Journal of Affective Disorders 116 (2009) 93–99

Contents lists available at ScienceDirect

Journal of Affective Disorders

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

Research report

Recurrent depression and the role of adult attachment: A prospective and a retrospective study

Henk Jan Conradi [a,b,*], Peter de Jonge [a,c,d]

[a] Department of Psychiatry, University Medical Center Groningen, University of Groningen, The Netherlands
[b] Department of Clinical Psychology, University of Amsterdam, The Netherlands
[c] Department of Internal Medicine, University Medical Center Groningen, University of Groningen, The Netherlands
[d] Centre of Research on Psychology and Somatic disease, Department of Medical Psychology, Tilburg University, The Netherlands

ARTICLE INFO

Article history:
Received 5 August 2008
Received in revised form 29 October 2008
Accepted 29 October 2008
Available online 16 December 2008

Keywords:
Adult attachment
Vulnerability
Recurrent depression
Primary care patients

ABSTRACT

Background: Recurrent depression is associated with interpersonal dysfunctioning which is related to underlying insecure attachment. In this study we examined associations between adult attachment and the long-term course of depression in depressed primary care patients.
Methods: Depressed primary care patients were 3-monthly assessed during a prospective 3-year follow-up regarding: (1) severity of depression (BDI); and proportions of: (2) depression-free time; (3) depressive symptom-free time; and (4) time on antidepressants (all CIDI interview). Attachment style was assessed by the Experiences in Close Relationships questionnaire at two points in time: (1) one year before the end of follow-up (1-year prospectively followed subsample; $n=68$); and (2) at the end of the 3-year follow-up (3-year retrospective subsample; $n=145$). Mixed model analyses and non-parametric tests were used to determine whether different attachment styles were associated with different courses of depression.
Results: Fearfully attached patients in the prospective sample reported a statistically significant worse depression course compared with securely attached patients (adjusted mean BDI 12.7 v. 6.8 respectively; $F=3.22$; $p=0.029$), which was confirmed in the retrospective sample (adjusted mean BDI 15.7 v. 8.8; $F=7.86$; $p<0.001$). They reported significantly more prior depressive episodes and residual symptoms, longer use of antidepressants, and worse social functioning as well.
Limitations: Size of the prospective sample was restricted.
Conclusion: Fearfully attached subjects constitute a particularly vulnerable category of depressed patients. Information on their attachment style may provide GPs with indications regarding intensity, goals and approach of treatment.

1. Introduction

The long-term course of depression is characterized by high recurrence rates and substantial levels of residual symptoms (e.g. Ormel et al., 1990; Solomon et al., 2000). Although many risk factors for recurrence are identified, most of them are not useful from the perspective of treatment for two reasons. First, a subcategory of risk factors, like number of prior episodes, is not modifiable. Kraemer et al. (1997) label these risk factors 'markers', whereas extensive study of modifiable risk factors, referred to as 'causal risk factors', is needed. Second, not all risk factors are informative with regard to intensity, goals and approach of treatment. Neuroticism may illustrate this. Although a powerful predictor for recurrence, genetic studies on personality traits chiefly support a hereditary transmission interpretation (Noftle and Shaver, 2006), meaning neuroticism is not easy to modify. Moreover, neuroticism is not specific enough to offer information on direction, content and approach of treatment. In contrast, insecure attachment seems more promising. Genetic studies on attachment mainly support a shared

* Corresponding author. Department of Psychiatry, University Medical Center Groningen, University of Groningen, P.O. Box 30.001, 9700 RB Groningen, The Netherlands. Tel.: +31 50 361 4610; fax: +31 50 361 9722.
E-mail address: h.j.conradi@med.umcg.nl (H.J. Conradi).

0165-0327/$ – see front matter © 2008 Elsevier B.V. All rights reserved.
doi:10.1016/j.jad.2008.10.027

environment explanation (Noftle and Shaver, 2006), implying it can be modified. Also, the patient's specific attachment quality may guide therapeutic interventions, because it refers to mechanisms underlying interpersonal problems which may lead to recurrence of depression.

Insecure attachment cognitions can distort understanding and evaluation of social relations. This may result in difficulties in maintaining satisfying relationships, leading to an impaired social support system, which may contribute to the development of psychopathology (Anderson et al., 1999; Hammen, 1999). Especially in times of distress when comfort and support are needed, such as during depressive episodes, dysfunctional attachment may become problematic. Clear associations between insecure adult attachment and depression are found in several studies (e.g. Shaver et al., 2005).

In contrast to most studies, which are cross-sectional or restricted to associations between attachment and measurement of depression at 2 points in time, in this study we examined the relationship between partner attachment and the long-term course of depression assessed in two subsamples at 4 and 12 points in time. This was done in a sample of primary care patients with a history of depression, which is a highly relevant group since the majority of depressed patients are treated by their GP (ESEMeD/MHEDEA 2000 consortium, 2004).

Partner attachment was measured by its two fundamental (bipolar) dimensions or working models (Brennan et al., 1998). These are: (1) *anxiety about rejection and abandonment*, referring to the expectation of being perceived by partners as unacceptable or unlovable (negative model of self); and (2) *avoidance of intimacy*, or the expectation of inaccessibility and unresponsiveness of partners to ones attachment needs like support and consolation (negative model of others). The combination of these two dimensions yields a fourfold typology, i.e. secure, preoccupied, dismissing and fearful attachment (Bartholomew and Horowitz, 1991).

On basis of this model and the mentioned former research, we hypothesized secure patients to report the most favorable depression course, because they can draw upon functional models of both self and others (low anxiety about rejection and low avoidance of intimacy). The reverse is the case for the fearfully attached. They are anxious about being rejected and at the same time they have difficulties in compensating this by means of generating support by partners, because they tend to avoid intimacy. We predicted the preoccupied and dismissing patients to report a less favorable depression course compared to the secure group, but better courses than fearful patients, because they have one functional working model to compensate for adverse effects of the other problematic working model. Dismissing persons compensate for a lack of social support, which is a consequence of their tendency to distrust others (high avoidance of intimacy), by means of their self-worth (low anxiety about rejection). Reversely, preoccupied attached can compensate their feelings of unlovability (high anxiety of rejection) by maintaining self-worth validating close relationships since they score low on avoidance of intimacy.

To shed some light on the extent of interpersonal problems associated with insecure attachment, experienced loneliness and marital functioning were examined. These are indications of social support which may protect against depression by buffering the effects of stress (Cohen and Wills, 1985).

2. Methods

2.1. Patients and procedure

Patients participated in a randomized clinical trial (Conradi et al., 2007) evaluating the effect of four treatment strategies for depression: (1) Usual Care (UC) by the GP; (2) the Psycho-Educational Prevention (PEP) program; (3) psychiatric consultation followed by PEP (psychiatric consultation plus PEP); and (4) brief cognitive behavioral therapy plus PEP (CBT-plus PEP). Patients were recruited by almost 50 GPs. We included patients who: had a (recent) diagnosis of depression, were between 18 and 70 years old, were not suffering from: a life threatening medical condition, psychotic disorder, bipolar disorder, dementia or a primary alcohol or drug dependency, and were not pregnant or receiving psychotherapy already.

From the 267 included primary care patients, two subsamples completed the attachment measurement: (1) 68 patients 1 year before the end of follow-up (1-year prospective sample); and (2) 145 patients at the end of follow-up (3-year retrospective sample). The fact that not all patients were enrolled in this secondary study was due to practical reasons. At the moment the main study started no reliable adult attachment questionnaire was available in the Netherlands. At the time it was constructed, tested and ready for use, some of the patients had already finished their follow-up and could not be approached for the present study.

2.2. Study measures

The *Experiences in Close Relationships* (ECR) questionnaire (Brennan et al., 1998; Conradi et al., 2006) measures adult attachment in romantic relationships in the past and the present. It contains two subscales: Anxiety about rejection and abandonment (Cronbach's $\alpha = 0.86$) and Avoidance of intimacy ($\alpha = 0.88$). A 7-point Likert scale ranging from 1 (disagree strongly) to 7 (agree strongly) and a middle position 4 (neutral/mixed) was used to score the items. When combined, these subscales yield the four mentioned attachment qualities: Secure, Preoccupied, Dismissing and Fearful. The Dutch ECR was found to be a valid and reliable measure (Conradi et al., 2006). Questions were added in order to establish whether patients had ever been involved in a romantic relationship, and were currently engaged in a relationship.

The *Beck Depression Inventory* (BDI) was 3-monthly administered during the 3-year follow-up to determine the course of severity of depression. The Dutch BDI has demonstrated good reliability and validity (Luteijn and Bouman, 1988).

An extended version of the depression section of the *Composite International Diagnostic Interview* (CIDI), a structured psychiatric interview with good reliability and validity (Wittchen, 1994) was administered 3-monthly by telephone during the 3-year follow-up. With this we measured the presence of each of nine DSM-IV depressive symptoms per week in the past 3 months. From these per week assessments, we derived two outcomes, covering total follow-up, namely: (1) proportion depression diagnosis-free time (i.e. the time patients were not fulfilling the DSM-IV criteria for major depressive episode); and (2) proportion depressive symptom-free time (i.e. the time patients did not report any of the DSM-IV depressive symptoms). The interviews also contained questions