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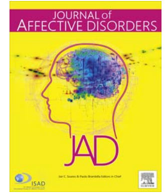

Research paper

Attachment representations, patterns of emotion regulation, and social exclusion in patients with chronic and episodic depression and healthy controls

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A R T I C L E I N F O

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A B S T R A C T

Background: The experience of social exclusion (ostracism) is linked to the etiology and maintenance of depression. Most individuals experience emotional stress in states of social exclusion. Insecurely attached individuals, especially with an unresolved trauma, show maladaptive coping in response to social stress. The present study examines (a) the differences with regards to attachment representations in episodic (ED) and chronic depressive (CD) inpatients and (b) how ostracism affects their emotional reactions.
Methods: Patients with CD (n=29) and ED (n=23) and healthy control subjects (n=29) were interviewed using the Adult Attachment Projective Picture System (AAP), a valid measure to assess attachment representation; and played a virtual ball tossing game simulating social exclusion (Cyberball). Multiple depression-related risk and protective factors were considered. We hypothesized that CD patients show the most severe attachment disorganization and are emotionally most affected by the social exclusion situation. Moreover, we explored the interaction between ostracism and attachment.
Results: Contradicting our hypotheses, ED and CD individuals were almost akin with regards to their attachment insecurity/disorganization and reactions to Cyberball. An emotionally altered reaction to social exclusion was identified in the insecure-disorganized depressive subgroup.
Limitations: Small sample size hampering further subgroup analyses. The ED sample may include single CD subjects with recent manifestation.
Conclusions: The pattern of emotion regulation in the depressive groups matches with findings from clinical studies, including attachment research. The relationship between attachment representations and ostracism should be further investigated in larger samples of depressive individuals.

1. Introduction

The experience of loss, social exclusion (ostracism) and rejection is linked to the etiology and maintenance of depression from different clinical perspectives (Bowlby, 1969; Coyne, 1976; McCullough, 2003; Allen and Badcock, 2003; Eisenberger, 2012; overview: Buchheim et al., 2012, 2013). The fifth version of the DSM (APA, 2013) acknowledges that episodic (ED) and chronic (CD) depression seems to be fundamentally different diseases (Klein et al., 2006; Moeller et al., 2014). Studies show that CD in comparison to ED is the more severe form (Angst et al., 2009; Jonsson et al., 2011; Brockmeyer et al., 2015; Koehler et al., 2015) as chronic depressive patients have more and longer hospital stays (e.g. Schramm et al., 2011; Brockmeyer et al., 2015; Koehler et al., 2015). The onset of CD is earlier and more CD patients report an early onset before the age of 21 (Klein et al., 2014; McCullough, 2003), which is associated with more severe impairment (Berndt et al., 2000), a more aversive progression (Klein et al., 1999; Brockmeyer et al., 2015), as well as more relapses (Agosti, 1999) than a late start. Persistent depression increases the vulnerability in adolescence to social, psychological, somatic and other psychiatric problems (Klein et al., 2004; Jonsson et al., 2011; Schramm et al., 2011). Individuals with CD report earlier childhood trauma (Lizardi et al.,

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1995; Wiersma et al., 2009), more interpersonal problems (Schramm et al., 2011), and emotional as well as cognitive-behavioral avoidance (Brockmeyer et al., 2015).

Since there is a relatively high amount of the documented therapy resistance in (chronic) depression the disorder is a big challenge for the health system worldwide (e.g. Kornstein and Schneider, 2001; Trivedi and Daly, 2008; Holtzheimer and Mayberg, 2011; WHO, 2012). Therefore specific therapeutic approaches are requested that consider the individual mechanism underlying ED and CD to enhance efficacy (e.g. McCullough, 2003; Holtzheimer and Mayberg, 2011; Jobst et al., 2016). A large recent review on psychotherapy in chronic depression provides a meta-analysis of the present literature and recommendations for evidence-based treatments (Jobst et al., 2016). One of the highly recommended treatments is CBASP (Cognitive Behavioral Analysis System of Psychotherapy, McCullough, 2000) based on the assumption that early attachment and interpersonal trauma has resulted in dysfunctional mechanisms of derailed affective and motivational regulation and a reduction of perceived functionality.

Affective disorders in general are associated with the predominance of insecure attachment representations (Bakermans-Kranenburg and van IJzendoorn, 2009; West and George, 2002). Moreover, recent research points at the particular relevance that the disorganized unresolved attachment pattern has for the CD (Buchheim and George, 2012). In this group unresolved trauma is mostly associated with experiences of loss of or rejection by a significant other (Bowlby, 1980; Buchheim et al., 2013). Bowlby (1969) conceptualized attachment as an evolutionarily developed biological-behavioral human system. The individual develops internalized mental representations of attachment and attachment figures in early infant-caregiver interactions. These may adapt to continuing experiences gained throughout the life span, but are nonetheless relatively stable (Bowlby, 1980) and generalized across various relationship-types, such as with parents or romantic partners (Waters et al., 2015). Secure attachment is characterized by integrated representations of self and others, and is considered to be a protective factor against mental illness (Bowlby, 1980; Fonagy et al., 1996; West and George, 2002; Ward et al., 2006; Bakermans-Kranenburg and van IJzendoorn, 2009; Buchheim and George, 2011, 2012). If individuals experience incomplete or compromised parental protection, they develop internal working models that may contain defensive processes (“deactivation” or “cognitive disconnection”) to exclude the overwhelming experience and to organize difficult emotions (George and Solomon, 2008; George and West, 2012). When the attachment figure is entirely unavailable, e.g. through loss, or is highly neglectful, abusive or showing failed protection, the individual makes use of a third, more extreme defensive process that Bowlby termed “segregated systems” (Bowlby, 1980). This process is linked to disorganized representations also called “unresolved trauma” (Main, 1995; George et al., 1999). Especially disorganized defensive processes turn out to be maladaptive later in life (George and West, 2012; Buchheim and George, 2012). These maladaptive processes are the basis for impaired affect regulation and a low level of interpersonal functioning (Diamond et al., 2014; Browne and Winkelman, 2007), as well they are related to impaired capacity to mentalize one's own or other's states of mind in attachment relevant contexts (Fonagy et al., 1998), and are risk factors for psychiatric illnesses (Buchheim and George, 2011; George et al., 1999).

Another factor underlying the development of depressive symptoms are experiences of social exclusion (Allen and Badcock, 2003). Williams (2009) proposes an evolutionarily grown “ostracism detection system” that senses even tiny markers of social exclusion. A lot of research proves the assumption, that ostracism threatens four fundamental human needs to belong, to self-esteem, to control and to meaningful existence and thus deprives the individual from the satisfaction of needs that are relevant for the motivation, survival, efficacy (overview: Williams et al., 2000). According to the temporal need-threat-model the reactions to social exclusion are separated in three phases (Williams, 2009). An immediate trans-individual reflexive impairment of mood can be differentiated from individually reflected coping, such as the fight, flight, and socialize responses. Prolonged exclusion may lead to resignation and depression. The virtual computer game “Cyberball” is a well-studied and described paradigm to efficiently and reliably induce and investigate the influence of social exclusion under standardized conditions on affective reactions and behavioral choices (Williams, 2009; Hartgerink et al., 2015), regardless of individual characteristics (Zadro et al., 2004, for groups with psychiatric diagnoses: Staebler et al., 2011; Jobst et al., 2014, 2015). To our knowledge, only one other research group has investigated the effects of ostracism on groups of depressive individuals and identified heightened activity in the ”social pain” brain area during the Cyberball game as a predictive marker for increased depressive symptoms one year later (Masten et al., 2011).

In this study, psycho-behavioral indicators for the “attachment” and the “ostracism detection” system were investigated in two groups of comparably severely affected inpatients with CD and ED compared to a healthy control (HC) group. On the basis of previous studies, we hypothesized that chronic depressive (CD) individuals would report (1) more childhood trauma and would show (2) a higher amount of unresolved trauma in their attachment representations than episodic depressive (ED) individuals. (3) In the social exclusion paradigm, an impaired reaction pattern would be more prominent in CD subjects compared to the ED and HC groups, i.e. they would have more indicators of emotion dysregulation (e.g. negative mood, need threat), and choose more passive behaviors, than ED subjects. (4) On an explorative level, we were interested to investigate in the attachment related subgroups of both depression groups the differences in the reactions to the Cyberball paradigm.

2. Method

2.1. Study population and procedure

A total of 81 individuals (42 male) between 18 and 75 years were included. The groups of CD (n=29) and ED (n=23) were inpatients of a German psychiatric university hospital. Inclusion criteria for ED were single or recurrent depressive episodes lasting less than 2 years, both with inter-episode full recovery. Key inclusion criterion for CD was a DSM-IV diagnoses (APA, 1994, German version: Saß et al., 1998) of (1) major depressive disorder (MD), (2) recurrent MD with no full inter-episode recovery, (3) dysthymic disorder, or (4) MD superimposed on a dysthymic disorder (double depression) lasting at least 2 years. Individuals with a history of psychosis, bipolar disorder, acute addiction, suicidal state, severe organic disease, or current pregnancy, were excluded.

Healthy controls (HC) (n=29) were recruited via announcements and were matched in age, gender, education and marital status (see Table 1) with the two depression groups. A semi-structured telephone interview included the screening questions of SCID-I (German version: Wittchen et al., 1997) supplemented by questions referring to affective disorders, psychosis and organic diseases. Moreover the Beck Depression Inventory (BDI-II, German version: Hautzinger et al., 2006) was administered (inclusion score: 10 maximum). Our included participants met the general criteria, never developed addiction (lifetime), and had no psychotherapy or severe organic disease within the last ten years. Persisting organic diseases should be under medicinal control. Only n=1 participant showed an accentuation of personality features (high score in SCID-II, German version: Wittchen et al., 1997).

Moreover instruments assessing the degree of functioning were administered (Fig. 1) to all participants: Severity of symptoms was ascertained by using validated clinical instruments: The Hamilton Rating Scale for Depression (HDRS, Hamilton, 1960), and BDI-II. Resilience was determined by using the commonly used Connor-Davidson-Resilience Scale (CD-RISC, 25 Items, Connor and

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