Journal of Affective Disorders 225 (2018) 160–166

Contents lists available at ScienceDirect

Journal of Affective Disorders

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

Research paper

Adult attachment predicts the seven-year course of recurrent depression in primary care

Henk Jan Conradi[a,*], Jan H. Kamphuis[a], Peter de Jonge[b]

[a] Department of Clinical Psychology, University of Amsterdam, Postbus 15933, 1001 NK Amsterdam, The Netherlands
[b] Department of Developmental Psychology, University of Groningen, Interdisciplinary Center Psychopathology and Emotion regulation, The Netherlands

ABSTRACT

Background: Attachment theory posits that attachment has a persistent, long-term impact on depression. Empirical data on associations between adult attachment and the long-term course of depression is, however, scarce. The present study addresses this omission.

Method: Primary care patients with a history of depression (n = 103) completed the Experiences in Close Relationships questionnaire measuring adult attachment *dimensions* (avoidance and anxiety) and *styles* (secure, preoccupied, dismissing and fearful). The subsequent seven-year course of depression was assessed with the face-to-face administered Composite International Diagnostic Interview (CIDI) and a life-chart interview based on the Longitudinal Interval Follow-up Evaluation (LIFE). At the end of the seven-year follow-up severity of depression was additionally measured with the Beck Depression Inventory (BDI).

Results: The attachment *dimensions* avoidance and anxiety both showed significant associations during the seven-year course with lower proportions of depressive symptom-free time and higher severity of depression (LIFE and BDI). The secure *style* predicted compared to preoccupied attachment a significantly higher proportion of symptom-free time (4.97 vs. 1.10 years), compared to dismissing attachment a higher proportion of symptom-free time (4.97 vs. 2.20 years) and lower severity of depression (LIFE: 1.65 vs. 2.14; BDI 6.04 vs. 9.52), and compared to fearful attachment a lower relapse/recurrence rate (45.7% vs. 76.9%), higher proportions of depression diagnosis-free time (7.31 vs. 6.65 years) and symptom-free time (4.97 vs. 0.29 years), and lower severity of depression (LIFE: 1.65 vs. 2.19; BDI 6.04 vs. 15.54).

Limitations: Sample size was restricted.

Conclusion: Insecure attachment predicts an unfavorable course of depression over a seven-year period.

1. Introduction

Depression is a chronic disorder characterized by relapses, substantial residual symptomatology (Solomon, 2000; Simon, 2000; ESEMeD/MHEDEA 2000 Investigators, 2004), and persistence in a subcategory of patients (Eaton et al., 2008). The unfavorable long-term course of depression suggests a stable underlying vulnerability driving the waxing and waning of depression-related symptoms. Attachment is a moderately stable personality characteristic that has been assumed to have an enduring influence on people's functioning (Fraley and Brumbaugh, 2004). Insecure attachment may contribute to the development of psychopathology by its corollaries with dysfunctional emotion-regulation and support-seeking (Hammen, 2006). Impact of attachment on the long-term course of depression has, however, rarely been studied. Therefore, we examined whether attachment predicted depression outcomes over a seven-year period.

1.1. Attachment

According to attachment theory, interactional experiences with caregivers, and subsequently with partners (Bowlby, 1973, 1980), mold attachment strategies related to emotion-regulation and support-seeking, which in turn may influence the development of psychopathology.

The primary attachment strategy to fulfill attachment needs of support and validation, is *proximity seeking* to the attachment figure. When proximity bids are consistently reinforced, secure attachment will develop. Secure attachment is characterized by low anxiety about rejection (self-worth) and low avoidance of intimacy (trust in others). Both strengthen functional emotion-regulation and support-seeking, which makes secure attachment an inner source of resilience (Mikulincer and Shaver, 2016).

When proximity seeking is intermittently reinforced by the

* Corresponding author.
E-mail address: h.j.conradi@uva.nl (H.J. Conradi).

http://dx.doi.org/10.1016/j.jad.2017.08.009
Received 3 March 2017; Received in revised form 17 July 2017; Accepted 9 August 2017
Available online 12 August 2017

attachment figure, preoccupied attachment may develop. This style is characterized by high anxiety about rejection by significant others (low self-worth). To deal with this attachment anxiety, the preoccupied attached person *hyperactivates* emotions in order to gain attention from others and to coerce them into providing support. This hyperactivation strategy may itself culminate in psychopathology, and the coercive way of mobilizing support may discourage others from offering help (Mikulincer and Shaver, 2016).

When proximity seeking remains consistently non-reinforced by attachment figures dismissing-avoidant attachment may develop. This style is characterized by high avoidance of intimacy (absence of trust in others). The distrust is dealt with by *deactivation* of the attachment system, which is associated with avoidance of support seeking, and the suppression of emotions. This strategy may leave distress unresolved and may accordingly contribute to the development of psychopathology. Especially with prolonged distress, that urges for support of others, this is problematic (Mikulincer and Shaver, 2016).

Alternation of both hyper- and deactivation is characteristic of fearful-avoidant attachment (Bartholomew and Horowitz, 1991). Fearful-avoidant individuals are high on anxiety about rejection (low self-worth), as well as high on avoidance of intimacy (lack of trust in others), resulting in an 'approach-avoidance' conflict. This means they have difficulties in functioning autonomously but also in generating support from others. Therefore, fearful-avoidant attachment is associated with the most severe psychopathology (Brennan et al., 1998).

1.2. Attachment and depression

A review of cross-sectional studies (Mikulincer and Shaver, 2016) consistently showed that insecure attachment, in particular attachment anxiety, was associated with higher severity of depression than secure attachment. A minority of the reviewed studies prospectively assessed associations between attachment and depression. Unfortunately, follow-up periods were generally quite short, ranging from several weeks to months. Moreover, only three studies focused on depressed patients (Grunebaum et al., 2010; Conradi and de Jonge, 2009; Bifulco et al., 2002) but the length of the prospective follow-up periods was limited to one year.

In sum, there is an empirical gap with respect to the presumed impact of insecure attachment on the long-term course of depression. We therefore examined a sample of primary care patients with a diagnosis of (recurrent) depression and tested whether attachment predicted the seven-year course of multiple depression-related outcomes. Based on the literature, we hypothesized that insecure attachment, i.e. preoccupied, dismissing-avoidant and in particular fearful-avoidant attachment, would show less favorable long-term depression outcomes than secure attachment.

2. Methods

2.1. Patients and procedure

The sample of the current long-term study (n = 103) was part of the sample (n = 145) of our mentioned study on associations between attachment and the short-term course of depression (Conradi and de Jonge, 2009). The sample participated in a randomized controlled trial (INSTEL) which aimed at the enhancement of treatment of depression in primary care (for details see Conradi et al., 2007). Included were primary care patients meeting criteria for a current or recent Major Depressive Episode (MDE) treated by the General Practitioner (GP). Patients were randomized to one of four treatments: (1) Care as Usual (CAU) by the GP; (2) the low intensity Psycho-education Prevention program (PEP); (3) one Psychiatric Consultation session followed by PEP (PC + PEP); or (4) 10 sessions Cognitive Behavioral Therapy followed by PEP (CBT + PEP). Patients were followed-up for three years.

The present study reports data on the subsequent seven-year follow-up after INSTEL, i.e. the Long-Term INSTEL (LTI) follow-up. Assessments took place between October 2010 and June 2012 (for details see Conradi et al., 2017). After consent from their GP was obtained, patients were contacted by mail and telephone. Upon reading the information brochure they signed the informed consent. Of these, n = 103 had completed at the closure of INSTEL the attachment measure which was used to predict the depression course during the subsequent LTI follow-up of 7.31 years (SD = 0.43). The LTI study was approved by the Medical Ethics Committee of the University Medical Center Groningen (METc2009.319). A 15 euro coupon was offered to patients in return for participation.

2.2. Study measures

2.2.1. Baseline measures

Adult attachment in romantic relationships in past and present was measured with the *Experiences in Close Relationships* questionnaire (ECR; Conradi et al., 2006) at the start of the seven-year follow-up. The ECR comprises 36 items and measures the two fundamental attachment *dimensions. Anxiety about rejection and abandonment* (Cronbach's α = 0.86), i.e. expectancies of being perceived by partners as unacceptable or unlovable, taps into hyperactivation strategies. A sample item is 'I worry about being abandoned'. *Avoidance of intimacy* (α = 0.88), i.e. expectancies of inaccessibility and unresponsiveness of partners to one's attachment needs, taps into deactivation strategies. One sample item is 'I try to avoid getting too close to my partner'. Items are rated on a 7-point Likert response scale ranging from 1 (disagree strongly) to 7 (agree strongly), with a middle position 4 (neutral/mixed). We also analyzed attachment styles, i.e. Secure, Preoccupied, Dismissing-avoidant and Fearful-avoidant, for two reasons. First, in clinical practice, use of styles prevails over dimensions, and we aimed for clinical utility. Second, we aimed to maximize comparability of the current long-term results with our earlier reported short-term follow-up (Conradi and de Jonge, 2009) by using the categorization of patients made in the 2009 study. This categorization was based on a two-step cluster analyses described by Brennan et al. (1998) using the Avoidance and Anxiety scores. Clustering in a general population sample (Conradi et al., 2006) resulted in Fisher linear discriminant functions that yielded population-based norms with which we categorized patients from the current sample into one of four styles, i.e. Secure (low Anxiety and Avoidance), Preoccupied (high Anxiety and low Avoidance), Dismissing-avoidant (low Anxiety and high Avoidance), and Fearful-avoidant (high Anxiety and Avoidance). Favorable psychometric properties in multiple samples have been observed in support of validity and reliability of the Dutch ECR (Conradi et al., 2006). All patients reported having had one or more present or past romantic relationship(s), and were therefore deemed able to meaningfully complete the questionnaire.

To obtain more insight in the extent of the (interpersonal) problems of the attachment groups, we concurrently administered several additional questionnaires. *Loneliness* was measured with the 11 items of the *Loneliness scale* (De Jong Gierveld and Kamphuis, 1985). Cronbach's α was 0.89 in the current study. *Relational dysfunctioning* was assessed with the *Marital Functioning* subscale of the *Maudsley Marital Questionnaire* (MMQ; Arrindell et al., 1983) consisting of 10 items (α = 0.92). Finally, *locus of control* was measured with the *Mastery scale* (Pearlin and Schooler, 1978) consisting of 7 items (α = 0.82).

2.2.2. Outcome instruments

The same outcome measures were elected as in our previous short-term course study (Conradi and de Jonge, 2009), as the current study was developed as its long-term follow-up. Outcomes regarding the seven-year follow-up were retrospectively assessed, seven years after administration of the ECR, by means of two face-to-face interviews at the patient's home. First, the depression section of the lifetime *Composite International Diagnostic Interview* (CIDI Auto 2.1; WHO, 1997; Ter Smitten et al., 1998), a widely used structured interview for the