase risk of impaired social functioning across the continuum of psychosis. However, the pathways by which adversity dictates functional outcome remain underexplored. This study investigated the association between childhood adversity and social functioning, and the clinical and cognitive mediators of this relationship. Fifty-four clinical (20 chronic, 20 first episode, 14 at ultra-high risk) and 120 non-clinical participants completed standardised questionnaires, semi-structured interviews and tests of theory of mind ability. The authors used multiple group structural equation modelling to fit mediation models allowing for differential relationships between the clinical and non-clinical samples. When examining each pathway separately, depression, paranoia and anxious attachment mediated the effect of childhood adversity on social functioning. In a combined model, depression was the only significant mediating variable with greater adversity predicting lower mood across groups. Childhood adversity did not significantly predict theory of mind ability in any of the models. This is the first study to indicate that childhood adversity acts on social functioning by increasing levels of depression, suggesting a common mechanism across the spectrum of psychosis. Clinical interventions should target low mood in order to improve social functioning at all stages of psychotic disorder.

© 2016 Elsevier Ireland Ltd. All rights reserved.

1. Introduction

Impaired social functioning is common in individuals at different stages of psychotic disorder (Addington et al., 2008), where it predicts relapse (Robinson et al., 1999) and hospitalisation (Perlick et al., 1992). However, despite its clinical significance, the factors leading to poor social functioning in psychosis remain unclear. One candidate risk factor for social impairment is childhood adversity. Childhood adversity (e.g. sexual abuse, physical abuse) is common in the general population (Kessler et al., 2010), but is particularly prevalent in individuals with psychosis (Varese et al., 2012). There is growing evidence that individuals with both psychosis and childhood adversity have poorer social functioning than those psychosis sufferers without (Lysaker et al., 2001; Stain et al., 2013; Cotter et al., 2014a, 2014b). Further research is

required to establish and delineate the pathways by which childhood adversity acts on social functioning in order to develop prevention and intervention strategies. In this paper, the authors explore four candidate mediators of this relationship, namely attachment style, theory of mind (ToM) ability, paranoia and depression.

According to attachment theory, traumatic or suboptimal parenting negatively influences individuals' interpretations and expectations of future relationships. These insecure 'internal working models' of relationships persist into adulthood, where they shape social interactions and behaviour (Bowlby, 1969). Several authors have posited that insecure attachment exists on two continua (Bartholomew, 1990; Shaver and Mikulincer, 2002). Attachment avoidance derives from consistently unresponsive caregiving, where the individual learns to be overly self-reliant and reject intimate relationships. Conversely, attachment anxiety is the result of inconsistent or contradictory caregiving, leading to an excessive need for approval and fear of rejection. Both anxious and avoidant attachment styles are associated with impaired interpersonal functioning in non-clinical and psychotic samples (Berry et al.,

* Correspondence to: Psychosis Research Unit, Greater Manchester West NHS Foundation Trust, Prestwich Hospital, Harrop House, Bury New Road, Prestwich, Manchester M253BL, UK.

E-mail address: Jasper.Palmier-Claus@manchester.ac.uk (J. Palmier-Claus).

2008; MacBeth et al., 2008). Additionally, studies have observed positive associations between childhood adversity and adult attachment anxiety (Berry et al., 2009; Picken et al., 2010); an effect that appears amplified in cases of intra-familial and severe forms of trauma (Swanson and Mallinckrodt, 2001). As of yet, no research has explored whether attachment style mediates the relationship between childhood adversity and social functioning in psychosis.

A further pathway to impaired social functioning may be through ToM ability. ToM represents an individual's ability to understand and make accurate inferences about the intentions and thoughts of others (Corcoran, 2001; Couture et al., 2006), which may be essential skills for developing and maintaining relationships (Couture et al., 2006). Although ToM ability has sometimes been found to predict social functioning in individuals at risk of and with psychosis (Bora et al., 2006; Cotter et al., 2014a, 2014b; Morosini et al., 2002), the strength of this relationship appears to be highly contingent on the choice of assessments and covariates included in the analysis (Fett et al., 2011).

Some authors have argued that ToM impairment is genetically influenced (Bora et al., 2009). However, it is plausible that childhood environmental factors also influence ToM development. Childhood adversity may limit ToM enriching experiences, whilst preventing skills acquisition. This is consistent with key theories of child development, whereby the individual learns to navigate social encounters through the behaviour and reactions of others (Bandura and Walters, 1963; Vygotsky, 1978). Such opportunities may be limited in cases of childhood neglect, whereas volatile and contradictory early interpersonal exchanges may make it difficult for the child to generalise, and therefore learn, from social experiences. Childhood adversity may also have a more direct impact on ToM ability. A wealth of literature now shows that childhood adversity, and associated stress, can lead to hypo-thalamic-pituitary axis dysregulation, which can have a deleterious effect on neuronal development (Corcoran et al., 2003; Teicher et al., 2003). Childhood adversity is associated with impaired cognitive capacity, limiting attention, memory, and language abilities (De Bellis et al., 2009), and there is some indication that adverse events can disrupt higher-order cognitive processes, including social perception (Nazarov et al., 2014) and emotion processing (Lysaker et al., 2011). A recent study found that children with a history of early life deprivation had depleted ToM ability (Colvert et al., 2008). There is currently no research describing the impact of childhood adversity on ToM in the context of psychosis.

In addition to attachment style and ToM impairment, the authors propose that depression and paranoia will act as mediators between childhood adversity and social functioning. Depression is characterised by demotivation and social withdrawal, whereas paranoia is often associated with active social avoidance and anxiety in social situations. Past research in this area has shown negative associations between clinical symptoms and a wide range of social processes (Combs et al., 2013; Corcoran et al., 2011). Additionally, depression (Scott et al., 2010) and paranoia (Bentall et al., 2012) are more likely in individuals with a history of childhood adversity, potentially suggesting a causative link between these variables.

In this study, the authors examined predictors of social functioning in both clinical and non-clinical populations. For the clinical sample, they recruited individuals with varying severities of psychosis, which had the advantage of being able to explore the cross-continuum determinants of social functioning. There is now considerable evidence to support a continuum model of psychosis, which extends to the general population (Johns and van Os, 2001).

The first hypothesis was that there would be a direct effect of childhood adversity on social functioning. The second hypothesis was that attachment anxiety, attachment avoidance, ToM ability,

paranoia and depression would mediate this relationship. In the absence of a mediation effect, the authors tested whether these variables independently predicted social functioning.

2. Materials and methods

2.1. Subjects

The clinical sample comprised of three groups defined a priori. Group 1 consisted of individuals meeting the criteria for a Diagnostic and Statistical Manual (Fourth Edition; DSM-IV) diagnosis of schizophrenia, schizoaffective, schizophreniform, or delusional disorder who had been experiencing psychotic symptoms for at least two years. The research team obtained these diagnoses from the referring clinician and the clients' clinical records. Group 2 consisted of individuals who had recently experienced a first episode of psychosis (FEP) and were receiving treatment from an Early Intervention Service (EIS). EIS are specialist services aimed at supporting individuals aged 16–35 in the first three years after their initial psychotic episode. These EIS operationally defined psychosis using cut-off scores on the Positive and Negative Syndrome Scale (Kay et al., 1987). Therefore, at entry to service, all clients had scored four or greater on the delusional thinking, hallucinations, or suspicious thoughts items of this interview. Group 3 consisted of individuals who met criteria for being at ultra-high risk (UHR) of developing psychosis according to the Comprehensive Assessment of At Risk Mental State (Yung et al., 2005) at some point in the past 12 months and who were enrolled with an EIS or Early Detection and Intervention Team. These individuals had not yet made transition to FEP, but their attenuated psychotic experiences were causing some distress and disability.

In addition to the three clinical samples, the researchers' opportunistically recruited non-clinical individuals through adverts placed around a University campus and an online research participation system. These participants were required to confirm that they had never received a diagnosis of a psychotic disorder or taken antipsychotic medication. All participants were aged 16 or older. The exclusion criteria for all groups were: i) a neurological disorder; ii) a moderate or severe learning disability; iii) organic or substance induced psychosis; or iv) known visual or hearing difficulties.

2.2. Procedures

Clinicians from inpatient and community mental health services in the North West of England identified and invited eligible clients to take part. All clients provided written consent prior to completing the tasks, questionnaires and interviews. The researchers then reviewed the participants' medical notes for demographic and background information. An NHS Research Ethics Committee approved this research study.

2.3. Measures

The variables presented in the current analysis were from a wider number of assessments administered as part of a study examining the impact of early life adversity, attachment styles, and social cognition on key outcomes in psychosis. The authors administered the PANSS to the chronic and FEP samples for descriptive purposes.

2.3.1. Independent variable

The Childhood Trauma Questionnaire (CTQ; Bernstein et al., 2003) is a validated 28-item self-report measure of childhood adversity. Respondents indicate whether they experienced a range of events on a scale from 1 (never true) to 5 (very often true). The CTQ consists of five subscales assessing physical abuse, emotional abuse, sexual abuse, physical neglect, and emotional neglect. Past research has attested to the reliability and validity of the CTQ in psychiatric (Bernstein et al., 1997) and non-clinical (Paivio and Cramer, 2004) samples.

2.3.2. Dependent variable

The Personal and Social Performance Scale (PSP; Morosini et al., 2000) was employed to assess participants' social functioning over the previous month. The interviewer scores the participant from one (absent) to six (very severe) on four dimensions of social functioning: socially useful activities, personal and social relationships, self-care and disturbing and aggressive behaviour. Based on these ratings, they then score the participant on a single scale ranging from zero to 100 using set criteria. The PSP has adequate reliability and validity in individuals with non-affective psychosis (Nasrallah et al., 2008; Patrick et al., 2009). For the current study, the lead author trained and supervised four researchers in the administration and scoring of this interview. Prior to recruitment starting, all researchers provided ratings for 12 clinical vignettes in order to assess inter-rater reliability. The intra-class correlation for the total PSP scores was 0.92 ($p < 0.001$), suggesting excellent levels of agreement.

Download English Version:

<https://daneshyari.com/en/article/6813390>

Download Persian Version:

<https://daneshyari.com/article/6813390>

[Daneshyari.com](https://daneshyari.com)